

Common Sense Business Regulation (BWC Rules)

(Note: The below criteria apply to existing and newly developed rules)

Rule 4123-17-68

Rule Review

1. The rule is needed to implement an underlying statute.

Citation: R.C. 4123.29

2. The rule achieves an Ohio specific public policy goal.

What goal(s): The revisions to this rule increase accountability for the certified primary and affiliate sponsors.

3. Existing federal regulation alone does not adequately regulate the subject matter.

4. The rule is effective, consistent and efficient.

5. The rule is not duplicative of rules already in existence.

6. The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

7. The rule has been reviewed for unintended negative consequences.

8. Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: There will be a stakeholder meeting prior to the Board's vote to ensure that an opportunity for input is provided.

9. The rule was reviewed for clarity and for easy comprehension.

10. The rule promotes transparency and predictability of regulatory activity.

11. The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

12. The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? _____

13. The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

Executive Summary

Rule 4123-17-68 Group experience and group retrospective safety program requirements

Introduction:

Rule 4123-17-68 of the Administrative Code establishes minimum safety requirements for group experience and group retrospective rating as provided by section 4123.29 of the Ohio Revised Code.

Rule Change:

The Division of Safety & Hygiene recommends changes to rule 4123-17-68 to increase accountability for the certified primary and affiliated sponsors. Specifically, the changes address training and communication regarding safety. The revisions require the sponsors to quantify the level of membership participation in training and encourages them to select training topics that are consistent with the claim activity of their membership. Additional changes are designed to modernize the rule for ease of understanding and implementation.

These revisions hold all sponsors (primary and affiliated) to the same standard and will positively influence all program participants. The changes provide clearer expectations, information and include the following:

- Requiring sponsors to publish the safety accountability letter to employers
- Requiring sponsors to document how many participants attend their 8-hour training
- Requiring sponsors to submit a list of employers who did not meet their two hour training requirement.
- Change language to reflect Ten Step Business Plan for Safety rather than Nine Key Safety Parameters
- Requiring sponsors to identify most common injury type among their group members

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4123-17-68 **Group experience and group retrospective safety program requirements.**

- (A) The purpose of this rule is to establish minimum safety requirements for group experience and group retrospective rating as provided by section 4123.29 of the Revised Code.
- (B) The bureau safety and hygiene division, upon the request of the sponsoring organization, shall provide assistance with implementing all of the provisions of this rule.
- (C) The primary or affiliated sponsoring organization of a group experience or group retrospective plan shall document its program to improve accident prevention and claims handling for the ~~employers~~ members in the group with the group ~~and group retrospective~~ application, and, for an existing group reapplying for group coverage annually, shall document the effectiveness of prior programs ~~as stipulated in paragraph (D) of this rule~~ and any proposed improvements to these programs. This analysis shall include identification of the most common injuries among group members and strategies aimed at increasing awareness and prevention of these injuries.
- (1) ~~Within sixty days after the application filing deadline, a~~ A bureau division of safety and hygiene loss prevention representative shall review the ~~group's sponsor's~~ safety program requirements annual report within sixty days of receipt. The safety and hygiene representative shall contact the primary or affiliated group sponsor or its authorized representative to assist in further developing ~~an~~ appropriate safety ~~program~~ strategies if there are deficiencies in the ~~program report~~. All primary and affiliated sponsoring organizations shall be required to sponsor a minimum of eight hours of safety ~~seminar (or safety seminars) - training~~ during the rating year for members of their group ~~rating program~~. Training shall be hosted by the sponsor or the sponsor's third party administrator. Training should be designed in increments of at least two hours. Training should be industry specific where possible. Webinars and online training hosted by the sponsor will qualify to fulfill this requirement. The sponsor must document the number of employers in attendance at safety training with a goal of at least fifty per cent membership attendance. If the same agenda is offered repeatedly in different regional sites, hour to hour credit will be granted. A bureau representative may attend ~~these seminars~~ training to ensure the requirement is being met. ~~If the requirement is not met, the sponsoring organization will be ineligible to sponsor a group rating program the following year.~~
- (2) If an employer that participates in group rating or group retrospective rating plan sustains a claim within the "green year" period or the prior year, the employer shall attend ~~an additional~~ two hours of safety training annually. The training can

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be offered by the sponsoring organization, the sponsoring organization's third party administrator, or the bureau. ~~The bureau shall reserve the right to request information from the sponsor to ensure compliance.~~ The sponsor will notify members of this requirement and maintain recordkeeping to track completion of this requirement. The sponsor will submit to the bureau a list of members who fail to comply at the conclusion of the first month following the end of the rating year (July 31st). The bureau shall reserve the right to request additional information from the sponsor to ensure compliance.

- (3) The bureau safety and hygiene division shall make a recommendation to the bureau ~~underwriting section~~ employer programs unit on whether the group's safety ~~program requirements annual report~~ annual report is acceptable for the following policy years ~~beginning January 1, 1997~~. A copy of the recommendations and findings of the safety and hygiene division shall be ~~mailed~~ communicated to the sponsoring organization or its authorized representative at the same time. The ~~underwriting section~~ employer programs unit shall consider this recommendation in making its decision whether to approve the group rating application and at the time of renewal sponsor recertification. ~~The underwriting section shall notify the sponsoring organization of the necessary changes and provide the sponsoring organization fourteen days to resubmit its group safety program with the recommended changes.~~
 - (4) The bureau safety and hygiene division shall evaluate the ~~group's safety program sponsor's safety requirements annual report~~ at the sponsoring organization level and not at the individual member level. The bureau safety and hygiene safety representative may conduct member visits to confirm and the sponsoring organization requirements are met.
 - (5) If the bureau's ~~underwriting section~~ employer programs unit does not approve a group for group rating based upon the ~~group's sponsor's safety program activities~~, the sponsoring organization may request a hearing before the adjudicating committee pursuant to rule 4123-14-06 of the Administrative Code.
 - (6) Primary and affiliated sponsoring organizations shall publish in the first quarter of the rating year, for the knowledge of the members in their group, a safety accountability letter outlining the group rating safety requirements and responsibilities of all associated parties.
- (D) ~~The following are guidelines and criteria that a sponsoring organization or its representative shall take into account in developing a safety program for its group members~~ Primary and affiliated sponsoring organizations shall communicate, educate, and verify the bureau's Ten-Step (10-Step) Business Plan for Safety to group members.
- (1) ~~The sponsoring organization shall utilize the following strategies to help group members improve safety efforts:~~

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- ~~(a) Communication and education, as detailed in paragraph (E) of this rule;~~
 - ~~(b) Linkage with the division of safety and hygiene, as detailed in paragraph (F) of this rule; and~~
 - ~~(c) Communication and promotion of key safety program parameters, as detailed in paragraph (G) of this rule.~~
- ~~(2) Key success factors in managing safety by group member employers are:~~
- ~~(a) Leadership from management;~~
 - ~~(b) Communication within and throughout the organization;~~
 - ~~(c) Involvement of all employees in the safety process; and~~
 - ~~(d) Training and education of employees and supervision in safety management and accident prevention.~~
- (E) The sponsoring organization shall provide information regarding safety resources to members in their group. Communication and education strategies of the sponsoring organization may include use of the following strategies: web sites, webinars, claims review and analysis, newsletters, seminars, professional consultants, videos, ~~group-sponsored safety committees,~~ personal contact, brochures, booklets, ~~stickers,~~ manuals, ~~self-help documents, claims review and analysis,~~ identifying key personnel ~~within the sponsoring organization,~~ and training in safety management for the sponsoring organization staff and/or representative its members. The bureau safety and hygiene division representative will be added to all member distribution lists to monitor safety education activity.
- (F) Linkage of the group-sponsoring organization with the division of safety and hygiene may include the following strategies:
- (1) The bureau shall link each sponsoring organization with a service representative from safety and hygiene.
 - (2) Safety and hygiene shall ~~review and comment on group's~~ assist the group with its development of safety ~~plans~~ strategies.
 - (3) Safety and hygiene and the sponsoring organization may sponsor joint seminars.
 - ~~(4) The sponsoring organization may use the safety congress to augment group safety communication and training.~~

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- ~~(5)~~(4) ~~Safety~~ The safety and hygiene representative shall provide a list of resources and expertise within each region upon request.
- ~~(6)~~(5) The sponsoring organization ~~may~~ shall promote bureau safety and hygiene - ~~division training~~ services to its members.
- ~~(7)~~(6) Safety and hygiene may ~~develop half day~~ provide training sessions ~~for remote locations~~ and written safety and health materials.
- ~~(8)~~ Safety and hygiene ~~may provide written safety and hygiene safety and health materials to companies~~.
- ~~(9)~~(7) ~~The sponsoring organization may use bureau safety and hygiene division expertise to help companies improve the management of safety (direct consultation with top managers)~~ Bureau safety and hygiene division consultation services may be utilized by member companies for customized safety management assistance.
- ~~(10)~~ Safety and hygiene ~~may provide video teleconferencing of topic related seminars~~.
- ~~(11)~~(8) Safety and hygiene and the sponsoring organization may develop joint programs in response to member needs.
- ~~(G)~~ ~~The sponsoring organization or its representative shall communicate, educate, and verify the following key safety program parameters to group members:~~
- ~~(1) A written safety and health policy signed by the top company official that expresses the employer's values and commitment to workplace safety and health.~~
 - ~~(2) Visible senior management leadership that promotes the belief that the management of safety is an organizational value.~~
 - ~~(3) Employee involvement and recognition that affords employees the opportunity to participate in the safety management process.~~
 - ~~(4) A program of regular communications on safety and health issues to keep all employees informed and to solicit feedback and suggestions.~~
 - ~~(5) Orientation and training for all employees.~~
 - ~~(6) Published safe work practices so that employees have a clear understanding of how to safely accomplish their job requirements.~~
 - ~~(7) Assigning an individual the role of coordinating safety efforts for the company.~~

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~~(8) Early return to work strategies to help injured or ill workers return to work.~~

~~(9) Internal program verification to assess the success of company safety efforts, to include audits, surveys, and record analysis.~~

~~(10) All applicable OSHA required programs are developed and associated training conducted.~~

~~(H)~~(G) The division of safety and hygiene shall schedule annual regional training seminars for sponsoring organizations. Each sponsoring organization must send at least one representative to the seminar. Additionally, the division of safety and hygiene shall develop a list of publications and support materials that assist the sponsoring organization in reinforcing the safety guidelines of this rule.

Effective Date: ~~7/1/10~~ 3/9/09

Prior Effective Dates: 3/9/09, 7/1/96, 7/1/01

Interested party feedback on the group experience and group retrospective safety program requirements (4123-17-68)

Prior to first committee reading - April, 2010

Line	Rule #	Draft Rule Suggestions	Stakeholder Rationale/Suggestions	BWC Response	Resolution
1	4123-17-68 (C)	"This analysis shall include identification of the most common injuries among group members and strategies aimed at increasing awareness and prevention of those injuries."	BWC should provide the data.	Because BWC is only asking for sponsors to list the most common type of injury sustained by all members within a particular group (as defined by counts of an ICD-9 code), we believe a group sponsor can identify and provide this information.	BWC did not modify the language in the draft rule.
2	4123-17-68 (C)(1)	"Training shall be hosted by the sponsor or sponsor's third-party administrator"	BWC should allow sponsoring associations and TPAs to sponsor Webinars and online training, which will reduce logistical burdens on employers and likely increase participation.	BWC agrees.	BWC modified the draft rule to specifically include Webinars and online training.
3	4123-17-68 (C)(1)	"The sponsor must document the number of employers in attendance at safety training with a goal of at least fifty percent membership attendance."	Sponsors were concerned that the 50 percent goal would be a factor that could result in decertification. They suggested that using the goal as a criteria for certification would only work if BWC required all group employers to attend.	BWC explained the 50 percent goal is only a goal and would not be used as a factor in sponsor certification at this time.	BWC did not modify the language in the draft rule.
4	4123-17-68 (C)(2)	"If an employer that participates in group rating...sustains a claim, the employer shall attend two hours of safety training annually. . . . The sponsor will submit to the bureau a list of members who fail to comply...."	Sponsoring associations believe BWC should provide them a list of their employers who are affected by this proposed rule change and chose to attend a BWC-sponsored training such as a Safety and Hygiene class or a Safety Congress seminar.	BWC requires sponsors to report to BWC employers who completed or did not complete the two-hour training requirement.	BWC did not modify the language in the draft rule.

Interested party feedback on the group experience and group retrospective safety program requirements (4123-17-68)

Prior to first committee reading - April, 2010

Line	Rule #	Draft Rule Suggestions	Stakeholder Rationale/Suggestions	BWC Response	Resolution
5	4123-17-68 (C)(2)	"If an employer that participates in group rating...sustains a claim, the employer shall attend two hours of safety training annually. . . . members who fail to comply . . . will not be eligible to participate in group experience or group retrospective rating in the next rating year."	While some interested parties believed that employers who did not comply with this proposed requirement should be ineligible for group rating, others believed that there should be no penalty or a lesser penalty involved. Still other organizations expressed concern that BWC refine this requirement to target employers who have a "sizeable" or lost-time claim.	At this time, BWC believes the proposed change gives sufficient motivation to affected employers to attend training and comply with the new rule.	BWC did not modify the language in the draft rule.
6	4123-17-68 (C)(6)	"Primary and affiliated sponsoring organizations shall publish in the first quarter of the rating year, for the knowledge of the members in their group, a safety accountability letter outlining the group rating safety requirements and responsibilities of all associated parties."	All interested parties thought this was a good idea but wanted to give feedback on the appropriateness of roles and responsibilities.	BWC agreed to continue working with these organizations to refine the letter.	BWC did not modify the language in the draft rule.

Interested party feedback on the group experience and group retrospective safety program requirements (4123-17-68)

Prior to second committee reading - May, 2010

Line	Rule #	Draft Rule Suggestions	Stakeholder Rationale/Suggestions	BWC Response	Resolution
7	4123-17-68 (C)(2)	"If an employer that participates in group rating...sustains a claim, the employer shall attend two hours of safety training annually. . . . members who fail to comply . . . will not be eligible to participate in group experience or group retrospective rating in the next rating year."	Based on first-year experiences to date with recordkeeping related to this requirement, sponsors reported a high number of employers may fail to provide evidence of two-hour training and will run the risk of losing benefits of group-rating, potentially based only on a paperwork violation.	BWC acknowledges accurate removal of members from group requires further development of processes and policy.	BWC modified the rule to remove the group membership penalty.
8	4123-17-68 (D)	"Primary and affiliated sponsoring organizations shall communicate, educate, and require implementation of the bureau's ten-step business plan to group members."	Requiring implementation of the bureau's ten-step business plan for safety may be redundant, burdensome and costly for employers with existing and effective safety management systems.	BWC will maintain the requirement for sponsoring organizations to communicate and educate about the bureau's ten-step business plan for safety which will, for now, accomplish our goal of employer awareness of this resource.	BWC modified the rule. All sponsoring organizations will be required to communicate to and educate group members about the ten-step business plan for safety.

Common Sense Business Regulation (BWC Rules)

(Note: The below criteria apply to existing and newly developed rules)

Rule 4123-17-59

Rule Review

1. The rule is needed to implement an underlying statute.

Citation: R.C. 4123.29

2. The rule achieves an Ohio specific public policy goal.

What goal(s): The revisions to this rule are necessary to bring BWC into compliance with HB 15 that established new guidelines for the program.

3. Existing federal regulation alone does not adequately regulate the subject matter.

4. The rule is effective, consistent and efficient.

5. The rule is not duplicative of rules already in existence.

6. The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

7. The rule has been reviewed for unintended negative consequences.

8. Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: The Fifteen Thousand Medical Only Program rule changes were presented during an interested party meeting held at BWC on March 16, 2010. Sixty e-mail invitations were sent to interested parties. Organizations that received notification of the meeting included, but were not limited to, TPAs such as CCI, Frank Gates, Sedgwick, Sheakley, etc. Sponsoring Organizations such as NFIB, Ohio Chamber, PIA, OMA, etc. There were no comments or feedback from the interested parties regarding these changes.

9. The rule was reviewed for clarity and for easy comprehension.

10. The rule promotes transparency and predictability of regulatory activity.

11. The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

12. The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? _____

13. The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

Executive Summary

4123-17-59 Fifteen thousand medical-only program

Introduction: Employers who choose to participate in the \$15K medical-only program may pay up to \$15,000 in medical bills for a medical-only claim – a claim with seven or fewer days lost from work. Lost time claims and claims in which salary continuation is paid by the employer are not eligible to be covered by this program. Employers are held to the same provider payment criteria as BWC so they must pay the bill within 30 days of receipt of the bill.

Rule Change:

With last years' passage of HB 15, new guidelines for this program became part of statute. As a result, changes must be made to the rule so that it is consistent with statute. The primary change includes a provision stating that employers shall pay medical bills for medical-only claims with a date of injury June 30, 2009 and after, at the BWC fee schedule and that medical providers must accept the fee schedule. Claims with a date of injury prior must still be paid as billed or negotiated with the medical provider. Additional language has been added to paragraph (A) to clarify that provider payment must be made within 30 days of receipt of the bill by the employer.

4123-17-59 Fifteen 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 fifteen 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. 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, and the employer agrees to pay bills within thirty days of receipt of the bill, 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 fifteen 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 only on any alleged medical-only injury. The provisions of this program and rule shall apply not apply to claims in which an employer with knowledge of a claimed compensable injury or occupational disease, has paid wages in lieu of compensation or total disability. 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 injured worker or the provider on behalf of the injured worker the first fifteen thousand dollars of a 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 fifteen thousand dollar maximum is reached and the employer provides notice to the bureau that the employer has paid the first fifteen thousand dollars of the bills in the claim by providing the bureau the date of service of the bill which reached the fifteen 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 after the withdrawal notification date.

(2) If the fifteen thousand dollar maximum has not been reached and the payment of a bill will exceed the fifteen thousand dollar maximum, the employer should pay that portion of the bill that will bring the payment to the fifteen 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 fifteen 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;

(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 the injured worker's representative upon request. Upon written request from the bureau, the employer shall provide documentation to the bureau of all medical-only bills that they are paying directly. Such requests from the bureau may not be made more frequently than on a semiannual basis. Failure to provide such documentation to the bureau within thirty days of receipt of the request may result in the employer's forfeiture of participation in the program for such injury.

(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. 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 within fourteen days of a claim being filed of the employer's intention not to cover the first fifteen thousand dollars of the medical costs of the claim. This notification 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 fifteen 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 fifteen 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 for claims with a date of injury prior to June 30, 2009. ~~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 must accept the bureau fee schedule as payment in full for claims with a date of injury after June 30, 2009.~~ A certified health care provider shall extend to an employer who participates in this program the same rates for services rendered to an employee of that employer as the provider bills the administrator for the same type of medical claim processed by the bureau and shall not charge, assess, or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of that rate. Providers may only balance bill the bureau on the occasion of a bill that would require an employer to exceed the one fifteen 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 after the date of the telephone call.

Effective:

Prior Effective Dates: 3/1/95, 7/22/06, 9/10/07



Pharmacy Program Overview
Presented to the Medical Services Committee of the BWC Board of
Directors
April 29, 2010

Introduction:

BWC allows injured workers to receive outpatient medications as part of their medical treatment. The Pharmacy Program is the area within the Medical Services Division that manages this benefit. The outpatient prescription benefit is only for medications that are self administered at home. Medications administered in acute care or other inpatient settings and physician offices are processed by the MCOs. The BWC pharmacy program deals with State Insurance Fund claims only. Self Insured employers are responsible for establishing their own prescription coverage programs within the parameters of BWC rules.

Operational Characteristics:

In 2009 the Medical Services Division benefit costs were \$814 million. The outpatient prescription benefit program represented nearly \$128 million or 16% of the division costs. The pharmacy program utilizes a Prescription Benefits Manager (PBM) to process prescriptions for injured workers. There are over 5,700 pharmacies filling prescriptions for our injured workers. During 2009 there were 1.47 million prescriptions processed in 77,000 claims. The collection of manufacturer's rebates from these prescriptions began in 2009. To date, \$4.5 million has been collected on the 400 drugs which were eligible for manufacturer rebates.

Core Business Functions:

Listed below are the six core processes that the program must accomplish if it is to operate effectively.

1. Pharmacy Benefits Manager (PBM) Operations Oversight

Efficient functioning of this process is crucial to program success. If prescriptions are not correctly and efficiently processed for injured workers and pharmacies are not properly and promptly reimbursed, then nothing else really matters about the program.

- The PBM provides the Point of Service software that enables a pharmacist to know that the injured worker has a valid claim, that the drug is approved in that claim, that the quantities and day's supply are appropriate and what the reimbursement for the prescription will be.
- Clinical Pharmacists at the PBM receive and review requests for Prior Authorization from physicians' offices. They approve drugs that are clearly related to the claim. For drugs that may not be related they forward the request to BWC for a review by one of our medical reviewers.
- Payments are generated to participating pharmacies every week. The turnaround on pharmacy reimbursement is 7-14 days, depending on when the bill is submitted. Injured workers who have paid out of pocket can file paper claims (BWC Form C-17 Request for Injured Worker Medication Reimbursement) with the PBM typically receive payment in three weeks. Monitoring the status and accuracy of these thousands of payments is a critical function for the program.
- Accurate prescription processing is ensured by the PBM's staff of pharmacy auditors. The process involves both desktop audits which review records requested from the pharmacy and onsite audits of pharmacies.

2. Pharmacy Benefits Manager Contract Compliance

- Ensuring that the PBM is meeting its contractual obligations is a critical role of program management. There are 26 performance guarantees to be monitored and reported. Performance guarantees include but are not limited to areas involving bill processing, prior authorizations and system availability.

3. Clinical Pharmacy Functions

- A drug formulary for the BWC pharmacy program will be established in 2010. This document will require regular maintenance to keep it current and accurate.
- The Pharmacy & Therapeutics Committee (P&T Committee) is a committee of practicing physicians and pharmacists who provide clinical guidance to the BWC Pharmacy Program. The committee reviews and recommends drug coverage policies to the administrator. This group guides selection of drugs for their formulary status.
- Drug Utilization Review is the process where conditions in the claim are matched against the drugs being used to ensure that coverage is appropriate. This process involves clinical staff in the field, the pharmacy department and medical reviewers.
- Surveillance for potential abuse of prescription drugs is another clinical function of the pharmacy department. The PBM software has filters in place to look for inappropriate prescribing or dispensing activities. The clinical staff of the pharmacy department reviews claims that are picked up by these filters as well as claims that are referred by field staff, fraud or employers.

4. Pharmaceutical Rebates Management

- Monitoring of this process requires ongoing coordination with multiple areas both within and outside of BWC. From the PBM's adjudication of the original submitted bill data, to its aggregation by the rebates vendor, to Finance receiving the funds, to Compliance auditing the funds handling and finally to allocation of the funds to the correct claims; attention to detail and thorough documentation is required.

5. Customer Support

- The service offices are the first line of contact with BWC for most injured workers. This is also where the most questions about the prescription benefits originate. Ensuring that each of the 18 Field Offices receives consistent and accurate assistance from the pharmacy department to answers to these questions is highly important for the public perception of how well the program functions.
- Likewise questions or issues raised by employers, injured workers or their representatives must be addressed promptly and accurately. Many times improvements to the program arise from these inquiries.

6. Program Policy Management

- The information that guides providers and prescribers in using the pharmacy benefit must be current and accurate. Keeping policies updated and dispersing information about changes to our stakeholders is a key facet in reducing operational friction.
- Having the necessary rules to permit the program to implement progressive policies to manage the pharmacy benefit is critical to future development.

Program Statistics

Over the past 10 years the pharmacy program has changed significantly.

In 1999 there was no PBM Administrative Fee because they were permitted to keep the rebates. Costs of the program peaked in 2004 at \$159 million. In 2005 the PBM put edits in place to stop inappropriate drugs from being paid in the claim, the Maximum Allowable Cost (MAC) program was initiated to ensure lowest pricing on multisource generic drugs. This program produced a documented savings of \$24 million by the end of the first year MAC pricing was implemented.

The 2007 annual expenditures for three drugs, Lidoderm, Actiq and Fentora, were over \$10 million. In 2007, the P&T Committee recommended restrictions in coverage of these drugs. This action produced 2009 savings on their cost of over nine million dollars. In 2009 rebate collections provided nearly \$4.5 million dollars in new funds. This amounted to a net revenue increase of \$2 million dollars after deductions for the administrative fees of the rebates manager and PBM administrative fees.

The total number of prescriptions was headed for two million in 2004, but has declined over 9% in the past 5 years. This is reflective of the general decline in claims seen by the Bureau and is attributed to the effects of our work safety initiatives.

The utilization of drugs within the pharmacy benefit reflects the environment of workers compensation. The top five drug categories over that past 5 years has shifted, however narcotic analgesics consistently remain the number one class in costs and utilization. Although not principally indicated for pain management, the use of psychotropic and anticonvulsants as adjunctive therapy in pain management has moved these two classes into our number two and three position. It should be noted that while the top five drug classes control 80% of our expenditures they represent only 49% of our total volume of prescriptions. This fact is significant not only in focusing on fiscal controls, but it is also important as we look at appropriate utilization of medications from the clinical perspective. Inappropriate use of relatively low cost agents can delay a return to work and set the stage for other untoward conditions for the injured worker.

Compared to 2009 data on group health pharmacy benefits, the BWC program is well above the average in generic fill rate and significantly below the average cost per prescription. Our average fill cost of \$86.97 Vs \$183.36 for group health plans reflects the absence of high levels of chronic conditions being treated in our plan.

Program Strategic Goals

The future efforts of the pharmacy department will be guided from the clinical perspective. To accomplish its mission of enhancing the general well being of Ohioans, BWC must provide high quality treatment outcomes for injured works that enable a prompt return to work. The pharmacy department will support this goal by focusing on medication utilization. This is the driver of both drug costs and clinical outcomes. Our strategy is built upon two initiatives – improve the utilization of medications and monitor the utilization of medications. Success will be measured by utilization metrics, program costs and stakeholder feedback. We believe that this strategy will bring improved treatments and lead to earlier return to work.

BWC Pharmacy Program Overview

April 29, 2010

Robert Balchick, M.D., M.B.A.

Medical Director

Johnnie Hanna, R.Ph., M.B.A.

Pharmacy Program Director

Christine Sampson

Pharmacy Program Operations Manager

Overview Discussion

- Program Description
- Annual Expenditures
- Current Operational State
- Core Business Functions
- Program Statistics
- Comparison of BWC vs. Group Health
- Strategic Goals for 2009 – 2012
- Our Vision

Program Description

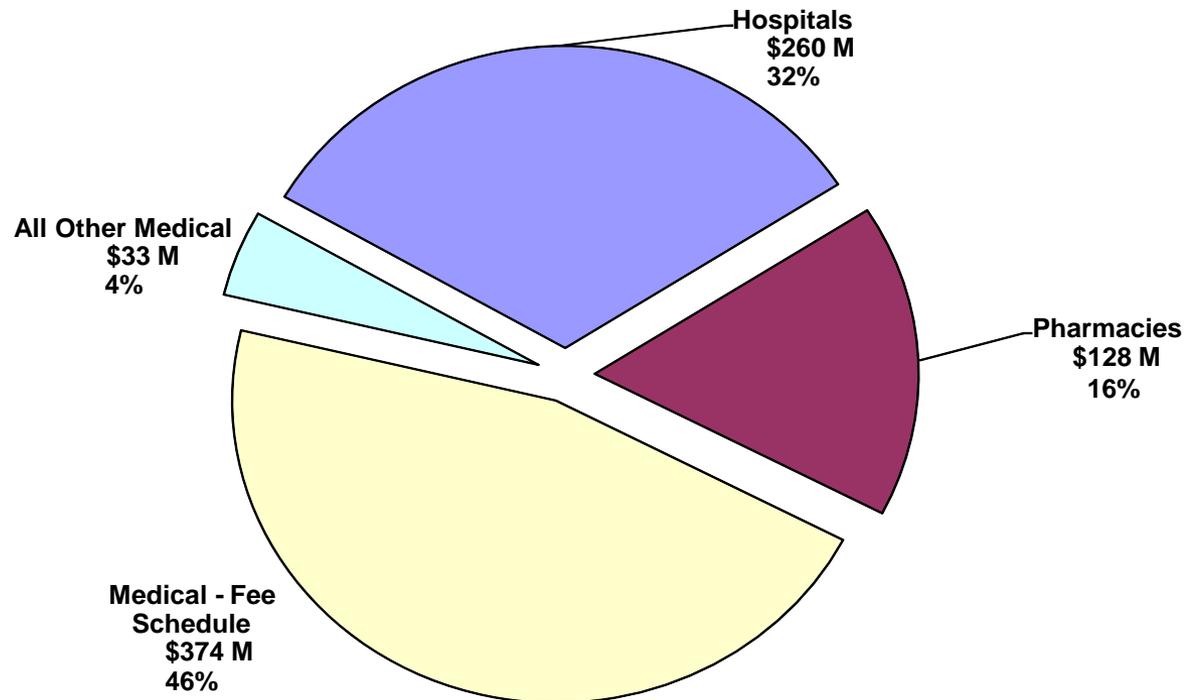
The BWC Pharmacy Program is the area within the Medical Services Division that manages outpatient prescription benefits for injured workers.

- These are prescriptions for home use only.
- Medications administered in a physician's office or inpatient drugs used in acute care or long term care settings are not covered. Claims for these drugs are processed by the Managed Care Organizations.
- The pharmacy program covers medications for state fund claims only. Prescriptions for self insured claims are not handled by this program.

Annual Expenditures

2009 – Medical Services Division

2009 Total medical payments = \$814 million



Current Operational State

During 2009 The Pharmacy Department:

- Managed the processing of 1.47 million prescriptions submitted by 5,700 pharmacies at a cost of \$128 million
- Covered prescriptions for 8,600 individual national drug codes, (over 3,800 different drugs) in 77,000 injury claims
- Collected nearly \$4.5 million in rebates on 400 eligible drugs
- Transitioned to a new Prescription Benefit Manager

Core Business Functions

- **Pharmacy Benefits Manager Operations Oversight**
 - Point of Service Bill Payment
 - Prior Authorization Processing by Clinical Pharmacists
 - Financial Controls
 - Pharmacy Provider Audits
- **Pharmacy Benefits Manager Contract Compliance**
 - Service Level Agreement Enforcement
- **Rebate Management Contract Compliance**
- **Customer Support**
 - Service Offices
 - Employers, Injured Workers and their Representatives

Core Business Functions (cont'd)

- **Clinical Program**
 - Formulary Management
 - Pharmacy and Therapeutics Committee Activities
 - Drug Utilization and Prior Authorization Review Procedures and Operations
 - Monitoring for Potential Medication Misuse
- **Program Policy Management**
 - Provider Billing & Reimbursement
 - Rules Development

Program Statistics

Calendar Year	Total Medical Costs	Total PBM Prescription Costs	Pharmacy Percentage of Total Medical Costs	Total Scripts	Average Price/Script	PBM Admin Costs	Dispensing Cost/Script	Total Rebates	Total Rebates/Script	Rebate Admin Costs	Rebate Admin Costs/Script
1999	\$594,814,508	\$75,222,053	13%	1,587,751	\$47.38	\$0	\$3.50	\$0	\$0	\$0	\$0
2000	\$650,172,015	\$94,722,738	15%	1,692,212	\$55.98	\$0	\$3.50	\$0	\$0	\$0	\$0
2001	\$742,538,393	\$107,711,177	15%	1,749,505	\$61.57	\$0	\$3.50	\$0	\$0	\$0	\$0
2002	\$834,057,688	\$119,008,905	14%	1,740,825	\$68.36	\$0	\$3.50	\$0	\$0	\$0	\$0
2003	\$873,771,575	\$136,092,053	16%	1,804,327	\$75.43	\$5,158	\$3.50	\$0	\$0	\$0	\$0
2004	\$875,085,855	\$158,973,401	18%	1,887,348	\$84.23	\$14,900	\$3.50	\$0	\$0	\$0	\$0
2005	\$884,797,101	\$144,261,751	16%	1,764,075	\$81.78	\$1,057,830	\$3.50	\$0	\$0	\$0	\$0
2006	\$811,560,210	\$120,221,826	15%	1,678,543	\$71.62	\$2,098,180	\$3.50	\$0	\$0	\$0	\$0
2007	\$796,612,362	\$124,264,422	16%	1,587,127	\$78.30	\$1,983,914	\$3.50	\$0	\$0	\$0	\$0
2008	\$862,736,555	\$130,494,502	15%	1,508,672	\$86.50	\$1,885,887	\$3.50	\$0	\$0	\$0	\$0
2009	\$813,975,386	\$127,845,939	16%	1,470,011	\$86.97	\$1,876,610	\$3.50	\$4,491,200	\$3.06	\$603,177	\$0.41

Program Statistics

TOP FIVE CLASSES - PERCENTAGES of TOTAL REIMBURSEMENT					
TC Code Description	2005	2006	2007	2008	2009
NARCOTIC ANALGESICS	34.6%	29.6%	33.2%	36.3%	39.9%
ALL ANTIPSYCHOTIC/PSYCHOTROPIC	10.4%	13.2%	12.9%	13.3%	16.1%
ANTICONVULSANTS	10.4%	11.0%	11.5%	12.3%	11.8%
NSAIDS	10.2%	8.7%	7.0%	6.7%	7.0%
PROTON PUMP INHIBITORS	*	*	*	*	5.5%
SKELETAL MUSCLE RELAXANTS	6.0%	*	*	*	*
TOPICAL LOCAL ANESTHETICS	*	8.2%	8.1%	5.6%	*
ALL OTHER CLASSES	28.3%	29.3%	27.3%	25.8%	19.7%

TOP FIVE CLASSES - PERCENTAGES OF TOTAL PRESCRIPTION VOLUME					
TC Code Description	2005	2006	2007	2008	2009
NARCOTIC ANALGESICS	32.9%	33.2%	33.8%	34.4%	26.0%
ALL ANTIPSYCHOTIC/PSYCHOTROPIC	7.0%	7.5%	7.9%	8.3%	6.8%
ANTICONVULSANTS	6.9%	7.8%	8.4%	9.1%	7.1%
NSAIDS	11.4%	10.5%	10.1%	9.7%	7.2%
PROTON PUMP INHIBITORS	*	*	*	*	2.1%
SKELETAL MUSCLE RELAXANTS	9.8%	*	*	*	*
TOPICAL LOCAL ANESTHETICS	*	2.2%	2.2%	1.6%	*
ALL OTHER CLASSES	28.3%	38.7%	37.7%	37.0%	50.8%

** Not in the top five for the year.*

Comparison of BWC vs. Group Health

- **2009 BWC Data**

- Generic Fill Rate = 74%
- Average Cost per Prescription = \$86.97
- Average Rebate per Prescription = \$3.06

- **2009 National Drug Benefit Report** *(Pharmacy Benefit Management Institute)*

- Generic Fill Rate = 61%
- Average Cost per Prescription = \$183.36
- Average Rebate per Prescription = \$3.31

Strategic Goals for 2009 – 2012

Improve Utilization

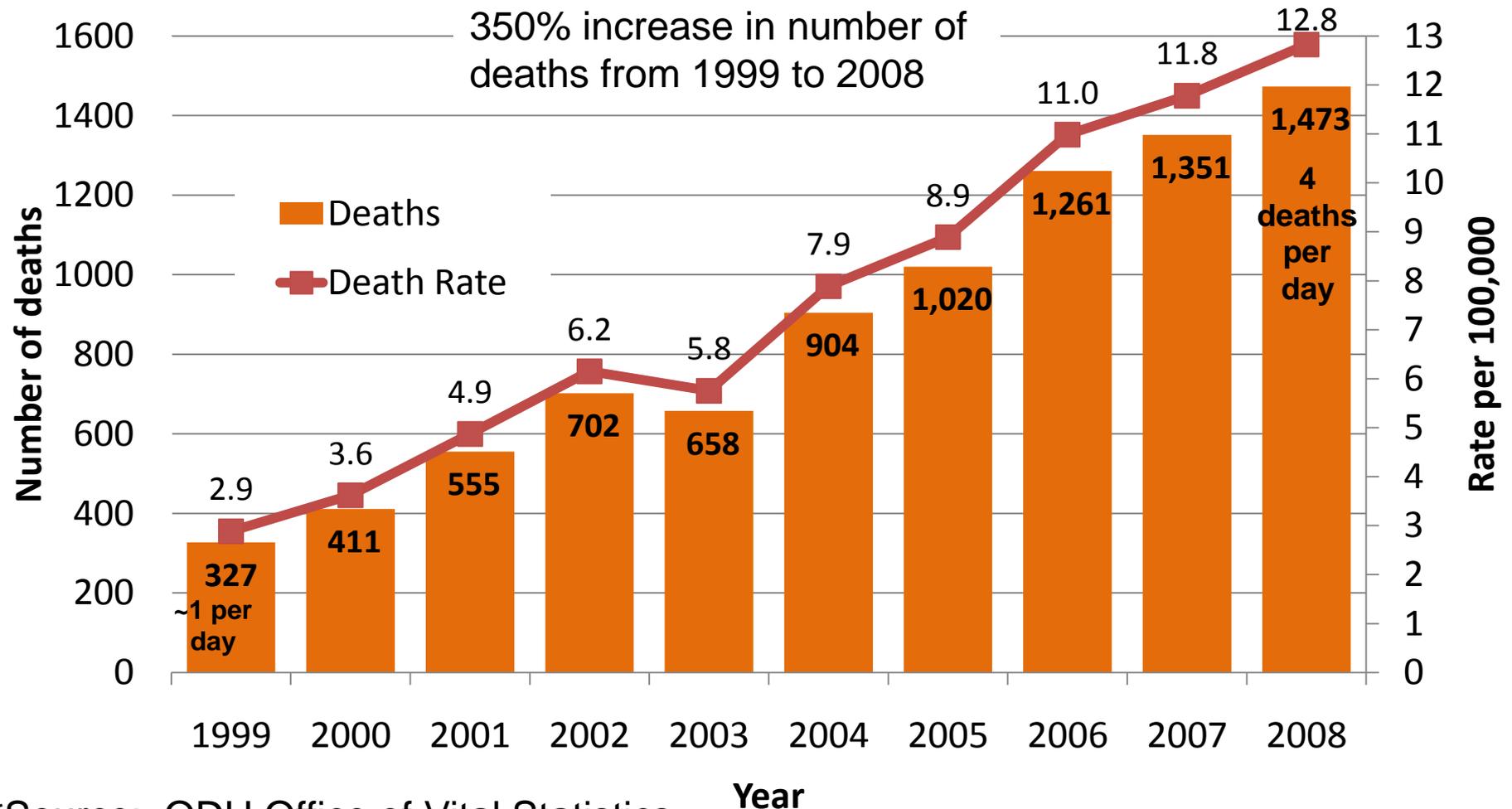
- **Develop a Formulary By Rule**
 - Provide prescribers with a comprehensive list of covered drugs
 - Proactively review new drugs for admission
 - Focus all formulary actions first on clinical safety and efficacy.
- **Amend or Promulgate Other Rules as Necessary**
 - First Fill Prescriptions & Assignment
 - Autonomous P&T Committee
 - Pharmacy Lock-In Program
 - Charge structure driven by strategic pricing
 - Manage Injectable drugs currently under the MCO's
- **Work to Improve Therapeutic Decisions & Outcomes**
 - Maximize application of the PBM's monitoring and intervention capacity
 - Implement Medication Therapy Management for chronic pain patients
 - Partner with Other State Agencies
 - Establish comparative metrics with the OSU Project

Strategic Goals for 2009 – 2012

Monitor Utilization

- **Centralize Management of the Drug Utilization and Prior Authorization Review Processes**
 - Maximize these opportunities to create Prospective and Retrospective interventions in medication use
- **Create and Monitor Key Utilization Metrics with PBM and BWC databases**
 - Program performance will be benchmarked against standard metrics to make sure that gains are documented and held
- **Engage the Pharmacy and Therapeutics Committee to provide therapeutic guidelines and oversight**
 - Drug utilization reviews and formulary decisions must be grounded in best practice standards, current medical literature

Ohio deaths and death rates per 100,000 due to unintentional drug poisoning by year, 1999-2008*



*Source: ODH Office of Vital Statistics

Number of U.S. deaths due to unintentional drug overdoses in 2006 exceeds that of a large jet crash killing 350 people *every day for 2.5 months* in a row.



Our Vision

By 2012:

The **BWC Pharmacy Program** will be **recognized as the national leader** for its efficient and clinically effective delivery of innovative pharmacy services to Ohio's injured workers.

12 - Month Medical Services & Safety Calendar

Date	May 2010	Notes
5/27/10	1. Group Experience and Group Retrospective Safety Program requirements - Rule 4123-17-68 (2 nd read)	
	2. Fifteen thousand dollar medical-only program - Rule 4123-17-59 (2 nd read)	
	3. Pharmacy Program overview	
	4. Follow-up report on MCO public forums	
	5. Customer Services Report	
Date	June 2010	
6/17/10	1. Medical & Service Provider Fee Schedule (1st read)	
	2. Medical Services Report	
Date	July 2010	
7/28/10	1. Medical & Service Provider Fee Schedule (2nd read)	
	2. Customer Services Report	
Date	August 2010	
8/26/10	1. Medical Services Report	
Date	September 2010	
9/23/10	1. Inpatient Hospital Fee Schedule (1st read)	
	2. Vocational Rehab fee schedule (1 st read)	
	3. Customer Services Report	
Date	October 2010	
10/21/10	1. Outpatient Hospital Fee Schedule (1st read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Vocational Rehab fee schedule (2nd read)	
	4. Charter review	
	5. Medical Services Report	
Date	November 2010	
11/18/10	1. Outpatient Hospital Fee Schedule (2nd read)	
	2. Ambulatory Surgical Center Fee Schedule Rule (1 st read)	
	3. Customer Services Report	
Date	December 2010	
12/15/10	1. Update Medical and Service Provider Fee Schedule to conform with new Medicare rates (possible waive 2 nd read)	
	2. Ambulatory Surgical Center Fee Schedule Rule (2nd read)	
	3. Medical Services Report	
2011		
Date	January 2011	
TBD	1. Customer Services Report	
Date	February 2011	
TBD	1. Medical Services Report	
Date	March 2011	
	1. Customer Services Report	
Date	April 2011	
	1. Medical Services Report	



Service Association of Ohio

To: Abe Al-Tarawneh, Superintendent of the Division of Safety & Hygiene
Ohio Bureau of Workers' Compensation (BWC)

cc: BWC Board of Directors – Actuarial Committee

From: Tony Fiore, Executive Vice President, Service Association of Ohio (SAO)

Re: Group Experience and Group Retrospective Safety Program Requirements

Date: May 25, 2010

SAO members have reviewed BWC's proposed rule changes to the Group Experience and Group Retrospective Safety Program (4123-17-68) and are providing feedback and recommendations below. From our discussion last week and SAO discussions with other BWC Staff, it is our understanding that two positive changes are being made to the proposed rule before the BWC Actuarial Committee considers a final vote during the May Board meeting. The two changes to the proposed rule are: (1) employers who fail to complete the two-hour safety requirement will not be prohibited from group/group retro participation, and (2) sponsors will not be required to make sure all of their group/group retro employers implement the 10 Step Business Plan.

The SAO is providing the following additional recommendations for BWC's consideration to ensure there is as much flexibility as possible in the rules for employers to attend effective safety training.

- (1) **4123-17-68 (C)(1)** – The SAO recommends that BWC not direct the length of individual training sessions but rather leave it up to the sponsor and members to develop training solutions that best meet the needs of the members. For example, two separate 1-hour online training courses with industry specific content may be more effective and attractive than a 2-hour course containing general content.
- (2) **4123-17-68 (C)(1)** – The SAO recommends deleting the language regarding 50% attendance since BWC stated this is a “goal” and not a requirement. If the goal is retained as part of the rule, it should be modified in the following manner. The proposed rule states that “Training shall be hosted by the sponsor or the sponsor's third party administrator.” The SAO believes “the BWC or other vendor” should be added to this language. Recognizing attendance at BWC or other vendor training programs will give employers flexibility in determining what training best fits their needs. The rule under (F) (5) requires that the sponsor promote BWC safety and hygiene services, therefore they should be given credit toward their safety training percentage if an employer uses the BWC or another vendor to obtain training. (If a training counts toward the 2-hour safety training, it should count under this section as well).

- (3) **4123-17-68 (C)(1)** – The SAO recommends the group safety form (SH-2) should be filed at the end of the policy year and not the group application deadline (ie. July 1st for private group vs. February 28th). The Group Safety Form (SH-2) filed on 2/28 requires sponsors to report on what they had done up to 2/28 and what they plan on doing between 2/28 and 6/30. The SAO recommendation of one SH-2 report filed on 6/30 would require the sponsor to report what they had actually done.
- (4) **4123-17-68 (C)(2)** – We suggest that the 2-hour training only be required if the employer has had a claim in the past two years that exceeds a specific dollar amount, such as \$5,000. The recommended threshold would eliminate the need for 2 hour training for minor injuries that may not be indicative of the need for safety training.
- (5) **4123-17-68 (C)** – Sponsors should work with their TPA and BWC to utilize association and industry-specific injury data and trending to design and implement risk management approaches and strategies that address the specific injury types that are occurring. This information will be helpful in determining whether the strategy is effective along with the associated cost savings.

Thank you for the opportunity to provide feedback on BWC's proposed rule change to the Group Experience and Group Retrospective Safety Program Requirements. The SAO members would welcome the opportunity to sit down with BWC staff or provide direct feedback to the BWC Board of Directors to further discuss our concerns and suggestions.

Please feel free to contact me at acfiore.laborlaw@live.com for any additional information.