ACT 234 H.B. NO. 2133

A Bill for an Act Relating to Workers' Compensation Reform.

Be It Enacted by the Legislature of the State of Hawaii:

PART I

SECTION 1. Section 386, Hawaii Revised Statutes, is amended by adding a new section to part II to be appropriately designated and to read as follows:

"**§386- Negotiation for benefit coverage.** (a) Notwithstanding any provision of law to the contrary, any employer may determine the benefits and coverage of a policy required under this chapter through collective bargaining with an appropriate bargaining unit; provided that the bargained agreement shall be reviewed by the director to ensure that the agreement does not provide benefits and coverage less than those provided in this chapter. The director shall approve the agreement within ninety days after submittal upon a finding that the agreement provides the benefits and coverage required. This section shall not apply to collective bargaining contracts negotiated pursuant to chapter 89. The director may adopt rules pursuant to chapter 91 to implement this section.

(b) This section shall apply only to collective bargaining agreements negotiated subsequent to the effective date of this Act."

SECTION 2. Chapter 386, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§386- Publication of fees by prepaid health care plan contractors.** (a) A prepaid health care plan contractor as defined in section 393-3 shall provide the director upon request with a schedule of all the maximum allowable medical fees.

(b) Pursuant to section 386-21(c), the director shall review and, to the extent possible, shall use the fee obtained under subsection (a) as the primary guideline in establishing prevalent charges for medical care, services, and supplies in adopting the fee schedule for workers' compensation claims."

SECTION 3. Chapter 396, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§396- Certification of safety and health professionals.** (a) Only individuals receiving certification from the department as safety and health professionals shall be qualified to certify that an employer:

(1) Has an effective safety and health program; and
(2) Qualifies for a reduction in workers' compensation insurance premiums under section 431:14-103(b).

(b) Certification as a safety and health professional shall be:

(1) Issued to an individual only; and
(2) Renewable.

(c) Certificates issued under this section may be revoked or suspended by the director on any grounds specified in rules adopted under this chapter."

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 9 to be appropriately designated and to read as follows:

"**§431:9- Workers' compensation claims adjusters; limited license.** The commissioner may issue a limited license to an adjuster who only adjusts workers' compensation claims; provided that the adjuster:

(1) Is domiciled in the State of Hawaii, or in a state that permits residents of the State of Hawaii to act as adjusters in that other state;
(2) Has had experience, special education, or training in handling loss claims under workers' compensation insurance contracts of sufficiently reasonable duration and to enable an individual to fulfill the responsibilities of an adjuster;
(3) Has a passing grade on the workers' compensation examination pursuant to section 431:9-206; and
(4) Pays the applicable fees.

An adjuster with a limited license issued under this subsection may extend the license biennially upon successfully passing a reexamination on workers' compensation."

SECTION 5. Chapter 431, Hawaii Revised Statutes, is amended by adding two new sections to article 14 to be appropriately designated and to read as follows:

"**§431:14- Disclosure of workers' compensation premium information.** (a) All policies issued to employers for workers' compensation insurance shall disclose clearly to employers as separate figures the portion of the premium charged for:

(1) Medical care, services, and supplies;
(2) Wage loss benefits including temporary total, temporary partial, and permanent total disability benefits and their related benefits;
(3) Indemnity benefits for permanent partial disability; and
(4) Death benefits.

In addition, a disclosure statement shall indicate to the employer the portion of the premium attributable to loss control and administrative costs, attorney's fees

of the insurer, the cost of employer requested medical examinations, and private investigation costs.

(b) When a policy is issued to employers for workers' compensation insurance, it shall be accompanied by a statement disclosing the percentages of premiums expended during the previous year by the insurer for claims paid in the categories specified in subsection (a), including loss control and administrative costs, attorney's fees of the insurer, the cost of employer requested medical examinations, and private investigation costs.

(c) The information provided to employers by insurers pursuant to this section shall be provided on an annual basis to the director of labor and industrial relations and to the commissioner.

(d) Any insurer found in violation of this section shall pay a fine of $5,000 per violation to the insured, plus attorney's fees and costs to the insured for enforcing this section.

§431:14- Contracting classification premium program. With respect to each classification of risk in the construction industry, the rating organization shall file with the commissioner a contracting classification premium program, which is a method of computing premiums, that does not impose a higher premium solely because of an employer's higher rate of wages."

SECTION 6. Section 386-3, Hawaii Revised Statutes, is amended to read as follows:

"**§386-3 Injuries covered.** If an employee suffers personal injury either by accident arising out of and in the course of the employment or by disease proximately caused by or resulting from the nature of the employment, the employee's employer or the special compensation fund shall pay compensation to the employee or the employee's dependents as hereinafter provided.

Accident arising out of and in the course of the employment includes the wilful act of a third person directed against an employee because of the employee's employment.

No compensation shall be allowed for an injury incurred by an employee by the employee's wilful intention to injure oneself or another [or by the employee's intoxication.] by actively engaging in any unprovoked non-work related physical altercation other than in self defense, or by the employee's intoxication."

SECTION 7. Section 386-21, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) The liability of the employer for medical care, [medical] services, and [medical] supplies shall be limited to the charges computed as set forth in [the] this section. The director shall make determinations of [such] the charges and [promulgate] adopt fee schedules based upon [such] those determinations [as are set forth in this section. For the calendar year 1974 and for each succeeding calendar year thereafter the charges shall be limited to the amounts determined in applicable regulations of the department which became effective on August 13, 1971, and amendments thereto, adjusted to reflect increases or decreases in the Consumer Price Index for the Honolulu region prepared by the Bureau of Labor Statistics of the United States Department of Labor which have occurred in the last twelve months ending June 30 of the year preceding.

The adjustments in charges provided for in this section shall be computed annually and rounded to the next higher multiple of 10 cents in each case.

Notwithstanding the foregoing, the director shall review and if necessary revise the applicable regulations every three years, the review and revision to be conducted in accordance with section 91-3. The first review and revision shall be completed no later than December 1, 1974, to be effective January 1, 1975, and subsequent reviews or revisions shall be made at each three year interval thereafter. In making such reviews and revisions and adopting fee schedules pursuant thereto, the director shall establish reasonable fees for medical care, medical services, and medical supplies and may take into consideration in making such determination the charges made in the State for similar treatment of injuries which are not compensable under this chapter]. [The] As of the effective date of this Act, and for each succeeding fiscal year thereafter, the charges shall not exceed one hundred ten per cent of fees prescribed in the Medicare Resource Based Relative Value Scale system applicable to Hawaii as prepared by the United States Department of Health and Human Services, except as provided in this subsection. The rates or fees provided for in this section shall be adequate to ensure at all times the standard of services and care intended by this chapter to injured employees.

If the director determines that an allowance under the Medicare program is not reasonable, or if a medical treatment, accommodation, product, or service existing as of the effective date of this Act is not covered under the Medicare program, the director [may] shall, at any time, [in the foregoing manner,] establish an additional fee schedule or schedules not exceeding the prevalent charge for fees for services actually received by providers of health care services to cover charges for [medical care, medical services, and medical supplies not previously regulated pursuant to this section.

The liability of the employer may exceed the amount set forth in such fee schedule or schedules only under conditions prescribed by the director.] that treatment, accommodation, product, or service. If no prevalent charge for a fee for service has been established for a given service or procedure, the director shall adopt a reasonable rate that shall be the same for all providers of health care services to be paid for that service or procedure.

The director shall update the schedules required by this section annually. The updates shall be based upon:

(1) Future charges or additions prescribed in the Medicare Resource Based Relative Value Scale system applicable to Hawaii as prepared by the United States Department of Health and Human Services; or

(2) A statistically valid survey by the director of prevalent charges for fees for services actually received by providers of health care services or based upon the information provided to the director by the appropriate state agency having access to prevalent charges for medical fee information.

When a dispute exists between an insurer or self-insured employer and a medical service provider regarding the amount of a fee for medical services, the director may resolve the dispute in a summary manner as the director may prescribe; provided that a provider shall not charge more than the provider's private patient charge for the service rendered."

SECTION 8. Section 386-26, Hawaii Revised Statutes, is amended to read as follows:

"**[[]§386-26[]] Guidelines on frequency of treatment and reasonable utilization of health care and services.** (a) The director shall issue guidelines for the frequency of treatment and for reasonable utilization of medical care and services by health care providers [which] that are considered necessary and appropriate under this chapter.

The frequency and extent of treatment shall not exceed the nature of the injury and the process a recovery requires; provided that no authorization shall be required for the initial five treatments. After the initial five treatments, in accordance with guidelines established by the director under this chapter, the director may authorize no more than ten additional treatments. For injuries requiring more than fifteen treatments, the director may authorize additional treatments upon a finding that such treatments are medically necessary and appropriate.

The guidelines shall be adopted pursuant to chapter 91 and shall not interfere with the injured employee's rights to exercise free choice of physicians under section 386-21.

In addition, the director shall [promulgate] adopt updated medical fee schedules referred to in section 386-21 and where deemed appropriate shall establish separate fee schedules for services of health care providers as defined in section 386-1 to become effective no later than June 30, 1986, in accordance with chapter 91."

SECTION 9. Section 386-32, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Permanent partial disability. Where a work injury causes permanent partial disability, the employer shall pay the injured worker compensation in an amount determined by multiplying the effective maximum weekly benefit rate prescribed in section 386-31 by the number of weeks specified for the disability as follow:

Thumb. For the loss of thumb, seventy-five weeks;

First finger. For the loss of a first finger, commonly called index finger, forty-six weeks;

Second finger. For the loss of a second finger, commonly called the middle finger, thirty weeks;

Third finger. For the loss of a third finger, commonly called the ring finger, twenty-five weeks;

Fourth finger. For the loss of a fourth finger, commonly called the little finger, fifteen weeks;

Phalanx of thumb or finger. Loss of the first phalanx of the thumb shall be equal to the loss of three-fourths of the thumb, and compensation shall be three-fourths of the amount above specified for the loss of the thumb. The loss of the first phalanx of any finger shall be equal to the loss of one-half of the finger, and compensation shall be one-half of the amount above specified for loss of the finger. The loss of more than one phalanx of the thumb or any finger shall be considered as loss of the entire thumb or finger;

Great toe. For the loss of a great toe, thirty-eight weeks;

Other toes. For the loss of one of the toes other than the great toe, sixteen weeks;

Phalanx of toe. Loss of the first phalanx of any toe shall be equal to the loss of one-half of the toe, and the compensation shall be one-half of the amount specified for the loss of the toe. The loss of more than one phalanx of any toe shall be considered as the loss of the entire toe;

Hand. For the loss of a hand, two hundred forty-four weeks;

Arm. For the loss of an arm, three hundred twelve weeks;

Foot. For the loss of a foot, two hundred five weeks;

Leg. For the loss of a leg, two hundred eighty-eight weeks;

Eye. For the loss of an eye by enucleation, one hundred sixty weeks. For the loss of vision in an eye, one hundred forty weeks. Loss of binocular vision or of eighty per cent of the vision of an eye shall be considered loss of vision of the eye;

Ear. For the permanent and complete loss of hearing in both ears, two hundred weeks. For the permanent and complete loss of hearing in one ear, fifty-two weeks. For the loss of both ears, eighty weeks. For the loss of one ear, forty weeks;

Loss of use. Permanent loss of the use of a hand, arm, foot, leg, thumb, finger, toe, or phalanx shall be equal to and compensated as the loss of a hand, arm, foot, leg, thumb, finger, toe, or phalanx;

Partial loss or loss of use of member named in schedule. Where a work injury causes permanent partial disability resulting from partial loss of use of a member named in this schedule, and where the disability is not otherwise compensated in this schedule, compensation shall be paid for a period that stands in the same proportion to the period specified for the total loss or loss of use of the member as the partial loss or loss of use of that member stands to the total loss or loss of use thereof;

More than one finger or toe of same hand or foot. In cases of permanent partial disability resulting from simultaneous injury to the thumb and one or more fingers of one hand, or to two or more fingers of one hand, or to the great toe and one or more toes other than the great toe of one foot, or to two or more toes other than the great toe of one foot, the disability may be rated as a partial loss or loss of use of the hand or the foot and the period of benefit payments shall be measured accordingly. In no case shall the compensation for loss or loss of use of more than one finger or toe of the same hand or foot exceed the amount provided in this schedule for the loss of a hand or foot;

Amputation. Amputation between the elbow and the wrist shall be rated as the equivalent of the loss of a hand. Amputation between the knee and the ankle shall be rated as the equivalent of the loss of a foot. Amputation at or above the elbow shall be rated as the loss of an arm. Amputation at or above the knee shall be rated as the loss of a leg;

Disfigurement. In cases of personal injury resulting in disfigurement the director may award compensation not to exceed [$15,000] $30,000 as the director deems proper and equitable in view of the disfigurement. Disfigurement shall be separate from other permanent partial disabilities and shall include scarring and other disfiguring consequences caused by medical, surgical, and hospital treatment of the employee;

Other cases. In all other cases of permanent partial disability resulting from the loss or loss of use of a part of the body or from the impairment of any physical function, weekly benefits shall be paid at the rate and subject to the limitations specified in this subsection for a period that bears the same relation to a period named in the schedule as the disability sustained bears to a comparable disability named in the schedule. In cases in which the permanent partial disability must be rated as a percentage of the total loss or impairment of a physical or mental function of the whole person, the maximum compensation shall be computed on the basis of the corresponding percentage of the product of three hundred twelve times the effective maximum weekly benefit rate prescribed in section 386-31.

Payment of compensation for permanent partial disability. Compensation for permanent partial disability shall be paid in weekly installments at the rate of sixty-six and two-thirds per cent of the worker's average weekly wage, subject to the limitations on weekly benefit rates prescribed in section 386-31.

Unconditional nature and time of commencement of payment. Compensation for permanent partial disability shall be paid regardless of the earnings of the disabled employee subsequent to the injury. Payments shall not commence until after termination of any temporary total disability that may be caused by the injury."

SECTION 10. Section 386-33, Hawaii Revised Statutes, is amended to read as follows:

"**§386-33 Subsequent injuries [which] that would increase disability.** (a) Where prior to any injury an employee suffers from a previous permanent partial disability already existing prior to the injury for which compensation is claimed, and the disability resulting from the injury combines with the previous disability, whether the previous permanent partial disability was incurred during past or present periods of employment, to result in a greater permanent partial disability or in permanent total disability or in death then weekly benefits shall be paid as follows:

(1) In cases where the disability resulting from the injury combines with the previous disability to result in greater permanent partial disability the employer shall pay the employee compensation for the employee's actual permanent partial disability but for not more than one hundred four weeks; the balance if any of compensation payable to the employee for the employee's actual permanent partial disability shall thereafter be paid out of the special compensation fund; provided that in successive injury cases where the claimant's entire permanent partial disability is due to more than one compensable injury, the amount of the award for the subsequent injury shall be offset by the amount awarded for the prior compensable injury;

(2) In cases where the disability resulting from the injury combines with the previous disability to result in permanent total disability, the employer shall pay the employee for one hundred four weeks and thereafter compensation for permanent total disability shall be paid out of the special compensation fund; and

(3) In cases where the disability resulting from the injury combines with the previous disability to result in death the employer shall pay weekly benefits in accordance with sections 386-41 and 386-43 but for not more than one hundred four weeks; the balance of compensation payable under those sections shall thereafter be paid out of the special compensation fund.

(b) [Subsection (a) to the contrary notwithstanding,] Notwithstanding subsection (a), in the case of permanent total disability or death, where the director or the appellate board determines that the previous permanent partial disability amounted to less than that necessary to support an award of thirty-two weeks of compensation for permanent partial disability there shall be no liability on the special compensation fund, and [in any such case] the employer shall pay the employee or the employee's dependents full compensation for the employee's [actual permanent partial or] permanent total disability or death.

(c) Subsections (a) and (b) shall apply in all cases where the work injury occurs on or after May 15, 1982, and combines with a previous disability to result in a greater permanent partial disability or in permanent total disability or in death. Effective July 1, 1995, subsection (a)(1), as amended, shall apply in all cases in which the work injury occurs on or after July 1, 1995, and combines with a previous disability from a compensable injury to result in a greater permanent partial disability."

SECTION 11. Section 386-51, Hawaii Revised Statutes, is amended to read as follows:

"**§386-51 Computation of average weekly wages.** Average weekly wages shall be computed in [such] a manner that the resulting amount represents most fairly, in the light of the employee's employment pattern and the duration of the employee's disability, the injured employee's average weekly wages from all covered employment at the time of the personal injury. In no event, however, shall an employee's average weekly wages be computed to be less than the employee's

hourly rate of pay multiplied by thirty-five[.]; provided that where the employee holds part-time employment of fewer than thirty-five hours per week, the employee's average weekly wages shall be the hourly rate at the place of employment where the injury occurred multiplied by the average hours worked in the fifty-two weeks (or portions thereof) preceding the week in which the injury occurred, for the calculation of temporary partial disability and temporary total disability benefits only. Other benefits including permanent partial disability, permanent total disability, and death shall be calculated as if the employee had been a full-time employee.

(1) Where appropriate and feasible [such], computation shall be made on the basis of the injured employee's earnings from covered employment during the twelve months preceding the employee's personal injury; but if during that period, the employee, because of sickness or similar personal circumstances was unable to engage in employment for one or more weeks then the number of [such] those weeks shall not be included in the computation of the average weekly wage.

(2) Where an employee at the time of the injury was employed at higher wages than during any other period of the preceding twelve months then the employee's average weekly wages shall be computed exclusively on the basis of [such] the higher wages.

(3) Where, by reason of the shortness of the time during which the employee has been in the employment or the casual nature or terms of the employment, it is not feasible to compute the average weekly wages on the basis of the injured employee's own earnings from [such] that employment, regard may be had to the average weekly wages which during the twelve months preceding the injury was being earned by an employee in comparable employment.

(4) [In no case shall] Except as otherwise provided, the total average weekly wages of any employee shall be computed at a lower amount than the average weekly wages earned at the time of the injury by an employee in comparable employment engaged as a full-time employee on an annual basis in the type of employment in which the injury occurred.

(5) If an employee, while under twenty-five years of age, sustains a work injury causing permanent disability or death, the employee's average weekly wages shall be computed on the basis of the wages which the employee would have earned in the employee's employment had the employee been twenty-five years of age.

(6) The director [of labor and industrial relations] may issue rules for the determination of the average weekly wages in particular classes of cases, consistent with the principles laid down in the first paragraph of this section."

SECTION 12. Section 386-78, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) No compromise in regard to a claim for compensation pending before the director shall be valid unless it is approved by decision of the director as conforming to this chapter and made a part of [such] the decision[; provided that any compromise in which the claimant waives or otherwise prejudices the claimant's right to reopen the claimant's case or to future medical benefits shall not be valid unless also approved in writing by the appellate board]."

SECTION 13. Section 386-79, Hawaii Revised Statutes, is amended to read as follows:

"**§386-79 Medical examination by employer's physician.** After an injury and during the period of disability, the employee, whenever ordered by the director of labor and industrial relations, shall submit oneself to examination, at reasonable times and places, by a duly qualified physician or surgeon designated and paid by the employer. The employee shall have the right to have a physician or surgeon designated and paid by the employee present at the examination, which right, however, shall not be construed to deny to the employer's physician the right to visit the injured employee at all reasonable times and under all reasonable conditions during total disability.

If an employee refuses to submit oneself to, or in any way obstructs, such examination the employee's right to claim compensation for the work injury shall be suspended until the refusal or obstruction ceases and no compensation shall be payable for the period during which the refusal or obstruction continues.

In cases where the employer is dissatisfied with the progress of the case or where major and elective surgery, or either, is contemplated, the employer may appoint a physician or surgeon of the employer's choice who shall examine the injured employee and make a report to the employer. If the employer remains dissatisfied this report may be forwarded to the director.

Employer requested examinations ordered by the director under this section shall not exceed more than one per case unless good and valid reasons exist with regard to the medical progress of the claimant's treatment. The cost of conducting the medical examination shall be limited to the complex consultation charges governed by the medical fee schedule established pursuant to section 386-21(c)."

SECTION 14. Section 386-92, Hawaii Revised Statutes, is amended to read as follows:

"**§386-92 Default in payments of compensation, penalty.** If any compensation payable under the terms of a final decision or judgment is not paid by a self-insured employer or an insurance carrier within thirty-one days after it becomes due, as provided by [such] the final decision or judgment, or if any temporary total disability benefits are not paid by [such] the employer or carrier within ten days, exclusive of Saturdays, Sundays, and holidays, after [being] the employer or carrier has been notified of the disability, and where the right to [such] benefits are not controverted in the employer's initial report of industrial injury or where temporary total disability benefits are terminated in violation of section 386-31, there shall be added to the unpaid compensation an amount equal to [ten] twenty per cent thereof payable at the same time as, but in addition to, the compensation, unless the nonpayment is excused by the director after a showing by the employer or insurance carrier that the payment of the compensation could not be made on the date prescribed therefor owing to the conditions over which the employer or carrier had no control."

SECTION 15. Section 386-96, Hawaii Revised Statutes, is amended to read as follows:

"**§386-96 Reports of physicians, surgeons, and hospitals.** (a) Any physician, surgeon, or hospital that has given any treatment or rendered any service to an injured employee shall make a report of the injury and treatment on forms prescribed by and to be obtained from the department as follows:

(1) Within seven days after the date of first attendance or service rendered, an initial report shall be made to the department and to the employer of the injured employee in the manner prescribed by the department[.]:

(2) Interim reports to the same parties and in the same manner as prescribed in paragraph (1) shall be made at appropriate intervals [of twenty-one days or less during continuing treatment.] to verify the claimant's continuing treatment, periods of temporary disability, the extent of permanent disability, and other information determined necessary by the director; and

(3) [Final] A final report to the same parties and in the same manner as prescribed in paragraph (1) shall be made within seven days after termination of treatment.

(b) No claim under this chapter for medical [or surgical] treatment, [or] surgical treatment, or hospital services and supplies, shall be valid and enforceable unless the reports are made as provided in this section, except that the director may excuse the failure to make the report within the prescribed period or a nonsubmission of [said] the report when the director finds it in the best interest of justice to do so. If the director does not excuse the submission of: [(a) an]

(1) An initial or interim report within the time prescribed in subsection (a)(1) and (2) [above, the delinquent physician shall be fined in an amount not to exceed $250; (b) a]; or

(2) A final report [which] that is thirty days late or a nonsubmission, the delinquent physician shall be fined [in an amount not to exceed] not more than $250.

(c) The director shall furnish to the injured employee a copy of the final report of the attending physician or surgeon or, if more than one physician or surgeon should treat or examine the employee, a copy of the final report of each physician or surgeon.

(d) Within fifteen days after being requested to do so by the injured employee or the employee's duly authorized representative, the employer shall furnish the employee or the employee's duly authorized representative with copies of all medical reports relating to the employee's injury [which] that are in the possession of the employer. The copies shall be furnished at the expense of the employer. The employer shall allow the employee or the employee's duly authorized representative to inspect and copy transcripts of depositions of medical witnesses, relating to the employee's injury, in the possession of the employer. Any employer who fails to furnish medical reports or to allow inspection and copying of transcripts of depositions of medical witnesses, as required by this paragraph shall be fined in an amount not to exceed $1,000.

(e) Deposit of the records required by [the first paragraph] subsection (a)(1) of [this section] in the United States mail, addressed to the director and to the employer, within the time limit specified, shall be deemed in compliance with the requirements of this section."

SECTION 16. Section 386-98, Hawaii Revised Statutes, is amended to read as follows:

"**§386-98 [Penalties for fraud.** No person shall willfully make a false statement or representation for the purpose of directly obtaining any compensation or payment or for the purpose of avoiding on behalf of employer or carrier any compensation or payment under this chapter.] **Fraud violations and penalties.** (a) A fraudulent insurance act, under this chapter, shall include acts or omissions committed by any person who knowingly and fraudulently intends to obtain benefits, deny benefits, obtain benefits compensation for services provided, or provides legal assistance or counsel to obtain benefits or recovery through fraud or deceit by doing the following:

(1) Presenting, or causing to be presented, any false information on an application;
(2) Presenting, or causing to be presented, any false or fraudulent claim for the payment of a loss;
(3) Presenting multiple claims for the same loss or injury, including presenting multiple claims to more than one insurer except when these multiple claims are appropriate and each insurer is notified immediately in writing of all other claims and insurers;
(4) Making, or causing to be made, any false or fraudulent claim for payment or denial of a health care benefit;
(5) Submitting a claim for a health care benefit that was not used by, or on behalf of, the claimant;
(6) Presenting multiple claims for payment of the same health care benefit;
(7) Presenting for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time;
(8) Assisting, abetting, soliciting, or conspiring with any person who engages in an unlawful act as defined under this section;
(9) Misrepresenting or concealing a material fact;
(10) Fabricating, altering, concealing, making a false entry in, or destroying a document;
(11) Making, or causing to be made, any false or fraudulent statements with regard to entitlements or benefits, with the intent to discourage an injured employee from claiming benefits or pursuing a workers' compensation claim; or
(12) Making, or causing to be made, any false or fraudulent statements or claims by, or on behalf of, a client with regard to obtaining legal recovery or benefits.

(b) No employer shall wilfully make a false statement or representation to avoid the impact of past adverse claims experience through change of ownership, control, management, or operation to directly obtain any workers' compensation insurance policy.

(c) It shall be inappropriate for any discussion on benefits, recovery, or settlement to include the threat or implication of criminal prosecution. Any threat or implication shall be immediately referred in writing to:
(1) The state bar if attorneys are in violation;
(2) The insurance commissioner if insurance company personnel are in violation;
(3) The regulated industries complaints office if health care providers are in violation; or
(4) The department and the state ethics commission if hearings officers are in violation,

for investigation and, if appropriate, disciplinary action.

(d) A criminal offense under this section shall constitute a:
(1) Class C felony if the value of the moneys obtained or denied is not less than $2,000;
(2) Misdemeanor if the value of the moneys obtained or denied is less than $2,000; or
(3) Petty misdemeanor if the providing of false information did not cause any monetary loss.

Any person subject to a criminal penalty under this section shall be ordered by a court to make restitution to an insurer or any other person for any financial loss sustained by the insurer or other person caused by the fraudulent act.

(e) In lieu of the criminal penalties set forth in subsection (d), [Any] any person who violates this section [shall] may be subject to the administrative penalties of restitution of benefits or payments fraudulently received under this chapter, whether received from an employer, insurer, or the special compensation fund, to be made to the source from which the compensation was received, and one or more of the following:

(1) A fine of not more than [$2,500] $10,000 for each violation;
(2) Suspension or termination of benefits in whole or in part;
(3) Suspension or disqualification from providing medical care or services, vocational rehabilitation services, and all other services rendered for payment under this chapter;
(4) Suspension or termination of payments for medical, vocational rehabilitation and all other services rendered under this chapter[.];
(5) Recoupment by the insurer of all payments made for medical care, medical services, vocational rehabilitation services, and all other services rendered for payment under this chapter; or
(6) Reimbursement of attorney's fees and costs of the party or parties defrauded.

(f) With respect to the administrative penalties set forth in subsection (e), [No] no penalty shall be imposed except upon consideration of a written complaint [which] that specifically alleges a violation of this section occurring within two years of the date of said complaint. A copy of [said] the complaint specifying the alleged violation shall be served promptly upon the person charged. The director or board shall issue, where a penalty is ordered, a written decision stating all findings following a hearing held not [less] fewer than twenty days after written notice to the person charged. Any person aggrieved by the decision may appeal [said] the decision under sections 386-87 and 386-88."

SECTION 17. Section 386-100, Hawaii Revised Statutes, is amended to read as follows:

"**§386-100 Deductible option for medical benefits in insurance policy.** (a) Each workers' compensation insurance policy issued by every insurer shall offer, at the option of the insured employer, a deductible for medical benefits in the amount of $100, $150, $200, $300, $400, $500, [or] $2,500[.], $5,000, or $10,000, or greater if agreed upon by the insurer and the insured employer. The insured employer, if choosing to exercise the option, shall choose only one of the amounts as the deductible. The provisions of this subsection shall be fully disclosed to the prospective purchaser in writing.

(b) If an insured employer exercises the option and chooses a deductible, the insured employer shall be liable for the amount of the deductible for the medical benefits paid for each claim of work injury suffered by an injured employee. The insurer shall not be liable for the deductible.

The insurer shall pay the entire cost of medical bills directly to the provider of services and then seek reimbursement from the insured for the deductible amount.

Deductible medical benefit amounts shall be reported by insurers as required by section 386-95 and shall be included in the total average annual compensation paid by all insurance carriers in determining the charge against employers not insured under section 386-121(a)(1) for the purpose of the special compensation fund."

SECTION 18. Section 431:14-103, Hawaii Revised Statutes, is amended to read as follows:

"**§431:14-103 Making of rates.** (a) Rates shall be made in accordance with the following provisions:

(1) Rates shall not be excessive, inadequate, or unfairly discriminatory.

(2) Due consideration shall be given to:

(A) Past and prospective loss experience within and outside this State; provided that if the claim does not exceed the selected deductible amount pursuant to section 386-100, and the employer reimburses the insurer for the amount, the claims shall not be calculated in the employer's experience rating or risk category;

(B) The conflagration and catastrophe hazards, if any;

(C) A reasonable margin for underwriting profit and contingencies;

(D) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(E) Past and prospective expenses both country-wide and those specially applicable to this State;

(F) Investment income from unearned premium and loss reserve funds; and

(G) All other relevant factors within and outside this State.

(3) In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which that experience is available.

(4) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any insurer or group with respect to any class of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(5) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans [which] that establish standards for measuring variations in hazards or expense provisions, or both. These standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification may be based upon race, creed, national origin, or the religion of the insured.

(6) Manual, minimum, class rates, rating schedules, or rating plans shall be made and adopted, except in the case of:

(A) Special rates where manual, minimum, class rates, rating schedules, or rating plans are not applicable; and

(B) Specifically rated inland marine risks.

(7) No insurer authorized to do business in this State shall issue any policy [which] that provides or makes available to any risks preferred rates based upon any grouping of persons, firms, or corporations by way of membership, license, franchise, contract, agreement, or any other means, other than common majority ownership of the risks, or except where:

(A) A common stock ownership in and management control of the risks are held by the same person, corporation, or firm;

(B) Permitted or authorized by filings in existence as of January 1, 1988, under the casualty rating law and the fire rating law, as these filings may be amended from time to time;

(C) Health care providers, as defined in section 671-1 [which] that could have joined the patients' compensation fund as it existed in chapter 671, part III, prior to May 31, 1984, joined together with one or more groups of related or unrelated health care providers;
(D) Permitted under article 12; or
(E) Otherwise expressly provided by law.

(b) In cases of workers' compensation insurance, all rates made in accordance with this section shall be given due consideration for good safety records of employers. By premium reductions, dividends, or both, insurance carriers shall recognize good safety performance records of employers in this State.

(c) [Except to the extent necessary to meet the provisions of subsection (a)(1), uniformity among insurers in any matters within the scope of this section shall neither be required nor prohibited.] Upon issuance of a certificate by a certified safety and health professional to an employer that the employer has an effective safety and health program pursuant to section 396- , the insurer shall provide the employer with a workers' compensation insurance premium discount of at least five per cent. Standards for the issuance of certificates shall be included in rules adopted by the department of labor and industrial relations pursuant to chapter 91.

(d) For the purpose of ratemaking, all insurers shall treat a volunteer firefighter the same as a firefighter employed by a county fire department; provided that the volunteer firefighters are attached to a station where a commercial drivers license holder is on duty at all times or at least four commercial drivers license holders are members of the volunteer unit.

(e) Except to the extent necessary to meet the provisions of subsection (a)(1), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited."

SECTION 19. Section 431:14-104, Hawaii Revised Statutes, is amended by amending subsections (i) and (j) to read as follows:

"(i) The commissioner shall review filings and hold public hearings on the filings as soon as reasonably possible after they have been made [in order] to determine whether they meet the requirements of this article. The commissioner shall calculate the investment income and accuracy of loss reserves upon which filings are based, and the insurer shall provide the information necessary to make the calculation.

(j) Subject to the exception specified in subsection (k), each filing shall be on file for a waiting period of [thirty] ninety days before the filing becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives written notice within the waiting period to the insurer, rating organization, or advisory organization [which] that made the filing that the commissioner needs the additional time for the consideration of the filing. Upon written application by the insurer, rating organization, or advisory organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the waiting period or any extension thereof."

PART II

SECTION 20. Chapter 431, Hawaii Revised Statutes, is amended by adding two new sections to article 14 to be appropriately designated and to read as follows:

"§431:14- **Assigned risk pool; experience rating plan.** No employer shall be placed in an assigned risk pool for workers' compensation insurance that does not utilize an experience rating plan that includes:

(1) Reasonable eligibility standards;
(2) Incentives for loss prevention;
(3) Sufficient premium differentials to encourage safety; and
(4) Provisions for reasonable and equitable limitations on the ability of policyholders to avoid the impact of past adverse claims experience through change of ownership, control, management, or operation.

§431:14- Assigned risk pool; residual market plan. (a) The commissioner shall establish a residual market plan to provide equitable apportionment of insurance that may be afforded to applicants who are in good faith entitled to, but who are unable to procure, such insurance through ordinary methods. The residual market plan shall include rules for classification of risks and rates.

(b) Any insured placed with the plan shall be notified that insurance coverage is being afforded through the plan and not through the private market. Written notification shall be given to the insured within ten days of placement with the plan.

(c) To ensure that plan rates are made adequate to pay claims and expenses, insurers shall develop a means of obtaining loss and expense experience at least annually. Each insurer shall submit a report on loss and expense experience, when available, with the department in sufficient detail to make a determination of rate adequacy.

(d) The plan shall provide a formula allowing an insurer who voluntarily removes an insured risk from the residual market to be eligible for a take-out credit applicable against that insurer's residual market assessment base levied by the plan. The terms and conditions of the take-out credit shall be as follows:

(1) An insurer shall receive a credit against its assessment base for the amount of the annual premium reflected in its financial statements for the respective calendar year. This reported premium shall be stated on the same financial basis as the premiums that are reported for use in determining each insurer's residual market assessment base and shall be subject to subsequent adjustments and audits;
(2) The credit applicable to the residual market assessment base shall be as follows:
First year: $2.00 credit for every $1.00 of premium removed; Second year: $1.00 credit for every $1.00 of premium removed; and Third year: $1.00 for every $1.00 of premium removed;
(3) If the insurer keeps the insured risk out of the residual market for three years, that insurer shall receive credit for each of three years. If the insurer does not write the business for three years, it shall receive credit only for the period of time that it covered the risk in the voluntary market. Under no circumstances shall an insurer receive credit for risks returned to the residual market within one policy year;
(4) An insurer shall not return an insured taken from the residual market to the residual market after one year of coverage to subsequently reissue insurance to the insured to obtain the higher credit established for the first year of residual market removal in paragraph (2);
(5) There shall be no maximum limit on credits received; provided that the credits shall not reduce the insurer's assessment base below zero;
(6) The kind and amount of coverage to be offered to voluntary risks shall not be less than those afforded by the policy being replaced, unless the kinds and amounts are refused by the insureds; and
(7) The commissioner may approve loss sensitive rating plans for larger companies that generate more than $150,000 in insurance premiums.

(e) The commissioner may adopt rules in accordance with chapter 91 to effectuate the purposes of this section.

(f) As used in this section, unless the context otherwise requires:

"Plan" means the residual market plan.

"Residual market assessment base" means the basis for assessing insurers for losses from the residual market, as provided for in a residual market plan."

SECTION 21. There is established a special fund for the administration of workers' compensation insurance by the insurance commissioner to be called the workers' compensation insurance administration special fund.

This fund shall be used to pay the costs incurred in administering workers' compensation insurance. Costs shall include but not be limited to:

(1) Costs related to public education and information;
(2) Costs relating to closed claims studies;
(3) Other studies and evaluations relating to workers' compensation insurance, which may include an analysis of the classifications of jobs and the assigned risk pool affecting the rates charged by insurers; and
(4) Costs related to administrative contracts with personnel necessary to carry out the purposes of this Act.

For each fiscal year beginning 1995-1996 until fiscal year 2000-2001, up to $150,000 shall be deposited into this special fund from the following sources:

(1) Fair and equitable assessments to be made by the insurance commissioner on April of each year, on each insurer authorized to transact workers' compensation insurance in this State and each self-insurer;
(2) Fair and equitable assessments to be made by the insurance commissioner for a one-time deposit into the fund, on each insurer authorized to transact workers' compensation insurance in this State and each self-insurer.

As of July 1, 2001, all unexpended and unencumbered balances remaining in the special fund shall transfer to the credit of the state general fund.

The insurance commissioner shall submit a complete and detailed report on the status of the fund's administration and expenditures to the legislature no later than twenty days before the convening of each regular legislative session.

The insurance commissioner may adopt rules effectuating the purposes of this section.

SECTION 22. The insurance commissioner is authorized to award residual market service contracts to one or more carriers through a bid process. This process shall be exempt from state procurement requirements under chapter 103D.

The insurance commissioner may establish personnel positions and appoint personnel as may be necessary for the performance of the insurance commissioner's duties in accordance with chapters 76 and 77; provided that the insurance commissioner may employ two auditors; and provided further that the auditors shall possess at least the minimum qualifications and experience required of comparable personnel in the workers' compensation insurance private sector.

The insurance commissioner shall examine the affairs, transactions, records, documents, classifications practices, pricing, safety programs, claims management, and service practices of assigned risk servicing carriers. The insurance commissioner shall also recommend improvements in the servicing and operations of the workers' compensation assigned risk pool in reports to be submitted to the legislature.

The insurance commissioner shall submit a preliminary report of its findings and recommendations, including recommendations for draft legislation, with regard to its examination of the assigned risk pool to the legislature no later than twenty

days before the regular session of 1996, and a final report no later than twenty days before the regular session of 1997.

PART III

SECTION 23. The director of labor and industrial relations and the insurance commissioner shall conduct a comprehensive feasibility study of coordinated health care delivery systems for consideration by the legislature as potential alternatives to the current system of providing medical care, services, and supplies under the medical care component of the workers' compensation system. The study shall include but not be limited to identification of various alternatives, applicable actuarial studies, medical benefits, and insurance premium cost comparisons, and any recommended legislation if applicable. The study, along with findings and recommendations, shall be submitted to the legislature no later than twenty days prior to the convening of the regular session of 1996.

SECTION 24. No later than July 1, 1996, the director of labor and industrial relations shall adopt rules, pursuant to chapter 91, for optional coordinated health care delivery systems under the workers' compensation system. The rules for optional coordinated health care delivery systems shall be submitted to the legislature no later than December 1, 1995. The legislature may disapprove the rules by concurrent resolution during the regular session of 1996.

SECTION 25. Statutory material to be repealed is bracketed. New statutory material is underscored.[1]

SECTION 26. This Act shall take effect upon its approval; provided that:
(1) Section 21 shall be repealed on July 1, 2001; and
(2) If the legislature disapproves the rules for optional coordinated health care delivery systems by concurrent resolution, section 24 shall be repealed.

(Approved June 29, 1995.)

Note

1. Edited pursuant to HRS §23G-16.5.