



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 May 5, 2017.

Arizona

SB 1331 was:

- Passed by the first chamber on February 16, 2017
- Included in NCCI's February 24, 2017 **Legislative Activity Report** (RLA-2017-07)
- Amended and passed by the second chamber on April 17, 2017
- Included in NCCI's April 28, 2017 **Legislative Activity Report** (RLA-2017-16)
- Enacted on May 2, 2017, with a projected effective date of August 8, 2017

SB 1331 amends **section 20-359. Deviations from filed workers' compensation rates** of the Arizona Revised Statutes as follows:
20-359. Deviations from filed workers' compensation rates

A. Every insurer shall adhere to the filings made by the rating organization of which it is a member, except that any member insurer may file with the director:

1. A Up to six uniform percentage deviations that decrease or increase to be applied to the statewide rate portion of the rating organization's rate filing. If more than one deviation is filed by an insurer, each deviation must be established consistent with the underwriting rules that are based on criteria that would lead to a logical distinction of potential risk.

...

C. A rating organization shall notify the director if the organization disapproves any deviation relating to workers' compensation insurance. The director shall notify the industrial commission of the disapproval within ten days of after receipt of the disapproval from the rating organization.

Maryland

HB 1476 and **SB 867** are identical.

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
- Included in NCCI's April 14, 2017 **Legislative Activity Report** (RLA-2017-14)
- Enacted on May 4, 2017, with an effective date of October 1, 2017

SB 867 was:

- Passed by the first chamber on March 20, 2017
- Included in NCCI's March 31, 2017 **Legislative Activity Report** (RLA-2017-12)

- Passed by the second chamber on March 30, 2017
- Included in NCCI's April 7, 2017 **Legislative Activity Report** (RLA-2017-13)
- Enacted on May 4, 2017, with an effective date of October 1, 2017

HB 1476/SB 867 amend **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 1484 and **SB 194** are identical.

HB 1484 was:

- Passed by the first chamber on March 14, 2017
- Included in NCCI's March 24, 2017 **Legislative Activity Report** (RLA-2017-11)
- Passed by the second chamber on March 31, 2017
- Included in NCCI's April 7, 2017 **Legislative Activity Report** (RLA-2017-13)
- Enacted on May 4, 2017, with an effective date of October 1, 2017

SB 194 was:

- Passed by the first chamber on March 7, 2017
- Included in NCCI's March 17, 2017 **Legislative Activity Report** (RLA-2017-10)
- Passed by the second chamber on March 28, 2017
- Included in NCCI's April 7, 2017 **Legislative Activity Report** (RLA-2017-13)
- Enacted on May 4, 2017, with an effective date of October 1, 2017

HB 1484/SB 194 amend **section 9-660. Provision of medical services and treatment** of the Annotated Labor and Employment Code of Maryland as follows:

§ 9-660. Provision of medical services and treatment

...

(d) (1) A provider who provides medical service or treatment to a covered employee under subsection (a) of this section shall submit to the employer or the employer's insurer a bill for providing medical service or treatment within 12 months from the later of the date:

- (i) medical service or treatment was provided to a covered employee;
- (ii) the claim for compensation was accepted by the employer or the employer's insurer; or
- (iii) the claim for compensation was determined by the commission to be compensable.

(2) The employer or the employer's insurer may not be required to pay a bill submitted after the time period required under paragraph (1) of this subsection unless:

- (i) the provider files an application for payment with the commission within 3 years from the later of the date:
 1. medical service or treatment was provided to the covered employee;
 2. the claim for compensation was accepted by the employer or the employer's insurer; or
 3. the claim for compensation was determined by the commission to be compensable; and
- (ii) the commission excuses the untimely submission for good cause.

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
- Included in NCCI's April 14, 2017 **Legislative Activity Report** (RLA-2017-14)
- Enacted on May 4, 2017, with an effective date of October 1, 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.
- ...

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending May 5, 2017.

Arizona

HB 2161 was:

- Passed by the first chamber on February 21, 2017
- Included in NCCI's March 3, 2017 **Legislative Activity Report** (RLA-2017-08)
- Amended and passed by the second chamber on May 4, 2017

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:
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 and who are diagnosed with a cancer that is listed in subsection B of this section not more than fifteen years after the firefighter's or peace officer's last date of employment as a firefighter or peace officer.
- ~~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 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 May 4, 2017

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 (NFPAa 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).

Florida

HB 837 was:

- Passed by the first chamber on April 26, 2017
- Included in NCCI's May 5, 2017 *Legislative Activity Report* (RLA-2017-17)
- Passed by the second chamber on May 3, 2017

HB 837, in part, amends *sections 631.021 Jurisdiction of delinquency proceeding; venue; change of venue; exclusiveness of remedy; appeal, 631.191 Special deposit claims and secured claims and 631.397 Use of certain marshaled assets* of the Florida Statutes as follows:

631.021 Jurisdiction of delinquency proceeding; venue; change of venue; exclusiveness of remedy; appeal; construction

(1) The circuit court shall have original jurisdiction of any delinquency proceeding under this chapter, and any court with jurisdiction is authorized to make all necessary or proper orders to carry out the purposes of this chapter. Any delinquency proceeding in this chapter is in equity.

(2) The venue of a delinquency proceeding or summary proceeding against a domestic, foreign, or alien insurer shall be in the Circuit Court of Leon County.

(3) A delinquency proceeding pursuant to this chapter constitutes the sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving an insurer. ~~A No court may not shall~~ entertain a petition for the commencement of such a proceeding unless the petition has been filed in the name of the state on the relation of the department. The Florida Insurance Guaranty Association, Incorporated, the Florida Workers' Compensation Insurance Guaranty Association, Incorporated, the Florida Health Maintenance Organization Consumer Assistance Plan, and the Florida Life and Health Guaranty Association, Incorporated, shall be given reasonable written notice by the department of all hearings ~~that which~~ pertain to an adjudication of insolvency of a member insurer.

(4) An appeal shall lie to the District Court of Appeal, First District, from an order granting or refusing rehabilitation, liquidation, or conservation and from every order in a delinquency proceeding having the character of a final order as to the particular portion of the proceeding embraced therein.

(5) No service of process against the department in its capacity as receiver shall be effective unless served upon a person designated by the receiver and filed with the circuit court having jurisdiction over the delinquency proceeding. The designated person shall refuse to accept service if acceptance would violate a stay against legal proceedings involving an insurer that is the subject of delinquency proceedings or would violate any orders of the circuit court governing a delinquency proceeding. The person denied service may petition the circuit court having jurisdiction over the delinquency proceeding for relief from the receiver's refusal to accept service. This subsection shall be strictly construed, and any purported service on the receiver or the department that is not in accordance with this subsection shall be null and void.

(6) The domiciliary court acquiring jurisdiction over persons subject to this chapter may exercise exclusive jurisdiction to the exclusion of all other courts, except as limited by the provisions of this chapter. Upon the issuance of an order of conservation, rehabilitation, or liquidation, the Circuit Court of Leon County ~~has shall have~~ exclusive jurisdiction over all with respect to assets or property of ~~the any~~ insurer, wherever located, including property located outside the territorial limits of the state subject to such proceedings and claims against said insurer's assets or property.

(7) This chapter constitutes this state's insurer receivership laws, and these laws must be construed as consistent with each other. If there is a conflict between this chapter and any other law, this chapter prevails.

631.191 Special deposit claims; ~~and~~ secured claims; administration of workers' compensation large deductible policies and insured collateral

(1) Special Deposit Claims The owners of special deposit claims against an insurer against which a liquidation order has been entered in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(2) Secured Claims

(a) The owner of a secured claim against an insurer against which a liquidation order has been entered in this or any other state may surrender her or his security and file her or his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this chapter, or if it has been adjudicated by a court of competent jurisdiction in a proceeding in which the domiciliary receiver has had notice and an opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

(b) The value of any security held by a secured creditor shall be determined under supervision of the court by:

1. Converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditor; or
2. If no such agreement exists, the court shall determine the value in the event the creditor and the receiver cannot agree upon same.

(3) Administration of Workers' Compensation Large Deductible Policies and Insured Collateral

(a) Definitions.—As used in this subsection, the term:

1. "Collateral" means cash, a letter of credit, a surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured's obligation under a large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay the insurer as may be required for other secured obligations.

2. "Deductible claim" means any claim that is within the deductible under a large deductible policy, including a claim for loss and defense and cost containment expense, unless such expense is excluded by the terms of the policy.

3.a. "Large deductible policy" means a combination of one or more workers' compensation policies and endorsements issued to an insured, and contracts or security agreements entered into between an insured and the insurer, in which the insured has agreed with the insurer to:

(I) Pay directly the initial portion of any claim under the policy up to a specified dollar amount or the expenses related to any claim;
or

(II) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

b. The term also includes policies that contain an aggregate limit on the insured's liability for all deductible claims in addition to a per-claim deductible limit. A policy must meet the current guidelines for large deductible workers' compensation filings as defined by the office, including the eligibility standards regarding the minimum standard premium and the minimum deductible to be deemed a large deductible policy.

c. The term does not include policies, endorsements, or agreements providing that the initial portion of any covered claim must be self-insured and that the insurer has no payment obligation within the self-insured retention.

d. The term does not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder's large deductible obligations.

4. "Other secured obligations" means obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations, the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy.

(b) Applicability.—

1. This subsection applies to workers' compensation large deductible policies issued by an insurer that is subject to delinquency proceedings under this chapter. This subsection does not apply to first-party claims, or to covered claims funded by a guaranty association above the deductible unless paragraph (c) applies. Large deductible policies must be administered in accordance with the terms of the policy, except to the extent such terms conflict with this subsection.

2. This subsection applies to all delinquency proceedings that commence on or after July 1, 2017.

(c) Handling of large deductible claims.—Unless otherwise agreed to by the responsible guaranty association, all large deductible claims that are also covered claims as defined by an applicable guaranty association law, including those that may have been funded by an insured before liquidation, must be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim pursuant to an agreement by the guaranty fund or otherwise, the insured's funding or payment

of a deductible claim extinguishes the obligations, if any, of the receiver and any guaranty association to pay such claim. A charge may not be made against the receiver or a guaranty association on the basis of an insured's funding or payment of a deductible claim.

(d) Deductible claims paid by a guaranty association.—

1. To the extent a guaranty association pays any deductible claim for which an insurer would have been entitled to reimbursement from an insured, a guaranty association is entitled to the amount of reimbursements received or collateral available, subject to paragraph (g). Reimbursements paid to the guaranty association pursuant to this paragraph may not be treated as distributions under s. 631.271 or as early access payments under s. 631.397(1).

2. To the extent that a guaranty association pays a deductible claim that is not reimbursed from collateral or by insured payments, or the guaranty association incurred expenses in connection with large deductible policies that are not reimbursed under this subsection, the guaranty association is entitled to assert a claim for those amounts in the delinquency proceeding.

3. This paragraph does not limit any right of the receiver or a guaranty association which may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses.

(e) Collections.—

1. The receiver may collect reimbursements owed for deductible claims as provided in this paragraph, and must use reasonable efforts to collect such reimbursements from the insured or the party that is obligated to pay the deductible as specified in the large deductible policy or other agreement. The receiver may bill insureds and others for reimbursement of deductible claims that are:

a. Paid by the insurer before the commencement of delinquency proceedings;

b. Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or

c. Paid or allowed by the receiver.

2. If the insured or other party does not make payment within the time specified in the large deductible policy, or, if no time is specified, within a reasonable time after the date of billing, the receiver may take reasonable steps to collect any reimbursements owed.

3. The insolvency of the insurer or its inability to perform any of its obligations under the large deductible policy may not be a defense to the insured's reimbursement obligation under the large deductible policy.

4. An allegation of improper handling or payment of a deductible claim by the receiver or a guaranty association may not be a defense to the insured's reimbursement obligations under the large deductible policy.

(f) Collateral.—

1. Subject to this paragraph, the receiver shall use collateral, when available, to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or payment obligations. A guaranty association is entitled to collateral as provided for in this paragraph to the extent needed to reimburse a guaranty association for the payment of a deductible claim. Any distributions made to a guaranty association pursuant to this paragraph may not be treated as distributions under s. 631.271 or as early access payments under s. 631.397(1).

2. The receiver shall draw down collateral to the extent necessary in the event the insured fails to:

a. Perform its funding or payment obligations under any large deductible policy;

b. Pay deductible claim reimbursements within the time specified in the large deductible policy, or, if no time is specified, within 60 days after the date of the billing;

c. Pay amounts due to the estate for preliquidation obligations;

d. Timely fund any other secured obligation; or

e. Timely pay expenses.

3. Claims that are validly asserted against the collateral must be satisfied in the order in which such claims are received by the receiver. However, if more than one creditor has a valid claim against the same collateral and the available collateral, along with billing collection efforts and to the extent that the collateral is subject to other known secured obligations, are together insufficient to pay each creditor in full, the receiver may prorate payments based on the ratio of the amount of claims each creditor has to the total claims paid by all such creditors.

4. Excess collateral may be returned to the insured, as determined by the receiver, after a periodic review of claims paid, outstanding case reserves, and a factor for claims that were incurred but not reported.

(g) Receiver's expenses.—The receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements as provided pursuant to s. 631.271.

(h) Construction.—This subsection does not limit or adversely affect any rights or powers a guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association under policies of the insolvent insurer, or for related expenses the guaranty association incurs.

631.397 Use of certain marshaled assets

(1) ~~Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state,~~ The department, as receiver, ~~may~~ shall apply to the court for approval of a proposal to disburse assets out of such insurer's marshaled

assets, as such assets become available, to each association entitled thereto or, if there are no assets available for such disbursement, then for approval of such proposal as the receiver deems appropriate. For the purposes of this section, the term "association" includes the Florida Insurance Guaranty Association, Incorporated, the Florida Workers' Compensation Insurance Guaranty Association, and any entity or person performing a function in another state similar to that performed in this state by the Florida Insurance Guaranty Association, Incorporated, or the Florida Workers' Compensation Insurance Guaranty Association, provided the Florida Insurance Guaranty Association, Incorporated, or the Florida Workers' Compensation Insurance Guaranty Association, is entitled to like payment under the laws of the association's state of domicile in respect to insolvent companies doing business in that state.

...

~~(4) Notice of such application shall be given by the department to the associations in, and to the commissioners of insurance of, each of the states to which disbursement may be made. Such notice shall be made by certified mail, first-class postage prepaid, at least 15 days prior to submission of such application to the court. Such notice shall be deemed to have been made when deposited in the mail.~~

~~(5) Action on the application may be taken by the court if notice has been given pursuant to subsection (4) and the department's proposal complies with subsection (2).~~

HB 1107 was:

- Passed by the first chamber on April 20, 2017
- Included in NCCI's April 28, 2017 *Legislative Activity Report* (RLA-2017-16)
- Amended and passed by the second chamber on May 2, 2017

HB 1107 creates **section 440.1851 Personal identifying information of an injured or deceased employee; public records exemption** of the Florida Statutes as follows:

440.1851 Personal identifying information of an injured or deceased employee; public records exemption.—

(1) The personal identifying information of an injured or deceased employee which is contained in reports, notices, records, or supporting documentation held by the department pursuant to this chapter is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(a) As used in this section, the term "personal identifying information" means the injured or deceased employee's name, date of birth, home address or mailing address, e-mail address, or telephone number.

(b) The department may disclose information made confidential and exempt under this section only:

1. To the injured employee, to the spouse or a dependent of the deceased employee, to the spouse or a dependent of the injured employee if authorized by the injured employee, or to the legal representative of the deceased employee's estate;

2. To a party litigant, or his or her authorized representative, in matters pending before the Office of the Judges of Compensation Claims;

3. To a carrier or an employer for the purpose of investigating the compensability of a claim or for the purpose of administering its anti-fraud investigative unit established pursuant to s. 626.9891;

4. In an aggregate reporting format that does not reveal the personal identifying information of any employee;

5. Pursuant to a court order or subpoena;

6. To an agency for administering its anti-fraud investigative function or in the furtherance of the agency's official duties and responsibilities; or

7. To a federal governmental entity in the furtherance of the entity's official duties and responsibilities.

A carrier, employer, agency, or governmental entity receiving personal identifying information from the department shall maintain the confidential and exempt status of the information.

(c) This public records exemption applies to personal identifying information held by the department before, on, or after the effective date of this exemption.

(2) A person who willfully and knowingly discloses personal identifying information made confidential and exempt under this section to an unauthorized person or entity commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.

HB 1107 also includes the following language:

The Legislature finds that it is a public necessity to make confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution the personal identifying information of an injured or deceased employee which is contained in reports, notices, records, or supporting documentation held by the Department of Financial Services pursuant to chapter 440, Florida Statutes. Such information is of a sensitive, personal nature, and disclosure of such information about an injured or deceased employee is an invasion of that employee's privacy or the privacy of his or her family. Because of Florida's workers' compensation system, an employee's personal identifying information becomes public record once the Department of Financial

Services is notified that the employee has been injured or has died in a work-related incident. Public records requests for this information have resulted in unwanted solicitation of injured workers and their families. Further, the release of such information could lead to discrimination against the employee by coworkers, potential employers, and others because of perceived social stigma related to injuries or disabilities. The harm caused to such an employee or his or her family by the release of this information outweighs any public benefit derived from its release.

*NCCI is unable to quantify the potential workers compensation system cost impact from the enactment of **HB 1107**, although it may exert downward pressure on Florida workers compensation system costs over time.*

HB 7085 was:

- Passed by the first chamber on April 19, 2017
- Included in NCCI's April 28, 2017 **Legislative Activity Report** (RLA-2017-16)
- Amended and passed by the second chamber on May 5, 2017

HB 7085 amends various provisions of the workers compensation law and insurance code to:

- Permit direct payment of attorneys by or for claimants
- Increase total combined temporary total disability (TTD) and temporary partial disability (TPD) wage replacement benefits from 104 weeks to 260 weeks
- Fill a benefit gap that happens when TTD/TPD ends, but the injured worker is not at overall maximum medical improvement and/or no overall permanent impairment rating
- Allow a Judge of Compensation Claims (JCC) to award an hourly fee that departs from the statutory percentage-based attorney fee schedule
 - This is only permitted if the statutory fee is less than 40% or greater than 125% of the hourly rate customarily charged in the local community by defense attorneys, with the JCC determining the relevant facts
 - If the departure fee is allowed, the JCC determines the hourly rate, not to exceed \$180 per hour, using statutory factors and the number of necessary attorney hours
- Make the injured worker responsible for any remaining attorney fees if required by their retainer agreement; the retainer agreements must be filed with the JCCs, but are not subject to JCC approval
- Allow insurers to uniformly reduce premiums by no more than 5%, if they file an informational-only notice within 30 days, subject to regulatory oversight
- Create a mechanism to fill vacancies on the Three-Member Panel; grant the Panel authority to fill gaps in statutory reimbursement when adopting schedules of maximum reimbursement allowances for medical care
- Require a good faith effort by the claimant and their attorney to resolve disputes prior to filing a petition for benefits; mandate a specified notice regarding attorney fees be signed by the claimant; increase the requirements applicable to petitions for benefits; eliminate carrier-paid attorney fees for services occurring before the filing of a petition; attach attorney fees 45 days, rather than 30 days, following the filing of a petition; requires a JCC to dismiss a petition for lack of specificity, without prejudice, within 10 days or 20 days, depending upon whether a hearing is required
- Eliminate the charge-based reimbursement of health care facility outpatient medical care in favor of reimbursing them at 200% (unscheduled care) and 160% (scheduled surgery) of Medicare; if no Medicare fee exists, then current reimbursement standards apply, which are incorporated into statute
- Require the authorization or denial of medical care authorization requests, unless there is a material deficiency
- Provide for collecting additional information on attorney fees

*NCCI estimates that the combination of the proposed changes to **HB 7085** would result in a sizable to significant decrease in Florida's overall workers compensation system costs.*

South Carolina

HB 3879 was:

- Passed by the first chamber on March 22, 2017
- Included in NCCI's March 31, 2017 **Legislative Activity Report** (RLA-2017-12)
- Amended and passed by the second chamber on May 3, 2017

HB 3879 amends **section 42-9-290. Amount of compensation for death of employee due to accident** of the South Carolina Code of Laws, in part, as follows:

Section 42-9-290. Amount of compensation for death of employee due to accident

(A) If death results proximately from an accident and within two years of the accident or while total disability still continues and within six years after the accident, the employer shall pay or cause to be paid, subject, however, to the provisions of the other sections of this title, in one of the methods provided in this chapter, to the dependents of the employee wholly dependent upon

his earnings for support at the time of the accident, a weekly payment equal to sixty-six and two-thirds percent of his average weekly wages, but not less than seventy-five dollars a week so long as this amount does not exceed his average weekly wages; if this amount does exceed his average weekly wages, the amount payable may not be less than his average weekly wages nor more than the average weekly wage in this State for the preceding fiscal year, for a period of five hundred weeks from the date of the injury, and burial expenses up to but not exceeding ~~twenty-five hundred~~ twenty-five hundred twelve thousand dollars. If the employee leaves dependents, only partly dependent upon his earnings for support at the time of the injury, the weekly compensation to be paid must equal the same proportion of the weekly payments for the benefit of persons wholly dependent as the amount contributed by the employee to such partial dependence bears to the annual earnings of the deceased at the time of his injury. When weekly payments have been made to an injured employee before his death, the compensation to dependents begins from the date of the last of such payments but does not continue more than five hundred weeks from the date of the injury. Compensation under this title to aliens not residents (or about to become nonresidents) of the United States or Canada is the same in amount as provided for residents, except that dependents in any foreign country are limited to a surviving spouse and child or children or, if there be no surviving spouse or child, to a surviving father or mother whom the employee has supported, either wholly or in part, for a period of three years before the date of the injury, and except that the commission may, at its option, or upon the application of the insurance carrier, commute all future installments of compensation to be paid to such aliens by paying or causing to be paid to them one-half of the commuted amount of future installments of compensation as determined by the commission.

...

Tennessee

SB 297 was:

- Passed by the first chamber on April 13, 2017
- Included in NCCI's April 21, 2017 **Legislative Activity Report** (RLA-2017-15)
- Amended and passed by the second chamber on May 3, 2017

SB 297, as amended, amends **sections 50-6-124. Utilization review system—Pre-admission review—Penalties for rendering excessive or inappropriate services—Legislative intent—Treatment guidelines** and **50-6-204. Medical treatment, attendance and hospitalization—Release of medical records—Reports—Disputes—Reimbursement or payment of expenses—Burial expenses—Physical examinations—Pain management—Impairment ratings** of the Tennessee Code as follows:

50-6-124. Utilization review system—Pre-admission review—Penalties for rendering excessive or inappropriate services—Legislative intent—Treatment guidelines.

...

(j) (1) Except as otherwise provided in subdivision (j)(2), the system of utilization review established by the administrator or provided by an employer shall not apply to:

(A) Diagnostic procedures ordered in accordance with the treatment guidelines by the authorized treating physician or chiropractor in the first thirty (30) days after the date of injury; or

(B) Diagnostic studies recommended by the treating physician in the event the initial treatment regimen is nonsurgical, without diagnostic testing, and is not successful in returning the injured worker to employment.

(2) A recommended invasive procedure shall be subject to utilization review at any time.

(3) For purposes of this subsection (j):

(A) "Diagnostic procedures" includes, but is not limited to, routine and specialty radiography, magnetic resonance imaging that is not for low back pain without radiculopathy, a computerized tomography scan, a myelogram, an arthrogram, an ultrasound, and electromyogram and nerve conduction velocity testing; and

(B) "Initial treatment" means the first series of treatments or therapies or first two (2) medication trials ordered by the authorized treating physician in accordance with the adopted treatment guidelines within sixty (60) days of a reported injury.

50-6-204. Medical treatment, attendance and hospitalization—Release of medical records—Reports—Disputes—Reimbursement or payment of expenses—Burial expenses—Physical examinations—Pain management—Impairment ratings.

(a)

...

(3)

...

(B) If three (3) or more independent reputable physicians, surgeons, chiropractors or specialty practice groups **not associated in practice together** are not available in the employee's community, the employer shall provide a list of three (3) independent reputable physicians, surgeons, chiropractors, or specialty practice groups within a one-hundred-~~twenty-five~~ (100) mile radius of the employee's community of residence. For purposes of this subdivision (a)(3)(B), "not associated in practice together" means at least one (1) physician, surgeon, chiropractor, or specialty practice group is not associated in practice with another physician, surgeon, chiropractor, or specialty practice group that is on the list or panel provided to an employee pursuant to this section.

...

(c) In case death results from the injury or occupational disease, as defined in § 50-6-102, the employer shall, in addition to the medical services, etc., referred to in subsections (a) and (b), pay the burial expenses of the deceased employee, not exceeding ~~seven thousand five hundred dollars (\$7,500)~~ **ten thousand dollars (\$10,000)**. If the deceased employee leaves no dependents entitled to compensation under this chapter, the employer shall pay to the employee's estate the additional benefits provided in § 50-6-209(b)(2) and (3), and shall also be liable for the medical and hospital services and burial expenses provided for in this section.

...

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending May 5, 2017.

Colorado

HB17-1119 adds **Article 67** to **Title 8** of the Colorado Revised Statutes, which creates the:

- Colorado Uninsured Employer Act to create a new mechanism for the payment of covered claims to workers who are injured while employed by employers who do not carry workers compensation insurance.
- Colorado uninsured employer fund, which consists of penalties for employers who do not carry workers compensation insurance.
- Uninsured employer board:
 - To establish the criteria for the payment of benefits
 - To set rates
 - To adjust claims
 - To adopt rules

The board is required to adopt, by rule, a plan of operation to administer the fund and to institute procedures to collect money due to the fund.

Rhode Island

HB 5934, in part, deletes **section 27-9-51 Excess profits for workers' compensation and employer's liability insurance prohibited**, as follows:

~~**27-9-51. Excess profits for workers' compensation and employer's liability insurance prohibited.**~~

~~(a) Each insurance group shall file with the department prior to July 1 of each year, on a form prescribed by the department, the following data for workers' compensation and employers' liability insurance:~~

~~(1) The calendar year earned premium;~~

~~(2) Accident year incurred losses and loss adjustment expenses;~~

~~(3) The administrative and selling expenses incurred in Rhode Island or allocated to Rhode Island for the calendar year; and~~

~~(4) Policyholder dividends applicable to the calendar year.~~

~~(b) (1) Excess profit has been realized if the underwriting gain is greater than the anticipated underwriting profit plus five percent (5%) of earned premiums for the three (3) most recent calendar years;~~

~~(2) As used in this section with respect to any three (3) year period, "anticipated underwriting profit" means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurance group in effect during that period, the earned premiums applicable to the rate filing during that period by the percentage factor included in the rate filing for profit and contingencies, the percentage factor having been determined with due recognition to investment income from funds generated by Rhode Island business. Separate calculations need not be made for consecutive rate filings containing the same percentage factor for profits and contingencies.~~

~~(c) Each insurance group shall also file a schedule of Rhode Island loss and loss adjustment experience for each of the three (3) most recent accident years. The incurred losses and loss adjustment expenses shall be valued as of December 31 of the accident year, developed to an ultimate basis, and two (2) twelve (12) month intervals after this, each developed to an ultimate basis so that a total of three (3) evaluations will be provided for each accident year. For reporting purposes unrelated to determining excessive profits, the loss and loss adjustment experience of each accident year shall continue to be reported until each accident year has been reported at eight (8) stages of development.~~

~~(d) Each insurance group's underwriting gain or loss for each calendar accident year shall be computed as follows: The sum of the accident year incurred losses and loss adjustment expenses as of December 31 of the year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder dividends applicable to the calendar year, shall be subtracted from the calendar year earned premium to determine the underwriting gain or loss.~~

~~(e) For the three (3) most recent calendar accident years, the underwriting gain or loss shall be compared to the anticipated underwriting profit.~~

~~(f) If the insurance group has realized an excess profit, the department shall order a return of the excess amounts after affording the insurance group an opportunity for a hearing and complying with the provisions of the Administrative Procedures Act, chapter~~

35 of title 42. The excess amounts shall be refunded in all instances unless the insurance group affirmatively demonstrates to the department that the refund of the excess amounts will render the insurance group insolvent under the provisions of this title.

(g) Any excess profit of an insurance group offering workers' compensation or employers' liability insurance shall be returned to policyholders in the form of a cash refund or be returned to policyholders in the form of a credit toward the future purchase of insurance. The excess amount shall be refunded on a pro rata basis in relation to the final compilation year earned premiums to the workers' compensation policyholders of record of the insurance group on December 31 of the final compilation year.

(h) (1) Cash refunds to policyholders may be rounded to the nearest dollar;
 (2) Data in required reports to the department may be rounded to the nearest dollar;
 (3) Rounding, if elected by the insurance group, shall be applied consistently.

(i) (1) Refunds shall be completed in one of the following ways:
 (i) If the insurance group elects to make a cash refund, the refund shall be completed within sixty (60) days of the entry of a final order indicating that excess profits have been realized; or
 (ii) If the insurance group elects to make refunds in the form of a credit to renewal policies, the credits shall be applied to policy renewal premium notices which are forwarded to insured more than sixty (60) calendar days after the entry of a final order indicating that excess profits have been realized. If an insurance group has made this election, but an insured after this cancels his or her policy or allows his or her policy to terminate, the insurance group shall make a cash refund not later than sixty (60) days after the termination of the coverage;
 (2) Upon completion of the renewal credits or refund payments, the insurance group shall immediately certify to the department that the refunds have been made.

(j) Any refund or renewal credit made pursuant to this section, for the purposes of reporting under this section for subsequent years, shall be treated as a policyholder dividend applicable to the year in which it is incurred.

Texas

HB 2057 amends *section 504.053 Election* of the Texas Labor Code as follows:

504.053 Election

...

(e) Nothing in this chapter waives sovereign immunity or creates a new cause of action, except that a political subdivision that self-insures either individually or collectively is liable for attorney's fees as provided by Section 417.003.

HB 2057 also includes the following language:

Section 504.053, Labor Code, as amended by this Act, applies only to a third-party action under Chapter 417, Labor Code, commenced on or after the effective date of this Act. A third-party action under Chapter 417, Labor Code, commenced before the effective date of this Act is governed by the law applicable to the action immediately before the effective date of this Act, and that law is continued in effect for that purpose.

BILLS VETOED BY GOVERNOR

The following workers compensation-related bills were vetoed by the governor within the one-week period ending May 5, 2017.

Montana

HB 358 was:

- Passed by the first chamber on February 27, 2017
- Included in NCCI's March 10, 2017 *Legislative Activity Report* (RLA-2017-09)
- Passed by the second chamber on March 23, 2017
- Included in NCCI's March 31, 2017 *Legislative Activity Report* (RLA-2017-12)
- Governor's proposed amendments rejected by first and second chamber on April 24, 2017
- Vetoed by the governor on May 4, 2017

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.

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
- Included in NCCI's April 14, 2017 **Legislative Activity Report** (RLA-2017-14)
- Governor's proposed amendments rejected by the first chamber on April, 18, 2017
- Governor's proposed amendments rejected by the second chamber on April 24, 2017
- Vetoed by the governor on May 4, 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.

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, ID, MT, NV, OR	Peter Burton	610-964-8852
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
IA, 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.