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 bills were enacted within the one-week period ending April 29, 2016.

## Alabama

**HB 270** was:

- Passed by the first chamber on March 23, 2016
- Included in NCCI's April 1, 2016 ***Legislative Activity Report*** (RLA-2016-12)
- Passed by the second chamber on April 19, 2016
- Included in NCCI's April 29, 2016 ***Legislative Activity Report*** (RLA-2016-16)
- Enacted on April 26, 2016, with an effective date of July 1, 2016

**HB 270** makes various changes to the Alabama Captive Insurers Act including, but not limited to, the following amendments:

**Section 27-31B-2 Definitions**

As used in this chapter, the following terms shall have the following meanings, unless the context clearly indicates otherwise:

…

~~(11)~~ (12) EXCESS WORKERS' COMPENSATION INSURANCE. In the case of an employer or group of employers that has insured or self-insured its workers' compensation risks in accordance with applicable state or federal law, insurance in excess of a specified per-incident or aggregate limit established by the commissioner.

…

**Section 27-31B-3 Licensing**

(a) Any captive insurance company, when permitted by its articles of association, charter, or other organizational document, may apply to the commissioner for a license to do any and all insurance defined in Sections 27-5-2, 27-5-4, and 27-5-5, in subdivisions (1), (2), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), and (14) of subsection (a) of Section 27-5-6, in Sections 27-5-7, 27-5-8, 27-5-9, and 27-5-10, and to grant annuity contracts as defined in Section 27-5-3, subject, however, to all of the following:

…

~~(6)~~ (7) Any captive insurance company may provide excess workers' compensation insurance to its parent and affiliated companies~~,~~ and member organizations unless prohibited by the laws of the state having jurisdiction over the transaction. Any captive insurance company may reinsure workers' compensation of a qualified self-insured plan of its parent and affiliated companies.

## Georgia

**HB 402** was:

- Passed by the first chamber on February 3, 2016
- Included in NCCI's February 12, 2016 ***Legislative Activity Report*** (RLA-2016-05)
- Passed by the second chamber on March 22, 2016
- Included in NCCI's April 1, 2016 ***Legislative Activity Report*** (RLA-2016-12)
- Enacted on April 26, 2016, with an effective date of July 1, 2016

 

**HB 402** adds several new sections to the Official Code of Georgia Annotated as follows:

**33-9-40.3**

(a) For each policy of workers' compensation insurance issued or renewed in the state on and after July 1, 2016, there may be granted by the insurer up to a 5 percent reduction in the premium for such policy if the insured has been certified by the State Board of Education to the State Board of Workers' Compensation as a work based learning employer pursuant to Article 12 of Chapter 9 of Title 34 and has notified its insurer in writing of such certification.

(b) If granted, the premium discount provided by this Code section shall be applied to an insured's policy of workers' compensation insurance pro rata as of the date the insured receives such certification and shall continue for as long as the insured maintains the certification; provided, however, that an insurer shall not be required to credit the actual amount of the premium discount to the account of the insured until the final premium audit under such policy. Certification of an insured shall be required for each year in which a premium discount is granted.

(c) If it is determined that an insured misrepresented its qualifications for certification pursuant to Article 12 of Chapter 9 of Title 34, the workers' compensation insurance policy of such insured may be subject to an additional premium for the purposes of reimbursement of a previously granted premium discount and to cancellation in accordance with the provisions of the policy.

(d) Each insurer shall make an annual report, in accordance with guidelines established by the Commissioner, to the rating and statistical organization designated by the Commissioner illustrating the total dollar amount of the premium discounts applied pursuant to this Code section.

(e) The Commissioner shall conduct a study to determine the impact of the premium discounts provided pursuant to this Code section in encouraging employers to provide work based learning opportunities for students age 16 or older.

(f) The Commissioner shall be authorized to promulgate rules and regulations necessary for the implementation and enforcement of this Code section.

**34-9-2.4**

(a) As used in this Code section, the term:

(1) 'Work based learning placement' or 'placement' shall have the same meaning as in Code Section 34-9-430.

(2) 'Work based learning student' or 'student' shall have the same meaning as in Code Section 34-9-430.

(b) Notwithstanding the provisions of paragraph (2) of Code Section 34-9-1:

(1) A work based learning student in a paid work based learning placement for an employer shall be deemed an employee of such employer for purposes of workers' compensation coverage; and

(2) A work based learning student in an unpaid work based learning placement for an employer shall be deemed an employee of such employer for purposes of workers' compensation coverage unless all of the following conditions apply:

(A) The placement, even though it includes actual operation of the facilities of the employer, is similar to training which would be given in an educational environment;

(B) The placement is for the benefit of the student;

(C) The student does not displace regular employees, but works under close supervision of existing staff;

(D) The employer that provides the training derives no immediate advantage from the activities of the student; and on occasion its operations may actually be impeded;

(E) The student is not necessarily entitled to a job at the conclusion of the placement; and

(F) The employer and the student understand that the student is not entitled to wages for the time spent in the placement.

**34-9-430**

As used in this article, the term:

(1) 'Employer' means a person or entity that is subject to the provisions of this chapter but shall not include the state or any department, agency, or instrumentality of the state; any county; any county or independent school system; any municipal corporation; or any employer which is self-insured for the purposes of this chapter.

(2) 'Employer member of a group self-insurance fund' means any employer who is a member of a fund certified pursuant to Code Section 34-9-153.

(3) 'Self-insured employer' means any employer certified pursuant to Code Section 34-9-127.

(4) 'Work based learning coordinator' means a school employee who coordinates and supervises students in work based learning placements.

(5) 'Work based learning employer' means an employer who provides work based learning placements in accordance with this article.

(6) 'Work based learning placement' or 'placement' means an arrangement between a business or industry partner and a local school system in which students are released for a portion of the school day for structured learning at an employer's job site in either a paid or unpaid position while receiving academic credit. Work based learning placements include, but are not limited to, employability skill development, service learning, cooperative education, internship, youth apprenticeship, and clinical experiences.

(7) 'Work based learning student' means a student age 16 or older in a work based learning placement for an employer.

**34-9-431**

(a) A work based learning employer that has been certified pursuant to this Code section may be eligible for a premium discount under such employer's workers' compensation insurance policy pursuant to Code Section 33-9-40.3.

(b) The State Board of Education shall certify to the State Board of Workers' Compensation that a work based learning employer meets the following requirements:
(1) Enters into a training agreement with one or more work based learning students, the student's parent or guardian, and the school's work based learning coordinator;
(2) Develops, in conjunction with the school's work based learning coordinator, a detailed training plan for the work based learning student that focuses on development of technical skills and employability skills;
(3) Assigns a mentor to the work based learning student and assist in monitoring the progress of such student;
(4) Provides workers' compensation insurance coverage for the work based learning student;
(5) Complies with all federal, state, and local laws and regulations regarding the employment of students; and
(6) Complies with the rules and regulations of the State Board of Education.

**34-9-432**
A self-insured employer or an employer member of a group self-insurance fund that provides work based learning placements for one or more work based learning students substantially in accordance with Code Section 34-9-431 and that complies with all other provisions of this article required of employers in order to qualify for insurance premium discounts may be certified by the State Board of Education to the State Board of Workers' Compensation as a work based learning employer in compliance with this article.

**HB 402** also contains the following clause:
All laws and parts of laws in conflict with this Act are repealed.

**HB 818** was:

- Passed by the first chamber on February 17, 2016
- Included in NCCI's February 26, 2016 ***Legislative Activity Report*** (RLA-2016-07)
- Passed by the second chamber on March 24, 2016
- Included in NCCI's April 1, 2016 ***Legislative Activity Report*** (RLA-2016-12)
- Enacted on April 26, 2016, with an effective date of July 1, 2016

**HB 818** amends numerous sections of the Official Code of Georgia Annotated as follows:
**§ 34-9-47. Trial division and appellate division created; composition; sessions**
…
(c) The trial division shall be composed of administrative law judges appointed by the board who shall serve as hearing officers and exercise judicial functions in implementing this chapter. ~~Administrative law judges~~ An administrative law judge shall have the power to subpoena witnesses and administer oaths and may take testimony in those cases brought before the board. An administrative law judge hearing a case shall make an award, subject to review and appeal as provided in this chapter. An administrative law judge shall be subject to the Georgia Code of Judicial Conduct.
…

**§ 34-9-121. Duty of employer to insure in licensed company or association or to deposit security, indemnity, or bond as self-insurer, application to out-of-state employers, and membership in mutual insurance company**
(a) Unless otherwise ordered or permitted by the board, every employer subject to the provisions of this chapter relative to the payment of compensation shall secure and maintain full insurance against such employer's liability for payment of compensation under this article, such insurance to be secured from some person, corporation, association, or organization licensed by law to transact the business of workers' compensation insurance in this state or from some mutual insurance association formed by a group of employers so licensed; or such employer shall ~~furnish~~ provide the board with sufficient information for the board to make an adequate assessment of the employer's workers' compensation exposure and liabilities and shall further provide evidence satisfactory ~~proof~~ to the board of such employer's financial ability to pay the compensation directly in the amount and manner and when due, as provided for in this chapter. In the latter case, the board may, in its discretion, require the deposit of acceptable security, indemnity, or bond to secure the payment of compensation liabilities as they are incurred; provided, however, that it shall be satisfactory proof of the employer's financial ability to pay the compensation directly in the amount and manner when due, as provided for in this chapter, and the equivalent of acceptable security, indemnity, or bond to secure the payment of compensation liabilities as they are incurred, if the employer shall show the board that such employer is a member of a mutual insurance company duly licensed to do business in this state by the Commissioner of Insurance, as provided by the laws of this state, or of an association or group of employers so licensed and as such is exchanging contracts of insurance with the employers of this and other states through a medium specified and located in their agreements with each other, but this proviso shall in no way restrict or qualify the right of self-insurance as authorized in this Code section. Nothing in this Code section shall be construed to require an employer to place such employer's entire insurance in a single insurance carrier.
…

**§ 34-9-261. Compensation for total disability**
While the disability to work resulting from an injury is temporarily total, the employer shall pay or cause to be paid to the employee a weekly benefit equal to two-thirds of the employee's average weekly wage but not more than ~~$550.00~~ $575.00 per week nor less

than $50.00 per week, except that when the weekly wage is below $50.00, the employer shall pay a weekly benefit equal to the average weekly wage. The weekly benefit under this Code section shall be payable for a maximum period of 400 weeks from the date of injury; provided, however, that in the event of a catastrophic injury as defined in subsection (g) of Code Section 34-9-200.1, the weekly benefit under this Code section shall be paid until such time as the employee undergoes a change in condition for the better as provided in paragraph (1) of subsection (a) of Code Section 34-9-104.

**§ 34-9-262. Compensation for temporary partial disability**
Except as otherwise provided in Code Section 34-9-263, where the disability to work resulting from the injury is partial in character but temporary in quality, the employer shall pay or cause to be paid to the employee a weekly benefit equal to two-thirds of the difference between the average weekly wage before the injury and the average weekly wage the employee is able to earn thereafter but not more than ~~$367.00~~ $383.00 per week for a period not exceeding 350 weeks from the date of injury.

**§ 34-9-265. Compensation for death resulting from injury and other causes, penalty for death from injury proximately caused by intentional act of employer, and payment of death benefits where no dependents found** …
(d) The total compensation payable under this Code section to a surviving spouse as a sole dependent at the time of death and where there is no other dependent for one year or less after the death of the employee shall in no case exceed ~~$220,000.00~~ $230,000.00.
…

**§ 34-9-380. Purpose of article**
It is the purpose of this article through the establishment of a guaranty trust fund to provide for the continuation of workers' compensation benefits due and unpaid, excluding penalties, fines, and attorneys' fees assessed against a participant, when ~~a self-insured employer becomes insolvent~~ such participant becomes an insolvent self-insurer.

**§ 34-9-381. Definitions**
As used in this article, the term:
(1) 'Applicant' means an employee entitled to workers' compensation benefits.
(2) 'Board' means the State Board of Workers' Compensation.
(3) 'Board of trustees' means the board of trustees of the fund.
(4) 'Company' means a corporation, association, partnership, proprietorship, firm, or other form of business organization.
~~(4)~~ (5) 'Fund' means the Self-insurers Guaranty Trust Fund established by this article.
~~(5)~~ (6) 'Insolvent self-insurer' means a self-insurer:
(A) ~~a self-insurer who~~ Who files for relief under the federal Bankruptcy Act~~, a~~ ;
(B) ~~self-insurer against~~ Against whom involuntary bankruptcy proceedings are filed~~, a~~ ;
(C) ~~self-insurer for~~ For whom a receiver is appointed in a federal or state court of this state or any other jurisdiction, ~~or a self-insurer who~~ ;
(D) Who is in default on workers' compensation obligations; or
(E) Who is determined by the board to be in ~~default of its~~ noncompliance with workers' compensation obligations or requirements ~~according to~~ under the laws of this state and the rules and regulations ~~promulgated by the board of trustees and approved by~~ of the board.
~~(6)~~ (7) 'Participant' means a self-insurer who is a member of the fund ~~and exclusive of those entities described in Article 5 of this chapter~~.
~~(7)~~ (8) 'Self-insurer' means a private employer, including any hospital authority created pursuant to the provisions of Article 4 of Chapter 7 of Title 31, the 'Hospital Authorities Law,' that has been authorized to self-insure its payment of workers' compensation benefits pursuant to this chapter~~, except any~~ . The term 'self-insurer' shall not mean or include any of the following:
(A) Any governmental ~~self-insurer or other~~ employer authorized by the board to self-insure;
(B) Any employer who elects to group self-insure pursuant to Code Section 34-9-152~~, captive~~ ;
(C) Captive insurers as provided for in Chapter 41 of Title 33~~, or employers~~ ;
(D) Any employer who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter; or
(E) Any individual or company who:
(i) Enters into a contract or agreement with an employer under which the employer outsources its workers' compensation risks, responsibilities, obligations, or liabilities to such individual or company; and
(ii) Pursuant to such contract or agreement, is required to provide workers' compensation benefits to an injured employee even though no common-law master-servant relationship or contract of employment exists between the injured employee and the individual or company providing the benefits.
~~(8)~~ (9) 'Trustee' means a member of the Self-insurers Guaranty Trust Fund board of trustees.

**§ 34-9-382 Establishment of Self-insurers Guaranty Trust Fund, use of fund, and application to be accepted in fund**
(a) There is established a Self-insurers Guaranty Trust Fund for the sole purpose of making payments in accordance with this article. The fund shall be administered by an administrator appointed by the chairperson of the board of trustees with the approval of the board of trustees. All moneys in the fund shall be held in trust and shall not be money or property of the state or the participants and

 

shall be exempt from levy, attachment, garnishment, or civil judgment for any claim or cause of action other than for not making payments in accordance with this article. ~~The board of trustees shall be authorized to invest the moneys of the fund in the same manner as provided by law for investments in government backed securities~~ The fund assets shall be invested only in obligations issued or guaranteed by the United States government.

…

(c) As a condition of self-insurance, all private employers, except ~~any governmental self-insurer or other employer who elects to group self-insure pursuant to Code Section 34-9-152, captive insurers as provided for in Chapter 41 of Title 33, or employers who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter, must~~ those precluded from membership in the fund pursuant to subsection (d) of this Code section, shall make application to and be accepted in the Self-insurers Guaranty Trust Fund.

(d) Membership in the fund shall not be permitted for any of the following:

(1) Any governmental employer authorized by the board to self-insure;

(2) Any employer who elects to group self-insure pursuant to Code Section 34-9-152;

(3) Captive insurers as provided for in Chapter 41 of Title 33;

(4) Any employer who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter; or

(5) Any individual or company who:

(A) Enters into a contract or agreement with an employer under which the employer outsources its workers' compensation risks, responsibilities, obligations, or liabilities to such individual or company; and

(B) Pursuant to such contract or agreement, is required to provide workers' compensation benefits to an injured employee even though no common-law master-servant relationship or contract of employment exists between the injured employee and the individual or company providing the benefits.

**§ 34-9-384. General powers of board of trustees**

…

(2)(A) The board of trustees shall meet not less than quarterly and shall meet at other times upon the call of the chairperson, issued to the trustees in writing not less than 48 hours prior to the day and hour of the meeting, or upon a request for a meeting presented in writing to the chairperson not less than 72 hours prior to the proposed day and hour of the meeting and signed by at least a majority of the trustees, whereupon the chairperson shall provide notice issued in writing to the trustees not less than 48 hours prior to the meeting and shall convene the meeting at the time and place stated in the request~~;~~ .

(B) Any trustee may participate in a meeting of the board of trustees by telephone conference or similar communications technology which allows all individuals participating in the meeting to hear and speak with each other. Participation in a meeting pursuant to this subparagraph shall constitute presence in person at such meeting.

…

**§ 34-9-385. Bankruptcy of participants**

(a) Any participant who files for relief under the federal Bankruptcy Act or against whom bankruptcy proceedings are filed or for whom a receiver is appointed shall file written notice of such fact with the board and the board of trustees within 30 days of the occurrence of such event.

(b) Any ~~person~~ individual who files an application for adjustment of a claim against a participant who is ~~in default or has filed for relief under the federal Bankruptcy Act or against whom bankruptcy proceedings have been filed or for whom a receiver has been appointed must~~ or becomes an insolvent self-insurer shall file a written notice of such ~~fact~~ participant's status with the board and the board of trustees within 30 days of such ~~person's~~ individual having knowledge of the ~~event~~ participant becoming an insolvent self-insurer.

(c) Upon receipt of any notice as provided in subsection (a) or (b) of this Code section, the board shall determine whether the participant is an insolvent ~~or in default according to procedures established by the board of trustees and approved by the board~~ self-insurer. Such determination shall be made within a reasonable time after the date the board and board of trustees receive notification as provided in subsection (a) or (b) of this Code section.

(d) When a participant is determined to be ~~in default or~~ an insolvent self-insurer, the board of trustees is empowered to and shall assume on behalf of the participant its outstanding workers' compensation obligations excluding penalties, fines, and claimant's attorneys' fees assessed against the participant pursuant to subsection (b) of Code Section 34-9-108 and shall take all steps necessary to collect, recover, and enforce all outstanding security, indemnity, insurance, or bonds furnished by such participant guaranteeing the payment of compensation provided in this chapter for the purpose of paying outstanding and continuing obligations of the participant. The board of trustees shall convert and deposit into ~~the fund~~ a separate account established within the fund such security and any amounts received under agreements of surety, guaranty, insurance, or otherwise on behalf of the participant. Any amounts remaining from such security, indemnity, insurance, bonds, guaranties, and sureties, following payment of all compensation costs and related administrative expenses and fees of the board of trustees including attorneys' fees, and following collection of all amounts assessed and received pursuant to subsections (a) and (d) of Code Section 34-9-121 and any applicable rule of the board may be refunded by the fund as directed by the board of trustees, subject to the approval of the board, to the appropriate party one year from the date of final payment and closure of all claims, provided no outstanding self-insured liabilities remain against the fund and ~~the~~ all applicable ~~statute~~ statutes of ~~limitations has~~ limitation have run.

…

**§ 34-9-386. Assessment of participants, liability of fund and participants for claims, and revocation of participant's authority to be self-insured**

…

(5) Funds obtained by such assessments shall be used only for the purposes set forth in this article and shall be deposited upon receipt by the board of trustees into the fund. If payment of any assessment, penalty, or fine made under this article is not made within 30 days of the sending of the notice to the participant, the board of trustees is authorized to do any or all of the following:
(A) Levy fines or penalties;
(B) Proceed in court for judgment against the participant, including the amount of the assessment, fines, penalties, the costs of suit, interest, and reasonable attorneys' fees;
(C) Proceed directly against the security pledged by the participant for the collection of same; or
(D) Seek revocation of the participant's ~~insured~~ self-insured status.
(b)(1) The fund shall be liable for claims arising out of injuries occurring after January 1, 1991; provided, however, that no claim may be asserted against the fund until the funding level has reached $1.5 million.
(2) All active participants shall be required to maintain surety bonds or the board of trustees may, in its discretion, accept ~~any~~ an irrevocable letter of credit ~~or other acceptable forms of security~~ in the amount of no less than $250,000.00. In addition, each active participant shall be required to purchase excess insurance for statutory limits with a self-insured retention specified by the board, and the excess policy shall include the bankruptcy endorsement required by the board and board of trustees. For participants who are no longer active, security in an amount commensurate with their remaining exposure, as determined by the board, shall be required until all self-insured claims have been closed and all applicable statutes of limitation have run.
(c) A participant who ceases to be a self-insurer shall be liable for any and all assessments, penalties, and fines made pursuant to this Code section for so long as indemnity or medical benefits are paid for claims which originated when the participant was a self-insurer. Assessments of such a participant shall be based on the indemnity and medical benefits paid by the participant during the previous calendar year.
(d) Upon refusal to pay assessments, penalties, or fines to the fund or upon refusal to comply with a board order ~~increasing security~~, the fund may treat the self-insurer as being in default with this chapter and the self-insurer shall be subject to revocation of its board authorization to self-insure and forfeiture of its security.

**§ 34-9-387. Reimbursement and security deposit from participant for compensation obligations** …
(c) The board of trustees shall be a party in interest in any action or proceeding to obtain the security deposit of a participant for the payment of the participant's compensation obligations, in any action or proceeding under the participant's excess insurance policy, and in any other action or proceeding to enforce an agreement of any security deposit or captive or excess insurance carrier and from any other guarantee to satisfy such obligations. The fund is authorized to file a claim against ~~a bankrupt~~ an insolvent participant or the participant's agents and seek reimbursement for any payments made by the fund on behalf of the participant pursuant to this chapter. The fund is subrogated to the claim of any employee whose benefits are paid by the fund. Further, the fund shall have a lien against any reimbursement payments the participant is entitled to from the Subsequent Injury Trust Fund in an amount equal to the payments made by the fund to satisfy the participant's liability for workers' compensation benefits.

**§ 34-9-388. Reports of participant's insolvency, participant's audits, review of applications for self-insurance and recommendations thereon**

…

(b) The board shall, at the inception of a participant's self-insured status and at least annually thereafter, so long as the participant remains self-insured, furnish the board of trustees with a complete, original bound copy of each participant's ~~audit~~ audited annual financial statement performed in accordance with generally accepted accounting standards by an independent certified public accounting firm, three to five years of loss history, name of the ~~person~~ individual or company to administer claims, and any other pertinent information submitted to the board to authenticate the participant's self-insured status. The board of trustees may contract for the services of a qualified certified public accountant or firm to review, analyze, and make recommendations on these documents. All financial information submitted by a participant shall be considered confidential and not public information.

**HB 818** also contains the following clause:
All laws and parts of laws in conflict with this Act are repealed.

*NCCI estimates that **HB 818** will result in an impact of +1.5% on total workers compensation system costs in Georgia.*

## Tennessee

**SB 2582** was:

- Passed by the first chamber on April 19, 2016
- Passed by the second chamber on April 20, 2016
- Included in NCCI's April 29, 2016 ***Legislative Activity Report*** (RLA-2016-16)
- Enacted on April 28, 2016, with an effective date of July 1, 2016

**SB 2582** amends various sections of the Tennessee Code as follows:

**Section 1**

**50-6-201. Notice of Injury**

(a) (1) Every injured employee or the injured employee's representative shall, immediately upon the occurrence of an injury, or as soon thereafter as is reasonable and practicable, give or cause to be given to the employer who has no actual notice, written notice of the injury, and the employee shall not be entitled to physician's fees or to any compensation that may have accrued under this chapter, from the date of the accident to the giving of notice, unless it can be shown that the employer had actual knowledge of the accident. No compensation shall be payable under this chapter, unless the written notice is given to the employer within fifteen (15) ~~thirty (30)~~ days after the occurrence of the accident, unless reasonable excuse for failure to give the notice is made to the satisfaction of the tribunal to which the claim for compensation may be presented.

(2) The notice of the occurrence of an accident by the employee required to be given to the employer shall state in plain and simple language the name and address of the employee and the time, place, nature, and cause of the accident resulting in injury or death. The notice shall be signed by the claimant or by some person authorized to sign on the claimant's behalf, or by any one (1) or more of the claimant's dependents if the accident resulted in death to the employee.

(3) No defect or inaccuracy in the notice shall be a bar to compensation, unless the employer can show, to the satisfaction of the workers' compensation judge before which the matter is pending, that the employer was prejudiced by the failure to give the proper notice, and then only to the extent of the prejudice.

(4) The notice shall be given personally to the employer or to the employer's agent or agents having charge of the business at which the injury was sustained by the employee.

(b) In those cases where the injuries occur as the result of gradual or cumulative events or trauma, then the injured employee or the injured employee's representative shall provide notice of the injury to the employer within fifteen (15) ~~thirty (30)~~ days after the employee:

(1) Knows or reasonably should know that the employee has suffered a work-related injury that has resulted in permanent physical impairment; or

(2) Is rendered unable to continue to perform the employee's normal work activities as the result of the work-related injury and the employee knows or reasonably should know that the injury was caused by work-related activities.

**Section 2**

**50-6-226. Fees of attorneys and physicians, and hospital charges. [Applicable to injuries occurring on and after July 1, 2014.]**

…

~~(d) In addition to any attorneys' fees provided for in this section, the Court of Corkers' Compensation Claims may award attorneys' fees and reasonable costs, including reasonable and necessary court reporter expenses and expert witness fees for depositions and trials incurred when the employer fails to furnish appropriate medical, surgical and dental treatment or care, medicine, medical and surgical supplies, crutches, artificial members and other apparatus to an employee provided for in a settlement or judgment under this chapter.~~

(d) (1) In addition to attorneys' fees provided for in this section, the Court of Workers' Compensation Claims may award reasonable attorneys' fees and reasonable costs, including reasonable and necessary court reporter expenses and expert witness fees, for depositions and trials incurred when the employer:

(A) Fails to furnish appropriate medical, surgical, and dental treatment or care, medicine, medical and surgical supplies, crutches, artificial members, and other apparatus to an employee provided for in a settlement, expedited hearing order, compensation hearing order, or judgment under this chapter; or

(B) Wrongfully denies a claim by filing a timely notice of denial, or fails to timely initiate any of the benefits to which the employee is entitled under this chapter, including medical benefits under § 50-6-204 or temporary or permanent disability benefits under § 50-6-207, if the workers' compensation judge makes a finding that such benefits were owed at an expedited hearing or compensation hearing.

(2) Subdivision (d)(1)(B) shall apply to injuries that occur on or after July 1, 2016, but shall not apply to injuries that occur after June 30, 2018.

**Section 3**

**50-9-101. Legislative Intent.**

(a) It is the intent of the general assembly to promote drug-free workplaces in order that employers in this state be afforded the opportunity to maximize their levels of productivity, enhance their competitive positions in the marketplace and reach their desired levels of success without experiencing the costs, delays and tragedies associated with work-related accidents resulting from drug or alcohol abuse by employees. It is further the intent of the general assembly that drug and alcohol abuse be discouraged and that employees who choose to engage in drug or alcohol abuse face the risk of unemployment and the forfeiture of workers' compensation benefits. It is also the intent of the general assembly that employers obtaining certification as a drug-free workplace under rules promulgated by the bureau should be able to renew that certification on an annual basis without requiring repeated annual training of existing employees; provided, however, the employer certifies on a form prescribed by the bureau that all existing employees have undergone training at least once and have acknowledged annually in writing the existence of the employer's drug-free workplace policy.

**Section 4**
**50-9-111. Rules and regulations—Guidelines for state testing program.**
…
(d) The administrator is authorized to set education program requirements for drug-free workplaces by rules promulgated in accordance with the requirements of the Uniform Administrative Procedures Act. The requirements shall not be more stringent than the federal requirements for workplaces regulated by the United States Department of Transportation rules. The requirements shall not require an employer to provide annual education or awareness training for each employee if all existing employees have undergone such training at least once and have acknowledged annually in writing the existence of the employer's drug-free workplace policy.

**Section 5**
**50-6-216 Ombudsman program. [Applicable to injuries occurring on and after July 1, 2014.]**
…
(e) (1) Any party that is not represented by legal counsel may request the services of a workers' compensation ombudsman by contacting the office of mediation services.
(2) The ombudsman's authority shall include, but not be limited to, the following:
(A) Meet with and provide information to unrepresented parties about the unrepresented party's rights and responsibilities under the law;
(B) Explain the administrative process for resolving workers' compensation claims;
(C) Investigate claims and attempt to resolve disputes without resort to alternative dispute resolution and court proceedings;
(D) Communicate with all parties and providers in the claim;
(E) Assist the parties in the completion of forms; ~~and~~
(F) Facilitate the exchange of medical records~~.~~; and
(G) Approve a settlement between an employer and employee who are not represented by an attorney in the claim as authorized by §50-6-240(f).
~~(3) An ombudsman shall not provide legal advice.~~
(3) An ombudsman who is not a licensed attorney shall not provide legal advice; however, an ombudsman who is a licensed attorney may provide limited legal advice but shall not represent any party as the party's attorney. No ombudsman shall make attorney referrals.

**SB 2582** also includes the following clause:
This act shall take effect July 1, 2016, the public welfare requiring it, and Sections 1, 2, and 5 shall apply to injuries that occur on or after that date.

**BILLS PASSING SECOND CHAMBER**

The following workers compensation-related bills passed the second chamber within the one-week period ending April 29, 2016.
**Note:** Any bill that passes the first chamber and is amended and passed by the second chamber must be returned to the first chamber for concurrence before going to the governor for signature.

## Missouri

**HB 1763 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 April 26, 2016

**HB 1763** adds new ***section 375.1605*** to the Missouri Annotated Statutes to read as follows:
**375.1605**
1. The provisions of this section shall apply to workers' compensation large deductible policies issued by an insurer subject to delinquency proceedings under this chapter. This section shall not apply to first party claims or to claims funded by a guaranty association net of the deductible unless subsection 3 of this section applies. Large deductible policies shall be administered in accordance with their terms, except to the extent such terms conflict with the provisions of this section.
2. For purposes of this section, the following terms mean:
(1) "Collateral", any cash, letters of credit, surety bond, or any other form of security posted by the insured or by a captive insurer or reinsurer to secure the insured's obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay the insurer as may be required for other secured obligations;
(2) "Commercially reasonable", to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter;
(3) "Deductible claim", any claim, including a claim for loss and defense and cost containment expense, unless such expenses are excluded, under a large deductible policy that is within the deductible;
(4) "Delinquency proceeding", shall have the same meaning ascribed to it in section 375.1152;

(5) “Guaranty association”, the Missouri property and casualty insurance guaranty association created by sections 375.771 to 375.779, as amended, and any other similar entities created by the laws of any other state for the payment of claims of insolvent insurers;
(6) “Large deductible policy”, any combination of one or more workers’ compensation policies and endorsements issued to an insured and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:
(a) Pay directly the initial portion of any claim under the policy up to a specified dollar amount or the expenses related to any claim; or
(b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.
The term “large deductible policy” also includes policies that contain an aggregate limit on the insured’s liability for all deductible claims in addition to a per-claim deductible limit. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer. Large deductible policies do not include policies, endorsements, or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insured shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder’s large deductible obligations;
(7) “Other secured obligations”, obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations, the performance of which is secured by collateral that also secures an insured’s obligations under a large deductible policy;
(8) “Receiver”, shall have the same meaning ascribed to it in section 375.1152.
3. Unless otherwise agreed by the responsible guaranty association, all large deductible claims which are also “covered claims”, as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim pursuant to an agreement by the guaranty fund or otherwise, the insured’s funding or payment of a deductible claim will extinguish the obligations, if any, of the receiver or any guaranty association to pay such claim. No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s funding or payment of a deductible claim.
4. To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Such reimbursements and collateral shall be subject to any reasonable and actual expenses recovered by the receiver as provided for under subsection 7 of this section. Reimbursements paid to the guaranty association under this subsection shall not be treated as distributions under section 375.1218 or as early access payments under section 375.1205. To the extent that a guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, or incurred expenses in connection with large deductible policies that are not reimbursed under this section, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding. Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association’s related expenses such as those affording the guaranty association the right to recover for claims payments made to or on behalf of high net worth insureds or claimants.
5. (1) The receiver shall have the obligation to collect reimbursements owed for deductible claims as provided for herein and shall take all commercially reasonable actions to collect such reimbursements. The receiver shall promptly bill insureds for reimbursement of deductible claims:
(a) Paid by the insurer prior to the commencement of delinquency proceedings;
(b) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or
(c) Paid or allowed by the receiver.
(2) If the insured does not make payment within the time specified in the large deductible policy, or within sixty days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed.
(3) Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured’s reimbursement obligation under the large deductible policy.
(4) Except for gross negligence, an allegation of improper handling or payment of a deductible claim by the insurer, the receiver, or any guaranty association shall not be a defense to the insured’s reimbursement obligations under the large deductible policy.
6. (1) Subject to the provisions of this subsection, the receiver shall utilize collateral if available to secure the insured’s obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payments of a deductible claim. Any distributions made to a guaranty association under this subsection shall not be treated as distributions under section 375.1218 or as early access payments under section 375.1205.
(2) All claims against the collateral shall be paid in the order received and no claim of the receiver, including those described in this subsection, shall supersede any other claim against the collateral as described in subdivision (4) of this subsection.
(3) The receiver shall draw down collateral to the extent necessary in the event that the insured fails to:
(a) Perform its funding or payment obligations under any large deductible policy;

(b) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty days after the date of the billing if no time is specified;
(c) Pay amounts due the estate for preliquidation obligations;
(d) Timely fund any other secured obligation; or
(e) Timely pay expenses.
(4) Claims that are validly asserted against the collateral shall be satisfied in the order in which such claims are received by the receiver; except that, if more than one creditor has a valid claim against the same collateral and the available collateral, along with billing collection efforts and to the extent that the collateral is subject to other known secured obligations, are together insufficient to pay each creditor in full, then the director as rehabilitator or liquidator shall prorate payments to each creditor based upon the relationship the amount of claims each creditor has paid bears to the total of all claims paid by all such creditors.
(5) Excess collateral may be returned to the insured as determined by the receiver after a periodic review of claims paid, outstanding case reserves, and a factor for incurred but not reported claims.
7. The receiver shall be entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements under the provisions of this section, subject to the review and approval by the court.
8. The court having jurisdiction over the delinquency proceedings under section 375.1154 shall have jurisdiction to resolve disputes arising under the provisions of this section.
9. The provisions of this section shall apply to all delinquency proceedings that either commence on or after the effective date of this section or are open and pending on the effective date of this section, provided that, the provisions of this section shall not affect any delinquency proceeding for which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction prior to the effective date of this section.
10. Nothing in this section is intended to limit or adversely affect any rights or powers a guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association under policies of the insolvent insurer, or for related expenses the guaranty association incurs.

**HB 1936** was:

- Passed by the first chamber on March 29, 2016
- Included in NCCI's April 8, 2016 ***Legislative Activity Report*** (RLA-2016-13)
- Amended and passed by the second chamber on April 26, 2016

**HB 1936** amends, in part, ***section 57.111 May act in adjoining county, when*** of the Missouri Annotated Statutes as follows:
**57.111 May act in adjoining county, when**
Whenever any sheriff or deputy sheriff of any county in this state is expressly requested, in each instance, by a sheriff ~~of an adjoining county~~ of this state to render assistance, such sheriff or deputy shall have the same powers of arrest in such county as he or she has in his or her own jurisdiction. Any sheriff, or deputy sheriff that a responding sheriff sends, of a county responding to a request for assistance in another county of the state shall be deemed an employee of the sending sheriff's office and shall be subject to the workers' compensation, overtime, and expense reimbursement provisions provided to him or her as an employee of the sending sheriff's office.

**SB 700 was:**

- Passed by the first chamber on March 3, 2016
- Included in NCCI's March 11, 2016 ***Legislative Activity Report*** (RLA-2016-09)
- Amended and passed by the second chamber on April 26, 2016

**SB 700** adds new section ***287.245*** and amends ***sections 287.090. Exempt employers and occupations—election to accept—withdrawal—notification required of insurance companies, 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 Workers Compensation Law as follows:
**287.245.**
1. As used in this section, the following terms shall mean:
(1) "Association", volunteer fire protection associations as defined in section 320.300;
(2) "State fire marshal", the state fire marshal selected under the provisions of sections 320.200 to 320.270;
(3) "Volunteer firefighter", the same meaning as in section 287.243.
2. Any association may apply to the state fire marshal for a grant for the purpose of funding such association's costs related to workers' compensation insurance premiums for volunteer firefighters.
3. Subject to appropriations, the state fire marshal shall disburse grants to each applying volunteer fire protection association according to the following schedule:
(1) Associations which had zero to five volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for two thousand dollars in grant money;
(2) Associations which had six to ten volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand five hundred dollars in grant money;

(3) Associations which had eleven to fifteen volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand dollars in grant money;
(4) Associations which had sixteen to twenty volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for five hundred dollars in grant money.
4. Grant money disbursed under this section shall only be used for the purpose of paying for the workers' compensation insurance premiums of volunteer firefighters.

**287.090. Exempt employers and occupations—election to accept—withdrawal—notification required of insurance companies.**
1. This chapter shall not apply to:
…
(4) Except as provided in section 287.243, volunteers of a tax-exempt organization which operates under the standards of Section 501(c)(3) or Section 501(c)(19) of the federal Internal Revenue Code, where such volunteers are not paid wages, but provide services purely on a charitable and voluntary basis;
…

**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.

In addition, **SB 700** amends ***section 44.023. Disaster volunteer program established, agency's duties—expenses—immunity from liability, exception*** of the Missouri Annotated Statutes as follows:
**44.023. Disaster volunteer program established, agency's duties—expenses—immunity from liability, exception.**
1. The Missouri state emergency management agency shall establish and administer an emergency volunteer program to be activated in the event of a disaster whereby volunteer architects, ~~and professional~~ engineers ~~registered~~ licensed under chapter 327, any individual including, but not limited to, building officials and building inspectors employed by local governments, qualified by training and experience, who has been certified by the state emergency management agency, and who performs his or her duties under the direction of an architect or engineer licensed under chapter 327, and construction contractors, equipment dealers and other owners and operators of construction equipment may volunteer the use of their services and equipment, either manned or unmanned,

 

for up to ~~three~~ five consecutive days for in-state deployments as requested and needed by the state emergency management agency.
2. In the event of a disaster, the enrolled volunteers shall, where needed, assist local jurisdictions and local building inspectors to provide essential demolition, cleanup or other related services and to determine whether ~~buildings~~ structures affected by a disaster:
(1) Have not sustained serious damage and may be occupied;
(2) Must be ~~vacated temporarily~~ restricted in their use pending repairs; or
(3) ~~Must be demolished in order to avoid hazards to occupants or other persons~~ Are unsafe and shall not be occupied pending repair or demolition.
3. Any person when utilized as a volunteer under the emergency volunteer program shall have his or her incidental expenses paid by the local jurisdiction for which the volunteer service is provided. Enrolled volunteers under the emergency volunteer program shall be provided workers' compensation insurance by the state emergency management agency during their official duties as authorized by the state emergency management agency.
4. Emergency volunteers who are certified by the state emergency management agency shall be considered employees of the state for purposes of the emergency mutual aid compact under Section 44.415 and shall be eligible for out-of-state deployments in accordance with such section.
5. Architects, ~~and professional~~ engineers, individuals including, but not limited to, building officials and building inspectors employed by local governments, qualified by training and experience, who have been certified by the state emergency management agency, and who perform their duties under the direction of an architect or engineer licensed under chapter 327, construction contractors, equipment dealers and other owners and operators of construction equipment and the companies with which they are employed, working under the emergency volunteer program, shall not be personally liable either jointly or separately for any act or acts committed in the performance of their official duties as emergency volunteers except in the case of willful misconduct or gross negligence.
~~5.~~ 6. Any individuals, employers, partnerships, corporations or proprietorships, that are working under the emergency volunteer program providing demolition, cleanup, removal or other related services, shall not be liable for any acts committed in the performance of their official duties as emergency volunteers except in the case of willful misconduct or gross negligence.

**BILLS PASSING FIRST CHAMBER**

The following workers compensation-related bills passed the first chamber within the one-week period ending April 29, 2016.

## Connecticut

**SB 101** amends ***section 31-286a Insurance requirements for contractors on public works projects and renewals of state business licenses*** of the Connecticut Workers Compensation Act as follows:

**31-286a Insurance requirements for contractors on public works projects and renewals of state business licenses.**
(a) Notwithstanding any provision of any general statute, special act, charter or ordinance, neither the state, or its agents, nor any political subdivision of the state, or its agents, may enter into any contract on or after October 1, 1986, for the construction, remodeling, refinishing, refurbishing, rehabilitation, alteration or repair of any public works project before receiving from each of the other parties to such contract (1) sufficient evidence of compliance with the workers' compensation insurance and self-insurance requirements of subsection (b) of section 31-284, and (2) a current statement from the State Treasurer that, to the best of his knowledge and belief, as of the date of the statement, the particular party was not liable to the state for any workers' compensation payments made pursuant to section 31-355, except that any sole proprietor who is a party to such contract shall not be subject to the provisions of this section, provided such sole proprietor (A) does not utilize any subcontractor in performing such contract, (B) is not acting as a principal employer, (C) has not accepted the provisions of chapter 568 in accordance with subdivision (10) of section 31-275, and (D) has liability insurance in lieu of workers' compensation insurance.
…

## Louisiana

**HB 476** amends ***section 22:890 Certificates of insurance*** of the Louisiana Revised Statutes, in part, as follows:

**§890. Certificates of insurance**
A. For the purposes of this Section:
(1) "Certificate" or "certificate of insurance" means any document, instrument, or record, including an electronic record, no matter how titled or described, which is prepared by an insurer or insurance producer and issued to a third person not a party to the subject insurance contract, as evidence of property and casualty insurance coverage. "Certificate" or "certificate of insurance" shall not mean an insurance binder.
(2) "Certificate holder" means any person, other than a policyholder, that is designated on a certificate of insurance as a "certificate holder" or any person, other than a policyholder, to whom a certificate of insurance has been issued by an insurer or insurance producer at the request of the policyholder.
(3) "Electronic record" shall have the meaning defined in R.S. 9:2602 (7).
(4) "Insurance" shall have the meaning defined in R.S. 22:46 (9).
(5) "Insurance producer" shall have the same definition as set forth in R.S. 22:1542.
(6) "Insurer" means an insurer as defined in R.S. 22:46 (10) and any other person engaged in the business of making property and casualty insurance contracts, including but not limited to self-insurers, syndicates, risk purchasing groups, and similar risk transfer entities. "Insurer" shall not mean any person self-insured for purposes of workers' compensation, including any group self-insurance fund authorized pursuant to R.S. 23:1195 et seq., any interlocal risk management agency authorized pursuant to R.S. 33:1341 et seq.,

or any self-insured employer authorized pursuant to R.S. 23:1168 et seq.
(7) "Lender" means an individual, partnership, corporation, limited liability company, association, federally insured depository institution, or other entity, agent, loan agent, servicing agent, or loan or mortgage broker, who makes, owns, or services a loan.
…
C. No person, other than a lender, wherever located, may prepare, issue, or request the issuance of a certificate of insurance for risks located in this state unless ~~the form has been filed with and approved by the commissioner of insurance. No person, wherever located, may alter or modify an approved certificate of insurance form unless the alteration or modification has been approved by the commissioner of insurance~~ certificate is issued on standard certificate of insurance forms promulgated by the insurer, the Association for Cooperative Operations Research and Development (ACORD), the American Association of Insurance Services (AAIS), or the Insurance Services Office (ISO).
D. ~~The commissioner of insurance shall disapprove a form filed under this Section or withdraw approval of a form if that form:~~
~~(1) Is unfair, misleading, or deceptive, or violates public policy.~~
~~(2) Violates any state statute or regulation validly promulgated by the commissioner of insurance.~~
~~(3) Requires certification of insurance coverages that are not available.~~
~~E. The commissioner may approve a certificate of insurance form that does not state that the form is provided for information only or similar language, provided that the form states that the certificate of insurance does not confer any rights or obligations other than those conveyed by the policy and that the terms of the policy control. Further, use of such a form shall not be, in and of itself, cause for disapproval by the commissioner under the provisions of Subsection D of this Section.~~
~~F.(1) The commissioner of insurance shall approve or disapprove certificate of insurance forms filed pursuant to this Section in writing within forty-five days of receipt of the form.~~
~~(2) Standard certificate of insurance forms promulgated by the Association for Cooperative Operations Research and Development (ACORD), the American Association of Insurance Services (AAIS), or the Insurance Services Office (ISO) shall be filed, but are deemed approved by the commissioner of insurance, provided these forms comply with the provisions of this Section.~~
~~G.~~ No person shall demand or request the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.
~~H.~~ E.(1)(a) No person may ~~prepare, issue, or~~ request an insurance producer prepare or issue, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document or correspondence, instrument, or record, including an electronic record~~, that is inconsistent with this Section;~~ .
(b) The provisions of Subparagraph (a) of this Paragraph shall not apply to lenders, as defined in this Section, or to certificates of insurance required or requested by a lender from a policyholder.
(2)(a) ~~however,~~ A person may request that an insurer ~~or insurance producer may~~ prepare or issue an addendum that clarifies, explains, summarizes, or provides a statement of the coverages provided by a policy of insurance and otherwise complies with the requirements of this Section.
(b) Notwithstanding Subparagraph (a) of this Paragraph, a lender may request that an insurer or insurance producer prepare or issue an addendum that clarifies, explains, summarizes, or provides a statement of the coverages provided by a policy of insurance and otherwise complies with the requirements of this Section.
…
~~J.~~ G. A certificate of insurance form which has been ~~approved by the commissioner~~ issued in accordance with this Section and properly executed and issued by a property and casualty insurer or an insurance producer, shall constitute a confirmation that the referenced insurance policy has been issued or that coverage has been bound notwithstanding the inclusion of "for information purposes only" or similar language on the face of the certificate. A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy or any validly executed endorsements of insurance provides.
~~K.~~ H. No certificate of insurance shall contain references to legal or insurance requirements contained in any contracts ~~other than the underlying contracts of insurance~~, including but not limited to construction or service contracts. The certificate of insurance may list only the specific forms or endorsements contained in the underlying contracts of insurance. No certificate holder or other interested party may require an interpretation of those forms or endorsements from the insurance agent. The provisions of this Subsection shall not apply to lenders, as defined in this Section, or to certificates of insurance required or requested by a lender from a policyholder.
…

## Missouri

**HB 1867** amends sections ***287.037 Member of limited liability company to receive coverage, rejection of coverage, rescission of rejection*** and ***287.090 Exempt employers and occupations—election to accept—withdrawal—notification required of insurance companies*** of the Missouri Workers' Compensation Law as follows:

**287.037 Member of limited liability company to receive coverage, rejection of coverage, rescission of rejection.**
1. …
2. Notwithstanding any other provision of law to the contrary, beginning January 1, 2017, a shareholder of an S corporation, as defined in subsection 1 of section 143.471, with at least forty percent or greater interest in the S corporation, may individually elect to reject coverage under this chapter by providing a written notice of such rejection to the S corporation and its insurer. Failure to provide notice to the S corporation shall not be grounds for any shareholder to claim that the rejection of such coverage is not legally effective. A shareholder who elects to reject such coverage shall not thereafter be entitled to workers' compensation benefits under

 

the policy, even if serving or working in the capacity of an employee of the S corporation, at least until such time as such shareholder provides the S corporation and its insurer with a written notice that rescinds the prior rejection of such coverage. Any rescission shall be prospective in nature and shall entitle the shareholder only to such benefits that accrue on or after the date the notice of rescission is received by the insurance company.

**287.090 Exempt employers and occupations—election to accept—withdrawal—notification required of insurance companies.**
1. This chapter shall not apply to:
…
(4) Except as provided in section 287.243, volunteers of a tax-exempt organization which operates under the standards of Section 501(c)(3) or Section 501(c)(19) of the federal Internal Revenue Code, where such volunteers are not paid wages, but provide services purely on a charitable and voluntary basis;
…

**HB 1955** amends various provisions of the Missouri Workers' Compensation Law, in part, as follows:
**287.037. Member of limited liability company to receive coverage, rejection of coverage, rescission of rejection.**
1. …
2. Notwithstanding any other provision of law to the contrary, beginning January 1, 2017, a shareholder of an S corporation, as defined in subsection 1 of section 143.471, with at least forty percent or greater interest in the S corporation, may individually elect to reject coverage under this chapter by providing a written notice of such rejection to the S corporation and its insurer. Failure to provide notice to the S corporation shall not be grounds for any shareholder to claim that the rejection of such coverage is not legally effective. A shareholder who elects to reject such coverage shall not thereafter be entitled to workers' compensation benefits under the policy, even if serving or working in the capacity of an employee of the S corporation, at least until such time as such shareholder provides the S corporation and its insurer with a written notice that rescinds the prior rejection of such coverage. Any rescission shall be prospective in nature and shall entitle the shareholder only to such benefits that accrue on or after the date the notice of rescission is received by the insurance company.

**287.090. Exempt employers and occupations—election to accept—withdrawal—notification required of insurance companies.**
1. This chapter shall not apply to:
…
(4) Except as provided in section 287.243, volunteers of a tax-exempt organization which operates under the standards of Section 501(c)(3) or Section 501(c)(19) of the federal Internal Revenue Code, where such volunteers are not paid wages, but provide services purely on a charitable and voluntary basis;
…

**287.140. Employer to provide medical and other services, transportation, artificial devices, reactivation of claim—duties of health care providers—refusal of treatment, effect—medical evidence—division, commission responsibilities—notice to health care provider of workers' compensation claim, contents, effect—use of employee leave time.**
…
4. The division shall, by regulation, establish methods to resolve disputes concerning the reasonableness of medical charges, services, or aids. This regulation shall govern resolution of disputes between employers and medical providers over fees charged, whether or not paid, and shall be in lieu of any other administrative procedure under this chapter. The employee shall not be a party to a dispute over medical charges, nor shall the employee's recovery in any way be jeopardized because of such dispute. Any application for payment of additional reimbursement, as such term is used in 8 CSR 50-2.030, as amended, shall be filed not later than:
(1) Two years from the date the first notice of dispute of the medical charge was received by the health care provider if such services were rendered before July 1, 2013; and
(2) One year from the date the first notice of dispute of the medical charge was received by the health care provider if such services were rendered after July 1, 2013.
Notice shall be presumed to occur no later than five business days after ~~transmission by certified United States mail~~ mailing. Notice shall be sent by United States Postal Service certificate of mailing, first class mail using Intelligent Mail barcode (IMb), or another mail tracking method used, approved, or accepted by the United States Postal Service. For the purposes of this section, the phrase "notice of dispute" means a written explanation of benefits clearly including the term "Notice of Fee Dispute", which prominently evidences the payment is considered to be the full payment of the fee or charge.
…

**287.955. Insurers to adhere to uniform classification system, plan—director to designate advisory organization, purpose, duties—risk premium modification plan, requirements.**
…
6. (1) A workers' compensation insurer may develop an individual risk premium modification rating plan which prospectively modifies premium based upon individual risk characteristics which are predictive of future loss. Such rating plan shall be filed thirty days prior to use and may be subject to disapproval by the director.

(2) Premium modifications under this subsection may be determined by an underwriter assessing the individual risk characteristics and applying premium credits and debits as specified under a schedule rating plan. Alternatively, an insurer may utilize software or a computer risk modeling system designed to identify and assess individual risk characteristics and which systematically and uniformly applies premium modifications to similarly situated employers. The rating plan shall establish objective standards for measuring variations in individual risks for hazards or expense or both. ~~The rating plan shall be actuarially justified and shall not result in premiums which are excessive, inadequate, or unfairly discriminatory.~~ The rating plan shall not utilize factors which are duplicative of factors otherwise utilized in the development of rates or premiums, including the uniform classification system and the uniform experience rating plan. ~~The premium modification factors utilized under the rating plan shall be applied on a statewide basis, with no premium modifications~~ No premium modification factors shall be based solely upon the geographic location of the employer.

(a) Premium modifications resulting from a schedule rating plan, with an underwriter determining individual risk characteristics, shall be limited to plus or minus twenty-five percent. Up to an additional ten percent credit may be given for a reduction in the insurer's expenses.

(b) Premium modifications resulting from a risk modeling system shall be limited to plus or minus fifty percent. Premium modifications resulting from a risk modeling system shall be reported separately under the uniform statistical plan from premium modifications resulting from a schedule rating plan.

(c) Changes in premium modification factors may occur if there is a change in the insurer, the insurer amends or withdraws the rating plan, or if there is a change in the insured employer's operations or risk characteristics underlying the premium modification factor.

…

~~(4) (a) Premium modifications under this subsection may be determined by an underwriter assessing the individual risk characteristics and applying premium credits and debits as specified under a schedule rating plan. Alternatively, an insurer may utilize software or a computer risk modeling system designed to identify and assess individual risk characteristics and which systematically and uniformly applies premium modifications to similarly situated employers.~~

~~(b) Premium modifications resulting from a schedule rating plan, with an underwriter determining individual risk characteristics, shall be limited to plus or minus twenty-five percent. An additional ten percent credit may be given for a reduction in the insurer's expenses.~~

~~(c) Premium modifications resulting from a risk modeling system shall be limited to plus or minus fifty percent. Premium modifications resulting from a risk modeling system shall be reported separately under the uniform statistical plan from premium modifications resulting from a schedule rating plan.~~

~~(d) Premium credits or reductions shall not be removed or reduced unless there is a change in the insurer, the insurer amends or withdraws the rating plan, or unless there is a corresponding change in the insured employer's operations or risk characteristics underlying the credit or reduction.~~

**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.**

…

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.

**SB 613** adds new section ***287.245*** and 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 Workers Compensation Law as follows:

**287.245**

1. As used in this section, the following terms shall mean:
(1) "Association", volunteer fire protection associations as defined in section 320.300;
(2) "State fire marshal", the state fire marshal selected under the provisions of sections 320.200 to 320.270;
(3) "Volunteer firefighter", the same meaning as in section 287.243.
2. Any association may apply to the state fire marshal for a grant for the purpose of funding such association's costs related to workers' compensation insurance premiums for volunteer firefighters.
3. Subject to appropriations, the state fire marshal shall disburse grants to each applying volunteer fire protection association according to the following schedule:
(1) Associations which had zero to five volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for two thousand dollars in grant money;
(2) Associations which had six to ten volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand five hundred dollars in grant money;
(3) Associations which had eleven to fifteen volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand dollars in grant money;
(4) Associations which had sixteen to twenty volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for five hundred dollars in grant money.
4. Grant money disbursed under this section shall only be used for the purpose of paying for the workers' compensation insurance premiums of volunteer firefighters.

**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.

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

# FEDERAL ISSUES

| Issue | Update |
|---|---|
| **Congress** | Congress continues to focus on fiscal issues. Federal Aviation Administration reauthorization legislation will receive significant consideration in the House, because the Senate passed an 18-month extension in April. An amendment was offered and defeated in the Senate that would have given states the authority to regulate air ambulance services. Such state regulation has been prohibited since the airline deregulation effort in the late 1970s. |
| **TRIPRA of 2015 Implementation** | NCCI continues to work closely with the Federal Insurance Office (FIO) and the National Association of Insurance Commissioners (NAIC) on the implementation of terrorism insurance data calls. The FIO issued a solicitation in March requesting that carriers report 2015 terrorism insurance data for all covered lines on an individual company basis by April 30, 2016.<br><br>To supplement the workers compensation portion of the FIO data request to individual carriers, NCCI coordinated with the independent bureaus to provide aggregated state data for all states except for California and the monopolistic states. FIO has indicated that the Section 111 Terrorism Risk Insurance Program Reauthorization Act (TRIPRA) reporting is voluntary for 2016, but also indicated that such reporting will become mandatory for carriers beginning in 2017.<br><br>The NAIC has issued a data call related to terrorism risk insurance coverage and has requested that NCCI coordinate the effort to provide aggregate workers compensation data by carrier to comply with the NAIC data call. The NAIC data call is intended to serve multiple regulatory and oversight objectives with respect to the affordability and availability of insurance coverage for acts of terrorism, as well as monitoring insurers' financial exposure to terrorism risk.<br><br>The workers compensation portion of the terrorism data call will be implemented in two phases:<br>In Phase One, 11 states will be included (CA, CT, DC, FL, IL, LA, MO, NY, PA, RI, and TX). These states will provide workers compensation data to the NAIC by the end of April 2016. In the initial phase of this call, NCCI will coordinate and facilitate the pass-through of the data for all participating states except CA. In the second phase, the data for the remaining NCCI states and the independent bureaus will be provided to the NAIC (September 2016). NCCI will also facilitate these efforts. The New York Department of Financial Services will receive the data call on behalf of the NAIC due to New York's robust statutory confidentiality provisions covering this type of data. |
| **Social Security Disability Insurance (SSDI)** | The Center for a Responsible Federal Budget's SSDI Solutions Initiative has released a report with recommendations on reforming the SSDI program. Some critics of the state workers compensation system assert that state-level reforms over the last several decades have resulted in a shifting of cost to the SSDI program. The Initiative's workers compensation-related recommendations are as follows:<br>• Eliminate the 15 states that are currently grand-fathered under the federal code to apply a reverse workers compensation offset to account for SSDI benefits<br>• Enact new Secondary Payer legislation that would require a set-aside from workers compensation settlements to account for future SSDI program expenditures<br><br>The SSDI Solutions Initiative did not adopt a proposed recommendation that would have advocated for national workers compensation standards. No significant SSDI legislation is expected this year, but it could receive consideration in the next Congress. |

# STATE COMMITTEE ACTIVITY

| State | Update |
|---|---|
| **Arizona** | The Arizona Physicians' and Pharmaceutical Fee Schedule currently establishes fees based on a survey of reimbursement values in seven peer states. The option of adopting the Medicare Resource Based Relative Value Scale (RBRVS) reimbursement methodology was discussed at the April 28, 2016, meeting of the Industrial Commission. |

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| **Florida** | The Three Member Panel has recommended that the Division of Workers' Compensation move forward with rulemaking on proposed revisions to the current reimbursement manuals for hospitals, ambulatory surgical centers (ASC), and health care providers. The health care provider manual changes will take effect after the completion of rulemaking.<br>*NCCI estimates that the workers compensation system cost impact of changes to the health care provider manual is –0.1% ($4M).*<br>The hospital and the ASC manual changes face an additional step after rulemaking; these changes will have to be ratified by the legislature and signed by the governor before taking effect.<br>*NCCI estimates that the workers compensation system cost impact of changes to the hospital manual is +2.2% ($80M), and impact of changes to the ASC manual is +0.6% ($22M).* |
| **Oregon** | The Workers' Compensation Board Advisory Committee is scheduled to meet on May 20, 2016, to develop advice for the Board's biennial review of all attorney fee schedules and to consider other concepts regarding the Board's administrative rules regarding attorney fees, such as:<br>• Including claimant's counsel's assistant's time in determination of reasonable assessed fee<br>• Including "contingent nature of practice" in factors for determination of reasonable assessed fee<br>• Establishing voluntary procedure of bifurcating attorney fee determination from merits of case<br>• Amending the requirement to pay an assessed fee award within 30 days after a final litigation order |
| **Tennessee** | The Medical Payment Committee met on April 26, 2016, to discuss a hospital fee schedule proposed by the Tennessee Hospital Association. The next meeting of the Committee will be on July 19, 2016. |

*The bill included in the following section has been filed, but has not yet passed the first chamber.*

# STATE LEGISLATIVE ACTIVITY

| State | Update |
|---|---|
| **Colorado** | **SB 16-198—** Requires the advisory organization and rating organization to annually submit sample forms of policies, riders, letters, notices, and other documents to the commissioner of insurance along with a certification by an officer of the organization that the documents comply with Colorado law. It also relieves a carrier of the obligation to file such documents and certifications if it uses, without modification, the documents supplied by an advisory organization or rating organization. |

# OTHER ITEMS OF INTEREST

| State | Update |
|---|---|
| **Florida** | On April 28, 2016, the Florida Supreme Court (FSC), in a 5-to-2 decision, in *Castellanos v. Next Door Company*, concluded that the mandatory attorney fee schedule established in section 440.34 of the Florida Statutes is unconstitutional under both the Florida and United States Constitutions as a violation of due process. After a Judge of Compensation Claims awarded attorney's fees of $164 for 107 hours of legal work, the case was appealed to the First District Court of Appeals (DCA). The DCA concluded that the statutory attorney fee schedule was constitutional on due process grounds, but certified the question regarding constitutionality of the statute on numerous grounds to the FSC.<br><br>Also on April 28, the FSC discharged its jurisdiction of *Stahl v. Hialeah Hospital* after initially accepting jurisdiction in October of 2015 and hearing Oral Arguments on April 6, 2016. The FSC gave no rationale for discharging its jurisdiction. The DCA decision is now final. This case was first initiated by Stahl after being denied permanent partial disability by the Office of the Judges of Compensation Claims (JCC). Stahl appealed the decision to the DCA asserting that the statutory addition of a $10 post-MMI co-payment and statutory deletion of permanent partial disability (PPD) benefits have rendered the law an inadequate exclusive remedy. The DCA upheld the JCC's decision and said that eliminating PPD benefits was constitutional and the (2003) reform was an adequate replacement for the prior common law.<br><br>The DCA has issued a ruling in *Miles v. Edgewater* that declares unconstitutional the attorney fee restrictions in the Florida workers compensation law when the fee is paid by the claimant. The DCA's ruling also strikes Section 440.105(3)(c), Florida Statutes, which is the provision that declares that it is a misdemeanor for an attorney to accept a fee beyond the statutory guideline from their client. |
| **Montana** | The Department of Labor and Industries has released their annual medical fee schedule update for comment, with a public hearing scheduled for May 13, 2016.<br>*NCCI has analyzed the updated fee schedule and estimates the proposed changes would result in a +0.7% impact on the Montana workers compensation system costs.* |

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| **New Hampshire** | On March 22, 2016, in the *Appeal of Northridge Environmental, LLC*, the New Hampshire Supreme Court affirmed the Compensation Appeals Board's decision to award compensation of wages to the injured employee's spouse for providing home health care services, despite the spouse's lack of professional medical training and the absence of written records of the home health care services provided to the employee. |
| **New Mexico** | On April 27, 2016, the New Mexico Supreme Court heard oral argument from dairy and ranch industry groups' lawyers in a case that will likely determine whether agricultural businesses in the state are required to carry workers compensation insurance for all employees. This case is a consolidation of two cases addressing the denial of workers compensation benefits to two farm workers in 2012: *Rodriguez v. Brand West Dairy* and *Aguirre v. M.A. & Sons Chili Products.* |
| **North Carolina** | The Industrial Commission has released a report to the legislature recommending the adoption of a workers compensation drug formulary no sooner than July 1, 2018. The report also recommended that the enabling legislation include the adoption of medical treatment guidelines. |
| **Oklahoma** | On April 12, 2016, in *Maxwell v. Sprint PCS* , the Oklahoma Supreme Court ruled, in part, that:<br>• Scheduled members, arms, hands, feet, legs, eyes, and ears, are exempt for evaluation for permanent partial disability benefits using the *AMA Guides*<br>• The deferral of permanent partial disability benefits if an injured worker returns to work is unconstitutional, as a violation of due process and as disparate treatment<br>• The calculation of permanent partial disability benefits to a scheduled member shall be tied to the amount in the schedule<br><br>*The ruling by the court that all scheduled member permanent partial disability (PPD) injuries are to be compensated under 85A O.S. § 46(A), is estimated to increase Oklahoma system costs by +3.4%. Any increase resulting from the elimination of the PPD benefits deferral provision will be reflected in future NCCI loss cost filings in Oklahoma.*<br><br>On April 19, 2016, the Oklahoma Supreme Court ruled in *Robinson v. Fairview Fellowship Home for Senior Citizens* that the Workers' Compensation Commission (Commission) has the power to determine whether a provision of Title 85A (Administrative Workers' Compensation Act) is being unconstitutionally applied to a particular party in a proceeding before the Commission, and that the Commission's decision is subject to review by the Oklahoma Supreme Court. |
| **South Dakota** | The Division of Labor and Management has scheduled a public hearing on May 10 to hear comments on proposed changes to the workers compensation medical fee schedule. The division is proposing to increase the maximum reimbursement for procedure codes 10000 through 99071 by increasing the multipliers that are used in combination with base unit values. |
| **Texas** | The Texas Department of Insurance, Division of Workers' Compensation has posted an informal working draft of proposed changes relating to approval or denial of a fee by the commission and guidelines for legal services provided to claimants and carriers. Notably, the draft increases the maximum allowable rate for legal services from $150 to $200 for attorneys and from $50 to $65 for legal assistants. Also included are increases to the maximum hours of legal services allowed for certain aspects of the claim handling process. |
| **Utah** | Updates to the physician fee schedule are being proposed to become effective for services performed on or after December 1, 2016. Changes include updating from the current edition of the *Medicare RBRVS* to the 2016 edition and increasing the conversion factor for anesthesia services from $53 to $57. All other conversion factors would remain unchanged under this proposal.<br>*NCCI estimates that the proposed changes would result in a +0.1% (+0.4M1) impact on overall workers compensation system costs*. |

**Contact Information**

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

| State | State Relations Executive | Phone Number |
|---|---|---|
| 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.