Legislative Activity Report

National Council on Compensation Insurance

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LEGISLATIVE ACTIVITY—LEGISLATIVE SESSION UPDATES

This report contains descriptions and/or excerpts of relevant bills that have passed the first chamber, passed the second chamber, or have been enacted during the specific periods. In addition, a recap of significant legislative and judicial activity impacting the workers compensation system will be included in the first report published each month. This report is issued on a weekly basis throughout the legislative season, and it provides updates on the content of these bills if and when they progress through the legislative process. This report includes bills from states where NCCI provides ratemaking services (see state list under Contact Information) and the US Congress.

BILLS ENACTED

The following bills were enacted within the one-week period ending April 17, 2015.

Arkansas

SB 956 was:

- Passed by the first chamber on March 25, 2015
- Passed by the second chamber on April 1, 2015
- Enacted and effective on April 7, 2015

SB 956 adds an additional subchapter to the Arkansas Code as follows:

Subchapter 9—Arkansas Healthcare Transparency Initiative Act of 2015

23-61-901. Title.

This subchapter shall be known and may be cited as the "Arkansas Healthcare Transparency Initiative Act of 2015".

23-61-902. Legislative intent and purpose.

(a) It is the intent of the General Assembly to create and maintain an informative source of healthcare information to support consumers, researchers, and policymakers in healthcare decisions within the state.

(b) The purpose of this subchapter is to:

(1) Empower Arkansans to drive, deliver, and seek out value in the healthcare system;

(2) Create the Arkansas Healthcare Transparency Initiative;

(3) Establish governance of the Arkansas Healthcare Transparency Initiative;

(4) Provide authority to collect healthcare information from insurance carriers and other entities; and

(5) Establish appropriate methods for collecting, maintaining, and reporting healthcare information, including privacy and security safeguards.

23-61-903. Definitions.

As used in this subchapter:

(1) "Arkansas Healthcare Transparency Initiative" means an initiative to create a database, including ongoing all-payer claims database projects funded through the State Insurance Department, that receives and stores data from a submitting entity relating to medical, dental, and pharmaceutical and other insurance claims information, unique identifiers, and geographic and demographic information for covered individuals as permitted in this subchapter, and provider files, for the purposes of this subchapter;

(2) "Arkansas resident" means an individual for whom the submitting entity has identified an Arkansas address as the individual's primary place of residence;

(3) "Claims data" means information included in an institutional, professional, or pharmacy claim or equivalent information transaction for a covered individual, including the amount paid to a provider of healthcare services plus any amount owed by the covered individual;

(4) "Covered individual" means a natural person who is an Arkansas resident and is eligible to receive medical, dental, or pharmaceutical benefits under any policy, contract, certificate, evidence of coverage, rider, binder, or endorsement that provides for or describes coverage;
(5)(A) "Direct personal identifiers" means information relating to a covered individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.
(B) "Direct personal identifiers" does not include geographic or demographic information that would not allow the identification of a covered individual;
(6) "Enrollment data" means demographic information and other identifying information relating to covered individuals, including direct personal identifiers;
(7) "Protected health information" means health information as protected by the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as it existed on January 1, 2015;
(8) "Provider" means an individual or entity licensed by the state to provide healthcare services;
(9)(A) "Submitting entity" means:
(i) An entity that provides health or dental insurance or a health or dental benefit plan in the state, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, or fraternal benefits society, provided that the entity has covered individuals and the entity had at least two thousand (2,000) covered individuals in the previous calendar year;
(ii) A health benefit plan offered or administered by or on behalf of the state or an agency or instrumentality of the state;
(iii) A health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government;
(iv) The Workers' Compensation Commission;
(v) Any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, a third-party administrator, or a pharmacy benefits manager, provided that the entity has covered individuals and the entity had at least two thousand (2,000) covered individuals in the previous calendar year;
(vi) A health benefit plan subject to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as permitted by federal law, provided that the health benefit plan does not include an employee welfare benefit plan, as defined by federal law, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the Labor Management Relations Act of 1947, 29 U.S.C. §§ 401 — 531; and
(vii) An entity that contracts with institutions of the Department of Correction or Department of Community Correction to provide medical, dental, or pharmaceutical care to inmates.
(B) "Submitting entity" does not include an entity that provides health insurance or a health benefit plan that is accident-only, specified disease, hospital indemnity, long-term care, disability income, or other supplemental benefit coverage; and
(10) "Unique identifier" means any identifier that is guaranteed to be unique among all identifiers for covered individuals but does not include direct personal identifiers.

23-61-904. Arkansas Healthcare Transparency Initiative.
(a) The Arkansas Healthcare Transparency Initiative is established with the purpose to create a database, including ongoing all-payer claims database projects funded through the State Insurance Department, that receives and stores data from a submitting entity relating to medical, dental, and pharmaceutical and other insurance claims information, unique identifiers, and geographic and demographic information for covered individuals as permitted in this subchapter, and provider files, for the purposes of this subchapter.
(b) The Arkansas Healthcare Transparency Initiative shall be governed by the State Insurance Department and advised by the Arkansas Healthcare Transparency Initiative Board.

23-61-905. Arkansas Healthcare Transparency Initiative Board—Membership—Duties.
(a)(1) There is created the Arkansas Healthcare Transparency Initiative Board, which shall be composed of the following members:
(A) A representative of the Department of Human Services;
(B) A representative of the Department of Health;
(C) A representative of the Office of Health Information Technology or its successor entity as provided by state law;
(D) The Surgeon General; and
(E) Nine (9) members appointed by the Governor as follows:
(i) Two (2) representatives from the health insurance industry, one (1) of whom shall be a multistate representative and one (1) of whom shall be a domestic representative;
(ii) Two (2) representatives from the healthcare provider community;
(iii) A representative from a self-insured employer;
(iv) A representative from an employer of fewer than one hundred (100) full-time employees that provides healthcare coverage to employees through a fully-insured product;
(v) A representative from a healthcare consumer organization;
(vi) A representative from the academic research community with expertise in healthcare claims data analysis; and
(vii) A representative with expertise in health data privacy and security.
(2) A Governor-appointed member of the board in subdivision (b)(1)(E) of this section shall serve for a term of three (3) years.

(3) The board shall appoint one (1) member as a chair and determine the qualifications, duties, and the term of office of the chair.
(4) Seven (7) members present constitutes a quorum.
(5) The Arkansas Healthcare Transparency Initiative Board shall hold its first meeting no later than July 1, 2015.
(b) The State Insurance Department shall:
(A) Have the authority to:
(i) Collect, validate, analyze, and present health data including claims data;
(ii) Assess penalties for noncompliance with this subchapter; and
(iii) Establish and convene additional subcommittees to carry out the purposes of this subchapter;
(B) Designate the Arkansas Center for Health Improvement as the administrator of the Arkansas Healthcare Transparency Initiative, which shall be responsible for development and implementation of a sustainability plan subject to data use and disclosure requirements of this subchapter and any rules promulgated under this subchapter;
(C) With the assistance of the administrator of the Arkansas Healthcare Transparency Initiative, establish and convene the following subcommittees:
(i) The Data Oversight Subcommittee of the Arkansas Healthcare Transparency Initiative, which shall:
(a) Consist of:
(1) Three (3) Governor-appointed board members; and
(2) One (1) individual healthcare consumer; and
(b) Review and make recommendations to the State Insurance Department regarding:
(1) Data requests for consistency with the intent and purpose of this subchapter, including whether the data request contains the minimum required information; and
(2) Reports and publications generated from data requests to ensure compliance with this subchapter;
(ii) The Scientific Advisory Subcommittee of the Arkansas Healthcare Transparency Initiative, which shall:
(a) Consist of:
(1) The Governor-appointed member of the board from the academic research community; and
(2) Two (2) nonmembers of the board who are academic researchers; and
(b) Serve as peer review for academic researchers and provide advice regarding data requests for academic proposals and the scientific rigor of analytic work; and
(D) Adopt any rules necessary to implement this subchapter under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.
(c) In consultation with the board, the State Insurance Department shall exercise its powers and duties under this subchapter to:
(1) Establish policies and procedures necessary for the administration and oversight of the Arkansas Healthcare Transparency Initiative, including procedures for the collection, processing, storage, analysis, use, and release of data;
(2) Identify and explore the key healthcare issues, questions, and problems that may be improved through more transparent information, including without limitation data required to be disclosed to patients related to provider relationships or affiliations with payers and providers, financial interests in healthcare businesses, and payments or items of any value given to providers from pharmaceutical or medical device manufacturers or agents thereof; and
(3) Provide a biennial report to the General Assembly on the operations of the Arkansas Healthcare Transparency Initiative.

23-61-906. Data submission.
(a) Except as provided in subsection (d) of this section, no later than January 1, 2016, and every quarter thereafter, a submitting entity shall submit health and dental claims data, unique identifiers, and geographic and demographic information for covered individuals as permitted in this subchapter, and provider files to the Arkansas Healthcare Transparency Initiative in accordance with standards and procedures adopted by the State Insurance Department.
(b) Data submitted under this subchapter shall be treated as confidential and are exempt from disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq., and are not subject to subpoena, except to the extent provided in § 23-61-205.
(c) The collection, storage, and release of data and other information under this section is subject to applicable state and federal data privacy and security law.
(d) No later than July 1, 2015, a submitting entity shall submit health and dental claims data, unique identifiers, and geographic and demographic information for covered individuals as permitted in this subchapter to the Arkansas Healthcare Transparency Initiative to support deliberations of the Arkansas Health Reform Legislative Task Force.

23-61-907. Data release.
(a) Data in the Arkansas Healthcare Transparency Initiative shall:
(1) To the extent authorized by the State Insurance Department, be available:
(A) When disclosed in a form and manner that ensures the privacy and security of protected health information as required by state and federal laws, as a resource to insurers, employers, purchasers of health care, researchers, state agencies, and healthcare providers to allow for assessment of healthcare utilization, expenditures, and performance in this state, including without limitation as a resource for hospital community health needs assessments; and
(B) To state programs regarding healthcare quality and costs for use in improving health care in the state, subject to rules prescribed by the State Insurance Department conforming to state and federal privacy laws or limiting access to limited-use data sets; and
(2) Not be used to:
(A) Disclose trade secrets of submitting entities;

(B) Reidentify or attempt to reidentify an individual who is the subject of any submitted data without obtaining the individual's consent; or
(C) Create or augment data contained in a national claims database.
(b) Notwithstanding Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, or any other provision of law, the Arkansas Healthcare Transparency Initiative shall not publicly disclose any data that contains direct personal identifiers.
23-61-908. Penalties for failure to submit data.
(a) Except for state or federal agencies that are submitting entities, a submitting entity that fails to submit data as required by this subchapter or the rules of the State Insurance Department may be subject to a penalty.
(b) The department shall adopt a schedule of penalties not to exceed one thousand dollars ($1,000) per day of violation, determined by the severity of the violation.
(c) A penalty imposed under this section may be remitted or mitigated upon such terms and conditions as the department considers proper and consistent with the public health and safety.
(d) A penalty remitted under this section shall be used for Arkansas Healthcare Transparency Initiative operations.

SB 956 also adds ***section 19-5-1142. Arkansas Healthcare Transparency Initiative Fun***d to read:
19-5-1142. Arkansas Healthcare Transparency Initiative Fund.
(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the Stat a trust fund to be known as the "Arkansas Healthcare Transparency Initiative Fund".
(b)(1) The fund shall be an interest-bearing account and may be invested in the manner permitted by law, with the interest income a proper credit to the fund and which shall not revert to general revenue, unless otherwise designated in law.
(2) The fund shall be overseen by the State Insurance Department, and shall be used to pay all proper costs incurred in implementing the provisions of the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq.
(c) The following moneys shall be paid into this fund:
(1) Penalties imposed on submitting entities pursuant to the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq. and rules promulgated under the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq.;
(2) Funds received from the federal government;
(3) Appropriations from the General Assembly; and
(4) All other payments, gifts, grants, bequests, or income from any source.
(d) Activities of the Arkansas Healthcare Transparency Initiative Board and the availability of data as authorized in § 23-61-905(c)(1) are contingent upon available funding.

In addition, **SB 956** includes the following clause:
Emergency clause. It is found and determined by the General Assembly of the State of Arkansas that there is a lack of available information to support the required evaluation of state programs and the deliberations of policymakers within the timeframe required by the Health Care Reform Act of 2015, and that there is an immediate need to collect data to support these activities so that policymakers may make more informed decisions about the cost-effectiveness of current programs and the future of the state's healthcare system. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:
(1) The date of its approval by the Governor;
(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or
(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

Note: SB 956 was not included in any previous version of NCCI's ***Legislative Activity Report.***

Arizona

SB 1290 was:
- Passed by the first chamber on February 19, 2015
- Passed by the second chamber on April 2, 2015
- Enacted on April 10, 2015, with an effective date of July 3, 2015

SB 1290 amends various sections of the Arizona Revised Statutes, related to independent medical examinations, to:
- Prohibit the filing of a complaint to a regulatory medical board for unprofessional conduct against podiatrists, medical doctors, or osteopathic physicians, if the complaint is based on a disagreement with the findings and opinions of an independent medical examination
- Stipulate that a complaint for unprofessional conduct may be filed, if the complaint is filed for reasons other than a disagreement of the findings or opinions of the examination
- Define independent medical examination
- Make technical and conforming changes

Note: SB 1290 was not included in any previous version of NCCI's ***Legislative Activity Report.***

Iowa

IA HF 259 was:

- Passed by the first chamber on March 10, 2015
- Included in NCCI's March 20, 2015 ***Legislative Activity Report*** (RLA-2015-11)
- Passed by the second chamber on April 7, 2015
- Included in NCCI's April 17, 2015 ***Legislative Activity Report*** (RLA-2015-15)
- Enacted on April 17, 2015, with an effective date of July 1, 2015

IA HF 259 amends ***section 87.22 Corporate officer exclusion from workers' compensation or employers' liability coverage.*** of the Code of Iowa to:

- Provide that the workers compensation commissioner shall maintain a list of corporate officers that reject workers compensation coverage or that terminate their rejection of the coverage. The list shall be a public record that is open to public inspection.
- Require a proprietor, limited liability company member or partner, or a partner, who does not elect workers' compensation coverage by purchasing valid coverage that specifically includes that person, to sign a nonelection of that coverage, which must be attached to the workers compensation or employer's liability policy or filed with the workers' compensation commissioner. The workers compensation commissioner is required to maintain a list of persons who do not elect such coverage or who terminate that nonelection of coverage. The list shall be a public record that is open to public inspection. The bill also provides a form for such a person to indicate that the person is not electing workers compensation coverage.
- Provide that when a corporate officer terminates a rejection of workers compensation coverage by filing a notice of termination with the workers compensation commissioner, the notice of termination restores the officer to the same status as if the rejection of coverage had not occurred, although the termination of rejection is not effective for any injury sustained, or disease incurred, less than one week after the notice is filed.
- Provide that a proprietor, limited liability company member or partner, or partner, may terminate a nonelection of workers' compensation coverage by filing a notice of termination with the workers compensation commissioner. The notice of termination restores that person to the same status as if the nonelection of coverage had not occurred and the person may elect to be covered by the workers compensation law of this state by purchasing valid workers compensation insurance specifically including that person, as provided in Code section 85.1A. However, the election of coverage shall not be effective for any injury sustained, or disease incurred, less than one week after the notice is filed.

Idaho

SB 1168 was:

- Passed by the first chamber on March 26, 2015
- Included in NCCI's April 3, 2015 ***Legislative Activity Report*** (RLA-2015-13)
- Passed by the second chamber on April 2, 2015
- Included in NCCI's April 10, 2015 ***Legislative Activity Report*** (RLA-2015-14)
- Enacted on April 10, 2015, with an effective date of July 1, 2015

SB 1168 amends ***section 72-523. Source of fund—premium tax*** of the Idaho Code as follows:

§72-523. Source of fund—premium tax. The state insurance fund, every authorized self-insurer and every surety authorized under the Idaho insurance code or by the director of the department of insurance to transact worker's compensation insurance in Idaho, in addition to all other payments required by statute, shall semiannually, within thirty (30) days after February 1 and July 1 of each year, pay into the state treasury to be deposited in the industrial administration fund a premium tax as follows:

(1) Commencing ~~July 1, 1993~~ January 1, 2016, every surety, other than self-insurers authorized to transact worker's compensation insurance, a sum equal to two ~~and one-half~~ percent (2~~.5~~%) of the net premiums written by each respectively on worker's compensation insurance in this state during the preceding six (6) months' period, but in no case less than seventy-five dollars ($75.00);

(2) Each self-insurer, a sum equal to two ~~and one-half~~ percent (2~~.5~~%) of the amount of premium such employer who is a self-insurer would be required to pay as premium to the state insurance fund, but in no case less than seventy-five dollars ($75.00);

(3) Notwithstanding the provisions of subsections (1) and (2) of this section, for the period January 1, 2012, through December 31, 2015:

(a) Every surety, other than self-insurers authorized to transact worker's compensation insurance, a sum equal to two percent (2%) of the net premiums written by each respectively on worker's compensation insurance in this state during the preceding six (6) months' period, but in no case less than seventy-five dollars ($75.00); and

(b) Each self-insurer, a sum equal to two percent (2%) of the amount of premium such employer who is a self-insurer would be required to pay as premium to the state insurance fund, but in no case less than seventy-five dollars ($75.00) .

(4) Any insurer making any payment into the industrial administration fund under the provisions of subsection (1) of this section or, during the period January 1, 2012, through December 31, 2015, any insurer making any payment into the industrial administration fund under the provisions of subsection (3) of this section, shall be entitled to deduct fifty percent (50%) of the premium tax paid pursuant to this section from any sum that it is required to pay into the department of insurance as a tax on worker's compensation premiums.

(5) In arriving at net premiums written, dividends paid, declared or payable shall not be deducted.
(6) For the purposes of this section and section 72-524, Idaho Code, net premiums written shall mean the amount of gross direct premiums written, less returned premiums and premiums on policies not taken.

Maryland

HB 358 was:

- Passed by the first chamber on March 12, 2015
- Included in NCCI's March 20, 2015 ***Legislative Activity Report*** (RLA-2015-11)
- Passed by the second chamber on April 3, 2015
- Included in NCCI's April 10, 2015 ***Legislative Activity Report*** (RLA-2015-14)
- Enacted on April 14, 2015, with an effective date of January 1, 2016

HB 358 amends ***section 19-406, Cancellations by insurer*** of the Insurance Code of the Annotated Code of Maryland as follows:
§ 19-406. Cancellations by insurer
(a) Except for a cancellation for nonpayment of premium, an insurer may not cancel or refuse to renew a workers' compensation insurance policy before its expiration unless, at least ~~30~~ 45 days before the date of cancellation or nonrenewal, the insurer:
…

SB 465 was:

- Passed by the first chamber on March 17, 2015
- Included in NCCI's March 27, 2015 ***Legislative Activity Report*** (RLA-2015-12)
- Passed by the second chamber on April 2, 2015
- Included in NCCI's April 10, 2015 ***Legislative Activity Report*** (RLA-2015-14)
- Enacted on April 14, 2015, with various effective dates

SB 465 amends various sections of the Insurance Code of the Annotated Code of Maryland, in part, to:

- Subject the Chesapeake Employers' Insurance Company (Chesapeake) to Title 11 of the Insurance Article, which requires workers compensation insurers in the state to join a rating organization
- Require the rating organization to:
  - Provide annual reports to specified committees of the General Assembly concerning the status of Chesapeake joining the rating organization
  - Create a classification code for governmental occupations that are not already included in police, firefighter, and clerical classifications
- Authorize Chesapeake to own a subsidiary under specified conditions
- Alter the selection process for Chesapeake board members

Note: SB 465 is identical to **HB 468**, which passed the second chamber on April 3, 2015.

Tennessee

SB 80 was:

- Passed by the first chamber on March 16, 2015
- Included in NCCI's March 27, 2015 ***Legislative Activity Report*** (RLA-2015-12)
- Passed by the second chamber on April 1, 2015
- Included in NCCI's April 10, 2015 ***Legislative Activity Report*** (RLA-2015-14)
- Enacted and effective on April 17, 2015

SB 80 amends ***Title 56*** of the Tennessee Code Annotated, relative to captive insurance companies, in part, to authorize the Commissioner of Commerce and Insurance to:

- Approve a rating service plan submitted by a licensed captive insurance company for the purpose of providing workers compensation coverage
- Waive certain self-insurance requirements of captives offering workers compensation coverage

United States

H.R. 2 was:

- Passed by the first chamber on March 26, 2015
- Included in NCCI's April 17, 2015 ***Legislative Activity Report*** (RLA-2015-15)
- Passed by the second chamber on April 14, 2015
- Enacted on April 16, 2015 with various effective dates

H.R. 2, in part, amends ***title XVIII*** (Medicare) of the Social Security Act to:

- Remove sustainable growth rate (SGR) methodology from the determination of annual conversion factors in the formula for payment for physicians' services

- Revise the update in rates for 2015 and subsequent years

Note: Many states base their workers compensation medical fee schedules on the Medicare physician reimbursement schedule.

BILLS PASSING SECOND CHAMBER

The following bills passed the second chamber within the one-week period ending April 17, 2015.

Hawaii

HB 1268 HD 2 SD 2 was:

- Passed by the first chamber on March 10, 2015
- Included in NCCI's March 20, 2015 ***Legislative Activity Report*** (RLA-2015-11)
- Amended and passed by the second chamber on April 14, 2015

HB 1268 HD 2 SD 2, in part, amends ***section 386-25. Vocational Rehabilitation*** of the Hawaii Revised Statues as follows:

§ 386-25. Vocational rehabilitation.

(a) The purposes of vocational rehabilitation are to restore an injured worker's earnings capacity as nearly as possible to that level that the worker was earning at the time of injury and to return the injured worker to suitable gainful employment in the active labor force as quickly as possible in a cost-effective manner. Vocational rehabilitation shall not be available for public employees who have retired from a public employer, as defined in section 76-11, with whom they sustained their work injury.

Employees of public employers, as defined in section 76-11, who are eligible for their respective public employer's return to work program, shall participate in and complete the return to work program, including temporary light duty placement efforts, as a prerequisite to vocational rehabilitation benefits under this section.

…

In addition, **HB 1268 HD 2 SD 2** includes the following clause:

This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SB 675 SD 2 HD 3 was:

- Passed by the first chamber on March 10, 2015
- Included in NCCI's March 20, 2015 ***Legislative Activity Report*** (RLA-2015-11)
- Amended and passed by the second chamber on April 14, 2015

SB 675 SD 2 HD 3, in part, adds new ***section 386—Injuries covered; firefighters.*** to the Hawaii Revised Statutes to read:

§ 386—Injuries covered; firefighters.

(a) In addition to the injuries covered pursuant to section 386-3, if a firefighter develops cancer, a blood-borne infectious disease, or develops methicillin-resistant staphylococcus aureus skin infection, it shall be presumed to arise out of and in the course of employment. The additional benefits shall include one-hundred per cent average weekly wages, disability indemnity, and death benefits as paid for by the employer through workers' compensation benefits.

(b) The presumption under subsection (a) is rebuttable only by a finding of substantial evidence to the contrary.

(c) If the firefighter's treating physician refers the firefighter to a consultation with a medical specialist, if within a month of the referral, the firefighter is unable to obtain an appointment for consultation, then the employer shall pay for a comparable consultation with a medical specialist, even if the medical specialist does not accept workers' compensation insurance.

(d) For the purposes of this section, "firefighters" shall have the same meaning as defined in section 88-21.

SB 1174 SD 2 HD 2 was:

- Passed by the first chamber on March 10, 2015
- Included in NCCI's March 20, 2015 ***Legislative Activity Report*** (RLA-2015-11)
- Amended and passed by the second chamber on April 14, 2015

SB 1174 SD 2 HD 2 amends ***section 386-79 Medical examination by employer's physician.*** of the Hawaii Revised Statutes as follows:

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

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

~~In cases where the employer is dissatisfied with the progress of the case or where major and elective surgery, or either, is~~

~~contemplated, the employer may appoint a physician or surgeon of the employer's choice who shall examine the injured employee and make a report to the employer. If the employer remains dissatisfied, this report may be forwarded to the director.~~
~~Employer requested examinations under this section shall not exceed more than one per case unless good and valid reasons exist with regard to the medical progress of the employee's treatment. The cost of conducting the ordered medical examination shall be limited to the complex consultation charges governed by the medical fee schedule established pursuant to section 386-21(c).~~
(a) Following an injury and after a claim is filed by the injured employee, the employer may appoint a qualified physician mutually agreed upon by the parties and paid for by the employer, to conduct an independent medical examination or a permanent impairment rating examination of the injured employee and make a report to the employer.
(b) The cover letter to the physician selected to perform an examination under this section shall notify the physician that the physician has been mutually selected by the parties to conduct an independent examination. The cover letter shall be transmitted to the injured employee at least five working days prior to the appointment. Upon the issuance of the report of the independent medical examination or permanent impairment rating examination, the employee or employee's representative shall be promptly provided with a copy thereof. (c) A physician selected pursuant to this section to perform an independent medical examination or a permanent impairment rating examination shall be willing to undertake the examination and be paid by the employer. The selected physician shall be currently licensed to practice in Hawaii pursuant to chapter 442 or 453; except that upon approval by the director, a physician in a specialty area who resides outside of the State and is licensed in another state as a physician with requirements equivalent to a physician's license under chapter 442 or 453, may be selected if no physician licensed by the State in that specialty area is available to conduct the examination.
If the employee does not reside in Hawaii, a physician who is licensed in and who resides in the state of the employee's residence may be selected if that state's physician licensing requirements are equivalent to a physician's license under chapter 442 or 453.
If the parties are unable to reach a mutual agreement on the selection of a physician to conduct the independent medical examination or permanent impairment rating examination, the parties shall prepare a list of five physicians qualified to do the examination. The employer shall appoint the first physician, the employee shall appoint the second physician, and the process shall continue by alternating appointments until there is a list of five physicians. The parties shall then alternate striking physicians from the list with the employee striking the first physician. The process shall continue until there is a single physician remaining on the list and that physician shall conduct the examination.
Any physician mutually selected or otherwise appointed to do an independent medical examination or permanent impairment rating examination pursuant to this section shall examine the employee within forty-five days of receiving notice of the selection or appointment, or otherwise, as soon as possible.
(d) In no event shall an independent medical examination and a permanent impairment rating examination be combined into a single medical examination unless the employee consents in writing to the single examination by the selected physician.
In no event shall the director, appellate board, or a court order more than one requested independent medical examination and one permanent impairment rating examination per case, unless valid reason exists with regard to the medical progress of the employee's medical treatment or when major surgery and elective surgery, or either, is contemplated. In the event of multiple examinations, the process of mutually selecting or otherwise appointing a physician set forth in this section shall apply.
(e) If an employee refuses to submit to, or unreasonably interferes with the examination, the employee's right to claim compensation for the work injury shall be suspended until the refusal or interference ceases. No compensation shall be payable to the employee for the period of suspension.
The cost of conducting the ordered independent medical examination or permanent impairment rating exam shall be limited to the complex consultation charges governed by the medical fee schedule established pursuant to section 386-21(c).
(f) When an employee has attained medical stability as determined by the employee's attending physician, a physician may be appointed to conduct a permanent impairment rating examination. The physician shall be mutually selected by the parties or otherwise appointed pursuant to this section.
For the purposes of this subsection, "medical stability" means that no further improvement of the employee's work-related condition can reasonably be anticipated from curative health care or the passage of time.

In addition, **SB 1174 SD 2 HD 2** includes the following clause:
This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

Indiana

HB 1019 was:

- Passed by the first chamber on February 23, 2015
- Amended and passed by the second chamber on April 15, 2015

HB 1019, in part, adds new ***section 35-43-5-21*** to the Indiana Code as follows:
Sec. 21. (a) A person who, with intent to avoid the obligation to obtain worker's compensation coverage as required by IC 22-3-5-1 and IC 22-3-7-34, falsely classifies an employee as one (1) of the following commits worker's compensation fraud:
(1) An independent contractor.
(2) A sole proprietor.
(3) An owner.

(4) A partner.
(5) An officer.
(6) A member in a limited liability company.
(b) The offense described in subsection (a) is a Class A misdemeanor.

Note: The version of **HB 1019** that was passed by the House did not contain any relevant workers compensation-related language; therefore, it was not included in any previous version of NCCI's ***Legislative Activity Report.***

Maryland

SB 331 was:

- Passed by the first chamber on March 24, 2015
- Included in NCCI's April 3, 2015 ***Legislative Activity Report*** (RLA-2015-13)
- Passed by the second chamber on April 13, 2015

SB 331, in part, adds new ***subsection 9-628(a)(9)*** to the Labor and Employment Code of the Annotated Code of Maryland, related to permanent partial disability benefits, as follows:

§ 9-628. Compensation for less than 75 weeks.

(a) In this section, "public safety employee" means:

…

(9) a Baltimore County deputy sheriff, but only when the deputy sheriff sustains an accidental personal injury that arises out of and in the course and scope of performing duties directly related to:
(i) courthouse security;
(ii) prisoner transportation;
(iii) service of warrants;
(iv) personnel management; or
(v) other administrative duties.

…

Montana

SB 288 was:

- Passed by the first chamber on February 21, 2015
- Included in NCCI's March 6, 2015 ***Legislative Activity Report*** (RLA-2015-09)
- Passed by the second chamber on April 13, 2015

SB 288, in part, amends ***section 39-71-414. Subrogation*** of the Montana Code Annotated as follows:

39-71-414. Subrogation.

(1) If an action is prosecuted as provided for in 39-71-412 or 39-71-413 and except as otherwise provided in this section, the insurer is entitled to subrogation for all compensation and benefits paid or to be paid under the Workers' Compensation Act. The insurer's right of subrogation is a first lien on the claim, judgment, or recovery.

…

(6) (a) ~~The~~ For all medical benefits paid, regardless of whether the claimant is able to demonstrate damages in excess of the workers' compensation benefits and third-party recovery combined, the insurer is entitled to full subrogation rights under this section~~,~~ . For all nonmedical compensation and benefits, the insurer is entitled to full subrogation rights under this section unless the claimant is able to demonstrate damages in excess of the workers' compensation benefits and the third-party recovery combined. If the insurer is entitled to subrogation under this section, the insurer may subrogate against the entire settlement or award of a third-party claim brought by the claimant or the claimant's personal representative without regard to the nature of the damages.

…

SB 288 also states as follows:

WHEREAS, subrogation is a device of equity "designed to compel the ultimate payment of a debt by the one who in justice, equity and good conscience should pay it", as noted in Skauge v. Mountain States Telephone and Telegraph Co. and Montana-Dakota Utilities Co., 172 Mont. 521, 524, 565 P.2d 628, 630 (1977); and

WHEREAS, in Zacher v. American Insurance Co., 243 Mont. 226, 794 P.2d 335 (1990) and Francetich v. State Compensation Mutual Insurance Fund, 252 Mont. 215, 827 P.2d 1279 (1992), the Montana Supreme Court held that a workers' compensation insurer or self-insurer has no subrogation interest in proceeds from a third-party action allowed pursuant to 39-71-412 and 39-71-413, MCA, until the claimant has been "made whole" for the claimant's entire loss; and

WHEREAS, the "made whole" analysis includes wage loss, loss of earning capacity, loss of fringe benefits, pensions, pain and suffering, and related damages as well as past and future medical costs, meaning that workers' compensation insurers, including self-insurers, are effectively precluded from exercising a subrogation interest in the proceeds of the third-party action; and

WHEREAS, in Zacher and in State Compensation Insurance Fund v. McMillan, 2001 MT 168, 306 Mont. 155, 31 P.3d 347, the Montana Supreme Court held that the "made whole doctrine" is not dependent upon a right of recovery of full legal redress under Article II, Section 16, of the Montana Constitution; and

WHEREAS, in Ridley v. Guaranty National Insurance Co., 286 Mont. 325, 951 P.2d 987 (1997), the Montana Supreme Court held that under the Unfair Trade Practices Act, an insurer has a duty to pay medical expenses (prior to final settlement) for an injured third party when liability is reasonably clear; and
WHEREAS, it is the intent of the Legislature to clearly articulate that for all medical benefits paid by the insurer, the "made whole doctrine" is not to be applied or considered in determining whether an insurer or self-insurer has a subrogation right in a third-party action as allowed for by 39-71-412 and 39-71-413, MCA.

NCCI estimates that Montana SB 288, as introduced on February 7, 2015, if enacted, would likely result in a decrease in workers compensation system costs in Montana, although the magnitude of the impact is uncertain. The magnitude of the decrease, if any, would depend on insurer recoveries on the medical portion of benefits paid.
SB 288 may have a retroactive impact because it may apply to outstanding cases regardless of the injury date. Such a retroactive application may result in medical loss recoveries that were not contemplated in the premiums charged for policies written prior to the effective date of the proposed change.

SB 347 was:

- Passed by the first chamber on February 26, 2015
- Included in NCCI's March 20, 2015 ***Legislative Activity Report*** (RLA-2015-11)
- Passed by the second chamber on April 11, 2015

SB 347 amends ***section 39-71-118 Employee, worker, volunteer, volunteer firefighter, and volunteer emergency medical technician defined.*** Of the Montana Code Annotated 2014 as follows:
39-71-118. Employee, worker, volunteer, volunteer firefighter, and volunteer emergency medical technician defined.
(1) As used in this chapter, the term "employee" or "worker" means:
…
(g) a volunteer firefighter as described in 7-33-4109 or a person who provides ambulance services under Title 7, chapter 34, part 1;
…
(3) With the approval of the insurer, an employer may elect to include as an employee under the provisions of this chapter a volunteer as defined in subsection (2)(b)~~, a volunteer emergency medical technician as defined in subsection (10),~~ or a volunteer firefighter as defined in 7-33-4510. ~~An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county may elect to include as an employee under the provisions of this chapter a volunteer emergency medical technician.~~
…
(10) (a) ~~With the approval of the insurer, an~~ An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county may elect to include as an employee within the provisions of this chapter a volunteer emergency medical technician who serves public safety through the ambulance service not otherwise covered by subsection (1)(g) or the paid or volunteer nontransporting medical unit. The ambulance service or nontransporting medical unit may purchase workers' compensation coverage from any entity authorized to provide workers' compensation coverage under plan No. 1, 2, or 3 as provided in this chapter.
(b) ~~In the event of~~ If there is an election under subsection (10)(a), the employer shall report payroll for all volunteer emergency medical technicians for premium and weekly benefit purposes based on the number of volunteer hours of each emergency medical technician, but no more than 60 hours, times the state's average weekly wage divided by 40 hours.
…

BILLS PASSING FIRST CHAMBER

The following bills passed the first chamber within the one-week period ending April 17, 2015.

Alaska

SB 58, in part, amends ***section 23.30.230. Persons not covered*** of the Alaska Workers' Compensation Act as follows:
Sec. 23.30.230. Persons not covered
(a) The following persons are not covered by this chapter:
…
(11) a person who operates a horse carriage service; and
(12) a transportation network company driver who provides a prearranged ride or is otherwise logged onto the digital network of a transportation network company as a driver.
…

Illinois

SB 1571 amends ***section 410 ILCS 130/40*** of the Illinois Compiled Statutes Annotated as follows:
§ 410 ILCS 130/40. (Section scheduled to be repealed on January 1, 2018) Discrimination prohibited
Sec. 40. (a)(1) No school, employer, or landlord may refuse to enroll or lease to, or otherwise penalize, a person solely for his or her status as a registered qualifying patient or a registered designated caregiver, unless failing to do so would put the school, employer, or landlord in violation of federal law or unless failing to do so would cause it to lose a monetary or licensing-related benefit under

federal law or rules. This does not prevent a landlord from prohibiting the smoking of cannabis on the premises.
(2) For the purposes of medical care, including organ transplants, a registered qualifying patient's authorized use of cannabis in accordance with this Act is considered the equivalent of the authorized use of any other medication used at the direction of a physician, and may not constitute the use of an illicit substance or otherwise disqualify a qualifying patient from needed medical care.
(b) A person otherwise entitled to custody of or visitation or parenting time with a minor may not be denied that right, and there is no presumption of neglect or child endangerment, for conduct allowed under this Act, unless the person's actions in relation to cannabis were such that they created an unreasonable danger to the safety of the minor as established by clear and convincing evidence.
(c) No school, landlord, or employer may be penalized or denied any benefit under State law for enrolling, leasing to, or employing a cardholder.
(d) Nothing in this Act may be construed to require a government medical assistance program, employer, property and casualty insurer, or private health insurer to reimburse a person for costs associated with the medical use of cannabis.
(e) Nothing in this Act may be construed to require any person or establishment in lawful possession of property to allow a guest, client, customer, or visitor who is a registered qualifying patient to use cannabis on or in that property.

SB 1781 amends ***section 215/ILCS 5/537.2*** of the Illinois Compiled Statutes Annotated as follows:

§ 215 ILCS 5/537.2 Obligation of Fund

Fund shall be obligated to the extent of the covered claims existing prior to the entry of an Order of Liquidation against an insolvent company and arising within 30 days after the entry of such Order, or before the policy expiration date if less than 30 days after the entry of such Order, or before the insured replaces the policy or on request effects cancellation, if he does so within 30 days after the entry of such Order. If the entry of an Order of Liquidation occurs on or after October 1, 1975 and before October 1, 1977, such obligations shall not: (i) exceed $100,000, or (ii) include any obligation to refund the first $100 of any unearned premium claim; and if the entry of an Order of Liquidation occurs on or after October 1, 1977 and before January 1, 1988, such obligations shall not: (i) exceed $150,000, except that this limitation shall not apply to any workers compensation claims, or (ii) include any obligation to refund the first $100 of any unearned premium claim; and if the entry of an Order of Liquidation occurs on or after January 1, 1988 and before January 1, 2011, such obligations shall not: (i) exceed $300,000, except that this limitation shall not apply to any workers compensation claims, or (ii) include any obligation to refund the first $100 of any unearned premium claim or to refund any unearned premium over $10,000 under any one policy. If the entry of an Order of Liquidation occurs on or after January 1, 2011, then such obligations shall not:
(i) exceed $500,000, except that this limitation shall not apply to any workers compensation claims or (ii) include any obligation to refund the first $100 of any unearned premium claim or refund any unearned premium over $10,000 under any one policy. In no event shall the Fund be obligated to a policyholder or claimant in an amount in excess of the face amount of the policy from which the claim arises. For purposes of this Act, obligations arising under an insurance policy written to indemnify a permissibly self-insured employer under subsection (a) of Section 4 of the Workers' Compensation Act for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention shall be subject to the applicable per-claim limits set forth in this Section.
In no event shall the Fund be liable for any interest on any judgment entered against the insured or the insolvent company, or for any other interest claim against the insured or the insolvent company, regardless of whether the insolvent company would have been obligated to pay such interest under the terms of its policy. The Fund shall be liable for interest at the statutory rate on money judgments entered against the Fund until the judgment is satisfied.
Any obligation of the Fund to defend an insured shall cease upon the Fund's payment or tender of an amount equal to the lesser of the Fund's covered claim obligation limit or the applicable policy limit.

SB 1782 amends ***sections 215 ILCS 5/537.4*** and ***215 ILCS 5/546*** of the Illinois Compiled Statutes Annotated as follows:

§ 215 ILCS 5/537.4 Fund assumes obligations of insolvent companies.

The Fund shall be deemed the insolvent company to the extent of the Fund's obligation for covered claims and to such extent shall have all rights, duties, and obligations of the insolvent company, subject to the limitations provided in this Article, as if the company had not become insolvent, with the exception that the liquidator shall retain the sole right to recover any reinsurance proceeds. The Fund's rights under this Section include, but are not limited to, the right to pursue and retain salvage and subrogation recoveries on paid covered claim obligations to the extent paid by the Fund. The extent of the Fund's subrogation rights and any other rights of reimbursement with respect to its covered claims payments shall not be limited as if the Fund were the insolvent company, but shall be determined independently by taking into account the Fund's rights under Section 546 of this Article.

§ 215 ILCS 5/546 Other insurance.

(a) An insured or claimant shall be required first to exhaust all coverage provided by any other insurance policy, regardless of whether or not such other insurance policy was written by a member company, if the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the Fund. The Fund's obligation under Section 537.2 shall be reduced by the amount recovered or recoverable, whichever is greater, under such other insurance policy. Where such other insurance policy provides uninsured or underinsured motorist coverage, the amount recoverable shall be deemed to be the full applicable limits of such coverage. To the extent that the Fund's obligation under Section 537.2 is reduced by application of this Section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount. If the Fund pays a covered claim without the exhaustion of all other coverage that could have been exhausted under this Section, the Fund shall have an independent right of recovery against each insurer whose coverage was not exhausted in the amount the Fund would not have had to pay if that insurer's coverage had been exhausted first.

(b) Any insured or claimant having a claim which may be recovered under more than one insurance guaranty fund or its equivalent shall seek recovery first from the Fund of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he shall first seek recovery from the Fund of the location of the property; if it is a workers' compensation claim, he shall first seek recovery from the Fund of the residence of the claimant. Any recovery under this Article shall be reduced by the amount of the recovery from any other insurance guaranty fund or its equivalent.

SB 1782 also contains the following clause:
Applicability. This amendatory Act applies to pending actions as well as actions commenced on or after the effective date of this amendatory Act of the 99th General Assembly.

Missouri

HB 148 amends ***section 287.037. Member of limited liability company to receive coverage, rejection of coverage, rescission of rejection*** of the Missouri Annotated Statutes as follows:

§ 287.037. Member of limited liability company to receive coverage, rejection of coverage, rescission of rejection

1. Notwithstanding any other provision of law to the contrary, beginning January 1, 1997, those insurance companies providing coverage pursuant to chapter 287, to a limited liability company, as defined in section 347.015, shall provide coverage for the employees of the limited liability company who are not members of the limited liability company. Members of the limited liability company, as defined in section 347.015, shall also be provided coverage pursuant to chapter 287, but such members may individually elect to reject such coverage by providing a written notice of such rejection on a form developed by the department of insurance, financial institutions and professional registration to the limited liability company and its insurer. Failure to provide notice to the limited liability company shall not be grounds for any member to claim that the rejection of such coverage is not legally effective. A member who elects to reject such coverage shall not thereafter be entitled to workers' compensation benefits under the policy, even if serving or working in the capacity of an employee of the limited liability company, at least until such time as said member provides the limited liability company and its insurer with a written notice which rescinds the prior rejection of such coverage. The written notice which rescinds the prior rejection of such coverage shall be on a form developed by the department of insurance, financial institutions and professional registration. Any rescission shall be prospective in nature and shall entitle the member only to such benefits which accrue on or after the date the notice of rescission form is received by the insurance company.

2. Notwithstanding any other provision of law to the contrary, beginning January 1, 2016, a shareholder of an S corporation, as defined in subsection 1 of section 143.471, with at least forty percent or greater interest in the S corporation may individually elect to reject coverage under this chapter by providing a written notice of such rejection to the S corporation and its insurer. Failure to provide notice to the S corporation shall not be grounds for any shareholder to claim that the rejection of such coverage is not legally effective. A shareholder who elects to reject such coverage shall not thereafter be entitled to workers' compensation benefits under the policy, even if serving or working in the capacity of an employee of the S corporation, at least until such time as such shareholder provides the S corporation and its insurer with a written notice which rescinds the prior rejection of such coverage. Any rescission shall be prospective in nature and shall entitle the shareholder only to such benefits which accrue on or after the date the notice of rescission is received by the insurance company.

HB 218 amend ***section 57.111*** of ***Title 6. County, Township and Political Subdivision Government*** as follows:

May act in adjoining county, when.

57.111. Whenever any sheriff or deputy sheriff of any county in this state is expressly requested, in each instance, by a sheriff ~~of an adjoining county~~ of this state to render assistance, such sheriff or deputy shall have the same powers of arrest in such county as he or she has in his or her own jurisdiction. The county where the sheriff or deputy sheriff rendering assistance is employed shall be responsible for workers' compensation insurance, overtime, expense reimbursement, and any and all other liability incurred as part of providing assistance in the requesting county.

HB 609 adds new ***section 375.1605.1*** to the Missouri Annotated Statutes as follows:

375.1605. 1. The provisions of this section shall apply to workers' compensation large deductible policies issued by an insurer subject to delinquency proceedings under this chapter. This section shall not apply to first party claims or to claims funded by a guaranty association net of the deductible unless subsection 3 of this section applies. Large deductible policies shall be administered in accordance with their terms except to the extent such terms conflict with this section.

2. For purposes of this section, the following terms shall mean:

(1) "Collateral", any cash, letters of credit, surety bond, or any other form of security posted by the insured or by a captive insurer or reinsurer to secure the insured's obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay the insurer as may be required for other secured obligations;

(2) "Commercially reasonable", to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter;

(3) "Deductible claim", any claim, including a claim for loss and defense and cost containment expense, unless such expenses are excluded, under a large deductible policy that is within the deductible;

(4) "Large deductible policy", any combination of one or more workers' compensation policies and endorsements issued to an insured and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:

(a) Pay directly the initial portion of any claim under the policy up to a specified dollar amount, or the expenses related to any claim;

or
(b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.
The term "large deductible policy" also includes policies which contain an aggregate limit on the insured's liability for all deductible claims in addition to a per-claim deductible limit. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer. A large deductible shall include any policy with a deductible of fifty thousand dollars or more. Large deductible policies do not include policies, endorsements, or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insured shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder's large deductible obligations;
(5) "Other secured obligations", obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations, the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy.
3. Unless otherwise agreed by the responsible guaranty association, all large deductible claims which are also "covered claims" as defined by the applicable guaranty association law including those that may have been funded by an insured before liquidation shall be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim pursuant to an agreement by the guaranty fund or otherwise, the insured's funding or payment of a deductible claim will extinguish the obligations, if any, of the receiver or any guaranty association to pay such claim. No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured's funding or payment of a deductible claim.
4. To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association under this subsection shall not be treated as distributions under section 375.1218 or as early access payments under section 375.1205. To the extent that a guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, or incurred expenses in connection with large deductible policies that are not reimbursed under this section, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding. Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses such as those affording the guaranty association the right to recover for claims payments made to or on behalf of high net worth insureds or claimants.
5. (1) The receiver shall have the obligation to collect reimbursements owed for deductible claims as provided for herein, and shall take all commercially reasonable actions to collect such reimbursements. The receiver shall promptly bill insureds for reimbursement of deductible claims:
(a) Paid by the insurer prior to the commencement of delinquency proceedings;
(b) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or
(c) Paid or allowed by the receiver.
(2) If the insured does not make payment within the time specified in the large deductible policy, or within sixty days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed.
(3) Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured's reimbursement obligation under the large deductible policy.
(4) Except for gross negligence, an allegation of improper handling or payment of a deductible claim by the insurer, the receiver, or any guaranty association shall not be a defense to the insured's reimbursement obligations under the large deductible policy.
6. (1) Subject to the provisions of this subsection, the receiver shall utilize collateral when available to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payments of a deductible claim. Any distributions made to a guaranty association under this subsection shall not be treated as distributions under section 375.1218 or as early access payments under section 375.1205.
(2) All claims against the collateral shall be paid in the order received and no claim of the receiver including those described in this subsection shall supersede any other claim against the collateral as described in subdivision (4) of this subsection.
(3) The receiver shall draw down collateral to the extent necessary in the event that the insured fails to:
(a) Perform its funding or payment obligations under any large deductible policy;
(b) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty days after the date of the billing if no time is specified;
(c) Pay amounts due the estate for preliquidation obligations;
(d) Timely fund any other secured obligation; or
(e) Timely pay expenses.
(4) Claims that are validly asserted against the collateral shall be satisfied in the order in which such claims are received by the receiver.

(5) Excess collateral may be returned to the insured as determined by the receiver after a periodic review of claims paid, outstanding case reserves, and a factor for incurred but not reported claims.

Nevada

SB 153 amends various sections of the Nevada Revised Statutes related to occupational disease presumptions, in part, as follows:

617.454. Physical examinations: Required tests.

1. Any physical examination administered pursuant to NRS 617.455 or 617.457 must include:
(a) A thorough test of the functioning of the hearing of the employee; and
(b) A purified protein derivative skin test to screen for exposure to tuberculosis.
2. Except as otherwise provided in subsection ~~7~~ 8 of NRS 617.457, the tests required by this section must be paid for by the employer

617.455. Lung diseases as occupational diseases of firefighters, police officers and arson investigators.

…

5. A disease of the lungs is conclusively presumed to have arisen out of and in the course of the employment of a person who has been employed in a full-time continuous, uninterrupted and salaried occupation as a police officer, firefighter or arson investigator for ~~5~~ 2 years or more before the date of disablement ~~.~~ if the disease is diagnosed and causes the disablement:
(a) During the course of that employment;
(b) If the person ceases employment before completing 20 years of service as a police officer, firefighter or arson investigator, during the period after separation from employment which is equal to the number of years worked; or
(c) If the person ceases employment after completing 20 years or more of service as a police officer, firefighter or arson investigator, at any time during the person's life.
Service credit which is purchased in a retirement system must not be calculated towards the years of service of a person for the purposes of this section.
6. Frequent or regular use of a tobacco product within 1 year, or a material departure from a physician's prescribed plan of care by a person within 3 months, immediately preceding the filing of a claim for compensation excludes a person who has separated from service from the benefit of the conclusive presumption provided in subsection 5.
7. Failure to correct predisposing conditions which lead to lung disease when so ordered in writing by the examining physician after a physical examination required pursuant to subsection 2 or 3 excludes the employee from the benefits of this section if the correction is within the ability of the employee.
~~7.~~ 8. A person who is determined to be:
(a) Partially disabled from an occupational disease pursuant to the provisions of this section; and
(b) Incapable of performing, with or without remuneration, work as a firefighter, police officer or arson investigator, may elect to receive the benefits provided under NRS 616C.440 for a permanent total disability.

617.457. Heart diseases as occupational diseases of firefighters, arson investigators and police officers.

1. Notwithstanding any other provision of this chapter, diseases of the heart of a person who, for ~~5~~ 2 years or more, has been employed in a full-time continuous, uninterrupted and salaried occupation as a firefighter, arson investigator or police officer in this State before the date of disablement are conclusively presumed to have arisen out of and in the course of the employment ~~.~~ if the disease is diagnosed and causes the disablement:
(a) During the course of that employment;
(b) If the person ceases employment before completing 20 years of service as a police officer, firefighter or arson investigator, during the period after separation from employment which is equal to the number of years worked; or
(c) If the person ceases employment after completing 20 years or more of service as a police officer, firefighter or arson investigator, at any time during the person's life.
Service credit which is purchased in a retirement system must not be calculated towards the years of service of a person for the purposes of this section.
2. Frequent or regular use of a tobacco product within 1 year, or a material departure from a physician's prescribed plan of care by a person within 3 months, immediately preceding the filing of a claim for compensation excludes a person who has separated from service from the benefit of the conclusive presumption provided in subsection 1.

…

SB 153 also includes the following language:
The amendatory provisions of this act:
1. Apply only to disablement which occurs on or after the effective date of this section; and
2. Do not apply to any person who, on the effective date of this section, has completed at least 20 years of creditable service, not including any service credit purchased in a retirement system, as a police officer, firefighter, volunteer firefighter or arson investigator in this State.

SB 194 amends ***sections 616B.710, 616B.712, 616B.725***, and ***616B.727*** of the Nevada Revised Statutes, in part, as follows:

616B.710. Establishment and administration of program: Prerequisites; mandatory participation; payments to contractors or subcontractors; commissioner to establish threshold cost for project eligible for program.

1. A private company, public entity or utility may:
(a) Establish and administer a consolidated insurance program to provide industrial insurance coverage for employees of contractors and subcontractors who are engaged in a construction project or series of projects of which the private company, public entity or utility is the owner or principal contractor, if the estimated total cost of the construction project or series of projects is equal to or greater than ~~the threshold amount established by the Commissioner pursuant to subsection 3;~~ $50,000,000; and
(b) As a condition precedent to the award of a contract to perform work on the construction project~~,~~ or any project that is part of the series of projects, require that contractors and subcontractors who will be engaged in the construction of the project or series of projects participate in the consolidated insurance program.
2. If a private company, public entity or utility:
(a) Establishes and administers a consolidated insurance program; and
(b) Pursuant to the contract for the construction of the project~~,~~ or series of projects, owes a periodic payment to a contractor or subcontractor whose employees are covered under the consolidated insurance program, the private company, public entity or utility shall not withhold such a periodic payment on the basis that the contractor or subcontractor has not signed an employer's report of industrial injury or occupational disease as required pursuant to NRS 616C.045.
3. ~~The Commissioner shall establish the threshold amount that the estimated total cost of a construction project must be equal to or greater than before a consolidated insurance program may be established and administered for that project pursuant to this section. The base amount for the threshold must initially be $150,000,000 and thereafter must be an amount equal to $150,000,000 as adjusted by the Commissioner on June 30 of each year to reflect the present value of that amount with respect to the construction cost index.~~
~~4.~~ As used in this section:
(a) ~~"Construction cost index" means the construction cost index published by the Engineering News-Record as a measure of inflation.~~
~~(b)~~ "Estimated total cost" means the estimated cost to complete all parts of a construction project~~,~~ or series of projects, including, without limitation, the cost of:
(1) Designing the project~~;~~ or series of projects;
(2) Acquiring the real property on which the project or series of projects will be constructed;
(3) Connecting the project or series of projects to utilities;
(4) Excavating and carrying out underground improvements for the project~~;~~ or series of projects; and
(5) Acquiring equipment and furnishings for the project~~.~~ or series of projects.
The term does not include the cost of any fees or charges associated with acquiring the money necessary to complete the project~~.~~ or series of projects.
(b) "Series of projects" means two or more projects of which the same private company, public entity or utility is the owner or principal contractor and which are specifically identifiable at the time a consolidated insurance program is established.

616B.712. Industrial insurance for program; contract to provide insurance to be filed and reviewed by commissioner.
1. A private carrier who is authorized to transact industrial insurance in this State may contract with a private company, public entity or utility to provide industrial insurance coverage for a consolidated insurance program.
2. A ~~private company,~~ public entity or utility that enters into a contract with a private carrier for the provision of industrial insurance coverage for a consolidated insurance program shall file a copy of the contract with the Commissioner at least 60 days before the date on which the construction project is scheduled to begin.
3. The Commissioner shall, within 60 days after receiving a copy of a contract pursuant to subsection 2, review and approve or disapprove the contract. If the Commissioner does not disapprove the contract within 60 days after receiving it, the contract shall be deemed approved.

616B.725. Safety requirements: Contents of safety program; qualifications and duties of safety coordinators; duties of owner or principal contractor.
…
3. The owner or principal contractor of the construction project shall hire or contract with two persons to serve as the primary and alternate coordinators for safety for the construction project. The primary and alternate coordinators for safety must:
(a) Possess credentials in the field of safety that the Administrator determines to be adequate to prepare a person to act as a coordinator for safety for a construction project, including, without limitation, credentials issued by : ~~the:~~
(1) The Board of Certified Safety Professionals; or
(2) ~~Insurance Institute of America;~~ The Institutes; or
(b) Have at least 3 years of experience in overseeing matters of occupational safety and health in the field of construction that the Administrator determines to be adequate to prepare a person to act as a coordinator for safety for a construction project.
…
7. The owner or principal contractor of the construction project shall allow the contractor, employer or subcontractor who employs an employee who is engaged in the construction project to access:
(a) The site of the construction project for the purpose of ensuring the occupational safety and health of the employees of the contractor, employer or subcontractor; and

(b) Any documents relating to claims filed by or on behalf of an employee of the contractor, employer or subcontractor who has been injured on the construction project.

616B.727. Administration of claims: Duties of administrator of claims; duties of owner or principal contractor.

…

2. The owner or principal contractor of the construction project shall hire or contract with a person to serve as the administrator of claims for industrial insurance for the construction project. ~~Such a person must not serve as an administrator of claims for industrial insurance for another construction project that is covered by a different consolidated insurance program.~~

3. Any policy or contract of insurance providing coverage for a consolidated insurance program must be issued by an insurer who is rated A- or better by A.M. Best with a Financial Size Category of Class VII or larger, or the equivalent as determined by the Commissioner.

…

SB 231 adds a new section to ***Chapter 616C*** of the Nevada Industrial Insurance Act of the Nevada Revised Statutes as follows:

1. With respect to drugs prescribed and dispensed directly to an injured employee by a provider of health care:

(a) The provider of health care may dispense an initial supply of a controlled substance which is listed in schedule II or III by the State Board of Pharmacy pursuant to NRS 453.146 to an injured employee. Any controlled substances prescribed to an injured employee beyond the initial supply must be filled by a pharmacy that is registered with the State Board of Pharmacy.

(b) The provider of health care shall include the original manufacturer's National Drug Code, as assigned by the United States Food and Drug Administration, on all bills and reports submitted to an insurer pursuant to this chapter.

(c) A repackaged National Drug Code must not be used and must not be considered an original manufacturer's National Drug Code for the purposes of this section.

(d) A provider of health care who provides care on an outpatient basis may not charge an insurer or seek reimbursement for dispensing a nonprescription drug to an injured employee.

2. As used in this section:

(a) "Initial supply" means a quantity of a controlled substance that when used as prescribed does not exceed a 15-day supply and that is provided on a one-time basis.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031, but does not include a pharmacist or a hospital as defined in NRS 449.012.

SB 231 also amends ***sections 616C.136 and 616C.230*** as follows**:**

616C.136. Action by insurer on bill from provider of health care; payment of interest; request for additional information; compliance with requirements.

1. Except as otherwise provided in this section, an insurer shall ~~approve or deny a bill for accident benefits received from a provider of health care within 30 calendar days after the insurer receives the bill. If the bill for accident benefits is approved, the insurer shall~~ pay ~~the~~ or deny a bill for accident benefits received from a provider of health care within ~~30~~ 45 calendar days after ~~it is approved.~~ the insurer or third-party administrator receives the bill. Except as otherwise provided in this section, if the ~~approved~~ bill for accident benefits is not paid within that period, the insurer shall pay interest to the provider of health care at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from ~~30~~ 45 calendar days after the date on which the bill is ~~approved~~ received until the date on which the bill is paid.

2. If an insurer needs additional information to determine whether to ~~approve~~ pay or deny a bill for accident benefits received from a provider of health care, the insurer shall notify the provider of health care of his or her request for the additional information within 20 calendar days after the insurer receives the bill. The insurer shall notify the provider of health care of all the specific reasons for the delay in ~~approving~~ paying or denying the bill for accident benefits. Upon the receipt of such a request, the provider of health care shall furnish the additional information to the insurer within 20 calendar days after receiving the request. If the provider of health care fails to furnish the additional information within that period, the provider of health care is not entitled to the payment of interest to which the provider of health care would otherwise be entitled for the late payment of the bill for accident benefits. The insurer shall ~~approve~~ pay or deny the bill for accident benefits within 20 calendar days after the insurer receives the additional information. ~~If the bill for accident benefits is approved, the insurer shall pay the bill within 20 calendar days after the insurer receives the additional information.~~ Except as otherwise provided in this subsection, if the ~~approved~~ bill for accident benefits is not paid within that period, the insurer shall pay interest to the provider of health care at the rate set forth in subsection 1. The interest must be calculated from 20 calendar days after the date on which the insurer receives the additional information until the date on which the bill is paid.

…

4. An insurer shall not pay only a portion of a bill for accident benefits that ~~has been approved and~~ is fully payable.

5. The Administrator may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements of this section, including, without limitation, payment within the time required of at least 95 percent of ~~approved~~ accident benefits. ~~or at least 90 percent of the total dollar amount of approved accident benefits.~~ If the Administrator determines that an insurer is not in substantial compliance with the requirements of this section, the Administrator may require the insurer to pay an administrative fine in an amount to be determined by the Administrator.

6. The payment of interest provided for in this section for ~~the~~ a late payment ~~of an approved claim~~ may be waived only if

the payment was delayed because of an act of God or another cause beyond the control of the insurer.
…

616C.230. Grounds for denial, reduction or suspension of compensation; evidence of and examination for use of alcohol or controlled substance.

1. Compensation is not payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS for an injury:
…
(c) ~~Proximately caused by the employee's~~ That occurred while the employee was in a state of intoxication~~. If the employee was intoxicated at the time of his or her injury, intoxication must be presumed to be a proximate cause unless rebutted by evidence to the contrary.~~ , unless the employee can prove by clear and convincing evidence that his or her state of intoxication was not the proximate cause of the injury. For the purposes of this paragraph, an employee is in a state of intoxication if the level of alcohol in the bloodstream of the employee meets or exceeds the limits set forth in subsection 1 of NRS 484C.110.
(d) ~~Proximately caused by the employee's use~~ That occurred while the employee was under the influence of a controlled or prohibited substance~~. If the employee had any~~ , unless the employee can prove by clear and convincing evidence that his or her being under the influence of a controlled or prohibited substance was not the proximate cause of the injury. For the purposes of this paragraph, an employee is under the influence of a controlled or prohibited substance if the employee had an amount of a controlled or prohibited substance in his or her system at the time of his or her injury that was equal to or greater than the limits set forth in subsection 3 of NRS 484C.110 and for which the employee did not have a current and lawful prescription issued in the employee's name . ~~or that the employee was not using in accordance with the provisions of chapter 453A of NRS, the controlled substance must be presumed to be a proximate cause unless rebutted by evidence to the contrary.~~
2. For the purposes of paragraphs (c) and (d) of subsection 1:
(a) The affidavit or declaration of an expert or other person described in NRS 50.310, 50.315 or 50.320 is admissible to prove the existence of ~~any~~ an impermissible quantity of alcohol or the existence, quantity or identity of ~~a~~ an impermissible controlled or prohibited substance in an employee's system. If the affidavit or declaration is to be so used, it must be submitted in the manner prescribed in NRS 616C.355.
(b) When an examination requested or ordered includes testing for the use of alcohol or a controlled or prohibited substance, the laboratory that conducts the testing must be licensed pursuant to the provisions of chapter 652 of NRS.
(c) The results of any testing for the use of alcohol or a controlled or prohibited substance, irrespective of the purpose for performing the test, must be made available to an insurer or employer upon request, to the extent that doing so does not conflict with federal law.
…
6. As used in this section, "prohibited substance" has the meaning ascribed to it in NRS 484C.080.

SB 232 amends sections ***616C.138, 616C.390,*** and ***616C.495*** of the Nevada Revised Statutes as follows:

616C.138. Payment of provider of health care upon insurer's denial of authorization or responsibility for treatment or other services provided; reimbursement of injured employee or health or casualty insurer; recovery of excess amount paid to provider of health care.

…
1. Except as otherwise provided in this section, if a provider of health care provides treatment or other services that an injured employee alleges are related to an industrial injury or occupational disease and an insurer, an organization for managed care, a third-party administrator or an employer who provides accident benefits for injured employees pursuant to NRS 616C.265 denies authorization or responsibility for payment for the treatment or other services, the provider of health care is entitled to be paid for the treatment or other services as follows:
(a) If the treatment or other services will be paid by a health insurer which has a contract with the provider of health care under a health benefit plan that covers the injured employee, the provider of health care is entitled to be paid the amount that is allowed for the treatment or other services under that contract.
(b) If the treatment or other services will be paid by a health insurer which does not have a contract with the provider of health care as set forth in paragraph (a) or by a casualty insurer or the injured employee, the provider of health care is entitled to be paid not more than:
(1) The amount which is allowed for the treatment or other services set forth in the schedule of fees and charges established pursuant to NRS 616C.260; or
(2) If the insurer which denied authorization or responsibility for the payment has contracted with an organization for managed care or with providers of health care pursuant to NRS 616B.527, the amount that is allowed for the treatment or other services under that contract.
2. The provisions of subsection 1:
(a) Apply only to treatment or other services provided by the provider of health care before the date on which the insurer, organization for managed care, third-party administrator or employer who provides accident benefits first denies authorization or responsibility for payments for the alleged industrial injury or occupational disease.
(b) Do not apply to a provider of health care that is a hospital as defined in NRS 439B.110. The provisions of this paragraph do not exempt the provider of health care from complying with the provisions of subsections 3 and ~~4.~~ 7.
3. If:
(a) The injured employee pays for the treatment or other services or a health or casualty insurer pays for the treatment or other services on behalf of the injured employee;

(b) The injured employee requests a hearing before a hearing officer or appeals officer regarding the denial of coverage; and
(c) The hearing officer or appeals officer ultimately determines that the treatment or other services should have been covered, or the insurer, organization for managed care, third-party administrator or employer who provides accident benefits subsequently accepts responsibility for payment,
the hearing officer or appeals officer shall order the insurer, organization for managed care, third-party administrator or employer who provides accident benefits to pay to the injured employee or the health or casualty insurer the amount which the injured employee or the health or casualty insurer paid that is allowed for the treatment or other services set forth in the schedule of fees and charges established pursuant to NRS 616C.260 or, if the insurer has contracted with an organization for managed care or with providers of health care pursuant to NRS 616B.527, the amount that is allowed for the treatment or other services under that contract.
4. If:
(a) A hearing officer, appeals officer or district court issues an order or otherwise renders a decision requiring an insurer, organization for managed care, third-party administrator or employer to pay for treatment or other services provided to an injured employee;
(b) The insurer, organization for managed care, third-party administrator or employer appeals the order or decision, but is unable to obtain a stay of the order or decision;
(c) Payment for the treatment or other services provided to the injured employee is made by the insurer, organization for managed care, third-party administrator or employer during the period between the date of the issuance of the order or decision and the date of the final resolution of the appeal; and
(d) The appeal is subsequently resolved in favor of the insurer, organization for managed care, third-party administrator or employer, the insurer, organization for managed care, third-party administrator or employer may recover from any health or casualty insurer of the injured employee an amount calculated pursuant to subsection 5. Any recovery from a health or casualty insurer pursuant to this subsection is subject to the exclusions and limitations of the policy of health or casualty insurance covering the injured employee that relate to the diseases set forth in NRS 617.453, 617.455 and 617.457.
5. An insurer, organization for managed care, third-party administrator or employer entitled to recover for an amount paid during the pendency of an appeal pursuant to subsection 4, may recover from a health or casualty insurer of the injured employee the lesser of:
(a) The amount actually paid by the insurer, organization for managed care, third-party administrator or employer during the period between the issuance of the order and the final resolution of the appeal;
(b) The amount established for the treatment or services provided to the injured employee pursuant to NRS 616C.260 or the usual fee charged by the provider of health care, whichever is less;
(c) The amount provided for the treatment or services provided to the injured employee on an in-network basis if there is a contract between the provider of health care and the health or casualty insurer of the injured employee and the treatment or services are covered under the terms of the policy of health or casualty insurance covering the employee; or
(d) The amount provided for the treatment or services provided to the injured employee on an out-of-network basis pursuant to the terms of the policy of health or casualty insurance covering the injured employee if there is not a contract between the provider of health care and the health or casualty insurer of the injured employee.
6. If an insurer, organization for managed care, third-party administrator or employer is entitled to recover for an amount paid during the pendency of an appeal pursuant to subsection 4, upon a final resolution of the appeal in favor of the insurer, organization for managed care, third-party administrator or employer, the hearing officer, appeals officer or district court shall order the injured employee to provide to the insurer, organization for managed care, third-party administrator or employer:
(a) Any documentation in the possession of the injured employee related to any policy of health or casualty insurance which may have provided coverage to the injured employee for treatment or other services provided to the injured employee; and
(b) The identity and contact information of the insurer providing such health or casualty insurance.
…

616C.390. Reopening claim: General requirements and procedure; limitations; applicability.
Except as otherwise provided in NRS 616C.392:
…
5. An application to reopen a claim must be made in writing within 1 year after the date on which the claim was closed if:
(a) The claimant ~~was not off work~~ did not meet the minimum duration of incapacity as set forth in NRS 616C.400 as a result of the injury; and
…

616C.495. Permanent partial disability: Payments in lump sum.
1. Except as otherwise provided in NRS 616C.380, an award for a permanent partial disability may be paid in a lump sum under the following conditions:
(a) A claimant injured on or after July 1, 1973, and before July 1, 1981, who incurs a disability that does not exceed 12 percent may elect to receive his or her compensation in a lump sum. A claimant injured on or after July 1, 1981, and before July 1, 1995, who incurs a disability that does not exceed ~~25~~ 30 percent may elect to receive his or her compensation in a lump sum.
(b) The spouse, or in the absence of a spouse, any dependent child of a deceased claimant injured on or after July 1, 1973, who is not entitled to compensation in accordance with NRS 616C.505, is entitled to a lump sum equal to the present value of the deceased claimant's undisbursed award for a permanent partial disability.

(c) Any claimant injured on or after July 1, 1981, and before July 1, 1995, who incurs a disability that exceeds ~~25~~ 30 percent may elect to receive his or her compensation in a lump sum equal to the present value of an award for a disability of ~~25~~ 30 percent. If the claimant elects to receive compensation pursuant to this paragraph, the insurer shall pay in installments to the claimant that portion of the claimant's disability in excess of ~~25~~ 30 percent.
(d) Any claimant injured on or after July 1, 1995, may elect to receive his or her compensation in a lump sum in accordance with regulations adopted by the Administrator and approved by the Governor. The Administrator shall adopt regulations for determining the eligibility of such a claimant to receive all or any portion of his or her compensation in a lump sum. Such regulations may include the manner in which an award for a permanent partial disability may be paid to such a claimant in installments.
Notwithstanding the provisions of NRS 233B.070, any regulation adopted pursuant to this paragraph does not become effective unless it is first approved by the Governor.
(e) If the permanent partial disability rating of a claimant seeking compensation pursuant to this section would, when combined with any previous permanent partial disability rating of the claimant that resulted in an award of benefits to the claimant, result in the claimant having a total permanent partial disability rating in excess of 100 percent, the claimant's disability rating upon which compensation is calculated must be reduced by such percentage as required to limit the total permanent partial disability rating of the claimant for all injuries to not more than 100 percent.
…

Oregon

HB 2211 amends ***section 656.745 Civil penalty for inducing failure to report claims; failure to pay assessments; failure to comply with statutes, rules or orders; amount; procedure*** and ***section 656.780 Certification and training of claims examiners; records of certification and training of examiners; department inspection of records; penalties; rules*** of the Oregon Revised Statutes as follows:

656.745 Civil penalty for inducing failure to report claims; failure to pay assessments; failure to comply with statutes, rules or orders; amount; procedure.

…
(2) The director may assess a civil penalty against an employer, insurer, ~~or~~ managed care organization or service company that:
…
(3) Except as specified in ORS 656.780, the director may assess a penalty against a service company only for claims processing performance deficiencies revealed in annual audits associated with claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer or service company for deficiencies revealed in annual audits associated with claims processing performance.
~~(3)~~ (4) A civil penalty shall be not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three-month period. Each violation, or each day a violation continues, shall be considered a separate violation.
~~(4)~~ (5) ORS 656.735 (4) to (6) and 656.740 also apply to orders and penalties assessed under this A-Eng. HB 2211 section.

656.780 Certification and training of claims examiners; records of certification and training of examiners; department inspection of records; penalties; rules.
(1) The Director of the Department of Consumer and Business Services shall:
(a) Adopt by rule standards for certification of workers' compensation claims examiners that shall be administered by workers' compensation insurers, self-insured employers and ~~third party administrators~~ service companies; and
(b) Develop or approve any training curriculum used by insurers, self-insured employers and ~~third party administrators~~ service companies that is related to interactions with independent medical examination providers required under ORS 656.325.
(2)(a) Each insurer, self-insured employer and ~~third party administrator~~ service company shall maintain records of the certification and training of their workers' compensation claims examiners. These records are subject to inspection and review by the director.
(b) The director may impose a civil penalty against any insurer, self-insured employer or ~~third party administrator~~ service company that fails to:
…
(3) Insurers, self-insured employers and ~~third party administrators~~ service companies may employ only certified workers' compensation claims examiners to process workers' compensation claims. The director may impose a civil penalty against any insurer, self-insured employer or ~~third party administrator~~ service company that violates this subsection.

HB 2797 amends ***section 656.262 Processing of claims and payment of compensation; payment by employer; acceptance and denial of claim; penalties and attorney fees; cooperation by worker and attorney in claim investigation; rules.***
of the Oregon Revised Statutes as follows:

656.262 Processing of claims and payment of compensation; payment by employer; acceptance and denial of claim; penalties and attorney fees; cooperation by worker and attorney in claim investigation; rules

…
(4)(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim and of the worker's disability, if the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 authorizes the payment of temporary disability compensation.
…

SB 2797 also includes the following clause:
The amendments to ORS 656.262 by section 1 of this 2015 Act apply to claims filed on or after the effective date of this 2015 Act.

HB 3114 amends ***section 656.265 Notice of accident from worker*** of the Oregon Revised Statutes as follows:
656.265 Notice of accident from worker.
(1)(a) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a ~~dependent~~ beneficiary of the worker to the employer, but not later than 90 days after the accident. The employer shall acknowledge forthwith receipt of such notice.
(b) Notwithstanding paragraph (a) of this subsection, if an injured worker has not submitted a claim under this chapter but has submitted a claim to a health benefit plan that provides benefits to the worker, and the health benefit plan rejects the claim as being work related, the injured worker may file a claim under this section within 90 days from the date the health benefit plan rejects the claim. If a claim filed under this section is denied, the workers' compensation insurer or self-insured employer shall inform the health benefit plan of the denial and the health benefit plan shall process the claim for payment in accordance with the terms, conditions and benefits of the plan.
…

South Carolina

HB 3396 adds new ***section 42-1-378*** to the South Carolina Code of Laws as follows:
Section 42-1-378.
This title does not apply to an employee who suffers an injury on or after July 1, 2016, for which there is jurisdiction under either the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. Section 901 et seq., and its extensions, or the Merchant Marine Act of 1920, 46 U.S.C. Section 30104 et seq., unless the employee suffers death where there are no financial dependents or sustains a nonscheduled injury under the Longshore and Harbor Workers' Compensation Act, or any of its extensions. However, this title must not be construed to eliminate or diminish any right that any person or, in the case of the person's death, his personal representative, may have under either the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. Section 901 et seq., and its extensions, or the Merchant Marine Act of 1920, 46 U.S.C. Section 30104 et seq.

Tennessee

SB 174 amends ***section 50-6-421. Requesting and obtaining information on employer workers' compensation insurance policies to ensure compliance with law—Confidentiality—What constitutes public record*** of the Tennessee Code as follows:
50-6-421. Requesting and obtaining information on employer workers' compensation insurance policies to ensure compliance with law—Confidentiality—What constitutes public record.
…
(b) The following information obtained by the administrator pursuant to subsection (a) shall constitute a public record, as defined in § 10-7-503, and shall be open for personal inspection by any citizen of this state:
(1) Employer name and business address;
(2) Workers' compensation insurance carrier name and business address; and
(3) Workers' compensation insurance policy number, policy effective date~~, and~~ policy expiration date~~.~~, policy cancellation date, and policy reinstatement date.

Note: SB 174 passed the first chamber on March 30, 2015, but was not included in any previous version of NCCI's ***Legislative Activity Report.***

Texas

SB 978 amends ***section 2053.004. Public Inspection of Information*** of the Texas Statutes as follows:
§ 2053.004. Public ~~Inspection of~~ Information
(a) Each filing made, including any supporting information filed, under this subchapter is ~~open to~~ public information subject to Chapter 552, Government Code, including any applicable exception from required disclosure under that chapter ~~inspection as of the date the filing is made~~.
(b) Each year the department shall make available to the public information concerning the department's general process and methodology for rate review under this chapter, including factors that contribute to the disapproval of a rate. Information provided under this subsection must be general in nature and may not reveal proprietary or trade secret information of any insurer.

SB 978 also includes the following language:
Section 2053.004, Insurance Code, as amended by this Act, applies only to a request to inspect information or to obtain public information made to the Texas Department of Insurance on or after the effective date of this Act. A request made before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and the former law is continued in effect for that purpose.

Contact Information
If you have any questions about the legislation or proposals mentioned, please contact the appropriate NCCI state relations executive (listed below) or a representative of your local insurance trade association.

State	State Relations Executive	Phone Number
CT, ME, NH, RI ,VT	Laura Backus Hall	802-454-1800
FL, IA	Chris Bailey	850-322-4047
AL, GA, KY, LA, MS	Cathy Booth	205-655-2699
AZ, CO, NM, NV, UT	Maggie Karpuk	818-707-8374
DC, MD, VA, WV	David Benedict	804-380-3005
AK, HI	Carolyn Pearl	808-524-6239
IN, NC, SC, TN	Amy Quinn	803-356-0851
AR, IL, KS, TX	Terri Robinson	501-333-2835
ID, MT, OR	Mike Taylor	503-892-1858
MO, NE, OK, SD	Carla Townsend	314-843-4001
Federal Issues	Tim Tucker	202-403-8526

This report is informational and is not intended to provide an interpretation of state and federal legislation.