



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 March 3, 2017.

#### Virginia

**HB 1659 Substitute** was:

- Passed by the first chamber on January 30, 2017
- Included in NCCI's February 10, 2017 **Legislative Activity Report** (RLA-2017-05)
- Passed by the second chamber on February 16, 2017
- Included in NCCI's February 24, 2017 **Legislative Activity Report** (RLA-2017-07)
- Enacted on March 3, 2017, with an effective date of July 1, 2017

**HB 1659 Substitute** 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 bills passed the second chamber.

#### Kentucky

**SB 151** was:

- Passed by the first chamber on February 16, 2017
- Passed by the second chamber on March 6, 2017

**SB 151**, in part, amends **section 342.690 Exclusiveness of liability** of the Kentucky Revised Statutes to read:  
**342.690 Exclusiveness of liability.**

...

(4) (a) Notwithstanding any voluntary agreement entered into between the United States Department of Labor and a franchisee, neither a franchisee nor a franchisee's employee shall be deemed to be an employee of the franchisor for any purpose under this chapter.

(b) Notwithstanding any voluntary agreement entered into between the United States Department of Labor and a franchisor, neither a franchisor nor a franchisor's employee shall be deemed to be an employee of the franchisee for any purpose under this chapter.

(c) For purposes of this subsection, "franchisee" and "franchisor" have the same meanings as in 16 C.F.R. sec. 436.1.

**Note: SB 151** was not included in any previous version of NCCI's **Legislative Activity Report**.

## Utah

**SB 120** was:

- Passed by the first chamber on February 17, 2017
- Included in NCCI's February 24, 2017 **Legislative Activity Report** (RLA-2017-07)
- Passed by the second chamber on February 27, 2017

**SB 120** amends section **34A-2-702. Employers' Reinsurance Fund—Injury causing death—Burial expenses—Payments to dependents** of the Utah Code, in part, as follows:

**34A-2-702. Employers' Reinsurance Fund—Injury causing death—Burial expenses—Payments to dependents.**

...

(5) (a) If injury causes death within a period of 312 weeks from the date of the accident, the employer or insurance carrier shall pay:

(i) the burial expenses of the deceased as provided in Section 34A-2-418; and

(ii) benefits in the amount and to a person provided for in this Subsection (5).

(b) (i) If there is a wholly dependent person at the time of the death, the payment by the employer or ~~its~~ the employer's insurance carrier shall be:

(A) subject to Subsections (5)(b)(i)(B) and (C), 66-2/3% of the decedent's average weekly wage at the time of the injury;

(B) not more than a maximum of 85% of the state average weekly wage at the time of the injury per week; and

(C) (I) not less than a minimum of \$45 per week, plus:

(Aa) ~~\$5~~ \$20 for a dependent spouse; and

(Bb) ~~\$5~~ \$20 for each dependent minor child under the age of 18 years, up to a maximum of four such dependent minor children; and

(II) not exceeding:

(Aa) the average weekly wage of the employee at the time of the injury; and

(Bb) 85% of the state average weekly wage at the time of the injury per week.

## BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending March 3, 2017.

## Arkansas

**HB 1586** amends **sections 11-9-501. Limitations on compensation—Death and disability, 11-9-502. Limitations on compensation—Exceptions, and 11-9-508. Medical services and supplies—Liability of employer** of the Arkansas Code as follows:  
**11-9-501. Limitations on compensation—Death and disability.**

...

(b) Compensation payable to an injured employee for disability, other than permanent partial disability as specified in subsection (d) of this section, and compensation payable to surviving dependents of a deceased employee, the total disability rate shall not exceed sixty-six and two-thirds percent (66 2/3%) of the employee's average weekly wage with a twenty dollar (\$20.00) per week minimum, subject to the following maximums:

...

(6) For injuries occurring on or after July 1, 2017, in cases of total disability adjudged to be permanent, sixty-six and two-thirds percent (66 2/3%) of the employee's average weekly wage, subject to the maximum limitations as to weekly benefits as set up in this chapter, shall be paid to the employee not to exceed four hundred fifty (450) weeks.

(e) Compensation payable to the dependents of a deceased employee, with the exception of those dependents described in § 11-9-527(d)(2), shall be in addition to the funeral allowance and those benefits ~~which that~~ were paid or to which the injured employee was entitled in his or her lifetime under §§ 11-9-508–11-9-517 and §§ 11-9-519–11-9-526, and shall not exceed four hundred fifty (450) weeks.

**11-9-502. Limitations on compensation—Exceptions.**

(a) The benefits shall be paid for a period not to exceed four hundred fifty (450) weeks of disability, ~~except that this limitation shall not apply in cases of permanent total disability or death.~~

...  
(b)(3) For injuries occurring on or after July 1, 2017, weekly benefits for permanent total disability or death shall not exceed four hundred fifty (450) weeks, except as provided in § 11-9-501(e).

(4) The trust fund shall consist of such funds as may be prescribed by law and shall be administered, invested, and disbursed by the Workers' Compensation Commission.

~~(4)~~ (5) Each employer or the insurance carrier of the employer in each case of death of an employee where there are no dependents shall pay into the trust fund the sum of five hundred dollars (\$500).

**11-9-508. Medical services and supplies—Liability of employer.**

(a)(1) The employer shall promptly provide for an injured employee such medical, surgical, hospital, chiropractic, optometric, podiatric, and nursing services and medicine, crutches, ambulatory devices, artificial limbs, eyeglasses, contact lenses, hearing aids, and other apparatus as may be reasonably necessary in connection with the injury received by the employee.

(2)(A) Rabies is a highly contagious and potentially deadly infectious disease, and exposure to rabies and the risk of infection under this section is the direct result of an injury caused by the bite of a rabies-infected animal or the exposure to saliva of a rabies-infected animal directly in the employee's eyes, mouth, nose, or open wound.

(B)(i) An employer shall promptly provide reasonably necessary medical treatment to an injured employee who is exposed to rabies as described in subdivision (a)(2)(A) of this section.

(ii) As used in subdivision (a)(2)(B)(i) of this section, "reasonably necessary medical treatment" means without limitation any diagnostic and preventive measures prescribed for detection, diagnosis, and prevention of rabies.

...  
*NCCI estimates that **HB 1586**, if enacted, could result in a small decrease in system costs in Arkansas initially. However, upon closure of the Death and Permanent Total Disability (DPTD) Trust Fund to claims filed on or after July 1, 2019, this proposed change could largely offset the estimated system cost increase to pre-fund indemnity benefits once the DPTD Trust Fund is closed to new claims.*

**Hawaii**

**HB 913 HD 2** adds a new chapter to the Hawaii Revised Statutes to provide expanded, employer-financed medical, disability indemnity, and death benefits to firefighters who develop cancer as a result of exposure to carcinogens in the line of duty. The new language includes, but is not limited to, the following section:

**Chapter**

**Hazardous Duty Related Diseases Treatment Insurance Benefits**

...  
**§ -3 Inapplicability of workers' compensation law.** Chapter 386 shall not apply to firefighters who develop a hazardous duty related disease and receive benefits pursuant to this chapter.

**HB 1181 HD2** amends ***section 386-21.7 Prescription drugs; pharmaceuticals*** of the Hawaii Revised Statutes as follows:

**§ 386-21.7 Prescription drugs; pharmaceuticals.**

(a) Notwithstanding any other provision to the contrary, immediately after a work injury is sustained by an employee and so long as reasonably needed, the employer shall furnish to the employee all prescription drugs as the nature of the injury requires; except that physician-dispensed prescription drugs shall only be provided during the first \_\_\_\_\_ days from the date of injury. The liability for the prescription drugs shall be subject to the deductible under section 386-100.

(b) Payment for all forms of prescription drugs including repackaged and relabeled drugs shall be ~~one hundred forty~~ \_\_\_\_\_ per cent of the average wholesale price set by the original manufacturer of the dispensed prescription drug as identified by its National Drug Code and as published in the Red Book: Pharmacy's Fundamental Reference as of the date of dispensing, except where the employer or carrier, or any entity acting on behalf of the employer or carrier, directly contracts with the provider or the provider's assignee for a lower amount.

(c) Payment for compounded prescription drugs shall be the sum of ~~one hundred forty~~ \_\_\_\_\_ per cent of the average wholesale price by gram weight of each underlying prescription drug contained in the compounded prescription drug. For compounded prescription drugs, the average wholesale price shall be that set by the original manufacturer of the underlying

prescription drug as identified by its National Drug Code and as published in the Red Book: Pharmacy's Fundamental Reference as of the date of compounding, except where the employer or carrier, or any entity acting on behalf of the employer or carrier, directly contracts with the provider or provider's assignee for a lower amount.

(d) All pharmaceutical claims submitted for repackaged, relabeled, or compounded prescription drugs shall include the National Drug Code of the original manufacturer. If the original manufacturer of the underlying drug product used in repackaged, relabeled, or compounded prescription drugs is not provided or is unknown, then reimbursement shall be one hundred forty per cent of the average wholesale price for the original manufacturer's National Drug Code number as listed in the Red Book: Pharmacy's Fundamental Reference of the prescription drug that is most closely related to the underlying drug product.

**SB 984** amends **section 386-1 Definitions** of the Hawaii Revised Statutes as follows:

**§386-1 Definitions.**

..

"Physician" includes a doctor of medicine, a dentist, a chiropractor, an osteopath, a naturopathic physician, a psychologist, an optometrist, an advanced practice registered nurse, and a podiatrist.

...

## Kentucky

**HB 306** amends **section 342.650 Exemptions of particular classes of employees from coverage** of the Kentucky Revised Statutes as follows:

**342.650 Exemptions of particular classes of employees from coverage.**

The following employees are exempt from the coverage of this chapter:

...

(9) Any licensed or unlicensed, commissioned, ordained or unordained, or lay minister of religion who has no set oral or written agreement with a church or religious organization to receive a fixed regular payment for services provided to the church or who works no more than ten (10) hours per week; and

(10) Any caretaker of a cemetery or property owned or operated by a church or religious organization who provides general cleanup services, including but not limited to mowing, raking, dusting, sweeping, and mopping which could be performed for other individuals or organizations, who works no more than ten (10) hours per week.

## Missouri

**HB 289** amends **section 287.037. Member of limited liability company to receive coverage, rejection of coverage, rescission of rejection** of the Missouri Annotated Statutes as follows:

**287.037. Member of limited liability company to receive coverage, rejection of coverage, rescission of rejection.**

1. Notwithstanding any other provision of law to the contrary, beginning January 1, 1997, those insurance companies providing coverage pursuant to chapter 287, to a limited liability company, as defined in section 347.015, shall provide coverage for the employees of the limited liability company who are not members of the limited liability company. Members of the limited liability company, as defined in section 347.015, shall also be provided coverage pursuant to chapter 287, but such members may individually elect to reject such coverage by providing a written notice of such rejection on a form developed by the department of insurance, financial institutions and professional registration to the limited liability company and its insurer. Failure to provide notice to the limited liability company shall not be grounds for any member to claim that the rejection of such coverage is not legally effective. A member who elects to reject such coverage shall not thereafter be entitled to workers' compensation benefits under the policy, even if serving or working in the capacity of an employee of the limited liability company, at least until such time as said member provides the limited liability company and its insurer with a written notice which rescinds the prior rejection of such coverage. The written notice which rescinds the prior rejection of such coverage shall be on a form developed by the department of insurance, financial institutions and professional registration. Any rescission shall be prospective in nature and shall entitle the member only to such benefits which accrue on or after the date the notice of rescission form is received by the insurance company.

2. Notwithstanding any other provision of law to the contrary, beginning January 1, 2018, a shareholder of an S corporation, as defined in subsection 1 of section 143.471, with at least forty percent or greater interest in the S corporation, may individually elect to reject coverage under this chapter by providing a written notice of such rejection to the S corporation and its insurer. Failure to provide notice to the S corporation shall not be grounds for any shareholder to claim that the rejection of such coverage is not legally effective. A shareholder who elects to reject such coverage shall not thereafter be entitled to workers' compensation benefits under the policy, even if serving or working in the capacity of an employee of the S corporation, at least until such time as such shareholder provides the S corporation and its insurer with a written notice that rescinds the prior rejection of such coverage. Any rescission shall be prospective in nature and shall entitle the shareholder only to such benefits that accrue on or after the date the notice of rescission is received by the insurance company.

## Montana

**HB 358** amends sections **39-71-604. Application for compensation—disclosure and communication without prior notice of health care information** and **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—failure to sign medical release or authorization—criteria for conversion of benefits**

of the Montana Code Annotated 2015, in part, as follows:

**39-71-604. Application for compensation—disclosure and communication without prior notice of health care information.**

...

(3) A signed claim for workers' compensation or occupational disease benefits or a signed release authorizes a workers' compensation insurer, as defined in 39-71-116, or the agent of the workers' compensation insurer to communicate with a physician or other health care provider about relevant health care information, as authorized in subsection (2), by telephone, letter, electronic communication, in person, or by other means, about a claim and to receive from the physician or health care provider the information authorized in subsection (2) without prior notice to the injured employee, to the employee's authorized representative or agent, or in the case of death, to the employee's personal representative or any person with a right or claim to compensation for the injury or death. Refusal or failure of the claimant to sign a medical release or authorization that complies with Montana law is subject to 39-71-609(2).

(4) If death results from an injury, the parties entitled to compensation or someone in their behalf shall file a claim with the insurer. The claim must be accompanied with proof of death and proof of relationship, showing the parties entitled to compensation, certificate of the attending physician, if any, and such other proof as may be required by the department.

**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—failure to sign medical release or authorization—criteria for conversion of benefits.**

(1) Except as provided in subsection ~~(2)~~ (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) (a) If a claimant refuses or fails to sign a medical release or authorization that complies with Montana law, an insurer may:

(i) deny liability if liability has not been accepted; or

(ii) terminate payment of all compensation benefits if liability has been accepted.

(b) The insurer is not under a duty to investigate the claimant's claim for compensation benefits after the denial or termination in subsection (2)(a).

(c) If a claimant signs a medical release or authorization that complies with Montana law after refusing or failing as specified in subsection (2)(a), the insurer shall:

(i) adjust the claimant's claim pursuant to Montana law; and

(ii) pay compensation benefits that are appropriate but were denied or terminated because the claimant refused or failed to sign a medical release or authorization.

~~(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.

*NCCI estimates that HB 358, if enacted, would have an uncertain impact on overall workers compensation system costs in Montana. Any cost impact would depend on the behavior of system participants (e.g., workers, insurers, physicians, and adjudicators) regarding how the provisions of HB 358 would be interpreted, applied, and adjudicated.*

**HB 449 amends section 39-71-123. Wages defined** of the Montana Code Annotated 2015 as follows:

**39-71-123. Wages defined.**

(1) "Wages" means ~~all~~ monetary remuneration paid for services performed by an employee for an employer, or income provided for in subsection ~~(1)(d)~~ ~~(1)(e)~~ (1)(D). Wages include only the cash ~~value of or other monetary~~ all remuneration paid ~~in any medium other than cash~~. The term includes but is not limited to:

(a) monetary commissions, bonuses, and remuneration at the regular hourly rate for overtime work, holidays, vacations, and periods of sickness;

(b) backpay or any similar pay made for or in regard to previous service by the employee for the employer, other than retirement or pension benefits from a qualified plan;

~~(c) tips or other gratuities received by the employee, to the extent that tips or gratuities are documented by the employee to the employer for tax purposes;~~

(c) tips or other gratuities received by the employee to the extent that tips or gratuities are documented by the employee to the employer for tax purposes;

~~(d) (e) (d) income or payment in the form of a draw, wage, net profit, or substitute for money received or taken by a sole proprietor or partner, regardless of whether the sole proprietor or partner has performed work or provided services for that remuneration;~~

~~(e) board, lodging, rent, or housing if it constitutes a part of the employee's remuneration and is based on its actual value; and~~

~~(f) (d) (e) payments made to an employee on any basis other than time worked, including but not limited to piecework, an incentive plan, or profit-sharing arrangement.~~

(2) The term "wages" does not include any of the following:

...

(d) special monetary rewards for individual invention or discovery; ~~or~~

(e) monetary ~~and other~~ and other benefits paid to a person as part of public assistance, as defined in 53-4-201; or

~~(f) tips or other gratuities received by the employee.~~

(f) board, lodging, rent, housing, or other nonmonetary remuneration received by an employee.

...

(4) (a) For the purpose of calculating compensation benefits for an employee working concurrent employments, the average actual wages must be calculated as provided in subsection (3). As used in this subsection, "concurrent employment" means employment in which the employee was actually employed at the time of the injury and would have continued to be employed without a break in the term of employment if not for the injury.

(b) Except as provided in 39-71-118(10)(c), the compensation benefits for a covered volunteer must be based on the average actual monetary wages in the volunteer's regular employment, except self-employment as a sole proprietor or partner who elected not to be covered, from which the volunteer is disabled by the injury incurred.

(c) The compensation benefits for an employee working at two or more concurrent remunerated employments must be based on the aggregate of average actual monetary wages of all employments, except for the wages earned by individuals while engaged in the employments outlined in 39-71-401(3)(a) who elected not to be covered, from which the employee is disabled by the injury incurred.

## New Mexico

**SB 155 Committee Substitute** amends **sections 52-1-25.1. Temporary total disability; return to work** and **52-1-26. Permanent Partial Disability** of the New Mexico Statutes Annotated as follows:

### **52-1-25.1. Temporary total disability; return to work.**

...

B. If, prior to the date of maximum medical improvement, an injured worker's health care provider releases the worker to return to work ~~the worker is not entitled to temporary total disability benefits if:~~

~~(1) the employer offers work at the worker's pre-injury wage; or~~

~~(2) the worker accepts employment with another employer at the worker's pre-injury wage and the employer does not make a reasonable work offer at the worker's pre-injury wage, the worker is disabled and shall receive temporary total disability compensation benefits equal to two-thirds of the worker's pre-injury wage.~~

C. If, prior to the date of maximum medical improvement, an injured worker's health care provider releases the worker to return to work and the ~~employer offers~~ worker returns to work at less than the worker's pre-injury wage, the worker is disabled and shall receive temporary total disability compensation benefits equal to two-thirds of the difference between the worker's pre-injury wage and the worker's post-injury wage.

D. ~~If the worker returns to work pursuant to the provisions of Subsection B of this section~~ A worker is not entitled to temporary total disability benefits as set forth in Subsection B or C of this section if:

(1) the employer makes a reasonable work offer at or above the worker's pre-injury wage, within medical restrictions, if any, as stated by the health care provider pursuant to Section 52-1-49 NMSA 1978, and the worker rejects the offered employment;

(2) the worker accepts employment with another employer at or above the worker's pre-injury wage; or

(3) the worker is terminated for misconduct connected with the employment that is unrelated to the workplace injury; if the court finds that an employer terminated the worker for pretextual reasons as a way of attempting to avoid payment of benefits to the worker or as retaliation against the worker for seeking benefits, the worker shall be entitled to temporary total disability benefits and the employer shall be subject to penalties as set forth in Sections 52-1-28.1 and 52-1-28.2 NMSA 1978.

E. Upon a finding that an employer has terminated a worker for pretextual reasons, the court at its discretion may also impose an additional fine, not to exceed ten thousand dollars (\$10,000), on the employer.

F. Notwithstanding the provisions of this section, the employer shall continue to provide reasonable and necessary medical care pursuant to Section 52-1-49 NMSA 1978.

G. If there is a dispute between the parties regarding the reasonableness of the employer's work offer or the worker's refusal to return to work, the court shall decide if the work offer or the worker's refusal to return to work is reasonable based on all of the circumstances.

#### **52-1-26. Permanent Partial Disability.**

...

C. Permanent partial disability shall be determined by calculating the worker's impairment as modified by ~~his~~ the worker's age, education and physical capacity, pursuant to Sections 52-1-26.1 through 52-1-26.4 NMSA 1978; provided that, regardless of the actual calculation of impairment as modified by the worker's age, education and physical capacity, the percentage of disability awarded shall not exceed ninety-nine percent.

D. ~~If On or after the date of maximum medical improvement, an injured worker returns to work at a wage equal to or greater than the worker's pre-injury wage~~ the worker's permanent partial disability rating shall be equal to ~~his~~ the worker's impairment and shall not be subject to the modifications calculated pursuant to Sections 52-1-26.1 through 52-1-26.4 NMSA 1978 if:

(1) the worker returns to work at a wage at or above the worker's pre-injury wage;

(2) the worker accepts employment with another employer at or above the worker's pre-injury wage;

(3) the employer makes a reasonable work offer, at or above the worker's pre-injury wage, within medical restrictions, if any, as stated by the health care provider pursuant to Section 52-1-49 NMSA 1978, and the worker rejects the offered employment; or

(4) the worker is terminated for misconduct connected with the employment that is unrelated to the workplace accident; if the court finds that an employer terminates the worker for pretextual reasons to avoid payment of benefits to the worker or as retaliation against the worker for seeking benefits, the worker shall be entitled to modifier benefits and the employer shall be subject to penalties as set forth in Sections 52-1-28.1 and 52-1-28.2 NMSA 1978.

E. Upon a finding that an employer has terminated a worker for pretextual reasons, the court at its discretion may also impose an additional fine, not to exceed ten thousand dollars (\$10,000), on the employer.

~~E. F.~~ In considering a claim for permanent partial disability, a workers' compensation judge shall not receive or consider the testimony of a vocational rehabilitation provider offered for the purpose of determining the existence or extent of disability.

G. If there is a dispute between the parties regarding the reasonableness of the employer's work offer or the worker's refusal to return to work, the court shall decide if the work offer or the worker's refusal to return to work is reasonable based on all of the circumstances.

## **Oregon**

**HB 2186 amends *section 656.430 Certification of self-insured employer; employer groups; insurance policy requirements; revocation of certification; rules* of the Oregon Revised Statutes as follows:**

**656.430 Certification of self-insured employer; employer groups; insurance policy requirements; revocation of certification; rules.**

...

(3) Two or more entities ~~shall may~~ not be included in the certification of one employer unless in each entity the same person, or group of persons, or corporation owns a majority interest. If an entity owns a majority interest in another entity which in turn owns the majority interest in another entity, all entities so related may be combined regardless of the number of entities in succession. If more than one entity is included in the certification of one employer, each entity included is jointly and severally liable for any compensation and other amounts due the Department of Consumer and Business Services under this chapter by any entity included in the certification.

...

(6) If the entity is a partnership, majority interest ~~shall must~~ be determined in accordance with the participation of each general partner in the profits of the partnership.

(7)(a) Notwithstanding any other provision of this section, the director may certify five or more subject employers as a self-insured employer group, which ~~shall be considered~~ is an employer for purposes of this chapter, if:

(A) The director finds that the employers as a group meet the requirements of ORS 656.407 (1)(b) and (2);

(B) The director determines that the employers as a group meet the insurance coverage retention and combined net worth requirements adopted by the director by rule;

(C) The director finds that the grouping is likely to improve accident prevention and claims handling for the employer;

(D) Each employer executes and files with the designated entity a written agreement, in such form as the director may prescribe, in which:

(i) The employer agrees to be jointly and severally liable for the payment of any compensation and other amounts due to the Department of Consumer and Business Services under this chapter incurred by a member of the group; or

(ii) The employer, if a city, county, special district described and listed in ORS 198.010 or 198.180, translator district formed under ORS 354.605 to 354.715, weed control district organized under ORS 569.350 to 569.445, intergovernmental agency created under ORS 225.050, school district as defined in ORS 255.005 (9), public housing authority created under ORS chapter 456 or regional

council of governments created under ORS chapter 190, agrees to be individually liable for the payment of any compensation and other amounts due to the department under this chapter incurred by the employer during the period of group self-insurance; (E) The director finds that the employer group is organized as a corporation or cooperative pursuant to ORS chapter 60, 62 or 65, is an intergovernmental entity created under ORS 190.003 to 190.130 or is a self-insurance program under ORS 30.282 (3), and the bylaws of the employer group require the governing employer group to obtain fidelity bonds;

...

**HB 2335** amends **section 656.268 Claim closure; termination of temporary total disability benefits; reconsideration of closure; medical arbiter to make findings of impairment for reconsideration; credit or offset for fraudulently obtained or overpaid benefits; rules** of the Oregon Revised Statutes as follows:

**656.268 Claim closure; termination of temporary total disability benefits; reconsideration of closure; medical arbiter to make findings of impairment for reconsideration; credit or offset for fraudulently obtained or overpaid benefits; rules.**

...

(8) ...

(b) If ~~neither party requests a medical arbiter and~~ the director determines that insufficient medical information is available to determine disability, the director may appoint, and refer the claim to, a medical arbiter ~~appointed by the director.~~

(c) At the request of either of the parties, the director shall appoint a panel of as many as three medical arbiters shall be appointed in accordance with criteria that the director sets by rule.

(d) The arbiter, or panel of medical arbiters, ~~shall~~ must be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) ~~who were selected by whom~~ the director selected in consultation with the Oregon Medical Board and the committee referred to in ORS 656.790.

(e) ...

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, ~~there shall be no further opportunity for the worker to~~ may not attend a medical arbiter examination for this claim closure. The reconsideration record ~~shall~~ must be closed, and the director shall issue an order on reconsideration based upon the existing record.

(D) All disability benefits suspended ~~pursuant to~~ under this subsection, including all disability benefits awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Compensation Board or upon court review, ~~shall not be~~ are not due and payable to the worker.

(f) The insurer or self-insured employer shall pay the costs of examination and review by the medical arbiter or panel of medical arbiters shall be paid by the insurer or self-insured employer.

(g) The findings of the medical arbiter or panel of medical arbiters ~~shall~~ must be submitted to the director for reconsideration of the notice of closure.

(h) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure.

(i)(A) ~~When~~ If the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of the reconsideration or that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter ~~prior to the completion of~~ before completing the reconsideration proceeding.

...

(13) An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments due a worker from that insurer or self-insured employer when the worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker ~~shall~~ may not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

...

**HB 2336**, as amended, amends **sections 656.443 Procedure upon default by employer or self-insured employer group, 656.591 Election not to bring action operates as assignment of cause of action, and 656.593 Procedure when worker elects to bring action; release of liability and lien of paying agency in certain cases** of the Oregon Revised Statutes as follows:

Section 1. **656.443 Procedure upon default by employer or self-insured employer group.**

...

(2) ~~Prior to~~ Before any default by the employer or self-insured employer group, the employer or group is entitled to all interest and dividends on securities on deposit and to exercise all voting rights, stock options and other similar incidents of ownership of the securities.

(3) If for any reason the certification of a self-insured employer or self-insured employer group is canceled or terminated, the surety bond or other security deposited with the director ~~shall~~ must remain on deposit or in effect, as the case may be, for a period of at least 62 months after the employer ceases to be a self-insured employer. The surety bond or other security ~~shall~~ must be

maintained in an amount necessary to secure the outstanding and contingent liability arising from the accidental injuries secured by the surety bond or other security, and to ~~assure~~ ensure the payment of claims for aggravation and claims arising under ORS 656.278 based on those accidental injuries. At the expiration of the 62-month period, or of another period the director may consider proper, the director may accept in lieu of the surety bond or other security deposited with the director a policy of paid-up insurance in a form approved by the director.

(4) If a self-insured employer or self-insured employer group is in default, is decertified by the director or cancels ~~its~~ the employer's or the group's certification under ORS 656.434, the director may:

(a) Order members of the group to pay an assessment for the continuing claim liabilities as specified in ORS 656.430 (7)(a)(D)(i); and

(b) Determine the claims processing agent that ~~shall process~~ processes claims of the self-insured employer or self-insured employer group. The claims processing agent may be the assigned claims agent selected under ORS 656.054.

(5) Member assessments collected under subsection (4) of this section ~~shall~~ must be deposited in the Consumer and Business Services Fund created in ORS 705.145.

(6) Failure to pay an assessment ordered under subsection (4) of this section subjects members of the self-insured employer group to civil penalties as provided in ORS 656.745.

(7) A claims processing agent that the director designates under subsection (4) of this section, other than the State Accident Insurance Fund Corporation, may choose the legal counsel the claims processing agent employs for representation under this section.

### Section 2. **656.591 Election not to bring action operates as assignment of cause of action.**

(1) An election made pursuant to ORS 656.578 not to proceed against ~~the~~ an employer or third person operates as an assignment to the paying agency of the cause of action, if any, of ~~the~~ a worker, or the beneficiaries or legal representative of ~~the~~ a deceased worker; against the employer or third person, and the paying agency may bring action against ~~such~~ the employer or third person in the name of the ~~injured~~ worker or other beneficiaries.

(2) Any sum ~~recovered by~~ the paying agency recovers in excess of the expenses the paying agency incurred in making ~~such~~ the recovery and the amount ~~expended by~~ the paying agency expended for compensation, first aid or other medical, surgical or hospital service, together with the present ~~worth~~ value of the monthly payments of compensation to which ~~such~~ the worker or other beneficiaries may be entitled under this chapter, ~~shall~~ must be paid ~~such~~ to the worker or other beneficiaries.

(3) A paying agency shall repay the Department of Consumer and Business Services for any expenditures from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve, the Self-Insured Employer Group Adjustment Reserve or the Workers' Benefit Fund that the department makes, together with the present value of any reasonably expected future expenditures from the funds or reserves that the department may make, to reimburse the paying agency for the paying agency's costs and to compensate or pay other costs of a worker's claim because of a self-insured employer's or self-insured employer group's insolvency, default or decertification.

### Section 3. **656.593 Procedure when worker elects to bring action; release of liability and lien of paying agency in certain cases.**

(1) If ~~the~~ a worker or the beneficiaries of the worker elect to recover damages from ~~the~~ an employer or third person, the worker or beneficiaries shall give notice of ~~such~~ the election ~~shall be given to~~ the paying agency by personal service or by registered or certified mail. The paying agency likewise ~~shall~~ must be given notice of the name of the court in which ~~such~~ the action is brought, and a return showing service of ~~such~~ the notice on the paying agency ~~shall~~ must be filed with the clerk of the court but ~~shall not be~~ is not a part of the record except to give notice to the defendant of the lien of the paying agency, as provided in this section. The proceeds of any damages ~~recovered~~ the worker or beneficiaries recover from an employer or third person ~~by the worker or beneficiaries shall be~~ are subject to a lien of the paying agency for ~~its~~ the paying agency's share of the proceeds as set forth in this section. ~~When~~ If the proceeds are paid in a series of payments, each payment ~~shall~~ must be distributed proportionately to each recipient according to the formula provided in this section, unless the parties otherwise agreed by the parties agree. The total proceeds ~~shall~~ must be distributed as follows:

(a) Costs and attorney fees incurred ~~shall~~ must be paid, such and the attorney fees in no event to may not exceed the advisory schedule of fees established by the Workers' Compensation Board for such actions.

(b) The worker or the beneficiaries of the worker ~~shall~~ must receive at least 33-1/3 percent of the balance of ~~such~~ the recovery.

(c) The paying agency ~~shall~~ must be paid and retain the balance of the recovery, but only to the extent that ~~it~~ the paying agency is compensated for ~~its~~ the paying agency's expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of ~~its~~ reasonably to be expected future expenditures the paying agency makes for compensation and other costs of the worker's claim under this chapter. ~~Such~~ Other costs include expenditures ~~of that~~ the Department of Consumer and Business Services makes from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve, the Self-Insured Employer Group Adjustment Reserve and the Workers' Benefit Fund ~~in reimbursement of~~ to reimburse the costs of the paying agency. ~~Such~~ Other costs also include assessments for the Workers' Benefit Fund; and ~~include~~ any compensation ~~which that~~ may become payable under ORS 656.273 or 656.278.

(d) The balance of the recovery ~~shall~~ must be paid to the worker or the beneficiaries of the worker forthwith. The board shall resolve any conflict as to the amount of the balance which that the paying agency may be retained by the paying agency shall be resolved by the board retain.

(2) The amount ~~retained by~~ the worker or the beneficiaries of the worker ~~shall~~ retain must be in addition to the compensation or other benefits to which ~~such~~ the worker or beneficiaries are entitled under this chapter.

(3) A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is ~~authorized to may~~ accept such a share of the proceeds ~~as may be~~ that is just and proper and the worker or the beneficiaries of the worker ~~shall~~ must receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. The board shall resolve any conflict as to what may be a just and proper distribution shall be resolved by the board.

(4) As used in this section, "paying agency" includes the Department of Consumer and Business Services with respect to ~~its~~ expenditures from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve, the Self-Insured Employer Group Adjustment Reserve and the Workers' Benefit Fund in reimbursement of the department makes, together with the present value of any reasonably expected future expenditures from the funds or reserves that the department may make, to reimburse the costs of another paying agency for vocational assistance and the costs of claims of noncomplying employers, and to compensate or pay other costs of a worker's claim because of a self-insured employer's or self-insured employer group's insolvency, default or decertification.

(5) The department ~~shall~~ must be repaid for ~~its~~ the department's expenditures from the proceeds the paying agency recovered ~~by the paying agency~~ in an amount proportional to the amount of the department's reimbursement of the paying agency's costs. The department shall deposit all moneys received by the department receives under this section shall be deposited in the same fund from which the paying agency's costs originally had been reimbursed department's expenditures originated.

(6) ~~Prior to~~ Before, and instead of, the distribution of proceeds ~~as described in subsection (1) of this section, when the if a worker or the beneficiaries of the a worker are entitled to receive payment pursuant to a judgment or a settlement in the a third party action in the amount of \$1 million or more, the worker or the beneficiaries of the worker may elect to release the paying agency from all further liability on the workers' compensation claim, thereby canceling the lien of the paying agency as to the present value of its the paying agency's reasonably expected future expenditures for workers' compensation and other costs of the worker's claim, if all of the following conditions are met as part of the claim release:~~

(a) The worker or the beneficiaries of the worker are represented by an attorney.

(b) The release of the claim is presented in writing and is filed with the Workers' Compensation Board, with a copy served on the paying agency, including the Department of Consumer and Business Services with respect to ~~its~~ the department's expenditures from ~~the Workers' Benefit Fund, the Consumer and Business Services Fund, and the Self-Insured Employer Adjustment Reserve, the Self-Insured Employer Group Adjustment Reserve and the Workers' Benefit Fund.~~

(c) The claim release specifies that the worker or the beneficiaries of the worker understand that the claim release means that no further benefits of any nature whatsoever ~~shall~~ will be paid to the worker or the beneficiaries of the worker.

(d) The release of the claim is accompanied by a settlement stipulation with the paying agency, outlining terms of reimbursement to the paying agency, covering ~~its~~ the paying agency's incurred expenditures for compensation, first aid or other medical, surgical or hospital service and for expenditures from ~~the Workers' Benefit Fund, the Consumer and Business Services Fund, and the Self-Insured Employer Adjustment Reserve, the Self-Insured Employer Group Adjustment Reserve and the Workers' Benefit Fund~~ to the date the release becomes final or the order of the board becomes final. If the payment of such incurred expenditures is in dispute, the release of the claim ~~shall~~ must be accompanied by a written submission of the dispute by the worker or the beneficiaries of the worker to the board for resolution of the dispute by order of the board under procedures allowing for board resolution under ORS 656.587, in which case the release of the claim ~~shall not be~~ is not final until such time as the order of the board becomes final. In such a case, the only issue to be decided by the board is the amount of incurred expenses by the paying ~~agent~~ agency.

(e) If a service, item or benefit has been provided but a bill for that service, item or benefit has not been received by the paying agency before the release or order becomes final, the reimbursement payment ~~shall~~ must cover the bill ~~pursuant to~~ in accordance with the following process:

(A) The paying agency may maintain a contingency fund in an amount reasonably sufficient to cover reimbursement for the billing.

(B) If a dispute arises as to reimbursement for any bill first received by the paying agency not later than 180 days after the date the release or order became final, the dispute ~~shall~~ must be resolved by order of the board.

(C) Any amount remaining in the contingency fund after the 180-day period ~~shall~~ must be paid to the worker or the beneficiaries of the worker.

(D) Any billing for a service, item or benefit that is first received by the paying agency more than 180 days after the date the release or order became final is unenforceable by the person who issued the bill.

(f) The settlement or judgment proceeds are available for payment or actually have been paid out and are available in a trust fund or similar account, or are available through a legally enforceable structured settlement agreement if sufficient funds are available to make payment to the paying agency.

(g) The agreed-upon payment to the paying agency, or the payment to the paying agency ordered by the board, is made within 30 days of the filing of the withdrawal of the claim with the board or within 30 days after the board has entered a final order resolving any dispute with the paying agency.

(7) ~~When~~ If a release of further liability on a claim, as provided in subsection (6) of this section, has been filed, and ~~when~~ if payment to the paying agency has been made, the effect of the release is that the worker or the beneficiaries of the worker ~~shall~~ have no further right to seek benefits ~~pursuant to~~ under the original claim, or any independent workers' compensation claim regarding the same circumstances, and the claim ~~shall~~ may not be reasserted, refiled or reestablished through any legal proceeding.

**HB 2336** also includes the following clause:

Section 4. The amendments to ORS 656.443, 656.591 and 656.593 by sections 1 to 3 of this 2017 Act apply to determinations as to a claims processing agent for, and expenditures that occur to or on behalf of, any self-insured employer or self-insured employer group that is insolvent or in default, that has canceled the employer's or group's certification under ORS 656.434 or that the Director of the Department of Consumer and Business Services has decertified, regardless of the date on which the insolvency, default, cancellation or decertification occurred.

### Contact Information

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

State	State Relations Executive	Phone Number
CT, ME, NH, RI, VT	Laura Backus Hall	802-454-1800
FL, IA	Chris Bailey	850-322-4047
AL, GA, KY, LA, MS	Laura Hart Bryan	225-618-8168
AK, AZ, CO, NM, UT	Maggie Karpuk	818-707-8374
DC, MD, VA, WV	David Benedict	804-380-3005
HI	Carolyn Pearl	808-524-6239
IN, NC, SC, TN	Amy Quinn	803-356-0851
AR, IL, KS, TX	Terri Robinson	501-333-2835
ID, MT, NV, OR	Jessica Epley	503-892-8919
MO, NE, OK, SD	Carla Townsend	314-843-4001
Federal Issues	Tim Tucker	202-403-8526

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