



State or Federal Issues Contacts: Please refer to the list of State Relations Executives at the end of this report.

LEGISLATIVE ACTIVITY—LEGISLATIVE SESSION UPDATES

This report contains descriptions and/or excerpts of relevant bills that passed the first chamber, passed the second chamber, or were enacted during the specific periods. In addition, a recap of significant legislative and judicial activity impacting the workers compensation system will be included in the first report published each month. This report is issued on a weekly basis throughout the legislative season, and it provides updates on the content of these bills if and when they progress through the legislative process. This report includes bills from states where NCCI provides ratemaking services (see state list under Contact Information) and the US Congress.

BILLS ENACTED

The following workers compensation-related bill was enacted within the one-week period ending February 24, 2017.

Virginia

SB 1175 was:

- Passed by the first chamber on January 27, 2017
- Included in NCCI's February 3, 2017 **Legislative Activity Report** (RLA-2017-04)
- Passed by the second chamber on February 10, 2017
- Included in NCCI's February 17, 2017 **Legislative Activity Report** (RLA-2017-06)
- Enacted on February 20, 2017, with an effective date of July 1, 2017

SB 1175 amends **section 65.2-309. Lien against settlement proceeds or verdict in third party suit; subrogation of employer to employee's rights against third parties; evidence; recovery; compromise** of the Code of Virginia as follows:

§ 65.2-309. Lien against settlement proceeds or verdict in third party suit; subrogation of employer to employee's rights against third parties; evidence; recovery; compromise

...

E. Any arbitration held by the employer in the exercise of such right of subrogation (i) shall be limited solely to arbitrating the amount and validity of the employer's lien, (ii) shall not affect the employee's rights in any way, and (iii) shall not be held unless:

1. Prior to the commencement of such arbitration the employer has provided the injured employee and his attorney, if any, with an itemization of the expenses associated with the lien that is the subject of the arbitration;
2. Upon receipt of the itemization of the lien, the employee shall have 21 days to provide a written objection to any expenses included in the lien to the employer, and if the employee does not do so any objections to the lien to be arbitrated shall be deemed waived;
3. The employer shall have 14 days after receipt of the written objection to notify the employee of any contested expenses that the employer does not agree to remove from the lien, and if the employer does not do so any itemized expense objected to by the employee shall be deemed withdrawn and not included in the arbitration; and
4. Any contested expenses remaining shall have been submitted to the Commission for a determination of their validity and the Commission has made such determination of validity prior to the commencement of the arbitration.

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bill passed the second chamber within the one-week period ending February 24, 2017.

Utah

HB 90 Substitute was:

- Passed by the first chamber on February 7, 2017
- Included in NCCI's February 17, 2017 **Legislative Activity Report** (RLA-2017-06)

- Passed by the second chamber on February 23, 2017

HB 90 Substitute, in part, creates **sections 31A-22-615. Insurance coverage for opioids—Policies—Reports, 34A-2-424, and 49-20-414. Prescribing policies for certain opioid prescriptions** of the Utah Code Annotated as follows:

31A-22-615. Insurance coverage for opioids—Policies—Reports.

(1) For purposes of this section:

(a) "Health care provider" means an individual, other than a veterinarian, who:

(i) is licensed to prescribe a controlled substance under Title 58, Chapter 37, Utah Controlled Substances Act; and

(ii) possesses the authority, in accordance with the individual's scope of practice, to prescribe Schedule II controlled substances and Schedule III controlled substances that are applicable to opioids and benzodiazapines.

(b) "Health insurer" means:

(i) an insurer who offers health care insurance as that term is defined in Section 31A-1-301;

(ii) health benefits offered to state employees under Section 49-20-202; and

(iii) a workers' compensation insurer:

(A) authorized to provide workers' compensation insurance in the state; or

(B) that is a self-insured employer as defined in Section 34A-2-201.

(c) "Opioid" has the same meaning as "opiate," as that term is defined in Section 58-37-2.

(d) "Prescribing policy" means a policy developed by a health insurer that includes evidence based guidelines for prescribing opioids, and may include the 2016 Center for Disease Control Guidelines for Prescribing Opioids for Chronic Pain, or the Utah Clinical Guidelines on Prescribing Opioids for the treatment of pain.

(2) A health insurer that provides prescription drug coverage may enact a policy to minimize the risk of opioid addiction and overdose from:

(a) chronic co-prescription of opioids with benzodiazapines and other sedating substances;

(b) prescription of very high dose opioids in the primary care setting; and

(c) the inadvertent transition of short-term opioids for an acute injury into long-term opioid dependence.

(3) A health insurer that provides prescription drug coverage may enact policies to facilitate:

(a) non-narcotic treatment alternatives for patients who have chronic pain; and

(b) medication-assisted treatment for patients who have opioid dependence disorder.

(4) The requirements of this section apply to insurance plans entered into or renewed on or after July 1, 2017.

(5) (a) A health insurer subject to this section shall on or before September 1, 2017, and before each September 1 thereafter, submit a written report to the Utah Insurance Department regarding whether the insurer has adopted a policy and a general description of the policy.

(b) The Utah Insurance Department shall, on or before October 1, 2017, and before each October 1 thereafter, submit a written summary of the information under Subsection (5)(a) to the Health and Human Services Interim Committee.

(6) A health insurer subject to this section may share the policies developed under this section with other health insurers and the public.

(7) This section sunsets in accordance with Section 63I-1-231.

34A-2-424. Prescribing policies for certain opioid prescriptions.

(1) This section applies to a person regulated by this chapter or Chapter 3, Utah Occupational Disease Act.

(2) A self-insured employer, as that term is defined in Section 34A-2-201.5, an insurance carrier, and a managed health care program under Section 34A-2-111 may implement a prescribing policy for certain opioid prescriptions in accordance with Section 31A-22-615.

49-20-414. Prescribing policies for certain opioid prescriptions.

A plan offered to state employees under this chapter may implement a prescribing policy for certain opioid prescriptions in accordance with Section 31A-22-615.

SB 92 was:

- Passed by the first chamber on February 14, 2017
- Included in NCCI's February 24, 2017 **Legislative Activity Report** (RLA-2017-07)
- Passed by the second chamber on February 24, 2017

SB 92 creates, repeals, and amends numerous sections of the Utah Code to, in part:

- Repeal the statute creating the Workers' Compensation Fund
- Remove statutory references to the Workers' Compensation Fund
- Address the obligation to write workers' compensation insurance and residual market mechanisms
- Provide for the Workers' Compensation Fund's transition to a mutual corporation

- Modify membership on the workers' compensation advisory council
- Address methods to obtain workers' compensation insurance
- Amend the provision addressing penalty for failure to obtain workers' compensation
- Modify the provision addressing exemptions for employees temporarily in state

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending February 24, 2017.

Arizona

HB 2161 amends *section 23-901.01. Occupational disease; proximate causation; definitions* of the Arizona Revised Statutes as follows:

23-901.01. Occupational disease; proximate causation; definitions

A. The occupational diseases as defined by section 23-901, paragraph 13, subdivision (c) shall be deemed to arise out of the employment only if all of the following six requirements exist:

1. There is a direct causal connection between the conditions under which the work is performed and the occupational disease.
2. The disease can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment.
3. The disease can be fairly traced to the employment as the proximate cause.
4. The disease does not come from a hazard to which workers would have been equally exposed outside of the employment.
5. The disease is incidental to the character of the business and not independent of the relation of employer and employee.
6. The disease after its contraction appears to have had its origin in a risk connected with the employment, and to have flowed from that source as a natural consequence, although it need not have been foreseen or expected.

B. Notwithstanding subsection A of this section and section 23-1043.01: 7

1. Any disease, infirmity or impairment of a firefighter's or peace officer's health that is caused by brain, bladder, rectal or colon cancer, lymphoma, leukemia or ~~aden carcinoma~~ adenocarcinoma or mesothelioma of the respiratory tract and that results in disability or death is presumed to be an occupational disease as defined in section 23-901, paragraph 13, subdivision (c) and is deemed to arise out of employment.

2. Any disease, infirmity or impairment of a firefighter's health that is caused by buccal cavity and pharynx, esophagus, large intestine, lung, kidney, prostate, skin, stomach or testicular cancer or non-hodgkin's lymphoma, multiple myeloma or malignant melanoma and that results in disability or death is presumed to be an occupational disease as defined in section 23-901, paragraph 13, subdivision (c) and is deemed to arise out of employment.

~~C. The presumption is~~ presumptions provided in subsection b of this section are granted if all of the following apply:

1. The firefighter or peace officer passed a physical examination before employment and the examination did not indicate evidence of cancer.
2. The firefighter or peace officer was assigned to hazardous duty for at least five years.
3. The firefighter or peace officer was exposed to a known carcinogen as defined by the international agency for research on cancer and informed the department of this exposure, and the carcinogen is reasonably related to the cancer.
4. For the presumption provided in subsection b, paragraph 2 of this section, the firefighter received a physical examination that is reasonably aligned with the national fire protection association standard on comprehensive occupational medical program for fire departments (NFPA 1582).

~~C. D.~~ Subsection B of this section applies to former firefighters and or peace officers who are sixty-five years of age or younger.

~~D. E.~~ Subsection B of this section does not apply to cancers of the respiratory tract if the firefighter or peace officer has smoked tobacco products there is evidence that the firefighter's or peace officer's exposure to cigarettes or tobacco products outside of the scope of the firefighter's or peace officer's official duties is a substantial contributing cause in the development of the cancer.

F. The presumptions provided in subsection b of this section may be rebutted by a preponderance of the evidence that there is a specific cause of the cancer other than an occupational exposure to a carcinogen as defined by the international agency for research on cancer.

~~E. G.~~ For the purposes of this section:

1. "Firefighter" means a full-time firefighter who was regularly assigned to hazardous duty.
2. "Peace officer" means a full-time peace officer who was regularly assigned to hazardous duty as a part of a special operations, special weapons and tactics, explosive ordinance disposal or hazardous materials response unit.

HB 2410 amends *section 23-901. Definitions* and adds new *section 23-1043.05. Heart-related, perivascular and pulmonary cases; firefighters; definition* of the Arizona Revised Statutes, in part, to read:

23-901. Definitions

...

13. "Personal injury by accident arising out of and in the course of employment" means any of the following:

- (a) Personal injury by accident arising out of and in the course of employment.

(b) An injury caused by the wilful act of a third person directed against an employee because of the employee's employment, but does not include a disease unless resulting from the injury.

(c) An occupational disease that is due to causes and conditions characteristic of and peculiar to a particular trade, occupation, process or employment, and not the ordinary diseases to which the general public is exposed, and subject to section 23-901.01 or, for heart-related, perivascular or pulmonary cases, section 23-1043.05.

...

23-1043.05. Heart-related, perivascular and pulmonary cases; firefighters; definition

A. A heart-related, perivascular or pulmonary injury, illness or death of a firefighter is presumed to be an occupational disease as defined in section 23-901, paragraph 13, subdivision (c), compensable pursuant to section 23-1043.01 and deemed to arise out of employment if all of the following apply:

1. The firefighter passed a physical examination before employment and the examination did not indicate evidence of heart-related, perivascular or pulmonary injury or illness.

2. The firefighter received a physical examination that is reasonably aligned with the national fire protection association standard on comprehensive occupational medical program for fire departments (nfpa 1582).

3. The firefighter was exposed to a known event and the heart-related, perivascular or pulmonary injury, illness or death occurred within twenty-four hours after the exposure and was reasonably related to the exposure.

B. The presumption provided in subsection a of this section may be rebutted by a preponderance of the evidence that there is a specific cause of the heart-related, perivascular or pulmonary injury, illness or death other than the employment.

C. Subsection A of this section does not apply if there is evidence that the firefighter's exposure to cigarettes or tobacco products outside the scope of the firefighter's official duties is a substantial contributing cause in the development of the heart-related, perivascular or pulmonary injury, illness or death.

D. For the purposes of this section, "firefighter" means a firefighter or volunteer firefighter as described in section 23-901, paragraph 6, subdivision (d).

HB 2482 amends *sections 23-901. Definitions, 23-1061. Notice of accident; form of notice; claim for compensation; reopening; payment of compensation, and 23-1070. Medical, surgical and hospital benefits provided by employer; pilot program* of the Arizona Revised Statutes to, in part:

23-901. Definitions

In this chapter, unless the context otherwise requires:

...

6. "Employee", "workman", "worker" and "operative" means:

...

(c) Lessees of mining property and ~~their~~ the lessees' employees and contractors engaged in the performance of work that is a part of the business conducted by the lessor and over which the lessor retains supervision or control are within the meaning of this paragraph employees of the lessor, and are deemed to be drawing wages as are usually paid employees for similar work. The lessor may deduct from the proceeds of ores mined by the lessees the premium required by this chapter to be paid for such employees.

...

(g) Regular members of a volunteer sheriff's reserve, which may be established by resolution of the county board of supervisors, to assist the sheriff in the performance of the sheriff's official duties. A roster of the current members shall monthly be certified to the clerk of the board of supervisors by the sheriff and shall not exceed the maximum number authorized by the board of supervisors. Certified members of an authorized volunteer sheriff's reserve shall be deemed to be employees of the county for the purpose of coverage under the Arizona workers' compensation laws and occupational disease disability laws and shall be entitled to receive the benefits of these laws for any compensable injuries or disabling conditions that arise out of and occur in the course of the performance of duties authorized and directed by the sheriff. Compensation benefits and premium payments shall be based ~~upon~~ on the salary received by a regular full-time deputy sheriff of the county involved for the first month of regular patrol duty as an officer for each certified member of a volunteer sheriff's reserve. This subdivision ~~shall not be construed to~~ does not provide compensation coverage for any member of a sheriff's posse who is not a certified member of an authorized volunteer sheriff's reserve except as a participant in a search and rescue mission or a search and rescue training mission.

(h) A working member of a partnership may be deemed to be an employee entitled to the benefits provided by this chapter ~~upon~~ on written acceptance, by endorsement, at the discretion of the insurance carrier for the partnership of an application for coverage by the working partner. The basis for computing premium payments and compensation benefits for the working partner shall be an assumed average monthly wage of not less than six hundred dollars nor more than the maximum wage provided in section 23-1041 and is subject to the discretionary approval of the insurance carrier. Any compensation for permanent partial or permanent total disability payable to the partner shall be computed on the lesser of the assumed monthly wage agreed to by the insurance carrier on the acceptance of the application for coverage or the actual average monthly wage received by the partner at the time of injury.

...

(j) A member of the Arizona national guard, Arizona state guard or unorganized militia shall be deemed a state employee and entitled to coverage under the Arizona workers' compensation law at all times while the member is receiving the payment of the member's military salary from ~~the~~this state under competent military orders or ~~upon~~on order of the governor. Compensation benefits shall be based ~~upon~~on the monthly military pay rate to which the member is entitled at the time of injury, but not less than a salary of four hundred dollars per month, nor more than the maximum provided by the workers' compensation law. ~~No~~ Arizona compensation benefits shall not inure to a member compensable under federal law.

...

(l) Volunteer workers of a licensed health care institution may be deemed to be employees and entitled to the benefits provided by this chapter ~~upon~~on written acceptance by the insurance carrier of an application by the health care institution for coverage of such volunteers. The basis for computing wages for premium payments and compensation benefits for volunteers shall be four hundred dollars per month.

...

(g) A working member of a limited liability company who owns less than twenty-five percent of the membership interest in the limited liability company may be deemed to be an employee entitled to benefits provided by this chapter on written acceptance, by endorsement, of an application for coverage by the working member at the discretion of the insurance carrier for the limited liability company. The basis for computing wages for premium payments and compensation benefits for the working member is an assumed average monthly wage of six hundred dollars or more but not more than the maximum wage provided in section 23-1041 and is subject to the discretionary approval of the insurance carrier. Any compensation for permanent partial or permanent total disability payable to the working member is computed on the lesser of the assumed monthly wage agreed to by the insurance carrier on the acceptance of the application for coverage or the actual average monthly wage received by the working member at the time of injury.

7. "General order" means an order applied generally throughout ~~the~~this state to all persons under jurisdiction of the commission.

8. "Heart-related or perivascular injury, illness or death" means myocardial infarction, coronary thrombosis or any other similar sudden, violent or acute process involving the heart or perivascular system, or any death resulting therefrom, and any weakness, disease or other condition of the heart or perivascular system, or any death resulting therefrom.

9. "Insurance carrier" means every insurance carrier duly authorized by the director of insurance to write workers' compensation or occupational disease compensation insurance in ~~the~~this state of ~~Arizona~~.

...

23-1061. Notice of accident; form of notice; claim for compensation; reopening; payment of compensation

A. Notwithstanding section 23-908, subsection E, ~~no~~a claim for compensation shall be ~~is not~~ valid or enforceable unless the claim is filed with the commission by the employee, or if resulting in death by the parties entitled to compensation, or someone on their behalf, in writing within one year after the injury occurred or the right thereto accrued. The time for filing a compensation claim begins to run when the injury becomes manifest or when the claimant knows or in the exercise of reasonable diligence should know that the claimant has sustained a compensable injury. Except as provided in subsection B of this section, neither the commission nor any court shall have jurisdiction to consider a claim ~~which~~that is not timely filed under this subsection, except if the employee or other party entitled to file the claim has delayed in doing so because of justifiable reliance on a material representation by the commission, employer or insurance carrier or if the employee or other party entitled to file the claim is insane or legally incompetent or incapacitated at the time the injury occurs or the right to compensation accrues or during the one-year period thereafter. If the insanity or legal incompetence or incapacity occurs after the one-year period has commenced, the running of the remainder of the one-year period shall be suspended during the period of insanity or legal incompetence or incapacity. If the employee or other party is insane or legally incompetent or incapacitated when the injury occurs or the right to compensation accrues, the one-year period commences to run immediately ~~upon~~on the termination of insanity or legal incompetence or incapacity. The commission ~~upon~~on receiving a claim shall give notice to the carrier.

B. Failure of an employee or any other party entitled to compensation to file a claim with the commission within one year or to comply with section 23-908 shall not bar a claim if the insurance carrier or employer has commenced payment of compensation benefits under section 23-1044, 23-1045 or 23-1046, except that the payments provided for by section 23-1046, subsection A, paragraph 1 and section 23-1065, subsection A shall not be considered compensation benefits for the purposes of this section.

~~C. If the commission receives a notification of the injury, the commission shall send a claim form to the employee.~~

~~D. C.~~ The issue of failure to file a claim must be raised at the first hearing on a claim for compensation in respect to the injury or death.

~~E. D.~~ Within ten days after receiving notice of an accident, the employer shall inform ~~his~~the employer's insurance carrier and the commission on such forms as may be prescribed by the commission.

~~F. E.~~ Each insurance carrier and self-insuring employer shall report to the commission a notice of the first payment of compensation and shall promptly report to the commission and to the employee by mail at ~~his~~the employee's last known address any denial of a claim, any change in the amount of compensation and the termination thereof, except that claims for medical, surgical and hospital benefits ~~which~~that are not denied shall be reported to the commission in the form and manner determined by the commission. In all cases where compensation is payable, the carrier or self-insuring employer shall promptly determine the average monthly wage

pursuant to section 23-1041. Within thirty days ~~of~~ after the payment of the first installment of compensation, the carrier or self-insuring employer shall notify the employee and commission of the average monthly wage of the claimant as calculated, and the basis for such determination. The commission shall then make its own independent determination of the average monthly wage pursuant to section 23-1041. The commission shall within thirty days after receipt of such notice notify the employee, employer and carrier of ~~such~~ the commission's determination. The amount determined by the commission shall be payable retroactive to the first date of entitlement. The first payment of compensation shall be accompanied by a notice on a form prescribed by the commission stating the manner in which the amount of compensation was determined.

~~G. E.~~ Except as otherwise provided by law, the insurance carrier or self-insuring employer shall process and pay compensation and provide medical, surgical and hospital benefits, without the necessity for the making of an award or determination by the commission.

~~H. G.~~ On a claim that has been previously accepted, an employee may reopen the claim to secure an increase or rearrangement of compensation or additional benefits by filing with the commission a petition requesting the reopening of the employee's claim ~~upon~~ on the basis of a new, additional or previously undiscovered temporary or permanent condition, ~~which~~ The petition shall be accompanied by a statement from a physician setting forth the physical condition of the employee relating to the claim. A claim shall not be reopened if the initial claim for compensation was previously denied by a notice of claim status or determination by the commission and the notice or determination was allowed to become final and no exception applies under section 23-947 excusing a late filing to request a hearing. A claim shall not be reopened because of increased subjective pain if the pain is not accompanied by a change in objective physical findings. A claim shall not be reopened solely for additional diagnostic or investigative medical tests, but expenses for any reasonable and necessary diagnostic or investigative tests that are causally related to the injury shall be paid by the employer or the employer's insurance carrier. Expenses for reasonable and necessary medical and hospital care and laboratory work shall be paid by the employer or the employer's insurance carrier if the claim is reopened as provided by law and if these expenses are incurred within fifteen days of the date that the petition to reopen is filed. The payment for such reasonable and necessary medical, hospital and laboratory work expense shall be paid for by the employer or the employer's insurance carrier if the claim is reopened as provided by law and if such expenses are incurred within fifteen days of the filing of the petition to reopen. Surgical benefits are not payable for any period ~~prior to~~ before the date of filing a petition to reopen, except that surgical benefits are payable for a period ~~prior to~~ before the date of filing the petition to reopen not to exceed seven days if a bona fide medical emergency precludes the employee from filing a petition to reopen ~~prior to~~ before the surgery. ~~No~~ Monetary compensation is not payable for any period ~~prior to~~ before the date of filing the petition to reopen.

~~I. H.~~ Upon the filing of a petition to reopen a claim the commission shall in writing notify the employer's insurance carrier or the self-insuring employer, which shall in writing notify the commission and the employee within twenty-one days after the date of such notice of its acceptance or denial of the petition. The reopened claim shall be processed thereafter in like manner as a new claim.

~~J. I.~~ The commission shall investigate and review any claim in which it appears to the commission that the claimant has not been granted the benefits to which such claimant is entitled. If the commission determines that payment or denial of compensation is improper in any way, it shall hold a hearing pursuant to section 23-941 within sixty days after receiving notice of such impropriety. Any claim for temporary partial disability benefits under this subsection must be filed with the commission within two years after the date the claimed entitlement to compensation accrued or within two years after the date on which an award for benefits encompassing the entitlement period becomes final. A claim for temporary partial disability compensation shall be deemed to accrue when the employee knew or with the exercise of reasonable diligence should have known that the carrier, self-insured employer or special fund denied or improperly paid compensation. A claim for temporary partial disability benefits shall not be deemed to have accrued any earlier than ~~the effective date of this amendment to this subsection~~ September 26, 2008.

~~K. J.~~ When there is a dispute as to which employer, or insurance carrier, is liable for the payment of a compensable claim, the commission, by order, may designate the employer or insurance carrier ~~which that~~ shall pay the claim. Payment shall begin within fourteen days after the employer or insurance carrier has been ordered by the commission to commence payment. When a final determination has been made as to which employer or insurance carrier is actually liable, the commission shall direct any necessary monetary adjustment or reimbursement among the parties or carriers involved.

~~L. K.~~ Upon application to the commission, and for good cause shown, the commission may direct that a document filed as a claim for compensation benefits be designated as a petition to reopen, effective as of the original date of filing. In like manner ~~upon~~ on application and good cause shown, the commission may direct that a document filed as a petition to reopen be designated a claim for compensation benefits, effective as of the original date of filing.

~~M. L.~~ If the insurance carrier or self-insurer does not issue a notice of claim status accepting or denying the claim within twenty-one days ~~from~~ after the date the carrier is notified by the commission of a claim or of a petition to reopen, the carrier shall pay immediately compensation as if the claim were accepted, from the date the carrier is notified by the commission of a claim or petition to reopen until the date ~~upon~~ on which the carrier issues a notice of claim status accepting or denying such claim. Compensation includes medical, surgical and hospital benefits. ~~This section shall not apply to cases involving seven days or less of time lost from work.~~

23-1070. Medical, surgical and hospital benefits provided by employer: ~~pilot program~~

A. An employer, ~~other than this state or a political subdivision of this state, who that~~ secures compensation to his the employer's employees in the manner provided in section 23-961, subsection A, paragraph 1 or 2, alone or jointly with other employers, in lieu of making premium payments for medical, surgical and hospital benefits, may provide such benefits to injured employees and may collect one-half of the cost thereof from his the employer's employees, not to exceed one dollar per month from any employee, which may be deducted from the wages of the employee.

B. An employer electing to provide such benefits shall notify his the employer's insurance carrier and the commission of the election and render a detailed statement of the arrangements made therefor to the commission.

C. An employer ~~who that~~ maintains a hospital for his the employer's employees or ~~who that~~ contracts with a physician for the hospital care of injured employees, on or before January 30 each year, shall make a verified written report to the commission for the preceding year showing the total amount of hospital fees collected and showing separately the amount contributed by the employees and the amount contributed by the employers. The report shall also contain an itemized account of the expenditures, investments or other disposition of the fees, and a statement showing the balance remaining.

D. An employer ~~who that~~ fails to notify his the employer's insurance carrier and the commission of his the employer's election to provide such benefits, or ~~who that~~ maintains a hospital or contracts for hospital service as provided in subsection C of this section, and ~~that~~ fails to make the financial report required therein, is liable for such benefits as provided in section 23-1062.

E. If the medical, surgical or hospital aid or treatment being furnished by an employer is such that there is reasonable ground to believe that the health, life or recovery of any employee is endangered or impaired thereby, the commission, ~~upon~~ on application of the employee or ~~upon~~ on its own motion, may order a change of physicians or other conditions. If the employer fails to comply with the order promptly, the injured employee may elect to have medical, surgical or hospital aid or treatment provided by or through the special fund established by section 23-1065. In that event the claim of the injured employee against the employer shall be assigned to the special fund for the benefit thereof, and the special fund shall furnish to the insured employee medical, surgical or hospital aid or treatment as provided in this chapter.

F. ~~Notwithstanding subsection A of this section, a pilot program is established to allow a city with a population of more than one hundred fifty thousand persons and a self-insured county insurance pool to provide medical, surgical and hospital benefits pursuant to this section. The purpose of the pilot program is to determine whether public sector entities that are self-insured can, through a directed care and medical management program, contain costs and improve health care and return to work results for injured employees. The industrial commission shall select the qualified city. The entities participating in the pilot program shall consult with the industrial commission on the protocol for assessment and reporting and shall submit all baseline data to the commission before the pilot program can begin. No earlier than January 1, 2012 and not later than January 1, 2013, the pilot program participants may begin providing medical, surgical and hospital benefits pursuant to this section on approval by the industrial commission. This subsection does not exempt pilot program participants from any other requirements for procurement of a medical network to direct care. The pilot program participants shall report in accordance with the protocol for assessment and reporting, with a final report two years after the start of the pilot program. The pilot program ends and pilot program participants may not provide medical, surgical and hospital benefits pursuant to this section from and after December 31, 2014.~~

SB 1332, in part, creates **section 23-941.01. Settlement of accepted claims; exception; definition** and amends **section 23-1062. Medical, surgical, hospital benefits; translation services; travel expenses; commencement of compensation; method of compensation** of the Arizona Revised Statutes as follows:

23-941.01. Settlement of accepted claims; exception; definition

A. The interested parties to a claim may:

1. Settle and release all or any part of an accepted claim for compensation, benefits, penalties or interest.
2. If the period of disability is terminated by the carrier or self-insured employer, negotiate a full and final settlement.

B. Any full and final settlement shall:

1. Be in writing.
2. Be signed by the carrier or self-insured employer and the employee or the employee's authorized representative.
3. Include the following attestations:
 - (a) The employee understands the rights settled and released by the agreement and was represented by counsel certified as a specialist in workers' compensation.
 - (b) The employee has been provided information from the carrier or self-insured employer that outlines any reasonable anticipated future medical, surgical and hospital benefits relating to the claim and the projected cost of those benefits and that provides an explanation of how those projected costs were determined.
 - (c) The employee is able to handle the monies received in the settlement and, if appropriate, has an investment plan or plan to deposit the monies into a separately administered account.
 - (d) The parties have considered and taken reasonable steps to protect any interests of Medicare, Medicaid and the United States Department of Veterans Affairs.
 - (e) The parties have conducted a search for and taken reasonable steps to satisfy any identified medical liens.

4. Include a description of the employee's medical conditions that have been identified and contemplated at the time of the settlement agreement.

C. A full and final settlement is not valid and enforceable unless the full and final settlement is approved by the commission. When determining whether to approve a settlement, the commission shall consider whether the settlement is in the best interests of the employee based on the following criteria:

1. Whether the employee's injuries are stabilized.

2. The permanency of the employee's injuries.

D. A lump sum settlement payment shall be made to the employee within fifteen days after the award approving the settlement becomes final.

E. The carrier or self-insured employer shall notify the attending physician of the approval of a full and final settlement if the full and final settlement terminates the employee's entitlement to medical benefits. Unless medical benefits rendered before the approval date of the full and final settlement are subject to a dispute or payment for the treatment was included in the full and final settlement agreement, the carrier or self-insured employer remains responsible for payment for the treatment not covered by the full and final settlement agreement as provided by this chapter.

F. Notwithstanding subsection A of this section, a full and final settlement may not be negotiated to settle issues resulting in total and permanent disability pursuant to section 23-1045, subsections C and D.

G. A full and final settlement agreement may not include the settlement of claims unrelated to the claim for compensation, benefits, penalties and interest.

H. This section does not apply to the settlement of claims that have been denied.

I. For the purposes of this section, "full and final settlement" means a settlement in which the injured employee or, if the injured employee is deceased, the employee's estate, surviving spouse or dependent waives any future entitlement to benefits on the claim and any future right to change the claim pursuant to section 23-1044, subsection F or reopen the claim pursuant to section 23-1061, subsection H.

23-1062. Medical, surgical, hospital benefits; translation services; travel expenses; commencement of compensation; method of compensation

A. Promptly, on notice to the employer, every injured employee shall receive medical, surgical and hospital benefits or other treatment, nursing, medicine, surgical supplies, crutches and other apparatus, including artificial members, reasonably required at the time of the injury, and during the period of disability. Such benefits shall be termed "medical, surgical and hospital benefits".²

B. Medical, surgical and hospital benefits include translation services, if needed. A carrier, self-insurance pool or employer that does not direct care pursuant to section 23-1070 may choose the translator if the translator is certified by an outside agency and is not an employee of the carrier, self-insurance pool or employer. If the carrier, self-insurance pool or employer is unable to locate a certified translator for the particular language or dialect needed, the parties may agree on a translator who is not a certified translator.

C. Compensation for medical, surgical and hospital benefits shall include reimbursement for reasonable travel expenses if the employee must travel more than twenty-five miles from the employee's place of residence to obtain medical care for the injury.

~~C. D.~~ D. The first installment of compensation is to be paid no later than the twenty-first day after written notification by the commission to the carrier of the filing of a claim unless the right to compensation is denied. Thereafter, compensation shall be paid at least once each two weeks during the period of temporary total disability and at least monthly thereafter. Compensation shall not be paid for the first seven days after the injury. If the incapacity extends beyond the period of seven days, compensation shall begin on the eighth day after the injury, but if the disability continues for one week beyond such seven days, compensation shall be computed from the date of the injury.

~~D. E.~~ E. Compensation shall be made by negotiable instrument, payable immediately on demand or, at the election of the employee and if offered by the employer or carrier, by another commonly accepted method for transferring money by banking institutions, including electronic fund transfers to the employee's account or a prepaid debit card account that is established for the purpose of making direct electronic payment to the employee.

SB 1332 also includes the following language:

Industrial commission of Arizona; review of authorization process; delayed repeal

A. On or before December 31, 2017, the industrial commission of Arizona shall review and determine a process for streamlining the authorization process for treatment that is within the evidence-based medical treatment guidelines.

B. This section is repealed from and after June 30, 2018.

Kentucky

HB 296 amends *sections 342.020, 342.035, 342.040, 342.125, 342.185, 342.320, 342.700, 342.730, and 342.990* of the Kentucky Revised Statutes, in part, as follows:

Section 1. **342.020 Medical treatment at expense of employer—Selection of physician and hospital—Payment—Managed health care system—Artificial members and braces—Waiver of privilege—Disclosure of interest in referrals.**

(1) In addition to all other compensation provided in this chapter, the employer shall pay for the cure and relief from the effects of an injury or occupational disease the medical, surgical, and hospital treatment, including nursing, medical, and surgical supplies and

appliances, as may reasonably be required at the time of the injury and thereafter ~~during disability~~, for the length of time set forth in this section, or as may be required for the cure and treatment of an occupational disease.

(2) In claims resulting in an award of permanent total disability or resulting from an injury described in subsection (10) of this section, the employer's obligation to pay the benefits specified in this section shall continue for so long as the employee is disabled regardless of the duration of the employee's income benefits.

(3) In all permanent partial disability claims not involving an injury described in subsection (10) of this section, the employer's obligation to pay the benefits specified in this section shall continue for seven hundred eighty (780) weeks from the date of injury or date of last exposure.

(4) Except in claims described in subsection (2) of this section, the employer's obligation to pay the benefits specified in this section shall terminate as of the date the employee reaches the age of seventy (70) or four (4) years after the employee's date of injury or last exposure, whichever last occurs.

...

(14) (a) Except as provided in paragraph (b) of this subsection, the employer, insurer, or payment obligor shall not be liable for urine drug screenings of patients in excess of:

1. One (1) per year for a patient considered to be low risk;

2. Two (2) per year for a patient considered to be moderate risk; and

3. Four (4) per year for patients considered to be high risk; based upon the screening performed by the medical provider and other pertinent factors.

(b) The employer, insurer, or payment obligor may be liable for urine drug screening at each office visit for patients that have exhibited aberrant behavior documented by multiple lost prescriptions, multiple requests for early refills of prescriptions, multiple providers prescribing or dispensing opioids as evidenced by the electronic monitoring system established in KRS 218A.020 or a similar system, unauthorized dosage escalation, or apparent intoxication.

(c) The commissioner shall promulgate administrative regulations related to urine drug screenings as part of the practice parameters or treatment guidelines required under Section 2 of this Act.

Section 2. 342.035 Medical fee schedule—Review and updating—Action for excess fees—Effect of failure to submit to or follow surgical or medical treatment or advice—Fee schedule for medical testimony—Other medical matters—Medical fee schedule for registered nurse first assistants.

...

(5) ...

(c) The commissioner shall promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to this chapter. Utilization review required under administrative regulations may be waived if the insurance carrier, self-insured group, or self-insured employer agrees that the recommended medical treatment is medically necessary and appropriate or if the injured employee elects not to proceed with the recommended medical treatment.

...

(8) (a) The commissioner shall develop or adopt practice parameters or treatment guidelines for clinical practice for use by medical providers under this chapter, including but not limited to chronic pain management treatment and opioid use, and promulgate administrative regulations in order to implement the developed or adopted practice parameters or treatment guidelines on or before December 31, 2018. The commissioner may adopt any parameters for clinical practice as developed and updated by the federal Agency for Health Care Policy Research, or the commissioner may adopt other parameters for clinical practice which are developed by qualified bodies, as determined by the commissioner, with periodic updating based on data collected during the application of the parameters.

(b) The commissioner shall develop or adopt a pharmaceutical formulary for medications prescribed for the cure of and relief from the effects of a work injury or occupational disease and promulgate administrative regulations to implement the developed or adopted pharmaceutical formulary on or before December 31, 2018.

(c) Any provider of medical services under this chapter who has followed the practice parameters or treatment guidelines or formularies developed or adopted and implemented pursuant to this subsection shall be presumed to have met the appropriate legal standard of care in medical malpractice cases regardless of any unanticipated complication that may thereafter develop or be discovered.

...

Section 3. 342.040 Time of payment of income benefits and retraining incentive benefits—Attorney's fees for recovery of overdue temporary total disability income benefits—Interest on overdue benefits.

(1) Except as provided in KRS 342.020, no income benefits shall be payable for the first seven (7) days of disability unless disability continues for a period of more than two (2) weeks, in which case income benefits shall be allowed from the first day of disability. All income benefits shall be payable on the regular payday of the employer, commencing with the first regular payday after seven (7) days after the injury or disability resulting from an occupational disease. ; Interest shall not accrue after the filing of an

application for resolution of a claim unless there is a delay in payment of benefits caused by the employer, insurance carrier, or payment obligor. If an administrative law judge determines that there was a delay caused by the employer, carrier, or payment obligor with interest at the rate of ~~six~~ twelve percent (6%) (~~12%~~) per annum shall be paid to the injured worker. on each installment from the time it is due until paid, except that If the administrative law judge determines that a denial, delay, or termination in the payment of income benefits was without reasonable foundation, the rate of interest shall be ~~twelve~~ eighteen percent (~~12%~~) (~~18%~~) per annum. In no event shall income benefits be instituted later than the fifteenth day after the employer has knowledge of the disability or death. Income benefits shall be due and payable not less often than semimonthly. If the employer's insurance carrier or other party responsible for the payment of workers' compensation benefits should terminate or fail to make payments when due, that party shall notify the commissioner of the termination or failure to make payments and the commissioner shall, in writing, advise the employee or known dependent of right to prosecute a claim under this chapter.

...

Section 4. 342.125 Reopening and review of award or order—Grounds—Procedures—Time limitations—Credit for previously-awarded retraining incentive benefits or income benefits awarded for coal-related pneumoconiosis.

...

(3) Except for reopening solely for determination of the compensability of medical expenses, fraud, or conforming the award as set forth in KRS 342.730(1)(c)2., or for reducing a permanent total disability award when an employee returns to work, or seeking temporary total disability benefits during the period of an award, no claim shall be reopened more than four (4) years following the date of the original award or original order granting or denying benefits, and no party may file a motion to reopen within one (1) year of any previous motion to reopen by the same party. Orders granting or denying benefits that are entered subsequent to an original final award or order granting or denying benefits shall not be considered to be an original order granting or denying benefits under this subsection and shall not extend the time to reopen a claim beyond four (4) years following the date of the original award or original order.

...

Section 5. 342.185 Notice of accident—Claim for compensation—Limitation.

(1) Except as provided in subsections ~~subsection~~ (2) and (3) of this section, no proceeding under this chapter for compensation for an injury or death shall be maintained unless a notice of the accident shall have been given to the employer as soon as practicable after the happening thereof and unless an application for adjustment of claim for compensation with respect to the injury shall have been made with the department within two (2) years after the date of the accident, or in case of death, within two (2) years after the death, whether or not a claim has been made by the employee himself or herself for compensation. The notice and the claim may be given or made by any person claiming to be entitled to compensation or by someone in his or her behalf. If payments of income benefits have been made, the filing of an application for adjustment of claim with the department within the period shall not be required, but shall become requisite within two (2) years following the suspension of payments or within two (2) years of the date of the accident, whichever is later.

...

(3) The right to compensation under this chapter resulting from work-related exposure to cumulative trauma injury shall be barred unless notice of the cumulative trauma injury is given in accordance with subsection (1) of this section and unless an application for adjustment of claim for compensation shall have been made with the commissioner within five (5) years after the last injurious exposure to the cumulative trauma.

Section 6. 342.320 Approval of attorney's and physician's fees and hospital charges—Limits on attorney's fees—Payment of attorney fees.

...

(2) In an original claim, attorney's fees for services under this chapter on behalf of an employee shall be subject to the following maximum limits:

(a) For attorney-client employment contracts entered into and signed after July 14, 2000, but before the effective date of this Act, twenty percent (20%) of the first twenty-five thousand dollars (\$25,000) of the award, fifteen percent (15%) of the next ten thousand dollars (\$10,000), and five percent (5%) of the remainder of the award, not to exceed a maximum fee of twelve thousand dollars (\$12,000). This fee shall be paid by the employee from the proceeds of the award or settlement; and

(b) For attorney-client employment contracts entered into and signed on or after the effective date of this Act, twenty percent (20%) of the first twenty-five thousand dollars (\$25,000) of the award, fifteen percent (15%) of the next ten thousand dollars (\$10,000), and five percent (5%) of the remainder of the award, not to exceed a maximum fee of eighteen thousand dollars (\$18,000). This fee shall be paid by the employee from the proceeds of the award or settlement ~~Attorney-client employment contracts entered into and signed after July 14, 2000, shall be subject to the conditions of paragraph (a) of this subsection.~~

...

(8) Attorney's fees for representing employers in proceedings under this chapter pursuant to contract with the employer shall be subject to approval of the administrative law judge in the same manner as prescribed for attorney representation of employees.

Employer attorney's fees are subject to the limitation of ~~eighteen~~ ~~twelve~~ thousand dollars (~~\$18,000~~) (~~\$12,000~~) maximum fees except that fees for representing employers shall not be dependent upon the result achieved. Employer attorney's fees may be paid on a periodic basis while a claim is adjudicated and the payments need not be approved until the claims resolution process is completed. Fees for legal services in presenting a claim for reimbursement from the Kentucky coal workers' pneumoconiosis fund shall not exceed one thousand dollars (\$1,000). All such approved fees shall be paid by the employer and in no event shall exceed the amount the employer agreed by contract to pay.

Section 7. 342.700 Remedies when third party is legally liable—Liability and indemnification rights of principal contractors, intermediates, and subcontractors—Requirement of waiver of remedies for award of contract unlawful.

(1) Whenever an injury for which compensation is payable under this chapter has been sustained under circumstances creating in some other person than the employer a legal liability to pay damages, the injured employee may either claim compensation or proceed at law by civil action against the other person to recover damages, or proceed both against the employer for compensation and the other person to recover damages, but he shall not collect from both. If the injured employee elects to proceed at law by civil action against the other person to recover damages, he shall give due and timely notice to the employer and the special fund of the filing of the action. If compensation is awarded or paid under this chapter, the employer, his insurance carrier, the special fund, the Kentucky coal workers' pneumoconiosis fund, and the uninsured employer's fund, or any of them, having paid the compensation or having become liable therefor, may recover in his or its own name or that of the injured employee from the other person in whom legal liability for damages exists, not to exceed the indemnity and medical expenses paid and payable to or on behalf of the injured employee, less a pro-rata share of the employee's legal fees and expense, ~~less the employee's legal fees and expense~~. The notice of civil action shall conform in all respects to the requirements of KRS 411.188(2).

...

Section 8. 342.730 Determination of income benefits for disability—Survivors' rights—Termination—Offsets—Notification of return to work.

...

(7) Income benefits otherwise payable pursuant to this chapter for temporary total disability during the period the employee has returned to a light duty or other alternative job position shall be offset by an amount equal to the net amount of wages paid to the employee by his or her employer during the period of light-duty work or work in an alternative job position.

(8) If an employee receiving a permanent total disability award returns to work, that employee shall notify the employer, payment obligor, insurance carrier, or special fund as applicable.

Section 9. 342.990 Penalties—Restitution.

...

(7) The following civil penalties shall be applicable for violations of particular provisions of this chapter:

...

(b) Any employer, insurer, or payment obligor acting on behalf of an employer who fails to make timely payment of a statement for services under KRS 342.020(5) ~~(4)~~ without having reasonable grounds to delay payment may be fined not less than one hundred dollars (\$100) nor more than one thousand dollars (\$1,000) for each offense;

(c) Any person who violates KRS 342.020(13) ~~(9)~~, 342.035(2), 342.040, 342.340, 342.400, 342.420, or 342.630 shall be fined not less than one hundred dollars (\$100) nor more than one thousand dollars (\$1,000) for each offense. With respect to employers who fail to maintain workers' compensation insurance coverage on their employees, each employee of the employer and each day of violation shall constitute a separate offense. With respect to KRS 342.040, any employer's insurance carrier or other party responsible for the payment of workers' compensation benefits shall be fined for failure to notify the commissioner of a failure to make payments when due if a report indicating the reason payment of income benefits did not commence within twenty-one (21) days of the date the employer was notified of an alleged work-related injury or disease is not filed with the commissioner within twenty-one (21) days of the date the employer received notice, and if the employee has not returned to work within that period of time. The date of notice indicated in the report filed with the department pursuant to KRS 342.038(1), shall raise a rebuttable presumption of the date on which the employer received notice;

...

(9) The following criminal penalties shall be applicable for violations of particular provisions of this chapter:

(a) Any person who violates KRS 342.020(13) ~~(9)~~, 342.035(2), 342.040, 342.400, 342.420, or 342.630, shall, for each offense, be fined not less than one hundred dollars (\$100) nor more than one thousand dollars (\$1,000), or imprisoned for not less than thirty (30) days nor more than one hundred eighty (180) days, or both;

...

HB 296 also includes the following clauses:

(1) Sections 1, 3, and 7 of this Act shall apply to any claim arising from an injury or occupational disease or last exposure to the hazards of an occupational disease or cumulative trauma occurring on or after the effective date of this Act.

(2) Sections 2, 4, 5, and subsection (7) of Section 8 of this Act are remedial and shall apply to all claims irrespective of the date of injury or last exposure.

Missouri

SB 113 amends *sections 287.120, 287.170, 287.243, and 287.780* of the Missouri Annotated Statutes, in part, as follows:

287.120. Liability of employer set out—compensation increased or reduced, when—use of alcohol or controlled substances or voluntary recreational activities, injury from—effect on compensation—mental injuries, requirements, firefighter stress not affected.

1. Every employer subject to the provisions of this chapter shall be liable, irrespective of negligence, to furnish compensation under the provisions of this chapter for personal injury or death of the employee by accident or occupational disease arising out of and in the course of the employee's employment. Any employee of such employer shall not be liable for any injury or death for which compensation is recoverable under this chapter and every employer and employees of such employer shall be released from all other liability whatsoever, whether to the employee or any other person, except that an employee shall not be released from liability for injury or death if the employee engaged in an affirmative negligent act that purposefully and dangerously caused or increased the risk of injury. The term "accident" as used in this section shall include, but not be limited to, injury or death of the employee caused by the unprovoked violence or assault against the employee by any person.

2. The rights and remedies herein granted to an employee shall exclude all other rights and remedies of the employee, ~~his wife, her husband and the employee's spouse,~~ parents, personal representatives, dependents, heirs or next kin, at common law or otherwise, on account of such injury or death by accident or occupational disease, except such rights and remedies as are not provided for by this chapter.

...

6. ...

(4) Any positive test result for a nonprescribed controlled drug from an employee, if confirmed by mass-spectrometry, using generally accepted medical or forensic testing procedures, shall give rise to a rebuttable presumption that the tested nonprescribed controlled drug was in the employee's system and, if the test was administered within twenty-four hours of the injury, such positive result shall give rise to a rebuttable presumption that the injury was sustained in conjunction with the use of the tested nonprescribed controlled drug. A preponderance of the evidence standard shall apply to rebut such presumption.

7. Where the employee's participation in a recreational activity or program is the prevailing cause of the injury, benefits or compensation otherwise payable under this chapter for death or disability shall be forfeited regardless that the employer may have promoted, sponsored or supported the recreational activity or program, expressly or impliedly, in whole or in part. The forfeiture of benefits or compensation shall not apply when:

- (1) The employee was directly ordered by the employer to participate in such recreational activity or program;
- (2) The employee was paid wages or travel expenses while participating in such recreational activity or program; or
- (3) The injury from such recreational activity or program occurs on the employer's premises due to an unsafe condition and the employer had actual knowledge of the employee's participation in the recreational activity or program and of the unsafe condition of the premises and failed to either curtail the recreational activity or program or cure the unsafe condition.

8. Mental injury resulting from work-related stress does not arise out of and in the course of the employment, unless it is demonstrated that the stress is work related and was extraordinary and unusual. The amount of work stress shall be measured by objective standards and actual events.

9. A mental injury is not considered to arise out of and in the course of the employment if it resulted from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination or any similar action taken in good faith by the employer.

10. The ability of a firefighter to receive benefits for psychological stress under section 287.067 shall not be diminished by the provisions of subsections 8 and 9 of this section.

11. The provisions of subsections 1 and 2 of this section shall apply to any case or causes of action pending on or brought on or after January 1, 2014, regardless of the date of injury or exposure.

287.170. Temporary total disability, amount to be paid—method of payment—disqualification, when—post injury misconduct defined.

1. For temporary total disability the employer shall pay compensation for not more than four hundred weeks during the continuance of such disability at the weekly rate of compensation in effect under this section on the date of the injury for which compensation is being made. The amount of such compensation shall be computed as follows:

- (1) For all injuries occurring on or after September 28, 1983, but before September 28, 1986, the weekly compensation shall be an amount equal to sixty-six and two-thirds percent of the injured employee's average weekly earnings as of the date of the injury; provided that the weekly compensation paid under this subdivision shall not exceed an amount equal to seventy percent of the state average weekly wage, as such wage is determined by the division of employment security, as of the July first immediately preceding the date of injury;

(2) For all injuries occurring on or after September 28, 1986, but before August 28, 1990, the weekly compensation shall be an amount equal to sixty-six and two-thirds percent of the injured employee's average weekly earnings as of the date of the injury; provided that the weekly compensation paid under this subdivision shall not exceed an amount equal to seventy-five percent of the state average weekly wage, as such wage is determined by the division of employment security, as of the July first immediately preceding the date of injury;

(3) For all injuries occurring on or after August 28, 1990, but before August 28, 1991, the weekly compensation shall be an amount equal to sixty-six and two-thirds percent of the injured employee's average weekly earnings as of the date of the injury; provided that the weekly compensation paid under this subdivision shall not exceed an amount equal to one hundred percent of the state average weekly wage;

(4) For all injuries occurring on or after August 28, 1991, the weekly compensation shall be an amount equal to sixty-six and two-thirds percent of the injured employee's average weekly earnings as of the date of the injury; provided that the weekly compensation paid under this subdivision shall not exceed an amount equal to one hundred five percent of the state average weekly wage;

(5) For all injuries occurring on or after September 28, 1981, the weekly compensation shall in no event be less than forty dollars per week.

2. Temporary total disability payments shall be made to the claimant by check or other negotiable instruments approved by the director which will not result in delay in payment and shall be forwarded directly to the claimant without intervention, or, when requested, to claimant's attorney if represented, except as provided in section 454.517, by any other party except by order of the division of workers' compensation.

3. An employee is disqualified from receiving temporary total disability during any period of time in which the claimant applies and receives unemployment compensation.

4. If the employee is terminated from post-injury employment based upon the employee's post-injury misconduct, neither temporary total disability nor temporary partial disability benefits under this section or section 287.180 are payable. As used in this section, the phrase "post-injury misconduct" shall not include absence from the workplace due to an injury unless the employee is capable of working with restrictions, as certified by a physician.

5. If an employee voluntarily separates from employment with an employer at a time when the employer had work available for the employee that was in compliance with any medical restriction imposed upon the employee within a reasonable degree of medical certainty as a result of the injury that is the subject of a claim for benefits under this chapter, neither temporary total disability nor temporary partial disability benefits available under this section or section 287.180 shall be payable.

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

1. This section shall be known and may be cited as the "Line of Duty Compensation Act".

2. As used in this section, unless otherwise provided, the following words shall mean:

...

(3) "Child", any natural, illegitimate, adopted, or posthumous child or stepchild of a deceased law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter who, at the time of the law enforcement officer's, emergency medical technician's, air ambulance pilot's, air ambulance registered professional nurse's, or firefighter's fatality is:

(a) Eighteen years of age or under;

(b) Over eighteen years of age and a student as defined in section 8101 of title 5, United States Code; or

(c) Over eighteen years of age and incapable of self-support because of physical or mental disability;

...

3. (1) A claim for compensation under this section shall be filed ~~by the estate of~~ by survivors of the deceased with the division of workers' compensation not later than one year from the date of death of a law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter. If a claim is made within one year of the date of death of a law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter killed in the line of duty, compensation shall be paid, if the division finds that the claimant is entitled to compensation under this section.

...

4. Any compensation awarded under the provisions of this section shall be distributed as follows:

(1) If there is no child who survived the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter, to the surviving spouse of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter;

(2) If there is at least one child who survived the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter, and a surviving spouse of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter, fifty percent to the surviving child, or children, in equal shares, and fifty percent to the surviving spouse;

- (3) If there is no surviving spouse of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter, to the surviving child, or children, in equal shares;
- (4) If there is no surviving spouse of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter and no surviving child:
- (a) To the surviving individual, or individuals, in shares per the designation or, otherwise, in equal shares, designated by the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter to receive benefits under this subsection in the most recently executed designation of beneficiary of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter on file at the time of death with the public safety agency, organization, or unit; or
- (b) If there is no individual qualifying under paragraph (a), to the surviving individual, or individuals, in equal shares, designated by the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter to receive benefits under the most recently executed life insurance policy of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter on file at the time of death with the public safety agency, organization, or unit;
- (5) If there is no individual qualifying under subdivisions (1), (2), (3), or (4) of this subsection, to the surviving parent, or parents, in equal shares, of the law enforcement officer, emergency medical technician, air ambulance pilot, air ambulance registered professional nurse, or firefighter; or
- (6) If there is no individual qualifying under subdivisions (1), (2), (3), (4), or (5) of this subsection, to the surviving individual, or individuals, in equal shares, who would otherwise qualify under the definition of the term "child" but for his or her age.
-

287.780. Discrimination because of exercising compensation rights prohibited—civil action for damages.

No employer or agent shall discharge or in any way discriminate against any employee for exercising any of his or her rights under this chapter when the exercising of such rights is the motivating factor in the discharge or discrimination. Any employee who has been discharged or discriminated against in such manner shall have a civil action for damages against his or her employer. For purposes of this section, "motivating factor" shall mean that the employee's exercise of his or her rights under this chapter actually played a role in the discharge or discrimination and had a determinative influence on the discharge or discrimination.

Montana

HB 137, in part, repeals *sections 33-1-115. Operation of state fund as authorized insurer—issuance of certificate of authority—exceptions—use of calendar year—risk-based capital—reporting requirements, 39-71-2316. Powers of state fund, and 39-71-2375. Operation of state fund as authorized insurer—issuance of certificate of authority—exceptions—use of calendar year—risk-based capital—reporting requirements* of the Montana Code Annotated 2015 as follows:

~~33-1-115. Operation of state fund as authorized insurer—issuance of certificate of authority—exceptions—use of calendar year—risk-based capital—reporting requirements.~~

- (1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and the provisions of Title 39, chapter 71, part 23.
- (2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.
- (b) The state fund shall pay the annual fee under 33-2-708, provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.
- (c) The state fund is subject to the reporting requirements under 33-2-705 but is not subject to the tax on net premiums.
- (3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:
- (i) formation requirements of an insurer under Title 33, chapter 3;
 - (ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;
 - (iii) liquidation or dissolution under Title 33;
 - (iv) participation in the guaranty association provided for in Title 33, chapter 10;
 - (v) 33-12-104; or
 - (vi) any assessment of punitive or exemplary damages.
- (b) The state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).
- (4) The state fund shall complete financial reporting and accounting on a calendar year basis.
- (5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature. If the legislature is not in session, the

report must go to the economic affairs interim committee and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312."

Section 8. Section 33-1-501, MCA, is amended to read:

"33-1-501. Filing of forms—approval—review of disapproval or withdrawal of approval—application. (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form and, for the purposes of disability insurance, an outline of coverage as required by 33-22-244 and 33-22-521 have been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer or the interstate insurance product regulation commission provided for in 33-39-101. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, other than ocean marine and foreign trade coverages, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

(b) A filing required by subsection (1)(a) must be submitted by an officer of the insurer with a certification in a form prescribed by the commissioner. The certification must state that to the best of the officer's knowledge and belief, the policy, contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate complies with the applicable provisions of Title 33.

(c) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

(2) (a) The filing must be made not less than 60 days before delivery and must be delivered by hand or sent by certified mail with a return receipt requested. The commissioner's office shall mark a filing with the date of receipt by the commissioner's office.

(b) (i) If after 60 days from the date of receipt by the commissioner's office the commissioner has not approved or disapproved the form by a notice pursuant to the provisions in subsection (4), the form is considered approved for all purposes, subject to subsection (2)(c).

(ii) The running of the 60-day period is tolled for a period commencing on the date that the commissioner notifies the insurer of problems or questions and requests additional information from the insurer concerning a form filed pursuant to subsection (1)(a) and ending on the date that the insurer submits its response to the commissioner.

(iii) For purposes of tolling the 60-day period as provided in subsection (2)(b)(ii), the commissioner's request notification may be made electronically.

(c) In a letter separate from the original filing and delivered by hand or sent by certified mail with return receipt requested, the insurer shall notify the commissioner, at least 10 days before the use of the form in the market, that the insurer believes that:

(i) the form has been or will be considered approved; and

(ii) the insurer will begin marketing the form in Montana.

(d) The commissioner's office shall mark a letter received pursuant to subsection (2)(c) with the date of receipt by the commissioner's office.

(3) Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the waiting period.

(4) The commissioner may at any time, after notice and for cause shown, withdraw any approval. Notice by the commissioner disapproving a form or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer of the specific reason or reasons for and the legal authority supporting the disapproval or withdrawal of approval in whole or in part. The disapproval or withdrawal of approval does not take effect unless it is issued after the commissioner has reviewed the form and provided notice to the person who filed the form pursuant to 33-1-314 and this subsection.

- (5) After the date of the insurer's receipt of notice of disapproval or withdrawal of approval by the commissioner, the insurer may not deliver the form or issue the form for delivery in Montana.
- (6) The insurer may request a hearing, as provided for in 33-1-701, for unresolved disputes regarding a disapproval or a withdrawal of approval.
- (7) The commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form to which, in the commissioner's opinion, this section may not practically be applied or the filing and approval of which are not desirable or necessary for the protection of the public.
- (8) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by the official and upon the commissioner's order requiring the form to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply to forms for domestic use.
- (9) Section 33-1-502 and this section do not apply to:
- (a) reinsurance;
 - (b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection (8);
 - (c) ocean marine and foreign trade insurances.
- (10) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner upon request. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law.
- ...

Section 49. Section 39-71-2316, MCA, is amended to read:

39-71-2316. Powers of state fund.

- (1) For the purposes of carrying out its functions, the state fund may:
- (a) insure any employer for workers' compensation and occupational disease liability as the coverage is required by the laws of this state and, as part of the coverage, provide related employers' liability insurance upon approval of the board;
 - (b) sue and be sued;
 - (c) enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;
 - (d) collect and disburse money received;
 - (e) except as provided in subsection (1)(f), use the uniform classification system as required in 33-16-1023 and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting;
 - (f) continue the use of special classification codes that were in use prior to January 1, 2016, for agriculture, municipalities, towns, cities, counties, and state agencies. The board shall file with the commissioner rates and supplementary rate information for these special classifications.
 - (g) use the uniform experience rating plan provided for in 33-16-1023, except upon approval of the board may adopt experience modification thresholds for use by the state fund for its insured employers;
 - (h) pay the amounts determined to be due under a policy of insurance issued by the state fund;
 - (i) hire personnel;
 - (j) declare dividends if there is an excess of assets over liabilities. However, dividends may not be paid until adequate actuarially determined reserves are set aside.
 - (k) adopt and implement one or more alternative personal leave plans pursuant to 39-71-2328;
 - (l) upon approval of the board, contract with licensed resident insurance producers;
 - (m) upon approval of the board, enter into agreements with licensed workers' compensation insurers, insurance associations, or insurance producers to provide workers' compensation coverage in other states to Montana domiciled employers insured with the state fund;
 - (n) upon approval of the board, expend funds for scholarship, educational, or charitable purposes;
 - (o) upon approval of the board, including terms and conditions, provide employers coverage under the federal Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901, et seq., the federal Merchant Marine Act, 1920 (Jones Act), 46 U.S.C. 688, and the federal Employers' Liability Act, 45 U.S.C. 51, et seq.;
 - (p) perform all functions and exercise all powers of a private insurance carrier that are necessary, appropriate, or convenient for the administration of the state fund.
- (2) The state fund shall include a provision in every policy of insurance issued pursuant to this part that incorporates the restriction on the use and transfer of money collected by the state fund as provided for in 39-71-2320.
- ...

Section 50. Section 39-71-2375, MCA, is amended to read:

39-71-2375. Operation of state fund as authorized insurer—issuance of certificate of authority—exceptions—use of calendar year—risk-based capital—reporting requirements.

(1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and the provisions of Title 39, chapter 71, part 23.

(2)(a) The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.

(b) The state fund shall pay the annual fee under 33-2-708, provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.

(c) The state fund is subject to the reporting requirements under 33-2-705 but is not subject to the tax on net premiums.

(3)(a) The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:

(i) formation requirements of an insurer under Title 33, chapter 3;

(ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

(iii) liquidation or dissolution under Title 33;

(iv) participation in the guaranty association provided for in Title 33, chapter 10;

(v) 33-12-104; or

(vi) any assessment of punitive or exemplary damages.

(b) The state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).

(4) The state fund shall complete financial reporting and accounting on a calendar year basis.

(5)(a) If the state fund's risk-based capital falls below the company action level RBC as defined in 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature. If the legislature is not in session, the report must go to the economic affairs interim committee and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312.

HB 346 amends *section 39-71-117. Employer defined* of the Montana Code Annotated 2015, in part, as follows:

Section 39-71-117. Employer defined

(1) "Employer" means:

...

(e) an approved and authorized fiduciary, agent, or other person acting as fiscal agent under section 3504 of the Internal Revenue Code, 26 U.S.C. 3504, and 26 CFR 31.3504-1.

...

(6) (A) A fiscal agent that qualifies under subsection (1)(e) and that is designated as a payor, using federal, state, or local government funds, under 26 cfr 31.3504-1 is considered to be the employer for the purposes of the workers' compensation act of those workers for whom the fiscal agent is making payments.

(B) The client of the fiscal agent, despite exercising control over the hiring, scheduling, and direction of the work tasks performed by the worker, is not the employer of that worker for the purposes of the workers' compensation act.

SB 184 amends *section 39-71-609. Denial of claim after payments made or termination of all benefits or reduction to partial benefits by insurer—14-day notice required—termination of payments based on fraud, mistake, or additional information—criteria for conversion of benefits* of the Montana Code Annotated 2015 as follows:

Section 39-71-609. Denial of claim after payments made or termination of all benefits or reduction to partial benefits by insurer—14-day notice required—termination of payments based on fraud, mistake, or additional information—criteria for conversion of benefits.

(1) Except as provided in ~~subsection~~ subsections (2) and (3), if an insurer determines to deny a claim on which payments have been made under 39-71-608 during a time of further investigation or, after a claim has been accepted, terminates all biweekly compensation benefits, it may do so only after 14 days' written notice to the claimant, the claimant's authorized representative, if

any, and the department. For injuries occurring prior to July 1, 1987, an insurer shall give 14 days' written notice to the claimant before reducing benefits from total to partial. However, if an insurer has knowledge that a claimant has returned to work, compensation benefits may be terminated as of the time the claimant returned to work.

(2) After accepting a claim, an insurer may reverse its decision to accept the initial claim under 39-71-601 and terminate payment of compensation benefits if:

(a) the claim was accepted because of fraud or mutual mistake of a material fact; or

(b) the insurer receives clear and convincing evidence that the insurer was not liable for the compensation benefits.

~~(2)~~ (3) Temporary total disability benefits may be terminated on the date that the worker has been released to return to work in some capacity. Unless the claimant is found, at maximum healing, to be without a permanent physical impairment from the injury, the insurer, prior to converting temporary total disability benefits or temporary partial disability benefits to permanent partial disability benefits:

(a) must have a physician's determination that the claimant has reached medical stability;

(b) must have a physician's determination of the claimant's physical restrictions resulting from the industrial injury;

(c) must have a physician's determination, based on the physician's knowledge of the claimant's job analysis prepared by a rehabilitation provider, that the claimant can return to work, with or without restrictions, on the job on which the claimant was injured or on another job for which the claimant is suited by age, education, work experience, and physical condition;

(d) shall give notice to the claimant of the insurer's receipt of the report of the physician's determinations required pursuant to subsections ~~(2)(a)~~ (3)(a) through ~~(2)(c)~~ (3)(c). The notice must be attached to a copy of the report.

SB 275 amends section **39-71-2211. Premium rates for construction industry—filing required** of the Montana Code Annotated 2015 as follows:

39-71-2211. Premium rates for construction industry—filing required.

(1) With respect to each classification of risk in the construction industry under plan No. 2, the advisory organization designated under 33-16-1023 shall file with the commissioner of insurance a method of computing premiums that does not impose a higher insurance premium solely because of an employer's higher rate of wages paid.

(2) The commissioner shall accept a filing under subsection (1) that includes a reasonable method of recognizing differences in rates of pay. This method must use a credit scale with the starting point set at 1.168 times the state's average weekly wage as reported by the department.

(3) The advisory organization shall file a revenue neutral plan for new and renewed policies for prompt and orderly transition to a method of computing premiums that is in compliance with the requirements of this section.

(4) The state compensation insurance fund, plan No. 3, shall ~~adopt~~ use the plan filed by the designated advisory organization or ~~adopt~~ use a credit scale plan that meets the requirements of this section.

(5) For the purposes of this section, "construction industry" means the construction group of code classifications filed with and approved by the commissioner to be used by the advisory organization to comply with this section.

SB 275 also includes the following clause:

Applicability. [This act] applies to policies issued or renewed on or after July 1, 2017.

SB 298 amends sections **39-71-117. Employer defined** and **39-71-118. Employee, worker, volunteer, volunteer firefighter, and volunteer emergency medical technician defined** of the Montana Code Annotated 2015 as follows:

39-71-117. Employer defined

(1) "Employer" means:

...

(d) subject to subsection (5), a religious corporation, religious organization, or religious trust receiving remuneration from nonmembers for:

...

(5) (a) The definition of "employer" in subsection (1)(d) is limited to implementing the administrative purposes of this chapter and may not be interpreted or construed to create an employment relationship in any other context.

(b) Subsection (1)(d) does not apply to a religious corporation, religious organization, or religious trust and its members that are adherents of established tenets or teachings by reason of which members are conscientiously opposed to accepting the benefits of any public or private insurance that makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or provides services for, medical bills, including the benefits of any insurance system established by the Social Security Act, and has the practice established for 10 or more years. To qualify for the exemption from the definition of "employer" under this subsection (5)(b), a religious corporation, religious organization, or religious trust must exclusively use the services of individuals meeting exemption from the definition of employee as provided in 39-71-118(2)(e).

39-71-118. Employee, worker, volunteer, volunteer firefighter, and volunteer emergency medical technician defined.

(1) As used in this chapter, the term "employee" or "worker" means:

...

(2) The terms defined in subsection (1) do not include a person who is:

...

(e) an individual who is a member of a religious sect or division that is an adherent of established tenets or teachings by reason of which members are conscientiously opposed to accepting the benefits of any public or private insurance that makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or provides services for, medical bills, including the benefits of any insurance system established by the Social Security Act, and has the practice established for 10 or more years. An individual and employer of a qualifying individual under this subsection (2)(e) shall retain a copy of the individual's internal revenue service form 4029 that has been approved by the federal social security administration. To qualify for the exemption from the definition of "employee" under this subsection (2)(e), the individual must exclusively perform services on behalf of the individual or a religious corporation, religious organization, or religious trust meeting the exemption from the definition of employer as provided in 39-71-117(5)(b).

...

SB 312, in part, amends **section 39-71-704. Payment of medical, hospital, and related services—fee schedules and hospital rates—fee limitation** of the Montana Code Annotated 2015 as follows:

39-71-704. Payment of medical, hospital, and related services—fee schedules and hospital rates—fee limitation.

...

(3) (a) The department shall establish by rule evidence-based utilization and treatment guidelines for primary and secondary medical services. There is a rebuttable presumption that the adopted utilization and treatment guidelines establish compensable medical treatment for an injured worker.

(b) (i) The department may adopt a drug formulary as part of its utilization and treatment guidelines. To implement this section, the department may annually adopt by rule an evidence-based commercial or other evidence-based drug formulary as part of its utilization and treatment guidelines.

(ii) If the department adopts a commercial drug formulary, the formulary automatically includes all of the changes and updates furnished by the commercial vendor that are made during the year. This process is independent of the provisions of 2-4-307.

(iii) If the department adopts a drug formulary, the department shall, by rule, provide for:

(A) an appropriate transition of treatment, if the treatment began prior to the adoption of a drug formulary, to treatment that is consistent with the application of the formulary; and

(B) a timely and responsive dispute resolution process for disputes related to use of the formulary.

~~(b) (c)~~ (c) An insurer is not responsible for treatment or services that do not fall within the utilization and treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer. If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for payment of the medical treatment or services.

~~(c) The department shall hire a medical director. The department may establish by rule an independent medical review process for treatment or services denied by an insurer pursuant to this subsection (3) prior to mediation under 39-71-2401.~~

(d) The department, in consultation with health care providers with relevant experience and education, shall provide for an annual review of the evidence-based utilization and treatment guidelines to consider amendments or changes to the guidelines.

(4) The department shall hire a medical director. The department may establish by rule an independent medical review process for treatment or services denied by an insurer pursuant to subsection (3) prior to mediation under 39-71-2401.

...

NCCI is analyzing this measure for impact on workers compensation system costs.

New Hampshire

SB 24 amends **section 400-A:37 Examinations** of the New Hampshire Statutes of follows:

400-A:37 Examinations.

...

(e) In order to assist in the performance of the commissioner's duties, the commissioner:

...

(4) May disclose the content of an examination report, preliminary examination report or results, or any matter relating thereto relative to workers' compensation audits, to the department of labor, and all such information disclosed and in the possession or control of the department of labor shall be confidential by law and privileged, shall not be subject to disclosure under RSA 91-A, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner of the department of labor shall agree in writing to hold such information confidential and in a manner consistent with this subparagraph.

...

FEDERAL ISSUES

Issue	Update
Congress	With most of the organizational issues related to a new congressional session and Administration settled, the attention of Congress will turn to many of the public policy issues on its agenda. It will likely take up discussion of several issues in the near term that could have a direct or indirect impact on workers compensation, including changes to the Affordable Care Act.
Medicare Set-Aside Reform	<p>Legislation is expected to be introduced in Congress that would bring about long sought-after reforms to the Medicare Set-Aside (MSA) process. Key provisions of the MSA reform legislation will include:</p> <ul style="list-style-type: none"> • Permitting injured workers who receive settlements to remit MSAs directly to the Centers for Medicare & Medicaid Services (CMS) rather than self-administer • Creating both a time frame (60 days) for the CMS to make MSA determinations and an appeal process • Requiring the CMS to apply workers compensation laws in determining future medical amounts to be included in MSAs • Setting a statutory threshold in cases of total settlements of \$25,000 or less • Exempting future medical amounts in lower dollar cases

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

STATE LEGISLATIVE ACTIVITY

State	Update
Alaska	<p>SB 14 exempts those working for transportation network companies (such as Uber and Lyft) from workers compensation coverage. The bill would treat transportation network company drivers the same as taxi drivers and would allow ride-hailing service to return to Alaska.</p> <p>SB 40 closes the Alaska Second Injury Fund (SIF) to all claims not accepted by July 1, 2018, shifting the full financial liability for workers compensation benefits to the employer/insurer for the entire life cycle of affected claims. It does so by providing reimbursements from the SIF for claims accepted before July 1, 2018. <i>NCCI estimates that, if enacted, SB 40 may result in a minimal impact on Alaska workers compensation system costs.</i></p>
Arkansas	HB 1586 caps workers compensation death and permanent total disability claims at 450 weeks. The bill also clarifies that employees exposed to rabies are entitled to treatment under workers compensation without presentation of symptoms. The measure initially failed in the House, but with the vote on that measure expunged, the bill can be considered again.
Connecticut	<p>HB 7132 ensures that an employer is expeditiously made aware of any workers compensation claim made by an employee.</p> <p>SB 763 provides workers compensation coverage to police officers, firefighters, and emergency medical technicians suffering from post-traumatic stress disorder as a direct result of witnessing the death of a human being or the immediate aftermath of such death.</p> <p>SB 802 requires the state to procure and administer workers compensation coverage for personal care attendants employed directly by consumers in the Community First Choice program.</p> <p>SB 882 allows individuals seeking compensation for a workers compensation claim to bring an action against an employer, insurer, or third party administrator that has unreasonably contested liability or delayed payments or adjustments of such compensation.</p>
Florida	<p>There are two measures dealing with mental injury, with respect to first responders, before the legislature this year.</p> <ul style="list-style-type: none"> • SB 516 provides that mental or nervous injuries of law enforcement officers, firefighters, emergency medical technicians, or paramedics are compensable under the workers compensation law under specified conditions. <i>NCCI estimates that, if enacted, this measure may result in an indeterminate increase in workers compensation system costs.</i> • SB 1008 provides an exemption from public records requirements for the personal identifying information of an injured or deceased employee which is contained in certain notices or reports filed with the Division of Workers' Compensation of the Department of Financial Services.

	<ul style="list-style-type: none"> • SB 1088 revises the standard by which a mental or nervous injury involving a first responder must be demonstrated for purposes of determining eligibility for benefits for employment-related accidents and injuries, removing the limitation that only medical benefits are payable for a mental or nervous injury unaccompanied by a physical injury.
Hawaii	<p>HB 913/SB 383 propose a new section of statute relating to benefits for firefighters who develop cancer, moving coverage for such benefits out of the workers compensation system.</p> <p>HB 808 and SB 413, calling for a medical fee schedule for workers compensation that would be based on the US Department of Labor Office of Workers' Compensation Program, have both been deferred.</p>
Idaho	SB 1058 provides for coverage for the cost of telehealth services.
Illinois	<p>HB 2622 establishes the Illinois Employers Mutual Insurance Company.</p> <p>The proposed amendment to SB 12 continues to be held in the Assignments Committee. <i>NCCI analysis indicates that, if enacted, a first-year impact of -1.9% on overall workers compensation system costs may be realized.</i></p> <p>SB 862/HB 2525 were introduced in the last days of the previous session and reintroduced in the current session. The measures propose to:</p> <ul style="list-style-type: none"> • Provide that a rate is excessive if it is likely to produce a long-run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high • Require prior approval of workers compensation insurance rates • Address compensability for traveling employees, safety and return-to-work programs, and awards for injuries to the shoulder, hip, or repetitive/cumulative injuries, as well as various other provisions • Establish the Workers' Compensation Premium Rates Task Force <p>SB 1454 establishes hours worked as the premium basis for employers correctly classified within the construction industry.</p>
Kansas	HB 2342 would allow an employee to choose a health care provider for medical benefits.
Maine	<p>LD 67 creates a rebuttable presumption that a personal injury to a paid or volunteer firefighter or a paid or volunteer emergency medical services person considered an employee is considered to arise out of and in the course of employment. Such injury is compensable under the workers compensation act if the personal injury occurs at any time after the firefighter or emergency medical services person receives notice of a fire or emergency and is in the process of responding.</p> <p>LD 489 establishes that if a firefighter meeting certain requirements contracts cancer, the cancer was contracted in the course of that employment. The presumption is conclusive, rather than rebuttable.</p> <p>LD 592 eliminates the requirement that the Maine Employers' Mutual Insurance Company (MEMIC) maintain a high-risk program.</p> <p>LD 609 prohibits an insurer from imposing a fee schedule, reducing reimbursement, or imposing limits on the type or frequency of health care services covered under any automobile insurance liability policy or workers compensation policy without the expressed written consent of the health care provider.</p> <p>LD 612 provides that if an employee is actively participating in a rehabilitation plan, there is a conclusive presumption that work is unavailable to the employee.</p> <p>LD 614 amends workers compensation laws by adding a presumption that heart disease or hypertension suffered by a corrections officer was caused in the course of employment.</p>
Maryland	<p>Three measures dealing with survival of claim issues are currently under consideration. Under current workers compensation law, if an injured worker receiving permanent total disability (PTD) benefits dies from a cause that is unrelated to the compensable accidental injury, the right to compensation survives to the dependents of the injured worker. The extent of compensation that survives is limited to the amount by which the weekly compensation benefits paid to the injured worker at the time of death is less than \$45,000.</p> <p>Introduced in response to the July 2016 Court of Appeals decision in <i>Hollingsworth, et al. v. Severstal Sparrows Point, LLC</i>, et al, SB 51 amends the existing statute such that it would only apply to benefits for PTD "... due</p>

	<p>solely to an accidental personal injury.” In addition, the bill would create a separate section that stipulates the survival of benefits for PTD “... due in part to an accidental personal injury or resulting from an occupational disease.” In <i>Hollingsworth</i>, the injured worker suffered a compensable accidental injury which, in combination with a preexisting condition, rendered Hollingsworth permanently and totally disabled. The employer was directed to pay the weekly benefits up to \$345,534.00; however, Hollingsworth subsequently died from a cause not related to the PTD after the employer had paid \$52,166.54 in weekly compensation benefits. The court affirmed that the surviving dependents were not entitled to benefits since the wage loss benefits already paid by the employer exceeded \$45,000.</p> <p><i>NCCI completed its analysis and determined that the impact of this measure would be a minimal increase in overall workers compensation system costs in the state.</i></p> <p>SB 425 would amend the existing statute so that compensation to surviving dependents would be limited to the lesser of the amount of PPD benefits that were unpaid at the time of the injured worker’s death and \$65,000. This measure is proposed to apply to claims arising from accidents occurring on or after October 1, 2017. <i>NCCI’s analysis of the bill estimated that the impact of this measure may result in a minimal decrease in overall workers compensation system costs in the state.</i></p> <p>SB 426 amends the existing statute so that the maximum compensation to surviving dependents or spouse would be increased from \$45,000 to \$65,000, less the benefit amount already paid to the injured worker. This measure is proposed to apply to claims arising from accidents occurring on or after October 1, 2017. <i>NCCI completed an analysis of the bill and determined that the impact would result in a minimal increase in overall workers compensation system costs in the state.</i></p>
Missouri	SB 415 expands firefighter presumptions under workers compensation to include cancer.
Montana	<p>HB 358 seeks to reverse the Montana Supreme Court decision in <i>Malcomson v. Liberty Northwest</i>.</p> <p>HB 490 exempts coaches and assistant coaches from workers compensation coverage.</p>
Nebraska	<p>LB 181 provides for reimbursement to employees for certain medical examinations under the Workers Compensation Act.</p> <p><i>Any cost impact of these changes, if enacted, would be reflected in the analysis of future claims experience contained in subsequent NCCI loss cost filings.</i></p>
Nevada	AB 83 defines and authorizes large deductible workers compensation policies.
New Mexico	<p>HB 359 waives exclusive remedy for bad-faith claims.</p> <p>SB 371 requires employers to pay for an injured worker’s medical marijuana if four conditions are met:</p> <ol style="list-style-type: none"> 1. The treating physician determines medical cannabis is reasonable and necessary for the worker’s injury 2. The provider is authorized to prescribe or administer controlled substances 3. The treatment provided to the worker by the provider is within the health care provider’s scope of practice 4. The worker has a valid registry identification card issued by the Department of Health <p>Under SB 401, employers would at most pay an amount equal to 4% of wages for workers compensation coverage. Existing law requires premium to be “... equalized and calculated on a basis that does not discriminate against, or penalize employers who, pay higher wages ...” than other similarly situated businesses. The Legislature declared in statute its finding that “calculating workers compensation premium rates strictly on the basis of an employer’s wages paid discriminated against and penalizes higher paying employers.”</p>
Oklahoma	<p>HB 1462 includes various amendments to the state’s workers compensation act, including:</p> <ul style="list-style-type: none"> • Amending the permanent partial disability (PPD) definition • Eliminating the Commission’s authority to hear matters of constitutionality • Terminating benefits with two missed medical appointments • Removing deferral of PPD, yet reinstating conversion of scheduled members • Reducing the days of notice from 30 to 15 • Requiring prescription drug reimbursement in the event of an appeal and • Amending provisions of opt-out <p>HB 1580 requires that telemedicine be treated the same for workers compensation as it is for personal health care services with respect to coverage and reimbursement.</p> <p><i>NCCI has reviewed this measure and finds that there is currently insufficient data available to quantify its potential impact.</i></p>

	<p>HB 1723 makes a number of changes to workers compensation law, including:</p> <ul style="list-style-type: none"> • Eliminating compensability when an injured employee has failed to follow safety rules • Expanding the definition of marriage to include common law and cohabitation • Eliminating permanent partial disability (PPD) if an injury is a nonsurgical soft tissue injury and the employee returns to work • Limiting payout to a surviving spouse to 520 weeks (the previous limitation was upon remarriage) • Capping mediator fee at \$500 <p><i>NCCI is currently conducting legislative pricing analysis of this measure.</i></p> <p>SB 738 (similar to HB 1462) contains several workers compensation amendments, including:</p> <ul style="list-style-type: none"> • Terminating benefits with two missed medical appointments • Specifying temporary partial disability (TPD) rating to explicit 70% • Removing reference to conversion of scheduled members • Amending awards for amputations • Allowing for an increase in the number of injections <p><i>This measure contains numerous provisions that may produce an impact to overall workers compensation system costs in the state; however, the only provision of the bill that can be quantified is the change in benefits for permanent partial disability (PPD) due to partial loss of use to scheduled members. NCCI has estimated that this change could impact workers compensation system costs in the state by -3.3%. This provision was previously enacted in 2014 but was challenged in 2016 before the Oklahoma Supreme Court in Maxwell v. Sprint PCS, where the court ruled against the provisional language. HB 1462 seeks to reverse the system cost impact of that decision.</i></p> <p>SB 777 revokes the Workers' Compensation Commission's authority to hear matters of constitutionality and provides authority for appointment of administrative law judges to an en banc panel, under certain circumstances.</p>
Oregon	<p>HB 2335 permits the Department of Consumer and Business Services to appoint up to three arbiters in certain situations.</p> <p>HB 2337 increases the minimum and maximum permanent total disability weekly benefit to 33% and 133% of the state average weekly wage, respectively. <i>NCCI has analyzed this measure and determined that it will result in a 0.1% increase to state workers compensation system costs.</i></p> <p>HB 2338 makes several revisions to the workers compensation death benefit structure. <i>NCCI has analyzed this measure and determined that it will result in a 0.1% increase to state workers compensation system costs; however, there are two elements of the proposal that cannot be quantified.</i></p> <p>HB 2387 requires implementation of a cost threshold and requires pharmaceutical manufacturers to provide 60 days' advance notice for price increases exceeding 3.4% in a 12-month period.</p> <p>SB 607 excludes sick-leave pay from the definition of "payroll." <i>NCCI has analyzed this measure and determined that, if enacted in its current form, it would result in a decrease in collected premiums on workers compensation policies, prior to any NCCI loss cost filing recommendation for such a change. To offset the expected reduction in premium, NCCI estimates that loss costs would need to increase between +4.1% and +6.3% in order to provide for expected system costs and achieve loss cost adequacy.</i></p>
South Dakota	<p>HB 1093 amends the definition of employer to include that a person providing a personal service to a religious entity, receiving remuneration from nonmembers for manufacturing or a construction project conducted by its members on or off the property of the religious entity, is an employee.</p>
Tennessee	<p>HB 666/SB 297 makes a number of changes to existing workers compensation law, including, but not limited to:</p> <ul style="list-style-type: none"> • Authorizing utilization review only for evaluation of medical care services that meet or exceed a cost threshold of \$1,500 as listed on the comprehensive medical fee schedule • Requiring that an employer provide a list of no fewer than three physicians, surgeons, chiropractors, or specialty practice groups from which the employee may select a provider of medical care • Limiting the liability of the employer for the services provided to the employee to the maximum allowable fees that are established in the applicable medical fee schedule

	<ul style="list-style-type: none"> • Requiring the employer to pay the burial expenses of up to \$10,000 if the employee dies of a work-related illness or injury • Allowing the employee to file a claim for increased benefits if, at the time the period of compensation ends, the employee has not returned to work earning at least 100% of the wages/salary that they were making at the time of injury
Utah	Long-standing Utah case law (<i>Lieber v. ITT Hartford Insurance Center</i>) holds that although the exclusive remedy for an injured worker to receive compensation from their employer is workers compensation, this exclusive remedy does not apply to recovery from a third party, such as the employer's auto insurer, even when the employee is driving in the course of employment. HB 153 makes Uninsured Motorist/Underinsured Motorist coverage mandatory for employers, providing that a person who employs an employee and allows the employee to drive a vehicle insured by the person may not reject underinsured or uninsured motorist coverage.
Vermont	<p>HB 137 directs the Department of Financial Regulation, in consultation with the Department of Labor, to examine why premiums for workers compensation insurance in certain occupations are lower in New Hampshire than in Vermont and to report back to the General Assembly with its findings and recommendations for legislative changes to reduce workers compensation premiums in Vermont.</p> <p>HB 197 provides workers compensation coverage for mental conditions that result from workplace conditions that are a characteristic of, or peculiar to, a particular occupation.</p> <p>HB 223 and HB 323 amend the definitions related to independent contractors in the workers compensation and unemployment insurance laws.</p> <p>HB 374 directs the Department of Financial Regulation to identify industries and occupations whose workers compensation insurance pools are characterized by high risk, high premiums, and few policy holders, and to examine various approaches to reducing the cost of workers compensation for these industries and occupations, including the use of risk pooling, self-insured trusts, voluntary safety practice certifications, and best practices from other states.</p> <p>SB 73 creates an interagency commission to investigate, evaluate, and address the negative impacts on workers compensation rates from employee misclassification in Vermont.</p>

STATE COMMITTEE ACTIVITY

State	Update
Oregon	The Management-Labor Advisory Committee cancelled its February 24 scheduled meeting. The next meeting is scheduled for March 10, and agenda materials should be available in advance.
North Carolina	On February 7, Industrial Commission Chairman Charlton Allen announced the establishment of a task force to study and recommend solutions for the problems arising from the intersection of the opioid epidemic and related issues in workers compensation claims.
Tennessee	The Workers' Compensation Medical Payment Committee will meet on March 14 to review cases and to discuss the medical fee schedule.

OTHER ITEMS OF INTEREST

State	Update
Nebraska	<p>The Workers' Compensation Court has implemented the following amendments effective January 1, 2017:</p> <ul style="list-style-type: none"> • Rule 26, <i>Schedules of Fees for Medical, Surgical, and Hospital Services</i>, adopting a new Schedule of Fees for Medical Services, including CPT codes and relative value units established by Centers for Medicare & Medicaid Services for calendar year 2017. Rule 26 was also amended to establish Medicare Diagnostic Related Groups to be included in the Diagnostic Related Group inpatient hospital fee schedule. • Rule 63, <i>Independent Medical Examiner Selection</i>, was amended to provide that once an independent medical examiner has been assigned, submission of additional questions by either party will not be allowed without prior approval of the court.
Oklahoma	In a February 22 ruling in the case of <i>Brown v. Claims Management Resources, Inc.</i> , the Oklahoma Supreme Court determined that even though the injured worker had clocked out from his workstation and chose to exit the building through a stairwell, the worker was "... complying with his employers' instructions and therefore was still performing employment services at the time of the injury." This has been referred to as the ingress/egress, or coming and going, rule.

State	Update
Oregon	The Workers' Compensation Division has proposed revisions to its rules governing medical services, medical billing, and payment that will increase the conversion factor for anesthesia services and payment for certified interpreters. A hearing was held February 16. <i>NCCI has analyzed the proposed changes and determined that they will result in an increase of 0.1% in workers compensation system costs.</i>

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
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Federal Issues	Tim Tucker	202-403-8526

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