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

The following workers compensation-related bill was enacted within the one-week period ending March 4, 2016.

New Mexico

SB 214 was:

- Passed by the first and second chamber on February 17, 2016
- Included in NCCI's February 26, 2016 ***Legislative Activity Report*** (RLA-2016-07)
- Enacted on March 2, 2016, with an effective date of May 18, 2016

SB 214 amends ***sections 52-1-11. Injuries due to intoxication, willfulness or intention of worker are noncompensable*** and ***52-1-12.1. Reduction in compensation when alcohol or drugs contribute to injury or death*** and repeals ***section 52-1-12. Compensation prohibited when worker under influence of certain drugs*** of the New Mexico Statutes Annotated as follows:

52-1-11. Injuries ~~due to intoxication~~ caused by the willfulness or intention of worker are noncompensable

No compensation shall become due or payable from any employer under the terms of the Workers' Compensation Act in the event such injury was ~~occasioned by the intoxication of such worker or~~ willfully suffered by ~~him~~ the worker or intentionally inflicted by ~~himself~~ the worker.

52-1-12.1. Reduction in compensation when alcohol or drugs contribute to injury or death

~~The compensation otherwise payable a worker pursuant to the Workers' Compensation Act shall be reduced ten percent in cases in which the injury to or death of a worker is not occasioned by the intoxication of the worker as stated in Section 52-1-11 NMSA 1978 or occasioned solely by drug influence as described in Section 52-1-12 NMSA 1978, but voluntary intoxication or being under the influence of a depressant, stimulant or hallucinogenic drug as defined in the New Mexico Drug, Device and Cosmetic Act or under the influence of a narcotic drug as defined in the Controlled Substances Act, unless the drug was dispensed to the person upon the prescription of a practitioner licensed by law to prescribe the drug or administered to the person by any person authorized by a licensed practitioner to administer the drug, is a contributing cause to the injury or death. Test results used as evidence of intoxication or drug influence shall not be considered in making a determination of intoxication or drug influence unless the test and testing procedures conform to the federal department of transportation "procedures for transportation workplace drug and alcohol testing programs" and the test is performed by a laboratory certified to do the testing by the federal department of transportation.~~

A. As used in this section, "intoxication" or "influence" means a temporary state or condition of impaired physical, mental or cognitive function by means of alcohol, a drug, a controlled substance or a combination of two or more substances at the time of injury or death. "Drug" or "controlled substance" pursuant to this section does not include medications prescribed to a worker by the worker's licensed health care provider and taken in accordance with directions of the prescribing health care provider or dispensing pharmacy, unless such medication is combined with alcohol or a non-prescribed drug or controlled substance to cause intoxication or influence.

B. Except as otherwise provided in this section, compensation benefits otherwise due and payable from an employer to the worker under the terms of the Workers' Compensation Act shall be reduced by the degree to which the intoxication or influence contributes to the worker's injury or death; provided that the reduction shall be a minimum of ten percent but no more than ninety percent.

C. Test results relied on as evidence of a worker's intoxication or influence shall not be considered in making a reduction in compensation determination unless the test and testing procedures conform with standard testing procedures generally accepted in the medical community and the test is performed by a laboratory certified to do the testing by an organization nationally recognized to do such certification. Testing may include testing methods for urine, breath or blood.
D. The director shall adopt rules regarding tests, testing and the cutoff levels for intoxication or influence.
E. If a post-accident test pursuant to Subsection C of this section is required of a worker and the worker refuses to submit to the test or to release the post-accident test results to the employer, no compensation otherwise payable from an employer under the terms of the Workers' Compensation Act shall be paid to the worker claiming compensation.
F. Testing shall be at the employer's expense and shall not be used as evidence in a criminal proceeding against the worker. Test samples shall be taken as a split sample. One part of the sample shall be held by the testing facility for twelve months from the date of the original test. Within this twelve-month period, the worker has the right to request a second test of the original sample at the worker's expense.
G. An employer shall be barred from claiming a reduction in compensation pursuant to this section if, before the accident, the employer has actual or constructive knowledge of the worker's intoxication or influence and a reasonable opportunity to take appropriate measures in response to the intoxication or influence but fails to take those measures.
H. An employer shall be barred from claiming a reduction in compensation pursuant to this section if the employer fails to implement a written policy that declares a drug- and alcohol-free workplace, which may include post-accident testing in accordance with this section, and that gives its employees notice that workers' compensation benefits may be reduced in the event intoxication or influence contributes to a workplace injury.
I. Reduction or denial of compensation benefits authorized under this section shall not affect payment of medical benefits provided for pursuant to Section 52-1-49 NMSA 1978.
J. Reduction or denial of compensation benefits authorized under this section shall not affect payments of benefits to the dependents of a deceased worker pursuant to Section 52-1-46 NMSA 1978.

~~**52-1-12 . Compensation prohibited when worker under influence of certain drugs.**~~
~~No compensation is payable from any employer under the provisions of the Workers' Compensation Act [52-1-1 NMSA 1978] if the injury to the person claiming compensation was occasioned solely by the person being under the influence of a depressant, stimulant or hallucinogenic drug as defined in the New Mexico Drug, Device and Cosmetic Act [26-1-1 NMSA 1978] or under the influence of a narcotic drug as defined in the Controlled Substances Act [30-31-1 NMSA 1978] unless the drug was dispensed to the person upon the prescription of a practitioner licensed by law to prescribe the drug or administered to the person by any person authorized by a licensed practitioner to administer the drug.~~

*NCCI estimates that **SB 214** may result in a negligible decrease in overall workers compensation system costs in New Mexico. The resulting impact, if any, would be realized in future experience and reflected in subsequent NCCI loss cost filings in New Mexico. Depending upon how various aspects are interpreted, this bill could result in increased frictional costs and litigation.*

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending March 4, 2016.

District of Columbia*

DC B21-0388 amends ***section 32-1535*** of the District of Columbia Official Code to require that if a person entitled to workers compensation institutes proceedings and recovers an amount against a third person, court costs and attorney fees shall be proportionally shared between the person entitled to the compensation and the employer, relative to the amount each received in the settlement against the third person.

*District of Columbia bills only need to pass one chamber (the Council) before going to the mayor for signature.

Also note that **B21-0388** was not included in any previous version of NCCI's ***Legislative Activity Report*****.**

Florida

HB 613 passed the first and second chambers on March 3, 2016.

HB 613 amends various provisions of the Florida workers compensation law including, but not limited to:

- Providing for a 25% penalty credit for certain employers
- Establishing a deadline for employers to file certain documentation to receive a penalty reduction
- Reducing the imputed payroll multiplier related to penalty calculations from 2 times to 1.5 times the statewide average weekly wage
- Requiring employers to simply notify their insurers of their employee's coverage exemption, rather than requiring that a copy of the exemption be provided
- Eliminating a three-day response requirement applicable to employer-held exemption information
- Removing the requirement that construction employers maintain written exemption acknowledgements
- Deleting a requirement that exemption revocations be filed by mail only

- Removing unnecessary information from the exemption application
- Relieving employers of the obligation to notify the Department of Financial Services (DFS) by telephone or telegraph within 24 hours of any work-related death and relying instead on other existing reporting requirements
- Removing insurers and employers from the medical reimbursement dispute provision since they meet their adjustment, disallowance, and provider violation reporting duties through other provisions of law
- Eliminating fees collected by the DFS related to new insurer registrations and Special Disability Trust Fund notices of claim and proofs of claim
- Revising the method for selecting an expert medical examiner
- Eliminating the Preferred Worker Program

Indiana

HB 1136 was:

- Passed by the first chamber on January 28, 2016
- Included in NCCI's February 5, 2016 ***Legislative Activity Report*** (RLA-2016-04)
- Amended and passed the second chamber on March 1, 2016

HB 1136, in part, amends ***section 27-9-1-2. Definitions***, and adds ***section 27-9-3-34.5*** to the Indiana Code relating to large deductible workers compensation policies, as follows:

27-9-1-2. Definitions

…

(b) "Collateral", for purposes of IC 27-9-3-34.5, means cash, a letter of credit, a surety bond, or another form of security posted by an insured, a captive insurer, or reinsurer, to secure the insured's obligation to:

(1) pay deductible claims or to reimburse the insurer for deductible claim payments under a large deductible policy; or

(2) reimburse or pay the insurer as required for other secured obligations.

(c) "Commercially reasonable" means:

(1) acting in good faith according to prevailing industry practices; and

(2) making all reasonable efforts considering the facts and circumstances of a matter.

…

(f) "Deductible claim" means a claim under a large deductible policy that does not exceed the deductible. The term includes a claim for loss, defense, and (unless excluded) cost containment expense.

…

(q) "Large deductible policy" means a combination of worker's compensation policies or endorsements, or both, issued to an insured and contracts or security agreements entered into between the insured and insurer in which the insured has agreed to pay directly, or reimburse the insurer for the insurer's payment of, the:

(1) initial part of a claim under the policy; or

(2) expenses related to a claim;

up to a specified dollar amount. The term includes a policy that contains, in addition to a per claim limit, an aggregate limit on the insured's liability for all deductible claims. The term also includes a policy with a deductible of at least fifty thousand dollars ($50,000). The term does not include a policy, an endorsement, or an agreement under which the initial part of a claim is self-insured and the insurer is not obligated to pay any part of the self-insured retention. The term also does not include a policy that provides for retrospectively rated premium payments or a reinsurance agreement, except to the extent that a reinsurance agreement assumes, secures, or pays the insured's large deductible obligations.

(r) "Other secured obligations", for purposes of IC 27-9-3-34.5, means obligations of an insured to an insurer other than obligations under a large deductible policy. The term includes obligations under a reinsurance agreement or another agreement that involves retrospective premium obligations the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy.

…

27-9-3-34.5

Sec. 34.5. (a) This section:

(1) applies to a worker's compensation large deductible policy issued by an insurer that is subject to this chapter; and

(2) does not apply to first party claims or claims funded by the guaranty association net of the deductible.

(b) To the extent that the terms of a large deductible policy conflict with this section, the policy must be administered in accordance with this section.

(c) Unless otherwise agreed by the guaranty association, all deductible claims that are covered claims (as defined in IC 27-6-8-4), including claims funded by an insured before liquidation, must be referred to the guaranty association for processing. To the extent an insured funds or pays a deductible claim under an agreement with the guaranty association or otherwise, the insured's funding or payment of the deductible claim extinguishes any obligation of the receiver or the guaranty association to pay the claim. A charge may not be made against the receiver or the guaranty association on the basis of an insured's funding or payment of a deductible claim.

(d) The following apply when the guaranty association pays a deductible claim:

(1) If the guaranty association pays a deductible claim for which the insurer would have been entitled to reimbursement from the insured, the guaranty association is entitled to the full amount of the reimbursement and available collateral to the extent necessary to reimburse the guaranty association.
Reimbursements paid to the guaranty association under this subsection are not early access payments under section 32 of this chapter or distributions under section 40 of this chapter.
(2) If the guaranty association pays:
(A) a deductible claim that is not reimbursed:
(i) from collateral; or
(ii) by payment by the insured; or
(B) an incurred expense in connection with a large deductible policy that is not reimbursed;
the guaranty association is entitled to assert a claim for the payments in the delinquency proceeding.
(e) Subsection (d) does not limit the receiver's or guaranty association's rights under other applicable law to obtain reimbursement from an insured for claim payments made by the guaranty association:
(1) under the policies of the insurer; or
(2) for the guaranty association's related expenses;
including payments described in IC 27-6-8-11.5 or under another state's similar law.
(f) A receiver shall do the following:
(1) Upon receipt by the receiver of notice from the guaranty association of reimbursable payments for which the guaranty association has not been reimbursed, bill an insured for reimbursement of deductible claims:
(A) paid by the insurer before the commencement of delinquency proceedings;
(B) paid by the guaranty association; or
(C) paid or allowed by the receiver.
(2) If an insured that is billed under subdivision (1) does not make payment within:
(A) the time specified in the large deductible policy; or
(B) if no time is specified in the large deductible policy, sixty (60) days after the date of billing;
the receiver shall pursue all commercially reasonable actions to collect the payment.
(g) The following do not relieve an insured from the insured's reimbursement obligation under a large deductible policy and this chapter:
(1) An insurer's insolvency.
(2) An insurer's inability to perform the insurer's obligations.
(3) An allegation of improper processing or payment of a deductible claim, except for gross negligence, by the:
(A) insurer;
(B) receiver; or
(C) guaranty association.
(h) With respect to collateral, the following apply:
(1) A receiver shall use available collateral to secure:
(A) an insured's obligation to fund or reimburse deductible claims; and
(B) other secured obligations or payment obligations.
The guaranty association is entitled to collateral to the extent needed to reimburse the guaranty association for the guaranty association's payment of a deductible claim. A distribution to the guaranty association under this subdivision is not an early access payment under section 32 of this chapter or a distribution under section 40 of this chapter.
(2) A receiver shall pay all claims against collateral in the order received, and a claim of the receiver, including claims described in this subsection, does not supersede any other claim against the collateral as described in subdivision (4).
(3) A receiver shall draw down collateral to the extent necessary if the insured fails to do any of the following:
(A) Perform the insured's funding or payment obligations under the large deductible policy.
(B) Pay a deductible claim reimbursement within the time specified in subsection (f)(2).
(C) Pay amounts due to the insurer estate for pre-liquidation obligations.
(D) Fund any other secured obligation within:
(i) the time specified in the large deductible policy; or
(ii) another reasonable period.
(E) Pay expenses within the time specified in subsection (f)(2).
(4) A receiver shall pay all claims that are validly asserted against the collateral in the order in which the claims are received by the receiver.
(5) A receiver shall return to an insured any excess collateral, as determined by the receiver after a periodic review of claims paid, outstanding case reserves, and a factor for incurred but not reported claims.

Utah

HB 116 was:

- Passed by the first chamber on February 8, 2016
- Included in NCCI's February 19, 2016 ***Legislative Activity Report*** (RLA-2016-06)
- Amended and passed by the second chamber on March 3, 2016

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.

…

Virginia

HB 1108 was:

- Passed by the first chamber on February 16, 2016
- Included in NCCI's February 26, 2016 ***Legislative Activity Report*** (RLA-2016-07)
- Passed by the second chamber on March 3, 2016

HB 1108 amends ***sections 2.2-4302.1. Process for competitive sealed bidding*** and ***2.2-4302.2. Process for competitive negotiation*** of the Code of Virginia as follows:

§ **2.2-4302.1. Process for competitive sealed bidding.**

The process for competitive sealed bidding shall include the following:

1. Issuance of a written Invitation to Bid containing or incorporating by reference the specifications and contractual terms and conditions applicable to the procurement. Unless the public body has provided for prequalification of bidders, the Invitation to Bid shall include a statement of any requisite qualifications of potential contractors. No Invitation to Bid for construction services shall condition a successful bidder's eligibility on having a specified experience modification factor. When it is impractical to prepare initially a purchase description to support an award based on prices, an Invitation to Bid may be issued requesting the submission of unpriced offers to be followed by an Invitation to Bid limited to those bidders whose offers have been qualified under the criteria set forth in the first solicitation;

…

5. Award to the lowest responsive and responsible bidder. When the terms and conditions of multiple awards are so provided in the Invitation to Bid, awards may be made to more than one bidder.

For the purposes of subdivision 1, "experience modification factor" means a value assigned to an employer as determined by a rate service organization in accordance with its uniform experience rating plan required to be filed pursuant to subsection D of Section 38.2-1913.

Section 2.2-4302.2. Process for competitive negotiation.

A. The process for competitive negotiation shall include the following:

1. Issuance of a written Request for Proposal indicating in general terms that which is sought to be procured, specifying the factors that will be used in evaluating the proposal, indicating whether a numerical scoring system will be used in evaluation of the proposal, and containing or incorporating by reference the other applicable contractual terms and conditions, including any unique capabilities, specifications or qualifications that will be required. In the event that a numerical scoring system will be used in the evaluation of proposals, the point values assigned to each of the evaluation criteria shall be included in the Request for Proposal or posted at the location designated for public posting of procurement notices prior to the due date and time for receiving proposals. No Request for Proposal for construction ~~services~~ authorized by this chapter shall condition a successful offeror's eligibility on having a specified experience modification factor;

…

For the purposes of subdivision A 1, "experience modification factor" means a value assigned to an employer as determined by a rate service organization in accordance with its uniform experience rating plan required to be filed pursuant to subsection D of Section 38.2-1913.

In addition, **HB 1108** adds the following new section to read:

§ **11-9.8. Construction of certain terms of offer to contract; use of experience modification factor prohibited.**

A. As used in this section:
"Contract" means an agreement for the provision of construction services under which the contractor will be required to have and maintain a policy of insurance as defined in Section 38.2-119.
"Experience modification factor" means a value assigned to an employer as determined by a rate service organization in accordance with its uniform experience rating plan required to be filed pursuant to subsection D of Section 38.2-1913.
"Offer to contract" means a solicitation of bids, Request for Proposals, or similar invitation to enter into a contract that is extended to potential contractors for construction services.
"Person" means any individual; firm; cooperative; association; corporation; limited liability company; trust; business trust; syndicate; partnership; limited liability partnership; joint venture; receiver; trustee in bankruptcy; club, society, or other group or combination acting as a unit; or public body, including but not limited to (i) the Commonwealth; (ii) any other state; and (iii) any agency, department, institution, political subdivision, or instrumentality of the Commonwealth or any other state.
B. A term of an offer to contract issued that requires that the successful bidder have a specified experience modification factor is prohibited.
C. Any contract or offer to contract that requires the contractor or bidder responding to the offer to contract to have a specified experience modification is prohibited.
…

HB 1108 also contains the following clause:
That the provisions of this act shall apply to any offer to contract, as defined in § 11-9.8 of the Code of Virginia, as created in this act; Invitation to Bid; or Request for Proposal for construction services issued on or after July 1, 2016.

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending March 4, 2016.

Arizona

HB 2350 amends ***section 23-901. Definitions*** and adds new ***section 23-901.09. Post-traumatic stress disorder*** to the Arizona Revised Statutes, in part, as follows:

23-901. Definitions
In this chapter, unless the context otherwise requires:
…
13. "Personal injury by accident arising out of and in the course of employment" means any of the following:
(a) Personal injury by accident arising out of and in the course of employment.
(b) An injury caused by the wilful act of a third person directed against an employee because of the employee's employment, but does not include a disease unless resulting from the injury.
(c) An occupational disease that is due to causes and conditions characteristic of and peculiar to a particular trade, occupation, process or employment, and not the ordinary diseases to which the general public is exposed, and subject to section 23-901.01.
(d) post-traumatic stress disorder that is caused by or is related to employment as a peace officer and that is subject to section 23-901.09.

23-901.09. Post-traumatic stress disorder
Notwithstanding section 23-1043.01, post-traumatic stress disorder of a peace officer is presumed to be a personal injury by accident arising out of and in the course of employment and is compensable pursuant to this chapter, if both of the following apply:
1. There is a direct causal connection between the peace officer's employment and the post-traumatic stress disorder.
2. The peace officer is diagnosed with post-traumatic stress disorder by a psychologist or psychiatrist who is licensed pursuant to title 32, chapter 13, 17 or 19.1.

HB 2652 adds new ***Chapter 10 Employment Relations*** to the Arizona Revised Statutes to read:

Chapter 10
Employment Relationships
Article 1. General Provisions
23-1601. Qualified marketplace contractors; definitions
A. A qualified marketplace contractor shall be treated as an independent contractor for all purposes under state and local laws, regulations and ordinances, including employment security laws prescribed in chapter 4 of this title and workers' compensation laws prescribed in chapter 6 of this title, if all of the following apply:
1. All or substantially all of the payment for the services performed by the contractor is related to the performance of services or other output.
2. The services performed by the contractor are governed by a written contract executed between the contractor and a qualified marketplace platform.
3. The written contract required by paragraph 2 of this subsection provides for all of the following:
(a) that the contractor is providing services as an independent contractor and not as an employee.
(b) that, pursuant to paragraph 1 of this subsection, all or substantially all of the payment paid to the contractor shall be based on the performance of services or other output.

(c) that the contractor is allowed to work any hours or schedules the contractor chooses. If the contractor elects to work specified hours or schedules, a contract may require the contractor to perform work during the selected hours or schedules.
(d) that the contract does not restrict the contractor's ability to perform services for other parties.
(e) that the contractor bears all or substantially all of the contractor's own expenses that are incurred by the contractor in performing the services.
(f) that the contractor is responsible for the taxes on the contractor's own income.
(g) that the contract and the association created by the contract may be terminated without cause by either party to the contract at any time on reasonable notice given to the other party.
B. For services performed by a qualified marketplace contractor before the effective date of this section, the contractor shall be treated as an independent contractor for all purposes under state and local laws, regulations and ordinances, including employment security laws prescribed in chapter 4 of this title and workers' compensation laws prescribed in chapter 6 of this title, if both of the following apply:
1. All or substantially all of the payment for the services performed by the contractor is related to the performance of services or other output.
2. The services performed by the contractor are governed by a written contract executed between the contractor and a qualified marketplace platform that conforms to the requirements of subsection a, paragraph 3 of this section.
C. For the purposes of this section:
1. "Qualified marketplace contractor" or "contractor" means any person or organization, including an individual, corporation, limited liability company, partnership, sole proprietor or other entity, that enters into an agreement with a qualified marketplace platform to use the qualified marketplace platform's digital platform to provide services to third-party individuals or entities seeking those services.
2. "Qualified marketplace platform" means an organization, including a corporation, limited liability company, partnership, sole proprietor or any other entity, that operates a digital platform that facilitates the provision of services by qualified marketplace contractors to third-party individuals or entities seeking those services

Florida

SB 1402 ratifies Rule 69L-7.020, F.A.C. The *Florida Workers' Compensation Health Care Provider Reimbursement Manual* (manual), 2015 Edition, sets out the policies, guidelines, codes, and maximum reimbursement allowances for services and supplies furnished by health care providers under the workers compensation statutes. The manual provides the reimbursement policies and payment methodologies for pharmacists and medical suppliers pertaining to workers compensation. The current manual was adopted by Rule 67-7.020, F.A.C. The rule must be ratified by the legislature before it may go into effect. The rule was adopted on July 16, 2015, and submitted for ratification on November 3, 2015. The bill authorizes the rule to go into effect. The scope of the bill is limited to this rulemaking condition and does not adopt the substance of any rule into the statutes.

Hawaii

HB 2363 HD1 amends various provisions of the Hawaii Revised Statues related to workers compensation and temporary disability insurance to:

- Exclude services performed by owners of at least 50% of a corporation, members and partners of limited liability corporations and partnerships with at least a 50% interest, partners in a partnership, and sole proprietors, from the definition of employment for purposes of triggering requirements to provide temporary disability insurance
- Allow the Director of Labor and Industrial Relations to receive electronic copies of injury and other reports related to workers compensation claims
- Amend penalty amounts for:
  - Failure to provide required temporary disability insurance coverage
  - Failure to timely pay temporary disability insurance benefits or improper termination of temporary disability insurance benefits
  - Failure of a physician to file medical reports required for a workers compensation claim
  - Failure of an employer to provide employee access to medical records required for a workers compensation claim
  - Failure to provide required workers compensation insurance coverage
  - Improperly requiring an employee to pay the cost of workers compensation insurance coverage

Idaho

HB 501 amends ***section 72-301. Security for payment of compensation*** of the Idaho Code as follows:
§ 72-301. Security for payment of compensation
…
(2) No insurer shall be permitted to transact worker's compensation insurance covering the liability of employers under this law unless it shall have been authorized to do business under the laws of this state and until it shall have received the approval of the commission. To the end that the workers secured under this law shall be adequately protected, the commission shall require such insurer to deposit and maintain in a custodial account with the state treasurer money or acceptable security instruments ~~of the United States~~ in an amount equal to the total amounts of all outstanding and unpaid compensation awards against such insurer. Acceptable security instruments are bonds, treasury bills, interest-bearing notes or other obligations of the United States for which the full faith and credit of the United States is pledged for the payment of principal and interest. Acceptable security instruments also include municipal bonds issued by the state of Idaho, its subdivisions, counties, cities, towns, villages and school districts. The insurer shall

have the responsibility to monitor the ratings for its bonds. Bonds held by worker's compensation insurers in support of insurance obligations must have been assigned a credit rating grade not less than "single A minus" by one (1) or more credit rating providers registered with the United States securities and exchange commission as a nationally recognized statistical rating organization (NRSRO) . If the credit rating assigned to the bond by the NRSRO is downgraded below "single A minus," the worker's compensation insurer shall within thirty (30) days of the downgrade replace the bond with one (1) that meets the credit quality requirement specified in this section. In lieu of such money or security instruments, the commission may allow or require such insurer to file or maintain with the state treasurer a surety bond of some company or companies authorized to do business in this state for and in the amounts equaling the total unpaid compensation awards against such insurer.

…

Maryland

HB 631 amends ***section 9-628. Compensation for less than 75 weeks*** of the Labor and Employment Annotated Code of Maryland by expanding the circumstances under which a Howard County deputy sheriff is considered a public safety employee, thereby making the deputy sheriff eligible for enhanced workers compensation benefits. Specifically, the bill repeals a provision that only considers a deputy sheriff a public safety employee when he or she is performing law enforcement duties expressly requested, defined, and authorized in accordance with a written memorandum of understanding executed between the Howard County Sheriff and other law enforcement agencies.

SB 851 amends ***section 27-608. Premium increase for commercial insurance—Notice required*** of the Annotated Code of Maryland as follows:

§ 27-608. Premium increase for commercial insurance—Notice required

(a) (1) This section applies to:
(i) policies of commercial insurance; and
(ii) policies of workers' compensation insurance.
(2) This section does not apply to policies:
(i) issued to exempt commercial policyholders, as defined in § 11-206(j) of this article; or
(ii) for which the renewal policy premium is ~~:~~
~~1. in excess of $1,000; and~~
~~2.~~ an increase over the expiring policy premium of ~~the lesser of 3% or $300~~ 15% OR LESS.
(b) Unless an insurer has given notice of its intention not to renew a policy subject to this section, if the insurer seeks to increase the renewal policy premium, the insurer shall send a notice to the named insured and insurance producer, if any, not less than 45 days prior to the renewal date of the policy.
(c) Subject to subsection (d) of this section, a notice under this section shall include:
(1) both the expiring policy premium and the renewal policy premium; and
(2) the telephone number for the insurer or insurance producer, if any, together with a statement that the insured may call to request additional information about the premium increase.
(d) (1) If an insurer seeks to increase the renewal policy premium and the insurer's rating methodology requires the insured to provide information to calculate the renewal policy premium, an insurer shall provide a reasonable estimate of the renewal policy premium if:
(i) the insurer has requested the required information from the insured; and
(ii) the insurer has not received the requested information.
(2) A reasonable estimate under this subsection shall be based upon the information available to the insurer at the time the notice is sent.
(e) The requirements of this section do not apply to the extent that the premium increase results from:
(1) an increase in the units of exposure;
(2) the application of an experience rating plan;
(3) the application of a retrospective rating plan;
(4) a change made by the insured that increases the insurer's exposure; or
(5) an audit of the insured.
(f) A notice required by this section shall be sent by first-class mail and may be sent together with the renewal policy.
(g) An insurer ~~shall be considered to have met the~~ may not be required to comply with any notice requirement of this section if, not less than 45 days before the effective date of the renewal policy, the insurer has sent:
(1) (i) to the named insured, a renewal policy that includes the renewal policy premium; and
(ii) to the independent insurance producer, if any:
1. a copy of the renewal policy that includes the renewal policy premium through postal or electronic mail; or
2. at the same time as the insurer sends the renewal policy to the insured, a notice of the availability of the renewal policy through the insurer's online electronic system;
(2) to the named insured and insurance producer, if any, a written notice of renewal or continuation of coverage that includes the renewal or continuation premium; or
(3) to the named insured and insurance producer, if any, a renewal offer that includes a reasonable estimate of the renewal policy premium.

SB 851 also contains the following language:

And be it further enacted, That this Act shall apply to all policies of commercial insurance and all policies of workers' compensation insurance issued, delivered, or renewed in the State on or after October 1, 2016.

Missouri

SB 700 amends ***sections 287.957. Experience rating plan, contents.*** and ***287.975. Pure premium rate, schedule of rates, filed with director, when—payroll differential, advisory organization to collect data, when, purpose.*** of the Missouri Annotated Statutes as follows:

287.957. Experience rating plan, contents.

The experience rating plan shall contain reasonable eligibility standards, provide adequate incentives for loss prevention, and shall provide for sufficient premium differentials so as to encourage safety. The uniform experience rating plan shall be the exclusive means of providing prospective premium adjustment based upon measurement of the loss-producing characteristics of an individual insured. An insurer may submit a rating plan or plans providing for retrospective premium adjustments based upon an insured's past experience. Such system shall provide for retrospective adjustment of an experience modification and premiums paid pursuant to such experience modification where a prior reserved claim produced an experience modification that varied by greater than fifty percent from the experience modification that would have been established based on the settlement amount of that claim. The rating plan shall prohibit an adjustment to the experience modification of an employer if the total medical cost does not exceed ~~one thousand dollars~~ twenty percent of the current split point of primary and excess losses under the uniform experience rating plan, and the employer pays all of the total medical costs and there is no lost time from the employment, other than the first three days or less of disability under subsection 1 of section 287.160, and no claim is filed. An employer opting to utilize this provision maintains an obligation to report the injury under subsection 1 of section 287.380.

287.975. Pure premium rate, schedule of rates, filed with director, when—payroll differential, advisory organization to collect data, when, purpose.

1. The advisory organization shall file with the director every pure premium rate, every manual of rating rules, every rating schedule and every change or amendment, or modification of any of the foregoing, proposed for use in this state no more than thirty days after it is distributed to members, subscribers or others.
2. The advisory organization which makes a uniform classification system for use in setting rates in this state shall collect data for two years after January 1, 1994, on the payroll differential between employers within the construction group of code classifications, including, but not limited to, payroll costs of the employer and number of hours worked by all employees of the employer engaged in construction work. Such data shall be transferred to the department of insurance, financial institutions and professional registration in a form prescribed by the director of the department of insurance, financial institutions and professional registration, and the department shall compile the data and develop a formula to equalize premium rates for employers within the construction group of code classifications based on such payroll differential within three years after the data is submitted by the advisory organization.
3. The formula to equalize premium rates for employers within the construction group of code classifications established under subsection 2 of this section shall be the formula in effect on January 1, 1999. This subsection shall become effective on January 1, 2014.
4. For the purposes of calculating the premium credit under the Missouri contracting classification premium adjustment program, an employer within the construction group of code classifications may submit to the advisory organization the required payroll record information for the first, second, third, or fourth calendar quarter of the year prior to the workers' compensation policy beginning or renewal date, provided that the employer clearly indicates for which quarter the payroll information is being submitted.

*NCCI estimates that proposed **SB 700**, if enacted in its current form, may result in a negligible impact to workers compensation system costs in Missouri. The proposed Missouri Contracting Classification Premium Adjustment Program (MCCPAP) changes may result in an increase in MCCPAP credits due to the employers' ability to select the payroll to be used in the calculation. This would likely result in offsetting increases in loss costs for the 80 eligible contracting classifications.*

Tennessee

SB 1758 adds new subsection to ***section 50-6-215. Rental and assignment of PPO network rights.*** of the Tennessee Code as follows:

50-6-215. Rental and assignment of PPO network rights. [Applicable to injuries occurring both prior to and on and after July 1, 2014.]

…

(e)(1) The administrator shall assess a civil penalty for violations of this section in an amount of not less than fifty dollars ($50.00) nor more than five thousand dollars ($5,000) per violation. Each separate incident shall be considered a violation for purposes of assessing a civil penalty. Appeals of any civil penalty assessed pursuant to this subdivision (e)(1) shall be in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(2) (A) In addition to any civil penalty assessed pursuant to subdivision (e)(1), if the administrator finds a violation of this section that caused an underpayment to a healthcare provider, the administrator shall require the workers' compensation payor to compensate the healthcare provider for the difference between the amount paid and the amount that should have been paid, and one percent (1%) interest per month accruing from the date the initial payment was made or the date of the denial of any payment.

(B) The administrator shall assess a civil penalty against a workers' compensation payor for the payor's failure to compensate a healthcare provider in a timely manner, as determined by the administrator. The civil penalty shall be in addition to the civil penalty

assessed pursuant to subdivision (e)(2)(A) and shall be not less than one thousand dollars ($1,000) nor more than ten thousand dollars ($10,000) per violation.

SB 1758 also contains the following clause:
This act shall take effect July 1, 2016, the public welfare requiring it, and shall apply to claims dated on or after that date.

Utah

SB 146 amends ***section 34A-2-413. Permanent total disability—Amount of payments—Rehabilitation*** of the Utah Code Annotated, in part, as follows:

34A-2-413. Permanent total disability—Amount of payments—Rehabilitation

…

(1) (a) In the case of a permanent total disability resulting from an industrial accident or occupational disease, the employee shall receive compensation as outlined in this section.

(b) To establish entitlement to permanent total disability compensation, the employee shall prove by a preponderance of evidence that:

(i) the employee sustained a significant impairment or combination of impairments as a result of the industrial accident or occupational disease that gives rise to the permanent total disability entitlement;

(ii) the employee has a permanent, total disability; and

(iii) the industrial accident or occupational disease is the direct cause of the employee's permanent total disability.

(c) To establish that an employee has a permanent, total disability the employee shall prove by a preponderance of the evidence that:

(i) the employee is not gainfully employed;

(ii) the employee has an impairment or combination of impairments that reasonably limit the employee's ability to do basic work activities;

…

SB 216 amends the workers' compensation and occupational disease acts in the Utah Code Annotated, relating to reimbursement of hospitals, in part, as follows:

34A-2-107. Appointment of workers' compensation advisory council—Composition—Terms of members—Duties—Compensation.

…

(7) The council shall study how hospital costs may be reduced for purposes of medical benefits for workers' compensation. The council shall report to the Business and Labor Interim Committee the council's recommendations by no later than November 30, 2017.

…

34A-2-407. Reporting of industrial injuries—Regulation of health care providers.

…

(11) (a) As used in this Subsection (11):

(i) "Balance billing" means charging a person, on whose behalf a workers' compensation insurance carrier or self-insured employer is obligated to pay medical benefits under this chapter or Chapter 3, Utah Occupational Disease Act, for the difference between what the workers' compensation insurance carrier or self-insured employer reimburses the hospital for covered medical services and what the hospital charges for those covered medical services.

(ii) "Covered medical services" means medical services provided by a hospital that are covered by workers' compensation medical benefits under this chapter or Chapter 3, Utah Occupational Disease Act.

(iii) "Health benefit plan" means the same as that term is defined in Section 31A-22-619.6.

(iv) "Self-insured employer" means the same as that term is defined in Section 34A-2-201.5.

(b) Subject to Subsection (11)(d), a workers' compensation insurance carrier or self-insured employer may contract, either in writing or by mutual verbal agreement, with a hospital to establish reimbursement rates.

(c) Subject to Subsection (11)(d), a workers' compensation insurance carrier or self-insured employer that is reimbursing a hospital that has not entered into a contract described in Subsection (11)(b) shall reimburse the hospital for covered medical services at 85% of the billed hospital fees for the covered medical services.

(d) A hospital may not engage in balance billing.

(e) Covered services paid under a health benefit plan are subject to coordination of benefits in accordance with Sections 31A-22-619.6 and 34A-2-213.

~~(11)~~ (12) (a) Subject to appellate review under Section 34A-1-303, the commission has exclusive jurisdiction to hear and determine:

(i) whether goods provided to or services rendered to an employee are compensable pursuant to this chapter or Chapter 3, Utah Occupational Disease Act, including:

(A) medical, nurse, or hospital services;

(B) medicines; and

(C) artificial means, appliances, or prosthesis;

(ii) except for amounts charged or paid under Subsection (11), the reasonableness of the amounts charged or paid for a good or service described in Subsection ~~(11)~~ (12)(a)(i); and

(iii) collection issues related to a good or service described in Subsection ~~(11)~~ (12)(a)(i).

(b) Except as provided in Subsection ~~(11)~~ (12)(a), Subsection 34A-2-211(6), or Section 34A-2-212, a person may not maintain a cause of action in any forum within this state other than the commission for collection or payment for goods or services described in Subsection ~~(11)~~ (12)(a) that are compensable under this chapter or Chapter 3, Utah Occupational Disease Act.

34A-2-418. Awards—Medical, nursing, hospital, and burial expenses—Artificial means and appliances.
(1) In addition to the compensation provided in this chapter or Chapter 3, Utah Occupational Disease Act, and subject to Subsection 34A-2-407(11), the employer or the insurance carrier shall pay reasonable sums for medical, nurse, and hospital services, for medicines, and for artificial means, appliances, and prostheses necessary to treat the injured employee.
…

34A-2-801. Initiating adjudicative proceedings—Procedure for review of administrative action.
…
(c) A person providing goods or services described in Subsections 34A-2-407~~(11)~~ (12) and 34A-3-108~~(12)~~ (13) may file an application for hearing in accordance with Section 34A-2-407 or 34A-3-108.
…

34A-3-108. Reporting of occupational diseases—Regulation of health care providers.
…
(11) (a) As used in this Subsection (11):
(i) "Balance billing" means charging a person, on whose behalf a workers' compensation insurance carrier or self-insured employer is obligated to pay medical benefits under this chapter or Chapter 2, Workers' Compensation Act, for the difference between what the workers' compensation insurance carrier or self-insured employer reimburses the hospital for covered medical services and what the hospital charges for those covered medical services.
(ii) "Covered medical services" means medical services provided by a hospital that are covered by workers' compensation medical benefits under this chapter or Chapter 2, Workers' Compensation Act.
(iii) "Health benefit plan" means the same as that term is defined in Section 31A-22-619.6.
(iv) "Self-insured employer" means the same as that term is defined in Section 34A-2-201.5.
(b) Subject to Subsection (11)(d), a workers' compensation insurance carrier or self-insured employer may contract, either in writing or by mutual verbal agreement, with a hospital to establish reimbursement rates.
(c) Subject to Subsection (11)(d), a workers' compensation insurance carrier or self-insured employer that is reimbursing a hospital that has not entered into a contract described in Subsection (11)(b), shall reimburse the hospital for covered medical services at 85% of the billed hospital fees for the covered medical services.
(d) A hospital may not engage in balance billing.
(e) Covered services paid under a health benefit plan are subject to coordination of benefits in accordance with Sections 31A-22-619.6 and 34A-2-213.
~~(11)~~ (12) (a) An application for a hearing to resolve a dispute regarding an occupational disease claim shall be filed with the Division of Adjudication.
(b) After the filing, a copy shall be forwarded by mail to:
(i) (A) the employer; or
(B) the employer's workers' compensation insurance carrier;
(ii) the applicant; and
(iii) the attorneys for the parties.
~~(12)~~ (13) (a) Subject to appellate review under Section 34A-1-303, the commission has exclusive jurisdiction to hear and determine:
(i) whether goods provided to or services rendered to an employee is compensable pursuant to this chapter and Chapter 2, Workers' Compensation Act, including the following:
(A) medical, nurse, or hospital services;
(B) medicines; and
(C) artificial means, appliances, or prosthesis;
(ii) except for amounts charged or paid under Subsection (11), the reasonableness of the amounts charged or paid for a good or service described in Subsection ~~(12)~~ (13)(a)(i); and
(iii) collection issues related to a good or service described in Subsection ~~(12)~~ (13)(a)(i).
(b) Except as provided in Subsection ~~(12)~~ (13)(a), Subsection 34A-2-211(6), or Section 34A-2-212, a person may not maintain a cause of action in any forum within this state other than the commission for collection or payment of goods or services described in Subsection ~~(12)~~ (13)(a) that are compensable under this chapter or Chapter 2, Workers' Compensation Act.

West Virginia

SB 287 adds new Article 3E. The West Virginia Safer Workplace Act to the Code of West Virginia, including, but not limited to, the following subsection:
§21-3E-17. Employer testing; notice; termination; forfeiture.
If an employer implements a drug-free workplace program in accordance with this article, which includes notice, education and procedural requirements for testing for drugs and alcohol pursuant to this law, the employer may require the employee to submit to a test for the presence of drugs or alcohol. If a drug or alcohol is found to be present in the employee's system at a level proscribed by

the employer's policy, the employee may be terminated and forfeits his or her eligibility for unemployment compensation benefits and, if injured at the time of the intoxication, indemnity benefits under the Worker Compensation Laws. However, the employer's drug-free workplace program must notify all employees that it is a condition of employment for an employee to refrain from reporting to work or working with the presence of drugs or alcohol in his or her body and that policy must also state that if an injured employee refuses to submit to a test for drugs or alcohol, that employee forfeits eligibility for unemployment compensation benefits, and if injured, for indemnity benefits under the Worker Compensation Laws. Employers who do not notify their employees of this condition of employment waive their right to assert that eligibility for benefits is entirely forfeited.

Nothing herein shall be construed or deemed to affect the provisions of subsection (a), section two, article four, chapter twenty-three of this code and the provisions of said section shall be the sole manner in which intoxication may be proven to establish such intoxication as the proximate cause of an injury for purposes of said chapter.

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
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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.