Legislative Activity Report

National Council on Compensation Insurance

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March 18, 2016 RLA-2016-10

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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 bills were enacted within the one-week period ending March 11, 2016.

## Florida

**HB 613** was:

- Passed by the first and second chambers on March 3, 2016
- Included in NCCI's March 11, 2016 ***Legislative Activity Report*** (RLA-2016-09)
- Enacted on March 10, 2016, with an effective date of October 1, 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

## 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
- Included in NCCI's March 4, 2016 ***Legislative Activity Report*** (RLA-2016-08)
- Enacted on March 11, 2016, with an effective date of July 1, 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/SB 631** are identical bills.

**HB 378** 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 February 25, 2016
- Included in NCCI's March 4, 2016 ***Legislative Activity Report*** (RLA-2016-08)
- Enacted and effective on March 7, 2016

**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
- Included in NCCI's March 4, 2016 ***Legislative Activity Report*** (RLA-2016-08)
- Enacted and effective on March 7, 2016

**HB 378/SB 631** make 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

**BILLS PASSING SECOND CHAMBER**

The following workers compensation-related bills passed the second chamber within the one-week period ending March 11, 2016.

## Arizona

**SB 1323** was:

- Passed by the first chamber on February 11, 2016
- Included in NCCI's February 19, 2016 ***Legislative Activity Report*** (RLA-2016-06)
- Passed by the second chamber on March 10, 2016

**SB 1323** amends ***section 23-941.02. Vexatious litigants; designation; definitions*** of the Arizona Revised Statutes as follows:

**23-941.02. Vexatious litigants; designation; definitions**

A. In a workers' compensation case before the commission, on the motion of a party, the chief administrative law judge or an administrative law judge designated by the chief administrative law judge may designate a pro se litigant a vexatious litigant. The pro se litigant shall respond within thirty days after the motion. The chief administrative law judge, or administrative law judge if designated by the chief administrative law judge, shall issue an order within thirty days after the pro se litigant's response is received or the time for response has elapsed. The vexatious litigant designation applies only to the claim at issue before the administrative law judge.

B. A pro se litigant who is designated a vexatious litigant may not file a new request for hearing, pleading, motion or other document without prior leave of the administrative law judge.

C. A pro se litigant is a vexatious litigant if the commission finds the pro se litigant engaged in vexatious conduct. A designation of vexatious litigant is suspended during the period in which the litigant is represented by legal counsel.

D. For the purposes of this section:

1. "vexatious conduct" includes any of the following:

(a) repeated filing of requests for hearing, pleadings, motions or other documents solely or primarily for the purpose of harassment.

(b) unreasonably expanding or delaying commission proceedings.

(c) bringing or defending claims without substantial justification.

(d) engaging in abuse of discovery or conduct in discovery that has resulted in the imposition of sanctions against the pro se litigant.

(e) a pattern of making unreasonable, repetitive and excessive requests for information.

(f) repeated filing of documents or requests for relief that have been the subject of previous rulings by the commission in the same claim.

2. "without substantial justification" has the same meaning prescribed in section 12-349.

## Florida

**SB 828** was:

- Passed by the first chamber on February 23, 2016
- Included in NCCI's March 4, 2016 ***Legislative Activity Report*** (RLA-2016-08)
- Passed by the second chamber on March 8, 2016

**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.

**SB 1402** was:

- Passed by the first chamber on March 3, 2016
- Included in NCCI's March 11, 2016 ***Legislative Activity Report*** (RLA-2016-09)
- Passed by the second chamber on March 8, 2016

**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.

*NCCI estimates that the proposal to update the* Florida Workers' Compensation Health Care Provider Reimbursement Manual *to the 2014 Medicare level, if ratified, would result in an overall Florida workers compensation system cost impact of +1.8% (+$64.0M ).*

## South Carolina

**HB 3576** was:

- Passed by the first chamber on March 4, 2015
- Included in NCCIs March 13, 2015 ***Legislative Activity Report*** (RLA-2015-10)
- Amended and passed by the second chamber on March 10, 2016

**HB 3576** adds new ***section 41-1-120*** to the South Carolina Code of Laws as follows:
**Section 41-1-120.**
(A) Notwithstanding another provision of law, a written agreement between a nonprofit youth sports organization and a coach which specifies that the coach is an independent contractor and not an employee of the nonprofit youth sports organization and also which otherwise satisfies the requirements of this subsection constitutes conclusive evidence that the relationship between the nonprofit youth sports organization and the coach is that of an independent contractor relationship rather than an employment relationship for the purposes of this section, and that the nonprofit youth sports organization consequently is not obligated to:
(1) secure compensation for the coach pursuant to the workers' compensation law; and
(2) withhold federal and state income taxes from money paid to the coach for services he provides to the organization pursuant to the contract.
(B) A written agreement provided in subsection (A) must contain a conspicuously located disclosure appearing in bold-faced, underlined, or large type. This agreement must be acknowledged by the parties as indicated by their signatures, initials, or other means to evince that the parties have read and understand the disclosure. This disclosure clearly must state that the coach is:
(1) an independent contractor and not an employee of the nonprofit youth sports organization for the purposes listed in (A)(1) and (2);
(2) not entitled to workers' compensation benefits in connection with his or her contract with the nonprofit youth sports organization; and
(3) obligated to pay federal and state income tax on any money paid pursuant to the contract for coaching services, and that as a consequence the nonprofit youth sports organization will not withhold any amounts from the coach for purposes of satisfying the coach's income tax liability.
(C) A written agreement between a nonprofit youth sports organization and a coach formed pursuant to this subsection may not, in and of itself, be construed as conclusive evidence that an independent contractor relationship exists for purposes of required coverage under the state unemployment compensation law or any civil action instituted by a third party.
(D) As used in this section, 'nonprofit youth sports organization' means an organization that is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and is primarily engaged in conducting organized sports programs for persons under twenty-one years of age.

## Utah

**HB 96** was:

- Passed by the first chamber on February 18, 2016
- Included in NCCI's February 26, 2016 ***Legislative Activity Report*** (RLA-2016-07)
- Passed by the second chamber on March 9, 2016

**HB 96** creates new ***Chapter 3*** in ***Title 63F*** of the Utah Code Annotated to read:
**Chapter 3. Single Sign-On Database**
**63F-3-101. Title.**

This chapter is known as "Single Sign-On Database."

**63F-3-102. Definitions.**
As used in this chapter:
(1) "Business data" means data collected by the state about a person doing business in the state.
(2) "Business database" means the database described in Subsection 63F-3-103(1).
(3) "Database" means an electronic means of storing information.
(4) "Single sign-on web portal" means the web portal described in Subsection 63F-3-103(2).
(5) "Web portal" means an Internet webpage that can be accessed by an individual where the individual enters the individual's unique user information in order to access secure information.

**63F-3-103. Single sign-on database—Creation.**
(1) The department shall, in consultation with the entities described in Subsection (4), design and create a prototype of a single database, and associated data entry screens, that stores business data agreed upon by the entities described in Subsection (4) that is:
(a) secure;
(b) centralized; and
(c) interconnected.
(2) The department shall create a web portal that allows a person doing business in the state to access, at a single point of entry, all relevant state-collected business data about the person, including information related to:
(a) business registration;
(b) workers' compensation;
(c) tax liability and payment; and
(d) other information collected by the state that the department determines is relevant to a person doing business in the state.
(3) The department shall develop the business database and the single sign-on web portal:
(a) using an open platform that:
(i) facilitates participation in the database and web portal by a state entity; and
(ii) allows for optional participation by a political subdivision of the state; and
(b) in a manner that anticipates expanding the database and web portal to include:
(i) a database for data collected by the state on an individual; and
(ii) a web portal for an individual to access all relevant data collected by the state on the individual.
(4) In developing the business database and the single sign-on web portal, the department shall consult with:
(a) the Department of Commerce;
(b) the State Tax Commission;
(c) the Labor Commission;
(d) the Department of Workforce Services;
(e) the Governor's Office of Management and Budget;
(f) the Utah League of Cities and Towns;
(g) the Utah Association of Counties; and
(h) the business community that is likely to use the business database and single sign-on web portal.

**63F-3-104. Report.**
The department shall report to the Public Utilities and Technology Interim Committee:
(1) no later than November 30, 2016, with an initial design and prototype of the business database and the single sign-on web portal, together with a minimum two-year plan, including projected cost, for the initial implementation phase of the project; and
(2) before November 30 of each year beginning in 2017 until the development of the business database and the single sign-on web portal is complete, regarding the progress the department has made in developing the business database and the single sign-on web portal.

**SB 146** was:
- Passed by the first chamber on March 1, 2016
- Included in NCCI's March 11, 2016 ***Legislative Activity Report*** (RLA-2016-09)
- Passed by the second chamber on March 8, 2016

**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** was:

- Passed by the first chamber on March 2, 2016
- Included in NCCI's March 11, 2016 ***Legislative Activity Report*** (RLA-2016-09)
- Amended and passed by the second chamber on March 10, 2016

**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 oral agreement, with a hospital to establish reimbursement rates.
(c) Subject to Subsection (11)(d) for the time period beginning on May 10, 2016, and ending on July 1, 2018, 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 oral agreement, with a hospital to establish reimbursement rates.
(c) Subject to Subsection (11)(d), for the time period beginning on May 10, 2016, and ending on July 1, 2018 , 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 621** was:

- Passed by the first chamber on February 24, 2016
- Included in NCCI's March 4, 2016 ***Legislative Activity Report*** (RLA-2016-08)
- Amended and passed by the second chamber on March 11, 2016

**SB 621** amends ***section 23-2-1. Employers subject to chapter; elections not to provide certain coverages; notices; filing of business registration certificates*** of the Code of West Virginia as follows:

**§23-2-1. Employers subject to chapter; elections not to provide certain coverages; notices; filing of business registration certificates.**

(a) The State of West Virginia and all governmental agencies or departments created by it, including county boards of education, political subdivisions of the state, any volunteer fire department or company and other emergency service organizations as defined by article five, chapter fifteen of this code, and all persons, firms, associations and corporations regularly employing another person or persons for the purpose of carrying on any form of industry, service or business in this state, are employers within the meaning of this chapter and are required to subscribe to and pay premium taxes into the Workers' Compensation Fund for the protection of their

 

employees and are subject to all requirements of this chapter and all rules prescribed by the Workers' Compensation Commission with reference to rate, classification and premium payment*: Provided*, That rates will be adjusted by the commission to reflect the demand on the compensation fund by the covered employer.
(b) The following employers are not required to subscribe to the fund, but may elect to do so:
…
(8) Taxicab drivers of taxicab companies operating under article two, chapter twenty-four-a of this code, who provide taxicab service pursuant to a written or electronic agreement that identifies the taxicab driver as an independent contractor consistent with the United States Internal Revenue code requirements for persons acting as independent contractors: *Provided*, That any such taxicab driver identified as an independent contractor shall not be eligible for workers' compensation benefits under this chapter as an employee of the taxicab company.
~~(8)~~ (9) Any employer whose employees are eligible to receive benefits under the federal Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §901, *et seq*., but only for those employees eligible for those benefits.
…

**BILLS PASSING FIRST CHAMBER**

The following workers compensation-related bills passed the first chamber within the one-week period ending March 11, 2016.

## Idaho

**HB 554** amends ***sections 72-102. Definitions*** and ***72-438. Occupational Diseases*** of the Idaho Code as follows:
**72-102. Definitions**. Words and terms used in the worker's compensation law, unless the context otherwise requires, are defined in the subsections which follow:
…
(12) "Employee" is synonymous with "workman" and means any person who has entered into the employment of, or who works under contract of service or apprenticeship with, an employer. It does not include any person engaged in any of the excepted employments enumerated in section 72-212, Idaho Code, unless an election as provided in section 72-213, Idaho Code, has been filed. It does, however, include a volunteer firefighter for purposes of section 72-438 (12) and (14), Idaho Code. Any reference to an employee who has been injured shall, where the employee is dead, include a reference to his dependents as herein defined, if the context so requires, or, where the employee is a minor or incompetent, to his committee or guardian or next friend.
(13) (a) "Employer" means any person who has expressly or impliedly hired or contracted the services of another. It includes contractors and subcontractors. It includes the owner or lessee of premises, or other person who is virtually the proprietor or operator of the business there carried on, but who, by reason of there being an independent contractor or for any other reason, is not the direct employer of the workers there employed. It also includes, for purposes of section 72-438(12) and (14), Idaho Code, a municipality, village, county or fire district that utilizes the services of volunteer firefighters. If the employer is secured, it means his surety so far as applicable.
(b) "Professional employer" means a professional employer as defined in chapter 24, title 44, Idaho Code.
(c) "Temporary employer" means the employer of temporary employees as defined in section 44-2403(7), Idaho Code.
(d) "Work site employer" means the client of the temporary or professional employer with whom a worker has been placed.
(14) "Farm labor contractor" means any person or his agent or subcontractor who, for a fee, recruits and employs ~~farm workers~~ farmworkers and performs any farm labor contracting activity.
…
(31) "United States," when used in a geographic sense, means the several states, the District of Columbia, the Commonwealth of Puerto Rico~~, the Canal Zone~~ and the territories of the United States.
(32) "Volunteer emergency responder" means a firefighter or peace officer, or publicly employed certified personnel ~~as that term is defined in section 56-1012, Idaho Code,~~ who is a bona fide member of a legally organized law enforcement agency, a legally organized fire department or a licensed emergency medical service provider organization who contributes services.
…

**72-438. Occupational diseases**. Compensation shall be payable for disability or death of an employee resulting from the following occupational diseases:
…
(2) Carbon monoxide poisoning or chlorine poisoning in any process or occupation involving direct exposure to carbon monoxide or chlorine in buildings, sheds, or ~~inclosed~~ enclosed places.
…
(6) Radium poisoning by or disability due to radioactive properties of substances or to ~~Roentgenray~~ roentgen ray (X-ray) in any occupation involving direct contact therewith, handling thereof, or exposure thereto.
…
(12) Cardiovascular or pulmonary or respiratory diseases of a ~~paid fireman~~ firefighter, employed by or volunteering for a municipality, village or fire district as a regular member of a lawfully established fire department, caused by overexertion in times of stress or danger or by proximate exposure or by cumulative exposure over a period of four (4) years or more to heat, smoke, chemical fumes or other toxic gases arising directly out of, and in the course of, his employment.
…

 

(14) Firefighter occupational diseases:
(a) As used in this subsection, "firefighter" means an employee whose primary duty is that of extinguishing or investigating fires as part of a fire district, fire department or fire brigade.
(b) If a firefighter is diagnosed with one (1) or more of the following diseases after the period of employment indicated in subparagraphs (i) through (xi) of this paragraph, and the disease was not revealed during an initial employment medical screening examination that was performed according to such standards and conditions as may be established at the sole discretion of the governing board having authority over a given fire district, fire department, or fire brigade, then the disease shall be presumed to be proximately caused by the firefighter's employment as a firefighter:
(i) Brain cancer after ten (10) years;
(ii) Bladder cancer after twelve (12) years;
(iii) Kidney cancer after fifteen (15) years;
(iv) Colorectal cancer after ten (10) years;
(v) Non-Hodgkin's lymphoma after fifteen (15) years;
(vi) Leukemia after five (5) years;
(vii) Mesothelioma after ten (10) years;
(viii) Testicular cancer after five (5) years if diagnosed before the age of forty (40) years with no evidence of anabolic steroids or human growth hormone use;
(ix) Breast cancer after five (5) years if diagnosed before the age of forty (40) years without a breast cancer 1 or breast cancer 2 genetic predisposition to breast cancer;
(x) Esophageal cancer after ten (10) years; and
(xi) Multiple myeloma after fifteen (15) years.
(c) The presumption created in this subsection may be overcome by substantial evidence to the contrary. If the presumption is overcome by substantial evidence, then the firefighter or the beneficiaries must prove that the firefighter's disease was caused by his or her duties of employment.
(d) The presumption created in this subsection shall not preclude a firefighter from demonstrating a causal connection between employment and disease or injury by a preponderance of evidence before the Idaho industrial commission.
(e) The presumption created in this subsection shall not apply to any specified disease diagnosed more than ten (10) years following the last date on which the firefighter actually worked as a firefighter as defined in paragraph (a) of this subsection. Nor shall the presumption apply if a firefighter or a firefighter's cohabitant has regularly and habitually used tobacco products for ten (10) or more years prior to the diagnosis.
(f) The periods of employment described in paragraph (b) of this subsection refer to periods of employment within the state of Idaho.
Recognizing that additional toxic or harmful substances or matter are continually being discovered and used or misused, the above enumerated occupational diseases are not intended to be exclusive, but such additional diseases shall not include hazards ~~which~~ that are common to the public in general and ~~which~~ that are not within the meaning of section 72-102 (22) (a), Idaho Code, and the diseases enumerated in subsection (12) of this section pertaining to ~~paid firemen~~ firefighters shall not be subject to the limitations prescribed in section 72-439, Idaho Code.

## New Hampshire

**HB 1459** amends ***sections 412:3. Definitions, 412:15. Rate Standards*** and ***412:16 Rate Filings*** of the New Hampshire Statutes as follows:

**412:3. Definitions**

…
XI. "Large commercial policyholder" means an insurance contract holder that is a corporation, partnership, trust, sole proprietorship, or other business or public entity and that has certified that it meets:
(a)At least ~~2~~ one of the following ~~3~~ 4 criteria:
(1)A net worth of $10,000,000 as certified by a certified public accountant or public accountant authorized to do business in this state;
(2) Net revenue or sales of $5,000,000 as certified by a certified public account or public accountant authorized to do business in this state; or
(3) A total of more than 25 employees per individual company or more than 50 employees per holding company~~.~~; ~~and~~
(4) Aggregate property and casualty insurance premiums, excluding workers' compensation, medical malpractice, life, health, and disability insurance premiums of $50,000 or more.
(b) ~~The following criteria~~
~~(1) The use of an employed or retained risk manager to procure insurance. For the purposes of this section, "risk manager" means a chartered property and casualty underwriter, a certified insurance counselor, an associate in risk management, a certified risk manager or a licensed insurance consultant; and~~
~~(2) Aggregate property and casualty insurance premiums, excluding workers' compensation, medical malpractice, life, health, and disability insurance premiums of $30,000 or more.~~
~~(c)~~ "Large commercial policyholder" also includes a nonprofit or public entity with an annual budget or assets of $25,000,000 or more that meets the criteria listed in subparagraph ~~(b)~~(a)(4), and a municipality with a population of 20,000 or more that meets the premium criteria listed in subparagraph ~~(b)(2)~~(a)(4).
~~(d) A commercial policyholder that meets the premium criteria listed in subparagraph (b)(2), but that does not meet 3 of the~~

 

~~qualifying criteria listed in either subparagraph (a) or subparagraph (b)(1) may petition the commissioner for a waiver of the remaining criteria. The commissioner may grant a waiver if the commissioner determines that the applicant for a waiver is sufficiently qualified to act as a large commercial policyholder.~~
(c) In this section, "risk manager" means a chartered property and casualty underwriter, certified insurance counselor, an associate in risk management, certified risk manager or a licensed insurance consultant.
…

**412:15. Rate Standards.**
…
IV. The commissioner may permit insurers to use appropriate systems of schedule rating filed by any insurer or rating bureau approved by the commissioner, subject to rules adopted under RSA 541-A, to assure the uniform and impartial application of such rating. Such ratings shall be:
(a) Based on an insured's management, safety, and loss control policies and record;
(b) No greater than plus or minus 40 percent of the insurer's base rates.
V. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer, advisory organization and statistical agent may exchange information and experience data with insurance supervisory officials, insurers and advisory organizations in other states and may consult with them with respect to the application of rating systems and the collection of statistical data.

**412:16 Rate Filings**
…
II. Every insurer shall file with the commissioner, except as to inland marine risks which are not written according to manual rates or rating plans, every manual, predictive models or telematics models or other models that pertain to the formulation of rates and/or premiums, minimum premium, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing which it proposes to use. Personal lines filings shall include underwriting rules used by insurers or a group of affiliated insurers to the extent necessary to determine the applicable rate and/or policy premium for an individual insured or applicant. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by RSA 412:23. Every such filing shall state the effective date, and shall indicate the character and extent of the coverage contemplated. Information contained in the underwriting rules that does not pertain to the formulation of rates and/or premiums shall be identified by the filer as proprietary and shall be kept confidential by the department and shall not be subject to the provisions of RSA 91-A.
…
VII(b) For all commercial risk policies, except policies issued to a large commercial policyholder, and except as provided in this chapter, the rates and supplementary rating information that will be used in this state shall be filed for informational purposes only within 30 days of the effective date.
…
VIII. In a noncompetitive market, subject to the exceptions specified in RSA 412:16, IX and X, and RSA 412:28, each filing shall be on file for a waiting period of 30 days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed ~~30~~ 60 days if written notice is given within such waiting period to the insurer or advisory organization which made the filing that additional time is needed for the consideration of the filing. Upon written application by the insurer, the commissioner may authorize a filing that has been reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof. Failure of the insurer or advisory organization to provide the requested information within the waiting period or the extension thereof shall be deemed a request to withdraw the filing from further consideration. Failure of the commissioner to act within the waiting period or the extension thereof shall result in the filing being deemed to meet the requirements of this chapter. Neither the insurer nor the commissioner may waive the timeliness requirements of the provisions in this section.
…

**HB 1633** adds new ***section 281-A:19-a Leave Time Due to Workers' Compensation Injury; Notification Required.*** to the New Hampshire Statutes to read:
**281-A:19-a Leave Time Due to Workers' Compensation Injury; Notification Required.**
An employer shall notify an employee, in writing, relative to the benefits and adverse effects of signing an application for, or accepting time off under the Family and Medical Leave Act of 1993, as amended, as a result of a workers' compensation injury when the employee is eligible. The employer shall provide such notification either prior to the employee being placed on family and medical leave or the employer accepting an application for family and medical leave from the employee.

## Oklahoma

**HB 1343** creates new ***section 40-901*** in the Oklahoma Statutes to read:
A. A qualified marketplace contractor shall be treated as an independent contractor for all purposes under state and local laws, regulations and ordinances, including but not limited to the Employment Security Act of 1980 and the Administrative Workers' Compensation Act, if:
1. All or substantially all of the remuneration for the services performed by such contractor is directly related to the performance of

 

services or other output rather than to the number of hours worked;
2. The services performed by the contractor are governed by a written contract executed between such contractor and a qualified marketplace platform; and
3. The written contract provided for in paragraph 2 of this subsection shall include, but not be limited to, provisions that provide for the following:
a. that the contractor shall be engaged as an independent contractor, not as an employee,
b. that the contractor shall, in accordance with paragraph 1 of subsection A of this section, be paid based on the performance of services or other output,
c. that the contractor shall be permitted to work any hours or schedules he or she chooses, provided that if a contractor elects to work specified hours or schedules, a contract may require the worker to perform work during the selected hours or schedules,
d. that the contractor shall be free to engage in any other occupation or business opportunity, including performing services through other qualified marketplace platforms,
e. that the contractor shall bear all or substantially all of his or her own expenses,
f. that the qualified marketplace contractor shall be responsible for tax on the qualified marketplace contractor's own income, and
g. that the contract and the association created thereby may be terminated without cause by either party thereto at any time upon reasonable notice given to the other.
B. For purposes of this section, the term "qualified marketplace platform" shall mean an organization, including, but not limited to, a corporation, limited liability company, partnership, sole proprietor, or any other entity, that operates a digital application or digital platform that facilitates the provision of services by qualified marketplace contractors to individuals or entities seeking such services.
C. For purposes of this section, the term "qualified marketplace contractor" or "contractor" shall mean any person or organization, including, but not limited to, a natural person, corporation, limited liability company, partnership, sole proprietor, or other entity, that enters into an agreement with a qualified marketplace platform to use the platform's digital application or digital platform to provide services to individuals or entities seeking such services.
D. For services performed by a marketplace contractor prior to the enactment of this section, the qualified marketplace contractor shall be treated as an independent contractor for all purposes under state and local laws, regulations and ordinances, including but not limited to the Employment Security Act of 1980 and the Administrative Workers' Compensation Act, if:
1. All or substantially all of the remuneration for the services performed by such contractor was directly related to the performance of services or other output rather than to the number of hours worked; and
2. The services performed by the contractor were governed by a written contract executed between the contractor and a qualified marketplace platform that conforms to the requirements of paragraph 3 of subsection A of this section.

**SB 1083** amends ***section 1151.22. A. Any contract entered into under the Roofing Contractor Registration Act shall include a statement that all individuals performing work under the contract are covered by workers' compensation insurance*** of the Oklahoma Statutes as follows:

**1151.22. A. Any contract entered into under the Roofing Contractor Registration Act shall include a statement that all individuals performing work under the contract are covered by workers' compensation insurance**

…

B. If ~~the individuals performing work under the contract are not covered by~~ an affidavit of exemption for workers' compensation insurance~~, the contractor shall provide a written statement to the homeowner advising that the individuals performing work under the contract are not covered by workers' compensation insurance, which~~ is used by a legitimately exempt person, it shall be ~~signed by all parties to the contract and~~ attached to the contract and it shall be used only for residential construction projects. All commercial projects shall require all individuals performing work on such project to be covered by workers' compensation insurance as employees of the person registered under the Roofing Contractor Registration Act. However, any day laborer who can show proof of being covered by workers' compensation insurance under the temporary labor agency for whom he or she is hired-out may provide an affidavit from the temporary labor agency to meet the requirement of this section for authority to use an affidavit of exemption. No roofing contractor required to be registered under the Roofing Contractor Registration Act shall hire any out-of-state company or person or use any person or independent contractor that is not registered under the Roofing Contractor Registration Act with the required workers' compensation insurance or who is not deemed his or her employee for purposes of workers' compensation insurance.
C. In no event shall a homeowner be held liable for injury or death to any person who performs work under a contract with a person required by law to be registered under the Roofing Contractor Registration Act and have workers' compensation on all persons performing work on the roofing project.

**Contact Information**

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

| State | State Relations Executive | Phone Number |
|---|---|---|
| CT, ME, NH, RI, VT | Laura Backus Hall | 802-454-1800 |
| FL, IA | Chris Bailey | 850-322-4047 |
| AL, GA, KY, LA, MS | Cathy Booth | 205-655-2699 |
| AZ, CO, NM, NV, UT | Maggie Karpuk | 818-707-8374 |
| DC, MD, VA, WV | David Benedict | 804-380-3005 |
| HI | Carolyn Pearl | 808-524-6239 |
| IN, NC, SC, TN | Amy Quinn | 803-356-0851 |
| AR, IL, KS, TX | Terri Robinson | 501-333-2835 |
| AK, ID, MT, OR | Jessica Epley | 503-892-8919 |
| MO, NE, OK, SD | Carla Townsend | 314-843-4001 |
| Federal Issues | Tim Tucker | 202-403-8526 |

This report is informational and is not intended to provide an interpretation of state and federal legislation.