Legislative Activity Report

National Council on Compensation Insurance

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LEGISLATIVE ACTIVITY—LEGISLATIVE SESSION UPDATES

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

BILLS ENACTED

The following bills were enacted within the one-week period ending May 29, 2015.

Nebraska

LB 480 was:

- Passed by the Legislature on May 21, 2015
- Included in NCCI's May 29, 2015 ***Legislative Activity Report*** (RLA-2015-21)
- Enacted on May 27, 2015, with an effective date of August 30, 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 231 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 19, 2015.
- Included in NCCI's May 29, 2015 ***Legislative Activity Report*** (RLA-2015-21).
- Enacted and effective on May 27, 2015, for the purposes of adopting any regulations or performing any preparatory administrative tasks that are necessary to carry out the provisions of this act. All other provisions are effective on January 1, 2016.

SB 231 adds a new section to ***Chapter 616C*** of the Nevada Industrial Insurance Act of the Nevada Revised Statutes as follows:
Section 1
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**:**

Section 2

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.
…

Section 3

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.

NCCI estimates that SB 231 may result in the following impacts:
Section 1—The bill limits the reimbursement for repackaged or relabeled drugs dispensed by a healthcare provider (other than a pharmacist or hospital) to the Average Wholesale Price of the original manufacturer National Drug Code. This would result in an impact of –0.1% (–$0.3M) on overall workers compensation costs in Nevada.
Sections 2 and 3—The proposed changes may result in a negligible decrease in overall workers compensation system costs in Nevada. The resulting impact, if any, will be realized in future experience and reflected in subsequent NCCI loss cost filings in Nevada. Depending upon how various aspects are interpreted, this bill could result in increased frictional costs and litigation.

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.
- Included in NCCI's May 29, 2015 ***Legislative Activity Report*** (RLA-2015-21).
- Enacted and effective on May 27, 2015, for the purposes of adopting any regulations or performing any preparatory administrative tasks that are necessary to carry out the provisions of this act. All other provisions are effective on January 1, 2016.

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.
...

Texas

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
- Included in NCCI's May 29, 2015 ***Legislative Activity Report*** (RLA-2015-21)
- Enacted on May 28, 2015, with an effective date of September 1, 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.

NCCI estimates the impact of SB 653 to the overall workers compensation system costs in Texas to be less than +0.1%.

BILLS PASSING SECOND CHAMBER

The following bills passed the second chamber within the one-week period ending May 29, 2015.

Illinois

SB 1781 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 28, 2015

SB 1781 amends ***section 215/ILCS 5/537.2*** of the Illinois Compiled Statutes Annotated as follows:
§ 215 ILCS 5/537.2 Obligation of Fund
Fund shall be obligated to the extent of the covered claims existing prior to the entry of an Order of Liquidation against an insolvent company and arising within 30 days after the entry of such Order, or before the policy expiration date if less than 30 days after the entry of such Order, or before the insured replaces the policy or on request effects cancellation, if he does so within 30 days after the entry of such Order. If the entry of an Order of Liquidation occurs on or after October 1, 1975 and before October 1, 1977, such obligations shall not: (i) exceed $100,000, or (ii) include any obligation to refund the first $100 of any unearned premium claim; and if the entry of an Order of Liquidation occurs on or after October 1, 1977 and before January 1, 1988, such obligations shall not: (i) exceed $150,000, except that this limitation shall not apply to any workers compensation claims, or (ii) include any obligation to refund the first $100 of any unearned premium claim; and if the entry of an Order of Liquidation occurs on or after January 1, 1988 and before January 1, 2011, such obligations shall not: (i) exceed $300,000, except that this limitation shall not apply to any workers compensation claims, or (ii) include any obligation to refund the first $100 of any unearned premium claim or to refund any unearned premium over $10,000 under any one policy. If the entry of an Order of Liquidation occurs on or after January 1, 2011, then such obligations shall not:

(i) exceed $500,000, except that this limitation shall not apply to any workers compensation claims or (ii) include any obligation to refund the first $100 of any unearned premium claim or refund any unearned premium over $10,000 under any one policy. In no event shall the Fund be obligated to a policyholder or claimant in an amount in excess of the face amount of the policy from which the claim arises. For purposes of this Act, obligations arising under an insurance policy written to indemnify a permissibly self-insured employer under subsection (a) of Section 4 of the Workers' Compensation Act for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention shall be subject to the applicable per-claim limits set forth in this Section.
In no event shall the Fund be liable for any interest on any judgment entered against the insured or the insolvent company, or for any other interest claim against the insured or the insolvent company, regardless of whether the insolvent company would have been obligated to pay such interest under the terms of its policy. The Fund shall be liable for interest at the statutory rate on money judgments entered against the Fund until the judgment is satisfied.
Any obligation of the Fund to defend an insured shall cease upon the Fund's payment or tender of an amount equal to the lesser of the Fund's covered claim obligation limit or the applicable policy limit.

SB 1782 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 28, 2015

SB 1782 amends ***sections 215 ILCS 5/537.4*** and ***215 ILCS 5/546*** of the Illinois Compiled Statutes Annotated as follows:
§ 215 ILCS 5/537.4 Fund assumes obligations of insolvent companies.
The Fund shall be deemed the insolvent company to the extent of the Fund's obligation for covered claims and to such extent shall have all rights, duties, and obligations of the insolvent company, subject to the limitations provided in this Article, as if the company had not become insolvent, with the exception that the liquidator shall retain the sole right to recover any reinsurance proceeds. The Fund's rights under this Section include, but are not limited to, the right to pursue and retain salvage and subrogation recoveries on paid covered claim obligations to the extent paid by the Fund. The extent of the Fund's subrogation rights and any other rights of reimbursement with respect to its covered claims payments shall not be limited as if the Fund were the insolvent company, but shall be determined independently by taking into account the Fund's rights under Section 546 of this Article.

§ 215 ILCS 5/546 Other insurance.
(a) An insured or claimant shall be required first to exhaust all coverage provided by any other insurance policy, regardless of whether or not such other insurance policy was written by a member company, if the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the Fund. The Fund's obligation under Section 537.2 shall be reduced by the amount recovered or recoverable, whichever is greater, under such other insurance policy. Where such other insurance policy provides uninsured or underinsured motorist coverage, the amount recoverable shall be deemed to be the full applicable limits of such coverage. To the extent that the Fund's obligation under Section 537.2 is reduced by application of this Section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount. If the Fund pays a covered claim without the exhaustion of all other coverage that could have been exhausted under this Section, the Fund shall have an independent right of recovery against each insurer whose coverage was not exhausted in the amount the Fund would not have had to pay if that insurer's coverage had been exhausted first.
(b) Any insured or claimant having a claim which may be recovered under more than one insurance guaranty fund or its equivalent shall seek recovery first from the Fund of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he shall first seek recovery from the Fund of the location of the property; if it is a workers' compensation claim, he shall first seek recovery from the Fund of the residence of the claimant. Any recovery under this Article shall be reduced by the amount of the recovery from any other insurance guaranty fund or its equivalent.

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

Louisiana

HB 256 was:

- Passed by the first chamber on May 4, 2015
- Included in NCCI's May 15, 2015 ***Legislative Activity Report*** (RLA-2015-19)
- Amended and passed by the second chamber on May 27, 2015

HB 256 amends ***sections 1342. Definitions; terms defined, 1343. Authority of governmental subdivisions to form, join, and participate in interlocal risk management agency; employer contributions toward premiums; ownership of record*** and ***1344 Governance of interlocal risk management agencies*** of ***Title 33*** of the Louisiana Revised Statutes as follows:
§ 1342. Definitions; terms defined
The following words and terms shall have the meaning indicated unless the context shall clearly indicate a different meaning.
(1) "Local governmental subdivision" means any parish or municipality, other governing or administrative body created under the charter of, or by the governing body of, such parish or municipality to serve a public purpose, or other local governing or

administrative body created by or pursuant to law or the Constitution of Louisiana to serve a public purpose. For purposes of this Subpart only, this term also means the offices of the various clerks of court and district public defender offices established in accordance with R.S. 15:141 et seq., ~~and~~ the members of a trust established by a statewide hospital association for the purposes of providing employers' liability or workers' compensation coverage for its members, provided the majority of the members of such trust consists of governmental subdivisions, and any city, parish, or other local public school system.

…

§ 1343. Authority of governmental subdivisions to form, join, and participate in interlocal risk management agency; employer contributions toward premiums; ownership of record

…

B. Each group self insurance fund shall be separate as to risk, and maintained as a separate pool, but one or more of the funds may be administered by a single interlocal risk management agency. Local governmental subdivisions concluding an agreement under the provisions hereof may by resolution duly adopted by the governing body thereof designate the Louisiana Municipal Association for the municipalities, ~~and~~ the Police Jury Association of Louisiana for the parishes, and the Louisiana School Board Association for the local public school systems to administer the interlocal risk management agency and any group self insurance fund established by said agency, and to further administer the terms and conditions of the intergovernmental agreement by which the agency and the group self insurance fund has been created.

…

F. In addition to local governmental subdivisions, statewide organizations composed of local governmental subdivisions and their wholly owned subsidiaries may become members of an interlocal risk management agency for purposes of providing accident and health protection to their employees and for purposes of providing coverage for those risks defined in R.S. 22:47(3), (6), ~~(7),~~ and (10), and public liability and worker's compensation coverage upon approval of the governing body of the association and the governing body of the interlocal risk management agency. For purposes of this Subsection, the Police Jury Association of Louisiana, ~~and~~ the Louisiana Municipal Association, and the Louisiana School Board Association shall be considered statewide organizations composed of local governmental subdivisions.

§ 1344. Governance of interlocal risk management agencies

~~In the event~~ If the Louisiana Municipal Association of Louisiana, ~~and/or~~ the Police Jury Association of Louisiana, or the Louisiana School Board Association is ~~be~~ designated to administer an interlocal risk management agency, the executive boards of the Louisiana Municipal Association and of the Police Jury Association of Louisiana, as the case may be, and the board of directors of the Louisiana School Board Association shall constitute the board of trustees of each such agency established as provided in ~~Section 1340(B)~~ R.S. 33:1343, and shall be authorized as such to adopt bylaws for the administration of their respective agencies.

SB 144 was:

- Passed by the first chamber on May 4, 2015
- Included in NCCI's May 15, 2015 ***Legislative Activity Report*** (RLA-2015-19)
- Passed by the second chamber on May 26, 2015

SB 144, in part, amends ***section 1267. Commercial insurance; cancellation and renewal*** of ***Title 22*** of the Louisiana Revised Statutes as follows:

§ 1267. Commercial insurance; cancellation and renewal

…

C. …

(3) ~~Nothing in this Section shall require an~~ An insurer ~~to~~ shall provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance ~~agency~~ company or other entity pursuant to a power of attorney or other agreement executed by or on behalf of the insured.

…

G.(1) An insurance premium finance company that finances any part of an insurance policy governed by this Section shall cooperate with the department in any investigation regarding such insurance policy.

(2) Upon request by the department, the insurance premium finance company shall make available to the department all documents, correspondence, and cancellation notices related to the insurance policy that have been received or sent by the insurance premium finance company.

(3) An insurance premium finance company that violates any provision of this Section shall be subject to the monetary penalties provided for in R.S. 22:13(A).

New Hampshire

HB 455 was:

- Passed by the first chamber on March 11, 2015
- Passed by the second chamber on May 28, 2015

HB 455 amends various sections of the New Hampshire Statutes including, but not limited to, the following:

281-A:61 Reports of the Commissioner.

I. The commissioner shall make a report to the governor, by October 1 of each odd-numbered year, showing the work done during the preceding 2 fiscal years. The report shall include a properly classified statement of department expenses, statistical information relating to the number and character of industrial accidents during such 2 years and such other information and recommendations as the commissioner deems pertinent. The report shall be printed as part of the commissioner's biennial report.
II. The commissioner shall make a workplace safety and injury report, which shall be submitted with the report required under paragraph I, to the governor and the legislature. The report shall provide statistical information pertaining to the nature, character and severity of industrial accidents, injuries, and illnesses in New Hampshire and information pertaining to the department's and employers' efforts in the area of safety promotion and accident prevention. ~~The statistical information related to workplace injuries shall be compiled from data gathered directly by the department through the required injury reports filed by employers.~~ This report shall include, but not be limited to, the types and frequency of reported injuries; ~~a breakdown and analysis of the types and size of industries, and~~ the job classifications from which such injuries have been reported; ~~the average length of disability;~~ a report of employer compliance with RSA 281-A:64; the annual listing of best and worst performers as prepared by the commissioner under the provisions of RSA 281-A:64; a report of all departmental activities required under RSA 281-A:65; specific recommendations for improved workplace safety promotion and injury prevention; and any other such information and recommendations pertaining to workplace injuries and injury prevention as the commissioner deems appropriate. ~~The report shall also include the same information for certified managed care programs and shall include information relative to the number of employees and the number of hearings of claimants participating in each certified managed care program.~~

Note: The version of **HB 455** that was passed by the first chamber did not contain any relevant workers compensation-related language; therefore, it was not included in any previous version of NCCI's ***Legislative Activity Report.***

Oregon

HB 3114 was:

- Passed by the first chamber on April 17, 2015
- Included in NCCI's April 24, 2015 ***Legislative Activity Report*** (RLA-2015-16)
- Passed by the second chamber on May 26, 2015

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

Texas

HB 1094 was:

- Passed by the first chamber on May 4, 2015
- Included in NCCI's May 15, 2015 ***Legislative Activity Report*** (RLA-2015-19)
- Amended and passed by the second chamber on May 26, 2015

HB 1094 amends ***section 408.183. Duration of Death Benefits*** of the Texas Statutes as follows:
§ 408.183. Duration of Death Benefits
…
(b) An eligible spouse is entitled to receive death benefits for life or until remarriage. On remarriage, the eligible spouse is entitled to receive 104 weeks of death benefits, commuted as provided by commissioner rule.
(b-1) Notwithstanding Subsection (b), an eligible spouse who remarried is eligible for death benefits for life if the employee was a first responder, as defined by Section 504.055, who suffered death in the course and scope of employment or while providing services as a volunteer.
…

HB 1094 also includes the following clause:
The change in law made by this Act to Section 408.183, Labor Code, applies only to a claim for workers' compensation 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 that date is governed by the law as it existed on the date the compensable injury occurred, and the former law is continued in effect for that purpose.

HB 1170 was:

- Passed by the first chamber on May 8, 2015
- Included in NCCI's May 15, 2015 ***Legislative Activity Report*** (RLA-2015-19)
- Amended and passed by the second chamber on May 27, 2015

HB 1170 adds new ***section 12.1058. Applicability of Other Laws*** to Subchapter D, Chapter 12, Education Code of the Texas Statutes as follows:

Sec. 12.1058. Applicability of Other Laws.

(a) An open-enrollment charter school is considered to be:

(1) a local government for purposes of Chapter 791, Government Code;

(2) a local government for purposes of Chapter 2259, Government Code, except that an open-enrollment charter school may not issue public securities as provided by Section 2259.031(b), Government Code;

(3) a political subdivision for purposes of Chapter 172, Local Government Code; and

(4) a local governmental entity for purposes of Subchapter I, Chapter 271, Local Government Code.

(b) An open-enrollment charter school may elect to extend workers' compensation benefits to employees of the school through any method available to a political subdivision under Chapter 504, Labor Code. An open-enrollment charter school that elects to extend workers' compensation benefits as permitted under this subsection is considered to be a political subdivision for all purposes under Chapter 504, Labor Code. An open-enrollment charter school that self-insures either individually or collectively under Chapter 504, Labor Code, is considered to be an insurance carrier for purposes of Subtitle A, Title 5, Labor Code.

(c) Notwithstanding Subsection (a) or (b), an open-enrollment charter school operated by a tax exempt entity as described by Section 12.101(a)(3) is not considered to be a political subdivision, local government, or local governmental entity unless the applicable statute specifically states that the statute applies to an open-enrollment charter school.

BILLS PASSING FIRST CHAMBER

The following bill passed the first chamber within the one-week period ending May 29, 2015.

Connecticut

SB 427 amends ***section 31-299a. Payments under group medical policy not defense to claim for benefits. Health insurer's duty to pay. Lien.*** of the Connecticut General Statutes as follows:

Sec. 31-299a. Payments under group medical policy not defense to claim for benefits. Health insurer's duty to pay. Lien

…

(b) Where an employer contests the compensability of an employee's claim for compensation, and the employee has also filed a claim for benefits or services under the employer's group health, medical, disability or hospitalization plan or policy, the employer's health insurer may not delay or deny payment of benefits due to the employee under the terms of the plan or policy by claiming that treatment for the employee's injury or disease is the responsibility of the employer's workers' compensation insurer. The health insurer may file a claim in its own right against the employer for the value of benefits paid by the insurer within two years from payment of the benefits. The health insurer shall not have a lien on the proceeds of any award or approval of any compromise made by the commissioner pursuant to the employee's compensation claim, in accordance with the provisions of section 38a-470, unless the health insurer actually paid benefits to or on behalf of the employee.

(c) Where an employer contests the compensability of an employee's claim for compensation, and the employee has also filed a claim for benefits or services under the employer's group health, medical, disability or hospitalization plan or policy, and the claim for compensation is ultimately resolved in favor of the claimant, twenty per cent of any amount recovered by the health insurer as a result of any claim that the health insurer may file in its own right against the employer for the value of benefits paid by the insurer pursuant to subsection (b) of this section shall be transferred to the claimant and no attorney's fees shall be payable from such transferred amount.

The following section contains monthly updates on significant legislative activity, judicial decisions, and regulatory committee activity that may impact the workers compensation system and will be included in the report the first week of every month throughout the year.

FEDERAL ISSUES

Issue	Update
Congress	Congress is expected to turn its focus to several pressing issues including defense spending authorization, tax reform, international trade, and highway infrastructure funding.
Cyber Security	Congress continues to focus significant attention on cyber security and insurance issues. Approximately 20 bills dealing with various aspects of cyber security have been introduced. The health care and financial services sectors have been identified as a desirable target for cyber criminals given the rich data associated with financial products. Congress is expected to act on several important pieces of legislation in the coming months, particularly those related to the sharing of information between entities whose data has been breached.

Medicare Set Aside (MSA)	Legislation is anticipated to be introduced in June that would bring about long-sought reforms to the current Medicare set-aside (MSA) process. Those provisions would make enhancements to the MSA process by creating timelines for the Centers for Medicare & Medicaid Services (CMS) to make determinations, allowing for the payment to CMS of set-aside amounts and instituting an appeals process.
Federal Black Lung Program	The US Department of Labor Office of Workers' Compensation Programs has filed regulations for comment on the Federal Black Lung Program. The proposed regulations would address procedural issues related to claims processing and adjudication. Regarding claims for benefit issues, parties would be required to disclose all medical information developed during the claims process. Additionally, the regulations would clarify that coal mine operators must pay benefits during post-award proceedings. Comments on the regulations can be filed through June 29.

The bills included in the following section have been filed, but have not yet passed the first chamber.

STATE LEGISLATIVE ACTIVITY

State	Update
Alabama	**SB 292** allows for electronic delivery to an email address or posting to an accessible network any property-casualty insurance notice or document, once the insured has consented to electronic delivery of all notices.
Maine	**LD 1379** establishes requirements for insurance coverage relating to the operation of transportation network companies (TNC). Provisions include that a TNC is not deemed to control, direct, or manage the TNC drivers that connect to the digital network, or the drivers' personal vehicles, except as expressly provided in a written contract between the driver and the TNC.
Ohio	**HB 205** allows employers and groups of employers to purchase workers compensation coverage from private insurance carriers. Currently, such coverage is only available through the Ohio Bureau of Workers Compensation, a monopolistic state fund.
South Carolina	Both **HB 4171** and **HB 4197** allow employers to opt-out of providing workers compensation coverage to their workers.

OTHER ITEMS OF INTEREST

State	Update
South Dakota	A recent state Supreme Court decision has been handed down in the case *Wheeler v. Cinna Bakers, LLC*. This case involved a claimant who worked part-time for Cinna Bakers, LLC, in addition to two other unrelated jobs. The claimant's injury was sustained while working for Cinna Bakers, and her lost-time benefits were based solely on wages from that employment. As a result of the injury, however, she was unable to work at any of her jobs. The district court affirmed the administrative law judge and denied the claimant's request to receive lost-time benefits based on the combined lost wages for all three of her jobs. On appeal, the South Dakota Supreme Court overturned the district court and held that the claimant could aggregate wages from all concurrently held jobs, not just similar or related employments. *NCCI is currently analyzing this ruling to determine the potential impact of the decision on overall workers compensation system costs.*

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.