2011 CHANGES TO ILLINOIS WORKERS COMPENSATION ACT (Public Act 97-18)

On June 28, 2011, Illinois Governor Pat Quinn signed a new law changing the workers compensation system. **Public Act 97-18** (H.B. 1698) amends the Workers' Compensation Act (820 ILCS 305/1 *et seq*.) by changing Sections 1, 4, 8, 8.2, 8.7, 11, 13, 13.1, 14, 19 and 25.5. It also added Sections 1.1, 4b, 8.1a, 8.1b, 8.2a, 16b, 18.1, 29.1, and 29.2.

Among other changes, the bill reduces the current medical fee schedule by 30%; establishes a Preferred Provider Program with an employee opt out provision; caps wage differential awards at five years or age 67, whichever is later; enhances the Utilization Review provisions; includes the use of the current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment"; and imposes a number of reporting obligations on insurers.

This document discusses the significant changes to the Act. Overall, we think the net effect of the bill will be to decrease medical costs. Long term, there may be some positive impact on employers' loss experience.

MAJOR PROVISIONS OF PUBLIC ACT 97-18

Medical Changes

- Reduces the current medical fee schedule by 30%
- Reduces the number of hospital and non-hospital geographic regions of the fee schedule
- Establishes a Preferred Provider Program with an employee opt out provision
- Strengthens Utilization Review by requiring use of nationally recognized treatment guidelines and evidence-based medicine
- Provides that employees are not liable for medical determined excessive or unnecessary by the Commission
- Provides that medical bills containing necessary data elements not paid within 30 days (instead of the current 60 days) of receipt will incur 1% interest per month
- Provides that if a medical bill does not contain enough information to allow for adjudication, or the claim is denied for other reasons, the employer or its insurer is required to provide written notification to the provider within 30 (instead of the current 60 days) days of receipt of the bill
- Sets reimbursement for implants to 25% above the manufacturer's net invoice price and non-implantable devices and supplies at 65% of the actual charge
- Requires health care providers to submit bills on standardized forms and specifies that electronic claims must be accepted

Indemnity Changes

- Caps wage differential awards at five years or age 67, whichever is later
- Requires the use of the current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment"
- Changes the calculation of Temporary Partial Disability payments from the gross amount earned in the modified job to the to net amount earned in the modified job
- Caps permanent partial disability for repetitive carpal tunnel payments

Arbitrator/Commission Changes

- Terminates all arbitrators, reduces their terms to three years and requires that they be Illinois-licensed attorneys (arbitrators continue to serve until reappointed or replaced, and current non-attorneys grandfathered in)
- Articulates Arbitrator Standards of Conduct

Causation

- Codifies existing case law concerning the employee's burden of proof
- Precludes recovery for injuries caused by the worker's own alcohol and drug intoxication

Miscellaneous Changes

- Enhances the existing fraud provisions
- Establishes a collective bargaining pilot in the construction industry
- Requires employee leasing companies to provide specific information to the Commission
- Imposes numerous reporting obligations on insurers

Effective dates:

- 6-28-2011 – Overall, the legislation is effective upon enactment (Section 99)
- 7-1-2011 – Changes with arbitrators (Section 13)
- 9-1-2011 – Reduction of hospital and non-hospital fee schedules (Section 8.2)
- 9-1-2011 – Determination of Permanent Partial Disability (Section 8.1b.)
- 9-1-2011 – Changes to Intoxication Defense for injuries occurring on or after this date (Section 11)
- 1-1-2012 – Reduction of hospital and non-hospital fee regions (Section 8.2)
- 6-28-2011 – Caps on repetitive carpal tunnel for injuries occurring on or after this date (Section 8(e)(9))

MEDICAL CHANGES

➢ **Hospital and Non-Hospital Geographic Reductions and Realignment of Regions Fee Schedule**

Section 8.2 reduces by 30% the amounts provided under hospital and non-hospital fee schedule for treatment rendered on or after September 1, 2011. Effective January 1, 2012, the geographic regions of hospital fee schedules are reduced from 29 to 14, and the geographic regions of non-hospital fee schedules are reduced from 29 to four regions.

Analysis/Impact: The reduction in the fee schedule should reduce medical costs. However, providers may change the frequency of treatment to minimize the reduction they are likely to see in fees. The reduction in fee schedule regions should reduce provider manipulation of fee schedule by location of treatment and streamline payments.

➢ **Utilization Review ("UR")**

Section 8.7 strengthens the Utilization Review process. Nationally recognized treatment guidelines and evidence-based medicine shall be used for treatment rendered or proposed after September 1, 2011. When a provider is notified in writing that the utilization process is invoked:

- The provider must submit to the UR process and make a reasonable, timely and complete report of clinical information needed to support the request. If a provider fails to make such reasonable efforts, the charges for treatment or services may not be compensable or collectible by the provider or claimant.
- Any findings upon utilization review must be provided to the provider and employee in writing.
- Employers may deny payment or refuse authorization only on the grounds that the extent and scope of medical treatment is excessive or unnecessary pursuant to UR guidelines. Significantly,

UR providers shall no longer be allowed to comment on causal connection, or at least such opinions will not be considered.
- The new law establishes a presumptive finding that medical care denied by UR is not necessary, and the employee will have the burden to show why such care is necessary.

Analysis/Impact:
- The presumption that medical care denied by UR is not necessary, and that the employee will have the burden to show why such care is necessary, should be useful in helping to reduce excessive chiropractic care and physical therapy.
- Attorneys representing injured workers may object to the UR being admissible, and therefore it is likely that depositions will need to be taken in litigated cases where denied treatment is an issue.

➢ **Preferred Provider Programs ("PPP") and Preferred Provider Networks ("PPN")**

Section 8(a)(4) creates a Preferred Provider Program ("PPP"), and requires that it contain:
- Adequate occupational and non-occupational providers
- Adequate number of type of physicians to treat common injuries in the geographic areas where the employee lives
- Readily available medical treatment
- Physician compensation which shall not be structured with a goal to reducing, delaying, or denying medical treatment
- Established terms and conditions with non-institutional providers

Section 8.1a requires that programs using an economic evaluation must file a description of the policies and procedures used with the Director of Insurance.

Sections 8.1a(c) & (d) provide that after a PPP is established:
- Employees may select a provider from within the network; however, the employee may still choose to treat with his/her choice of provider.
- Employers are responsible for medical treatment received by an employee within the preferred provider program.
- Once an injury is reported or a claim is filed, the employer is responsible for notifying the employee of his right to treat with a physician of his choice from the PPP.
- Employees may choose a provider outside of the network, at the employer's expense, upon a finding by the Commission that the care rendered by the employee's second choice within the network is improper or inadequate; the Commission is required to issue a decision on this issue within five working days.

Section 8(a)(4) provides that after an Employer PPN is established:
- An employer shall inform employees of the PPN in writing on a Commission form
- After the report of an injury, the injured worker can decline the PPN in writing, which would constitute one choice of providers
- An injured worker treating outside the PPN before reporting the injury will be deemed to have used his or her one choice of medical providers

Section 8(a)(4) provides that it is effective for injuries occurring on or after the effective date of this legislation and the employer has an approved PPP.

Section 8.7(i)(4) shifts the burden of proof to the employee when payments have been denied or authorizations refused on the grounds that the extent and scope of the treatment is excessive and unnecessary based on an accredited utilization review program; the employee must show by a preponderance of the evidence that a variance from the standards is reasonably required to cure or relieve the effects of employee's injury.

Section 8.7(i)(5) provides that the medical professional responsible for the final stages of the review or appeal must be available within the State, either in person or via telephone or video conference, for

interview or deposition. The expenses of remote interviews or depositions shall be paid by the employer and shall be conducted in a fair manner, administered under oath and recorded unless agreed otherwise. Admissible utilization review shall be considered by the Commission and must be addressed along with all other evidence.

Analysis/Impact: These provisions should be beneficial to employers in reducing medical costs, but not as effective as in other jurisdictions.

- Since the section limits the ability of an injured worker to choose multiple medical providers, it is anticipated that preferred medical providers will reduce the cost of treatment especially where employees are likely to treat with poor medical facilities and without PPO agreements with the employer's carrier.

- Because injured workers can opt out of the PPN, this section is not as effective as in other jurisdictions which allow the employer to direct medical treatment.

- The Commission is likely to limit the employer's ability to contest opinions of PPN doctors it chose with an IME or utilization review.

- Employers will need to diligently inform employees of the PPN, and it may become necessary for the employer to obtain the employee declination of the PPN in writing.

➢ **Employers Without a Preferred Provider Network Choice of Medical Providers**

Section 8 (a)(1) & (2) now provides that if the employer does not have a preferred provider network then the employee still has two choices of medical providers.

Analysis/Impact: There is no change to current law.

➢ **Employees Not Liable for Medical Expenses the Commission Determines are Excessive or Unnecessary**

Section 8.2(e) now provides that medical providers cannot collect payment from the employee should the Commission rule the bills excessive or unnecessary.

Analysis/Impact: This section will likely increase compromises by providers with disputed bills since the provider will not be able to collect from the employee on bills denied by the Commission.

➢ **Medical Bill Payment Timeline**

Section 8.2(d)(1-3) reduces the time by which bills must be paid or rejected from 60 to 30 days:

- Bills containing necessary data elements which are not paid within 30 days of receipt of the bill will incur 1% interest per month. Any required interest must be made within 30 days after payment.
- If a bill does not contain enough information to adjudicate the bill or the claim is denied for other reasons, the employer or its insurer are required to provide written notification to the provider within 30 days of receipt of the bill.

Analysis/Impact: The shortened time period (from 60 to 30 days) will require faster bill processing to avoid interest payments.

➢ **Health Care Providers Right to Assign Debt**

Section 8 now grants Health Care Providers the right to sell, transfer, or assign accounts receivable for treatment.

Analysis/Impact: This section clarifies the ability of debt transfer to a third party. There will likely be an increased use of debt collection agencies and medical finance groups. In light of this provision, as well as the changes in the medical fee schedule and reduction in payment due times avoid interest it is likely that such third party debt collection agencies will be aggressive pursuing payment.

➢ **Out-of-State Treatment**

Section 8.2 changes the amount at which out-of-state treatment(s) will be reimbursed: out-of-state procedures, treatments, services, products, or supplies will be reimbursed at the lesser of that state's fee schedule amount or the fee schedule amount for the region in which the employee resides and if no fee schedule exists in that state, reimbursement at the lesser of the actual charge or the fee schedule amount for the region in which the employee resides.

Analysis/Impact: This will result in a savings to the employer in this limited circumstance.

➢ **Implants, Non-implantable Devices and Supplies Amounts**

Section 8.2(a-1)(5), a new provision, sets the amount implants are reimbursed to 25% above the manufacturer's net invoice price, less rebates, plus actual reasonable and customary shipping charges. Amounts for non-implantable devices and supplies are reimbursed at 65% of the actual charge.

Analysis/Impact: This provision should result in some reduction in medical expenses, although the ultimate financial impact may be hard to quantify.

➢ **Prescriptions Filled and Dispensed Outside of a Licensed Pharmacy**

Section 8.2(a-3), is a new provision which states that the fee schedule amount will not exceed the Average Wholesale Price plus a dispensing fee of $4.18.

Analysis/Impact: The majority of prescriptions are filled by licensed pharmacies, but this new provision will provide some savings. It is likely to result in the decreased use of non-licensed pharmacies.

➢ **Electronic claims**

Section 8.2a, a new provision, obligates the Director of Insurance to establish necessary rules/criteria to:

- Require all health care providers to submit medical bills for payment on standardized forms
- Require electronic claims acceptance by employers and insurers on of before June 30, 2012; and
- Ensure confidentiality of medical information for payment of medical services consistent with HIPAA to the extent possible

Analysis/Impact: This section may streamline medical payments.

INDEMNITY CHANGES

➢ **Wage Differential Caps**

Section 8(d)1 caps the wage differential, and provides that for injuries on or after September 1, 2011, benefits are to be paid until the employee reaches age 67 or five years from the date the award becomes final, which ever occurs later.

Analysis/Impact: Since under the prior law wage differentials are payable for life, this section could result in significant savings particularly involving workers under 60 years of age.

Example: An employee, born on October 1, 1954, was injured on June 1, 2011, when he was 56 years old. At the time of the injury, he was earning $1200 per week. As a result of the accident, the employee cannot return to his prior occupation, but does get new employment paying $400.00 per week.	
Old Law – Total Payout is $668,373.33	**New Law – Total Payout is $284,266.67**
Wage Differential Weekly Benefit: $533.33 Life Expectancy: 24.10 Years Total Months of Benefits: 289 Total Payout: $668,373.33	Wage Differential Weekly Benefit: $533.33 Age: 67 Total Months of Benefits: 123 Total Payout: $284,266.67

➢ **Determination of Permanent Partial Disability**

Section 8.1b, effective for injuries on or after September 1, 2011, provides that permanent partial disability shall be established using the following criteria:

- Written report of a licensed physician utilizing the most recent edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment"
- The occupation of the injured employee
- Age of the employee at the time of the injury
- The employee's future earning capacity
- Evidence of disability corroborated by the treating medical records
- No single enumerated factor is the sole determinant of disability
- The relevance and weight of any factors used in addition to the level of impairment must be explained in a written order

Analysis/Impact: It is difficult to assess the impact this change will have on the determination of permanent partial disability awards. Although the section provides the factors to use to determine the PPD rating and requires an explanation of the relevance and weighting of the factors, it does not provide a certain rating methodology. Initially, Commission and court decisions will determine the manner in which the ratings are assessed. Also, Illinois physicians will need to develop an understanding of the AMA Guide and proficiency in its application.

➢ **Carpal Tunnel Caps**

Section 8(e)9 as amended, creates a cap on awards for repetitive trauma carpal tunnel:

- Caps PPD for repetitive trauma carpal tunnel syndrome ("CTS") at 15% of the hand except for cause, by a showing of clear and convincing evidence, in which case the PPD award cannot exceed 30% of the hand
- The value is to be determined by using 190 weeks rather than 205 weeks
- Applies to injuries that occur on or after June 28, 2011, if the accidental injury involves CTS due to repetitive or cumulative trauma
- Does not apply to traumatically induced CTS

Analysis/Impact: This section will reduce payments on repetitive or cumulative CTS cases.

- It returns the number of number of weeks for the loss of a hand from 205 weeks to the pre-February 1, 2006, level of 190 weeks for non-traumatically induced CTS.
- Employees with repetitive trauma CTS may seek wage differential benefits or permanent total benefits in order to try to avoid this cap.

Example: An employee earning $1,000 per week suffers a compensable repetitive carpal tunnel injury and as a result has surgery.	
Old Law – Value not capped.	**New Law –** Value capped at 15% of the hand totaling $17,100. (190 weeks x 15%= 28.5 weeks x $600 (PPD Rate). By a showing of clear and convincing evidence the value could increase to but not exceed 30% of the hand, totaling $34,200.

➢ **Temporary Partial Disability –Gross Wages**

Section 8(a) changes the calculation of Temporary Partial Disability ("TPD"). The 2006 reforms mandated that Temporary Partial Disability (TPD) be paid at two-thirds of the wage the petitioner would be earning compared to the Net amount in the modified job. The new section changes the calculation from the Net amount to the Gross amount.

Analysis/Impact: This section rectifies a prior situation whereby employers were essentially subsidizing the employees on TPD: taxes, health care costs, 401(k), etc., while employees being paid TTD were not afforded these benefits. The provision streamlines TPD payments since only the amount of hours worked/rate of pay is needed to calculate instead of a review of each paycheck.

Example: An employee is married with two children. He elects to take the maximum amount out of his weekly check to pay for taxes. Employee earns $15.00 per hour, which comes to $600.00 per week. His net weekly take home pay is $400. The employee is injured as the result of a compensable accident. After treatment, he returns to work although not yet at maximum medical improvement, and is assigned to a light duty position. He is paid $9.00 per hour, which is $360 in weekly gross wages or $200.00 in weekly net wages. He is entitled to TPD.	
Old Law – TPD Payout is $266.67/week	**New Law – TPD Payout is $160.00/week**
$600-$200=$400 x 2/3-$266.67 While on light duty, the employee receives $360 in salary and $266.67 for TPD	$600-$360=$240.00 x 2/3=$160.00 While on light duty, the employee receives $360 in salary and $160.00 for TPD

ARBITRATOR/COMMISSION CHANGES

➢ Arbitrator Termination, Appointment, Training, Assigned Venues

Section 14 makes a number of changes to the terms and qualifications of Commission Arbitrators, including:

- All arbitrators shall be terminated on July 1, 2011 with incumbents continuing to exercise all of their duties until they are reappointed or their successors are appointed.
- Initial Arbitrator appointments shall be made by the Governor with the advice and consent of the Senate.
- Arbitrators will have staggered 3 year terms - 12 arbitrators shall be appointed with terms expiring July 1, 2012, 12 other Arbitrators shall be appointed with terms expiring July 1, 2013, and all additional arbitrators shall be appointed with terms expiring July 1, 2014; thereafter Arbitrators shall be appointed to three-year terms by the full Commission.
- Upon expiration of a term, the Chairman shall evaluate performance of the Arbitrator and may recommend he or she be reappointed
- Arbitrators must be licensed to practice law in the State of Illinois (current non-attorney Arbitrators are grandfathered in).
- The Commission shall also assign no fewer than three Arbitrators to each hearing site, and the Commission shall establish a procedure to ensure cases are assigned randomly.
- No Arbitrator shall hear cases in any county other than Cook for more than two years in each three-year term.
- Arbitrators are subject to the same ethical and training requirements as Commissioners.

Analysis/Impact: These changes could impact the handling of workers' compensation cases. Governor Quinn has not publicly indicated whether he will be reappointing the current Arbitrators but has appointed the new members to the WC Advisory Board.

➢ Standards of Conduct

Section 1.1 creates standards for the Arbitrators and directs the Commission to take appropriate disciplinary measures against Arbitrators, Commissioners, or Lawyers who violate these standards. It also provides that decisions must be based exclusively on evidence in the record and that any findings based on inspections or the like made by the arbitrator must be entered into the record. It also allows pre-trial conferences between the Arbitrators and the parties or their counsel.

Analysis/Impact: Since there is no formal discovery in Illinois workers compensation hearings, pre-trial conferences (prior Commission Chairman had disallowed them and current practice was somewhat unclear), can be beneficial. Pre-trial conferences can be used to obtain information prior to trial to resolve cases where further litigation is unnecessary.

➢ Claims by Former and Current Employees of the Commission and Judicial Review

Section 18.1 is new, and establishes that worker compensation cases involving current and former Commission employees not settled by agreement of the parties will be assigned to a certified independent arbitrator not employed by the Commission and designated by the Chairman. The decision of the independent arbitrator will become the decision of the Commission. An appeal of the independent arbitrator's decision shall be subject to judicial review.

➢ Commission Training Program

Amended Section 13 provides that new members of the Commission, in addition to existing training, will also be trained in the following: professional and ethical standards pursuant to the newly adopted sections; detection of workers' compensation fraud and reporting obligations of Commission employees and appointees; established standards for evidence-based medical treatment including AMA guidelines

and UR; and coal workers' pneumoconiosis (black lung) cases. It also establishes that each Commissioner shall complete 20 hours of training in the above-mentioned areas every two years.

➢ **Gift Ban**

Section 16b is new and prohibits an attorney appearing before the Commission from providing gifts of over $75 a day to any person in exchange for the referral of a client involving a matter except for a division of a fee between lawyers. Violation of this Section is a Class A misdemeanor.

➢ **Commission Powers**

Section 4(d) enhances the power of Commission investigators, authorizing them to issue citations of no less than $500 and no more than $2,500 to employers without workers compensation insurance with proof that insurance was obtained. It also provides authority for civil penalty against self-insureds who knowingly and willfully fail to comply with citations issued by a Commission investigator.

Analysis/Impact: This section provides the Commission with additional enforcement tools/powers to promote workers compensation coverage for all employers and additional enforcement measures against self-insureds.

CAUSATION CHANGES

➢ **Burden of Proof**

Section 1(d) codifies existing case law outlining that "an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment."

Analysis/Impact: This section merely codifies the causation standard currently set forth in case law.

➢ **Alcohol & Drug Intoxication**

Section 11, as amended, enhances the intoxication defense:

- It provides that no compensation shall be payable if the employee's intoxication is the proximate cause of the employee's accidental injury, or if the employee was so intoxicated that the intoxication constituted a departure from the employment.
- It creates a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury if at the time of the accidental injury: there was 0.08% alcohol in the employee; any evidence of impairment due to the unlawful or unauthorized use of cannabis or a controlled substance listed in the Illinois Controlled Substances Act or an intoxicating compound listed in the Use of Intoxicating Compounds Act; or if the employee refuses to submit to testing.
- The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries.
- The Commission is tasked with establishing rules for collection, labeling, storage, and testing, and affords the employee the opportunity to provide notification of relevant information such as prescription or non-prescription drugs used.
- This section is effective for injuries occurring on or after September 1, 2011.

Analysis/Impact: The testing requirement and the provision shifting of the burden of proof to the employee upon positive testing should preclude most intoxication cases where the intoxication is related to the injury.

MISCELLANEOUS CHANGES

➢ Fraud

Section 25.5 enhances the existing fraud provision. Among other changes, it expressly provides that intentionally presenting a bill for payment of medical services not provided constitutes fraud. It also provides that a person convicted under this Section shall be ordered to pay monetary restitution including any court costs and attorney fees as well as expenses incurred and paid by the State of Illinois or an insurance company or self-insured entity in connection with any medical evaluation or treatment services.

The Section also changes the fraud unit:

- The Department of Insurance is now tasked with handling the Workers Compensation fraud unit.
- The Unit must procure and implement a system utilizing advanced analytics inclusive of: predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud and waste.
- The Unit must provide a report on July 1, 2012, and annually thereafter, detailing its activities and providing recommendations regarding opportunities for additional fraud waste and abuse detection and prevention. The unit shall also report:
  - The number of allegations of insurance non-compliance and fraud reported to the fraud and insurance non-compliance unit.
  - The source of the reported allegations (individual, employer, or other).
  - The number of allegations investigated by the fraud and insurance non-compliance unit.
  - The number of criminal referrals made in accordance with this Section and the entity to which the referral was made.
  - All proceedings under this Section.

Analysis/Impact: These changes strengthen and enhance the existing fraud statutes. The statute adds that the intentional presentation of a bill for services not rendered is a criminal act. It increases the penalties for fraud and makes any fraudulent claim over $300 a Class 3 felony. The restitution provision should help prosecutors and carriers recover investigation expenses as well as payments, court costs and attorneys fees.

➢ Collective Bargaining Pilot

Section 4b establishes a pilot collective bargaining agreement within the construction industry with the following parameters:

- Director of the Department of Labor designates two labor organizations to participate in a collective bargaining process.
- After appropriate filings of the collective bargaining agreement, the Commission and the State shall recognize the collective bargaining as a binding agreement between the construction employer and the labor organization which contains certain obligations and procedures relating to workers compensation. The terms may include: Alternative dispute resolution; medical treatment providers; limited list of IME doctors; light/modified duty programs; exclusive vocational rehabilitation/retraining service; and joint labor management safety committee.
- Specifically prohibits any collective bargaining agreement from diminishing or increasing a construction employer's entitlements under the Act or an employee's entitlement to benefits. The Commission is to record any settlements under the "alternative dispute resolution plan."

The construction employer must notify its insurance carrier of its intention to enter into such a collective bargaining agreement.

Analysis/Impact: It is anticipated that the pilot, limited to two unions (most likely operating engineers and laborers) will have limited present use. Collective bargaining represents a significant change in Illinois workers compensation and if successful could lead to an expansion outside the construction industry; therefore, the impact of the section to non-construction employers is presently unknown.

➢ **Employee Leasing Companies**

Section 4(a)(5)(a-2) is new and directs employee leasing companies to provide the Commission: the name of any client listed as an additional named insured; information regarding the client company, including name, FEID, location and any certificates of insurance specifying rights under the master policy.

Analysis/Impact: This should help clarify insurance coverage issues regarding employee leasing companies.

➢ **Workers Compensation Advisory Board**

Section 13.1(d) terminates the active Advisory Board members and provides that the Governor shall appoint new members within 30 days. The Board is to make recommendations to the Governor on new Arbitrator and Commissioner appointments.

➢ **Evaluation of State Purchasing of Insurance**

Section 405-105 of the Civil Administrative Code of Illinois (20 ILCS 405/405-105) was amended by adding a new Section (10a) directing the Director of Insurance to determine if the State should purchase workers compensation insurance, use a third party administrator of self-insurance, or use a combination of both. A contract would be selected based on: administrative cost, service capability of the carrier or contract, premiums, fees, or charges.

➢ **Recalculation of Premiums and Insurance Oversight**

Section 29.1 imposes a requirement upon the Director of Insurance to immediately direct any workers' compensation rate setting advisory organization to recalculate workers' compensation advisory premium rates and assigned risk pool premium rates incorporating the new provisions of this act, and publish such rates on or before September 1, 2011.

Section 29.2 directs the Department of Insurance to provide an annual comprehensive report on Illinois workers compensation.

➢ **Subpoena Practice**

Enhances existing statutory authority providing for the release of medical records upon subpoena.

➢ **Insurer Reporting**

Section 29.2 is new and requires the Director of Insurance to promulgate rules requiring each insurer licensed to write workers' compensation coverage in the state to record and report certain information on an aggregate basis to the Department of Insurance before March 1 of each year, relating to claims in the state opened within the prior calendar year:

No.	Reportable Category
1	The number of claims opened
2	The number of reported medical only claims
3	The number of contested claims
4	The number of claims for which the employee has attorney representation
5	The number of claims with lost time and the number of claims for which temporary total disability was paid
6	The number of claim adjusters employed to adjust workers' compensation claims
7	The number of claims for which temporary total disability was not paid within 14 days from the first full day off, regardless of reason
8	The number of medical bills paid 60 days or later from date of service and the average days paid on those paid after 60 days for the previous calendar year

9	The number of claims in which in-house defense counsel participated, and the total amount spent on in-house legal services
10	The number of claims in which outside defense counsel participated, and the total amount paid to outside defense counsel
11	The total amount billed to employers for bill review
12	The total amount billed to employers for fee schedule savings
13	The total amount charged to employers for any and all managed care fees
14	The number of claims involving in-house medical nurse case management, and the total amount spent on in-house medical nurse case management
15	The number of claims involving outside medical nurse case management, and the total amount paid for outside medical nurse case management
16	The total amount paid for Independent Medical exams
17	The total amount spent on in-house Utilization Review for the previous calendar year
18	The total amount paid for outside Utilization Review for the previous calendar year