Legislative Activity Report

National Council on Compensation Insurance

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June 12, 2015 RLA-2015-23

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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 June 5, 2015.

Alaska

HB 178 was:

- Passed by the first chamber on April 10, 2015
- Included in NCCI's April 17, 2015 ***Legislative Activity Report*** (RLA-2015-15)
- Passed by the second chamber on April 26, 2015
- Included in NCCI's May 8, 2015 ***Legislative Activity Report*** (RLA-2015-18)
- Enacted on June 1, 2015, with an effective date of June 2, 2015

With the passage of **HB 316** in 2014, the Medical Services Review Committee was tasked with creating conversion factors for a fee schedule produced by the Centers for Medicare & Medicaid Services for workers compensation medical billings. **HB 178** postpones the effective date of the new fee schedule from July 1, 2015, to December 1, 2015.

Louisiana

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
- Included in NCCI's June 5, 2015 ***Legislative Activity Report*** (RLA-2015-22)
- Enacted on June 5, 2015, with an effective date of August 1, 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 480 was:

- Passed by the first chamber on March 11, 2015
- Passed by the second chamber on May 7, 2015
- Included in NCCI's May 15, 2015 ***Legislative Activity Report*** (RLA-2015-19)
- Enacted on June 2, 2015, with an effective date of August 1, 2015

HB 480 amends ***section 412:5. Approval of Form*** of the New Hampshire Statutes, related to property and casualty insurance policies, as follows:

412:5. Approval of Form.

…

III. No liability policy issued or delivered in this state shall contain coverage for payment of a fine or penalty for a criminal offense provided, however, the policy may provide coverage for defense costs and restitution to injured parties.
IV. An insurer may authorize an advisory organization to file policy forms, endorsements and other contract language on its behalf.
~~IV.~~ V. Every insurer and advisory organization shall provide reasonable means whereby any person aggrieved by the application of an insurer's rating system, claims practices, sales practices or underwriting procedures may be heard, in person or by an authorized representative, upon the person's written request to review the manner in which such procedures were applied in connection with insurance afforded or tendered to the person.

Oklahoma

HB 2238 was:

- Passed by the first chamber on May 20, 2015
- Passed by the second chamber on May 22, 2015
- Included in NCCI's May 29, 2015 ***Legislative Activity Report*** (RLA-2015-21)
- Enacted on June 1, 2015, with an effective date of July 1, 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.~~
~~I.~~ 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.

SB 767 was:

- Passed by the first chamber on March 11, 2015
- Included in NCCI's March 20, 2015 ***Legislative Activity Report*** (RLA-2015-11)
- Passed by the second chamber on April 22, 2015
- Included in NCCI's May 22, 2015 ***Legislative Activity Report*** (RLA-2015-20)
- Amended and enacted on June 4, 2015, with an effective date of November 1, 2015

SB 767 amends various sections of ***Title 85A*** of the Oklahoma Statutes including, but not limited to, the following:

§ 6. Fraud

A. 1. a. Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of:

(1) obtaining any benefit or payment,

(2) increasing any claim for benefit or payment, or

(3) obtaining workers' compensation coverage under this act, shall be guilty of a felony punishable pursuant to Section 1663 of Title 21 of the Oklahoma Statutes.

…

K. If the Attorney General's Office is in compliance with the discovery provisions of Section 258 of Title 22 of the Oklahoma Statutes, medical records created for the purpose of treatment and medical opinions obtained during the investigation shall be admissible at the preliminary hearing without the appearance of the medical professional creating such records or opinions. However, when material evidence dispositive to the issues of whether there was probable cause the crime was committed and whether the defendant committed the crime, was not included in a report or opinion admitted at preliminary hearing, but might be presented at a pretrial hearing by a medical professional who created such report or opinion, the judge may, upon the motion of either party, order the appearance of the medical professional creating such report or opinion. Questions of fact regarding the conduct of the defendant that conflict with the findings of the medical professional evaluating the defendant shall not constitute material evidence. In the event of such motion, notice shall be given to the Attorney General's Workers Compensation Fraud and Investigation and Prosecution Unit. A hearing shall be held and, if the motion is granted, the evidence shall not be presented fewer than five (5) days later.

L. Any person or entity who, in good faith and exercising due care, reports suspected workers' compensation fraud or insurance fraud, or who allows access to medical records or other information pertaining to suspected workers' compensation or insurance fraud, by persons authorized to investigate a report concerning the workers' compensation and insurance fraud, shall have immunity

from any civil or criminal liability for such report or access. Any such person or entity shall have the same immunity with respect to participation in any judicial proceeding resulting from such reports. For purposes of any civil or criminal proceeding, there shall be a presumption of good faith of any person making a report, providing medical records or providing information pertaining to a workers' compensation or insurance fraud investigation by the Attorney General, and participating in a judicial proceeding resulting from a subpoena or a report.

§ 45. Temporary total disability—Temporary partial disability—Permanent partial disability—Permanent total disability

…

C. Permanent Partial Disability.

…

2. Permanent partial disability shall not be allowed to a part of the body for which no medical treatment has been received. A determination of permanent partial disability made by the Commission or administrative law judge which is not supported by objective medical findings provided by a treating physician who is a medical doctor, ~~or~~ doctor of osteopathy, chiropractor or a qualified independent medical examiner shall be considered an abuse of discretion.

…

§ 65. Occupational disease

…

D. 2. No compensation shall be payable for any contagious or infectious disease unless contracted in the course and scope of employment ~~in or immediately connected with a hospital or sanatorium in which persons suffering from that disease are cared for or treated~~.

…

F. 1. An employer shall not be liable for any compensation for an occupational disease unless:

a. the disease is due to the nature of an employment in which the hazards of the disease actually exist and ~~are characteristic thereof and peculiar to the trade, occupation, process, or employment and~~ is actually incurred in the course and scope of his or her employment. This includes any disease due to or attributable to exposure to or contact with any radioactive material by an employee in the course and scope of his or her employment,

…

§ 203. Written benefit plan

…

A. An employer voluntarily electing to become a qualified employer shall adopt a written benefit plan that complies with the requirements of this section. Qualified-employer status is optional for eligible employers. The benefit plan shall not become effective until the date that the qualified employer first satisfies the notice requirements in Section ~~109~~ 202 of this ~~act~~ title.

B. The benefit plan shall provide for payment of the same forms of benefits included in the Administrative Workers' Compensation Act for temporary total disability, temporary partial disability, permanent partial disability, vocational rehabilitation, permanent total disability, disfigurement, amputation or permanent total loss of use of a scheduled member, death and medical benefits as a result of an occupational injury, on a no-fault basis, ~~with the same statute of limitations,~~ and with dollar, percentage, and duration limits that are at least equal to or greater than the dollar, percentage, and duration limits contained in Sections 45, 46 and 47 of this ~~act~~ title. For this purpose, the standards for determination of average weekly wage, death beneficiaries, and disability under the Administrative Workers' Compensation Act shall apply under the Oklahoma Employee Injury Benefit Act; but no other provision of the Administrative Workers' Compensation Act defining covered injuries, medical management, dispute resolution or other process, funding, notices or penalties shall apply or otherwise be controlling under the Oklahoma Employee Injury Benefit Act, unless expressly incorporated.

…

F. Information submitted to the Commissioner as part of the application for approval as a qualified employer, to confirm eligibility for continuing status as a qualified employer, or as otherwise required by the Oklahoma Employee Injury Benefit Act may not be made public by the Commissioner or by an agent or employee of the Commissioner without the written consent of the applicant, except that:

1. The information may be discoverable by a party in a civil action or contested case to which the employer that submitted the information is a party, upon a showing by the party seeking to discover the information that:

a. the information sought is relevant to and necessary for the furtherance of the action or case,

b. the information sought is unavailable for other non-confidential sources, and

c. a subpoena issued by a judicial or administrative officer of competent jurisdiction has been submitted to the Commissioner; and

2. The Commissioner may disclose the information to a public officer having jurisdiction over the regulation of insurance in another state if:

a. the public officer agrees in writing to maintain the confidentiality of the information, and

b. the laws of the state in which the public officer serves require the information to be kept confidential.

§ 205. Oklahoma Option Insured Guaranty Fund—Oklahoma Option Self-insured Guaranty Fund

…

F. On determination by the ~~Commission~~ Commissioner that a self-insurer has become an impaired insurer, the ~~Commission~~ Commissioner shall release the security required by paragraph 2 of subsection B of Section 111 of this act and advise the Guaranty Association of the impairment. Claims administration, including processing, investigating and paying valid claims against an impaired self-insurer under this act, may include payment by the surety that issued the surety bond or be under a contract between the ~~Commission~~ Commissioner and an insurance carrier, appropriate state governmental entity or an approved service organization.

…

§ 211. Denial of claim—Appeal rights

B. The benefit plan shall provide the following minimum appeal rights:

…

5. If any part of an adverse benefit determination is upheld by the committee, the claimant may then file a petition for review with the Commission ~~sitting en banc~~ within one (1) year after the date the claimant receives notice that the adverse benefit determination, or part thereof, was upheld. The Commission ~~en banc~~ shall appoint an administrative law judge to hear any appeal of an adverse benefit determination as a trial de novo. The Commission shall prescribe additional rules governing the authority and responsibility of the parties, the administrative law judge and the Commission during the appeal processes. The administrative law judge and Commission shall act as the court of competent jurisdiction under 29 U.S.C.A. Section 1132(e)(1), and shall possess adjudicative authority to render decisions in individual proceedings by claimants to recover benefits due to the claimant under the terms of the claimant's plan, to enforce the claimant's rights under the terms of the plan, or to clarify the claimant's rights to future benefits under the terms of the plan;

6. The Commission shall rely on the record established by the internal appeal process and use an objective standard of review that is not arbitrary or capricious. Any party aggrieved by the judgment, decision, or award made by an administrative law judge may, within ten (10) days of issuance, appeal to the Commission. After hearing, the Commission may reverse or modify the decision of the administrative law judge only if it determines that the decision was against the clear weight of evidence or contrary to law. All such proceedings of the Commission shall be recorded by a court reporter. Any judgment of the Commission which reverses a decision of the administrative law judge shall contain specific findings relating to the reversal. Any award by the administrative law judge or Commission shall be limited to benefits payable under the terms of the benefit plan and, to the extent provided herein, attorney fees and costs; and

7. If the claimant appeals to the Commission and any part of the adverse benefit determination is upheld, he or she may appeal to the Oklahoma Supreme Court. The judgment, decision or award of the Commission shall be final and conclusive on all questions within its jurisdiction between the parties unless an action is commenced in the Supreme Court of this state to review the judgment, decision or award within twenty (20) days of being sent to the parties. Any judgment, decision or award made by an administrative law judge shall be stayed until all appeal rights have been waived or exhausted. The Supreme Court may modify, reverse, remand for rehearing, or set aside the judgment, decision or award only if it was:

a. in violation of constitutional provisions,

b. in excess of the statutory authority or jurisdiction of the Commission,

c. made on unlawful procedure,

d. affected by other error of law,

e. clearly erroneous in view of the reliable, material, probative and substantial competent evidence,

f. arbitrary or capricious,

g. procured by fraud, or

h. missing findings of fact on issues essential to the decision.

Such action shall be commenced by filing with the Clerk of the Supreme Court a certified copy of the judgment, decision or award of the Commission attached to a petition which shall specify why the judgment, decision or award is ~~contrary to law within twenty (20) days of the decision being issued. The Supreme Court may modify, reverse, remand for rehearing, or set aside the decision only if the decision was contrary to law~~ erroneous or illegal.

The Supreme Court shall require the ~~claimant~~ appealing party to file within forty-five (45) days from the date of the filing of an appeal a transcript of the record of the proceedings before the Commission, or such later time as may be granted by the Supreme Court on application and for good cause shown. The action shall be subject to the law and practice applicable to comparable civil actions cognizable in the Supreme Court.

…

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

- Included in NCCI's May 29, 2015 ***Legislative Activity Report*** (RLA-2015-21)
- Enacted on June 2, 2015, with an effective date of January 1, 2016

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
- Included in NCCI's April 29, 2015 ***Legislative Activity Report*** (RLA-2015-21)
- Enacted on June 2, 2015, with an effective date of January 1, 2016

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.

…

HB 2797 also includes the following clause:

The amendments to ORS 656.262 by section 1 of this 2015 Act apply to claims filed on or after the effective date of this 2015 Act.

HB 3114 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
- Included in NCCI's June 5, 2015 ***Legislative Activity Report*** (RLA-2015-22)
- Enacted on June 4, 2015, with an effective date of January 1, 2016

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 1388 was:

- Passed by the first chamber on April 28, 2015
- Passed by the second chamber on May 15, 2015
- Enacted and effective on May 29, 2015

HB 1388 amends ***section 607.058. Presumption Rebuttable*** and ***section 409.022. Refusal to Pay Benefits; Notice; Administrative Violation*** of the Texas Statutes as follows:

§ 607.058. Presumption Rebuttable.

(a) A presumption under Section 607.053, 607.054, 607.055, or 607.056 may be rebutted through a showing by a preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter or emergency medical technician caused the individual's disease or illness.

(b) A rebuttal offered under this section must include a statement by the person offering the rebuttal that describes, in detail, the evidence that the person reviewed before making the determination that a cause not associated with the individual's service as a firefighter or emergency medical technician caused the individual's disease or illness.

§ Sec. 409.022 Refusal to Pay Benefits; Notice; Administrative Violation

…

(d) In this subsection, the terms "emergency medical technician" and "firefighter" have the meanings assigned by Section 607.051, Government Code. In addition to the other requirements of this section, if an insurance carrier's notice of refusal to pay benefits under Section 409.021 is sent in response to a claim for compensation resulting from an emergency medical technician's or a firefighter's disability or death for which a presumption is claimed to be applicable under Subchapter B, Chapter 607, Government Code, the notice must include a statement by the carrier that:

(1) explains why the carrier determined a presumption under that subchapter does not apply to the claim for compensation; and

(2) describes the evidence that the carrier reviewed in making the determination described by Subdivision (1).

HB 1388 also includes the following clause:

The changes in law made by this Act apply to a claim for benefits or compensation brought on or after the effective date of this Act. A claim for benefits or compensation brought before that date is covered by the law in effect on the date the claim was made, and that law is continued in effect for that purpose.

Note: HB 1388 was not included in any previous version of NCCI's ***Legislative Activity Report***.

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

The following bills passed the second chamber within the one-week period ending June 5, 2015.

Connecticut

HB 6868 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 June 2, 2015

HB 6868, in part, amends various sections of the Connecticut General Statutes governing the Connecticut Insurance Guaranty Association (CIGA) to:
- Expand the claims CIGA must cover to include claims from policies that an insurer, who subsequently becomes insolvent, acquired through a merger or acquisition. Covered claims are those that the insurer assumed as a direct obligation by one of the following:
  - By acquiring another insurer's assets and assuming its liabilities
  - Through an assumption reinsurance transaction (i.e., where one insurer assumes liability for another insurer's obligations)
- Specify that the residence of claimants or insureds other than individuals (e.g., businesses) is the state where their principal place of business is located at the time of the insured event
- Change the point at which CIGA payments are triggered from a determination of insolvency to a final order of liquidation
- Specify that CIGA is not responsible for:
  - Claims arising from policies originally issued by a surplus lines carrier or risk retention group (i.e., a type of captive insurer or self-insured group organized under state and federal laws)
  - Obligations assumed by an insolvent insurer after a delinquency proceeding starts, unless the claim would have been covered regardless of the insolvent insurer assuming it
  - Obligations assumed by an insolvent insurer in a transaction in which the original insurer remains separately liable

HB 7000 was:
- Passed by the first chamber on May 19, 2015
- Included in NCCI's May 29, 2015 ***Legislative Activity Report*** (RLA-2015-21)
- Passed by the second chamber on June 2, 2015

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.~~
…

Illinois

SB 1805 was:
- Passed by the first chamber on April 22, 2015
- Included in NCCI's May 1, 2015 ***Legislative Activity Report*** (RLA-2015-17)

- Amended and passed by the second chamber on May 30, 2015

SB 1805 adds new ***section 215 ILCS 5/155.44 Financial requirements; large deductible agreements for workers' compensation insurance*** to the Illinois Compiled Statutes Annotated, as follows:

Sec. 155.44. Financial requirements; large deductible agreements for workers' compensation insurance.

(a) An insurer shall:

(1) require full collateralization of the outstanding obligations owed under a large deductible agreement by using one of the following methods:

(A) a surety bond issued by a surety insurer authorized to transact business by the Department and whose financial strength and size ratings from A.M. Best Company are not less than "A" and "V", respectively;

(B) an irrevocable letter of credit issued by a financial institution with an office physically located within the State and the deposits of which are federally insured; or

(C) cash or securities held in trust by a third party or by the insurer and subject to a trust agreement for the express purpose of securing the policyholder's obligation under a large deductible agreement, provided that if the assets are held by the insurer those assets are not commingled with the insurer's other assets; and

(2) limit the size of the policyholder's obligations under a large deductible agreement to no greater than 20% of the total net worth of the policyholder at each policy inception, as determined by an audited financial statement as of the most recently available fiscal year end.

(b) As used in this Section, "insurer" means any insurer authorized to issue a workers' compensation policy covering risks located in this State that has an A.M. Best Company rating below "A–" and does not have at least $200,000,000 in surplus.

(c) As used in this Section, "large deductible agreement" means any combination of one or more policies, endorsements, contracts, or security agreements which provide for the policyholder to bear the risk of loss $100,000 or greater per claim or occurrence covered under a policy of workers' compensation insurance and which may be subject to the aggregate limit of policyholder reimbursement obligations.

(d) Except when approved by the Director of Insurance, any insurer determined to be in a financially hazardous condition pursuant to Article XII 1/2 or XIII of this Code by the Director of Insurance in this State or the equivalent in any other state is prohibited from issuing or renewing a policy that includes a large deductible agreement.

(e) This Section applies to large deductible agreements issued or renewed by any insurer on or after January 1, 2016.

Louisiana

HB 393 was:

- Passed by the first chamber on May 12, 2015
- Included in NCCI's May 22, 2015 ***Legislative Activity Report*** (RLA-2015-20)
- Amended and passed by the second chamber on June 4, 2015

HB 393 amends ***section 23:1196.1. Investments*** of the Louisiana Revised Statutes, related to group self-insurance funds for workers compensation, as follows:

§ 23:1196.1. Investments

…

B. Amounts not needed for current obligations may be invested by the board of trustees as provided in this Section, and not otherwise, in any or all of the following:

…

(4) Obligations of the state of Louisiana or its subdivisions having a minimum rating of "A" by Moody's, Standard & Poor's, or Fitch. No more than five percent of the fund's assets may be invested in any one issue nor can this type of investment exceed fifteen percent of the fund's assets in the aggregate.

(5) Obligations of any state or its subdivisions having a minimum rating of "A" by Moody's, Standard & Poor's, or Fitch. No more than five percent of the fund's assets may be invested in any one issue nor can this type of investment exceed fifteen percent of the fund's assets in the aggregate.

(6) Commercial mortgage-backed securities with purchases having a minimum rating of Aaa by Moody's, AAA by Standard and Poor's, or AAA by Fitch. No more than two percent of the fund's assets may be invested in one issue, nor can this type of investment exceed ten percent of the fund's assets in the aggregate.

(7) Asset-backed securities with purchases having a minimum rating of Aa by Moody's, AA by Standard and Poor's, or AA by Fitch. No more than five percent of the fund's assets may be invested in one issue, nor can this type of investment exceed ten percent of the fund's assets in the aggregate.

(8) Repurchase agreements, without limitation, when the collateral for the agreement is a direct obligation of the United States government, provided that the repurchase agreement shall:

(a) Be in writing.

(b) Have a specific maturity date.

(c) Adequately identify each security to which the agreement applies.

(d) State that in the event of default by the party agreeing to repurchase the securities described in the agreement at the term contained in the agreement, title to the described securities shall pass immediately to the fund without recourse.
~~(6)~~ (9) Corporate bonds, subject to the following limitations:
(a) The bonds must have a minimum rating of ~~"A"~~ Baa by Moody's, BBB by Standard and Poor's, or BBB by Fitch.
(b) Except as provided in Subparagraph ~~(6)(d)~~ (d) of this Paragraph, not more than five percent of a fund's assets may be invested in corporate bonds of any one issue or issuer.
(c) Except as provided in Subparagraph ~~(6)(d)~~ (d) of this Paragraph, not more than fifty percent of a fund's assets may be invested in corporate bonds of all types.
(d) The five percent and fifty percent limitations specified in Subparagraphs ~~(6)(b) and (c)~~ (b) and (c) of this Paragraph, respectively, may be exceeded up to an additional ten percent of a fund's assets in the event, and only in the event, of financial circumstances acceptable to the Department of Insurance, such as an increase in market value after initial purchase of a corporate bond, provided that:
~~(I)~~ (i) The initial purchase of corporate bonds was within the limitations specified in Subparagraphs ~~(6)(b) and (c); and~~ (b) and (c) of this Paragraph.
(ii) For the purpose of determining the financial condition of a fund, the Louisiana Department of Insurance will not include as assets of a fund corporate bonds which exceed fifty percent of a fund's total assets.
(10) Mutual or trust fund institutions which are registered with the Securities and Exchange Commission under the Securities Act of 1933 and the Investment Company Act of 1940, and which have underlying investments consisting solely of and limited to securities approved for investment as set forth in this Subsection. This type of investment shall not exceed fifty percent of the fund's assets in the aggregate.
(11)(a) Equities subject to the following limitations:
(i) The equity sector shall not exceed fifteen percent of the overall investment fund.
(ii) A minimum of five different issues shall be held in the equity sector to provide for diversification.
(iii) No single issue may represent more than five percent, at cost, of the overall investment fund.
(iv) Market capitalization of each issue shall be at least one billion dollars.
(v) Each eligible issue shall be paying a cash dividend.
(vi) Equity holdings shall be restricted to high quality, readily marketable securities corporations that are domiciled in the United States and that are actively traded on the major United States exchanges including the New York Stock Exchange and the National Association of Securities Dealers Automated Quotation Stock Market, LLC (NASDAQ).
(b) Foreign domiciled corporations are eligible if they trade American Depositary Receipts on the major United States exchanges.
(c) In lieu of individual securities, a mutual fund or exchange traded fund which pays a dividend and consists of securities which have an average market capitalization of at least one billion dollars shall be acceptable. The same general quality constraints shall be met and the aggregate total of the funds, plus any individual securities, may not exceed fifteen percent of the overall investment fund.
…

New Hampshire

SB 133 was:

- Passed by the first chamber on March 12, 2015
- Included in NCCI's March 20, 2015 ***Legislative Activity Report*** (RLA-2015-11)
- Amended and passed by the second chamber on June 3, 2015

SB 133 amends ***sections 281-A:24 Payment for Reasonable Value of Services*** and ***420-G:11-a Development of a Comprehensive Health Care Information System*** of the New Hampshire Statutes as follows:

281-A:24 Payment for Reasonable Value of Services.

~~I. The employer or the employer's insurance carrier shall pay the full amount of the health care provider's bill unless the employer or employer's insurance carrier can show just cause as to why the total amount should not be paid. Effort shall be made to resolve any dispute as to the reasonable value of service prior to applying to the commissioner for resolution of such a dispute. Whenever an injured employee receives medical and hospital service or other remedial care under the provisions of this chapter and a dispute arises between the employer and the person, firm, or corporation rendering such service or care as to the reasonable value of the service or care, the commissioner shall have exclusive jurisdiction to determine the reasonable value of such service or care. Following the commissioner's determination, any interested party may petition for a hearing and all interested parties shall be entitled to notice and hearing if it is determined that all reasonable efforts to resolve the dispute have failed. The commissioner or the commissioner's authorized representative shall make a finding as to the reasonable value of such services or care rendered, and such findings shall be final.~~

~~II. If the commissioner finds that a health care provider, health care facility, or rehabilitation provider has required unnecessary treatment, hospitalization, rehabilitation services or office visits, or other excessive charges, the health care provider, health care facility, or rehabilitation provider shall not receive payment under this chapter from a carrier, employer, or employee for the excessive fees or unnecessary treatment, hospitalization, rehabilitation services, or visits. In addition, the health care provider, health~~

~~care facility, or rehabilitation provider shall be required to return to the carrier, self-insurer, employer or injured employee any such fees or charges already collected.~~
~~III, IV. [Repealed.]~~
~~V. The commissioner shall assess a civil penalty not to exceed $2,500 for violations of this section which are willful or which demonstrate a pattern of improperly charging or overcharging employers or workers' compensation insurers.~~
I.(a) The employer or the employer's insurance carrier shall pay the reasonable value of medical services provided under this chapter.
(b) The health care provider shall have the burden of establishing that its bill for services is reasonable.
(c) Effort shall be made to resolve any dispute as to the reasonable value of service prior to applying to the commissioner for resolution of such a dispute.
(d) Whenever an injured employee receives medical or hospital service or other remedial care under the provisions of this chapter and a dispute arises between the employer or the employer's insurance carrier and the person, firm, or corporation rendering such service or care as to the reasonable value of the service or care, the commissioner shall have exclusive jurisdiction to determine the reasonable value of such service or care. Any interested party may petition for a hearing and all interested parties shall be entitled to notice and hearing if it is determined that all reasonable efforts to resolve the dispute have failed.
(e) The commissioner or the commissioner's authorized representative shall make a finding as to the reasonable value of such services or care rendered.
(f) Any party in interest aggrieved by such a finding may appeal to the compensation appeals board under RSA 281-A:43.

420-G:11-a Development of a Comprehensive Health Care Information System.
I. The department and the department of health and human services shall enter into a memorandum of understanding for collaboration in the development of a comprehensive health care information system. The memorandum of understanding shall include a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited use data sets, the criteria and procedures to ensure that Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant limited use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system. To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size. Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not include or disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers'' include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and social security number.
II. The commissioner of the department of health and human services, with the approval of the commissioner of the insurance department, shall adopt rules, under RSA 541-A, as may be necessary to provide for the release of claims data from the comprehensive health care information system (CHIS).
III. The department shall make available to the public a public use data set for purposes of facilitating transparency in health care costs.

SB 133 also adds new ***section 412:37-b Advisory Organizations; Required Activity*** as follows:
412:37-b Advisory Organizations; Required Activity.
The commissioner shall consult with workers' compensation advisory organizations, workers' compensation carriers, and third party administrators or self-insureds regarding the most effective options for including workers' compensation medical claims data in the New Hampshire comprehensive health information system, as defined under RSA 420-G:11-a. The commissioner shall make a report with recommendations on options for including workers' compensation medical claims data in the New Hampshire comprehensive health information system on or before December 1, 2015 to the speaker of the house of representatives, the president of the senate, the governor. and the chairpersons of the house and senate committees having jurisdiction over health and human services.

Oregon

HB 2644 was:
- Passed by the first chamber on March 18, 2015
- Included in NCCI's March 27, 2015 ***Legislative Activity Report*** (RLA-2015-12)
- Passed by the second chamber on June 3, 2015

HB 2644 allows claims for wrongful death against the state that are typically barred by ORS 30.265(6)(a) in a narrow set of circumstances. The claim for wrongful death is only allowable against the state and not against local public bodies. The death must have occurred in the scope and course of the decedent's employment, it must have occurred as a result of the conduct of another person who is subsequently convicted of murder or found guilty except for insanity of murder, and the decedent was not employed

by a public body at the time of death. The measure would only apply to wrongful death claims based on a crime of murder committed on or after May 1, 2012, and is repealed on January 2, 2017. If the measure revives a claim that was barred under ORS 30.265(6)(a) before the effective date of HB 2644, the claimant must begin the action within one year after the effective date of HB 2644.

BILLS PASSING FIRST CHAMBER

The following bill passed the first chamber within the one-week period ending June 5, 2015.

Illinois

HB 1287, in part, makes various changes to the Illinois Insurance Code and Workers' Compensation Act of the Illinois Compiled Statues Annotated. Changes to the Illinois Insurance Code are as follows:

§ 215 ILCS 5/456. Making of rates

Sec. 456. Making of rates. (1) All rates shall be made in accordance with the following provisions:

…

A rate ~~in a competitive market is not excessive. A rate in a noncompetitive market~~ is excessive if it is likely to produce a long run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to the services rendered.

…

§ 215 ILCS 5/457. Rate filings

Sec. 457. Rate filings. (1) Every ~~Beginning January 1, 1983, every~~ company shall prefile ~~file~~ with the Director every manual of classifications, every manual of rules and rates, every rating plan and every modification of the foregoing which it intends to use. Such filings shall be made at least ~~not later than~~ 30 days before ~~after~~ they become effective. A company may satisfy its obligation to make such filings by adopting the filing of a licensed rating organization of which it is a member or subscriber, filed pursuant to subsection (2) of this Section, in total or, with the approval of the Director, ~~by notifying the Director in what respects it intends to~~ deviate from such filing. If a company intends to deviate from the filing of a licensed rating organization of which it is a member, the company shall provide the Director with supporting information that specifies the basis for the requested deviation and provides justification for the deviation. Any company adopting a pure premium filed by a rating organization pursuant to subsection (2) must file with the Director the modification factor it is using for expenses and profit so that the final rates in use by such company can be determined.

(2) Each ~~Beginning January 1, 1983, each~~ licensed rating organization must prefile ~~file~~ with the Director every manual of classification, every manual of rules and advisory rates, every pure premium which has been fully adjusted and fully developed, every rating plan and every modification of any of the foregoing which it intends to recommend for use to its members and subscribers, at least ~~not later than~~ 30 days before ~~after~~ such manual, premium, plan or modification thereof takes effect. Every licensed rating organization shall also file with the Director the rate classification system, all rating rules, rating plans, policy forms, underwriting rules or similar materials, and each modification of any of the foregoing which it requires its members and subscribers to adhere to not later than 30 days before such filings or modifications thereof are to take effect. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated.

(3) A filing and any supporting information made pursuant to this Section shall be open to public inspection as soon as filed ~~after the filing becomes effective~~ .

(4) A filing shall not be effective nor used until approved by the Director. A filing shall be deemed approved if the Director fails to disapprove within 30 days after the filing.

§ 215 ILCS 5/458. Disapproval of filings

Sec. 458. Disapproval of filings. (1) If within 30 ~~thirty~~ days of any filing the Director finds that such filing does not meet the requirements of this Article, he shall send to the company or rating organization which made such filing a written notice of disapproval of such filing, specifying therein in what respects he finds that such filing fails to meet the requirements of this Article ~~and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective~~ . A company or rating organization whose filing has been disapproved shall be given a hearing upon a written request made within 30 days after the disapproval order. ~~If the company or rating organization making the filing shall, prior to the expiration of the period prescribed in the notice, request a hearing, such filings shall be effective until the expiration of a reasonable period specified in any order entered thereon. If the rate resulting from such filing be unfairly discriminatory or materially inadequate, and the difference between such rate and the approved rate equals or exceeds the cost of making an adjustment, the Director shall in such notice or order direct an adjustment of the premium to be made with the policyholder either by refund or collection of additional premium. If the policyholder does not accept the increased rate, cancellation shall be made on a pro rata basis.~~

~~Any policy issued pursuant to this subsection shall contain a provision that the premium thereon shall be subject to adjustment upon the basis of the filing finally approved.~~

…

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

that a specified portion of the premiums be placed in an escrow account approved by him or her. When new rates become legally effective, the Director shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimus shall not be required.

§ 215 ILCS 5/462a (new)

Sec. 462a. Premiums; review.

(a) Premiums shall not be excessive. A premium is excessive if it is likely to produce a long run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to the coverage or services rendered.

(b) At any time, an insured may file a request for review of a premium with the Director. The request shall be in such form as the Director prescribes and shall specify the grounds on which the premium is excessive.

If within 30 days of any proper request for review under this Section, the Director finds that the premium does not meet the requirements of this Section, he or she shall send to the insurer a written notice of disapproval of premium, specifying therein in what respects he or she finds that the premium fails to meet the requirements of this Section, stating when, within a reasonable period thereafter, the premium shall be deemed no longer effective, and ordering an adjustment of the premium. An insurer whose premium has been disapproved shall be given a hearing upon a written request made within 30 days after the disapproval order. If the insurer requests a hearing, the premium shall be effective until the expiration of a reasonable period specified in any order entered thereon. If, after a hearing, the premium is found to be excessive, the Director shall order an adjustment of the premium. The insurer shall refund to the insured any amount found to be excessive under this Section.

If the Director finds that a review is not warranted or a premium is not excessive, he or she shall provide notice of that decision to the insured and the insurer.

(c) An insurer shall provide all information requested by the Director as he or she determines necessary to assist in review of premiums under this Section.

§ 215 ILCS 5/460 (repealed)

~~Sec. 460. Competitive Market, Approval of Rates. (a) Beginning January 1, 1983, a competitive market is presumed to exist unless the Director, after a hearing, determines that a reasonable degree of competition does not exist in the market and the Director issues a ruling to that effect. For purposes of this Article only, market shall mean the statewide workers' compensation and employers' liability lines of business. In determining whether a reasonable degree of competition exists, the Director shall consider relevant tests of workable competition pertaining to market structure, market performance and market conduct. Such tests may include, but need not be limited to, the following: size and number of firms actively engaged in the market, market shares and changes in market shares of firms, ease of entry and exit from a given market, underwriting restriction, and whether profitability for companies generally in the market is unreasonably high. The determination of competition involves the interaction of the various tests and the weight given to specific tests depends upon the particular situation and pattern of test results.~~

~~In determining whether or not a competitive market exists, the Director shall monitor the degree of competition in this State. In doing so, he shall utilize existing relevant information, analytical systems and other sources; cause or participate in the development of new relevant information, analytical systems and other sources; or rely on some combination thereof. Such activities may be conducted internally within the Department of Insurance, in cooperation with other state insurance departments, through outside contractors, or in any other appropriate manner.~~

~~(b) If the Director finds that a reasonable degree of competition does not exist in a market, he may require that the insurers in that market file supporting information in support of existing rates. If the Director believes that such rates may violate any of the requirements of this Article, he shall call a hearing prior to any disapproval. If the Director determines that a competitive market does not exist in the workers' compensation market as provided in a ruling pursuant to this Section, then every company must prefile every manual of classifications, rules, rates, rating plans, rating schedules, and every modification of the foregoing covered by such rule. Such filing shall be made at least 30 days prior to its taking effect, and such prefiling requirement shall remain in effect as long as there is a ruling in effect pursuant to this Section that a reasonable degree of competition does not exist.~~

~~(c) The Director shall disapprove a rate if he finds that the rate is excessive, inadequate or unfairly discriminatory as defined in Section 456. An insurer whose rates have been disapproved shall be given a hearing upon a written request made within 30 days after the disapproval order.~~

~~If the Director disapproves a rate, he shall issue an order specifying in what respects it fails to meet the requirements of this Article and stating when within a reasonable period thereafter such rate shall be discontinued for any policy issued or renewed after a date specified in the order. The order shall be issued within 30 days after the close of the hearing or within such reasonable time extension as the Director may fix. Such order may include a provision for premium adjustment for the period after the effective date of the order for policies in effect on such date.~~

~~(d) Whenever an insurer has no legally effective rates as a result of the Director's disapproval of rates or other act, the Director shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interest of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him. When new rates become legally effective, the Director shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimus shall not be required.~~

Changes to the Illinois Workers' Compensation Act are as follows:

§ 820 ILCS 305/4e (new)

Sec. 4e. Safety programs and return to work programs; recalculation of premiums and waiver of self-insurers fee.

(a) An employer may file with the Commission a workers' compensation safety program or a workers' compensation return to work program implemented by the employer. The Commission may certify any such safety program as a bona fide safety program after reviewing the program for the following minimum requirements: adequate safety training for employees; establishment of joint employer-employee safety committees; use of safety devices; and consultation with safety organizations. The Commission may certify any such return to work program as a bona fide return to work program after reviewing the program for the following minimum requirements: light duty or restricted duty work; leave of absence policy; and full duty return to work policy. The Commission shall notify the Department of Insurance of the certification.

(b) Upon receipt of a certification notice from the Commission under this Section related to an employer that provides workers' compensation through an insurer, the Director of Insurance shall immediately direct in writing the employer's workers' compensation insurer to recalculate the workers' compensation premium rates for the employer so that those premium rates incorporate and take into account the certified program.

(c) If any workers' compensation safety program or a workers' compensation return to work program implemented by a self-insured employer is certified under this Section, the annual fee under Section 4d of this Act is waived for the self-insured employer as long as the workers' compensation safety program or a workers' compensation return to work program continues. The self-insured employer shall certify the continuation of the program by each July 1 after the waiver is obtained.

§ 820 ILCS 305/1. [Liability of employer to pay compensation]

Sec. 1. This Act may be cited as the Workers' Compensation Act.

…

(d) To obtain compensation under this Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. Except as provided in subsection (e) of this Section, accidental injuries sustained while traveling to or from work do not arise out of and in the course of employment.

For the purposes of this subsection (d):

"In the course of employment" refers to the time, place, and circumstances surrounding the accidental injuries.

"Arising out of the employment" refers to causal connection. It must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injuries. An injury arises out of the employment if, at the time of the occurrence, the employee was performing acts he or she was instructed to perform by his or her employer, acts which he or she had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his or her assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his or her duties.

(e) Where an employee is required to travel away from his or her employer's premises in order to perform his or her job, the traveling employee's accidental injuries arise out of his or her employment, and are in the course of his or her employment, when the conduct in which he or she was engaged at the time of the injury is reasonable and when that conduct might have been anticipated or foreseen by the employer. Accidental injuries while traveling do not occur in the course of employment if the accident occurs during a purely personal deviation or personal errand unless such deviation or errand is insubstantial.

820 ILCS 305/35 (new)

Sec. 35. Repetitive and cumulative injuries; right of contribution.

(a) Any accidental injury which results from repetitive or cumulative trauma and occurs within 3 months after the employee begins his or her employment shall not be considered by a workers' compensation insurer in setting the premium rate for the employer.

(b) If an award is made for benefits in connection with repetitive or cumulative injury resulting from employment with more than one employer, the employer liable for award or its insurer is entitled to contributions or reimbursement from each of the employee's prior employers which are subject to this Act or their insurers for the prior employer's pro rata share of responsibility as determined by the Commission. The right to contribution or reimbursement under this Section shall not delay, diminish, restrict, or alter in any way the benefits to which the employee or his or her dependents are entitled under this Act. At any time within one year after the Commission or the Arbitrator has made an award for benefits in connection with repetitive or cumulative injury, the employer liable under the award or its insurer may institute proceedings before the Commission for the purpose of determining the right of contribution or reimbursement. The proceeding shall not delay, diminish, restrict, or alter in any way the benefits to which the employee or his or her dependents are entitled under this Act, but shall be limited to a determination of the respective contribution or reimbursement rights and the responsibilities of all the employers joined in the proceeding. The employee has the duty of rendering reasonable cooperation in any such proceeding.

(c) No contribution or reimbursement may be sought for any payment of benefits more than 2 years after the employer seeking contribution or reimbursement has made the payment.

(d) This Section shall apply only to injuries occurring on or after the effective date of this amendatory Act of the 99th General Assembly.

(e) The Commission shall adopt emergency rules under Section 5-45 of the Illinois Administrative Procedure Act to implement the provisions of this Section to implement this Section.

§ 820 ILCS 305/29.2

Sec. 29.2. Insurance and self-insurance oversight.

…

(a-5) The Department of Insurance shall annually submit to the Governor, the Chairman of the Commission, and the General Assembly a written report that details the state of self-insurance for workers' compensation in Illinois. The report shall be completed by October 1, 2015 and April 1 of each year thereafter or later if necessary data or analyses are only available to the Department at a later date. The report shall be posted on the Department of Insurance's Internet website. Information to be included in the report shall be for the preceding calendar year. The report shall include, at a minimum, the following:

(1) The number of employers that self-insure for workers' compensation.

(2) The total number of employers belonging to a group workers' compensation pool.

(3) The total amount of indemnity payments made by self-insureds and by group workers' compensation pools in Illinois.

(4) The total amount of medical payments made by self-insureds and by group workers' compensation pools in Illinois, and the national rank of Illinois based on average cost of medical claims per injured worker.

(5) The growth of total paid indemnity benefits by temporary total disability, scheduled and non-scheduled permanent partial disability, and total disability.

(6) The number of injured workers receiving wage loss differential awards and the average wage loss differential award payout.

(7) Illinois' rank, relative to other states, for:

(i) the maximum and minimum temporary total disability benefit levels;

(ii) the maximum and minimum scheduled and non-scheduled permanent partial disability benefit levels;

(iii) the maximum and minimum total disability benefit levels; and

(iv) the maximum and minimum death benefit levels.

(8) The aggregate growth of medical benefit payouts by non-hospital providers and hospitals.

(9) The aggregate growth of medical utilization for the top 10 most common injuries to specific body parts by non-hospital providers and hospitals.

(b) The Director of Insurance shall promulgate rules requiring each insurer licensed to write workers' compensation coverage in the State self-insured employer, and group workers' compensation pool to record and report the following information on an aggregate basis to the Department of Insurance before March 1 of each year, relating to claims in the State opened within the prior calendar year:

(1) The number of claims opened.

(2) The number of reported medical only claims.

(3) The number of contested claims.

(4) The number of claims for which the employee has attorney representation.

(5) The number of claims with lost time and the number of claims for which temporary total disability was paid.

(6) The number of claim adjusters employed to adjust workers' compensation claims.

(7) The number of claims for which temporary total disability was not paid within 14 days from the first full day off, regardless of reason.

(8) The number of medical bills paid 60 days or later from date of service and the average days paid on those paid after 60 days for the previous calendar year.

(9) The number of claims in which in-house defense counsel participated, and the total amount spent on in-house legal services.

(10) The number of claims in which outside defense counsel participated, and the total amount paid to outside defense counsel.

(11) The total amount billed to employers for bill review.

(12) The total amount billed to employers for fee schedule savings.

(13) The total amount charged to employers for any and all managed care fees.

(14) The number of claims involving in-house medical nurse case management, and the total amount spent on in-house medical nurse case management.

(15) The number of claims involving outside medical nurse case management, and the total amount paid for outside medical nurse case management.

(16) The total amount paid for Independent Medical exams.

(17) The total amount spent on in-house Utilization Review for the previous calendar year.

(18) The total amount paid for outside Utilization Review for the previous calendar year.

The Department shall make the submitted information publicly available on the Department's Internet website or such other media as appropriate in a form useful for consumers.

820 ILCS 305/29.3 (new)

Sec. 29.3. Workers' Compensation Premium Rates Task Force.

(a) There is created the Workers' Compensation Premium Rates Task Force consisting of 12 members appointed as follows: 2

legislative members appointed by the Speaker of the House of Representatives; 2 legislative members appointed by the Minority Leader of the House of Representatives; 2 legislative members appointed by the President of the Senate; 2 legislative members appointed by the Minority Leader of the Senate; and one member appointed by the Governor from each of the following organizations:
(i) a statewide association representing retailers;
(ii) a statewide association representing manufacturers;
(iii) a statewide association representing labor interests; and
(iv) a statewide association representing injured workers. The members of the Task Force shall be appointed by August 1, 2015. Two co-chairpersons, representing different political parties, shall be selected by the members of the Task Force. Members of the Task Force shall receive no compensation for their service on the Task Force.
(b) The Task Force shall study the National Council on Compensation Insurance's recommendations for workers' compensation premium rates and the extent to which Illinois employers' actual premiums reflect these recommended rates. The Department of Insurance shall provide administrative support to the Task Force.
(c) The Task Force shall report its findings and recommendations to the General Assembly no later than December 31, 2015.
(d) This Section is repealed on December 31, 2016.

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.