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 26, 2016.

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending February 26, 2016.

Indiana

SB 20 was:

- Passed by the first chamber on January 19, 2016
- Amended and passed by the second chamber on February 22, 2016

SB 20, in part, creates new ***chapter 22-1-6*** in the Indiana Code to read as follows:

Chapter 6. Classification of Qualified Marketplace Contractors

Sec. 1. The following definitions apply throughout this chapter:

(1) "Person" means an individual, a partnership, a corporation, a limited liability company, or other organization.

(2) "Qualified marketplace contractor" means a person that enters into an agreement with a qualified marketplace platform to use the qualified marketplace platform's digital application or digital platform to provide services to an individual or entity that seeks to obtain the services.

(3) "Qualified marketplace platform" means a person that operates a digital application or digital platform that facilitates the provision of services by a qualified marketplace contractor to an individual or entity that seeks to obtain the services.

Sec. 2. For the purpose of construing any statute, rule, ordinance, or resolution, including IC 22-3 and IC 22-4, a qualified marketplace contractor is to be treated as an independent contractor if the following conditions are met:

(1) Substantially all of the remuneration received by the qualified marketplace contractor for the services that the qualified marketplace contractor performs, whether paid in cash or some other form, is directly related to the performance of the services or other output rather than the number of hours worked.

(2) The services performed by the qualified marketplace contractor are governed by a written contract executed between the qualified marketplace contractor and a qualified marketplace platform.

(3) A written contract described in subdivision (2) must include the following provisions:

(A) The qualified marketplace contractor:

(i) is engaged under the contract as an independent contractor and not an employee of the qualified marketplace platform; and

(ii) is to be treated as an independent contractor for all purposes, including federal, state, and local taxation, withholding, worker's compensation, and unemployment insurance.

(B) The qualified marketplace contractor:

(i) is to be paid based on the performance of the qualified marketplace contractor's services or other output; and

(ii) is not be treated as an employee for the purpose of determining the federal, state, and local tax obligations of the qualified marketplace contractor or the qualified marketplace platform.

(C) The qualified marketplace contractor may work any hours or schedule that the qualified marketplace contractor chooses to work, except that if the qualified marketplace contractor elects to work specific hours or a specific schedule, the qualified marketplace platform may require the qualified marketplace contractor to perform work during the elected hours or schedule.
(D) The qualified marketplace contractor is free to engage in outside employment and to perform services through other qualified marketplace platforms.
(E) The qualified marketplace contractor bears the qualified marketplace contractor's own expenses.
(F) The contract may be terminated without cause by the qualified marketplace platform or the qualified marketplace contractor at any time after reasonable notice to the other party.

Sec. 3. For the purpose of construing any statute, rule, ordinance, or resolution, including IC 22-3 and IC 22-4, the term "employment" before July 1, 2016, did not include services performed by a qualified marketplace contractor if the following conditions were met:
(1) Substantially all of the remuneration received by the qualified marketplace contractor for the services that the qualified marketplace contractor performed, whether paid in cash or some other form, was directly related to the performance of the services or other output rather than the number of hours worked.
(2) The services performed by the qualified marketplace contractor were governed by a written contract executed between the qualified marketplace contractor and a qualified marketplace platform that included the provisions specified under section 2(3) of this chapter.

Sec. 4. The provisions of this chapter are severable in the manner provided by IC 1-1-1-8(b).

SB 20 also, in part, adds the following language:
(a) As used in this Section, "legislative council" refers to the legislative council established by IC 2-5-1.1-1.
(b) The legislative council is urged to assign to the interim study committee on employment and labor established by IC 2-5-1.3-4 or another appropriate interim study committee during the 2016 legislative interim the topics of:
(1) employee misclassification;
(2) payroll fraud; and
(3) the use of independent contractor status.
(c) If the topics described in subsection (b) are assigned to an interim study committee, the interim study committee shall issue a final report to the legislative council containing the interim study committee's findings and recommendations, including any recommended legislation, in an electronic format under IC 5-14-6 not later than November 1, 2016.
(d) This Section expires December 31, 2016.

Note: The version of **SB 20** passed by the first chamber did not contain any relevant workers compensation-related language, therefore, it was not included in any previous version of NCCI's ***Legislative Activity Report***.

Utah

SB 76 was:

- Passed by the first chamber on February 16, 2016
- Included in NCCI's February 26, 2016 ***Legislative Activity Report*** (RLA-2016-07)
- Amended and passed by the second chamber on February 25, 2016

SB 76 adds new ***section 34A-2-104.5. Nongovernment entity volunteers*** to the Utah Code Annotated to read as follows:
34A-2-104.5. Nongovernment entity volunteers.
(1) As used in this section:
(a) (i) "Intern" means a student or trainee who works without pay at a trade or occupation in order to gain work experience.
(ii) Notwithstanding Subsection (1)(a)(i), "intern" does not include an intern described in Section 53A-29-103 or 53B-16-403.
(b) "Nongovernment entity" means an entity or individual that:
(i) is an employer as provided in Section 34A-2-103; and
(ii) is not a government entity.
(c) "Utah minimum wage" means the highest wage designated as Utah's minimum wage under Title 34, Chapter 40, Utah Minimum Wage Act.
(d) (i) "Volunteer" means an individual who donates service without pay or other compensation except expenses actually and reasonably incurred as approved by the supervising nongovernment entity.
(ii) "Volunteer" includes an intern of a nongovernment entity.
(iii) "Volunteer" does not include an individual participating in human subjects research to the extent that the participation is governed by federal law or regulation inconsistent with this chapter.
(2) A volunteer for a nongovernment entity is not an employee of the nongovernment entity for purposes of this chapter and Chapter 3, Utah Occupational Disease Act, unless the nongovernment entity elects in accordance with this section to provide coverage under this chapter and Chapter 3, Utah Occupational Disease Act.
(3) (a) A nongovernment entity may elect to secure coverage for all of the nongovernment entity's volunteers by obtaining coverage for the volunteers in accordance with Section 34A-2-201 under the same policy it uses to cover the nongovernment entity's

employees.
(b) If a nongovernment entity obtains coverage under Section 34A-2-201 for the nongovernment entity's volunteers, for purposes of receiving benefits under this chapter and Chapter 3, Utah Occupational Disease Act:
(i) a volunteer is considered an employee of the nongovernment entity; and
(ii) these benefits are the exclusive remedy of the volunteer in accordance with Section 34A-2-105 for an industrial injury or disease covered by this chapter and Chapter 3, Utah Occupational Disease Act.
(4) A nongovernment entity shall keep sufficient records of the nongovernment entity's volunteers and the volunteers' duties to determine compliance with this section.
(5) To compute the disability compensation benefits under Subsection (3), the disability compensation shall be calculated in accordance with Part 4, Compensation and Benefits, with the average weekly wage of the nongovernment volunteer assumed to be the Utah minimum wage at the time of the industrial accident or occupational disease that is the basis for the volunteer's workers' compensation claim.
(6) A workers' compensation insurer shall calculate the premium for a nongovernment entity's volunteer on the basis of the Utah minimum wage on the actual hours the volunteer provides service to the nongovernment entity, except that a workers' compensation insurer may assume 30 hours worked per week if the nongovernment entity does not provide a record of actual hours worked. The imputed wages shall be assigned to the class code on the policy that best describes the volunteer's duties.
(7) The failure or refusal of a nongovernment entity to make an election under this section in regard to volunteers does not alter, have an effect on, or give rise to any implication or presumption regarding:
(a) the nongovernment entity's duties or liabilities with respect to volunteers; or
(b) the rights of volunteers.
(8) Subject to Subsection (3)(b)(ii), nothing in this section affects a volunteer's right to seek remedies available to the volunteer through a personal insurance policy that the volunteer obtains for the volunteer in addition to any workers' compensation benefits obtained under this section
~~(8)~~ (9) A nongovernment entity shall notify a volunteer of an election under Subsection (3)(a) by posting:
(a) printed notices where volunteers are likely to see the notices in conspicuous places about the nongovernment entity's place of business; and
(b) notices on a website that the nongovernment entity uses to recruit or provide information to volunteers.

Virginia

HB 44 was:

- Passed by the first chamber on February 15, 2016
- Included in NCCI's February 26, 2016 ***Legislative Activity Report*** (RLA-2016-07)
- Passed by the second chamber on February 25, 2016

HB 44 amends ***section 65.2-105. Presumption that certain injuries arose out of and in the course of employment*** of the Code of Virginia as follows:

§ 65.2-105. Presumption that certain injuries arose out of and in the course of employment.

In any claim for compensation, where the employee (i) is physically or mentally unable to testify as confirmed by competent medical evidence, (ii) dies with there being no evidence that he ever regained consciousness after the accident, (iii) dies at the accident location or nearby, or (iv) is found dead where he is reasonably expected to be as an employee, and where the factual circumstances are of sufficient strength from which the only rational inference to be drawn is that the accident arose out of and in the course of employment, it shall be presumed the accident arose out of and in the course of employment, unless such presumption is overcome by a preponderance of competent evidence to the contrary.

HB 378 was:

- Passed by the first chamber on February 15, 2016
- Included in NCCI's February 26, 2016 ***Legislative Activity Report*** (RLA-2016-07)
- Passed by the second chamber on February 25, 2016

HB 378 makes various changes to the Code of Virginia, as it relates to workers compensation medical fee schedules, as described below:

- Directs the Workers' Compensation Commission (the Commission) to adopt regulations that will become effective January 1, 2018. It establishes fee schedules setting the maximum pecuniary liability of the employer for medical services provided to an injured person pursuant to the Virginia Workers' Compensation Act, in the absence of a contract under which the provider has agreed to accept a specified amount for the medical service.
- The Commission is required to retain a firm to assist it in establishing the initial fee schedules. It will set amounts based on a reimbursement objective constituting the average of all amounts paid to providers in the same category of providers for the medical service in the same medical community.
- Reimbursements for medical services provided to treat traumatic injuries and serious burns are excluded from the fee schedules, and liability for their treatment costs will be based, absent a contract, on 80% of the provider's charges. However, the required reimbursement will be 100% of the provider's charges if the employer unsuccessfully contests the compensability of the claim.
- The Commission is required to review and revise the fee schedules in the year after they become effective and biennially

thereafter.

- The liability of the employer for certain medical services not included in a fee schedule will be set by the Commission.
- A stop-loss feature allows hospitals to receive payments or reimbursements that exceed the fee schedule amount for certain claims when the total charges exceed a charge outlier threshold, which initially is 150% of the maximum fee for the service set forth in the applicable fee schedule. Providers are prohibited from using a different charge master or schedule of fees for any medical service provided for workers compensation patients than the provider uses for health care services provided to patients who are not claimants.
- When determining whether the employee's attorney's work, with regard to a contested claim, resulted in an award of benefits that inure to the benefit of a third-party insurance carrier or health care provider (and in determining the reasonableness of the amount of any fee awarded to an attorney), the measure requires the Commission:
  - To consider only the amount paid by the employer or insurance carrier to the third-party insurance carrier or health care provider for medical services rendered to the employee through a certain date
  - Not to consider additional amounts previously paid to a health care provider or reimbursed to a third-party insurance carrier
- The Commission shall have an independent, peer-reviewed study conducted every two years. The existing peer review provisions are repealed.
- The regulations setting fee schedules are exempt from the Administrative Process Act if the Commission utilizes a regulatory advisory panel to assist in the development of such regulations and provides an opportunity for public comment on the regulations prior to adoption.
- The measure prohibits certain practices involving the use by third parties of contracts, such as:
  - When a provider agrees to accept payment of less than the fee scheduled amount—including restricting the sale, lease, or other dissemination of information regarding the payment amounts or terms of a provider contract—without the express written consent and prior notification of all parties to the provider contract
  - When an employer shops for the lowest discount for a specific provider among the provider contracts held in multiple preferred provider organization networks
- The regulatory advisory panel is directed to make recommendations to the Commission prior to July 1, 2017, on workers compensation issues relating to:
  - Pharmaceutical costs not previously included in the fee schedules
  - Durable medical equipment costs not previously included in the fee schedules
  - Certain awards of attorney fees
  - Peer review of medical costs
  - Prior authorization for medical services
  - Other issues that the Commission assigns to it

Note: HB 378 is similar, but not identical, to **SB 631** below, which passed the first chamber on February 5, 2016, and was included in NCCI's February 12, 2016 ***Legislative Activity Report*** (RLA-2016-05).

SB 631 was:

- Passed by the first chamber on February 5, 2016
- Included in NCCI's February 12, 2016 ***Legislative Activity Report*** (RLA-2016-05)
- Amended and passed by the second chamber on February 22, 2016

SB 631 makes various changes to the Code of Virginia, as it relates to workers compensation medical fee schedules, as described below:

- Directs the Workers' Compensation Commission (the Commission) to adopt regulations that will become effective January 1, 2018. The regulations will establish fee schedules setting the maximum pecuniary liability of the employer for medical services provided to an injured person pursuant to the Virginia Workers' Compensation Act, in the absence of a contract under which the provider has agreed to accept a specified amount for the medical service.
- The Commission is required to retain a firm to assist it in establishing the initial fee schedules. It will set amounts based on a reimbursement objective constituting the average of all amounts paid to providers in the same category of providers for the medical service in the same medical community.
- Reimbursements for medical services provided to treat traumatic injuries and serious burns are excluded from the fee schedules, and liability for their treatment costs will be based, absent a contract, on 80% of the provider's charges. However, the required reimbursement will be 100% of the provider's charges if the employer unsuccessfully contests the compensability of the claim.
- The Commission is required to review and revise the fee schedules in the year after they become effective and biennially thereafter.
- The liability of the employer for certain medical services not included in a fee schedule will be set by the Commission.
- A stop-loss feature allows hospitals to receive payments or reimbursements that exceed the fee schedule amount for certain claims when the total charges exceed a charge outlier threshold, which initially is 150% of the maximum fee for the service set forth in the applicable fee schedule. Providers are prohibited from using a different charge master or schedule of fees for any

medical service provided for workers compensation patients than the provider uses for health care services provided to patients who are not claimants.

- When determining whether the employee's attorney's work, with regard to a contested claim, resulted in an award of benefits that inure to the benefit of a third-party insurance carrier or health care provider (and in determining the reasonableness of the amount of any fee awarded to an attorney), the measure requires the Commission:
  - To consider only the amount paid by the employer or insurance carrier to the third-party insurance carrier or health care provider for medical services rendered to the employee through a certain date
  - Not to consider additional amounts previously paid to a health care provider or reimbursed to a third-party insurance carrier
- The Commission shall have an independent, peer-reviewed study conducted every two years. The existing peer review provisions are repealed.
- The regulations setting fee schedules are exempt from the Administrative Process Act if the Commission utilizes a regulatory advisory panel to assist in the development of such regulations and provides an opportunity for public comment on the regulations prior to adoption.
- The measure prohibits certain practices involving the use by third parties of contracts, such as:
  - When a provider agrees to accept payment of less than the fee scheduled amount—including restricting the sale, lease, or other dissemination of information regarding the payment amounts or terms of a provider contract—without the express written consent and prior notification of all parties to the provider contract
  - When an employer shops for the lowest discount for a specific provider among the provider contracts held in multiple preferred provider organization networks
- The regulatory advisory panel is directed to make recommendations to the Commission prior to July 1, 2017, on workers compensation issues relating to:
  - Pharmaceutical costs not previously included in the fee schedules
  - Durable medical equipment costs not previously included in the fee schedules
  - Certain awards of attorney fees
  - Peer review of medical costs
  - Prior authorization for medical services
  - Other issues that the Commission assigns to it

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending February 26, 2016.

Florida

SB 828 amends ***section 631.914 Assessments*** of the Florida Statutes as follows:

631.914 Assessments

(1)(a) To the extent necessary to secure the funds for the payment of covered claims, and also to pay the reasonable costs to administer the same, the Office of Insurance Regulation ~~department~~, upon certification by the board, shall levy assessments on each insurer initially estimated in the proportion that the insurer's net direct written premiums in this state bears to the total of said net direct written premiums received in this state by all such workers' compensation insurers for the preceding calendar year. Assessments levied against insurers and self-insurance funds pursuant to this paragraph must be computed and levied on the basis of the full policy premium value on the net direct written premium amount as set forth in the state for workers' compensation insurance without consideration of any applicable discount or credit for deductibles. Insurers and self-insurance funds must report premiums in compliance with this paragraph. Assessments shall be remitted to and administered by the board of directors in the manner specified by the approved plan of operation and paragraph (d). ~~The board shall give each insurer so assessed at least 30 days' written notice of the date the assessment is due and payable.~~ Each assessment shall be a uniform percentage applicable to the net direct written premiums of each insurer writing workers' compensation insurance.

~~1. Beginning July 1, 1997,~~ Assessments levied against insurers and ~~, other than~~ self-insurance funds~~,~~ shall not exceed in any calendar year more than 2 percent of that insurer's net direct written premiums in this state for workers' compensation insurance ~~during the calendar year next preceding the date of such assessments~~.

(b) Member insurers shall collect surcharges at a uniform percentage rate on new and renewal policies issued and effective during the period of 12 months beginning on January 1, April 1, July 1, or October 1, whichever is the first day of the following calendar quarter as specified in an order issued by the office directing insurers to pay an assessment to the association. The surcharge may not begin until 90 days after the board of directors certifies the assessment.

~~2. Beginning July 1, 1997, assessments levied against self-insurance funds shall not exceed in any calendar year more than 1.50 percent of that self-insurance fund's net direct written premiums in this state for workers' compensation insurance during the calendar year next preceding the date of such assessments.~~

~~3. Beginning July 1, 2003, assessments levied against insurers and self-insurance funds pursuant to this paragraph are computed and levied on the basis of the full policy premium value on the net direct premiums written in the state for workers' compensation~~

~~insurance during the calendar year next preceding the date of the assessment without taking into account any applicable discount or credit for deductibles. Insurers and self-insurance funds must report premiums in compliance with this subparagraph.~~
~~(b) Assessments shall be included as an appropriate factor in the making of rates.~~
(c)~~1. Effective July 1, 1999,~~ If assessments otherwise authorized in paragraph (a) are insufficient to make all payments on reimbursements then owing to claimants in a calendar year, then upon certification by the board, the office ~~department~~ shall levy additional assessments of up to 1.5 percent of the insurer's net direct written premiums in this state ~~during the calendar year next preceding the date of such assessments against insurers to secure the necessary funds~~.
(d) The association may use an installment method to require the insurer to remit the assessment as premium is written or may require the insurer to remit the assessment to the association before collecting the policyholder surcharge. If the assessment is remitted before the surcharge is collected, the assessment remitted must be based on an estimate of the assessment due based on the proportion of each insurer's net direct written premium in this state for the preceding calendar year as described in paragraph (a) and adjusted following the end of the 12-month period during which the assessment is levied.
1. If the association elects to use the installment method, the office may, in the order levying the assessment on insurers, specify that the assessment is due and payable quarterly as premium is written throughout the assessment year. Insurers shall collect surcharges at a uniform percentage rate specified by order as described in paragraph (b). Insurers are not required to advance funds if the association and the office elect to use the installment option. Assessments levied under this subparagraph are paid after policy surcharges are collected, and the recognition of assets is based on actual premium written offset by the obligation to the association.
2. If the association elects to require insurers to remit the assessment before surcharging the policyholder, the following shall apply:
a. The levy order shall provide each insurer so assessed at least 30 days written notice of the date the initial assessment payment is due and payable by the insurer.
b. Insurers shall collect surcharges at a uniform percentage rate specified by the order, as described in paragraph (b).
c. Assessments levied under this subparagraph are paid before policy surcharges are billed and result in a receivable for policy surcharges to be billed in the future. The amount of billed surcharges, to the extent it is likely that it will be realized, meets the definition of an admissible asset as specified in the National Association of Insurance Commissioners' Statement of Statutory Accounting Principles No. 4. The asset shall be established and recorded separately from the liability. If an insurer is unable to fully recoup the amount of the assessment, the amount recorded as an asset shall be reduced to the amount reasonably expected to be recouped.
3. Insurers must submit a reconciliation report to the association within 120 days after the end of the 12-month assessment period and annually thereafter for a period of three years. The report must indicate the amount of the initial payment or installment payments made to the association and the amount of written premium pursuant to paragraph (a) for the assessment year. If the insurer's reconciled assessment obligation is more than the amount paid to the association, the insurer shall pay the excess surcharges collected to the association. If the insurer's reconciled assessment obligation is less than the initial amount paid to the association, the association shall return the overpayment to the insurer.
(2) Assessments levied under this section are not premium and are not subject to any premium tax, fees, or commissions. Insurers shall treat the failure of an insured to pay assessment-related surcharges as a failure to pay premium. An insurer is not liable for any uncollectible assessment-related surcharges.
(3) Assessments levied under this section may be levied only upon insurers. This section does not create a cause of action by a policyholder with respect to the levying of an assessment or a policyholder's duty to pay assessment-related surcharges.
~~2. To assure that insurers paying assessments levied under this paragraph continue to charge rates that are neither inadequate nor excessive, each insurer that is to be assessed pursuant to this paragraph, or a licensed rating organization to which the insurer subscribes, may make, within 90 days after being notified of such assessments, a rate filing for workers' compensation coverage pursuant to ss. 627.072 and 627.091. If the filing reflects a percentage rate change equal to the difference between the rate of such assessment and the rate of the previous year's assessment under this paragraph, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of ss. 627.072 and 627.091.~~
(4) ~~(2)~~(a) The board may exempt any insurer from an assessment if, in the opinion of the office ~~department~~, an assessment would result in such insurer's financial statement reflecting an amount of capital or surplus less than the minimum amount required by any jurisdiction in which the insurer is authorized to transact insurance.
(b) The board may temporarily defer, in whole or in part, assessments against an insurer if, in the opinion of the office ~~department~~, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the case of a self-insurance fund, the trustees of the fund determined to be endangered must immediately levy an assessment upon the members of that self-insurance fund in an amount sufficient to pay the assessments to the corporation.
(c) The board may allow an insurer to pay an assessment on a quarterly basis.

Georgia

HB 216 amends ***section 34-9-280 Definitions*** of the Official Code of Georgia Annotated as follows:
§ 34-9-280 Definitions
As used in this article, the term:
(1) 'Disablement' means the event of an employee becoming actually disabled to work, as provided in Code Sections 34-9-261, 34-9-262, and 34-9-263, because of occupational disease.
(2) 'Occupational disease' means those diseases which arise out of and in the course of the particular trade, occupation, process, or employment in which the employee is exposed to such disease, provided the employee or the employee's dependents first prove to

the satisfaction of the State Board of Workers' Compensation all of the following:
(A) A direct causal connection between the conditions under which the work is performed and the disease;
(B) That the disease followed as a natural incident of exposure by reason of the employment;
(C) That the disease is not of a character to which the employee may have had substantial exposure outside of the employment;
(D) That the disease is not an ordinary disease of life to which the general public is exposed; provided, however, that for firefighters, as defined in Code Section 25-4-2, the disease of cancer, otherwise considered an ordinary disease of life, is shown by a preponderance of the competent and credible evidence, which shall include medical evidence, to have been attributable to the firefighter's performance of his or her duties as a firefighter; and
(E) That the disease must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence. For the purposes of this paragraph, partial loss of hearing due to noise shall not be considered an occupational disease. Psychiatric and psychological problems and heart and vascular diseases shall not be considered occupational diseases, except where they arise from a separate occupational disease.

HB 216 also includes the following language:
All laws and parts of laws in conflict with this Act are repealed.

Missouri

HB 1964, in part, amends ***section 287.243. Line of duty compensation—definitions—claim procedure—no subrogation rights for employers or insurers—grievance procedures—sunset date—fund created, use of moneys—rulemaking authority*** of the Missouri Annotated Statutes as follows:

§ 287.243. Line of duty compensation—definitions—claim procedure—no subrogation rights for employers or insurers—grievance procedures—sunset date—fund created, use of moneys—rulemaking authority

…
2. As used in this section, unless otherwise provided, the following words shall mean:
…
(4) "Firefighter", any person, including a volunteer firefighter, employed by the state or a local governmental entity as an employer defined under subsection 1 of section 287.030, or otherwise serving as a member or officer of a fire department either for the purpose of the prevention or control of fire or the underwater recovery of drowning victims, a uniformed employee of the office of the state fire marshal, or an emergency medical technician as defined in subdivisions (15), (16), (17), (18), and (19) of section 190.100;
…
3. (1) A claim for compensation under this section shall be filed by the spouse, child, or personal representative of the estate of the deceased with the division of workers' compensation not later than one year from the date of death of a law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter. If a claim is made within one year of the date of death of a law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter killed in the line of duty, compensation shall be paid, if the division finds that the claimant is entitled to compensation under this section, as follows:
(a) If there is a surviving spouse but no surviving child of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter, then to such person's surviving spouse;
(b) If there is a surviving spouse and at least one surviving child of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter, then fifty percent to the surviving spouse and fifty percent in equal shares to the surviving child or children;
(c) If there is no surviving spouse and at least one surviving child of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter, then to the surviving child or children in equal shares;
(d) If there is no surviving spouse and no surviving child of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter, then to the decedent's estate.
…
7. Effective August 28, 2016, the spouse, child, or personal representative of any person who was killed in the line of duty on or after June 19, 2009, who would have been eligible to receive benefits under the provisions of this section, shall be eligible to a claim for compensation under this section.
…

Note: Although claims for compensation under this section are filed by the estate of the deceased with the Division of Workers' Compensation (Division), and the Division authorizes the payment of compensation and benefits; compensation provided for under this section is in addition to, and not exclusive of, any pension rights, death benefits, or other compensation the claimant may otherwise be entitled to by law, and claims are paid from the Line of Duty Compensation Fund.

Mississippi

SB 2193, in part, amends ***section 83-17-401 Definitions*** of the Mississippi Code of 1972 as follows:

§ 83-17-401 Definitions

As used in this article, unless the context otherwise requires:
…
(e) "Workers' compensation adjuster" means an adjuster whose scope of licensure is limited to workers' compensation insurance. A

workers' compensation adjuster may not represent an insured individual. A workers' compensation adjuster must comply with all licensing and continuing education requirements as are prescribed by the commissioner pursuant to this article.

…

West Virginia

SB 525 amends numerous sections of the Code of West Virginia, all relating to the West Virginia Insurance Guaranty Association (association) Act (act), to:

- Modify the scope and construction of the act
- Add and amend definitions
- Clarify and add powers, duties, and rights of the association
- Modify provisions concerning the effect of paid claims, exhaustion of coverage, prevention of insolvencies, and stay of proceedings
- Change the due date of the annual financial report
- Limit covered claims
- Expand the association's right to recover and be reimbursed
- Provide for confidentiality of financial information
- Exempt certain reports and recommendations from the Freedom of Information Act

SB 553 amends ***section 33-2-21a. State agency workers' compensation programs.*** of the Code of West Virginia as follows:

§ 33-2-21a. State agency workers' compensation programs.

(a) The intent of this section is to provide a means of managing workers' compensation coverage for persons directly employed by the State of West Virginia and the Volunteer Fire Departments Workers' Compensation Subsidy Program and the Volunteer Fire Department Workers' Compensation Premium Subsidy Fund. For the purposes of this section:

(1) Discretionary participant means the Parkways Authority, offices of the State Auditor, the State Treasurer, the Secretary of State, the Attorney General, the Department of Agriculture, the state Senate and House of Delegates or their related entities, the Supreme Court of Appeals, the State Police, Volunteer Fire Departments and any other spending unit of the state that is required by section twelve, article two, chapter eleven-b of this code to provide a detailed expenditure schedule to the Secretary of Revenue in his or her capacity as Director of the Budget: *Provided,* That the term discretionary participant does not include any executive state entity other than the State Police and the Parkways Authority, any county board of education, any other county entity or its instrumentality or any municipality or its instrumentality.

…

(b) Notwithstanding any provision of this code to the contrary, the commissioner has sole responsibility for managing the workers' compensation risks of all executive state entities and for supervising and controlling the workers' compensation programs for such entities: *Provided,* That any discretionary participant may participate in the program upon application to the commissioner under the same terms and conditions as are applicable to executive state entities: *Provided,~~further~~ however,* That a discretionary participant is, in accordance with rules governing the program, permitted to withdraw from continued participation in the program.

…

(e) (1) There is hereby established the State Entities Workers' Compensation Program Fund. All premiums, surcharges, assessments, deposits or any other moneys or funds deposited or otherwise designated or accruing to the fund as well as all earnings payable to it, shall be deposited in the State Treasury to the credit of the fund. Expenditures from the fund shall be for the purposes set forth in this section, are authorized from collections, and shall not revert to the General Fund. The fund shall be a separate and distinct fund upon the books and records of the Auditor and Treasurer, and disbursements therefrom shall be made upon requisitions signed by the Insurance Commissioner: *Provided,* That notwithstanding any provision of this section to the contrary, effective July 1, 2016, the "Volunteer Fire Department Workers' Compensation Subsidy Program" created by section fourteen-a, article four, chapter twelve of this code, and the "Volunteer Fire Department Workers' Compensation Premium Subsidy Fund" created by section thirty-three-a, article three of this chapter and all of the provisions and purposes of those sections, shall be merged with this section.

…

SB 621 adds new ***section 24A-2-7. Workers' compensation coverage.*** to the Code of West Virginia as follows:

§24A-2-7. Workers' compensation coverage.

A taxicab company operating under this chapter is not required to provide workers' compensation coverage to a driver who provides taxicab service pursuant to a written or electronic agreement that identifies the taxicab driver as an independent contractor and any such taxi driver identified as an independent contractor pursuant to this section, shall not be eligible for workers' compensation benefits under chapter twenty-three of this Code, as an employee of the taxicab company.

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

FEDERAL ISSUES

Issue	Update
Congress	Congress continues its work on several significant public policy issues including cybersecurity and tax reform, with the majority of activity in committee hearings and other committee work.

Issue	Update
TRIPRA of 2015 Implementation	The Federal Insurance Office (FIO) is developing guidance on how it intends to collect terrorism insurance information as required by Section 111. Workers compensation is the only line of insurance covered by the Terrorism Risk Insurance Program Reauthorization Act (TRIPRA) requiring evaluation in the FIO's annual report on the impact of TRIPRA on insurance markets. The FIO will be promulgating rules on the data collection mechanism it will use for all TRIPRA-covered insurance lines, including workers compensation, in the near future but it will not be confirmed until the regulations are released. The National Association of Insurance Commissioners (NAIC) also plans to collect terrorism insurance data. Eleven states (CA, CT, DC, FL, IL, LA, MO, NY, PA, RI, and TX) have agreed to participate in the first terrorism insurance data call, with New York taking a coordinating role. The NAIC indicated that, given the changes to TRIPRA made during the reauthorization in 2015, it is necessary that terrorism insurance data be collected for purposes of solvency regulation and general market oversight. *NCCI is actively engaged with the NAIC on the availability of workers compensation terrorism insurance data. The workers compensation portion of the data call has been approved by the participating states, and NCCI anticipates providing the NAIC with the workers compensation data in the second quarter of 2016.*
Administration's 2017 Budget Proposal	In early February, the Obama Administration released its 2017 Federal Budget Proposal which outlines priorities for the coming year. Consistent with past years' proposals, the 2017 budget includes several elements that could impact workers compensation, such as a budget request for $10 million to implement a Workers Compensation Information Reporting program. The budget document does not describe the program but it is assumed that it mirrors past proposals to develop a process to collect workers compensation information in a timely manner from states and private insurers. The Administration has proposed the data collection initiative in the previous four budgets, arguing that the information is necessary to correctly offset disability income benefits and reduce Supplemental Security Income payments from the Social Security Administration. This proposal has not been included in Congressional budget agreements in the preceding years. Additionally, the 2017 proposal seeks to allow the Centers for Medicare & Medicaid Services (CMS) to receive payments from certain lump-sum settlements (e.g., workers compensation) to ensure that Medicare's interests under these third-party settlements are protected. In many cases, settlement sums set aside for future CMS reimbursement are administered by individual claimants. This provision is consistent with the approach taken in bipartisan Medicare set-aside legislation and signals the Administration's support for advance payments to CMS.

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

STATE LEGISLATIVE ACTIVITY

State	Update
Connecticut	**HB 5075** calls for a study to evaluate the current workers compensation system in the state. **HB 5262** provides workers compensation coverage for current and former uniformed members of a paid or volunteer fire department who suffer from certain diseases as a result of performing their jobs. **HB 5372** proposes to study the feasibility of establishing a program to provide uniformed members of paid and volunteer fire departments in the state with disability insurance policies. **HB 5449** allows individuals seeking compensation for a workers compensation claim to bring an action against an employer or insurer that has unreasonably contested liability or unreasonably delayed payments or adjustments of such compensation. **SB 101** enables certain sole proprietors who do not carry workers compensation insurance to perform on public works projects. **SB 134** extends workers compensation coverage to police officers, firefighters, or ambulance workers suffering from a severe mental or emotional impairment as a direct result of witnessing the death or maiming of another human being that was caused by an act of violence of another human being. **SB 225** requires the chairman of the Workers' Compensation Commission to augment the fee schedule for certain radiology services by 15%.

Florida	**HB 345** and **SB 456** are similar, but not identical measures dealing with presumption of compensability for full-time first responders, with **HB 345** relating to firefighters and paramedics and **SB 456** relating only to firefighters. Both bills establish a presumption that a condition or impairment of health caused by cancer was accidental and in the line of duty—subject to certain conditions being met—and provide requirements for physical examination. **HB 771/SB 1154** relate to drug-free workplaces and: • Revises the definition of "drug" to include controlled substances classified as Schedule I, II, III, IV, and V • Revises the contents of employer policy statements with respect to employee drug use • Increases the frequency of follow-up drug testing • Revises the specimen collection, verification, and documentation procedures • Revises the requirements for confirmation testing **HB 1005** and **SB 1086** relate to prejudgment interest, requiring a court to include interest on economic damages and costs in the final judgment of a negligence action as a result of a personal injury.
Hawaii	**HB 2715** has been revised by removing all of the language calling for the repeal of the Hawaii Employers Mutual Insurance Company and creation of a state-run monopoly for workers compensation. As amended, **HB 2715 HD1** now calls for a closed claim study of the workers compensation system in the state.
Illinois	There have been a number of new bills introduced this session in addition to the many workers compensation-related bills that have carried over from the 2015 session. Since workers compensation is an issue in the budget negotiations, it is unclear at this time which legislation has been introduced primarily for negotiating purposes. **HB 5653** establishes that the payment of temporary benefits is without prejudice and is not an admission of liability. It also permits, upon a determination that a payor is not responsible for the payments of benefits, the payments made to be recovered from the recipient of such benefits. **HB 5754** makes several changes in the payment of disability benefits in specific instances. **HB 6225** and **SB 3083** deal with employee leasing arrangements and the provision of workers compensation benefits under such arrangements. **SB 3083** appears to be in response to a recent judicial decision (*Chaney v. Yetter*) and may have significant impacts for clients of employee leasing and professional employer organization arrangements. **SB 2598** calls for the amount charged to employers correctly classified within the construction industry for workers compensation and employers' liability insurance to be based upon hours worked by employees in specific job categories or classifications, not on the wages or salaries paid to the employees. **SB 2750** provides that, in the event of insufficient funds in the Injured Workers' Benefit Fund to pay all claims, an amount of money sufficient to make up the deficiency shall be considered to be always appropriated from the Illinois Workers' Compensation Commission Operations Fund, the Rate Adjustment Fund, the Settlement Fund, and the Second Injury Fund. The bill also sets the minimum payout from the Injured Workers' Benefit Fund for death or permanent total disability at 364 weeks of benefits payable in a lump sum. **SB 2919** enables employers to file safety and return-to-work programs with the Illinois Workers' Compensation Commission and authorizes the Commission to certify the programs, upon review, for certain minimum requirements. It also provides that the Director of Insurance must direct any workers compensation rate setting advisory organization to recalculate rates with respect to employers that file safety and return-to-work programs.
Kansas	**HB 2691** permits the legal use of cannabis for medical conditions.
Missouri	**HB1528/HB 1836** amend the threshold requirement for any person or corporation in the construction industry (who erects, demolishes, alters, or repairs improvements) to obtain workers compensation coverage. The requirement changes from employing one person to employing five persons. **HB 1703/SB 877** are similar, but not identical, measures to regulate the professional employer organization (PEO) industry including definitions, responsibilities, taxes, and insurance provisions. Several revisions have been discussed thus far, including removal of the insurance provisions. **HB 1703** was amended to include reporting for experience rating purposes, whether in or out of PEO arrangements. **HB 1867** permits certain shareholders of S corporations to reject workers compensation insurance coverage. **HB 1955/SB 700** are similar, but not identical, measures amending the Contractors Credit Premium Adjustment Program (CCAP) to allow payroll reports for any previous quarter to be allowable for premium credit

	determination. The measures also allow consideration of medical-only claims up to 20% of the current split point value, as opposed to the current flat amount of $1,000. *NCCI completed pricing an analysis of these measures and concluded that the potential for impact on workers compensation system costs is negligible on an overall system cost basis. Note that the proposed CCPAP changes may result in an increase in CCPAP credits, likely resulting in offsetting increases in loss costs for the 80 eligible contracting classifications.* **HB 2218** deems certain prosthetists, orthotists, and pedorthists eligible for workers compensation and other health care reimbursements. **SB 601** modifies the definition of occupational disease to include post-traumatic stress disorder (PTSD) and creates a rebuttable presumption that PTSD in first responders is work-related. *If enacted in its current form, this bill may result in an indeterminable increase in overall workers compensation (WC) system costs in Missouri. The cost impact is expected to be more pronounced in firefighters, emergency medical technicians (EMTs), and other first responders who are exposed to distressing events that may result in PTSD more frequently than the general population. The ultimate cost impact would be realized through future loss experience and reflected in subsequent NCCI loss cost filings in the state.* **SB 1027** objectively defines maximum medical improvement (MMI) to that beyond which the injured employee can no longer reasonably improve and makes MMI the determining factor to cease payment of temporary total or temporary partial disability benefits. The measure is being considered in response to the recent Missouri Supreme Court case *Greer v. Sysco Foods* wherein the Court ruled that MMI is not a bright line determination to end such benefits.
Nebraska	**LB 743** establishes that, when determining disability compensation, loss or loss of use of an arm does not include injuries to the shoulder. *NCCI has completed analysis of this measure, concluding that while the impact on overall workers compensation system costs is not possible to quantify at this time, upward pressure on cost is likely.* **LB 1001** changes provisions relating to a compensation schedule for injuries to the leg, ear, eye, or nose that result in disability. *NCCI is currently reviewing this measure for potential impact on system costs.* **LB 1005** includes provisions for the adoption of an Occupation Disease Guideline (ODG)-based drug formulary. *NCCI analysis of this measure concluded that while a decrease in overall workers compensation system cost is likely, there is insufficient existing information to quantify the amount of that decrease.*
New Hampshire	**SB 449** authorizes payment of compensation under the workers' compensation law to be made to an injured worker by direct deposit.
Oklahoma	**SB 1152** strikes current statutory language disallowing benefits for incarcerated employees for a compensable work-related injury incurred prior to their imprisonment. Additionally, **SB 1152** stipulates that employees sentenced to a term of incarceration of 90 days or more and who are awarded permanent total disability or temporary partial disability benefits would have those benefit payments made during the period of incarceration distributed to the Department of Corrections in order to cover the costs of incarceration.
Rhode Island	**HB 7629** allows an employer or workers' compensation insurer to recover any overpayments for benefits made to the injured employee by a set-off against future payments due to an employee for loss of use or disfigurement. **HB 7631** restricts the awarding of disfigurement workers compensation benefits to scarring of the neck, face, and hands and prohibits them from being awarded less than one year from the date of the event that caused the disfigurement. **HB 7632** broadens the definition of "suitable alternative employment" and expands the circumstances under which an earning capacity can be set by the workers' compensation court.
South Carolina	**SB 1064** codifies the current process followed by the Department of Insurance (Department) for filing and reviewing of a carrier's loss cost multipliers (LCM). It would extend the Department's statutory review period from 30 days to 60 days and add a requirement for carriers to adopt the most recently approved voluntary loss costs. It also adds a requirement that carriers use their most recently approved LCM until the Department approves their new LCM. This last provision appears to potentially eliminate the deemer provision as it currently exists.
Vermont	**HB 669** requires the Department of Labor to conduct a study of the workers' compensation system and opiate abuse. **HB 767** directs the Commissioner of Financial Regulation to adopt rules requiring workers compensation insurers

	to permit employers to pay workers compensation premiums either annually, quarterly, or on a monthly basis. **HB 773** amends definitions related to independent contractors in the workers compensation and unemployment compensation statutes. **HB 803** creates a committee to study mechanisms for creating portable insurance, retirement, and other employee benefits to address the needs of individuals that are freelance workers in e-commerce, self-employed workers, or workers in the "on-demand" or "app" economy.

OTHER ITEMS OF INTEREST

State	Update
Alaska	Alaska's Workers Compensation Division adopted a permanent medical fee schedule which goes into effect March 11, 2016. The new schedule replaces the emergency fee schedule enacted on December 1, 2015. *NCCI is analyzing the permanent fee schedule for its impact on the Alaska workers compensation system.*
Arizona	A revised statute requires the Industrial Commission to develop and implement a process for the use of evidence-based medical treatment guidelines for treatment of injured workers. These guidelines are intended to improve the quality of medical care outcomes and the efficiency and effectiveness of that medical care. The Industrial Commission is creating these rules to comply with the directive; the effective date will be established once the rulemaking process comes to a close. The guidelines are not expected to be implemented before July 2016. *NCCI estimates that the proposed Arizona Rules R20-5-1301–R20-5-1312 (medical treatment guidelines) would have the following impacts on overall workers compensation (WC) costs in Arizona:* *• If ultimately enacted as proposed, the adoption of a closed drug formulary, based on the most current edition of the Official Disability Guidelines (ODG) Drug Formulary and assumed to be effective July 1, 2016, would result in an impact of –2.3% (–$19M) on overall workers compensation costs in Arizona.* *• The implementation of medical treatment guidelines other than the adoption of a closed drug formulary has the potential to further reduce overall WC costs, depending on the actual level of utilization of the guidelines. Any cost impact from the implementation of medical treatment guidelines would be reflected in the analysis of future claims experience contained in subsequent NCCI rate filings in Arizona.*
Colorado	The single-payer ballot initiative, sponsored by ColoradoCare, is scheduled to appear on the November 2016 ballot. If voted into law, ColoradoCare will create a new $25 billion dollar tax. This tax will be used to establish a health care payment system to fund the health care for all individuals whose primary residence is in Colorado, and create a governmental entity called ColoradoCare to administer the health care payment system. The initiative includes transferring responsibility to ColoradoCare for medical care that would otherwise be paid for by workers compensation insurance.
Montana	On February 25, 2016, the state Supreme Court, in *Montana Cannabis Industry Association, et al. v. State of Montana*, upheld provisions of the state's 2011 Marijuana Act (the "Act") including: • Requiring the Department of Public Health and Human Services to notify the Board of Medical Examiners of any doctor who certifies 25 or more medical marijuana patients a year • Limiting medical marijuana providers to a maximum of three patients • Banning advertising by medical marijuana providers • Barring individuals on probation from eligibility to receive medical marijuana • Allowing warrantless inspections of the businesses of medical marijuana providers In its decision, the Court also invalidated the Act's provision prohibiting providers from receiving financial remuneration for medical marijuana products or services.
New Mexico	On February 15, 2016, the state Supreme Court issued a stay in *Noe Rodriguez v. Brand West Dairy and New Mexico Uninsured Employers Fund*, consolidated with *Maria Angelica Aguirre v. M.A. & Sons Chili Products and Food Industry Self Insurance Fund of New Mexico.* In June 2015, the Court of Appeals ruled unconstitutional the exclusion of farm and ranch laborers from the state's workers compensation act. While the Supreme Court reviews the case, its stay of the lower court's decision means that the prior ruling cannot be enforced until a final determination is made.

Oklahoma	On January 15, 2016, the Workers Compensation Commission proposed changes to the medical fee schedule for workers compensation. *NCCI has completed analysis of the proposal and determined that the impact on overall workers compensation system costs will be negligible.* On February 26, 2016, the Oklahoma Workers Compensation Commission issued an order in the case of *Vasquez v. Dillard's Inc.* finding the Oklahoma Employee Injury Benefit Act, also known as "opt out," unconstitutional. This case is immediately appealable to the Oklahoma Supreme Court which would be required to accept the Dillard's appeal and consider the case on an expedited basis. The ruling is stayed pending appeal to and a final decision by the Oklahoma Supreme Court. The Oklahoma Insurance Department will hold a public hearing on March 22, 2016, to take comments and questions on proposed rules to amend or define workers compensation small, large, and mega deductibles. The proposed rules would impact an employer's experience rating calculations by expanding the net reporting mechanism. *NCCI is currently reviewing this measure to determine potential impacts on overall workers compensation system costs.*
Oregon	Oregon's Workers Compensation Division convened a hearing regarding proposed changes to the Oregon medical fee schedule and payment rules which have been in effect since January 1, 2016. The new proposal, if adopted, will become effective on April 1, 2016. The proposal will: • Update the physician, ambulatory surgical center (ASC), and durable medical equipment, prosthetics, orthotics, and supplies fee schedules containing the maximum allowable reimbursement (MAR) amounts for such medical services. The current fee schedules have been in effect since January 1, 2016. • Update the maximum reimbursement amount per single hearing aid from $2,500 to $3,500. • Clarify reimbursement for compound drugs (Currently drugs are reimbursed at a rate of 83.5% of the Average Wholesale Price (AWP) plus a $2 dispensing fee per prescription): o Nonsterile compound drugs will now be billed and reimbursed at the ingredient level at a rate of 83.5% of the AWP plus a $2 compounding fee per ingredient o Sterile compound drugs will now be billed and reimbursed at the ingredient level at a rate of 83.5% of the AWP plus a $4 compounding fee per ingredient *NCCI estimates that the proposed changes will result in an overall impact of +0.5% on Oregon workers compensation system costs.*

Contact Information

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

State	State Relations Executive	Phone Number
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This report is informational and is not intended to provide an interpretation of state and federal legislation.