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24-HOUR HEALTH CARE COVERAGE AND WORKERS' COMPENSATION

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TABLE OF CONTENTS

Page

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INTRODUCTION

The current public policy focus on health care extends to concerns regarding the cost and implications of treating employees injured in the workplace. A number of states, including Nevada, have implemented cost containment strategies as part of efforts to reform their workers' compensation systems. With few exceptions, reform proposals in other states mirror recent enactments in Nevada. Examples of reforms recently implemented in a number of other states include:

- Managed care programs;
- Provisions to combat fraud;
- Medical fee schedules;
- Enhanced workplace safety; and
- Limitations on mental stress claims.

Several states have also begun consideration of hybrid systems that integrate workers' compensation medical benefits and other traditional health care benefits supplied by employers. These hybrid systems, often labeled "24-hour coverage" plans or "merged care" plans, tend to obscure the differences between occupational and nonoccupational injuries and diseases. Under 24-hour coverage plans, the roles of workers' compensation participants, including regulators, are changing. Traditional relationships between employers, injured employees, insurers, and medical providers are evolving into new forms.

This document describes 24-hour health care coverage, discusses the potential advantages and disadvantages associated with 24-hour coverage, highlights some of the significant issues regarding 24-hour coverage plans, discusses evaluation of pilot projects, and summarizes 24-hour coverage pilot projects in other states. In addition, this document discusses the main features of the National Association of Insurance Commissioners' (NAIC) 24-Hour Coverage Pilot Project Model Act and identifies a bill draft request for the 1997 Legislative Session that addresses 24-hour coverage.

WORKERS' COMPENSATION AND GROUP HEALTH INSURANCE DIFFERENTIATED

Workers' Compensation Insurance

Workers' compensation insurance is specialized insurance purchased by employers to provide medical care, disability compensation (indemnity) payments, and rehabilitation services for workers who are injured on the job or who contract occupational diseases in the course of their employment. Benefits also may be provided for dependents of those workers who are killed as a result of work-related accidents or illnesses. Workers' compensation benefits are specified by state statutes and vary from state to state.

The amount of medical expense coverage payable under a workers' compensation policy is generally unlimited, except that payment is allowed only for health care treatment that is medically necessary. Employees do not participate in the payment of medical benefits; therefore, deductibles, copayments, or other mechanisms to share costs with employees are not used in workers' compensation insurance.

Payments may be made to injured employees for various levels of disabilities and the amount of payment depends on the wage of the employee at the time of injury or illness and on the severity and duration of the disability. Four types of disability that are recognized under workers' compensation laws are (1) temporary total disability, (2) permanent total disability, (3) temporary partial disability, and (4) permanent partial disability.

Work-related injuries usually are compensated without regard to fault. Exceptions to the no-fault nature of workers' compensation insurance are identified later in this report under the discussion of exclusive remedy.

Group Health Insurance

Most private health insurance in the United States is provided as group insurance, usually covering the employees of a single employer or of multiple employers. Other eligible groups can purchase group health insurance contracts including fraternal organizations, labor unions, and trade associations.

Benefits typically available under a group health plan include basic hospital-surgical-medical benefits, catastrophic or major medical benefits, or comprehensive medical benefits. Group health plans can also provide a variety of other coverages including dental care, extended care facility, hearing care, home heath care, hospice care, prescription drug, and vision care. Some employers also offer coverage to dependents of their employees.

Some group health plans provide short-term disability income benefits. Generally, such plans do not cover disabilities caused by occupational injuries or illnesses and are limited to 26 weeks of benefits. Many short-term disability plans have at least a seven-day waiting period for sickness, but they may have a shorter waiting period for disabilities caused by nonoccupational accidents. Some group health plans also contain long-term disability income insurance under which an employee may receive disability income benefits until the normal retirement age.

Group health plans may be paid for entirely by the employer (noncontributory plans) or may require the employee to share in the cost of coverage (contributory plans). In addition, many group health plans require that employees and their covered dependents pay deductibles and copayments.

WHAT IS 24-HOUR COVERAGE?

The general concept of 24-hour coverage is to integrate workers' compensation and other employee benefits, such as health care coverage and disability income benefits. There is no single generally accepted definition of 24-hour coverage. Twenty-four-hour coverage can be defined as the joint issuance of a workers' compensation policy with a disability insurance policy or other medical coverage for nonoccupational injuries and illnesses. Another definition of 24-hour coverage is a plan that combines into a single package coverage for work-related and nonwork-related illnesses and injuries. Some definitions also include coverage for personal injuries suffered in automobile accidents. In an October 1991 report entitled, "Understanding 24-Hour Coverage," the American Legislative Exchange Council (ALEC) stated, "At its broadest, 24-hour coverage would ignore causation in compensating for medical care or lost wages."[1]

A report prepared by the Alliance of American Insurers explained that there are numerous basic types of 24-hour coverage proposals, but provided detailed explanations of six variations.[2] These six variants are summarized below:

- *24-Hour Coverage Marketing Product*—This variant offers integrated management of an employer's workers' compensation and group health insurance coverage.

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[1] American Legislative Exchange Council, "Understanding 24-Hour Coverage," *The State Factor*, Vol. 17, No. 11 (October 1991).

[2] Bateman, Keith T. and Veldman, Cynthia J. *Twenty-four Hour Coverage: An Analysis and Report About Current Developments*. Schaumberg, Illinois: Alliance of American Insurers, February 1991. See also American Legislative Exchange Council, "Understanding 24-Hour Coverage," *The State Factor*, Vol. 17, No. 11 (October 1991) and "A Progress Report on the Implementation of 24-Hour Coverage," National Association of Insurance Commissioners (September 1996).

Under this program, an insurer agrees to coordinate the claims settlement process so that duplicate claims under a workers' compensation policy and a health insurance policy are avoided. The integration process allows an insurer to utilize the discounted provider rates secured under a health plan for workers' compensation claims. Insurers continue to provide separate contracts to their policyholders;

- *24-Hour Medical Coverage*—This variant provides, in a single policy, medical benefits for all of an employee's injuries and diseases whether work-related or not. Disability benefits are provided only for work-related injuries and diseases;

- *24-Hour Disability Coverage*—This variant offers disability benefits for all of an employee's injuries and diseases, but medical benefits are provided for work-related injuries and diseases only;

- *24-Hour Coverage of Accidents(Injuries)*—This variant provides medical and disability benefits for all injuries, but only work-related diseases are covered. Diseases such as chicken pox, influenza, and mumps, are not covered under this approach to 24-hour coverage;

- *24-Hour Coverage of Diseases*—This variant provides medical and disability benefits for all diseases, but only covers work-related injuries; and

- *24-Hour Medical and Disability Coverage*—This variant is an all-inclusive approach that provides medical and disability benefits for all diseases and injuries. This approach is also known as "universal 24-hour coverage" or "universal disability program," and may be the approach envisioned by most people when they think of 24-hour coverage.

ADVANTAGES AND DISADVANTAGES OF 24-HOUR COVERAGE

As is the case with any proposal to modify an existing program, 24-hour coverage appears to have associated with it certain advantages and disadvantages. Clearly, it is not possible to outline all of the possible advantages and disadvantages of a 24-hour coverage program without knowing the details of the program to be implemented. Nevertheless, following are some of the commonly stated potential advantages and disadvantages of 24-hour coverage programs. Some of these topics are explained in greater detail in the next section of this report, entitled "Issues Regarding 24-Hour Coverage Programs."

Potential Advantages of 24-Hour Coverage

Following are the most commonly cited advantages associated with 24-hour coverage plans:

- Marketing a single 24-hour coverage product may be administratively easier and/or more cost-effective for an insurer than marketing separate product lines for workers' compensation and group health;

- Certain sources of inefficiency may be eliminated through application of 24-hour coverage. For example, an insurer who handles a 24-hour policy for an employer could evaluate a preexisting medical history that could clarify issues in a workers' compensation claim. An insurance company that is not both the health insurer and the workers' compensation insurer (a) may find it very costly to access information that would be available to an insurer who provides both coverages under a 24-hour coverage mechanism, or (b) might not even be aware that the condition was preexisting;

- Double billings may be reduced or eliminated under a 24-hour coverage program. Presumably, some health care providers bill both the workers' compensation insurer and the group health insurer for the same set of health care services. Whether such acts are inadvertent or are fraudulently undertaken, they are less likely to occur under a program of 24-hour coverage;

- Compensability determinations may be quicker and less complicated under a 24-hour coverage program, depending upon the type of program adopted;[3]

- Cost savings to employers may develop under a 24-hour coverage program because the employer could have a single administrator of health benefits;

- Gaps in coverage may be reduced as employees receive health care coverage for both occupational and nonoccupational illnesses and diseases;

- Total health care costs could be reduced under a 24-hour coverage program if the workers' compensation part of the program takes on certain characteristics that are common to most group health care programs. These characteristics include employee deductibles and copayments, and waiting periods before coverage begins; and

- Litigation concerning the cause of an injury or disease may be reduced.

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[3] See discussion of the types of 24-hour coverage programs beginning on page 3.

Potential Disadvantages and Barriers to Implementation

Possible impediments to 24-hour coverage include:

- Workers' compensation is intended to provide workers with no-fault coverage for illness or injury arising during the course of employment, in exchange for relinquishing the right to sue their employers who may have caused the accident or illness. Employers' exclusive remedy protection might be impaired if the lines between occupational cases and nonindustrial injuries and diseases is blurred. The National Association of Insurance Commissioners notes that this is not a problem faced by the health insurance portion of a 24-hour coverage plan because the employer typically is not obligated to provide health benefits and may not be sued for injuries and diseases that are not work-related;[4]

- States could lose the ability to regulate workers' compensation programs because of preemption under the Employee Retirement Income Security Act[5] of 1974 (ERISA). This federal statute governs a broad range of employer-provided benefits including medical and disability insurance. The act creates fiduciary duties for plan administrators, insurance brokers, trustees, upper management, and others with regard to the way they invest and distribute money that funds a benefit plan and the way they treat participants and beneficiaries;

- State insurance departments usually regulate health care policies while state industrial commissions or state workers' compensation agencies often oversee workers' compensation programs. This jurisdictional split may affect dispute resolution as well as regulatory issues;

- Smaller carriers may find it more difficult to compete in a multiple line insurance environment, preferring to specialize in a single insurance product;

- Many group health programs have deductibles and copayments where the employee is required to pay for some portion of his or her medical treatment. Workers' compensation programs generally do not have deductibles[6] and copayments,

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[4] "A Progress Report on the Implementation of 24-Hour Coverage," National Association of Insurance Commissioners (September 1996), p.3.

[5] 29 *United States Code* (U.S.C.), Section 1001, *et. seq.*

[6] An exception to this statement is the use of waiting periods in workers' compensation programs. For example, Nevada has a five-day waiting period before an injured employee becomes entitled to compensation payments. Such waiting periods are also referred to as "time deductibles."

however, adoption of a 24-hour coverage program may lead to pressure to impose employee paid deductibles and copayments. Such cost sharing may lead to opposition by employees and may also raise questions regarding possible erosion of the exclusive remedy defense;

- Total health care costs could increase under a 24-hour coverage program if the group health care part of the program takes on certain characteristics that are common to most workers' compensation programs. These characteristics include first dollar full coverage, no dollar limits on care, eligibility for a very broad range of health care services, no exclusions for preexisting conditions,[7] and coverage beginning on the first day of employment; and

- Other concerns relate to the operation of the voluntary market versus the assigned-risk market for the workers' compensation portion of the plan, and the relationship of various guarantee funds, subsequent injury funds, and other special funds.

ISSUES REGARDING 24-HOUR COVERAGE PROGRAMS

Many issues that surround 24-hour coverage programs stem from the basic differences between workers' compensation insurance as a third-party insurance and group health as first-party insurance.[8] Other issues stem from uncertainties regarding the actual operation of such a program and how various interested parties (employees, employers, health care providers, and insurance companies) will be affected by the new insurance environment. Following are some of the issues involved in consideration of a 24-hour coverage program.

Applicability of the Plan

Many employers, especially small employers, do not provide group health insurance coverage for their employees. Many of these employers are, however, required by statute to provide workers' compensation insurance coverage. A question could arise regarding whether implementation of a 24-hour coverage plan should be voluntary for all employers or if it should be mandatory for some or all employers. For example, would implementation of a 24-hour coverage plan require employers who do not provide group health insurance coverage for their employees to begin offering such coverage? Twenty-four hour coverage pilot programs typically provide for voluntary participation by employers.

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[7] Nevada is one of just a few states that limit coverage for preexisting conditions.

[8] Third-party insurance is purchased by an insured (first party) from an insurance company (second party) for protection against possible claims or suits brought by another person or entity (third party). First party insurance is coverage for the insured's personal or real property or the insured's own person.

Costs of 24-Hour Coverage

Little is known about the cost implications of 24-hour coverage. Pilot programs may be a useful method of estimating potential cost savings associated with 24-hour coverage. The research methodology associated with pilot programs (including data collection methods, selection of control groups, how to handle claims that have not closed, and selection of pilot participants) is an important consideration in evaluating potential cost savings.

A study conducted by the actuarial firm Milliman & Robertson, Inc., in 1993 concluded that total savings of approximately 30 to 44 percent were associated with a "coordinated" approach to health care services (as opposed to a "merged care" approach). The coordinated care approach used the existing state-based systems to provide medical care and cash benefits to injured employees but applied certain cost and quality assurance features not present in the then existing systems such as managed care, treatment protocols, and restrictions on choice of physicians by injured employees. The merged care approach combined occupational and nonoccupational medical care and included a community rating feature for determining premiums for the medical portions of claims that Milliman & Robertson concluded could reduce safety and increase lost time due to injury.[9]

Coverage Rules

Different eligibility and underwriting rules apply under workers' compensation and group health plans. Typically, under workers' compensation insurance, any employee is covered for injuries incurred in the course and scope of employment. While a few states, including Nevada, have statutory provisions that limit coverage for preexisting conditions, many states have no such restrictions. However, under group health plans, eligibility may be limited by the insurance contract. For example, a group health policy may stipulate that only employees who work 30 hours or more per week are eligible. The policy also may impose a 30-day waiting period or deny coverage for preexisting conditions.

The recently enacted Health Insurance Portability and Accountability Act of 1996 also must be considered because of its provisions that limit preexisting condition exclusions.

Employee Retirement Income Security Act

An employer is not required by ERISA to provide an employee benefit plan, but an employer's obligations under ERISA arise if the employer provides such a plan. The act preempts all state laws relating to employee benefit plans, except state laws that regulate

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[9] The Milliman & Robertson report, entitled "Workers Compensation and Healthcare Reform: An Actuarial and Economic Analysis of Two Proposals," was conducted at the request of the American Insurance Association, 1130 Connecticut Avenue N.W., Suite 1000, Washington, D.C. 20036 (202-828-7100).

insurance, banking, or securities. Programs providing benefits solely in compliance with workers' compensation statutes are specifically exempted. However, because 24-hour coverage plans include several types of coverage, an argument might be made that coverage falls under federal control through ERISA.

Under ERISA, an employee welfare benefit plan is defined as:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).[10]

If the benefits being provided meet the above criteria, they still may not be subject to ERISA if they fall within an authorized exemption. The act does not apply to any employee benefit plan if:

> such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws.[11]

The concern regarding whether a state may lose its ability to regulate workers' compensation benefits under a 24-hour coverage plan stems from the term "solely" in the ERISA exemption. Under an integrated plan, it may be difficult to argue that the "medical, surgical or hospital care or benefits in the event of sickness, accident, disability . . ." are provided "solely for the purpose of complying with applicable workmens' compensation laws."

Exclusive Remedy

As noted above, workers' compensation is intended to provide workers with no-fault coverage for illness or injury arising during the course of employment. The doctrine of

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[10] 29 U.S.C. Section 1002(1).

[11] 29 U.S.C. Section 1003(b)(3).

exclusive remedy is fundamental to Nevada's workers' compensation statutes. Once an employer becomes subject to the Nevada Industrial Insurance Act, the act affords the exclusive remedy by the employee (or his dependents) against the employer for the job-related injury. The exclusive remedy provisions of Nevada law are included in *Nevada Revised Statutes* (NRS) 616A.020. In addition, the exclusive remedy provisions were clarified with the addition of NRS 616D.030 to the statutes in 1995. This section states in relevant part:

> No cause of action may be brought or maintained against an insurer or a third-party administrator who violates any provision of this chapter or chapter 616A, 616B, 616C, or 617 of NRS.

Exclusive remedy protects an employer from tort suits, including protection from punitive damages and damages for pain and suffering, which generally result in awards that are higher than workers' compensation benefits.

In workers' compensation generally, the barring of other actions against employers is part of the *quid pro quo* in which the rights and obligations of employees and employers are to some extent in balance. Under the exclusive remedy provision, employers assumed liability without fault for injuries suffered by their workers and were relieved of the prospect of large damage verdicts in cases where they were at fault. In addition, employers gave up certain defenses available to them under common law in exchange for a promise to promptly pay benefits to which injured employees are entitled. These common law defenses included the following:

- Contributory negligence—Using this defense, an employer would have argued that the employee was at least partially at fault and, therefore, was not entitled to as much compensation as he was seeking.

- Fellow-servant doctrine—Using this defense, an employer would have argued that fault for the injury to an employee rested with a coworker and not with the employer. Under such a situation, the employer would have denied liability for any expenses associated with the employee's injury.

- Doctrine of assumption of risk—Under this defense, an employer would have argued that the employee knew and accepted the risks of employment when he accepted the job. Therefore, according to the employer, the injured employee was obligated to assume the known risks of being injured on the job.

Under certain circumstances, employer immunity may not apply to injuries arising out of and in the course of employment. Possible exceptions to employers' general immunity from lawsuit include:

- Injuries not covered by workers' compensation;
- Injuries sustained by an employee of a noncomplying employer;[12]
- Injuries caused by the employer's intentional act; and
- Injuries sustained while the employer and employee entered into a separate relationship or "dual capacity" independent of their master/servant relationship.

Conditions not covered by workers' compensation can include certain occupational diseases. For example, in *Niles v. Marine Colloids, Inc.*,[13] the Maine Supreme Court held that immunity did not extend to an employer whose alleged negligence resulted in a disease which was not compensable as an occupational disease under state law.

If an employer has not complied with the coverage requirements of state law, then he has no immunity from suit. Under NRS 616C.220, an injured employee may elect to receive compensation from the uninsured employers' claim fund, as well as pursue a civil action against the noncomplying employer.

Deliberate and knowing intent cases, in which the employer actually means to harm an employee, are generally recognized as exceptions to employer immunity. These cases often involve physical assaults and common law tort actions are usually permitted. For example, in the case of *Barjesteh v. Faye's Pub, Inc.*,[14] the Nevada Supreme Court ruled that the Nevada Industrial Insurance Act did not provide an exclusive remedy where the employer committed an intentional act against an employee by closing a refrigerator door on her arm.

Employers who expose workers to known hazards are usually protected by the exclusive remedy provision, and are generally held not to be subject to common law suit. The usual justification for this view is that such injuries necessarily are work-related or that the exception for intentional torts should be narrowly construed.

Under the "dual capacity doctrine," an employer's immunity does not provide protection from common law actions by employees if, in addition to being their employer, the company stands in a second or "dual" capacity that confers obligations unrelated to and independent of those imposed upon it as an employer. Typical cases include alleged

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[12] A noncomplying employer is one that has not complied with the coverage requirements of the law. In Nevada, a noncomplying employer is referred to as an uninsured employer.

[13] *Niles v. Marine Colloids, Inc.*, Me., 249 A.2d 277 (1969).

[14] *Barjesteh v. Faye's Pub, Inc.*, 106 Nev. 120, 787 P.2d 405 (1990).

medical malpractice for emergency room care of an employee of the treating medical facility, or a truck driver injured because of a blowout caused by a defective tire manufactured by his employer.

An employer may also be liable in a tort or damages action for discharging, demoting, or taking other punitive action in retaliation for an employee filing a workers' compensation claim or otherwise pursuing his rights under workers' compensation laws. In *Hansen v. Harrah's*,[15] the Nevada Supreme Court held that retaliatory discharge of an employee based upon filing of a claim for workers' compensation is an action for which an employer may be sued.

Exclusive remedy protection might be impaired if the line between occupational and nonindustrial injuries and diseases is blurred, leading to greater litigation on the part of injured employees and a return by employers to common law defenses.

Experience Rating

Experience rating is a mechanism used in workers' compensation insurance to induce employers to provide and maintain safe and healthful work environments for their employees. Blending group health costs with workers' compensation costs could weaken or dilute the benefits and purpose of experience rating. With a 24-hour coverage approach, employers' premiums might be subject to community rating. Under community rating, all insureds in the same general geographic area are charged the same premium rate for medical expense insurance.[16] A company that has an exemplary record of controlling losses might not have its rates adjusted to reflect its own better-than-average loss experience as it would under a typical experience rating plan.

Some 24-hour coverage plans, however, provide for community rating only for the medical care component of the plan. With those plans, class and experience rating is used to establish premiums for the indemnity portion of the plan.

Insurance Pricing, Regulation, and Services

The price of workers' compensation insurance is subject to regulatory approval of the Commissioner of Insurance. By contrast, the price of a health insurance contract is market-determined, and not subject to approval by the Commissioner. Services that are provided under the workers' compensation policy are uniform for all carriers. Services

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[15] *Hansen v. Harrah's*, 100 Nev. 60, 675 P.2d 394 (1984).

[16] Hallman, G. Victor and Karen L. Hamilton, *Personal Insurance: Life, Health, and Retirement* (Malvern, PA: American Institute for Chartered Property Casualty Underwriters, 1994), p. 65.

under health insurance vary by insurance carrier, employer, and by class of employees (part-time versus full-time, new employee versus longer term worker, and so on).[17]

Litigation

Workers' compensation involves a significant amount of litigation, whereas group health care is relatively free of litigation. To what extent might a merger of the two programs affect litigation? Does the fact that compensability determination is less important under most 24-hour coverage approaches argue that less litigation will occur under merged care? Compensability issues will arise in any case where there may be eligibility for indemnity benefits. Also, the presence of 24-hour coverage may not affect many of the kinds of issues over which much of the workers' compensation litigation currently occurs. These issues include appropriateness of treatment, the desire to change treating physicians, whether or not the injured employee can return to work, the nature of work restrictions, the determination that the injured employee has reached maximum medical improvement, and measurement of the extent of residual physical impairment.

Period of Worker Protection

Workers' compensation insurers are liable for the costs of injuries[18] and illnesses that arise out of an occurrence in the policy year of coverage. Incurred costs for which the insurer is responsible may extend many years into the future. Group health insurers are responsible for the costs of treatment provided during the year of coverage. Reconciliation of these differences would help ensure that a change in the insurance provider from one year to the next does not leave an employee without protection, or adversely affect the ultimate liability of the employer.

EVALUATING PILOT PROJECTS

In an effort to evaluate the efficacy of 24-hour coverage programs, several states have implemented pilot programs. Many of these pilot programs are discussed in the following section of this document. Two basic questions to be answered include:

1. Does 24-hour coverage reduce total costs when compared to the current dual program arrangement?; and

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[17] Nevada law, however, includes several provisions that mandate certain benefits be provided under certain circumstances. For example, NRS 689B.030 requires that each group health policy contain a provision for benefits payable for expenses incurred for the treatment of the abuse of alcohol or drugs.

[18] These costs include health care, rehabilitation, and indemnity costs.

2. Does 24-hour coverage detract from quality medical care to injured employees?

These and related questions can be answered by looking at quantitative outcomes that can be used to indicate the level of success achieved. These outcome measures could include, but are not limited to, the following:

- Total losses (in dollars) and premiums per policy;
- Total exposure to loss measured by employment or payroll;
- Frequency of workplace injuries;
- Average cost per workplace injury;
- Indemnity (wage replacement) benefits for each workers' compensation claim;
- Medical costs per claim;
- Duration, frequency, and types of medical services rendered;
- Detailed information regarding hospitalization including length of stay and per diem costs;
- Detailed information regarding litigation, including a breakdown of related expenditures; and
- Loss adjustment expenses.

From a regulatory perspective, any evaluation of 24-hour coverage should consider the plan's effect on insurer solvency, product pricing, and statutory compliance. That is, premium rates under a 24-hour coverage plan must not be inadequate, excessive, or unfairly discriminatory.

From the perspective of an employer, consideration should be given to an evaluation of employee satisfaction with the plan, in addition to the obvious concerns regarding cost savings and administrative efficiency.

Employees will be concerned that the plan either improves the quality of health care received in the event of an injury or illness, or that the plan does not result in any deterioration in the quality of health care services provided. Employee deductibles, copayments, and other potential out-of-pocket expenses are likely to result in unfavorable reviews from employees. In cases where indemnity payments are involved, employees also

may be concerned with how 24-hour coverage affects the duration of disability, work restrictions, and the method of determining permanent impairment.

Other factors that may need to be considered in the evaluation process include coordination of benefits, case management practices, and physician selection.

24-HOUR COVERAGE PILOT PROJECTS IN OTHER STATES

Following are descriptions of 24-hour pilot projects that have been implemented in other states. More current information may be available since the date this report was prepared.

California

In 1992, the California Legislature enacted Assembly Bill 3757, which allows a health care organization to provide medical treatment for both work-related and nonoccupational injuries and illnesses. The Research and Evaluation Unit of the Division of Workers' Compensation, Department of Industrial Relations, is charged with administering the pilot projects. The law, within specified parameters, gives participants freedom to experiment with various innovative merged care benefit delivery systems.[19] The pilot projects are limited to four designated counties where the employer contracts with a licensed health care services plan to serve as the exclusive provider of medical, surgical, and hospital benefits to the employees for all injuries and illnesses.

The employer is required to pay the entire insurance premium for the occupational medical benefits. Employees cannot be assessed deductible amounts or copayments. Dependent coverage must be made available, however, the employer is not required to pay the premiums for such coverage. The employer, through the health care services plan, is allowed to direct the employee to a participating physician, as long as adequate care is provided.

The first pilot program established under that law was offered by Kaiser Permanente of San Diego County on June 1, 1994. The program, called Kaiser On-the-Job, offers the following features:

- *Continuity of Care*—While a worker gives up his right to predesignate a personal Kaiser physician, the injured worker's personal physician is brought in as part of the occupational injury treatment team.

[19] Section 4612 of the *California Labor Code* is included in this report as Appendix A.

- *Convenience*—The Kaiser 24-hour merged care plan provides, with some exceptions, one-stop treatment services for all work and nonwork injuries and illnesses.

- *Occupational Medicine Expertise*—Kaiser's San Diego Medical Center features an Occupational Medicine Department that specializes in the treatment of industrial injuries. It works with an injured worker's employer to bring the worker back to the job as soon as possible, often in light duty or a modified work assignment.

Because Kaiser's group medical plan does not offer all medical services authorized under California's workers' compensation law, the health maintenance organization (HMO) has contracts with outside providers for such services as chiropractic, acupuncture, and long-term skilled nursing. These extended health care services are available only to plan enrollees with work-related injuries or illnesses.

Twelve employers currently are participating in the Kaiser On-the-Job pilot project in San Diego County. Included in the project are three public sector employers and eight private businesses. The public sector employers are the County of San Diego, Padre Dam Municipal Water District, and San Diego Community College District. Five of the private sector employers are insured by the State Compensation Insurance Fund, while the other three are self-insured.

In 1993, the California Legislature amended the pilot project enabling legislation with enactment of Assembly Bill 1692. This bill amends evaluation specifications, allows the Division of Workers' Compensation to seek outside grants to fund evaluation aspects of the pilot projects, changes reporting requirements for final evaluation of the projects, and exempts from compliance with California's minimum rate law for workers' compensation rates, subject to approval of the Insurance Department.

In January 1995, three more pilot projects were approved by the Division of Workers' Compensation. They are:

- "The 24 Hour Care Alliance." An alliance between Sharp HealthCare and TIG Insurance Company has developed a 24-hour care product sold primarily to small employers in San Diego;

- Kaiser Permanente's Northern California region. This pilot project includes both public and private sector employees in Sacramento and Santa Clara Counties. A Santa Clara County fruit packing company and a Sacramento County automobile dealership were the pilot's first enrollees. Six other employers, including the State of California are enrolling employees in this pilot; and

- Maxicare Life and Health Insurance Company. Maxicare has established a network of doctors and medical groups in Los Angeles County whose workers are trained in both occupational and nonoccupational medicine. Patients visit the same primary care physician for all types of injuries, a feature which is unique to the Maxicare pilot. In other pilots, an employee may be required to see a physician who specializes in occupational medicine for work-related injuries.

All four pilot projects vary in details, but one common factor is that they all allow employers to direct injured workers' health care for up to 365 days after an injury. Kaiser On-the-Job explicitly advises employee enrollees that neither Kaiser nor the employer will pay for treatment sought outside the plan. In addition, by law, all the plans are voluntary for employees. Participating employers must offer traditional group health insurance and workers' compensation coverage in addition to the experimental plans.

These four pilot projects are scheduled to terminate on December 31, 1997, followed by a report to the California Legislature regarding the efficacy of 24-hour, merged, managed care health insurance. If the report shows the pilot projects to be successful, supporters of merged care are likely to seek to expand the program statewide. The Research and Evaluation Unit is working on evaluation criteria for the pilots. The final report to the California Legislature is due in December 1998.

Further information regarding the California pilot project may be obtained from Glenn Shor, Ph.D., Acting Research Manager, Research and Evaluation Unit, Division of Workers' Compensation (415-975-0750).

Florida

Section 440.135 of *Florida Statutes* authorizes the establishment of one or more 24-hour pilot projects.[20] The purpose of the pilot projects is to determine whether the total cost to an employer that provides a policy of health insurance and a separate policy of workers' compensation insurance for its employees can be reduced by combining both coverages under a single policy that provides 24-hour health insurance coverage.

Subsection 5(e) of Section 440.38 of *Florida Statutes* allows an employer to offer 24-hour coverage to its employees. The 24-hour health insurance policy may provide health care services through an HMO or a preferred provider organization (PPO). The premium for the coverage must be paid entirely by the employer, but the insurance policy may use deductibles and coinsurance provisions that require the employee to pay a portion of the actual costs of medical care received by the employee.

[20] Section 440.135 of *Florida Statutes* is included in this report as Appendix B.

Further information regarding Florida's 24-hour pilot project can be obtained from Julie Eddy, Executive Assistant, Florida Department of Insurance (904-922-3252, ext. 5114) or Ms. Kenney Shipley, Florida Department of Insurance (904-922-3252, ext. 5110).

Georgia

In 1993, the Georgia General Assembly authorized merged care pilot projects.[21] Policies must provide benefits at least as comprehensive as those under the workers' compensation law, but may include managed care provisions and may include employee deductibles and copayments capped at $5 for an office visit or $50 per occurrence.

Five entities are providing alternative coverage including 24-hour policies. Three of these entities are involved in 24-hour pilot projects under Section 34-9-122.1 of the *Georgia Code*. Pilots have been approved for affiliates of Fireman's Fund, Travelers, and Zurich-American. In addition, Liberty Mutual and Guarantee Mutual Life are providing coverage under the alternative coverage law. There are nine additional alternative product filings pending review and approval by the Department of Insurance. The department is currently performing in-depth investigations into the alternative coverage products. The investigations include market conduct examinations to ascertain that the alternatives are delivering the required benefits.

Further information regarding Georgia's alternative coverage products can be obtained from Mr. Stan Miller, Georgia Department of Insurance (404-656-6054) or Mr. Steve Manders (404-656-2022).

Kentucky

In 1994, the Kentucky General Assembly approved legislation to allow one or more pilot programs.[22] Coverage must match state workers' compensation requirements and may not include deductibles or copayments. A proposed rule of the Health Policy Board requires adoption of regulations to establish standards for the 24-hour pilot insurance program that combines general health insurance and the health component of workers' compensation. The proposal defines relevant terms, specifies prohibitions, establishes an application process, establishes criteria for authorizing pilot plans, and adopts conditions for revoking pilot plan authority. The proposal also establishes dispute resolution procedures, identifies medical services covered under the plan, authorizes the board and commissioner of workers' claims to examine records, and adopts statistical reporting requirements.

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[21] Sections 34-9-14 and 34-9-122.1 of the *Georgia Code* are included in this report as Appendix C.

[22] Section 342.352 of *Kentucky Revised Statutes* is included in this report as Appendix D.

In the first quarter of 1995, the Kentucky Department of Insurance announced that it had approved an alternative equivalent coverage program for Fireman's Fund Insurance Company called the Employee Benefit and Indemnification Plan. The plan provides occupational accident and indemnity insurance under the accident and health insurance provisions of Kentucky law. It allows for provision of workers' compensation benefits through collective bargaining agreements to establish the alternative equivalent coverage or through the 24-hour coverage pilot projects. This program uses managed care and offers several options to employers, including a premium credit to employers for establishing a return-to-work program for injured employees. One unique feature of the plan is a merit rating plan that offers premium credits for using PPO and HMO networks, establishing formal return-to-work programs, implementing education programs, and encouraging employees to participate in safety committees.

Further information can be obtained from Mr. Dan Mitchell or Ms. Mona Carter, Kentucky Department of Insurance (502-564-6046).

Louisiana

Louisiana Revised Statutes allows up to five two-year pilot projects.[23] The pilot projects authorize a form of 24-hour medical coverage where an employer can secure a 24-hour health insurance policy from a traditional health insurer, an HMO, or a PPO. Indemnity benefits may be purchased through a separate source so that the total benefits package provides all of the benefits required by the Louisiana Workers' Compensation Act. The act provides for initial employer choice of physician; however, an employee retains the right to select his health care providers. The employer is obligated to pay the entire premium for the 24-hour health insurance policy. Deductibles and copayments may not be applied to work-related injuries or illnesses. The law incorporates the terms of the Louisiana Workers' Compensation Act by reference in its provisions.

A Department of Insurance ad hoc committee has been established to select the participants and assist in implementing the pilot projects. The process of interviewing prospective employers is under way. The committee also is considering a pilot using a group of state employees.

Further information can be obtained from Denise Cassano, Executive Director, Louisiana Health Care Commission (504-342-0819).

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[23] Sections 22:21 through 22:23 of *Louisiana Revised Statutes* are included in this report as Appendix E.

Maine

The Maine Legislature enacted legislation in 1991 to allow a 24-hour coverage pilot program.[24] A proposal for funding has been approved by the Robert Wood Johnson Foundation (RWJ), which provided funding for 24-hour pilot projects in Oregon. The Maine Bureau of Insurance currently is soliciting proposals for pilot projects.

Further information can be obtained from Mr. Eric Cioppa or Mr. Bob Wake, Maine Bureau of Insurance (207-624-8475).

Oklahoma

The Oklahoma Insurance Commissioner is empowered to establish a 24-hour pilot program of integrated management of an employer's workers' compensation and group health claims.[25] The Commissioner also is authorized to promulgate rules for the program's implementation. Current workers' compensation law cannot be affected by an integrated policy. The Insurance Department currently is working to set up both a public sector and a private sector pilot project.

Further information can be obtained from Mr. Bob Card, Oklahoma Insurance Department (405-522-4608).

Oregon

On March 6, 1992, a proposal was submitted to the Robert Wood Johnson Foundation for funding of a 24-hour coverage pilot program in Oregon. On February 4, 1994, Oregon was awarded a $336,658 grant from RWJ to fund an 18-month pilot project to test the combination of workers' compensation and health insurance. The grant pays for set-up costs and supervision of the pilot projects. On March 26, 1993, the Department of Consumer and Business Services formally solicited employers to participate in the pilot project. Enabling legislation was passed by the Oregon Legislative Assembly (H.B. 2285) that provides for implementation of pilot projects.[26]

The initial pilot plan became operational in January 1994. This plan provides a coordinated product consisting of a joint venture between a Blue Cross/Blue Shield HMO

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[24] Chapter 39-A, Section 403 of *Maine Revised Statutes* is included in this report as Appendix F.

[25] Section 14.1 of Title 85 of the *Oklahoma Statutes* is included in this report as Appendix G.

[26] Section 656.016 of *Oregon Revised Statutes* is included in this report as Appendix H.

and the State Accident Insurance Fund Corporation (SAIF).[27] This plan includes a variety of employers and currently is the largest pilot plan in Oregon. The plan provides services to nine employers with a total of approximately 2,200 covered employees. In a coordinated plan, an employer receives two separate contracts; however, the insurer and the health plan use the same managed care network and physician payment rates, thus providing seamless delivery to the covered employees.

A second pilot plan was approved in April 1994. Under this plan—a partnership between the Kaiser Permanente HMO and employers that are self-insured for workers' compensation—members receive all medical care from HMO health care providers and the HMO accepts capitated payment for all services. Two self-insured employers with more than 900 covered employees are participating in the plan. Four other pilot plans are approved and are providing coverage to 3,600 employees of 14 participating employers.

According to Edward G. Nieubuurt, Project Director, Oregon Department of Consumer and Business Services (503-378-4100), the pilot project was expected to enroll between 10,000 and 20,000 employees. However, only about 3,600 employees have been recruited to date. He stated that one reason for the slow acceptance of 24-hour coverage by employers is that group health care and workers' compensation rates in Oregon are either flat or have fallen in the wake of reform. With lower rates, employers appear to be less motivated to experiment with new policy alternatives.

In spite of the lower than expected number of enrollees in Oregon's pilot project, Mr. Nieubuurt said that early indications from employers in the program suggest that 24-hour coverage works. He explained that none of the employers have dropped out of the program. However, he is cautious, having noted that the "jury is still out on whether 24-hour managed care is better or worse than stand-alone workers' compensation managed care."

Because of the small number of enrollees in the pilot program, statistical analysis of existing data would not be meaningful, according to Mr. Nieubuurt. Consequently, as the pilot program moves to its completion on July 31, 1998, it will be impossible to quantify the pilot project's actual cost savings for employers.

Washington

Senate Bill 5304 was passed in 1993 and provides a form of universal coverage available to all state residents, to be phased in over five years beginning July 1995. The plan is similar to 24-hour coverage and includes establishment of Health Insurance Purchasing

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[27] The SAIF is a state-owned, nonprofit company that provides one-third of the workers' compensation coverage in Oregon.

Cooperatives (HIPCs). These HIPCs will be spread over four regions of the state, with one HIPC per region. The act also requires certification of health plans with various requirements placed upon them. Antitrust immunity for insurers and health care organizations also is provided under the act.

Officials in the State of Washington are concerned about interactions of its 24-hour coverage act and ERISA. Because its request for a waiver from ERISA was denied, the Washington Legislature repealed many of the provisions of the act. The current pilot project in Washington is limited to testing the use of managed care in workers' compensation.

Further information can be obtained from Kathleen Conner, Washington Department of Insurance (360-586-2990).

SUMMARY OF THE NAIC MODEL ACT

On September 18, 1994, the NAIC adopted a model act that, if enacted by a state legislature, would allow a state to establish 24-hour coverage pilot projects as a means of reducing workers' compensation costs.[28] According to the model act, the purpose of pilot projects is to determine whether the costs of workers' compensation systems and health care delivery systems could be more effectively managed by combining the benefits required by workers' compensation plans and those offered under group health insurance policies.

The act allows employers to provide their employees with 24-hour medical insurance, which would provide health care benefits for both work-related and nonwork-related injuries. It also allows for the provision of either disability benefits only for work-related injuries, or for both work-related and nonwork-related injuries.

Under the act, a state could approve up to ten pilot projects, each to be administered by the state's insurance department. Rules and regulations for the projects would be promulgated by the Commissioner of Insurance after consultation with the state's workers' compensation administrator. In Nevada, the workers' compensation administrator is the Administrator of the Division of Industrial Relations, Department of Business and Industry. The Commissioner would establish regulations for project benefits, reporting requirements, and grievance procedures. The Commissioner also would have the authority to determine the rights of employees who are terminated or who have their coverage canceled prior to the project's expiration.

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[28] The NAIC 24-Hour Coverage Pilot Project Model Act is included in this report as Appendix I.

Insurance carriers providing 24-hour coverage would have to comply with all provisions of the state's workers' compensation act in their coverage of work-related injuries and illnesses. Coverage of nonwork-related injuries and illnesses would have to comply with the terms of the group health plan portion of the project.

The model act also stipulates that once an employee with a work-related injury achieves maximum medical improvement, coverage of services that are included in the group health portion of the plan but are not compensable under the state's workers' compensation act could not be denied solely because the services have been prescribed to treat a work-related injury.

Each pilot program must include a schedule of allowable copayments and deductibles. The act provides six alternative schedules, ranging from no copayments or deductibles for work-related injuries, to copayments that may be waived with the use of provider networks, to deductibles and copayments in exchange for 24-hour disability payments or employer payment of the entire insurance premium.

The act provides that the pilot projects can use provider networks to deliver health care services. Pilot projects also may implement cost-containment features which may include preadmission certification for inpatient services, second opinions for nonemergency surgery, limitations of services and providers, and the use of utilization review mechanisms. The use of a provider network, and its cost-containment features, may not unfairly deny benefits for medically necessary covered services.

Also included in the act is a provision that coverage under a pilot project would be required to provide disability income and rehabilitation benefits for work-related injuries at least equivalent to those ordinarily provided under a workers' compensation policy as stated in the state's workers' compensation act. It states that no provision of a pilot project may decrease the weekly payments for disability compensation under the state's workers' compensation act.

The model act also requires each insurer participating in a pilot project to submit to a state's insurance commissioner its manual of rules, rates, and rating systems applicable to the project. The act stipulates that rates must not be excessive, inadequate, or unfairly discriminatory.

Under the model act, each pilot project could last up to five years. Within six months of a project's end, the state insurance regulator would be required to issue a report on the project's activities, and issue findings and recommendations. The regulator would be required to monitor and evaluate the project's cost savings, effectiveness, effect on indemnity payments, and complaints from injured workers and participating employers. The regulator also would be required to recommend whether the project should continue, and whether any legislative changes were needed.

BILL DRAFT REQUEST

Bill Draft Request No. 53-168 was submitted by Senator Ernest E. Adler to provide for 24-hour workers' compensation coverage.

ADDITIONAL RESOURCES AND CONCLUDING REMARKS

Section 242 of Senate Bill 316 (Chapter 265, *Statutes of Nevada 1993*) included a provision that created a full-time position assigned to the Legislative Counsel Bureau for the purpose of conducting research and reviewing and evaluating data related to industrial insurance. One of the tasks assigned to that position is to publish a quarterly workers' compensation newsletter. Copies of the *Workers' Compensation Newsletter* or information regarding workers' compensation issues may be obtained by contacting Vance A. Hughey, Senior Research Analyst, Research Division, Legislative Counsel Bureau, 401 South Carson Street, Carson City, Nevada 89701-4747, telephone: (702) 687-6825.

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APPENDIX A

Section 4612 of the *California Labor Code*

West's
ANNOTATED
CALIFORNIA CODES

LABOR CODE

Sections 3201 to 5299

[Includes Section 3200]

Volume 44A

1997
Cumulative Pocket Part

Replacing 1996 Pocket Part supplementing 1989 main volume

Includes laws through the 1995–1996 Regular and First through Fourth Extraordinary Sessions, and the November 5, 1996, election

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purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(Amended by Stats.1990, c. 770 (S.B. 1), § 3.)

Historical and Statutory Notes

1990 Legislation

The 1990 amendment rewrote the section.

Section 6 of Stats.1990, c. 770, provides:

"The amendments to Section 4608.2 of the Labor Code made by Section 3 of this act shall apply to injuries occurring on or after January 1, 1991."

Legislative findings and declaration for Stats.1990, c. 770, see Historical and Statutory Notes under § 8715.

§ 4603.5. Format and content of notices; reasonable geographic areas; time limits for notices and responses; notification of employees' rights

Code of Regulations References

Obligations of employer covered by contracts with health care organizations, see 8 Cal. Code of Regs. § 9779.3.

§ 4612. Pilot project; occupational-related medical treatment; contract with health care service plan for exclusive coverage of employees; designated physician; report

(a) A pilot project is hereby authorized, for a duration of up to 36 months, under regulations to be developed and implemented by the administrative director. The purpose of the pilot project is to authorize an employer participating in the pilot project to contract with a licensed health care service plan to be the exclusive provider of medical, surgical, and hospital treatment for occupational and nonoccupational injuries and illnesses incurred by its employees. The health care service plan shall provide all occupational-related medical treatment coverage required by this division without any payment by the employee of deductibles, copayments, or any share of the premium. Employers participating in the pilot project shall make available health plan coverage for their employees' dependents for the treatment of nonindustrial injuries and illnesses. Nothing herein shall require an employer to pay for that dependent coverage. An employer participating in the pilot project shall offer its employees a choice between the exclusive provider of care option and a traditional health benefits plan which allows employees to obtain workers' compensation treatment from a traditional workers' compensation provider. In the case of a pilot project established by a multiemployer, collectively bargained employee welfare benefit plan, or by a recognized exclusive bargaining agent for state employees that sponsors an employee welfare benefit plan for the benefit of employees, this choice may be exercised by an exclusive or certified bargaining agent that represents employees of the employer.

(b) That pilot project may be implemented in four counties as designated by the administrative director and may include more than one health care service plan. One county shall be in northern California, one in central California, and two in southern California. Multiemployer, collectively bargained employee welfare benefit plans that operate in one or more of the designated counties, or recognized bargaining agents for state employees that sponsor a welfare benefit plan, may implement a pilot project in all counties in which participants are employed and covered for nonoccupational injuries and illnesses.

(c) Notwithstanding the terms of Section 4600, 4601, or any other provision of this article, an employee employed by an employer participating in the pilot project who has elected to enroll in the pilot project shall not have the option of predesignating a personal physician, other than a physician provided by the licensed health care service plan designated by the participating employer, as his or her treating physician, nor shall an employee have the option of changing to a physician not provided by the health care service plan pursuant to Section 4601. However, this section shall not be construed to limit the requirement under Section 4600 that an employer provide treatment reasonably required to cure or relieve the effects of an injury, nor shall this section be construed to prohibit an employee from changing to another provider of health care services during any annual open enrollment period.

(d) The administrative director shall, * * * at the completion of the second year of the pilot project, or sooner if feasible, prepare a preliminary report, and within one year after completion of the pilot project, prepare a final report to the Legislature and the Governor describing the pilot project. The report shall include a review of the following:

(1) Employer costs.

* * *

(2) Vocational rehabilitation implications of 24-hour care pilot projects.

(3) Numbers and percentages of employees in pilot worksites that enroll in the plan.

(4) Incentives used by employers to encourage enrollment in the plan.

(5) Extent to which dependents of pilot project employees enroll in health plans.

(6) Determination of employee satisfaction with the pilot program.

(7) Extent to which employees enrolling in the pilot plan continue to stay within it during the length of the pilot program.

(8) Differentials in costs of treatment between different types of pilot programs for occupational and nonoccupational injuries and illnesses.

(9) Differentials in costs of treatment and of indemnity benefits among workplaces comparable in size, type of industry, and location, between pilot programs and non-24-hour care for occupational and nonoccupational injuries and illnesses.

(10) Differentials in costs of claims administration between pilot programs.

(11) Percentage of occupational injury claims litigated and the type of dispute giving rise to litigation.

(12) How continuing obligations for medical treatment under workers' compensation will be secured after completion of the pilot project.

(13) Whether the pilot project was or could be utilized by small employers.

The pilot project shall be deemed a success if the administrative director can verify that the information contained in the report required by paragraphs (1) to (13), inclusive, compares favorably with that of employers and employees not included in the pilot project. * * * In order to prepare the report, the administrative director shall prescribe information to be collected by each approved pilot program for submission to the division in a timely manner.

(e) The administrative director shall prepare an itemization of the costs to the division associated with preparation of the report described in subdivision (d). The cost of the report shall be borne by the employers participating in the pilot project, and, if available, by other external sources outside of the General Fund. Contribution by the employers shall be apportioned on a per capita basis based upon the number of employees * * * enrolled under the pilot project.

(f) For purposes of this section, "health care service plan" includes health care service plans and disability insurers that offer a managed care product within a pilot project county, * * * workers' compensation insurers as defined in Section 3211 of the Labor Code that offer a managed care product within a pilot project county, multiemployer collectively bargained employee welfare benefit plans that offer a managed care product within a pilot project county, and welfare benefit plans sponsored by recognized exclusive bargaining agents for state employees. Pilot projects covering state employees shall be approved by the state employer and approved pursuant to Part 5 (commencing with Section 22751) of Title 2 of the Government Code.

(g) The employer's contract with the health care service plan shall include a surcharge or other provision to cover the cost of the medical care of an injured employee which is required by this division after the employee leaves the contracting employer's employment.

(h) Enrollment or subscription in the pilot project may not be canceled or not renewed except in the following:

(1) Failure to pay the charge for that coverage if the subscriber has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

(2) Fraud or deception in the use of the services or facilities of the plan or knowingly permitting that fraud or deception by another.

(3) Any other good cause as is agreed upon in the contract between the plan and a group or the subscriber.

(i) Notwithstanding any other provision of this section, no employer that is required to bargain with an exclusive or certified bargaining agent which represents employees of the employer in accordance with state or federal employer-employee relations law for represented employees, shall contract with a managed care organization for purposes of this section unless authorized to do so by mutual agreement between the bargaining agent and the employer.

(Added by Stats.1992, c. 1131 (A.B.3767), § 1. Amended by Stats.1993, c. 807 (A.B.1692), § 2, eff. Oct. 4, 1993.)

Additions or changes indicated by underline; deletions by asterisks * * *

Historical and Statutory Notes

1993 Legislation

The 1993 amendment at the end of subd. (a) added the sentence relating to the exercise of the choice by an exclusive or certified bargaining agent; in subd. (b) added the final sentence relating to multiemployer, collectively bargained employee welfare benefit plans operated in one or more of the designated counties; in subd. (e) inserted "to the division"; inserted "and, if available, by other external sources outside of the General Fund"; and substituted "enrolled under the pilot project" for "receiving care under the pilot project; at the end of subd. (f) added "multiemployer collectively bargained employee welfare benefit plans that offer a managed care product within a pilot project county, and welfare benefit plans sponsored by recognized exclusive bargaining agents for state employees. Pilot projects covering state employees shall be approved by the state employer and approved pursuant to Part 5 (commencing with Section 22751) of Title 2 of the Government Code."; and rewrote subd. (d) which had read:

"(d) The administrative director shall, within three months after completion of the pilot project, or sooner if feasible, prepare a report to the Legislature and the Governor describing the pilot project. The report shall include a review of the following:

"(1) Employer costs.

"(2) Average time before employees receive vocational rehabilitation services.

"(3) Average time employees receive vocational rehabilitation services.

"(4) Percent of employees returned to work.

"(5) Percent of employees placed in new jobs.

"(6) Percent of employees unable to return to any job.

"(7) Whether the pilot project was or could be utilized by small employers.

"The pilot project shall be deemed a success if the administrative director can verify that the information contained in the report required by paragraphs (1) to (7), inclusive, compares favorably with that of employers and employees not included in the pilot project. For purposes of this pilot project, a favorable comparison is defined as one in which a differential of 3 percent is noted between those participating in the pilot project and those not participating in the pilot project."

Code of Regulations References

Pilot project proposal requirements, see 8 Cal. Code of Regs. § 10178.

§ 4614. Fee limitations

(a)(1) * * * Notwithstanding Section 5307.1, where the employee's individual or organizational provider of health care services rendered under this division and paid on a fee-for-service basis is also the provider of health care services under contract with the employee's health benefit program, and the service or treatment provided is included within the range of benefits of the employee's health benefit program, and paid on a fee-for-service basis, the amount of payment for services provided under this division, for a work-related occurrence or illness, shall be no more than the amount that would have been paid for the same services under the health benefit plan, for a non-work-related occurrence or illness.

(2) * * * A health care service plan that arranges for health care services to be rendered to an employee under this division under a contract, and which is also the employee's organizational provider * * * for nonoccupational injuries and illnesses shall be paid by the employer for services rendered under this division only on a capitated basis.

(b)(1) Where the employee's individual or organizational provider of health care services rendered under this division * * * who is not providing services under a contract is not the provider of health care services under contract with the employee's health benefit program or where the services rendered under this division are not within the benefits provided under the employer-sponsored health benefit program, the provider shall receive payment that is no more than the average of the payment that would have been paid by five of the largest * * * preferred provider organizations by geographic region. Physicians, as defined in Section 3209.3, shall be reimbursed at the same averaged rates, regardless of licensure, for the delivery of services under the same procedure code * * *. This subdivision shall not apply to a health care service plan that provides its services on a capitated basis.

(2) The administrative director shall identify the regions and the five largest carriers in each region. The carriers shall provide the necessary information to the administrative director in the form and manner requested by the administrative director. The administrative director shall make this information available to the affected providers on an annual basis.

(c) Nothing in this section shall prohibit * * * an individual or organizational health care provider from being paid fees different from those set forth in the official medical fee schedule by an employer, insurance carrier, * * * third-party administrator on behalf of employers, or preferred provider organization representing an employer or insurance carrier provided that * * * the administrative director has determined that the alternative negotiated rates between the * * * organizational or individual provider and a payor, a * * * third-party administrator on behalf of employers, or a preferred provider organization will produce greater savings in the aggregate than if each item on * * * billings were to be charged at the scheduled rate.

Additions or changes indicated by underline; deletions by asterisks * * *

APPENDIX B

Section 440.135 of *Florida Statutes*

apply for a new authorization by compliance with all application requirements applicable to first-time applicants.

(20) Suspension of an insurer's authority to offer a workers' compensation managed care arrangement shall be for such period, not to exceed 1 year, as is fixed by the agency. The agency shall, in its order suspending the authority of an insurer to offer workers' compensation managed care, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the insurer prior to reinstatement of its authority. The order of suspension is subject to rescission or modification by further order of the agency prior to the expiration of the suspension period. Reinstatement shall not be made unless requested by the insurer; however, the agency shall not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(21) Upon expiration of the suspension period, the insurer's authorization shall automatically be reinstated unless the agency finds that the causes of the suspension have not been rectified or that the insurer is otherwise not in compliance with the requirements of [1]this part. If not so automatically reinstated, the authorization shall be deemed to have expired as of the end of the suspension period.

(22) If the agency finds that one or more grounds exist for the revocation or suspension of an authorization issued under this section, the agency may, in lieu of such revocation or suspension, impose a fine upon the insurer. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of a lawful order or rule of the agency or a provision of this section, the agency may impose a fine upon the insurer in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

(23) The agency shall immediately notify the Department of Insurance and the Department of Labor and Employment Security whenever it issues an administrative complaint or an order or otherwise initiates legal proceedings resulting in, or which may result in, suspension or revocation of an insurer's authorization.

(24) Nothing in [1]this part shall be deemed to authorize any entity to transact any insurance business, assume risk, or otherwise engage in any other type of insurance unless it is authorized as an insurer or a health maintenance organization under a certificate of authority issued by the Department of Insurance under the provisions of the Florida Insurance Code.

History.—s. 18, ch. 93-415.

[1]Note.—Chapter 440 is not divided into parts

440.135 Pilot programs for medical and remedial care in workers' compensation.—

(1) It is the intent of the Legislature to determine whether the costs of the workers' compensation system can be effectively contained by monitoring more closely the medical, hospital, and remedial care required by s. 440.13, while providing injured workers with more prompt and effective care and earlier restoration of earning capacity without diminution of the quality of such care. It is the further intent of the Legislature to determine whether the total cost to an employer that provides a policy or plan of health insurance and a separate policy or plan of workers' compensation and employer's liability insurance for its employees can be reduced by combining both coverages under a policy or plan that provides 24-hour health insurance coverage as set forth in this section. Therefore, the Legislature authorizes the establishment of one or more pilot programs to be administered by the Department of Insurance after consulting with the division. Each pilot program shall terminate 2 years after the first date of operation of the program, unless extended by act of the Legislature. In order to evaluate the feasibility of implementing these pilot programs, the Department of Insurance shall consult with the division regarding:

(a) Establishing alternate delivery systems using a health maintenance organization model, which includes physician fees, competitive bidding, or capitation models.

(b) Controlling and enhancing the selection of providers of medical, hospital, and remedial care and using the peer review and utilization review procedures in s. 440.13(1) to control the utilization of care by physicians providing treatment pursuant to s. 440.13(2)(a).

(c) Establishing, by agreement, appropriate fees for medical, hospital, and remedial care pursuant to this chapter.

(d) Promoting effective and timely utilization of medical, hospital, and remedial care by injured workers.

(e) Coordinating the duration of payment of disability benefits with determination made by qualified participating providers of medical, hospital, or remedial care.

(f) Initiating one or more pilot programs under which participating employers would provide a 24-hour health insurance policy to their employees under a single insurance policy or self-insured plan. The policy or plan must provide a level of health insurance benefits which meets criteria established by the Department of Insurance but which provides medical benefits for at least occupational injuries and illnesses comparable to those required by this chapter and which may use deductibles and coinsurance provisions that require the employee to pay a portion of the actual medical care received by the employee, notwithstanding any other provisions of this chapter. The policy or plan may also provide indemnity benefits as specified in s. 440.38(1)(e). The employer shall pay the entire premium for the 24-hour health insurance policy or self-insured plan other than the portion of the premium which relates to dependent coverage.

(g) Other methods of monitoring reduced costs within the workers' compensation system while maintaining quality care.

(2) The Department of Insurance, after consulting with the division, may, without a bidding process, negotiate and enter into such contracts as may be necessary or appropriate in its judgment to implement the pilot program.

(3) The Department of Insurance may also accept grants and moneys from any source and may expend such grants and moneys for the purposes of the program.

(4) No provision of the pilot programs may vary the methods for calculating weekly payments for disability compensation under this chapter. Likewise, no provision of the pilot programs shall limit the right to a hearing under s. 440.25.

(5) The Department of Insurance shall make an interim report on or before December 1, 1991, and a final report on or before the termination date specified in subsection (1) to the Speaker of the House of Representatives, the President of the Senate, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Governor, on the activities, findings, and recommendations of the Department of Insurance relative to the pilot programs. The Department of Insurance shall monitor, evaluate, and report the following information regarding physicians, hospitals, and other remedial care providers:

(a) Cost savings.
(b) Effectiveness.
(c) Effect on earning capacity and indemnity payments.
(d) Complaints from injured workers and providers.
(e) Concurrent review of quality of care.
(f) Other pertinent matters.

The information from the pilot programs shall be reported in a format to permit comparisons to other similar data.

History.—s. 19, ch. 90-201; s. 17, ch. 91-1; s. 19, ch. 93-415.

440.14 Determination of pay.—

(1) Except as otherwise provided in this chapter, the average weekly wages of the injured employee at the time of the injury shall be taken as the basis upon which to compute compensation and shall be determined, subject to the limitations of s. 440.12(2), as follows:

(a) If the injured employee has worked in the employment in which he was working at the time of the injury, whether for the same or another employer, during substantially the whole of 13 weeks immediately preceding the injury, his average weekly wage shall be one-thirteenth of the total amount of wages earned in such employment during the 13 weeks. As used in this paragraph, the term "substantially the whole of 13 weeks" shall be deemed to mean and refer to a constructive period of 13 weeks as a whole, which shall be defined as a consecutive period of 91 days, and the term "during substantially the whole of 13 weeks" shall be deemed to mean during not less than 90 percent of the total customary full-time hours of employment within such period considered as a whole.

(b) If the injured employee has not worked in such employment during substantially the whole of 13 weeks immediately preceding the injury, the wages of a similar employee in the same employment who has worked substantially the whole of such 13 weeks shall be used in making the determination under the preceding paragraph.

(c) If an employee is a seasonal worker and the foregoing method cannot be fairly applied in determining the average weekly wage, then the employee may use, instead of the 13 weeks immediately preceding the injury, the calendar year or the 52 weeks immediately preceding the injury. The employee will have the burden of proving that this method will be more reasonable and fairer than the method set forth in paragraphs (a) and (b) and, further, must document prior earnings with W-2 forms, written wage statements, or income tax returns. The employer shall have 30 days following the receipt of this written proof to adjust the compensation rate, including the making of any additional payment due for prior weekly payments, based on the lower rate compensation.

(d) If any of the foregoing methods cannot reasonably and fairly be applied, the full-time weekly wages of the injured employee shall be used, except as otherwise provided in paragraph (e) or paragraph (f).

(e) If it is established that the injured employee was under 22 years of age when injured and that under normal conditions his wages should be expected to increase during the period of disability, the fact may be considered in arriving at his average weekly wages.

(f) If it established that the injured employee was a part-time worker at the time of the injury, that he had adopted part-time employment as his customary practice, and that under normal working conditions he probably would have remained a part-time worker during the period of disability, these factors shall be considered in arriving at his average weekly wages. For the purpose of this paragraph, the term "part-time worker" means an individual who customarily works less than the full-time hours or full-time workweek of a similar employee in the same employment.

(g) If compensation is due for a fractional part of the week, the compensation for such fractional part shall be determined by dividing the weekly compensation rate by the number of days employed per week to compute the amount due for each day.

(2) If, during the period of disability, the employer continues to provide consideration, including board, rent, housing, or lodging, the value of such consideration shall be deducted when calculating the average weekly wage of the employee so long as these benefits continue to be provided.

(3) The division shall establish by rule a form which shall contain a simplified checklist of those items which may be included as "wage" for determining the average weekly wage.

(4) Upon termination of the employee or upon termination of the payment of fringe benefits of any employee who is collecting indemnity benefits pursuant to s. 440.15(2) or [1](3)(b), the employer shall within 7 days of such termination file a corrected 13-week wage statement reflecting the wages paid and the fringe benefits that had been paid to the injured employee as defined in [2]s. 440.02(24).

History.—s. 14, ch. 17481, 1935; CGL 1936 Supp. 5966(14); s. 3, ch. 20672, 1941; s. 2, ch. 28241, 1953; s. 1, ch. 63-160; s. 8, ch. 74-197; s. 1, ch. 77-290; s. 23, ch. 78-300; ss. 9, 124, ch. 79-40; s. 21, ch. 79-312; s. 4, ch. 82-237; s. 3, ch. 88-203; ss. 11, 43, ch. 89-289; s. 56, ch. 90-201; s. 52, ch. 91-1.

[1]Note.—Section 440.15(3)(b) was substantially reworded by s. 20, ch. 93-415.

[2]Note.—Substituted by the editors for a reference to s. 440.02(21) to conform to the redesignation of new subsections by s. 3, ch. 89-289, and by s. 9, ch. 90-201.

APPENDIX C

Sections 34-9-14 and 34-9-122.1 of the *Georgia Code*

CODE OF GEORGIA ANNOTATED

Book 45

1994 REVISION

With O.C.G.A. Statutory Materials

Including
Annotations of All Cases
Decided Under the O.C.G.A.

Prepared by
The Editorial Staff of The Publisher

O.C.G.A.
TITLE 34 Section 34-1-1
to
TITLE 37 Section 37-10-3

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3 9-14

(GCA § 114-605) Substitute systems: approval; termination; preservation of employer's immunity from civil action

(a) Subject to the joint approval of the board and the Commissioner of Insurance, any employer may enter into or continue any agreement with its employees to provide a system of compensation, benefit, or insurance in lieu of the compensation and insurance provided by this chapter. No such substitute system shall be approved unless it complies with the following requirements:

(1) The benefits provided for injured employees must at least equal the benefits required by this chapter;

(2) Except as provided in Code Section 34-9-122.1, no contributions may be required from employees unless the substitute system of compensation confers benefits in addition to this chapter and the contributions are applied to the additional benefits;

(3) The system must contain all provisions required of a standard policy of workers' compensation insurance issued in this state, including a workers' compensation benefits policy and an employer liability policy, and one of these policies may not be canceled independently of the other policy;

(4) Any substitute system shall be required to file statistical data which would be required with regard to a standard policy of workers' compensation insurance; and

(5) Such other standards as are necessary to ensure the compliance of such substitute system with the provisions of this chapter as are jointly promulgated by rule or regulation of the State Board of Workers' Compensation and the Commissioner of Insurance.

(b) Such substitute system may be terminated by the board on reasonable notice and hearing to the interested parties if it shall appear that the system is not fairly administered or if its operation shall disclose defects threatening its solvency or if for any substantial reason it fails to accomplish the purpose of this chapter and is not in compliance with the provisions of this Code section; and in this case the board shall determine the proper distribution of all remaining assets, if any, subject to the right of any party at interest to take an appeal to the superior court of the county wherein the principal office or chief place of business of the employer is located.

(c) It is the specific intent of the General Assembly that any alternative system of workers' compensation which is approved by the board and the Commissioner of Insurance pursuant to this Code section shall preserve an employer's immunity from civil action resulting from an injury which is compensable under this chapter as provided in Code Section 34-9-11, and the provisions of this Code section shall not be construed to the contrary.

(Acts 1920, p. 205; 1931, pp. 7, 43; 1993, p. 491, eff. April 5, 1993.)

82

Liability of employer: Court affirmed judgment in favor of employee for reimbursement of cost of workers' compensation insurance deducted from his wages. Even if employee agreed to deduction, agreement would be contrary to law and to public policy of this state. Change in statutory wording from "fully insure and keep insured" to "secure and maintain full insurance" did not release employer from obligation to pay for its own insurance. Cost of statutory liability may not be passed on to employee. That employer is required to bear cost of workers' compensation insurance is further supported by O.C.G.A. § 34-9-14(a) (GCA § 114-605), which prohibits those employers who offer board-approved substitute system of compensation from requiring contribution from employees unless substitute system confers benefits in addition to those minimally required by Act. Morgan Southern, Inc. v. Lee, 190 Ga. App. 410, 379 S. E. 2d 219 (1989).

34-9-15

(GCA § 114-106) Settlements encouraged

Nothing contained in this chapter shall be construed so as to prevent settlements made by and between the employee and employer but rather to encourage them, so long as the amount of compensation and the time and manner of payment are in accordance with this chapter. A workers' compensation insurer shall not be authorized to settle a claim on behalf of its insured employer without giving prior notice to such employer of the terms of the settlement agreement. A copy of any such settlement agreement shall be filed by the employer with the board, and no such settlement shall be binding until approved by the board. Whenever it shall appear to the board, by stipulation of the parties or otherwise, that there is a bona fide dispute as to facts, the determination of which will materially affect the right of the employee or dependent to recover compensation or the amount of compensation to be recovered, or that there is a genuine dispute as to the applicability of this chapter, and it further appears that the parties have agreed upon a settlement between themselves, which settlement gives due regard and weight to the conflicting evidence available relating to the disputed facts or to the questions as to the applicability of this chapter, then, upon such determination, the board shall approve the settlement and enter an award conforming to the terms thereof even though such settlement may provide for the payment of compensation in a sum or sums less than would be payable if there were no conflict as to the employee's right to recover compensation. When such settlement has been agreed upon and approved by the board, it shall constitute a complete and final disposition of all claims on account of the incident, injury, or injuries referred to therein, and the board shall not be authorized to enter upon any award subsequent to such board approval amending, modifying, or changing in any manner the settlement, nor shall the settlement be subject to review by the board under Code Section 34-9-104.

(Acts 1920, p. 178; 1931, pp. 7, 43; 1963, pp. 141, 142; 1975, pp. 190, 192; 1992, p. 1942, eff. July 1, 1992.)

Cited. Griggs v. All-Steel Buildings, Inc., 201 Ga. App. 111, 410 S. E. 2d 309 (1991).

Stated. Aetna Cas. & Surety Co. v. Barden, 179 Ga. App. 442, 346 S. E. 2d 588 (1986).

Approval: After appellee-employee received $1,500 for and in consideration of her execution of release, appellee filed claim for workers' compensation benefits. Release was never submitted to or approved by Board, so as to any claim for workers' compensation benefits, it is void and has no effect. Original award specified amount of compensation which was to be paid appellee and was res judicata. Requirement that appellants pay appellee $1500 plus additional 20% of that amount was correct. Any issue regarding appellants' entitlement to "credit" could and should have been raised in context of proceedings regarding original award. To extent that $1,500 payment was intended to settle appellee's pre-termination non-injury claims rather than to constitute payment of post-disability weekly benefits, appellants clearly would not be entitled to credit under § 114-415 [34-9-243]. Evidence authorized finding that appellee had undergone economic change in condition as result of her compensable injury. Appellants failed to timely file request for review of assessment of penalty. Caldwell v. Perry, 179 Ga. App. 682, 347 S. E. 2d 286 (1986).

On day following submission of settlement agreement for approval by Board of Workers' Compensation, employee died in automobile collision unconnected with his employment. Before Board could act on their lump-sum settlement agreement, appellees withdrew their consent thereto. Any settlement that may be reached between employer and his employee represents no more than their proposed mutual offer to settle, which offer must be accepted and approved by Board before binding settlement agreement between them is created. In absence of such mutual offer, there is nothing for Board to accept and approve. Justice v. Davidson Kennedy Co., 194 Ga. App. 585, 391 S. E. 2d 414 (1990).

Attorney's fees: ALJ assessed attorney's fees against employer shortly after claimant had dismissed his attorney. Board subsequently approved settlement negotiated by another attorney which was silent as to matter of assessed attorney's fees to original attorney. Board subsequently found that original attorney was entitled to assessed attorney's fees. Agreement which fixes compensation between employer and employee, approved by board of workmen's compensation, and not appealed, is res judicata as to matters therein determined and parties thereafter cannot challenge or contradict matters embodied in agreement. Settlement did not allude to "assessed attorney fees" and was not signed by original attorney, who was not aware of its existence. Don Mac Golf Shaping Co., Inc. v. Register, 185 Ga. App. 159, 363 S. E. 2d 583 (1987).

Motion to set aside: Employer sought to "set aside . . . on the basis of fraud and misrepresentation" consent agreement filed with and approved by State Board of Workers' Compensation. Although appellant denominated its complaint as one in equity, appellant's motion was actually one to set aside judgment for fraud, which is governed by O.C.G.A. § 9-11-60(d)(2) (GCA § 81A-160). Given that allegations of appellant's motion to set aside do not disclose when and under what circumstances appellant learned of alleged fraud, it does not appear with certainty that

34-9-122

(GCA § 114-613) Standard policy to be issued. Rules and regulations when lack of accident prevention and safety engineering is questioned

Any policy of insurance issued under this chapter shall be the standard workers' compensation policy of insurance containing the usual and customary provisions found in such policies and shall include a provision that the premium charge shall be promptly paid. If there is any question regarding the lack of accident prevention and safety engineering with respect to a particular risk, reasonable rules and regulations are to be promulgated, which shall be put into full force and effect when approved by the board. The requirements of this Code section and Code Sections 34-9-131 through 34-9-134 shall be in addition to anything required of insurance companies under the general laws of this state as embodied in Title 33.

(Acts 1935, p. 147; 1981, pp. 1585, 1586; 1982, pp. 644, 647, eff. Jan. 1, 1984.)

34-9-122.1

(GCA § 114-613.1) Workers' compensation health benefits pilot projects

(a) Notwithstanding any provision of this chapter to the contrary, workers' compensation health benefits pilot projects are authorized under the provisions of this Code section.

(b) The Commissioner of Insurance shall adopt rules to enable employers and employees to enter into agreements to provide the employees with workers' compensation medical payments benefits through comprehensive health insurance that covers workplace injury and illness. The Commissioner of Insurance shall review all pilot project proposals and may approve a proposal only if it confers medical benefits upon injured employees substantially similar to benefits available under this chapter. The Commissioner shall revoke approval if the pilot project fails to deliver the intended benefits to the injured employees.

(c) The comprehensive health insurance may provide for health care by a health maintenance organization or a preferred provider organization. The premium must be paid entirely by the employer. The program may use deductibles, coinsurance, and copayment by the employees not to exceed $5.00 per visit or $50.00 maximum per occurrence.

(d) The Commissioner of Insurance shall report annually to the standing committees of the General Assembly having jurisdiction over insurance and labor matters by November 1 on the status of any pilot projects approved by the Commissioner.

(Acts 1992, p. 2424, eff. April 20, 1992.)

34-9-123

(GCA § 114-606) Knowledge of injury

All policies insuring the payment of compensation under this chapter, including all contracts of mutual, reciprocal, or interinsurance must contain a clause to the effect that, as between the employer and the insurer or insurers, the notice to or knowledge of the occurrence of the injury on the part of the insured employer shall be deemed notice or knowledge, as the case may be, on the part of the insurer or insurers; that jurisdiction of the insured, for the purposes of this chapter, shall be jurisdiction of the insurer or insurers; and that the insurer or insurers shall in all things be bound by and subject to awards, judgments, or decrees rendered against such insured employer.

(Acts 1920, p. 205; 1933, pp. 182, 183.)

34-9-124

(GCA § 114-607) Policy or contract of insurance

(a) No policy or contract of insurance shall be issued unless it contains the agreement of the insurer or insurers that it or they will promptly pay all benefits conferred by this chapter and all installments of the compensation that may be awarded or agreed upon to the person entitled to them and that the obligation shall not be affected by any default of the insured after the injury or by any default in giving notice required by such policy or otherwise. Such agreement shall be construed to be a direct promise by the insurer or insurers to the person entitled to compensation and shall be enforceable in his name.

(b) A policy of insurance issued under this chapter shall always first be construed as an agreement to pay compensation; and an insurer who issues a policy of compensation insurance to an employer not subject to this chapter shall not plead as a defense that the employer is not subject to the chapter; and an insurer who issues to an employer subject to this chapter a policy of compensation insurance covering an employee or employees ordinarily exempt from its provisions shall not plead the exemption as a defense. In either case compensation shall be paid to an injured employee or to the dependents of a deceased employee for a compensable accident as if the employer or the employee or both were subject to this chapter, the policy of compensation insurance constituting a definite contract between all parties concerned.

(Acts 1920, p. 206; 1933, pp. 184, 185.)

Cited. Little Suwannee Lumber Co. v. Fitzgerald, 172 Ga. App. 144, 322 S. E. 2d 347 (1984); Insurance Co. of North America v. United States, 643 F. Supp. 465 (M. D. Ga. 1986); Winn Express Co. v. Hall, 202 Ga. App. 45, 413 S. E. 2d 505 (1991).

APPENDIX D

Section 342.352 of *Kentucky Revised Statutes*

1996

CUMULATIVE SUPPLEMENT

Kentucky Revised Statutes

Annotated

OFFICIAL EDITION

Containing the laws of a permanent and general nature of the 1993 First Extraordinary Session through the 1996 Regular Session of the General Assembly

Volume 12A

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regulations drawn by the commissioner and are not to be in any way subject to the provisions of subsections (1), (2), and (3) of this section; however, the Governor may assign the regulatory authority under this subsection to another board or agency pursuant to KRS 12.028.

(4948: amend. Acts 1976 (Ex. Sess.), ch. 26, § 4, effective January 1, 1977; 1980, ch. 104, § 11, effective July 15, 1980; 1982, ch. 447, § 11, effective January 1, 1984; 1990, ch. 35, § 1, effective July 13, 1990; 1990, ch. 490, § 5, effective July 13, 1990; 1994, ch. 181, Part 15, § 84, effective April 4, 1994.)

342.352. Voluntary pilot programs for integrated management of employer's worker compensation and group health insurance claims — Twenty-four hour coverage.

(1) The commissioner may establish one (1) or more pilot programs for interested employers of integrated management of an employer's workers' compensation and group health insurance claims by an insurer authorized to do business in the Commonwealth and may promulgate any administrative regulations necessary to implement the provisions of this subsection. The integrated management of such claims shall in no event affect any benefits, rights, or coverage established pursuant to a workers' compensation insurance policy. Treatment for work-related conditions shall not be subject to either copayments or deductibles. The commissioner shall make a report comparing the results of each pilot program to the expected results under traditional workers' compensation insurance and traditional workers' compensation with a managed care program. The pilot program shall serve as a tentative model for future experiments.

(2) No policy for twenty-four (24) hour coverage shall become effective until it is reviewed and approved by the commissioner, in consultation with the commissioner of the Department of Insurance.

(3) The purchase of a twenty-four (24) hour health policy shall not constitute an exemption from statutory provisions which require other nonmedical insurance coverage. However, an insurance carrier shall reduce its premium for insurance coverage written without the medical or health care component. Notwithstanding the provisions of Subtitle 13 of KRS Chapter 304, the premium reduction required in this subsection shall be subject to the approval of the commissioner of the Department of Insurance.

(4) If an employer obtains a twenty-four (24) hour health insurance policy, pursuant to this section, to secure payment of compensation for medical care and treatment under this chapter, the employer shall also procure an insurance policy which shall provide indemnity benefits to ensure that the total coverage afforded by both the twenty-four (24) hour insurance policy and the policy providing indemnity benefits, shall provide the total compensation required by this chapter.

(5) The participants in a pilot project for twenty-four (24) hour health coverage shall comply with periodic reporting requirements of the commission.

(6) Each agency of state government shall cooperate with the commissioner if requested to provide information for the purposes of this section.

(Enact. Acts 1994, ch. 181, Part 6, § 23, effective April 4, 1994; 1996, ch. 355, § 13, effective July 15, 1996.)

Kentucky Bench & Bar. Jones, A Defense Perspective of the Kentucky Workers' Compensation Reform Legislation (House Bill 928), Vol. 58, No. 4, Fall 1994, Ky. Bench & Bar 20.

Northern Kentucky Law Review. Jones, House Bill 928: Solution or Band-Aid for Kentucky Workers' Compensation?, 22 N. Ky. L. Rev. 357 (1995).

342.375. Policy to cover entire liability of employer — Separate policy for specified plant or location may be authorized.

Every policy or contract of workers' compensation insurance under this chapter, issued or delivered in this state, shall cover the entire liability of the employer for compensation to each employee subject to this chapter, except as otherwise provided in KRS 216.2960, 342.020, 342.345, or 342.352. However, if specifically authorized by the commissioner, a separate insurance policy may be issued for a specified plant or work location if the liability of the employer under this chapter to each employee subject to this chapter is otherwise secured and provided that no employee transferred from one plant or work location to another within the employment of the same employer shall thereby lose any benefit rights accumulated under the average weekly wage concept.
(4953: amend. Acts 1968, ch. 159, § 1; 1987 (Ex. Sess.), ch. 1, § 44, effective January 4, 1988; 1994, ch. 181, Part 6, § 24, effective April 4, 1994; 1994, ch. 512, Part 6, § 21, effective July 15, 1994.)

Legislative Research Commission Note. (7/15/94). This section was amended by 1994 Ky. Acts chs. 181 and 512 which do not appear to be in conflict and have been codified together.

Compiler's Notes. Acts 1994, Chapter 181, § 24 which amended this section, became effective April 4, 1994 and not July 15, 1994 as shown in the historical citation in the 1994 Cumulative Supplement.

342.380. Commissioner of Department of Insurance to approve policy — Review — Appeal.

No policy of insurance or rider to be used therewith shall be issued or delivered until a copy of its form has been filed with the commissioner of the Department of Insurance at least thirty (30) days before such issue or delivery, unless before the expiration of thirty (30) days the commissioner of the Department of Insurance has approved the form thereof in writing; nor if the commissioner of the Department of Insurance notifies the company in writing that in his opinion the form of the policy or rider does not comply with the laws of this state, specifying fully the reasons for his opinion. Upon petition of the company, the decision of the commissioner of the Department of Insurance shall be subject to review by the Franklin Circuit Court and to appeal therefrom to the Court of Appeals.
(4954; 1994, ch. 181, Part 15, § 85, effective April 4, 1994; 1996, ch. 355, § 14, effective July 15, 1996.)

342.382. Report of workers' compensation experience.

(1) Any insurer authorized to write a policy of workers' compensation insurance shall transmit the following information on its workers' compensation experience only to the Department of Workers' Claims and the Workers' Compensation Advisory Council each year, and that information shall be certified and reported on a net basis with respect to reinsurance for nationwide experience and direct basis with respect to Kentucky experience:
(a) Direct premiums written;
(b) Direct premiums earned;
(c) Dividends paid or credited to policyholders;

APPENDIX E

Sections 22:21 through 22:23 of *Louisiana Revised Statutes*

WEST'S

LOUISIANA STATUTES

ANNOTATED

REVISED STATUTES

Sections 22:1 to 22:610

This Edition Designated as the
Official Edition of the Louisiana Revised Statutes

Volume 15

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PART I–A. PILOT PROGRAMS

Section
21. Pilot programs: Department of Insurance: establishment.
22. Pilot program: certain provisions.
23. Pilot program: requirements, contents.

§ 21. Pilot programs: Department of Insurance: establishment

The Department of Labor and the Department of Insurance, conjunctively, after consultation with the office of worker's compensation administration in the Department of Labor, are hereby authorized to establish no more than five pilot health insurance programs, each such program to consist of only one employer, by participating employers for twenty-four-hour insurance coverage that shall terminate two years after the first date of operation of the program, unless extended by an act of the legislature. The pilot program shall monitor the medical, hospital, and remedial care of employees and the provision of prompt, effective care and earlier restoration of earning capacity without diminution of the quality of that care of the injured or disabled employee. In order to implement the pilot health insurance program for employees, the Department of Labor and the Department of Insurance, conjunctively, shall:

(1) Initiate an initial pilot project for reimbursement to hospitals on diagnostic-related groups upon determination that it is cost-effective and a statistically valid method for reimbursement.

(2) Establish alternate delivery systems using a health maintenance organization model, which includes physician fees, competitive bidding, or capitation models.

(3) Provide for the selection of providers of medical, hospital, and remedial care and utilization review procedures established pursuant to R.S. 40:2725 to control the utilization of care by physicians providing treatment pursuant to R.S. 23:1121 through 1212.

(4) Establish by written agreement all appropriate fees for medical, hospital, and remedial care pursuant to pertinent worker's compensation laws.

(5) Promote effective and timely utilization of medical, hospital, and remedial care of and by insured persons under the pilot program.

(6) Coordinate the duration of payment of disability benefits with a determination by qualified participating providers of medical, hospital, or remedial care.

(7) Establish other methods of monitoring the reduction of costs within the worker's compensation system for health and disability care while maintaining a quality of care.

(8) Provide public input and comment concerning the benefits, deductibles, pre-existing conditions exclusions, and related components of the health care portion of the twenty-four-hour employee insurance pilot program.

Added by Acts 1993, No. 656, § 1.

Historical and Statutory Notes

An R.S. 22:21 was contained within Title 22 of the Louisiana Revised Statutes of 1950 as amended and reenacted by Acts 1991, No. 1031. Acts 1991, No. 1031 was to become effective January 1, 1993. However, Acts 1992, No. 3, § 1 repealed Acts 1991, No. 1031 in its entirety, effective August 21, 1992. Consequently, the revision of Title 22 by Acts 1991, No. 1031 did not take effect.

This section, enacted as R.S. 22:10 in 1993, was redesignated as R.S. 22:21, pursuant to the statutory revision authority of the Louisiana State Law Institute.

Title of Act:

An Act to enact R.S. 22:10 through 12, relative to the Department of Labor and the Department of Insurance, conjunctively; to authorize the departments to conduct a two-year pilot program for twenty-four-hour health insurance coverage; to provide for its contents, requirements, and report; and to provide for related matters. Acts 1993, No. 656.

WESTLAW Electronic Research

See WESTLAW Electronic Research Guide following the Preface.
Louisiana Insurance Cases are available on WESTLAW database: LAIN-CS.
Annotated Louisiana Insurance Statutes are available on WESTLAW database: LAIN-ST.

§ 22. Pilot program; certain provisions

A. The Department of Labor and the Department of Insurance, conjunctively, may negotiate and enter into such contracts or agreements as may be necessary or appropriate to implement the pilot program herein.

B. The Department of Labor and the Department of Insurance, conjunctively, may also accept grants and monies from any source as allowed by law and may expend such grants and monies for the purposes of the program.

C. (1) No provision of the pilot program shall vary the methods for calculating weekly payments for disability compensation required under R.S. 23:1221 et seq.

(2) No provision of the pilot program shall limit or abrogate the right to a hearing concerning benefits, coverage, or quality of care under state law. Furthermore, each pilot program shall incorporate within its terms all provisions of the Louisiana Workers' Compensation law including but not limited to the employee's rights with respect to selection of health care providers.

D. The Department of Labor and the Department of Insurance, conjunctively, shall issue an interim report on or before December 1, 1994, and a final report on or before the termination date of August 15, 1995, to the speaker of the House of Representatives, the president of the Senate, the members of the respective committees on insurance in the House of Representatives and Senate, and the governor, on its activities, findings, and recommendations about the pilot program herein. The Department of Labor and the Department of Insurance, conjunctively, shall monitor, evaluate, and report the following information regarding physicians, hospitals, facilities, and other medical care providers:

(1) Cost savings.

(2) Effectiveness.

(3) Effect on earning capacity and indemnity payments.

(4) Complaints from injured workers and providers.

(5) Concurrent review of quality of care.

(6) Other pertinent matters.

E. The information from the pilot program shall be reported in a format to permit comparisons to other similar data or states.

Added by Acts 1993, No. 656, § 1.

Historical and Statutory Notes

An R.S. 22:22 was contained within Title 22 of the Louisiana Revised Statutes of 1950 as amended and reenacted by Acts 1991, No. 1031. Acts 1991, No. 1031 was to become effective January 1, 1993. However, Acts 1992, No. 3, § 1 repealed Acts 1991, No. 1031 in its entirety, effective August 21, 1992. Consequently, the revision of Title 22 by Acts 1991, No. 1031 did not take effect.

This section, enacted as R.S. 22:11 in 1993, was redesignated as R.S. 22:22, pursuant to the statutory revision authority of the Louisiana State Law Institute.

§ 23. Pilot program; requirements, contents

A. Every employer under the pilot program shall secure the payment of compensation by obtaining a twenty-four-hour health insurance policy which shall provide medical benefits authorized by R.S. 22:21 through 23 and which shall meet criteria established conjunctively by the Department of Labor and the Department of Insurance by rule or regulation, promulgated pursuant to the Administrative Procedure Act.[1]

B. The twenty-four-hour health insurance policy herein may provide for health care by a health maintenance organization established by R.S. 22:2001 et seq. or a preferred provider organization established pursuant to R.S. 40:2201 et seq.

C. The premium for such twenty-four-hour health insurance policy shall be paid entirely by the employer.

D. The twenty-four-hour health insurance policy may utilize deductibles and coinsurance provisions that require the employee to pay a portion of the actual medical services received by the employee. However, such policy shall exempt the employee from deductibles and coinsurance provisions related to work or occupational injuries or diseases.

E. In the event the employer purchases a twenty-four-hour health insurance policy to secure payment of compensation as to medical benefits, the employer shall also obtain an insurance policy which shall provide indemnity benefits, so that the total coverage afforded by both the twenty-four-hour health insurance policy and the policy providing indemnity benefits, shall provide the total compensation required by state law.

F. Any insurance policy issued under a pilot program shall insure the employer's obligation to a named insured throughout the entire period of any illness or disability, specifically, but not limited to the duration of benefits as provided under the Louisiana Workers' Compensation law or the Louisiana Insurance law for an employee and his dependents.

Added by Acts 1993, No. 656, § 1.

[1] R.S. 49:950 et seq.

Historical and Statutory Notes

This section, enacted as R.S. 22:12 in 1993, was redesignated as R.S. 22:24, pursuant to the statutory revision authority of the Louisiana State Law Institute. Pursuant to the same authority, the reference to "R.S. 22:10 through 11" in subsec. A was changed to "R.S. 22:21 through 23" to conform to redesignations of the referenced sections.

APPENDIX F

Chapter 39-A, Section 403 of *Maine Revised Statutes*

Maine
REVISED STATUTES ANNOTATED
1964

Volume 16B
Title 38
§ 1061 to End

Titles 39 to 39–A

1996
Cumulative Pocket Part

For Use In 1996–1997

Replacing 1995 Pocket Part in back of volume
copyrighted in 1989

**Includes laws through the
117th Legislature, 1996 Second Special Session**

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§ 402. Prepayment of premium

An insurance company that issues workers' compensation insurance policies may not require prepayment of premium more than ¼ year in advance.

1991, c. 885, § A–8, eff. Jan. 1, 1993.

Historical and Statutory Notes

Derivation:

Laws 1973, c. 559, § 1.
Laws 1977, c. 696, § 398.
Laws 1991, c. 885, § A–7.
Former § 22–A of title 39.

§ 403. Insurance by assenting employer; requirements as to self-insurers

An employer subject to this Act shall secure compensation and other benefits to the employer's employees in one or more of the ways described in this section. The failure of any employer subject to this Act to procure insurance coverage for the payment of compensation and other benefits to the employer's employees in one of the ways described in this section constitutes failure to secure payment of compensation provided for by this Act within the meaning of section 324, subsection 3 and subjects the employer to the penalties prescribed by that section.

1. Insuring under workers' compensation insurance policy. The employer may comply with this section by insuring and keeping insured the payment of such compensation and other benefits under a workers' compensation insurance policy. The insurance company shall file with the board notice, in the form required by the board, of the issuance of any workers' compensation policy to an employer. The insurance may not be cancelled within the time limited in such policy for its expiration until at least 30 days after the insurance company mails to the board and to the employer a notice of the cancellation of the insurance. In the event that the employer has obtained a workers' compensation policy from another insurance company, or has otherwise secured compensation as provided in this section, and such insurance or other security becomes effective prior to the expiration of the 30–day notice period, cancellation takes effect on the effective date of the other insurance or on receipt of security.

2. Pilot projects. Workers' compensation health benefits pilot projects are authorized under the following provisions.

A. The Superintendent of Insurance shall adopt rules to enable employers and employees to enter into agreements to provide the employees with health care benefits covering workplace injury and illness and nonworkplace injury and illness and other health care benefits, or health care and indemnity benefits covering workplace injury and illness and nonworkplace injury and illness and other health care and indemnity benefits, in comprehensive pilot projects. The health care and indemnity benefits may be provided by: organizations authorized to do business under Title 24; insurers or health maintenance organizations authorized to do business under Title 24–A; employee benefit plans; and benefit plans of employers who self-insure under this section. The superintendent shall review all pilot project proposals and may approve a proposal only if it confers medical benefits, or medical and indemnity benefits depending on the pilot project proposal, upon injured employees that are equal to or greater than the benefits available under this Title. Indemnity benefits may only be modified in those pilot projects providing medical and disability benefits for all workplace and nonworkplace diseases and injuries. The superintendent shall revoke approval if the pilot project fails to deliver the benefits contained in the proposal. A pilot project proposal that provides indemnity benefits deviating in any way from the indemnity benefits provided under this Title must include in its application to the superintendent for approval under this section a methodology for identifying both the costs and benefits of the deviations and a methodology for comparing those costs and benefits to the costs and benefits provided under this Title. The superintendent may not approve a pilot project that does not provide, as determined by the superintendent, an adequate basis for making the foregoing cost-benefit comparison between the pilot project and this Title.

B. Notwithstanding the provisions of section 206, the comprehensive health care benefits pilot project may allow for case management and cost control mechanisms, including the use of preferred provider organizations. The premium for coverage of the employee for benefits available under this Title must be paid entirely by the employer. The premium for other benefits may be paid by the employer, the employee or the employer and employee together. The deductible for the health care of the employee may not exceed a maximum of $50 per injury or illness and the coinsurance may not exceed $5 per treatment of the employee by the health care provider.

C. The Superintendent of Insurance shall report annually to the joint standing committees of the Legislature having jurisdiction over banking and insurance and labor matters by November 1st on the status of any pilot projects approved by the superintendent.

Text of subsection 2, paragraph D, as amended by Laws 1995, c. 36, § 1.

D. Unless continued or modified by law, this subsection is repealed on January 1, 2001.

Text of subsection 2, paragraph D, as amended by Laws 1995, c. 277, § 1.

D. Unless continued or modified by law, this subsection is repealed January 1, 2001.

3. **Proof of solvency and financial ability to pay; trust.** The employer may comply with this section by furnishing satisfactory proof to the Superintendent of Insurance of solvency and financial ability to pay the compensation and benefits, and depositing cash, satisfactory securities, irrevocable standby letters of credit issued by a qualified financial institution or a surety bond with the board, in such sum as the superintendent may determine pursuant to subsection 8, the bond to run to the Treasurer of State and to be conditional upon the faithful performance of this Act relating to the payment of compensation and benefits to any injured employee. In case of cash or securities being deposited, the cash or securities must be placed in an account at interest by the Treasurer of State, and the accumulation of interest on the cash or securities so deposited must be credited to the account and may not be paid to the employer to the extent that the interest is required to support any present value discounting in the determination of the amount of the deposit. Any security deposit must be held by the Treasurer of State in trust for the benefit of the self-insurer's employees for the purposes of making payments under this Act. If the superintendent determines that the self-insurer has experienced a deterioration in financial condition that adversely affects the self-insurer's ability to pay obligations under this Act, the security amount may be in excess of the minimum amount required by this Title.

A self-insurer may, with the approval of the Superintendent of Insurance, use the following types of security to satisfy the self-insurer's responsibility to post security required by the superintendent: a surety bond; an irrevocable standby letter of credit; cash deposits and acceptable securities; and an actuarially determined fully funded trust. For purposes of this section, "tangible net worth" means equity less assets that have no physical existence and depend on expected future benefits for their ascribed value. A group self-insurer that maintains a trust actuarially funded to the confidence level required by the superintendent may use an irrevocable standby letter of credit as follows: Only in an amount not greater than the difference between the funding to the required confidence level and funding to the confidence level reduced by 10 percentage points; only as long as the trust assets are not used as collateral for the letter of credit; and only as long as the value of trust assets, excluding the value of the letter of credit, are at least equal to the present value of ultimate expected incurred claims, claims settlement costs and, if determined necessary by the superintendent, administrative costs.

A. An individual self-insurer providing an irrevocable standby letter of credit as security shall file with the Superintendent of Insurance a letter of credit, on a form approved by the superintendent, copies of any agreements or other documents establishing the terms and conditions of the employer's reimbursement obligations to the financial institution issuing the letter of credit, together with copies of any required security agreements, mortgages or other agreements or documents granting security for the employer's reimbursement obligations and any other agreements that contain conditions, restrictions or limitations of any kind upon the employer, the superintendent or the Treasurer of State. The form of letter of credit approved by the superintendent must include, but is not limited to, all terms specifically required by this subsection and all

APPENDIX G

Section 14.1 of Title 85 of the *Oklahoma Statutes*

OKLAHOMA STATUTES ANNOTATED

Title 85
Workers' Compensation

§§ 1 to 25

1997 Cumulative Annual Pocket Part

For Use In 1996–1997

Replacing 1996 pocket part supplementing 1992 main volume

Includes laws through the 1996 Second Regular Session of the 45th Legislature

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once award based on joint petition was granted; hospital which treated worker did not have notice of joint petition settlement proceeding and was not party to joint petition, consequently, joint petition was not final as to hospital, and Court retained jurisdiction as it was required to ensure that hospital was paid for its services. Thomas v. Oklahoma Orthopedic & Arthritis Foundation Inc., Okla., 903 P.2d 279 (1995), rehearing denied.

49. —— Claims, jurisdiction

Workers' compensation court is not vested with jurisdiction over medical care provider's claim for services rendered in absence of filing of initial claim or notice of injury by injured employee or his employer. Romero v. Workers' Compensation Court, Okla., 863 P.2d 1251 (1993).

58. Out-of-state providers

Amounts recoverable by medical providers under workers' compensation statutes are limited to those set forth in schedule of fees, and no statutory language exempts out-of-state providers from its limit. Bill Cooper Frac Tank Co. v. Columbia Regional Hosp., Okla.App., 856 P.2d 586 (1993), certiorari denied.

When Missouri hospital chose to avail itself of remedy under Oklahoma workers' compensation scheme, it subjected itself to limitations on that remedy. Bill Cooper Frac Tank Co. v. Columbia Regional Hosp., Okla.App., 856 P.2d 586 (1993), certiorari denied.

Any claim Missouri hospital had under Oklahoma workers' compensation laws for compensation for medical services provided to worker injured in the course and scope of his employment in Oklahoma under Oklahoma contract of employment derived from injured worker's rights, and thus Oklahoma law governed claim. Bill Cooper Frac Tank Co. v. Columbia Regional Hosp., Okla.App., 856 P.2d 586 (1993), certiorari denied.

§ 14.1. Integrated management of claims pilot program

The Insurance Commissioner of the State of Oklahoma shall establish a pilot program of integrated management of an employer's workers' compensation and group health insurance claims by an insurer authorized to do business in the state and shall promulgate such rules as may be necessary to implement the provisions of this section. The integrated management of such claims shall in no event affect any benefits, rights or coverage established pursuant to a workers' compensation insurance policy.

Added by Laws 1993, c. 349, § 8, eff. Sept. 1, 1993.

§ 14.2. Certified workplace medical plans—Election by employee

A. If a self-insured employer, group self-insurance association plan, an employer's workers' compensation insurance carrier or an insured, which shall include any member of an approved group self-insured association, policyholder or public entity, regardless of whether such entity is insured by the State Insurance Fund, has contracted with a workplace medical plan that is certified by the Commissioner of Health as provided in Section 14.3 of this title, an employee shall exercise the election for which provision is made in subsection C of Section 14 of this title. If a self-insured employer approved by the Workers' Compensation Court has in force a collective bargaining agreement with its employees, the certified workplace medical plan shall be selected with the approval of both parties signatory to the collective bargaining agreement. Notwithstanding any other provision of law, those employees who are subject to such certified workplace medical plan shall receive medical treatment in the manner prescribed by the plan. Qualified employers shall, when a contract of employment is made or on the annual open enrollment date for the insurer's certified plan, provide the employee with written notice of and the opportunity to enroll in the plan or to indicate the employee's desire to select a physician pursuant to paragraph 1 of subsection C of Section 14 of this title. The election must be made in writing:

1. Within thirty (30) days of employment;

2. Within thirty (30) days after an employee receives notice that a self-insured employer, group self-insurance association plan, or an employer's workers' compensation insurance carrier implements a certified workplace medical plan; or

3. On the annual open enrollment date of the certified workplace medical plan.

B. If an employee elects not to enroll in the certified workplace medical plan, the employee shall provide a list of physicians who meet the requirements set forth in paragraph 1 of subsection C of Section 14 of this title. The employee's list of physicians may be updated on the annual open enrollment date of the certified workplace medical plan. Procedures and forms for enrollment shall be provided by the self-insured employer, group self-insurance association plan, insurance carrier or an insured, which

APPENDIX H

Section 656.016 of *Oregon Revised Statutes*

1995

OREGON REVISED STATUTES

INCLUDING
All material affected by Acts of the 1995 regular session and special session of the Sixty-eighth Legislative Assembly

Volume 10

Containing, with some exceptions, the statute laws of Oregon of a general, public and permanent nature in effect on September 9, 1995, the normal effective date of Acts passed by the regular session of the Sixty-eighth Legislative Assembly, which adjourned on June 10, 1995, and the statute laws of Oregon of a general, public and permanent nature in effect on November 3, 1995, the normal effective date of Acts passed by the special session, July 28 to August 4, 1995

PUBLISHED PURSUANT TO ORS 171.275
by the
LEGISLATIVE COUNSEL COMMITTEE
of the
LEGISLATIVE ASSEMBLY
of the
STATE OF OREGON

support for the injured workers and their dependents; and

(c) An exclusive, statutory system of compensation will provide the best societal measure of those injuries that bear a sufficient relationship to employment to merit incorporation of their costs into the stream of commerce.

(2) In consequence of these findings, the objectives of the Workers' Compensation Law are declared to be as follows:

(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;

(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable;

(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable;

(d) To encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents; and

(e) To provide the sole and exclusive source and means by which subject workers, their beneficiaries and anyone otherwise entitled to receive benefits on account of injuries or diseases arising out of and in the course of employment shall seek and qualify for remedies for such conditions.

(3) In recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balanced manner. [1981 c.535 §29 (enacted in lieu of 656.004); 1995 c.332 §4]

Note: See notes under 656.202.

Note: The amendments to 656.012 by section 4a, chapter 332, Oregon Laws 1995, become operative December 31, 2000. See section 4a, chapter 332, Oregon Laws 1995. The text that is operative on and after December 31, 2000, is set forth for the user's convenience.

656.012. (1) The Legislative Assembly finds that:

(a) The performance of various industrial enterprises necessary to the enrichment and economic well-being of all the citizens of this state will inevitably involve injury to some of the workers employed in those enterprises; and

(b) The method provided by the common law for compensating injured workers involves long and costly litigation, without commensurate benefit to either the injured workers or the employers, and often requires the taxpayer to provide expensive care and support for the injured workers and their dependents.

(2) In consequence of these findings, the objectives of the Workers' Compensation Law are declared to be as follows:

(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;

(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable;

(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable; and

(d) To encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents.

(3) In recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balanced manner.

COVERAGE

(Combined Health Coverage Pilot Program)

Note: Sections 1 to 6, chapter 758, Oregon Laws 1993, provide:

Sec. 1. (1) The Director of the Department of Consumer and Business Services may initiate a pilot program under which participating employers may meet the requirements to provide medical coverage under ORS chapter 656 along with nonwork-connected health care provided by the employer by providing the coverage through a health or workers' compensation insurance policy or plan or self-funded health plan.

(2) The director may authorize participation by an employer, insurer or health care service contractor in the pilot program on or before July 1, 1994, for a period not to exceed four years. The director may revoke the authority at any time at the discretion of the director.

(3) On January 1, 1995, and each six months thereafter during the pilot period, the director shall report to the President of the Senate and the Speaker of the House of Representatives for referral to appropriate interim or standing committees of the Legislative Assembly on the status of the pilot program, including any recommendation for legislation, if necessary, to improve the efficiency of the program.

(4) The director by rule shall adopt standards to govern the pilot program. Participating employers, insurers and health care service contractors must comply with applicable provisions of ORS chapters 654, 656 and 659, and the Insurance Code. Except as otherwise provided in this subsection, for the purposes of the pilot program, the director by rule may exempt participating employers, insurers and health care service contractors from administrative provisions of ORS chapter 656, including, but not limited to, ORS 656.248, 656.252 and 656.254. The director shall not establish exemptions affecting benefits or other rights of a subject worker or other person whose benefits or other rights derive from the subject worker.

(5) The presentation of a medical bill to the carrier or the employer under the pilot program authorized under subsection (1) of this section does not in itself constitute a claim under ORS chapter 656. A claim for coverage under ORS chapter 656 must be filed in the manner prescribed in ORS chapter 656. [1993 c.758 §1]

Sec. 2. (1) For the purpose of participating in the pilot program described in section 1 of this Act, an insurer transacting health insurance may offer medical coverage required under ORS chapter 656 as part of the health insurance coverage offered under a health insurance policy under the Insurance Code. However, except as the director provides by rule under section 1 of this Act, for purposes of providing medical coverage required under ORS chapter 656, such an insurer is subject to the requirements of ORS chapter 656.

(2) An insurer offering medical coverage as provided in subsection (1) of this section is not required to obtain authorization under its certificate of authority to transact workers' compensation insurance in order to offer the medical coverage.

(3) An insurer to whom this section applies is not subject to ORS 731.554 (2), 731.628 or 742.041 with respect to the coverage offered under this section.

(4) This section does not authorize an insurer to provide workers' compensation disability coverage unless the certificate of authority of the insurer authorizes the insurer to transact workers' compensation insurance. [1993 c.758 §2]

Sec. 3. (1) For the purpose of participating in the pilot program described in section 1 of this Act, a health care service contractor as defined in ORS 750.005 may offer medical coverage required under ORS chapter 656 as part of the health care services as defined in ORS 750.005 provided by the health care service contractor. However, except as the director provides by rule under section 1 of this Act, for purposes of providing the medical coverage, such a health care service contractor is subject to the requirements of ORS chapter 656.

(2) A health care service contractor offering medical coverage as provided in subsection (1) of this section is not required to obtain separate authority to transact workers' compensation insurance in order to offer the medical coverage as part of the health care services provided by the health care service contractor.

(3) This section does not authorize a health care service contractor to provide workers' compensation disability coverage under its certificate of authority. [1993 c.758 §3]

Sec. 4. (1) For the purpose of participating in the pilot program described in section 1 of this Act, an insurer transacting workers' compensation coverage may offer health insurance governed by the provisions of the Insurance Code in conjunction with the workers' compensation coverage meeting the requirements of ORS chapter 656.

(2) An insurer offering health insurance as provided in subsection (1) of this section is not required to obtain authorization under its certificate of authority to transact health insurance in order to offer health insurance.

(3) An insurer to whom this section applies is not subject to ORS 731.554 (1) or 742.041 with respect to the coverage offered under this section. [1993 c.758 §4]

Sec. 5. The Director of the Department of Consumer and Business Services shall establish an advisory committee to assist in the implementation and evaluation of the pilot program described in section 1 of this Act. The advisory committee shall include representatives of employers, workers and their representatives, insurers and health care providers. [1993 c.758 §5]

Sec. 6. This Act is repealed on July 1, 1998. [1993 c.758 §6]

656.016 [1965 c.285 §5; 1967 c.341 §3; repealed by 1975 c.556 §20 (656.017 enacted in lieu of 656.016)]

656.017 Employer required to pay compensation and perform other duties; state not authorized to be direct responsibility employer. (1) Every employer subject to this chapter shall maintain assurance with the director that subject workers of the employer and their beneficiaries will receive compensation for compensable injuries as provided by this chapter and that the employer will perform all duties and pay other obligations required under this chapter, by qualifying:

(a) As a carrier-insured employer; or

(b) As a self-insured employer as provided by ORS 656.407.

(2) Notwithstanding ORS chapter 278, this state shall provide compensation insurance for its employees through the State Accident Insurance Fund Corporation.

(3) Any employer required by the statutes of this state other than this chapter or by the rules, regulations, contracts or procedures of any agency of the Federal Government, this state or a political subdivision of this state to provide or agree to provide workers' compensation coverage, either directly or through bond requirements, may provide such coverage by any method provided in this section. [1975 c.556 §21 (enacted in lieu of 656.016); 1977 c.659 §1; 1979 c.815 §1; 1981 c.854 §3; 1985 c.731 §30]

656.018 Effect of providing coverage; exclusive remedy. (1)(a) The liability of every employer who satisfies the duty required by ORS 656.017 (1) is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such conditions, except as specifically provided otherwise in this chapter.

(b) This subsection shall not apply to claims for indemnity or contribution asserted by a corporation, individual or association of individuals which is subject to regulation pursuant to ORS chapter 757 or 759.

(c) Except as provided in paragraph (b) of this subsection, all agreements or warranties contrary to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void.

(2) The rights given to a subject worker and the beneficiaries of the subject worker under this chapter for injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment are in lieu of any remedies they might otherwise have for such injuries, diseases, symptom complexes or similar conditions

APPENDIX I

National Association of Insurance Commissioners
24-Hour Coverage Pilot Project Model Act

TWENTY-FOUR HOUR COVERAGE PILOT PROJECT MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known as the Twenty-Four Hour Coverage Pilot Project Model Act.

Section 2. Purpose

It is the intent of the Legislature of [insert state] to determine whether the costs of the workers' compensation system and the health care delivery system can be more effectively managed than under the current system by combining the benefits required by [insert section requiring the provision of workers' compensation medical benefits] with the benefits offered under a group health insurance policy or benefit plan. Therefore, the Legislature of [insert state] authorizes the establishment of up to ten (10) pilot projects to be administered by the [insert state] Department of Insurance after consulting with the [insert appropriate workers' compensation administrator]. Each pilot project shall terminate five (5) years after the first date of operation of the project, unless extended by an Act of the Legislature.

Section 3. Commissioner's Authority and Responsibility

All pilot projects are subject to approval by the commissioner. The commissioner shall promulgate rules and regulations in order to implement these pilot projects, after consulting with the [insert workers' compensation administrator] regarding:

Drafting Note: Wherever the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be inserted.

A. Benefits required to be provided by the contract;

B. (1) Benefits required to be paid after the expiration of the pilot projects for compensable work-related injuries which occurred during the term of the project: The Insurance Commissioner shall determine if the additional benefits may be provided under a twenty-four hour insurance policy or under a traditional workers' compensation policy;

(2) Health insurance benefits required to be paid after the expiration of the pilot projects: Policies issued to provide health insurance benefits following the pilot project shall not exclude conditions which first became known or manifested during the period of the pilot project unless treatment is being rendered under a workers' compensation policy;

C. Rights of the employee to benefits in the event of cancellation of coverage or termination of employment prior to the expiration of the pilot project;

D. All reporting requirements; and

E. Grievance procedures.

Section 4. Definitions

A. "Carrier" means an insurance company, [nonprofit hospital and surgical corporation] or health maintenance organization licensed to transact the business of insurance in this state.

Drafting Note: Where the phrase "nonprofit hospital and surgical corporation" appears in this Act, the appropriate designation for the Blue Cross/Blue Shield plan of the state should be substituted, if desired.

B. "Commissioner" means the Insurance Commissioner of this state.

C. "Complaint" means any dissatisfaction expressed to a twenty-four hour medical insurance policy carrier or [insert name(s) of relevant state agencies that can accept complaints] by an employer, injured worker or covered dependent concerning health care provided, services or a decision rendered under a twenty-four hour medical insurance policy.

D. "Designated workers' compensation statistical agency" means the entity licensed to collect and analyze workers' compensation experience by [insert name of relevant state agency].

E. "Experience modification factors" mean factors promulgated in accordance with the approved plan, for prospective application, which reflect the relative loss experience of an insured.

F. "Form" or "policy form" means the contractual agreement between the carrier and the insured that provides the terms and conditions of the coverage granted. It includes the contract or policy, any declarations or certificate, any endorsement or rider, the benefits plan or any other document that amends the insurance contract.

G. "Group health plan" means a group policy of health insurance, or group contract with a health care service contractor, in compliance with the insurance code.

H. "Subject worker" means an employee who is subject to the provisions of [insert applicable provisions of the workers' compensation act of the state].

960-2

I. "Twenty-four hour medical insurance policy" means a single insurance policy or plan that provides health care benefits for both work-related and non-work-related injuries, but which may provide either disability benefits only for work-related injuries or both work-related and non-work-related injuries.

J. "Work-related injury" means that type of injury, illness or disease, including death, which is considered to be a "compensable injury" under [insert section defining "compensable injury" under state's workers' compensation law].

Section 5. Carriers Authorized to Participate in the Pilot Projects

A carrier authorized to write workers' compensation insurance pursuant to Section [insert section of insurance law granting authority to write workers' compensation] or authorized to write health insurance or health benefits plans pursuant to Section [insert section of insurance law granting authority to write health insurance] may, without further amending its certificate of authority, participate [either singly, jointly or by contract,] in the pilot project and issue insurance contracts of the type specified in Section 8, if approved by the commissioner. The commissioner shall consider at least the following criteria in the approval process for carriers to participate [either singly, jointly or by contract,] in the pilot project:

Drafting Note: The bracketed phrase may be added if your state desires to allow more than one carrier to be involved in a single pilot project.

A. A demonstrated history of financial stability;

B. The ability to establish reserves and additional deposits the commissioner decides may be necessary for occurrence based claims;

C. The ability to commit necessary resources for the duration of the entire pilot project;

D. The structural ability to establish managed care arrangements;

E. A demonstrated ability to comply with the reporting requirements of the pilot project;

F. The ability to provide recommendations to employers and implement safety, wellness and loss control programs;

G. Minimum capital and surplus as determined by the commissioner;

H. The acceptance by all employers of the terms and conditions of the pilot project; and

I. An approved complaint procedure, described in writing and provided to all affected workers and health care providers.

Section 6. Contracts to Provide Pilot Projects

The commissioner, after consultation with the [insert workers' compensation administrator], is authorized, without a requirement that there be a bidding process, to enter into contracts with carriers, health care providers and other persons and entities as may be deemed necessary and appropriate to carry out the purposes of this pilot project.

Section 7. Grant Moneys

The commissioner may accept grants and gifts of money from any public or private public-interest or eleemosynary institution, person or foundation as may be deemed reasonably appropriate and in the best interests of the state for the purpose of implementing the pilot project.

Section 8. Pilot Plan Coverage

A. Covered members: for work-related injuries, covered members of the plan shall be limited to subject workers of the participating employer, as defined in [insert reference to employees covered under the workers' compensation act of the state]. For non-work-related injuries, covered members may be restricted to those workers designated by the employer to be covered by the twenty-four hour medical insurance policy and may include their family members.

B. Disclosure to covered members: each pilot plan must provide written disclosure of plan provisions to covered members in a timely, accurate, complete and understandable manner. Each disclosure to plan members must comply with the provisions of the [insert insurance law, workers' compensation act and related rules of the state].

C. Health care services:

(1) Coverage of work-related injuries must comply with all provisions of [insert reference to the workers' compensation act of the state], except as provided in this Act. It is the responsibility of the carrier to ensure that all required health care services are provided for every work-related injury;

(2) Coverage of non-work-related injuries must comply with the terms of the group health plan portion of the pilot project;

(3) Nothing in this law shall be construed to establish concurrent or double coverage for the same injury, illness or disease under Paragraphs (1) and (2) of this subsection; and

(4) Notwithstanding the provisions of [insert reference to statutory or regulatory fee schedules], carriers writing twenty-four hour coverage under the pilot project may negotiate provider and hospital fees for all health care services provided under the plan.

D. Coordination of health care coverage: once a subject worker suffering a work-related injury has achieved maximum medical improvement, coverage of health care services that are included in the group health plan portion of a pilot project, but are not compensable under [insert reference to the workers' compensation act of the state], shall not be denied to pilot project plan members solely because the services have been prescribed to treat a work-related injury.

E. Copayments and deductibles: all twenty-four hour pilot plans shall include a schedule of allowable copayments and deductibles, which shall be in accordance with one of the following six (6) alternatives:

(1) First alternative: no copayments and/or deductibles allowed for work-related injuries

(a) Coverage of work-related injuries shall not require any copayment or deductible to be paid by subject workers. Coverage of non-work-related injuries may require copayments or deductibles to be paid by plan members;

(b) If a workers' compensation claim has been filed by a covered worker, copayments and deductibles may not be collected from the worker for any health care services related to the claim, unless the claim has been denied. If the claim is subsequently denied or the services are determined to be unrelated to the claim, the worker may be billed retroactively and held liable for the copayment or deductibles; and

(c) If any copayment or deductible is paid by a subject worker for health care services that are later determined to be work-related, the pilot project plan shall refund the amount paid within fifteen (15) days of the determination.

(2) Second alternative: small, equal copayments allowed for work-related injuries and non-work-related injuries

(a) Twenty-four hour coverage pilot projects may require copayments of up to $10 per office visit to be paid by subject workers, for health care services required as a result of work-related injuries. Twenty-four hour coverage pilot projects may require the same copayments of up to $10 per office visit to be paid by those workers entitled to coverage under the pilot project for health care services required as a result of non-work-related injuries. No other copayments or deductibles may be charged to workers covered under the pilot; provided, however, that other copayments or deductibles may be charged for various health care services and pharmaceuticals required as a result of injuries, illnesses or diseases of family members of workers covered under the family plan; and

(b) For purposes of data integrity and premium calculation, the carrier shall keep track of those health care services initially thought to be work-related and later determined not to have been work-related, and those health care services initially thought not to be work-related but later determined to have been work-related, and shall apply any deductibles received to the appropriate accounts.

(3) Third alternative: copayments allowed for work-related injuries and non-work-related injuries but may be waived with use of provider networks

(a) Twenty-four hour coverage pilot projects may require copayments of $25 per office visit to be paid by subject workers for health care services required as a result of work-related injuries. Twenty-four hour coverage pilot projects may require the same $25 copayments per office visit to be paid by those workers entitled to coverage under the pilot project for health care services required as a result of non-work-related injuries. No other copayments or deductibles may be charged to workers covered under the pilot; provided, however, that

other copayments or deductibles may be charged for various health care services and pharmaceuticals required as a result of injuries, illnesses or diseases of family members of workers covered under the family plan;

(b) The copayments payable by subject workers for work-related injuries shall be waived if the subject workers agree to secure health care services through health care provider networks designated by the employer or carrier. Copayments and deductibles for other injuries, illnesses and diseases covered under the plan shall be appropriately reduced if the other workers and family members agree to secure health care services through health care provider networks designated by the employer or carrier; and

(c) For purposes of data integrity and premium calculation, the carrier shall keep track of those health care services initially thought to be work-related and later determined not to have been work-related, and those health care services initially thought not to be work-related but later determined to have been work-related, and shall apply any deductibles or copayments received to the appropriate accounts.

(4) Fourth alternative: deductibles or copayments, or both, on work-related injuries and non-work-related injuries in return for twenty-four hour disability benefits

(a) Twenty-four hour coverage pilot projects may require copayments or deductibles for various health care services and pharmaceuticals required as a result of work-related injuries or non-work-related injuries covered under the pilot;

(b) All disability income and rehabilitation benefits available for work-related injuries under the pilot shall also be available for non-work-related injuries of employees under the group health portion of the pilot; and

(c) For purposes of data integrity and premium calculation, the carrier shall keep track of those health care services initially thought to be work-related and later determined not to have been work-related, and those health care services initially thought not to be work-related but later determined to have been work-related, and shall apply any deductibles or copayments received to the appropriate accounts.

(5) Fifth alternative: deductibles or copayments, or both, on work-related injuries and non-work-related injuries in return for employer payment of entire premium

(a) Twenty-four hour coverage pilot projects may require copayments or deductibles for various health care services and pharmaceuticals required as a result of work-related injuries or non-work-related injuries covered under the pilot project; provided, however, that the employer shall pay the entire premium for the plan, including the same level of contribution for dependents' coverage that was in place prior to the implementation of the pilot project; and

(b) For purposes of data integrity and premium calculation, the carrier shall keep track of those health care services initially thought to be work-related and later determined not to have been work-related, and those health care services initially thought not to be work-related but later determined to have been work-related, and shall apply any deductibles or copayments received to the appropriate accounts.

(6) Sixth alternative: deductibles or copayments, or both, and managed care on work-related injuries and non-work-related injuries in return for disability benefits.

(a) Twenty-four hour coverage pilot projects may require copayments or deductibles for various health care services, disability and rehabilitation services, behavioral health services, and pharmaceuticals required as a result of work-related injuries or non-work-related injuries;

(b) All income and disability benefits available for work-related injuries shall be available for non-work-related injuries of covered members;

(c) All non-emergency services covered under the twenty-four hour coverage plan may be provided through a limited network of participating providers; and

(d) For purposes of data integrity and premium calculation, the carrier shall keep track of those services initially thought to be work-related and later determined not to have been work-related, and those services initially thought not to be work-related but later determined to have been work-related, and shall apply any payments made by covered members to the appropriate accounts.

F. The use of provider networks is subject to the following conditions:

(1) A pilot project may deliver health care services through a limited network of participating health care providers and may restrict coverage for non-network providers by application of the deductibles and copayments specified in this act;

(2) The pilot project may establish the amount and manner of payment to the provider network. Pilot projects may implement cost containment features which may include, but are not limited to, preadmission certification for inpatient and selected outpatient services, second medical opinions for non-emergency surgery, reasonable limitations on services and providers, and the use of utilization review mechanisms. These arrangements shall not unfairly deny benefits for medically necessary covered services. Further, the arrangements shall not create a situation whereby the provider network is required to accept a transfer of risk from the employer to the provider network, unless the provider network has also been properly licensed by the insurance department. Agreements to provide reduced fees for service would be considered acceptable. Agreements to provide services on a capitation basis would be considered to involve a transfer of risk requiring proper licensure;

(3) If network restrictions apply, the pilot project plan shall include provisions to assure adequate coverage of emergency services and treatment needs outside the pilot project's service area;

(4) The provider network must be shown to have the skills and resources necessary to provide for the care and treatment of work-related injuries; and

(5) The terms and conditions of network coverage and a listing of all participating providers by service category shall be fully disclosed in the pilot project application and to all plan members.

G. Disability and rehabilitation benefits: coverage under a pilot project shall provide disability income and rehabilitation benefits for work-related injuries at least equivalent to that ordinarily provided under a workers' compensation policy, as specified in [insert reference to the workers' compensation act]. No provision of the pilot project may decrease the weekly payments for disability compensation under [insert applicable provisions of the workers' compensation act].

H. Employers' liability coverage: coverage under a pilot project shall provide the employers' liability coverage that is ordinarily provided under a workers' compensation policy.

I. Effective date of coverage: coverage under a pilot plan shall begin on the effective date specified in the pilot plan agreement. Workers' compensation coverage shall not be interrupted because of the initiation of a pilot plan. Injured subject workers will continue to receive workers' compensation benefits from the current workers' compensation carrier without interruption.

J. Coverage beyond the expiration of the pilot project:

(1) Coverage of work-related injuries beyond the expiration of a pilot project must comply with the provisions of [insert reference to the workers' compensation act]. No interruption of workers' compensation coverage shall occur solely because of the expiration of the pilot project.

(2) To ensure continuity of care, the pilot project application shall specify the manner in which covered members will receive health care services beyond the expiration of the pilot project.

K. Payment of premiums: premiums for the group health plan portion of pilot project may be shared by the employer and the covered members in accordance with the terms of that portion of the plan. Premiums for the workers' compensation portion must be fully paid by the employer. A delineation of the premiums attributable to the two portions of coverage must be maintained by the plan to ensure compliance with this subsection.

Section 9. Exclusive Remedy and Prohibited Defenses

The exclusive remedy provisions pursuant to Section [insert section providing workers' compensation exclusive remedy provisions] apply to work-related injuries covered by the twenty-four hour medical insurance policy. Likewise, the prohibited defense provisions pursuant to Section [insert section providing workers' compensation prohibited defense provisions] apply to actions to recover damages brought by employees against employers for work-related injuries covered by the twenty-four hour medical insurance policy.

Section 10. Approval of Policy Language

The twenty-four hour medical insurance policy, any declarations or certificate and any endorsement or rider shall not be issued or delivered to a participating employer until a copy of the form is filed with the Department of Insurance and approved by the commissioner as conforming with the requirements of this Act and any other applicable law. The commissioner shall promptly review the filing and either approve or disapprove the filing within [insert number] days of the date the filing was received by the Department of Insurance. The commissioner may, by rule, direct the use of specific policy language for the period of the pilot project.

Section 11. Approval of Rates and Rating Plans

Each insurer participating in the pilot project shall file with the commissioner its manual of rules, rates and rating systems that will be applicable to the pilot project. Rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner shall promptly review the filing and either approve or disapprove the filing within [insert number] days of the date the filing was received by the Department of Insurance. The insurer shall not apply a rating plan that will prohibit it from complying with the statistical reporting requirements of Section 14.

Section 12. Examination of Records

The commissioner may, as often as the commissioner deems necessary, make or cause to be made an examination of the books and records of the carriers and insured employers participating in the pilot project.

Section 13. Loss Reserve Standards

The commissioner shall review, approve and monitor standards for the estimation of the ultimate losses incurred under the twenty-four hour medical insurance policy. Carriers shall report data on loss reserves in at least as much detail as required for reporting workers' compensation loss reserves on Schedule P of the annual statement. Every carrier participating in a pilot project shall annually submit the opinion of a qualified actuary as to whether the reserves held in support of the twenty-four hour medical insurance policy are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner may, by rule, define the specifics of this opinion.

Section 14. Statistical Reporting

The commissioner shall, by rule, establish reasonable and necessary standards for collecting and compiling the premium and loss experience incurred under the twenty-four hour medical insurance policy. The commissioner may require that experience under the pilot projects be split as to work-related and non-work-related medical claims. These standards shall include, but are not limited to, provision of information necessary for the commissioner to complete the report specified in Section 19, provision of information to the designated workers' compensation statistical agency consistent with its statistical plan so that the integrity of the workers' compensation statistical database is maintained, and provision of information to the designated workers' compensation statistical agency consistent with its statistical plan so that the experience rating plan may be applied to the participating employer in accordance with the applicable experience rating plan approved for use in the state. The carrier shall continue to report data on losses that remain open after the termination of the pilot project in the same manner prescribed in this section until all losses have been paid.

Section 15. Guaranty Fund Participation

The twenty-four hour medical insurance policy shall be classified as property and casualty coverage regardless of the carrier approved to provide the coverage. As such, the carrier shall be obligated to participate in the property and casualty guaranty association specified in [insert applicable section providing for participation in the property and casualty insurance guaranty association]. All premiums collected for the twenty-four hour medical insurance policy shall be considered assessable premiums for purposes of participation in the guaranty association. In the event of insolvency of the carrier, the guaranty association shall honor the full extent of the contractual obligation assumed by the carrier under the twenty-four hour medical insurance policy.

Section 16. Special Assessments

A carrier providing coverage to an employer through the twenty-four hour medical insurance policy is obligated to participate in the [insert reference to residual market mechanism, second injury fund or other fund that relies on assessments from workers' compensation insurance premiums]. For purposes of calculation of this special assessment, the commissioner shall establish by rule, or order, the amount of premium generated under the twenty-four hour medical insurance policy which shall be considered assessable premium.

Drafting Note: A state should consider the ratio of the workers' compensation standard premium to the total premium for both workers' compensation and the health insurance plan used by the employer in choosing an appropriate amount. States with relatively small residual market shares for workers' compensation may choose to exclude this section. States should consider loss based assessments, if applicable.

Section 17. Premium Taxation

All premium received by any carrier under a twenty-four hour pilot project shall be reported by that carrier as direct written property and casualty premium, and shall be subject to premium taxation as such.

Drafting Note: Workers' compensation premium is subject to a variety of taxation approaches. States should consider the ramifications of the premium taxation approach to be taken upon the proposed pilot project.

Section 18. Complaints

Any participating employer who is aggrieved by a participating carrier may file a compliant with the commissioner. Additionally, any employee of a participating employer who is aggrieved by a participating carrier may file a compliant with the commissioner. The commissioner shall review the complaint and refer any complaints involving work-related injury to [insert the appropriate workers' compensation administrator]. The commissioner may, by rule, establish procedures to address complaints received under the pilot project. The commissioner shall maintain a record of all complaints received.

A participating carrier shall have an approved complaint procedure, described in writing and provided to the affected workers and their covered dependents, employers and health care providers.

At the time the twenty-four hour policy is issued, the carrier shall provide detailed information to employers and covered dependents, workers and health care providers describing how a complaint may be registered with the carrier.

Carriers shall review complaints in a timely manner and shall transmit them to the individuals employed by the carrier who have the authority to fully investigate the issue and take corrective action.

The complaint procedure shall provide that decisions be made upon complaints within [insert number] days of receipt by the carrier and that corrective action is taken upon complaints determined to be valid by the carrier within [insert number] days of the determination.

The carrier shall report annually, not later than March 31 to the Insurance Commissioner and for work-related injuries to [insert the appropriate workers' compensation administrator] regarding its complaint procedure activities for the prior calendar year. The report shall be in a format approved by the Insurance Commissioner and shall contain the number of complaints filed in the past year and a summary of the subject, nature and resolution of the complaints.

Any participating employer who is aggrieved by a determination of a participating carrier pursuant to its complaint procedure may file a complaint with the commissioner. Additionally, any employee of a participating employer or a covered employee's dependent who is aggrieved by a determination of a participating carrier pursuant to its complaint procedure may file a complaint with the commissioner. The commissioner shall review complaints. For complaints involving work-related injury, any unresolved or disputed complaint result, after completion of the approved complaint procedure, and review by the commissioner, shall be referred to [workers' compensation administrator] on appeal.

Drafting Note: In some states complaints may be filed with the industrial accident board or commission. States should consider this when adopting a dispute resolution process. This is intended to establish an informal procedure. States who already have a structured procedure may choose to refer the complaint to the appropriate authorities.

Section 19. Report to the Legislature

The Commissioner of Insurance shall make an interim report on or before [insert date], and a final report within six (6) months after the termination date of the pilot project to [insert those individuals who should receive the report] on the activities, findings and recommendations of the Commissioner of Insurance relative to the pilot projects. The Commissioner of Insurance shall monitor, evaluate and report the following information regarding the pilot projects:

A. Cost savings;

B. Effectiveness;

C. Effect on indemnity payments;

D. Complaints from injured workers and participating employers;

E. Recommendations to continue or discontinue testing;

F. Recommendations for any legislative changes; and

G. Other pertinent matters.

The information from the pilot projects shall be reported in a format which facilitates comparisons to other similar data.

Section 20. Effective Date

This Act shall take effect [insert date].

Legislative History (all references are to the Proceedings of the NAIC).

1994 2nd Quarter (adopted).