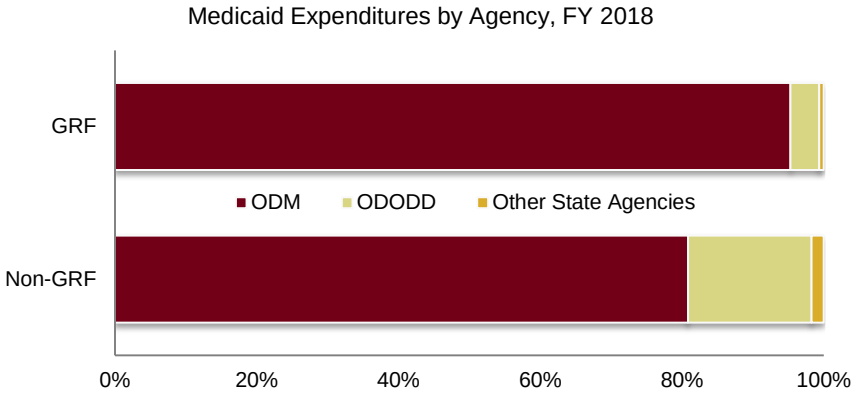
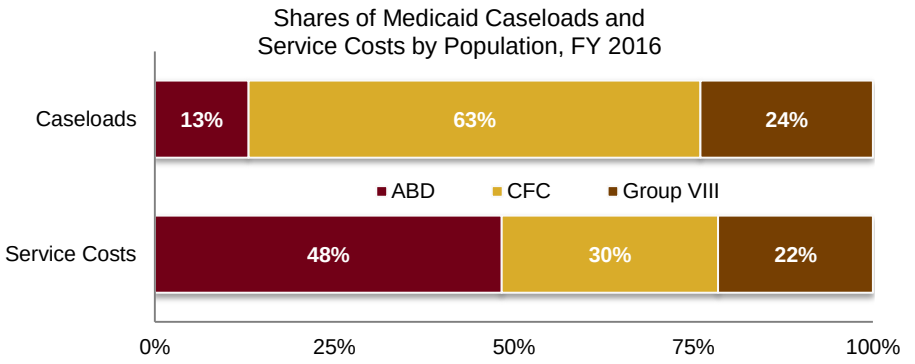
Department of Medicaid Disburses the Majority of Payments for Ohio Medicaid



Source: Ohio Administrative Knowledge System

- GRF Medicaid expenditures were $14.48 billion in FY 2018, of which 95.3% ($13.81 billion) was disbursed by the Ohio Department of Medicaid (ODM). Non-GRF Medicaid expenditures were $11.86 billion in FY 2018, of which 80.9% ($9.59 billion) was disbursed by ODM. Across all funds, Medicaid expenditures totaled $26.34 billion. ODM accounted for 88.8% of this total.
- Ohio Medicaid is administered by ODM with the assistance of seven other state agencies – Developmental Disabilities, Job and Family Services, Mental Health and Addiction Services, Health, Aging, Education, and the Pharmacy Board – as well as various local entities.
- The Ohio Department of Developmental Disabilities (ODODD) had the second largest share of Medicaid expenditures, accounting for 4.0% ($583.2 million) of the GRF total, 17.4% ($2.07 billion) of the non-GRF total, and 10.1% of the all funds total. Together, ODM and ODODD accounted for 98.9% of the all funds total. The remaining 1.1% was accounted for by the other six agencies.
- GRF Medicaid expenditures are paid with a combination of state and federal resources. Of the $14.48 billion GRF Medicaid expenditures in FY 2018, $9.48 billion (65.5%) came from federal reimbursements and $5.00 billion (34.5%) was funded with state resources.
- The practice of depositing federal Medicaid reimbursements into the GRF started in FY 1976. Since then, GRF appropriations for Medicaid include both state and federal dollars.
- In FY 2018, the federal government reimbursed about 68.3% of all Medicaid expenditures. The state was responsible for the remaining 31.7%.

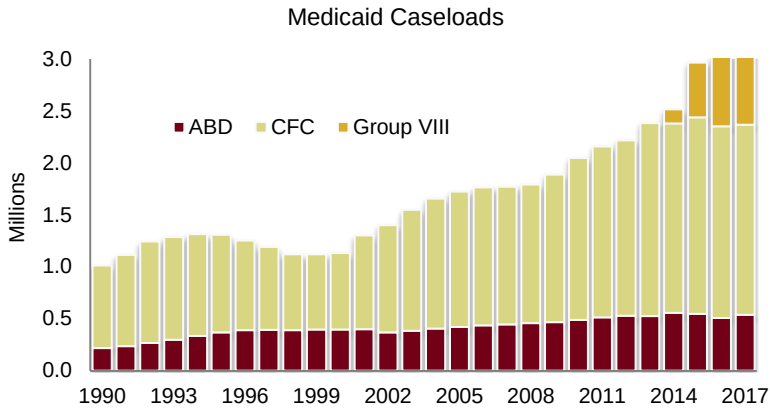
Aged, Blind, and Disabled Account for 13% of Medicaid Caseloads but 48% of Service Costs



Source: Ohio Department of Medicaid

- In FY 2016, the aged, blind, and disabled (ABD) population made up 13% of the Medicaid caseloads in Ohio, but accounted for 48% of the service costs. In contrast, the covered families and children (CFC) population made up 63% of caseloads, but only contributed 30% of the service costs. Lastly, the Medicaid expansion population (Group VIII) represented 24% of caseloads and 22% of service costs.
- In FY 2016, Ohio Medicaid caseloads totaled about 2.9 million, excluding individuals that receive only partial Medicaid coverage (e.g., premium assistance). Of this number, approximately 386,000 were ABD, 1.8 million were CFC, and 685,000 were Group VIII. Of the $21.41 billion in total Medicaid service costs for these populations, $10.34 billion was expended on the ABD population, while $6.45 billion and $4.62 billion was expended on the CFC and Group VIII populations, respectively.
- The ABD population includes low-income elderly who are age 65 or older and individuals with disabilities. The CFC population consists of low-income children and adults who are age 64 or younger. The Group VIII population includes recipients made newly eligible in 2014 who are age 19 to 64 with incomes at or below 138% of the federal poverty level.
- The average monthly Medicaid service cost was approximately $2,235 for an ABD member, compared to $300 for a CFC member and $562 for a Group VIII member in FY 2016.
- The cost of long-term care, which is provided primarily to the ABD population, is one of the main reasons for the higher expense. Long-term care includes services provided in institutions, such as nursing facilities, or in the home or community through Medicaid waiver programs, such as PASSPORT or Individual Options.

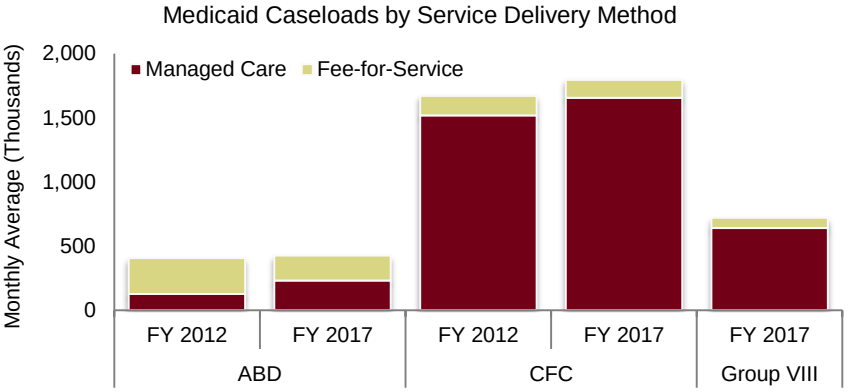
Medicaid Caseloads Continue to Increase



Source: Ohio Department of Medicaid

- In FY 2017, total Medicaid caseloads grew by 1.6% (49,000) to 3.1 million. The majority of the increases in recent fiscal years were the result of the Medicaid expansion that started in January 2014, which allowed previously ineligible adults between the ages of 19 to 64 with incomes below 138% of the federal poverty level to qualify for coverage (Group VIII). During the four-year period leading up to the Medicaid expansion (FY 2011-FY 2014) total caseloads grew at an average annual rate of 5.3% as the economy gradually improved following the Great Recession.
- CFC (covered families and children) caseloads experienced an increase in the four-year period after the Great Recession (FY 2011-FY 2014), growing on average 4.1% per year. This increase is partially due to the addition of family planning services as a limited Medicaid benefit, which was available from 2012 through 2015. CFC caseloads have remained relatively constant from FY 2015 to FY 2017, increasing at an average annual rate of 0.1%.
- ABD (aged, blind, and disabled) caseloads also experienced growth following the Great Recession, with caseloads increasing 3.3% on average from FY 2011 to FY 2014. Average annual ABD caseload growth has decreased over the following three-year period (FY 2015-FY 2017) at an average annual rate of 0.9%.
- Due to the Great Recession, total caseloads increased by 5.4% in FY 2009 and another 8.4% in FY 2010. Medicaid caseloads also increased rapidly in the early 2000s as a result of the economic slowdown and several eligibility expansions for family and child coverage. From FY 2000 to FY 2004, total caseloads increased by 8.2% per year on average.
- From FY 1990 to FY 2017, total caseloads tripled from 1.0 million to 3.1 million.

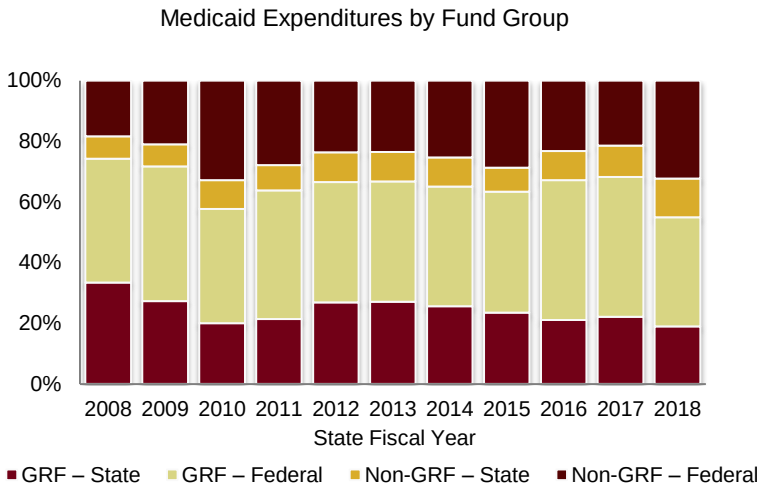
Medicaid Managed Care Caseloads Continue to Expand



Source: Ohio Department of Medicaid

- Following expansions in Medicaid coverage in FY 2014, Medicaid managed care caseloads increased from 1.6 million in FY 2012 to 2.5 million in FY 2017. As a share of total Medicaid caseloads, the managed care portion increased from 79% in FY 2012 to 86% in FY 2017.
- Under the managed care system, the state pays a fixed monthly premium per enrollee for any health care included in the benefit package, regardless of the amount of services actually used. Under the fee-for-service system, Medicaid reimburses service providers based on set fees for the specific types of services rendered.
- For the aged, blind, and disabled (ABD) category, managed care caseloads grew from 127,000 to 232,000, increasing its share from 31% to 55%. This is due in part to the implementation of the MyCare Program in 2014. MyCare is a system of managed care plans that coordinate physical, behavioral, and long-term care services for individuals eligible for both Medicaid and Medicare (dual-eligibles). This includes older adults, individuals with disabilities, and individuals who receive behavioral health services.
- For the covered families and children (CFC) category, managed care caseloads grew from 1.5 million in FY 2012 to 1.7 million in FY 2017, increasing its share from 91% to 92%.
- Medicaid expansion through the federal Affordable Care Act began in January 2014 in Ohio. These individuals (Group VIII) are generally enrolled in managed care, but can receive services through fee-for-service until they choose a Medicaid managed care plan. Under the Group VIII category, managed care caseloads were 640,000 in FY 2017, or 89% of the Group VIII caseload total.

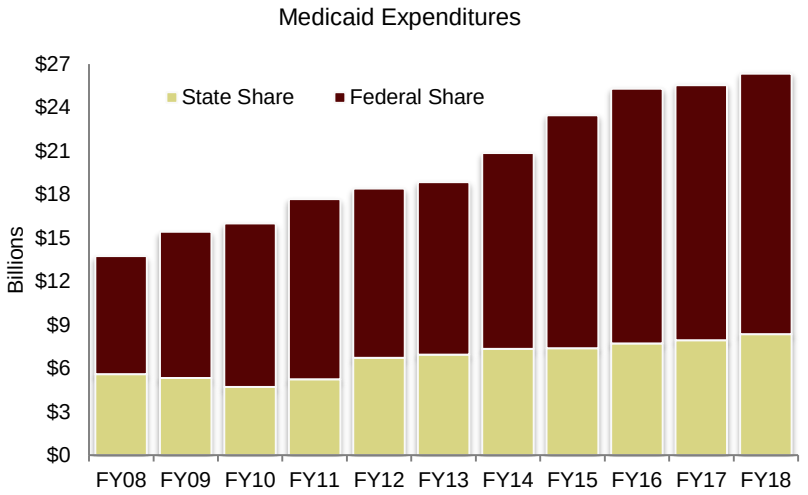
The GRF Is the Main Funding Source for Ohio Medicaid



Sources: Ohio Department of Medicaid; Ohio Administrative Knowledge System

- Ohio Medicaid is primarily funded by the GRF, but it is also supported by various non-GRF funds. From FY 2008 to FY 2018, on average, approximately two-thirds of Medicaid expenditures were made from the GRF, which consists of state tax receipts, state nontax receipts, and federal grants. The vast majority of federal grants deposited into the GRF are federal reimbursements for Medicaid.
- The lowest GRF share during this 11-year period was 55.0%, which was recorded in FY 2018. This shift in expenditures from GRF to non-GRF funds is largely due to the replacement of the sales tax on Medicaid managed care organizations with a franchise fee on all health insuring corporations (HICs). The sales tax was deposited into the GRF, whereas the HIC tax is deposited into a non-GRF fund.
- The GRF share increased from 63.3% in FY 2015 to 67.2% in FY 2016 due largely to an accounting practice change related to Group VIII individuals who became eligible for Ohio Medicaid beginning in January 2014 through the ACA expansion. Medicaid expenditures for these individuals were accounted for in non-GRF funds in FY 2014 and FY 2015 but in the GRF beginning in FY 2016.
- State non-GRF funds for Medicaid come from sources such as hospital assessments, HIC franchise fees, and nursing facilities franchise fees that are used for specific purposes. Federal non-GRF funds for Medicaid consist of federal reimbursements for expenditures made with these non-GRF funds.

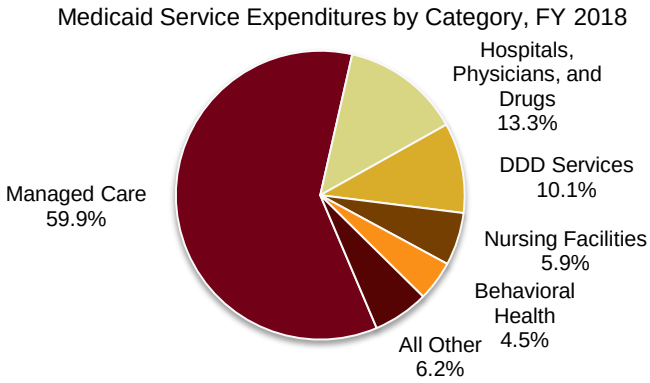
Medicaid Expenditures Almost Doubled Since FY 2008



Source: Ohio Administrative Knowledge System

- From FY 2008 to FY 2018, Medicaid expenditures almost doubled, increasing from $13.7 billion to $26.3 billion. The average annual growth rate during this period was 6.8%.
- Medicaid expenditures increased by 10.6% from FY 2013 to FY 2014 and by 12.5% from FY 2014 to FY 2015. This is primarily due to the expansion in coverage for the Group VIII population, which began in January 2014.
- Medicaid expenditures are affected by policy, the economy, population, and health care prices. Due to the Great Recession, total Medicaid expenditures increased by 12.2% in FY 2009. In contrast, expenditures grew by 5.2% per year from FY 2010 to FY 2013 as the economy gradually expanded.
- The federal government typically reimburses more than 60% of Ohio's Medicaid expenditures. The federal share is determined annually based on the most recent per capita income for Ohio relative to that of the nation. However, from October 1, 2008 to June 30, 2011, federal reimbursement was enhanced under the American Recovery and Reinvestment Act of 2009 and P.L. 111-226.
- The federal share for certain Medicaid programs is higher than the typical share. For instance, the federal reimbursement for Group VIII was 100% through 2016 and 95% for 2017. It is 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. In addition, the State Children's Health Insurance Program rate was about 74% through FFY 2015. Beginning in FFY 2016, the rate increased to about 97% as a result of Affordable Care Act provisions.

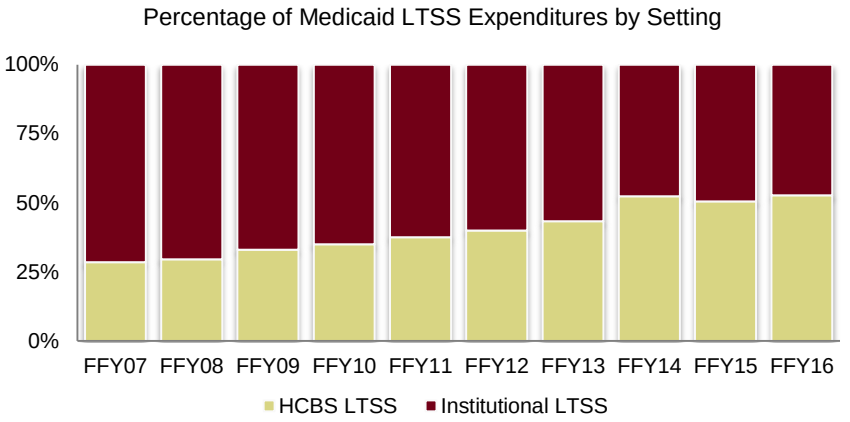
Managed Care Comprises Over Half of Total Medicaid Service Expenditures



Source: Ohio Administrative Knowledge System

- In FY 2018, Medicaid service (excluding administration) expenditures totaled $25.42 billion. Managed Care comprised the largest share at $15.24 billion (59.9%), including $4.07 billion for the Group VIII population. The Group VIII caseload averaged 692,000 in FY 2018. The federal reimbursement rate for this group is 94% in 2018, 93% in 2019, and 90% in 2020 and beyond.
- In FY 2018, spending totaled $3.39 billion (13.3%) for the Hospitals, Physicians, and Drugs category. This figure represents spending for individuals that receive services through the fee-for-service Medicaid delivery system. Expenses for these services for individuals enrolled in Medicaid managed care are accounted for in the Managed Care category.
- Spending for DDD services totaled $2.57 billion (10.1%) in FY 2018 and funds services for individuals with intellectual disabilities.
- Spending on Nursing Facilities (NF) totaled $1.50 billion (5.9%) in FY 2018. This represents expenditures for 50,000 NF residents. NF expenditures for the MyCare Program, which serves recipients eligible for both Medicaid and Medicare (dual-eligibles), are included in the Managed Care category. Approximately 20,000 NF residents are enrolled on the MyCare Program.
- Behavioral Health spending, which totaled $1.14 billion (4.5%) in FY 2018, supports enrollees with mental health or addiction-related needs.
- The $1.58 billion (6.2%) spending in the All Other category includes expenditures for the following: Medicare Buy-In, which assists with premiums and coinsurance payments; Medicare Part D, which repays the federal government the amount the state would have spent on Medicaid prescription drugs for dual-eligibles; and Medicaid waiver programs, which allow individuals to receive home and community-based services.

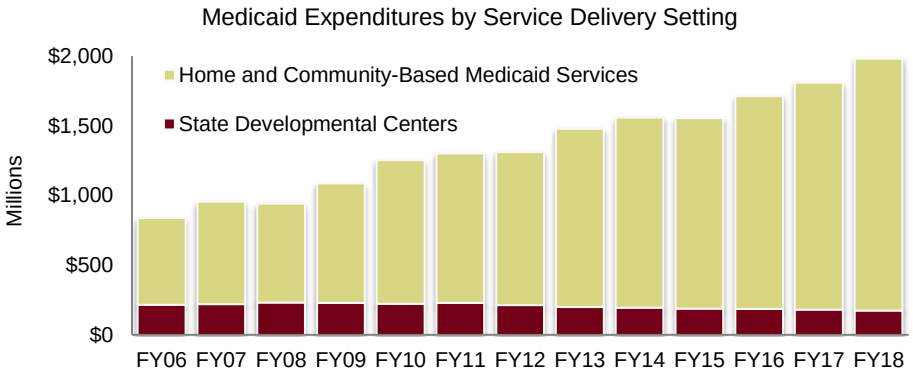
Percentage of Medicaid Expenditures for Home and Community-Based Services Increases Steadily



Sources: Centers for Medicare & Medicaid Services; Kaiser Family Foundation

- The home and community-based services (HCBS) share of Medicaid long-term services and supports (LTSS) expenditures increased from 28.5% in FFY 2007 to 52.7% in FFY 2016. In contrast, the percentage expended on institutional LTSS decreased from 71.5% to 47.3% during this time period.
- LTSS are medical and personal care services provided to individuals who have limitations in their capacity for self-care due to a physical, cognitive, or mental disability. LTSS are provided in institutional facilities (nursing facilities or intermediate care facilities for individuals with intellectual disabilities) or in the home or community through programs such as PASSPORT or Individual Options.
- LTSS spending for HCBS has increased for several reasons, including: recipient preference, HCBS are generally less expensive than institutional care, states are required by the Americans with Disabilities Act to provide persons with disabilities access to HCBS, and federal support for new initiatives to expand HCBS, such as the Balancing Incentive Program (BIP).
- BIP required at least 50% of a state's total Medicaid LTSS expenditures to be for HCBS by September 30, 2015 in return for additional Medicaid reimbursements. Ohio achieved this milestone on September 10, 2014. In total, Ohio received a total of $169.1 million in BIP reimbursements.
- Between FFY 2012 (the first year of BIP operations) and FFY 2016, Ohio experienced a 12.7% increase in HCBS expenditures as a percentage of total Medicaid LTSS expenditures. This was the third highest increase in the nation. Only Missouri and Massachusetts had higher increases with 14.9% and 14.1%, respectively.

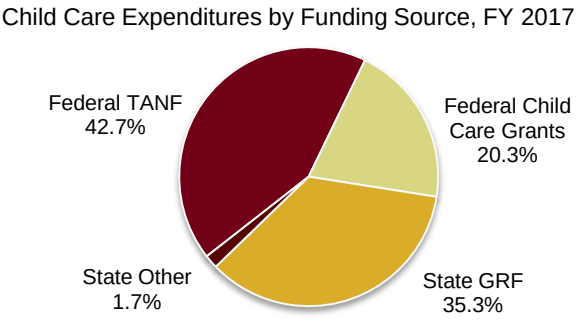
Spending on Community-Based Services Increases as Spending on State Developmental Centers Decreases



Source: Ohio Department of Developmental Disabilities

- From FY 2006 to FY 2018, Medicaid expenditures for home and community-based services (HCBS) for individuals with developmental disabilities increased 191% from $621.7 million to $1.81 billion, while expenditures for individuals in state developmental centers (DCs) decreased 19% from $217.6 million to $175.9 million.
- The Ohio Department of Developmental Disabilities (ODODD) administers three Medicaid HCBS waiver programs that enable individuals with developmental disabilities to remain in their homes or community settings. These programs provide services to increase skills, competencies, and self-reliance to maximize quality of life while ensuring health and safety.
- Enrollment in ODODD's HCBS waiver programs grew from about 18,200 in FY 2006 to 39,200 in FY 2018, an increase of 115%.
- ODODD currently operates eight regional DCs that provide habilitative environments for individuals with severe disabilities. Two DCs (Montgomery and Youngstown) closed near the end of FY 2017. In FY 2006, there were about 1,605 residents living in DCs. By FY 2018, the number of residents was 648, a decrease of roughly 60%.
- In FY 2018, the average monthly cost of an individual in a DC was about $22,500, while the average monthly cost of an individual on an HCBS waiver was about $900 for Level 1, $5,900 for Individual Options, and $1,000 for the Self-Empowered Life Funding waivers.
- In addition to state developmental centers and HCBS waiver services, Medicaid also pays for individuals in private intermediate care facilities. In FY 2006, payments to these facilities totaled $516.5 million. By FY 2018, payments to these facilities totaled $496.1 million, a decrease of about 4%.

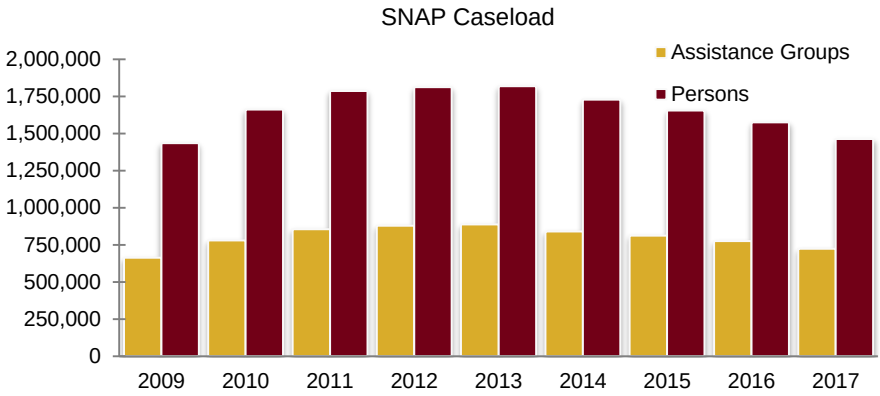
Majority of Subsidized Child Care Was Funded by Federal Grants in FY 2017



Sources: Ohio Department of Job and Family Services; Public Assistance Monthly Statistics

- Of the $639.6 million Ohio spent on subsidized child care in FY 2017, $403.3 million (63.0%) was from federal funds. A monthly average of 130,642 children received care, at an average monthly cost of $408 per child.
- The federal Temporary Assistance for Needy Families (TANF) Block Grant portion totaled $273.3 million, accounting for 67.8% of federal child care funding and 42.7% of the combined state-federal total. Ohio's TANF Block Grant is $728 million per year and is also used for cash assistance and other programs for the indigent.
- Federal Child Care and Development Fund (CCDF) grants accounted for $130.0 million (20.3%) of the total. There are three separate CCDF grants: a discretionary grant, a mandatory grant, and a matching grant. In addition to direct child care spending, the grants are also used for administration, quality activities (e.g., rating program quality), and other nondirect services.
- State dollars accounted for the remaining $236.4 million (37.0%), including $225.5 million in GRF and $10.8 million in other state funds paid by casino operators. Ohio is required by the federal government to annually expend approximately $84.7 million to receive the CCDF mandatory and matching grants and $416.9 million to meet the maintenance of effort requirements for TANF. Childcare spending makes up a significant portion of the required TANF spending.
- For families enrolled in, or transitioning out of, the Ohio Works First Program, child care is guaranteed. However, for most families, eligibility is based on income level. Families with incomes up to 130% of the federal poverty level (FPL) ($27,014 for a family of three in 2018) are eligible for initial services if funding is available; families may remain eligible until their incomes rise above 300% FPL ($62,340 for a family of three in 2018). Families pay copayments to providers on a sliding scale based on income.

Ohio's Supplemental Nutrition Assistance Program Caseload Drops for the 4th Consecutive Year



Sources: Ohio Department of Job and Family Services; Public Assistance Monthly Statistics

- The federal Supplemental Nutrition Assistance Program (SNAP) has seen a drop in the number of people and assistance groups receiving benefits in Ohio since 2013. In 2013, Ohio had an average monthly caseload of 1.82 million individuals in 888,000 assistance groups. By 2017, this decreased to 1.46 million individuals in 723,000 assistance groups.
- In 2017, Ohio disbursed $2.17 billion in SNAP benefits, with an average benefit of $124 per recipient per month. Benefits are paid entirely by the federal government and are transmitted directly to the processer Ohio contracts with to distribute benefits. This amount is never considered part of the state treasury and is not appropriated by the General Assembly.
- Determinations for SNAP benefits are made by county departments of job and family services. The federal government reimburses state and local administration costs at a rate of 50%.
- To qualify for benefits, recipients must earn less than 130% of the federal poverty level ($27,014 annually for an assistance group of three in 2018). The benefit amount varies based on the income and size of the assistance group.
- An assistance group's monthly benefit is automatically loaded onto their Ohio Direction Card, which can be used like a debit card to purchase eligible food items. Most grocery stores accept the Ohio Direction Card.
- SNAP is a United States Department of Agriculture/Food and Nutrition Service program that assists low-income households to purchase food from authorized merchants. A household that receives benefits under the program is a group of people who purchase and prepare meals together. This would generally be a family, but may also include unrelated adults who share a home and meals.

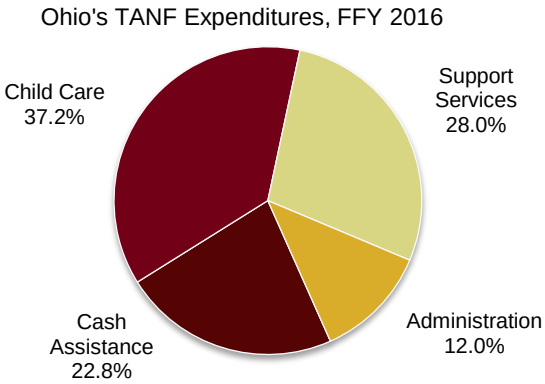
Ohio's Percentage of Preterm Births and Infant Mortality Rate Exceed National Statistics

Ohio and United States Population Statistics		
Category	**Ohio**	**United States**
% of Preterm Births, 2016	**10.4%**	**9.9%**
Non-Hispanic White	9.6%	9.0%
Non-Hispanic Black	14.6%	13.8%
Hispanic	11.0%	9.5%
Infant Mortality Rate (per 1,000 births), 2015	**7.2**	**5.9**
Non-Hispanic White	5.7	4.8
Non-Hispanic Black	15.1	11.7
Hispanic	6.0	5.2

Sources: Kaiser Family Foundation; Centers for Disease Control and Prevention

- In 2016, 10.4% of all births in Ohio were preterm births (less than 37 weeks of gestation) compared to the national average of 9.9%. Similar to the national pattern, the percentage of preterm births in Ohio for non-Hispanic black infants (14.6%) was higher than the percentage for both non-Hispanic white (9.6%) and Hispanic (11.0%) infants.
- In 2016, there were a total of 14,388 preterm births in Ohio. Preterm birth makes infants more vulnerable to developmental delays and both short-term and long-term medical problems. The average health care cost in the first year of life for a premature infant is about $55,400 as compared to $5,100 for a full-term, healthy infant.
- Factors that increase the risk of preterm birth include: having a previous preterm birth or a chronic medical condition, sustaining a physical injury, being very overweight or underweight before pregnancy, smoking or substance use, and having a birth interval shorter than 18 months.
- During 2015, Ohio's overall infant mortality rate of 7.2 (infant deaths per 1,000 live births) was higher than the national rate of 5.9. The rate for non-Hispanic blacks in Ohio and in the United States was more than twice the rate for non-Hispanic white infants.
- The leading causes of infant mortality are preterm birth, birth defects, sudden infant death syndrome, maternal pregnancy complications, and injury, such as accidental rollover or suffocation.

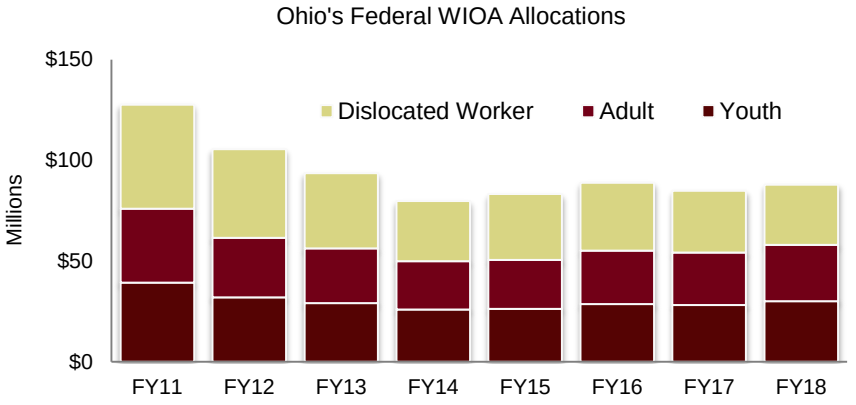
Child Care Accounted for Over a Third of Ohio's TANF Expenditures in Federal Fiscal Year 2016



Source: U.S. Department of Health and Human Services

- In FFY 2016, subsidized child care accounted for $419.2 million (37.2%) of Ohio's $1.13 billion in total Temporary Assistance for Needy Families (TANF) expenditures. Subsidized child care is available to children in families with incomes up to 130% of the federal poverty level (FPL). An average of 117,000 children received subsidized child care each month in state fiscal year 2016. In addition to TANF dollars, other state and federal funds are also used to pay child care providers.
- Cash assistance payments provided under the Ohio Works First (OWF) program accounted for $256.5 million (22.8%) of total TANF expenditures. In state fiscal year 2016, an average of 58,000 assistance groups per month received OWF benefits with an average benefit of $194 per recipient.
- OWF assistance groups must include a minor child or pregnant woman and have income of no more than 50% of the FPL. Heads-of-household must sign a self-sufficiency contract that includes a work plan. Benefits are limited to 36 consecutive months (with a lifetime limit of 60 months), but time and income limits and work requirements do not apply to "child-only" cases, in which a relative caregiver receives the benefit on behalf of a child.
- Support services ($315.0 million, 28.0%) are short-term noncash benefits provided at the local level and may include shelter, job-required clothing, household necessities, transportation, and other services allowable under federal law. Administration ($135.2 million, 12.0%) includes both state and local activities such as eligibility determination and case management.
- Ohio's TANF resources total about $1.15 billion each year: $728 million from the federal TANF Block Grant and $417 million in state funds to meet the TANF maintenance of effort requirement.

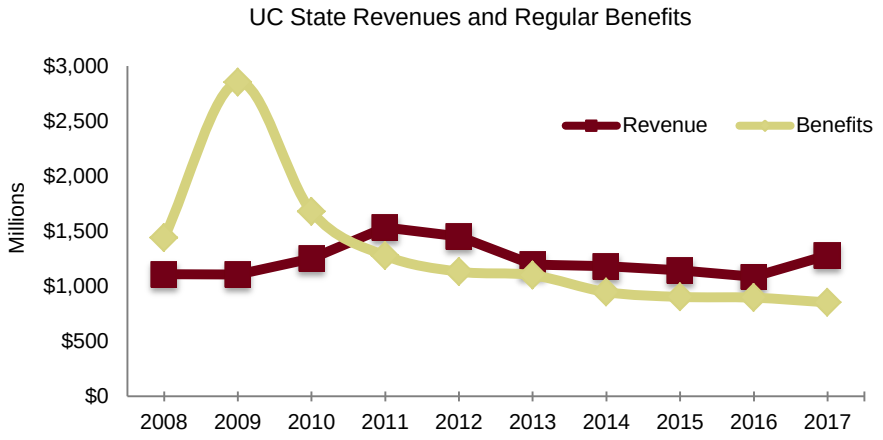
Ohio's Federal Workforce Innovation and Opportunity Act Grants Remained Fairly Stable Since FY 2014



Sources: U.S. Department of Labor; Federal Funds Information for States; ODJFS

- Ohio's federal Workforce Innovation and Opportunity Act (WIOA) grants, which superseded the Workforce Investment Act, fell from $127.6 million in FY 2011 to $87.9 million in FY 2018, a decrease of 31.1%. Grants decreased steadily from FY 2011 through FY 2014, but have remained fairly stable since that time.
- Ohio's WIOA grants in FY 2018 totaled $87.9 million, including $30.1 million for youth, $28.0 million for adults, and $29.8 million for dislocated workers.
- WIOA grants are largely distributed based on each state's share of the total unemployed and economically disadvantaged nationwide.
- WIOA is administered at the state level by the Ohio Department of Job and Family Services (ODJFS) and locally by 20 regional workforce investment boards. Service delivery is provided by 88 local OhioMeansJobs (One-Stop) centers, with one center in each county.
- ODJFS is required to distribute 85% of the state's total annual WIOA grants to Ohio's workforce investment boards for service delivery. Boards have two years to expend WIOA grants. The remaining WIOA dollars are used by ODJFS to help areas in the state that experience mass layoffs (10%) and for administration and other statewide workforce programs (5%). ODJFS may expend WIOA funds over three years for these purposes.
- Statewide WIOA activities include support for OhioMeansJobs.com, a statewide job posting board that is free for employers and job seekers.
- In addition to its regular WIOA grants, Ohio can receive Dislocated Worker Grants to respond to large, unexpected, numbers of dislocated workers due to layoffs, international trade effects, and natural disasters.

Ohio's Unemployment Compensation Revenues Exceeded Benefit Payments the Last Seven Years



Source: Ohio Department of Job and Family Services

- The state's regular unemployment compensation (UC) revenues have exceeded benefits every calendar year since 2011. In 2017, UC revenues totaled $1.28 billion, $426.9 million higher than net benefit payments of $854.2 million.
- After depleting the Unemployment Compensation Fund in January 2009, Ohio borrowed $3.39 billion from the federal government to continue paying benefits. The remaining balance of this federal debt was paid in August 2016 with an intrastate loan from the Department of Commerce's unclaimed funds. Since this date, Ohio has not borrowed any additional amounts.
- Of the total 2017 revenue, $274.0 million was used to repay the intrastate loan. H.B. 390 of the 131st General Assembly raised additional revenue for repayment via a 0.6% surcharge on employer UC taxes in 2017. This surcharge will not be in effect in 2018 or in future years.
- Regular state UC revenue is derived from taxes paid by Ohio employers on the first $9,000 of each employee's wages. Rates are set in state law and are based on an employer's "experience" of unemployment. In 2017, tax rates ranged from 0.9% to 9.4% (including the 0.6% surcharge) and averaged about 3.0%, or $270 per employee. S.B. 235 of the 131st General Assembly temporarily increases taxable wages to $9,500 for 2018 and 2019.
- Recipients of UC are eligible to receive amounts equal to half their employed wages up to a maximum amount that is adjusted annually based on the statewide average weekly wage. In 2017, the average recipient received $363 weekly for 14.7 weeks. S.B. 235 of the 131st General Assembly freezes maximum benefit amounts for 2018 and 2019 at the 2017 level.

Workers' Compensation Claims and Benefits Continued to Decline in 2017

Workers' Compensation Benefits and Claims Paid from the State Insurance Fund					
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Benefits ($ in Millions)					
Medical	$705.8	$662.3	$614.4	$580.3	$550.6
Lost Time	$1,076.0	$1,061.4	$1,033.1	$1,021.6	$940.8
Total	$1,781.8	$1,723.7	$1,647.4	$1,601.9	$1,491.4
Number of New Allowed Claims					
Total	97,041	97,572	93,936	88,170	86,290
Number of Open Claims					
Total	958,625	858,773	791,638	752,312	704,756

Source: Ohio Bureau of Workers' Compensation

- Total benefits paid by the Bureau of Workers' Compensation (BWC) for lost time and medical claims declined steadily between FY 2013 and FY 2017. In FY 2017, lost time and medical benefits paid totaled $1.49 billion, 16.3% ($290.4 million) less than the $1.78 billion paid in FY 2013.
- From FY 2013 to FY 2017, medical claims declined by 22.0% ($155.2 million) while lost-time benefits declined by 12.6% ($135.2 million).
- Most claims come from the service industries, with the manufacturing and commercial industries constituting the next largest portion.
- Except for a slight uptick in new allowed claims in FY 2014, the number of claims, both new and open, also declined over this five-year span. Between FY 2013 and FY 2017, new allowed claims dropped 11.1% and open claims dropped 26.5%.
- BWC provided coverage to 242,474 employers in FY 2017, including 3,917 state and local public employers. Slightly fewer than 1,200 employers qualified to self-insure in FY 2017. Premiums and administrative assessments collected from BWC-insured employers totaled $1.55 billion in FY 2017.
- BWC's net assets totaled almost $9.76 billion at the close of FY 2017, 11.5% higher than the $8.75 billion at the close of FY 2016.