



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 includes 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 is included in the first report published each month. This report is issued on a weekly basis throughout the legislative season and provides updates on the content of these bills if and when they progress through the legislative process. This report covers bills from states where NCCI provides ratemaking services (see state list under Contact Information) and the US Congress.

BILLS ENACTED

There were no relevant workers compensation-related bills enacted within the one-week period ending March 2, 2018.

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending March 2, 2018.

Indiana

SB 369 was:

- Passed by the first chamber on February 6, 2018
- Included in NCCI's February 16, 2018 **Legislative Activity Report** (RLA-2018-07)
- Amended and passed by the second chamber on February 27, 2018

SB 369 adds new **sections 22-3-3-4.7** and **22-3-7-17.6**, related to reimbursement for certain prescription medications under the Indiana workers compensation drug formulary, to the Indiana Labor and Safety code to read:

22-3-3-4.7:

Sec. 4.7. (a) As used in this section, "formulary" refers to the Official Disability Guidelines (ODG) Workers' Compensation Drug Formulary Appendix A published by MCG Health.

(b) As used in this section, "medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected to result in:

- (1) serious jeopardy to the employee's health or bodily functions; or
- (2) serious dysfunction of a body part or organ.

(c) Beginning January 1, 2019, reimbursement is not permitted for a claim for payment for a drug that:

- (1) is prescribed for use by an employee who files a notice of injury under this chapter; and
- (2) according to the formulary, is an "N" drug.

However, if the employee begins use of the "N" drug before July 1, 2018, and the use continues after January 1, 2019, reimbursement is permitted for the "N" drug until January 1, 2020.

(d) If a prescribing physician submits to an employer a request to permit use of an "N" drug described in subsection (c), including the prescribing physician's reason for requesting use of an "N" drug, and the employer approves the request, the prescribing physician may prescribe the "N" drug for use by the injured employee.

(e) If the employer does not approve the prescribing physician's request under subsection (d) to permit use of an "N" drug, the employer shall:

- (1) send the request to a third party that is certified by the Utilization Review Accreditation Commission to make a determination concerning the request; and

(2) notify the prescribing physician and the injured employee of the third party's determination not more than five (5) business days after receiving the request.
(f) If an employer fails to provide the notice required by subsection (e)(2), the prescribing physician's request under subsection (d) is considered approved, and reimbursement of the "N" drug prescribed for use by the injured employee is authorized.
(g) If the third party's determination under subsection (e) is to deny the prescribing physician's request to permit the use of an "N" drug:
(1) the employer shall notify the prescribing physician and the injured employee; and
(2) the injured employee may apply to the worker's compensation board for a final determination concerning the third party's determination under subsection (e).
(h) Notwithstanding subsections (c) through (f), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is an "N" drug according to the formulary.

22-3-7-17.6:

17.6. (a) As used in this section, "formulary" refers to the Official Disability Guidelines (ODG) Workers' Compensation Drug Formulary Appendix A published by MCG Health.
(b) As used in this section, "medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected to result in:
(1) serious jeopardy to the employee's health or bodily functions; or
(2) serious dysfunction of a body part or organ.
(c) Beginning January 1, 2019, reimbursement is not permitted for a claim for payment for a drug that:
(1) is prescribed for use by an employee who files a notice of occupational disease under this chapter; and
(2) according to the formulary, is an "N" drug.
However, if the employee begins use of the "N" drug before July 1, 2018, and the use continues after January 1, 2019, reimbursement is permitted for the "N" drug until January 1, 2020.
(d) If a prescribing physician submits to an employer a request to permit use of an "N" drug described in subsection (c), including the prescribing physician's reason for requesting use of an "N" drug, and the employer approves the request, the prescribing physician may prescribe the "N" drug for use by the disabled employee.
(e) If the employer does not approve the prescribing physician's request under subsection (d) to permit use of an "N" drug, the employer shall:
(1) send the request to a third party that is certified by the Utilization Review Accreditation Commission to make a determination concerning the request; and
(2) notify the prescribing physician and the disabled employee of the third party's determination not more than five (5) business days after receiving the request.
(f) If an employer fails to provide the notice required by subsection (e)(2), the prescribing physician's request under subsection (d) is considered approved, and reimbursement of the "N" drug prescribed for use by the disabled employee is authorized.
(g) If the third party's determination under subsection (e) is to deny the prescribing physician's request to permit the use of an "N" drug:
(1) the employer shall notify the prescribing physician and the disabled employee; and
(2) the disabled employee may apply to the worker's compensation board for a final determination concerning the third party's determination under subsection (e).
(h) Notwithstanding subsections (c) through (f), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is an "N" drug according to the formulary.

South Dakota

SB 20 was:

- Passed by the first chamber on January 18, 2018
- Included in NCCI's January 26, 2018 *Legislative Activity Report* (RLA-2018-04)
- Passed by the second chamber on February 27, 2018

SB 20 adds a new section to *chapter 48A Emergency Management* of *title 34 Public Health and Safety* of the South Dakota Codified Laws, in part, to read:

The State and Province Emergency Management Assistance Memorandum of Understanding is hereby enacted into law and entered into by the State of South Dakota with all other states legally joining the agreement, in the form substantially as follows:

ARTICLE I - PURPOSE AND AUTHORITIES

The State and Province Emergency Management Assistance Memorandum of Understanding, hereinafter referred to as the compact, is made and entered into by and among such of the jurisdictions as shall enact or adopt this compact, hereinafter

referred to as participating jurisdictions. For the purposes of this compact, the term, jurisdictions, may include any or all of the states of Illinois, Indiana, Ohio, Michigan, Minnesota, Montana, North Dakota, Pennsylvania, New York, and Wisconsin, and the Canadian Provinces of Alberta, Manitoba, Ontario, and Saskatchewan, and such other states and provinces as may hereafter become a party to this compact. The term, states, means the several states, the Commonwealth of Puerto Rico, the District of Columbia, and all territorial possessions of the United States. The term, province, means the ten political units of government within Canada.

The purpose of this compact is to provide for the possibility of mutual assistance among the participating jurisdictions in managing any emergency or disaster when the affected jurisdiction or jurisdictions ask for assistance, whether arising from natural disaster, technological hazard, manmade disaster, or civil emergency aspects of resource shortages. This compact also provides for the process of planning mechanisms among the agencies responsible and for mutual cooperation, including civil emergency preparedness exercises, testing, or other training activities using equipment and personnel simulating performance of any aspect of the giving and receiving of aid by participating jurisdictions or subdivisions of participating jurisdictions during emergencies, with such actions occurring outside emergency periods.

...

ARTICLE VIII – WORKERS’ COMPENSATION AND DEATH BENEFITS

Each participating jurisdiction shall provide, in accordance with its own laws, for the payment of workers’ compensation and death benefits to injured members of the emergency contingent of that participating jurisdiction and to representatives of deceased members of those forces if the members sustain injuries or are killed while rendering aid pursuant to this compact, in the same manner and on the same terms as if the injury or death were sustained within their own jurisdiction.

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BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending March 2, 2018.

Arizona

SB 1111 amends *sections 23-908* and *23-1062.02* of the Arizona Revised Statutes, in part, as follows:

23-908. Injury reports by employer and physician; schedule of fees; violation; classification

...

B. The commission shall fix a schedule of fees to be charged by physicians, physical therapists or occupational therapists attending injured employees and, subject to subsection C of this section, for prescription medicines required to treat an injured employee under this chapter. Notwithstanding subsection C of this section, the schedule of fees may include other reimbursement guidelines for medications dispensed in settings that are not accessible to the general public. The commission shall annually review the schedule of fees.

...

23-1062.02. Use of controlled substances; prescription of schedule II controlled substances; reports; treatment plans; monitoring program inquiries; preauthorizations; definitions

A. A physician who prescribes a schedule ii controlled substance to an employee shall comply with title 32, chapter 32, article 4, including the provisions in that article relating to patients with traumatic injuries.

~~A. B.~~ A physician shall include in the report required under commission rule the following information pertaining to the following:

- ~~1. The off-label use of a narcotic, opium-based controlled substance or schedule II controlled substance by a claimant.~~
- ~~2. The use of a narcotic or opium-based controlled substance or the prescription of a combination of narcotics or opium-based controlled substances at or exceeding a one hundred twenty milligram morphine equivalent dose per day.~~
- ~~3. The prescription of a long-acting or controlled release opioid for acute pain.~~

~~B.~~ The information required pursuant to subsection A of this section shall include the use of a narcotic or opium-based controlled substance that is listed in Schedule II or the prescription of any opioid medication:

1. Justification for the use of the controlled substance, and including documentation of the following:

- (a) That a physical examination of the employee was conducted.
- (b) That a substance use risk assessment of the employee was conducted.
- (c) That the employee gave informed consent for any opioid treatment.

2. A treatment plan that includes a description of describing the measures that the physician will implement to monitor and prevent the development of abuse, dependence, addiction or diversion by the employee. The physician shall include in the treatment plan all of the following:

- (a) A medication agreement, ~~a plan for subsequent~~
- (b) The frequency of face-to-face follow-up visits and to reevaluate the employee’s continued use of opioids.
- (c) Random drug testing. ~~and~~

(d) Documentation that the medication regime is providing relief that is demonstrated by clinically meaningful improvement in function.

(e) Criteria and procedures for tapering and discontinuing opioid prescription or administration as part of the treatment.

(f) Criteria and procedures for offering or referring the employee for treatment for dependence on or addiction to opioids.

C. If the drug test of the employee reveals inconsistent results, the physician within five business days shall provide a written report to the carrier, self-insured employer or commission setting forth a treatment plan to address the inconsistent drug test results.

~~C. D. Within two business days of writing or dispensing an initial prescription order for at least a thirty day supply of an opioid medication for the employee, a physician shall submit an inquiry to the Arizona state board of pharmacy requesting the employee's prescription information that is compiled under the controlled substances prescription monitoring program prescribed in title 36, chapter 28. Before prescribing an opioid analgesic or benzodiazepine controlled substance that is listed in Schedule II, III or IV for an employee and at least quarterly while that prescription remains a part of the treatment, the physician shall obtain a patient utilization report regarding the employee from the controlled substances prescription monitoring program's central database tracking system as required by section 36-2606. The physician shall report the results to the carrier, self-insured employer or commission as soon as reasonably practicable but ~~no~~ not later than thirty days ~~from~~ after the date of the inquiry. Thereafter, the carrier, self-insured employer or commission may request ~~no~~ not more than once every two months that the physician ~~perform~~ additional inquiries to obtain a patient utilization report regarding the employee from the Arizona state board of pharmacy controlled substances prescription monitoring program's central database tracking system.~~

~~D. E. If the result of an inquiry to patient utilization report from the Arizona state board of pharmacy controlled substances prescription monitoring program's central database tracking system reveals that the employee is receiving opioids from another undisclosed health care provider, the physician shall within five business days report the results to the carrier, self-insured employer or commission.~~

~~E. F. If the physician does not comply with this section:~~

- ~~1. The carrier, self-insured employer or commission is not responsible for payment for the physician's services until the physician complies with this section.~~
- ~~2. Except for a self-insured employer that provides medical care pursuant to section 23-1070, ~~an~~ the employer, carrier or commission may request a change of physician after making a written request to the physician to comply with this section and the request identifies the area of noncompliance. If a change of physician is ordered and the order becomes final, the employee shall select a physician ~~whose practice includes pain management and~~ who agrees to comply with this section. If other medical providers are not available in the employee's area of residence, the employer, carrier or commission shall pay in advance for the employee's reasonable travel expenses, including the cost of transportation, food, lodging and loss of pay, if applicable.~~

~~...~~

~~H. This section does not apply to medications administered to the employee while the employee is receiving inpatient hospital treatment.~~

~~I. A carrier, a self-insured employer or the commission may require physician compliance with this section notwithstanding the existence of a prior award addressing medical maintenance benefits for medications. A carrier or self-insured employer is not liable for bad faith or unfair claims processing for any act taken in compliance of and consistent with this section or any act reasonably necessary to monitor or assess the appropriateness and effectiveness of an employee's opioid use.~~

~~J. For the purposes of this section:~~

~~1. "Clinically meaningful improvement in function" means ~~any~~ both of the following:~~

~~(a) A clinically documented improvement in range of motion.~~

~~(b) (a) An increase A significant improvement in the performance of activities of daily living or a reduction in work restrictions.~~

~~(c) A return to gainful employment.~~

~~(b) A reduction in dependency on continued medical treatment.~~

~~2. "Inconsistent results" means:~~

~~...~~

~~3. "Off label use" means use of a prescription medication by a physician to treat a condition other than the use for which the drug was approved by the United States food and drug administration.~~

~~3. "Substance use risk assessment" means an evaluation of an employee's unique likelihood for addiction, misuse, diversion or another adverse consequence resulting from the employee being prescribed or receiving treatment with opioids.~~

~~4. "Traumatic injury" as used in title 32, chapter 32, article 4 means physical injury that creates a reasonable risk of death or that causes serious or permanent disfigurement, serious impairment of health or loss or protracted impairment of the function of any bodily organ or limb.~~

SB 1111 also includes the following language:

Industrial commission of Arizona; review of medication reimbursement guidelines; delayed repeal

A. On or before July 1, 2019, as part of the industrial commission of Arizona's annual review of the schedule of fees pursuant to section 23-908, Arizona Revised Statutes, as amended by this act, the industrial commission of Arizona shall review information and data, consult with physician, employee and business and industry stakeholders and hold at least one public hearing in

considering whether to adopt additional reimbursement guidelines for medications dispensed in settings that are not accessible to the general public.

B. This section is repealed from and after June 30, 2020.

Florida

HB 1437 creates new *sections 413.15* and *413.209* in the Florida Statutes to require that participants in an adult or youth work experience activity under either the Division of Blind Services or the Division of Vocational Rehabilitation be deemed an employee of the state for the purposes of workers compensation coverage.

Georgia

HB 734, in part, amends *sections 33-9-3, 33-9-23, 33-9-30, 33-9-36, 34-9-121, 34-9-132, and 34-9-368* of the Official Code of Georgia Annotated as follows:

§ 33-9-3. Application of Chapter

(b)(1) This chapter shall apply to all insurers, including stock and mutual companies, Lloyd's associations, and reciprocal and interinsurance exchanges, which under any laws of this state write any of the kinds of insurance to which this chapter applies.
(2) ~~The provisions of this chapter regarding rates shall apply to any insurer, fraternal benefit society, health care plan, health maintenance organization, or preferred provider organization providing any accident or sickness insurance or health benefit plan issued, delivered, issued for delivery, or renewed in this state to the extent required by subsection (c) of this Code section.~~
(c) Provisions of this chapter regarding rates shall apply only to a proposed rate for any insurance or health benefit plan:
(1) Which alone or in combination with any previous rate change for such insurance or plan would result in a rate increase of:
(A) Any amount, but no decrease shall be subject to such provisions; provided, however,
(B) The provisions of this chapter shall not apply to accident and sickness insurance; or
(2) Made within 36 months after any rate change described by paragraph (1) of this subsection.

...

§ 33-9-23. Examination of admitted insurers; examination of insurers transacting workers' compensation insurance

(b) In addition to and apart from the examination required by subsection (a) of this Code section, the Commissioner may, at any reasonable time, examine or cause to be examined by some examiner duly authorized by him or her all insurers transacting workers' compensation insurance in this state. This examination will include a review of the loss ratios, reserves, reserve development information, expenses including commissions paid and dividends paid, investment income, pure premium data adjusted for loss development and loss trending, profits, and all other data and information used by that insurer in formulating its workers' compensation ~~premium~~ rates which are used in this state and any other information or data required by the Commissioner. Upon completion of this examination, a report in such form as the Commissioner shall prescribe shall be filed in his or her office.

§ 33-9-30. Suspension or revocation of license or certificate of authority for failure to comply with order of Commissioner

In addition to other penalties provided in this title, the Commissioner, by order pursuant to Code Section 33-9-29, may suspend or revoke, in whole or in part, the license of any rating organization or the certificate of authority of any insurer with respect to the class or classes of insurance specified in such order ~~which if such entity fails to comply within the time limited by such order or any extension thereof which that the Commissioner may grant with an order of the Commissioner lawfully made by him pursuant to Code Section 33-9-29.~~

§ 33-9-36. Unauthorized premiums; unlawful inducements

...

(e) Nothing in this Code section shall be construed as prohibiting the payment for food or refreshments by an insurer or ~~an agent, broker, or employee of an insurer~~ employee of such insurer or a broker or an agent for current or prospective clients during sales presentations and seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars.

(f) Nothing in this Code section shall be construed as prohibiting ~~insurers or insurance producers~~ an insurer or employee of such insurer or a broker or an agent from advertising or conducting promotional programs by insurers or insurance producers whereby prizes, goods, wares, store gift cards, gift certificates, sporting event tickets, or merchandise, not exceeding \$100.00 in value per customer in the aggregate in any one calendar year, are given to current or prospective customers; provided, however, that the giving of any item or items of value under this subsection shall not be contingent on the sale or renewal of a policy.

§34-9-121. Duty of employer to insure in licensed company or association or to deposit security, indemnity, or bond as self-insurer; application to out-of-state employers; membership in mutual insurance company

...

(c) The board shall have the authority to promulgate rules and regulations to set forth requirements for third-party administrators and servicing agents, including insurers acting as third-party administrators or servicing agents, with regard to their management or administration of workers' compensation claims. All Title 33 regulations shall remain in the ~~Insurance~~ Department of Insurance.

...

§34-9-132. Grounds for revocation of insurance carrier's permit

The board is authorized, of its own motion or upon complaint filed with it, after notice of not less than ten days and a hearing thereon, to revoke any permit granted under Code Section 34-9-131 if an employer is ready, willing, and able to pay a premium at the rate prescribed by the ~~Insurance~~ Department of Insurance but it appears that the holder of such permit declines to accept and underwrite the risk assigned to it by the board or a bureau established and approved for rating purposes; or if it appears that the holder of any such permit fails and refuses to obey any valid order of the board or to pay any award entered against it by the board and not appealed from or affirmed on appeal; or if it appears that the holder of such permit is otherwise not qualified to carry on such business.

§34-9-368. Reimbursement of self-insured employers or insureds; actuarial study required; dissolution of Subsequent Injury Trust Fund

...

(c)(5) The transfer of the books, records, and property of the fund to the custody of the ~~Insurance~~ Department of Insurance.

...

HB 760 in part, amends *section 33-24-47. Notice required of termination or nonrenewal, increase in premium rates, or change restricting coverage; failure of insurer to comply* of the Official Code of Georgia Annotated as follows:

§ 33-24-47. Notice required of termination or nonrenewal, increase in premium rates, or change restricting coverage; failure of insurer to comply

...

(b) A notice of termination, including a notice of cancellation or nonrenewal, by the insurer, a notice of an increase in premiums, other than an increase in premiums due to a change in risk or exposure, including a change in experience modification or resulting from an audit of auditable coverages, which exceeds 15 percent of the current policy's premium, ~~or a notice of change in any policy provision which limits or restricts coverage~~ shall be delivered to the insured as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the last address of record of the insured, at least 45 days prior to the termination date of such policy; provided, however, that a notice of cancellation or nonrenewal of a policy of workers' compensation insurance shall be controlled by the provisions of subsection (f) of this Code section. In those instances where an increase in premium exceeds 15 percent, the notice to the insured shall indicate the dollar amount of the increase. The insurer may obtain a receipt provided by the United States Postal Service as evidence of mailing such notice or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

...

(g) An insurer shall provide a written notice of a reduction in coverage to the named insured no less than 45 days prior to the effective date of the proposed reduction in coverage. A reduction in coverage shall mean a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion. Reduction in coverage shall not include the elimination of any coverage that is no longer offered by an insurer in accordance with its filed rating plan or any change, reduction, or elimination of coverage made at the request of the insured. The correction of typographical or scrivener's errors or the application of mandated legislative changes shall not be considered a reduction in coverage.

HB 878 amends, *section 33-24-44.1—Procedure for cancellation by insured and notice* of the Official Code of Georgia Annotated as follows:

§ 33-24-44.1. Procedure for cancellation by insured and notice

(a) An insured may request cancellation of an existing insurance policy by returning the original policy to the insurer or by making a ~~written~~ request for cancellation of an insurance policy to the insurer or its duly authorized agent orally, electronically, or in writing stating a future date on which the policy is to be canceled. The insurer or its duly authorized agent may require that the insured provide written, electronic, or other recorded verification of the request for cancellation prior to such cancellation taking effect. Such cancellation shall be accomplished in the following manner:

(1) If only the interest of the insured is affected, the policy shall be canceled on the later of the date the returned policy or ~~written~~ request is received by the insurer or its duly authorized agent or the date specified in the ~~written~~ request; provided, however, that upon receipt of a ~~written~~ request for cancellation from an insured, an insurer may waive the future date requirement by confirming the date and time of cancellation in writing to the insured and the insurer shall document in its policy file the request for cancellation along with the date of the requested cancellation;

...

Hawaii

HB 1778 HD1 adds two new sections to the Hawaii Workers' Compensation Law as follows:

~~§386-~~ Medical care, services, and supplies for controverted claims.

In the event of a controverted claim, the injured employee's private health care plan shall pay for or provide medical care, services, and supplies in accordance with the private health care contract. When the claim is accepted or determined to be compensable, the employer shall reimburse the private health care plan and the injured employee in amounts as authorized by this chapter and rules adopted by the director.

§386- Medical care, services, and supplies for firefighters suffering from cancer.

If a claim for leukemia, multiple myeloma, non-Hodgkin lymphoma, or cancer of the lung, brain, stomach, esophagus, intestines, rectum, kidney, bladder, prostate, or testes filed by an employee with five or more years of service as a firefighter is accepted or determined to be compensable, the provisions of section 386-21 shall remain applicable; provided that the employer shall be liable for medical care, services, and supplies for a minimum of one hundred ten per cent, and not to exceed _____ per cent of fees prescribed in the Medicare Resource Based Relative Value Scale applicable to Hawaii as prepared by the United States Department of Health and Human Services.

HB 2191 HD1 amends the appellate jurisdiction of the Hawaii Supreme Court and Intermediate Court of Appeals to conditions as they existed prior to Act 202, Session Laws of Hawaii 2004, taking effect on July 1, 2006. Specifically, this measure reestablishes:
(1) The requirement that most appeals be filed with the Supreme Court instead of the Intermediate Court of Appeals
(2) Criteria for assigning appeals

HB 2202 HD2 amends **section 386-79** of the Hawaii Workers' Compensation Law as follows:

§386-79 Medical examination by employer's duly qualified physician or duly qualified surgeon.

(a) After an injury and during the period of disability, the employee, whenever ordered by the director of labor and industrial relations, shall submit to examination, at reasonable times and places, by a duly qualified physician or duly qualified surgeon designated and paid by the employer. The employee shall have the right to have a duly qualified physician, duly qualified surgeon, or chaperone designated and paid by the employee present at the examination, which right, however, shall not be construed to deny to the employer's physician the right to visit the injured employee at all reasonable times and under all reasonable conditions during total disability. The employee shall also have the right to record such examination by a recording device designated and paid for by the employee; provided that the examining duly qualified physician or duly qualified surgeon approves of the recording. If an employee refuses to submit to, or the employee or the employee's designated chaperone in any way obstructs such examination, the employee's right to claim compensation for the work injury shall be suspended until the refusal or obstruction ceases and no compensation shall be payable for the period during which the refusal or obstruction continues.

(b) In cases where the employer is dissatisfied with the progress of the case or where major and elective surgery, or either, is contemplated, the employer may appoint a duly qualified physician or duly qualified surgeon of the employer's choice who shall examine the injured employee and make a report to the employer. If the employer remains dissatisfied, this report may be forwarded to the director.

Employer requested examinations under this section shall not exceed more than one per case unless good and valid reasons exist with regard to the medical progress of the employee's treatment. The cost of conducting the ordered medical examination shall be limited to the complex consultation charges governed by the medical fee schedule established pursuant to section 386-21(c).

(c) A duly qualified physician or duly qualified surgeon who is selected and paid for by the employer to perform a medical examination on an employee pursuant to this section shall:

(1) Be duly qualified to treat the injury being examined;

(2) Possess medical malpractice insurance; and

(3) Owe the same duty of care to the injured employee while performing such a medical examination as would be owed to a traditional patient.

(d) As used in this section, "duly qualified" means a doctor whose specialty is appropriate for the injury to be examined.

HB 2202 HD2 also includes the following clause:

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

HB 2377 HD1 amends **sections 386-25** and **386-71.5** of the Hawaii Workers' Compensation Law as follows:

§386-25 Vocational rehabilitation.

...

(e) A provider shall file the employee's plan with the approval of the employee. Upon receipt of the plan from the provider, an employee shall have ten days to review and sign the plan. The plan shall be submitted to the employer and the employee and be filed with the director within two days from the date of the employee's signature. A plan shall include a statement of the feasibility of the vocational goal, using the process of:

...

(4) Then providing training to obtain employment in another occupational field. When training to obtain employment in another occupational field is required, the first appropriate option among the following options shall be selected for the employee:

(A) On-the-job training;

(B) Short-term retraining program (less than fifty-two weeks); or

(C) Long-term retraining program (more than fifty-two weeks); and
(5) Lastly, if training under paragraph (4) is not feasible, then self-employment may be considered.

...

§386-71.5] Rehabilitation unit. There is established within the department of labor and industrial relations a rehabilitation unit. All professional and clerical employees of this unit shall be appointed and administered by the director. The rehabilitation unit shall have the duties and responsibilities provided in section 386-25. Employees of the unit shall be subject to chapter 76.

SB 2244 SD1 creates new **sections 386-A** and **386-B**, and amends **section 386-21.7** of the Hawaii Workers' Compensation Law as follows:

§386-A Opioid therapy; qualifying injured employees; informed consent process.

(a) Beginning on July 1, 2019, any health care provider authorized to prescribe opioids shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the health care provider authorized to prescribe opioids and a qualifying injured employee.

(b) The department shall make available on its website a copy of the template developed by the department of health pursuant to section 329-38.5(b). The template shall be posted to the department's website no later than December 31, 2018.

(c) For the purposes of this section, "qualifying injured employee" means:

(1) An injured employee requiring opioid treatment for more than three months;

(2) An injured employee who is prescribed benzodiazepines and opioids together; or

(3) An injured employee who is prescribed a dose of opioids that exceeds ninety morphine equivalent doses.

(d) A violation of this section shall not be subject to the penalty provisions of part IV of chapter 329.

§386-B Qualifying injured employees; initial concurrent prescriptions; opioids and benzodiazepines.

(a) Initial concurrent prescriptions for opioids and benzodiazepines shall not be for longer than seven consecutive days unless a supply of longer than seven days is determined to be reasonably needed for the treatment of:

(1) Pain experienced while the qualifying injured employee is in post-operative care;

(2) Chronic pain and pain management;

(3) Substance abuse or opioid or opiate dependence;

(4) Cancer;

(5) Pain experienced while the qualifying injured employee is in palliative care; or

(6) Pain experienced while the qualifying injured employee is in hospice care; provided that if a health care provider authorized to prescribe opioids issues a concurrent prescription for more than a seven-day supply of an opioid and benzodiazepine, the health care provider shall document in the qualifying injured employee's medical record the condition for which the health care provider issued the prescription and that an alternative to the opioid and benzodiazepine was not appropriate treatment for the condition.

(b) After an initial concurrent prescription for opioids and benzodiazepines has been made, a health care provider authorized to prescribe opioids may authorize subsequent prescriptions through a telephone consultation with the qualifying injured employee when the health care provider deems such action to be reasonably needed for post-operative care and pain management; provided that the health care provider shall consult with a qualifying injured employee in person at least once every ninety days for the duration during which the health care provider concurrently prescribes opioids and benzodiazepines to the qualifying injured employee.

(c) For the purposes of this section, "qualifying injured employee" has the same meaning as in section 386-A.

§386-21.7 Prescription drugs; pharmaceuticals.

(a) Notwithstanding any other provision to the contrary, immediately after a work injury is sustained by an employee and so long as reasonably needed, the employer shall furnish to the employee all prescription drugs as the nature of the injury requires; ; provided that initial concurrent prescriptions for opioids and benzodiazepines shall meet the requirements of section 386-B. The liability for the prescription drugs shall be subject to the deductible under section 386-100.

Iowa

SF 2305 adds to and amends various sections of the Code of Iowa related to workers compensation and insurance fraud, and other prohibited health service provider practices, as follows:

507F.1 Definitions.

As used in this chapter, unless the context otherwise requires, "workers' compensation insurer" includes any insurer as defined in section 507A.3 that issues a policy of workers' compensation liability insurance and any group or self-insured plan as described in section 87.4.

507F.2 Purpose of workers' compensation fraud unit.

A workers' compensation fraud unit is created within the insurance fraud bureau within the insurance division. Upon a reasonable determination by the workers' compensation fraud unit, by its own inquiries or as a result of complaints filed with the insurance

fraud bureau or the workers' compensation fraud unit, that a person has engaged in, is engaging in, or may be engaging in an act or practice that violates this chapter, the workers' compensation fraud unit may administer oaths and affirmations, issue and serve subpoenas ordering the attendance of witnesses, collect evidence related to such act or practice, commence a suit, and prosecute a violation of this chapter.

507F.3 Workers' compensation fraudulent practice—penalties.

1. A person commits the offense of workers' compensation fraudulent practice if the person, with the intent to defraud a workers' compensation insurer does any act that constitutes a violation of section 507E.3.
2. A person who commits an offense under this section that results in a loss to a workers' compensation insurer of ten thousand dollars or less is, upon conviction, guilty of a class "D" felony.
3. A person who commits an offense under this section that results in a loss to a workers' compensation insurer of more than ten thousand dollars is, upon conviction, guilty of a class "C" felony.
4. Fifty percent of the criminal penalty collected under this section shall be deposited in the workers' compensation fraud penalty fund created in section 507F.5. The remaining fifty percent of the criminal penalty collected under this section shall be deposited pursuant to section 602.8108.

507F.4 Restitution.

In addition to the criminal penalties established in this chapter, the court shall order a person who commits an offense under this chapter to pay restitution to persons aggrieved by the violation. Restitution shall be ordered in addition to a fine and the possibility of imprisonment, but not in lieu of a fine and the possibility of imprisonment.

507F.5 Fund created.

A workers' compensation fraud penalty fund is created in the state treasury as a separate fund under the control of the commissioner of insurance for purposes of this chapter. Notwithstanding section 8.33, any balance in the fund on June 30 of each fiscal year shall not revert to the general fund of the state, but shall be available for purposes of this chapter in subsequent fiscal years. The commissioner of insurance may request additional full time equivalent positions as needed and the request shall be granted so long as sufficient funds are within the workers' compensation fraud penalty fund.

507F.6 Examination of information outside the state.

As a unit within the insurance fraud bureau, the workers' compensation fraud unit, pursuant to section 507E.4, may obtain and examine any information that is related to enforcement of this chapter in possession of a person located outside the state.

507F.7 Confidentiality.

As a unit within the insurance fraud bureau, all of the provisions of section 507E.5 shall apply to the workers' compensation fraud unit.

507F.8 Immunity from liability.

A person is immune from civil liability for acts under this chapter if the person meets the requirements set forth in section 507E.7.

507F.9 Election of prosecution.

If a person commits an offense under this chapter, the prosecuting attorney may elect to proceed under this chapter or any other law of this state.

507F.10 Prosecuting attorney status.

1. The workers' compensation fraud unit shall employ at least one full-time prosecuting attorney. The prosecuting attorney, having specialized knowledge and training, shall in all counties in this state prosecute all criminal actions which may be brought under this chapter in which the workers' compensation fraud unit may be interested, when, in the prosecuting attorney's judgment, the interest of the unit requires such action.
2. The prosecuting attorney may request a county attorney to assist with or handle the prosecution of a criminal action which may be brought under this chapter.
3. The prosecuting attorney shall report to the commissioner of insurance.

507F.11 Law enforcement officer status.

As a unit within the insurance fraud bureau, all of the provisions of section 507E.8 shall apply to the workers' compensation fraud unit.

507F.12 Suspension of benefits.

If a person is currently receiving or has a pending application for workers' compensation benefits under chapter 85, 85A, or 85B

and the workers' compensation fraud unit makes a determination to file charges in district court alleging a violation of this chapter by a person receiving benefits under chapter 85, 85A, or 85B, the workers' compensation fraud unit shall notify the workers' compensation commissioner, who shall suspend benefits or suspend any pending application.

A person convicted of a workers' compensation fraudulent practice shall be prohibited from receiving benefits under chapters 85, 85A, and 85B for the particular claim or injury giving rise to the criminal action. If the person is acquitted or the charges are dismissed, the workers' compensation fraud unit shall notify the workers' compensation commissioner of such action and the commissioner shall resume the payment of any benefits previously suspended or resume any suspended application. A person whose benefits have been suspended and the payment of benefits resumed has the option to receive a back payment in a lump sum upon resumption of payment of benefits.

507F.13 Rulemaking authority.

The commissioner of insurance may adopt rules pursuant to chapter 17A to administer this chapter.

85.27 Services—release of information—charges—payment—debt collection prohibited.

...

3. A medical service provided under this chapter or chapter 85A or 85B shall not be billed at a rate higher than a health service provider's standard retail rate for the medical service. A health service provider who bills and receives payment in excess of the health service provider's standard rate for a medical service provided to treat a workers' compensation injury shall reimburse the employer or insurance carrier which paid for the medical service for the excess payments received by the health service provider.

...

4. For purposes of this section, the employer is obliged to furnish reasonable services and supplies to treat an injured employee, and has the right to choose the care. The employer retains the right to choose the employee's care for all services throughout the course of treatment. If the employer chooses the care, the employer shall hold the employee harmless for the cost of care until the employer notifies the employee that the employer is no longer authorizing all or any part of the care and the reason for the change in authorization. An employer is not liable for the cost of care that the employer arranges in response to a sudden emergency if the employee's condition, for which care was arranged, is not related to the employment. The treatment must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the employee. If the employee has reason to be dissatisfied with the care offered, the employee should communicate the basis of such dissatisfaction to the employer, in writing if requested, following which the employer and the employee may agree to alternate care reasonably suited to treat the injury. If the employer and employee cannot agree on such alternate care, the commissioner may, upon application and reasonable proofs of the necessity therefor, allow and order other care. In an emergency, the employee may choose the employee's care at the employer's expense, provided the employer or the employer's agent cannot be reached immediately. An application made under this subsection shall be considered an original proceeding for purposes of commencement and contested case proceedings under section 85.26. The hearing shall be conducted pursuant to chapter 17A. Before a hearing is scheduled, the parties may choose a telephone hearing or an in-person hearing. A request for an in-person hearing shall be approved unless the in-person hearing would be impractical because of the distance between the parties to the hearing. The workers' compensation commissioner shall issue a decision within ten working days of receipt of an application for alternate care made pursuant to a telephone hearing or within fourteen working days of receipt of an application for alternate care made pursuant to an in-person hearing. The employer shall notify an injured employee of the employee's ability to contest the employer's choice of care pursuant to this subsection

85.37A Suspension of benefits for workers' compensation fraud.

Section 507F.12 requires the workers' compensation commissioner to suspend a person's benefits if the workers' compensation fraud unit makes a determination to file charges in district court alleging the person has violated chapter 507F.

86.39A Criminal penalty for workers' compensation fraud.

Chapter 507F sets forth criminal penalties for committing a workers' compensation fraudulent practice.

507E.6 Duties of insurer and fraud bureau.

1. An insurer which believes that a claim or application for insurance coverage is being made which is a violation of section 507E.3 or believes that a violation of section 507E.3A has occurred, shall provide, within sixty days of the receipt of such claim or application becoming aware of a possible violation, written notification to the bureau of the claim or application suspected violation on a form prescribed by the bureau, including any additional information requested by the bureau related to the claim or application or the party making the claim or application.

2. The fraud bureau shall review each notification and determine whether further investigation is warranted.

3. If the bureau determines that further investigation is warranted, the bureau shall conduct an independent investigation of the facts surrounding the claim or application for insurance coverage notification to determine the extent, if any, to which fraud occurred in the submission of the claim or application. If the notification pertains to workers' compensation insurance fraud, the bureau shall deliver the notice to the workers' compensation fraud unit, which shall determine if an investigation and prosecution

are warranted. Upon formal request made by the bureau, the insurer shall provide all additional information related to the notification within ten business days or a time period specifically identified by the bureau.

4. The bureau shall report any alleged violation of law disclosed by the investigation to the appropriate licensing agency or prosecuting authority having jurisdiction with respect to such violation.

507E.8 Law enforcement officer status.

1. Bureau investigators shall have the power and status of law enforcement officers who by the nature of their duties may be required to perform the duties of a peace officer when making arrests for criminal violations established as a result of their investigations pursuant to this chapter or chapter 507F.

2. The general laws applicable to arrests by law enforcement officers of the state also apply to bureau investigators. Bureau investigators shall have the power to execute arrest warrants and search warrants for the same criminal violations, serve subpoenas issued for the examination, investigation, and trial of all offenses identified through their investigations, and arrest upon probable cause without warrant a person found in the act of committing a violation of the provisions of this chapter or chapter 507F.

In addition, **SF 2305** includes the following clause:

Applicability. This Act applies on and after the effective date of this Act to acts of workers' compensation fraudulent practices or prohibited health service providers' practices committed on or after the effective date of this Act.

Missouri

SB 769 repeals and adds numerous sections to the Missouri Annotated Statutes, including, but not limit to, adding the following new sections:

8.301.

1. Neither the state nor any political subdivision thereof shall:

(1) Condition a contract upon a requirement that a bidder have a specified experience modification factor;

(2) Make an offer to contract conditioned upon bidder having a specified experience modification factor;

(3) Issue an advertisement for bids on a contract containing a requirement that the bidder have a specified experience modification factor;

(4) Solicit bids for a contract conditioned upon a bidder having a specified experience modification factor; or

(5) Weight any bidder for a contract favorably or unfavorably based upon the bidder's experience modification factor.

2. For purposes of this section, the phrase "experience modification factor" shall mean the factor calculated pursuant to the provisions of chapter 287.

...

386.205.

1. A public utility shall not:

(1) Condition a contract upon a requirement that a bidder have a specified experience modification factor;

(2) Make an offer to contract conditioned upon bidder having a specified experience modification factor;

(3) Issue an advertisement for bids on a contract containing a requirement that the bidder have a specified experience modification factor;

(4) Solicit bids for a contract conditioned upon a bidder having a specified experience modification factor; or

(5) Weight any bidder for a contract favorably or unfavorably based upon the bidder's experience modification factor.

2. For purposes of this section, the phrase "experience modification factor" shall mean the factor calculated pursuant to the provisions of chapter 287.

Utah

HB 209 amends, in part, **section 34A-2-102** and adds new **section 34a-2-107.2** to the Utah Workers' Compensation Act as follows:

34A-2-102. Definition of terms.

(1) As used in this chapter:

...

(h) "First responder" means:

(i) a law enforcement officer, as defined in Section 53-13-103;

(ii) an emergency medical technician, as defined in Section 26-8c-102;

(iii) an advanced emergency medical technician, as defined in Section 26-8c-102;

(iv) a paramedic, as defined in Section 26-8c-102;

(v) a firefighter, as defined in Section 34A-3-113; or

(vi) a dispatcher, as defined in Section 53-6-102.

...

34A-2-107.2. Mental Health Protections for First Responders Workgroup.

- (1) There is created the Mental Health Protections for First Responders Workgroup within the commission consisting of the following members:
- (a) the commissioner or the commissioner’s designee;
 - (b) one member of the Senate, appointed by the president of the Senate, and one member of the House, appointed by the speaker of the House;
 - (c) three representatives of the workers’ compensation insurance industry appointed by the chair, one of whom is a voting member of the employer side of the Workers’ Compensation Advisory Council, as follows:
 - (i) one member representing the insurance carrier designated to write coverage for the residual market;
 - (ii) one member representing an insurance carrier other than the carrier described in Subsection (1)(c)(i); and
 - (iii) one member representing self-insured employers which may be a representative from the Utah Association of Counties;
 - (d) one member representing the Division of Risk Management;
 - (e) four representatives of first responders appointed by the chair, two of whom are voting members of the employee side of the Workers’ Compensation Advisory Council;
 - (f) one representative from the Utah League of Cities and Towns;
 - (g) one representative from the Utah Association of Special Districts;
 - (h) the director of the Division of Substance Abuse and Mental Health, or the director’s designee;
 - (i) one representative who is a voting member of the Workers’ Compensation Advisory Council and who represents private employers; and
 - (i)[sic] as appointed by the chair, one or more individuals with expertise in mental stress or occupational medicine to serve as ex officio, nonvoting members of the workgroup.
- (2) The commissioner or the commissioner’s designee is the chair of the workgroup.
- (3) (a) A majority of the members of the workgroup constitutes a quorum.
- (b) The action of a majority of a quorum constitutes the action of the workgroup.
- (4) (a) The salary and expenses of each member of the workgroup who is a legislator shall be paid in accordance with Section 36-2-2 and Legislative Joint Rules, Title 5, Legislative Compensation and Expenses.
- (b) A member of the workgroup who is not a legislator may not receive compensation, benefits, per diem, or travel expenses for the member’s service on the workgroup.
- (5) The commission shall provide staff support to the workgroup.
- (6) The workgroup shall review and make recommendations on the following issues:
- (a) the alleviation of barriers, including financial barriers, to mental health treatment for first responders inside and outside of the workers’ compensation system;
 - (b) statutory requirements for compensability of mental stress claims from first responders under Chapter 2, Workers’ Compensation Act, and Chapter 3, Utah Occupational Disease Act;
 - (c) improving a first responder’s accessibility to mental health treatment; and
 - (d) any additional issue that the workgroup:
 - (i) determines is an important issue related to workers’ compensation for first responders; and
 - (ii) decides to review.
- (7) The workgroup shall present a final report on the items described in Subsection (6), including any legislative recommendations, to the Business and Labor Interim Committee on or before September 30, 2019.

...

HB 209 also amends **section 631-2-234** as follows:

631-2-234. Repeal dates—Title 34A.

(1) Section 34A-2-107.1 is repealed November 30, 2017.

(2) Section 34A-2-107.2 is repealed January 1, 2020.

Vermont

HB 731, in part, amends **section 625 of Title 21, Chapter 9**, Employer’s Liability and Workers’ Compensation, of the Vermont Statutes Annotated as follows:

§ 625. Contracting out forbidden; prohibited acts; penalties

(a) An employer shall not be relieved in whole or in part from liability created by the provisions of this chapter by any contract, rule, regulation, or device whatsoever.

(b) A person who, for the purpose of avoiding its obligations under this chapter, provides an individual who is or will be performing services for the person with substantial and material assistance related to the establishment of an independent business, including the registration of an unincorporated business with the Vermont Secretary of State, the establishment of a corporation or L.L.C., or the acquisition of a federal Employer Identification Number, may, after notice and an opportunity for a hearing, be assessed an administrative penalty of not more than \$5,000.00. As used in this subsection, “substantial and material assistance” does not include:

- (1) inquiring about whether an unincorporated business, corporation, or L.L.C. is actively registered with the Secretary of State;
(2) inquiring about whether an individual operates an unincorporated business, corporation, or L.L.C.; or
(3) referring an individual to a State agency, department, or website related to the registration or establishment of an unincorporated business, corporation, or L.L.C.

...

West Virginia

HB 4628 amends and reenacts **section 23-2C-3** of the Code of West Virginia as follows:

§23-2C-3. Creation of employers' mutual insurance company as successor organization of the West Virginia Workers' Compensation Commission.

...

(f)(3)(B) By May 1 each year, the self-insured employer community shall be assessed a cumulative total of \$9 million. The methodology for the assessment shall be fair and equitable and determined by exempt legislative rule issued by the Industrial Council. The amount collected pursuant to this subdivision shall be remitted to the Insurance Commissioner for deposit in the Workers' Compensation Debt Reduction Fund created in section five, article two-d of this chapter: *Provided*, That, notwithstanding any provision of this subdivision or any other provision of this code to the contrary, if the budget shortfall, as determined by the state Budget Office as of December 1, 2015, is greater than \$100 million, then the Governor may, by Executive Order, redirect deposits of the amount collected pursuant to this subdivision, for any period commencing after February 29, 2016, and ending before July 1, 2016, to the General Revenue Fund, instead of to the fund otherwise mandated in this subdivision, in article two-d, chapter twenty-three of this code or in any other provision of this code: *Provided, however*, That, notwithstanding any provision of this subdivision or any other provision of this code to the contrary, the Governor may, by Executive Order, redirect one-half of the deposits of the amount collected pursuant to this subdivision, for any period commencing after June 30, 2016, and ending before July 1, 2017, to the General Revenue Fund, instead of to the funds otherwise mandated in this subdivision, in article two-d, chapter twenty-three of this code or in any other provision of this code, until certification of the Governor to the Legislature that an independent actuary has determined that the unfunded liability of the Old Fund, as defined in chapter twenty-three of this code, has been paid or provided for in its entirety: *Provided further*, That, notwithstanding any provision of this subdivision or any other provision of this code to the contrary, the Governor may, by Executive Order, redirect seventy-five percent of the deposits of the amount collected pursuant to this subdivision, for any period commencing after June 30, 2017, and ending before July 1, 2018, to the General Revenue Fund, instead of to the funds otherwise mandated in this subdivision, in article two-d, chapter twenty-three of this code or in any other provision of this code, until certification of the Governor to the Legislature that an independent actuary has determined that the unfunded liability of the Old Fund, as defined in chapter twenty-three of this code, has been paid or provided for in its entirety: And provided further, That, notwithstanding any provision of this subdivision or any other provision of this code to the contrary, seventy-five percent of the deposits of the amount collected pursuant to this subdivision, for any period commencing after June 30, 2018, and ending before January 1, 2019, shall be deposited into the General Revenue Fund instead of to the funds otherwise mandated in this subdivision, in article two-d, chapter twenty-three of this code or in any other provision of this code, until certification of the Governor to the Legislature that an independent actuary has determined that the unfunded liability of the Old Fund, as defined in chapter twenty-three of this code, has been paid or provided for in its entirety.

...

(h) Notwithstanding any other provisions of this section to the contrary, after December 31, 2018, no surcharges may be assessed under subdivision (3), subsection (f) of this section or subsection (g) of this section. Except as otherwise provided in this subsection, the provisions of subdivision (3), subsection (f) of this section and subsection (g) of this section are terminated and shall be of no force or effect beginning on and after January 1, 2019: *Provided*, that liability for surcharges assessed under subdivision (3), subsection (f) of this section for periods prior to January 1, 2019, shall continue until paid.

SB 82, in part, amends **section 23-4-1** of the Code of West Virginia as follows:

§23-4-1. To whom compensation fund disbursed; occupational pneumoconiosis and other occupational diseases included in "injury" and "personal injury"; definition of occupational pneumoconiosis and other occupational diseases; rebuttable presumption for cardiovascular injury and disease or pulmonary disease for firefighters.

...

(g) No award ~~shall~~ may be made under the provisions of this chapter for any occupational disease contracted prior to July 1, 1949. An employee ~~shall be considered to have~~ has contracted an occupational disease within the meaning of this subsection if the disease or condition has developed to such an extent that it can be diagnosed as an occupational disease.

(h) (1) For purposes of this chapter, a rebuttable presumption that a professional firefighter who has developed a cardiovascular or pulmonary disease or sustained a cardiovascular injury or who has developed leukemia, lymphoma, or multiple myeloma arising out of and in the course of employment as a firefighter has received an injury or contracted a disease arising out of and in the course of his or her employment exists if: (A) The person has been actively employed by a fire department as a professional firefighter for a minimum of two years prior to the cardiovascular injury or onset of a cardiovascular or pulmonary disease or death; ~~and~~ (B) the injury or onset of the disease or death occurred within six months of having participated in firefighting or a training or drill exercise which actually involved firefighting; and (C) in the case of the development of leukemia, lymphoma, or

multiple myeloma the person has been actively employed by a fire department as a professional firefighter for a minimum of five years in the state prior to the development of leukemia, lymphoma, or multiple myeloma, has not used tobacco products for at least 10 years, and is not over the age of 65 years. When the above conditions are met, it shall be presumed that sufficient notice of the injury, disease, or death has been given and that the injury, disease, or death was not self inflicted.

~~(2) The Insurance Commissioner shall study the effects of the rebuttable presumptions created in this subsection on the premiums charged for workers' compensation for professional municipal firefighters; the probable effects of extending these presumptions to volunteer firefighters; and the overall impact of the risk management programs, wage replacement, premium calculation, the number of hours worked per volunteer, treatment of nonactive or "social" members of a volunteer crew and the feasibility of combining various volunteer departments under a single policy on the availability and cost of providing workers' compensation coverage to volunteer firefighters. The Insurance Commissioner shall file the report with the Joint Committee on Government and Finance no later than December 1, 2008.~~

(2) The amendments made to this section during the 2018 regular session of the Legislature to include leukemia, lymphoma, or multiple myeloma arising out of and in the course of employment as a firefighter as a rebuttable presumption shall expire on July 1, 2023, unless extended by the Legislature.

(i) Claims for occupational disease as defined in §23-4-1(f) of this code, except occupational pneumoconiosis for all workers and pulmonary disease and cardiovascular injury and disease for professional firefighters, shall be processed in like manner as claims for all other personal injuries.

~~(j) On or before January 1, 2004, the Workers' Compensation Commission shall adopt standards for the evaluation of claimants and the determination of a claimant's degree of whole-body medical impairment in claims of carpal tunnel syndrome.~~

SB 485 amends and reenacts **section 23-2C-3** of the Code of West Virginia as follows:

§23-2C-3. Creation of employers' mutual insurance company as successor organization of the West Virginia Workers' Compensation Commission.

...

(f)(3)(B) By May 1 each year, the self-insured employer community shall be assessed a cumulative total of \$9 million: *Provided, That notwithstanding any other provision of §23-2C-3(f)(3) of this section or any other provision of this code to the contrary, the \$9 million assessment terminates on June 30, 2018, and no further assessment pursuant to §23-2C-3(f)(3) of this section may be made against the self-insured employer community after that date.* The methodology for the assessment shall be fair and equitable and determined by exempt legislative rule issued by the Industrial Council. The amount collected pursuant to this subdivision shall be remitted to the Insurance Commissioner for deposit in the Workers' Compensation Debt Reduction Fund created in §23-2D-5 of this code: *Provided, That notwithstanding any provision of this subdivision or any other provision of this code to the contrary, if the budget shortfall, as determined by the state Budget Office as of December 1, 2015, is greater than \$100 million, then the Governor may, by Executive Order, redirect deposits of the amount collected pursuant to this subdivision, for any period commencing after February 29, 2016, and ending before July 1, 2016, to the General Revenue Fund, instead of to the fund otherwise mandated in this subdivision, in §23-2D-1 et seq. of this code or in any other provision of this code: *Provided, however, That notwithstanding any provision of this subdivision or any other provision of this code to the contrary, the Governor may, by Executive Order, redirect one half of the deposits of the amount collected pursuant to this subdivision, for any period commencing after June 30, 2016, and ending before July 1, 2017, to the General Revenue Fund, instead of to the funds otherwise mandated in this subdivision, in §23-2D-1 et seq. of this code or in any other provision of this code, until certification of the Governor to the Legislature that an independent actuary has determined that the unfunded liability of the Old Fund, as defined in chapter 23 of this code, has been paid or provided for in its entirety: *Provided further, That notwithstanding any provision of this subdivision or any other provision of this code to the contrary, the Governor may, by Executive Order, redirect 75 percent of the deposits of the amount collected pursuant to this subdivision, for any period commencing after June 30, 2017, and ending before July 1, 2018, to the General Revenue Fund, instead of to the funds otherwise mandated in this subdivision, in §23-2D-1 et seq. of this code or in any other provision of this code, until certification of the Governor to the Legislature that an independent actuary has determined that the unfunded liability of the Old Fund, as defined in chapter 23 of this code, has been paid or provided for in its entirety.***

SB 625 amends, in part, **section 33-3-33** and adds new **section 33-3-33b** to the Code of West Virginia as follows:

§33-3-33. Surcharge on fire and casualty insurance policies to benefit volunteer and part-volunteer fire departments and emergency medical services; Public Employees Insurance Agency and municipal pension plans; special fund created; allocation of proceeds; effective date.

(a) For the purpose of providing additional revenue for volunteer fire departments, part-volunteer fire departments, and emergency medical services providers for operations, equipment, training, and workers' compensation coverage, and certain retired teachers and the teachers retirement reserve fund, there is hereby authorized and imposed on and after July 1, 1992 2018, on the policyholder of any fire insurance policy or casualty insurance policy issued by any insurer, authorized or unauthorized, or by any risk retention group, a policy surcharge equal to one percent of the taxable premium for each such policy. After June 30, 2005, the surcharge shall be imposed as specified in subdivisions (2) and (3) of this subsection. For purposes of this section, casualty insurance may not include insurance on the life of a debtor pursuant to, or in connection with, a specific loan or other credit transaction or insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction

while the debtor is disabled as defined in the policy. The policy surcharge may not be subject to premium taxes, agent commissions, or any other assessment against premiums.

~~(2) After June 30, 2005, through December 31, 2005, for the purpose of providing additional revenue for volunteer fire departments, part-volunteer fire departments and to provide additional revenue to the Public Employees Insurance Agency and municipal pension plans, there is hereby authorized and imposed on and after July 1, 2005, on the policyholder of any fire insurance policy or casualty insurance policy issued by any insurer, authorized or unauthorized, or by any risk retention group, a policy surcharge equal to one percent of the taxable premium for each such policy.~~

~~(3) After December 31, 2005, for the purpose of providing additional revenue for volunteer fire departments and part-volunteer fire departments, there is hereby authorized and imposed on the policyholder of any fire insurance policy or casualty insurance policy issued by any insurer, authorized or unauthorized, or by any risk retention group, a policy surcharge equal to fifty-five one hundredths of one percent of the taxable premium for each such policy.~~

~~(4) For purposes of this section, casualty insurance may not include insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction or insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy. The policy surcharge may not be subject to premium taxes, agent commissions or any other assessment against premiums.~~

...

~~(d)(1) All money from the policy surcharge shall be collected by the Commissioner who shall disburse the money received from the surcharge as follows:~~

~~(1) Fifty-five percent of the moneys received shall be deposited into a special account in the State Treasury, designated the Fire Protection Fund. The net proceeds of this portion of the tax and the interest thereon, after appropriation by the Legislature, shall be distributed quarterly on the first day of the months of January, April, July, and October to each volunteer fire company or department on an equal share basis by the State Treasurer. After June 30, 2005, the money received from the surcharge shall be distributed as specified in subdivisions (2) and (3) of this subsection.~~

~~(2)(A) After June 30, 2005, through December 31, 2005, all money from the policy surcharge shall be collected by the Commissioner who shall disburse one-half of the money received from the surcharge into the Fire Protection Fund for distribution as provided in subdivision (1) of this subsection.~~

~~(B) The remaining portion of moneys collected shall be transferred into the fund in the state Treasury of the Public Employees Insurance Agency into which are deposited the proportionate shares made by agencies of this state of the Public Employees Insurance Agency costs of those agencies, until November 1, 2005. After the October 31, 2005, through December 31, 2005, the remain portion shall be transferred to the special account in the state Treasury, known as the Municipal Pensions and Protection Fund.~~

~~(2) Twenty percent of the moneys received shall be deposited into the Volunteer Fire Department Workers' Compensation Subsidy Program, established pursuant to §12-4-14a of this code.~~

~~(3) Fifteen percent of the moneys received shall be deposited into the Fire Service Equipment and Training Fund, established pursuant to §29-3-5f of this code.~~

~~(4) Ten percent of the moneys received shall be deposited into the Emergency Medical Services Equipment and Training Fund, established pursuant to §16-4C-24 of this code.~~

~~(3) After December 31, 2005, all money from the policy surcharge shall be collected by the Commissioner who shall disburse all of the money received from the surcharge into the Fire Protection Fund for distribution as provided in subdivision (1) of this subsection.~~

...

§33-3-33b. Report regarding volunteer firefighter workers' compensation coverage.

(a) The Insurance Commissioner, in consultation with the State Fire Marshal, the State Auditor, the Legislative Auditor, and the Board of Risk and Insurance Management, shall study the feasibility of combining the volunteer fire departments in our state under a single policy for workers' compensation coverage, self-insuring workers' compensation coverage for volunteer fire departments, or other workers' compensation coverage options. Such study shall also include an evaluation of the benefit, necessity, and feasibility of expanding the current scope of workers' compensation coverage for volunteers, including, but not limited to, presumptions for cardiovascular or pulmonary disease, occupational pneumoconiosis, or other occupational disease, as well as a comparison of those proposals to other means of supplementing workers' compensation insurance through secondary insurance policies.

(b) On or before July 1, 2019, the Insurance Commissioner shall submit to the Joint Committee on Government Organization a comprehensive report of the review and the Insurance Commissioner's recommendations, substantiated by the findings of the review, and steps that may be taken to meet the needs of and sustain the volunteer fire departments for their workers' compensation coverage.

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
IN, NC, SC, TN	Amy Quinn	803-356-0851
MO, NE, NV, OK, SD	Carla Townsend	314-843-4001
AZ, IA, KS, KY	Clarissa Preston	561-945-4517
DC, MD, VA, WV	David Benedict	804-380-3005
FL	Dawn Ingham	561-893-3165
CT, ME, NH, RI	Justin Moulton	860-969-7903
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This report is informational and is not intended to provide an interpretation of state and federal legislation.