WORKERS COMPENSATION TASK FORCE REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY OF THE STATE OF DELAWARE

Submitted pursuant to House Joint Resolution No. 3, 147th General Assembly

The Workers Compensation Task Force was created on January 30, 2013 by the Delaware General Assembly and the Governor, and charged with an expedited review of Delaware law relating to workers compensation, the impact that the 2007 amendments to that law had upon workers compensation premiums, the reasons for recent increases in workers compensation premiums, and whether any additional changes to statutes, regulations, or practices are required to control growth in premiums.[1] The reason for the creation of the task force was to address the dramatic increase in Delaware's workers compensation premiums over the past two years, after four consecutive years of decreases that totaled over 40%. The task force was given just over three months to investigate, deliberate, and issue this report.

Process

The task force held its first meeting one week after its creation, on February 8, 2013. Meetings were held weekly, and were held via videoconference between Wilmington and Dover in order to maximize the opportunity for members of the public to attend. Time was allowed at the end of each meeting for members of the public to address the task force, and several members of the public took advantage of that opportunity. Members of the public also had the opportunity to present comments in writing to the task force. Audio recordings of each task force meeting and all printed materials reviewed by the task force were made available on the Lieutenant Governor's web site.

The task force is very grateful to members of the public for attending and participating in its meetings. Some of the recommendations in this report were the direct result of public comments made during the course of the task force's meetings.

House Joint Resolution No. 3 also gave the task force authority to direct the Delaware Compensation Rating Bureau, Inc. (DCRB) to submit factual information to the task force for consideration. The task force used this authority very aggressively, asking for and receiving hundreds of pages of narrative information and data from the DCRB which was helpful to the task force in reaching its decisions. All information received from DCRB is also posted on the Lieutenant Governor's web site.

Prior Reform Efforts

Delaware's workers compensation system has been the subject of two significant statutory reforms since 1997. The first such effort was the Workers Compensation Improvement Act of 1997, which was not the product of a concern over premium costs but rather a concern over delays in the delivery of benefits to injured workers. That reform effort resulted in an

1 House Joint Resolution No. 3, 147th General Assembly

expansion of the Office of Workers Compensation, the creation of hearing officers and workers compensation specialists, and an expedited hearing process.

Attention eventually turned to Delaware's high workers compensation premiums. According to the only national ranking of state workers compensation premiums, the Oregon Department of Consumer and Business Services Workers Compensation Premium Rate Ranking Report, Delaware's premiums had risen by calendar year 2006 to be the third most expensive in the country. The primary reason for Delaware's high premiums was generally agreed to be medical costs – the DCRB indicated that in 2006, medical costs were 60% of total workers compensation system costs in Delaware, as compared to 40% in surrounding states.

Two parallel reform efforts were initiated to address Delaware's high and escalating workers compensation premiums. First, the Department of Insurance (DOI) began a new process for analyzing the DCRB's annual request for 'loss cost' changes, which form the basis for rate change requests by all workers compensation carriers. The Department began using a second actuarial expert, demanding that the DCRB provide the Department's experts with a larger universe of supporting information and sufficient time to analyze it, and scheduled public hearings where DCRB representatives could be questioned about the assumptions underlying their rate increase requests. These changes resulted in a voluntary market rate freeze in December, 2006 (applying to voluntary market policies renewing in late 2006 and most of 2007), a 17.75% - 22% cut in average rates in 2007, and a cut of 15.16% - 16.46% in 2008.[2] The 2007 cut applied to policies renewing from December 1, 2007 to November 30, 2008; the 2008 cut applied to policies renewing from December 1, 2008 to November 30, 2009.

The second effort was a statutory reform effort led by Representative William Oberle and Senator Anthony DeLuca, with the assistance of Governor Ruth Ann Minner. Representative Oberle and Senator DeLuca convened a large group of stakeholders in the latter half of 2006, and the group produced a consensus workers compensation reform bill (Senate Bill 1) that was enacted into law almost immediately when the General Assembly convened in January 2007. These reforms resulted in an additional 11.57% rate reduction in 2008, along with four years of one-time reductions ranging from 5% to 6% of the 2008 rates.

Cumulatively, these regulatory and statutory reforms had a dramatic impact on Delaware's overall rates (which dropped by over 40%) and on its standing with respect to other states. From 2006 to 2010, Delaware had moved from having the nation's 3rd most expensive workers compensation premiums to having its 34th most expensive premiums. Rates continued to drop in the 2009 and 2010 loss cost filings, as indicated in the chart below.

2 For 2007, the lower percentage figure indicates the reduction in voluntary market loss costs, while the more negative numbers represent the reduction in residual market rates for companies that cannot locate coverage in the voluntary market. For 2008 the situation was reversed with the voluntary market having a larger reduction than the residual market. "Residual market" refers to the state's requirement that workers compensation carriers doing business in Delaware create a market where companies that cannot purchase coverage in the private market can buy workers compensation insurance.

Workers compensation rate changes since 2007 reform:

DATE	VOLUNTARY (Standard Policy Premiums)	RESIDUAL (Assigned Risk Premiums)
12/01/2007	↓ 17.75%	↓ 22.00%
10/01/2008	↓ 11.57%	↓ 11.57%
12/01/2008	↓ 16.46%	↓ 15.16%
12/01/2009	↓ 8.40%	↓ 9.17%
12/01/2010	↓ 2.51%	↓ 4.06%

However, in 2011 and 2012, loss cost ratios significantly increased. In addition, the four-year period of one-time rate reductions expired in connection with the 2012 filing. The Department of Insurance approved average voluntary market loss cost and residual market rate increases of 12.6% and 18.3% respectively in 2011. In 2012 the increases were 21.7% (voluntary market) and 26.1% (residual market).

DATE	VOLUNTARY (Standard Policy Premiums)	RESIDUAL (Assigned Risk Premiums)
12/01/2011	↑ 12.60%	↑ 18.30%
12/01/2012	↑ 21.70%	↑ 26.10%

This substantial increase in average workers compensation rates – some of which have yet to be seen by policyholders – prompted the Governor and General Assembly to ask this task force to undertake an expedited review of Delaware law relating to workers compensation, to determine the impact that the 2007 amendments to that law had upon workers compensation premiums, to look at the reasons for recent increases in workers compensation premiums, and to determine whether any additional changes to statutes, regulations, or practices are required to control growth in premiums.

The 2007 Statutory Amendments

The 2007 amendments to the Delaware Code covered a broad array of topics.

The General Assembly required the Department of Insurance to create an advisory committee that would "evaluate the workers compensation system in the State of Delaware, identify systemic cost drivers and provide objective information to guide policy formulation." The law also required the Department of Insurance to report annually to the Governor and General Assembly the progress of data collection efforts and information obtained from the analysis of the data collected.

The General Assembly also created a Health Care Advisory Panel (HCAP), which proposed a payment system later incorporated by the Department of Labor into a regulation. The system was required to establish payment rates, instructions, guidelines, and payment guides and policies regarding application of the payment system.

The initial permissible fees under the system set up by HCAP allowed fees of 90% of the 75th percentile of actual charges by providers at the time the system was initially set up in a given zip code. Yearly increases after that would correspond to the overall consumer price index (not the rate of medical inflation). When the system did not set a fee in this way, the allowed charge was simply 85% of the actual charge.

The system separated out ambulatory surgical treatment centers, anesthesia and related services, dental and related services, hospital care, and professional services. Non-emergency room hospital services and ambulatory surgical centers were to be reimbursed at 85% of actual 2006 charges (with an annual CPI inflation adjustment based upon the medical rate of inflation). HCAP was assigned to develop fee schedules for lab and pharmaceuticals that would result in a 15% cost savings from 2006 charges.

HCAP was also assigned by the new law to develop practice guidelines for the most common workplace injuries. Services provided by certified medical professionals to injured workers would be presumed reasonable if they conformed to these guidelines.

The General Assembly created a certification process for health care providers treating workers compensation recipients. Other than an initial office visit, any treatment by a non-certified doctor of a workers compensation recipient would need to be pre-authorized by the employer or insurance company.

The General Assembly also assigned HCAP to develop standardized forms for employers to use in reporting initial injuries and forms for health care professionals to use in describing an injured employee's injuries and work capabilities on a regular basis. Employers are also required to promptly provide to health care providers lists of modified-duty jobs for injured employees.

The General Assembly created a utilization review process for employers or insurers who wished to challenge compliance with treatment guidelines, charges, or other components of the workers compensation medical care system. However, the decisions of utilization review entities can be reviewed and reversed by the Industrial Accident Board.

The General Assembly specified the information and format required in billings from medical providers treating workers compensation patients, and required payment within 30 days of uncontested bills that complied with the required format.

The General Assembly revised the section of the code relating to contractors, subcontractors, and independent contractors to make it more difficult for entities to avoid the requirements of covering employees.

The General Assembly required greater disclosure by attorneys representing workers compensation claimants of the work performed in exchange for fees, and placed restrictions on the ability of attorneys representing claimants to deduct fees from workers compensation checks being issued to a claimant.

The General Assembly allowed employers to make "payments without prejudice" to injured workers so that workers would not need to wait until the final disposition of disputed claims to receive compensation or treatment.

Payments to Hospitals and Ambulatory Surgical Centers Revised in 2012

On June 2, 2012, a bill (Senate Bill 238) revising the rate at which hospitals and ambulatory surgical centers would be reimbursed for treating workers compensation recipients was introduced. It passed the General Assembly on June 30, 2012, was signed by the Governor, and took effect on January 31, 2013. S.B. 238 removed the provisions of the Delaware Code that required that hospital and ambulatory surgical centers be reimbursed at 85% of their actual charges for a given procedure in 2006, and, on January 31, 2013, replaced that requirement with one that they be reimbursed at 80% of their actual charges for a given procedure, adjusted for annual changes in the CPI for medical care. S.B. 238 also included emergency room charges within its scope. During the task force's meetings, the task force learned that hospitals had not been complying with the payment procedures set in 2007. The hospitals claimed that they could not comply with the 2007 statute because it imposed obligations that were inconsistent with federal Medicare rules and because of technology restrictions.

Impact of Past Statutory Revisions Upon Rates

As previously indicated, the 2007 amendments to the Delaware Code were immediately credited with an 11.57% rate reduction in 2008, along with four years of one-time reductions ranging from 5% to 6%. It had been anticipated that some provisions of the 2007 statute, such as the creation of treatment protocols for frequent injuries, would generate additional savings when they went into effect. It is possible that those changes played a role in the 2010 reductions in average rates, but it is impossible to determine that with certainty. Although the results of the

2012 statutory changes are not yet possible to trace since they went into effect on January 13, 2013, the DCRB indicated to the task force that it did not expect the 2012 changes to produce any initial reduction in residual market rates or voluntary market loss costs because prior rate applications had been based on the expectation that hospitals and ambulatory surgical centers were following the procedures required by the 2007 law, and it had turned out that was not the case.

Reasons for Recent Increases in Workers Compensation Premiums

The DCRB indicated during the task force's meetings that the primary basis for the 2012 increases in loss costs was an increase in the cost of medical care for workers compensation recipients. There was concern expressed by members of the Data Collection Committee that the DCRB had (a) initially suggested that the 2011 increases were primarily the result of a one-time increase in claim frequency concurrent with the 2009 economic crisis, and (b) failed to timely inform the Data Collection Committee of an upward trend in medical costs that would have allowed the Health Care Advisory Panel to promptly respond to that trend. The DCRB has observed that "in the last two filings claim frequency trend has become less favorable than the comparable levels for earlier DCRB filings (although claim frequency remains significantly negative)" and "DCRB's measurements of medical severity trends have increased successively in each of the last four filings."

Several members of the task force expressed concern at a perceived discrepancy between the actual rate of medical cost inflation indicated by statistics provided to the task force by DCRB, and the amount by which loss costs have increased. DCRB provided the task force with two years of medical cost data: July, 2010 through June, 2011 (Year 1), and July 2011 through June 2012 (Year 2). The difference in claims from Year 1 to Year 2 was statistically small, and by a variety of different measures, total workers compensation medical expenditures increased by under 7% from Year 1 to Year 2. (As a rough comparison, the national urban consumer price index for medical care increased by 3% in calendar year 2011 versus calendar year 2010.) Yet, as indicated above, the increased medical costs have resulted in average premium increases far in excess of 7%.

In addition to concern over whether the rate increases were justified by the actual increase in medical costs, the task force examined several subcategories of medical cost increases:

> In an effort to determine whether particular types of medical procedures were contributing disproportionately to increases in Delaware medical costs, the task force directed DCRB to identify specific procedures where the cost of performing the procedure had increased significantly or the frequency with which the procedure was performed had increased significantly. The DCRB provided this information in different formats, one of which described the increase in the percentage of total medical payments represented by particular procedures in Year 2 compared to Year 1. This analysis showed some procedures significantly increasing in number in Year 2, both in raw numbers and as a percentage of total treatments, most significantly (a) office/outpatient visits with physicians by established patients (from 8,026 in Year 1 to 9,446 in Year 2), (b) 15

minute therapeutic procedures including massage (from 4,442 to 6,038), (c) extra supplies and materials provided by physicians (from 3,259 to 4,366), (d) drug screens (from 2,227 to 3,213), (e) physical therapy (from 1,194 to 2,493), and (f) opiates (from 707 to 1,636). The next largest set of increases reported by DCRB come from a variety of prescription drug categories. These statistics are not a precise measure of whether these particular procedures are being over utilized; some of the increase could result from a change in the injuries suffered by claimants.

The task force also attempted to determine whether particular types of medical providers were charging larger sums than other providers for similar or identical procedures. The task force directed the DCRB to provide per-claim average payments for the 30 most frequent medical procedures, from each of the different types of providers that performed those procedures. The DCRB's report showed a marked variation in the charges.

(a) The most common procedure in workers compensation during the relevant time period is coded as "Therapeutic Procedure, 1 or More Areas, Each 15 Minutes: Therapeutic Exercises to Develop Strength and Endurance, Range of Motion and Flexibility." Provider billings for 15 minute increments ranged from $40.75 (managed care organizations) and $52.32 (physician assistants and advanced practice nurses) to $132.23 (agencies) and $100.81 (hospitals).
(b) The second most common procedure was "Manual Therapy Techniques (e.g. Mobilization/Manipulation, Manual Lymphatic Drainage, Manual Traction), 1 or More Regions, Each 15 Minutes." The per-procedure charges ranged from $30.32 (managed care organizations) and $42.28 (agencies) to $81.63 (hospitals) and $111.79 (hospital units).
(c) The third most common procedure was "Application of a Modality to 1 or More Areas: Hot or Cold Packs." The per-procedure charges ranged from $21.64 ("other) and $22.07 (chiropractors) to $34.48 (hospital units) and $42.47 (hospitals).

Finally, in a number of instances the task force was presented with facts suggesting some insurance carriers were not being sufficiently diligent with respect to enforcing medical costs controls that are already in place. Although the DCRB did not attempt to characterize the factual information it provided, the data indicated that annual medical cost increases varied significantly among its member carriers, that carriers had for a period of years been reimbursing hospitals and ambulatory surgical centers in a manner differently than that required by Delaware statute, and that reimbursements for procedures not listed on the state's fee schedule were being reimbursed at 85% of the medical provider's current charge (versus the amount permitted by statute, which is 85% of the 2006 charge with a CPI inflation increase).

In addition to medical reimbursements, several members of the task force expressed concerns that upward pressure on medical costs was being exerted by the failure of most employers to comply with provisions in the 2007 statute designed to encourage a prompt return to work by injured employees. In particular, task force representatives from the medical community noted that employers rarely filled out the form they are required to fill out by law which details work available in the employer's workplace that can be performed by an injured employee receiving

workers compensation benefits, based upon the employee's physical capabilities as determined by his or her doctor. Completion of this form had been considered a primary means of returning workers to the workplace by the authors of the 2007 statute.

Comparison of Delaware Workers Compensation Rates to Other States

Comparison of Delaware's workers compensation rates to other states' is inexact because of the time lag of comparative studies. The most recent state-by-state study conducted by the Oregon Department of Business and Consumer Services was published in October, 2012, based upon rate survey data from January, 2012. This study – which ranked Delaware's rates the third worst in America in 2006 – ranked Delaware as number 30 in America (with a lower number meaning lower premiums). Delaware slipped from 34th (in 2010) to 30th (in 2012) By comparison, New Jersey's rates are 7th worst in the United States, and Pennsylvania's are 12th worst (Pennsylvania's ranking has also worsened since 2010). During the same period Maryland's rates went from 42nd in 2010 to 34th in 2012.

In short, Delaware's workers compensation rates as a whole remain better than New Jersey or Pennsylvania, but Maryland's average rates remain lower than Delaware's. This is significant given that many Delaware companies must bid for work against companies located in Maryland. Additionally, because the most recent study does not reflect the substantial rate increase allowed in 2012, there is reason to be concerned that Delaware's standing with respect to other states will worsen when the 2014 study is published.

Recommendations

The task force has concluded that a number of statutory and regulatory changes are required in order to avoid significant future increases in workers compensation premiums. In making its specific recommendations, which are detailed below, the task force took the view that the 2007 statutory amendments and subsequent regulatory work done by the Health Care Advisory Panel had initially been effective in both controlling premiums and ensuring that injured workers continued to have prompt access to qualified doctors to treat their workplace injuries. Therefore, the task force's recommendations focus on revisions and improvements to the 2007 statute, not a wholesale rejection of that law and replacement of it with an entirely new system. However, if the task force's recommendations are implemented and do not result in manageable increases in workers compensation premiums, the task force believes that more significant changes should be considered both with respect to the levels and methods of paying medical claims, and the system for calculating injured workers permanency and lost wage claims.

In addition to the continued existence of the Data Collection Committee, which the task force is recommending be given broader authority to order examinations of specific insurers, and the Health Care Advisory Panel, the task force also recommends that its own existence be maintained. The purpose of maintaining the task force would be (a) to allow sufficient time to examine other potential savings in the workers compensation system that the task force was not able to investigate due to the limited time available for this report (including indemnity issues), and (b) to observe the outcome of its recommendations and consider more restrictive measures with respect to medical costs if the below recommendations do not have an adequate impact on premiums.

The task force's recommendations fall into four areas. Not all recommendations were unanimous, and task force members who disagreed with any of the task force's recommendations were permitted by House Joint Resolution 3 to submit separate statements with this report explaining their disagreement with specific recommendations. The DCRB, a member of the task force, abstained on all votes.

1. **PLACE TIGHTER CONTROLS ON WORKERS COMPENSATION MEDICAL COSTS**

Although the task force does not believe that it is yet necessary to take some of the extraordinary steps that other states have taken with respect to control of workers compensation medical reimbursements, the task force does believe that additional cost control measures should be added to those implemented in 2007.

Freeze all inflation increases for medical providers for a period of two years. Although the Delaware Code provides that the state's medical reimbursement fee schedule for workers compensation injuries, and the statutory formula for reimbursement of hospitals and ambulatory surgical centers, be adjusted each year for inflation, the task force recommends a two year freeze in inflation increases for all medical providers who currently receive one under state law.

Change the inflation index for hospital reimbursements from CPI-medical to CPI-urban. The 2007 workers compensation reforms allowed hospitals and ambulatory surgical centers to receive annual inflation increases based upon the medical consumer price index, rather than the non-medical consumer price index. The decision in 2007 to limit most providers to the non-medical CPI for their annual increases was a purposeful one by the General Assembly and Governor, designed to be a long-term control on workers compensation medical costs. For reasons of equity, and because hospital costs significantly exceed those of other providers for many of the most common workers compensation procedures, the task force believes that future hospital and ambulatory surgical center inflation increases after the two-year freeze expires should be limited to CPI-urban just as they are for all other medical providers.

Minimize the number of procedures that are reimbursed outside the state's fee schedule, and place all CPT and HCPCS codes, radiology and pathology/laboratory reimbursements on the fee schedule. The task force recommends that all medical procedures other than a trivial number which do not have "relative value units" be placed on the state's fee schedule. Previously, many procedures were not on the fee schedule, which allowed for those procedures to be reimbursed at 85% of their 2006 costs plus inflation. In addition, HCAP will place all radiology and pathology/laboratory reimbursements on the fee schedule.

Place ambulatory surgical center reimbursements on a fee schedule. The task force recommended that 19 Del.C. § 2322B(9), which governs reimbursement of ambulatory surgical centers, be amended to require the Health Care Advisory Panel to develop a fee schedule for ambulatory surgical centers in a manner similar to the process outlined in Sections 2322B(1) through 2322B(4) for doctors.

Place new price controls on the cost of pharmaceuticals used by workers compensation recipients. The Health Care Advisory Panel should recommend changing the pharmacy reimbursement for workers compensation patients from 100%AWP

(average wholesale price)/actual charge to a system where AWP is defined and reimbursement is AWP minus 12% for brand name drugs or 20% for generic drugs, plus a dispensing fee. HCAP will also recommend a ban on adding charges for repackaging and a ban on oxycontin use for patients who are not already receiving it, and will recommend adoption of the DMAP preferred drug list.

Place a new cap on the frequency and cost of drug testing. One of the most significant increases in utilization in recent years has been repeat drug tests ordered by doctors treating workers compensation patients. To place a reasonable control on these serial drug tests, HCAP should order a cap of four times per year absent pre-authorization from an insurer, banning confirmatory testing unless the point-of-care testing is not consistent with the prescriber's expectations based on the current prescription, and changing the allowed charge from 85% of current charge to a maximum of $100.

Revise downward the permitted number of therapy treatment visits for a workplace injury, and timely reconsider other treatment protocols for workers compensation recipients. Therapy treatments constitute one of the largest aggregate components of workers compensation medical costs, and as noted above, the number of workers compensation related therapy treatments between Year 1 and Year 2 increased significantly. For that reason, the task force recommends that HCAP revise downward the number of therapy treatments presumptively permitted for an injury to a workers compensation recipient. In addition, the task force recommends that HCAP timely complete a planned review of other existing medical procedures to determine whether additional revisions to treatment guidelines should be implemented.

Place a new cap on the reimbursement for anesthesia. The task force recommends that HCAP change the reimbursement formula for anesthesia from 85% of current charge to a flat fee, indexed for inflation.

Amend the Delaware Code to impose a time limitation on appeals of utilization review decisions. The Delaware Supreme Court recently invalidated a time limitation on appeals of utilization review decisions, because the time limitation had been established by regulation rather than by statute. The time limitation should be written into the Delaware Code, so that there is some level of finality to decisions about whether certain types of medical care have been over utilized.

2. **Ensure that insurance carriers' requests for rate increases receive a high level of scrutiny.**

As noted above, several task force members expressed concern about whether the rates ultimately approved for workers compensation insurance carriers were justified by the actual increases seen in medical costs, and relatedly, whether insurance carriers were overstating the amount that they needed to reserve in order to pay future claims. In addition, several task force members expressed frustration that some amount of rate increase appeared to be driven by the failure of individual insurance carriers to be sufficiently diligent about enforcing existing medical cost controls when paying claims. The following recommendations are targeted at ensuring that a high level of scrutiny is applied to rate increase requests by insurance carriers, both collectively and with respect to specific carriers that have unusually high medical cost increases.

Change Title 18, Section 2610 of the Delaware Code to require appointment by the Department of Insurance (DOI) of an attorney to represent ratepayers through the rate-setting process, with authority for the appointed attorney to retain an actuarial expert and demand additional data and other factual information from the applicant. By appointing an outside advocate for rate-payers and providing that advocate with adequate time, data, and expert assistance to prepare for a rate hearing, DOI can ensure that the hearing officer for any rate increase application will hear evidence of any excessive reserve requests or other unnecessary costs being sought by insurance carriers during the DCRB's annual rate filing. The task force contemplates that the outside advocate would be hired at a flat fee for a limited period of months, and that DOI would need only one actuary to analyze the rate filing rather than two if the outside advocate is using his or her own actuary. Costs would be borne by the applicant.

Require that both DCRB and DOI provide an estimate for the rate impact of each of the task force's recommendations (or, if no estimate can be provided, explain why no estimate can be provided), as part of the 2013 rate filing and analysis.

Require that both DCRB and the Insurance Department provide an estimated rate impact based on analysis of initial medical cost data resulting from implementation of Senate Bill 238, as part of the 2013 rate filing and analysis.

Require by statute that any rating bureau, as part of its annual lost cost filing with DOI, provide the Data Collection Committee with data indicating the total medical cost increases for each individual carrier with a 1% or greater share of the Delaware market whose losses are included in the data underlying the rate filing. The Data Collection Committee shall, in turn, direct DOI to conduct an examination of any carriers whose medical expenses are deemed by the Data Collection Committee to be so high as to warrant further examination. The purpose of this statutory change would be to identify those carriers who are not being sufficiently diligent about tracking frequency of treatment and complying with the requirements of the fee schedule.

Require that standing committees established to monitor and respond to changes in medical costs receive more frequent reports from insurance carriers and have the ability to properly analyze those reports. Specifically, the task force recommends that Title 19, Section 2301E of the Delaware Code be amended to require quarterly reporting by the relevant rating bureau of medical costs to the Data Collection Committee, and that the Data Collection Committee promptly share that data with the Health Care Advisory Panel so that HCAP's analysts can make appropriate recommendations for cost control.[3]

3 The task force also discussed a recommendation to amend 18 Del.C. § 2604 to eliminate language requiring the Department of Insurance to find a non-competitive market before finding workers compensation rates to be excessive. The Department of Insurance asked the task force not to make this recommendation because DOI did not have sufficient time to consider the recommendation. The task force deferred to the DOI's request, but indicated that it would hold DOI responsible for the consequences of leaving the statute unamended.

3. **MAKE THE STATE'S LAWS ENCOURAGING INJURED WORKERS TO RETURN TO WORK MORE EFFECTIVE.**

Place primary responsibility for ensuring that employers are informing doctors of available light duty work on the employer's workers compensation insurance carrier. Specifically, the task force recommends changing Delaware law to require that once an injury is deemed a compensable "lost time" case and an Agreement as to Compensation is entered into by the carrier and/or employer and the injured worker, the insurance carrier shall be required to send a Modified Duty Availability Report to the employer and ensure that it is completed and delivered to the physician. The trigger for the Modified Duty report will no longer be the Report of Workers Compensation Injury from the physician.

Require that any inspection to determine an employer's eligibility for the workplace safety discount on its insurance premiums include verification that it has completed Modified Duty Availability Reports for all workplace injuries in the prior three years. The task force recommends that this requirement be phased in over a three year period, given its findings that few employers have been completing these forms to date.

4. **IMPROVE THE STATE'S WORKPLACE SAFETY PROGRAM TO BOTH INCREASE ITS USAGE AND ENSURE THAT IT ACCURATELY DETERMINES WHICH WORKPLACES ARE USING APPROPRIATE SAFETY PRACTICES.**

   Revise Title 19, Section 2379 of the Delaware Code to require that employers inform any entity conducting a workplace safety examination of the details and outcomes of any workers compensation claims filed against the employer in the prior three years in Delaware. Any report recommending that an employer receive a workplace safety credit should explicitly discuss such claims and why they did or did not impact the employer's eligibility for a workplace safety credit.

   Revise Title 19, Section 2379 to make the workplace safety credit available to an employer who has been certified by its insurance carrier to have a safe workplace following an examination which is at least as rigorous as that conducted by the state's workplace safety inspectors. Under this recommendation, the Department of Insurance would promulgate regulations to allow insurance carriers to have their workplace safety examinations certified as being at least as rigorous as existing state examinations.