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 passed the first chamber, passed the second chamber, or were 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

There were no relevant workers compensation-related bills enacted within the one-week period ending February 12, 2016.

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bill passed the second chamber within the one-week period ending February 12, 2016.

South Dakota

HB 1084 was:

- Passed by the first chamber on February 2, 2016
- Included in NCCI's February 12, 2016 ***Legislative Activity Report*** (RLA-2016-05)
- Passed by the second chamber on February 10, 2016

HB 1084 adds and amends various sections of the South Dakota Codified Laws related to when concurrent employment may be used to calculate earnings in workers compensation cases. The bill amends the following sections to read:

58-20-3.1. Premiums on wages for vacations, holidays, or sick leave prohibited.
Premiums for workers' compensation insurance may not be based on wages paid to employees while they are on vacation, holidays, or sick leave or on wages received from employment not performed for the insured employer.

62-1-1 Definitions
…
(6) "Earnings," the amount of compensation for the number of hours commonly regarded as a day's work for the employment in which the employee was ~~engaged~~ working at the time of ~~his~~ the employee's injury. It includes payment for all hours worked, including overtime hours at straight-time pay, and does not include any sum which the employer has been accustomed to pay the employee to cover any special expense entailed by ~~him~~ the employee by the nature of ~~his~~ the employment; wherever allowances of any character made to an employee in lieu of wages are specified as a part of the wage contract, ~~they~~ the allowances shall be deemed a part of ~~his~~ the employee's earnings;…

A new section is added to ***Chapter 62-1*** to read:
For a workers' compensation claim arising before May 6, 2015, an employee's earnings up to the claimed date of injury are calculated exclusively on the wages earned at the place of employment where the injury occurred.

For a workers' compensation claim arising after May 5, 2015, if an employee was working for more than one employer, the employee's earnings used to calculate the employee's average weekly wage in §§ 62-4-24, 62-4-25, or 62-4-26 shall include the amount of compensation for the number of hours commonly regarded as a day's work for each employer in which the person was concurrently employed at the time of the person's injury; however, an employee's earnings from concurrent employment are aggregated only if the injury occurred when the employee was actively working in the concurrent employment and when the injury prevents the employee from performing the employee's duties at the employee's other concurrent employment.

A new section is added to ***Chapter 62-6*** to read:
An employer which complies with this title shall produce, if demanded by any employer or insurer against whom an injured employee has made a workers' compensation claim, the work-related records referring to its employee available for the fifty-two weeks preceding the employee's claimed dates of injury, such as:
(1) The weeks in which the employee performed services;
(2) The earnings the employee received for the services, as defined in subdivision 62-1-1(6);
(3) Interruptions in employment if the employee was rehired or seasonally employed;
(4) Changes in the employee's grade of employment;
(5) The employee's job description; and
(6) Federal or state tax deductions.

The employer receiving this demand shall produce the employee's work-related records in ten business days, and may charge a fee for the production of the records. The fee for the production of the employee's work-related records may not exceed fifteen dollars.

An employee waives any right to privacy to these work-related records when the employee makes a claim for workers' compensation benefits and the employee consents to the release of these work-related records to the employer or insurer against which the employee is making a claim for workers' compensation benefits.

A new section is added to ***Chapter 62-2*** to read:
The Workers' Compensation Advisory Council shall include in its annual report data about the average amount of disability or fatality benefits paid for a claim over the most recent calendar years, the ratio of disability and fatality benefits to overall benefits paid, and any changes in premium base rates directly attributable to including concurrent earnings in benefits. It shall report to the 2019 Legislature the impact of this Act.

HB 1084 also includes the following language:
The Legislature finds that the aggregation of wages from concurrent employment was not within the Legislature's intent when it enacted the definition of earnings in subdivision 62-1-1(6). Therefore, the holding in Wheeler v. Cinna Baker LLC, 2015, 864 N.W. 2d, regarding the aggregation of wages is abrogated.

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending February 12, 2016.

Arizona

SB 1323 amends ***section 23-941.02. Vexatious litigants; designation; definitions*** of the Arizona Revised Statutes as follows:
23-941.02. Vexatious litigants; designation; definitions
A. In a workers' compensation case before the commission, on the motion of a party, the chief administrative law judge or an administrative law judge designated by the chief administrative law judge may designate a pro se litigant a vexatious litigant. The pro se litigant shall respond within thirty days after the motion. The chief administrative law judge, or administrative law judge if designated by the chief administrative law judge, shall issue an order within thirty days after the pro se litigant's response is received or the time for response has elapsed. The vexatious litigant designation applies only to the claim at issue before the administrative law judge.
B. A pro se litigant who is designated a vexatious litigant may not file a new request for hearing, pleading, motion or other document without prior leave of the administrative law judge.
C. A pro se litigant is a vexatious litigant if the commission finds the pro se litigant engaged in vexatious conduct. A designation of vexatious litigant is suspended during the period in which the litigant is represented by legal counsel.
D. For the purposes of this section:
1. "vexatious conduct" includes any of the following:
(a) repeated filing of requests for hearing, pleadings, motions or other documents solely or primarily for the purpose of harassment.
(b) unreasonably expanding or delaying commission proceedings.
(c) bringing or defending claims without substantial justification.
(d) engaging in abuse of discovery or conduct in discovery that has resulted in the imposition of sanctions against the pro se litigant.
(e) a pattern of making unreasonable, repetitive and excessive requests for information.
(f) repeated filing of documents or requests for relief that have been the subject of previous rulings by the commission in the same claim.
2. "without substantial justification" has the same meaning prescribed in section 12-349.

Mississippi

HB 112, in part, amends ***section 33-15-15. Mobile support units*** as follows:
§ 33-15-15.Mobile support units
…

(b) Personnel of emergency management support forces while on duty, whether within or without the state, shall:
(1) If they are employees of the state, have the powers, duties, rights, privileges and immunities and receive the compensation incidental to their employment;
(2) If they are employees of a political subdivision of the state, and whether serving within or without such political subdivision, have the powers, duties, rights, privileges and immunities and receive the compensation incidental to their employment; and
(3) If they are not employees of the state or a political subdivision thereof, be entitled to compensation by the state at a rate commensurate with their duties and responsibilities and to the same rights and immunities as are provided by law for the employees of this state.
All personnel of emergency management support forces shall, while on duty, be subject to the operational control of the authority in charge of emergency management activities in the area in which they are serving, and shall be reimbursed for all actual and necessary travel and subsistence expenses, and for death, disability or injury to such personnel while on such emergency duty as a member of an emergency management support force, the state shall pay compensation to the heirs in event of death or the individual in event of injury or disability in accordance with payment schedules contained in the Mississippi Workers' Compensation Law.
(c) Personnel who are not otherwise covered by subsection (b) of this section, but who are registered in the Mississippi Responder Management System, developed to facilitate health and medical response through identification, credentialing and deployment of responders for the State of Mississippi, shall be reimbursed for death, disability or injury to such personnel, and the state shall pay compensation to the heirs in event of death or to the individual in event of injury or disability in accordance with payment schedules contained in the Mississippi Workers' Compensation Law, for death or injuries to the individual while responding to an officially declared emergency or during emergency preparedness training.
…

HB 523 amends ***section 71-3-111. Mississippi Workers' Compensation Assigned Risk Plan; commissioner's duties and responsibilities; temporary joint underwriting association*** of the Mississippi Code of 1972 to read, in part:
§ 71-3-111. Mississippi Workers' Compensation Assigned Risk Plan; commissioner's duties and responsibilities; temporary joint underwriting association
…
(6) Whenever a workers' compensation policy is purchased using the Mississippi Assigned Risk Pool and a minimum premium applies to the policy, the insurer shall notify the insured in writing before the policy is issued that the minimum premium will be fully earned and no refund of any premium will be given regardless of the date of cancellation or the reason for cancellation. Such notice shall be in letter form or in the form of a stamp clearly visible on the policy face page.
…
(8) Any employer or person affected by the operation of the Mississippi Workers' Compensation Assigned Risk Plan or the actions of a servicing carrier of the plan who has a dispute with respect to any aspect of the plan or the actions of a servicing carrier of the plan shall exhaust all administrative dispute resolution remedies provided for in the plan prior to commencement of a civil action against any servicing carrier of the plan.

Missouri

HB 1763 adds new ***section 375.1605*** to the Missouri Annotated Statutes to read as follows:
375.1605
1. The provisions of this section shall apply to workers' compensation large deductible policies issued by an insurer subject to delinquency proceedings under this chapter. This section shall not apply to first party claims or to claims funded by a guaranty association net of the deductible unless subsection 3 of this section applies. Large deductible policies shall be administered in accordance with their terms, except to the extent such terms conflict with the provisions of this section.
2. For purposes of this section, the following terms mean:
(1) "Collateral", any cash, letters of credit, surety bond, or any other form of security posted by the insured or by a captive insurer or reinsurer to secure the insured's obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay the insurer as may be required for other secured obligations;
(2) "Commercially reasonable", to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter;
(3) "Deductible claim", any claim, including a claim for loss and defense and cost containment expense, unless such expenses are excluded, under a large deductible policy that is within the deductible;
(4) "Delinquency proceeding", shall have the same meaning ascribed to it in section 375.1152;
(5) "Guaranty association", the Missouri property and casualty insurance guaranty association created by sections 375.771 to 375.779, as amended, and any other similar entities created by the laws of any other state for the payment of claims of insolvent insurers;
(6) "Large deductible policy", any combination of one or more workers' compensation policies and endorsements issued to an insured and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:
(a) Pay directly the initial portion of any claim under the policy up to a specified dollar amount or the expenses related to any claim; or
(b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term "large deductible policy" also includes policies that contain an aggregate limit on the insured's liability for all deductible claims in addition to a per-claim deductible limit. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer. Large deductible policies do not include policies, endorsements, or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insured shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder's large deductible obligations;

(7) "Other secured obligations", obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations, the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy;

(8) "Receiver", shall have the same meaning ascribed to it in section 375.1152.

3. Unless otherwise agreed by the responsible guaranty association, all large deductible claims which are also "covered claims", as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim pursuant to an agreement by the guaranty fund or otherwise, the insured's funding or payment of a deductible claim will extinguish the obligations, if any, of the receiver or any guaranty association to pay such claim. No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured's funding or payment of a deductible claim.

4. To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Such reimbursements and collateral shall be subject to any reasonable and actual expenses recovered by the receiver as provided for under subsection 7 of this section. Reimbursements paid to the guaranty association under this subsection shall not be treated as distributions under section 375.1218 or as early access payments under section 375.1205. To the extent that a guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, or incurred expenses in connection with large deductible policies that are not reimbursed under this section, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding. Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses such as those affording the guaranty association the right to recover for claims payments made to or on behalf of high net worth insureds or claimants.

5. (1) The receiver shall have the obligation to collect reimbursements owed for deductible claims as provided for herein and shall take all commercially reasonable actions to collect such reimbursements. The receiver shall promptly bill insureds for reimbursement of deductible claims:

(a) Paid by the insurer prior to the commencement of delinquency proceedings;

(b) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or

(c) Paid or allowed by the receiver.

(2) If the insured does not make payment within the time specified in the large deductible policy, or within sixty days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed.

(3) Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured's reimbursement obligation under the large deductible policy.

(4) Except for gross negligence, an allegation of improper handling or payment of a deductible claim by the insurer, the receiver, or any guaranty association shall not be a defense to the insured's reimbursement obligations under the large deductible policy.

6. (1) Subject to the provisions of this subsection, the receiver shall utilize collateral if available to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payments of a deductible claim. Any distributions made to a guaranty association under this subsection shall not be treated as distributions under section 375.1218 or as early access payments under section 375.1205.

(2) All claims against the collateral shall be paid in the order received and no claim of the receiver, including those described in this subsection, shall supersede any other claim against the collateral as described in subdivision (4) of this subsection.

(3) The receiver shall draw down collateral to the extent necessary in the event that the insured fails to:

(a) Perform its funding or payment obligations under any large deductible policy;

(b) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty days after the date of the billing if no time is specified;

(c) Pay amounts due the estate for preliquidation obligations;

(d) Timely fund any other secured obligation; or

(e) Timely pay expenses.

(4) Claims that are validly asserted against the collateral shall be satisfied in the order in which such claims are received by the receiver; except that, if more than one creditor has a valid claim against the same collateral and the available collateral, along with billing collection efforts and to the extent that the collateral is subject to other known secured obligations, are together insufficient to pay each creditor in full, then the director as rehabilitator or liquidator shall prorate payments to each creditor based upon the relationship the amount of claims each creditor has paid bears to the total of all claims paid by all such creditors.

(5) Excess collateral may be returned to the insured as determined by the receiver after a periodic review of claims paid, outstanding case reserves, and a factor for incurred but not reported claims.
7. The receiver shall be entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements under the provisions of this section, subject to the review and approval by the court.
8. The court having jurisdiction over the delinquency proceedings under section 375.1154 shall have jurisdiction to resolve disputes arising under the provisions of this section.
9. The provisions of this section shall apply to all delinquency proceedings that either commence on or after the effective date of this section or are open and pending on the effective date of this section, provided that, the provisions of this section shall not affect any delinquency proceeding for which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction prior to the effective date of this section.
10. Nothing in this section is intended to limit or adversely affect any rights or powers a guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association under policies of the insolvent insurer, or for related expenses the guaranty association incurs.

New Mexico

HB 194 amends ***sections 52-1-25.1. Temporary Total Disability—Return To Work*** and ***52-1-26. Permanent Partial Disability*** of the New Mexico Statutes Annotated as follows:

52-1-25.1. Temporary Total Disability—Return To Work

…

B. If, prior to the date of maximum medical improvement, an injured worker's health care provider releases the worker to return to work, the worker is not entitled to temporary total disability benefits if:
(1) the employer offers work at the worker's pre-injury wage; or
(2) the worker accepts employment with another employer at the worker's pre-injury wage.
C. If, prior to the date of maximum medical improvement, an injured worker's health care provider releases the worker to return to work and the employer offers work at less than the worker's pre-injury wage, the worker is disabled and shall receive temporary total disability compensation benefits equal to two-thirds of the difference between the worker's pre-injury wage and the worker's post-injury wage.
D. ~~If the worker returns to work pursuant to the provisions of Subsection B of this section~~ A worker is not entitled to temporary total disability benefits as set forth in Subsection B or C of this section if the worker is terminated for post-injury misconduct connected with the employment; provided that, if an employer terminates the worker for the pretextual reasons of attempting to avoid payment of benefits to the worker or as retaliation against the worker for seeking benefits, the worker shall be entitled to temporary total disability benefits and the employer shall be subject to penalties as set forth in Sections 52-1-28.1 and 52-1-28.2 NMSA 1978.
E. Notwithstanding the provisions of this section, the employer shall continue to provide reasonable and necessary medical care pursuant to Section 52-1-49 NMSA 1978.

52-1-26. Permanent Partial Disability

…

C. Permanent partial disability shall be determined by calculating the worker's impairment as modified by ~~his~~ the worker's age, education and physical capacity, pursuant to Sections 52-1-26.1 through 52-1-26.4 NMSA 1978; provided that, regardless of the actual calculation of impairment as modified by the worker's age, education and physical capacity, the percentage of disability awarded shall not exceed ninety-nine percent.
D. If, on or after the date of maximum medical improvement, an injured worker returns to work at a wage equal to or greater than the worker's pre-injury wage, the worker's permanent partial disability rating shall be equal to ~~his~~ the worker's impairment and shall not be subject to the modifications calculated pursuant to Sections 52-1-26.1 through 52-1-26.4 NMSA 1978.
E. A worker is not entitled to modification if the worker is terminated for post-injury misconduct connected with the employment; provided that, if an employer terminates the worker for the pretextual reasons of attempting to avoid payment of benefits to the worker or as retaliation against the worker for seeking benefits, the worker shall be entitled to modification and the employer shall be subject to penalties as set forth in Sections 52-1-28.1 and 52-1-28.2 NMSA 1978.
~~E.~~ F. In considering a claim for permanent partial disability, a workers' compensation judge shall not receive or consider the testimony of a vocational rehabilitation provider offered for the purpose of determining the existence or extent of disability.

HB 195 amends ***sections 52-1-49. Medical and Related Benefits—Selection of Health Care Provider—Artificial Members***, ***52-3-15. Disablement Compensation Restrictions—Medical and Related Services—Selection of Health Care Provider—Artificial Members*** and ***52-4-5. Fee Schedule*** of the New Mexico Statutes Annotated as follows:

52-1-49. Medical and Related Benefits—Selection of Health Care Provider—Artificial Members

…

B. A workers' compensation carrier or an employer providing workers' compensation benefits is not liable for a claim for reimbursement associated with medical cannabis.
~~B.~~ C. The employer shall initially either select the health care provider for the injured worker or permit the injured worker to make the selection. Subject to the provisions of this section, that selection shall be in effect during the first sixty days ~~from~~ after the date the worker receives treatment from the initially selected health care provider.
~~C.~~ D. After the ~~expiration of the~~ initial sixty-day period set forth in Subsection ~~B~~ C of this section, the party who did not make the

initial selection may select a health care provider of ~~his~~ the party's choice. Unless the worker and employer otherwise agree, the party seeking ~~such a~~ the change shall file a notice of the name and address of ~~his~~ the party's choice of health care provider with the other party at least ten days before treatment from that health care provider begins. The director shall adopt rules ~~and regulations~~ governing forms, which employers shall post in conspicuous places, to enable this notice to be promptly and efficiently provided. This notice may be filed on or after the fiftieth day of the sixty-day period set forth in Subsection ~~B~~ C of this section.

~~D.~~ E. If a party objects to the choice of health care provider made pursuant to Subsection ~~C~~ D of this section, ~~then he~~ the party shall file an objection to that choice pursuant to Subsection ~~E~~ F of this section with a workers' compensation judge within three days ~~from~~ after receiving the notice. ~~He~~ The party shall also provide notice of that objection to the other party. If the employer does not file ~~his~~ an objection within the three-day period, ~~then he shall be~~ the employer is liable for the cost of treatment provided by the worker's health care provider until the employer does file ~~his~~ an objection and the workers' compensation judge has rendered ~~his~~ a decision as set forth in Subsection ~~F~~ G of this section. If the worker does not file ~~his~~ an objection within the three-day period, ~~then~~ the employer ~~shall~~ is only ~~be~~ liable for the cost of treatment from the health care provider selected by the employer, subject to the provisions of Subsections ~~E, F and G~~ F through H of this section. Nothing in this section shall remove the employer's obligation to provide reasonable and necessary health care services to the worker so long as the worker complies with the provisions of this section.

~~E.~~ F. If the worker or employer disagrees with the choice of the health care provider of the other party at any time, including in the initial sixty-day period, and they cannot otherwise agree, ~~then he~~ the worker or employer shall submit a request for a change of health care provider to a workers' compensation judge. The director shall adopt rules ~~and regulations~~ governing forms, which employers shall post in conspicuous places, to submit to a workers' compensation judge a request for change of a health care provider.

~~F.~~ G. The request shall state the reasons for the request and may state the applicant's choice for a different health care provider. The applicant shall bear the burden of proving to the workers' compensation judge that the care being received is not reasonable. The workers' compensation judge shall render ~~his~~ a decision within seven days ~~from~~ after the date the request was submitted. If the workers' compensation judge grants the request, ~~he~~ the judge shall designate either the applicant's choice of health care provider or a different health care provider.

~~G.~~ H. If the worker continues to receive treatment or services from a health care provider rejected by the employer and not in compliance with the workers' compensation judge's ruling, ~~then~~ the employer is not required to pay for any of the additional treatment or services provided to that worker by that health care provider.

~~H.~~ I. In all cases where the injury ~~is such as to permit~~ permits the use of artificial members, including teeth and eyes, the employer shall pay for the artificial members.

52-3-15. Disablement Compensation Restrictions—Medical and Related Services—Selection of Health Care Provider—Artificial Members

A. No compensation ~~shall be~~ is allowed for the first seven days after the employee has suffered disablement unless ~~such~~ the disablement continues for ~~a period of~~ more than four weeks after the disablement occurs, or in any case, unless the employer is notified ~~thereof~~ of the disablement within the period specified in Section 52-3-16 NMSA 1978.

B. After disablement and continuing so long as medical and surgical attention is reasonably necessary, the employer shall, subject to the provisions of this section, provide the worker in a timely manner reasonable and necessary health care services from a health care provider.

C. A workers' compensation carrier or an employer providing workers' compensation benefits is not liable for a claim for reimbursement associated with medical cannabis.

~~C.~~ D. The employer shall initially either select the health care provider for the injured worker or permit the injured worker to make the selection. Subject to the provisions of this section, that selection shall be in effect during the first sixty days ~~from~~ after the date the worker receives treatment from the initially selected health care provider.

~~D.~~ E. After the expiration of the initial sixty-day period set forth in Subsection ~~C~~ D of this section, the party who did not make the initial selection may select a health care provider of ~~his~~ the party's choice. Unless the worker and employer otherwise agree, the party seeking ~~such a~~ the change shall file a notice of the name and address of ~~his~~ the party's choice of health care provider with the other party at least ten days before treatment from that health care provider begins. The director shall adopt rules ~~and regulations~~ governing forms, which employers shall post in conspicuous places, to enable this notice to be promptly and efficiently provided. This notice may be filed on or after the fiftieth day of the sixty-day period set forth in Subsection ~~C~~ D of this section.

~~E.~~ F. If a party objects to the choice of health care provider made pursuant to Subsection ~~D~~ E of this section, then ~~he~~ the party shall file an objection to that choice pursuant to Subsection ~~F~~ G of this section with a workers' compensation judge within three days ~~from~~ after receiving the notice. ~~He~~ The party shall also provide notice of that objection to the other party. If the employer does not file ~~his~~ an objection within the three-day period, ~~then he shall be~~ the employer is liable for the cost of treatment provided by the worker's health care provider until the employer does file ~~his~~ an objection and the workers' compensation judge has rendered ~~his~~ a decision as set forth in Subsection ~~G~~ H of this section. If the worker does not file ~~his~~ an objection within the three-day period, ~~then~~ the employer ~~shall~~ is only ~~be~~ liable for the cost of treatment from the health care provider selected by the employer, subject to the provisions of Subsections ~~F, G and H~~ G through I of this section. Nothing in this section shall remove the employer's obligation to provide reasonable and necessary health care services to the worker so long as the worker complies with the provisions of this section.

~~F.~~ G. If the worker or employer disagrees with the choice of the health care provider of the other party at any time, including in the initial sixty-day period, and they cannot otherwise agree, ~~then he~~ the worker or employer shall submit a request for a change of health care provider to a workers' compensation judge. The director shall adopt rules ~~and regulations~~ governing forms, which

employers shall post in conspicuous places, to submit to a workers' compensation judge a request for a change of a health care provider.
~~G.~~ H. The request shall state the reasons for the request and may state the applicant's choice for a different health care provider. The applicant shall bear the burden of proving to the workers' compensation judge that the care being received is not reasonable. The workers' compensation judge shall render ~~his~~ a decision within seven days ~~from~~ after the date the request was submitted. If the workers' compensation judge grants the request, ~~he~~ the judge shall designate either the applicant's choice of health care provider or a different health care provider.
~~H.~~ I. If the worker continues to receive treatment or services from a health care provider rejected by the employer and not in compliance with the workers' compensation judge's ruling, ~~then~~ the employer is not required to pay for any of the additional treatment or services provided to that worker by that health care provider.
~~I.~~ J. In all cases where the disablement ~~is such as to permit~~ permits the use of artificial members, including teeth and eyes, the employer shall pay for ~~such~~ those artificial members.

52-4-5. Fee Schedule

…
B. A health care provider shall be paid ~~his~~ the provider's usual and customary fee for services rendered or the maximum charge established pursuant to Subsection A of this section, whichever is less. However, in no case shall the usual and customary fee exceed the maximum charge allowable.
…
E. If it is determined by the person primarily responsible for payment that the charges of a health care provider exceed the amount established pursuant to Subsection B of this section or that a health care provider ~~over-utilized~~ overutilized or otherwise rendered or ordered inappropriate health care or health care services, and payment is withheld on those grounds, the health care provider may appeal to the director regarding that determination. The director shall establish by regulation procedures for an appeal by a health care provider.
F. The director shall establish an advisory committee that shall:
…
(4) assist in establishing the schedules of maximum charges ~~under~~ required by Subsection A of this section for any fees that are payable to health care providers;
…
I. Nothing in this section shall be construed to require a workers' compensation carrier or an employer providing workers' compensation benefits to pay for costs associated with the purchase or use of medical cannabis.

Utah

HB 116, in part, amends ***section 34A-2-103. Employers enumerated and defined—Regularly employed—Statutory employers—Exceptions.*** of the Utah Code Annotated, as follows:
34A-2-103. Employers enumerated and defined—Regularly employed—Statutory employers—Exceptions.
…
(10) (a) For purposes of this Subsection (10), "federal executive agency" means an executive agency, as defined in 5 U.S.C. Sec. 105, of the federal government.
(b) For purposes of determining whether two or more persons are considered joint employers under this chapter or Chapter 3, Utah Occupational Disease Act, an administrative ruling of a federal executive agency may not be considered a generally applicable law unless that administrative ruling is determined to be generally applicable by a court of law, or adopted by statute or rule.
(11) (a) As used in this Subsection (11):
(i) "Franchise" means the same as that term is defined in 16 C.F.R. Sec. 436.1.
(ii) "Franchisee" means the same as that term is defined in 16 C.F.R. Sec. 436.1.
(iii) "Franchisor" means the same as that term is defined in 16 C.F.R. Sec. 436.1.
(b) For purposes of this chapter, a franchisor is not considered to be an employer of:
(i) a franchisee; or
(ii) a franchisee's employee.
(c) With respect to a specific claim for relief under this chapter made by a franchisee or a franchisee's employee, this Subsection (11) does not apply to a franchisor under a franchise that exercises a type or degree of control over the franchisee or the franchisee's employee not customarily exercised by a franchisor for the purpose of protecting the franchisor's trademarks and brand.
…

SB 127 amends ***sections 34A-2-416. Additional benefits in special cases*** and ***34A-2-703. Payments from Employers' Reinsurance Fund.*** of the Utah Code Annotated as follows:
34A-2-416. Additional benefits in special cases
~~(1)~~ Benefits received by a wholly dependent person under this chapter or Chapter 3, Utah Occupational Disease Act, extend indefinitely if at the termination of the benefits:
~~(a)~~ (1) the wholly dependent person is still in a dependent condition; and
~~(b)~~ (2) under all reasonable circumstances the wholly dependent person should be entitled to additional benefits.
~~(2) If benefits are extended under Subsection (1):~~
~~(a) the liability of the employer or insurance carrier involved may not be extended; and~~

~~(b) the additional benefits allowed shall be paid out of the Employers' Reinsurance Fund created in Subsection 34A-2-702(1).~~

34A-2-703. Payments from Employers' Reinsurance Fund.
If an employee, who has at least a 10% whole person permanent impairment from any cause or origin, subsequently incurs an additional impairment by an accident arising out of and in the course of the employee's employment during the period of July 1, 1988, to June 30, 1994, inclusive, and if the additional impairment results in permanent total disability, the employer or its insurance carrier and the Employers' Reinsurance Fund are liable for the payment of benefits as follows:
….
(4) If it is determined that the employee is permanently and totally disabled, the employer or its insurance carrier shall be given credit for all prior payments of temporary total, temporary partial, and permanent partial disability compensation made as a result of the industrial accident. ~~Any~~ An overpayment by the employer or its insurance carrier shall be reimbursed by the Employers' Reinsurance Fund under Subsection (5).
(5) (a) (i) Upon receipt of a duly verified petition, the Employers' Reinsurance Fund shall reimburse the employer or its insurance carrier for the Employers' Reinsurance Fund's share of medical benefits and compensation paid to or on behalf of an employee.
(ii) A request for Employers' Reinsurance Fund reimbursements shall be accompanied by satisfactory evidence of payment of the medical or disability compensation for which the reimbursement is requested. ~~Each~~
(iii) A request is subject to review as to reasonableness by the administrator. The administrator may determine the manner of reimbursement.
(b) A decision of the administrator under Subsection (5)(a) may be appealed in accordance with Part 8, Adjudication.
(c) An employer or its insurance carrier shall submit to the Employers' Reinsurance Fund, by June 30, 2018, a request for reimbursement related to medical benefits or compensation paid on or before July 1, 2016.
(d) An employer or its insurance carrier shall submit to the Employers' Reinsurance Fund a request for reimbursement related to medical benefits or compensation paid after July 1, 2016, within 24 months of the later of:
(i) the date the benefits or compensation are paid by the employer or its insurance carrier; or
(ii) the date the Employers' Reinsurance Fund is determined to be liable.
(e) Requests for reimbursement not submitted in accordance with Subsection (5)(c) or (5)(d) are considered untimely and the Employers' Reinsurance Fund may not reimburse the benefits or compensation paid.
…

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
HI	Carolyn Pearl	808-524-6239
IN, NC, SC, TN	Amy Quinn	803-356-0851
AR, IL, KS, TX	Terri Robinson	501-333-2835
AK, ID, MT, OR	Jessica Epley	503-892-8919
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.