Legislative Activity Report

National Council on Compensation Insurance

The nation's most experienced provider of workers compensation information, tools, and services Regulatory Services

May 29, 2015 RLA-2015-21

Report Contact: Legislative_Activity@ncci.com State Issues Contacts: Please refer to the list of State Relations Executives at the end of this report.

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 May 22, 2015.

Oregon

SB 371 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 May 13, 2015
- Included in NCCI's April 22, 2015 ***Legislative Activity Report*** (RLA-2015-20)
- Enacted and effective on May 21, 2015

SB 371 amends ***sections 656.268*** and ***656.218*** of the Oregon Revised Statutes, in part, as follows:

656.268 Claim closure; termination of temporary total disability benefits; reconsideration of closure; medical arbiter to make findings of impairment for reconsideration; credit or offset for fraudulently obtained or overpaid benefits; rules.

…

(5)(b) The insurer or self-insured employer shall issue a notice of closure of ~~such a~~ the claim to the worker, to the worker's attorney if the worker is represented, and to the director. If the worker is deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last known address and may mail copies of the notice of closure to any known or potential beneficiaries to the estate of the deceased worker.

(c) The notice of closure must inform:

(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice of closure;

(B) The worker of:

(i) The amount of any further compensation, including permanent disability compensation to be awarded;

(ii) ~~of~~ The duration of temporary total or temporary partial disability compensation;

(iii) ~~of~~ The right of the worker or beneficiaries of the worker who were mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within 60 days of the date of the notice of ~~claim~~ closure;

(iv) The right of beneficiaries who were not mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection;

(v) ~~of~~ The right of the insurer or self-insured employer to request reconsideration by the director under this section within seven days of the date of the notice of ~~claim~~ closure;

(vi) ~~of~~ The aggravation rights; and

(vii) ~~of such~~ Any other information as the director may require; and

(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.
~~(b)~~ (d) If the insurer or self-insured employer has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or self-insured employer shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of:
(A) The decision not to close; ~~of~~
(B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to close ~~the claim~~;
(C) ~~of~~ The right to be represented by an attorney; and
(D) ~~of such~~ Any other information as the director may require.
~~(c)~~ (e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. If the worker is deceased at the time the notice of closure is issued, a request for reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure. A request for reconsideration by a beneficiary to the estate of a deceased worker who was not mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.
…
(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each notice of closure. At the reconsideration proceeding:
(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance with this subparagraph may be received as evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration proceeding.
…
(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's or a beneficiary's request for reconsideration pursuant to subsection ~~(5)(c)~~ (5)(e) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker~~,~~ or beneficiary, the date of receipt of a waiver from the worker or beneficiary of the right to request reconsideration or the date of expiration of the right of the worker or beneficiary to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.
…

656.218 Continuance of permanent partial disability payments to survivors; effect of death prior to final claim disposition.
…
(3) If the worker has filed a request for ~~a~~ hearing pursuant to ORS 656.283 or a request for reconsideration pursuant to ORS 656.268 and death occurs prior to the final disposition of the request, the persons described in subsection (5) of this section shall be entitled to pursue the matter to final determination of all issues presented by the request ~~for hearing~~.
(4) If the worker dies before filing a request for hearing or a request for reconsideration, the persons described in subsection (5) of this section shall be entitled to file a request for hearing or a request for reconsideration and to pursue the matter to final determination as to all issues presented by the request ~~for hearing~~.
…

Texas

SB 784 was:

- Passed by the first chamber on April 9, 2015
- Included in NCCI's April 17, 2015 ***Legislative Activity Report*** (RLA-2015-15)
- Passed by the second chamber on May 5, 2015
- Included in NCCI's May 15, 2015 ***Legislative Activity Report*** (RLA-2015-19)
- Enacted on May 19, 2015, and effective on September 1, 2015

SB 784, in part, amends various sections of the Texas Statutes relating to collection and use of certain information reported to and by

the Texas Department of Insurance and certain approval authority and hearings held in connection with reported information, as follows:

§ 2053.056. Rate Hearings.

a) The commissioner may ~~shall~~ conduct a public hearing each biennium~~, beginning not later than December 1, 2008,~~ to review rates to be charged for workers' compensation insurance written in this state. A public hearing under this section is not a contested case as defined by Section 2001.003, Government Code.

(b) Not later than the 30th day before the date of a ~~the~~ public hearing conducted ~~required~~ under Subsection (a), each insurance company subject to this subtitle ~~and Article 5.66~~ shall file the insurance company's rates, supporting information, and supplementary rating information with the commissioner.

§ 2251.008. Annual ~~Quarterly~~ Report of Insurer; Legislative Report.

(a) The commissioner shall require each insurer subject to this subchapter to annually ~~quarterly~~ file with the commissioner information relating to changes in losses, premiums, and market share since January 1, 1993. The commissioner may require an insurer subject to this subchapter to report to the commissioner, in the form and in the time required by the commissioner, any other information the commissioner determines is necessary to comply with this section.

(b) Annually ~~Quarterly~~, the commissioner shall report to the governor, the lieutenant governor, the speaker of the house of representatives, the legislature, and the public regarding:

…

(c) The report required by this section must cover a calendar year ~~quarter~~ and:

(1) for each insurer that writes a line of insurance subject to this subchapter, must state the insurer's:

…

(D) whether the insurer submitted a rate filing during the year ~~quarter~~ covered in the report; and

…

(d) Except as provided by Subsection (e), the annual ~~quarterly~~ report required by this section must be made available to the governor, lieutenant governor, speaker of the house of representatives, legislature, and public not later than the 90th day after the last day of the calendar year ~~quarter~~ covered by the report.

(e) If the commissioner determines that it is not feasible to provide the report required by this section within the period specified by Subsection (d) for all lines of insurance subject to this subchapter, the department:

(1) shall make the annual ~~quarterly~~ report, as applicable to lines of residential property insurance and personal automobile insurance, available within the period specified by Subsection (d); and

(2) may delay publication of the annual ~~quarterly~~ report as it relates to other lines of insurance subject to this subchapter until a date specified by the commissioner.

…

§ 2251.101. Rate Filings and Supporting Information

…

(b) The commissioner by rule shall:

…

(C) ~~, including~~ information necessary to evidence that the computation of the rate does not include disallowed expenses for personal lines; and

(D) ~~(C)~~ information concerning policy fees, service fees, and other fees that are charged or collected by the insurer under Section 550.001 or 4005.003; and

…

§ 1501.109. Refusal to Renew; Discontinuation of Coverage

(a) A small or large employer health benefit plan issuer may elect to refuse to renew all small or large employer health benefit plans delivered or issued for delivery by the issuer in this state or in a geographic service area ~~approved under Section 1501.101~~. The issuer shall notify:

…

(b) A small employer health benefit plan issuer that elects under this section to refuse to renew all small employer health benefit plans in this state or in a ~~an approved~~ geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date notice is provided to the commissioner under Subsection (a).

(c) A large employer health benefit plan issuer that elects under this section to refuse to renew all large employer health benefit plans in this state or in a ~~an approved~~ geographic service area may not write a new large employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date notice is provided to the commissioner under Subsection (a).

…

§ 2206.002. Applicability of Other Laws
…
(b) The pool~~:~~
~~(1) shall collect the necessary information and file with the department the reports required by Subchapter D, Chapter 38; and~~
~~(2)~~ is subject to Chapter 541 and Section 543.001.

§ 2207.002. Pool Not Engaged in Business of Insurance
…
(b) A pool~~:~~
~~(1) shall collect the necessary information and file with the department the reports required by Subchapter D, Chapter 38; and~~
~~(2)~~ is subject to Chapter 541 and Section 543.001.

§ 2208.002. Pool Not Engaged in Business of Insurance
…
(b) The pool is subject to Chapter 541 ~~and Subchapter D, Chapter 38~~.

§ 2212.053. Filing Requirements
(a) A trust shall file with the department:
(1) all rates and forms, for informational purposes only; and
(2) ~~all liability claims reports required under Subchapter D, Chapter 38; and~~
~~(3)~~ the trust's independently audited annual financial statement.
…

In addition, **SB 784** includes the following language:
(a) Sections 2206.002(b), 2207.002(b), 2208.002(b), and 2212.053(a), Insurance Code, as amended by this Act, and the repeal by this Act of Subchapter D, Chapter 38, Insurance Code, apply only to a claim closed on or after January 1, 2016. A claim closed before January 1, 2016, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.
(b) Section 2251.008, Insurance Code, as amended by this Act, applies with respect to reporting by insurers to, and reporting to the legislature by, the commissioner of insurance on or after January 1, 2016. Reporting by insurers and the commissioner before that date is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SB 901 was:
- Passed by the first chamber on April 9, 2015
- Included in NCCI's April 17, 2015 ***Legislative Activity Report*** (RLA-2015-15)
- Passed by the second chamber on May 5, 2015
- Included in NCCI's May 15, 2015 ***Legislative Activity Report*** (RLA-2015-19)
- Enacted on May 21, 2015, with an effective date of September 1, 2015

SB 901 amends ***section 408.103. Amount of Temporary Income Benefits*** of the Texas Statutes as follows:
§ 408.103. Amount of Temporary Income Benefits
(a) Subject to Sections 408.061 and 408.062, the amount of a temporary income benefit is equal to:
(1) 70 percent of the amount computed by subtracting the employee's weekly earnings after the injury from the employee's average weekly wage; or
(2) for the first 26 weeks, 75 percent of the amount computed by subtracting the employee's weekly earnings after the injury from the employee's average weekly wage if the employee earns less than $10 ~~$8.50~~ an hour.
…

SB 901 also includes the following language:
The change in law made by this Act applies to a claim for temporary income benefits based on a compensable injury that occurs on or after the effective date of this Act. A claim based on a compensable injury that occurs before the effective date of this Act is governed by the law in effect on the date the compensable injury occurred, and the former law is continued in effect for that purpose.

BILLS PASSING SECOND CHAMBER

The following bills passed the second chamber within the one-week period ending May 22, 2015.

Maine

LD 125 was

- Passed by the first chamber on May 12, 2015
- Included in NCCI's May 22, 2015 ***Legislative Activity Report*** (RLA-2015-20)
- Passed by the second chamber on May 19, 2015

LD 125 amends **39-A MRSA, §*328-B. Cancer suffered by a firefighter*** of the Maine Revised Statutes as follows:

§328-B. Cancer suffered by a firefighter

…

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

B. "Employed" means to be employed as an active duty firefighter or by the Office of the State Fire Marshal or to be an active member of a volunteer fire association with no compensation other than injury and death benefits.

C. "Firefighter" means a member of a municipal fire department or volunteer fire association whose duties include the extinguishment of fires or an investigator or sergeant in the Office of the State Fire Marshal.

2. Presumption. If a firefighter who contracts cancer has met the requirements of subsections 3, 6 and 7, there is a rebuttable presumption that the firefighter contracted the cancer in the course of employment as a firefighter and as a result of that employment, that sufficient notice of the cancer has been given and that the disease was not occasioned by any willful act of the firefighter to cause the disease.

…

6. Length of service. In order to qualify for the presumption under subsection 2, the firefighter must have been employed as a firefighter for 5 years and, except for an investigator or sergeant in the Office of the State Fire Marshal, regularly responded to firefighting or emergency calls.

…

Nebraska

LB 480 was:

- Passed by the Legislature on May 21, 2015

LB 480 amends various sections of the Nebraska Revised Statutes as follows:

Section 1. No compensation shall be allowed if, at the time of or in the course of entering into employment or at the time of receiving notice of the removal of conditions from a conditional offer of employment: (1) The employee knowingly and willfully made a false representation as to his or her physical or medical condition by acknowledging in writing that he or she is able to perform the essential functions of the job with or without reasonable accommodation based upon the employer's written job description; (2) the employer relied upon the false representation and the reliance was a substantial factor in the hiring; and (3) a causal connection existed between the false representation and the injury.

§ 48-120. Medical, surgical, and hospital services; employer's liability; fee schedule; physician, right to select; procedures; powers and duties; court; powers; dispute resolution procedure; managed care plan.

(1)…(e) The provider or supplier of such services shall not collect or attempt to collect from any employer, insurer, government, or injured employee or dependent or the estate of any injured or deceased employee any amount in excess of (i) the fee established by the compensation court for any such service, (ii) the fee established under section 48-120.04, or (iii) the fee contracted under subdivision (1)(d) of this section, including any finance charge or late penalty.

…

§ 48-125. Compensation; method of payment; delay; appeal; attorney's fees; interest.

…

(3) When an attorney's fee is allowed pursuant to this section, there shall further be assessed against the employer an amount of interest on the final award obtained, computed from the date compensation was payable, as provided in section 48-119, until the date payment is made by the employer. For any injury occurring prior to the effective date of this act, the interest rate shall be ~~, at a rate~~ equal to the rate of interest allowed per annum under section 45-104.01, as such rate may from time to time be adjusted by the Legislature. For any injury occurring on or after the effective date of this act, the interest rate shall be equal to six percentage points above the bond investment yield, as published by the Secretary of the Treasury of the United States, of the average accepted auction price for the first auction of each annual quarter of the twenty-six-week United States Treasury bills in effect on the date of entry of the judgment. Interest shall apply only to those weekly compensation benefits awarded which have accrued as of the date payment is made by the employer. If the employer pays or tenders payment of compensation, the amount of compensation due is disputed, and the award obtained is greater than the amount paid or tendered by the employer, the assessment of interest shall be determined solely

upon the difference between the amount awarded and the amount tendered or paid.
…

§ 48-145. Employers; compensation insurance required; exceptions; effect of failure to comply; self-insurer; payments required; deposit with State Treasurer; credited to General Fund.
48-145 To secure the payment of compensation under the Nebraska Workers' Compensation Act:
(1) Every employer in the occupations described in section 48-106, except the State of Nebraska and any governmental agency created by the state, shall either (a) insure and keep insured its liability under such act in some corporation, association, or organization authorized and licensed to transact the business of workers' compensation insurance in this state, (b) in the case of an employer who is a lessor of one or more commercial vehicles leased to a self-insured motor carrier, be a party to an effective agreement with the self-insured motor carrier under section 48-115.02, (c) be a member of a risk management pool authorized and providing group self-insurance of workers' compensation liability pursuant to the Intergovernmental Risk Management Act, or (d) with approval of the Nebraska Workers' Compensation Court, self-insure its workers' compensation liability.

An employer seeking approval to self-insure shall make application to the compensation court in the form and manner as the compensation court may prescribe, meet such minimum standards as the compensation court shall adopt and promulgate by rule and regulation, and furnish to the compensation court satisfactory proof of financial ability to pay direct the compensation in the amount and manner when due as provided for in the Nebraska Workers' Compensation Act. Approval is valid for the period prescribed by the compensation court unless earlier revoked pursuant to this subdivision or subsection (1) of section 48-146.02. Notwithstanding subdivision (1)(d) of this section, a professional employer organization shall not be eligible to self-insure its workers' compensation liability. The compensation court may by rule and regulation require the deposit of an acceptable security, indemnity, trust, or bond to secure the payment of compensation liabilities as they are incurred. The agreement or document creating a trust for use under this section shall contain a provision that the trust may only be terminated upon the consent and approval of the compensation court. Any beneficial interest in the trust principal shall be only for the benefit of the past or present employees of the self-insurer and any persons to whom the self-insurer has agreed to pay benefits under subdivision (11) of section 48-115 and section 48-115.02. Any limitation on the termination of a trust and all other restrictions on the ownership or transfer of beneficial interest in the trust assets contained in such agreement or document creating the trust shall be enforceable, except that any limitation or restriction shall be enforceable only if authorized and approved by the compensation court and specifically delineated in the agreement or document. The trustee of any trust created to satisfy the requirements of this section may invest the trust assets in the same manner authorized under subdivisions (1)(a) through (i) of section 30-3209 for corporate trustees holding retirement or pension funds for the benefit of employees or former employees of cities, villages, school districts, or governmental or political subdivisions, except that the trustee shall not invest trust assets into stocks, bonds, or other obligations of the trustor. If, as a result of such investments, the value of the trust assets is reduced below the acceptable trust amount required by the compensation court, then the trustor shall deposit additional trust assets to account for the shortfall.

48-1, 110. Act, how cited
Sections 48-101 to 48-1,117 and section 1 of this act shall be known and may be cited as the Nebraska Workers' Compensation Act.

Note: Nebraska has only one chamber in its Legislature. After the Legislature passes a bill, it goes to the governor for consideration.

Nevada

SB 67 was:
- Passed by the first chamber on April 20, 2015
- Included in NCCI's May 1, 2015 ***Legislative Activity Report*** (RLA-2015-17)
- Amended and passed by the second chamber on May 22, 2015

SB 67 amends various sections of the Nevada Revised Statutes including, but not limited to, the following:
681B.260. Opinion of qualified actuary: Confidentiality of material provided by insurer to Commissioner.
1. Except as otherwise provided in this section and NRS 239.0115, and sections 33, 38 and 39 of this act, ~~an opinion,~~ any documents and ~~any~~ other material or information provided by an insurer to the Commissioner , which constitute a memorandum in support of an opinion, and any other material provided to the Commissioner in connection ~~therewith,~~ with such a memorandum, must be kept confidential by the Commissioner, is not open to the public, and is not subject to subpoena, except for the purpose of defending an action seeking damages from any person by reason of any action required by NRS 681B.200 to 681B.260, inclusive, or by any regulation adopted under those sections.
2. A memorandum or other material may be released by the Commissioner with the written consent of the insurer or to the American Academy of Actuaries or its successor organization upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum or other material.
3. If any portion of a confidential memorandum is cited by the insurer in its marketing or is cited before any governmental agency

other than a state commissioner of insurance or is released by an insurer to the public, all portions of the memorandum are no longer confidential.
4. The Commissioner may use the documents, materials and other information described in this section in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.
5. Neither the Commissioner nor any other person in receipt of documents, materials or other information obtained while acting under the authority of the Commissioner may be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to this section.
6. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or other information described in this section shall occur as a result of disclosure to the Commissioner pursuant to this section or as a result of sharing as authorized in subsection 8 of NRS 679B.190.
7. A memorandum in support of an opinion, and any other material provided by the applicable company or insurer to the Commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this section.
8. Except as otherwise provided in section 39.5 of this act, the provisions of this section apply only before the operative date of the Valuation Manual.

683A.08528. Annual report: Requirements; review by Commissioner; fee.
1. Not later than ~~July 1 of each year,~~ 90 days after the expiration of the fiscal year of the administrator, or within such other period as the Commissioner may allow, each holder of a certificate of registration as an administrator shall file with the Commissioner an annual report for ~~the most recently completed~~ that fiscal year . ~~of the administrator.~~ Each annual report must be verified by at least two officers of the administrator.
2. Each annual report filed pursuant to this section must include all the following:
(a) A financial statement of the administrator that has been reviewed by an independent certified public accountant.
(b) The complete name and address of each person, if any, for whom the administrator agreed to act as an administrator during the ~~most recently completed~~ fiscal year . ~~of the administrator.~~
(c) A statement regarding the total money handled by the administrator on behalf of contracted entities in connection with his or her activities as an administrator. The statement must be on a form prescribed or approved by the Commissioner for the purpose of calculating the amount of the bond required by NRS 683A.0857.
(d) Any other information required by the Commissioner.
3. ~~In~~ Except as otherwise provided in subsection 4, in addition to the information required pursuant to subsection 2, if an annual report is prepared on a consolidated basis, the annual report must include ~~a columnar or combining worksheet~~ supplemental exhibits that:
(a) ~~Includes the amounts shown on the consolidated financial statement accompanying the annual report;~~ Have been reviewed by an independent certified public accountant; and
(b) ~~Separately sets forth the amounts for each entity included in the worksheet; and~~
~~(c) Includes an explanation of each consolidating and eliminating entry included in the worksheet.~~ Include a balance sheet and income statement for each holder of a certificate of registration as an administrator in this State.
4. In lieu of complying with the requirements set forth in paragraphs (a) and (b) of subsection 3, an administrator who is a wholly owned subsidiary of a parent company and who does not hold a certificate of registration in this State may submit to the Commissioner:
(a) The financial statement of the parent company that has been audited by an independent certified public accountant; and
(b) A parental guaranty that is signed by an officer of the parent company and which guarantees the financial solvency of the administrator.
5. Each administrator who files an annual report pursuant to this section shall, at the time of filing the annual report, pay a filing fee in an amount determined by the Commissioner.
~~5.~~ 6. The Commissioner shall, for each administrator, review the annual report that is most recently filed by the administrator. As soon as practicable after reviewing the report, the Commissioner shall:
…

616B.336. Self-insured employers to furnish annual financial statements to commissioner; commissioner may examine records and interview employees.
1. Each self-insured employer shall furnish ~~audited~~ financial statements~~, certified by an auditor licensed to do business in this State,~~ audited by an independent certified public accountant, or foreign equivalent, to the Commissioner annually within 120 days after the expiration of the self-insured employer's fiscal year~~.~~ , or within such other timeframe as the Commissioner may allow.
…

SB 153 was:
- Passed by the first chamber on April 16, 2015
- Included in NCCI's April 24, 2015 ***Legislative Activity Report*** (RLA-2015-16)
- Amended and passed by the second chamber on May 22, 2015

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 12 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.
~~8.~~ 9. A person who files a claim for a disease of the lungs specified in this section after he or she retires from employment as a police officer, firefighter or arson investigator is not entitled to receive any compensation for that disease other than medical benefits.

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.

…

13. A person who files a claim for a disease of the heart specified in this section after he or she retires from employment as a firefighter, arson investigator or police officer is not entitled to receive any compensation for that disease other than medical benefits.

…

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 was:

- Passed by the first chamber on April 15, 2015
- Included in NCCI's April 24, 2015 ***Legislative Activity Report*** (RLA-2015-16)
- Amended and passed by the second chamber on May 22, 2015

SB 194 amends ***sections 616B.710, 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 acts as the sponsor under which a consolidated insurance program is established.

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 was:

- Passed by the first chamber on April 15, 2015
- Included in NCCI's April 24, 2015 ***Legislative Activity Report*** (RLA-2015-16)
- Passed by the second chamber on May 19, 2015

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 was:

- Passed by the first chamber on April 14, 2015
- Included in NCCI's April 24, 2015 ***Legislative Activity Report*** (RLA-2015-16)
- Passed by the second chamber on May 19, 2015

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.
…

Oklahoma

HB 2238 was:
- Passed by the first chamber on May 20, 2015
- Passed by the second chamber on May 22, 2015

HB 2238 amends ***sections 28. Workers' Compensation Fund—Multiple Injury Trust Fund—Self-insurance Guaranty Fund, 31. Multiple Injury Trust Fund***, and ***122. Costs of administering act*** of ***Title 85-A*** in the Oklahoma Statutes as follows:
§ 28. Workers' Compensation Fund—Multiple Injury Trust Fund—Self-insurance Guaranty Fund
A. There are established within the Office of the State Treasurer ~~three~~ two separate funds:
1. ~~The "Workers' Compensation Fund";~~
~~2.~~ The "Multiple Injury Trust Fund"; and
~~3.~~ 2. The "Self-insurance Guaranty Fund".
…
D. All incomes derived through investment of the ~~Workers' Compensation Fund and the~~ Multiple Injury Trust Fund shall be credited as investment income to the fund that participated in the investment.
…
H. ~~The Workers' Compensation Fund shall be used to fund the activities of the Commission in administering the Administrative Workers' Compensation Act and for any other purposes related to the Administrative Workers' Compensation Act that the Commission deems appropriate, subject to the provisions of Section 122 of this title.~~
~~1.~~ Unless provided otherwise in the Administrative Workers' Compensation Act, all fines and penalties assessed under the Administrative Workers' Compensation Act shall be deposited into the Workers' Compensation Commission Revolving Fund. Any monies remaining in the Workers' Compensation Fund on June 30, 2015, shall be transferred to the Workers' Compensation Commission Revolving Fund.

§ 31. Multiple Injury Trust Fund
F. The Multiple Injury Trust Fund shall be derived from the following additional sources:

…
3. The assessments shall be paid to the Tax Commission. Insurance carriers, self-insurers, group self-insurance associations and CompSource Oklahoma shall pay the assessment in four equal installments not later than the fifteenth day of the month following the close of each quarter of the calendar year of the assessment. Assessments shall be determined based upon gross direct written premiums, normal premiums or actual paid losses of the paying party, as applicable, during the calendar quarter for which the assessment is due. Uninsured employers shall pay the assessment not later than the fifteenth day of the month following the close of each quarter of the calendar year of the assessment. For purposes of this section, "uninsured employer" means an employer required by law to carry workers' compensation insurance but who has failed or neglected to do so. ~~Only one-third (1/3) of assessments against insurance carriers and CompSource Oklahoma may be charged to policyholders and shall not be considered in determining whether any rate is excessive. The remaining two-thirds (2/3) of assessments against insurance carriers and CompSource Oklahoma may not be included in any rate, premium, charge, fee, assessment or other amount to be collected from a policyholder. Insurance carriers and CompSource Oklahoma shall not separately state the amount of the assessment on any invoice or billing assessment.~~
…
I. The Tax Commission shall pay, monthly, to the State Treasurer to the credit of the Multiple Injury Trust Fund all monies collected pursuant to the provisions of this section~~, less the annual sum of Two Million Five Hundred Fifty Thousand Dollars ($2,550,000.00), of which One Million Two Hundred Seventy-five Thousand Dollars ($1,275,000.00) shall be payable by the Tax Commission to the State Treasurer in equal monthly installments to the credit of the Department of Labor, Six Hundred Thirty-seven Thousand Five Hundred Dollars ($637,500.00) shall be payable in equal monthly installments to the credit of the Office of the Attorney General, and Six Hundred Thirty-seven Thousand Five Hundred Dollars ($637,500.00) shall be payable in equal monthly installments to the credit of the Oklahoma Department of Career and Technology Education. Monies received by the Department of Labor under this section shall be used for safety consultation and the regulation of the safety of public employees through the Occupational Safety and Health Act of 1970. Monies received by the Office of the Attorney General shall be deposited to the credit of the Attorney General's Workers' Compensation Fraud Unit Revolving Fund created pursuant to Section 19.2 of Title 74 of the Oklahoma Statutes. Monies received by the Oklahoma Department of Career and Technology Education shall supplement other funding to the Department for purposes of implementing the provisions of subsection B of Section 414 of Title 40 of the Oklahoma Statutes~~. The State Treasurer shall pay out of the Multiple Injury Trust Fund only upon the order and direction of the Workers' Compensation Commission acting under the provisions hereof.
…

§ 122. Costs of administering act

A. The Workers' Compensation Commission Revolving Fund established by Section ~~28~~ 2 of this act shall be used for the costs of administering this act and for other purposes ~~pursuant to legislative appropriation~~ as authorized by law.

B. For the purpose of providing funds for the Workers' Compensation Commission Revolving Fund, ~~each~~ for the Workers' Compensation Administrative Fund created in Section 5 of this act, for the Multiple Injury Trust Fund created in Section 28 of this title, and to fund other provisions within this title, the following tax rates shall apply:

1. Each mutual or interinsurance association, stock company, CompSource Oklahoma or other insurance carrier writing workers' compensation insurance in this state shall pay to the Oklahoma Tax Commission an assessment at a rate of one percent (1%) of all gross direct premiums written during each quarter of the calendar year for workers' compensation insurance on risks located in this state after deducting from such gross direct premiums, return premiums, unabsorbed portions of any deposit premiums, policy dividends, safety refunds, savings and other similar returns paid or credited to policyholders. Such payments to the Tax Commission shall be made not later than the fifteenth day of the month following the close of each quarter of the calendar year in which such gross direct premium is collected or collectible. Contributions made by insurance carriers and CompSource Oklahoma, under the provisions of this section, shall be considered for the purpose of computing workers' compensation rates~~.~~ ; and

~~C.~~ 2. When an employer is authorized to become a self-insurer, the Commission shall so notify the Tax Commission, giving the effective date of such authorization. The Tax Commission shall then assess and collect from the employers carrying their own risk an assessment at the rate of two percent (2%) of the total compensation for permanent total disability awards, permanent partial disability awards and death benefits paid out during each quarter of the calendar year by the employers. Such assessment shall be payable by the employers and collected by the Tax Commission according to the provisions of this section regarding payment and collection of the assessment created in paragraph 1 of this subsection ~~C of this section~~.

~~D.~~ C. It shall be the duty of the Tax Commission to collect the payments provided for in this ~~act~~ title. The Tax Commission is hereby authorized to bring an action for the recovery of any delinquent or unpaid payments required in this section. The Tax Commission may also enforce payments by proceeding in accordance with the provisions of Section 98 of this ~~act~~ title.

~~E.~~ D. The Tax Commission shall pay monthly to the State Treasurer to the credit of the ~~General Revenue~~ Multiple Injury Trust Fund all monies collected under the provisions of this section less the annual amounts which shall be apportioned by the Oklahoma Tax Commission as follows:

1. Five Million Dollars ($5,000,000.00) shall be payable in equal monthly installments to the credit of the Workers' Compensation Commission Revolving Fund established in Section 2 of this act for the fiscal year ending June 30, 2016, and Three Million Dollars ($3,000,000.00) for the fiscal year ending June 30, 2017, and for all subsequent years to be used to implement the provisions of this title; and

2. Four Million Dollars ($4,000,000.00) shall be payable in equal monthly installments to the credit of the Workers' Compensation Administrative Fund established in Section 5 of this act for the fiscal year ending June 30, 2016, Three Million Five Hundred Thousand Dollars ($3,500,000.00) for the fiscal year ending June 30, 2017, Three Million Five Hundred Thousand Dollars ($3,500,000.00) for the fiscal year ending June 30, 2018, Three Million Dollars ($3,000,000.00) for the fiscal year ending June 30, 2019, and Two Million Five Hundred Thousand Dollars ($2,500,000.00) for the fiscal year ending June 30, 2020. Monies deposited in the Workers' Compensation Administrative Fund shall be used by the Workers' Compensation Court of Existing Claims to implement provisions provided for in this title.

~~F.~~ E. The refund provisions of Sections 227 through 229 of Title 68 of the Oklahoma Statutes shall be applicable to any payments made pursuant to this section.

HB 2238 also adds new ***Section 28.1*** and ***Section 401.1*** to ***Title 85A*** as follows:

§ 28.1

There is hereby created in the State Treasury a revolving fund for the Workers' Compensation Commission to be designated the "Workers' Compensation Commission Revolving Fund". The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of all monies received by the Workers' Compensation Commission from the revenues apportioned pursuant to Section 122 of Title 85A of the Oklahoma Statutes and such other sources as may be provided by law. All monies accruing to the credit of said fund are hereby appropriated and may be budgeted and expended by the Workers' Compensation Commission for the purpose of funding the operations of the Commission and administering the Administrative Workers' Compensation Act and for any other purposes related to the Administrative Workers' Compensation Act that the Commission deems appropriate. Expenditures from said fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services for approval and payment.

§ 401.1

There is hereby created in the State Treasury a revolving fund for the Workers' Compensation Court of Existing Claims to be designated the "Workers' Compensation Administrative Fund". The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of all monies received by the Workers' Compensation Court of Existing Claims from revenues apportioned pursuant to Section 122 of Title 85A of the Oklahoma Statutes. All monies accruing to the credit of said fund are hereby appropriated and may be budgeted and expended by the Workers' Compensation Court of Existing Claims for the purpose of funding the operations of the Court, for administering the provisions of Titles 85 and 85A of the Oklahoma Statutes, and for any other purpose related to the Administrative Workers' Compensation Act that the Court deems appropriate. Expenditures from said fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services for approval and payment.

Oregon

HB 2211 was:

- Passed by the first chamber on April 16, 2015
- Included in NCCI's April 24, 2015 ***Legislative Activity Report*** (RLA-2015-16)
- Passed by the second chamber on May 20, 2015

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 was:

- Passed by the first chamber on April 16, 2015
- Included in NCCI's April 24, 2015 ***Legislative Activity Report*** (RLA-2015-16)
- Passed by the second chamber on May 20, 2015

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.

Texas

HB 2466 was:

- Passed by the first chamber on May 6, 2015
- Included in NCCI's May 15, 2015 ***Legislative Activity Report*** (RLA-2015-19)
- Passed by the second chamber on May 20, 2015

HB 2466 adds new ***section 411.1031. Safety Reimbursement Program*** to the Texas Statutes as follows:
Sec. 411.1031. Safety Reimbursement Program.
(a) In this section:
(1) "Eligible employer" means an employer, other than this state or a political subdivision of this state subject to Subtitle C, that has workers' compensation insurance coverage and that:
(A) employed at least two but not more than 50 employees on each business day during the preceding calendar year; or
(B) is a type of employer designated as eligible to participate in the program by the commissioner.
(2) "Program" means the workers' compensation safety reimbursement program established under this section.
(b) The commissioner shall adopt rules establishing a safety reimbursement program designed to assist eligible employers in the creation of safe and healthy workplaces for employees of this state. The rules must include requirements for eligible employer applications and appropriate use of allocated funds.
(c) The program shall reimburse an eligible employer for expenses incurred by the employer to facilitate a safe and healthy workplace for employees of the employer. Reimbursement under this section to an eligible employer may not exceed $5,000 per calendar year. Allowable expenses may include:
(1) physical modifications to the worksite;
(2) safety equipment, devices, and tools;
(3) safety training for employees; and
(4) other measures or equipment necessary to correct identified safety hazards and protect employees from unsafe working conditions.
(d) The commissioner by rule shall establish an optional preauthorization plan for eligible employers that participate in the program. The plan must require that an eligible employer submit to the division a proposal in compliance with division rules that describes the workplace modifications and other changes that the employer proposes to make to facilitate a safe and healthy workplace for

employees of the employer.
(e) If the division approves an eligible employer's proposal submitted under Subsection (d), the division shall guarantee reimbursement of the expenses incurred by the employer in implementing the modifications and changes approved by the division unless the division determines that the modifications and changes differ materially from the employer's proposal. Reimbursement under this subsection is subject to the limit imposed under Subsection (c).
(f) From administrative penalties collected by the division, the commissioner shall annually deposit the first $100,000 into the general revenue fund of the state treasury to the credit of the Texas Department of Insurance operating account for the purposes of funding the program. Money for the program may be spent by the division, on appropriation by the legislature, only for the purposes of implementing this section.
(g) An insurance company shall notify eligible employers of the availability of the program as provided by commissioner rule.
(h) Notwithstanding Subsections (a)–(g), this section may be implemented only to the extent funds are available.
(i) Not later than December 1, 2018, the commissioner shall report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature regarding:
(1) the implementation of the program;
(2) the results of the program; and
(3) recommendations regarding the continuation of the program, including any changes necessary to enhance the effectiveness of the program.
(j) This section expires September 1, 2019.

HB 2466 also includes the following language:
(a) As soon as practicable after the effective date of this Act, the commissioner of workers' compensation shall adopt rules necessary to implement the workers' compensation safety reimbursement program established under Section 411.1031, Labor Code, as added by this Act.
(b) The division of workers' compensation of the Texas Department of Insurance shall implement the workers' compensation safety reimbursement program established under Section 411.1031, Labor Code, as added by this Act, beginning January 1, 2016.
(c) An eligible employer may not receive reimbursement under Section 411.1031, Labor Code, as added by this Act, for costs incurred before January 1, 2016.

HB 2771 was:

- Passed by the first chamber on April 28, 2015
- Included in NCCI's May 8, 2015 ***Legislative Activity Report*** (RLA-2015-18)
- Passed by the second chamber on May 22, 2015

HB 2771 adds new ***Section 401.026*** to the Texas Workers' Compensation Act as follows:
Sec. 401.026. Applicability to certain emergency response personnel.
For purposes of this subtitle, the travel of a firefighter or emergency medical personnel en route to an emergency call is considered to be in the course and scope of the firefighter's or emergency medical personnel's employment.

SB 653 was:

- Passed by the first chamber on April 1, 2015
- Included in NCCI's April 10, 2015 ***Legislative Activity Report*** (RLA-2015-14)
- Passed by the second chamber on May 18, 2015

SB 653 amends ***section 408.186. Burial Benefits*** of the Texas Code as follows:
§ 408.186. Burial Benefits
(a) If the death of an employee results from a compensable injury, the insurance carrier shall pay to the person who incurred liability for the costs of burial the lesser of:
(1) the actual costs incurred for reasonable burial expenses; or
(2) $10,000 ~~$6,000~~.
…

SB 653 further states:
The change in law made by this Act applies to a claim for workers' compensation burial benefits based on a compensable injury that occurs on or after the effective date of this Act. A claim based on a compensable injury that occurs before the effective date of this Act is governed by the law in effect on the date the compensable injury occurred, and the former law is continued in effect for that purpose.

If SB 653 is enacted in its current form, overall workers compensation system costs in Texas are estimated to be impacted by less than +0.1%.

SB 978 was:

- Passed by the first chamber on April 14, 2015
- Included in NCCI's April 24, 2015 ***Legislative Activity Report*** (RLA-2015-16)
- Passed by the second chamber on May 19, 2015

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.

BILLS PASSING FIRST CHAMBER

The following bills passed the first chamber within the one-week period ending May 22, 2015.

Connecticut

HB 7000 amends various sections of the Connecticut General Statutes including, but not limited to, the following:

Sec. 31-284a. State contracting with private insurance carrier. Duties and powers of Commissioner of Administrative Services.

…

(b) The Commissioner of Administrative Services may exclude from participation in the state workers' compensation managed care program any medical provider found, through a systematic program of utilization review, to exceed generally accepted standards of the scope, duration or intensity of services rendered to patients with similar diagnostic characteristics. ~~The state shall not make any payment to a facility owned in whole or in part by the referring practitioner.~~

…

SB 593 amends ***sections 31-275. Definitions***, and ***31-294j. Eligibility of municipal firefighters, police officers, constables and volunteer ambulance service members re benefits for diseases arising out of and in the course of employment*** of the Connecticut General Statutes as follows:

Sec. 31-275. Definitions.

As used in this chapter, unless the context otherwise provides:

…

(16) (A) "Personal injury" or "injury" includes, in addition to accidental injury that may be definitely located as to the time when and the place where the accident occurred, an injury to an employee that is causally connected with the employee's employment and is the direct result of repetitive trauma or repetitive acts incident to such employment, and occupational disease.

(B) "Personal injury" or "injury" shall not be construed to include:

(i) An injury to an employee that results from the employee's voluntary participation in any activity the major purpose of which is social or recreational, including, but not limited to, athletic events, parties and picnics, whether or not the employer pays some or all of the cost of such activity;

(ii) A mental or emotional impairment, unless such impairment (I) arises from a physical injury or occupational disease, (II) in the case of a police officer, arises from such police officer's use of deadly force or subjection to deadly force in the line of duty, regardless of whether such police officer is physically injured, provided such police officer is the subject of an attempt by another person to cause such police officer serious physical injury or death through the use of deadly force, and such police officer reasonably believes such police officer to be the subject of such an attempt, **[**or**]** (III) in the case of a firefighter, is diagnosed as post-traumatic stress disorder by a licensed and board certified mental health professional, determined by such professional to be originating from the firefighter witnessing the death of another firefighter while engaged in the line of duty and not subject to any other exclusion in this section, or (IV) in the case of any police officer, is diagnosed by a psychiatrist licensed pursuant to chapter 370 or a psychologist licensed pursuant to chapter 383, and determined by such psychiatrist or psychologist to be originating from the police officer visually witnessing the death, or visually witnessing the immediate aftermath of such death, of one or more human beings, whose death was caused by an act of another human being, and which is not the result of some natural cause, provided such death is not the result of a motor vehicle collision and the visual witnessing of such death, or the visual witnessing of the aftermath of such death, was causally connected with the police officer's employment. As used in this clause, "police officer" means a member of

the Division of State Police within the Department of Emergency Services and Public Protection, an organized **[**local**]** police department or a municipal constabulary, "firefighter" means a uniformed member of a **[**municipal**]** paid or volunteer fire department, **[**and**]** "in the line of duty" means any action that a police officer or firefighter is obligated or authorized by law, rule, regulation or written condition of employment service to perform, or for which the police officer or firefighter is compensated by the public entity such officer serves, and "immediate aftermath" means the scene at which such death occurred for a period of time not to exceed six hours after such scene is secured by law enforcement officers;
(iii) A mental or emotional impairment that results from a personnel action, including, but not limited to, a transfer, promotion, demotion or termination; or
(iv) Notwithstanding the provisions of subparagraph (B)(i) of this subdivision, "personal injury" or "injury" includes injuries to employees of local or regional boards of education resulting from participation in a school-sponsored activity but does not include any injury incurred while going to or from such activity. As used in this clause, "school-sponsored activity" means any activity sponsored, recognized or authorized by a board of education and includes activities conducted on or off school property and "participation" means acting as a chaperone, advisor, supervisor or instructor at the request of an administrator with supervisory authority over the employee.
…

Sec. 31-294j. Eligibility of municipal firefighters, police officers, constables and volunteer ambulance service members re benefits for diseases arising out of and in the course of employment.
(a) For the purpose of adjudication of claims for payment of benefits under the provisions of this chapter, a uniformed member of a paid municipal or volunteer fire department, a regular member of a paid municipal police department, a constable, as defined in section 31-294i, or a member of a volunteer ambulance service shall be eligible for such benefits for any disease arising out of and in the course of employment, including, but not limited to, hepatitis, meningococcal meningitis, tuberculosis, Kahler's Disease, non-Hodgkin's lymphoma, and prostate or testicular cancer that results in death or temporary or permanent total or partial disability.
(b) (1) Notwithstanding any provisions of the general statutes, for the purpose of adjudication of claims for payment of benefits under the provisions of this chapter, a uniformed member of a paid fire department, a certified interior firefighter belonging to a volunteer fire department or a uniformed member of the Department of Emergency Services and Public Protection Fire and Explosion Unit assigned to investigate arson, shall be eligible for such benefits for the following types of cancers arising out of and in the course of employment: Kahler's Disease, non-Hodgkin's lymphoma, or any condition of cancer affecting the brain, skin, digestive system, endocrine system, respiratory system, lymphatic system, reproductive system, urinary system or hematological system that results in death or temporary or permanent total or partial disability. Such cancer shall be presumed to have been suffered in the line of duty as a result of the inhalation, absorption or ingestion of noxious fumes or poisonous gases, unless the contrary be shown by a preponderance of the evidence, provided (A) such uniformed member of a paid fire department, certified interior firefighter belonging to a volunteer fire department or uniformed member of the Department of Emergency Services and Public Protection Fire and Explosion Unit assigned to investigate arson successfully passed a physical examination upon entry into such service, or subsequent to entry, as the case may be, that failed to reveal any evidence of such cancer, (B) (i) such uniformed member has worked for not less than five years at a paid fire department or the Department of Emergency Services and Public Protection Fire and Explosion Unit assigned to investigate arson, or (ii) such certified interior firefighter belonging to a volunteer fire department has worked for not less than fifteen years at such fire department, at the time such cancer is discovered, or should have been discovered, and (C) such cancer is one that is known to result from exposure to heat, radiation or a known or suspected carcinogen as determined by the International Agency for Research on Cancer or the National Toxicology Program of the United States Department of Health and Human Services.
(2) Any individual who is no longer actively serving as a uniformed member of a paid fire department, a certified interior firefighter belonging to a volunteer fire department or a uniformed member of the Department of Emergency Services and Public Protection Fire and Explosion Unit assigned to investigate arson, but who otherwise would be eligible for such benefits pursuant to the provisions of subdivision (1) of this subsection, may apply for such benefits not more than five years from the date such individual last served with such paid fire department, volunteer fire department or the Department of Emergency Services and Public Protection Fire and Explosion Unit assigned to investigate arson.
(3) Any uniformed member of a paid fire department, certified interior firefighter belonging to a volunteer fire department or uniformed member of the Department of Emergency Services and Public Protection Fire and Explosion Unit assigned to investigate arson or individual applying for benefits pursuant to subdivision (1) or (2) of this subsection shall be required to submit to annual physical examinations as a condition of receiving such benefits, the results of which shall be reported to such paid fire department, volunteer fire department or the Department of Emergency Services and Public Protection Fire and Explosion Unit.
(4) No uniformed member of a paid fire department, certified interior firefighter belonging to a volunteer fire department or uniformed member of the Department of Emergency Services and Public Protection Fire and Explosion Unit assigned to investigate arson shall be eligible for such benefits pursuant to the provisions of subdivision (1) of this subsection if it is proven that such uniformed member or certified interior firefighter has smoked any cigarettes, as defined in section 12-285, or otherwise used any tobacco products, as defined in section 12-330a, that are found to have caused such incapacity.

SB 593 also repeals ***section 31-294h. Benefits for police officers and firefighters suffering mental or emotional impairment.***

~~**Sec. 31-294h. Benefits for police officers and firefighters suffering mental or emotional impairment.**~~
~~Notwithstanding any provision of this chapter, workers' compensation benefits for any (1) police officer, as defined in subparagraph (B)(ii) of subdivision (16) of section 31-275, who suffers a mental or emotional impairment arising from such police officer's use of deadly force or subjection to deadly force in the line of duty, or (2) firefighter, as defined in subparagraph (B)(ii) of subdivision (16) of section 31-275, who suffers a mental or emotional impairment diagnosed as post-traumatic stress disorder originating from the firefighter witnessing the death of another firefighter while engaged in the line of duty, shall be limited to treatment by a psychologist or a psychiatrist who is on the approved list of practicing physicians established by the chairman of the Workers' Compensation Commission pursuant to section 31-280.~~

Rhode Island

SB 874 Substitute A amends various sections of the State of Rhode Island General Laws as follows:

28-30-22. Medical advisory board

(a) The chief judge of the workers' compensation court, in consultation with the appropriate medical or professional association, shall appoint a medical advisory board which shall serve at the chief judge's pleasure and consist of eleven (11) members in the following specialties: one orthopedic surgeon; one neurologist; ~~one neurosurgeon;~~ one physiatrist; one chiropractor; one physical therapist; one internist; one psychiatrist or psychologist; and ~~three (3)~~ four (4) ad hoc physician members appointed at the discretion of the chief judge. Members of the board shall be reimbursed three hundred dollars ($300) per day served in the discharge of the board's duties, not to exceed six thousand dollars ($6,000) per member in any year. The chief judge shall designate the chairperson of the board.

…

28-33-17.2. Employee's affirmative duty to report earnings—Penalties for failure to provide earnings report—Civil and criminal liability.

…

(c) (1) The department of labor and training, employer, or insurer shall notify any employee receiving weekly workers' compensation benefits, on forms prescribed by the department, of that employee's affirmative duty to report earnings and shall specifically notify the employee that a failure to report earnings may subject him or her to civil or criminal liability.

(2) The notice by the employer or insurer may be satisfied by printing the notice on the employee payee statement (check stub) portion of indemnity checks sent to the employee, or by incorporating said notice in an agreement for electronic fund transfer or use or issuance of an electronic access device, signed by both the employee and the employer or its insurer.

…

28-33-17.3. Fraud and abuse

…

(b) (2) For the purposes of this section, "Statement" includes, but is not limited to, any endorsement of a benefit check, signature on an agreement for electronic fund transfer of compensation benefits or issuance of an electronic access device, application for insurance coverage, oral or written statement, proof of injury, bill for services, diagnosis, prescription, hospital or provider records, x-rays, test results, or other documentation offered as proof of, or in the absence of, a loss, injury, or expense.

…

28-33-18.3. Continuation of benefits—Partial incapacity

(a)(1) For all injuries occurring on or after September 1, 1990, in those cases where the employee has received a notice of intention to terminate partial incapacity benefits pursuant to Section 28-33-18, the employee, or his or her duly authorized representative, may file with the workers' compensation court a petition for continuation of benefits on forms prescribed by the workers' compensation court. In any proceeding before the workers' compensation court on a petition for continuation of partial incapacity benefits, where the employee demonstrates by a fair preponderance of the evidence that his or her partial incapacity poses a material hindrance to obtaining employment suitable to his or her limitation, partial incapacity benefits shall continue. For injuries on and after July 1, ~~2018~~ 2021, "material hindrance" is defined to include only compensable injuries causing a greater than sixty-five percent (65%) degree of functional impairment and/or disability. Any period of time for which the employee has received benefits for total incapacity shall not be included in the calculation of the three hundred and twelve-week (312) period.

(2) The provisions of this subsection apply to all injuries from Sept. 1, 1990, to July 1, ~~2018~~ 2021.

…

28-35-39. Payment of compensation.—Compensation under chapters 29-38 of this title shall be paid by check as defined in Section 6A-3-104(f) and not by draft, or if mutually agreed upon by both the employee and the employer or its insurer in accordance with Section 28-35-40, by electronic fund transfer, or by electronic access device, at no cost to the employee, with the exception of third-party transactional fees incurred by the employee and shall be paid promptly and directly to the person entitled to it. The check shall contain the following language: "I understand that endorsement hereon or deposit to my accounts constitutes my affirmation that I am receiving these workers' compensation benefits pursuant to law, that I have made no false claims or statements or concealed any material fact, in order to receive these benefits and that doing so would make me liable for civil and criminal penalties, including

jail". If paid by electronic fund transfer or by electronic access device said notice shall be satisfied in accordance with Section 28-33-17.2(c)(2). The insurer/employer and/or its third-party administrator shall not have or be entitled to gain access to the details of electronic transactions, without the express written consent of the employee or court order from a court of competent jurisdiction.

28-35-40. ~~Mailing of weekly compensation~~ Delivery of weekly compensation.—Whenever the employee is entitled to weekly compensation under chapters 29-38 of this title, the employer, and/or insurance carrier, until further order of the workers' compensation court, shall cause to be paid by electronic fund transfer or, issued as an electronic access device, or mailed first class mail to the employee, addressed to his or her last known residence, each week the amount of compensation payable to the employee as it may be due. Electronic funds transfer payments or issuance of an electronic access device shall be permitted if mutually agreed upon by the employee and the employer or its insurer on forms provided by the department of labor and training, which may be rescinded at will be either party on forms provided by the department of labor and training and filed with the department.

28-53-2. Establishment—Sources—Administration.—(a) There shall be established within the department of labor and training a special restricted receipt account to be known as the Rhode Island uninsured employers fund. The fund shall be capitalized from excise taxes assessed against uninsured employers pursuant to the provisions of Section 28-53-9 of this chapter and from general revenues appropriated by the legislature. Beginning in state fiscal year ending June 30, ~~2016~~ 2017, the legislature may appropriate up to two million dollars ($2,000,000) in general revenue funds annually for deposit into the Rhode Island uninsured employers fund.

28-53-7. Payments to employees of uninsured employers

(a) Where it is determined that the employee was injured in the course of employment while working for an employer who fails to maintain a policy of workers' compensation insurance as required by Rhode Island general laws Section 28-36-1, et seq., the uninsured employers fund shall pay the benefits to which the injured employee would be entitled pursuant to chapters 29 to 38 of this title subject to the limitations set forth herein.

(b) The workers' compensation court shall hear all petitions for payment from the fund pursuant to Rhode Island general laws Section 28-30-1, et seq., provided, however, that the uninsured employers fund and the employer shall be named as parties to any petition seeking payment of benefits from the fund.

(c) Where an employee is deemed to be entitled to benefits from the uninsured employers fund, the fund shall pay benefits for disability and medical expenses as provided pursuant to chapters 29 to 38 of this title except that the employee shall not be entitled to receive benefits for loss of function and disfigurement pursuant to the provisions of Rhode Island general laws Section 28-33-19.

(d) The fund shall pay cost, counsel and witness fees as provided in Rhode Island general laws Section 28-35-32 to any employee who successfully prosecutes any petitions for compensation, petitions for medical expenses, petitions to amend a pretrial order or memorandum of agreement and all other employee petitions and to employees who successfully defend, in whole or in part, proceedings seeking to reduce or terminate any and all workers' compensation benefits; provided, however, that the attorney's fees awarded to counsel who represent the employee in petitions for lump sum commutation filed pursuant to Rhode Island general laws Section 28-33-25 or in the settlement of disputed cases pursuant to Rhode Island general laws Section 28-33- 25.1 shall be limited to the maximum amount paid to counsel who serve as court appointed attorneys in workers' compensation proceedings as established by rule or order of the Rhode Island supreme court.

(e) In the event that the uninsured employer makes payment of any monies to the employee to compensate the employee for lost wages or medical expenses, the fund shall be entitled to a credit for all such monies received by or on behalf of the employee against any future benefits payable directly to the employee.

(f) This section shall apply to injuries that occur on or after January 1, ~~2016~~ 2017.

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.