Impact of Public Act 94-0277 on Illinois Employers

What Public Act 94-0277 Means To You

During the 2005 State of the State message, Governor Blagojevich indicated that he wanted to get business and labor leaders together to reform the workers' compensation process in Illinois. As a result of meetings between a number of groups, the Illinois legislature passed House Bill 2137 on May 28, 2005. It was later renamed Public Act 94-0277. Public Act 94-0277 amends the Workers' Compensation Act by changing Sections 4, 7, 8, 12, 13, 13.1, 14, 16, and 19. It also added Sections 8.2, 8.3, 8.7, and 25.5.

The changes expand the workers' rights to benefits. It is the result of what has been termed an agreed bill between some employer and labor groups. However, not all employer groups participated in the discussions. Nevertheless, the bill is a compromise bill. Many argue that the compromise favors employees much more than employers. There are some beneficial provisions for employers in this statute.

In reality, "what Public Act 94-0277 means to you" is that we think the net effect of the bill will be to increase workers' compensation costs to the system and your claims as the benefits are small and have a potential not to materialize, while the costs are certain. You will begin seeing this in the reserves for lost time claims as many of the law changes adjust the average weekly wage and maximum number of weeks up by 7.5% immediately on July 20, 2005. You will not see any offset in the medical reserve as any amount historically balance billed amount was not reflected in your loss cost experience, and the fee schedule benefit not effective until 2006, and even then, it is difficult to estimate any potential savings that may occur at this point.

Long term, these amounts will flow into your loss experience. Feel confident that we will ensure compliance with the law change, and look to incorporate all aspects of the law that help mitigate loss costs. As we get information on what impact this may have from the NCCI, WCRI, or other sources, we will forward the estimates on to you.

II. SUMMARY

PUBLIC ACT 94-0277 Major Provisions:

Cost Increases

- An increased burial benefit and increased weeks in permanent partial disability benefits covered under Sections 8(c) and 8(e);
- Higher minimum rates for TTD and PPD tied to the state minimum wage, a higher maximum wage differential rate, and an increase in the minimum death benefit;
- Clarification of the law's vocational rehabilitation provision, including a definition of maintenance and temporary partial disability benefits;
- Employer assessments to deal with the shortfall of the Rate Adjustment Fund, which pays cost-of-living benefits to workers who were permanently and totally disabled or the survivors of fatally, injured workers. The bill provides for increased funding of the Rate Adjustment Fund, which pays cost of living increases for death benefit recipients and permanent benefit recipients. Therefore, employers are required to pay into the fund twice a year at an amount equal to 1% of compensation payments made in the prior six months.

Cost Decreases

- A medical fee schedule with a utilization review component;

- Elimination of balance billing, in which injured workers are billed for the unpaid balance of medical bills;

Administrative Penalties

- Increased penalties for employers failure to obtain Workers' Compensation insurance;
- A requirement that medical providers shall be paid within 60 days of receipt of sufficient information to pay the bills, with interest accruing at 1% per month after 60 days;
- An increase in 19(l) penalties from $10 to $30/day, with a higher maximum of $10,000.

Structural/Procedural Changes

- A new unit at the Division of Insurance to fight fraud;
- A third panel of commissioners, and redefined 19(b) hearings with a 180-day requirement for commissioners to issue expedited decisions;
- To expedite cases at the arbitration level, a requirement that arbitrators issue full written decisions only if requested by either party;

Several key effective dates are provided below:

- The law became effective July 20, 2005;
- Rate Adjustment Fund payments by the employer as per Section 7 were effective July 20, 2005;
- The scheduled benefit increases as per Section 8(e) for this benefit were July 20,2005;
- The maximum number of weeks as per Section 8(c) for this benefit were effective July 20,2005;
- The fee schedule as per Section 8.2 was effective February 1, 2006;
- Wage Differential Maximum changes as per Section 8(b) were effective February 1, 2006;
- Death Benefit Changes as per Sections 7 and 8 were effective February 1, 2006.

III. COMPENSATION BENEFITS (Section 8)

Temporary Partial Benefits

Section 8(a) creates Temporary Partial Disability Benefits (TPD) effective February 1, 2006. It provides that, if an employee is working light duty on a part time basis or full time basis and is earning less than the employee would employed in the full capacity of his/her regular job, then the employee is entitled to temporary disability benefits. Temporary Partial Disability Benefits are equal to 2/3 of the difference between what the injured worker would be able to earn in the full performance of his/her regular job compared to the net amount he is earning in the modified job provided by the employer or in any other job the employee is working.

Minimum Rates

Section 8(b) changes TTD and PPD minimums effective February 1, 2006. The new minimums are equal to 66 2/3% of the federal minimum wage under the Fair Labor Standards Act or the Illinois minimum wage under the Minimum Wage Law, whichever is more, multiplied by 40 hours. The minimum rate is increased 10% for each spouse and child but shall not exceed 100% of the total minimum wage calculation. The minimum benefit rate for amputations or enucleation of an eye is raised to half of the state wage, which is also the current minimum for death and total and permanent benefits.

Wage Differential - Maximum Rates

Section 8(b) notes an increase in the maximum wage differential benefit. For injuries occurring on or after February 1, 2006, the maximum wage differential shall be up to 100% of the state's average weekly wage.

Disfigurement - Maximum Number of Weeks

Section 8(c) states the maximum compensation for disfigurement is increased from 150 weeks to 162 weeks.

Permanent Partial Disability/Scheduled Benefit Increases

Section 8(e) increased weekly benefits for all members by 7.5% effective July 20, 2005. The members are now worth the following:

Part of Body/Member	Number of Weeks
Thumb	76 (70 weeks previously)
Index finger	43 (40 weeks previously)
Second finger	38 (35 weeks previously)
Third finger	27 (25 weeks previously)
Fourth finger	22 (20 weeks previously)
Great toe	38 (35 weeks previously)
Other toes	13 (12 weeks previously)
Hand	205 (190 weeks previously)
Arm	253 (235 weeks previously)
Foot	167 (155 weeks previously)
Leg	215 (200 weeks previously)
Eye	162 (150 weeks previously)
Hearing one ear	54 (50 weeks previously)
Total loss of hearing in both ears	215 (200 weeks previously)
Testicle	54 (50 weeks previously)

Vocational Rehabilitation

Section 8(a) requires that any Vocational Rehabilitation counselor providing service under the Act must have the appropriate certifications. It may include but is not limited to counseling for job searches, supervising a job search program, and vocation retraining including education at an accredited learning institution. Both parties may petition to the Commission to decide disputes relating to Vocational Rehabilitation.

Maintenance Benefits

Section 8(a) defines the term Maintenance Benefit. The Maintenance Benefit shall not be less than the temporary total disability rate determined for the employee. In addition, maintenance is to include the cost and expenses incidental to the Vocational Rehabilitation program.

Rate Adjustment Fund

Section 8(g) indicates that claimants who receive an award of either permanent total disability or death benefits are entitled to annual adjustments for inflation. The benefit adjustments are to be made by the employer and paid by the employer. The statute indicates that the employer shall increase the weekly compensation rate proportionately by the same percentage as the percentage of increase in the State's average weekly wage. The adjustment is to be made on July 15 every year commencing in the second year after the date of the entry of the award and annually thereafter. The increase is to not exceed the maximum rate. If the state's average weekly wage decreases, the rate remains the same.

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• This will impact claim resolution on some cases. • Low wage earners may have little motivation to return to work. • The addition of TPD represents a significant benefit increase to the employee. • If you have a workforce that consists of many part time employees, your cost will increase due to the creation of TPD. • Although employers are familiar with paying TPD in other states, the formula for the TPD benefit is not favorable to employers and could lead to increased claim cost or disputes. • The wage differential changes represent a 40% increase in exposure. • Benefits for PPD are up 7.5% immediately.	• Travelers has conducted focused training for its claim management staff on this section. • The Travcomp model focuses on aggressive RTW. Travelers works hard to forge a strong partnership with our accounts and the doctors to get injured workers back to work as soon as possible. • Travelers will work closely with you to make sure you have the tools to find appropriate permanent, modified or alternative work early in the claim.

IV. DEATH BENEFITS (Section 7 and Section 8)

Section 7 of the Act has provisions regarding the benefits payable upon death of an employee for injuries occurring on or after 2/1/06. Death benefits are increased from $250,000 to $500,000. The new death benefit cap is increased to the greater of $500,000 or 25 years. Burial expenses are increased from $4,200 to $8,000. In addition, the bill provides for increased funding of the Rate Adjustment Fund, which pays cost of living increases for death benefit recipients and permanent benefit recipients therefore, employers are required to pay into the fund twice a year at an amount equal to 1% of compensation payments made in the prior six months.

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• This change will increase the cost of a fatality case. • If you have a high density of employees, the death benefit increase may have an impact on your insurability. • Employers will have an additional cost tied to financing the Rate Adjustment Fund.	• Travelers will continue to investigate all claims to ensure we only pay what we owe. • Travelers will also move quickly in providing these benefits if they are owed.

V. MEDICAL BENEFITS AND FEE SCHEDULE (Section 8.2)

Section 8 of the Act contains changes that include the addition of a new section 8.2. An injured worker's basic right to medical treatment hasn't changed. Doctor selection is still employee choice with a limit of two doctors and their referrals. The employer is only required to provide and pay fees to medical providers for reasonable and necessary charges at the negotiated rate or the lesser of the health care provider's actual charges or to a fee schedule subject to Section 8.2.

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• This portion of the Act has not significantly changed from the perspective of doctor choice.	• Injured workers will continue to have access to our provider listings from the www.mywcinfo.com website.

Creation of a State Fee Schedule

Medical fees will now be limited by statute. Previously, there were no limits on the fees doctors and hospitals could charge for their services. The only requirement was that the fees be reasonable and necessary. If there was a dispute about the fees, the employer or carrier would pay what it determined was reasonable and necessary and doctors would balance bill the patients for the remainder. The statute now imposes a fee schedule on doctors, hospitals and all other medical providers. It eliminates balance billing.

- Section 8.2 is effective for treatment performed on or after February 1, 2006. It provides that "the maximum allowable payment for procedures, treatment, or services covered under this Act shall be 90% of the 80th percentile of charges and fees as determined by the Commission using information provided by employers and insurers' national databases.
    - The charges to be considered are based on billed amounts and not discounted charges. The Commission is to adjust these historical charges as of August 1, 2004 by the Consumer Price Index – U for the period August 1, 2004 through September 30, 2005.
    - The Commission established fee schedules for essentially all medical treatment and procedures. The fee schedules are determined by the location where the medical treatment is provided. There are 29 geographic fee schedules, organized by "geozip" -- a geographic location in which all zip codes have the same first three digits.

- Payment for out of state treatment is based on the greater of 76% of the amount charged or the fee schedule of the state in which treatment was provided.
- The Commission will review and automatically increase or decrease the maximum allowable payment for a procedure on September 30, 2006 based on the percentage change in the Consumer Price Index – U for the 12-month period ending August 31, 2006. The effective date of the increase or decrease is the following January 1 and will be updated annually.
- This is not a Medicare based fee schedule. The fee schedule was created using actual bills from the Illinois Department of Public Health from 8/1/02 through 8/1/04. If there were not at least 9 charges for a specific medical treatment billed or if the code did not exist during that time the fee schedule will not apply to the charge and payment will be based on 76% of the billed amount. Please refer to the Illinois Workers' Compensation web site for additional information regarding the fee schedule. http://iwcc.ingenixonline.com/IWCC.asp
- Emergency room, ambulatory surgical treatment centers, hospital outpatient and inpatient hospital bills from state-designated Level I and Level II trauma centers which contain an admission type 5 as designated by the provider are reimbursed at 76% of the billed amount.
- Prosthetics/Orthotics, Pacemakers, Lens Implants, Implants, Investigational Devices and Drugs requiring detailed coding are classified as "pass-through charges" and are paid at 65% of the charged amount.
- The fee schedule does not apply to pharmacy, outpatient renal dialysis, psychiatric hospitals, outpatient renal dialysis, or skilled nursing facilities. These treatments are paid at usual and customary rates or the Travelers network rates.

The fee schedule does not effect any privately and independently negotiated rates or agreements between a provider and a carrier, or a provider and an employer, that are negotiated for the purpose of providing services covered under the Act.

Changes in Billing Guidelines and Interest on Medical Bills

Section 8(d) provides that when a patient notifies a provider that the treatment is for a work related injury, the provider is to bill the employer directly.

- The provider is required to submit bills and records in accordance with the Act.
- The provider must be paid in accordance with the fee schedule.
- The provider must be paid within 60 days of receipt of the bill so long "as the claim contains substantially all the required data elements necessary to adjudicate the bill."
- If the bill is not paid within 60 days, the employer incurs interest on the bill at a rate of 1% per month payable to the provider.

It provides that a medical provider shall not hold an employee liable for the costs of a non-disputed procedure in connection with a compensable injury. There are some exceptions to the act when the claim is disputed.

Balance Billing

Section 8.2(e) states that a provider shall not hold an employee liable for costs related to a non-disputed procedure in connection with a compensable injury. Section 8.2(e) eliminates balance billing for accepted workers' compensation cases in most circumstances. Balance billing will remain allowed in any disputed case. The bill provides that in the event a claimant also has group health coverage, the provider may seek payment from the heath carrier.

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• The fee schedule does not cover all treatment or pharmacy charges. Use of the Travelers provider network could help contain the cost of treatment and pharmacy charges not covered by the fee schedule. • The limitation on medical charges will provide a benefit for claims involving providers selected by the employee that are not in the Travelers network. The fee schedule could help contain your cost with these out of network doctors. • It will be important to have medical bills routed to us for processing on a timely basis to avoid delays. • We continue to encourage employers to direct providers to send their bills to Travelers directly.	• Travelers will continue to provide network providers that are accessible to our customers to help contain medical costs. • Travelers has an existing medical bill review process to ensure that all bills are examined and paid timely as per statute. • Travelers medical bill scanning center will apply all necessary fee schedules and network discount applicable to any given bill. • Travelers has staff dedicated to updating state fee schedule amounts in our bill re-pricing software system. Travelers has previously reduced Illinois WC bills to usual and customary charges. Going forward we will ensure that all bills comply or are paid according to the imposed fee schedule. • Travelers will help alleviate concern from providers regarding fee schedule or any other reductions. Travelers also has a separate unit, the Provider Inquiry Center, dedicated to handling questions regarding the discounts we capture. This center's name and phone number are available on the Explanation of Benefits that is issued with our medical payments. • Travelers has conducted focused training for its claim management staff on this section. • Please ensure all bills involving Illinois

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	claims are sent to: PO BOX 3205 Naperville, IL 60566-7205. • Please use the Provider Inquiry Center for any billing questions. They can be contacted at 1-877-228-2758 or by e-mail at mbmpinqs@spt.com.

VI. INSURANCE REQUIREMENTS AND PENALTIES (Section 4)

Section 4 requires employers to self insure or insure their Workers' Compensation liability. The bill provides for increased fines and sanctions, including criminal liability, for non-compliance. If a Commission Panel finds that an employer failed to provide coverage, that failure will subject the employer to the following sanctions:

- A work stop order
- Criminal liability for a Class IV felony violation
- Monetary Penalties with a minimum of $10,000 and an additional $500 a day

Any penalties and fines collected are to be deposited into a special fund known as the Injured Workers' Benefit Fund. Payments from the fund would be made to injured employees who do not receive benefits because the employer failed to provide them. If benefits are paid from this fund, the Commission can seek reimbursement from the non-complying employer.

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• Ensure you have the proper Workers' Compensation insurance to be in compliance with this portion of the Act.	• An Account Executive from Travelers would be happy to review your program with you as it relates to this requirement.

VII. WORKERS' COMPENSATION MEDICAL FEE ADVISORY BOARD (Section 8.3)

Section 8.3 created the Workers' Compensation Medical Fee Advisory Board. It consists of nine members -- three from the employee class, three from the employer class and three from the medical provider class. The board advises the commission on the establishment of fees for medical services and accessibility of medical treatment. They do not set the fee schedule.

VIII. UTILIZATION REVIEW (SECTION 8.7)

Section 8.7 is newly created. This section creates the right of employers to arrange for Utilization Review (UR) in handling workers' compensation claims. It is defined as the evaluation of proposed or provided healthcare services to determine the appropriateness of both the level of healthcare services medically necessary and the quality of healthcare services provided to a patient, including the evaluation of their efficiency, efficacy and appropriateness of treatment, hospitalization or office visits based upon medically accepted standards. The evaluation must be based on standards of care or nationally recognized evidence based upon standards as provided in the Act. Utilization review techniques may include prospective review, second opinions, concurrent review, discharge planning, peer review, independent medical examinations and retrospective review. UR doesn't apply to first aid or emergency treatment. Only a health care professional may make determinations regarding the medical necessity of

health care services during the course of utilization review. This section further states that a UR will be considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of the reasonableness and necessity of the medical bills and treatment.

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• Utilization reports will now be considered by the Commission as evidence. • Utilization Review represents another tool for the employer to ensure that the medical treatment provided is reasonable and necessary.	• Travelers Utilization Review program meets the criteria for compliance as described in the Act. • Travelers is conducting focused training for its claim management staff on this section. • Travelers will use Utilization Review as a tool to control treatments as best as possible.

IX. INDEPENDENT MEDICAL EXAMS (SECTION 12)

Independent Medical Examinations

Section 12 of the Act contains the provisions guaranteeing the employer a right to an independent medical examination. This Section was not significantly changed. Many employers and carriers send notices of IME appointments and later send travel expense checks. This change in the Act requires the travel expense check to be received by the employee at the time the employee receives notice of the examination.

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• The only change requires that when an employer notifies an employee of an IME, the employer is required to provide travel expense along with the notice of the examination.	• Travelers will adjust our workflows to make sure that we are in compliance with sending the travel expense check with the IME appointment letter that goes out to the employee. • Travelers is conducting focused training for its claim management staff on this section.

X. ILLINOIS WORKERS' COMPENSATION COMMISSION (Section 13.1)

Illinois Workers' Compensation Commission

Section 13 establishes the Illinois Workers' Compensation Commission. This Section is modified to increase the number of members of the Commission from 7 to 10. This means that instead of two panels of Commissioners to hear appeals, there will be three panels of 10 Commissioners to hear appeals. No more than 6 members of the Commission can be from the same political party.

The Commission is required to promulgate rules to govern its administration. The rules are to be voted upon by the entire Commission. In the event of a tie, the Chairman's vote can break the tie vote. The three new members of the Commission are to be appointed immediately. One

commissioner will be assigned a term that will end in January, 2007 and two will get terms that end in January, 2009.

XI. ARBITRATOR APPOINTMENTS (Section 14)

Arbitrators are appointed for terms of six years. They can be reappointed. They can be removed by a vote of the Commission. Eight out of ten commissioners must vote in the negative to terminate an arbitrator.

XII. HEARINGS BEFORE THE COMMISSION (Section 16 and 19)

Hearings before the Commission – Evidence (Section 16)

This section deals with hearings before the Commission and the admission of evidence along with the subpoena power.

- The statute previously allowed that certified hospital records could be offered into evidence without having to present a record keeper.
- The new revised statute allows for the admission into evidence of the certified records, reports and bills of any treating hospital, treating physician, or other treating healthcare provider.
- The Act provides that there is a rebuttal presumption that any records, reports, or bills received in response to a Commission subpoena are certified as true and correct.
- The statute further states “this provision does not apply to reports prepared by treating providers for use in litigation.”

Hearings before the Commission – Expedited Hearings (Section 19)

Section 19(b) section reflects the change in the statute to require that the arbitrator issue a written decision only if requested by either party. It is also amended to give employees and employers greater rights to demand expedited hearings before the Commission. The amendment allow for a petition for immediate hearing be filed for the following provisions.

- If an employee is not receiving the medical treatment he thinks he is entitled to under Section 8(a) or the employee is not receiving the current compensation or has not received past compensation that the employee feels he is entitled to under Section 8(b). This is regardless of the employee is working or not.
- If an employer wants to challenge an employee’s right to TTD or medical. This can be done only if the employer is currently paying TTD and continues to pay TTD until there is a decision of the arbitrator or the employee’s treating doctor releases the employee back to work or if the employee returns to work at any other job.
- If two or more carriers are disputing coverage for the same injury, any one of the carriers can request an expedited hearing to determine the issue of coverage, provided coverage is the sole issue in dispute and all other issues are stipulated and agreed to. All compensation including medical must continue through this process. The party found liable for coverage shall reimburse the party that paid benefits.

Expedited hearings are to have priority over all other cases.

Hearings before the Commission – Reopenings (Section 19)

Section 19(h) indicates that awards can be reopened. It provides that any award can be reopened by filing a petition within 30 months from the date of the final award on the grounds that the disability of the employee has recurred, increased, diminished or ended. The statute also contains new language that allows parties to reopen an award within 60 months in the case of an award pursuant to Section (d) (1), wage differential section of the Act. This allows both employers and employees to reopen wage differential awards within 60 months.

Hearings before the Commission – Penalties (Section 19)

Section 19(k) and 19(l)have been modified. Section 19(k) had previously provided that penalties could be awarded equal to 50% of the award in the event the Commission found that the employer acted unreasonably or vexatiously to delay payment or to intentionally underpay the employee. This portion of the statute doesn't change. Wording has been added which states that when determining whether Section 19(k) applies, the Commission shall consider whether the arbitrator has determined that the case is not compensable and whether the employer has made payments under Section 8(j). Section 19(k) penalties are discretionary.

Section 19 (l) provides that if an employee makes a written demand for payment of benefits under Section 8(a) or Section 8(b) (medical or TTD), the employer has 14 days after the receipt of the demand to respond in writing setting forth the reasons for the delay. In the case of demand for medical, the time for the employer to respond does not commence until expiration of the allotted 60 days specified under Section 8.2(d). If the employer fails to pay or unreasonably delays the payment of benefits and the delay is without good and just cause, the Commission shall allow compensation of $30.00 per day up to a maximum of $10,000.

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• There is a significant increase in the amount of Section 19(l) penalties. • Demands for benefits must be routed to Travelers immediately for handling and investigation. • Case reopenings for wage differential cases could lead to increases in benefits for numerous cases. • 19(b) hearings will come up faster that they have in the past. • Employers should expect more hearings before the commission which in turn will have an effect on legal expenses on the file.	• Travelers is conducting focused training for its claim management staff to make sure they understand the new procedures and timelines and that we react accordingly. • Travelers has existing procedures and system edits in place to minimize the chances of a payment being missed and we will also be conducting focused training for our claim management staff on these changes. • Late payment penalties that are the result of Travelers action will not be billed to the claim file. • Travelers has always made it a practice to utilize delay in decision letters early in the file investigation to explain our reasoning for the delay.

XIV. FRAUD (Section 25.5)

This new section makes it illegal for anyone to present a fraudulent case for workers' compensation benefits. It is now unlawful to present a fraudulent case making false or fraudulent statement to get benefits and to make any false or fraudulent statements to avoid liability for benefits. The statute applies to both employees and employers. It is also illegal to make any false statements to deny a claim or prepare or present a fake certificate of insurance or make any statement designed to improperly obtain workers' compensation insurance. Any person guilty of committing workers' compensation fraud is guilty of a Class 4 felony. A unit will be established for investigating incidents of fraud and insurance non-compliance. Anyone can report allegations of fraud to the unit but it cannot be done anonymously.

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• This is an additional tool for employers to combat fraud in the workplace involving workers' compensation claims. • This is the first time this type of unit has been codified in Illinois and it may prove a benefit for employers, depending on how well the unit is funded, the thoroughness of the investigation and how strictly the anti-fraud procedures are enforced.	• Travelers uses a Special Investigation Unit that will focus on these types of claims so we only pay what we owe. • Travelers has had success with these types of units in other states where fraud units are in place. • Travelers automates reporting to ISO to try to maximize our chances of finding out that the employee had a prior injury in case they don't volunteer it. • Travelers will seek remedies in the event the employee does not fully disclose past injuries or health conditions. • The existence of a fraud unit sanctioned by the state may now provide leverage to resolve disputed cases, particularly where facts are suspicious.