



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 bills were enacted within the one-week period ending April 7, 2017.

Arkansas

SB 760 was:

- Passed by the first chamber on March 29, 2017
- Passed by the second chamber on March 31, 2017
- Included in NCCI's April 7, 2017 **Legislative Activity Report** (RLA-2017-13)
- Enacted on April 6, 2017, with a projected effective date of July 30, 2017

SB 760 amends **section 11-9-805. Joint petition for final settlement** of the Arkansas Code as follows:

11-9-805. Joint petition for final settlement.

~~(a)(1) Upon~~ Except as provided in subdivision (a)(2) of this section, upon petition filed by the employer or carrier and the injured employee requesting that a final settlement be had between the parties, the Workers' Compensation Commission shall hear the petition and take testimony and make investigations as may be necessary to determine whether a final settlement should be had.

~~(2)(A) If a claimant has been determined to be eligible for Medicare, the parties may petition the commission for a partial settlement of all issues other than future medical treatment.~~

~~(B) A partial settlement under subdivision (a)(2) of this section is final concerning all issues except future medical treatment.~~

~~(b)(1)(A) If the commission decides it is for that a final settlement award is in the best interests of the claimant that a final award be made, it parties, the commission may order an award that shall be is final as to concerning the rights of all the parties to the joint petition.~~

~~(B) After the commission enters an order with regard to any full settlement, the commission does not have jurisdiction over any claim for the same injury or any results arising from it.~~

~~(2)(A) Thereafter, the commission shall not have jurisdiction over any claim for the same injury or any results arising from it. If the commission decides that a partial settlement award is in the best interests of the parties, the commission may order an award that is final concerning the partial settlement of the rights of all the parties to the joint petition.~~

~~(B) After the commission enters an order with regard to any partial settlement, the commission does not have jurisdiction over any claim for the same injury or any results arising from it other than claims for future medical expenses.~~

(c) If an employee has returned to work or agreed to return to work, the commission shall not approve a joint petition which has allotted moneys for vocational rehabilitation or any indemnity benefits in excess of that payable as an anatomical impairment as established by objective and measurable findings.

(d) If the commission denies the petition, the denial shall be without prejudice to either party.

~~(e) No~~ An appeal shall not lie from an order or award denying or approving a joint petition.

New Mexico

SB 155 Committee Substitute was:

- Passed by the first chamber on February 28, 2017

- Included in NCCI's March 10, 2017 **Legislative Activity Report** (RLA-2017-09)
- Amended and passed by the second chamber on March 16, 2017
- Amended and approved by the Conference Committee on March 16, 2017
- Included in NCCI's March 24, 2017 **Legislative Activity Report** (RLA-2017-11)
- Enacted on April 3, 2017, with an effective date of June 16, 2017

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 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 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 workers' compensation judge 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 workers' compensation judge at the judge's discretion may also impose an additional fine, not to exceed ten thousand dollars (\$10,000), on the employer to be paid to the worker.

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 workers' compensation judge 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 workers' compensation judge 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 workers' compensation judge at the judge's discretion may also impose an additional fine, not to exceed ten thousand dollars (\$10,000), on the employer to be paid to the worker.

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 workers' compensation judge shall decide if the work offer or the worker's refusal to return to work is reasonable based on all of the circumstances

BILLS PASSING SECOND CHAMBER

Hawaii

SB 859 SD1 HD1 was:

- Passed by the first chamber on March 7, 2017
- Included in NCCI's March 17, 2017 *Legislative Activity Report* (RLA-2017-10)
- Amended and passed by the second chamber on April 7, 2017

SB 859 SD1 HD1 amends *section 386-79 Medical examination by employer's physician* of the Hawaii Revised Statutes, in part, as follows:

§ 386-79 Medical examination by employer's physician.

(a) After an injury and during the period of disability, the employee, whenever ordered by the director of labor and industrial relations, shall submit to examination, at reasonable times and places, by a duly qualified physician or surgeon designated and paid by the employer. The employee shall have the right to have a physician or surgeon, or chaperone designated and paid by the employee present at the examination, which right, however, shall not be construed to deny to the employer's physician the right to visit the injured employee at all reasonable times and under all reasonable conditions during total disability. The employee shall also have the right to record such examination by a recording device designated and paid for by the employee; provided that the examining physician or surgeon approves of the recording.

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SB 859 SD1 HD1 also includes the following clause:

This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SB 984 HD1 was:

- Passed by the first chamber on March 3, 2017
- Included in NCCI's March 10, 2017 *Legislative Activity Report* (RLA-2017-09)
- Amended and passed by the second chamber on April 3, 2017

SB 984 HD1 amends *section 386-1 Definitions* of the Hawaii Revised Statutes as follows:

§ 386-1 Definitions.

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"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.

...

Kansas

HB 2140 was:

- Passed by the first chamber on February 22, 2017
- Amended and passed by the second chamber on March 29, 2017

HB 2140 authorizes the governor to enter into the great plains interstate fire compact. The language includes, but is not limited to, the following:

Section 1.

...

ARTICLE V

Each member state shall assure that workers compensation benefits in conformity with the minimum legal requirements of the state are available to all employees and contract firefighters sent to a requesting state pursuant to this compact.

...

Section 2.

A volunteer firefighter entitled to benefits under the workers compensation act who is engaged by the state of Kansas under the compact pursuant to section 1, and amendments thereto, shall be deemed to be an employee of the state of Kansas solely for purposes of the workers compensation act.

Note: HB 2140 was not included in any previous version of NCCI's *Legislative Activity Report*.

Maryland

HB 1294 was:

- Passed by the first chamber on March 18, 2017
- Included in NCCI's March 31, 2017 *Legislative Activity Report* (RLA-2017-12)
- Passed by the second chamber on April 3, 2017

HB 1294 amends *section 9-640 Survival of compensation* of the Annotated Labor and Employment Code of Maryland, related to permanent total disability benefits, as follows:

§ 9-640 Survival of compensation

(a) Scope of section.—This section does not apply to compensation paid under Title 10, Subtitle 2 of this article.

(b) In general.—If a covered employee dies from a cause that is not compensable under this title, the right to compensation that is payable under this Part V of this subtitle and unpaid on the date of death survives in accordance with this section to the extent of ~~\$45,000~~ \$65,000, as increased by the cost of living adjustments under § 9-638 of this Part V of this subtitle.

...

HB 1294 also includes the following clause:

That this Act shall be construed to apply only prospectively and may not be applied or interpreted to have any effect on or application to any claim arising from events occurring before the effective date of this Act.

HB 1294 is identical to **SB 426**.

HB 1476 was:

- Passed by the first chamber on March 18, 2017
- Included in NCCI's March 31, 2017 *Legislative Activity Report* (RLA-2017-12)
- Passed by the second chamber on April 3, 2017

HB 1476 amends *section 9-1102 Failure to report accident* of the Annotated Labor and Employment Code of Maryland as follows:

§ 9-1102 Failure to report accident

An employer who knowingly fails to report an accidental personal injury within the time required under § 9-707(a) of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$500 ~~\$50~~.

HB 1476 is identical to **SB 867**.

SB 32 was:

- Passed by the first chamber on January 24, 2017
- Included in NCCI's February 3, 2017 *Legislative Activity Report* (RLA-2017-04)
- Passed by the second chamber on April 5, 2017

SB 32, in part, amends *sections 12-106. Binders or contracts for temporary insurance* and *19-406. Cancellations by insurer* of the Maryland Insurance Code as follows:

12-106. Binders or contracts for temporary insurance

...

(f) (1) Except as provided in paragraph (2) of this subsection, a notice of cancellation under this section shall:

- (i) be in writing;
- (ii) have an effective date not less than 15 days after mailing;
- (iii) state clearly and specifically the insurer's actual reason for the cancellation; and
- (iv) be sent by a first-class mail tracking method to the named insured's last known address.

(2) A notice of cancellation under this section for nonpayment of premium shall:

- (i) be in writing;
- (ii) have an effective date of not less than 10 days after mailing;
- (iii) state the insurer's intent to cancel for nonpayment of premium; and

(iv) be sent by a first-class mail tracking method to the named insured's last known address.

(3) With respect to a workers' compensation insurance policy or binder, the insurer shall file a copy of the notice of cancellation required under paragraph (1) or (2) of this subsection with the designee of the Workers' Compensation Commission.

...

19-406. Cancellations by insurer

(a) This section does not apply to the cancellation of a policy or binder of workers' compensation insurance by an insurer during the 45-day underwriting period in accordance with § 12-106 of this article.

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Maine

LD 592 was:

- Passed by the first chamber on March 30, 2017
- Included in NCCI's April 7, 2017 **Legislative Activity Report** (RLA-2017-13)
- Passed by the second chamber on April 4, 2017

LD 592 amends **Title 24-A, Chapter 52, section 3714. Accounting; assessments** of the Maine Revised Statutes as follows:

§ 3714. Accounting; assessments

...

7. High-risk program. The company shall maintain a high-risk program subject to the following provisions-

A. An employer must be placed in the high-risk program if the employer has at least 2 lost time claims, each greater than \$10,000 of incurred loss, and a loss ratio greater than 1.0 during the previous 3-year experience rating period. Notwithstanding paragraph C, an employer may also be placed in the high-risk program during the term of a policy for noncompliance with reasonable safety standards. [2001, c. 350, §10 (NEW).]

B. The board, with the approval of the superintendent, may modify the eligibility standards for the high-risk program if those standards limit those in the program to employers who have measurably adverse loss experience, have a relatively high claim frequency record or have demonstrated an attitude or practice of noncompliance with reasonable safety requirements or claims management standards. [2001, c. 350, §10 (NEW).]

C. Eligibility requirements must be applied annually at the policy renewal date or, if the necessary claim history is not available at that time, 30 days after notice to the insured. [2001, c. 350, §10 (NEW).]

D. Deductibles in the high-risk program are subject to this paragraph.

(1) A deductible applies to all coverage for policyholders in the high-risk program that meet the following qualifications:

- (a) A net annual premium of \$20,000 or more, subject to adjustment pursuant to this paragraph, in the State;
- (b) A premium not subject to retrospective rating; and
- (c) The policyholder's threshold loss ratio is 1.0 or greater.

The deductible is \$1,000 a claim but applies only to wage loss benefits paid on injuries occurring during the year of coverage. The sum of all deductibles in one year of coverage may not exceed the lesser of 15% of net annual payment for coverage or \$25,000. Each loss to which a deductible applies must be paid in full by the company. After the year of coverage has expired, the policyholder shall reimburse the company the amount of the deductibles. This reimbursement is considered as payment for coverage for purposes of cancellation or nonrenewal.

The board shall adjust annually the \$20,000 payment-of-coverage level established in this subparagraph to reflect any change in rates for the high-risk program and any change in wage levels in the preceding calendar year. Changes in wage levels are determined by reference to changes in the state average weekly wage, as computed by the Department of Labor. Any adjustment is rounded off to the nearest \$1,000 increment.

(2) The board may modify, with the approval of the superintendent, the mandatory deductible elements. Any modification or elimination of this rating feature must consider the incentive impact on an employer, the reasonableness of the retained cost relative to the claim history, safety record or claims management practices of affected employers and the ability of all employers to absorb these costs. [2001, c. 350, §10 (NEW).]

E. The board may file with the superintendent retrospective rating plans that, after hearing, may be imposed on an employer with a demonstrated record of repeated serious violations of workplace health and safety rules and regulations such as those adopted under Title 26, chapter 6 or 29 United States Code, Chapter 15, whichever is applicable. [2001, c. 350, §10 (NEW).]

F. The board shall develop and file with the superintendent and, if not disapproved by the superintendent, make available to policyholders on a voluntary basis retrospective rating plans. [2001, c. 350, §10 (NEW).]

G. Not more than 30 days after assignment to the high-risk program, a policyholder may appeal the assignment in writing to the bureau. [2001, c. 350, §10 (NEW).]

H. The board, with the approval of the superintendent, shall implement a plan for surcharges for policyholders in the high-risk program based on the policyholder's specific loss experience beyond the uniform experience rating plan approved by the

superintendent. Any plan of surcharges must consider the actual claims experience of the employer and must provide for rate adjustments reasonably related to the employer's risk of loss.

8. Filing of retrospective rating plans. The board may file with the superintendent retrospective rating plans that, after hearing, may be imposed on an employer with a demonstrated record of repeated serious violations of workplace health and safety rules and regulations such as those adopted under Title 26, chapter 6 or 29 United States Code, Chapter 15, whichever is applicable.

9. Availability of retrospective rating plans. The board shall develop and file with the superintendent and, if not disapproved by the superintendent, make available to policyholders on a voluntary basis retrospective rating plans.

Montana

HB 449 was:

- Passed by the first chamber on February 28, 2017
- Included in NCCI's March 10, 2017 *Legislative Activity Report* (RLA-2017-09)
- Amended and passed by the second chamber on April 7, 2017

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 remuneration paid for services performed by an employee for an employer, or income provided for in subsection (1)(d). Wages include the cash value of 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;
- (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) 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;~~board, lodging, rent, or housing if it constitutes a part of the employee's remuneration and is based on its actual value; and~~
- (f) ~~board if it constitutes a part of the employee's remuneration and is based on its actual value; and 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.~~
- (g) lodging, rent, or housing if it constitutes part of the employee's remuneration and is based on a value as set by administrative rule. The values set by administrative rule must address the general geographic proximity to available housing and may consider other reasonable factors that affect value.

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

- (a) employee expense reimbursements or allowances for meals, lodging, travel, subsistence, and other expenses, as set forth in department rules;
- (b) the amount of the payment made by the employer for employees, if the payment was made for:
 - (i) retirement or pension pursuant to a qualified plan as defined under the provisions of the Internal Revenue Code;
 - (ii) sickness or accident disability under a workers' compensation policy;
 - (iii) medical or hospitalization expenses in connection with sickness or accident disability, including health insurance for the employee or the employee's immediate family;
 - (iv) death, including life insurance for the employee or the employee's immediate family;
- (c) vacation or sick leave benefits accrued but not paid;
- (d) special monetary rewards for individual invention or discovery; or
- (e) monetary and other benefits paid to a person as part of public assistance, as defined in 53-4-201.

...

(4)

...

(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.

...

SB 116 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 April 7, 2017

SB 116 creates new section *False statement on employment questionnaire—definition* to *Title 39, Chapter 71, Part 1* of the Montana Code Annotated 2015 as follows:

False statement on employment questionnaire—definition.

(1) A false statement made by an employee in an employer-provided written questionnaire calling for the disclosure of an employee's medical condition that is relevant to the essential functions of the job following a conditional offer of employment bars all wage-loss or medical benefits under this chapter if all of the following conditions are met:

(a) the employee knowingly or willfully, by omission or commission, makes a false representation regarding the employee's physical condition that is relevant to the essential functions of the job;

(b) the employer relies on the false representation and that reliance is a contributing factor in the hiring of the employee; and

(c) there is a causal connection between the falsely represented condition and the injury or occupational disease for which wage-loss or medical benefits are claimed.

(2) The employee has the right to petition the workers' compensation court after satisfying the mediation requirements of this chapter if the employee disagrees with a decision to terminate benefits or bar benefits as provided under subsection (1).

SB 184 was:

- Passed by the first chamber on February 21, 2017
- Included in NCCI's March 3, 2017 *Legislative Activity Report* (RLA-2017-08)
- Passed by the second chamber on April 1, 2017

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.

West Virginia

SB 398 was:

- Passed by the first chamber on March 22, 2017
- Included in NCCI's March 31, 2017 *Legislative Activity Report* (RLA-2017-12)

- Passed by the second chamber on April 4, 2017 with title amendment

SB 398 creates several new sections in the Code of West Virginia, including, but not limited to, the following:

§ 29-30-11. Rulemaking

The Secretary of the Department of Health and Human Resources may promulgate rules pursuant to article three, chapter twenty-nine-a of this code to implement the provisions of this article. These rules shall include measures to facilitate the receipt of benefits for injury or death pursuant to the workers' compensation laws of this state by volunteer health practitioners who reside in other states.

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending April 7, 2017.

Alabama

HB 242 amends *section 25-5-50 Applicability; exemption for corporate officers; coverage for school boards, volunteer fire departments, and rescue squads; sports officials* of the Code of Alabama 1975, in part, as follows:

25-5-50 Applicability; exemption for corporate officers; coverage for school boards, volunteer fire departments, and rescue squads; sports officials.

...

(b) Notwithstanding subsection (a), an officer of a corporation or individual limited liability company member may elect ~~annually~~ to be exempt from coverage by filing written certification of the election with ~~the department and~~ the employer's insurance carrier. The exemption shall remain in effect at all times, unless properly revoked as provided herein, including subsequent coverage years with the same workers' compensation carrier.

At the end of any calendar year, a corporate officer or individual limited liability company member who has been exempted, by proper certification from coverage, may revoke the exemption and thereby accept coverage by filing written certification of his or her election to be covered with ~~the department and~~ the employer's insurance carrier.

The certification for exemption or reinstatement of coverage shall become effective on the first day of the calendar month following the filing of the certification of exemption or reinstatement of coverage with ~~the department~~ the employer's insurance carrier.

If the corporate officer or individual limited liability company member elects to be exempt from coverage, the election shall not relieve the employer from continuing coverage for all other eligible employees who may have been covered prior to the election or who may subsequently be employed by the ~~firm~~ employer. Notwithstanding any election made pursuant to this provision, the election by the corporate officer or individual limited liability company member does not otherwise change his or her status as an employee for the purpose of determining the threshold number of employees necessary to invoke or trigger the applicability of this chapter.

(c) A corporate officer or individual limited liability company member seeking to secure coverage by revoking an existing exemption, at any time other than the end of the calendar year, in addition to complying with the provisions of subsection (b), shall execute an affidavit verifying that he or she has not suffered an employment accident, exposure, or injury from the date of exemption until the date of the written certification of the election to reinstate coverage. Any corporate officer or individual limited liability company member who fails to execute an affidavit or comply with other terms and conditions of the workers' compensation carrier shall not be entitled to revoke the previous exemption until the end of the calendar year.

The revocation of the exemption and reinstatement of coverage shall become effective on the first day of the calendar month following the written acceptance of the certification of exemption or reinstatement of coverage by the employer's workers' compensation insurance carrier.

...

SB 196 amends *section 13A-11-124 Making false statements to obtain workers' compensation benefits* of the Code of Alabama 1975 as follows:

Section 13A-11-124 Making false statements to obtain workers' compensation benefits.

Any person who ~~makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation, as defined in Section 25-5-1(1), as amended, for himself or herself or any other person does any of the following relating to a claim for benefits under Chapter 5 of Title 25 is guilty of a Class C felony:~~

(1) When making a claim for compensation, as defined in Section 25-5-1(1), knowingly, with intent to deceive, makes, or causes to be made, a false or misleading statement, representation, or submission concerning any fact that is material to that claim for the purpose of wrongfully obtaining the compensation.

(2) Coerces, solicits, or encourages, or employs or contracts with a person to coerce, solicit, or encourage, any individual to make a false or misleading statement, representation or submission concerning any fact that is material to a claim for compensation or the payment of compensation or premiums, pursuant to Chapter 5, Title 25, for the purpose of wrongfully obtaining the compensation or of evading the full payment of the compensation or premiums.

(3) Presents, or causes to be presented, multiple claims for the same loss or injury.

(4) Fabricates, alters, conceals, makes a false entry in, or destroys a document that is material to the claim for the purpose of wrongfully obtaining the compensation.

...

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 | Peter Burton | 610-964-8852 |
| AL, GA, KY, LA, MS | Laura Hart Bryan | 225-618-8168 |
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This report is informational and is not intended to provide an interpretation of state and federal legislation.