

Oversight Commission

William E. Sopko, Chairman
President,
STAMCO Industries
representing state-fund employers

Thomas H. Bainbridge, Jr.
Partner,
Ward, Kaps, Bainbridge,
Maurer & Meivan
representing injured workers

William A. Burga
President,
Ohio AFL-CIO
representing organized labor

Mary Beth Carroll
Vice President,
FirstEnergy
representing self-insured employers

Michael C. Koettters
Retired Chief Investment Officer,
Wellpoint, Inc.
representing the public

Denise M. Farkas, CFA
Senior Vice President,
Spero Smith Investment Advisers
representing investments

Edwin McCusland, CFA
President,
Investment Perspectives, LLC
representing investments

2 hour meeting

Agenda

May 25, 2006
William Green Building, Second Floor, Room 3
11 a.m.

- Approval of previous meeting minutes William Sopko
- Approval of April 24 Mercer educational session minutes
..... William Sopko
- Chairman's comments William Sopko
- Administrator's comments Bill Mabe
- CFO financial statement review Tracy Valentino
- Audit committee update Denise Farkas
- Investment committee update Mike Koettters
- Wilshire quarterly portfolio performance review
 Mike Koettters and Mark Brubaker

Rules

1. SB 7 Rules: \$5K medical only program (4123-17-59 OAC), first consideration, possible vote Tom Sico
2. SB 7 Rules: Continuing jurisdiction (4123-6-23 & 4123-07-01 OAC), first consideration Tom Sico
3. SB 7 Rules: Provider fraud/MCO rule (4123-6-02.51 OAC), first consideration Tom Sico
4. Provider credentialing rules (4123.6.02.2; 4123-6-02.21 [to be rescinded]; 4123-6-02.9 OAC), first consideration Dr. Greg Jewell
5. Hospital in-patient reimbursement (4123-6-03.71 OAC), first consideration Dr. Greg Jewell
6. Payment for medical supplies (4123-6-25, 4123-7-03 OAC), first consideration Dr. Greg Jewell
7. Self Insured five-year rule review, second consideration, possible vote David Boyd

Public Companies
Oversight
 Commission

William E. Sopko, Chairman
 President,
 BAWCO Industries
 representing steel mill employees

Thomas H. Bainbridge, Jr.
 Partner
 Ward, Kass, Bainbridge
 Maurer & Mohr
 representing health care

William A. Burga
 President,
 Ohio AFJ-CIO
 representing public employees

Mary Beth Carroll
 Vice President,
 FirstEnergy
 representing utility employees

Michael C. Koettler
 Retired Chief Investment Officer
 Wellington, Inc.
 representing mutual funds

Danise M. Farkas, CFA
 Senior Vice President,
 Commonwealth Investment Advisors
 representing investors

Edwin McCausland, CFA
 President,
 Investment Perspectives, LLC
 representing investors

Agenda
 May 25, 2006
 William Green Building, Level 2, Room 3
 11 a.m.

Continued

Rates

1. Coal Workers' Pneumoconiosis Fund, first consideration,
 possible vote..... Tracy Valentino and Liz Bravender
2. Marine Industry Rates, first consideration, possible vote
 Tracy Valentino and Liz Bravender
3. Disabled Workers' Relief Fund 1 & 2, first consideration,
 possible vote Tracy Valentino and Liz Bravender

Old business

Agenda 06 update Bill Mabe

New business

1. No Lift Loan Program fund allocation, first consideration,
 possible vote Tracy Valentino and Carol Morrison
2. Confirmation of CIO Bill Mabe

Adjourn William Sopko

The next WCOC meeting is scheduled for:
 June 16 2006
 William Green Building, Level 2, Room 3
 11:00 A.M.

Business Continuity Plan Overview

The original BWC Business Continuity Plan was developed in response to the Governor's mandate for continuity of operations. The governor required every state agency to institute a plan for addressing possible disruptions of operations caused by Y2K. Later, fall out surrounding 911 required additional contingencies be considered.

The plan evolved into a document that outlines our agency's response to varying levels of business interruptions, from small, localized occurrences to state, regional and even national impacts.

The plan followed the DAS guidelines, which required that each agency list:

- Critical functions
- Essential staff to maintain critical functions
- Detailed step by step instructions on responses to possible business disruptions
- Recovery plans to enable the return to normal business operations following a disruption

The current document is a staggering 500+ pages and details every business process and the individuals and departments responsible for the processes.

The plan is in the process of being streamlined and updated to make it a living document. Essential staff and critical functions are being updated; new business processes are being added to the plan. For example, Pandemic Influenza response is a new threat to business continuity and the results of this planning will dovetail into the new plan.

The newly revised Business Continuity Plan will enhance our agency's ability to respond to many different operational disruptions. While no plan is foolproof, the more we plan and practice responses to business interruption scenarios, the more prepared we will be in an actual emergency.

Web Disaster Recovery

The use of BWC's web site, known as Dolphin, has grown significantly since its inception in October 2000. More than 12 million requests were processed through the site in February of this year. Dolphin has become an integral component for interaction with our customers.

BWC has maintained an active IT disaster recovery program for its core applications, such as the V3 claims management system, WCIS employer system and the Rates and Payment systems. Because of the increased reliance by our customers, a disaster recovery initiative is being undertaken for BWC's web site. We want to insure that critical components of the web site can be made available within prescribed timeframes should a significant event disrupt our computer facility.

One of the most significant aspects of the project is to select a location to act as the computer hot site in the event that BWC's computer facility is significantly impacted by some event. Two avenues are being pursued. We are working in conjunction with the State Office of Information Technology (OIT) to determine if there is enough synergy that BWC could share the same site. We will also be exploring the use of the State of Ohio Computer Center (SOC) for this purpose.

The scope of the project has been defined and the preliminary requirements have been identified. Based upon these requirements, it is estimated that the initial project costs will be \$5M, including the lease of space, hardware, software, network and consulting services needed to get the site operational.

It is estimated that the project will be completed by June 30, 2007.

Executive Summary
Chapter 4123-6: Health Partnership Program
Chapter 4123-7: Payments to Health Care Providers

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers. Chapter 4123-7 of the Administrative Code contains BWC medical rules for self-insuring employers.

BWC enacted the bulk of the Chapter 4123-6 HPP medical rules (Ohio Administrative Code 4123-6-20 to 4123-6-46) in January and February 1997, and the bulk of the Chapter 4123-7 rules in January 1978. Ohio Administrative Code 4123-6-25 and 4123-7-03, which deal with payment for medical services and supplies, are being updated to reflect statutory and policy changes.

This rule proposal contains 1 Chapter 4123-6 rule which BWC recommends amending, and 1 Chapter 4123-7 rule BWC recommends rescinding and replacing with a new rule.

Amended rule:

4123-6-25 Payment for medical services and supplies.

The proposed changes to Paragraph (A) of the rule provide that payment for services rendered to a claimant shall be paid to a health care provider only when (1) The provider has certified the fee bill and (2) The provider has either rendered or directly supervised the examination, treatment, evaluation or any other medically necessary and related services provided to the claimant. The changes also state that by submitting any fee bill to the bureau, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by the rule.

Proposed changes to what shall now be Paragraph (C) of the rule specify that practitioners are required to use the most current edition of the health care financing administration's common procedure coding system (HCPCS) to indicate the procedure or service rendered to injured workers, that inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes, and that outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual. Several other minor changes are also made.

Rescind/Replace rules:

4123-7-03 Criteria used for the determination of the amount to be paid for medical services rendered by licensed practitioners.

4123-7-03 Payment for medical supplies and services.

The existing Chapter 7 rule, unchanged since 1978, is being rescinded and replaced with a new Chapter 7 rule that "mirrors" the changes to the corresponding Chapter 6 rule, so that the medical services provided to state-fund and self-insuring injured workers are equivalent.

4123-6-25 Payment for medical supplies and services.

(A) Medical supplies and services will be considered for payment when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider ~~physically examines or treats the claimant, has either renders or directly supervises treatment, and certifies the fee bill filed delivered, rendered or directly supervised the examination, treatment, evaluation or any other medically necessary and related services provided to the claimant. By submitting any fee bill to the bureau, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by this rule.~~

~~(B)~~ Services rendered by a health care ~~provider~~ providers ~~is~~ are subject to review for coding requirements outlined in paragraph ~~(B)(C)~~ of this rule. Payments to a health care ~~provider~~ providers may be adjusted based upon these guidelines.

~~(B)(C)~~ Coding systems.

(1) Billing codes.

(a) ~~Providers~~ Practitioners are required to use the most current edition of the health care financing administration's common procedure coding system (HCPCS) to indicate the procedure or service rendered to ~~the injured worker~~ workers. ~~Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes. Outpatient medication services must be billed using the national drug coding (NDC) system.~~

(b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes.

(c) Outpatient medication services must be billed using the national drug coding (NDC) system pursuant to the requirements described in the bureau's provider billing and reimbursement manual.

~~(b)(d)~~ To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, ~~or~~ QHP or self-insuring employer.

(2) ICD-9 diagnosis codes.

Providers must use the most current edition of the "International Classification of Diseases, clinical modification" to indicate diagnoses.

~~(C)(D)~~ Prior to services being delivered, the provider must make reasonable effort to notify the ~~injured worker claimant~~, bureau, MCO, ~~or~~ QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is ~~noncovered~~ non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insuring employer for services that are not related to the claimed or allowed condition(s) related to the industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the ~~injured worker~~ claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

* * * **TO BE RESCINDED** * * *

~~**4123-7-03 — Criteria used for the determination of the amount to be paid for medical services rendered by licensed practitioners.**~~

~~Payment for professional services rendered by licensed practitioners in claims other than self-insuring employers' claims will be the usual, customary and reasonable fee charged for like services in the area in which the services are provided, as determined by the industrial commission's medical section through accumulation and merging of data with other health care insurance systems and with professional associations. "Licensed practitioners", as used in this rule, includes, but is not limited to, physicians, dentists, chiropractors, mechanotherapists, physiotherapists, neurologists, podiatrists and optometrists, duly authorized to practice within their respective fields. Fee ranges applicable to services rendered shall thus be established to serve as guidelines in everyday processing of fee bills by the bureau. Fees outside the allowable range shall be submitted to the industrial commission's medical section for evaluation. Fee ranges shall be at least annually reviewed by the industrial commission's medical section for such changes as may be indicated. In self-insuring employers' claims, payment for professional services rendered by licensed practitioners must amount to at least the usual, customary and reasonable fee, as outlined in this rule.~~

4123-7-03 Payment for medical supplies and services.

(A) Medical supplies and services will be considered for payment by a self-insuring employer when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider has either delivered, rendered or directly supervised the examination, treatment, evaluation or any other medically necessary and related services provided to the claimant. By submitting any fee bill to a self-insuring employer, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by this rule.

(B) Services rendered by health care providers are subject to review for coding requirements outlined in paragraph (C) of this rule. Payments to health care providers may be adjusted based upon these guidelines.

(C) Coding systems.

(1) Billing codes.

(a) Practitioners are required to use the most current edition of the health care financing administration's common procedure coding system (HCPCS) to indicate the procedure or service rendered to injured workers.

(b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes.

(c) Outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual.

(d) To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, QHP or self-insuring employer.

(2) ICD-9 diagnosis codes.

Providers must use the most current edition of the "International Classification of Diseases, clinical modification" to indicate diagnoses.

(D) Prior to services being delivered, the provider must make reasonable effort to notify the claimant, bureau, MCO, QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insuring employer for services that are not related to the claimed or allowed condition(s) related to the industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

Executive Summary

Proposed HPP Hospital Inpatient Services Payment Rule

Background

The Health Partnership Program (HPP) rules were first promulgated in 1996 prior to the implementation of the HPP in 1997. Subsequently, HPP rules establishing criteria for the payment of various specific medical services were adopted in February 1997.

Ohio Administrative Code 4123-6-37 provides general criteria for the payment of inpatient and outpatient hospital services under the HPP. Proposed new rule OAC 4123-6-37.1 would provide specific methodology for the payment of inpatient hospital services.

Proposed rule:

4123-6-37.1 Payment of hospital inpatient services.

The proposed rule provides that, except for outliers, BWC fees for hospital inpatient services shall be equal to one hundred fifteen percent (115%) of the applicable diagnosis related group (DRG) reimbursement rate for the hospital inpatient service under the Medicare program.

For hospitals with a reported cost-to-charge ratio, outliers are defined as hospital inpatient stays in which the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio is more than two standard deviations above the applicable medicare DRG value, and the rule provides that reimbursement for outliers shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio, not to exceed sixty percent (60%) of the hospital's allowable billed charges;

For hospitals without a reported cost-to-charge ratio, outliers are defined as hospital inpatient stays in which sixty percent (60%) of the hospital's allowable billed charges is more than two standard deviations above the applicable medicare DRG value, and the rule provides that reimbursement for outliers shall be equal to sixty percent (60%) of the hospital's allowable billed charges.

4123-6-37.1 Payment of hospital inpatient services.

(A) Reimbursement for hospital inpatient services, excluding outliers as defined in paragraph (B) of this rule, shall be equal to one hundred fifteen percent (115%) of the applicable diagnosis related group (DRG) reimbursement rate for the hospital inpatient service under the medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395 as amended.

(B) Reimbursement for outliers shall be determined as follows:

(1) For hospitals with a reported cost-to-charge ratio, outliers shall be defined as hospital inpatient stays in which the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio, not to exceed sixty percent (60%) of the hospital's allowable billed charges;

(2) For hospitals without a reported cost-to-charge ratio, outliers shall be defined as hospital inpatient stays in which sixty percent (60%) of the hospital's allowable billed charges is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to sixty percent (60%) of the hospital's allowable billed charges.

Bureau of Workers' Compensation
2004 Oversight Commission Annual Report

Pursuant to O.R.C. 4121.12 (F)(2) the Oversight Commission shall issue an annual report on the cost and quality objectives of the Ohio Bureau of Workers' Compensation (BWC). This document details the voting actions of the Workers' Compensation Oversight Commission during 2004.

The nine-member Oversight Commission (OC) met 9 times throughout 2004 for public meetings to provide advice and consent to Administrator/Chief Executive Officer James Conrad on various BWC rules, policy resolutions, investment fund policy oversight, premium rates and administrative rates.

The WCOC was formed to serve the customers of Ohio's workers' compensation system, injured workers and employers. In addition the WCOC represents the views of its stakeholders, i.e. providers, labor - both union and non-union, and business, both small and large, throughout BWC's yearly business cycle. The nine-member commission comprises five voting members, including the chairperson, who are appointed by the governor. The ranking majority and minority members of the Ohio House Commerce and Labor Committee and Ohio Senate Insurance, Commerce and Labor Committee provide non-voting guidance.

The Oversight Commission represented all of BWC's stakeholder viewpoints on premium rates, investment policies, managed-care initiatives and policies impacting the handling of claims and employer's experiences. In addition, Commission members provided suggestions on communication to:

- Injured workers' rules on claim management;
- Public, private and self-insuring employers on premium rates and administrative assessments;
- The medical community on billing fee schedules and Health Partnership Program (managed care) updates.

Investments

The market value of the State Insurance Fund (Fund) grew by 2.72 percent during calendar year 2004 to a value of approximately \$14.4 billion. The overall rate of return on Fund assets for the year was 8.52%, exceeding the performance benchmark for the fund of 7.61% by 91 basis points. The asset allocation strategy for the Fund saw a slight shift away from fixed income into domestic equity, international equity and private equity. At year-end 2004, bonds and short-term cash represented approximately 48.5% of the Fund, domestic stocks made up 35.5%, international equity 14.0% and private equity 2.0%.

At year-end, BWC had 93 Ohio-qualified and minority brokers approved to conduct business for the Fund. BWC utilized the services of 25 Ohio-qualified brokers and 24 minority brokers. In addition, BWC employed a relatively large number of external investment managers. At year-end there were 52 domestic equity investment managers, 20 fixed income managers, 9 international equity managers and had funded 56 private equity firms and/or partnerships representing 70 distinct funds.

At the April 22, 2004 meeting, Resolution 04-08 added the names of private equity managers that were recommended per the Request for Proposal related to the Third Frontier & Minority Manager initiative.

Throughout the course of the year, BWC Investments dismissed two (2) domestic equity managers, one (1) fixed income manager, and one (1) international equity manager.

At the May 20, 2004 meeting, Resolution 04-12 added three Ohio-qualified brokers to the Approved List.

At the August 19, 2004 meeting, Resolution 04-25 was approved changing the asset allocation target in the Statement of Investment Policy & Guidelines to 38% for equities, 54% for fixed-income and 8% for alternative investments.

Premium Rates

The Oversight Commission reviewed and approved aggregate premium rate levels for private and public employers and state agencies, as recommended by the Administrator. The Oversight Commission approved the subsequent rules necessary for filing the rates. Private employer rates on average are 32% lower than those for 1995.

Listed below are the percentages of rate changes compared to the prior year’s rates for each sector of employers:

Type of Employer	Rate Change	Effective Date
Private Employer Rates	2% Increase	7/1/2004
Public Employer Taxing Districts	2% Increase	1/1/2005
Public Employer State Agencies	10% Increase	7/1/2004
Marine Industry Fund	No Change	7/1/2004
Coal Workers’ Pneumoconiosis Fund	No Change	7/1/2004

Additionally, the commission supported resolutions giving a 20% dividend to be credited to qualified private employers for the July 1, 2004, through June 30, 2004, reporting period. This dividend reduced the premium obligations of these employers by approximately \$170 million. The commission also approved a 20% dividend to qualified private employers for the July 1, 2004 through December 31, 2004 reporting period. This dividend reduced private employer

premium obligations by about \$176 million. A 20% dividend was also credited to qualified public employer taxing districts for the January 1, 2004, through December 31, 2004, reporting period. This dividend reduced premium obligations for these employers by approximately \$61 million. At the conclusion of the dividend process, the commission ensured that the State Insurance Fund balance would still be reflective of a balance above required levels.

The Oversight Commission reviewed and accepted BWC's audited financial statements for the 2004 fiscal year as presented by external auditors, KPMG Peat Marwick. The result of the audit was unqualified opinion, which reflects no material issues involving the accuracy, integrity and procedural propriety of BWC financial data, statements, analysis and/or compliance.

Resolution and Rule Activity

In 2004, there were a total of 34 resolutions acted upon by the Oversight Commission.

Issue	Resolutions	Rules Involved
Rate Recommendations/rates	9	9
Rate Programs	4	6
HPP/medical	3	3
Claims/SI Employers	3	3
Investments	3	0
Reduction of future premiums	3	0
Five year rule review:		
Claims Procedures	1	5
HPP, QHP	3	103
Self-insured medical	2	36
BWC Organization	1	15
Safety	1	2
Rating rules	1	8
Total	34	190

Conclusion

In 2004 the Oversight Commission saw Mr. Burga's reappointment for 5 more years as a voting member. Mr. Burga's term extended from September 1st, 2004 to September 1st, 2009.

**Premium Rates
Coal Workers' Pneumoconiosis Fund,
Marine Insurance Fund, Disabled Workers' Relief Fund**

WCOC Summary

Coal Workers' Pneumoconiosis Fund (CWPF)

Policy Year: 7-1-2006 through 6-30-2007

Rate Method: Calculate and apply premium rates designed to provide premiums to equal the cost of all coal mining lung related occupational diseases that have injury dates during the policy year. Attached is a table showing the rate changes over the past several years and a copy of Rule 4123-17-20. The Administrator has been provided information from which to make a rate recommendation. The current rates will apply to new employers to the fund. A moratorium on premium collections will continue for all employers that subscribed prior to May 15, 1998 to the fund.

The CWPF provides benefits for workers under the Federal Coal Mine Health and Safety Act of 1969. The federal government sets benefit levels and determines claim eligibility for benefits. New regulations of the U.S. Department of Labor liberalizing benefits under the Black Lung Benefits Act were effective January 19, 2001. The CWPF provides voluntary coverage (employers may choose to purchase the insurance from BWC, from a private carrier, or self insure) to employers who have employee exposure to coal dust, as required by federal law. BWC collected about \$824,000 in premiums last year to support this fund.

Rate Rule Process:

- Administrator of Ohio Bureau of Workers' Compensation recommends to the Workers' Compensation Oversight Commission an overall rate change
- Workers' Compensation Oversight Commission provides advice and consent to the overall rate change by resolution
- Administrator provides specific rules that are necessary to implement the approved rate change (Rule 4123-17-20) at the May 2006 WCOC meeting
- Rules are filed with Legislative Services Commission and Secretary of State by June 20, 2006
- Rates become effective July 1, 2006

Coal-Workers Pneumoconiosis (Black Lung) Fund Rate History

7-1-74	Rates: Manual 1112 - \$6.30 Manual 1115 - \$3.68
7-1-75	No Change
7-1-76	No Change
7-1-77	No Change
7-1-78	No Change
7-1-79	No Change
7-1-80	No Change; Administrative Cost now included as a part of the base rate
7-1-81	30% increase
7-1-82	30% increase; Manual 1116 was added
7-1-83	30% decrease for Manual 1115 and Manual 1116 only
7-1-84	30% decrease for Manual 1115 and Manual 1116 only
7-1-85	30% decrease
7-1-86	30% decrease
7-1-87	30% decrease
7-1-88	No Change
7-1-89	No Change
7-1-90	30% decrease
7-1-91	30% decrease
7-1-92	No Change
7-1-93	No Change
7-1-94	No Change
7-1-95	No Change
7-1-96	No Change
7-1-97	10% decrease
7-1-98	No Change
7-1-99	No Change
7-1-2000	No Change
7-1-2001	Rates: Manual 1112 - \$3.70 Manual 1115 - \$1.07 Manual 1116 - \$0.83
7-1-2002	No Change
7-1-2003	No Change
7-1-2004	No Change
7-1-2005	No Change

4123-17-20 EMPLOYER CONTRIBUTION TO THE COALWORKERS PNEUMOCONIOSIS FUND

4123-17-20 Employer contribution to the Coal-Workers Pneumoconiosis (Black Lung) Fund eff. 07/01/01. The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to establish contributions made to the coal-workers pneumoconiosis fund by employers pursuant to sections 4121.121 and 4131.04 of the Revised Code. The administrator hereby sets the premium rates per one hundred dollar unit of payroll to be effective July 1, 2001, as indicated in attached Appendix A. Note: the above premium rates shall only apply to employers who newly subscribe to the coal-workers pneumoconiosis fund on or after May 15, 1999. The bureau shall institute a moratorium on premium collections from all employers who were subscribers to the coal-workers pneumoconiosis fund prior to May 15, 1999, and who remain subscribers to the fund.

Appendix A

Coal-Workers Pneumoconiosis Fund Rates

Effective July 1, 2001

Rates are for each \$100 unit of payroll

NCCI Manual Code	Manual Rate
1112	\$3.70
1115	1.07
1116	0.83

NOTE: The above premium rates shall apply only to employers who newly subscribe to the coal-workers pneumoconiosis fund on or after May 15, 1999. The bureau shall institute a moratorium on premium collections from all employers who were subscribers to the coal workers pneumoconiosis fund prior to May 15, 1999, and who remain subscribers to the fund.

Ohio's underwriting coverage of these manuals is subject to approval by the Federal Government.

Marine Industry Fund (MIF)

Policy Year: 7-1-2006 through 6-30-2007

Rate Method: Calculate and apply premium rates designed to provide premiums to equal the cost of all injury/occupational diseases that have injury dates during the policy year. Attached is a table showing the rate changes over the past several years and a copy of Rule 4123-17-19. The Administrator has been provided information from which to make a rate recommendation.

Rate Rule Process:

- Administrator of Ohio Bureau of Workers' Compensation recommends to the Workers' Compensation Oversight Commission an overall rate change
- Workers' Compensation Oversight Commission provides advice and consent to the overall rate recommendation by resolution
- Administrator provides specific rules that are necessary to implement the approved rate change (Rule 4123-17-19) at the May 2006 WCOC meeting
- Rules are filed with Legislative Services Commission and Secretary of State by June 20, 2006
- Rates become effective July 1, 2006

Marine Industry Fund Rate History

7-1-80	Inception of the Marine Industry Fund with the creation of Manuals 9705, 9711, 9719, 9725 and 9741
1-1-81	Manuals 9702 and 9740 were added
7-1-81	No Change
7-1-82	30% increase All Marine Industry Fund risks must have Manual 7772 in the Ohio State Insurance Fund
7-1-83	30% increase
7-1-84	No Change
7-1-85	No Change
7-1-86	No Change
7-1-87	No Change
7-1-88	No Change
7-1-89	No Change
7-1-90	No Change
7-1-91	No Change
7-1-92	No Change
7-1-93	No Change
7-1-94	No Change
7-1-95	No Change
7-1-96	No Change
7-1-97	10% decrease
7-1-98	No Change
7-1-99	No Change
7-1-2000	No Change
7-1-2001	No Change
7-1-2002	No Change
7-1-2003	No Change
7-1-2004	No Change
7-1-2005	12% decrease

4123-17-19 Employer contribution to the marine industry fund

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to establish contributions made to the marine industry fund by employers pursuant to sections 4121.121 and 4131.14 of the Revised Code. The administrator hereby sets the premium rates per one hundred dollar unit of payroll to be effective July 1, 2005 as indicated in attached Appendix A.

To Be Reenacted

Appendix A

Rates are for each \$100 unit of payroll

<u>NCCI Manual Code</u>	<u>Manual Rate</u>
6802	\$18.57
6847	\$35.62
7310	\$17.22
7325	\$46.68
7330	\$18.57
8707	\$46.68
8708	\$11.87

Ohio's underwriting coverage of these manuals is subject to approval by the Federal Government.

Disabled Workers' Relief Fund (DWRF 1 & 2)

Policy Year: 7-1-2006 through 6-30-2007

Rate Method: Calculate and apply assessment rates designed to provide premiums to equal the cost paid during the policy year. Attached is a table showing the rate changes over the past several years and a copy of the Rule 4123-17-29. DWRF 1 for Private Employers is at the legislative maximum of \$0.10 per \$100 payroll. The DWRF 1 rate for the policy year 1-1-2005 Public Employer Taxing Districts was \$0.08 per \$100 payroll. The DWRF 1 rate for the policy year 7-1-2005 Public Employer State Agencies was \$0.06 per \$100 payroll. The DWRF 1 rate was first changed from the maximum for both the Public Employers and for the Public Employer State Agencies two years ago. A subsidy from the OSIF may be used to pay costs not covered by the assessments. DWRF 2 is at the level of 0.1% of premium at base rate. This fund has a significant positive balance that can be used to pay current claim obligations.

Rate Rule Process:

- Administrator of Bureau of Workers' Compensation recommends to the Workers' Compensation Oversight Commission an overall rate change
- Workers' Compensation Oversight Commission provides advice and consent to the overall rate recommendation by resolution
- Administrator provides specific rules that are necessary to implement the approved rate change (Rule 4123-17-29) at the May 2006 WCOC meeting
- Rules are filed with Legislative Services Commission and Secretary of State by June 20, 2006
- Rates become effective July 1, 2006 for Private Employers and Public Employer State Agencies and January 1, 2006 for Public Employer Taxing Districts

Disabled Workers' Relief Fund -- History--Assessment

For Injuries Prior to 1-1-87 (DWRF 1)

EMPLOYER GROUP			
Private Fund:	1959 to 1975	.03	Per \$100 Unit of Payroll
	1976 to 6-30-80	.05	
	7-1-80 to 6-30-2005	.10	
Self-Insured:	1959 to 1975	.03	Per \$100 Unit of Payroll
	1976 to 6-30-80	.05	
	7-1-80 to 6-30-81	.08	
	7-1-81 to 8-21-86	.05	
	8-22-86*		
*Effective 8-22-86 self-insured employers must reimburse the Bureau of Workers' Compensation for DWRF benefits paid to claimants in claims which the employer was the employer of record.			
Public Employer Taxing Districts	1959 to 1975	.03	Per \$100 Unit of Payroll
	1976 to 1979	.05	
	1980 to 2003	.10	
	1-1-2004 to 12-31-2004	.09	
	1-1-2005 to 12-31-2005	.08	
Public Employer State Agencies	1959 to 1975	.03	Per \$100 Unit of Payroll
	1976 to 6-30-1980	.05	
	7-1-1980 to 6-30-2004	.10	
	7-1-2004 to 6-30-2005	.08	
	7-1-2005 to 6-30-2006	.06	

Disabled Workers' Relief Fund -- History--Assessment

For Injuries On and After 1-1-87 (DWRF 2)

EMPLOYER GROUP	PERIOD	PERCENT OF PREMIUM COMPUTED AT BASE RATE
Private Employers:	1-1-87 to 12-31-87	2%
	1-1-88 to 12-31-88	3%
	1-1-89 to 12-31-89	4%
	1-1-90 to 12-31-90	5%
	1-1-91 to 12-31-91	5%
	1-1-92 to 06-30-93	5%
	7-1-93 to 12-31-2005	.1%
Self-Insured:		
	Reimburse the Bureau of Workers' Compensation for DWRF benefits to claimants in claims in which the employer is the employer of record.	
Public Employer Taxing Districts:		
	1-1-87 to 12-31-87	2%
	1-1-88 to 12-31-88	3%
	1-1-89 to 12-31-89	4%
	1-1-90 to 12-31-90	5%
	1-1-91 to 12-31-91	5%
	1-1-92 to 12-31-92	5%
	1-1-93 to 12-31-2005	.1%
Public Employer State Agencies:		
	1-1-87 to 12-31-87	2%
	1-1-88 to 12-31-88	3%
	1-1-89 to 12-31-89	4%
	1-1-90 to 12-31-90	5%
	1-1-91 to 12-31-91	5%
	1-1-92 to 06-30-93	5%
	7-1-93 to 12-31-2005	.1%

Disabled workers' relief fund; employers' assessments and self-insurers' payments.**(A) State fund employers.**

(1) In order to make disabled workers' relief fund ("DWRF") payments to claimants having dates of injury or disability prior to January 1, 1987, assessments shall be levied in the following manner for so long as payments to such claimants are required:

- (a) Private state fund employers: ten cents per one-hundred-dollar unit of payroll, effective January 1, 1980;
- (b) Public employer taxing districts: eight cents per one-hundred-dollar unit of payroll, effective January 1, 2005;
- (c) Public employer state agency: six cents per one-hundred-dollar unit of payroll, effective July 1, 2005.

These assessments shall be billed at the same time state insurance fund premiums are billed and payments shall be credited to the disabled workers' relief fund.

(2) In order to make DWRF payments to claimants having dates of injury on or after January 1, 1987, assessments shall be levied in the following manner for so long as payments to such claimants are required:

- (a) Private state fund employers: one-tenth of one per cent of premium, computed at basic rate, effective July 1, 1993;
- (b) Public employer taxing districts: one-tenth of one per cent of premium, computed at basic rate, effective January 1, 1993;
- (c) Public employer state agency: one-tenth of one per cent of premium, computed at basic rate, effective July 1, 1993;

These assessments shall be billed at the same time state insurance fund premiums are billed and payments shall be credited to the disabled workers' relief fund.

(B) Self-insuring employers.

(1) Each self-insuring employer shall reimburse the bureau for DWRF payments made in claims in which it is the employer of record, without regard to the date the employer was granted the privilege to pay compensation directly, for all DWRF payments made on or after August 22, 1986. Upon default and a finding of noncompliance by the administrator of workers' compensation, reimbursement shall be made from the self-insuring employers' guaranty fund.

(2) Self-insuring employers shall be billed on a semi-annual basis for the DWRF payments made pursuant to this rule.

Executive Summary

HPP Provider Certification Rule Changes

Background

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules pertaining to the credentialing of providers to participate in the HPP.

The HPP provider credentialing rules were first promulgated in 1996, prior to the implementation of the HPP in 1997. The rules were amended in 2002 to more specifically spell out the provider recertification and recertification process, make both the initial certification and recertification process a one-step process, add specific minimum criteria for certification of non-CARF accredited chronic pain management programs, and address inappropriate marketing of injured workers by certified providers.

The proposed rule changes add several quality-oriented criteria to the provider certification criteria, and rescind the non-CARF accredited chronic pain program certification criteria rule and replace it with a rule regarding enrollment of eligible non-certified providers and non-provider types to receive payment for goods and services rendered to injured workers.

The proposed rule changes also add a new rule that would allow BWC to decertify (or refuse to certify or recertify) providers or MCOs who are owned by (more than 5%) or who have one or more officers, directors, partners, members, or managing employees who have a felony conviction, etc., and to terminate any agreement with and cease reimbursement to a person, provider, managed care organization, or owner as provided by to newly-enacted Ohio Revised Code section 4121.444.

Finally, the proposed rule changes add a provider solicitation “anti-kickback” provision to the current BWC certified provider marketing rule.

Proposed rules:

4123-6-02.2 Provider access to the HPP - provider credentialing criteria.

The proposed rule changes add several new credentialing criteria, specifying that the provider must:

- Be currently licensed to practice without disciplinary restrictions that are related to chemical dependency or substance abuse.
- Not have a history of court supervised intervention or treatment in lieu of conviction pursuant to section 2951.041 of the Revised Code or the equivalent law of another state.
- Provide proof of and maintain adequate, current professional malpractice and liability insurance, as determined by the bureau.
- Provide proof of and maintain workers' compensation coverage to the extent required under Ohio law or the equivalent law of another state, as applicable.
- Not have been excluded or removed from participation in other health plans for cause, or have lost hospital privileges for cause.
- Not have a pattern or practice (three or more documented instances) of failing to comply with bureau administrative procedures and requirements as set forth in the bureau's provider billing and reimbursement manual, including but not limited to submission of retroactive medical

treatment reimbursement requests, without just cause, for services which require prior authorization.

- Not have a pattern or practice (three or more documented instances) of failing to comply with vocational rehabilitation case management procedures and requirements as set forth in the bureau's provider billing and reimbursement manual, including but not limited to submission of initial rehabilitation plan more than forty five (45) calendar days from date of case manager assignment without just cause.
- Not have a pattern or practice (three or more documented instances) of failing to submit medical documentation, upon request, as required by rule 4123-6-20 of the Administrative Code and the bureau's provider billing and reimbursement manual.
- Not have a pattern or practice (three or more documented instances) of submitting medical bills that demonstrate inappropriate coding, or are abusive or violate the coding procedures and requirements set forth in the bureau's provider billing and reimbursement manual (including but not limited to such practices as upcoding and/or unbundling), and that, if relied upon by the bureau, MCO, QHP or self-insuring employer, have the potential of improperly increasing the provider's reimbursement.

The proposed rule also adds a training requirement for vocational rehabilitation case managers and interns, clarifies that only CARF accredited programs shall be eligible for certification, changes several references from "Medicare certification" to "Medicare participation" and the "Health Care Financing Administration (HCFA)" to the "Centers for Medicare & Medicaid Services (CMS)" to reflect changes in terminology, and makes additional minor changes.

4123-6-02.21 Provider access to the HPP - chronic pain program requirements.

4123-6-02.21 Provider access to the HPP – non-certified provider enrollment.

Current Ohio Administrative Code rule 4123-6-022.1, dealing with certification requirements for non-CARF accredited chronic pain programs, is being rescinded (only CARF accredited programs shall be eligible for certification), and is being replaced with a rule allowing BWC to enroll non-BWC certified providers who are eligible for payment, and persons or entities who do not fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code, to receive payment for goods and services rendered to injured workers.

The proposed rule changes also provide that persons or entities who do not fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code are not eligible for certification as providers in the HPP, that the certification of any such persons or entities who were certified prior to the effective date of the new rule shall expire on a schedule determined by the bureau, that expiration of their provider certification pursuant to the rule does not constitute an adjudication order and is not subject to appeal, and that such persons or entities shall not be eligible for recertification as providers in the HPP.

4123-6-02.51 Provider access to the HPP -- Denial of provider, entity or MCO certification based on criminal conviction or outcomes measurement criteria.

The proposed rule changes reflect that the Administrator may decertify (or refuse to certify or recertify) providers or MCOs who are owned by (more than 5%) or who have one or more officers, directors, partners, members, managing employees, etc. who have a felony conviction, a conviction under a federal controlled substance act, a misdemeanor conviction for an act involving dishonesty, fraud, or

misrepresentation or committed in the course of practice, a felony or misdemeanor conviction involving dishonesty, fraud, or misrepresentation related to workers' compensation, or court supervised intervention or treatment in lieu of conviction.

Pursuant to newly-enacted Ohio Revised Code section 4121.444, the proposed rule changes also provide that the Administrator may terminate any agreement between the bureau and a person or a health care provider or managed care organization or its owner and cease reimbursement to that person, provider, organization, or owner if:

- The person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization is convicted of or pleads guilty to a violation of sections 2913.48 (workers' compensation fraud) or 2923.31 to 2923.36 (engaging in a pattern of corrupt activity) of the Revised Code or any other criminal offense related to the delivery of or billing for health care benefits; or
- There is an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization and proof of the specific intent of the person, health care provider, managed care organization, or owner to defraud, in a civil action brought pursuant to newly-enacted Ohio Revised Code section 4121.444; or
- There is an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization in a civil action brought pursuant to sections 2923.31 to 2923.36 of the Revised Code.

The proposed rule changes further provide, pursuant to newly-enacted Ohio Revised Code section 4121.444, that no person, health care provider, or managed care organization that has had its agreement with and reimbursement from the bureau terminated by the Administrator, or an owner, officer, authorized agent, associate, manager, or employee of that person, health care provider, or managed care organization shall either:

- Directly provide services to any other bureau provider or have an ownership interest, as an individual or through any other entity or entities, of five percent or more in a provider of services that furnishes services to any other bureau provider; or
- Arrange for, render, or order services for claimants during the period that the agreement of the person, health care provider, managed care organization, or its owner is terminated as described in newly-enacted Ohio Revised Code section 4121.444.

4123-6-02.9 Provider access to the HPP - provider marketing.

The proposed changes to the rule add a provider solicitation "anti-kickback" provision stating that no bureau certified provider shall pay, allow or give, or offer to pay, allow or give, any consideration, money or other thing of value to an injured worker (including but not limited to free or discounted examinations, treatment or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any goods or services for which payment may be made by the bureau, MCO, QHP or self-insuring employer under Chapters 4121, 4123, 4127 or 4131 of the Revised Code.

4123-6-02.2 Provider access to the HPP - provider credentialing criteria.

(A) The bureau shall establish minimum credentialing criteria for providers to qualify for participation in the HPP. Providers must meet all licensing, certification, or accreditation requirements necessary to provide services in Ohio. A provider licensed, certified or accredited pursuant to the equivalent law of another state shall qualify as a provider under this rule in that state.

(B) The minimum credentials for a provider, where applicable based upon the type of provider, are as follows. The provider shall:

(1) Be currently licensed to practice, as applicable, without disciplinary restrictions that affect the provider's ability to treat patients, or that compromise patient care, or that are related to chemical dependency or substance abuse.

(2) Meet other general certification requirements for the specific provider type, as provided in paragraph (C) of this rule.

(3) Possess a current and unrestricted drug enforcement agency registration, unless it is not required by the provider's discipline and scope of practice.

(4) Be currently eligible for participation in medicare, medicaid or the Ohio workers' compensation system.

(5) Not have a history of a felony conviction in any jurisdiction, a conviction under a federal controlled substance act, a conviction for an act involving dishonesty, fraud, or misrepresentation, a conviction for a misdemeanor committed in the course of practice, or court supervised intervention or treatment in lieu of conviction pursuant to section 2951.041 of the Revised Code or the equivalent law of another state.

(6) Provide proof of and maintain adequate, current professional malpractice and liability insurance. The bureau shall establish the appropriate amount of such insurance coverage for each provider type. In establishing the appropriate amount of insurance coverage for out of state providers, the bureau may consider the regulations or the community standards of the provider's state of practice.

(7) Provide documentation of the provider's malpractice history for the previous five years.

(8) Not have any outstanding provider overpayment or other indebtedness to the bureau which has been certified to the attorney general for collection.

(9) Provide proof of and maintain workers' compensation coverage to the extent required under Ohio law or the equivalent law of another state, as applicable.

(10) Not have been excluded or removed from participation in other health plans for cause, or have lost hospital privileges for cause.

(11) Not have a pattern or practice (three or more documented instances) of failing to comply with bureau administrative procedures and requirements as set forth in the bureau's provider billing and reimbursement manual, including but not limited to submission of retroactive medical treatment reimbursement requests, without just cause, for services which require prior authorization.

(12) Not have a pattern or practice (three or more documented instances) of failing to comply with vocational rehabilitation case management procedures and requirements as set forth in the bureau's provider billing and reimbursement manual, including but not limited to submission of initial rehabilitation

plan more than forty five (45) calendar days from date of case manager assignment without just cause.

(13) Not have a pattern or practice (three or more documented instances) of failing to submit medical documentation, upon request, as required by rule 4123-6-20 of the Administrative Code and the bureau's provider billing and reimbursement manual.

(14) Not have a pattern or practice (three or more documented instances) of submitting medical bills that demonstrate inappropriate coding, or are abusive or violate the coding procedures and requirements set forth in the bureau's provider billing and reimbursement manual (including but not limited to such practices as upcoding and/or unbundling), and that, if relied upon by the bureau, MCO, QHP or self-insuring employer, have the potential of improperly increasing the provider's reimbursement.

(C) The following minimum credentials apply to the providers listed below as provided in this rule.

(1) Air Ambulance, ambulette or air ambulance or, transport operator service: FAA pilot license; air ambulance, treating attendant: certified paramedic with basic life support training license from Ohio medical transportation board if private; Medicare participation if government/public.

(2) Ambulance service: license from state ambulance board or medicare certification Ambulatory surgical center: license from Ohio department of health and medicare participation.

(3) Ambulatory surgical facility: license from Ohio department of health Athletic trainer: license from Ohio occupational therapy, physical therapy, and athletic trainer board.

(4) Athletic trainer: licensed by the Ohio occupational therapy, physical therapy, and athletic trainer board Audiologist: license from Ohio board of speech-language pathology and audiology.

(5) Audiologist: license from state board of speech pathology and audiology; CCC-A certificate of clinical competence in audiology Alcohol and drug counseling clinic: certified by Ohio department of alcohol and drug addiction services to administer outpatient counseling.

(6) Alcohol and drug counseling clinic: certified with the state department of alcohol and drug addiction services to administer outpatient counseling Chiropractor: license from Ohio state chiropractic board.

(7) Dialysis center: license from Ohio department of health and medicare certification participation.

(8) Durable medical equipment supplier, excludes orthotics, prosthetics and pedorthics: state vendors license, medicare certification participation, or joint commission on accreditation of healthcare organization ("JCAHO") accreditation.

(9) Ergonomist: certification for certified professional ergonomist (CPE), certified human factors professional (CHFP), associate ergonomics professional (AEP), associate human factors professional (AHFP), certified ergonomics associate (CEA), certified safety professional (CSP) with "ergonomics specialist" designation, certified industrial ergonomist (CIE), certified industrial hygienist (CIH), assistive technology practitioner (ATP), or rehabilitation engineering technologist (RET).

(10) Hearing aid dealer: license required by state from Ohio hearing aid dealers and fitters licensing board.

(11) Home health agency: medicare certification participation, joint commission on accreditation of healthcare organization (JCAHO) accreditation, or community health accreditation program (CHAP) accreditation.

(12) Hospital: approved by ~~health care financing administration (HCFA)~~ the centers for medicare & medicaid services (CMS) for medicare, title XVIII of the Social Security Act; obtained national accreditation (joint commission on accreditation of healthcare organization (JCAHO), or American osteopathic association (AOA) accreditation, or commission on accreditation of rehabilitation facilities (CARF) for rehabilitation hospitals).

(13) ~~Independent~~ Licensed social worker or licensed independent social worker (LSW) (LISW): ~~licensed by the~~ license from Ohio counselor and social worker board.

(14) Laboratory: valid licensing from clinical laboratory improvement amendment (CLIA); ~~acceptable error rates.~~

(15) Massage therapist: certified by ~~the~~ Ohio state medical board.

(16) Non-physician acupuncturist: certificate of registration from ~~the~~ Ohio state medical board.

(17) Certified registered nurse anesthetist (CRNA): certified by ~~the~~ national council on certification of nurse anesthetists or other certifying agency recognized by the ~~state nursing~~ Ohio board of nursing.

(18) Certified nurse practitioner: certified by ~~the~~ American nurses credentialing center or other certifying agency recognized by the ~~state nursing~~ Ohio board of nursing.

(19) Clinical nurse specialist: certified by ~~the~~ American nurses credentialing center or other certifying agency recognized by the ~~state nursing~~ Ohio board of nursing.

(20) Nursing home: ~~medicaid certification or state~~ license from Ohio department of health.

(21) Occupational therapist: ~~licensed by the~~ license from Ohio occupational therapy, physical therapy, and athletic trainer board.

(22) Optician: ~~licensed by the state~~ license from Ohio optical dispensers board.

(23) Optometrist: ~~must be a doctor of optometry, licensed by the state~~ license from Ohio board of optometry; ~~therapeutic certification to prescribe drugs (if applicable to practice).~~

(24) Orthotist, prosthetist or pedorthist: ~~licensed by the~~ license from Ohio state board of orthotics, prosthetics and pedorthics.

(25) Physical therapist: ~~licensed by~~ license from Ohio occupational therapy, physical therapy, and athletic trainer board.

(26) Physician assistant: certified by ~~the~~ national commission on certification of physician assistants; and certificate of registration from Ohio state medical board.

(27) Physician (M.D. or D.O.): license from Ohio state medical board.

(28) Podiatrist: license from Ohio state medical board.

~~(27)~~ (29) ~~Professional~~ Licensed professional clinical counselor (~~PCC~~) or (LPCC) or licensed professional counselor (LPC): ~~licensed by the~~ license from Ohio counselor and social worker board.

~~(28)~~ (30) ~~Professional counselor (PC) or (LPC)~~: ~~licensed by the Ohio counselor and social worker board~~ Psychologist: license from Ohio state board of psychology .

~~(29)~~ (31) Radiology services: (free-standing) state licensing, registration or accreditation; (mobile) state, county or city registration, or medicare participation or medicaid certification.

~~(30)~~ (32) Residential care/assisted living facility: ~~medicaid certification or state~~ license from Ohio department of health.

~~(34)~~ (33) Social worker (SW) or ~~(LSW)~~: ~~licensed by the~~ license from Ohio counselor and social worker board.

~~(32)~~ (34) Speech pathologist: ~~licensed by the state~~ license from Ohio board of speech pathology and audiology.

~~(33)~~ (35) Traumatic brain injury (TBI) program: CARF accreditation for brain injury services (acute or post-acute).

~~(34)~~ (36) Vocational/~~medical~~ rehabilitation case managers: certification for occupational health nursing (COHN(S)), certified rehabilitation counselor (CRC), ~~or~~ certified disability management specialist (CDMS), certified vocational evaluator (CVE), certified rehabilitation nurse (CRRN), or certified case manager (CCM); must attend one full day BWC sponsored orientation class prior to initial certification (or recertification, for vocational case managers initially certified prior to the effective date of this requirement), and obtain at least twelve (12) hours of BWC sponsored vocational rehabilitation training every two (2) years thereafter.

~~(35)~~ (37) Vocational rehabilitation case management interns:

(a) Vocational rehabilitation case management may be provided by a bureau-certified intern. An intern is a non-credentialed individual who provides vocational case management services and is supervised by a credentialed vocational case manager, as identified in paragraph (C)(34) of this rule.

(b) To become eligible for bureau certification and provide service as an intern, the intern must:

(i) Enroll with the bureau as an intern.

(ii) Qualify to take one of the examinations to become credentialed, as identified in paragraph (C)~~(34)~~ (36) of this rule.

(iii) Attend one full day BWC sponsored orientation class prior to certification, and obtain at least twelve (12) hours of BWC sponsored vocational rehabilitation training every two (2) years thereafter.

(c) Bureau certification of vocational rehabilitation case management interns shall be for a period of four years.

(d) Vocational rehabilitation case management interns may not be recertified for additional four-year periods.

~~(36)~~ (38) Comprehensive pain management services program ~~category one or two~~: CARF accreditation ~~or compliance with rule 4123-6-02.21 of the Administrative Code.~~

~~(37)~~ (39) Occupational rehabilitation programs ~~category one or two~~: CARF accreditation.

* * * TO BE RESCINDED * * *

~~4123-6-02.21—Provider access to the HPP—chronic pain program requirements.~~

~~To be eligible for participation in the HPP as a comprehensive pain management services program category one or two, chronic pain programs must either have CARF accreditation or comply with the following minimum criteria:~~

~~(A) The program must be a multidisciplinary treatment program that addresses physical, psychosocial, medical, vocational and social aspects of chronic pain.~~

~~(B) All components of the program with the exception of aquatic therapy, must be provided at a single facility. This requirement does not in any way limit the approval or provision of non-program services to injured workers participating in chronic pain management programs certified under this rule.~~

~~(C) Staffing requirements:~~

~~(1) The program medical director must:~~

~~(a) Be a bureau certified medical doctor or doctor of osteopathic medicine and surgery who has American Board of Medical Specialties certification or American Osteopathic Association Board certification in one of the following specialties:~~

~~(i) Physical medicine and rehabilitation;~~

~~(ii) Psychiatry;~~

~~(iii) Neurology;~~

~~(iv) Neurosurgery;~~

~~(v) Orthopedic surgery;~~

~~(vi) Pain anesthesiology;~~

~~(vii) Occupational medicine;~~

~~(viii) Family practice with documented training (fellowship or pain management training program) in pain management;~~

~~(ix) Internal medicine with documented training (fellowship or pain management training program) in pain management; and~~

~~(b) Have a minimum of twenty hours of continuing medical education (CME) annually from a pain management or rehabilitation conference.~~

~~(2) The program medical staff (providers on staff, or that the program has arrangements with) must:~~

~~(a) Be bureau certified medical doctors or doctors of osteopathic medicine and surgery who have American Board of Medical Specialties certification or American Osteopathic Association Board certification or who have successfully completed a recognized residency or fellowship for a specialty listed below within the past three years and have eligibility for certification and are pursuing board~~

certification in one of the following specialties:

~~(i) Physical medicine and rehabilitation;~~

~~(ii) Psychiatry;~~

~~(iii) Neurology;~~

~~(iv) Neurosurgery;~~

~~(v) Orthopedic surgery;~~

~~(vi) Pain anesthesiology;~~

~~(vii) Occupational medicine;~~

~~(viii) Family practice with documented training (fellowship or pain management training program) in pain management;~~

~~(ix) Internal medicine with documented training (fellowship or pain management training program) in pain management; or~~

~~(x) Bureau certified doctors of chiropractic with documented training in pain management;~~

~~(b) Must include at least three specialties recognized by the American board of medical specialties, including psychiatry, or two medical specialties with a clinical psychologist; and~~

~~(c) Must each have a minimum of twenty hours of continuing medical education (CME) annually from a pain management or rehabilitation conference.~~

~~(3) The program must have an adequate number of bureau certified physical therapists, occupational therapists or doctors of chiropractic to meet program needs of the injured workers.~~

~~(4) The program ancillary staff may include, but are not limited to, pharmacists, registered nurses, case managers, dieticians, exercise physiologists, therapeutic recreation leaders, career counselors, vocational evaluators, work simulators and doctors of chiropractic.~~

~~(D) No later than twenty-four months after the effective date of this rule, the administrator shall conduct a study evaluating the treatment outcomes of chronic pain management programs certified under this rule.~~

~~(1) The administrator shall collaborate with private stakeholder groups in conducting the study required by this paragraph. The study may consider, but is not limited to, the following criteria:~~

~~(a) Pain reduction;~~

~~(b) Reduction of addictive medications;~~

~~(c) Reduction of emotional distress;~~

~~(d) Reduction of health care utilization;~~

~~(e) Iatrogenic consequences;~~

~~(f) Increased activity (including return to work); and~~

~~(g) Closure of disability claims.~~

4123-6-02.21 Provider access to the HPP – non-certified provider enrollment.

(A) The bureau may enroll non-certified providers eligible under rules 4123-6-06.3 or 4123-6-12 of the Administrative Code or division (J) of section 4121.44 of the Revised Code to receive reimbursement for goods and services provided to injured workers, and for this purpose may require such non-certified providers to complete and sign an enrollment application and agreement as the bureau deems appropriate, provided such non-certified providers meet the minimum qualifications for their provider category as set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code.

(B) Persons or entities who do not fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code are not eligible for certification as providers in the HPP. The bureau may enroll such persons or entities to receive reimbursement for goods and services provided to injured workers, and for this purpose may require such persons or entities to complete and sign an enrollment application and agreement as the bureau deems appropriate.

(C) The certification of persons or entities certified as providers in the HPP prior to the effective date of this rule who do not fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code shall expire on a schedule determined by the bureau, and such persons or entities shall not be eligible for recertification as providers in the HPP.

(D) Expiration of provider certification pursuant to this rule does not constitute an adjudication order and is not subject to appeal pursuant to rule 4123-6-17 of the Administrative Code.

4123-6-02.51 Provider access to the HPP -- Denial of provider, entity or MCO certification based on criminal conviction or civil action.

(A) The administrator may refuse to certify or recertify, or may decertify from participation in the HPP, any provider, entity or MCO that:

(1) Is owned, directly or indirectly, by an individual or entity that has a felony conviction in any jurisdiction, a conviction under a federal controlled substance act, a misdemeanor conviction for an act involving dishonesty, fraud, or misrepresentation, a conviction for a misdemeanor committed in the course of practice, a felony or misdemeanor conviction involving dishonesty, fraud, or misrepresentation related to any compensation or benefits payable under Chapter 4121, 4123, 4127, or 4131 of the Revised Code, or court supervised intervention or treatment in lieu of conviction pursuant to section 2951.041 of the Revised Code or the equivalent law of another state.

(2) Has one or more owners, shareholders, members, partners, managing employees, officers or directors, who have a conviction or court supervised intervention or treatment in lieu of conviction as described in (A) (1) of this rule; and including any provider, entity or MCO that is no longer so described because of a transfer of ownership or interest to an immediate family member or a member of the person's household in anticipation of or following a conviction or court supervised intervention or treatment in lieu of conviction as described in (A) (1) of this rule.

(3) For the purposes of this paragraph:

(a) "Entity" means any sole proprietorship, partnership, corporation, professional association, limited liability company or any other business organization doing business in this or any other state.

(b) "Immediate family member" means a person's spouse; natural or adoptive parent; child or sibling, stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law;

grandparent or grandchild; or spouse of a grandparent or grandchild.

(c) "Managing employee" means an individual (including a general manager, office manager, business manager, administrator or director) who exercises operational or managerial control over the provider, entity or MCO or part thereof, or directly or indirectly conducts the day-to-day operations of the provider, entity or MCO or part thereof, or is involved in the billing functions of the provider, entity or MCO or part thereof.

(d) "Member of household" means, with respect to a person, any individual with whom they are sharing a common abode.

(e) "Owned directly or indirectly" means having an interest that includes ownership, as an individual or through any other entity or entities, of five percent or more in the provider, entity or MCO at issue.

(B) Notwithstanding and in addition to the provisions set forth above, pursuant to division (C)(1) of section 4121.444 of the Revised Code the administrator may terminate any agreement between the bureau and a person or a health care provider or managed care organization or its owner and cease reimbursement to that person, provider, organization, or owner for services rendered if any of the following apply:

(1) The person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization is convicted of or pleads guilty to a violation of sections 2913.48 or 2923.31 to 2923.36 of the Revised Code or any other criminal offense related to the delivery of or billing for health care benefits.

(2) There exists an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization and proof of the specific intent of the person, health care provider, managed care organization, or owner to defraud, in a civil action brought pursuant to section 4121.444 of the Revised Code.

(3) There exists an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization in a civil action brought pursuant to sections 2923.31 to 2923.36 of the Revised Code.

(C) No person, health care provider, or managed care organization that has had its agreement with and reimbursement from the bureau terminated by the administrator pursuant to division (C)(1) of section 4121.444 of the Revised Code, or an owner, officer, authorized agent, associate, manager, or employee of that person, health care provider, or managed care organization shall do either of the following:

(1) Directly provide services to any other bureau provider or have an ownership interest, as an individual or through any other entity or entities, of five percent or more in a provider of services that furnishes services to any other bureau provider;

(2) Arrange for, render, or order services for claimants during the period that the agreement of the person, health care provider, managed care organization, or its owner is terminated as described in division (C)(1) of section 4121.444 of the Revised Code.

(D) The administrator shall not terminate the agreement or reimbursement if the person, health care provider, managed care organization, or owner demonstrates that the person, provider, organization, or owner 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 as described in division (C)(1) of section 4121.444 of the Revised Code.

(E) Nothing in division (C) of section 4121.444 of the Revised Code prohibits an owner, officer, authorized agent, associate, manager, or employee of a person, health care provider, or managed care organization from entering into an agreement with the bureau if the provider, organization, owner, officer, authorized agent, associate, manager, or employee demonstrates absence of knowledge of the action of the person, health care provider, or managed care organization with which that individual or organization was formerly associated that resulted in a conviction, plea of guilty, or entry of judgment as described in division (C)(1) of section 4121.444 of the Revised Code.

(F) Actions taken by the administrator pursuant to paragraph (A) of this rule shall be subject to rule 4123-6-17 of the Administrative Code. Actions taken by the administrator pursuant to paragraph (B) of this rule shall include a clear indication of the beginning date of such action and the specific medical services or dates of medical services or supplies that shall be excluded from payment, and shall be final unless the person, provider, managed care organization or owner, within seven days of the action, requests a hearing before the administrator where the person, provider, managed care organization or owner shall show cause why the action should not be final. The action of the administrator shall remain in force during the pendency of the show cause hearing.

4123-6-02.9 Provider access to the HPP - provider marketing.

(A) No bureau certified provider shall engage in any advertising or solicitation directed to injured workers which is false, fraudulent, deceptive, or misleading.

(B) No bureau certified provider shall hire, arrange for, or allow any other individual or entity to engage in any advertising or solicitation directed to injured workers on behalf of the provider which is false, fraudulent, deceptive, or misleading.

(C) No bureau certified provider shall pay, allow or give, or offer to pay, allow or give, any consideration, money or other thing of value to an injured worker (including but not limited to free or discounted examinations, treatment or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any goods or services for which payment may be made by the bureau, MCO, QHP or self-insuring employer under Chapters 4121, 4123, 4127 or 4131 of the Revised Code.

(D) A bureau certified provider that violates this rule may be subject to decertification or disciplinary sanctions pursuant to the rules of this chapter of the Administrative Code.

Executive Summary
SB 7 rules: Continuing Jurisdiction, R.C. 4123.52
Rules 4123-6-23 and 4123-7-01

Background Law

S.B. 7 was signed into law by Gov. Bob Taft to be effective June 30, 2006. This legislation made various reforms in the workers' compensation system.

The Act amends R.C. 4123.52 to change the continuing jurisdiction of the Industrial Commission or BWC to make a modification, change, finding, or award from six years in the absence of the payment of medical benefits and ten years in the absence of payment of compensation to a five-year limit in both cases. As provided in Section 3 of the Act, this change applies to all claims arising on and after the effective date of the Act, or June 30, 2006.

Note: This provision of the Act is one of the provisions included in the pending referendum effort.

Overview of Rules

Rules 4123-6-23 and 4123-7-01 detail jurisdictional principles applicable to the payment of bills for medical services by health care providers in workers' compensation claims. Rule 4123-6-23 applies to employers participating in the Health Partnership Program, and rule 4123-7-01 applies to medical payments made by self-insured employers.

Rule Amendments

4123-6-23 Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers.

4123-7-01 Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers.

The amendments to Rules 4123-6-23 and 4123-7-01 are essentially identical, since the rules are parallel rules.

Paragraph (B) is amended to reflect a change in the continuing jurisdiction principles from H.B. 107 effective October 20, 1993, and an Ohio Supreme Court decision interpreting the retroactive application of the H.B. 107 changes. See State ex rel. Romans v. Elder Beerman Stores Corp., 100 Ohio St.3d 165, 2003-Ohio-5363. The amendment provides that where the date of injury is on or after December 11, 1967, and prior to June 30, 2006, BWC cannot pay a medical bill if six years or more have elapsed since the date of the last payment of a medical bill and no compensation has been paid. If compensation has been paid, the time limit is ten years for claims within these dates.

Paragraph (D) is a new paragraph in both rules to reflect the S.B. 7 amendments to R.C. 4123.52. This amendment states:

In claims where the date of injury is on or after June 30, 2006, there is no jurisdiction to consider payment for medical services if five years or more have elapsed since the payment of compensation or benefits. The provisions of paragraph (B) of this rule shall apply to the payment of medical bills in claims where the date of injury is on or after June 30, 2006, except that where those provisions reference six year and ten year time limits, the time limits shall be five years.

EXECUTIVE SUMMARY
Five Year Rule Review: Self-Insured Rules

Background Law

Pursuant to H.B. 473, effective September 26, 1996, state agencies are required to review all agency rules every five years to determine whether to amend the rules, rescind the rules, or continue the rules without change. The legislation requires the agency to assign a rule review date for each of its rules so that approximately one-fifth of the rules are scheduled for review during each calendar year. This year, the rules scheduled for review include the rules of Chapter 4123-19, the Self-Insured employer rules. BWC last performed a five year rule review of these rules in 2001.

Self-Insured Rules

The rules of Chapter 4123-19 of the Administrative Code chiefly apply to and regulate self-insuring employers. The rule revisions clarify various aspects of the self-insured rules to provide a clear direction to employers and injured workers on BWC's expectations. BWC is recommending that some of the rules remain unchanged. The following is a summary of each of the rules.

- 4123-19-01 Definition: state risks, self-insuring risks.
- 4123-19-02 General procedures in the processing of applications for industrial coverage.
- 4123-19-05 Where an employer is a self-insuring risk and desires to become a state risk.
- 4123-19-07 Rules controlling the renewals of risks.
- 4123-19-12 Grounds for holding public hearings to evaluate the program for self-insuring employers.
- 4123-19-13 Self-insuring employers evaluation board.
- 4123-19-14 Self-insured review panel.
- 4123-19-16 Self-insured construction projects.

No changes are proposed for these rules.

- 4123-19-03 Where an employer desires to secure the privilege to pay compensation, etc., directly.

In 2001, paragraph (J) of this rule was amended to provide that any employer granted SI privilege on or after July 1, 2001, shall report its paid compensation electronically via the bureau's web site, and that effective January 1, 2002, all SI employers shall report paid compensation electronically via the bureau's web site. Because these dates have passed, the amendment removes these dates and reflects that all SI shall report paid compensation electronically.

Paragraph (L)(2) corrects a typographical error, changing "file" to "filed."

In paragraph (L)(3), the amendment indicates that instead of the administrator's executive order, BWC shall issue to an SI employer a "self-insured certificate."

4123-19-06 Procedures for revocation of self-insuring status.

This rule has been revised to clarify and make more specific the administrative and financial requirements a self-insured employer must maintain or be subject to revocation.

In paragraph (A)(1), the amendment refers to the SI employer's failure to file medical reports "requested by" BWC or the IC.

Paragraph (A)(6) clarifies response times for self-insured employers to respond to various requests to conform to language contained in rule 4123-19-03(K)(5); adds that if the employer contests these requests, the employer shall notify not only the employee but also the provider; provides for notice of contested matters upon request of the bureau or the industrial commission; adds that the employer shall state the specific reason for contesting requests.

Paragraph (E) corrects a typographical error, changing "nor" to "or."

4123-19-08 Renewal of self-insuring risks.

In paragraph (B), the rule strikes the requirement that "the employer shall include with the renewal application a recording of the number of lost time claims."

Paragraph (E) contains amendments clarifying the appeal process to the self-insured review panel.

4123-19-09 In regard to complaints filed by employees against self-insuring employers under the provisions of section 4123.35 of the Revised Code.

Paragraph (B) corrects a typographical error, changing "reasonable" to "reasonably."

4123-19-10 In regard to audits by the bureau of workers' compensation.

Paragraph (B) corrects a typographical error, changing a lower case "s" to an upper case "S."

Paragraph (C) adds that BWC shall report finding to both the self-insuring employers evaluation board and the self-insured review panel, where the panel or board has requested an audit.

4123-19-11 Fixing time limits beyond which the failure of a self-insuring employer to provide for the necessary medical examinations and evaluations may not delay a decision on a claim.

Executive Summary: Self Insured rules
Page 3

This rule contains minor rule cross-reference correction.

4123-19-15 Assessment for self-insuring employers' guaranty fund.

Note: This rule is addressed in a separate presentation.

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March 21, 2006



OBWC State Insurance Fund Asset-Liability Valuation – Draft

Investment Committee Presentation

May 25, 2006

Mark E. Brubaker, CFA
Managing Director

Dimitry D. Mindlin, ASA, MAA, PhD
Managing Director



Agenda

- I. Executive Summary / Recommendations / Timeline** **Slide 2**
 - II. Background** **Slide 18**
 - 1. Mission
 - 2. Roles and Fiduciary Responsibilities
 - 3. What is OBWC?
 - 4. Purpose of Study/Definition of Risk
 - III. Mean-Variance Optimization (Asset Only)** **Slide 25**
 - 1. Historical Return Perspective
 - 2. Wilshire's 2006 10-Year Forward Looking Capital Markets Expectations
 - 3. Efficient Portfolios
 - IV. Inputs to Asset-Liability Valuation Model** **Slide 31**
 - V. Surplus Optimization (Accounting Based)** **Slide 35**
 - VI. Cost-Risk Optimization (Cash-Flow Based)** **Slide 41**
- Appendix – Wilshire's 2006 Capital Markets Expectations**



I. Executive Summary



What is Asset Allocation?

- Wilshire believes that the core business of a workers' compensation insurance fund is to provide the benefits promised to injured workers.
- Asset Allocation is the process of selecting a policy portfolio - allocating a portfolio's assets among asset classes that have the potential to serve the financial objectives of the fund.
- The role of asset allocation is to manage the risk to the fund's core business.
- The goal of asset allocation is to maximize the safety of promised benefits at a minimum cost (premiums).

A Multitude of Risks

- Workers' compensation funds face a multitude of risks. Prioritizing those risks is crucial in determining a proper methodology for selection of the policy portfolio.

Example 1 - Risk of an Asset Loss

- It is undesirable to lose money.

Example 2 - Risk of Mismatch Between Assets and “Accounting” Liabilities

- It is undesirable to have a negative surplus as defined by GASB accounting standards.

Example 3 - Insufficient Asset Risk

- It is undesirable to have insufficient assets to pay benefits promised to injured workers.
- Wilshire believes this is the primary risk.
- This risk is directly related to the Fund's core business.
- This risk can be managed through Asset Liability Valuation.

A Long Term Capital Market Perspective

	<u>1802-2005</u>	<u>1926-2005</u>	<i>High Inflation</i> <u>1970-1979</u>	<i>Bull Market</i> <u>1980-1999</u>	<i>Wilshire</i> <u>Forecast</u>
<u>Total Returns</u>					
Stocks	8.2%	10.4%	5.9%	17.8%	8.3%
Bonds	4.9	5.7	7.2	10.0	5.0
T-Bills	4.3	3.8	6.4	7.2	3.0
Inflation	1.4	3.0	7.4	4.0	2.3
<u>Real Returns</u>					
Stocks	6.8	7.4	-1.5	13.8	6.0
Bonds	3.5	2.7	-0.2	6.0	2.8
T-Bills	2.9	0.8	-1.0	3.2	0.8
<u>Risk (Std. Dev.)</u>					
Stocks		19.3	16.0	15.0	17.0
Bonds		5.2	6.4	6.6	5.0
T-Bills		1.0	0.6	1.0	1.0
Stocks minus Bonds	3.3	4.7	-1.3	7.8	3.3



Wilshire's 10-Year Capital Market Assumptions

Asset Class	U.S. Equity	Non-U.S. Equity	Fixed Income - Core	Fixed Income - Long Duration/Dedicated	Fixed Income - High Yield	Fixed Income - Inflation Protected	Cash Equivalents
Return	8.25	8.25	5.00	5.25	6.50	4.75	3.00
Risk	17.00	19.00	5.00	7.00	10.00	6.00	1.00
Yield	1.80	2.50	5.00	5.25	6.50	2.50	3.00
Correlations							
U.S. Equity	1.00						
Non-U.S. Equity	0.78	1.00					
Fixed Income - Core	0.29	0.08	1.00				
Fixed Income - Long Duration/Dedicated	0.34	0.09	0.95	1.00			
Fixed Income - High Yield	0.48	0.29	0.39	0.40	1.00		
Fixed Income - Inflation Protected	0.00	0.10	-0.01	0.00	0.01	1.00	
Cash Equivalents	0.00	-0.10	0.10	0.10	0.00	0.25	1.00

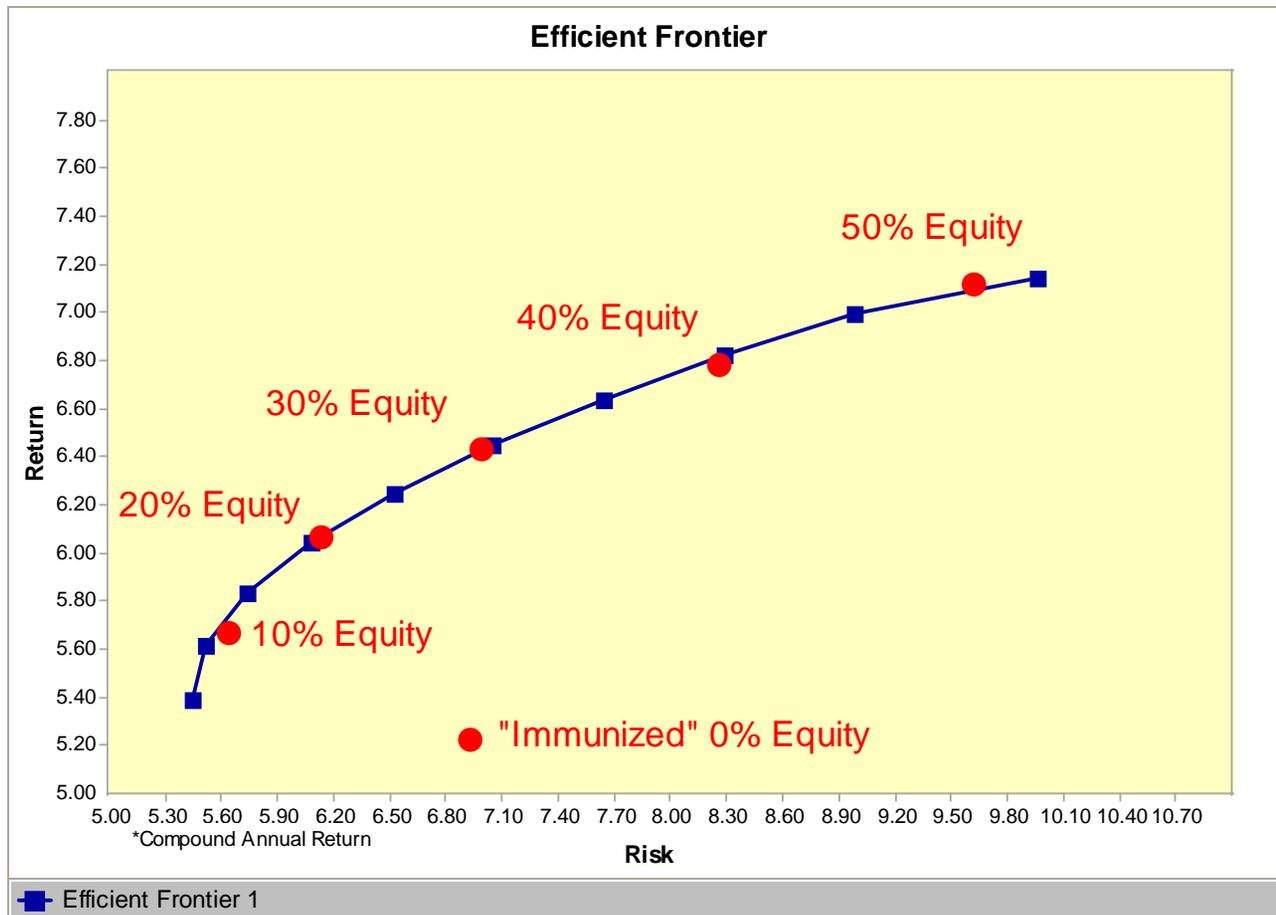
- **The above figures represent Wilshire's 10-year forward-looking risk, return and correlation assumptions.**
 - ♦ Risk represents the expected standard deviation of each portfolio – in two out of three years, the asset class is expected to produce returns that are within +/- one standard deviation of the expected return.

Source: Wilshire Consulting: 2006 Asset Allocation Return and Risk Assumptions



Efficient Frontier

- The efficient frontier is comprised of portfolios that generate the highest level of expected return for a given level of risk in *asset-only space* – SIF liabilities are not considered in this exhibit:



Efficient Portfolios

Asset Class	Portfolio Weights					
	"Immunized"	Total Return				
	0% Equity	10% Equity	20% Equity	30% Equity	40% Equity	50% Equity
U.S. Equity	0	8	15	22	30	38
Non-U.S. Equity	0	2	5	8	10	12
Total Equity	0	10	20	30	40	50
Fixed Income - Core	0	0	0	0	0	0
Fixed Income - Long Duration/Dedicated	99	65	54	44	39	34
Fixed Income - High Yield	0	4	5	5	5	5
Fixed Income - Inflation Protected	0	20	20	20	15	10
Total Fixed Income	99	89	79	69	59	49
Cash Equivalents	1	1	1	1	1	1
Return	5.23	5.67	6.07	6.43	6.79	7.12
Risk	6.93	5.64	6.13	6.99	8.25	9.62

➤ **Constraints:**

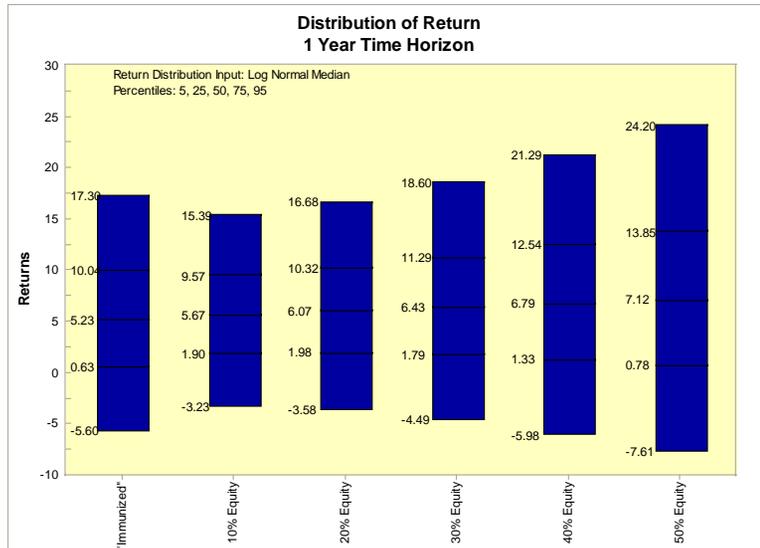
- Total Equity < 50%; High Yield < 5%; Inflation Protected < 20%; Cash Equivalents < 1%

- **Long Duration Bonds and Inflation-Protected Securities are favored by the ALV model due to the long term and embedded medical and wage inflation components of the claim payment stream.**
- **Risk represents the expected standard deviation of each portfolio – in two out of three years, the asset mix is expected to produce returns that are within +/- one standard deviation of the expected return.**

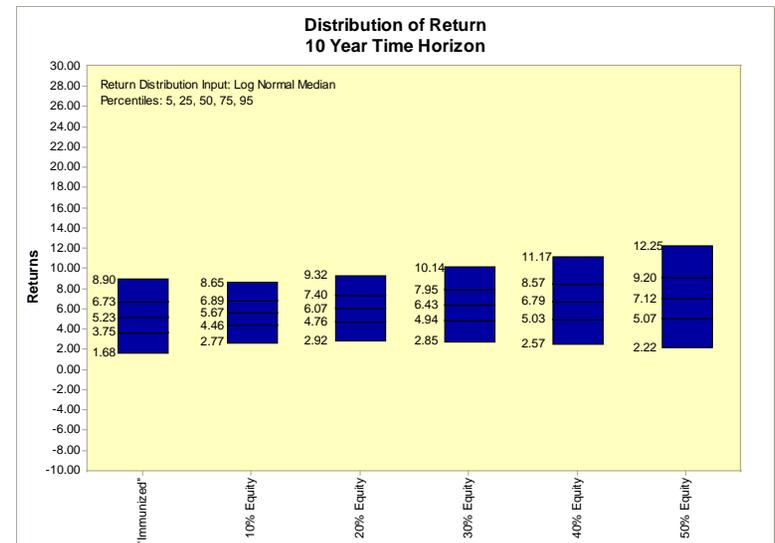


1 and 10-Year Distribution of Expected Returns

- Distributions of returns are quite wide for any one year period...

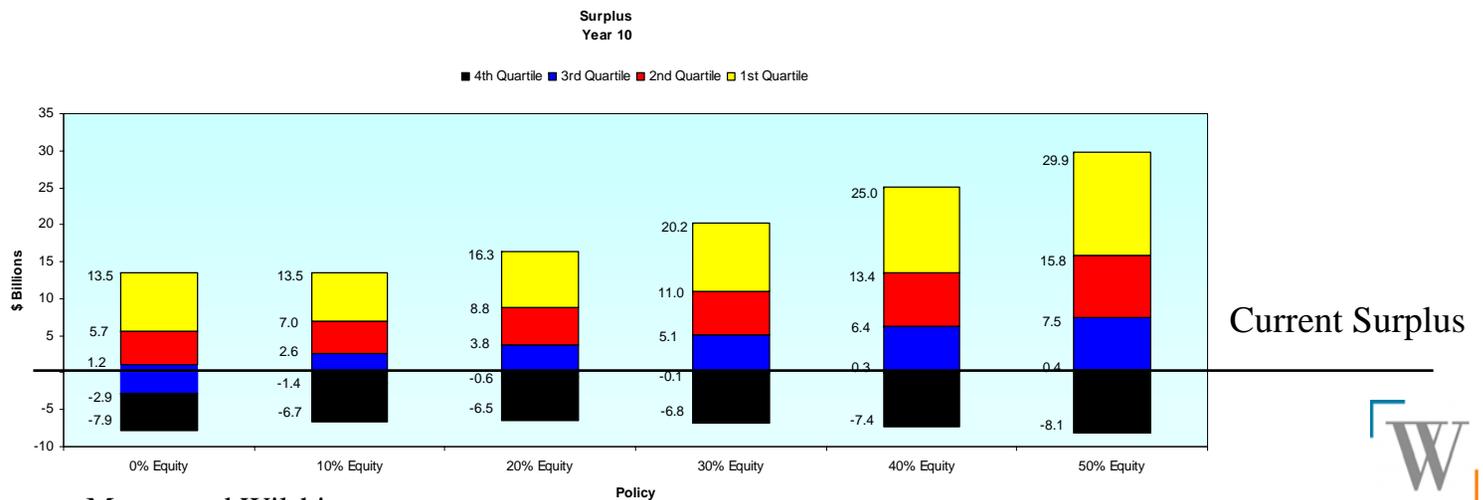
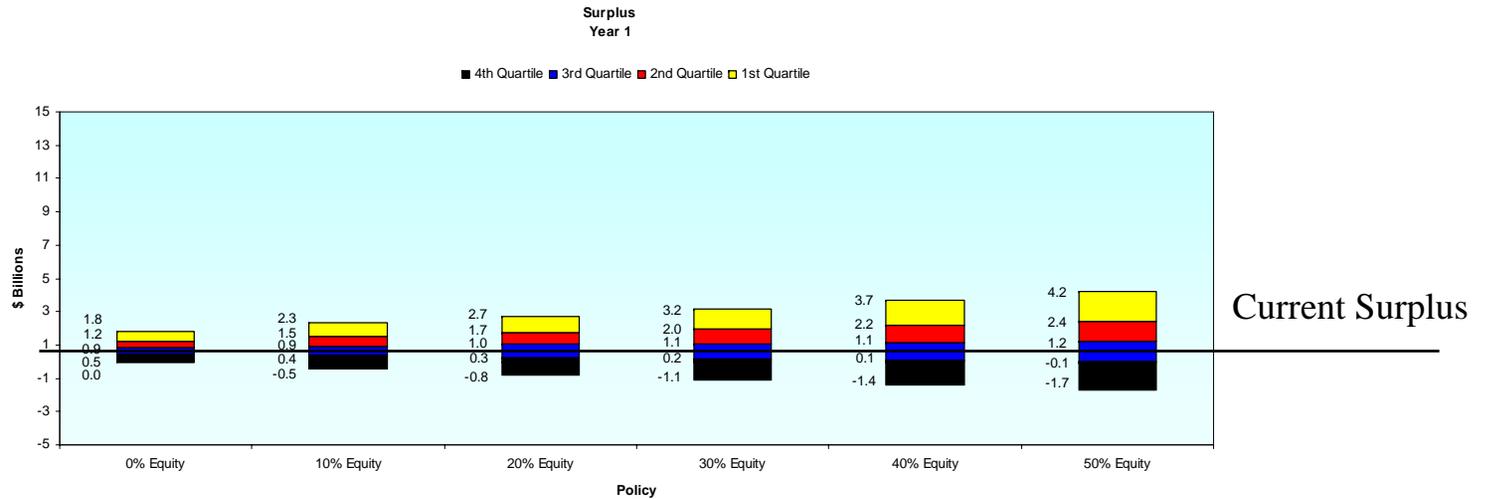


- ...but they narrow considerably over a 10-year period



Stochastic Simulation of Surplus: Year 1 and Year 10

- The floating bar charts incorporate a stochastic simulation of assets, premiums, claims and reserves under potential interest rate, inflation and capital market environments and illustrate the potential SIF surplus under various asset mixes over short and long-term time horizons:



Observations

- **The optimal asset mix is highly dependent on the Fund’s ultimate objective and time horizon:**
 - If minimizing short term volatility of the accounting surplus is the sole objective, then the “Immunized” fixed income portfolio is optimal
 - If minimizing the long-term (10-year) downside risk of the accounting surplus is the objective, then a 20% equity allocation is optimal
 - If maximizing the safety of benefit claims is the objective (and the Fund can withstand downside risk to the accounting surplus), then an equity allocation greater than 20% may be justified (please see slide 45)
- **The immunized bond portfolio will not likely preserve the surplus in periods when medical and/or wage inflation exceed current expectations**
 - There is no financial instrument that can effectively hedge this inflation risk
- **Regardless of the asset mix selected, Wilshire recommends that OBWC build a larger surplus before considering future premium refunds to employers**
 - Under any asset allocation policy mix, there exists the probability of a shortfall (please see slide 45) in the future
 - Because of the positive cash flow characteristics (slide 44) of the SIF, any shortfall would likely not be an issue until well into the future



Recommendation

- If the OBWC's time horizon is longer-term (i.e. 10-years), then Wilshire recommends a 20% equity allocation and the specific asset mix as detailed below:

<i>Asset Class</i>	<i>Portfolio Weights</i>	
	<i>"Immunized"</i>	<i>Recommended</i>
	<i>0% Equity</i>	<i>20% Equity</i>
U.S. Equity	0	15
Non-U.S. Equity	0	5
Total Equity	0	20
Fixed Income - Core	0	0
Fixed Income - Long Duration/Dedicated	99	54
Fixed Income - High Yield	0	5
Fixed Income - Inflation Protected	0	20
Total Fixed Income	99	79
Cash Equivalents	1	1
Return	5.23	6.07
Risk	6.93	6.13

- This mix provides a balance between the long-term growth of the surplus with the preservation of the surplus over intermediate time horizons



Investment Structure

- **Wilshire recommends the following investment structure for implementing the asset allocation policy:**

<i>Asset Class</i>	SIF Allocation		<i>Benchmark</i>
	%	\$ mm	
U.S. Equity	15	2,265	Wilshire 5000
<i>Large Cap</i>	<i>12</i>	<i>1,812</i>	<i>S&P 500</i>
Active (0%)	0	-	
Passive (100%)	12	1,812	
<i>Small/Mid Cap</i>	<i>3</i>	<i>453</i>	<i>Wilshire 4500 / Russell 2500</i>
Active (100%)	3	453	
Passive (0%)	0	-	
Non-U.S. Equity	5	755	MSCI ACWI ex-U.S.
Active (80%)	4	604	
Passive (20%)	1	151	
Fixed Income - Long Duration	54	8,153	Lehman Long Government/Credit
Active (50%)	27	4,076	
Passive (50%)	27	4,076	
High Yield	5	755	Merrill Lynch High Yield Master II
Active (100%)	5	755	
Passive (0%)	0	-	
Inflation-Protected Securities	20	3,020	Lehman U.S. TIPS
Active (0%)	0	-	
Passive (100%)	20	3,020	
Cash Equivalents	1	151	90-Day T-Bill

Please refer to the following page for an analysis of the long-duration fixed income benchmark.



Long-Duration Fixed Income Benchmark

- Due to the marginal benefit derived from Customized Benchmark 2 (yield-to-maturity of 5.8% vs. 5.6%) and the credit risk that it entails, Wilshire recommends that OBWC utilize the Lehman Long Government/Credit Index for the fixed income allocation
- The Lehman Long Government/Credit index sector allocation as of March 31, 2006 was approximately 55% government / 45% credit
 - Active fixed income managers may elect to overweight credit sectors when they present relative value

Customized Benchmark 1:	
99%	Lehman Long-Term Govt/Corp
1%	91 Day T-Bill

Customized Benchmark 2:	
40%	Lehman Long-Term Govt
56%	Lehman Long-Term Corporate
4%	Lehman Int-Term Corporate

Portfolio Statistics	Lehman Aggregate	Customized Benchmark 1	Customized Benchmark 2	Liability Stream
Effective duration	4.59	10.38	10.30	10.38
Effective d2	2.87	8.70	8.61	8.67
Effective d3	3.57	6.43	6.24	6.06
Yield to Maturity	5.48	5.57	5.81	--
Cash flow yield	5.46	5.56	5.79	--
Current yield	5.19	5.90	6.08	--
Average coupon	5.24	6.79	6.80	--
Average price	100.04	100.00	110.27	--
Years to maturity	12.91	19.77	20.55	--
Est. Annual Income (\$)	\$900,446,055	\$916,937,742	\$954,868,619	--

Optimized portfolio duration, D2, D3

Effective duration: measures risk to changes in level of the yield curve

Effective D2: measures risk to changes in slope of the yield curve

Effective D3: measures risk to changes in the curvature of the yield curve



Illustrative Transition Timeline

Jun-06
Present asset allocation recommendation to WCOC
Present revised Investment Policy Statement to WCOC for approval
Issue RFPs for transition management and index managers
Jul-06
Issue RFPs for long-duration fixed income active managers
Aug-06
Evaluate RFP responses for transition management and index managers
Issue RFP for non-U.S. equity active managers
Sep-06
Evaluate RFP responses for transition management and index managers
Evaluate RFP responses for active long-duration fixed income managers
Issue RFP for small cap U.S. equity active managers
Oct-06
Present transition management and index manager recommendations to WCOC
Commence allocating assets to U.S. equity, non-U.S. equity, fixed income and TIPS index manager(s) (6 months)
Evaluate RFP responses for active long-duration fixed income managers
Evaluate RFP responses for non-U.S. equity active managers

The above calendar is for illustrative purposes only. Actual implementation may differ due to a variety of factors. Expected completion during Q2 2007.



Illustrative Transition Timeline

Nov-06
Present long-duration fixed income active manager recommendations to WCOC
Commence implementing active long-duration fixed income allocation (4 months)
Evaluate RFP responses for non-U.S. equity active managers
Evaluate small cap U.S. equity active managers
Issue RFP for high yield active managers
Dec-06
Present non-U.S. equity active manager recommendations to WCOC
Commence implementing non-U.S. equity active manager allocation (4 months)
Evaluate small cap U.S. equity active managers
Evaluate high yield active managers
Jan-07
Present small cap U.S. equity active manager recommendations to WCOC
Commence implementing small cap U.S. equity allocation (3 months)
Evaluate high yield active managers
Feb-07
Present high yield active manager recommendations to WCOC
Commence implementing high yield allocation (3 months)

The above calendar is for illustrative purposes only. Actual implementation may differ due to a variety of factors. Expected completion during Q2 2007.



Mark E. Brubaker, CFA

Managing Director

Mark joined the Pittsburgh, PA office of Wilshire Associates as a Senior Consultant in 1997. Mark works with a broad range of fund sponsors including public and corporate pensions, endowments and foundations and insurance companies. In addition to his client responsibilities, he serves on Wilshire's investment committee and chairs Wilshire's small cap value and growth manager research committees. He is a frequent speaker on investment-related topics including asset/liability management, alternative investments and emerging markets.

Mark earned a B.A. from Yale University and an MBA from Carnegie Mellon University with a concentration in finance. Before joining Wilshire, Mark worked at Westinghouse Electric Corporation, where he was responsible for over \$9 billion in defined benefit, defined contribution and foundation assets and at PNC Bank where he managed pension client relationships for the Investment Management and Trust Division.

He holds the Chartered Financial Analyst designation and is a member of the CFA Institute and Pittsburgh Society of Financial Analysts.

Dimitry D. Mindlin, ASA, MAAA, PhD

Managing Director

Dimitry Mindlin joined Wilshire in 1998 and is responsible for the development and maintenance of Wilshire's asset allocation models. Dr. Mindlin works closely with Wilshire's investment research group in the development of capital market assumptions. Prior to joining Wilshire, he spent several years as an actuary with an insurance company and an actuarial consulting company. He earned his Ph.D. from Academy of Sciences of USSR. Dr. Mindlin is an Associate of the Society of Actuaries and a member of the American Academy of Actuaries.

II. Background



➤ **The OBWC was established by the Ohio Constitution, Article II, Section 35:**

- ♦ “For the purpose of providing compensation to workmen and their dependents, for death, injuries or occupational disease, occasioned in the course of such workmen’s employment, laws may be passed establishing a state fund to be created by compulsory contribution thereto by employers, and administered by the state...”

➤ **Ohio Revised Code Section 4123.34:**

- ♦ “The administrator of workers’ compensation, in the exercise of the powers and discretion conferred upon him in section 4123.29 of the Revised Code, shall fix and maintain, with the advice and consent of the workers’ compensation oversight commission...the lowest possible rates of premium consistent with the maintenance of a solvent state insurance fund and the creation and maintenance of a reasonable surplus...”

➤ **Ohio Revised Code Section 4123.44**

- ♦ “The voting members of the workers’ compensation oversight commission, the administrator of workers’ compensation, and the bureau of workers’ compensation chief investment officer are the trustees of the state insurance fund. The administrator of workers’ compensation, in accordance with (the Ohio Revised Code) and the investment objectives, policies and criteria established by the workers’ compensation oversight commission pursuant to section 4121.12 of the Revised Code, and in consultation with the bureau of workers’ compensation chief investment officer, may invest any of the surplus or reserve belonging to the state insurance fund.”
- ♦ “The administrator and other fiduciaries shall discharge their duties with respect to the funds with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, and by diversifying the investments of the assets of the funds so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.”

What is Ohio Bureau of Workers' Compensation?

➤ **Insurance Company**

- ♦ OBWC's primary role is to pay compensation and medical expenses for injured workers, but...
 - It is not subject to statutory accounting standards and capital requirements
 - It is not subject to regulation by the state insurance department
 - It incurs longer-tailed liabilities than typical workers' compensation insurance company
 - It is run solely for the benefit of Ohio employers and employees – there is no profit motive

➤ **Public Policy Tool**

- ♦ Ohio employers benefit from premium refunds when the assets of the Fund perform well
- ♦ Ohio employees benefit from enhanced safety programs when the assets of the Fund perform well

➤ **Is it more similar to a Pension Fund?**

- ♦ 10.4 year duration of claims stream comparable to the benefit stream of pension funds, which typically have a duration of 11-13 years
- ♦ Medical claims and indemnity claims each account for roughly 50% of the discounted loss reserves

Insurance and Pension Comparison

- **OBWC is thinly capitalized when compared to other workers' compensation insurance funds; however, OBWC's "funded status" is very high when compared to state pension funds**
- **The duration (using a market AA yield curve) of the OBWC claim payment stream is higher than the typical workers' compensation fund (due primarily to their use of reinsurance) and more comparable to the benefit payment stream of public pension funds**

	OBWC Financials	Insurance Industry Comparison ³		Public Pension Fund Comparison	
	OBWC	OBWC	Industry Average	OBWC	Industry Average
Discount Rate	5.25%		0.00%		8.00%
Assets ¹	18,918	18,918		18,918	
Liabilities ²	18,048	35,733		13,359	
Surplus	870	(16,815)		5,559	
Assets/Liabilities	1.05	0.53	1.45	1.42	0.87
Equity as % of Total Investments	2.4%	2.4%	7.0%	2.4%	67.7%
Duration of Liabilities		10.4	~4.0	10.4	13.0

Sources: BWC Financial and Operational Report - March 2006
 AM Best and BlackRock
 2006 Wilshire Report on State Retirement Systems: Funding and Asset Allocation
 Mercer Oliver Wyman

¹ Assets are as reported under GASB by BWC. Not adjusted to reflect statutory accounting.

² Liabilities under the Insurance Industry Comparison and Public Pension Fund Comparison are approximated using the discount rates indicated.

³ Insurance Industry Comparison represents 72 private insurance companies that wrote 75% or more of 2004 net premiums in workman's compensation



What is Asset Allocation?

- Wilshire believes that the core business of a workers' compensation insurance fund is to provide the benefits promised to injured workers.
- Asset Allocation is the process of selecting a policy portfolio - allocating a portfolio's assets among asset classes that have the potential to serve the financial objectives of the fund.
- The role of asset allocation is to manage the risk to the fund's core business.
- The goal of asset allocation is to maximize the safety of promised benefits at a minimum cost (premiums).

A Multitude of Risks

- Workers' compensation funds face a multitude of risks. Prioritizing those risks is crucial in determining a proper methodology for selection of the policy portfolio.

Example 1 - Risk of an Asset Loss

- It is undesirable to lose money.

Example 2 - Risk of Mismatch Between Assets and “Accounting” Liabilities

- It is undesirable to have a negative surplus as defined by GASB accounting standards.

Example 3 - Insufficient Asset Risk

- It is undesirable to have insufficient assets to pay benefits promised to injured workers.
- Wilshire believes this is the primary risk.
- This risk is directly related to the Fund's core business.
- This risk can be managed through Asset Liability Valuation.

III. Mean-Variance Optimization (Asset-only)



A Long Term Capital Market Perspective

	<u>1802-2005</u>	<u>1926-2005</u>	<i>High Inflation</i> <u>1970-1979</u>	<i>Bull Market</i> <u>1980-1999</u>	<i>Wilshire</i> <u>Forecast</u>
<u>Total Returns</u>					
Stocks	8.2%	10.4%	5.9%	17.8%	8.3%
Bonds	4.9	5.7	7.2	10.0	5.0
T-Bills	4.3	3.8	6.4	7.2	3.0
Inflation	1.4	3.0	7.4	4.0	2.3
<u>Real Returns</u>					
Stocks	6.8	7.4	-1.5	13.8	6.0
Bonds	3.5	2.7	-0.2	6.0	2.8
T-Bills	2.9	0.8	-1.0	3.2	0.8
<u>Risk (Std. Dev.)</u>					
Stocks		19.3	16.0	15.0	17.0
Bonds		5.2	6.4	6.6	5.0
T-Bills		1.0	0.6	1.0	1.0
Stocks minus Bonds	3.3	4.7	-1.3	7.8	3.3



Wilshire's 10-Year Capital Market Assumptions

Asset Class	U.S. Equity	Non-U.S. Equity	Fixed Income - Core	Fixed Income - Long Duration/Dedicated	Fixed Income - High Yield	Fixed Income - Inflation Protected	Cash Equivalents
Return	8.25	8.25	5.00	5.25	6.50	4.75	3.00
Risk	17.00	19.00	5.00	7.00	10.00	6.00	1.00
Yield	1.80	2.50	5.00	5.25	6.50	2.50	3.00
Correlations							
U.S. Equity	1.00						
Non-U.S. Equity	0.78	1.00					
Fixed Income - Core	0.29	0.08	1.00				
Fixed Income - Long Duration/Dedicated	0.34	0.09	0.95	1.00			
Fixed Income - High Yield	0.48	0.29	0.39	0.40	1.00		
Fixed Income - Inflation Protected	0.00	0.10	-0.01	0.00	0.01	1.00	
Cash Equivalents	0.00	-0.10	0.10	0.10	0.00	0.25	1.00

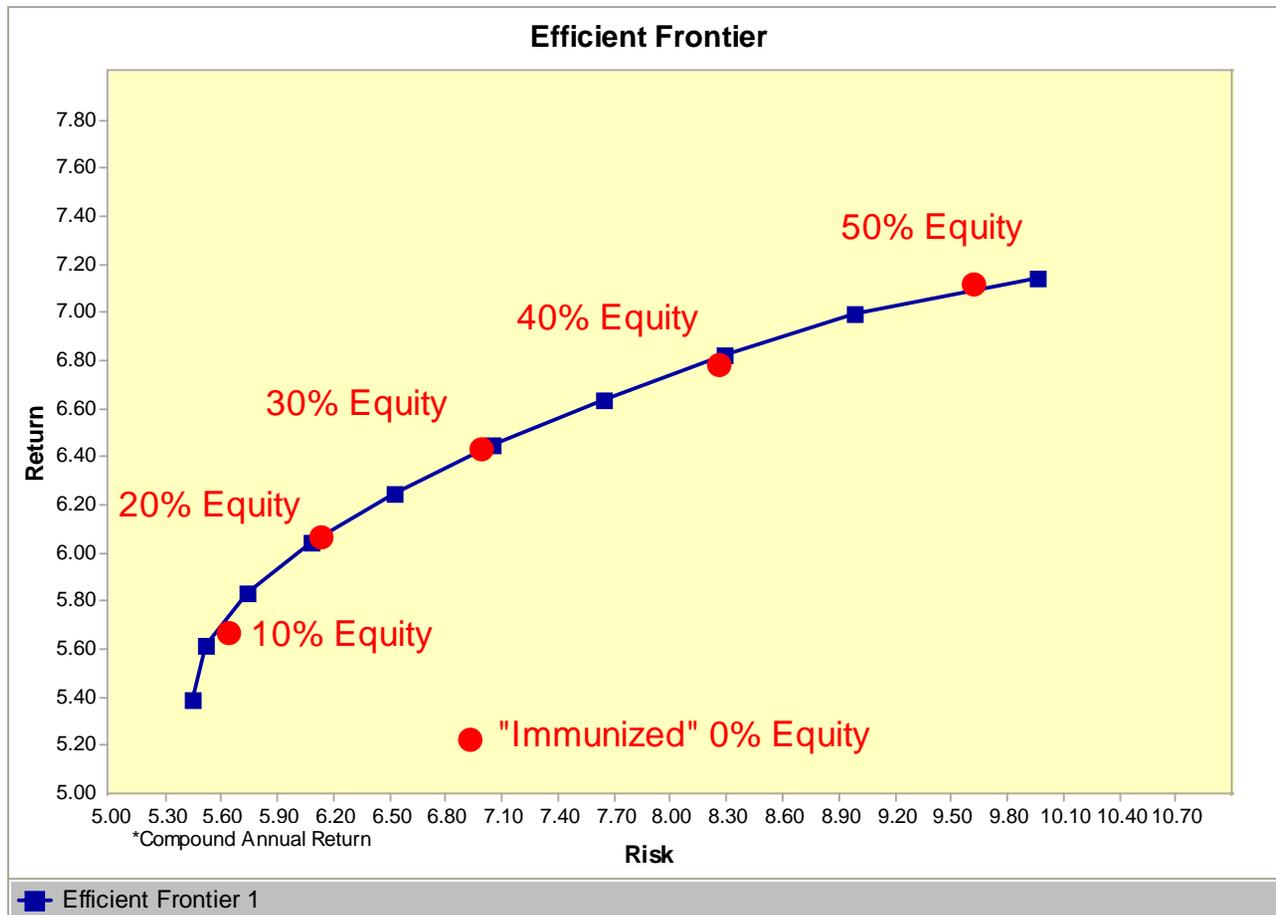
- **The above figures represent Wilshire's 10-year forward-looking risk, return and correlation assumptions.**
 - ♦ Risk represents the expected standard deviation of each portfolio – in two out of three years, the asset class is expected to produce returns that are within +/- one standard deviation of the expected return.

Source: Wilshire Consulting: 2006 Asset Allocation Return and Risk Assumptions



Efficient Frontier

- The efficient frontier is comprised of portfolios that generate the highest level of expected return for a given level of risk in *asset-only space* – SIF liabilities are not considered in this exhibit:



Efficient Portfolios

Asset Class	Portfolio Weights					
	"Immunized"	Total Return				
	0% Equity	10% Equity	20% Equity	30% Equity	40% Equity	50% Equity
U.S. Equity	0	8	15	22	30	38
Non-U.S. Equity	0	2	5	8	10	12
Total Equity	0	10	20	30	40	50
Fixed Income - Core	0	0	0	0	0	0
Fixed Income - Long Duration/Dedicated	99	65	54	44	39	34
Fixed Income - High Yield	0	4	5	5	5	5
Fixed Income - Inflation Protected	0	20	20	20	15	10
Total Fixed Income	99	89	79	69	59	49
Cash Equivalents	1	1	1	1	1	1
Return	5.23	5.67	6.07	6.43	6.79	7.12
Risk	6.93	5.64	6.13	6.99	8.25	9.62

➤ **Constraints:**

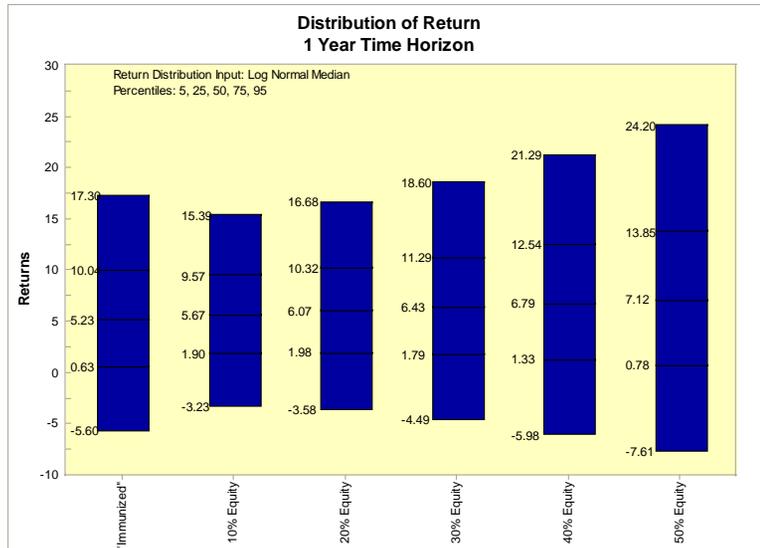
- Total Equity < 50%; High Yield < 5%; Inflation Protected < 20%; Cash Equivalents < 1%

- **Long Duration Bonds and Inflation-Protected Securities are favored by the ALV model due to the long term and embedded medical and wage inflation components of the claim payment stream.**
- **Risk represents the expected standard deviation of each portfolio – in two out of three years, the asset mix is expected to produce returns that are within +/- one standard deviation of the expected return.**

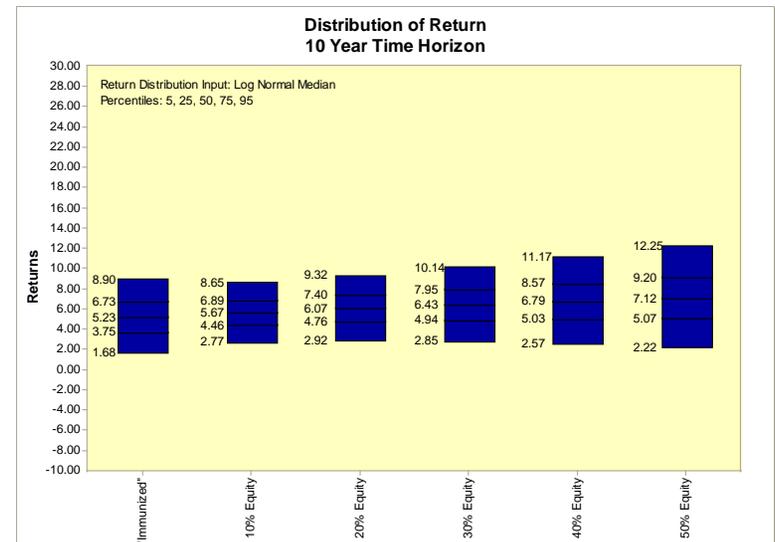


1 and 10-Year Distribution of Expected Returns

- Distributions of returns are quite wide for any one year period...



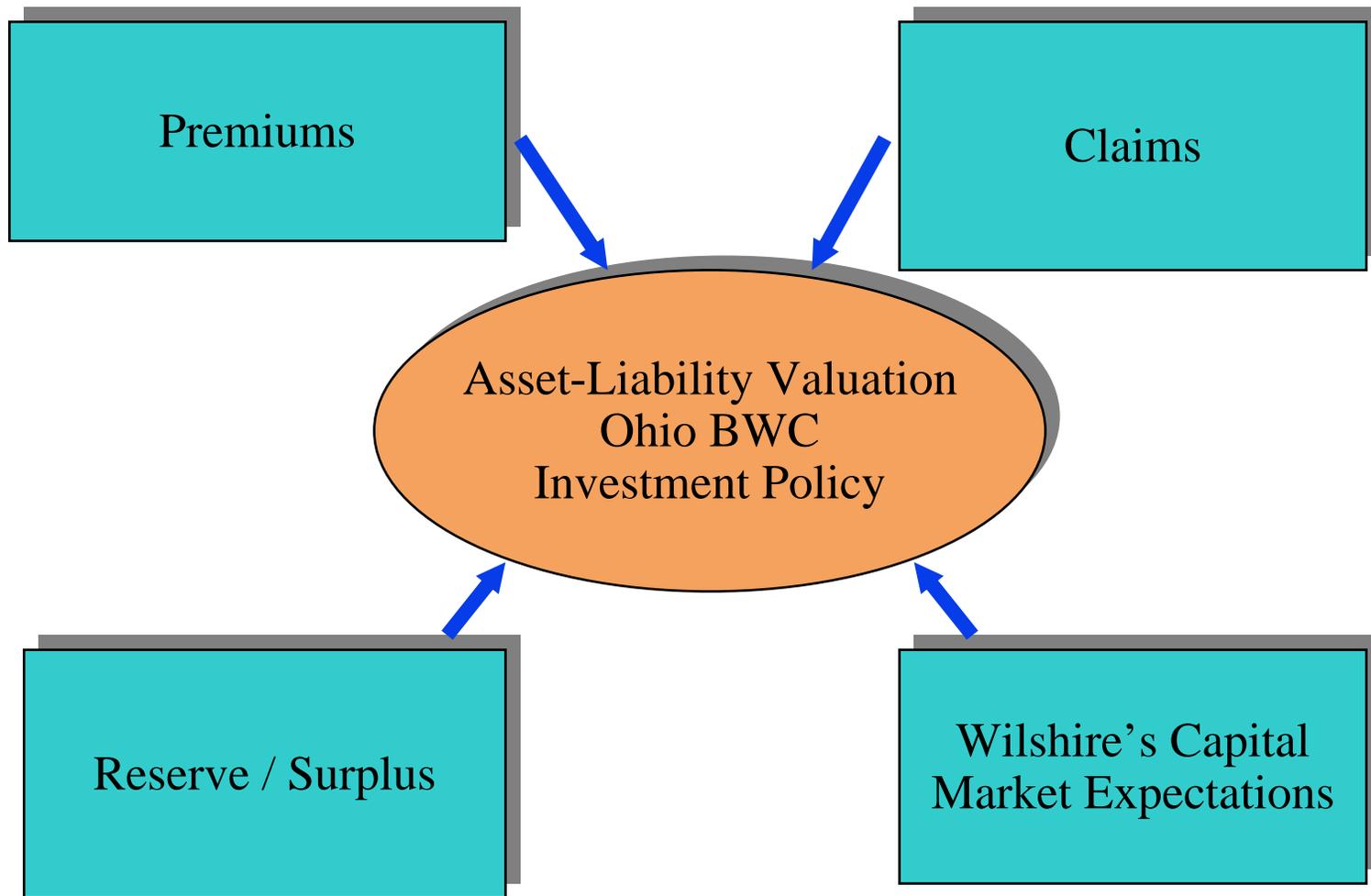
- ...but they narrow considerably over a 10-year period



IV. Inputs to Asset-Liability Valuation Model



- **Wilshire's Asset-Liability Model integrates key economic and accounting data**



Key Actuarial Assumptions

➤ **Medical Inflation = 9%**

- ◆ Expectation for 2006 and beyond
- ◆ A 1% unexpected increase in the rate of medical inflation (i.e. to 10%), would increase reserves by over \$1.3 billion over a 10-year timeframe (estimate)

➤ **Wage Inflation = 3.5%**

➤ **Discount Rate = 5.25%**

- ◆ 5-year average of 30-year Treasury Constant Maturity Index

➤ **Premium pricing policy:**

- ◆ Premiums are priced to reflect the current year's future claims (discounted)

➤ **Population:**

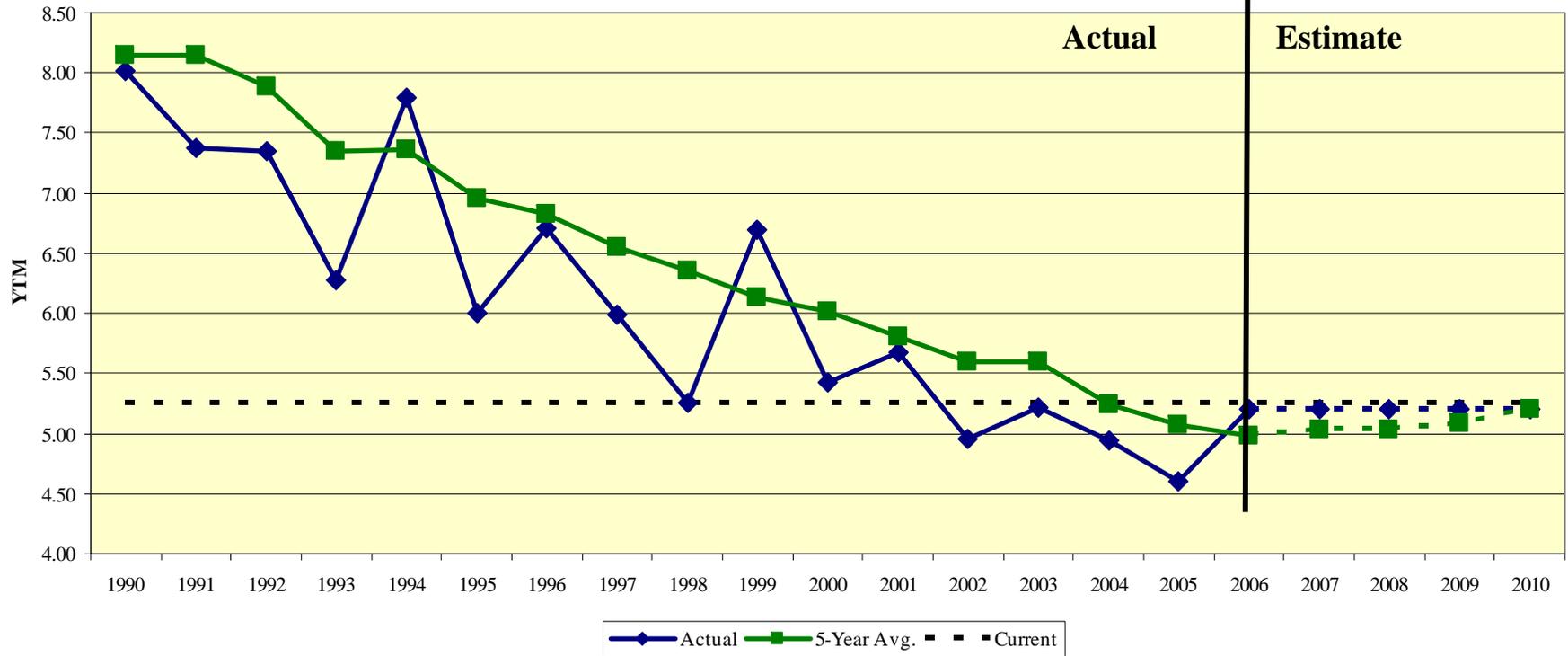
- ◆ Wilshire used an open population consisting of existing claimants plus 30 years of new entrants



Historical Yield Curve

- **BWC currently uses a five year average of the U.S. 30-Year Treasury yield as its discount rate**

U.S. 30-Year Treasury Yield



Estimate based on 30-Year Treasury YTM as of 4/30/2006



V. Surplus Optimization (Accounting-based)



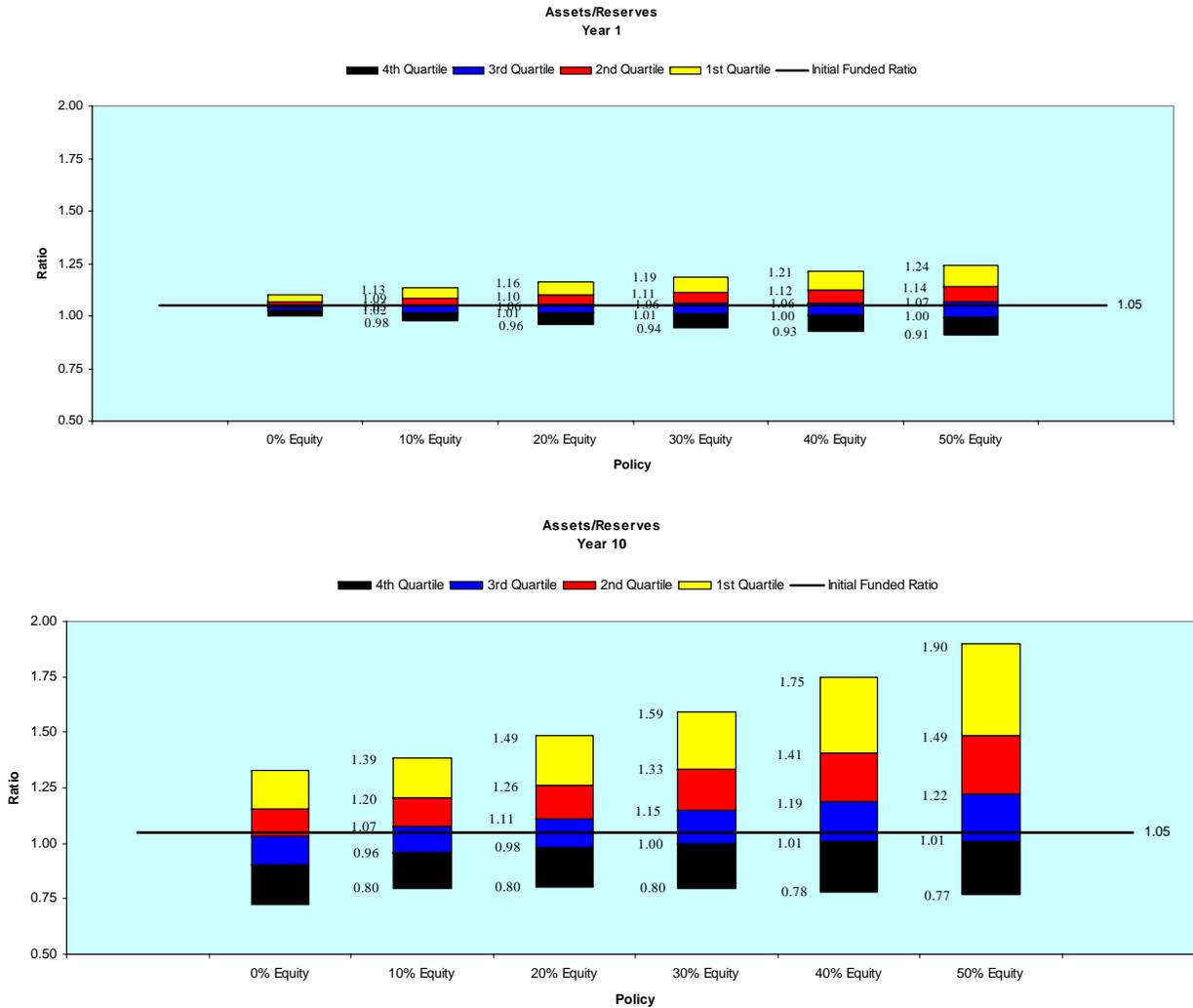
Current BWC Accounting Status

Assets (\$ mm)	
Total Cash and Investments	16,458.00
Accrued Premiums	1,981.00
Other Accounts Receivable	349.00
Investment Receivables	2.00
Other Assets	128.00
Total Assets	18,918.00
Liabilities (\$ mm)	
Reserve	17,308.00
Accounts Payable	39.00
Investment Payables	-
Other Liabilities	701.00
Total Liabilities	18,048.00
Net Assets (\$ mm)	870.00

Source: BWC Financial and Operational Report – March 2006

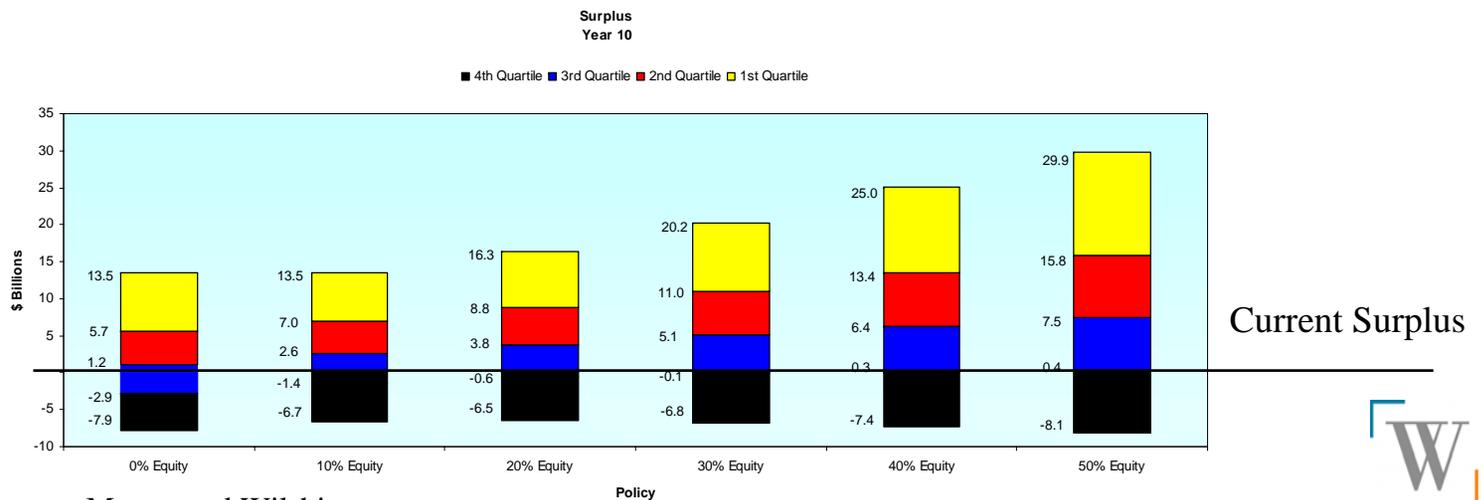
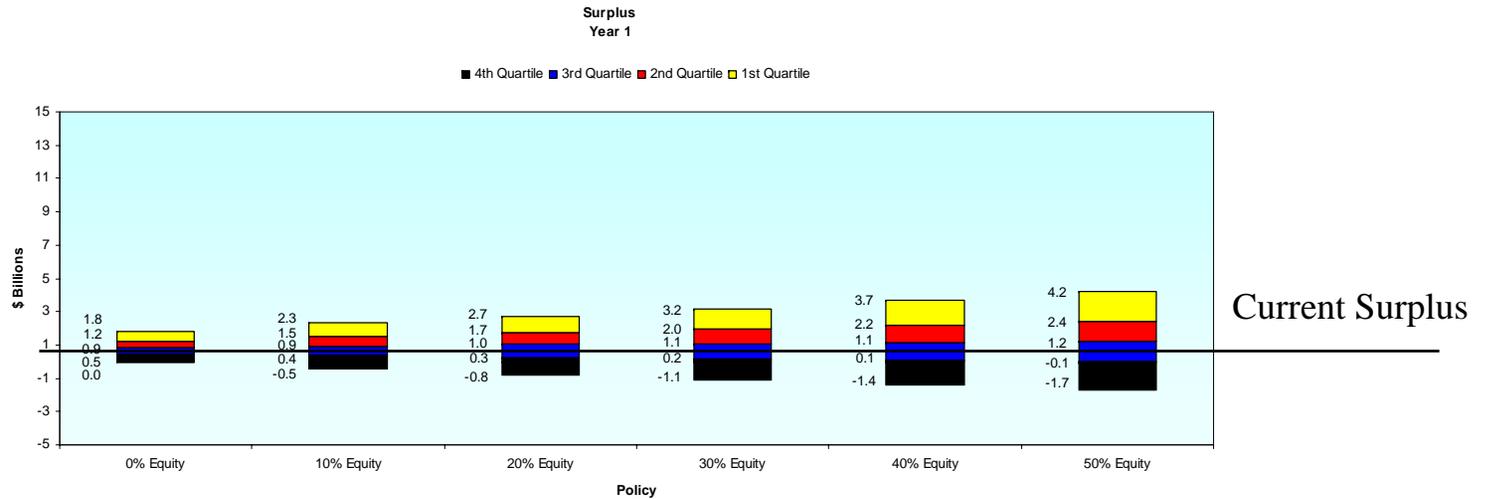


Stochastic Simulation of Assets as a % of Reserves: 1-Year and 10-Year



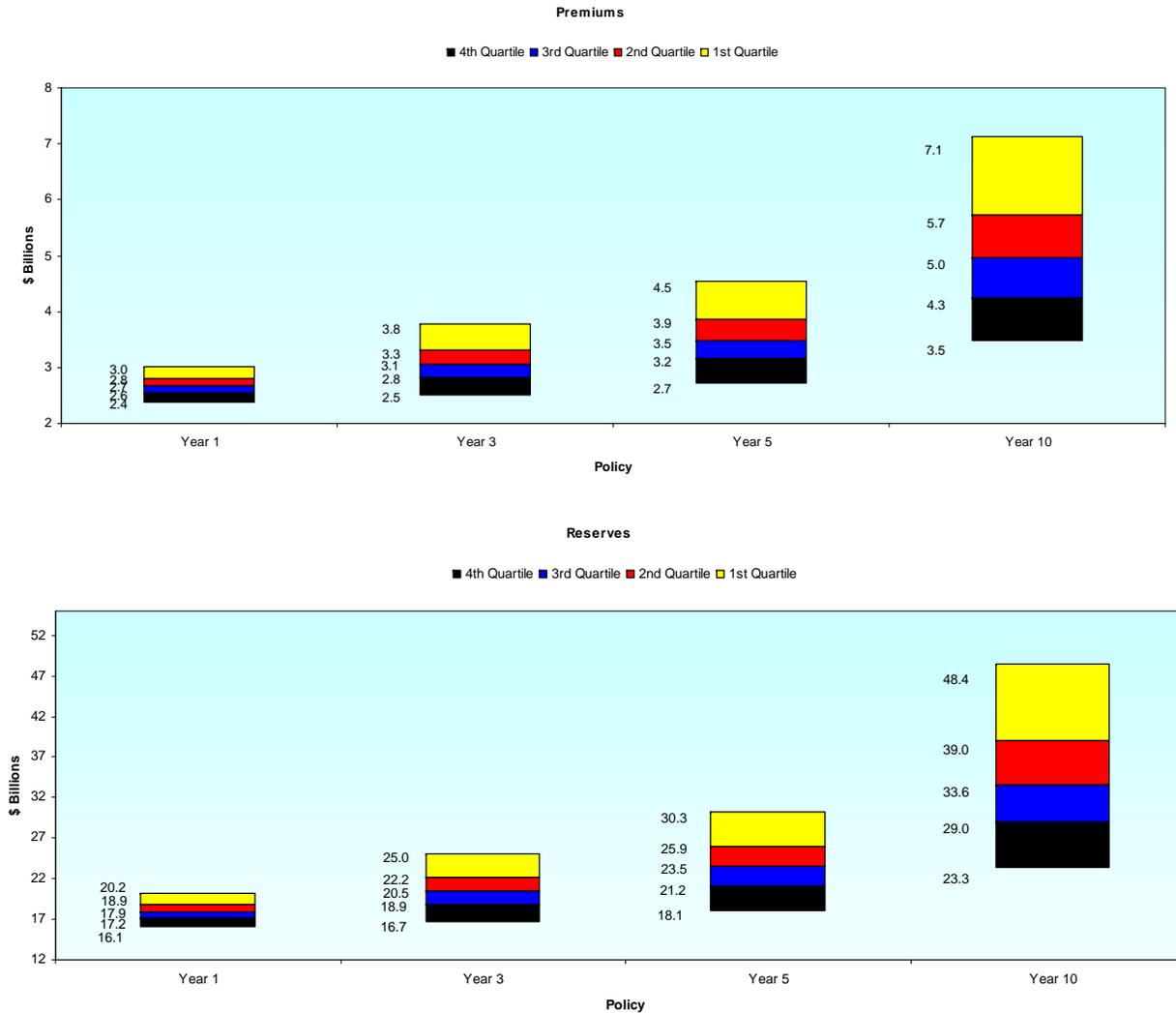
Stochastic Simulation of Surplus: Year 1 and Year 10

- The floating bar charts incorporate a stochastic simulation of assets, premiums, claims and reserves under potential interest rate, inflation and capital market environments and illustrate the potential SIF surplus under various asset mixes over short and long-term time horizons:



Stochastic Simulation of Premiums and Reserves

➤ Distribution of Expected Premiums and Reserves:



Surplus Optimization - Observations

- **Surplus Optimization measures the volatility of the difference in accounting assets vs. liabilities**
- **Over a one year time horizon, the “Immunized” Portfolio (i.e. 0% Equity) results in the least downside risk to the surplus of the Fund**
- **Over a longer term horizon (10 years), the 20% Equity portfolio results in the least downside risk to the surplus of the Fund due to time diversification and the inflation risk embedded in the liabilities**



VI. Cost-Risk Optimization (Cash Flow-based)



The Core Business of a Workers' Compensation Fund

- The core business of a workers' compensation insurance fund is to pay claims as promised to injured workers.
- The primary risk to the core business is to have insufficient assets to pay promised benefits.

Stakeholders – Employees

- Given expected premiums, we can maximize the probability that all claims obligations will be met. That is, we can minimize the risk to the core business at a given level of cost.
- For each cost level, there exists a policy portfolio which maximizes the chance that all benefits will be paid.
- Wilshire's asset allocation methodology - Asset Liability Valuation - yields a frontier of portfolios which are in the best interest of Employees

Stakeholders – Employers

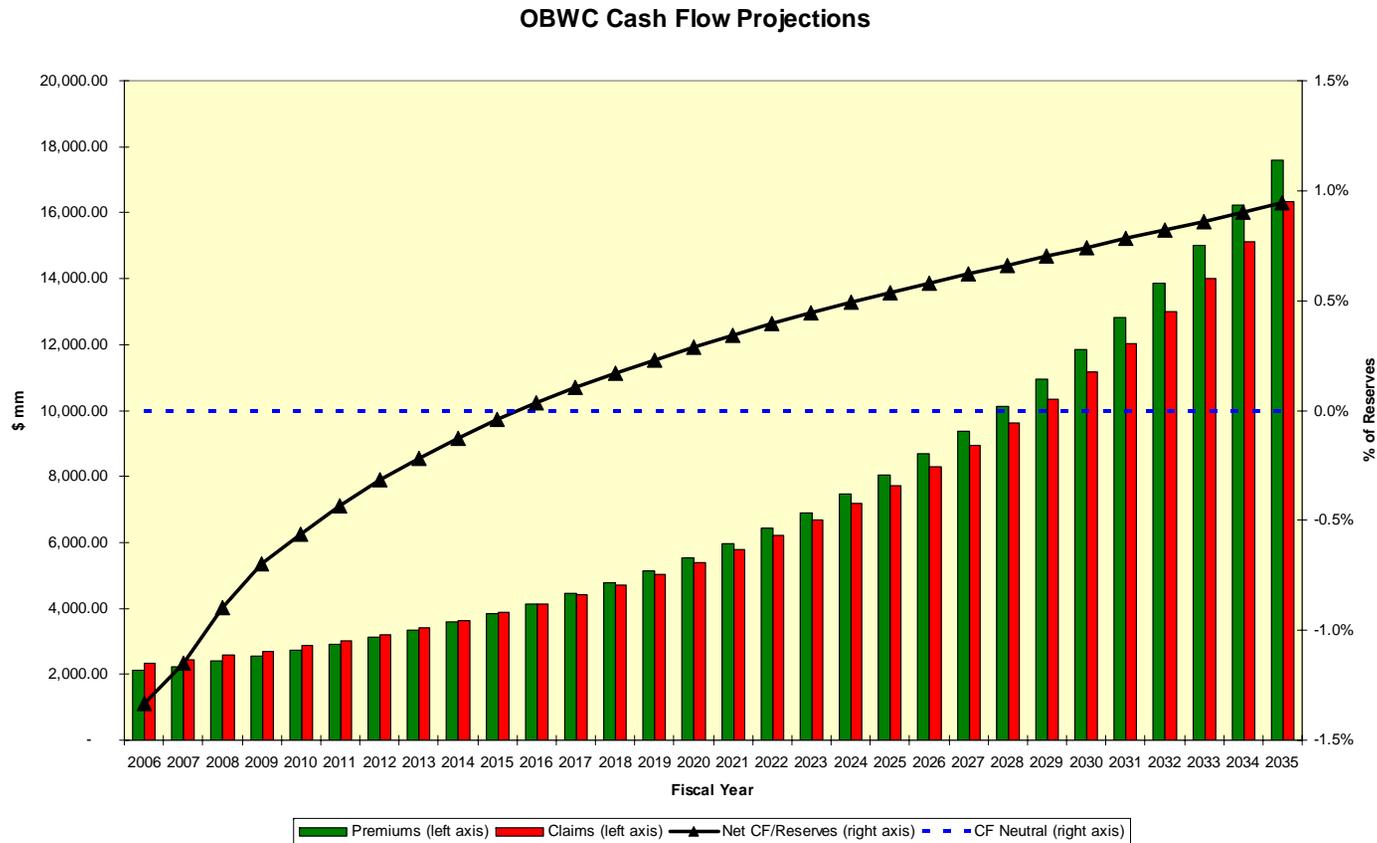
- Given a level of benefit security – a probability that all benefits will be paid – we can minimize the cost to the core business.
- For each probability, there exists a policy portfolio which minimizes the cost necessary to pay benefits.
- Asset Liability Valuation yields a frontier of portfolios which are in the best interest of the Employers. It can be shown that this set of policies is identical to the set of policies which are in the best interest of Employees.

The Role of Asset Allocation

- It is in the best interest of the employees to make promised benefits as secure as possible. Asset Liability Valuation will identify policies which maximize the safety of benefits at a given cost
- It is in the best interest of employers to limit the cost of funding benefits at an appropriate level of risk. Asset Liability Valuation will identify policies which minimize the cost of paying for promised benefits

OBWC Cash Flow Projections

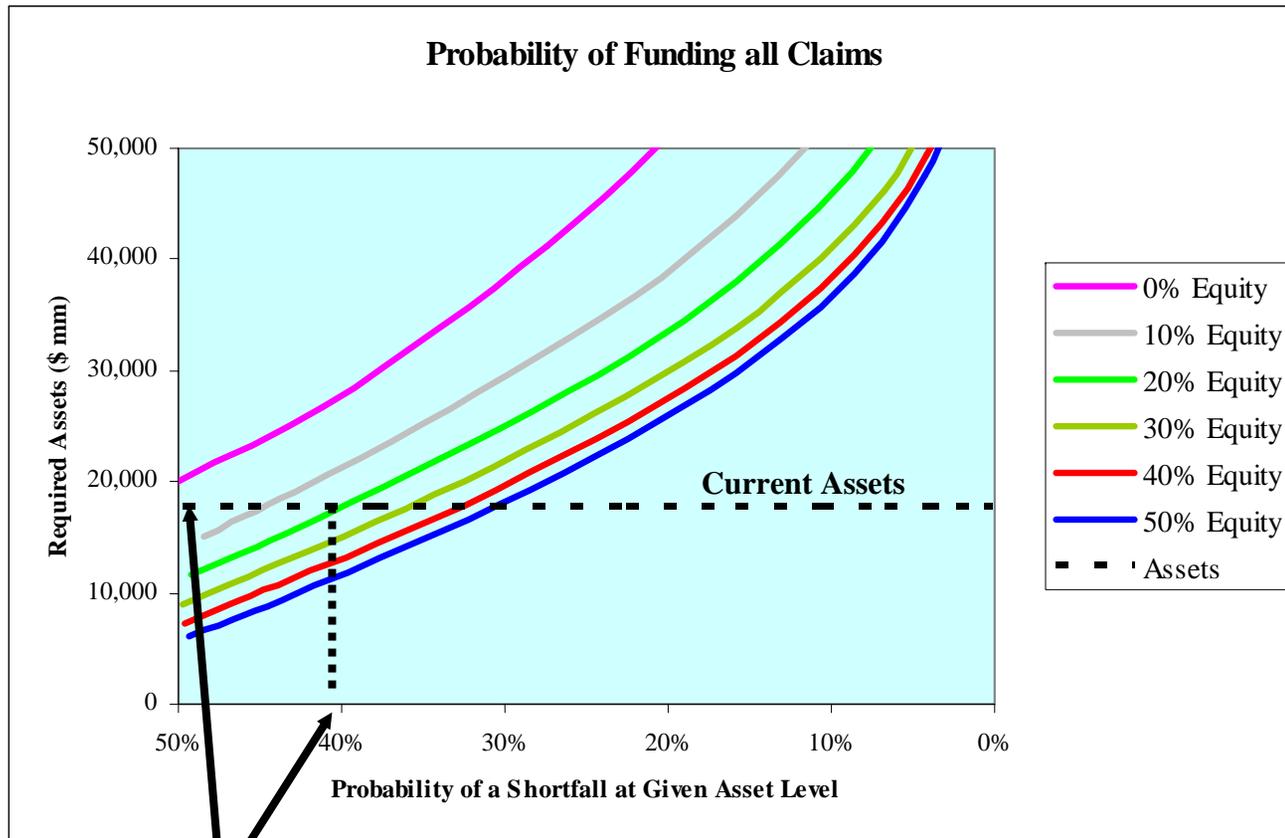
- Modest negative cash flows (premiums less claims) are expected over the next 10 years, followed by positive cash flows
- This illustration excludes expected investment income



Source: Mercer Oliver Wyman Projections



- The graph below, based on Wilshire's Asset-Liability Valuation model, illustrates the probability of funding all future claims based on current assets and a stochastic simulation of expected returns and future premiums and claims:



A 20% equity allocation results in a ~10% greater probability of funding all claims than a 100% fixed income allocation given the current assets and expected premiums.

Observations

- **The cost-risk optimization is a multi-period model that measures the ability of the Fund to pay all claims when due.**
- **The objective is to maximize the safety of claims payments**
- **Due primarily to the expected future positive cash flows to the Fund and the inflation risk embedded in the claims payment streams, asset mixes that include equity result in a higher probability of funding all benefit claims than the “Immunized” fixed income portfolio.**



Observations

- **The optimal asset mix is highly dependent on the Fund’s ultimate objective and time horizon:**
 - If minimizing short term volatility of the accounting surplus is the sole objective, then the “Immunized” fixed income portfolio is optimal
 - If minimizing the long-term (10-year) downside risk of the accounting surplus is the objective, then a 20% equity allocation is optimal
 - If maximizing the safety of benefit claims is the objective (and the Fund can withstand downside risk to the accounting surplus), then an equity allocation greater than 20% may be justified (please see slide 45)
- **The immunized bond portfolio will not likely preserve the surplus in periods when medical and/or wage inflation exceed current expectations**
 - There is no financial instrument that can effectively hedge this inflation risk
- **Regardless of the asset mix selected, Wilshire recommends that OBWC build a larger surplus before considering future premium refunds to employers**
 - Under any asset allocation policy mix, there exists the probability of a shortfall (please see slide 45) in the future
 - Because of the positive cash flow characteristics (slide 44) of the SIF, any shortfall would likely not be an issue until well into the future



Recommendation

- If the OBWC's time horizon is longer-term (i.e. 10-years), then Wilshire recommends a 20% equity allocation and the specific asset mix as detailed below:

<i>Asset Class</i>	<i>Portfolio Weights</i>	
	<i>"Immunized"</i>	<i>Recommended</i>
	<i>0% Equity</i>	<i>20% Equity</i>
U.S. Equity	0	15
Non-U.S. Equity	0	5
Total Equity	0	20
Fixed Income - Core	0	0
Fixed Income - Long Duration/Dedicated	99	54
Fixed Income - High Yield	0	5
Fixed Income - Inflation Protected	0	20
Total Fixed Income	99	79
Cash Equivalents	1	1
Return	5.23	6.07
Risk	6.93	6.13

- This mix provides a balance between the long-term growth of the surplus with the preservation of the surplus over intermediate time horizons



Investment Structure

- **Wilshire recommends the following investment structure for implementing the asset allocation policy:**

<i>Asset Class</i>	SIF Allocation		<i>Benchmark</i>
	%	\$ mm	
U.S. Equity	15	2,265	Wilshire 5000
<i>Large Cap</i>	<i>12</i>	<i>1,812</i>	<i>S&P 500</i>
Active (0%)	0	-	
Passive (100%)	12	1,812	
<i>Small/Mid Cap</i>	<i>3</i>	<i>453</i>	<i>Wilshire 4500 / Russell 2500</i>
Active (100%)	3	453	
Passive (0%)	0	-	
Non-U.S. Equity	5	755	MSCI ACWI ex-U.S.
Active (80%)	4	604	
Passive (20%)	1	151	
Fixed Income - Long Duration	54	8,153	Lehman Long Government/Credit
Active (50%)	27	4,076	
Passive (50%)	27	4,076	
High Yield	5	755	Merrill Lynch High Yield Master II
Active (100%)	5	755	
Passive (0%)	0	-	
Inflation-Protected Securities	20	3,020	Lehman U.S. TIPS
Active (0%)	0	-	
Passive (100%)	20	3,020	
Cash Equivalents	1	151	90-Day T-Bill

Please refer to the following page for an analysis of the long-duration fixed income benchmark.



Appendix – Wilshire’s 2006 Asset Class Assumptions



Executive Summary

Long Term Care Loan Program

Background History

Since July 1999, the BWC SafetyGRANT\$ program has provided grant funds to Ohio employers to assist with the reduction or elimination of workplace injuries and illnesses through the purchase of intervention equipment. Preliminary results of the grant program have determined that the use of floor-based patient lifting devices in nursing homes resulted in a payback period of 2.5 months and a marked improvement in the incidence of cumulative trauma disorder (44% improvement), lost days (38% improvement), restricted days (10% improvement), and employee turnover (25% improvement). The use of ceiling mounted patient-lifting devices resulted in improvements in restricted days and employee turnover.

Preliminary results also indicate that the use of electric beds can greatly reduce upper extremity cumulative trauma disorder as well as trunk flexion leading to back injuries. The use of electric beds resulted in a payback period of 8.5 months and an improvement in the incidence of cumulative trauma disorder (29% improvement), lost days (72% improvement), restricted days (31% improvement), and employee turnover (9% improvement).

To further assist Ohio nursing homes in eliminating the risk of injury resulting from patient lifting, the General Assembly included language in our last budget bill to establish the Long-Term Care Loan program.

Program Summary

The Long-Term Care Loan program will provide interest free loans to nursing homes in Ohio to assist with purchasing, improving, installing or erecting sit-to-stand floor lifts, ceiling lifts, other lifts and fast electric beds, and to pay for the education and training of personnel to implement a facility policy of no manual lifting of residents by employees. Employers who are nursing homes as defined in section 3721.01 of the Revised Code are eligible to apply.

The loan limitations include a cap of \$100,000 per loan and a stipulation that the loan amount will not exceed 90% of the purchase price of the equipment. BWC will contract with a loan institution to issue and service the loans to eligible employers. BWC will place in the Long Term Care Loan fund \$2 million to cover the costs related to administering the program and to buy down the points for the no-interest loan.

Determination of the applicant's loan eligibility and the amount of the loan made by the financial institution will be final.



Wilshire Consulting

2006 Asset Allocation Return and Risk Assumptions

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January 25, 2006

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Introduction

This report is Wilshire Associates' annual study on asset allocation for institutional portfolios. The return and risk recommendations contained within the report should be used for asset-liability and asset allocation studies conducted in 2006. All return assumptions are median geometric returns based on a log-normal distribution.

The asset allocation process is comprised of four steps. The initial step requires forecasting return, risk, and correlation for all asset classes. The second step is client specific and involves a review of a fund's unique financial commitments. Next, using inputs from the first two steps, an efficient frontier of diversified portfolios is constructed. The portfolios residing on this frontier are specific to each client's liabilities, or spending objectives, and represent varying tradeoffs between expected risk and funding cost or expected risk and real return. The final step is to select an asset mix from the efficient frontier that matches the institutions' attitude toward risk. The research presented here aids in completing the first step of the asset allocation process. Wilshire Consulting works with funds individually to complete the remaining steps and to select the optimal portfolio which best reflects the risk tolerance and environment for that institution.

Expected Future Returns

At the beginning of each year, Wilshire reviews its long-term return and risk assumptions for the major asset classes. We define 'long-term' as forecasts that cover at least the next ten years. This extended time horizon is consistent with the benefit/spending obligations of institutional investors, which generally average at least ten years. Wilshire's forecasting methodology has a strong degree of accuracy, which will be illustrated in exhibits throughout the paper, over intervals of ten or more years and is superior to short-term estimates that are notoriously error prone.

Because of their long-term horizon, Wilshire's assumptions typically change very little from year to year. One would only expect significant changes following a period of volatile directional swings in asset markets or valuations. It is routine practice for us to alter our return assumptions up or down to better fit changing market levels. This year is no exception. Wilshire's real return forecasts for several of the major asset classes have increased by 50 basis points. These increases have been fueled in part by a 25 basis point reduction in our inflation forecast – from 2.50% to 2.25% - and by increases in the asset classes' nominal return forecasts. For example, our return forecast for U.S. stocks and bonds have both increased by 25 basis points from 8.0% and 4.75% a year ago to 8.25% and 5.00% this year, bringing their forecasted real rates of return from 5.50% and 2.25% to 6.00% and 2.75%, respectively¹. Wilshire's high yield bond forecast has been increased by 25 basis points - from 6.25% to 6.50% - as a result of a general increase in bond yields and a widening of credit spreads. Additionally, as was detailed in a recent research report on Wilshire's private market model, our private markets portfolio return has also been increased from 11% to 11.75%. Conversely, we trimmed our return forecast for REITs by 75 basis points, from 7.00% to 6.25%, due to the continuing decline in yields.

¹ For simplicity, real returns have been shown here as the difference between nominal returns and inflation. The simplification ignores the cross-compounding effect of inflation and real returns. For example, the 'true' embedded real rate of return in Wilshire's stock forecast is 5.87% ($= 1.0825/1.0225 - 1$).

Building on research Wilshire conducted in 2005, we have made two important modifications to the list of asset classes included in this year's report. First, our research report on the institutional use of hedge funds² has led us to discontinue providing "asset class" assumptions for hedge fund strategies. It is Wilshire Consulting's belief that, as with other potential sources of alpha, decisions regarding the use of hedge funds in the pursuit of active returns are separate from the asset allocation process. While we will no longer publish formal "asset class" forecasts for hedge funds, Wilshire will continue to work with our clients individually to assist in the development of assumptions for funds interested in incorporating hedge fund vehicles as a separate asset class. Next, as a result of our recent research on commodity futures investing³, this year's report is Wilshire's first to include asset class assumptions for commodities.

The importance of long-term return forecasts is growing. Actuarial interest rate assumptions, which are essentially portfolio return forecasts, are increasingly scrutinized because of their potential impact on plan contributions in the current environment. Wilshire has been forecasting asset class returns using forward looking assumptions since 1981 with a strong record of success over 10-year periods. We believe the methods used in this report are both intuitive and robust.

Exhibit 1 presents Wilshire's 2006 return forecasts and contrasts them with our 2005 assumptions; while Exhibit 2 displays our 2006 projections in graphical form.

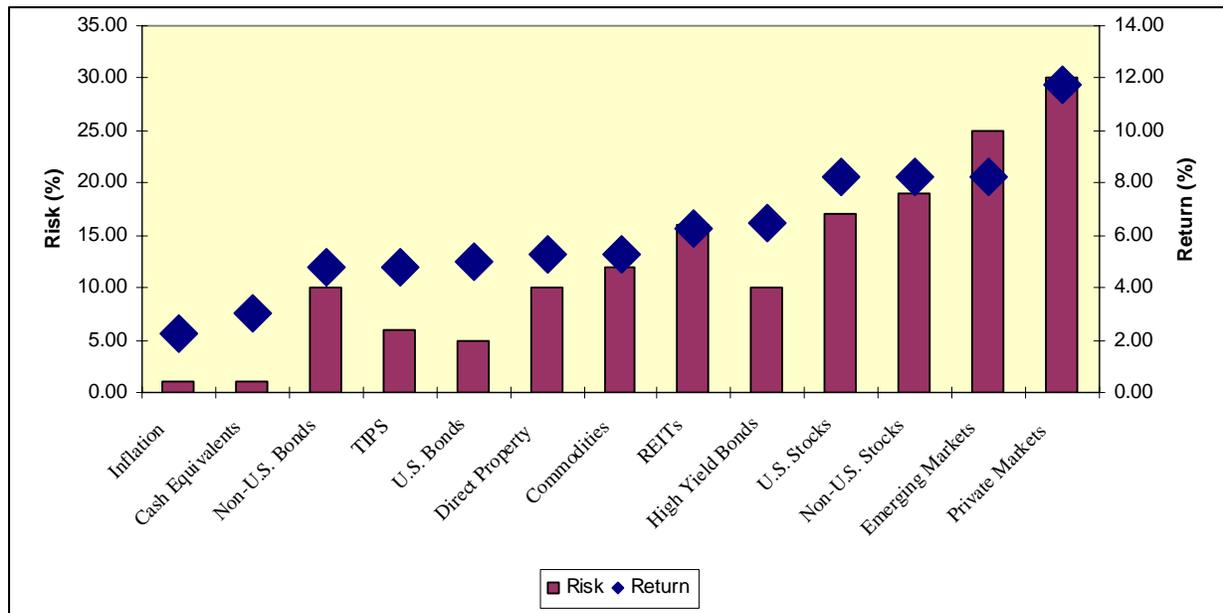
Exhibit 1 Wilshire's Expected Return Assumptions

	Total Return			Risk
	2005	2006	Change	
<u>Investment Categories:</u>				
U.S. Stocks	8.00 %	8.25 %	0.25 %	17.00 %
U.S. Bonds	4.75	5.00	0.25	5.00
Cash Equivalents	3.00	3.00	0.00	1.00
Non-U.S. Stocks	8.00	8.25	0.25	19.00
Non-U.S. Bonds	4.50	4.75	0.25	10.00
Emerging Markets	8.00	8.25	0.25	25.00
High Yield Bonds	6.25	6.50	0.25	10.00
TIPS	4.25	4.75	0.50	6.00
Real Estate Securities (REITs)	7.00	6.25	-0.75	16.00
Direct Property	6.00	5.25	-0.75	10.00
Private Markets	11.00	11.75	0.75	30.00
Commodities	n.a.	5.25	n.a.	12.00
Hedge Funds: Portable Alpha *	5.00	n.a.	n.a.	n.a.
Inflation:	2.50	2.25	-0.25	1.00
<u>Total Returns minus Inflation:</u>				
U.S. Stocks	5.50	6.00	0.50	
U.S. Bonds	2.25	2.75	0.50	
Cash Equivalents	0.50	0.75	0.25	
<u>Stocks minus Bonds:</u>	3.25	3.25	0.00	
<u>Bonds minus Cash:</u>	1.75	2.00	0.25	

² "Institutional Use of Hedge Funds: Penetrating the Darkness on the Hedge of Town?" July 26, 2005.

³ "Commodity Futures Investing: Is All That Glitters Gold?" March 9, 2005.

Exhibit 2 Wilshire's Expected Return and Risk Assumptions



These return forecasts are more fully explained in subsequent sections dedicated to each asset class.

Historical Returns

A key check on the reasonableness of Wilshire's assumptions is their relationship to historical returns. Exhibit 3 contrasts Wilshire return assumptions with historical returns over various periods of time and market scenarios.

Exhibit 3 Historical Returns vs. Wilshire Forward-Looking Assumptions

	Historical Returns				Wilshire Forecast
	1802-2005 *	1926-2005	High Inflation 1970-1979	Bull Market 1980-1999	
Total Returns:					
Stocks	8.2 %	10.4 %	5.9 %	17.8 %	8.3 %
Bonds	4.9	5.7	7.2	10.0	5.0
T-bills	4.3	3.8	6.4	7.2	3.0
Inflation:	1.4	3.0	7.4	4.0	2.3
Total Returns minus Inflation:					
U.S. Stocks	6.8	7.3	-1.5	13.8	6.0
U.S. Bonds	3.5	2.6	-0.2	6.0	2.8
T-bills	2.8	0.8	-1.0	3.1	0.8
Stocks minus Bonds:	3.3	4.7	-1.3	7.8	3.3

* Jeremy Siegel return history from 1802-2001 ("Stocks for the Long Run" McGraw-Hill 2002) updated to 2005 using S&P 500 Index and Lehman Aggregate Bond Index

There are several relationships worth noting. Wilshire's stock and bond return forecasts, 8.3% and 5.0%, respectively, are close to the actual returns achieved over the 204-year period ending 2005. However, despite having increased by 50 basis points since last year's report, the real return forecast for stocks falls below its historical averages while the return spread between stocks and bonds is forecasted to be 3.3%, equal to the 204-year return history.

The remainder of the report explains the methodologies behind Wilshire's return forecasts.

Inflation

Wilshire’s long-term inflation forecast is 2.25%, 25 basis points lower than one year ago.

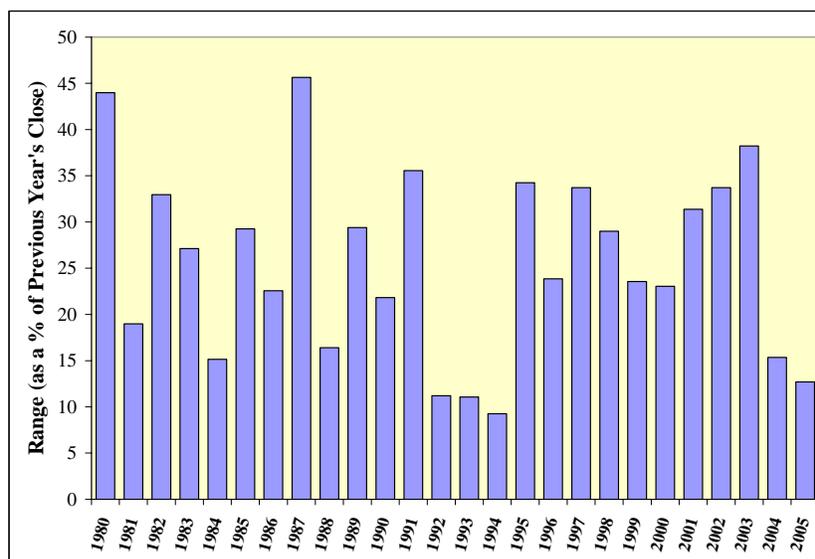
A market-based inflation forecast can be derived by subtracting a TIPS yield-to-maturity from a traditional Treasury bond yield-to-maturity with the same maturity. For example, on December 30th, 2005, the 10-year Treasury had a yield of 4.36% while the yield on the 10-year TIPS was 2.07%. The 2.29% difference in yields is the bond market’s estimate for inflation over the next ten years, which is also referred to as the 10-year breakeven inflation rate. Wilshire’s practice is to select a return forecast rounded to the nearest 0.25%. Consequently, we round the 2.29% breakeven inflation rate to our 2.25% inflation rate forecast.

Equity

U.S. Stocks

Wilshire’s long-term expected return for U.S. stocks is 8.25%, up from 8.00% one year ago. As mentioned earlier, absent any volatile market events or shifts in pricing multiples, one would expect only minor changes in long-term return forecasts from year to year. Continuing on the pricing stability experienced in 2004, the year 2005 proved to be one of the most tranquil equity markets in recent memory. As illustrated in Exhibit 4, the Dow Jones Wilshire 5000 Indexsm traded within a 12.7% price range in 2005, its narrowest trading range since 1994 (9.2%). The market’s relative tranquility over the past two years has been in stark contrast to volatility levels seen over the prior three years, which all exceed 31%. Price-to-earnings valuation ratios declined further as prices increased at a slower pace than earnings. The price of the S&P 500 Index rose 3% versus a more accelerated growth in earnings of 13%. Price to trailing-earnings multiples for the S&P 500 have compressed from 29.6 in December of 2001 to 16.3 at the end of 2005.

Exhibit 4
Dow Jones Wilshire 5000 Trading Ranges



It is Wilshire’s practice to employ a dividend-discount model (“DDM”) to forecast long-term U.S. stock returns⁴.

Wilshire’s current expected return for stocks incorporates the following assumptions:

- A year-end 2005 S&P 500 Index price of 1,248, up from 1,212 a year earlier;
- A base earnings level of \$77 per share, up from \$68 per share a year earlier;
- Earnings-per-share growth of 8.5% over the next five years, dropping incrementally to 4.8% from years six through 15;
- A 29% dividend payout ratio over the next five years, increasing incrementally from years six through 15 to 45% - its historical average over the past 25 years;
- Long-term earnings and dividend growth of 4.8% after 15 years, equal to a 2.25% inflation rate and a 2.50% real growth rate.

When establishing long-term return projections, it is helpful to identify the model’s sensitivity to each of the assumptions which are used as inputs. This echelon of understanding is vital in forecasting returns that can be used with high levels of confidence. Exhibit 5 demonstrates the model’s sensitivity to changes in 5-year earnings growth estimates and dividend payout ratios.

Exhibit 5
DDM Forecast Sensitivity to Inputs

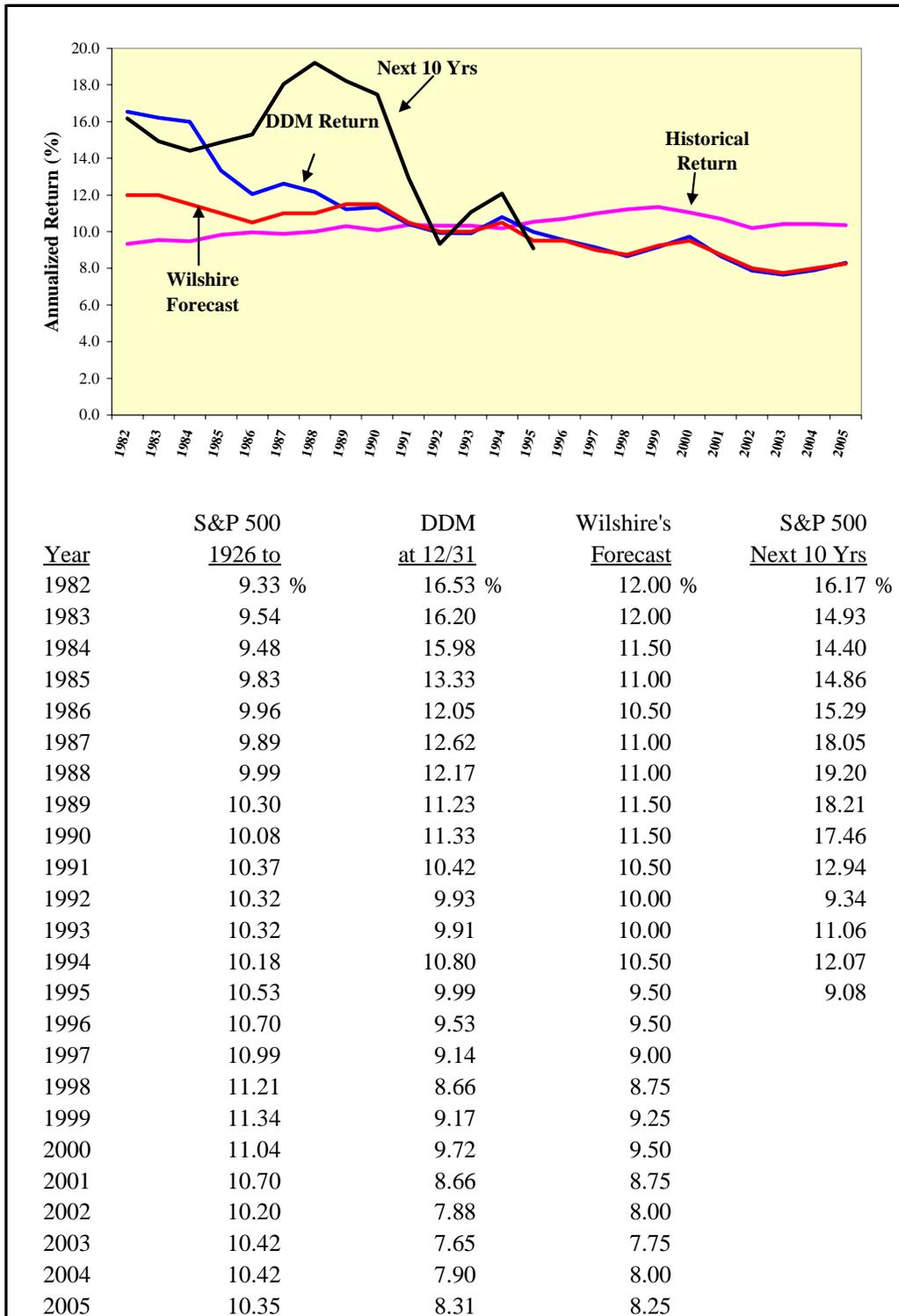
		Dividend Payout Ratio (Long Term)					
(%)		25	30	35	40	45	50
5-Year EPS Growth	7.0	6.66	6.97	7.26	7.54	7.81	8.06
	7.5	6.75	7.06	7.37	7.65	7.93	8.19
	8.0	6.83	7.16	7.47	7.77	8.05	8.32
	8.5	6.92	7.26	7.58	7.89	8.18	8.46
	9.0	7.01	7.36	7.70	8.01	8.31	8.60
	9.5	7.11	7.47	7.81	8.14	8.45	8.74
	10.0	7.20	7.58	7.93	8.27	8.58	8.89
	10.5	7.30	7.69	8.06	8.40	8.73	9.04
	11.0	7.41	7.81	8.18	8.54	8.87	9.19
	11.5	7.52	7.93	8.31	8.68	9.02	9.35
	12.0	7.63	8.05	8.45	8.82	9.17	9.51

Wilshire’s assumption of 8.5% earnings growth over the next five years falls between the I/B/E/S ‘top-down’ median strategist estimate of 8.0% and the implied ‘bottom-up’ growth rate of 12% from the I/B/E/S security level median EPS forecasts. Our expectation for earnings growth is closer to the ‘top-down’ median estimate, as past experience suggests that the ‘bottom-up’ estimates tend to be overly optimistic and prone to ‘over shoot’ error. We expect dividend payout ratios to move towards their historical average of 45% over the next 15 years.

⁴ “Wilshire’s Expected U.S. Stock Return: An Explanation,” November 13, 2002.

Exhibit 6 details the history of Wilshire's stock return forecasts together with the dividend-discount model return forecasts, historical returns, and the rolling returns for the 10-year period following each estimate. Beginning in the mid-1980s, Wilshire chose to base its stock return forecast on its DDM whereas previously our forecast averaged the model return with historical stock returns. With the exception of periods beginning in the late 1980s and early 1990s, Wilshire's DDM forecast has been a very good predictor of the S&P 500's return over the following ten-year period. Actual 10-year returns that began in those years included the technology bubble of the late 1990s, something we would not expect our methodology to predict. Equity returns have subsequently deflated and Wilshire's forecasts from 1992 through 1995 (the last estimates with ten years of subsequent actual returns) are once again consistent with actual S&P 500 returns for the subsequent ten years.

Exhibit 6
Wilshire Stock Return Forecast vs.
DDM Return, Historical Return, & Actual 10-Year Return Following Forecast



Non-U.S. Stocks

Wilshire uses the same 8.25% expected return for non-U.S. stocks of developed markets as it does for U.S. stocks. While this view has gained wider acceptance in recent years, some institutional investors and their money managers assume that the non-U.S. developed stock market will average somewhat higher returns than U.S. stocks. As demonstrated in Exhibit 7, the historical record does not support a non-U.S. return premium.

Exhibit 7
Historical Returns (through 2005)

	U.S. Dollar		Local Currency	
	Return	Risk	Return	Risk
S&P 500 Index	11.1 %	15.4 %	11.1 %	15.4 %
MSCI EAFE Index	10.5	16.6	8.8	14.3
Europe	10.7	16.6	10.3	15.2
Pacific	10.8	20.7	8.2	17.1

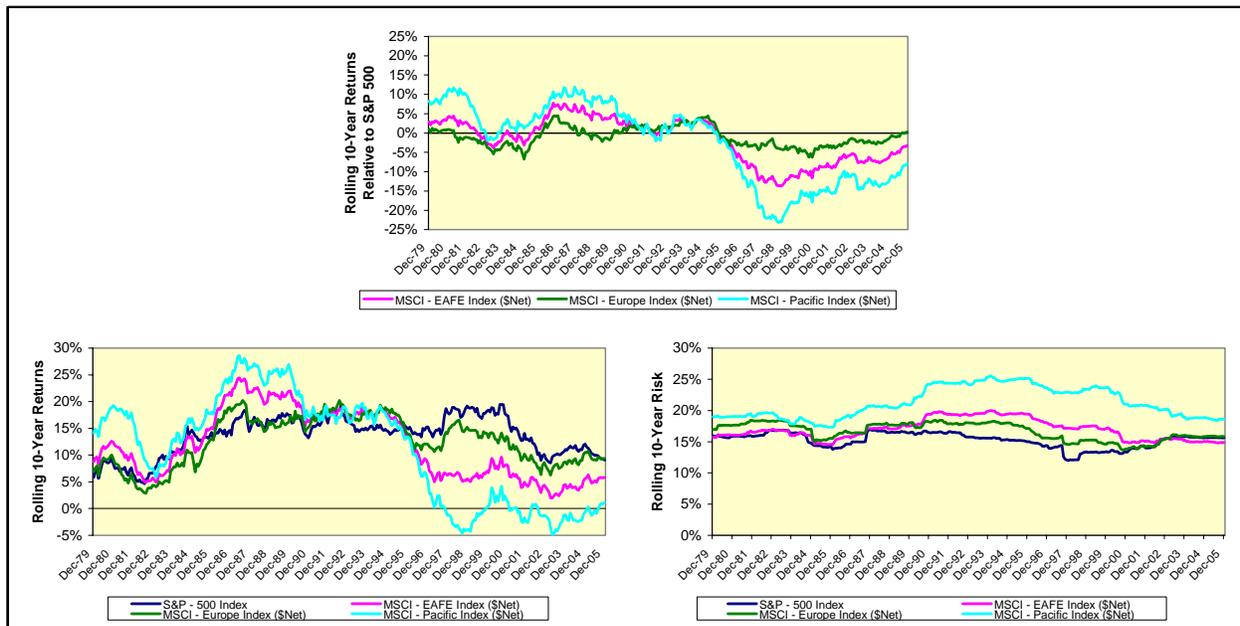
Reliable returns for non-U.S. stocks are available beginning 1970. Since that time U.S. stocks, as represented by the S&P 500 Index, have returned 11.1% per year, versus 10.5% for non-U.S. stocks as measured by Morgan Stanley Capital International's ("MSCI") EAFE Index in U.S. dollars.

When the two chief components of the EAFE Index are examined, we see support for the same conclusion. Since December 31, 1969, European stocks have returned 10.7% per year, or 40 basis points below U.S. stocks. Given this long-term performance record, similar risk levels, and common financial attitudes toward risk-taking, it would seem reasonable to forecast similar long-term returns for the U.S. and Europe. In fact, evidence might suggest slightly lower expected returns on European stocks due to higher costs (transaction costs, taxes and dividend withholding) of investing in the European stock markets.

The Pacific component of EAFE tells a similar story. Actual Asian returns have been comparable to the U.S., averaging 10.8% over the past 36 years. Japan, the largest country within the Pacific, returned 11.3% during the same period.

Exhibit 8 shows a long stretch of time (roughly 1985 to 1995) over which the MSCI EAFE Index outperformed the S&P 500 Index due to the then robust Japanese market. However, we believe the subsequent nearly 10-year out-performance of U.S. stocks versus non-U.S. stocks supports our assumption that the economic theories of Purchasing Power Parity ("PPP") and Interest Rate Parity ("IRP") prevail over long time periods and justify the selection of a single return assumption for both asset classes.

Exhibit 8 Rolling 10-Year Return & Risk Comparisons



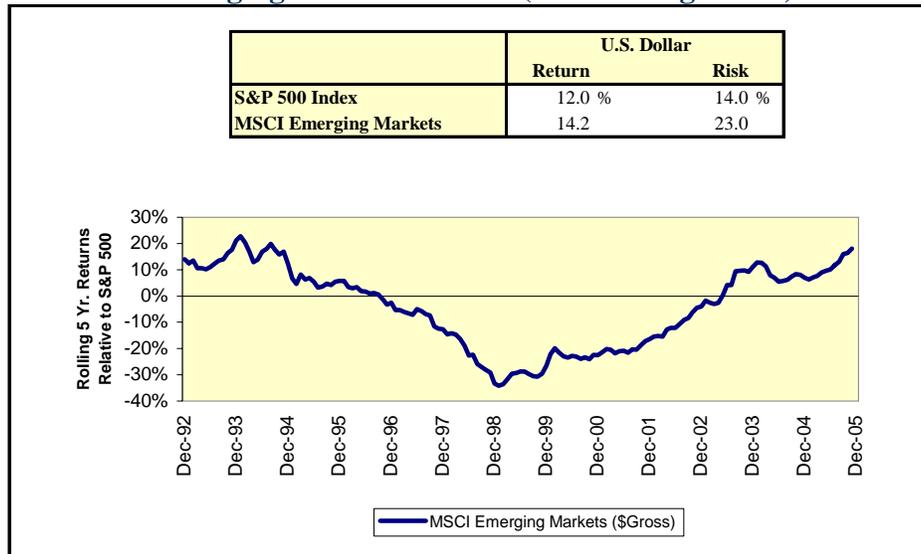
With the deficiency of concrete evidence that supports a non-U.S. equity return premium, Wilshire forecasts an 8.25% return for non-U.S. stocks of developed nations, the same as for U.S. stocks.

Emerging Markets

Money managers have long supported the view that emerging markets should produce returns above the developed EAFE markets. However, poor returns in the late 1990s combined with emerging markets' high volatility have caused some money managers to re-evaluate their position. In fact, it is important to understand that the historical record on emerging market performance is short and shows mixed results. This gives us less confidence in predicting a return premium to emerging markets above our return forecast for the developed stock markets. For example, prior to 2004, the historical return of the MSCI Emerging Markets Index was 12.4%, almost directly in line with the return on the S&P 500. Exhibit 9 illustrates this point.

The last three years, however, have seen emerging markets outperform developed equity markets by a wide margin, as measured from the start of the MSCI Emerging Markets Index. This has caused the relative returns for emerging markets to again be superior to those of the developed markets in a similar fashion to that seen in the early 1990's. As shown in Exhibit 9, this appears to be a cyclical phenomenon and as such, is not a sufficient reason to justify a long-term return premium.

**Exhibit 9
Emerging Market Returns (1988 through 2005)**



Since our 1999 report⁵, Wilshire has recommended an emerging market expected return equal to the return for developed markets, rather than assuming a small return premium to emerging markets. This change in approach is now consistent with Wilshire’s treatment of the U.S. stock market where large stocks are not separated from small stocks and value stocks are not separated from growth stocks in the asset allocation process. Wilshire believes that emerging markets have become sufficiently integrated into the fabric of institutional money management that market capitalization weighting will give most investors a near optimal return/risk tradeoff. Effectively, the MSCI All Country World Index (ACWI) ex US Index becomes the non-U.S. proxy of the Dow Jones Wilshire 5000 Indexsm.

Wilshire’s asset allocation work – unless otherwise directed by client circumstances – will implicitly assume an emerging markets component within the non-U.S. equity asset class. The emerging markets component will be market-weighted, which, as of 2005 end of year market values, represents 13% of total non-U.S. equity. Return, risk, and correlation assumptions for non-U.S. equity will incorporate emerging markets and Wilshire’s preferred benchmark will be the MSCI ACWI ex US, which includes all non-U.S. developed markets and emerging markets in market-weighted proportions.

Some clients, including most non-U.S. fund sponsors, will prefer to treat emerging markets as a separate asset class and Wilshire will continue to provide risk forecasts for emerging markets. Our research shows that efficient portfolios include a small allocation to emerging markets, consistent with a market-weighting, even with a level of return equal to the developed equity markets. In this framework, emerging stock markets become a risk management or diversification vehicle rather than an asset class that is expected to generate higher long-term returns.

⁵ “1999 Asset Allocation Report,” February 1999.

Fixed Income

U.S. Bonds

Bond market yields provide the most reliable forecast of long-term future bond returns. On December 31, 2005, the yield-to-maturity on the Lehman Aggregate Bond Index was 5.08%, 70 basis points higher than its 4.38% yield-to-maturity one year earlier. Wilshire’s practice is to use the current yield-to-maturity as the predictor of future bond returns.

The flattening of the U.S. yield curve has received a great deal of attention this year.⁶ However, the curve’s current shape, which is notably different from its more “normal” upward sloping shape, does not materially impact Wilshire’s return assumptions for bonds. Instead, as will be explained in the discussion of our Treasury and TIPS forecasts, subtle rounding adjustments have been made in consideration of the yield curve’s current flatness. Exhibit 10 illustrates the dramatic change in treasury yield spreads during 2005 along with their historical 10- and 20-year averages.

Exhibit 10
Historical Treasury Yield Spreads

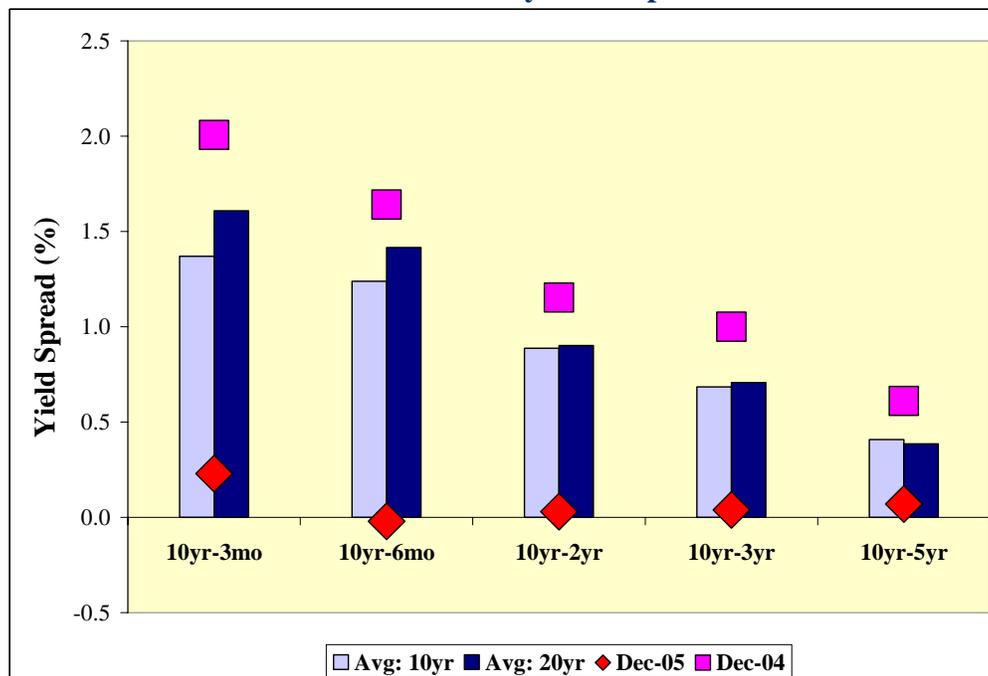
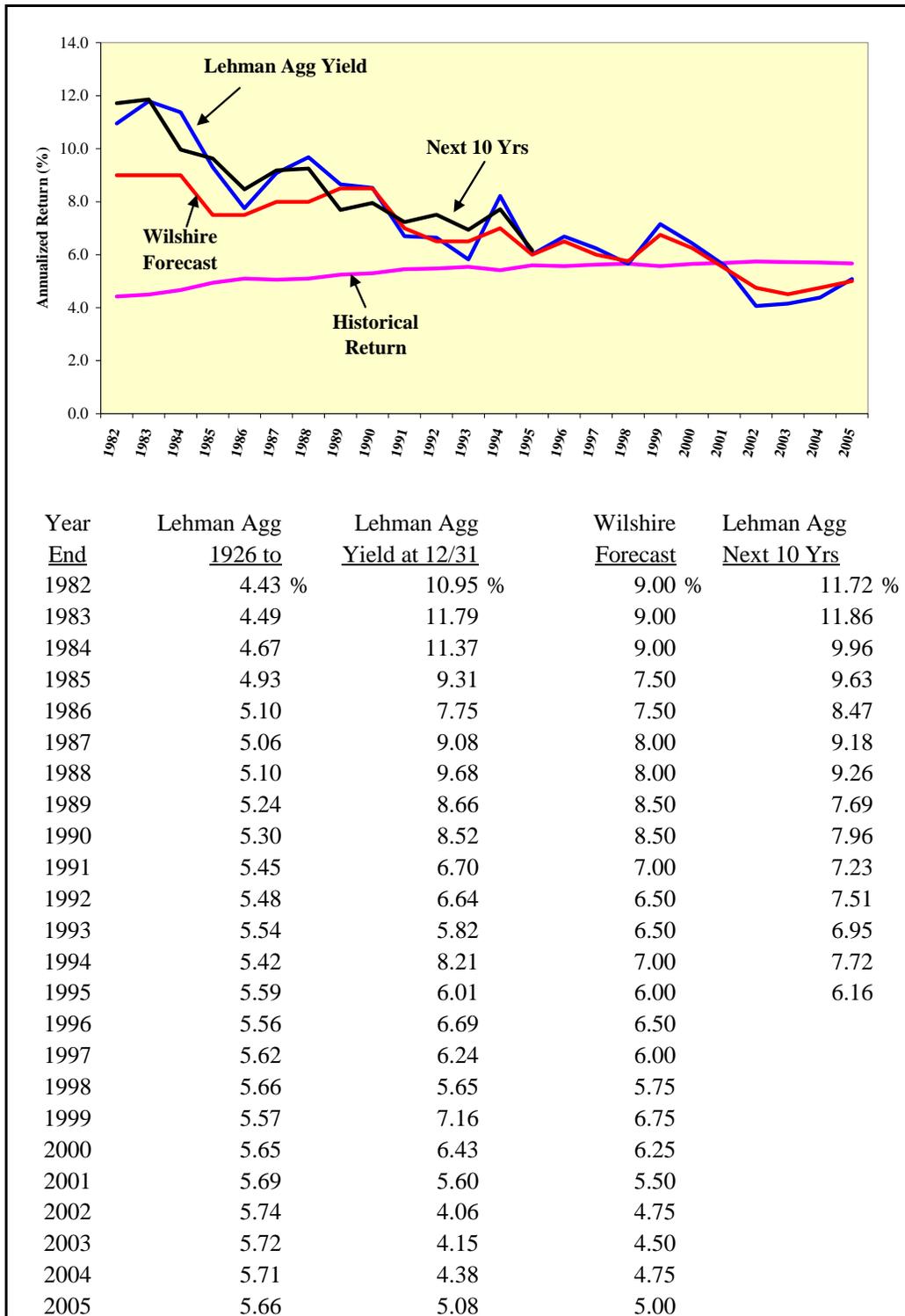


Exhibit 11 compares Wilshire’s past bond return assumptions with historical returns, yields, and the rolling returns for the ten year period following each estimate.

⁶ “Is the Fed’s ‘Conundrum’ Resolving?” Wilshire Consulting, March 28th, 2005
 “Is the Yield Curve a Crystal Ball?” Wilshire Consulting, June 17th, 2005

Exhibit 11
Wilshire Bond Return Forecast vs.
Current Yield, Historical Return, & Actual 10-Year Return Following Forecast



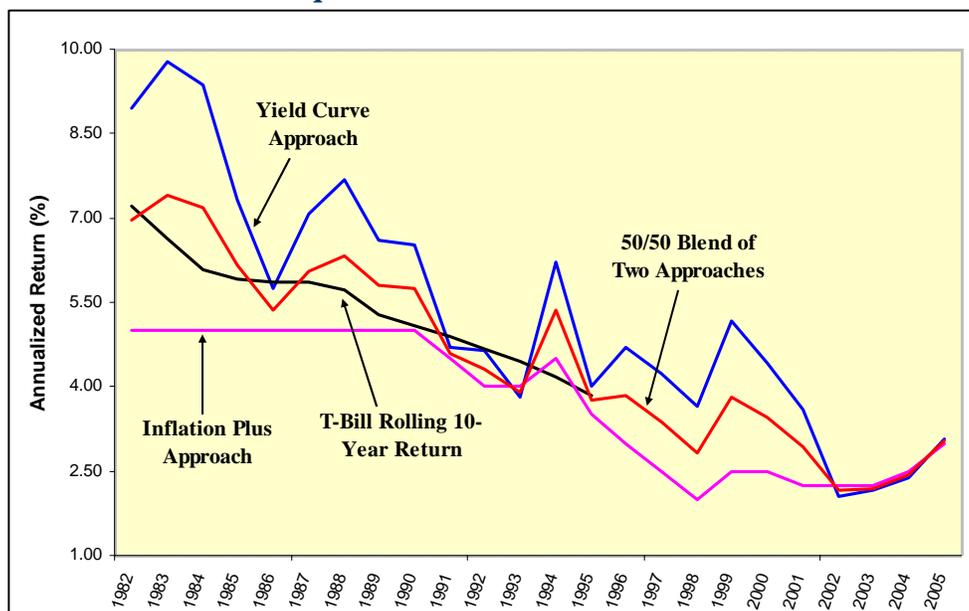
Cash Equivalents

Wilshire blends two methodologies in forecasting returns for cash equivalents: the “yield curve approach” and the “inflation-plus approach.”

The yield curve approach starts with the yield-to-maturity on bonds and subtracts the average yield premium between short and long bond yields. Since 1979, the yield curve premium has averaged 2%. Subtracting 2% from our 5.00% bond return forecast gives a 3.00% cash return forecast. The inflation-plus approach adds a short-term real return component to our inflation rate forecast. Since 1946, real returns for Treasury bills have averaged 0.75% that, when added to our 2.25% inflation rate assumption, equals a 3.00% cash return forecast. Since both approaches confirm the same return forecast, Wilshire has selected a 3.00% cash return forecast.

Exhibit 12 compares Wilshire’s yield curve approach, inflation-plus approach, and a 50/50 blend of the two approaches, with the Treasury bill return for the ten year period following each estimate.

Exhibit 12
Wilshire’s Cash Equivalents Forecast vs. Actual 10-Year Return



Non-U.S. Bonds

Investment theory suggests that non-U.S. bond yields will be equivalent to U.S. bond yields when currency adjustments are taken into account. This would imply using the same 5.00% U.S. bond return forecast for non-U.S. bonds.

However, since our 1996 report⁷, Wilshire has deducted 25 basis points from the non-U.S. bond return. The result is a 4.75% expected return for non-U.S. bonds. Experience shows that custodial costs, taxes, transaction fees, and a higher credit quality versus the U.S. bond market (because of the large proportion of government debt in non-U.S. bond indexes) reduce non-U.S. bond returns. Exhibit 13 compares historical U.S. bond return and risk values, as defined by the Lehman Aggregate, with non-U.S. unhedged and hedged values, as defined by the Citigroup Non-U.S. Government Bond indices.

Exhibit 13
U.S. vs. Non-U.S. Bond Returns (1985 through 2005)

	U.S. Dollar		Local Currency	
	Return	Risk	Return	Risk
U.S. Bonds (Lehman Agg.)	8.5 %	4.9 %	8.5 %	4.9 %
Citigroup Non-U.S. Govt.	10.1	11.9	7.9	4.1

Unhedged non-U.S. bonds offered better returns over the 21-year period thanks to a net fall in the dollar for the entire time period. Hedged non-U.S. bond returns take out expected and unexpected currency movements and show returns 80 basis points below U.S. bonds at less risk. A long-term forecast for non-U.S. bonds should not include a currency return, positive or negative, and should rely upon historical hedged returns. Risk forecasts, however, should come from the experience of the unhedged indexes unless a hedged strategy is employed.

In summary, Wilshire is using a 4.75% expected return for unhedged non-U.S. bonds and a 4.65% expected return for hedged non-U.S. bonds, with a ten basis point deduction in return for hedged non-U.S. bonds the result of expected additional hedging costs.

Treasury Bonds and Treasury Inflation Protected Securities (TIPS)

Wilshire's return assumption for Treasuries is derived from the yield-to-maturity of the Lehman Treasury Index. Our return forecast for Treasuries is 4.50%, which is based on the index's December 31, 2005 yield-to-maturity of 4.44%. As was mentioned earlier, the current flatness of the yield curve has a subtle impact on our expectation for Long-Term Treasury Bonds. Rather than round the yield-to-maturity of the Lehman Long-Term Treasury Index down eight basis points, from 4.58% to 4.50%, we round our forecast up to 4.75% to reflect the added return premium that is expected from a yield curve with a shape more consistent with historical observations. We anticipate that the move back to a normal shape will occur with a slight increase in long-term interest rates.

Wilshire recommends using an expected return for Treasury Inflation Protection Securities (TIPS) equal to the expected return for similar maturity, nominal Treasury bonds. Our return forecast for TIPS is 4.75%, 25 basis points higher than our forecast for Treasuries and equal to our long-term Treasury assumption. This forecast reflects a TIPS portfolio that mirrors the Lehman U.S. TIPS Index, which has a longer average maturity than the Lehman Treasury Index.

⁷ "1996 Asset Allocation Report: Rethinking Alternative Investments," February 1996.

For the reasons discussed above with respect to our long-term Treasury assumption, we add a 25 basis point premium to our 4.50% Treasury forecast, resulting in an expected TIPS return of 4.75%.

High Yield Bonds

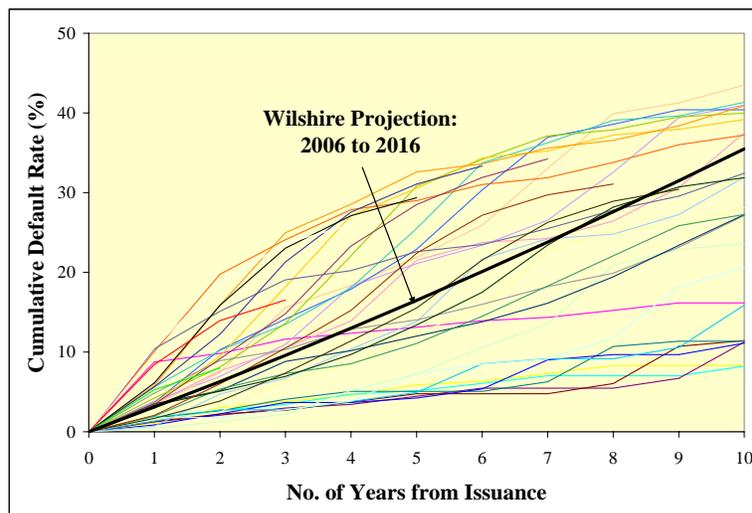
Wilshire’s return forecast for high yield bonds is 6.50%. This return forecast is based upon our high yield bond model that accounts for the dynamic nature of credit yield spreads, defaults and recoveries.

Wilshire’s 6.50% high yield expected return incorporates the following assumptions:

- An actual yield spread of 3.75%, up from 3.00% one year prior;
- An initial default rate of 3.0%, increasing incrementally over the next ten years to its historical average of 4.0% in years 10 and beyond, resulting in a 10-year cumulative default rate of 35.5%;
- A constant 40% recovery rate, equal to the historical average recovery rate;
- A 10-year cumulative loss rate – defaults minus recoveries – equal to 21.3% versus 18.3% last year.

Wilshire’s high yield bond model incorporates the ability to input variable default rates. In Exhibit 14 we graph Wilshire’s expected future default rates against all historical cumulative default rates from 1970 through 2004. Each line represents the historical cumulative default rates for high yield bonds issued in a single vintage year. The dark solid line is Wilshire’s forward-looking default rate that is used in our expected return model for high yield bonds. Wilshire’s default forecast line represents default expectations for a market portfolio holding bonds issued across various years. While it differs in nature from the vintage year default lines, which represent cumulative default rates specific to each single year of issue, the chart is useful in comparing our projection to historical default rate paths.

Exhibit 14
Historical Cumulative Default Paths - 1970 to 2004



Wilshire's report on high yield bonds⁸, published one year ago, explains in greater detail the rationale behind our long-term return forecast.

Private Market Investments

Wilshire's recommended assumptions for individual private market asset classes are contained in Appendix B together with comparisons to some of the major public asset classes.

Wilshire's private markets return forecasts are shown in the first row of Appendix B. Our expected returns are based on drawing parallels to the public markets where appropriate as detailed in the second part of our recent three part series.⁹ In addition, we have studied actual returns earned by large institutional private markets portfolios covering time periods of 15 years using Wilshire's own databases and *Venture Economics*, a firm specializing in measuring private equity returns, as a check on our estimates.

Wilshire's risk forecasts are reported in row two in Appendix B. These are expected standard deviations of annual returns. Risk forecasts for private market asset classes are especially challenging because short-term returns cannot be calculated due to infrequent partnership valuations. Risk estimates based upon accounting data consistently understate risk. Wilshire's approach has been to estimate risk by drawing parallels to the public markets and adjusting for any added risk contributed by financial leverage, the absence of liquidity, or greater business risk. The remaining rows in Appendix B contain correlation forecasts. Again, these estimates come from parallels to the public markets and are useful in assessing the diversification benefits of private markets. Generally, private equity is most useful as a type of super-charged equity return rather than a diversification tool as private equity returns rely on the receptiveness of the capital markets to generate returns.

Buyouts

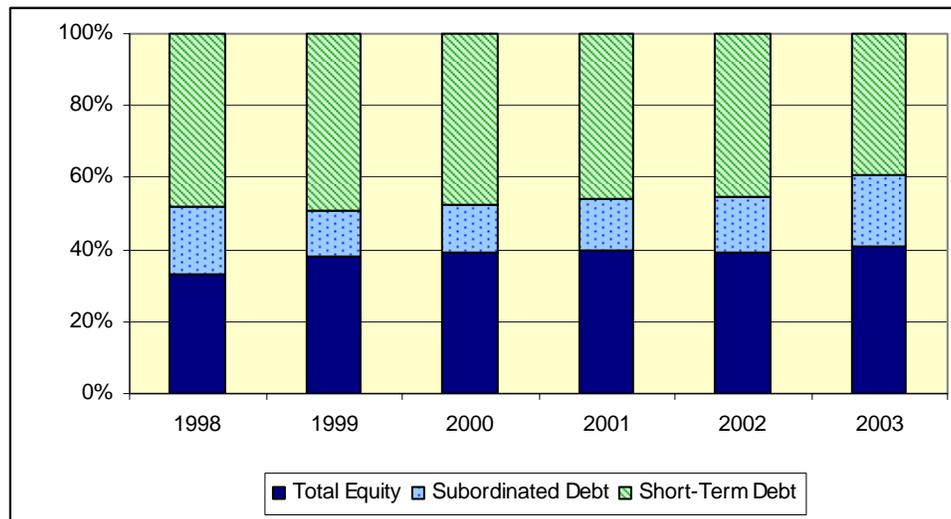
For 2006, our expected return for U.S. buyouts is 10.25%. The assumption is that buyouts will exhibit similar business risks as publicly traded companies but will have greater financial risk. Therefore, it is appropriate to model buyout returns using public market proxies for equity returns and financing costs. All expected returns in Appendix B are intended to be net returns. For example, the 10.25% expected return for buyouts should be viewed as net of all fees, including carried interest. Wilshire's methodology is discussed in more detail in the second part of our recent three part series on private equity.

Wilshire's risk forecast, expressed as a standard deviation of annualized return, is 30% for buyouts. This forecast is considerably higher than the 17% risk for public stocks and is attributable to greater financial risk due to a more leveraged capital structure in buyout companies. We measured risk by simulating historical buyout returns using Wilshire's Buyout Index, which adjusts public stock returns for the capital structure found in buyouts. Our leverage assumption assumes a capital structure with 40% short-term debt, 20% high yield debt, and 40% equity for buyouts which is consistent with historical measurements as shown in Exhibit 15.

⁸ "High Yield Market Update," January 14, 2005.

⁹ Private Equity Investing Part 2 - Generating Asset Class Assumptions. Wilshire Consulting, January 2006

Exhibit 15
Historic Buyout Capital Structure (1998 through 2003)



Venture Capital

Wilshire's return assumption for venture capital has increased to 12.00%, which increases in line with our view on the public markets. The valuation of venture capital investments can vary by manager. This mix of current and stale valuations becomes an issue when aggregating venture performance for use in asset allocation. Therefore the presence of stale valuations suggests that to the extent venture capital performance is related to public market performance it will have some sensitivity to both recent and past returns. By including lagged data from the public markets, a more correct beta can be derived versus one naively found with a regression on contemporaneous data.

Our analysis indicates that venture capital exhibits a beta of 1.7 to the public market. Using the familiar CAPM formula $E(r) = \beta(R_m - R_f) + R_f$, we can derive an expected return for venture capital. This return estimate makes intuitive sense as investors should demand a return premium for making venture investments considering the uncertainty inherent in investing in new ventures.¹⁰

$$E(r) = 1.7(8.25 - 3.00) + 3.00 = 11.93\% \text{ - which we round to } 12.00\%.$$

The first three quarters of 2005 saw total venture capital investments of \$21.7 billion versus \$21.6 billion for the same time period in 2004.¹¹ This stable level of interest in the asset class indicates that investors believe in the necessity of including venture capital when making strategic allocations.

¹⁰ Private Equity Investing Part 2 - Generating Asset Class Assumptions. Wilshire Consulting, January, 2006

¹¹ MoneyTree Survey 2005

To gauge the risk characteristics of venture capital investments, we examined a number of public market proxies: the Goldman Sachs Technology Composite Index, the Wilshire Internet Index, and the performance of aggressive growth mutual funds investing primarily in post-venture technology and biotech companies. Historical return standard deviations for the Goldman Sachs Index and the mutual funds were approximately 35%. The Wilshire Internet Index had a higher 45% standard deviation. We increased the 35% measure for public post-venture companies by a factor of 1.3 to estimate a 45% risk for private, earlier stage, venture capital. This would give venture capital the same risk level as pure Internet stocks.

Non-U.S. Buyouts

Return and risk forecasts for non-U.S. buyouts follow the same methodology used for U.S. buyouts with two changes: non-U.S. equity is used as a public market proxy instead of U.S. equity and Wilshire's non-U.S. bond assumption is used as the corporate debt proxy. The result is a 10.00% expected return and 35% risk. A higher risk for non-U.S. buyouts might be anticipated because of the addition of currency risk. However, we adjusted for our expectation that non-U.S. buyouts would have a different country profile than the MSCI EAFE Index, with non-U.S. buyouts over-weighting less risky Europe and investing little in higher risk Japan. This resulted in only a slightly higher level of non-U.S. buyout risk, 35% versus 30% for U.S. buyouts.

Distressed Debt

The Citigroup Global Markets Bankrupt/Defaulted Debt Index was selected as a public market proxy for distressed debt investments. The index contains virtually all issues in default. The 20% risk forecast and correlations reported in Appendix B for distressed debt are based upon historical measurements for the Citigroup Index. The 8.75% expected return for distressed debt comes from our view that successful distressed investors take equity-like control positions in distressed companies with significant upside potential but less risk than other buyouts because companies have already encountered financial distress.

Our analysis suggests that one of the benefits of including distressed debt in a private markets portfolio is its low correlation with public asset classes, particularly stocks, when compared with other private market asset classes.

Mezzanine Debt

Wilshire views mezzanine debt like a convertible bond. However, unlike publicly traded convertibles with characteristics combining stocks and bonds, mezzanine debt possesses characteristics combining buyouts and high yield bonds. Consequently, we expect their return and risk measures to lie somewhere between buyouts and high yield bonds. Therefore, the 8.75% return and 20% risk forecast for mezzanine debt in Appendix B is based upon a blend of our buyout and high yield assumptions.

Opportunistic Real Estate

Like buyouts, opportunistic real estate funds make levered investments in properties and real estate related companies such as hotels, property companies, casinos, and real estate service companies. Like many of the private market sectors, opportunistic real estate has seen high levels of capital coming from pension funds, foundations, and endowments looking for enhanced returns relative to the public markets. It is estimated that approximately \$17.5 billion in capital is available for investment in addition to a number of new funds in the process of raising \$18 billion.¹²

Debt usage often approaches 70% of asset values, leaving equity values subject to much higher volatility when compared to traditional real estate or REITs. Wilshire's modeling of opportunistic real estate relies upon REIT returns but adjusted for the amount and type of debt used in opportunistic strategies. Wilshire's forecast return is 8.25%, and forecast risk is 25%. The reduction of 25 basis points is primarily a consequence of our reduced outlook for REIT returns going forward.

Private Markets Portfolio

The return and risk forecast for a diversified private markets portfolio is provided in Appendix B. The makeup of the private portfolio is:

Buyouts	60%
Venture Capital	30%
Non-U.S. Buyouts	<u>10%</u>
	100%

The weightings were chosen because they are typical private market allocations of large institutional investors. When the components are geometrically calculated with a lognormal assumption, the forecast return for a diversified private markets portfolio is 11.80%, which we round in Appendix A to 11.75% given our convention to round to the nearest quarter percent. This level of return is 3.50% above the 8.25% expected return for U.S. stocks. The forecast risk for the diversified private markets portfolio is 30%, almost twice the forecast risk of U.S. stocks.

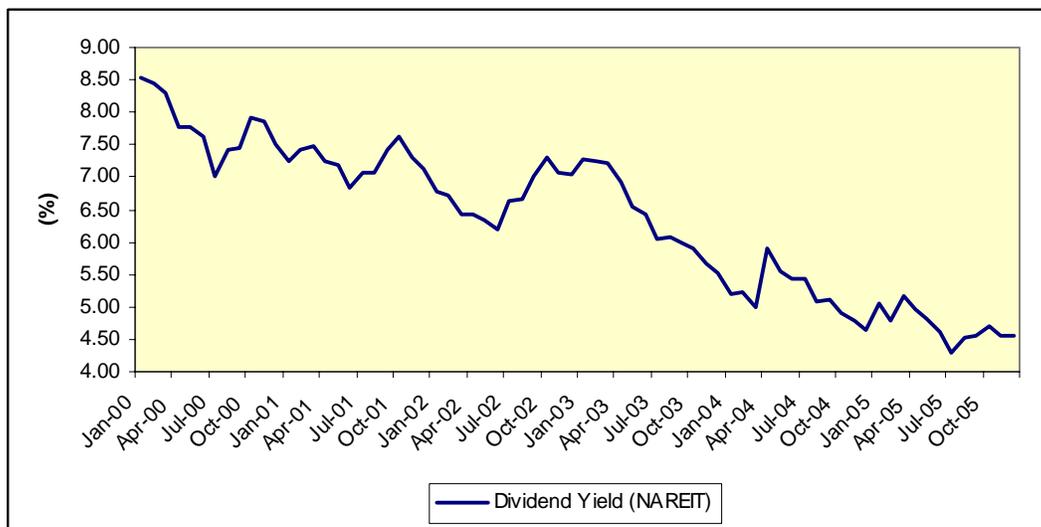
Investors in private markets and real estate have traditionally tried to estimate risk and return expectations from cost- and appraisal-based indexes. Time has shown that this practice understates risk and overstates return. Wilshire substitutes sound investment analysis by directly linking private investments to the public markets.

¹² Ernst & Young. "Market Outlook: Trends in the Real Estate Private Equity Industry." Fall 2005

Real Estate (REITs and Direct Property)

For 2005, Wilshire is forecasting an expected return of 6.25% for REIT portfolios, reduced from 7.00%. This assumption is derived from combining the current REIT dividend yield of 4.57% with an expected dividend growth rate of 1.69%. Examining REIT dividend growth over the past 32 years, Wilshire found that REITs were able to pass through about three-quarters of inflation through rent and dividend increases. The 1.69% expected dividend growth equals three-quarters of Wilshire's 2.25% inflation forecast. The REIT sector followed up the 34% gain in 2004 with a further 13.8% gain in 2005. Exhibit 16 shows that the dividend yield declined throughout the year and is a key reason the expected return assumption for REITs has been reduced 75 basis points from 2005's return forecast of 7.00%.

Exhibit 16
REIT Dividend Yield



Source: NAREIT.

Wilshire continues to recommend REITs as the best 'core' investment for clients making a significant strategic allocation to real estate.

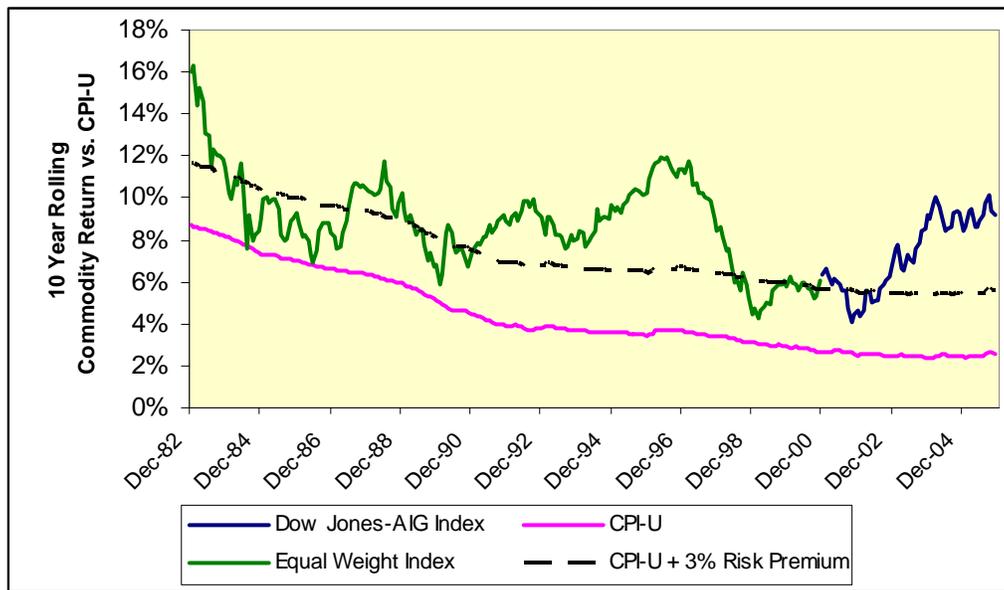
Investors in large separate account direct property portfolios should expect a 5.25% return. Our assumption is that direct property holdings will have a 1% lower return due to less utilization of leverage – REITs have an average 40% debt-to-asset ratio – and less risk than REITs, 10% versus 16%, respectively.

Commodities

The recent performance of commodities has thrust the asset class into the spotlight as investors continue to search for enhanced returns and portfolio diversification. Institutional investors can gain exposure to commodities through the futures market. Investable commodity indices, constructed from a combination of commodity futures contracts, can provide investors broad

access to the return and diversification attributes of underlying commodities. The returns for commodity futures differ from other asset classes because commodity futures do not represent compensation for the risk associated with future cash flow uncertainty. Instead, investors in commodity futures are compensated for bearing the risk of short-term commodity price fluctuations. In other words, a majority of a commodity future investor’s exposure is to short-term economic conditions, while forecasting plays a much smaller role than in the stock or bond markets. Wilshire’s recent paper “Commodity Futures Investing: Is All That Glitters Gold?” provides a more in depth examination of the history of commodities and their use in an institutional portfolio. Exhibit 17 lays out a return history for a commodity index over time. From this historical record, we estimate that the future expected return for commodities will be inflation plus a 3% risk premium, or 5.25%.

**Exhibit 17
Historical Commodity Returns**



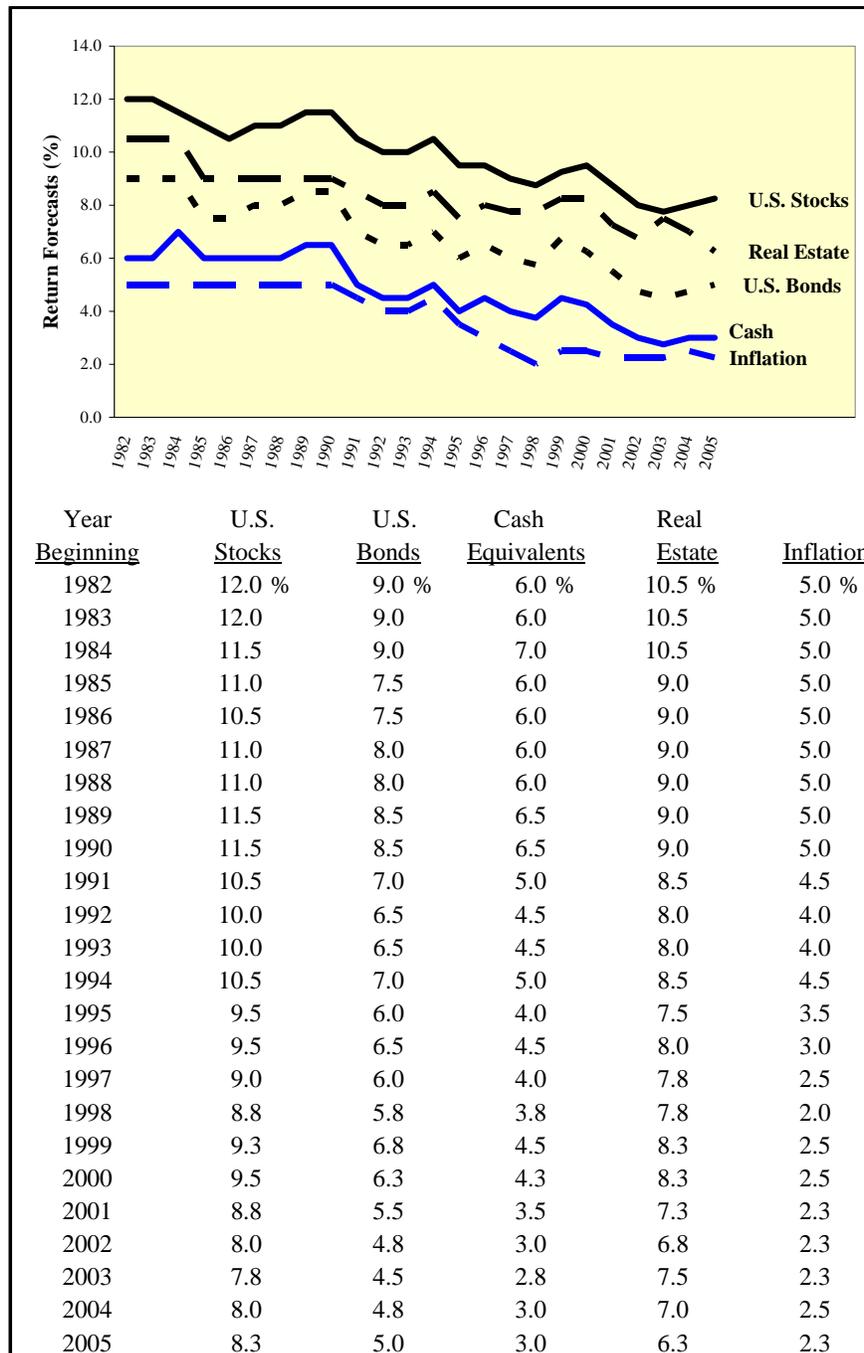
The forecasted risk for commodity futures is 12% based on the historical record of the Dow Jones-AIG Commodity Index. It is important to note that other indexes differ in composition from the Dow Jones-AIG index and therefore may be substantially more or less risky. For a more complete discussion of some of the popular commodity indexes, please see Wilshire’s “Commodities Index Report” from 2005.

The low measured correlation of commodity returns with more traditional assets, such as stocks and bonds, stems from their price sensitivity to current economic supply and demand forces. In contrast, stock and bond valuations are more heavily driven by forward-looking expectations. Historically, these factors have caused traditional assets and commodities to have lower correlations. A complete list of correlations for commodities versus other asset classes can be found in Appendix A.

Wilshire Forecasts Over Time

Exhibit 18 shows how Wilshire’s return forecasts have changed over the past 24 years. Notice the relative relationship between asset classes and how, when the assumptions change, they generally move together.

Exhibit 18
Wilshire’s Past Forecasts for Asset Class Returns



Risk and Correlation

Wilshire's approach to forecasting long-term risk and correlation is largely based on observed historical asset class behavior. Generally, past relationships serve as very good predictors of future risk and correlation. In practice, Wilshire applies sound financial theory and judgment to the interpretation and analysis of historical results. The role of judgment ('art') versus measured statistics ('science') is more extreme for investment categories with less historical data or that have experienced material structural changes. For example, while we've recently increased our correlation assumptions for TIPS against several other asset classes, Wilshire's assumptions are significantly lower than historical correlations, as the history of TIPS is short (less than nine years) and since there has been no material or sustained occurrence of unanticipated inflation during which TIPS should exhibit its lowest correlation with nominal bonds.

Wilshire places much more confidence in the predictive accuracy of past relationships for asset classes with longer and more robust historical data. In this report we rely upon historical measurements of risk and correlation through 2005 to estimate future risk and correlation. To maximize the quality of our estimates, we observe this historical behavior over various time horizons (i.e. five years, ten years, full history, etc.). Wilshire does not use a preset or static rolling time period to derive these forecasts; as such an approach could result in forward numbers reacting too quickly to what may prove to be short-term relationships or event driven anomalies between markets.

A full listing of Wilshire risk and diversification assumptions for all the asset classes is found in Appendix A.

We would like to thank Peter Matheos from Wilshire Analytics for his assistance in parameterizing the correlation matrices.

Appendix A: Wilshire 2006 Correlation Matrix

	U.S. Stock	Leh Aggr	Citi LPF	LT Treas	Cash	Non-U.S. Stock	Non-U.S. Bond	Emerg Mkt	TIPS	High Yield	REITs	Direct Prop	Prvt Mkts	Cmdty	Hdgd Int'l Stock	Hdgd Int'l Bond	EAFE Stock	U.S. CPI
Expected Return (%)	8.25	5.00	5.25	4.75	3.00	8.25	4.75	8.25	4.75	6.50	6.25	5.25	11.75	5.25	8.15	4.65	8.25	2.25
Expected Risk (%)	17.00	5.00	7.00	13.00	1.00	19.00	10.00	25.00	6.00	10.00	16.00	10.00	30.00	12.00	18.00	4.00	19.00	1.00
Cash Yield (%)	1.80	5.00	5.25	4.75	3.00	2.50	4.75	2.50	2.50	6.50	4.50	4.50	0.00	3.00	2.50	4.65	2.40	
Correlations:																		
U.S. Stock	1.00																	
Lehman Aggregate	0.29	1.00																
Citigroup LPF	0.34	0.95	1.00															
LT Treasury	0.19	0.85	0.87	1.00														
Cash Equivalents	0.00	0.10	0.10	0.10	1.00													
Non-U.S. Stock	0.78	0.08	0.09	0.07	-0.10	1.00												
Non-U.S. Bonds	-0.01	0.33	0.34	0.32	-0.10	0.28	1.00											
Emerging Markets	0.61	0.00	0.01	-0.09	-0.05	0.64	-0.04	1.00										
TIPS	0.00	-0.01	0.00	0.00	0.25	0.10	0.01	0.00	1.00									
High Yield Debt	0.48	0.39	0.40	0.21	0.00	0.29	0.01	0.35	0.01	1.00								
REITs	0.30	0.15	0.15	0.10	0.00	0.20	0.05	0.24	0.20	0.30	1.00							
Property (Direct)	0.30	0.15	0.15	0.10	0.00	0.19	0.05	0.25	0.20	0.30	0.90	1.00						
Private Markets	0.73	0.30	0.30	0.16	0.00	0.61	0.12	0.12	0.10	0.31	0.35	0.30	1.00					
Commodities	0.00	0.00	0.00	0.00	-0.05	0.20	0.15	0.24	0.20	0.08	0.25	0.20	0.00	1.00				
Hdgd Non-U.S. Stock	0.74	0.04	0.05	0.03	-0.01	0.77	-0.07	0.46	0.11	0.40	0.19	0.19	0.56	0.15	1.00			
Hdgd Non-U.S. Bond	0.16	0.60	0.59	0.58	0.10	0.21	0.50	-0.01	0.22	0.38	0.00	0.00	0.31	0.00	0.25	1.00		
EAFE Stock	0.74	0.11	0.09	0.13	-0.09	0.92	0.32	0.58	0.18	0.28	0.20	0.20	0.51	0.20	0.79	0.26	1.00	
Inflation (CPI)	-0.10	-0.12	-0.12	-0.12	0.10	-0.15	-0.05	-0.13	0.00	-0.08	-0.10	-0.10	-0.10	0.20	-0.05	-0.08	-0.15	1.00

Appendix B: Wilshire 2006 Private Markets Correlation Matrix

	Buyouts	Venture Capital	Distressed Debt	Mezz Debt	Opport RE	Non-U.S. Pvt Equity	Pvt Mkts Portfolio	U.S. Stocks	Non-U.S. Stocks	Fixed Income	Real Estate	High Yield Bonds	Cash
Expected Return (%)	10.25	12.00	8.75	8.75	8.25	10.00	11.75	8.25	8.25	5.00	6.25	6.50	3.00
Expected Risk (%)	30.00	45.00	20.00	20.00	25.00	35.00	30.00	17.00	19.00	5.00	16.00	10.00	1.00
Correlations:													
Buyouts	1.00							0.70	0.55	0.40	0.35	0.30	0.00
Venture Capital	0.65	1.00						0.60	0.50	0.10	0.30	0.25	0.00
Distressed Debt	0.10	0.05	1.00					0.30	0.25	0.05	0.10	0.55	0.00
Mezzanine Debt	0.50	0.25	0.60	1.00				0.70	0.55	0.20	0.50	0.75	0.10
Opportunistic RE	0.35	0.30	0.10	0.25	1.00			0.35	0.25	0.35	0.70	0.40	0.05
Non-U.S. Pvt Equity	0.78	0.50	0.15	0.30	0.25	1.00		0.60	0.70	0.25	0.20	0.25	0.00
Pvt Mkts Portfolio							1.00	0.73	0.61	0.30	0.35	0.31	0.00

Appendix C: Historical 1-Year Rolling Returns: 1926 to 2005

Year	S&P 500 Index	Bond Index	T-bills	CPI	Year	S&P 500 Index	Bond Index	T-bills	CPI
1926	11.6	7.4	3.3	-1.5	1966	-10.1	0.2	4.8	3.4
1927	37.5	7.4	3.1	-2.1	1967	24.0	-5.0	4.2	3.0
1928	43.6	2.8	3.5	-1.0	1968	11.1	2.6	5.2	4.7
1929	-8.4	3.3	4.7	0.2	1969	-8.5	-8.1	6.6	6.1
1930	-24.9	8.0	2.4	-6.0	1970	4.0	18.4	6.5	5.5
1931	-43.4	-1.9	1.1	-9.5	1971	14.3	11.0	4.4	3.4
1932	-8.2	10.8	1.0	-10.3	1972	19.0	7.3	3.8	3.5
1933	54.0	10.4	0.3	0.5	1973	-14.8	2.3	6.9	8.7
1934	-1.4	13.8	0.2	2.0	1974	-26.4	0.2	8.2	12.4
1935	47.7	9.6	0.1	3.0	1975	37.2	12.3	5.8	7.0
1936	33.9	6.7	0.2	1.2	1976	24.1	15.6	5.0	4.9
1937	-35.0	2.8	0.3	3.1	1977	-7.3	3.0	5.4	6.7
1938	31.1	6.1	0.0	-2.8	1978	6.4	1.4	7.5	9.0
1939	-0.4	4.0	0.0	-0.5	1979	18.5	1.9	10.3	13.3
1940	-9.8	3.4	0.0	1.0	1980	32.2	2.7	11.8	12.5
1941	-11.6	2.7	0.0	9.7	1981	-4.9	6.3	14.5	8.9
1942	20.4	2.6	0.3	9.3	1982	21.1	32.6	11.1	3.8
1943	25.9	2.8	0.4	3.2	1983	22.4	8.4	8.8	3.8
1944	19.7	4.7	0.3	2.1	1984	6.1	15.2	9.9	4.0
1945	36.4	4.1	0.3	2.3	1985	32.1	22.1	7.7	3.8
1946	-8.1	1.7	0.4	18.2	1986	18.6	15.3	6.1	1.1
1947	5.7	-2.3	0.5	9.0	1987	5.2	2.8	5.4	4.4
1948	5.5	4.1	0.8	2.7	1988	16.8	7.9	6.7	4.4
1949	18.8	3.3	1.1	-1.8	1989	31.5	14.5	9.0	4.6
1950	31.7	2.1	1.2	5.8	1990	-3.2	9.0	8.3	6.1
1951	24.0	-2.7	1.5	5.9	1991	30.6	16.0	6.4	3.1
1952	18.4	3.5	1.7	0.9	1992	7.7	7.4	3.9	2.9
1953	-1.0	3.4	1.8	0.6	1993	10.0	9.8	3.2	2.8
1954	52.6	5.4	0.9	-0.5	1994	1.3	-2.9	4.2	2.7
1955	31.6	0.5	1.6	0.4	1995	37.5	18.5	6.1	2.5
1956	6.6	-6.8	2.5	2.9	1996	23.1	3.6	5.4	3.3
1957	-10.8	8.7	3.2	3.0	1997	33.3	9.7	5.5	1.7
1958	43.4	-2.2	1.5	1.8	1998	28.8	8.7	5.4	1.6
1959	12.0	-1.0	3.0	1.5	1999	21.0	-0.8	4.6	2.7
1960	0.5	9.1	2.7	1.5	2000	-9.1	11.6	6.2	3.4
1961	26.9	4.8	2.1	0.7	2001	-11.9	8.4	4.4	1.6
1962	-8.7	8.0	2.7	1.2	2002	-22.1	10.3	1.8	2.4
1963	22.8	2.2	3.1	1.7	2003	28.7	4.1	1.2	1.9
1964	16.5	4.8	3.5	1.2	2004	10.9	4.3	1.3	3.3
1965	12.5	-0.5	3.9	1.9	2005	4.9	2.4	3.1	3.4

Winning Percentage: 63% 24% 14%

Appendix C: Historical 5-Year Rolling Returns: 1926 to 2005

Year	S&P 500 Index	Bond Index	T-bills	CPI	Year	S&P 500 Index	Bond Index	T-bills	CPI
1926-30	8.7	5.8	3.4	-2.1	1964-68	10.2	0.4	4.3	2.8
1927-31	-5.1	3.9	3.0	-3.7	1965-69	5.0	-2.2	4.9	3.8
1928-32	-12.5	4.5	2.5	-5.4	1966-70	3.4	1.2	5.4	4.5
1929-33	-11.2	6.0	1.9	-5.1	1967-71	8.4	3.3	5.4	4.5
1930-34	-9.9	8.1	1.0	-4.8	1968-72	7.5	5.8	5.3	4.6
1931-35	3.1	8.4	0.5	-3.0	1969-73	2.0	5.8	5.6	5.4
1932-36	22.5	10.3	0.3	-0.8	1970-74	-2.4	7.6	6.0	6.6
1933-37	14.3	8.6	0.2	2.0	1971-75	3.2	6.5	5.8	6.9
1934-38	10.7	7.8	0.1	1.3	1972-76	4.9	7.4	5.9	7.2
1935-39	10.9	5.8	0.1	0.8	1973-77	-0.2	6.5	6.3	7.9
1936-40	0.5	4.6	0.1	0.4	1974-78	4.3	6.3	6.4	8.0
1937-41	-7.5	3.8	0.1	2.0	1975-79	14.8	6.7	6.8	8.1
1938-42	4.6	3.8	0.1	3.2	1976-80	13.9	4.8	8.0	9.2
1939-43	3.8	3.1	0.1	4.5	1977-81	8.0	3.1	9.9	10.1
1940-44	7.7	3.3	0.2	5.0	1978-82	13.9	8.4	11.0	9.5
1941-45	17.0	3.4	0.3	5.3	1979-83	17.2	9.8	11.3	8.4
1942-46	17.9	3.2	0.3	6.8	1980-84	14.6	12.6	11.2	6.5
1943-47	14.8	2.2	0.4	6.8	1981-85	14.6	16.5	10.4	4.8
1944-48	10.9	2.4	0.5	6.7	1982-86	19.7	18.4	8.7	3.3
1945-49	10.7	2.2	0.6	5.8	1983-87	16.4	12.5	7.6	3.4
1946-50	9.9	1.8	0.8	6.6	1984-88	15.4	12.4	7.1	3.5
1947-51	16.7	0.9	1.0	4.3	1985-89	20.4	12.3	7.0	3.7
1948-52	19.4	2.0	1.3	2.7	1986-90	13.2	9.8	7.1	4.1
1949-53	17.9	1.9	1.5	2.2	1987-91	15.4	9.9	7.1	4.5
1950-54	23.9	2.3	1.4	2.5	1988-92	15.9	10.9	6.8	4.2
1951-55	23.9	2.0	1.5	1.4	1989-93	14.5	11.3	6.1	3.9
1952-56	20.2	1.1	1.7	0.8	1990-94	8.7	7.7	5.2	3.5
1953-57	13.6	2.1	2.0	1.3	1991-95	16.6	9.5	4.8	2.8
1954-58	22.3	1.0	1.9	1.5	1992-96	15.2	7.0	4.6	2.8
1955-59	15.0	-0.3	2.3	1.9	1993-97	20.2	7.5	4.9	2.6
1956-60	8.9	1.4	2.6	2.1	1994-98	24.1	7.3	5.3	2.4
1957-61	12.8	3.8	2.5	1.7	1995-99	28.6	7.7	5.4	2.4
1958-62	13.3	3.6	2.4	1.3	1996-00	18.3	6.5	5.4	2.5
1959-63	9.8	4.5	2.7	1.3	1997-01	10.7	7.4	5.2	2.2
1960-64	10.7	5.7	2.8	1.2	1998-02	-0.6	7.5	4.5	2.3
1961-65	13.2	3.8	3.1	1.3	1999-03	-0.6	6.6	3.6	2.4
1962-66	5.7	2.9	3.6	1.9	2000-04	-2.3	7.7	3.0	2.5
1963-67	12.4	0.3	3.9	2.2	2001-05	0.5	5.9	2.4	2.5

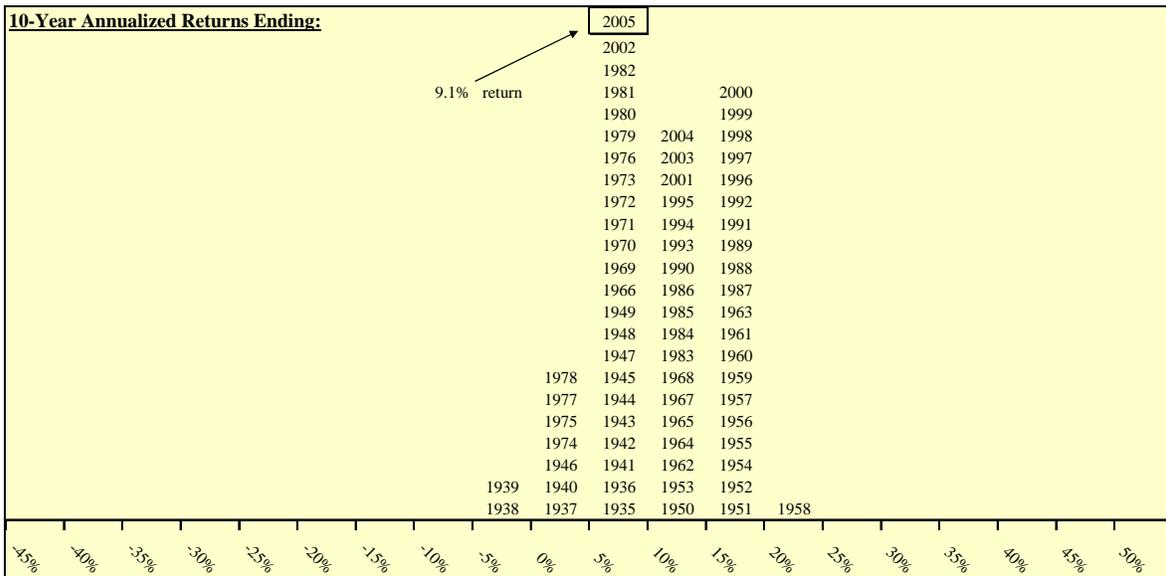
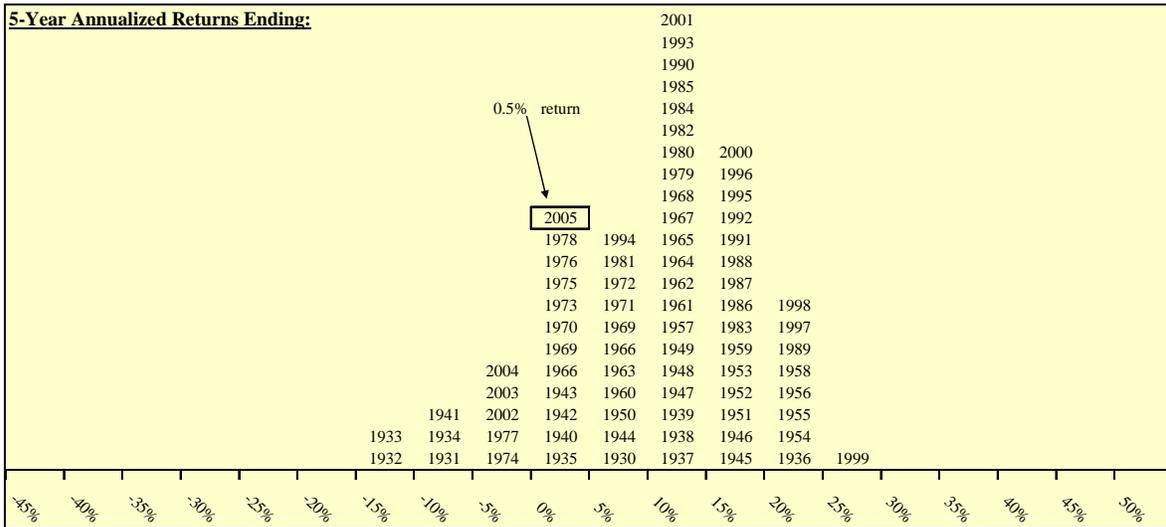
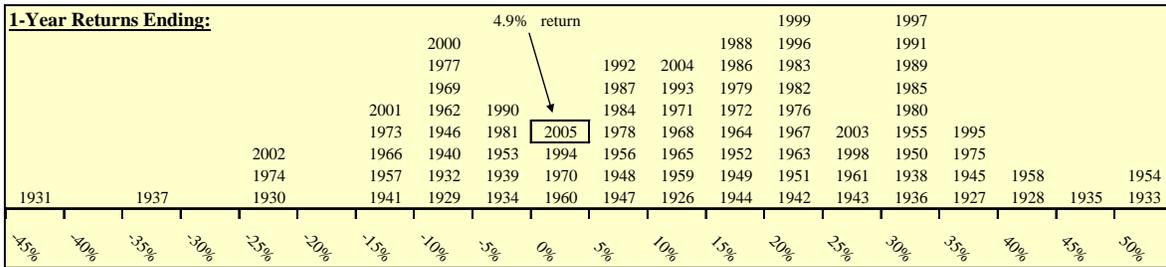
Winning Percentage: 74% 22% 4%

Appendix C: Historical 10-Year Rolling Returns: 1926 to 2005

Year	S&P 500 Index	Bond Index	T-bills	CPI	Year	S&P 500 Index	Bond Index	T-bills	CPI
1926-35	5.9	7.1	2.0	-2.6	1962-71	7.1	3.1	4.5	3.2
1927-36	7.8	7.0	1.7	-2.3	1963-72	9.9	3.0	4.6	3.4
1928-37	0.0	6.5	1.4	-1.8	1964-73	6.0	3.0	5.0	4.1
1929-38	-0.9	6.9	1.0	-2.0	1965-74	1.2	2.6	5.4	5.2
1930-39	-0.1	6.9	0.6	-2.0	1966-75	3.3	3.8	5.6	5.7
1931-40	1.8	6.5	0.3	-1.3	1967-76	6.7	5.3	5.7	5.9
1932-41	6.4	7.0	0.2	0.6	1968-77	3.6	6.2	5.8	6.2
1933-42	9.4	6.2	0.1	2.6	1969-78	3.2	6.1	6.0	6.7
1934-43	7.2	5.4	0.1	2.9	1970-79	5.9	7.2	6.4	7.4
1935-44	9.3	4.5	0.2	2.9	1971-80	8.4	5.6	6.9	8.1
1936-45	8.4	4.0	0.2	2.8	1972-81	6.4	5.2	7.9	8.6
1937-46	4.4	3.5	0.2	4.4	1973-82	6.6	7.4	8.6	8.7
1938-47	9.6	3.0	0.2	5.0	1974-83	10.6	8.1	8.8	8.2
1939-48	7.3	2.8	0.3	5.6	1975-84	14.7	9.6	9.0	7.3
1940-49	9.2	2.7	0.4	5.4	1976-85	14.2	10.5	9.2	7.0
1941-50	13.4	2.6	0.5	5.9	1977-86	13.7	10.5	9.3	6.6
1942-51	17.3	2.0	0.7	5.5	1978-87	15.2	10.4	9.3	6.4
1943-52	17.1	2.1	0.8	4.7	1979-88	16.3	11.1	9.2	5.9
1944-53	14.3	2.2	1.0	4.4	1980-89	17.5	12.4	9.1	5.1
1945-54	17.1	2.2	1.0	4.2	1981-90	13.9	13.1	8.7	4.5
1946-55	16.7	1.9	1.1	4.0	1982-91	17.5	14.1	7.9	3.9
1947-56	18.4	1.0	1.3	2.5	1983-92	16.2	11.7	7.2	3.8
1948-57	16.4	2.1	1.6	2.0	1984-93	14.9	11.9	6.6	3.7
1949-58	20.1	1.4	1.7	1.9	1985-94	14.4	10.0	6.1	3.6
1950-59	19.4	1.0	1.9	2.2	1986-95	14.9	9.6	5.9	3.5
1951-60	16.2	1.7	2.0	1.8	1987-96	15.3	8.5	5.8	3.7
1952-61	16.4	2.4	2.1	1.3	1988-97	18.0	9.2	5.9	3.4
1953-62	13.4	2.9	2.2	1.3	1989-98	19.2	9.3	5.7	3.1
1954-63	15.9	2.7	2.3	1.4	1990-99	18.2	7.7	5.3	2.9
1955-64	12.8	2.7	2.6	1.6	1991-00	17.5	8.0	5.1	2.7
1956-65	11.1	2.6	2.8	1.7	1992-01	12.9	7.2	4.9	2.5
1957-66	9.2	3.3	3.0	1.8	1993-02	9.3	7.5	4.7	2.5
1958-67	12.9	1.9	3.1	1.8	1994-03	11.1	6.9	4.5	2.4
1959-68	10.0	2.4	3.5	2.1	1995-04	12.1	7.7	4.2	2.4
1960-69	7.8	1.7	3.9	2.5	1996-05	9.1	6.2	3.9	2.5
1961-70	8.2	2.5	4.3	2.9					

Winning Percentage: 82% 13% 6%

Appendix D: Histogram of 1-, 5-, and 10-Year S&P 500 Index Returns



Executive Summary
SB 7 rules: \$5,000 medical only program, R.C. 4123.29
Rule 4123-17-59

Background Law

S.B. 7 was signed into law by Gov. Bob Taft to be effective June 30, 2006. This legislation made various reforms in the workers' compensation system.

The Act amends R.C. 4123.29 to increase the threshold for BWC's \$1,000 medical-only claim program to \$5,000. Current law requires BWC make available to every state fund employer a program whereby the employer pays to the claimant or on behalf of the claimant the first \$1,000 of a compensable workers' compensation medical-only claim. If an employer elects to enter the program, BWC does not reimburse the employer for the payments and must not charge the first \$1,000 of any medical-only claim paid by an employer to the employer's experience.

In addition to increasing the amount of the medical-only claim program to \$5,000, the Act specifies that if an employer elects to enter the program and the employer fails to pay a bill for a medical-only claim in the program, the employer is liable for that bill, and the employee for whom the employer failed to pay that bill is not liable for that bill.

Note: This provision of the Act is not one of the provisions included in the pending referendum effort.

Overview of Rule

Rule 4123-17-59 is an existing BWC rule for the \$1,000 medical only program. The rule has been in effect since March 1, 1995. BWC adopted the rule following the amendment of R.C. 4123.29 to provide for this program in H.B. 107, effective October 20, 1993. Under R.C. 119.01, the rule is exempt from the public hearing and Joint Committee on Agency Rule Review process, since the rule related to a BWC rating program.

Rule Amendments

4123-17-59 Five thousand dollar medical-only program

Throughout the rule, references to the one thousand dollar medical only program are changed to the five thousand dollar medical only program.

Paragraph (D)(1) clarifies that where an employer elects to pay bills in its employees' medical-only claims under the program and the employer provides notice to BWC that the employer no longer wishes to be responsible for the bills in a particular claim, BWC will process all related bills received after the withdrawal notification date.

Paragraph (E)(1) is amended to remove the requirement that the employer provide notice to BWC of a claim under the program on specific BWC forms.

Paragraph (G) adds the provision from the legislation that “if an employer elects to enter the program and the employer fails to pay a bill for a medical-only claim included in the program, the employer shall be liable for that bill and the employee for whom the employer failed to pay the bill shall not be liable for that bill.”

4123-17-59 ~~Thousand~~ Five thousand dollar medical-only program.

(A) Any employer who is paying premiums to the state insurance fund and whose coverage is in force may elect to participate in the five thousand dollar medical-only program as provided in section 4123.29 of the Revised Code. No formal application is required; however, an employer must elect to participate by telephoning the bureau ~~after July 1, 1995~~. Once an employer has elected to participate in the program, the employer will be responsible for all bills in all medical-only claims with a date of injury the same or later than the election date, unless the employer notifies the bureau within fourteen days of receipt of the notification of a claim being filed that it does not wish to pay the bills in that claim, or the employer notifies the bureau that the ~~one~~ five thousand dollar maximum has been paid, or the employer notifies the bureau of the last day of service on which it will be responsible for the bills in a particular medical-only claim.

(B) Employers may pay bills on any alleged medical-only injury. Payment of a bill by an employer does not waive the bureau's right to adjudicate the claim, nor does it waive the employer's right to contest the claim should a claim be filed.

(C) This program in no way supersedes the right of any injured worker to file a workers' compensation claim with the bureau.

(D) An employer or its agent may elect to pay to the ~~claimant~~ injured worker or the provider on behalf of the ~~claimant~~ injured worker the first ~~one~~ five thousand dollars of a ~~filed-compensable~~ medical-only claim. Employers may elect which medical-only claims they do not wish to cover under this program.

(1) An employer electing to pay bills in its employees' medical-only claims is responsible for all bills in a claim until the ~~one~~ five thousand dollar maximum is reached and the employer provides notice to the bureau that the employer has paid the first ~~one~~ five thousand dollars of the bills in the claim by providing the bureau the date of service of the bill which reached the ~~one~~ five thousand dollar maximum, or the employer provides notice to the bureau that it no longer wishes to be responsible for the bills in a particular claim by providing the bureau the last date of service that it will pay. The bureau will process all related bills received ~~with a~~ after the withdrawal notification date ~~of service later than that date. The employer will be responsible for all bills from the date of injury until that date of service.~~

(2) If the five thousand dollar maximum has not been reached and the payment of a bill will exceed the ~~one~~ five thousand dollar maximum, the employer should pay that portion of the bill that will bring the payment to the ~~one~~ five thousand dollar maximum and inform the provider to bill the bureau for the remainder of the bill. The employer should then notify the bureau that the first ~~one~~ five thousand dollars has been paid, and provide proof of such payment and copies of all bills paid, in the proper billing format, to the bureau. The bureau will then be responsible for processing all future bills.

(3) The employer cannot elect to pay only certain bills for a claim and submit other bills in that claim to the bureau for payment; ~~once the employer notifies the bureau for the bureau to pay the bills, the bureau will process all the related bills in that claim after the date of service indicated by the employer.~~

(4) Once an employer has elected to pay bills in medical-only claims under this program, the employer must pay all bills under this program within thirty days of receipt of the bill. The employer shall provide copies of the bills paid in the claim, in the proper billing format, to the bureau and the injured worker or ~~their~~ the injured worker's representative upon request.

(E) An employer electing this program must keep a record of the injury to include: name, address, and social security number of the injured worker; date and time of injury; type of injury; part of body injured; and a brief description of the accident ~~or occurrence~~. The employer also shall keep a copy of all bills with proof and date of payment under this program. This information will be made available to the bureau and the injured worker or their representative upon request. The information must be kept on file for six years from the last date a bill has been paid by the employer or the information has been received by the bureau.

(1) An employer in the program must notify the bureau ~~on the medical-only claim application (C-3), the additional information request form (C-63), or by telephone~~ of its within fourteen days of a claim being filed of the employer's intention not to cover the first one five thousand dollars of the medical costs of the claim. This notification must be received by the bureau within fourteen days of the employer's notification that a claim has been filed may be by telephone or in writing.

(2) The bureau will process all related bills in a filed medical-only claim in the normal manner unless the employer has previously notified the bureau that it has elected to participate in the ~~one~~ five thousand dollar program.

(3) In those cases in which the bureau has been properly notified by the employer of the employer's intention to directly pay the bills, the bureau shall not pay any bills submitted to the bureau directly from the provider but will notify the provider that the bill should be submitted to the employer until the provider is notified by the employer that the bureau is responsible for the bills in the claim. No interest shall be paid by the bureau on account of bills not paid within thirty days if such bills are the responsibility of the employer.

(4) All bills submitted to the bureau or the employer for payment must be in the proper billing format and must be received by the bureau or the employer within two years of the ~~last~~ date of service on the bill.

(F) An employer electing this program has the responsibility to notify the injured worker and medical provider, in writing, of the acknowledgment of the alleged medical-only injury, that it has elected under section 4123.29 of the Revised Code to pay the first ~~one~~

five thousand dollars, that all bills should be submitted to the employer, and that the injured worker and the bureau should not be billed.

(1) Once an employer in this program pays a bill on a work-related injury the bureau will not reimburse that employer.

(2) In the event that a duplicate payment is made, it will be the employer's responsibility to seek reimbursement from the provider. The employer may request reimbursement of such bills from the provider, and the provider shall reimburse the employer where the bureau has paid the bill.

(3) In the event that a medical-only claim changes to a lost time claim, the bureau will not reimburse the employer for bills that have been paid by the employer under this program.

(G) The employer shall pay all bills as billed or agree upon an appropriate reimbursement level with the provider. The bureau will not assist the employer in determining the fee payable; however, the bureau UCR fee schedule and other fee maxima programs used by the bureau will be made available for the use of the employer. Providers must bill the employer using the proper bureau format and their usual and customary fee. Providers may not balance bill the injured worker. Providers may only balance bill the bureau on the occasion of a bill that would require an employer to exceed the ~~one~~ five thousand dollar maximum. The bureau will not mediate fee disputes between the employer and the provider. If an employer elects to enter the program and the employer fails to pay a bill for a medical-only claim included in the program, the employer shall be liable for that bill and the employee for whom the employer failed to pay the bill shall not be liable for that bill.

(H) Payments made by the employer in this program will not be charged to that employer's experience modification; however, if a claim has been filed with the bureau and bills paid by the bureau, these payments will be included in the employer's experience modification. The bureau will not adjust the employer's experience modification to remove such payments unless the employer has complied with this rule and the bureau has made such payments in contravention of this rule. Failure by an employer to make timely payments on all bills will not affect the coverage of that employer and will not obligate the bureau to pay interest to the medical provider; however, the bureau may exclude employers who do not make timely payment on all bills in this program from participation in this program. An employer may appeal a decision of the bureau excluding the employer from this program to the adjudicating committee under rule 4123-14-06 of the Administrative Code.

(I) An employer who elects to participate in this program may cancel its participation in the program at any time by telephoning the bureau. The bureau will process all related bills in all medical-only claims against that employer's account ~~with an injury date the same as~~ after the date of the telephone call ~~or later~~.

HISTORY: Eff 3-1-95
Rule promulgated under: RC 111.15
Rule authorized by: RC 4121.12, 4121.121
Rule amplifies: RC 4123.29

Five Year Rule Review
Self Insured Rules
Chapter 4123-19 of the Administrative Code

4123-19-01 Definition: state risks, self-insuring risks.

(A) “State risks” are hereby defined as those employers who pay their full premium into the state insurance fund.

(B) “Self-insuring risks” are hereby defined as those employers who are of sufficient financial ability to carry their own insurance; who do not desire to insure the payment thereof, except as provided in division (B) of section 4123.82 of the Revised Code; who secure authority from the administrator of workers’ compensation to pay compensation, etc., directly; who pay into the state insurance fund an assessment as established by a rule of the bureau of workers’ compensation adopted in accordance with section 111.15 of the Revised Code; who pay to the bureau a contribution to the self-insuring employers’ guaranty fund pursuant to section 4123.351 of the Revised Code; and who provide an additional security, where required by the bureau, in the amount or form that may be specified by the bureau.

(C) “Self-insurance” is a privilege granted or denied by the administrator of workers’ compensation. Once granted the privilege of self-insurance, the employer determines the first level of a claim and must have employees with a working knowledge of current Ohio workers’ compensation law and all rules and regulations of the bureau of workers’ compensation and the industrial commission. A self-insuring employer may, without any prior order from the commission or bureau, grant or refuse to grant any claim made under the Ohio Workers’ Compensation Act. In granting a claim or awarding payment of compensation or benefits, the employer may provide to its employees compensation or benefits which are greater than those required by law. The employer may not pay compensation or benefits less than that which is required by law.

HISTORY: Eff 1-2-78; 2-17-81; 5-9-90; 11-19-93
Rule promulgated under: RC Chapter 119.
Rule authorized by: RC 4121.12, 4121.30
Rule amplifies: RC 4123.01(B), 4123.30, 4123.35
119.032 Review Date: 9-28-01; 3-1-06

4123-19-02 General procedures in the processing of applications for industrial coverage.

(A) To secure the initial quotation of rate and premium, the employer shall complete and return to the Columbus central office of the bureau of workers’ compensation an application prepared by the bureau and entitled “Application for Classification of Industry and for Premium.” Blank forms of this application will be mailed to the employer upon request to the bureau and such form(s) must be used in making such application.

(B) Upon receipt of the completed application as indicated under paragraph (A) of this rule, the bureau shall forthwith issue a premium advice and pay-in-order on the same, setting forth the classification, rate and thirty per cent of the eight months' premium security deposit of the applicant, not to exceed one thousand dollars and not less than ten dollars.

(C) Two copies of the premium advice and pay-in-order shall be forwarded to the employer.

(D) In the event the applicant has one or more employees and intends to become a state risk, then such applicant, upon receipt of the pay-in-order, shall immediately forward such pay-in-order together with the amount of money specified therein to the treasurer of state or to the bureau of workers' compensation.

(E) The applicant's protection shall date from the time the payment of the premium security deposit is actually received by the treasurer, state of Ohio, or bureau, or the date the written binder of new coverage has been approved.

(F) Upon the receipt of the employer's premium security deposit, the accounting section shall issue forthwith to the employer a "Certificate of Premium" statement. Such statement shall certify to the employer that the employer has paid into the state insurance fund the premium due according to the law and the rules of the bureau, and that said applicant is entitled to the rights and benefits of said fund beginning from the date such insurance became effective, such date being inserted in this statement, for a period as indicated on the statement.

(G) Coverage that is extended to a person who in his household employs household worker(s) pursuant to section 4123.01 of the Revised Code does not include such person himself.

(H) Any employer who makes the semiannual premium payment at least one month prior to the last day on which such payment may be made without penalty shall be entitled to a discount at such rate as the bureau may from time to time declare.

HISTORY: Replaces rule 4121-9-02; Eff 6-30-74; 12-11-78; 11-26-79; 5-9-90

Rule promulgated under: RC Chapter 119.

Rule amplifies: R.C. SECS. 4121.35(G), 4123.32, 4123.01(A)(2) In conjunction with 4123.29, 4123.34 and 4123.36

119.032 Review Date: 9-28-01; 3-1-06

4123-19-03 Where an employer desires to secure the privilege to pay compensation, etc., directly.

(A) All employers granted the privilege to pay compensation directly shall demonstrate sufficient financial strength and administrative ability to assure that all obligations under section 4123.35 of the Revised Code will be met promptly. The administrator of workers' compensation shall deny the privilege to pay compensation, etc., directly, where the

employer is unable to demonstrate its ability to promptly meet all the obligations under the rules of the commission and bureau and section 4123.35 of the Revised Code. The administrator shall consider, but shall not be limited to the factors in divisions (B)(1) and (B)(2) of section 4123.35 of the Revised Code where they are applicable in determining the employer's ability to meet all obligations under section 4123.35 of the Revised Code.

The administrator shall review all financial records, documents, and data necessary to provide a full financial disclosure of the employer, certified by a certified public accountant, including but not limited to, the balance sheets and a profit and loss history for the current year and the previous four years. For purposes of this rule, certified financial statements shall be construed by the administrator as audited by a certified public accountant, in accordance with generally accepted accounting principles, and shall include the certified public accountant's audit opinion.

(1) In determining whether to grant a waiver of the requirement of division (B)(1)(e) of section 4123.35 of the Revised Code for certified financial records, the administrator shall consider the following criteria and conditions.

(a) The administrator shall require reviewed financial statements, including full footnote disclosure, to be prepared and submitted in accordance with generally accepted accounting principles. For the purposes of this rule, "reviewed financial statements" shall mean financial statements that have been subject to procedures performed by a certified public accountant in accordance with AICPA Professional Standards, specifically, Statements on Standards for Accounting and Review Services, Section 100, Paragraph .24 through .38, December 1978.

(b) The administrator may utilize the services of a commercial credit reporting bureau to assist in the evaluation of an applicant's ability to meet its workers' compensation obligations. The cost of this commercial reporting service shall be assumed by the applicant employer.

(c) Notwithstanding the above criteria, the administrator may deem it necessary for an applicant employer to provide additional security to ensure meeting its workers' compensation obligations. The amount of such additional security shall be in the form and amount as determined by the administrator and paid prior to the granting of self-insurance. Pursuant to paragraph (F) of this rule, in the event of the default of the self-insuring employer, the bureau shall first seek reimbursement from the additional security, which shall be first liable and exhausted, before payment is made from the self-insuring employers' guaranty fund under section 4123.351 of the Revised Code.

(2) The administrator shall not grant the status of self-insuring employer to the state, except that the administrator may grant the status of self-insuring employer to a state institution of higher education, excluding its hospitals.

(B) The employer shall secure from the bureau of workers' compensation proper application form(s) for completion. The completed application shall be filed with the

bureau at least ninety days prior to the effective date of the employer's requested status as a self-insurer. The administrator may require that the application be accompanied by an application fee as established by bureau resolution to cover the cost of processing the application in accordance with section 4123.35 of the Revised Code. The application shall not be deemed complete until all required information is attached thereto. Prior to presentation to the administrator, applicable items listed in divisions (B)(1) and (B)(2) of section 4123.35 of the Revised Code shall be made available to the bureau and shall be reviewed by the bureau of workers' compensation. The bureau shall only accept applications which contain the required information.

(C) The bureau shall recognize only such application forms which provide answers to all questions asked and furnish such information as may be required.

(D) Return of the completed forms required by this rule and any additional information required by the bureau to process the employer's application should be submitted at least ninety days prior to the effective date of the employer's requested status as a self-insurer.

(1) If the administrator determines to grant the privilege of self-insurance, the bureau shall issue a "Finding of Facts" statement which has been prepared by the bureau, signed by the administrator, subject to all conditions outlined in paragraph (L)(3) of this rule.

(2) If the administrator determines not to grant the privilege of self-insurance, the bureau shall so notify the employer, whereupon the employer shall be required to continue to pay its full premium into the state insurance fund.

(E) All employers that have secured the privilege to pay compensation, etc., directly, will be required to make contributions as determined by the administrator to the self-insuring employers' guaranty fund established under section 4123.351 of the Revised Code, and, if an additional security is required by the bureau, in the amount or form that may be specified by the bureau. If the additional security is in the form of a surety bond, the bond shall be from a company approved by the bureau and authorized to do business in the state of Ohio by the Ohio department of insurance. The surety bond shall be in the form prescribed by the bureau. The penal amount of such additional security is to be fixed by the administrator.

(F) The surety bond or additional security furnished by the employer shall be for an amount and period as established by the bureau and may be periodically reviewed and reevaluated by the bureau. The surety bond or additional security shall provide on its face that the surety shall be responsible for the payment of all claims where the cause of action, as determined by the date of injury or date of occupational disease, arose during the liability of the surety bond or additional security. The liability under the surety bond or additional security and the rights and obligations of the surety shall be limited to reimbursement for the amounts paid from the surplus accounts of the state insurance fund by reason of the default of the self-insuring employer in accordance with division (B) of section 4123.82 of the Revised Code; however, in the event of such self-insuring employer's default, the bureau shall first seek reimbursement from the surety bond or

additional security, which shall be first liable and exhausted, before payment is made from the self-insuring employers' guaranty fund established under section 4123.351 of the Revised Code. Upon default of the self-insuring employer, it shall be the responsibility of the administrator of the bureau of workers' compensation to represent the interests of the state insurance fund and the self-insuring employers' guaranty fund. The administrator, on behalf of the self-insuring employers' guaranty fund, has the rights of reimbursement and subrogation and shall collect from a defaulting self-insuring employer or other liable person all amounts the bureau has paid or reasonably expects to pay from the guaranty fund on account of the defaulting self-insuring employer.

(G) The security herein required to be given by the employer shall be given to the state of Ohio, for the benefit of the disabled or the dependents of killed employees of the employer filing the same, and shall be conditioned for the payment by the employer of such compensation to disabled employees or the dependents of killed employees of such employer, and the furnishing to them of medical, surgical, nursing and hospital attention and services, medicines and funeral expenses equal to or greater than is provided by the Ohio workers' compensation law and for the full compliance with the rules and regulations of the commission and bureau and rules of procedure.

(H) If another or parent corporation or entity owns more than fifty per cent of the stock of an employer, such employer must furnish a contract of guaranty executed by the ultimate domestic parent corporation or entity. If the employer establishes to the bureau that such contract of guaranty cannot be given by the ultimate domestic parent corporation, then the bureau may, in its discretion, waive the requirement of a contract of guaranty. The bureau may require an alternative form of security.

(I) From the effective date of this rule, employees having one or more years of experience as a workers' compensation administrator for a self-insuring employer in Ohio shall be deemed sufficiently competent and knowledgeable to administer a program of self-insurance. Those self-insuring employers that employ workers' compensation administrators who have less than one year of experience as a workers' compensation administrator in Ohio shall not have its status as a self-insuring employer affected pending notification by bureau of workers' compensation as to whether mandatory attendance of the administrator at a bureau of workers' compensation training program is required. If the bureau determines that the administrator is not able to administer a self-insuring program, the bureau may direct mandatory attendance of the administrator at a bureau of workers' compensation training program until such time as the bureau determines that the administrator is sufficiently competent and knowledgeable to run such a workers' compensation program. The cost of the bureau's training of the administrator(s) under this rule will be borne by the self-insuring employer or self-insuring employer applicant. By accepting the privilege of self-insurance, an employer acknowledges that the ultimate responsibility for the administration of workers' compensation claims in accordance with the law and rules of the bureau of workers' compensation and the commission rests with that employer. The self-insuring employer's records and compliance with the bureau of workers' compensation and commission rules shall be subject to periodic audit by the bureau of workers' compensation.

A self-insuring employer or applicant shall designate one of its Ohio employees who is knowledgeable and experienced with the requirements of the Ohio Workers' Compensation Act and rules and regulations therein, as administrator of its self-insuring program. The requirement for an Ohio administrator may be waived at the discretion of the bureau. The name and telephone number of the Ohio administrator, or non-Ohio administrator where the Ohio requisite has been waived, shall be posted by the employer in a prominent place at all the employer's locations. The administrator's duties shall include, but not be limited to:

- (1) Acting as liaison between the employer, the bureau of workers' compensation and the commission, and providing information to the agency upon request;
- (2) Providing assistance to claimants in the filing of claims and applications for benefits;
- (3) Providing information to claimants regarding the processing of claims and the benefits to which claimants may be entitled;
- (4) Providing the various forms to be used in seeking compensation or benefits;
- (5) Accepting or rejecting claims for benefits;
- (6) Approving the payment of compensation and benefits to, or on behalf of, claimants, pursuant to paragraph (K) of this rule.

This rule is not intended to prevent the hiring of an attorney or representative to assist the employer in the handling and processing of workers' compensation claims.

(J) Employers that are granted the privilege of paying compensation, etc., directly, in accordance with these rules and regulations shall file with the bureau a report of paid compensation annually, shall keep a record of all injuries and occupational diseases resulting in more than seven days of temporary total disability or death occurring to its employees and report the same to the bureau upon forms to be furnished by it, and shall observe all the rules and regulations of the commission and bureau and their rules of procedure with reference to determining the amount of compensation, etc., due to the disabled employee or the dependents of killed employees, and payment of the same. ~~Any employer granted the privilege of paying compensation, etc., directly on or after July 1, 2001, shall report its paid compensation electronically via the bureau's web site. Effective January 1, 2002, all employers that have been granted the privilege of paying compensation, etc., directly shall report paid compensation electronically via the bureau's web site.~~ **ALL EMPLOYERS GRANTED THE PRIVILEGE OF PAYING COMPENSATION, ETC., DIRECTLY SHALL ANNUALLY REPORT PAID COMPENSATION ELECTRONICALLY VIA THE BUREAU'S WEBSITE.**

If a self-insured employer fails to timely file its annual report of paid compensation, the bureau may estimate the amount of paid compensation and assess the employer based on

this estimate pursuant to rule 4123-17-32 of the Administrative Code. If the employer subsequently provides the bureau with actual paid compensation figures, the bureau shall adjust the paid compensation and any assessment accordingly. A self-insured employer that is no longer a self-insured employer in Ohio and has failed to timely file a report of paid compensation shall be subject to this rule.

(K) Minimal level of performance as a criterion for granting and maintaining the privilege to pay compensation directly.

(1) The employer must be able to furnish or make arrangements for reasonable medical services during all working hours. A written explanation of what arrangements have been made or will be made to provide medical treatment shall be supplied with the application for self-insurance.

For an employer desiring to be first granted the privilege of self-insured status on or after the effective date of this rule, the employer shall provide to the bureau for the bureau's approval the employer's plan for the following:

(a) Criteria for the selective contracting of health care providers;

(b) Plan structure and financial stability for the medical management of claims;

(c) Procedures for the resolution of medical disputes between an employee and the employer, an employee and a provider, or the employer and a provider, prior to an appeal under section 4123.511 of the Revised Code;

(d) Upon the request of the bureau, provide a timely and accurate method of reporting to the administrator necessary information regarding medical and health care service and supply costs, quality, and utilization; and,

(e) Provide an employee the right to change health care providers.

(2) The employer shall promptly pay the fees of outside medical specialists to whom the commission or bureau shall refer claimants for examination or where the commission or bureau refers the claim file for review and opinion by such specialist except as provided by law in cases where the claim was subsequently disallowed. Such fees shall be paid within the time limits provided for payment of medical bills under paragraph (K)(5) of this rule.

(3) Every employer shall keep a record of all injuries and occupational diseases resulting in more than seven days of total disability or death as well as all contested or denied claims and shall report them to the bureau, and to the employee or the claimant's surviving dependents in accordance with rule 4123-3-03 of the Administrative Code.

(4) The employer shall provide to the claimant and upon request, shall file with the bureau or the commission, medical reports relating thereto and received by it from the

treating physician and physicians who have seen the claimant in consultation for the allowed injury or occupational disease, or any injury or occupational disease for which a claim has been filed. The claimant shall provide to the employer and, upon request, shall file with the bureau or the commission, medical reports relating thereto and received from the treating physician and physicians who have seen the claimant in consultation for the allowed injury or occupational disease or any injury or occupational disease for which a claim has been filed. The claimant shall honor the employer's request for appropriate written authorization to obtain medical reports to the extent that such reports pertain to the claim.

(5) Within thirty days after receipt of a hospital, medical, nursing or medication bill duly incurred by the claimant, the employer shall either pay such bill, or if the employer contests any of such matters, shall notify the provider, the employee, and, only upon request, the bureau or commission in writing. Such written notice shall specifically state the reason for nonpayment. The employer's notification to the employee shall indicate that the employee has the right to request a hearing before the industrial commission. If the matter is heard by the industrial commission, the employer shall pay compensation and benefits due and payable under an order as provided by section 4123.511 of the Revised Code. If the self-insuring employer allows a claim for benefits or compensation without a hearing, the employer shall pay such benefits or compensation no later than twenty-one days from acquiring knowledge of the claim or the claimant's filing of the C-84 form, whichever is later. The employer shall approve a written request for a change of physicians within seven days of receipt of such request that includes the name of the physician and proposed treatment. The employer shall approve or deny a written request for treatment within ten days of the receipt of the request. If the employer fails to respond to the request, the authorization for treatment shall be deemed granted and payment shall be made within thirty days of receipt of the bill.

(6) The employer shall make its records and facilities available to the employees of the bureau at all reasonable times during regular business hours. A public employer shall make the reports required by section 4123.353 of the Revised Code available for inspection by the administrator of workers' compensation and any other person at all reasonable times during regular business hours.

(7) The employer shall pay all compensation as required by the workers' compensation laws of the state of Ohio. By becoming self-insuring, the employer agrees to abide by the rules and regulations of the bureau and commission and further agrees to pay compensation and benefits subject to the provisions of these rules. The self-insuring employer shall proceed to make payment of compensation or medical benefits without any previous order from the bureau or commission and shall start such payments as required under the Workers' Compensation Act, unless it contests the claim.

(8) The employer may notify the medical section and the claimant at least sixty days prior to the completion of the payment of two hundred weeks of compensation for temporary total disability with the request that the claimant be scheduled for examination by the medical section. Payment of temporary total disability compensation after two hundred

weeks shall continue uninterrupted until further order of the commission up to the maximum required by law, unless the claimant has returned to work, or the treating physician has made a written statement that the claimant is capable of returning to his former position of employment or has reached maximum medical improvement or that the disability has become permanent, or, after hearing, an order is issued approving the termination of temporary total disability compensation.

(9) Upon written request by the claimant or claimant's representative, the employer shall make available for review all the employer's records pertaining to the claim. Such review is to be made at a reasonable time (not to exceed seventy-two hours) and place. The claimant, upon written request, shall provide the employer or its representative with an appropriate written authorization to obtain medical reports and records pertaining to the claim.

Except as provided for in this rule, an employer may not assess a fee or charge the claimant or the claimant's representative for the cost of providing a copy of the employer's records pertaining to the claim. Where the employer has previously provided a copy of the record or records pertaining to the claim to the claimant or the claimant's representative, the employer may charge a fee for the copies. The employer's fee shall be based upon the actual cost of furnishing such copies, not to exceed twenty-five cents per page.

(10) The employer shall inform a claimant, and the bureau of workers' compensation, in writing, within thirty days from the filing of the claim, as to what conditions it has recognized as related to the injury or occupational disease and what, if any, it has denied. The same timeframe shall apply when the employer rejects a medical only claim.

(11) The employer shall post notices of its self-insuring status indicating the location in the plant(s) for the filing of a claim and the job title and department of the employees designated by the employer to be the person or persons responsible for the processing of workers' compensation claims.

(12) A public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or a publicly owned utility, who is granted the status of self-insuring employer pursuant to section 4123.35 of the Revised Code shall comply with the section 4123.353 of the Revised Code.

(L) If a state insurance fund employer or a succeeding employer, as described in rule 4123-17-02 of the Administrative Code, applies for the privilege of paying compensation, etc., directly, by transferring from state fund to self-insurance, the actuary of the bureau shall determine the amount of the liability of such employer to the bureau for its proportionate share of any deficit in the fund. To determine an employer's liability under this rule, the actuary of the bureau shall develop a set of factors to be applied to the pure premium paid by an employer on payroll for a seven year period, as described below. The factors shall be based on the full past experience of the commission and bureau as

reflected in the most recent calendar year end audited combined financial statement of the commission and bureau, and shall also accommodate any projected change in the financial condition of the fund for the current calendar year, or any additional period for which an audited combined financial statement is unavailable. The factors shall be revised annually effective July first based on the most recent calendar year audited combined financial statement and the projected change in the financial condition of the fund in the current calendar year or any additional period for which an audited combined financial statement is unavailable. The annually revised factors shall be adopted by rule 4123-17-40 of the Administrative Code, and filed with the secretary of state and the legislative service commission at least ten days prior to July first of each year. Factors effective July first of each year shall apply to all applications for self-insurance filed on or after July first of that year through June thirtieth of the following year. The revised factors shall be applied to the pure premium paid by the employer on payroll for the seven calendar accident years ending December thirty-first of the year preceding the year in which the factors are adopted under rule 4123-17-40 of the Administrative Code. In the event the audited combined financial statement of the commission and bureau reveals that no deficit exists, or in the event the application of the factors adopted by rule 4123-17-40 of the Administrative Code yields a negative number, the employer will incur no liability under this paragraph, but will not receive any refund for prior premiums paid except for those matters specifically addressed in paragraph (L)(2) of this rule. As used in this rule, "pure premium paid" means premiums actually paid under a base rating plan or an experience rating plan and minimum premium paid under a retrospective rating plan. It does not include premiums billed for actual claims costs, including reserves at the end of ten years, under a retrospective rating plan. Obligations under a retrospective rating plan remain the responsibility of the employer regardless of the employer's status. The same principles shall apply to cases of a merger by a self-insuring employer and a state fund employer under the self-insurer's status. In addition, the provisions listed below shall apply:

(1) Within thirty days of the receipt from the employer of the necessary forms and of a separate statement of assets and liabilities, the bureau will forward to the employer a letter stating the amount of liability (if any) due the state fund as outlined above and a copy of the computation of such liability (if any).

(2) Within thirty days of the date of mailing of the letter by the bureau as outlined in paragraph (L)(1) of this rule, the employer shall reply by a letter, signed in handwriting, acknowledging that the employer agrees with the amount of liability specified in the letter and that there are no protests or claims hearings pending which could affect the amount of the liability. If any such matters are pending and would affect the liability, they must be detailed and set forth in the letter from the employer. This letter must also acknowledge that any protest letters, applications for handicap reimbursement or other requests affecting the risk's state fund experience **FILED** file subsequent to the date of this letter shall be considered invalid for both rebate of premium on state fund experience and the calculation of liability cited above. This letter must also specify the suggested effective date of the transfer to self-insurance which the employer requests, subject to paragraph (B) of this rule which requires that the effective date must be at least ninety

days after the date the application forms are received by the bureau. Failure to comply with the requirements set forth herein shall terminate further consideration of the application.

(3) Subsequent to the approval of the employer's self-insurance status and the effective date thereof by the administrator, the bureau shall issue a settlement sheet statement containing the adjustment required above and billing for an advance deposit as required by other rules of the commission. The employer shall pay the amounts required by this paragraph, pay the contribution to the self-insuring employers' guaranty fund under section 4123.351 of the Revised Code, submit a performance surety bond or additional security, if required by the bureau, and estimated final payroll report as a state fund risk, all within thirty days of the date of the mailing of the administrator's **SELF-INSURED CERTIFICATE**, ~~executive order~~.

(4) The final adjustments of all premiums due the state fund for the final payroll reports and final bureau audit (if any), as well as the pending protests, etc., as specified in paragraph (L)(2) of this rule, shall all be settled and paid within six months from the date of transfer from state fund to self-insuring status. Employer's records must be made available promptly for final audit which must also be completed within six months from the date of the transfer from state risk to self-insurance.

(M) If there is any change involving additions, mergers, or deletions of entities or ownership changes of a self-insuring employer, which would materially affect the administration of the employer's self-insuring employer program or the number of employees included in such program, the employer shall notify the bureau self-insuring employer's section within thirty days after the change occurs. Based upon the information provided or additional information requested by the bureau, the bureau will determine the effect of the change on the employer's self-insuring employer status, the adequacy of the employer's contribution to the self-insuring employers' guaranty fund, and the need for additional security.

(N) Public employers granted the privilege of self-insurance shall include volunteers and probationers performing services for the political subdivision as employees to be covered under the self-insurance policy.

HISTORY: Eff 7-1-76; 1-2-78; 12-11-78; 11-26-79; 2-17-81; 9-3-85; 8-22-86 (Emer.); 11-17-86 (Emer.); 1-10-87; 7-16-90; 11-23-92 (Emer.); 2-22-93; 11-19-93; 12-17-01; 4-28-03; 11-14-03

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.121, 4121.30, 4123.05, 4121.12

Rule amplifies: RC 4123.35, 4123.58

R.C. 119.032 review dates: 03/01/2006

4123-19-05 Where an employer is a self-insuring risk and desires to become a state risk.

(A) Where an employer that is a self-insuring risk desires to become a state risk, the employer transferring from a self-insuring risk to a state risk shall be rated at the

appropriate experience modifier to the employer's basic premium rate. Such a rate shall be determined pursuant to section 4123.29 of the Revised Code.

(B) The adjustment of the self-insurance premium of such employer shall be computed on an earned premium basis as of the date of transfer from self-insurance to the state fund, which adjustment shall be controlled by the rules controlling the ordinary premium adjustment.

(C) A self-insuring employer that transfers to the state insurance fund shall continue to administer self-insured claims for dates of injury, disease, or death during the period of self-insurance, and the employer shall be responsible to continue to pay compensation and benefits directly. Further, the employer shall remain obligated to pay to the bureau the self-insuring employer assessment calculated on the basis of the paid compensation for such claims attributable to the individual self-insuring employer according the provisions of division (I) of section 4123.35 of the Revised Code and a rule of the bureau of workers' compensation adopted in accordance with section 111.15 of the Revised Code.

HISTORY: Eff 7-1-62; 8-22-86 (Emer.); 11-17-86 (Emer.); 1-10-87; 5-9-90; 12-17-01

Rule promulgated under: RC Chapter 119.

Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05

Rule amplifies: RC 4123.35

119.032 Review date: 9/28/01; 3/1/06

4123-19-06 Procedures for revocation of self-insuring status.

(A) The bureau may direct that a public hearing be held on the question of revocation of a self-insuring employer's privilege of self-insurance if the employer that has elected with the approval of the bureau to pay compensation, etc., directly thereafter fails in any one of the following:

(1) Continued failure to file medical reports **REQUESTED BY** with the bureau or industrial commission or to submit reports to the injured worker required under law or rule;

(2) Continued failure to pay compensation or benefits in accordance with any law or bureau or commission rules in a timely manner;

(3) Failure to provide reasonable medical facilities;

(4) Continued failure to pay all costs of administration including fees of medical specialists to whom the commission or bureau refers claimants for physical examinations or refers claim files for review and opinion, or failure to pay claimant's travel expenses within thirty days as required by law or rule;

(5) Continued failure to keep a record of all injuries and occupational diseases resulting in more than seven days of temporary total disability or death or involving seven days or

less of lost time where it appears that there will be permanent partial disability compensable under division (B) of section 4123.57 of the Revised Code, or where the employer denies the claim, and to report the same to the bureau and to furnish a copy of such report to the employee it concerns or to his surviving dependents;

(6) Continued failure to pay compensation within three weeks or benefits including failure to respond to a **WRITTEN** request for authorization to change physicians **WITHIN SEVEN DAYS, FAILURE TO APPROVE OR DENY A WRITTEN REQUEST FOR TREATMENT** approval of medical treatment **WITHIN TEN DAYS, FAILURE TO PAY HOSPITAL, MEDICAL, NURSING OR MEDICATION BILLS DULY INCURRED BY THE CLAIMANT** etc., within the period of thirty days after receipt of a **physician's fee bill** or request for any of the above mentioned benefits, unless the employer contests any of such matters, in which event the employer shall promptly notify the employee in writing, **AS WELL AS THE PROVIDER, FOR REQUESTS TO CHANGE PHYSICIANS OR FOR TREATMENT REQUESTS OR FOR FEE BILLS,** and, **ONLY UPON REQUEST**, the bureau **OR THE INDUSTRIAL COMMISSION**, of such contest, **SPECIFICALLY STATING THE REASON FOR CONTESTING SUCH MATTER, AND NOTIFYING** along with the employer's notification to the employee **that** the employee **OF has** the right to request a hearing before the industrial commission;

(7) Failure to make its records and facilities available to employees of the bureau

(8) Repeated failure to permit a claimant, his dependents or the representatives of either, to review all of the employer's medical records pertaining to the claim at all reasonable times and places within seventy-two hours of receiving a request;

(9) Repeated failure to inform a claimant or his dependents and the bureau of workers' compensation, in writing, as to what conditions it has recognized as related to his injury or occupational disease and what, if any, conditions it denies;

(10) Harassing, dismissing or disciplining employees who have made complaints to the bureau;

(11) Failure to pay contributions to the self-insuring employers' guaranty fund as set forth in section 4123.351 of the Revised Code; or,

(12) Repeated failure to comply strictly with any rule, regulation or order prescribed by the commission and bureau.

(B) Should the bureau have reason to believe that the self-insuring employer has failed to comply with any of the matters listed in paragraph (A) of this rule involving the employer's financial strength or administrative ability to meet its obligations as a self-insuring employer, the bureau shall refer the matter for a public hearing on the question of revocation of the employer's privilege of self-insurance. Such public hearing shall be conducted before the self-insured review panel in accordance with the provisions of rule 4123-19-14 of the Administrative Code for issues involving the financial strength or the

administrative ability of the employer to operate a self-insured workers' compensation program. The public hearing shall be conducted before the self-insuring employers evaluation board in accordance with the provisions of rule 4123-19-13 of the Administrative Code for issues involving unresolved complaints by injured workers or allegations of misconduct by the self-insuring employer.

(C) The employer and its representative shall be notified in writing that such a public hearing will be held and shall be furnished with copies of any complaint of an employee or report from the employees of the bureau. For matters to be heard before the self-insured review panel, the bureau shall mail a notice of hearing to the employer and its representatives by regular mail, setting forth the date, time, and place of the hearing not less than twenty one days before such hearing. For matters to be heard before the self insured employers evaluation board, the bureau shall mail a notice of the hearing to the claimant and the claimant's representative if the issue is a complaint. The notice shall be mailed not less than fourteen days before such hearing.

(D) At the hearing the testimony given shall be taken by a court reporter and copies of the transcript of such testimony shall be furnished to the self-insuring employer, the complaining claimant, their representatives, the administrator and the members of the self-insured review panel or the self-insuring employers evaluation board.

(1) Should the self-insured review panel find that the self-insuring employer has materially violated any parts of this rule or is incapable of operating a self-insuring program, or refuses to conform to the rules and regulations of the industrial commission and bureau, then the administrator will forthwith issue a revocation of authority to pay compensation, etc., directly,

(2) Should the self-insuring employers evaluation board recommend to the administrator that an employer's privilege of self-insurance be revoked, the administrator shall promptly and fully implement such recommendation without further hearing.

(3) An employer that has been revoked pursuant to paragraph (D)(1) or (D)(2) of this rule shall be required to pay forthwith its eight months' advance estimated premium into the state insurance fund.

(E) The bureau may, at its discretion and after proper hearing, revoke the self-insuring status of a unit of a parent company when the evidence presented at the hearing clearly shows that the unit is operating at a different location from the parent company, and its actions causing the revocation were not directed **nor** authorized by the parent company.

HISTORY: Eff 1-2-78; 1-10-87; 7-16-90; 11-19-93; 12-17-01
Rule promulgated under: RC Chapter 119.
Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05
Rule amplifies: RC 4123.35, 4123.352
119.032 Review date: 9/28/01; 3/1/06

4123-19-07 Rules controlling renewals of risks.

(A) One week prior to the date of expiration of insurance of each private risk the bureau shall mail to each such risk a "Payroll Report" form.

(B) The employer shall, within one month from the date of expiration of his last six months' insurance period, complete and return the payroll report to the bureau with premium remittance.

(C) If, within two months immediately after the expiration of the six months' period, an employer fails to file a report of the employer's actual payroll expenditures for the period, the premium found to be due from such employer for the period shall be increased in an amount equal to one per cent, the increase, however, not to be less than three dollars nor more than fifteen dollars.

(1) The premium determined by the bureau to be due from an employer shall be payable on or before the end of the coverage period established by the premium security deposit, or within the time specified by the bureau if the period for which the advance premium has been paid is less than eight months. If an employer fails to pay such premium when due, there shall be added to such premium an amount equal to three per cent of such premium. If the failure to pay continues for more than one month, the premium shall be further increased in an amount equal to two per cent of such premium for each additional month or part of a month, but the total of all such additional amounts shall not exceed twelve per cent of such premium. However, if the employer files an appropriate payroll report within the time provided by law or within the time specified by the bureau if the period for which he has paid an estimated premium is less than eight months, the employer shall not be in default and these provisions will not apply if the employer pays such premium within fifteen days after he has been first notified by the bureau of the amount due.

(2) Any deficiencies in amounts of premium security deposit paid by an employer for any period or periods shall be subject to an interest charge of six per cent per annum from the respective dates of the notice by the bureau to the employer of such deficiency in the premium security deposit. In determining the interest due on deficiencies in premium security deposit payments, a charge in each case shall be made against the employer in a sum equal to interest at the rate of six per cent per annum on the premium security deposit due but remaining unpaid sixty days after notice by the bureau.

(3) Any interest charges or penalties provided for in paragraphs (C)(1) and (C)(2) of this rule and paid, shall be credited to the employer's account for rating purposes in the same manner as premium.

(4) The amount of premium due from such employer may be certified to the attorney general for collection.

(D) The question of classification or rating shall not be permitted to operate so as to delay the making of premium payment.

(E) When the risk has paid its adjustments and renewal premium to the bureau, the bureau shall forthwith mail to such a risk a "Certificate of Premium Payment," which certificate shall set forth the renewal, effective and expiration dates of coverage for the risk.

(F) For counties and public employer taxing districts, payment of premium is due in accordance with the schedule established under division (B) of section 4123.41 of the Revised Code. Where such employer fails to pay at least forty-five per cent of the premium due by May fifteenth or the full premium due by September first, the bureau may impose an interest penalty for late payment for any amount due for each month or part of a month past due as scheduled at the interest rate established by the state tax commissioner pursuant to section 5703.47 of the Revised Code.

HISTORY: Eff 7-1-71; 8-19-77; 12-11-78; 11-26-79; 5-9-90; 12-14-92
Rule promulgated under: RC Chapter 119.
Rule amplifies: R.C. SEC. 4123.32 AS AMENDED BY H.B. 1017, 4123.41
119.032 Review Date: 9-28-01; 3-1-06

4123-19-08 Renewal of self-insuring risks.

(A) The privilege of an employer to pay compensation, etc., directly, must be renewed annually. Beginning with the effective date of this rule, prior to renewal of the employer's privilege of self-insurance, the bureau shall re-evaluate the employer's financial strength and administrative ability as described in rule 4123-19-03 of the Administrative Code. The bureau will consider past performance of the self-insuring employer as an additional factor in determining whether to renew the privilege of self-insurance. The five-hundred employee requirement in division (B)(1) of section 4123.35 of the Revised Code will not be considered mandatory in the case of an employer seeking to renew its privilege of self-insurance. Waivers granted for good cause by the administrator pursuant to paragraph (H) of rule 4123-19-03 of the Administrative Code will continue in effect indefinitely unless there is a significant change, in the opinion of the bureau of workers' compensation.

(B) Self-insuring risks desiring to continue paying compensation, etc., directly, shall secure from the bureau a copy of the appropriate form of application which shall be completed and returned to the bureau. ~~The employer shall include with the renewal application a recording of the number of lost time claims.~~ The employer may also be required to include a reporting of the amount of payments made and the amount of reserves established for the aforementioned claims as sufficient to cover future liabilities. The properly completed renewal forms shall be signed by the Ohio self-insuring program administrator who has been designated by the employer to the bureau or an officer of the company and filed ninety days prior to the renewal date.

(C) The application forms and the employer's financial statement shall be reviewed by the bureau. In order to renew its status as a self-insuring employer, the employer shall establish the following to the bureau's satisfaction: that the employer has fulfilled the

minimal level of performance standards that an employer is required to meet before being granted permission to pay compensation and benefits directly, as provided in paragraph (K) of rule 4123-19-03 of the Administrative Code; that the employer has substantially resolved all outstanding complaints filed with the bureau; and that the employer has achieved a satisfactory rating in its most recent audit report. Upon compliance with these requirements, the administrator may approve the renewal application. If the application is granted, the bureau will so notify the applicant within thirty days prior to the renewal date. In this notification, the bureau shall specify the contribution to the self-insuring employers' guaranty fund and the amount of the additional security, if required.

(D) If the aforesaid employer, upon receipt of such notification, promptly provides the bureau with the security in the amount and form specified by the bureau, the bureau thereafter will issue said employer a revised "Findings of Facts" statement and certificate which will be sent to the risk by the bureau.

(E) In the event the bureau finds that the minimum criteria set forth in the rules have not been met, the bureau shall give written notice to the applicant that the privilege to pay compensation, etc., directly, will not be renewed. Said notice shall give the employer two weeks to exercise the right to a public hearing before ~~the administrator, or~~ the self-insured review panel, in accordance with the provisions of rule 4123-19-14 of the Administrative Code. If no hearing is requested or if the ~~administrator or~~ the self-insured review panel **OR, ON APPEAL, THE ADMINISTRATOR** upholds the non-renewal, the applicant shall forthwith be required to pay its full premium **INTO THE STATE INSURANCE FUND** for the intervening period from the date of the expiration of the last renewal date to the date of the **ORDER OF NON-RENEWAL ISSUED BY THE SELF-INSURED REVIEW PANEL OR THE ADMINISTRATOR**, ~~administrator's or self-insured review panel's order of non-renewal~~ into the state insurance fund or to obtain a binder for state fund coverage as of the expiration date of its last renewal.

(F) If, for any reason, the self-insuring risk is not renewed and said risk does not pay its premium security deposit for the ensuing period into the state insurance fund or obtain a binder for state fund coverage as of the expiration date of its last renewal, said risk shall be deemed an amenable but noncomplying employer pursuant to sections 4123.01 to 4123.99 of the Revised Code.

(G) If, for any reason, it is not possible to finally pass on the employer's application for renewal prior to the expiration of its present authorization, an extension may be granted until such time as the final disposition of the application for renewal can be made.

HISTORY: Eff 7-1-62; 1-2-78; 11-26-79; 2-17-81; 9-3-85; 7-16-90; 11-19-93; 12-17-01

Rule promulgated under: RC Chapter 119.

Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05

Rule amplifies: RC 4123.32, 4123.35

119.032 Review date: 9/28/01; 3/1/06

4123-19-09 In regard to complaints filed by employees against self-insuring employers under the provisions of section 4123.35 of the Revised Code.

(A) The bureau shall receive all complaints concerning any employer engaged in paying compensation directly to its employees. The bureau shall transfer to the self-insuring employers evaluation board only those complaints which are not resolved. An employer shall respond in writing to a complaint within fourteen days of receipt thereof, and the employer's response shall be made a part of the complaint file.

(B) The administrator of the bureau of workers' compensation shall investigate and process all complaints against a self-insuring employer through the self-insuring employers section of the bureau. However, the bureau may dismiss a complaint based upon the employer's action or lack of action with respect to events that occurred more than two years prior to the filing of the complaint, unless the facts could not have been **REASONABLY** ~~reasonable~~ known to the claimant.

(C) The bureau shall maintain a file by employers of all complaints that relate to the employer, together with any information filed by the employer as to such complaints. A copy of all complaints shall become a part of the self-insuring employer's record file and shall be available at the time of renewal consideration. The bureau shall evaluate each complaint and take appropriate action as follows:

(1) If the bureau records for such employee does not contain full information as to the matter which is the subject of the complaint, the bureau may attempt to obtain such information by correspondence with the self-insuring employer, the claimant, and their authorized representatives, if any.

(2) The bureau may also audit the program of the employer in the manner provided in section 4123.35 of the Revised Code.

(D) Following receipt of all necessary information, including bureau records, correspondence from the employee and the employer, or an audit by the bureau of workers' compensation, the bureau may dismiss the complaint as invalid or find that the complaint has been resolved. Any unresolved complaint against a self-insuring employer shall be referred to the self-insuring employers evaluation board for further action in accordance with the provisions of rule 4123-19-13 of the Administrative Code. If the bureau determines that a complaint is invalid or resolved and decides not to present the complaint to the self-insuring employers evaluation board, the claimant may request that the complaint be presented to the administrator or the self insuring employers evaluation board for further consideration.

(E) Complaints referred to the bureau as provided above shall be retained in the employer's file for the period of four years from the date of resolution.

(F) No employer that elects to pay compensation directly shall harass, dismiss or otherwise discipline any employee for making a complaint. Upon receipt of this information that such harassment, dismissal or other disciplinary action has been taken, the bureau shall assign the matter for hearing pursuant to the provisions of rule 4123-19-

13 of the Administrative Code before the members of the self-insuring employers evaluation board. If the board finds that such employer is guilty of harassing, dismissing or otherwise disciplining the claimant for making the complaint, the board shall levy a reasonable financial penalty under the circumstances as the board deems appropriate, payable by the employer to the surplus fund.

(G) Repeated violations of this rule shall be grounds for revocation of the employer's privilege to pay compensation, etc., directly.

HISTORY: Eff 1-2-78; 8-22-86 (Emer.); 11-8-86; 5-9-90; 12-17-01 (Emer.); 8-8-03

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05

Rule amplifies: RC 4123.35, 4123.352

R.C. 119.032 review dates: 03/01/2006

4123-19-10 In regard to audits by the bureau of workers' compensation.

(A) The bureau of workers' compensation shall audit the programs of employers who elect to pay compensation directly in the following situations:

(1) Audit shall be conducted by the bureau on a random basis.

(2) In addition, the bureau shall make such audits whenever the bureau has grounds for believing that an employer is not in full compliance with the rules of the commission or the provisions of Chapter 4123. of the Revised Code.

(3) Upon request from the self-insured review panel or the self-insuring employers evaluation board

(B) Such audits shall include the employer's methods of furnishing medical, surgical, nursing and hospital attention services, medicines and funeral expenses; the employer's payment of compensation or benefits to claimants and dependents and whether this is being done in a proper and timely manner; whether the employer has promptly filed all reports required under the rules of the commission and bureau and the provisions of Chapter 4123 of the Revised Code. Such audits may also be used to evaluate whether the employer is providing medical examinations and evaluations in a timely manner; and whether the employer has harassed, dismissed or otherwise disciplined employees who have filed complaints against such employer with the bureau of workers' compensation.

(C) The bureau shall report its findings on such audits to the employer, **THE SELF-INSURED REVIEW PANEL OR** and the self-insuring employers evaluation board, where the **PANEL OR** board had requested the audit, and shall evaluate such findings and take such action as is indicated.

HISTORY: Eff 1-2-78; 5-9-90; 12-17-01

Rule promulgated under: RC Chapter 119.

Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05

Rule amplifies: RC 4123.35

119.032 Review date: 9/28/01; 3/1/06

4123-19-11 Fixing time limits beyond which the failure of a self-insuring employer to provide for the necessary medical examinations and evaluations may not delay a decision on a claim.

(A) When a self-insuring employer has provided or arranged for a necessary medical examination or evaluation, in accordance with paragraph ~~(B)~~ (A) of rule 4121-03-09 of the Administrative Code it shall promptly notify the commission that it has done so.

(B) Failure of a self-insuring employer to provide for or arrange for the scheduling of such necessary medical examinations and evaluations within the period of fifteen days from the notification shall not delay a decision in claim.

HISTORY: Eff 1-2-78; 5-9-90; 12-17-01
Rule promulgated under: RC Chapter 119.
Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05
Rule amplifies: RC 4123.35
119.032 Review date: 9/28/01; 3/1/06

4123-19-12 Grounds for holding public hearings to evaluate the program for self-insuring employers.

The administrator of workers' compensation shall hold a public hearing to evaluate the program for self-insuring employers in the following situations:

(A) If there has been a substantial amendment of the statutes relating to self-insuring employers.

(B) If decisions are rendered by the supreme court of Ohio which materially change the interpretation of such statutes or invalidate material portions of the rules of the industrial commission or the bureau of workers' compensation.

(C) If there is substantial evidence that the self-insuring employers are not complying with the laws of the state of Ohio, the rules and procedures of the bureau of workers' compensation and the industrial commission.

HISTORY: Replaces rule 4121-9-12; Eff 1-2-78; 5-9-90
Rule promulgated under: RC Chapter 119.
Rule amplifies: R.C. SEC. 4123.35 IN CONJUNCTION WITH 4121.13
119.032 Review Date: 9-28-01; 3-1-06

4123-19-13 Self-insuring employers evaluation board.

(A) Section 4123.352 of the Revised Code establishes a self-insuring employers evaluation board. The board shall consist of three members:

- (1) The member of the industrial commission representing the public shall serve, ex officio, as chairman.
 - (2) A member of the "Ohio Self-Insurers Association" shall be appointed by the governor with the advice and consent of the senate.
 - (3) A member of labor shall be appointed by the governor with the advice and consent of the senate.
 - (4) Not more than two of the members shall be of the same party.
 - (5) For purposes of administration, the board shall be part of the bureau of workers' compensation. The bureau shall furnish the necessary office space, staff and supplies. The board shall meet as the board determines or as requested by the bureau.
- (B) All unresolved complaints or allegations of misconduct against a self-insuring employer shall be referred to the board by the bureau. At the claimant's request, the board may elect to hear a complaint that had been dismissed by the bureau.
- (1) The board shall investigate and may order the employer to take corrective action in accordance with such schedule as the board fixes.
 - (2) A board determination need not be made by formal hearing but must be issued in written form and contain the signatures of at least two members.
 - (3) If after a hearing pursuant to Chapter 119. of the Revised Code and rules of the commission and bureau, the board determines an employer has failed to correct deficiencies within the time fixed by the board, or is otherwise violating Chapter 4123. of the Revised Code or the rules of the industrial commission or the bureau of workers' compensation, the board shall recommend to the administrator:
 - (a) Revocation of employer's privilege of self-insurance;
 - (b) Probation;
 - (c) A civil penalty not to exceed ten thousand dollars for each violation of the law or rules, payable into the self-insuring employers' surety bond fund; or
 - (d) Any other appropriate penalty.
 - (4) A board recommendation to revoke an employer's privilege of self-insurance must be by unanimous vote.
 - (5) A penalty other than revocation shall be by majority vote of the board and will be the responsibility of the bureau to monitor for compliance.

(6) The bureau shall promptly and fully implement recommendations from the board for disciplining a self-insuring employer.

HISTORY: Eff 8-22-86 (Emer.); 11-17-86 (Emer.); 1-10-87; 5-9-90; 12-17-01

Rule promulgated under: RC Chapter 119.

Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05

Rule amplifies: RC 4123.352

119.032 Review date: 9/28/01; 3/1/06

4123-19-14 Self-insured review panel.

(A) The administrator of the bureau of workers' compensation may delegate the authority granted to the administrator under Chapters 4121. and 4123. of the Revised Code for determining self-insuring employer matters as may be authorized. For this purpose, the administrator may appoint a self-insured review panel to provide advice to the administrator and the bureau's self-insured department and provide employers with hearings on matters referred to the panel, or as requested by the employer. The bureau shall refer all unresolved issues involving the financial strength or the administrative ability of the employer to operate a self-inured workers' compensation program to the panel for a hearing.

(B) The self-insured review panel shall consist of three members appointed by the administrator. The members shall consist of persons who shall have expertise or experience in matters relating to self-insuring employers.

(C) The self-insured review panel shall hold meetings and hearings to determine matters referred to it by the administrator or the bureau's self-insured department for a review. The panel may issue decisions without formal hearing, and may advise the administrator or the self-insured department on issues referred to it. The panel shall afford an employer the opportunity for a formal hearing before the panel upon request.

(D) If an employer requests a hearing before the review panel or the panel determines that a hearing is in the best interests of the employer or the state insurance fund, the panel shall mail a notice of hearing to the employer and its representatives by regular mail, setting forth the date, time and place of the hearing. The notice shall be mailed not less than twenty one days before the date of such hearing. In justifiable cases, an emergency hearing may be arranged with the review panel.

(E) The panel shall keep a record of its dockets and proceedings. The panel's decisions shall be reduced to writing and mailed to all interested parties and shall state the evidence upon which the decision was based and the reasons for the panel's actions. The decision of the panel shall be the decision of the administrator. If the employer files a written appeal within fourteen days of the employer's receipt of the panel's decision, at the administrator's discretion, the administrator may reconsider the decision of the panel, and may conduct a formal hearing for such purpose.

(F) The administrator may authorize the review panel to consider the following matters:

- (1) Granting or denying an application for the privilege to pay compensation, etc., directly;
- (2) Non-renewals of self-insured status;
- (3) Revocation of self-insuring employer status;
- (4) Issues of a self-insuring employer's adequacy of contribution to the self-insuring employers' guaranty fund or need for additional security under section 4123.351 of the Revised Code;
- (5) Any other self-insuring employer matter as authorized and delegated by the administrator under Chapters 4121. and 4123. of the Revised Code.

HISTORY: Eff 5-9-90; 11-19-93; 12-17-01
Rule promulgated under: RC Chapter 119.
Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05
Rule amplifies: RC 4123.35, 4123.351, 4123.352
119.032 Review date: 9/28/01; 3/1/06

4123-19-15 Assessment for self-insuring employers' guaranty fund.

Note: This rule is addressed in a separate rule presentation.

4123-19-16 Self-insured construction projects.

(A) As used in this rule:

(1) "Responsible self-insured employer" or "responsible employer" means the self-insuring employer or the public school employer that enters into a construction contract and applies for permission to self-insure the construction contract. The responsible employer is the entity responsible for the cost of the construction project and generally will be the owner of the project. The responsible employer is the payor under the contract.

"Responsible self-insured employer" or "responsible employer" may include a self-insured general contractor or construction manager whose principal source of business is the execution of construction projects.

(2) "Public school employer" means an employer defined in division (R) of section 4123.35 of the Revised Code that enters into a construction contract exceeding twenty five million dollars and applies for permission to self-insure the construction contract, whether or not the employer is a self-insuring employer.

(3) “General contractor” means a self-insured employer that has entered into a contract with an owner to perform more than fifty per cent, by value, of the work on a construction project.

(4) “Construction manager” means a self-insured employer that has entered into a contract with an owner to provide substantially the same services described in division (A) of section 9.33 of the Revised Code in connection with a construction project. Regardless of any contrary terms of section 9.33 of the Revised Code, for purposes of this rule, the term “construction manager” is not limited to public projects and may apply even if the construction manager also performs construction work on the project.

(5) “Contracting employer” or “subcontracting employer” means any employer, whether state fund or self-insured, that has contracted either directly with a responsible self-insuring employer or with a contracting or subcontracting employer to perform construction services on the construction project. The contracting employer is the payee under the contract, except for where the contracting employer has subcontracted with another contracting employer.

(B) The purpose of this rule is to establish standards by which the administrator may permit a responsible self-insuring employer to self-insure a construction project entered into by the responsible self-insuring employer pursuant to division (O) of section 4123.35 of the Revised Code.

(C) The administrator’s authority to grant self-insured status for a construction project is permissive. The bureau of workers’ compensation may establish criteria for granting self-insured status to ensure the financial stability and claims continuity of the workers’ compensation program. The burden of proof is on the responsible self-insured employer to satisfy the requirements of divisions (O), (P), and (Q) of section 4123.35 of the Revised Code, including designation of a safety professional and employment of an ombudsperson for the construction project, and such other requirements as the administrator may establish by this rule or other policy for granting permission to self-insure a construction project.

(D) A responsible employer filing an application to self-insure a construction project shall be a self-insuring employer under the Ohio workers’ compensation statutes, except that a public school employer may be a state fund employer. A public school employer shall be self-insured for the construction project only and shall maintain state fund coverage for its employees.

(E) In order for a responsible employer to be considered for self-insurance under division (O) of section 4123.35 of the Revised Code, the responsible employer must submit an application including, but not limited to, the following information:

(1) Dates the construction project is scheduled to begin and end, including the site(s) of the construction project;

- (2) The estimated cost of the project;
- (3) The contracting and subcontracting employers whose employees are to be self-insured by the responsible employer, including estimated payroll (any changes to the list of contracting and subcontracting employers during the duration of the project shall be sent to the bureau within two business days);
- (4) The provisions of a safety program specifically designed for the project;
- (5) A statement as to whether a collective bargaining agreement governing the rights, duties, and obligations of each of the parties to the agreement with respect to the project exists between the self-insuring employer and a labor organization.
- (6) All applications must be submitted ninety days prior to the desired effective date.

The administrator may require other information as needed to aid in the decision-making process.

(F) If the administrator approves the application, the administrator shall mail to the responsible self-insured employer a certificate granting the privilege to self-insure the construction project. Upon approval, the responsible employer is responsible for the administration and payment for the life of the claim of all claims under Chapters 4121. and 4123. of the Revised Code for the employees of any contracting employers and subcontracting employers covered under the certificate who receive injuries or are killed in the course of and arising out of employment on the project, or who contract an occupational disease in the course of employment on the project.

(G) The responsible employer is entitled to all of the protections provided under Chapters 4121. and 4123. of the Revised Code with respect to the employees of the contracting and subcontracting employers covered under the certificate as if the employees were employees of the responsible employer.

(H) The contracting and subcontracting employers included under the certificate are entitled to the protections provided under Chapters 4121. and 4123. of the Revised Code with respect to the contracting and subcontracting employer's employees who are employed on the construction project which is the subject of the certificate.

(I) The contracting and subcontracting employers included under the certificate shall identify in their payroll records for audit and compliance purposes the employees who are considered the employees of the responsible employer listed in that certificate for purposes of Chapters 4121. and 4123. of the Revised Code, and the amount that those employees earned from employment on the project that is subject to the certificate. The contracting or subcontracting employer shall exclude the payroll for its employees under the construction project from its payroll report and the administrator shall not consider the payroll when determining those contracting or subcontracting employers' premiums or assessments required under Chapters 4121. and 4123. of the Revised Code.

(J) The responsible employer shall include in the amount of paid compensation it reports pursuant to division (L) of section 4123.35 of the Revised Code, the amount of paid compensation that the responsible employer paid pursuant to division (O) of section 4123.35 of the Revised Code.

(K) For a public school employer, the bureau may grant the privilege of participating as a self-insured employer for a construction project under this rule on a one year basis, and shall consider the project for renewal annually pursuant to rule 4123-19-08 of the Administrative Code.

(1) Surety bond or letter of credit.

(a) A public school employer shall be required to make contributions as determined by the administrator to the self-insuring employers' guaranty fund established under section 4123.351 of the Revised Code.

In addition, the employer shall provide additional security as required by the bureau in the amount or form that may be specified by the bureau. At a minimum, the additional security shall be one hundred and twenty-five per cent of the expected workers' compensation losses of the construction project as determined by the bureau. The security shall be in force on or before the administrator grants the privilege to self-insure the construction project. In the event the initial calculation of expected losses is shown to be less than the actual losses, additional security shall be provided as required by the bureau.

(b) The public school employer shall assign the additional security required by this rule to the bureau for the benefit of the disabled employees or the dependents of killed employees of the public school employer for the construction project. In addition, the security shall be applied to disabled workers' relief fund payments to employees of the construction project and administrative expenses of the bureau in the management of such claims of employees of the construction project.

(c) Notwithstanding the authority of the bureau to seek reimbursement from the self insuring employers' guaranty fund, or from surety, excess loss insurance, and any other sources provided by the employer, the legal obligation to pay the costs of injuries, occupational diseases, and deaths incurred under the construction project remains with the public school employer.

(2) Disabled workers relief fund.

A public school employer shall be required to pay the ultimate costs of disabled workers relief fund payments to employees of the construction project, no matter the status of the construction project at the time the disabled workers relief fund payments are made to the employees of the construction project.

(3) Excess loss insurance.

A public school employer may purchase excess loss insurance subject to the rules applying to self-insuring employers. In the event the excess loss insurance is purchased, all rights to recovery from that insurance must be assignable to the bureau in the event of bankruptcy of the public employer school facility employer.

(4) Reducing the costs of the construction project.

As a condition precedent to the bureau granting the privilege to self-insure the construction project, a public school employer shall certify to the bureau by a written document signed by the highest elected official(s) of the employer, the costs savings of self insuring the construction project. The certification shall include data as required by the bureau, including but not limited to a cost analysis showing the costs of insuring the project with the Ohio state insurance fund and the costs of self insuring the project.

(5) Safety plan.

A safety professional shall be assigned to each construction project. The safety professional shall be responsible for ensuring that activities are performed in accordance with the site-specific health and safety plan (“HASP”) and training of site personnel.

A site-specific “HASP” shall be created prior to the start of the project and shall, at a minimum, contain the following elements:

- (a) Identify all recognized site hazards associated with each phase of the project. Particular attention should be given to fall hazards, trenching operations, and electrical hazards.
- (b) Identify key personnel and alternates responsible for site safety and health and the appointment of a site safety and health officer. Roles and responsibilities must be defined.
- (c) Evaluate the risks associated with each operation and identify the appropriate control measures to be taken to minimize or eliminate those risks.
- (d) Address training requirements for both routine and non-routine activities.
- (e) Include contingencies in the “HASP.” Contingencies may include: communications (internal and external), first aid provisions and providers, identification of nearest medical facility, post emergency phone numbers, and site control (prevent access by unauthorized personnel).
- (f) Include employee involvement, such as involvement in inspections, incident investigations, and hazard analyses.

(g) Collect documentation of information, such as hazard inspections, audits of the “HASP,” injury/illness data, incident investigations, industrial hygiene surveys, maintenance records, and job hazard analyses.

(6) Organizational Plan Criteria.

The public school employer shall:

(a) Identify a self-insured program administrator to be knowledgeable in the rules and laws of Ohio self-insurance for workers’ compensation;

(b) Identify its plan to obtain timely payroll information for all contractors and subcontractors covered, to ensure timely calculation and distribution of injured worker benefits; its methodology for payment of compensation and medical fee bills; and its method of educating each contractor and its employers as to proper claim reporting and access to medical care procedures;

(c) Designate where claim files will be located;

(d) Provide to the bureau for the bureau’s approval the employer’s plan for medical management of claims as required by paragraph (K)(1) of rule 4123-19-03 of the Administrative Code;

(e) Plan to ensure accurate accounting of workers covered under the construction project;

(f) Identify the bank being used for the workers’ compensation account.

(7) Ombudsperson duties.

The public school employer shall employ an ombudsperson for the construction project. The ombudsperson shall:

(a) Have experience in workers’ compensation or the construction industry, or both.

(b) Communicate with and provide information to employees who are injured in the course of, and arising out of, employment on the construction project.

(c) Investigate the status of a claim upon the request of an employee.

(d) Provide information to claimants, third party administrators, employers, and other persons in protecting their rights under the workers’ compensation laws and rules.

HISTORY: Eff 12-15-98; 4-9-03 (Emer.); 7-14-03; 9-17-04

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.121, 4121.13, 4121.30

Rule amplifies: RC 4123.29, 4123.35

R.C. 119.032 review dates: 03/01/2006

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November 25, 2005

4123-6-23 Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers.

Jurisdictional requirements for payment for medical services rendered by a health care provider are as follows:

(A) Bills must be filed within the time provided in rule 4123-3-23 of the Administrative Code.

(B) In claims where the date of injury is on or after December 11, 1967, and prior to ~~October 20, 1993~~ June 30, 2006, there is no jurisdiction to consider payment for medical services, if six years or more have elapsed since the date of ~~injury and no compensation has been paid, except as provided in this rule. In claims where the date of injury is on or after October 20, 1993, there is no jurisdiction to consider payment for medical services~~ if six years or more have elapsed since the date of the last payment of a medical bill and no compensation has been paid, except as provided in the following cases:

(1) A bill filed within the six-year period for services rendered within the period can be paid after the six-year period when, except for the time passage, it would have been paid.

(2) When an application requesting the payment of medical bills and/or compensation is filed within the six-year period, there is justification to act on the application after the period.

(a) Bills for services rendered within the six-year period can be ordered paid and can be paid after the period. However, these bills must be filed no later than two years after the date that services were rendered. ~~Their payment does not open the claim for any further payments, except for claims where the date of injury is on or after October 20, 1993.~~

(b) Compensation can be ordered paid provided that evidence in the claim supports an award. If compensation is paid, the claim is opened for an additional ten years for the payment of compensation and bills. When there has been a payment of compensation under section 4123.56, 4123.57, or 4123.58 of the Revised Code, the claim is active for ten years from either the date of the last payment of compensation, or ten years from the last payment of a medical bill, whichever is later.

(3) Payment for medical services can be made when the claimant has received wages paid by the employer, instead of compensation for total disability. Medical services may be reimbursed when wages have been paid within six years of the date of injury with the employer's knowledge that an allowed claim exists.

(4) When a request for authorization of treatment beyond the six-year period is filed within the six-year period, the authorization for treatment after that period cannot be granted, unless the claim has been opened by the payment of compensation.

(5) There is no jurisdiction to consider the merits of any application filed after the six-year period, even though supporting evidence for the application was on file within the period.

(6) A bill filed within the six-year period that requires reactivation of the claim cannot be paid when an application for reactivation is not filed within the period. This rule also applies to bills filed after the expiration of the six-year period for treatment rendered within that period.

(C) In claims where the date of injury is prior to December 11, 1967, there is no jurisdiction to consider payment for medical services if ten years or more have elapsed since the payment of compensation or benefits, or, when no compensation has been awarded, ten years have elapsed since the date of injury.

(D) In claims where the date of injury is on or after June 30, 2006, there is no jurisdiction to consider payment for medical services if five years or more have elapsed since the payment of compensation or benefits. The provisions of paragraph (B) of this rule shall apply to the payment of medical bills in claims where the date of injury is on or after June 30, 2006, except that where those provisions reference six year and ten year time limits, the time limits shall be five years.

HISTORY: Eff 2-12-97

Rule promulgated under: RC Chapter 119.

Rule authorized by: RC 4121.12, 4121.30, 4121.31, 4123.05

Rule amplifies: RC 4121.121, 4121.44, 4121.441, 4123.52, 4123.66

4123-7-01 Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers.

Jurisdictional requirements applicable to payment for medical services rendered by a health care provider are as follows:

(A) Bills must be filed within the time as provided in rule 4121-3-23 of the Administrative Code or be forever barred.

(B) In claims where the date of injury is on or after December 11, 1967, and prior to June 30, 2006, there is no jurisdiction to consider payment for medical services, if six years or more have elapsed since the date of ~~injury~~ the last payment of a medical bill and no compensation has been paid, except as provided in the following cases:

(1) A bill filed within the six-year period for services rendered within the period can be paid after the six-year period in those cases in which, except for the time passage, it would have been paid.

(2) Where an application requesting the payment of medical bills and/or compensation is filed within the six-year period, there is justification to act on the application after the period.

(a) Bills for services rendered within the six-year period can be ordered paid and can be paid after the period. However, such bills must be filed no later than two years after the date that the services were rendered. ~~Their payment does not open the claim for any further payments.~~

(b) Compensation can be ordered paid provided the proof supports an award. If compensation is paid, the claim is opened for an additional ten years for the payment of compensation and bills. Where there has been a payment of compensation under section 4123.56, 4123.57 or 4123.58 of the Revised Code, the claim is active for ten years from the date of the last payment of compensation or ten years from the last payment of a medical bill, whichever is later.

(3) Where wages in lieu of compensation for total disability were paid by the employer within six years of injury, with knowledge of a claimed compensable injury, as provided in section 4123.52 of the Revised Code, amended effective January 1, 1979.

(4) Where a request for authorization of treatment beyond the six-year period is made in an application filed within the six-year period, the authorization for treatment after that period cannot be granted, unless the claim has been opened by the payment of compensation.

(5) There is no jurisdiction to consider the merits of any application filed after the six-year period, even though supporting proof for the application was on file within the period.

(6) A bill filed within the six-year period but requiring an application to reactivate claim cannot be paid when such application is not filed within the period. The same applies to bills filed after the expiration of the six-year period for treatment rendered within that period.

(C) In claims where the date of injury is prior to December 11, 1967, there is no jurisdiction to consider payment for medical services if ten years or more have elapsed since the payment of compensation or benefits, or ten years have elapsed since the injury in cases in which no compensation has been awarded.

(D) In claims where the date of injury is on or after June 30, 2006, there is no jurisdiction to consider payment for medical services if five years or more have elapsed since the payment of compensation or benefits. The provisions of paragraph (B) of this rule shall apply to the payment of medical bills in claims where the date of injury is on or after June 30, 2006, except that where those provisions reference six year and ten year time limits, the time limits shall be five years.

HISTORY: Eff (Amended) 1-1-78; 12-21-79
Rule promulgated under: RC Chapter 119.
Rule amplifies: 4123.52 as amended by H.B. 1282

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May 17, 2006

4123-17-36 Administrative cost contribution.

(A) The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, has authority to calculate contributions to the administrative cost fund by employers pursuant to sections 4121.121, 4123.341, and 4123.342 of the Revised Code. The administrator hereby sets administrative cost rates as indicated in paragraph (D) of this rule for the bureau of workers' compensation and the workers' compensation oversight commission. ~~Based upon the information provided to the administrator by the industrial commission pursuant to section 4123.342 of the Revised Code, the administrator, with the approval of the chairperson of the industrial commission, hereby sets administrative cost rates as indicated in paragraph (E) of this rule for the industrial commission.~~

(B) The administrative cost rate for each employer's assessment, except for self-insuring employers, is calculated as follows:

(1) If the employer qualifies for experience rating, either as an individual or through participation in group rating, the assessment is calculated based on a percentage of the employer's experience rated premium.

(2) If the employer is not experience rated, the assessment is calculated based on a percentage of the employer's base rate premium.

(3) If the employer is retrospectively rated, the assessment is calculated based on a percentage of the employer's experience rated premium or base rated premium (but not the minimum premium percentage from the retrospective rating plan) that the employer would have paid if the employer were not participating in retrospective rating.

(4) For state agencies, including state universities and state university hospitals, the assessment is calculated based on a percentage of the employer's premium.

(C) Whenever administrative cost rates established under this rule and rule 4123-17-32 of the Administrative Code prove inadequate or excessive, the same may be adjusted at any time during the biennial period.

(D) Administrative cost rates for the bureau of workers' compensation and workers' compensation oversight commission.

(1) Private employers: ~~13.55~~ 14.09 per cent of premium effective July 1, ~~2004~~ 2006.

(2) Public employer taxing districts: ~~7.84~~ 8.15 per cent of premium effective January 1, ~~2004~~ 2006.

(3) Public employer state agencies: ~~11.95~~ 12.43 per cent of premium effective July 1, ~~2004~~ 2006.

~~(E) Administrative cost rates for the industrial commission.~~

~~(1) Private employers: 1.71 per cent of premium effective July 1, 2004.~~

~~(2) Public employer taxing districts: 1.13 per cent of premium effective January 1, 2004.~~

~~(3) Public employer state agencies: 1.97 per cent of premium effective July 1, 2004.~~

HISTORY: Eff. 7-1-90; 7-1-91; 7-1-91; 7-1-93; 7-1-94; 1-1-95; 7-1-95; 7-1-96; 7-1-97; 7-1-98; 7-1-99; 7-1-00; 7-1-01; 7-1-02; 7-1-03; 7-1-04

Rule promulgated under: RC 111.15

Rule authorized by: RC 4121.12, 4121.121

Rule amplifies: RC 4123.341, 4123.342