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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1 Session of 1993

Report of the Committee of Conference

To the Members of the Senate and House of Representatives:

We, the undersigned, Committee of Conference on the part of the Senate and House of Representatives for the purpose of considering Senate Bill No. 1, entitled:
"An act amending the act of June 2, 1915 (P.L.736, No.338), entitled, as reenacted and amended, 'An act defining the liability of an employer to pay damages for injuries received by an employe in the course of employment; establishing an elective schedule of compensation; * * *; and prescribing penalties,' adding and amending certain definitions; redesignating referees as workers' compensation judges; * * *; adding provisions relating to insurance, self-insurance pooling, self-insurance guaranty fund, health and safety~~,~~ AND the prevention of insurance fraud; further providing for certain penalties; making repeals; and making editorial changes,"

respectfully submit the following bill as our report:

ROBERT J.MELLOW

J. WILLIAM LINCOLN

ROGER A. MADIGAN

(Committee on the part of the Senate.)

MICHAEL R. VEON

WILLIAM R. LLOYD, JR.

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(Committee on the part of the House of Representatives.)

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AN ACT

Amending the act of June 2, 1915 (P.L.736, No.338), entitled, as reenacted and amended, "An act defining the liability of an employer to pay damages for injuries received by an employe in the course of employment; establishing an elective schedule of compensation; providing procedure for the determination of liability and compensation thereunder; and prescribing penalties," adding and amending certain definitions; redesignating referees as workers' compensation judges; further providing for contractors, for insurance and self-insurance, for compensation and for payments for medical services; providing for coordinated care organizations; further providing for procedures for the payment of compensation and for medical services and for procedures of the department, referees and the board; adding provisions relating to insurance, self-insurance pooling, self-insurance guaranty fund, health and safety and the prevention of insurance fraud; further providing for certain penalties; making repeals; and making editorial changes.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 101 of the act of June 2, 1915 (P.L.736, No.338), known as The Pennsylvania Workmen's Compensation Act, reenacted and amended June 21, 1939 (P.L.520, No.281) and amended December 5, 1974 (P.L.782, No.263), is amended to read:

Section 101. That this act shall be called and cited as [The Pennsylvania Workmen's] <u>the Workers'</u> Compensation Act, and shall apply to all injuries occurring within this Commonwealth, irrespective of the place where the contract of hiring was made, renewed, or extended, and extraterritorially as provided by section 305.2.

Section 2. Section 104 of the act, amended March 29, 1972 (P.L.159, No.61), is amended to read:

Section 104. The term "employe," as used in this act is declared to be synonymous with servant, and includes--

All natural persons who perform services for another for a valuable consideration, exclusive of persons whose employment is casual in character and not in the regular course of the

business of the employer, and exclusive of persons to whom articles or materials are given out to be made up, cleaned, washed, altered, ornamented, finished or repaired, or adapted for sale in the worker's own home, or on other premises, not under the control or management of the employer. [Every] Except as hereinafter provided in clause (c) of section 302 and sections 305 and 321 of this act, every executive officer of a corporation elected or appointed in accordance with the charter and by-laws of the corporation, except elected officers of the Commonwealth or any of its political subdivisions, shall be an employe of the corporation [except as hereinafter provided in sections 302 (c), 305 and 321]. An executive officer of a corporation may, however, elect not to be an "employe" of the corporation for the purposes of this act. For purposes of this section, an executive officer is an individual who has an ownership interest in the corporation, in the case of a Subchapter S corporation as defined by the act of March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of 1971," or an ownership interest in the corporation of at least five per centum, in the case of a Subchapter C corporation as defined by the Tax Reform Code of 1971.

Section 3. The act is amended by adding sections to read:

Section 105.3. The term "construction design professional," as used in this act, means a professional engineer or land surveyor licensed by the State Registration Board for Professional Engineers and Professional Land Surveyors under the act of May 23, 1945 (P.L.913, No.367), known as the "Professional Engineers and Professional Land Surveyors Registration Law," a landscape architect who is licensed by the State Board of Landscape Architects under the act of January 24,

1966 (1965 P.L.1527, No.535), known as the "Landscape Architects' Registration Law," an architect who is licensed by the Architects Licensure Board under the act of December 14, 1982 (P.L.1227, No.281), known as the "Architects Licensure Law," or any corporation or association (including professional corporations) organized or registered under the act of December 21, 1988 (P.L.1444, No.177), known as the "General Association Act of 1988," practicing engineering, architecture, landscape architecture or surveying in this Commonwealth.

Section 109. In addition to the definitions set forth in this Article, the following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Bill" means a statement or invoice for payment of services under clause (f) of section 306 of this act which identifies the claimant, the date of injury, the payment codes referred to in clause (f) of section 306 of this act and a description of the services provided on or in standard form prescribed by the Department of Labor and Industry.

"Burn facility" means a facility which meets the service standards of the American Burn Association.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Coordinated care organization" or "CCO" means an organization licensed in Pennsylvania and certified by the Secretary of Health on the basis of established criteria possessing the capacity to provide medical services to an injured worker.

"DRG" means diagnosis related groups.

"HCFA" means the Health Care Financing Administration.

"Health care provider" means any person, corporation, facility or institution licensed or otherwise authorized by the Commonwealth to provide health care services, including, but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, chiropractor or pharmacist and an officer, employe or agent of such person acting in the course and scope of employment or agency related to health care services.

"Health maintenance organization" means an entity defined in and subject to the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

"Hospital plan corporation" means an entity defined in and subject to Chapter 61 (relating to hospital plan corporations) of Title 40 (relating to insurance) of the Pennsylvania Consolidated Statutes.

"Insurance Company Law of 1921" means the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

"Insurer" means an entity subject to the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," including the State Workmen's Insurance Fund, with which an employer has insured liability under this act pursuant to section 305 or a self-insured employer or fund exempted by the Department of Labor and Industry pursuant to section 305 of this act.

"Intermediary" means an organization with a contractual relationship with the Health Care Financing Administration to process Medicare Part A or Part B claims.

"Life-threatening injury" shall be as defined by the American College of Surgeons' triage guidelines regarding use of trauma

centers for the region where the services are provided.

"Occupational Disease Act" means the act of June 21, 1939 (P.L.566, No.284), known as "The Pennsylvania Occupational Disease Act."

"Pass-through costs" means Medicare reimbursed costs to a hospital that "pass through" the prospective payment system and are not included in the diagnosis related group payments. The term includes medical education, capital expenditures, insurance and interest expense on fixed assets.

"Peer review," for the purpose of undertaking reviews and reports pursuant to section 420, means review by:

(1) an impartial physician or other health care provider selected by the Secretary of Labor and Industry upon recommendation of the deans of the medical colleges located in this Commonwealth;

(2) a panel of such professionals and providers selected by the Secretary of Labor and Industry upon recommendation of the deans of the medical colleges located in this Commonwealth or recommendation of professional associations representing such professionals and providers; or

(3) a Peer Review Organization approved by the commissioner and selected by the Secretary of Labor and Industry.

"Professional health service corporation" means an entity defined in and subject to Chapter 63 (relating to professional health services plan corporations) of Title 40 (relating to insurance) of the Pennsylvania Consolidated Statutes.

"Provider" means a health care provider.

"Referee" means a workers' compensation judge, as designated under section 401.

"Secretary" means the Secretary of Labor and Industry of the

Commonwealth.

"Trauma center" means a facility accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L.164, No.45), known as the "Emergency Medical Services Act."

"Urgent injury" shall be as defined by the American College of Surgeons' triage guidelines regarding use of trauma centers for the region where the services are provided.

"Usual and customary charge" means the charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

"Utilization review organizations" shall be those organizations consisting of an impartial physician, surgeon or other health care provider or a panel of such professionals and providers as authorized by the Secretary of Labor and Industry and published as a list in the form of a notice in the Pennsylvania Bulletin, for the purpose of reviewing the reasonableness and necessity of treatment by a health care provider pursuant to section 306(f.1)(6).

Section 4. Section 204 of the act, amended December 5, 1974 (P.L.782, No.263), is amended to read:

Section 204. (a) No agreement, composition, or release of damages made before the date of any injury shall be valid or shall bar a claim for damages resulting therefrom; and any such agreement is declared to be against the public policy of this Commonwealth. The receipt of benefits from any association, society, or fund shall not bar the recovery of damages by action at law, nor the recovery of compensation under article three

hereof; and any release executed in consideration of such benefits shall be void: Provided, however, That if the employe receives unemployment compensation benefits, such amount or amounts so received shall be credited as against the amount of the award made under the provisions of [section 108.] sections 108 and 306, except for benefits payable under section 306(c) or 307.

(b) For the exclusive purpose of determining eligibility for compensation under the "Unemployment Compensation Law," weekly compensation paid to an employe under this act shall be deemed to be a credit week as that term is defined in the "Unemployment Compensation Law."

Section 5. Section 301(a) and (c)(1) of the act, amended October 17, 1972 (P.L.930, No.223) and December 5, 1974 (P.L.782, No.263), are amended to read:

Section 301. (a) Every employer shall be liable for compensation for personal injury to, or for the death of each employe, by an injury in the course of his employment, and such compensation shall be paid in all cases by the employer, without regard to negligence, according to the schedule contained in sections three hundred and six and three hundred and seven of this article: Provided, That no compensation shall be paid when the injury or death is intentionally self inflicted, or is caused by the employe's violation of law, including, but not limited to, the illegal use of drugs, but the burden of proof of such fact shall be upon the employer, and no compensation shall be paid if, during hostile attacks on the United States, injury or death of employes results solely from military activities of the armed forces of the United States or from military activities or enemy sabotage of a foreign power. In cases where

the injury or death is caused by intoxication, no compensation shall be paid if the injury or death would not have occurred but for the employe's intoxication, but the burden of proof of such fact shall be upon the employer.

* * *

(c) (1) The terms "injury" and "personal injury," as used in this act, shall be construed to mean an injury to an employe, regardless of his previous physical condition, arising in the course of his employment and related thereto, and such disease or infection as naturally results from the injury or is aggravated, reactivated or accelerated by the injury; and wherever death is mentioned as a cause for compensation under this act, it shall mean only death resulting from such injury and its resultant effects, and occurring within three hundred weeks after the injury. The term "injury arising in the course of his employment," as used in this article, shall not include an injury caused by an act of a third person intended to injure the employe because of reasons personal to him, and not directed against him as an employe or because of his employment; nor shall it include injuries sustained while the employe is operating a motor vehicle provided by the employer if the employe is not otherwise in the course of employment at the time of injury; but shall include all other injuries sustained while the employe is actually engaged in the furtherance of the business or affairs of the employer, whether upon the employer's premises or elsewhere, and shall include all injuries caused by the condition of the premises or by the operation of the employer's business or affairs thereon, sustained by the employe, who, though not so engaged, is injured upon the premises occupied by or under the control of the employer, or

upon which the employer's business or affairs are being carried on, the employe's presence thereon being required by the nature of his employment.

* * *

Section 6. Section 302 of the act, amended December 5, 1974 (P.L.782, No.263), is amended to read:

Section 302. (a) A contractor who subcontracts all or any part of a contract and his insurer shall be liable for the payment of compensation to the employes of the subcontractor unless the subcontractor primarily liable for the payment of such compensation has secured its payment as provided for in this act. Any contractor or his insurer who shall become liable hereunder for such compensation may recover the amount thereof paid and any necessary expenses from the subcontractor primarily liable therefor.

For purposes of this subsection, a person who contracts with another (1) to have work performed consisting of (i) the removal, excavation or drilling of soil, rock or minerals, or (ii) the cutting or removal of timber from lands, or (2) to have work performed of a kind which is a regular or recurrent part of the business, occupation, profession or trade of such person shall be deemed a contractor, and such other person a subcontractor. This subsection shall not apply, however, to an owner or lessee of land principally used for agriculture who is not a covered employer under this act and who contracts for the removal of timber from such land.

(b) Any employer who permits the entry upon premises occupied by him or under his control of a laborer or an assistant hired by an employe or contractor, for the performance upon such premises of a part of such employer's regular business

entrusted to that employe or contractor, shall be liable for the payment of compensation to such laborer or assistant unless such hiring employe or contractor, if primarily liable for the payment of such compensation, has secured the payment thereof as provided for in this act. Any employer or his insurer who shall become liable hereunder for such compensation may recover the amount thereof paid and any necessary expenses from another person if the latter is primarily liable therefor.

For purposes of this subsection (b), the term "contractor" shall have the meaning ascribed in section 105 of this act.

(c) Any employer employing persons in agricultural labor shall be required to provide workmen's compensation coverage for such employes according to the provisions of this act, if such employer is otherwise covered by the provisions of this act or if during the calendar year such employer pays wages to one employe for agricultural labor totaling one hundred fifty dollars ($150) or more or furnishes employment to one employe in agricultural labor on twenty or more days in any of which events the employer shall be required to provide coverage for all employes.

(d) A contractor shall not subcontract all or any part of a contract unless the subcontractor has presented proof of insurance under this act.

(e) (1) Prior to issuing a building permit to a contractor, a municipality shall require the contractor to present proof of workers' compensation insurance or an affidavit that the contractor does not employ other individuals and is not required to carry workers' compensation insurance.

(2) Every building permit issued by a municipality to a contractor shall clearly set forth the name and workers'

compensation policy and the contractor's Federal or State Employer Identification Number. This information shall be in addition to any information required by municipal ordinance. If the building permit is issued to an applicant which affirms it is not obligated to maintain workers' compensation insurance under this act, the permit shall clearly set forth the contractor's Federal or State Employer Identification Number and the substance of the affirmation and that the applicant is not permitted to employ any individual to perform work pursuant to the building permit.

(3) Every municipality issuing a building permit shall be named as a workers' compensation policy certificate holder of a contractor-issued building permit. This certificate shall be filed with the municipality's copy of the building permit. An insurer issuing a policy which names a municipality as a workers' compensation policy certificate holder pursuant to this section shall be required to notify that municipality of the expiration or cancellation of any such policy of insurance or policy certificate within three working days of such cancellation or expiration.

(4) A municipality shall issue a stop-work order to a contractor who is performing work pursuant to a building permit, upon receiving actual notice that the contractor's workers' compensation insurance or State-approved self-insured status has been cancelled. Also, if the municipality receives actual notice that a permittee, having filed an affidavit of exemption from workers' compensation insurance, has hired persons to perform work pursuant to a building permit and does not maintain required workers' compensation insurance, the municipality shall issue a stop-work order. This order shall remain in effect until

proper workers' compensation coverage is obtained for all work performed pursuant to the building permit.

(f) (1) Where a contractor is performing work for a public body or political subdivision, all contractors and subcontractors shall provide proof of workers' compensation insurance to the public body or political subdivision effective for the duration of the work.

(2) The public body or political subdivision shall issue a stop work order to any contractor who is performing work for that public body or political subdivision upon receiving notice that any public contractor's workers' compensation insurance, or State-approved self-insurance status, has expired or has been cancelled. If the public body or political subdivision receives actual notice that a contractor, having filed an affidavit of exemption from workers' compensation insurance, has hired persons to perform work for a public body or political subdivision and does not maintain the required workers' compensation insurance or self-insurance, the public body or political subdivision shall issue a stop work order, which order shall remain in effect until proper workers' compensation coverage is obtained for all work performed pursuant to the contract of work for the public body or political subdivision.

(g) Should such policy of workers' compensation insurance be cancelled or expire during the duration of the work or should the workers' compensation self-insurance status change during the said period, the contractor shall immediately notify, in writing, the municipality, public body or political subdivision of such cancellation, expiration or change in status.

(h) Nothing in this act shall be the basis of any liability on part of the municipality.

(i) For purposes of subsections (d), (e) and (f) of this section, "proof of insurance" shall include a certificate of insurance or self-insurance, demonstrating current coverage and compliance with the requirements of this act, the Occupational Disease Act and the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 33 U.S.C. § 901 et seq.), its amendments and supplements, where applicable.

(j) For purposes of subsections (d), (e) and (f) of this section, "proof of insurance" shall not be required when the employer has been exempted pursuant to section 304.2 of this act.

Section 7. Section 305 of the act, amended December 5, 1974 (P.L.782, No.263) and repealed in part April 28, 1978 (P.L.202, No.53), is amended to read:

Section 305. (a) (1) Every employer liable under this act to pay compensation shall insure the payment of compensation in the State Workmen's Insurance Fund, or in any insurance company, or mutual association or company, authorized to insure such liability in this Commonwealth, unless such employer shall be exempted by the department from such insurance. Such insurer shall assume the employer's liability hereunder and shall be entitled to all of the employer's immunities and protection hereunder except, that whenever any employer shall have purchased insurance to provide benefits under this act to persons engaged in domestic service, neither the employer nor the insurer may invoke the provisions of section 321 as a defense. An employer desiring to be exempt from insuring the whole or any part of his liability for compensation shall make application to the department, showing his financial ability to pay such compensation, whereupon the department, if satisfied of

the applicant's financial ability, shall, upon the payment of a fee of [one hundred dollars ($100.00)] five hundred dollars ($500), issue to the applicant a permit authorizing such exemption.

(2) In securing the payment of benefits, the department shall require an employer wishing to self-insure its liability to establish sufficient security by posting a bond or other security, including letters of credit drawn on commercial banks with a Thomson Bank Watch rating of B or better or a CD rating of BBB or better by Standard and Poor's or Baa 2 or better by Moody's. This paragraph shall not apply to municipalities.

(3) The department shall establish a period of twelve (12) calendar months, to begin and end at such times as the department shall prescribe, which shall be known as the annual exemption period. Unless previously revoked, all permits issued under this section shall expire and terminate on the last day of the annual exemption period for which they were issued. Permits issued under this act shall be renewed upon the filing of an application, and the payment of a renewal fee of one hundred dollars ($100.00). The department may, from time to time, require further statements of the financial ability of such employer, and, if at any time such employer appear no longer able to pay compensation, shall revoke its permit granting exemption, in which case the employer shall immediately subscribe to the State Workmen's Insurance Fund, or insure his liability in any insurance company or mutual association or company, as aforesaid.

(b) Any employer who fails to comply with the provisions of this section for every such failure, shall, upon [summary conviction before any official of competent jurisdiction, be

sentenced to pay a fine of not less than five hundred dollars ($500) nor more than two thousand dollars ($2,000), and costs of prosecution, or imprisonment for a period of not more than one (1) year, or both.] conviction in the court of common pleas, be guilty of a misdemeanor of the third degree. If the failure to comply with this section is found by the court to be intentional, the employer shall be guilty of a felony of the third degree. Every day's violation shall constitute a separate offense. A judge of the court of common pleas may, in addition to imposing fines and imprisonment, include restitution in his order: Provided, That there is an injured employe who has obtained an award of compensation. The amount of restitution shall be limited to that specified in the award of compensation. It shall be the duty of the department to enforce the provisions of this section; and it shall investigate all violations that are brought to its notice and shall institute prosecutions for violations thereof. All fines recovered under the provisions of this section shall be paid to the department, and by it paid into the State Treasury if the prosecutor is the Attorney General and to the operating fund of the county in which the district attorney is elected if the prosecutor is a district attorney.

(c) In any proceeding against an employer under this section, a certificate of non-insurance issued by the official Workmen's Compensation Rating and Inspection Bureau and a certificate of the department showing that the defendant has not been exempted from obtaining insurance under this section, shall be prima facie evidence of the facts therein stated.

(d) When any employer fails to secure the payment of compensation under this act as provided in sections 305 and

305.2, the injured employe or his dependents may proceed either under this act or in a suit for damages at law as provided by article II.

(e) Every employer shall post a notice at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employes or for the administration of first aid, containing:

(1) Either the name of the employer's carrier and the address and telephone number of such carrier or insurer or, if the employer is self-insured, the name, address and telephone number of the person to whom claims or requests for information are to be addressed.

(2) The following statement: "Remember, it is important to tell your employer about your injury."

The notice shall be posted in prominent and easily accessible places at the site of employment, including such places as are used for treatment and first aid of injured employes. Such a listing shall contain the information as specified in this section, typed or printed on eight and one-half inch by eleven inch or eight and one-half inch by thirteen inch paper in standard size type or larger.

Section 8. Section 306(a) and (f) of the act, amended December 5, 1974 (P.L.782, No.263) and July 1, 1978 (P.L.692, No.119), are amended and the section is amended by adding clauses to read:

Section 306. The following schedule of compensation is hereby established:

(a) (1) For total disability, sixty-six and two-thirds per centum of the wages of the injured employe as defined in section

three hundred and nine beginning after the seventh day of total disability, and payable for the duration of total disability, but the compensation shall not be more than the maximum compensation payable [nor less than fifty per centum of the Statewide average weekly wage. If at the time of injury, the employe receives wages equal to or less than fifty per centum of the Statewide average weekly wage, then he shall receive ninety per centum of his average weekly wage as compensation, but in no event less than thirty-three and one-third per centum of the maximum weekly compensation payable] as defined in section 105.2. Nothing in this clause shall require payment of compensation after disability shall cease. If the benefit so calculated is less than fifty per centum of the Statewide average weekly wage, then the benefit payable shall be the lower of fifty per centum of the Statewide average weekly wage or ninety per centum of the worker's average weekly wage.

(2) Nothing in this act shall require payment of compensation for any period during which the employe is incarcerated after a conviction.

* * *

[(f) (1) The employer shall provide payment for reasonable surgical and medical services, services rendered by duly licensed practitioners of the healing arts, medicines, and supplies, as and when needed: Provided, That if a list of at least five designated physicians or other duly licensed practitioners of the healing arts or a combination thereof is provided by the employer, the employe shall be required to visit one of the physicians or other practitioners so designated and shall continue to visit the same or another physician or practitioner for a period of fourteen days from the date of the

first visit. Subsequent treatment may be provided by any physician or any other duly licensed practitioner of the healing arts or a combination thereof, of the employes own choice, and such treatment shall be paid for by the employer. Any employe who next following the termination of the fourteen-day period is provided treatment from a physician or other duly licensed practitioner of the healing arts who is not one of the physicians or practitioners designated by the employer, shall notify the employer within five days of the first visit to said physician or practitioner. However, if the employe fails to so notify the employer, the employe shall suffer no loss of rights or benefits to which he is otherwise entitled under the act.

(2) If and only if the employer has designated at least five physicians or other duly licensed practitioners of the healing arts or a combination thereof as permitted by the preceding paragraph, the following reporting provisions shall apply. Nothing in the following paragraphs shall eliminate rights of the employer to obtain all records and data as permitted under any other sections of this act.

(i) The physician or other duly licensed practitioner of the healing arts shall be required to file periodic reports with the employer on a form prescribed by the department which shall include, where pertinent, history, diagnosis, treatment, prognosis and physical findings. The report shall be filed within twenty-one days of commencing treatment and at least once a month thereafter, as long as treatment continues. The employer shall not be liable to pay for such treatment until a report has been filed.

(ii) The employer shall have the right to petition the department for review of the necessity or frequency of treatment

or reasonableness of fees for services provided by a physician or other duly licensed practitioner of the healing arts. Such a petition shall in no event act as a supersedeas, and during the pendency of any such petition the employer shall pay all medical bills if the physician or other practitioner of the healing arts files a report or reports as required by subparagraph (i) of paragraph (2) of this subsection.

(3) After an employe has elected to be treated by a physician or other duly licensed practitioner of the healing arts who is not one of the physicians or practitioners designated by the employer, he may thereafter elect to be treated by another physician or other duly licensed practitioner of the healing arts upon notice to his employer: Provided, however, That no such notice shall be required in emergencies, or in cases of referrals by one physician or practitioner to another physician or practitioner or if the new physician or practitioner makes a timely report to the employer within twenty-one days after commencing treatment.

(4) In addition to the above service, the employer shall provide payment for medicines and supplies, hospital treatment, services and supplies and orthopedic appliances, and prostheses. The cost for such hospital treatment, service and supplies shall not in any case exceed the prevailing charge in the hospital for like services to other individuals. If the employe shall refuse reasonable services of duly licensed practitioners of the healing arts, surgical, medical and hospital services, treatment, medicines and supplies, he shall forfeit all rights to compensation for any injury or any increase in his incapacity shown to have resulted from such refusal. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an

eye, the employer shall also provide payment for an artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury and any replacements for an artificial limb or eye which the employe may require at any time thereafter, together with such continued medical care as may be prescribed by the doctor attending such employe in connection with such injury as well as such training as may be required in the proper use of such prostheses. The provisions of this section shall apply in injuries whether or not loss of earning power occurs. If hospital confinement is required, the employe shall be entitled to semi-private accommodations but if no such facilities are available, regardless of the patient's condition, the employer, not the patient, shall be liable for the additional costs for the facilities in a private room.

(5) The payment by an insurer for any medical, surgical or hospital services or supplies after any statute of limitations provided for in this act shall have expired shall not act to reopen or review the compensation rights for purposes of such limitations.]

(f.1) (1) (i) The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than two of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employe shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician

or health care provider for a period of thirty days from the date of the first visit: Provided, however, That the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should the employe not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employe's rights and duties under this section to the employe. The employer shall further ensure that the employe has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employe's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employe from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employe's own choice. Any employe who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

(ii) In addition to the above service, the employer shall provide payment for medicines and supplies, hospital treatment,

services and supplies and orthopedic appliances, and prostheses in accordance with this section. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall also provide for an artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury and any replacements for an artificial limb or eye which the employe may require at any time thereafter, together with such continued medical care as may be prescribed by the doctor attending such employe in connection with such injury as well as such training as may be required in the proper use of such prostheses. The provisions of this section shall apply to injuries whether or not loss of earning power occurs. If hospital confinement is required, the employe shall be entitled to semi-private accommodations but if no such facilities are available, regardless of the patient's condition, the employer, not the patient, shall be liable for the additional costs for the facilities in a private room.

(iii) Nothing in this section shall prohibit an insurer or an employer from contracting with any individual, partnership, association or corporation to provide case management and coordination of services with regard to injured employes.

(2) Any provider who treats an injured employe shall be required to file periodic reports with the employer on a form prescribed by the department which shall include, where pertinent, history, diagnosis, treatment, prognosis and physical findings. The report shall be filed within ten days of commencing treatment and at least once a month thereafter, as long as treatment continues. The employer shall not be liable to pay for such treatment until a report has been filed.

(3) (i) For purposes of this clause, a provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of one hundred thirteen per centum of the prevailing charge at the seventy-fifth percentile; one hundred thirteen per centum of the applicable fee schedule, the recommended fee or the inflation index charge; one hundred thirteen per centum of the DRG payment, plus pass-through costs and applicable cost or day outliers; or one hundred thirteen per centum of any other Medicare reimbursement mechanism, as determined by the Medicare carrier or intermediary, whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services rendered. If the commissioner determines that an allowance for a particular provider group or service under the Medicare program is not reasonable, it may adopt, by regulation, a new allowance. If the prevailing charge, fee schedule, recommended fee, inflation index charge, DRG payment or any other reimbursement has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may not exceed eighty per centum of the charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

(ii) Commencing on January 1, 1995, the maximum allowance for a health care service covered by subparagraph (i) of this paragraph shall be updated as of the first day of January of each year. The update, which shall be applied to all services performed after January 1 of each year, shall be equal to the

percentage change in the Statewide average weekly wage. Such updates shall be cumulative.

(iii) Notwithstanding any other provision of law, it is unlawful for a provider to refer a person for laboratory, physical therapy, rehabilitation, chiropractic, radiation oncology, psychometric, home infusion therapy, or diagnostic imaging, goods or services pursuant to this section if the provider has a financial interest with the person, or in the entity, that receives the referral. It is unlawful for a provider to enter into an arrangement or scheme such as a cross-referral arrangement, which the provider knows, or should know, has a principal purpose of assuring referrals by the provider to a particular entity which, if the provider directly made referrals to such entity, would be in violation of this section. No claim for payment shall be presented by an entity to any individual, third-party payer, or other entity for a service furnished pursuant to a referral prohibited under this section.

(iv) The secretary shall retain the services of an independent consulting firm to perform an annual accessibility study of health care provided under this act. The study shall include information as to whether there is adequate access to quality health care and products for injured workers and a review of the information that is provided. If the secretary determines based on this study that as a result of the health care fee schedule there is not sufficient access to quality health care or products for persons suffering injuries covered by this act, the secretary may recommend to the commissioner the adoption of regulations providing for a new allowance.

(v) An allowance shall be reviewed for reasonableness whenever the commissioner determines that the use of the

allowance would result in payments more than ten per centum lower than the average level of reimbursement the provider would receive from coordinated care insurers, including those entities subject to the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," and those entities known as preferred provider organizations which are subject to section 630 of the Insurance Company Law of 1921 for like treatments, accommodations, products or services. In making this determination, the commissioner shall consider the extent to which allowances applicable to other providers under this section deviate from the reimbursement such providers would receive from coordinated care insurers. Any information received as a result of this subparagraph shall be confidential.

(vi) The reimbursement for prescription drugs and professional pharmaceutical services shall be limited to one hundred ten per centum of the average wholesale price of the product.

(vii) The applicable Medicare fee schedule shall include fees associated with all permissible procedure codes. If the Medicare fee schedule also includes a larger grouping of procedure codes and corresponding charges than are specifically reimbursed by Medicare, a provider may use these codes, and corresponding charges shall be paid by insurers or employers. If a Medicare code exists for application to a specific provider specialty, that code shall be used.

(viii) A provider shall not fragment or unbundle charges imposed for specific care except as consistent with Medicare. Changes to a provider's codes by an insurer shall be made only as consistent with Medicare and when the insurer has sufficient information to make the changes and following consultation with

the provider.

(4) Nothing in this act shall prohibit the self-insured employer, employer or insurer from contracting with a coordinated care organization for reimbursement levels different from those identified above.

(5) The employer or insurer shall make payment, and providers shall submit bills and records, in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6). A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department. Within thirty days of the filing of such an application, the department shall render an administrative decision.

(6) Except in those cases in which a referee asks for an opinion from peer review under section 420 of this act, disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions:

(i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Organizations not authorized by the department may not engage in such utilization

review.

(ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty days of a request. If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization, a request for reconsideration must be filed no later than thirty days after receipt of the utilization review report. The request for reconsideration must be in writing.

(iii) The employer or the insurer shall pay the cost of the initial utilization review. The party which does not prevail on reconsideration of an initial review shall bear the costs of such reconsideration.

(iv) If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization on reconsideration, a petition for review by the department must be filed within thirty days after receipt of the reconsideration report. The department shall assign the petition to a referee for a hearing.

(7) A provider shall not hold an employe liable for costs related to care or service rendered in connection with a compensable injury under this act. A provider shall not bill or otherwise attempt to recover from the employe the difference between the provider's charge and the amount paid by the employer or the insurer.

(8) If the employe shall refuse reasonable services of health care providers, surgical, medical and hospital services, treatment, medicines and supplies, he shall forfeit all rights to compensation for any injury or increase in his incapacity shown to have resulted from such refusal.

(9) The payment by an insurer or employer for any medical,

surgical or hospital services or supplies after any statute of limitations provided for in this act shall have expired shall not act to reopen or revive the compensation rights for purposes of such limitations.

(10) If acute care is provided in an acute care facility to a patient with an immediately life threatening or urgent injury by a Level I or Level II trauma center accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L.164, No.45), known as the "Emergency Medical Services Act," or to a burn injury patient by a burn facility which meets all the service standards of the American Burn Association, or if basic or advanced life support services, as defined and licensed under the "Emergency Medical Services Act," are provided the amount of payment shall be the usual and customary charge.

(f.2) (1) Medical services required by the act may be provided through a coordinated care organization which is certified by the Secretary of Health subject to the following:

(i) Each application for certification shall be accompanied by a reasonable fee prescribed by the Department of Health. A certificate is valid for such period as the Department of Health may prescribe unless sooner revoked or suspended.

(ii) Application for certification shall be made in such form and manner as the Department of Health shall require and shall set forth information regarding the proposed plan for providing services.

(2) The coordinated care organization shall include an adequate number and specialty distribution of licensed health care providers in order to assure appropriate and timely delivery of services required under the act and an appropriate

flexibility to workers in selecting providers. Services may be provided directly, through affiliates or through contractual referral arrangements with other health care providers.

(3) The Secretary of Health shall certify an entity as a coordinated care organization if the Secretary of Health finds that the entity:

(i) Possesses the capacity to provide all primary medical services as designated by the Secretary of Health in a manner that is timely and effective.

(ii) Maintains a referral capacity to treat other injuries and illnesses not covered by primary services but which are covered by this act.

(iii) Provides a case management and evaluation system which includes continuous monitoring of treatment from onset of injury or illness until final resolution.

(iv) Provides a case communication system which relates necessary and appropriate information among the employe, employer, health care providers and insurer.

(v) Provides appropriate peer and utilization review and a care dispute resolution system.

(vi) Meets quality of care and cost-effectiveness standards based upon accepted standards in the profession, including health care effectiveness measures of the Pennsylvania Health Care Cost Containment Council and recommendations on quality of care by the Workers' Compensation Advisory Council.

(vii) Complies with any other requirements of law regarding delivery of health care services.

(viii) Establishes a written grievance procedure for prompt and effective resolution of patient grievances.

(4) The Secretary of Health shall refuse to certify or may

revoke or suspend certification of any coordinated care organization if the Secretary of Health finds that:

(i) the plan for providing health care services fails to meet the requirements of this section;

(ii) service under the plan is not being provided in accordance with terms of the plan as certified; or

(iii) services under the plan do not meet accepted professional standards for quality, cost-effective health care.

(5) A person participating in utilization review, quality assurance or peer review activities pursuant to this section shall not be examined as to any communication made in the course of such activities or the findings thereof, nor shall any person be subject to an action for civil damages for actions taken or statements made in good faith.

(6) Health care providers designated as rural by HCFA or located in a county with a rural Health Professional Shortage Area, who are attempting to form or operate a coordinated care organization, may be excluded from meeting some or all of the minimum requirements set forth in paragraphs (2) and (3) of this clause, as shall be determined in rules or regulations promulgated by the Department of Health.

(7) The Department of Health shall have the power and authority to promulgate, adopt, publish and use regulations for the implementation of this section.

* * *

Section 9. Section 307 of the act, amended December 5, 1974 (P.L.782, No.263), is amended to read:

Section 307. In case of death, compensation shall be computed on the following basis, and distributed to the following persons: Provided, That in no case shall the wages of

the deceased be taken to be less than fifty per centum of the Statewide average weekly wage for purposes of this section:

1. If there be no widow nor widower entitled to compensation, compensation shall be paid to the guardian of the child or children, or, if there be no guardian, to such other persons as may be designated by the board as hereinafter provided as follows:

(a) If there be one child, thirty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(b) If there be two children, forty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(c) If there be three children, fifty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(d) If there be four children, sixty-two per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(e) If there be five children, sixty-four per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

(f) If there be six or more children, sixty-six and two-thirds per centum of wages of deceased, but not in excess of the Statewide average weekly wage.

2. To the widow or widower, if there be no children, fifty-one per centum of wages, but not in excess of the Statewide average weekly wage.

3. To the widow or widower, if there be one child, sixty per centum of wages, but not in excess of the Statewide average

weekly wage.

4. To the widow or widower, if there be two children, sixty-six and two-thirds per centum of wages but not in excess of the Statewide average weekly wage.

4 1/2. To the widow or widower, if there be three or more children, sixty-six and two thirds per centum of wages, but not in excess of the Statewide average weekly wage.

5. If there be neither widow, widower, nor children entitled to compensation, then to the father or mother, if dependent to any extent upon the employe at the time of the injury, thirty-two per centum of wages but not in excess of the Statewide average weekly wage: Provided, however, That in the case of a minor child who has been contributing to his parents, the dependency of said parents shall be presumed: And provided further, That if the father or mother was totally dependent upon the deceased employe at the time of the injury, the compensation payable to such father or mother shall be fifty-two per centum of wages, but not in excess of the Statewide average weekly wage.

6. If there be neither widow, widower, children, nor dependent parent, entitled to compensation, then to the brothers and sisters, if actually dependent upon the decedent for support at the time of his death, twenty-two per centum of wages for one brother or sister, and five per centum additional for each additional brother or sister, with a maximum of thirty-two per centum of wages of deceased, but not in excess of the Statewide average wage, such compensation to be paid to their guardian, or if there be no guardian, to such other person as may be designated by the board, as hereinafter provided.

7. Whether or not there be dependents as aforesaid, the

reasonable expense of burial, not exceeding [one thousand five hundred dollars] three thousand dollars ($3,000), which shall be paid by the employer or insurer directly to the undertaker (without deduction of any amounts theretofore paid for compensation or for medical expenses).

Compensation shall be payable under this section to or on account of any child, brother, or sister, only if and while such child, brother, or sister, is under the age of eighteen unless such child, brother or sister is dependent because of disability when compensation shall continue or be paid during such disability of a child, brother or sister over eighteen years of age or unless such child is enrolled as a full-time student in any accredited educational institution when compensation shall continue until such student becomes twenty-three. No compensation shall be payable under this section to a widow, unless she was living with her deceased husband at the time of his death, or was then actually dependent upon him and receiving from him a substantial portion of her support. No compensation shall be payable under this section to a widower, unless he be incapable of self-support at the time of his wife's death and be at such time dependent upon her for support. If members of decedent's household at the time of his death, the terms "child" and "children" shall include step-children, adopted children and children to whom he stood in loco parentis, and children of the deceased and shall include posthumous children. Should any dependent of a deceased employe die or remarry, or should the widower become capable of self-support, the right of such dependent or widower to compensation under this section shall cease except that if a widow remarries, she shall receive one hundred four weeks compensation at a rate computed in accordance

with clause 2. of section 307 in a lump sum after which compensation shall cease: Provided, however, That if, upon investigation and hearing, it shall be ascertained that the widow or widower is living with a man or woman, as the case may be, in meretricious relationship and not married, or the widow living a life of prostitution, the board may order the termination of compensation payable to such widow or widower. If the compensation payable under this section to any person shall, for any cause, cease, the compensation to the remaining persons entitled thereunder shall thereafter be the same as would have been payable to them had they been the only persons entitled to compensation at the time of the death of the deceased.

The board may, if the best interest of a child or children shall so require, at any time order and direct the compensation payable to a child or children, or to a widow or widower on account of any child or children, to be paid to the guardian of such child or children, or, if there be no guardian, to such other person as the board as hereinafter provided may direct. If there be no guardian or committee of any minor, dependent, or insane employe, or dependent, on whose account compensation is payable, the amount payable on account of such minor, dependent, or insane employe, or dependent may be paid to any surviving parent, or such other person as the board may order and direct, and the board may require any person, other than a guardian or committee, to whom it has directed compensation for a minor, dependent, or insane employe, or dependent to be paid, to render, as and when it shall so order, accounts of the receipts and disbursements of such person, and to file with it a satisfactory bond in a sum sufficient to secure the proper application of the moneys received by such person.

Section 10. The act is amended by adding a section to read:

Section 308.1. (a) The eligibility of professional athletes for compensation under this act shall be limited as provided in this section.

(b) The term "professional athlete," as used in this section, shall mean a natural person employed as a professional athlete by a franchise of the National Football League, the National Basketball Association, the National Hockey League, the National League of Professional Baseball Clubs or the American League of Professional Baseball Clubs, under a contract for hire or a collective bargaining agreement, whose wages as defined in section 309 are more than eight times the Statewide average weekly wage.

(c) In the case of a professional athlete, any compensation payable under this act with respect to partial disability shall be reduced by the after-tax amount of any:

(1) Wages payable by the employer during the period of disability under a contract for hire or collective bargaining agreement.

(2) Payments under a self-insurance, wage continuation, disability insurance or similar plan funded by the employer.

(3) Injury protection or other injury benefits payable by the employer under a contract for hire or collective bargaining agreement.

(d) No reduction shall be made pursuant to clause (c) against any compensation payable under this act which becomes due and payable on a date after the expiration or termination of the professional athlete's employment contract, except for any amounts paid by the employer pursuant to the contract.

(e) In the case of a professional athlete, the term "wages

of the injured employe" as used in section 306(b) for the purpose of computing compensation for partial disability shall mean two times the Statewide average weekly wage.

Section 11. Section 314 of the act, amended February 28, 1956 (1955 P.L.1120, No.356), is amended to read:

Section 314. (a) At any time after an injury the employe, if so requested by his employer, must submit himself for examination, at some reasonable time and place, to a physician or physicians legally authorized to practice under the laws of such place, who shall be selected and paid by the employer. If the employe shall refuse upon the request of the employer, to submit to the examination by the physician or physicians selected by the employer, [the board] a referee assigned by the department may, upon petition of the employer, order the employe to submit to an examination at a time and place set by [it] the referee, and by the physician or physicians selected and paid by the employer, or by a physician or physicians designated by [it] the referee and paid by the employer. The [board] referee may at any time after such first examination, upon petition of the employer, order the employe to submit himself to such further examinations as [it] the referee shall deem reasonable and necessary, at such times and places and by such physicians as [it] the referee may designate; and in such case, the employer shall pay the fees and expenses of the examining physician or physicians, and the reasonable traveling expenses and loss of wages incurred by the employe in order to submit himself to such examination. The refusal or neglect, without reasonable cause or excuse, of the employe to submit to such examination ordered by the [board] referee, either before or after an agreement or award, shall deprive him of the right to compensation, under

this article, during the continuance of such refusal or neglect, and the period of such neglect or refusal shall be deducted from the period during which compensation would otherwise be payable.

(b) The employe shall be entitled to have a physician or physicians of his own selection, to be paid by him, participate in any examination requested by his employer or ordered by the [board] referee.

Section 12. Section 321 of the act, added March 29, 1972 (P.L.159, No.61), is amended to read:

Section 321. [Nothing contained in this act shall apply to or in any way affect any person who at the time of injury is engaged in domestic service: Provided, however, That in cases where the employer of any such person shall have, prior to such injury, by application to the Workmen's Compensation Board, approved by the board, elected to come within the provisions of the act, such exemption shall not apply.] Nothing contained in this act shall apply to or in any way affect:

(1) Any person who at the time of injury is engaged in domestic service: Provided, however, That in cases where the employer of any such person shall have, prior to such injury, by application to the department, and approved by the department, elected to come within the provisions of the act, such exemption shall not apply.

(2) Any person who is a licensed real estate salesperson or an associate real estate broker, affiliated with a licensed real estate broker, under a written agreement, remunerated on a commission only basis and who qualifies as an independent contractor for State tax purposes under the act of March 4, 1971 (P.L.6, No.2), known as the "Tax Reform Code of 1971."

Section 13. The act is amended by adding sections to read:

Section 322. It shall be unlawful for any employe to receive compensation under this act if he is at the same time receiving workers' compensation under the laws of the Federal Government or any other state for the same injury. Further, it shall be unlawful for an employe receiving compensation under this act simultaneously from two or more employers or insurers during any period of total disability to receive total compensation in excess of the maximum benefit under this act. Nothing in this section shall be deemed to prohibit payment of workers' compensation on a pro-rata basis, where an employe suffers from more than one injury while in the employ of more than one employer: Provided, however, That the total compensation paid shall not exceed the maximum weekly compensation payable under this act: And, Provided further, That any such pro rata calculation shall be based upon the earnings by such an employe in the employ of each such employer and that all wage losses suffered as a result of any injury which is compensable under this act shall be used as the basis for calculating the total compensation to be paid on a pro rata basis.

Section 323. (a) A construction design professional who is retained to perform professional services on a construction project, or any employe of a construction design professional who is assisting or representing the construction design professional in the performance of professional services on the site of the construction project, shall not be liable under this act for any injury or death of a worker not an employe of such design professional on the construction project for which workers' compensation is payable under the provisions of this act.

(b) Notwithstanding any provisions to the contrary, this

section shall apply to claims for compensation based on injuries or death which occurred after the effective date of this section.

Section 14. The first paragraph of section 401 of the act, amended February 8, 1972 (P.L.25, No.12), is amended to read:

Section 401. The term "referee," when used in this [article] act, shall mean [Workmen's Compensation Referee] a Workers' Compensation Judge of the Department of Labor and Industry, appointed by and subject to the general supervision of the Secretary of Labor and Industry for the purpose of conducting departmental hearings under this act. The secretary may establish different classes of [referees.] these judges. Any reference in any statute to a workmen's compensation referee shall be deemed to be a reference to a workers' compensation judge.

* * *

Section 15. Sections 406.1 and 420 of the act, amended or added February 8, 1972 (P.L.25, No.12), are amended to read:

Section 406.1. (a) The employer and insurer shall promptly investigate each injury reported or known to the employer and shall proceed promptly to commence the payment of compensation due either pursuant to an agreement upon the compensation payable or a notice of compensation payable as provided in section 407 or pursuant to a notice of temporary compensation payable as set forth in clause (d) of this section, on forms prescribed by the department and furnished by the insurer. The first installment of compensation shall be paid not later than the twenty-first day after the employer has notice or knowledge of the employe's disability. Interest shall accrue on all due and unpaid compensation at the rate of ten per centum per annum.

Any payment of compensation prior or subsequent to an agreement or notice of compensation payable or a notice of temporary compensation payable or greater in amount than provided therein shall, to the extent of the amount of such payment or payments, discharge the liability of the employer with respect to such case.

(b) Payments of compensation pursuant to an agreement or notice of compensation payable may be suspended, terminated, reduced or otherwise modified by petition and subject to right of hearing as provided in section 413.

(c) If the insurer controverts the right to compensation it shall promptly notify the employe or his dependent, on a form prescribed by the department, stating the grounds upon which the right to compensation is controverted and shall forthwith furnish a copy or copies to the department.

(d) (1) In any instance where an employer is uncertain whether a claim is compensable under this act or is uncertain of the extent of its liability under this act, the employer may initiate compensation payments without prejudice and without admitting liability pursuant to a notice of temporary compensation payable as prescribed by the department.

(2) The notice of temporary compensation payable shall be sent to the claimant and a copy filed with the department and shall notify the claimant that the payment of temporary compensation is not an admission of liability of the employer with respect to the injury which is the subject of the notice of temporary compensation payable. The department shall, upon receipt of a notice of temporary compensation payable, send a notice to the claimant informing the claimant that:

(i) the payment of temporary compensation and the claimant's

acceptance of that compensation does not mean the claimant's employer is accepting responsibility for the injury or that a compensation claim has been filed or commenced;

(ii) the payment of temporary compensation entitles the claimant to a maximum of six weeks of compensation; and

(iii) the claimant may need to file a claim petition in a timely fashion under section 315 of this act, enter into an agreement with his employer or receive a notice of compensation payable from his employer to ensure continuation of compensation payments.

(3) Payments of temporary compensation shall commence, and the notice of temporary compensation payable shall be sent within the time set forth in clause (a) of this section.

(4) Payments of temporary compensation may continue until such time as the employer decides to controvert the claim or six weeks from the date the employer has notice or knowledge of the employe's disability, whichever shall first occur.

(5) (i) If the employer ceases making payments pursuant to a notice of temporary compensation payable, a notice in the form prescribed by the department shall be sent to the claimant and a copy filed with the department, but in no event shall this notice be sent or filed later than five days after the last payment.

(ii) This notice shall advise the claimant that if the employer is ceasing payment of temporary compensation that the payment of temporary compensation was not an admission of liability of the employer with respect to the injury subject to the notice of temporary compensation payable, and the employe must file a claim to establish the liability of the employer.

(iii) If the employer ceases making payments pursuant to a

notice of temporary compensation payable, after complying with this clause, the employer and employe retain all the rights, defenses and obligations with regard to the claim subject to the notice of temporary compensation payable, and the payment of temporary compensation may not be used to support a claim for compensation.

(iv) Payment of temporary compensation shall be considered compensation for purposes of tolling the statute of limitations under section 315 of this act.

(6) If the employer does not file a notice under paragraph (5) of clause (d) of this section within the six-week period during which temporary compensation is paid or payable, the employer shall be deemed to have admitted liability and the notice of temporary compensation payable shall be converted to a notice of compensation payable.

Section 420. (a) The board, the department or a referee, if it or he deem it necessary, may, of its or his own motion, either before, during, or after any hearing, make or cause to be made an investigation of the facts set forth in the petition or answer or facts pertinent in any injury under this act. The board, department or referee may appoint one or more impartial physicians or surgeons to examine the injuries of the plaintiff and report thereon, or may employ the services of such other experts as shall appear necessary to ascertain the facts. The referee when necessary or appropriate or upon request of a party in order to rule on requests for review filed under clause (f.1) of section 306 of this act, or under other provisions of this act, may ask for an opinion from peer review about the necessity or frequency of treatment under clause (f.1) of section 306 of this act. The peer review report or the peer report of any

physician, surgeon, or expert appointed by the department or by a referee, including the report of a peer review organization, shall be filed with the board or referee, as the case may be, and shall be a part of the record and open to inspection as such. The referee shall consider the report as evidence but shall not be bound by such report.

(b) The board or referee, as the case may be, shall fix the compensation of such physicians, surgeons, and experts, and other peer review organizations which, when so fixed, shall be paid out of the [sum appropriated to the Department of Labor and Industry for such purpose.] Workmen's Compensation Administration Fund.

Section 16. Section 422 of the act, amended February 8, 1972 (P.L.25, No.12) and March 29, 1972 (P.L.159, No.61), is amended to read:

Section 422. (a) Neither the board nor any of its members nor any referee shall be bound by the common law or statutory rules of evidence in conducting any hearing or investigation, but all findings of fact shall be based upon sufficient competent evidence to justify same. All parties to an adjudicatory proceeding are entitled to a reasoned decision, containing findings of fact and conclusions of law based upon the evidence as a whole which clearly and concisely states and explains the rationale for the decisions so that all can determine why and how a particular result was reached. The adjudicator shall specify the evidence upon which the adjudicator relies in conformity with this section. The adjudication shall provide the basis for meaningful appellate review.

(b) If any party or witness resides outside of the

Commonwealth, or through illness or other cause is unable to testify before the board or a referee, his or her testimony or deposition may be taken, within or without this Commonwealth, in such manner and in such form as the department may, by special order or general rule, prescribe. The records kept by a hospital of the medical or surgical treatment given to an employe in such hospital shall be admissible as evidence of the medical and surgical matters stated therein.

(c) Where any claim for compensation at issue before a referee involves [twenty-five] fifty-two weeks or less of disability, either the employe or the employer may submit a certificate by any qualified physician as to the history, examination, treatment, diagnosis and cause of the condition, and sworn reports by other witnesses as to any other facts and such statements shall be admissible as evidence of medical and surgical or other matters therein stated and findings of fact may be based upon such certificates or such reports.

(d) Where an employer shall have furnished surgical and medical services or hospitalization in accordance with the provisions of [subsection (f) of] section 306(f.1), or where the employe has himself procured them, the employer or employe shall, upon request, in any pending proceeding, be furnished with, or have made available, a true and complete record of the medical and surgical services and hospital treatment, including X rays, laboratory tests, and all other medical and surgical data in the possession or under the control of the party requested to furnish or make available such data.

(e) The department may adopt rules and regulations governing the conduct of all hearings held pursuant to any provisions of this act, and hearings shall be conducted in accordance

therewith, and in such manner as best to ascertain the substantial rights of the parties.

Section 17. Sections 438 and 440 of the act, added February 8, 1972 (P.L.25, No.12), are amended to read:

Section 438. (a) An employer shall report all injuries received by employes in the course of or resulting from their employment immediately to the employer's insurer. If the employer is self-insured such injuries shall be reported to the person responsible for management of the employer's compensation program.

(b) An employer shall report such injuries to the Department of Labor and Industry by filing directly with the department on the form it prescribes a report of injury within forty-eight hours for every injury resulting in death, and mailing within [three] seven days after the date of injury for all other injuries except those resulting in disability continuing less than the day, shift, or turn in which the injury was received. A copy of this report to the department shall be mailed to the employer's insurer forthwith.

(c) Reports of injuries filed with the department under this section shall not be evidence against the employer or the employer's insurer in any proceeding either under this act or otherwise. Such reports may be made available by the department to other State or Federal agencies for study or informational purposes.

Section 440. (a) In any contested case where the insurer has contested liability in whole or in part, including contested cases involving petitions to terminate, reinstate, increase, reduce or otherwise modify compensation awards, agreements or other payment arrangements or to set aside final receipts, the

employe or his dependent, as the case may be, in whose favor the matter at issue has been finally determined in whole or in part shall be awarded, in addition to the award for compensation, a reasonable sum for costs incurred for attorney's fee, witnesses, necessary medical examination, and the value of unreimbursed lost time to attend the proceedings: Provided, That cost for attorney fees may be excluded when a reasonable basis for the contest has been established[: And provided further, That if] by the employer or the insurer.

(b) If counsel fees are awarded and assessed against the insurer or employer, then the referee must make a finding as to the amount and the length of time for which such counsel fee is payable, based upon the complexity of the factual and legal issues involved, the skill required, the duration of the proceedings and the time and effort required and actually expended: If the insurer has paid or tendered payment of compensation and the controversy relates to the amount of compensation due, costs for attorney's fee shall be based only on the difference between the final award of compensation and the compensation paid or tendered by the insurer.

[In contested cases involving petitions to terminate, reinstate, increase, reduce or otherwise modify compensation awards, agreements or other payment arrangements or to set aside final receipts, where the contested issue, in whole or part, is resolved in favor of the claimant, the claimant shall be entitled to an award of reasonable costs as hereinabove set forth.]

Section 18. Section 447 of the act, added May 20, 1976 (P.L.135, No.61) is amended to read:

Section 447. (a) There is hereby created an advisory

council, to be known as the Pennsylvania [Workmen's] Workers' Compensation Advisory Council[, and to be composed of men and women with an equal number of employer, employe, and public representatives who may fairly be representative because of their vocation, employment, or affiliations]. The council shall [consist] be comprised of [a maximum of seven] eight members [including the], with four members being employe representatives and four members being employer representatives. The Secretary of the Department of Labor and Industry[, who] shall be an ex officio member. The members of such council shall be appointed as follows: one employe representative and one employer representative by the [secretary within thirty days of the effective date of this amendatory act and shall serve a term of two years and until their successors have been appointed and qualified] President pro tempore of the Senate, one employe representative and one employer representative by the Speaker of the House of Representatives, one employe representative and one employer representative by the Minority Leader of the Senate and one employe representative and one employer representative by the Minority Leader of the House of Representatives. The members of the council shall select one of their number to be chairman. [Such council shall consider and advise the department upon all matters related to the administration of The Pennsylvania Workmen's Compensation Act and The Pennsylvania Occupational Disease Act. Such council may recommend to the secretary upon its own initiative such changes in the provisions of these acts and the administration thereof as it deems necessary and shall make periodic reports to the secretary regarding the performance of its duties and functions.]

(b) [In the performance of its duties, the] (1) The council

may hold hearings, receive testimony, solicit and receive comments [and information] from interested parties and the general public and shall have full access to information relating to the [purpose of these acts] administration of this act by the Department of Labor and Industry. The council shall not have access to confidential medical information pertaining to individual claimants, but may develop statistical studies and surveys concerning [the] aspects of incidence of [occupational] injuries [and diseases generally.], claims management, litigation, and adherence to the provisions of this act and the Occupational Disease Act.

(2) The council shall review annually any requests for funding by the department and any assessments against employers or insurers related thereto and provide a report to the Governor, the secretary and the General Assembly regarding the appropriateness of such requests.

(3) The council shall review proposed legislation and regulations pertaining to this act and provide comment at least quarterly to the Governor, the secretary and the General Assembly on the effects of such proposals.

(4) The council shall provide to the Governor, the secretary and the General Assembly, on an annual basis, a report on the activities of the council, making recommendations concerning needed improvements in the workers' compensation system and the administration of the system. The report under this paragraph shall be made during the General Assembly's consideration of the General Appropriations Act for the succeeding fiscal year. The report shall be due no later than May 1.

(5) The council shall make recommendations to the Secretary of Health regarding quality and cost-effective health care.

(6) The council shall review the annual accessibility study required by section 306(f.1)(iii) of this act and shall make recommendations to the Secretary of Health regarding the need for new allowances for health care providers.

(7) The council shall make recommendations to the Secretary of Health regarding the certification of coordinated care organizations and the approval of utilization review organizations and persons qualified to perform peer review.

(8) The council shall consult with health care providers and professional associations representing health care providers with regard to its recommendations under paragraphs (5), (6) and (7).

(c) The members of the advisory council, once appointed, shall serve until the expiration of the terms of office of their appointing authority. Members shall serve without compensation, but shall be entitled to be reimbursed for all necessary expenses incurred in the discharge of their duties. The secretary shall [appoint an executive secretary and such other personnel as he shall deem necessary to aid] provide facilities and clerical and professional support as needed by the council in the performance of its [functions] duties. The compensation of such [employes] staff and the amounts allowed them and to members of the council for traveling and other council expenses shall be deemed part of the expenses incurred in connection with the administration of [The Pennsylvania Workmen's Compensation and The Pennsylvania Occupational Disease Acts] this act.

Section 19. The act is amended by adding sections to read:

Section 448. (a) An insurer issuing a workers' compensation and employers' liability insurance policy shall offer, upon request, as part of the policy or by endorsement, deductibles

optional to the policyholder for benefits payable under the policy, subject to approval by the commissioner and subject to underwriting by the insurer consistent with the principles in clause (b). The commissioner shall promulgate at least three plans with varying deductible options, the least amount of which shall be no less than one thousand dollars ($1,000), nor more than two thousand five hundred dollars ($2,500). The commissioner's authority to promulgate any such plans shall not preclude an insurer from negotiating a deductible in excess of the largest deductible plan herein authorized, subject to approval by the commissioner and subject to underwriting by the insurer consistent with the principles in subsection (b) of this section.

(b) The following standards shall govern the commissioner's promulgation, and an insurer's offer, of deductible plans:

(1) Claimants' rights are properly protected and claimants' benefits are paid without regard to any such deductible.

(2) Appropriate premium reductions reflect the type and level of any deductible approved by the commissioner and selected by the policyholder.

(3) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge or premium discount.

(4) Recognition is given to policyholder characteristics, including size, financial capabilities, nature of activities and number of employes.

(5) If the policyholder selects a deductible, the policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(6) The insurer pays all of the deductible amount,

applicable to a compensable claim, to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.

(7) Failure to reimburse deductible amounts by the policyholder to the insurer is treated under the policy in the same manner as non-payment of premiums.

Section 20. The act is amended by adding articles to read:

ARTICLE VII

INSURANCE RATES

Section 701. It is the intent of the General Assembly:

(1) To protect policyholders and the public against the adverse effect of excessive, inadequate or unfairly discriminatory rates.

(2) To encourage, as the most effective way to produce rates that conform to the standards of paragraph (1) of this section, independent action by and reasonable price competition among insurers.

(3) To provide formal regulatory controls for use if price competition fails.

(4) To authorize cooperative action among insurers in the ratemaking process, and to regulate such cooperation in order to prevent practices that tend to bring about monopoly or to lessen or destroy competition.

(5) To provide rates that are responsive to competitive market conditions and to improve the availability of insurance in this Commonwealth.

Section 702. This article applies to the classification of risks, underwriting rules, expenses, losses and profits for insurance of employers and employes under this act, for insurance under the Occupational Disease Act and for insurance

with respect to the Commonwealth as to liability under the Federal Coal Mine Health and Safety Act of 1969 (Public Law 91-173, 30 U.S.C. § 801 et seq.).

Section 703. As used in this article:

"Classification system" or "classification" means the plan, system or arrangement for recognizing differences in exposure to hazards among industries, occupations or operations of insurance policyholders.

"Department" means the Insurance Department of the Commonwealth.

"Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.

"Market" means the interaction in this State, between buyers and sellers of workers' compensation and employers' liability insurance within this Commonwealth pursuant to the provisions of this article.

"Provision for claim payment" means historical aggregate losses projected through development to their ultimate value and through trending to a future point in time, but excluding all loss adjustment or claim management expenses, other operating expenses, assessments, taxes, and profit or contingency allowances.

"Rate" or "rates" means rate of premium, policy and membership fee, or any other charge made by an insurer for or in connection with a contract or policy of insurance of the kind to which this article applies.

"Rating organization" means one or more organizations situate within this Commonwealth, subject to supervision and to examination by the commissioner and approved by the commissioner as adequately equipped to perform the functions specified in this article on an equitable and impartial basis.

"Statistical plan" means the plan, system or arrangement used in collecting data.

"Supplementary rate information" means any manual or plan of rates, statistical plan, classification system, rating schedule, minimum premium policy fee, rating rule, rate-related underwriting rule, and any other information, not otherwise inconsistent with the purposes of this article, prescribed by rule of the commissioner.

"Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, description or methods used in making the rates, and any other similar information required to be filed by the commissioner.

Section 704. (a) The following standards shall apply to the making and use of rates under this article:

(1) Rates may not be:

(i) excessive or inadequate, as defined under this article; or

(ii) unfairly discriminatory.

(2) A rate may not be held to be excessive unless it is likely to produce a long run profit that is unreasonably high in relation to the risk undertaken and the services to be rendered.

(3) A rate may not be held to be inadequate unless:

(i) it is unreasonably low for the insurance provided and

continued use of it would endanger solvency of the insurer; or

(ii) the rate is unreasonably low for the insurance provided and the use of the rate by the insurer has had or, if continued, will have the effect of destroying competition or of creating monopoly.

(b) In determining whether rates comply with standards under clause (a), due consideration shall be given to:

(1) Past and prospective loss experience within and outside this Commonwealth in accordance with sound actuarial principles.

(2) Catastrophe hazards.

(3) A reasonable margin for underwriting profit and contingencies.

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

(5) Past and prospective expenses, both countrywide and those specially applicable to this Commonwealth.

(6) Investment income earned or realized by insurers both from their unearned premium and from their loss reserve funds.

(7) All relevant factors within and outside this Commonwealth in accordance with sound actuarial principles.

(c) As to the kinds of insurance to which this article applies, the systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of any other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

Section 705. (a) Each authorized insurer shall file with the commissioner all rates and supplementary rate information and all changes and amendments thereof made by it for use in

this Commonwealth by the date they become effective. Each rating organization shall file with the commissioner a filing for the provision for claim payment and such other filings as are authorized pursuant to this article. The Secretary of Labor and Industry shall be a member of the board of directors or governing body of any rating organization.

(b) An insurer may not make or issue a contract or policy of insurance of the kind to which this article applies, except in accordance with the filings which are in effect for the insurer as provided in this article.

Section 706. Each filing and any supporting information filed under this article shall, as soon as filed, be open to public inspection. Copies may be obtained by any person on request and upon payment of a reasonable charge.

Section 707. (a) Each workers' compensation insurer shall be a member of a rating organization. Each workers' compensation insurer shall adhere to the policy forms filed by the rating organization.

(b) (1) Every workers' compensation insurer shall adhere to the uniform classification system and uniform experience rating plan filed with the commissioner by the rating organization to which it belongs: Provided, That the system and plan have been approved by the commissioner as part of the approval of the rating organization's most recent filing for the provision for claim payment.

(2) (i) Subject to the conditions of this paragraph, an insurer may develop subclassifications of the uniform classification system upon which a rate may be made.

(ii) Any subclassification developed under subparagraph (i) shall be filed with the rating organization and the commissioner

thirty days prior to its use.

(iii) If the insurer fails to demonstrate that the data produced under a subclassification can be reported in a manner consistent with the rating organization's uniform statistical plan and classification system, the commissioner shall disapprove the subclassification.

(c) Every workers' compensation insurer shall record and report its workers' compensation experience to a rating organization as set forth in the rating organization's uniform statistical plan approved by the commissioner.

(d) (1) Subject to the approval of the commissioner, a rating organization shall develop and file rules reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan, and the uniform classification system.

(2) Every workers' compensation insurer shall adhere to the approved rules and experience rating plan in writing and reporting its business.

(3) An insurer shall not agree with any other insurer or with a rating organization to adhere to rules which are not reasonably related to the recording and reporting of data pursuant to the uniform classification system or the uniform statistical plan.

(e) The experience rating plan shall have as a basis:

(1) reasonable eligibility standards;

(2) adequate incentives for loss prevention;

(3) sufficient premium differential so as to encourage safety; and

(4) predictive accuracy.

(f) (1) The uniform experience rating plan shall be the

exclusive means of providing prospective premium adjustment based upon measurement of the loss producing characteristics of an individual insured.

(2) An insurer may file a rating plan that provides for retrospective premium adjustments based upon an insured's past experience.

Section 708. (a) The commissioner may investigate and determine whether or not rates in this Commonwealth under this article are excessive, inadequate or unfairly discriminatory.

(b) In any such investigation and determination the commissioner shall follow the procedures specified in sections 709 and 710.

Section 709. (a) (1) Except as provided in clause (d), the commissioner shall review each workers' compensation insurance filing made by a rating organization or an insurer as soon as reasonably possible after the filing has been made in order to determine whether it meets the requirements of this article. No filing for the provision for claim payment shall become effective prior to its approval by the commissioner unless the commissioner fails to approve or disapprove the filing within the time period described in clause (b)(1) or any extension of that period under clause (b)(2).

(2) Notwithstanding the provisions of paragraph (1), any insurer filing for loss adjustment or claim management expenses, other operating expenses, assessments, taxes and profits or contingency allowances filed with the commissioner with respect to the period after December 1, 1994, shall not be subject to the commissioner's approval unless such insurer's rates are found to be in violation of sections 704 and 711.

(b) (1) The effective date of each filing under this

article shall be the date specified in the filing. The effective date of the filing may not be earlier than thirty days after the date the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing if such supporting information is required by the commissioner.

(2) The period during which the filing may not become effective may be extended by the commissioner for an additional period not to exceed one hundred fifty days if the commissioner gives written notice within the period described in paragraph (1) to the insurer or rating organization which made the filing that the commissioner needs additional time for the consideration of the filing. No filing shall be made effective for any period prior to the later of the proposed effective date or the expiration of an extension by the commissioner pursuant to this clause.

(3) Upon written application by an insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the period described in paragraph (1).

(4) A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the period described in paragraph (1) or any extension thereof.

(c) (1) Subject to approval or disapproval under clause (b), a rating organization shall file with the commissioner:

(i) On an annual basis, workers' compensation rates and rating plans that are limited to provision for claim payment.

(ii) Each workers' compensation policy form to be used by its members.

(iii) The uniform classification system.

(iv) The uniform experience rating plan and related rules.

(v) Any other information that the commissioner requests relevant to the foregoing and is otherwise entitled to receive under this article.

(2) Notwithstanding any other provisions of this article, the commissioner may approve or disapprove any filing by a rating organization without determining whether a reasonable degree of competition exists within the market.

(d) If the loss cost provision in a schedule of workers' compensation rates for specific classifications of risks filed by an insurer does not differ from the provision for claim payment contained in the schedule of workers' compensation rates for those classifications filed by a rating organization under clause (c) and approved pursuant to the provisions of this article, then the schedule of rates filed by the insurer shall not be subject to clause (b) but shall become effective for the purposes of section 705.

(e) Notwithstanding clause (d), the commissioner may investigate and evaluate all workers' compensation filings to determine whether the filings meet the requirements of this article.

(f) Notwithstanding the provisions of section 705, the commissioner may require any insurer or rating organization to comply with the requirements of clause (b) if the commissioner has found pursuant to section 710, that a reasonable degree of competition does not exist within the workers' compensation insurance market.

Section 710. (a) If the commissioner finds after a hearing that a rate is not in compliance with section 704 or that a rate had been set in violation of section 713, the commissioner shall order that its use be discontinued for any policy issued or

renewed after a date specified in the order and the order may prospectively provide for premium adjustment of any policy then in force. Except as provided in clause (b), the order shall be issued within thirty days after the close of the hearing or within a reasonable time extension as fixed by the commissioner. The order shall expire one year after its effective date unless rescinded earlier by the commissioner.

(b) (1) Pending a hearing, the commissioner may order the suspension prospectively of a rate filed by an insurer and reimpose the last previous rate in effect if the commissioner has reasonable cause to believe that:

(i) an insurer is in violation of section 704;

(ii) unless the order of suspension is issued, certain insureds will suffer irreparable harm;

(iii) the hardship insureds will suffer absent the order of suspension outweighs any hardship the insurer would suffer if the order of suspension were to issue; and

(iv) the order of suspension will cause no substantial harm to the public.

(2) In the event the commissioner suspends a rate under this clause, the commissioner must, unless waived by the insurer, hold a hearing within fifteen working days after issuing the order suspending the rate. In addition, the commissioner must make a determination and issue the order as to whether or not the rate should be disapproved within fifteen working days after the close of the hearing.

(c) (1) At any hearing to determine compliance with section 704, pursuant to clause (a), the commissioner may first determine whether a reasonable degree of competition exists within the market, and shall give a ruling to that effect. All

insurers operating within such market shall have the burden of establishing that a reasonable degree of competition exists within that market. The commissioner shall consider all relevant factors in determining the competitiveness of the market, including:

(i) the number of insurers actively engaged in providing coverage;

(ii) market shares;

(iii) changes in market shares; and

(iv) ease of entry.

(2) If the commissioner determines that a reasonable degree of competition does not exist in the market, any insurer designated by the commissioner shall have the burden of justifying its rate in such market.

(3) All determinations made by the commissioner shall be on the basis of findings of fact and conclusions of law.

(4) If the commissioner disapproves a rate, the disapproval shall take effect not less than fifteen days after his order and the last previous rate in effect for the insurer shall be reimposed for a period of one year unless the commissioner approves a rate under clause (d) or (e).

(d) Within one year after the effective date of a disapproval order, no rate adopted to replace one disapproved under such order may be used until it has been filed with the commissioner and not disapproved within thirty days thereafter.

(e) Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates, the commissioner shall, on the insurer's request, specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion

of the premiums be placed in a special reserve established by the insurer. When new rates become legally effective, the commissioner shall order the specially reserved funds or any overcharge, in the interim rates to be distributed appropriately to the insureds or insurer as the case may be, except that refunds to policyholders that are minimal may not be required.

Section 711. (a) (1) If the commissioner finds after hearing that competition is not an effective regulator of the rates charged or that a substantial number of companies are competing irresponsibly through the rates charged, or that there are widespread violations of this article, the commissioner may adopt a rule requiring that any subsequent changes in the rates or supplementary rate information be filed with the commissioner at least thirty working days before they become effective.

(2) In the event that the waiting period is imposed pursuant to paragraph (1), the commissioner may extend the waiting period for a period not to exceed thirty additional working days by written notice to the filer before the first thirty-day period expires.

(b) In the event that the commissioner has entered an order pursuant to paragraph (1) of clause (a), the commissioner may require the filing of supporting data as the commissioner deems necessary for the proper functioning of the rate monitoring and regulating process. The supporting data shall include:

(1) the experience and judgment of the filer, and to the extent the filer wishes or the commissioner requires, the experience and judgment of other insurers or rate service organizations;

(2) the filer's interpretation of any statistical data relied upon;

(3) a description of the actuarial and statistical methods employed in setting the rate; and

(4) any other relevant matters required by the commissioner.

(c) A rule adopted under this section shall expire not more than one year after issue. The commissioner may renew it for an additional one-year period after a hearing and appropriate findings under this section.

(d) Whenever a filing is not accompanied by the information as the commissioner has required under clause (a), the commissioner may so inform the insurer and the filing shall be deemed to be made when the information is furnished.

Section 712. (a) No rating organization shall provide any service relating to the rates of any insurance subject to this article, and no insurer shall utilize the service of such organization for those purposes unless the organization has obtained a license pursuant to this article.

(b) No rating organization shall refuse to supply services for which it is licensed in this Commonwealth to any insurer authorized to do business in this Commonwealth and offering to pay the fair and usual compensation for the services.

Section 713. (a) As used in this section, the word "insurer" includes two or more affiliated insurers:

(1) under common management; or

(2) under common controlling ownership or under other common effective legal control and in fact engaged in joint or cooperative underwriting, investment management, marketing, servicing or administration of their business and affairs as insurers.

(b) An insurer or rating organization may not:

(1) monopolize or attempt to monopolize, or combine or

conspire with any other person or persons, or monopolize the business of insurance of any kind, subdivision, or class thereof;

(2) agree with any other insurer or rating organization to charge or adhere to any rate, although insurers and rating organizations may continue to exchange statistical information;

(3) make any agreement with any other insurer, rating organization or other person to unreasonably restrain trade;

(4) make any agreement with any other insurer, rating organization, or other person where the effect of the agreement may be substantially to lessen competition in the business of insurance of any kind, subdivision, or class; or

(5) make any agreement with any other insurer or rating organization to refuse to deal with any person in connection with the sale of insurance.

(c) An insurer may not acquire or retain any capital stock or assets of, or have any common management with, any other insurer if such acquisition, retention, or common management substantially lessens competition in the business of insurance of any kind, subdivision, or class.

(d) A rating organization or member or subscriber thereof may not interfere with the right of any insurer to make its rates independently of that rating organization or to charge rates different from the rates made by that rating organization.

(e) Except as required under section 707, a rating organization may not have or adopt any rule or exact any agreement, formulate or engage in any program which would require any member, subscriber or other insurer to:

(1) utilize some or all of its services;

(2) adhere to its rates, rating plan, rating systems,

underwriting rules; or

(3) prevent any insurer from acting independently.

Section 714. Any rate in violation of section 713 shall be disapproved by the commissioner in accordance with the procedures prescribed in section 710, and each violator shall be subject to the penalties provided in section 720.

Section 715. The commissioner may maintain an action to enjoin any violation of section 713.

Section 716. Notwithstanding any other provision of this article, upon written application of an insurer stating its reasons therefor, accompanied by the written consent of the insured or prospective insured, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used as to any specific risk.

Section 717. (a) Each rating organization and every insurer to which this article applies which makes its own rates shall provide within this Commonwealth reasonable means whereby any person aggrieved by the application of its rating system may be heard in person or by the person's authorized representative on the person's written request to review the manner in which such rating system has been applied in connection with the insurance afforded the aggrieved person.

(b) If the rating organization or insurer fails to grant or reject the aggrieved person's request within thirty days after it is made, the applicant may proceed in the same manner as if the application had been rejected.

(c) Any party affected by the action of that rating organization or insurer on the request may, within thirty days after written notice of that action, make application, in writing, for an appeal to the commissioner, setting forth the

basis for the appeal and the grounds to be relied upon by the applicant.

(d) The commissioner shall review the application, and if the commissioner finds that the application is made in good faith, and that it sets forth on its face grounds which reasonably justify holding a hearing, the commissioner shall conduct a hearing held on not less than ten days' written notice to the applicant and to the rating organization or insurer. The commissioner, after hearing, shall affirm or reverse the action.

Section 718. (a) Cooperation among rating organizations or among rating organizations and insurers in ratemaking or in other matters within the scope of this article is authorized, if the filings resulting from that cooperation are subject to all the provisions of this article which are applicable to filings generally.

(b) The commissioner may review these cooperative activities and practices, and if, after hearing, the commissioner finds that any activity or practice is unfair, unreasonable, or otherwise inconsistent with this article, the commissioner may issue a written order specifying in what respects that activity or practice is unfair, unreasonable, or otherwise inconsistent with this article, and requiring the discontinuance of that activity or practice.

Section 719. (a) A person or organization may not wilfully withhold information from or knowingly give false or misleading information which will affect the rates or premiums chargeable under this article to:

(1) the commissioner; or

(2) any rating organization or any insurer.

(b) A violation of this section shall subject the one who

commits that violation to the penalties provided in section 720, and anyone who violates this section with intent to deceive commits perjury, and is subject to prosecution therefor in a court of competent jurisdiction.

Section 720. (a) Any person, organization, or insurer found by the commissioner after notice and hearing to be guilty of a violation of any provision of this article, including a regulation of the commissioner adopted under this article may be ordered to pay a penalty of five hundred dollars ($500) for each violation. Upon finding such violation to be wilful, the commissioner may impose a penalty of not more than one thousand dollars ($1,000) for each such violation in addition to any other penalty provided by law. The commissioner has the right to suspend or revoke or refuse to renew the license of any person, organization, or insurer for violation of any of the provisions of this article.

(b) The commissioner may determine when a suspension or revocation of license will become effective, and the suspension or revocation shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds the suspension or revocation, or until the order upon which the suspension or revocation is based is modified or reversed as the result of an appeal therefrom.

(c) A fine may not be imposed nor a license suspended or revoked by the commissioner except upon written order stating the commissioner's findings, made after a hearing held on not less than ten days' written notice to the person, organization, or insurer specifying the alleged violation.

Section 721. All decisions and findings of the commissioner under this article shall be subject to judicial review in

accordance with 2 Pa.C.S. (relating to administrative law and procedure).

Section 722. The commissioner shall report to the General Assembly annually, beginning on December 31, 1993, on the status, operation and procedures for the determination of classification systems as they apply to this article.

ARTICLE VIII

SELF-INSURANCE POOLING

Section 801. The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Actuarially appropriate loss reserves" shall mean those reserves needed to pay known claims for compensation and expenses associated therewith and claims for compensation incurred but not reported and expenses associated therewith.

"Administrator" means an individual, partnership or corporation engaged by a fund's plan committee to carry out the policies established by the plan committee and to provide day-to-day management of the fund.

"Compensation" includes compensation paid under this act or the Occupational Disease Act.

"Department" means the Department of Labor and Industry of the Commonwealth.

"Employer" means an employer as defined in section 103 of this act or as defined in section 103 of the Occupational Disease Act, where applicable.

"Excess insurance" means insurance, purchased from an insurance company appropriately approved or authorized or licensed in this Commonwealth covering losses in excess of an amount established between the group and the insurer up to the

limits of coverage set forth in the insurance contract on a specific per occurrence or per accident or annual aggregate basis.

"Fund" means a group self-insurance fund organized by employers to pool workers' compensation liabilities and approved by the department under the authority of this act. A fund shall not be deemed to be an insurer or insurance company and shall not be subject to the provisions of the insurance laws and regulations, except as specifically otherwise provided herein.

"Homogeneous employer" means employers who have been assigned to the same classification series for at least one year or are engaged in the same or similar types of business, including political subdivisions.

"Independent actuary" means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries who has been identified by the Academy as meeting its qualification standards for signing casualty loss reserve opinions. Said actuary must not be an officer, director or employe of the fund or a member of the fund for which he or she is providing reports, certifications or services.

"Insolvent fund" means the inability of a fund to pay its outstanding liabilities as they mature, as may be shown either by an excess of its required reserves and other liabilities over its assets or by not having sufficient assets to reinsure all of its outstanding liabilities after paying all accrued claims owed by it.

"Permit" means the document issued by the department to a fund which authorizes the fund to operate as a fund under the provisions of this act.

"Plan committee" means a committee composed of representatives of each employer participating in a fund.

"Political subdivision" means any county, city, borough, incorporated town, township, school district, vocational school district and county institution district, municipal authority or other entity created by a political subdivision pursuant to law.

"Security" means surety bonds, cash, negotiable securities of the United States Government or the Commonwealth or other negotiable securities, such as letters of credit, acceptable to the department which are posted by the fund to guaranty the payment of compensation.

"Surplus" means that amount of moneys found in the trust to be in excess of all fixed costs and incurred losses attributed to the pool net any occurrence or aggregate excess insurance.

"Trust" means a written contract signed by the members of the fund which separates the legal and equitable rights to the moneys held by an independent trustee as a fiduciary for the benefit of employes of employers participating in the fund.

Section 802. (a) Employers shall be permitted to pool their liabilities under this act and the Occupational Disease Act and their employers' liability through participation in a fund approved by the department.

(b) A group of homogeneous employers may be approved by the department to act as a fund if the proposed group:

(1) Includes five or more homogeneous employers.

(2) Is comprised of at least five members of which each have been employers for at least three years prior to the filing of the group's application.

(3) Has been created in good faith for the purpose of becoming a fund.

(4) Has, except for political subdivisions, an aggregate net worth of the employers participating calculated according to generally accepted accounting principles which equals or exceeds one million dollars ($1,000,000) or such amount as may be adjusted and promulgated annually by the department and published in the Pennsylvania Bulletin to take effect January 1 of each year.

(5) Has a combined annual payroll of fund members multiplied by the rate utilized by the State Workmen's Insurance Fund which is equal to or greater than five hundred thousand dollars ($500,000) as adjusted annually by the percentage increase in the Statewide average weekly wage or such amount as may be adjusted and promulgated annually by the department and published in the Pennsylvania Bulletin to take effect January 1 of each year.

(6) Guarantees benefit levels equal to those required by this act and the Occupational Disease Act.

(7) Demonstrates sufficient aggregate financial strength and liquidity to assure that all obligations under this act and the Occupational Disease Act will be met as required by that act and proposes a plan for the prompt payment of such benefits. Information documenting an individual member's financial strength and liquidity shall be presented to the department upon the department's request or with the application as required by the department.

(8) Executes a trust agreement under which each member agrees to jointly and severally assume and discharge the liabilities arising under this act and the Occupational Disease Act of each and every party to such agreement.

(9) Files with the department the proposed trust agreement.

(10) Provides for excess insurance with retention amounts in such amount as the department deems acceptable on a single accident (single occurrence) and aggregate excess basis. The department may waive the requirement for one or both types of excess insurance if convinced that the fund's financial strength is sufficient to assure payment of its obligations under this act and the Occupational Disease Act.

(11) Provides security in a form and amount prescribed by the department.

(12) Provides letters of intent from prospective fund members and evidence that each prospective member:

(i) Has never defaulted on compensation due under this act or the Occupational Disease Act as an individual self-insurer.

(ii) Has not been delinquent in payment of or canceled for non-payment of workers' compensation premiums for a period of at least two years prior to application.

(iii) Has not been found to have violated section 305 or section 435 of this act or the Occupational Disease Act as an individual self-insurer.

(iv) Has not been and is not in default on or owes money assessed under this act or the Occupational Disease Act.

(13) Provides that the fund will initiate and maintain a loss prevention and safety program of the nature and extent that would be required of members under the provisions of this act, the Occupational Disease Act or regulations promulgated hereunder.

(14) Provides for assessment upon employers participating in the fund to establish and maintain actuarially appropriate loss reserves and a plan for payment of such assessments.

(15) Provides proof of competent personnel and ample

facilities within its own organization with respect to claims administration, underwriting matters, loss prevention and safety engineering or presents a contract with a reputable service company to provide such assistance.

(16) Meets the other criteria established by this act or by the department pursuant to regulations promulgated under this act or the Occupational Disease Act.

(c) Each application for approval of a fund shall be accompanied by a nonrefundable fee of one thousand dollars ($1,000), payable to the department which shall be deposited in the Workmen's Compensation Administration Fund.

Section 803. (a) (1) The department shall, in accordance with section 802, review, approve or disapprove fund applications under such rules and requirements relating to applications under section 305 of this act and the Occupational Disease Act as may be applicable and such rules and regulations as are specifically adopted with regard to fund applications.

(2) During the pendency of the processing of any fund application, the group of employers shall not operate as a fund.

(b) Permits shall identify an annual reporting period for the fund as established by the department.

Section 804. All permits issued under this article shall remain in effect unless terminated at the request of the fund or revoked by the department.

Section 805. (a) If at any time the fund is found to be insolvent, fails to pay any required assessments under this act or the Occupational Disease Act, or fails to comply with any provision of this act or the Occupational Disease Act or with any rules promulgated thereunder, the department may revoke its permit after notice and opportunity for a hearing.

(b) In the case of revocation of a permit, the department may require the fund to insure or reinsure all incurred liability with an authorized insurer. All fund members shall immediately obtain coverage required by this act.

Section 806. (a) Members of said fund shall pay a minimum of twenty-five per centum of their annual assessment into the fund on or before the inception of the fund. The balance of the annual assessments shall be paid to the fund on a monthly, quarterly or semiannual basis as required by the fund's bylaws and approved by the department.

(b) Each member's annual assessment to the fund shall equal such member's annual payroll times the applicable rates utilized by the State Workmen's Insurance Fund minus the premium discount specified in Schedule Y as approved by the commissioner. Dividends may be returned to members in accordance with section 809.

(c) Nothing contained in this section shall preclude the assessment and payment of supplemental assessments as provided in section 810.

Section 807. After the final permit approval date of the fund, prospective new members of the fund shall submit an application for membership to the fund's plan committee or administrator in a form approved by the department. This application shall include an agreement of joint and several liability as required in section 803. The administrator or plan committee may approve the application for membership pursuant to the bylaws of the fund. The application approved by the fund shall be filed with the department. The fund shall retain the authority to reject any applicant.

Section 808. (a) Individual members may elect to terminate

their participation in a fund or be subject to cancellation by the fund pursuant to the bylaws of the fund for non-payment of premium or other violations. Any member withdrawing from a fund or member terminated by the fund for non-payment of assessments shall remain fully obligated for claims incurred during the period of its membership in accord with fund bylaws, including, but not limited to, amounts owed as annual or supplemental assessments. Notice of termination of any participant shall be filed with the fund. The fund shall attach any such notices of termination to the renewal application filed with the department.

(b) The fund shall notify the department immediately if termination of a member causes the fund to fail to meet the requirements of clause (b) of section 802. Within fifteen days of the notice of withdrawal or decision to expel, the fund shall advise the department of its plan to bring the fund into compliance with clause (b) of section 802. If the plan does not bring the fund into compliance with the requirements, the department shall immediately review and revoke its permit.

(c) The department shall not grant the request of any fund to terminate its permit unless the fund has insured or reinsured all incurred workers' compensation obligations with an authorized insurer under an agreement filed with and approved in writing by the department. These obligations shall include both known claims and expenses associated therewith and claims incurred but not reported and expenses associated therewith. These same requirements shall apply where the department revokes a permit.

Section 809. Any fund may return to its members dividends based upon the recommendation of an independent actuary.

Dividends shall not be returned if the payment of such dividends would impair the fund's ability to meet its obligations under this act or the Occupational Disease Act, nor shall dividends be returned prior to the beginning of the thirteenth month following the expiration of the preceding annual reporting period. The initial dividend payment for any annual reporting period shall not exceed thirty per centum of the surplus available for the applicable annual reporting period. The fund may, however, seek annual approval for payment of dividends from the surplus remaining from any annual reporting period which has been completed for at least twenty-five months or longer and may include such dividend payments with initial dividend payments from the subsequent annual reporting period.

Section 810. (a) If the assets of a fund are at any time insufficient to enable the fund to discharge its legal liabilities and other obligations and to maintain the actuarially appropriate loss reserves required of it under paragraph (14) of clause (b) of section 802, the fund shall forthwith make up the deficiency or levy an assessment upon the fund members for the amount needed to make up the deficiency.

(b) In the event of a deficiency in any annual reporting period, such deficiency shall be made up immediately, either from surplus from a year other than the current year, assessment of the fund members if ordered by the fund or such alternate method as the department may approve or direct.

(c) If the fund fails to assess its members or to otherwise make up such deficit within thirty days the department shall order it to do so.

(d) If the fund fails to make the required assessment of its members within thirty days after the department orders it to do

so, or if the deficiency is not fully made up within sixty days after the date on which such assessment is made or within such longer period of time as may be specified by the department, the fund shall be deemed to be insolvent.

(e) The department shall proceed against an insolvent fund in the same manner as the department would proceed against a self-insurer under Article IX.

(f) In addition, in the event of the liquidation or default of a fund, the department may levy an assessment upon the fund members for such an amount as the department determines to be necessary to discharge all liabilities of the fund including the reasonable cost of liquidation and shall deposit such assessments into the Self-insurance Guaranty Fund for distribution and payment by the Guaranty Fund as provided for in Article IX.

Section 811. The annual assessment of each fund member shall be based upon the annual payroll of fund members multiplied by the rates as utilized by the State Workmen's Insurance Fund for members minus any premium discounts. A fund may deviate from these rates and establish its own rates with the approval of an independent actuary and the department.

Section 812. Each fund shall request classifications for its participants from the bureau or bureaus approved by the commissioner and shall utilize those classifications making assessments based upon rates as utilized by the State Workmen's Insurance Fund for such classification except as provided in section 811. The fund shall pay the appropriate bureau a reasonable charge, approved by the commissioner, for this service. The fund may appeal classifications as provided in the applicable sections of the Insurance Company Law of 1921 for

other employers.

Section 813. Each fund may invest any surplus moneys not needed for current obligations in United States Government obligations, United States Treasury Notes, investment share accounts in any savings and loan association whose deposits are insured by a Federal agency and certificates of deposit issued by a duly chartered commercial bank. Deposits in savings and loan associations and commercial banks shall be limited to institutions in this Commonwealth and shall not exceed the federally insured amount in any one account. Investments may also be made in any permitted investments of capital or surplus of stock casualty insurance companies set forth in section 602 or 603 of the Insurance Company Law of 1921, as may be authorized by regulation approved by the commissioner.

Section 814. (a) Funds approved under this article shall purchase excess insurance by reason of any single accident or any single occurrence as provided in section 653 of the Insurance Company Law of 1921 and aggregate excess insurance. The department may waive the requirement for either single accident (single occurrence) or aggregate excess insurance or the requirement for both single accident (single occurrence) and aggregate excess insurance.

(b) A policy of insurance by an insurance carrier may include provisions for aggregate excess insurance in addition to the single accident (single occurrence) excess insurance which is authorized under section 653 of the Insurance Company Law of 1921.

Section 815. (a) A report shall be prepared by each fund for each annual reporting period and shall be filed with the department and made available to each fund member.

(b) The information contained in the annual report shall include, for each member of the fund and the fund itself:

(1) Summary loss reports.

(2) An annual statement of the financial condition of the fund prepared by a certified public accountant and performed in accordance with generally accepted accounting principles.

(3) Reports of outstanding liabilities showing the number of claims, amounts paid to date and current reserves as certified by an independent actuary.

(4) Such other information as required by regulation of the department as may be applicable to applicants for self-insurance under section 305 of this act and the Occupational Disease Act or regulations in regard to fund applications.

(c) The annual report shall be accompanied by a one thousand dollar evaluation fee.

(d) The department may, at any time, examine the affairs, transactions, accounts, records and assets of a fund and the fund shall make all such items as are needed for such examination available to the department. The department shall bill the fund for the reasonable costs associated with such examinations.

(e) If at any time there is a change in the fund, during an annual reporting period other than as set forth in section 808, that affects the ability of the fund to comply with the requirements of clause (b) of section 802, the fund shall notify the department of the change within thirty days after such change.

Section 816. Each fund shall be assessed annually by the department in a like manner and amount as other insurers or self-insurers are now or hereafter assessed under this act and

the Occupational Disease Act and shall pay such assessment in accordance with this act and the Occupational Disease Act. All contributions received in accordance with this section shall be deposited into the appropriate fund as required by the applicable provision of law.

Section 817. Any group of five homogeneous employers who will provide to the fund an annual volume of premium of at least five hundred thousand dollars ($500,000) may become subscribers as a group to the State Workmen's Insurance Fund for the purpose of insuring therein their liability to those of their employes. Such group shall become legally obligated to pay any employe compensation required by this act because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by such employe arising out of and in the course of his employment. Such group shall make a written application for subscription for group insurance to the board. Such application shall designate the name of the group subscriber and shall include such information as determined by the board as will allow the board to identify the employers and to adequately assess risks and premiums to be charged to employers to be insured by the fund under the group subscription.

Section 818. The department is authorized to promulgate rules and regulations for the administration and enforcement of this article.

ARTICLE IX

SELF-INSURANCE GUARANTY FUND

Section 901. The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Compensation" means benefits paid pursuant to sections 306 and 307.

"Employer" means a self-insured employer or the employer as defined in this act.

"Guaranty Fund" or "fund" means the Self-Insurance Guaranty Fund established in section 902 for injuries and exposures occurring on or after the establishment of the Self-Insurance Guaranty Fund.

"Security" means surety bonds, cash, negotiable securities of the United States Government or the Commonwealth or other negotiable securities, such as letter of credit, acceptable to the department which are posted by the fund to guaranty the payment of workers' compensation benefits.

"Self-insurer" means an employer exempted under section 305 or a group self-insurance fund permitted to operate under Article VIII.

Section 902. (a) (1) There is hereby established a special fund to be known as the Self-Insurance Guaranty Fund.

(2) The fund shall be maintained as two distinct custodial accounts in the State Treasury as separate and distinct accounts subject to the procedures and provisions set forth in this article.

(b) The moneys in each custodial account shall consist of security and assessments, as defined in section 907 and interest accumulated thereon.

(c) The administrator shall establish and maintain the following two distinct and separate custodial accounts. The moneys and other assets in each account are not to be commingled or used to pay claims from the other account.

(1) Custodial account for self-insured employers for the

exclusive benefit of claims arising from defaulting individual self-insured employers.

(2) Custodial account for self-insurance pooling as defined under section 801 for the exclusive benefit of claims arising from defaulting members of pooling arrangements.

(d) The secretary shall be the administrator of the fund and shall have the power to collect, dispense and disperse money from the fund.

Section 903. The fund shall be maintained to make payments to any claimant or his dependents upon the default of the self-insurer liable to pay compensation due under this act and the Occupational Disease Act or costs associated therewith and shall be maintained in an amount sufficient to pay such compensation and costs or reasonably anticipated to be needed by virtue of default by self-insurers.

Section 904. (a) When a self-insurer fails to pay compensation when due, the department shall determine the reasons for such failure.

(b) If the department determines that the failure to pay compensation is due to the self-insurer's financial inability to pay compensation, the department shall notify the self-insurer of same and direct compensation to be paid within fifteen days of such notice.

(c) If the self-insurer fails to pay the compensation as directed and within the time set forth in this section, the department shall declare the self-insurer in default.

(d) Whenever the department determines that a default has occurred it shall:

(1) Investigate the circumstances surrounding the default, the amount of security available and the ability of the self-

insured to cure the default.

(2) Determine whether the liabilities of the self-insurer for compensation exceed or are less than the security:

(i) If the liabilities are less than the security, the department shall demand the custodian of the security utilize the security to cure the default and the department shall monitor the situation to insure that compensation is paid as due under this act or the Occupational Disease Act.

(ii) If at any time the liabilities exceed or can reasonably be expected to exceed the security, in the opinion of the department, the department may order payment of the security into the fund's appropriate custodial account, and shall order payment from the Guaranty Fund, as appropriate, to cure the default and insure that compensation is paid as due under this act or the Occupational Disease Act.

Section 905. (a) When payments are ordered from the Guaranty Fund's appropriate custodial account, the fund assumes the rights and obligations of the self-insurer under this act or the Occupational Disease Act with regard to the payment of compensation and shall have and may exercise the rights set forth in this section.

(b) The Guaranty Fund shall have the right to:

(1) Institute and prosecute legal action against any self-insurer and each and every member of a fund, jointly and severally, on behalf of the employes of the self-insured employer or fund members' employes and their dependents to require the payment of compensation and the performance of any other obligations of the self-insurer under this act or the Occupational Disease Act.

(2) Appear and represent the Guaranty Fund in any

proceedings in bankruptcy involving the self-insurer on whose behalf payments were made, including the ability to appear and move to lift any stay orders affecting payment of compensation.

(3) Obtain, in any manner or by the use of any process or procedure, including, but not limited to, the commencement and prosecution of legal action, reimbursement from a self-insurer and its successors, assigns and estate all moneys paid on account of the self-insurer's obligation assumed by the fund, including, but not limited to, reimbursement for all compensation paid as well as reasonable administrative and legal costs associated with such payment.

(4) Purchase reinsurance and take any and all other action which effects the purpose of the Guaranty Fund.

Section 906. (a) (1) Security or funds from security demanded and paid to the department under section 904 shall be deposited into the Guaranty Fund.

(2) These funds and interest thereon shall be segregated in individual custodial accounts within the Guaranty Fund by the custodian and maintained solely for the payment of compensation or costs associated therewith upon order of the department to the employes of the defaulting self-insurer providing the security from the appropriate custodial account.

(3) If there are funds from security or interest thereon remaining in the individual account after all outstanding obligations of the insolvent self-insurer have been satisfied and the costs of administration and defense have been paid, such amount as remains shall be returned upon order of the department from the Guaranty Fund individual account to the self-insurer.

(b) Assessments made under section 907 and interest thereon shall be deposited into the Guaranty Fund's appropriate

custodial account.

Section 907. (a) On a date to be determined by the department following the effective date of this article, employers who are self-insurers as of that effective date shall pay an initial assessment of one-half per centum of the compensation paid by each self-insurer in the year preceding the assessment. Self-insurers who, prior to such effective date, were not self-insurers, shall pay an assessment based on one-half per centum of their modified manual premium for the twelve months immediately prior to becoming self-insurers.

(b) (1) The department may, in addition to the initial assessment, from time to time, assess each self-insurer a pro rata share of the amounts needed for the fund to carry out the requirements of this article.

(2) Such assessments shall be based on the ratio that each self-insurer's payments of compensation bears to the total compensation paid by all self-insurers in the year preceding the year of assessment.

(3) In no event shall a self-insurer be assessed in any one calendar year more than one per centum of the compensation paid by that self-insurer during the previous calendar year.

(c) A self-insurer which ceases to be a self-insurer shall be liable for any and all assessments made pursuant to this section during the period following the date its authority to self-insure is withdrawn, revoked or surrendered until such time as it has discharged all obligations to pay compensation which arose during the period of time said former self-insurer was self-insured. Assessments of such a former self-insurer shall be based on the compensation paid by the former self-insurer during the preceding calendar year on claims that arose during the

period of time said former self-insurer was self-insured.

Section 908. The department may promulgate rules and regulations for the administration and enforcement of this article.

ARTICLE X

HEALTH AND SAFETY

Section 1001. (a) Notwithstanding any other provision of law, an insurer desiring to write workers' compensation insurance in this Commonwealth shall maintain or provide accident and illness prevention services as a prerequisite for a license to write such insurance. Proof of compliance with this section shall be provided to the commissioner. Such services shall be adequate to furnish accident prevention required by the nature of its business or its policyholders' operations and shall include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services to implement the program of accident prevention services. The insurer, pursuant to its responsibilities under this section, shall employ or otherwise make available qualified accident and illness prevention personnel. Such personnel shall meet the qualifications set forth in regulations issued by the department.

(b) A self-insured employer shall maintain an accident and illness prevention program as a prerequisite for retention of its self-insured status. Such program shall be adequate to furnish accident prevention required by the nature of its business and shall include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services. The self-insured employer pursuant to its responsibilities under this section,

shall employ or otherwise make available qualified accident and illness prevention personnel. Such personnel shall meet the qualifications set forth in regulations issued by the department.

(c) The department may conduct inspections to determine the adequacy of the accident prevention services required by this section at least once every two years for each insurer.

(d) Notice that services required by this section are available to the employer from an insurer must appear in no less than ten-point bold type and must accompany each workers' compensation insurance policy delivered or issued for delivery in this Commonwealth.

(e) At least once each year each insurer must submit to the department detailed information on the type of accident prevention services offered or provided to the insurer's policyholders. The information must include:

(1) The amount of money spent by the insurer on accident prevention services.

(2) The number and qualifications of field safety representatives employed by the insurer.

(3) The number of site inspections performed.

(4) Any accident prevention services for which the insurer contracts.

(5) A breakdown of the premium size of the risks to which the insurer provided services.

(6) Evidence of the effectiveness of and accomplishments in accident prevention.

(f) Failure to maintain or provide the accident prevention services required by this section shall constitute a continuing civil violation subject to a maximum fine of two thousand

dollars ($2,000) per day for each day the accident prevention services are not maintained or provided. Each day of noncompliance with this section is a separate violation. All fines recovered under this section shall be paid to the department and deposited by the department into the Workmen's Compensation Administration Fund created by section 446 of this act.

(g) The insurer, the agent, servant or employe of the insurer and the past and present employer and employe members of the safety committee established under section 1002 and any collective bargaining representative shall not be liable on any cause of action or in any proceeding, civil or criminal, arising out of or based upon allegations and pleadings relating to the performance of services under or in compliance with this article. This immunity shall not, however, affect the liability of the employer or the insurer for compensation as otherwise provided in this act. The recommendations, findings and minutes of a safety committee shall not be admissible evidence in any civil action filed on behalf of an employe against a third party regarding any injury incurred in the course and scope of employment.

Section 1002. (a) An insured employer may make application to the department for the certification of any established safety committee operative within its workplace, developed for the purpose of hazard detection and accident prevention. The department shall develop such certification criteria.

(b) Upon the renewal of the employer's workers' compensation policy next following receipt of department certification, the employer shall receive a five per centum discount in the rate or rates applicable to the policy for a period of one year.

ARTICLE XI

INSURANCE FRAUD

Section 1101. The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Attorney" means an individual admitted by the Pennsylvania Supreme Court to practice law in this Commonwealth.

"Health care provider" means a person licensed or certified pursuant to law to perform health care activities.

"Insurance claim" means a claim for payment or other benefits pursuant to an insurance policy for workers' compensation.

"Insurance policy" means a document setting forth the terms and conditions of a contract of insurance or agreement for workers' compensation.

"Insurer" means a company, association or exchange defined by section 101 of the Insurance Company Law of 1921 and the State Workmen's Insurance Fund; an unincorporated association of underwriting members; a hospital plan corporation; a professional health services plan corporation; a health maintenance organization; a fraternal benefit society; and a self-insured health care entity under the act of October 15, 1975 (P.L.390, No.111), known as the "Health Care Services Malpractice Act."

"Person" means an individual, corporation, partnership, association, joint-stock company, trust or unincorporated organization. The term includes any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, beneficial association and any other legal entity engaged or proposing to become engaged, either directly or indirectly, in the business

of insurance, including agents, brokers, adjusters and health care plans as defined in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations), 63 (relating to professional health services plan corporations), 65 (relating to fraternal benefit societies) and 67 (relating to beneficial societies) and the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act." For purposes of this article, health care plans, fraternal benefit societies and beneficial societies shall be deemed to be engaged in the business of insurance.

"Statement" means any oral or written presentation or other evidence of loss, injury or expense, including, but not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X-ray, test result or computer-generated documents.

Section 1102. A person, including, but not limited to, the employer, the employe, the health care provider, the attorney, the insurer, the State Workmen's Insurance Fund and self-insureds, commits an offense if the person does any of the following:

(1) Knowingly and with the intent to defraud a State or local government agency files, presents or causes to be filed with or presented to the government agency a document that contains false, incomplete or misleading information concerning any fact or thing material to the agency's determination in approving or disapproving a workers' compensation insurance rate filing, a workers' compensation transaction or other workers' compensation insurance action which is required or filed in

response to an agency's request.

(2) Knowingly and with the intent to defraud any insurer, presents or causes to be presented to any insurer any statement forming a part of, or in support of, a workers' compensation insurance claim that contains any false, incomplete or misleading information concerning any fact or thing material to the workers' compensation insurance claim.

(3) Knowingly and with the intent to defraud any insurer, assists, abets, solicits or conspires with another to prepare or make any statement that is intended to be presented to any insurer in connection with, or in support of, a workers' compensation insurance claim that contains any false, incomplete or misleading information concerning any fact or thing material to the workers' compensation insurance claim.

(4) Engages in unlicensed agent or broker activity as defined by the act of May 17, 1921 (P.L.789, No.285), known as "The Insurance Department Act of one thousand nine hundred and twenty-one," knowingly and with the intent to defraud an insurer or the public.

(5) Knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this section due to the assistance, conspiracy or urging of any person.

(6) Is the owner, administrator or employe of any health care facility and knowingly allows the use of such facility by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this section.

(7) Knowingly and with the intent to defraud assists, abets, solicits or conspires with any person who engages in an unlawful act under this section.

(8) Makes or causes to be made any knowingly false or

fraudulent statement with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.

(9) Knowingly and with the intent to defraud makes any false statement for the purpose of avoiding or diminishing the amount of the payment in premiums to an insurer or self-insurance fund.

Section 1103. (a) A lawyer may not compensate or give anything of value to a nonlawyer to recommend or secure employment by a client or as a reward for having made a recommendation resulting in employment by a client; except that the lawyer may pay:

(1) the reasonable cost of advertising or written communication as permitted by the rules of professional conduct; or

(2) the usual charges of a not-for-profit lawyer referral service or other legal service organization.

Upon a conviction of an offense under this clause, the prosecutor shall certify the conviction to the disciplinary board of the Supreme Court for appropriate action, including suspension or disbarment.

(b) With respect to a workers' compensation insurance benefit or claim, a health care provider may not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the provider's service to or employment by a patient; except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct. Upon a conviction of an offense under this clause, the prosecutor shall certify the conviction to the appropriate

licensing board in the Department of State which shall suspend or revoke the health care provider's license.

(c) A lawyer or health care provider may not compensate or give anything of value to a person for providing names, addresses, telephone numbers or other identifying information of individuals seeking or receiving medical or rehabilitative care for accident, sickness or disease, except to the extent a referral and receipt of compensation is permitted under applicable professional rules of conduct. A person may not knowingly transmit such referral information to a lawyer or health care professional for the purpose of receiving compensation or anything of value. Attempts to circumvent this clause through use of any other person, including, but not limited to, employes, agents or servants, shall also be prohibited.

Section 1104. If an insurance claim is made by means of computer billing tapes or other electronic means, it shall be a rebuttable presumption that the person knowingly made the claim if the person has advised the insurer in writing that claims will be submitted by use of computer billing tapes or other electronic means.

Section 1105. (a) A person who violates section 1102 shall be guilty of a felony of the third degree, and, upon conviction thereof, shall be sentenced to pay a fine of not more than fifty thousand dollars ($50,000) or double the value of the fraud, or to undergo imprisonment for a period of not more than seven years, or both.

(b) A person who violates section 1103 shall be guilty of a misdemeanor of the first degree, and, upon conviction thereof, shall be sentenced to pay a fine of not more than twenty

thousand dollars ($20,000) or double the amount of the fraud, or both.

(c) A health care provider or lawyer who is guilty of an offense under section 1102 while acting on behalf of others shall be subject to disciplinary action, including suspension or revocation of a license or certificate or recommendation for suspension or disbarment to the Supreme Court, on the same basis as a health care provider or lawyer who is guilty of an offense under section 1103.

Section 1106. The court may, in addition to any other sentence authorized by law, sentence a person convicted of violating this section to make restitution under 18 Pa.C.S § 1106 (relating to restitution for injuries to person or property).

Section 1107. An insurer and any agent, servant or employe thereof acting in the course and scope of his employment shall be immune from civil or criminal liability arising from the supply or release of written or oral information to any entity duly authorized to receive such information by Federal or State law, or by Insurance Department regulations, only if the information is supplied to the agency in connection with an allegation of fraudulent conduct on the part of any person relating to a violation of this article and the insurer, agent, servant or employe has reason to believe that the information supplied is related to the allegation of fraud.

Section 1108. Nothing in this article shall be construed to prohibit any conduct by an attorney or law firm which is expressly permitted by the Rules of Professional Conduct of the Supreme Court, by statute or by regulation, or prohibit any conduct by a health care provider which is expressly permitted

by law or regulation.

Section 1109. (a) The district attorneys of the several counties shall have authority to investigate and to institute criminal proceedings for any violation of this article.

(b) In addition to the authority conferred upon the Attorney General by the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act," the Attorney General shall have the authority to investigate and to institute criminal proceedings for any violation of this section or any series of such violations involving more than one county of this Commonwealth or involving any county of this Commonwealth and another state. No person charged with a violation of this article by the Attorney General shall have standing to challenge the authority of the Attorney General to investigate or prosecute the case, and, if any such challenge is made, the challenge shall be dismissed and no relief shall be available in the courts of the Commonwealth to the person making the challenge.

Section 1110. Nothing contained in this article shall be construed to limit the regulatory or investigative authority of any department or agency of the Commonwealth whose functions might relate to persons, enterprises or matters falling within the scope of this article.

Section 1111. All fines and penalties imposed following a conviction for a violation of this article shall be collected in the manner provided by law and shall be paid in the following manner:

(1) If the prosecutor is a district attorney, the fines and penalties shall be paid into the operating fund of the county in which the district attorney is elected.

(2) If the prosecutor is the Attorney General, the fines and penalties shall be paid into the State Treasury.

ARTICLE XII

FRAUD ENFORCEMENT

Section 1201. The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Antifraud plan" means the insurance antifraud plan required to be filed and maintained pursuant to this article.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Department" means the Insurance Department of the Commonwealth.

Section 1202. (a) The department is authorized to refer to the appropriate law enforcement official violations of Article XI if the department has reason to believe that a person has engaged in or is engaging in an act or practice that violates Article XI.

(b) The department shall furnish all papers, documents, reports, complaints or other facts or evidence to any police, sheriff or other law enforcement agency or governmental entity duly authorized to receive such information, when so requested, and shall assist and cooperate with those agencies.

Section 1203. A workers' compensation insurer shall institute and maintain an insurance antifraud plan.

Section 1204. All workers' compensation insurers shall annually provide to the department a summary report on actions taken under an antifraud plan to prevent and combat insurance fraud, including, but not limited to, measures taken to protect and ensure the integrity of electronic data processing-generated

data and manually compiled data, statistical data on the amount of resources committed to combating fraud and the amount of fraud identified and recovered during the reporting period.

Section 1205. (a) Every workers' compensation insurer, and its employes, agents and brokers, are authorized to refer to the appropriate law enforcement official violations of Article XI if the insurer, employe, agent or broker has reason to believe that a person has engaged in or is engaging in an act or practice that violates Article XI.

(b) The insurer, its employes, agents and brokers, shall furnish all papers, documents, reports, complaints or other facts or evidence to any police, sheriff or other law enforcement agency or governmental entity duly authorized to receive such information, when so requested, and shall assist and cooperate with those agencies.

ARTICLE XIII

SMALL BUSINESS ADVOCATE

Section 1301. As used in this article:

"Department" means the Insurance Department of the Commonwealth.

Section 1302. In addition to his powers and duties under the act of December 21, 1988 (P.L.1871, No.181), known as the "Small Business Advocate Act," the small business advocate shall have standing to represent the interest of employers as a party in proceedings before the department or any court involving filings by rating organizations and insurers pursuant to Article VII of this act.

Section 1303. In addition to any other assessment authorized by section 446, an additional annual assessment shall be made on insurers, including the State Workmen's Insurance Fund but not

including self-insureds, as a percentage of the total compensation paid, for the purpose of funding the operations of the Office of Small Business Advocate pursuant to this act. Assessments under this section shall be made by the department and deposited into the Workmen's Compensation Administration Fund in a restricted account to be used by the Office of Small Business Advocate. The total amount assessed shall be the amount of the budget approved annually by the General Assembly for the operations of the Office of Small Business Advocate pursuant to this act.

Section 1304. Nothing contained in this article shall in any way limit the right of any person to bring a proceeding before either the department or a court.

Section 21. No later than December 31, 1993, the Secretary of Labor and Industry shall submit to the General Assembly an analysis of the average workload per workers' compensation judge and a plan to reduce the delays in deciding workers' compensation petitions, including any necessary increases in the number of judges and supporting staff.

Section 22. Notwithstanding any other provision of law to the contrary, regulations promulgated under the authority of section 306(f.1)(3)(ii) of the act, as amended by this act, shall not be subject to the provisions of the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act, or the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

Section 23. The Commonwealth, its political subdivisions, their officials and employees acting within the scope of their duties shall enjoy and benefit from sovereign and official immunity from claims of subrogation or reimbursement from a

claimant's tort recovery with respect to workers' compensation benefits.

Section 24. For purposes of the initial filing only, notwithstanding any other provisions of this act, the following provision shall apply:

(1) Each rating organization shall file, within 60 days after enactment of this act, a loss cost filing pursuant to section 709(c) of Article VII of the act for new and renewal policies for workers' compensation insurance to be effective on and after December 1, 1993. Such filing shall be subject to approval or disapproval by the Insurance Commissioner pursuant to Article VII of the act, but such approval or disapproval shall be made not later than 60 calendar days after first receipt of the loss cost filing.

(2) In the absence of an order approving or disapproving the loss cost filing within 60 calendar days of its first receipt, the filing shall be deemed to meet all the requirements of this act.

(3) No later than 30 days from the date of the actual or deemed approval of the above loss cost filing, each individual insurer shall file for the commissioner's approval or disapproval provisions for loss adjustment, or claim management expenses, other operating expenses, assessments, taxes and profit or contingency allowances for new and renewal policies to be effective on and after December 1, 1993, but such approval or disapproval shall be made not later than 30 days after the first receipt of the filing. The effective date of such filings shall be the date specified in the filing, but shall not be earlier than 30 days after the filing is received by the commissioner.

(4) In the absence of an order approving or disapproving any filing for loss adjustment, or claim management expenses, other operating expenses, assessments, taxes and profit or contingency allowances within 30 days of its first receipt, such filing shall be deemed to meet all the requirements of this act.

(5) No later than the approval date of the loss cost filing, the commissioner shall publish an aggregate factor reflecting the experience of stock insurance companies and including the effect of applicable premium discount programs, for loss adjustment, or claim management expenses, other operating expenses, assessments, taxes and profit or contingency allowances which all insurers may use in the foregoing initial filings. Any insurer filing which uses an aggregate factor not in excess of the appropriate foregoing factor shall be deemed approved upon filing for purposes of this section.

(6) Subsequent to the approval of rates pursuant to paragraphs (1) through (5), no loss cost filing or filings for loss adjustment, or claim management expenses, other operating expenses, assessments, taxes and profit or contingency allowances shall be made prior to December 1, 1994, except as the commissioner deems necessary in extraordinary circumstances.

Section 25. (a) The following act and parts of acts are repealed to the extent specified:

Section 654 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, except with regard to insurance as to liability under the Longshore and Harbor Workers' Compensation Act (44 Stat. 1424, 23 U.S.C. § 901 et

seq.).

75 Pa.C.S. §§ 1735 and 1737, absolutely.

(b) The provisions of 75 Pa.C.S. §§ 1720 and 1722 are repealed insofar as they relate to workers' compensation payments or other benefits under the Workers' Compensation Act.

(c) All other acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 26. No changes in indemnity compensation payable by this act shall affect payments of indemnity compensation for injuries sustained prior to the effective date of this section.

Section 27. This act shall take effect as follows:

(1) The addition of Article VII of the act shall take effect immediately.

(2) The addition of Articles VIII and IX of the act shall take effect in 120 days.

(3) Sections 24 and 25(a) of this act shall take effect immediately.

(4) This section shall take immediately.

(5) The remainder of this act shall take effect in 60 days.