



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 12, 2017.

Arizona

SB 1332 was:

- Passed by the first chamber on February 23, 2017
- Included in NCCI's March 3, 2017 **Legislative Activity Report** (RLA-2017-08)
- Amended and passed by the second chamber on April 17, 2017
- Included in NCCI's April 28, 2017 **Legislative Activity Report** (RLA-2017-16)
- Amended by Conference Committee on April 20, 2017
- Passed by the first chamber as amended by the Conference Committee on April 27, 2017
- Passed by the second chamber as amended by the Conference Committee on May 4, 2017
- Enacted on May 8, 2017, with an effective date of October 31, 2017

SB 1332, in part, repeals **section 23-941.01 Final settlement agreement; definition** and replaces it with **section 23-941.01 Settlement of accepted claims; exceptions; definitions**, and amends **section 23-1062. Medical, surgical, hospital benefits; translation services; commencement of compensation; method of compensation** of the Arizona Revised Statutes as follows:

23-941.01. Final settlement agreement; definition

A. Any final settlement agreement involving a workers' compensation claim is not valid and enforceable until the final settlement agreement is approved by the commission.

B. Subject to the following requirements, the parties may enter into a final settlement and release of a claim for undisputed entitlement to supportive medical maintenance benefits after the period of temporary disability is terminated by a final notice of claim status or award of the commission. The carrier or employer shall submit a summary of all reasonably anticipated future supportive medical maintenance benefits and the projected cost of the benefits for review by the employee. The summary shall also be included with the final settlement agreement filed with the commission. All medical conditions subject to the final settlement agreement must be described in the final settlement agreement. The final settlement provisions defined in this subsection shall only apply to future supportive medical maintenance benefits for the described condition.

C. The employer or carrier shall inform the attending physician of the approval of a final settlement agreement if the final settlement agreement terminates the employee's entitlement to supportive medical maintenance benefits. Unless supportive medical maintenance benefits rendered prior to the date of the final settlement are subject to a dispute or payment for the treatment was included in the final settlement agreement, the employer or carrier shall remain responsible for payment for the treatment not covered by the final settlement agreement as provided by this chapter.

D. For the purposes of this section, "final settlement" means a settlement in which the injured worker waives any future entitlement to supportive medical maintenance benefits for known conditions described in the agreement.

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

A. The interested parties to a claim may:

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

B. Any full and final settlement shall:

1. Be in writing.
2. Be signed by the carrier, special fund or self-insured employer and the employee or the employee's authorized representative.
3. Acknowledge that the employee had the opportunity to seek legal advice and be represented by counsel.
4. Include a description of the employee's medical conditions that have been identified and contemplated at the time of the settlement agreement.

C. If the employee is represented by counsel, the full and final settlement shall include the following attestations:

1. The employee understands the rights settled and released by the agreement and was represented by counsel.
2. The employee has been provided information from the carrier, special fund or self-insured employer that outlines any reasonable anticipated future medical, surgical and hospital benefits relating to the claim and the projected cost of those benefits and that provides an explanation of how those projected costs were determined.
3. The employee understands that monies received for future medical treatment associated with the industrial injury should be set aside to ensure that the costs of such treatment will be paid.
4. The parties have considered and taken reasonable steps to protect any interests of Medicare, Medicaid, the Indian Health Service and the United States Department of Veterans Affairs, including establishing a Medicare savings account if necessary.
5. The parties have conducted a search for and taken reasonable steps to satisfy any identified medical liens.

D. If the employee is not represented by counsel, the employee shall appear before an administrative law judge and the administrative law judge shall make specific factual findings regarding whether the requirements of subsection B and subsection C, paragraphs 2, 3, 4 and 5 of this section are satisfied. The administrative law judge may not approve the settlement if the requirements of subsection B of this section are not met or if the settlement is not deemed fair and reasonable to the employee.

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

1. Whether the employee's injuries are stabilized.
2. The permanency of the employee's injuries.

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

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

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

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

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

K. For the purposes of this section:

1. "Full and final settlement" means a settlement in which the injured employee or, if the injured employee is deceased, the employee's estate, surviving spouse or dependent waives any future entitlement to benefits on the claim and any future right to change the claim pursuant to section 23-1044, subsection F or reopen the claim pursuant to section 23-1061, subsection H.
2. "Special fund" means the special fund established by section 23-1065.

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

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

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

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

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

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

SB 1332 also includes the following language:

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

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

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

Maine

LD 612 was:

- Passed by the first chamber on April 18, 2017
- Amended and passed by the second chamber on April 20, 2017
- Included in NCCI's April 28, 2017 **Legislative Activity Report** (RLA-2017-16)
- Enacted without the governor's signature on May 10, 2017, with a projected effective date of September 19, 2017

LD 612 amends ***Title 39-A, Chapter 5, section 217. Employment rehabilitation*** as follows:

§ 217. Employment rehabilitation

...

~~**8. Presumption.** If an employee is participating in a rehabilitation plan ordered pursuant to subsection 2, there is a presumption that work is unavailable to the employee for as long as the employee continues to participate in employment rehabilitation.~~

9. Reduction of benefits. If an employee is actively participating in a rehabilitation plan ordered pursuant to subsection 2, benefits may not be reduced except:

A. Under section 205, subsection 9, paragraph A, upon the employee's return to work with or an increase in pay from an employer who is paying the employee compensation under this Act;

B. Under section 205, subsection 9, paragraph B, based on the amount of actual documented earnings paid to the employee; or

C. When the employee reaches the durational limit of benefits paid under section 213.

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
- Included in NCCI's May 12, 2017 **Legislative Activity Report** (RLA-2017-18)
- Enacted and effective on May 11, 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 1214 was:

- Passed by the first chamber on April 17, 2017
- Included in NCCI's April 28, 2017 *Legislative Activity Report* (RLA-2017-16)
- Passed by the second chamber on April 27, 2017
- Included in NCCI's May 5, 2017 *Legislative Activity Report* (RLA-2017-17)
- Enacted and effective on May 9, 2017

SB 1214 makes various changes to the Tennessee Workers' Compensation Law as follows:

- Renames the Second Injury Fund the Subsequent Injury and Vocational Recovery Fund.
- Authorizes a sole proprietor, a partner, and members of a Limited Liability Company (LLC) who devote full time to the company to elect to be a covered employee for workers compensation purposes by filing written notice of the election with the partnership, proprietorship, or LLC; and requires that the election be filed with the insurer. Such a sole proprietor, a partner, or member of an LLC may at any time withdraw the election by giving notice of the withdrawal to the partnership, proprietorship, or LLC.
- Specifies, with regard to an officer of a corporation electing to be exempt from the Workers' Compensation Law, that notice of such election will not be effective until filed with the corporation; and adds provisions regarding the revocation of the exemption.
- Requires that only the employer must be provided the notice and affidavit. Present law authorizes corporate officers, other than corporate officers engaged in the construction industry, to elect exemption from the Workers' Compensation Law by providing notice of the election to the bureau and the officer's employer along with an affidavit affirming that the election was not advised, counseled, or encouraged by the employer.
- Requires that an employer with less than five regular employees who wants to opt into the law must purchase a workers compensation insurance policy rather than provide notice to the bureau. Present law generally exempts nonconstruction services employers who have less than five regular employees from the Workers' Compensation Law; and any such exempt employer may opt into the law by filing a notice with the bureau.
- Authorizes any employee who has exhausted eligibility for permanent partial disability benefits and, following a workers compensation injury, has not returned to work with any employer or has returned to work and is receiving wages or a salary that is less than 100% of the wages or salary the employee received from the employee's pre-injury employer on the date of injury, to request vocational recovery assistance from the subsequent injury and vocational recovery fund. Vocational recovery assistance may include, but is not limited to, vocational assessment, employment training, job analysis, vocational testing, GED classes and testing, and education through a public Tennessee higher education institution, including books and materials required for courses. All vocational recovery assistance is subject to the maximum limit of \$5,000 per eligible employee in a fiscal year, not to exceed a total sum of \$20,000 per employee who participates in the program for all years. The total aggregate amount to be paid from the subsequent injury and vocational recovery fund as to all eligible employees will be limited to a total of \$500,000 in a calendar year. The administrator of the bureau will determine whether to grant requests for vocational recovery assistance. The bill also sets financial parameters for use of the monies in the subsequent injury and vocational recovery fund for vocational recovery assistance and deletes the present law requirement that the administrator cause the bureau of workers' compensation to refer all feasible cases for vocational rehabilitation to the department of education. The provisions described here are limited to injuries that occur on or after July 1, 2018, but before July 1, 2021.
- Specifies that oral argument may be heard for appeals to the workers compensation appeals board; deletes from present law the authorization for the workers compensation appeals board to reverse or modify and remand the decision of a workers compensation judge when the rights of any party have been prejudiced because findings, inferences, conclusions, or decisions of a workers compensation judge:

(A) Violate constitutional or statutory provisions;

- (B) Exceed the statutory authority of the workers' compensation judge;
- (C) Do not comply with lawful procedure;
- (D) Are arbitrary, capricious, characterized by abuse of discretion, or clearly an unwarranted exercise of discretion; or
- (E) Are not supported by evidence that is both substantial and material in the light of the entire record
- Requires any employer of a construction services provider to, upon request by the bureau, provide proof of valid workers' compensation insurance coverage at the employer's place of business and at job sites where the employer is providing construction services; authorizes the administrator to assess a penalty of \$50 to \$5,000 per violation for failure to provide proof of valid workers' compensation insurance coverage, and the administrator may assess not less than \$50 nor more than \$5,000 per violation for subsequent violations.
- Authorizes the administrator to assess a penalty of \$50 to \$5,000 per violation against any person or representative of an entity who knowingly enters or directs a party to enter false or unauthorized information on a construction services provider's application to the secretary of state. Present law generally requires all construction services providers to carry workers compensation insurance; provided, that a construction service provider who meets certain criteria may apply to the secretary of state for an exemption.
- Requires insurers to advise policy holders who are construction services providers about the availability of electronic downloads of policy information to facilitate field inspection of proof of workers compensation coverage.

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending May 12, 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.

HB17-1119 also amends **section 8-40-301** *Scope of term "employee"* of the Colorado Revised Statutes as follows:

8-40-301. Scope of term "employee"—definition.

(1) (a) "Employee" excludes any person employed by a passenger tramway area operator, as defined in section 25-5-702 (1), C.R.S., or other employer, while participating in recreational activity, who at such time is relieved of and is not performing any duties of employment, regardless of whether such person is utilizing, by discount or otherwise, a pass, ticket, license, permit, or other device as an emolument of employment.

(b) (I) "Employee" excludes any person employed by an out-of-state employer performing incidental work in Colorado where the employee is covered at the time of injury under the workers' compensation act of another state regardless of where the contract for employment was created.

(II) For purposes of this section, "incidental work" means work that is randomly or fortuitously in Colorado.

(III) This section only applies to a workers' compensation act of another state that includes a reciprocal provision exempting Colorado employers from liability under the other state's act for incidental work.

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Oregon

HB 2186 was:

- Passed by the first chamber on March 1, 2017
- Included in NCCI's March 10, 2017 *Legislative Activity Report* (RLA-2017-09)
- Passed by the second chamber on May 11, 2017

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

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

...

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

...

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

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

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

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

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

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

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

(ii) The employer, if a city, county, special district described and listed in ORS 198.010 or 198.180, translator district formed under ORS 354.605 to 354.715, weed control district organized under ORS 569.350 to 569.445, intergovernmental agency created under ORS 225.050, school district as defined in ORS 255.005 (9), public housing authority created under ORS chapter 456 or regional council of governments created under ORS chapter 190, agrees to be individually liable for the payment of any compensation and other amounts due to the department under this chapter incurred by the employer during the period of group self-insurance;

(E) The director finds that the employer group is organized as a corporation or cooperative pursuant to ORS chapter 60, 62 or 65, is an intergovernmental entity created under ORS 190.003 to 190.130 or is a self-insurance program under ORS 30.282 (3), and the bylaws of the employer group require the governing employer group to obtain fidelity bonds;

...

HB 2335 was:

- Passed by the first chamber on March 2, 2017
- Included in NCCI's March 10, 2017 **Legislative Activity Report** (RLA-2017-09)
- Passed by the second chamber on May 9, 2017

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

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

...

(8) ...

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

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

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

(e) ...

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

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

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

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

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

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

...

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

...

HB 2336 was:

- Passed by the first chamber on March 2, 2017
- Included in NCCI's March 10, 2017 **Legislative Activity Report** (RLA-2017-09)
- Passed by the second chamber on May 9, 2017

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

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

...

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

(3) If for any reason the certification of a self-insured employer or self-insured employer group is canceled or terminated, the surety bond or other security deposited with the director ~~shall~~ must remain on deposit or in effect, as the case may be, for a period of at least 62 months after the employer ceases to be a self-insured employer. The surety bond or other security ~~shall~~ must be maintained in an amount necessary to secure the outstanding and contingent liability arising from the accidental injuries secured by the surety bond or other security; and to ~~assure~~ ensure the payment of claims for aggravation and claims arising under ORS 656.278 based on those accidental injuries. At the expiration of the 62-month period, or of another period the director may consider proper, the director may accept in lieu of the surety bond or other security deposited with the director a policy of paid-up insurance in a form approved by the director.

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

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

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

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

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

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

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

(1) An election made pursuant to ORS 656.578 not to proceed against ~~the an~~ an employer or third person operates as an assignment to the paying agency of the cause of action, if any, of ~~the a~~ a worker, or the beneficiaries or legal representative of ~~the a~~ a deceased

worker; against the employer or third person, and the paying agency may bring action against ~~such the~~ employer or third person in the name of the ~~injured~~ worker or other beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

(6) ~~Prior to~~ Before, and instead of, the distribution of proceeds as described in subsection (1) of this section, ~~when the if~~ a worker or the beneficiaries of ~~the a~~ worker are entitled to receive payment pursuant to a judgment or a settlement in ~~the a~~ third party action in the amount of \$1 million or more, the worker or the beneficiaries of the worker may elect to release the paying agency

from all further liability on the workers' compensation claim, thereby canceling the lien of the paying agency as to the present value of ~~its~~ the paying agency's reasonably expected future expenditures for workers' compensation and other costs of the worker's claim, if all of the following conditions are met as part of the claim release:

- (a) The worker or the beneficiaries of the worker are represented by an attorney.
- (b) The release of the claim is presented in writing and is filed with the Workers' Compensation Board, with a copy served on the paying agency, including the Department of Consumer and Business Services with respect to ~~its~~ the department's expenditures from ~~the Workers' Benefit Fund,~~ the Consumer and Business Services Fund, ~~and~~ the Self-Insured Employer Adjustment Reserve, the Self-Insured Employer Group Adjustment Reserve and the Workers' Benefit Fund.
- (c) The claim release specifies that the worker or the beneficiaries of the worker understand that the claim release means that no further benefits of any nature whatsoever ~~shall~~ will be paid to the worker or the beneficiaries of the worker.
- (d) The release of the claim is accompanied by a settlement stipulation with the paying agency, outlining terms of reimbursement to the paying agency, covering ~~its~~ the paying agency's incurred expenditures for compensation, first aid or other medical, surgical or hospital service and for expenditures from ~~the Workers' Benefit Fund,~~ the Consumer and Business Services Fund, ~~and~~ the Self-Insured Employer Adjustment Reserve, the Self-Insured Employer Group Adjustment Reserve and the Workers' Benefit Fund to the date the release becomes final or the order of the board becomes final. If the payment of such incurred expenditures is in dispute, the release of the claim ~~shall~~ must be accompanied by a written submission of the dispute by the worker or the beneficiaries of the worker to the board for resolution of the dispute by order of the board under procedures allowing for board resolution under ORS 656.587, in which case the release of the claim ~~shall not be~~ is not final until such time as the order of the board becomes final. In such a case, the only issue to be decided by the board is the amount of incurred expenses by the paying ~~agent~~ agency.
- (e) If a service, item or benefit has been provided but a bill for that service, item or benefit has not been received by the paying agency before the release or order becomes final, the reimbursement payment ~~shall~~ must cover the bill ~~pursuant to~~ in accordance with the following process:
 - (A) The paying agency may maintain a contingency fund in an amount reasonably sufficient to cover reimbursement for the billing.
 - (B) If a dispute arises as to reimbursement for any bill first received by the paying agency not later than 180 days after the date the release or order became final, the dispute ~~shall~~ must be resolved by order of the board.
 - (C) Any amount remaining in the contingency fund after the 180-day period ~~shall~~ must be paid to the worker or the beneficiaries of the worker.
 - (D) Any billing for a service, item or benefit that is first received by the paying agency more than 180 days after the date the release or order became final is unenforceable by the person who issued the bill.
 - (f) The settlement or judgment proceeds are available for payment or actually have been paid out and are available in a trust fund or similar account, or are available through a legally enforceable structured settlement agreement if sufficient funds are available to make payment to the paying agency.
 - (g) The agreed-upon payment to the paying agency, or the payment to the paying agency ordered by the board, is made within 30 days of the filing of the withdrawal of the claim with the board or within 30 days after the board has entered a final order resolving any dispute with the paying agency.
- (7) ~~When~~ If a release of further liability on a claim, as provided in subsection (6) of this section, has been filed, and ~~when~~ if payment to the paying agency has been made, the effect of the release is that the worker or the beneficiaries of the worker ~~shall~~ have no further right to seek benefits ~~pursuant to~~ under the original claim, or any independent workers' compensation claim regarding the same circumstances, and the claim ~~shall~~ may not be reasserted, refiled or reestablished through any legal proceeding.

HB 2336 also includes the following clause:

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

HB 2337 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 May 9, 2017

HB 2337 amends **section 656.206 Permanent Total Disability** of the Oregon Revised Statutes, in part, as follows:

Section 1. **656.206 Permanent Total Disability.**

...

(2) ~~When~~ If permanent total disability results from ~~the a~~ a worker's injury, the worker shall receive during the period of that disability compensation benefits equal to 66-2/3 percent of wages ~~not to exceed 100,~~ no more than 133 percent of the average weekly wage

~~not or no~~ less than the amount of 90 percent of wages a week or the amount of \$50, whichever amount is lesser 33 percent of the average weekly wage .

...

HB 2337 also includes the following clause:

Section 2. The amendments to ORS 656.206 by section 1 of this 2017 Act apply to injuries occurring on or after the effective date of this 2017 Act.

HB 2338 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 May 9, 2017

HB 2338 amends **sections 656.005 Definitions, 656.204 Death, and 656.208 Death during permanent total disability** of the Oregon Revised Statutes, in part, as follows:

Section 1. **656.005 Definitions.**

...

(5) "Child" means a child of an injured worker, including:

(a) includes A posthumous child; ;

(b) A child legally adopted ~~prior to~~ before the injury; ;

(c) A child toward whom the worker stands in loco parentis; ;

(d) A child born out of wedlock ;

(e) ~~and~~ A stepchild, if ~~such the~~ stepchild was, at the time of the injury, a member of the worker's family and substantially dependent upon the worker for support. ; and

(f) A dependent child ~~of any age~~ who is an invalid is a child, for purposes of benefits, regardless of age, so long as the child was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support. For purposes of this chapter, a dependent child who is an invalid is considered to be a child under 18 years of age ~~was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support.~~

...

(10) (a) "Dependent" means any of the ~~following named~~ following relatives of the worker who, at the time of an accident, depended in whole or in part for the relative's support on the earnings of a worker ~~whose death results from any who dies as a result of an injury: Parent, grandparent, stepparent, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. Unless otherwise provided by treaty, aliens not residing within the United States at the time of the accident other than parent, spouse in a marriage or children are not included within the term "dependent."~~

(A) A parent, grandparent or stepparent;

(B) A grandson or granddaughter;

(C) A brother or sister or half-brother or half-sister; and

(D) A niece or nephew.

(b) "Dependent" does not include an alien who does not reside within the United States at the time of the accident, other than a parent, a spouse or children, unless a treaty provides otherwise.

...

Section 2. **656.204 Death.** If death results from ~~the an~~ accidental injury, payments ~~shall~~ must be made as follows:

(1)(a) The cost of final disposition of the body and funeral expenses, including but not limited to transportation of the body, ~~shall~~ must be paid, not to exceed 20 times the average weekly wage in any case.

(b) The insurer or self-insured employer shall pay bills submitted for disposition and funeral expenses up to the benefit limit established in paragraph (a) of this subsection. If any part of the benefit remains unpaid 60 days after the date of death or the date of claim acceptance, whichever is later, the insurer or self-insured employer shall pay the unpaid amount to the estate of the worker.

(2)(a) If ~~the a~~ worker is survived by a spouse, monthly benefits ~~shall~~ must be paid in an amount equal to 4.35 times 66-2/3 percent of the average weekly wage to the surviving spouse until remarriage. The payment shall cease at the end of the month in which the remarriage occurs.

~~(b) If the worker is survived by a spouse, monthly benefits also shall be paid in an amount equal to 4.35 times 10 percent of the average weekly wage for each child of the deceased who is substantially dependent on the spouse for support, until such child becomes 18 years of age.~~

~~(c) If the worker is survived by a spouse, monthly benefits also shall be paid in an amount equal to 4.35 times 25 percent of the average weekly wage for each child of the deceased who is not substantially dependent on the spouse for support, until such child becomes 18 years of age.~~

~~(d) If a surviving spouse receiving monthly payments dies, leaving a child who is entitled to compensation on account of the death of the worker, a monthly benefit equal to 4.35 times 25 percent of the average weekly wage shall be paid to each such child until the child becomes 18 years of age or the child's entitlement to benefits under subsection (8) of this section ceases, whichever is later.~~

~~(e) If a child who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.~~

~~(f) In no event shall the total monthly benefits provided for in this subsection exceed 4.35 times 133 1/3 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each child will be reduced proportionally.~~

~~(3)(a) (b) Upon remarriage, a surviving spouse shall must be paid 36 times the monthly benefit in a lump sum as final payment of the claim, but the monthly payments for each child shall continue as before surviving spousal benefit.~~

~~(b) (c) If, after the date of the subject worker's death, the surviving spouse cohabits with another person for an aggregate period of more than one year and a child has resulted from the relationship, the surviving spouse shall must be paid 36 times the monthly benefit in a lump sum as final payment of the claim, but the monthly payment for any child who is entitled to compensation on account of the death of the worker shall continue as before surviving spousal benefit.~~

~~(4)(a) (3)(a) If the a worker does not leave a spouse but leaves a child under 18 19 years of age, a monthly benefit equal to 4.35 times 25 percent of the average weekly wage shall must be paid to each such child until the child becomes 18 19 years of age.~~

~~(b) If a child who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.~~

~~(c) (b) In no event shall The total benefits provided for in this subsection may not exceed 4.35 times 133-1/3 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each child ~~will~~ must be reduced proportionally.~~

~~(5)(a) (4)(a) If the a worker leaves a dependent other than a surviving spouse or a child, a monthly payment shall must be made to each dependent that is equal to 50 percent of the average monthly support the dependent actually received ~~by such dependent~~ from the worker during the 12 months ~~next~~ preceding the occurrence of the accidental injury. If a dependent is under the age of 18 19 years at the time of the accidental injury, the payment to the dependent shall must cease when ~~such the~~ dependent becomes 18 19 years of age. The payment to any dependent shall must cease under the same circumstances that would have terminated the dependency had the injury not happened.~~

~~(b) If the dependent who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.~~

~~(c) (b) In no event shall The total benefits provided for in this subsection may not exceed 4.35 times 10 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each dependent ~~will~~ must be reduced proportionally.~~

~~(6) (5) If a child is an invalid at the time the child otherwise becomes ineligible for benefits under this section, the payment to the child shall must continue while the child remains an invalid. If a person is entitled to payment because the person is an invalid, payment shall must terminate when the person ceases to be an invalid.~~

~~(7) If, at the time of the death of a worker, the child of the worker or dependent has become 17 years of age but is under 18 years of age, the child or dependent shall receive the payment provided in this section for a period of one year from the date of the death. However, if after such period the child is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.~~

~~(8)(a) (6)(a) Benefits under this section which are to be paid as provided in this subsection shall be paid for the child or dependent until the child or dependent becomes 19 years of age. If, however, the child or dependent is attending higher education or begins attending higher education within six months of the date the child or dependent leaves high school, benefits shall be paid until the child or dependent becomes 23 years of age, ceases attending higher education or graduates from an approved institute or program, whichever is earlier. If a child or dependent is between 19 and 26 years of age at the time of a worker's death, or becomes 19 years of age after the worker's death, monthly benefits must be paid for not more than 48 months until the age of 26 during a period in which the child or dependent is completing secondary education, is obtaining a general educational development certificate or is attending a program of higher education. The child or dependent must provide an insurer or self-insured employer with documentation that enables the insurer or self-insured employer to determine the child's or dependent's eligibility for monthly benefits.~~

~~(b) If a child or dependent who is eligible for benefits under this subsection ~~has no~~ does not have a surviving parent, the child or dependent shall must receive 4.35 times 66-2/3 percent of the average weekly wage ~~until the child or dependent becomes 23 years of age, ceases attending higher education or graduates from an approved institute or program, whichever is earlier.~~~~

~~(c) As used in this subsection, "attending a program of higher education" means regularly attending community college, college or university, or regularly attending a course of vocational or technical training designed to prepare the participant for gainful~~

employment. A child or dependent enrolled in an educational course load of less than one-half of that determined by the educational facility to constitute “full-time” enrollment is not “attending a program of higher education.”

~~(9)~~ (7) As used in this section, “average weekly wage” has the meaning for that term provided in ORS 656.211.

Section 3. **656.208 Death during permanent total disability.** ~~(1) If the an~~ injured worker dies during the period of the worker’s permanent total disability, whatever the cause of death, leaving a spouse or any dependents listed in ORS 656.204, and the worker leaves a beneficiary, payment ~~shall~~ must be made in the same manner and in the same amounts as provided in ORS 656.204.

~~(2) If any surviving spouse to whom the provisions of this section apply remarries, the payments on account of a child or children shall continue to be made to the child or children the same as before the remarriage.~~

HB 2338 also includes the following clauses:

Section 4. The Director of the Department of Consumer and Business Services shall adjust under ORS 656.506 (7) the amount and duration of benefits that accrue on and after the effective date of this 2017 Act for injuries that occurred before the effective date of this 2017 Act. An insurer, or a self-insured employer, shall pay benefits that exceed the amount and duration of benefits that would have been due to a worker under the law that existed at the time of the worker’s injury and the director shall reimburse the insurer or selfinsured employer from the Workers’ Benefit Fund.

Section 5. The amendments to ORS 656.005, 656.204 and 656.208 by sections 1 to 3 of this 2017 Act apply to injuries that occur on or after the effective date of this 2017 Act, except that ORS 656.204 (6)(a) applies to benefits that accrue on or after the effective date of this 2017 Act regardless of the date on which the injury occurred. The insurer shall deduct from the 48-month maximum specified for benefits in ORS 656.204 (6)(a) the number of months during which a child or dependent received benefits after the age of 19 if the child or dependent became 19 years of age before the effective date of this 2017 Act.

South Carolina

HB 3406 was:

- Passed by the first chamber on January 27, 2017
- Included in NCCI’s February 3, 2017 *Legislative Activity Report* (RLA-2017-04)
- Amended and passed by the second chamber on May 10, 2017

HB 3406, in part, amends *Section 2 of Act 95 of 2013*, relating to the maintenance tax imposed by the Workers’ Compensation Commission on self-insurers as follows:

Time effective

Section 2. This act takes effect ~~July 1, 2013,~~ July 1, 2017, and must be terminated five years after the effective date of the act unless otherwise authorized by the General Assembly. Beginning on July 1, 2014, and on each July first thereafter, the South Carolina Workers’ Compensation Commission must report to the Chairman of House Ways and Means Committee, the Chairman of Senate Finance, and the Governor the amount of money the agency has received in the previous fiscal year pursuant to this act.

Texas

HB 1456 was:

- Passed by the first chamber on April 20, 2017
- Included in NCCI’s April 28, 2017 *Legislative Activity Report* (RLA-2017-16)
- Passed by the second chamber on May 12, 2017

HB 1456 amends *section 415.035. Judicial Review.* of the Texas Labor Code as follows:

415.035. Judicial Review.

~~(a)~~ A decision under Section 415.034 is subject to judicial review in the manner provided for judicial review under Chapter 2001, Government Code.

~~(b) If an administrative penalty is assessed, the person charged shall:~~

~~(1) forward the amount of the penalty to the division for deposit in an escrow account; or~~

~~(2) post with the division a bond for the amount of the penalty, effective until all judicial review of the determination is final.~~

~~(c) Failure to comply with Subsection (b) results in a waiver of all legal rights to contest the violation or the amount of the penalty.~~

~~(d) If the court determines that the penalty should not have been assessed or reduces the amount of the penalty, the division shall:~~

~~(1) remit the appropriate amount, plus accrued interest, if the administrative penalty was paid; or~~

~~(2) release the bond.~~

HB 1456 also states the following:

Section 415.035, Labor Code, as amended by this Act, applies only to judicial review of a decision issued on or after the effective date of this Act. Judicial review of a decision issued before the effective date of this Act is governed by the law in effect on the date the decision was issued, and the former law is continued in effect for that purpose.

HB 2061 was:

- Passed by the first chamber on April 20, 2017
- Included in NCCI's April 28, 2017 *Legislative Activity Report* (RLA-2017-16)
- Passed by the second chamber on May 12, 2017

HB 2061 amends *sections 410.253. Service; Notice* and *410.258. Notification of Division of Proposed Judgments and Settlements; Right to Intervene* of the Texas Labor Code as follows:

Sec. 410.253. Service; Notice.

(a) A party seeking judicial review shall simultaneously:

- (1) file a copy of the party's petition with the court;
- (2) serve any opposing party to the suit; and
- (3) provide a copy written notice of the party's petition suit or notice of appeal to the division.

(b) A party may not seek judicial review under Section 410.251 unless the party has provided the copy written notice of the petition suit to the division under Subsection (a)(3) as required by this section.

Sec. 410.258. Notification of Division of Proposed Judgments and Settlements; Right to Intervene.

(a) The party who initiated a proceeding under this subchapter or Subchapter G must file any proposed judgment or settlement ~~made by the parties to the proceeding~~, including a proposed default judgment or proposed agreed judgment, with the division not later than the 30th day before the date on which the court is scheduled to enter the judgment or approve the settlement.

(a-1) If the terms of the proposed settlement or proposed agreed judgment, including all payments to be made, are not described in the proposed settlement or proposed agreed judgment, the party must also file with the division at the time of filing the proposed settlement or proposed agreed judgment a separate document that fully describes the terms of the proposed settlement or proposed agreed judgment.

(a-2) The proposed judgment or settlement or proposed agreed judgment and any separate document described by Subsection (a-1) must be mailed to the division by certified mail, return receipt requested.

(a-3) The separate document filed with the division under Subsection (a-1) is not subject to disclosure under Chapter 552, Government Code.

HB 2061 also states the following:

Section 410.253, Labor Code, as amended by this Act, applies to a petition for judicial review filed on or after the effective date of this Act.

Section 410.258, Labor Code, as amended by this Act, applies to a proposed judgment or settlement related to a proceeding under Subchapter F or G, Chapter 410, Labor Code, initiated on or after the effective date of this Act.

SB 1494 was:

- Passed by the first chamber on April 20, 2017
- Included in NCCI's April 28, 2017 *Legislative Activity Report* (RLA-2017-16)
- Passed by the second chamber on May 9, 2017

SB 1494 amends *section 413.014. Preauthorization Requirements; Concurrent Review and Certification of Health Care* of the Texas Labor Code as follows:

Sec. 413.014. Preauthorization Requirements; Concurrent Review and Certification of Health Care.

...

(c) The commissioner's rules adopted under this section must provide that preauthorization and concurrent review are required at a minimum for:

- (1) spinal surgery, as provided by Section 408.026;
- (2) work-hardening or work-conditioning services ~~provided by a health care facility that is not credentialed by an organization recognized by commissioner rules;~~
- (3) inpatient hospitalization, including any procedure and length of stay;
- (4) physical and occupational therapy;
- (5) outpatient or ambulatory surgical services, as defined by commissioner rule; and
- (6) any investigational or experimental services or devices.

(c-1) Notwithstanding Subsection (c)(2), the commissioner by rule may exempt from preauthorization and concurrent review work-hardening or work-conditioning services provided by a health care facility that is credentialed by an organization designated by commissioner rule.

...

SB 1494 also states the following:

The change in law made by this Act applies only to health care services provided on or after the effective date of this Act in conjunction with a claim for workers' compensation benefits, regardless of the date on which the compensable injury that is the basis of the claim occurred.

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending May 12, 2017.

Nevada

AB 458 adds to and revises various provisions of *Chapter 616C—Industrial Insurance: Benefits for Injuries or Death* of the Nevada Revised Statutes as follows:

- **Section 2** of this bill specifies that a physician or chiropractor may use interchangeably certain phrases that relate to a claim for compensation when determining the causation of an industrial injury or occupational disease
- **Section 3:**
 - Sets forth that an injured employee is entitled to an independent medical examination for a claim for compensation that is open or when the closure of a claim is under dispute
 - Authorizes the injured employee to obtain an independent medical examination:
 - (1) when a dispute arises from a determination issued by the insurer;
 - (2) within 30 days after the injured employee receives a certain report generated by a medical examination; or
 - (3) by leave of a hearing officer or appeals officer
 - Requires an injured employee to select a physician or chiropractor from the panel of physicians or chiropractors established by the Administrator of the Division of Industrial Relations of the Department of Business and Industry
 - Requires the insurer to:
 - (1) pay for an independent medical examination; and
 - (2) upon request, receive a copy of any report or other document that is generated as a result of the independent medical examination
 - Allows the injured employee to obtain only one independent medical examination per calendar year
- **Section 4** provides for a vocational rehabilitation counselor to be appointed by the insurer and injured employee when a written assessment is requested or when a plan for a program of vocational rehabilitation is required.
- Existing law requires, where there is a previous disability, the percentage of disability for a subsequent injury to be determined by deducting from the entire disability of the person the percentage of previous disability as it existed at the time of the subsequent injury. (NRS 616C.490) The Division of Industrial Relations of the Department of Business and Industry previously implemented a regulation that required an apportionment to be made by subtracting the percentage of previous disability as it existed at the time of the previous disability from the percentage of present disability as it existed at the time of the present disability. (NAC 616C.490) The Nevada Supreme Court in *Pub. Agency Comp. Trust v. Blake*, 127 Nev. 863 (2011), found this regulation to be invalid since it was in conflict with the existing statute.
- **Section 8** incorporates the substance of the regulation at issue into existing law
- Existing law authorizes an insurer, after sending notice to the claimant, to close a claim if, during the first 12 months after a claim is opened, the medical benefits required to be paid for the claim are less than \$300. Existing law further requires an insurer to send to a claimant who receives less than \$300 in medical benefits within 6 months after the claim is opened a written notice that explains how the claim may be closed if, during the first 12 months after the claim is opened, the medical benefits required to be paid for the claim are less than \$300. (NRS 616C.235)
- **Section 7.3** increases the amount of medical benefits required to be paid for the claim from \$300 to \$800
- Existing law sets forth that if an employee's claim is reopened, the employee is not entitled to vocational rehabilitation services or benefits for a temporary total disability if, before the claim was reopened, the employee retired for reasons unrelated to the injury for which the claim was originally made. (NRS 616C.390)
- **Section 7.7** defines the term "retired" for the purposes of these existing provisions
- **Section 9:**
 - Specifies the maximum amount of a lump sum that a person injured on or after July 1, 1995, and before January 1, 2016, on or after January 1, 2016, and before July 1, 2017, and on or after July 1, 2017, may elect to receive as his or her compensation
 - Requires the tables used to calculate the lump sum to be adjusted on July 1 of each year

Texas

HB 1689 amends *section 101.028. Workers' Compensation Insurance.* of the Texas Civil Practice and Remedies Code, and *section 504.053. Election.* of the Texas Labor Code as follows:

Sec. 101.028. Workers' Compensation Insurance.

(a) In this section, "political subdivision" has the meaning assigned by Section 504.001, Labor Code.

(b) A governmental unit that has workers' compensation insurance or that accepts the workers' compensation laws of this state is entitled to the privileges and immunities granted by the workers' compensation laws of this state to private individuals and corporations.

(c) A political subdivision that self-insures either individually or collectively is liable for sanctions, administrative penalties, and other remedies authorized under Chapter 415, Labor Code.

Sec. 504.053. Election.

...

(e) Nothing in this chapter waives sovereign immunity or creates a new cause of action beyond the actions, damages, and remedies authorized by Chapter 101, Civil Practice and Remedies Code.

HB 1689 also includes the following language:

Section 101.028, Civil Practice and Remedies Code, as amended by this Act, applies only to an administrative violation under Chapter 415, Labor Code, that occurs on or after the effective date of this Act. An administrative violation under Chapter 415, Labor Code, that occurs before the effective date of this Act is governed by the law applicable to the violation immediately before the effective date of this Act, and that law is continued in effect for that purpose.

HB 2082 adds new **section 404.1525. First Responder Liaison** to the Texas Labor Code to read:

Sec. 404.1525. First Responder Liaison.

(a) In this section, "first responder" has the meaning assigned by Section 504.055.

(b) The public counsel shall designate an employee of the office to act as first responder liaison.

(c) The first responder liaison shall assist an injured first responder and, if applicable, the ombudsman assigned to the first responder's case, during a workers' compensation administrative dispute resolution process.

(d) The first responder liaison:

(1) must meet the qualifications for designation as an ombudsman under this subchapter; and

(2) is subject to the training and education requirements for an ombudsman under this subchapter.

In addition, **HB 2082** amends **section 404.153. Employer Notification; Administrative Violation.** of the Texas Labor Code as follows:

Sec. 404.153. Employer Notification; Administrative Violation.

(a) Each employer shall notify its employees of the ombudsman program in the manner prescribed by the office.

(a-1) An employer that employs first responders or supervises volunteer first responders shall notify the first responders of the first responder liaison in the manner prescribed by the office. In this subsection, "first responder" has the meaning assigned by Section 504.055.

(b) An employer commits an administrative violation if the employer fails to comply with this section.

HB 2119 amends **section 408.183 Duration of Death Benefits.** of the Texas Labor Code as follows:

Sec. 408.183 Duration of Death Benefits.

...

(b) An eligible spouse is entitled to receive death benefits for life or until remarriage. On remarriage, the eligible spouse is entitled to receive 104 weeks of death benefits, commuted as provided by commissioner rule.

(b-1) Notwithstanding Subsection (b), an eligible spouse who remarried is eligible for death benefits for life if the employee was a first responder, as defined by Section 504.055, who suffered death in the course and scope of employment or while providing services as a volunteer. This subsection applies regardless of the date on which the death of the first responder occurred.

...

HB 2119 also repeals Chapter 1018 (H.B. 1094), Acts of the 84th Legislature, Regular Session, 2015.

In addition, **HB 2119** states the following:

The change in law made by this Act to Section 408.183, Labor Code, applies only to an eligible spouse who remarries on or after the effective date of this Act. An eligible spouse who remarried before that date is governed by the law as it existed immediately before the effective date of this Act, and the former law is continued in effect for that purpose.

HB 3702 amends **section 404.109. Injured Employee Rights; Notice.** of the Texas Labor Code as follows:

Sec. 404.109. Injured Employee Rights; Notice.

(a) The public counsel shall adopt, in the form and manner prescribed by the public counsel and after consultation with the commissioner of workers' compensation, a notice of injured employee rights and responsibilities to be distributed by the division as provided by commissioner or commissioner of insurance rules.

(b) The notice adopted under Subsection (a) must inform an injured employee that the employee has the right to choose a treating doctor, including a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(c) A right or responsibility included in the notice adopted under Subsection (a) ~~this section~~ must be consistent with the requirements of this subtitle and division rules.

(d) This section may not be construed as establishing an entitlement to benefits to which the claimant is not otherwise entitled under this subtitle.

HB 3702 also states the following:

The public counsel of the office of injured employee counsel shall adopt the notice required under Section 404.109, Labor Code, as amended by this Act, not later than December 1, 2017.

BILLS VETOED BY GOVERNOR

The following workers compensation-related bill was vetoed by the governor within the one-week period ending May 12, 2017.

Montana

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
- Included in NCCI's April 14, 2017 *Legislative Activity Report* (RLA-2017-14)
- Vetoed by the Governor on May 11, 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).

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.