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HOUSE OF REPRESENTATIVES
147th GENERAL ASSEMBLY

HOUSE BILL NO. 373

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

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

Section 1. Amend Chapter 26, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 2610 Review of insurance filings.

(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~~ Workers' Compensation Oversight Panel authorized in Title 19 of the Delaware Code 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. The Department of Labor shall provide staff support for the Workers' Compensation Oversight Panel in carrying out this responsibility.

(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, 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) of this section. 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) of this section shall be paid for by the Department of Insurance.

Section 2. Amend Chapter 23, Title 19 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

~~§ 2301E 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, provide objective information to guide policy formulation, and identify carrier-specific cost drivers.~~

~~(b) The Insurance Commissioner shall appoint a 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 2 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 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.~~

~~(d) The Insurance Commissioner, with the advice of the 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 § 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 12 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 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.~~

~~§ 2322A Health Care Advisory Panel.~~

~~(a) The General Assembly recognizes that issues related to health care in workers' compensation require the expertise of the medical community and other health care professionals for resolution. A Health Care Advisory Panel is hereby established. The purpose of the Health Care Advisory Panel shall be to carry out the provisions of this chapter, with a diversity of perspectives, on matters relating to the provision of health care to employees pursuant to this chapter.~~

~~(b) Membership; terms. — The Health Care Advisory Panel shall consist of 17 members. All members shall be appointed by the Governor by and with the consent of the Senate. As provided below, a majority of members shall be health care providers or representatives of providers. Members shall be appointed for a term of up to 3 years and may be re-appointed. Terms of members shall be staggered so that less than half of the members' terms expire in any 1 year. Members shall receive no compensation.~~

~~(c) Representation. — The Health Care Advisory Panel shall include: 1 representative of insurance carriers providing coverage pursuant to this chapter; 1 representative of employers; 1 representative of employees; 2 attorneys licensed to practice law, 1 who regularly represents employees and 1 who regularly represents employers in matters arising under this chapter; 3 public members; and 9 provider members. A public member: may not be nor may ever have been certified, licensed, or registered in any health-related field; may not be the spouse of someone certified, licensed, or registered in any health-related field; at the time of appointment may not be a member of the immediate family of someone certified, licensed, or registered in any health-related field; may not be employed by a company engaged in a directly health-related business; and may not have a material financial interest in providing goods or services to persons engaged in the practice of medicine. The 9 provider members appointed to the Health Care Advisory Panel shall include a diverse group of health care~~

~~providers (or provider representatives) who are most representative of those providing medical care to employees pursuant to this chapter. The provider members shall include representatives nominated by the following professional societies or associations:~~

~~(1) Four representatives of the Medical Society of Delaware (including 1 in the field of primary care, 1 in the field of neurosurgery, 1 in the field of occupational medicine and 1 at large representative);~~

~~(2) One representative of the Delaware Society of Orthopaedic Surgeons;~~

~~(3) One representative of the Delaware Academy of Physical Medicine and Rehabilitation;~~

~~(4) One representative of the Delaware Healthcare Association;~~

~~(5) One representative of the Delaware Chiropractic Association; and~~

~~(6) One representative of the Delaware Physical Therapy Association.~~

~~One member may represent more than 1 category. In addition to their ability to represent the perspective of their profession, provider members shall be selected for their ability to represent the interests of the community at large. The Department of Labor, Office of Workers' Compensation shall provide at least 1 nonvoting staff to assist the Panel in its work.~~

~~(d) Any person appointed to fill a vacancy on the Health Care Advisory Panel shall serve for the remainder of the unexpired term of the former member and shall be eligible for reappointment.~~

~~(e) Regular attendance is vital to the purposes of the Health Care Advisory Panel. Members shall accept the duty and obligation to attend meetings. Repeated absences shall be grounds for removal from the Panel at the discretion of the Governor.~~

~~(f) A Chair and Vice Chair shall be elected by a majority of members of the Health Care Advisory Panel for terms of 1 year. The Chair and/or Vice Chair may be replaced at any time by a majority vote of members of the Health Care Advisory Panel. The Chair and Vice Chair of the Health Care Advisory Panel shall set an agenda for each meeting, shall preside at meetings, and shall forward recommendations, opinions and other communications of the Health Care Advisory Panel to the Governor and General Assembly.~~

~~(g) The Health Care Advisory Panel is authorized to appoint by majority vote such committees as it may deem appropriate and to define the powers duties and responsibilities of such committees. Such committees may include persons who are not regular members of the Health Care Advisory Panel.~~

~~(h) Order of business and schedule of meetings. — Meetings of the Health Care Advisory Panel shall be held at least 4 times annually and shall be scheduled by the Chair. Agendas for meetings shall be developed by the Chair and/or Vice-Chair of the Panel. Any member wishing to include an item on the agenda has the responsibility to draft and present the agenda item to the Chair for approval and inclusion. An agenda shall be distributed by the Office of Workers'~~

~~Compensation to members at least 14 days prior to the next meeting. Staff from Office of Workers' Compensation shall record all meeting proceedings and prepare minutes for approval by the Health Care Advisory Panel prior to the next meeting. The Health Care Advisory Panel is authorized to adopt by majority vote bylaws and other procedures for meetings not inconsistent with this chapter. For any matter considered by the Health Care Advisory Panel that does not have unanimous approval, members shall be authorized to issue minority reports. Neither the Health Care Advisory Panel nor any committee thereof shall be subject to the provisions of Chapter 100 of Title 29.~~

~~(i) Quorum and voting. — Administrative decisions, including the election of officers, recommendations to remove a member, or the adoption or amendment of bylaws, shall be effective upon approval by a majority of all members of the Health Care Advisory Panel. All other matters shall be subject to approval for by a majority of persons present at a duly constituted meeting consisting of at least a quorum of members. A quorum of at least 9 members, at least 5 of whom shall be provider representatives referred to in subsection (c) of this section above.~~

§ 2322A Workers' Compensation Oversight Panel

(a) Membership; terms. — The Workers' Compensation Oversight Panel shall consist of 23 members. Members serving by virtue of position may appoint a designee to serve at their pleasure in their stead. The Governor shall appoint the 12 non provider members who are not serving by virtue of position. The Governor appointed members shall be appointed for a term up to 3 years to allow that no more than 4 Governor appointed members' terms shall expire in any year. The provider members shall be appointed by the appointing authority and for a term of 3 years.

(b) Representation. — The Workers' Compensation Oversight Panel shall include: 2 representatives of insurance carriers providing coverage pursuant to this chapter; 2 representatives of employers; 2 representatives of employees; 2 attorneys licensed to practice law, 1 who regularly represents employees and 1 who regularly represents employers in matters arising under this chapter; the Secretary of Labor; the Insurance Commissioner; 4 public members; and 9 provider members. A public member: may not be nor may ever have been certified, licensed, or registered in any health-related field; may not be the spouse of someone certified, licensed, or registered in any health-related field; at the time of appointment may not be a member of the immediate family of someone certified, licensed, or registered in any health-related field; may not be employed by a company engaged in a directly health-related business; and may not have a material financial interest in providing goods or services to persons engaged in the practice of medicine. The 9 provider members appointed to the Workers' Compensation Oversight Panel shall include a diverse group of health care providers (or provider representatives) who are most representative of those providing medical care to employees pursuant to this chapter. The provider members shall consist of the following:

(1) the President of the Medical Society of Delaware shall appoint 4 Delaware licensed physicians which shall include 1 in the field of primary care, 1 in the field of neurosurgery, and 2 at large representatives;

(2) the President of the Delaware Society of Orthopaedic Surgeons shall appoint a Delaware licensed Orthopedic surgeon;

(3) the President of the Delaware Academy of Physical Medicine and Rehabilitation shall appoint one representative;

(4) the President of the Delaware Healthcare Association shall appoint one representative;

(5) the President of the Delaware Chiropractic Association shall appoint a Delaware licensed Chiropractor; and

(6) the President of the Delaware Physical Therapy Association shall appoint a Delaware licensed Physical Therapist.

In addition to their ability to represent the perspective of their profession, provider members shall be selected for their ability to represent the interests of the community at large. The Department of Labor, Office of Workers' Compensation shall provide staff support to the Panel.

(c) Members of the former Health Care Advisory Panel shall, absent contrary action by the Governor, serve the remainder of their terms for which they were appointed to the Health Care Advisory Panel as members of the Workers Compensation Oversight Panel.

(d) A Chair and Vice Chair shall be selected by the Governor. The Chair and Vice Chair of the Workers' Compensation Advisory Panel shall set an agenda for each meeting, shall preside at meetings, and shall forward recommendations, opinions and other communications of the Panel to the Governor and General Assembly.

(e) Data Collection. It is the intent of the General Assembly that, among its other duties, the Workers' Compensation Oversight Panel be provided with data enabling it to conduct studies to evaluate the workers' compensation system in the State of Delaware, identify systemic cost drivers, provide objective information to guide policy formulation and identify carrier specific cost drivers. To that end, the Panel is authorized to collect 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. The Panel is also charged with ensuring compliance by individual carriers with their responsibilities relating to medical cost control. On at least a quarterly basis, the Insurance Commissioner shall collect and provide to the Panel data sufficient for the Panel to carry out the duties described in this subsection. In addition, the Panel or its designee shall have the authority to demand directly from any person or entity providing health care services under this Chapter data sufficient for the Panel to carry out the duties described in this subsection. The advisory organization designated pursuant to 18 Del.C. § 2607 shall also on an annual basis provide the Panel with carrier-specific

medical cost data for each workers' compensation carrier having a market share in Delaware of 1% or greater over the 12 preceding months. If, after reviewing said data and making necessary inquiries with individual carriers, the Panel determines that there is a well-founded concern that an individual carrier is not sufficiently scrutinizing medical payments, the Panel may direct the Insurance Commissioner to conduct a formal examination of a carrier to determine compliance with applicable laws and regulations regarding medical reimbursements. The Department of Insurance may exercise its authority granted under Title 18 to address legitimate competitive, trade secret, or health privacy concerns that arise in connection with its responsibilities under this section, provided that the Department's exercise of this authority shall not interfere with the Panel's ability to fulfill its statutory obligations. The Secretary of Labor shall have authority to address legitimate competitive, trade secret, or health privacy concerns that arise in connection with the Panel's collection of data directly from persons or entities providing health care services under this Chapter, provided that the Secretary's exercise of this authority shall not interfere with the Panel's ability to fulfill its statutory obligations.

~~§ 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://odia.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)a. 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 paragraphs (3)d. and e. of this section in subsequent years.~~

~~b. On a 1-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 paragraphs (3)d. and e. of this section in subsequent years.~~

~~c. For procedures, treatments, and services not covered by paragraph (3)a. or b. of this section or other provisions of this chapter, the Health Care Advisory Panel may recommend an alternative payment system.~~

~~d. 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.~~

~~e. 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 paragraph (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.~~

(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, as published by the United States Bureau of Labor Statistics (CPI-U), each hospital's reimbursement rate shall be reduced by the difference between such blended rate and the CPI-U. If the arithmetic average of the blended rate for the hospitals submitting reports to the DHA pursuant to this paragraph is less than the CPI-U, each hospital's reimbursement rate shall be increased by the difference between such blended rate and the CPI-U. 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 changes 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 (9)a. and b. of this section 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.~~

~~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, 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 nonphysician 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 paragraphs (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. 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. 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 nonclinical 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.~~

~~76 Del. Laws, c. 1, § 11; 76 Del. Laws, c. 143, §§ 1, 2; 77 Del. Laws, c. 94, §§ 1-4; 78 Del. Laws, c. 186, § 1; 78 Del. Laws, c. 391, § 1; 79 Del. Laws, c. 55, § 2.;~~

§ 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 to reduce overall medical expenditures for the treatment of workers' compensation related injuries by 33% by January 31, 2017, and to reduce said expenditures by 20% by January 31, 2015.

(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://odia.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) The maximum allowable payment for health care related payments covered under this chapter shall be the lesser of the health care provider's actual charges or the fee set by the payment system.

(a) The Workers' Compensation Oversight Panel shall, by October 1, 2014, establish a fee schedule for all Delaware workers' compensation funded procedures, treatments, and services based on the Resource Based Relative Value Scale ("RBRVS"), Medical Severity Diagnosis Related Group (MS-DRG), Ambulatory Payment Classification (APC), or equivalent scale used by the Centers for Medicare and Medicaid Services. The RBRVS, MS-DRG, APC, or other equivalent factor shall be multiplied by a Delaware specific geographically adjusted factor to ensure adequate participation by providers. The fee schedule shall result in a reduction of 20% in aggregate workers compensation medical expenses in the year beginning January 31, 2015, an additional reduction of 5% of current expenses by the year beginning January 31, 2016, and an additional reduction of 8% of current expenses by the year beginning January 31, 2017.

(b) In addition, by January 31, 2017, no individual procedure in Delaware paid for through the workers' compensation system (as identified by HCPCS level 1 or level 2 code) shall be reimbursed at a rate greater than 200% of that reimbursed by the federal Medicare system, provided that radiology services may be reimbursed at up to 250% of the federal Medicare reimbursement and surgery services may be reimbursed at up to 300% of the federal Medicare reimbursement.

(c) The Workers' Compensation Oversight Panel shall report to the Governor and General Assembly by January 31, 2016 with respect to medical savings recognized as a result of this paragraph (3) and possible unforeseen consequences of the procedure-specific caps required by subparagraphs (3)(b) and (5), and the General Assembly may at that time reconsider the specific percentage caps required by subparagraphs (3)(b) and (5). The cost reductions required by subparagraph (3)(a) shall be permanent, with the exception of inflation increases beginning in 2018 as permitted by paragraph 5 of this section.

(4) An independent actuary appointed by the Secretary of Labor shall verify for the Secretary that the fee schedule developed by the Workers Compensation Oversight Panel under paragraph (3) of this section complies with its requirements. If the fee schedule does not comply with its requirements, or is not completed by October 1, 2014, the Secretary of Labor shall promulgate a fee schedule meeting the requirements of paragraph (3) by regulation.

(5) Beginning on January 1, 2018, 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. Notwithstanding the annual CPI-Urban increase permitted by this paragraph, no individual procedure in Delaware paid for through the workers' compensation system (as identified by HCPCS level 1 or level 2 code) shall be reimbursed at a rate greater than 200% of that reimbursed by the federal Medicare system, provided that radiology services may be reimbursed at up to 250% of the federal Medicare reimbursement and surgery services may be reimbursed at up to 300% of the federal Medicare reimbursement. The Workers Compensation Oversight Panel may, without consent of the General Assembly and Governor, reduce reimbursements for any procedures it deems appropriate, but cannot increase reimbursements beyond the amounts permitted by this Chapter.

(6) 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.

(7) 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.

(8) 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 Workers' Compensation Oversight Panel, and adopted as part of the health care payment system. Such fees shall be revised periodically on the recommendation of the 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 nonclinical 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.

§ 2322C Development of health care practice guidelines.

Health care practice guidelines shall be developed in accordance with the following provisions:

(1) The ~~Health Care Advisory Panel~~ Workers' Compensation Oversight Panel shall adopt, ~~and~~ recommend and maintain a coordinated set of health care practice guidelines and associated procedures to guide utilization of health care treatments in workers' compensation, including but not limited to care provided for the treatment of employees by or under the supervision of a licensed health care provider, prescription drug utilization, inpatient hospitalization and length of stay, diagnostic testing, physical therapy, chiropractic care and palliative care. ~~The health care practice guidelines shall apply to all treatments provided after the effective date of the regulation referred to in paragraph (7) of this section, regardless of the date of injury.~~

(2) The guidelines shall be, to the extent permitted by the most current medical science or other applicable science, based on well-documented scientific research concerning efficacious treatment for injuries and occupational disease. To the extent that well-documented scientific research concerning efficacious treatment is not available at the time of adoption or

revision of the guidelines, the guidelines shall be based upon the best available information concerning national consensus regarding best health care practices in the relevant health care community.

(3) The guidelines shall, to the extent practical consistent with this section, address treatment of those physical conditions which occur with the greatest frequency (for services compensable under this chapter), or which require the most expensive treatments (for services compensable under this chapter), based upon currently available Delaware data.

(4) The guidelines shall contain a section guiding the utilization of prescription medications.

(5) ~~The original~~ health care practice guidelines may be based upon an existing model, already in use, to guide treatment of medical care for workers' compensation. Additional guidelines may be initially adopted, pursuant to the same criteria, to obtain coverage of areas or issues of treatment not included in other adopted guidelines. In no event shall multiple guidelines covering the same aspects of the same medical condition be simultaneously in force.

(6) Services rendered by any health care provider certified to provide treatment services for employees shall be presumed, in the absence of contrary evidence, to be reasonable and necessary if such services conform to the most current version of the Delaware health care practice guidelines. Services provided by health care providers that are not certified shall not be presumed reasonable and necessary unless such services are preauthorized by the employer or insurance carrier, subject to the exception set forth in § 2322D(b) of this title. It is intended that these guidelines will be ~~produced~~ recommended to the Panel by ~~Health Care Advisory Panel~~ Panel subcommittees in coordination with a qualified contractor with expertise in establishing treatment guidelines, developing the rules that define the use of such guidelines, and disseminating the guidelines in a manner that streamlines the delivery of health care.

(7) ~~Subject to the foregoing provisions, after receiving the approval and recommendation of the Health Care Advisory Panel, the guidelines shall be adopted by regulation of the Department of Labor pursuant to Chapter 101 of Title 29. Such regulations shall be adopted and effective not later than 1 year after the first meeting of the Health Care Advisory Panel.~~ Health care practice guidelines shall be subject to review and revision by the ~~Health Care Advisory Panel~~ Workers' Compensation Oversight Panel on at least an annual basis. It is the intent of the General Assembly that the development of health care guidelines will be ~~directed~~ recommended by a predominantly medical or other health professional ~~panel~~ subcommittee, recognizing that health care professionals are best equipped to determine appropriate treatment. It is further intended that subcommittees comprised of representatives from appropriate specialties will make comment and offer recommendations to the Health Care Advisory Panel.

§ 2322D Certification of health care providers.

(a)(1) Certification shall be required for a health care provider to provide treatment to an employee, pursuant to this chapter, without the requirement that the health care provider first preauthorize each health care procedure,

office visit or health care service to be provided to the employee with the employer or insurance carrier. The provisions of this subsection shall apply to all treatments to employees provided after the effective date of the rule provided by subsection (c) of this section, regardless of the date of injury. A health care provider shall be certified only upon meeting the following minimum certification requirements:

a. Have a current license to practice, as applicable;

b. Meet other general certification requirements for the specific provider type;

c. Possess a current and valid Drug Enforcement Agency ("DEA") registration, unless not required by the provider's discipline and scope of practice;

d. Have no previous involuntary termination from participation in Medicare, Medicaid or the Delaware workers' compensation system, which shall be determined to be inconsistent with certification under regulations adopted pursuant to subsection (c) of this section;

e. Have no felony convictions in any jurisdiction, under a federal-controlled substance act or for an act involving dishonesty, fraud or misrepresentation, which shall be determined to be inconsistent with certification under regulations adopted pursuant to subsection (c) of this section; and

f. Provide proof of adequate, current professional malpractice and liability insurance.

(2) The certification rules shall require that any health care provider to be certified agree to the following terms and conditions:

a. Compliance with Delaware workers' compensation laws and rules;

b. Maintenance of acceptable malpractice coverage;

c. Completion of State-approved continuing education courses in workers' compensation care every 2 years;

d. Practice in a best-practices environment, complying with practice guidelines and Utilization Review Accreditation Council ("URAC") utilization review determinations;

e. Agreement to bill only for services and items performed or provided, and medically necessary, cost-effective and related to the claim or allowed condition;

f. Agreement to inform an employee of that employee's liability for payment of noncovered services prior to delivery;

g. Acceptance of reimbursement and not unbundled charges into separate procedure codes when a single procedure code is more appropriate; and

h. Agreement not to balance bill any employee or employer. Employees shall not be required to contribute a copayment or meet any deductibles.

(b) Notwithstanding the provisions of this section, any health care provider may provide services during 1 office visit, or other single instance of treatment, without first having obtained prior authorization, and receive reimbursement for reasonable and necessary services directly related to the employee's injury or condition at the health care provider's usual and customary fee, or the maximum allowable fee pursuant to the workers' compensation health care payment system adopted pursuant to § 2322B of this title, whichever is less. The provisions of this subsection are limited to the occasion of the employee's first contact with any health care provider for treatment of the injury, and further limited to instances when the health care provider believes in good faith, after inquiry, that the injury or occupational disease was suffered in the course of the employee's employment. The provisions of this subsection shall apply to all treatments to injured employees provided after the effective date of the rule provided by subsection (c) of this section, regardless of the date of injury.

(c) Subject to the foregoing provisions, complete rules and regulations relating to provider certification shall be approved and proposed by the ~~Health Care Advisory Panel~~ Workers Compensation Oversight Panel. ~~Thereafter, such regulations~~ Regulations arising from the Panel's work shall be adopted by regulation of the Department of Labor pursuant to Chapter 101 of Title 29. ~~Such regulations shall be adopted and effective not later than 1 year after the first meeting of the Health Care Advisory Panel.~~

§ 2322E Development of consistent forms for health care providers.

(a) The ~~Health Care Advisory Panel~~ Workers' Compensation Oversight Panel is authorized and directed to approve ~~and~~ propose and maintain standard forms for the provision of health care services pursuant to this chapter. Upon ~~such~~ recommendation by the Workers' Compensation Oversight Panel, such forms and provisions governing their use shall be adopted by regulation of the Department of Labor, pursuant to Chapter 101 of Title 29. ~~Such regulations shall be adopted and effective not later than 180 days after the first meeting of the Health Care Advisory Panel.~~ Forms authorized by this section shall provide for prompt initial report of an employee's condition upon the initial occurrence of injury treated pursuant to this chapter and upon reasonable intervals thereafter to report the conditions and limitations of an employee. At a minimum the initial reporting form shall provide for an outline of the physical capabilities of the employee in order to enable and encourage the injured employee to return to work at the highest level of capability.

(b) The health care provider most responsible for the treatment of the employee's work-related injury shall complete and submit, as expeditiously as possible and not later than 10 days after the date of first evaluation or treatment, a report of employee condition and limitations, on a form adopted for that purpose pursuant to this section, and shall expeditiously provide copies of the report of employee condition and limitations to the employee, the employer and the employer's

insurance carrier, if applicable. In the event that an employee is treated and released from the emergency department of a hospital, the health care provider most responsible for follow up care, if applicable, or the emergency room attending physician, shall provide the report of employee condition and limitations to the employee upon release, and the employee shall be responsible for provision of the report to the employer and the employer's insurance carrier, if applicable, within the time period provided by the rules adopted pursuant to this section.

(c) Every health care provider shall prepare supplemental reports of employee condition and limitations on forms prescribed pursuant to this section, and shall expeditiously provide copies of the report of employee condition and limitations to the employee, the employer and the employer's insurance carrier, if applicable.

(d) Within 14 days of 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 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.

(e) Fees for completion, copying and transmission of the forms shall be ~~developed~~ maintained by the ~~Health Care Advisory Panel~~ Workers' Compensation Oversight Panel. The employer or the employer's insurance carrier shall be liable for payment of the fee for all such reports of employee condition and limitations, provided however, that the employer or insurance carrier shall not be liable for any such reports, requested by an employee more frequently than once during each 3-month period.

§ 2322F Billing and payment for health care services.

(j) Utilization review. — The ~~Health Care Advisory Panel~~ Workers Compensation Oversight Panel shall ~~develop~~ approve, propose and maintain a utilization review program. The intent is to provide reference for employers, insurance carriers, and health care providers for evaluation of health care and charges. The intended purpose of utilization review services shall be the prompt resolution of issues related to treatment and/or compliance with the health care payment system or practice guidelines for those claims which have been acknowledged to be compensable. An employer or insurance carrier may engage in utilization review to evaluate the quality, reasonableness and/or necessity of proposed or provided health care services for acknowledged compensable claims. Any person conducting a utilization review program for workers' compensation shall be required to contract with the Office of Workers' Compensation once every 2 years and

certify compliance with Workers' Compensation Utilization Management Standards or Health Utilization Management Standards of Utilization Review Accreditation Council ("URAC") sufficient to achieve URAC accreditation or submit evidence of accreditation by URAC. If a party disagrees with the findings following utilization review, a petition may be filed with the Industrial Accident Board for de novo review. Complete rules and regulations relating to utilization review shall be ~~approved and recommended~~ approved, proposed and maintained by the ~~Health Care Advisory Panel~~ Workers' Compensation Oversight Panel. ~~Thereafter, such rules~~ Rules recommended by the Panel shall be adopted by regulation of the Department of Labor pursuant to Chapter 101 of Title 29. ~~Such regulations shall be adopted and effective not later than 1 year after the first meeting of the Health Care Advisory Panel.~~

Section 3. 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. Any order issued by the Department of Insurance relating to said filing shall explicitly account for all statutory changes that are enumerated by the advisory organization in the filing required by this Section.

SYNOPSIS

This Act makes substantial changes to Titles 18 and 19 of the Delaware Code designed to control the level of workers' compensation premiums in Delaware. The most significant changes are (a) a 33% reduction in medical costs to the workers' compensation system, phased in over a period of three years; (b) absolute caps, expressed as a percentage of Medicare per-procedure reimbursements, on all workers' compensation medical procedures beginning on January 1, 2017; and (c) increased independence for the Ratepayer Advocate who represents ratepayers during the workers compensation rate approval process and for the committee that oversees the cost control practices of individual workers compensation insurance carriers.