

CHAPTER 55
FORMERLY
HOUSE BILL NO. 175

AN ACT TO AMEND TITLES 18 AND 19 OF THE DELAWARE CODE RELATING TO WORKERS' COMPENSATION.

WHEREAS, permitted workers' compensation loss cost ratios, used to determine workers' compensation rates, have increased by over 30% in Delaware over the last two years; and

WHEREAS, the General Assembly and Governor created a task force through House Joint Resolution No. 3 to recommend steps that the State could take to stem future significant increases in workers' compensation rates; and

WHEREAS, the task force created by House Joint Resolution No. 3 has delivered a report to the General Assembly and Governor that has recommended a substantial number of steps designed to control medical costs in the workers' compensation system, ensure that rate applications from insurance carriers are scrutinized, speed the return to work of injured workers, and improve workplace safety;

NOW, THEREFORE:

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend §2301E, Title 19 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§2301E. ~~Data collection and reporting~~ Data Collection Committee.

(a) It is the intent of the General Assembly that the Insurance Commissioner, and an advisory organization designated pursuant to Chapter 26 of Title 18, be provided with data enabling them to conduct studies to evaluate the workers' compensation system in the State of Delaware, identify systemic cost drivers, ~~and provide objective information to guide policy formulation, and identify carrier-specific cost drivers.~~

(b) The Insurance Commissioner shall appoint a ~~committee of interested persons~~ Data Collection Committee to advise the Commissioner concerning the adoption of a standardized data transmission protocol, developed and supported by a national workers' compensation organization, to facilitate the collection of data concerning reports of industrial injuries and occupational disease, the cost of benefits associated with such injuries and diseases, and compliance with the mandatory workers' compensation insurance requirement, and to ensure compliance by individual carriers with their responsibilities relating to medical cost control. The committee shall be chaired by the Insurance Commissioner or the Commissioner's designee, and shall also include 4 representatives of insurance carriers, including at least 1 insurance carrier that writes at least 10% of the total workers' compensation premiums in the State, and 1 insurance carrier that writes less than 5% of the total workers' compensation premiums in the State, ~~and all members of the workers' compensation advisory group established by § 2301D(e) of this title~~ two representatives each from the medical community, the business community, the legal community, and organizations representing employees.

(c) The Insurance Commissioner, with the advice of the ~~committee referenced in subsection (b) of this section above~~ Data Collection Committee, shall adopt rules establishing a standardized data collection protocol, the data elements that will be mandated for collection, and a schedule for implementation of mandatory data submission and sanctions for noncompliance. ~~The electronic collection of data concerning first reports of injuries or occupational disease and the electronic collection of information concerning compliance with the mandatory workers' compensation insurance requirement shall receive the highest priority for implementation. The next highest priority shall be the reporting of health care data relating to procedures performed and cost of health care services.~~

(d) The Insurance Commissioner, with the advice of the ~~committee referenced in subsection (b) of this section above~~ Data Collection Committee, shall annually report to the Governor and the General Assembly the progress of data collection efforts and information obtained from the analysis of the data collected pursuant to this section.

(e) Data shall be provided to the Data Collection Committee on at least a quarterly basis, and the committee shall share the data it collects with the Health Care Advisory Panel created by Section 2322A of this Title.

(f) The advisory organization shall, on an annual basis beginning on August 1, 2013, provide the Data Collection Committee with carrier-specific medical cost data for each workers' compensation carrier having a market share in Delaware of 3% or greater over the twelve preceding months. If, after reviewing said data and making necessary inquiries with individual carriers, the Data Collection Committee determines that there is a well-founded concern that an individual carrier is not sufficiently scrutinizing medical payments, the Data Collection Committee may direct the Insurance Commissioner to conduct a formal examination of a carrier to determine compliance with applicable laws and regulations regarding medical reimbursements.

(g) The Department of Insurance may exercise its authority granted under Title 18 of the Delaware Code to address legitimate competitive, trade secret, or health privacy concerns that arise in connection with compliance with this Section, provided that the Department's exercise of this authority shall not interfere with the Data Collection Committee's ability to fulfill its statutory obligations.

Section 2. Amend §2322B, Title 19 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§2322B. Procedures and requirements for promulgation of health care payment system.

The health care payment system developed pursuant to this section shall be subject to the following procedures and requirements:

(1) The intent of the General Assembly in authorizing a health care payment system is not to establish a "push down" system, but is instead to establish a system that eliminates outlier charges and streamlines payments by creating a presumption of acceptability of charges implemented through a transparent process, involving relevant interested parties, that prospectively responds to the cost of maintaining a health care practice, eliminating cost-shifting among health care service categories and avoiding institutionalization of upward rate creep.

(2) The health care payment system shall include payment rates, instructions, guidelines, and payment guides and policies regarding application of the payment system. When completed, the payment system shall be published on the Internet at no charge to the user via a link from the Office of Workers' Compensation website at <http://dia.delawareworks.com/workers-comp/>, or a successor website. The payment system shall also be made available in written form at the Office of Workers' Compensation during regular business hours.

(3) (i) The maximum allowable payment for health care treatment and procedures covered under this chapter shall be the lesser of the health care provider's actual charges or the fee set by the payment system. The payment system will set fees at 90% of the seventy-fifth percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in employers' and insurer carriers' national databases. For pathology, laboratory, and radiological services and durable medical equipment, the payment system will set fees at 85% of 90% of the 75th percentile of actual charges. For purposes of this section, "geozip" means an area defined by reference to United States ZIP Codes; Delaware shall consist of 1 "197 geozip" (comprised of all areas within the State where the address has a ZIP Code beginning with the 3 digits "197" or "198"), and 1 "199 geozip" (comprised of all areas within the State where the address has a ZIP Code beginning with the 3 digits of "199"). If a geozip does not have the necessary number of charges and fees to calculate a valid percentile for a specific procedure, treatment, or service, the Health Care Advisory Panel in its discretion may combine data from Delaware's 2 geozips for a specific procedure, treatment, or service. Those fees shall then be subject to the adjustments described in subparagraphs (iv) and (v) in subsequent years.

(ii) On a one-time basis in 2013, with respect to all possible procedures, treatments, and services for which there was insufficiently reliable data prior to 2013 for the Health Care Advisory Panel to determine a payment based upon the formula described above, the Health Care Advisory Panel shall use a formula based upon Relative Value Units as determined by the Centers for Medicare and Medicaid Services to determine fees for said procedures, treatments, and services. Those fees shall then be subject to the adjustments described in subparagraphs (iv) and (v) in subsequent years. ~~In the event that the Health Care Advisory Panel determines there is insufficient data to calculate a valid percentile for a procedure, treatment or service, or that data from a commercial vendor is not sufficiently reliable to implement a payment system for professional services for a specific procedure, treatment or service, then the Health Care Advisory Panel may reco~~

(iii) For procedures, treatments, and services not covered by subparagraphs (i) or (ii) or other provisions of this Chapter, the Health Care Advisory Panel may recommend an alternative payment system.

(iv) The payment system will be adjusted yearly based on percentage changes to the Consumer Price Index-Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics. After January 17, 2010, the Health Care Advisory Panel shall review the geozip reporting system and make a recommendation concerning whether the State should operate its workers' compensation health care payment system on a geozip basis or on a single statewide basis.

(v) Notwithstanding the above, the payment system shall not be adjusted for inflation between July 1, 2013 and January 1, 2016. After January 1, 2016, the payment system shall resume its adjustment as described above and in subsection (14) of this Section, but inflation increases for the time period July 1, 2013 through January 1, 2016 shall not be recouped.

(4) Upon adoption of the health care payment system, an employer and/or insurance carrier shall pay the lesser of the rate set forth by the payment system or the health care provider's actual charge. If an employer or insurance carrier contracts with a provider for the purpose of providing services under this chapter, the rate negotiated in any such contract shall prevail.

(5) Whenever the health care payment system does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be at 85% of actual charge ~~as of November 1, 2008.~~

(6) Procedures and requirements for promulgation of health care payment system. -- The health care payment system shall include provisions for health care treatment and procedures performed outside of the State of Delaware. If any procedure, treatment or service is rendered by a health care provider, hospital or ambulatory surgery center, who is licensed or permitted to render such procedure, treatment or service within the State of Delaware, but performs such procedure, treatment or service outside of the State of Delaware, the amount of reimbursement shall be the amount as set forth in the health care payment system. In the event that a procedure, treatment or service is rendered outside the State of Delaware by a health care provider, hospital or ambulatory surgery center, not licensed or permitted to render such procedure, treatment or service within the State of Delaware, the amount of reimbursement shall be the greater of:

a. The amount set forth in the workers' compensation health care payment system or a fee schedule adopted by the state in which the procedure, treatment or service is rendered, if such a schedule has been adopted; or

b. The amount that would be authorized by the payment system adopted pursuant to this chapter if the service or treatment were performed in the geozip where the injury occurred or where the employee was principally assigned.

Charges for a procedure, treatment or service outside the State of Delaware shall be subject to the instructions, treatment guidelines, and payment guides and policies in the health care payment system.

(7) The health care payment system shall include separate service categories for the fields of: ambulatory surgical treatment centers, anesthesia and related services, dental and related services, hospital care, and professional services. The Health Care Advisory Panel is directed to implement a specific cap on fees for anesthesia, which shall not be dependent on current charges, by January 1, 2014.

(8) Hospital reimbursement developed in the healthcare payment system shall be determined in accordance with the following provisions:

a. Hospital fees billed for inpatient services, outpatient surgical services, and emergency services provided to injured workers pursuant to this chapter shall be reimbursed at a rate equal to 80.0% of each hospital's current actual charges as of date of service, subject to adjustment provided by this paragraph. Hospital fees billed for outpatient nonsurgical services shall be billed subject to the provisions of paragraphs (3), (4), and (6) of this section; whenever the healthcare payment system does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be at 80.0% of each hospital's current actual charges as of date of service, subject to adjustment provided by this paragraph. On October 31, 2012, and every year thereafter by the same date, each hospital, with the exception of pediatric hospitals, shall provide to the Delaware Healthcare Association (DHA) a written report submitted by each hospital's independent financial auditor or certified public

accountant setting forth its blended rate increase or decrease for the prior year. Within 30 days of receipt of the aforementioned reports, the DHA shall submit to the Department of Labor a written report prepared by an independent financial auditor or certified public accountant setting forth the following:

1. The arithmetic average of the blended rate increases or decreases for the hospitals submitting reports to the DHA pursuant to this subsection; and
2. A statement as to whether the hospitals have changed their mark-up methodologies for implants, supplies and devices.

The aforementioned report submitted by the DHA to the Department of Labor shall include copies of the individual hospitals reports to the DHA, as referenced above, but shall not identify the individual hospitals by name. Inpatient and outpatient pharmaceutical charges shall be excluded from the blended rate calculation referenced above. Implants, supplies and other cost-based services shall also be excluded from the blended rate calculation referenced above as long as the mark-up factor does not change from 1 year to the next. However, if the mark-up factor changes, the percentage increase or decrease, confirmed by each hospital through its annual financial statement, as referenced herein, shall be included in the blended rate calculation for that year. The Department of Labor shall, through a request for proposal (RFP) process, retain an independent financial auditor(s) or certified public accountant(s) to verify the validity of the rate change as it is set forth in the report submitted by the DHA. The DHA shall cooperate fully with any request for information made by the Department of Labor's retained financial advisor. Any proprietary information obtained, received or reviewed by the Department of Labor and/or their financial advisor(s) shall remain privileged and confidential, not subject to disclosure pursuant to the provisions of Chapter 100 of Title 29. Based upon the information received, the Department of Labor's financial advisor shall calculate the overall rate change applicable to all hospitals for the following year. If the arithmetic average of the blended rate for the hospitals submitting reports to the DHA pursuant to this subsection is greater than the Consumer Price Index-Urban, U.S. City Average ~~for Medical Care~~, as published by the United States Bureau of Labor Statistics (CPI-U, ~~Medical~~), each hospital's reimbursement rate shall be reduced by the difference between such blended rate and the CPI-U, ~~Medical~~. If the arithmetic average of the blended rate for the hospitals submitting reports to the DHA pursuant to this subsection is less than the CPI-U, ~~Medical~~, each hospital's reimbursement rate shall be increased by the difference between such blended rate and the CPI-U, ~~Medical~~. Such calculation shall be completed no later than January 31 of each year. The overall rate change shall be instituted on January 31, 2013, and every year thereafter on the same date. Reasonable costs associated with the overall rate change verification and calculation, as referenced above, shall be reimbursed to the Department of Labor by the DHA. Such verification may be subject to further review and/or audit by the Department of Insurance. Reasonable costs of any review or audit for purposes of this section shall be reimbursed to the Department of Insurance by the DHA. The failure on the part of any hospital and/or the DHA to comply with the requirements set forth above shall result in the nonpayment of charges during the period of noncompliance. Notwithstanding any language to the contrary, no increase in a hospital's reimbursement rate shall be permitted between July 1, 2013 and January 1, 2016. No reimbursement rate increases on or after January 1, 2016 shall allow for recoupment of increases that might otherwise have been permitted by this paragraph between July 1, 2013 and January 31, 2016.

b. Healthcare provider services provided in an emergency department of a hospital, or any other facility subject to the Federal Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, and any emergency medical services provided in a prehospital setting by ambulance attendants and/or paramedics, shall be exempt from the healthcare payment system and shall not be subject to the requirement that a healthcare provider be certified pursuant to § 2322D of this title, requirements for preauthorization of services, or the healthcare practice guidelines adopted pursuant to § 2322C of this title.

c. The hospital reimbursement rate will be adjusted yearly as set forth in paragraph (8)a. of this section, except as otherwise indicated. Notwithstanding this yearly overall rate adjustment, the Health Care Advisory Panel, beginning February 1, 2015, and every 3 years thereafter, shall review the overall rate changes and make a determination whether the overall rate change reimbursement method adequately addresses the intent of the General Assembly as set forth in paragraph (1) of this section. The Health Care Advisory Panel shall provide the

Secretary of Labor with its determination and any proposal to address concerns that may be identified during its review.

(9) Ambulatory Surgery Center ("ASC") reimbursement developed in the healthcare payment system shall be determined in accordance with the following provisions:

a. Ambulatory Surgery Center fees billed for services provided to injured workers pursuant to this chapter by an ASC shall be reimbursed at a rate equal to 85% of each ASC's current actual charges for such services as of date of service, subject to adjustment provided by this subsection as follows: On October 31, 2012, and every year thereafter by the same date, each ASC shall provide to the Department of Labor its rate change for the prior fiscal year. Verification of such rate change shall be provided by each ASC to the Office of Workers' Compensation in accordance with the above through a written report submitted by each ASC's independent financial auditor or certified public accountant. The Department of Labor shall, through a request for proposal (RFP) process, retain an independent financial auditor or auditors or certified public accountant or accountants to verify the validity of the rate change submitted by each ASC. Each ASC shall cooperate fully with any request for information made by the Department of Labor's retained financial advisor. Any proprietary information obtained, received or reviewed by the Department of Labor and/or their financial advisor(s) shall remain privileged and confidential, and not subject to disclosure pursuant to the provisions of Chapter 100 of Title 29. Based upon the information received, the Department of Labor's financial advisor shall calculate the rate change applicable to each ASC for the following year. If any ASC's rate change is greater than the CPI-U, Medical, then that ASC's reimbursement rate shall be reduced by the difference between that ASC's rate change and the CPI-U, Medical. If any ASC's rate change is less than the CPI-U, Medical, then that ASC's reimbursement rate shall be increased by the difference between that ASC's rate change and the CPI-U, Medical. Such calculation shall be completed no later than January 31 of each year. The rate changes for the ASCs, as referenced above, shall be instituted on January 31, 2013, and every year thereafter on the same date. Reasonable costs associated with each rate change verification and calculation, as referenced above, shall be reimbursed to the Department of Labor by the ASC for which the rate change verification and calculation has been performed. Such verification may be subject to further review and/or audit by the Department of Insurance. Reasonable costs of any review or audit for purposes of this section shall be reimbursed to the Department of Insurance by the ASC and/or ASCs whose billing is audited. The failure on the part of any ASC to comply with the requirements set forth above shall result in the nonpayment of charges during the period of noncompliance

b. Ambulatory Surgery Center reimbursement rates will be adjusted yearly as set forth in paragraph (9)a. of this section. Notwithstanding this yearly overall rate adjustment, the Health Care Advisory Panel, beginning February 1, 2015, and every 3 years thereafter, shall review the overall rate changes and make a determination whether the overall rate change reimbursement method adequately addresses the intent of the General Assembly as set forth in paragraph (1) of this section. The Health Care Advisory Panel shall provide the Secretary of Labor with its determination and any proposal to address concerns that may be identified during its review.

c. The Health Care Advisory Panel is directed to develop by January 1, 2014 a system of maximum allowable payments for services provided in Ambulatory Surgical Centers which shall result in stable charges and be cost neutral with respect to medical costs. Upon the implementation of this system of maximum allowable payments for treatments in Ambulatory Surgical Centers, paragraphs (a) and (b) of this subsection shall cease to have legal effect.

d. Notwithstanding any language to the contrary, no adjustments for inflation shall be made to any payment schedule developed pursuant to this subsection until at least January 1, 2016. Subsequent to January 1, 2016, no permitted inflation increases shall allow for recoupment of inflation-based expenses incurred prior to January 31, 2016.

(10) Professional service fees developed in the health care payment system shall be determined in accordance with the following provisions:

a. The payment system for professional services shall conform to the Current Procedural Terminology ("CPT"), American Medical Association, 515 North State Street, Chicago, Illinois, 60610, ~~2006, no later dates or editions.~~

b. Services covered by the payment system shall include evaluation and management, surgery, physician, medicine, radiology, pathology and laboratory, chiropractic, physical therapy, and other services covered under the CPT.

c. The health care payment system shall require that services be reported with the Healthcare Common Procedural Coding System Level II ("HCPCS Level II") or CPT codes that most comprehensively describe the services performed. Proprietary bundling edits more restrictive than the National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0, U.S. Department of Health and Human Services, Centers for Medicare and Medicare Services, 7500 Security Boulevard, Baltimore, Maryland, 21244, ~~2006, no later dates or editions,~~ shall be prohibited. Bundling edits is the process of reporting codes so that they most comprehensively describe the services performed.

d. An allied health care professional, such as a certified registered nurse anesthetist ("CRNA"), physician assistant ("PA"), or nurse practitioner ("NP"), shall be reimbursed at the same rate as other health care professionals when the allied health care professional is performing, coding and billing for the same services as other health care professionals if a physician health care provider is physically present when the service or treatment is rendered, and shall be reimbursed at 80% of the primary health care provider's rate if a physician health care provider is not physically present when the service or treatment is rendered.

e. Charges of an independently operated diagnostic testing facility shall be subject to the professional services and HCPCS Level II health care payment system where applicable. An independent diagnostic testing facility is an entity independent of a hospital or physician's office, whether a fixed location, a mobile entity, or an individual nonphysician practitioner, in which diagnostic tests are performed by licensed or certified non-physician personnel under appropriate physician supervision.

f. The Health Care Advisory Panel shall adopt and recommend regulations pertaining to the methodology for updating the fee schedule for professional service fees developed in the health care payment system as set forth in subsections (5) , (10)a, and (10)c of this Section.

(11) As part of the health care payment system, the Health Care Advisory Panel shall adopt and recommend a reimbursement schedule for pathology, laboratory and radiological services and durable medical equipment. ~~Such schedule shall be designed to result in savings of 15% from charges prevailing in workers' compensation matters as of October 31, 2006.~~ The Health Care Advisory Panel shall implement by September 1, 2013 a specific limitation on drug screenings absent pre-authorization and a specific limitation on per-procedure reimbursements for drug testing.

(12) As part of the health care payment system, the Health Care Advisory Panel shall adopt and recommend a formulary and fee methodology for pharmacy services, prescription drugs and other pharmaceuticals, ~~and for durable medical equipment.~~ ~~Such formulary and fee methodology shall be designed to result in savings of 15% from charges prevailing in workers' compensation matters as of October 31, 2006.~~ The formulary and fee methodology system developed by the Health Care Advisory Panel for pharmacy services, prescription drugs and other pharmaceuticals shall include by September 1, 2013 a mandated discount from average wholesale price that shall be defined by the state, a ban on repackaging fees, and adoption of a preferred drug list.

(13) Fees for nonclinical services, such as retrieving, copying and transmitting medical reports and records, testimony by affidavit, deposition or live testimony at any hearing or proceeding, or completion and transmission of any required report, form or documentation, and associated regulations and procedures for the determination of and verification of containment of fees, shall be developed and proposed by the Health Care Advisory Panel, and adopted as part of the health care payment system. Such fees shall be revised periodically on the recommendation of the Health Care Advisory Panel to reflect changes in the cost of providing such services. Following the adoption of the initial health care payment system, adjustments to fees for non-clinical services shall be adopted by regulation of the Department of Labor pursuant to Chapter 101 of Title 29. The nonclinical service

fees adopted pursuant to this paragraph shall apply to all services provided after the effective date of the regulation, regardless of the date of injury.

(14) Subject to the foregoing provisions, the health care payment system authorized by this section shall be approved and proposed by the Health Care Advisory Panel. Thereafter, the health care payment system shall be adopted by regulation of the Department of Labor pursuant to Chapter 101 of Title 29. Such regulation shall be promulgated and adopted within 180 days of the first meeting of the Health Care Advisory Panel. One year after the effective date of the regulation and each January thereafter, the Department of Labor shall make an automatic adjustment to the maximum payment for a procedure, treatment or service in effect in January of that year. Except with respect to hospital charges that shall be adjusted in accordance with paragraph (8) of this section, the Department of Labor shall increase or decrease the maximum payment by the percentage change of increase or decrease in the Consumer Product Index -- Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics. The adjustment provided for in this section shall not be applied to fees for nonclinical services and supplies. Notwithstanding the above, the payment system shall not be adjusted for inflation between July 1, 2013 and January 1, 2016. After January 1, 2016, the payment system shall resume its adjustment as described above, but inflation increases for the time period July 1, 2013 through January 1, 2016 shall not be recouped.

Section 3. Amend §2322E (d), Title 19 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

(d) Within 14 days of ~~receiving the initial "Physician's Report of Workers' Compensation Injury"~~ the issuance of an Agreement As To Compensation to an employee for any period of total disability, the employer shall provide to the health care provider/physician ~~who issued the aforementioned report~~ most responsible for the treatment of the employee's work-related injury and to the employer's insurance carrier, if applicable, a report of the modified-duty jobs which may be available to the employee. The insurance carrier for an insured employer shall send to such employer the aforementioned report for completion, and shall be independently responsible for providing a completed report of modified-duty jobs to the health care provider/physician. The health care provider portion of the employer's modified duty availability report must be signed and returned by the health care provider within 14 days of the next date of service after receipt of the form from the employer, but not later than 21 days from the health care provider's receipt of such form.

Section 4. Amend §2361(c), Title 19 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

(c) Notwithstanding the above, and in furtherance of and accordance with the provisions of Section 2322F(j) regarding Utilization Review, any utilization review decision issued pursuant to applicable rules and regulations promulgated pursuant to Section 2322F(j) shall be final and conclusive as to any interested party unless within 45 days from the date of receipt of the utilization review decision any interested party files a petition with the Industrial Accident Board for de novo review.

(d) All claims for compensation for compensable occupational disease or for an ionizing radiation injury shall be forever barred unless a petition is filed in duplicate with the Department within 1 year after the date on which the employee first acquired such knowledge that the disability was or could have been caused or had resulted from employment. In case of death, all claims for compensation for compensable occupational disease or for an ionizing radiation injury shall be forever barred unless a petition is filed in duplicate with the Department within 1 year after the date on which the person or persons entitled to file such claims know, or by the exercise of reasonable diligence should know, the possible relationship of the death to the employment.

Section 5. Amend §2379(f), Title 19 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows

(f) Inspections and cost. --

(1) All inspections shall be made by a representative from an independent safety expert company under contract to the Department of Insurance. The Department of Insurance shall notify the inspector of the employer's request. The inspector, in turn, will then contact the employer to set up the first of 2 inspections. A second

unannounced inspection shall be made no later than the expiration date of the policy to which any workplace safety credit based on the inspection will apply to confirm the initial certifications of safety in the workplace. The Department of Insurance shall notify the Delaware Compensation Rating Bureau (or such other organization designated by the Insurance Commissioner) when an employer successfully completes each scheduled and/or nonscheduled inspection. Failure to pass a scheduled inspection shall result in a denial of an employer's eligibility to participate in the workplace safety program. However, an employer, after failing an inspection can request another inspection, after successful completion of which will make the employer eligible for participation in the workplace safety program.

(2) Any application for the workplace safety credit shall include a statement by the applicant as to any workplace injuries that have occurred in the three years prior to the application and the outcome of those injuries, including the specific nature of the injuries, any findings or fines relating to workplace safety resulting from the injuries, and any safety measures taken by the employer as a result of the injuries. This information shall be explicitly considered in determining whether an employer should receive the workplace safety credit.

(3) Notwithstanding paragraph (1) of this subsection, the Department of Insurance shall permit insurance carriers issuing workers compensation insurance in Delaware to submit their own workplace safety inspection procedures for review by the Department. If the Department certifies that an insurer's workplace safety inspection procedures are at least as rigorous as those employed by the Department and its independent safety expert, the Department shall permit that insurer's inspection to satisfy the inspection requirements of paragraph (1). The Department may require insurers to have their safety inspection procedures re-certified on a bi-annual basis to maintain status as an acceptable substitute for the inspection described in paragraph (1).

(4) Beginning on September 1, 2013, each workplace safety inspection conducted pursuant to paragraphs (1) or (3) shall include a determination as to whether the employer has complied with its obligations under Section 2322E(d) of this Title to provide a list of possible b assignments for injured workers. Failure to comply with the requirements of Section 2322E(d) shall disqualify an employer from receiving the workplace safety credit. The period of review shall extend back to July 1, 2013, and beginning on July 1, 2016 shall be limited to a period of three years prior to the date of application for the workplace safety credit.

~~(5)~~ (5) The cost of each inspection will be borne by the employer. The minimum charge for safety inspection is \$150 per location. This amount can be adjusted by the Insurance Commissioner by regulation. Each work location must successfully pass both inspections before an employer is entitled to a premium credit under the program. Inspection fees for large and/or complex employers may be established by the Department of Insurance.

Section 6. Amend §318, Title 18 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§318. Examination of insurers.

(a) The Commissioner or any of the Commissioner's examiners may conduct an examination under this section of any company as often as the Commissioner in the Commissioner's sole discretion deems appropriate, but shall, at a minimum, conduct an examination of every insurer licensed in this State but not less frequently than every 5 years. In scheduling and determining the nature, scope and frequency of the examinations, the Commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the Examiner's Handbook adopted by the National Association of Insurance Commissioners and in effect when the Commissioner exercises discretion under this section. Examination of an alien insurer shall be limited to its insurance transactions, assets, trust deposits and affairs in the United States except as otherwise required by the Commissioner.

(b) The Commissioner shall examine, in like manner, each insurer applying for an initial certificate of authority to transact insurance in this State.

(c) In lieu of making an examination, the Commissioner may accept, in the Commissioner's discretion, a full report of the most recent examination of a foreign or alien insurer, certified to by the insurance supervisory official of another state.

(d) As far as practical, the examination of a foreign or alien insurer shall be made in cooperation with the insurance supervisory officials of other states in which the insurer transacts business.

(e) In lieu of an examination under this section of any foreign or alien insurer licensed in this State, the Commissioner may accept an examination report on such company as prepared by the insurance department for the company's state of domicile or port-of-entry state, so long as:

(1) The insurance department, at the time of the examination, was accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or

(2) The examination is performed under the supervision of an accredited insurance department, or with the participation of 1 or more examiners, who are employed by such an accredited state insurance department, and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(f) The Commissioner shall also conduct examinations as required by Title 18, Section 2301E of this Code.

Section 7. Amend §2610, Title 18 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows

§2610. Review of insurance filings.

(a) The Commissioner shall investigate and review each insurance filing under the following guidelines:

(1) The effective date of each workers' compensation insurance filing shall be the date specified in the filing. The effective date of the filing may not be earlier than 30 days after the date the filing is received by the Commissioner or the date of receipt of the information furnished in support of the filing if such supporting information is required by the Commissioner.

(2) Upon written application of the insurer or advisory organization, the Commissioner may authorize a filing, which the Commissioner has reviewed, to become effective before the expiration of the period described in paragraph (1) of this subsection.

(3) A filing shall be deemed to meet the requirements of this chapter unless disapproved by the Commissioner within the period described in paragraph (1) of this subsection or any extension thereof.

(b) Subject to subsection (a) of this section, a workers' compensation advisory organization shall file with the Commissioner:

(1) Workers' compensation rates and rating plans that are limited to prospective loss costs;

(2) Each workers' compensation policy form to be used by its members;

(3) The uniform classification plan and rules;

(4) The uniform experience rating plan and rules; and

(5) Any other information that the Commissioner requests and is otherwise entitled to receive under this chapter.

(c) Whenever a filing is not accompanied by the information required under this section, the Commissioner shall so inform the filer within 10 days of the initial filing. The filing shall be deemed to be made when the required information is furnished or when the filer certifies to the Commissioner that the additional information requested by the Commissioner is not maintained or cannot be provided.

(d) If each rate in a schedule of workers' compensation rates for specific classifications of risks filed by an insurer is not lower than the prospective loss costs contained in the schedule of workers' compensation rates for those classifications filed by an advisory organization under subsection (b) of this section, and approved by the Commissioner, then the schedule of rates filed by the insurer shall not be subject to subsection (a) of this section but shall become effective upon filing for the purposes of § 2609 of this title.

(e) Upon the filing of any application by a workers compensation advisory organization with the Commissioner relating to rates or prospective loss costs, the Commissioner shall, with the consent of the Attorney General, retain a member of the Delaware bar to represent the interests of Delaware workers compensation rate-payers during the Commissioner's consideration of the application (the "ratepayer advocate"). The cost of the

ratepayer advocate shall be borne by the advisory organization. It is the expectation of the General Assembly that \$40,000 should be sufficient to adequately compensate the ratepayer advocate for his or her services during the course of an application (including any appeals), and compensation for the ratepayer advocate is limited to this amount, which may be adjusted by the Attorney General for inflation on an annual basis.

(f) Applications by a workers compensation advisory organization relating to rates or prospective loss costs shall be subject to the case decision provisions of Title 29, Chapter 101, Subchapter III of the Delaware Code, and the ratepayer advocate shall be considered a party to the case. The Department of Insurance shall promulgate regulations within 60 days to ensure that the ratepayer advocate has adequate time and means to properly participate in the hearing required by Title 29, Chapter 101, Subchapter III. The advisory organization may, but need not be, represented by counsel in this proceeding.

(g) The ratepayer advocate shall select an actuary to work with him or her and testify in the rate-setting proceeding outlined in subsections (e) and (f). The cost of this actuary shall be borne by the advisory organization. It is the expectation of the General Assembly that any other actuaries used by the Department of Insurance during the rate-setting process outlined in subsections (e) and (f) shall be paid for by the Department of Insurance.

Section 8. The advisory organization designated by the Department of Insurance pursuant to Title 18, Section 2607 of the Delaware Code shall, within 90 days of enactment of this Act, file for approval by the Commissioner prospective loss costs that shall explicitly and individually account for the impact of any statutory changes in this Act or Senate Bill 238 of the 146th General Assembly, as well as any regulatory changes proposed by the Health Care Advisory Panel within 60 days of the enactment of this Act. Any order issued by the Department of Insurance relating to said filing shall explicitly account for all statutory changes and regulatory proposals that are enumerated by the advisory organization in the filing required by this Section.

Section 9. The Workers Compensation Task Force created by House Joint Resolution No. 3 of the 147th General Assembly shall remain in existence through June 30, 2014 and shall make such recommendations from time to time as it deems helpful to the Governor and General Assembly. The task force shall continue its practices of allowing public comment at all meetings, and posting all data it considers and audio recordings of its meetings on a web site. In addition to the 19 current members of the task force, the Governor shall appoint one insurance agent or broker licensed in Delaware, one physical therapist, and one chiropractor to the task force. The Governor may ask relevant professional associations for recommendations with respect to the aforementioned appointments.

Approved June 27, 2013