



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

The following workers compensation-related bills were enacted within the one-week period ending March 9, 2018.

#### Idaho

**HB 366** was:

- Passed by the first chamber on January 31, 2018
- Included in NCCI's February 9, 2018 **Legislative Activity Report** (RLA-2018-06)
- Passed by the second chamber on February 23, 2018
- Included in NCCI's March 2, 2018 **Legislative Activity Report** (RLA-2018-09)
- Enacted on March 7, 2018, with an effective date of July 1, 2018

**HB 366** amends **section 72-205. Public Employment Generally—Coverage** of the Idaho Worker's Compensation Law to read as follows:

**72-205. Public Employment Generally—Coverage.** The following shall constitute employees in public employment and their employers subject to the provisions of this law:

...

(9) A work experience student, as that term is defined in section 72-102, Idaho Code, who does not receive wages while participating in the school's work experience program shall be covered by the school district's policy or by the Idaho higher education policy when the work experience student is not covered by the private or governmental entity that is the student's work experience employer.

#### Mississippi

**SB 2311** was:

- Passed by the first chamber on January 31, 2018
- Included in NCCI's February 9, 2018 **Legislative Activity Report** (RLA-2018-06)
- Passed by the second chamber on February 21, 2018
- Included in NCCI's March 2, 2018 **Legislative Activity Report** (RLA-2018-09)
- Enacted on March 5, 2018, with an effective date of July 1, 2018

**SB 2311**, in part, amends **section 71-3-77. Insurance policy regulations** of the Mississippi Worker's Compensation Law to read as follows:

**§ 71-3-77. Insurance policy regulations**

(1) Every contract for the insurance of the compensation herein provided, or against liability therefor, shall be deemed to be made subject to the provisions of this chapter, and provisions thereof inconsistent with this chapter shall be void. Such contract shall be allowed to offer deductibles on all liability of the assured under and according to the provisions of this chapter, notwithstanding

any agreement of the parties to the contrary. However, the payments of the claims, including the deductible amounts, shall be made directly from the insurance company to the employee, except for medical benefits which shall be paid to the medical provider. A copy of such payments shall be forwarded to the employer. The insurance company shall collect the deductible from the employer as shall be provided in the contract between the employer and the insurer. No such policy shall be subject to nonrenewal, or cancelled by the insurer within the policy period, until a notice in writing shall be given to the commission and to the insured, fixing the date on which it is proposed to cancel it or declaring that the company does not intend to renew the policy upon expiration date. Notice to the insured shall be served personally or by registered or certified mail. Notice to the commission shall be provided in such manner and on such form as the commission may prescribe or direct. No such cancellation or nonrenewal shall be effective until thirty (30) days after the service of such notice on the insured and the provision of notice to the commission, unless the employer has obtained other insurance coverage, in which case such policy shall be deemed cancelled as of the effective date of such other insurance, whether or not such notice has been given. The notice requirements of this section shall not apply when a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or when transfer of an insured to a licensed affiliate providing the same or substantially similar coverage occurs. Whenever a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or when a transfer of an insured to a licensed affiliate of the insurer providing the same or substantially similar coverage occurs, documents signed by the insured are applicable to the replacement policy and to coverage being transferred, and remain valid and enforceable.

The insured may also cancel such a policy on the day that the insured either (a) returns the policy to the agent, or (b) signs and delivers to the agent a "lost policy release." If the insured desires to cancel a policy before the policy has become effective, he may cancel the policy by written notice of cancellation to the agent or company without return of the policy or a release.

Whenever a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or by a licensed affiliate insurer, such insurer shall mail or deliver to the policyholder, at least thirty (30) days in advance of the effective date of renewal, written notice of any terms or conditions that are less favorable to the policyholder.

A transferring insurer shall notify the Mississippi Insurance Department and the Mississippi Workers' Compensation Commission at least forty-five (45) days in advance of notifying a policyholder that its personal or commercial lines insurance policies will be transferred to another licensed insurer within the same insurance group or same holding company. The notice shall include the name of insurer transferring the personal or commercial lines policies and the name and financial rating of the insurer receiving the transferred personal or commercial lines policies.

A transferring insurer shall provide the policyholder written notice of the policy transfer at least thirty (30) days prior to expiration of the policy term and shall include the financial rating of the insurer receiving the transferred policy. Such notice must be provided to the policyholder with the notice of renewal premium at least thirty (30) days before the effective date of the transfer.

...

**(3) As used in this section:**

(a) "Affiliate transfer" is when an insurer transfers, at renewal or policy expiration, its personal or commercial lines insurance policies to an affiliated licensed insurer that is a member of the same insurance group or same holding company as the transferring insurer. The issuance of a replacement policy form providing the same or substantially similar coverage issued by the same insurer, or the transfer of personal or commercial insurance policies to a licensed affiliate insurer that will issue the same or substantially similar policy, are considered a renewal and will not be treated as a cancellation or nonrenewal. The affiliate transfer must be to a licensed affiliate insurer that has been determined by the commissioner to have the same or better financial strength as the transferring insurer. The policy transfer must be selected on a nondiscriminatory basis.

(b) "Substantially similar" means a policy that provides the same basic coverages but may add, alter or eliminate incidental coverages and may provide coverages using different textual language.

## 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
- Included in NCCI's March 9, 2018 **Legislative Activity Report** (RLA-2018-10)
- Enacted on March 8, 2018, with an effective date of July 1, 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.

...

### **Virginia**

**HB 82** was:

- Passed by the first chamber on January 22, 2018
- Included in NCCI’s February 2, 2018 *Legislative Activity Report* (RLA-2018-05)
- Passed by the second chamber on February 22, 2018
- Included in NCCI’s March 2, 2018 *Legislative Activity Report* (RLA-2018-09)
- Enacted on March 9, 2018, with an effective date of July 1, 2018

**HB 82** repeals an enactment clause in **section 65.2-1201. Financing; tax** of the Virginia Workers’ Compensation Act that provides that the maximum tax rate that may be assessed on insurance carriers or self-insured employers for the purpose of funding workers compensation benefits that are awarded against uninsured employers from the Uninsured Employer’s Fund will revert from 0.5% to 0.25% on July 1, 2018. Repealing the enactment will maintain the maximum rate at its current level of 0.5%.

**HB 531** was:

- Passed by the first chamber on January 24, 2018
- Included in NCCI’s February 2, 2018 *Legislative Activity Report* (RLA-2018-05)
- Passed by the second chamber on February 22, 2018
- Included in NCCI’s March 2, 2018 *Legislative Activity Report* (RLA-2018-09)
- Enacted on March 9, 2018, with an effective date of July 1, 2018

**HB 531** amends and reenacts **section 65.2-804. Evidence of compliance with title; notices of cancellation of insurance** of the Virginia Workers’ Compensation Act as follows:

**§ 65.2-804. Evidence of compliance with title; notices of cancellation of insurance.**

A1. Each employer subject to this title shall file with the Workers’ Compensation Commission, in form prescribed by it, annually or as often as may be necessary, evidence of his compliance with the provisions of § 65.2-801 and all others relating thereto; however, if the employer secures his liability under this title pursuant to subdivision A 1 of § 65.2-801 then the insurance carrier shall make a filing on behalf of the employer, and such filing shall be made electronically in the form as prescribed and to the agent as designated by the Commission, within 30 days of the inception of the policy. Evidence of an employer’s compliance with the provisions of subdivision A 1 of § 65.2-801 shall be deemed to satisfy such provisions if it includes the name and address of the insured, the insured’s federal employer identification number, his policy number, dates of insurance coverage, the name and address of his insurer, and the insurer’s identification number. ~~Proof of coverage information filed with the Commission by an insurance carrier or rate service organization on behalf of an employer shall in no event be aggregated by the Commission with the proof of coverage information filed by or on behalf of other employers.~~ Every employer who has complied with the foregoing provision and has subsequently cancelled his insurance or his membership in a licensed group self-insurance association shall immediately notify the Workers’ Compensation Commission of such cancellation, the date thereof and the reasons therefor. Every insurance carrier or group self-insurance association shall in like manner notify the Workers’ Compensation Commission immediately upon the cancellation of any policy issued by it or any membership agreement, whichever is applicable, under the

provisions of this title, except that a carrier or group self-insurance association need not set forth its reasons for cancellation unless requested by the Workers' Compensation Commission.

...

**HB 558** was:

- Passed by the first chamber on January 24, 2018
- Included in NCCI's February 2, 2018 *Legislative Activity Report* (RLA-2018-05)
- Passed by the second chamber on February 22, 2018
- Included in NCCI's March 2, 2018 *Legislative Activity Report* (RLA-2018-09)
- Enacted on March 9, 2018, with an effective date of July 1, 2018

**HB 558** amends and reenacts *sections 65.2-605. Liability of employer for medical services ordered by Commission; fee schedules for medical services; malpractice; assistants-at-surgery; coding* and **65.2-605.1. Prompt payment; limitation on claims** of the Virginia Workers' Compensation Act as follows:

**§ 65.2-605. Liability of employer for medical services ordered by Commission; fee schedules for medical services; malpractice; assistants-at-surgery; coding.**

A. As used in this section, unless the context requires a different meaning:

...

"Medical community" means one of the following six regions of the Commonwealth:

1. Northern region, consisting of the area for which three-digit ZIP code prefixes 201 and 220 through 223 have been assigned by the U.S. Postal Service.
2. Northwest region, consisting of the area for which three-digit ZIP code prefixes 224 through 229 have been assigned by the U.S. Postal Service.
3. Central region, consisting of the area for which three-digit ZIP code prefixes 230, 231, 232, 238, and 239 have been assigned by the U.S. Postal Service.
4. Eastern region, consisting of the area for which three-digit ZIP code prefixes 233 through 237 have been assigned by the U.S. Postal Service.
5. Near Southwest region, consisting of the area for which three-digit ZIP code prefixes 240, 241, 244, and 245 have been assigned by the U.S. Postal Service.
6. Far Southwest region, consisting of the area for which three-digit ZIP code prefixes 242, 243, and 246 have been assigned by the U.S. Postal Service.

The applicable community for providers of medical services rendered in the Commonwealth shall be determined by the zip code of the location where the services were rendered. The applicable community for providers of medical services rendered outside of the Commonwealth shall be determined by the zip code of the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the zip code of the location where the Commission hearing regarding a dispute concerning the services would be conducted.

...

B. The pecuniary liability of the employer for a:

1. Medical, surgical, and hospital service herein required when ordered by the Commission that is provided to an injured person prior to the transition date, regardless of the date of injury, shall be limited absent a contract providing otherwise, to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person. As used in this subdivision, "same community" for providers of medical services rendered outside of the Commonwealth shall be deemed to be the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the location where the Commission hearing regarding the dispute is conducted;

...

**§ 65.2-605.1. Prompt payment; limitation on claims.**

...

~~G. Any health care provider located outside of the Commonwealth who provides health care services under the Act to a claimant shall be reimbursed as provided in this section, and the "same community," as used in subdivision B 1 of § 65.2-605 for treatment provided prior to the transition date as defined in subsection A of § 65.2-605, shall be deemed to be the principal place of business of the employer if located in the Commonwealth or, if no such location exists, then the location where the Commission hearing regarding the dispute is conducted.~~

~~H. The Commission, by January 1, 2016, shall establish a schedule pursuant to which employers, employers' workers' compensation insurance carriers, and providers of workers' compensation medical services shall be required, by a date determined by the Commission that is no earlier than July 1, 2016, and no later than December 31, 2018, to adopt and implement infrastructure under which (i) providers of workers' compensation medical services (providers) shall submit their billing, claims, case management, health records, and all supporting documentation electronically to employers or employers' workers' compensation insurance~~

carriers, as applicable (payers) and (ii) payers shall return actual payment, claim status, and remittance information electronically to providers that submit their billing and required supporting documentation electronically. The Commission shall establish standards and methods for such electronic submissions and transactions that are consistent with International Association of Industrial Accident Boards and Commission Medical Billing and Payment guidelines. The Commission shall determine the date by which payers and providers shall be required to adopt and implement the infrastructure, which determinations shall be based on the volume and complexity of workers' compensation cases in which the payer or provider is involved, the resources of the payer or provider, and such other criteria as the Commission determines to be appropriate.

## BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending March 9, 2018.

### Florida

#### HB 1437 was:

- Passed by the first chamber on March 1, 2018
- Included in NCCI's March 9, 2018 *Legislative Activity Report* (RLA-2018-10)
- Passed by the second chamber on March 6, 2018

**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.

#### SB 376 was:

- Passed by the first chamber on March 3, 2018
- Passed by the second chamber on March 5, 2018

**SB 376** amends **section 112.1815** of Title X of the Florida Statutes to read:

**112.1815 Firefighters, paramedics, emergency medical technicians, and law enforcement officers; special provisions for employment-related accidents and injuries.—**

...

(5)(a) For the purposes of this section and chapter 440, and notwithstanding sub-subparagraph (2)(a)3. and ss. 440.093 and 440.151(2), posttraumatic stress disorder, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association, suffered by a first responder is a compensable occupational disease within the meaning of subsection (4) and s. 440.151 if:

1. The posttraumatic stress disorder resulted from the first responder acting within the course of his or her employment as provided in s. 440.091; and
2. The first responder is examined and subsequently diagnosed with such disorder by a licensed psychiatrist who is an authorized treating physician as provided in chapter 440 due to one of the following events:
  - a. Seeing for oneself a deceased minor;
  - b. Directly witnessing the death of a minor;
  - c. Directly witnessing an injury to a minor who subsequently died before or upon arrival at a hospital emergency department;
  - d. Participating in the physical treatment of an injured minor who subsequently died before or upon arrival at a hospital emergency department;
  - e. Manually transporting an injured minor who subsequently died before or upon arrival at a hospital emergency department;
  - f. Seeing for oneself a decedent whose death involved grievous bodily harm of a nature that shocks the conscience;
  - g. Directly witnessing a death, including suicide, that involved grievous bodily harm of a nature that shocks the conscience;
  - h. Directly witnessing a homicide regardless of whether the homicide was criminal or excusable, including murder, mass killing as defined in 28 U.S.C. s. 530C, manslaughter, self-defense, misadventure, and negligence;
  - i. Directly witnessing an injury, including an attempted suicide, to a person who subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience;
  - j. Participating in the physical treatment of an injury, including an attempted suicide, to a person who subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience; or
  - k. Manually transporting a person who was injured, including by attempted suicide, and subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience.

(b) Such disorder must be demonstrated by clear and convincing medical evidence.

(c) Benefits for a first responder under this subsection:

1. Do not require a physical injury to the first responder; and
2. Are not subject to:

- a. Apportionment due to a preexisting posttraumatic stress disorder;
- b. Any limitation on temporary benefits under s. 440.093; or
- c. The 1-percent limitation on permanent psychiatric impairment benefits under s. 440.15(3).
- (d) The time for notice of injury or death in cases of compensable posttraumatic stress disorder under this subsection is the same as in s. 440.151(6) and is measured from one of the qualifying events listed in subparagraph (a)2. or the manifestation of the disorder, whichever is later. A claim under this subsection must be properly noticed within 52 weeks after the qualifying event.
- (e) As used in this subsection, the term:
  - 1. “Directly witnessing” means to see or hear for oneself.
  - 2. “Manually transporting” means to perform physical labor to move the body of a wounded person for his or her safety or medical treatment.
  - 3. “Minor” has the same meaning as in s. 1.01(13).
- (f) The Department of Financial Services shall adopt rules specifying injuries qualifying as grievous bodily harm of a nature that shocks the conscience for the purposes of this subsection.
- (6) An employing agency of a first responder, including volunteer first responders, must provide educational training related to mental health awareness, prevention, mitigation, and treatment.

**SB 376** also includes the following clause:

The Legislature determines and declares that this act fulfills an important state interest.

*NCCI’s analysis indicates that if enacted in its current form, **SB 376** may result in an indeterminate increase on system costs for law enforcement officer, firefighter, emergency medical technician, and paramedic (collectively defined as first responders) classifications in Florida. However, the impact on overall privately insured workers compensation costs is expected to be minimal, since data reported to NCCI shows that first responder classifications represent approximately 2% of losses in Florida. Much of the cost impact to first responders would be felt by governmental entities who are typically the employers of such professions.*

## Kentucky

**HB 220** was:

- Passed by the first chamber on February 7, 2018
- Included in NCCI’s February 16, 2018 **Legislative Activity Report** (RLA-2018-07)
- Passed by the second chamber on March 7, 2018

**HB 220** adds a new section to **Chapter 336** of the Kentucky Labor and Human Rights law to read:

(1) As used in this section:

- (a) “Marketplace contractor” means a person or entity that enters into an agreement with a marketplace platform to use its digital network or mobile application to receive connections to third party individuals or entities seeking services; and
- (b) “Marketplace platform” means a person or entity that:
  - 1. Offers a digital network or mobile application that connects marketplace contractors to third party individuals or entities seeking the type of services offered by a marketplace contractor;
  - 2. Accepts service requests from the public exclusively through its digital network or mobile application and does not accept service requests by telephone, facsimile or in person at a physical retail location; and
  - 3. Does not perform the services offered by the marketplace contractor at or from a physical business location that is operated by the platform in the state.
- (2) A marketplace contractor shall not be deemed to be an employee of a marketplace platform for any purpose under state and local laws, regulations, and ordinances, including but not limited to KRS Chapters 336, 341, and 342, so long as:
  - (a) The marketplace platform and the marketplace contractor agree in writing that the marketplace contractor is an independent contractor with respect to the marketplace platform;
  - (b) The marketplace platform does not unilaterally prescribe specific hours during which the marketplace contractor must be available to accept service requests from third party individuals or entities submitted solely through the online-enabled application, software, Web site, or system of the marketplace platform;
  - (c) The marketplace platform does not prohibit the marketplace contractor from using any online-enabled application, software, Web site, or system offered by another marketplace platform;
  - (d) The marketplace platform does not restrict the marketplace contractor from engaging in another occupation or business;
  - (e) The marketplace contractor bears all or substantially all of the expenses incurred by the marketplace contractor in performing the services; and
  - (f) The marketplace platform does not supply instrumentalities or tools for the person doing the work;
- (3) For services performed by a marketplace contractor prior to the effective date of this Act, the marketplace contractor shall be treated as an independent contractor of the marketplace platform and not an employee of the marketplace platform if the requirements set forth in subsection (2) of this Act were met at the time at which the services were performed.

(4) This section shall not apply to:

(a) Service performed in the employment of a state or any political subdivision of a state, or in the employ of an Indian tribe, or any instrumentality of a state, any political subdivision of a state or any Indian tribe that is wholly owned by one (1) or more states or political subdivisions of Indian tribes, provided such service is excluded from employment as defined in 26 U.S.C. secs. 3301 to 3311;

(b) Service performed in the employment of a religious, charitable, educational, or other organization that is excluded from employment as defined in 26 U.S.C. secs. 3301 to 3311, solely by reason of 26 U.S.C. sec. 3306(c)(8); or

(c) Services consisting of transporting freight, sealed envelopes, boxes or parcels, or other sealed containers for compensation.

**HB 220** also includes the following clause:

If any provisions of this Act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

## Utah

**HB 288** was:

- Passed by the first chamber on February 15, 2018
- Included in NCCI's February 23, 2018 *Legislative Activity Report* (RLA-2018-08)
- Passed by the second chamber on March 7, 2018

**HB 288** adds new *section 34A-2-114. Unlawful interference—Penalties* to the Utah Workers Compensation Act as follows:

**34A-2-114. Unlawful interference—Penalties.**

(1) An employer may not knowingly or intentionally:

(a) impede or diminish an employee's efforts to make a claim or receive workers' compensation benefits under this chapter or Chapter 3, Utah Occupational Disease Act; or

(b) intimidate, coerce, or harass an employee with the intent of preventing the employee from making a claim or receiving workers' compensation benefits under this chapter or Chapter 3, Utah Occupational Disease Act.

(2) An employer may not suspend, discharge, discipline, threaten to discharge or discipline, or otherwise retaliate against an employee solely because the employee:

(a) claims or attempts to claim workers' compensation benefits under this chapter or Chapter 3, Utah Occupational Disease Act;

(b) reports an employer's noncompliance with a provision of this chapter or Chapter 3, Utah Occupational Disease Act; or

(c) testifies or intends to testify in a workers' compensation proceeding.

(3) In accordance with Title 63G, Chapter 4, Administrative Procedures Act, the division may impose a fine of up to \$5,000 against an employer for each violation of Subsection (1) or (2).

(4) The division shall deposit any money collected under this section into the Uninsured Employers' Fund created in Section 34A-2-704.

(5) This section does not affect the rights or obligations of an employee or employer under common law.

**SB 40** was:

- Passed by the first chamber on February 6, 2018
- Included in NCCI's February 16, 2018 *Legislative Activity Report* (RLA-2018-07)
- Passed by the second chamber on March 8, 2018

**SB 40** amends *sections 34A-2-410. Temporary disability—Amount of payments—State average weekly wage defined, 34A-2-411. Temporary partial disability—Amount of payments, 34A-2-412. Permanent partial disability—Scale of payments, and 34A-2-413. Permanent total disability—Amount of payments—Rehabilitation.* of the Utah Workers Compensation Act as follows:

**34A-2-410. Temporary disability—Amount of payments—State average weekly wage defined.**

(1) (a) Subject to Subsections (1)(b) and (5), in case of temporary disability, so long as the disability is total, the employee shall receive 66-2/3% of that employee's average weekly wages at the time of the injury but:

(i) not more than a maximum of 100% of the state average weekly wage at the time of the injury per week; and

(ii) (A) subject to Subsections (1)(a)(ii)(B) and (C), not less than a minimum of \$45 per week plus:

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

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

...

**34A-2-411. Temporary partial disability—Amount of payments.**

(1) If the injury causes temporary partial disability for work, the employee shall receive weekly compensation equal to:

(a) 66-2/3% of the difference between the employee's average weekly wages before the accident and the weekly wages the employee is able to earn after the accident, but not more than 100% of the state average weekly wage at the time of injury; plus

(b) \$5 \$20 for a dependent spouse and \$5 \$20 for each dependent child under the age of 18 years, up to a maximum of four such dependent children, but only up to a total weekly compensation that does not exceed 100% of the state average weekly wage at the time of injury.

...

**34A-2-412. Permanent partial disability—Scale of payments.**

(1) An employee who sustained a permanent impairment as a result of an industrial accident and who files an application for hearing under Section 34A-2-417 may receive a permanent partial disability award from the commission.

(2) Weekly payments may not in any case continue after the disability ends, or the death of the injured person.

(3) (a) In the case of the injuries described in Subsections (4) through (6), the compensation shall be 66-2/3% of that employee's average weekly wages at the time of the injury, but not more than a maximum of 66-2/3% of the state average weekly wage at the time of the injury per week and not less than a minimum of \$45 per week plus \$5 \$20 for a dependent spouse and \$5 \$20 for each dependent child under the age of 18 years, up to a maximum of four dependent children, but not to exceed 66-2/3% of the state average weekly wage at the time of the injury per week.

(b) The compensation determined under Subsection (3)(a) shall be:

(i) paid in routine pay periods not to exceed four weeks for the number of weeks provided for in this section; and

(ii) in addition to the compensation provided for temporary total disability and temporary partial disability.

...

**34A-2-413. Permanent total disability—Amount of payments—Rehabilitation.**

...

(2) For permanent total disability compensation during the initial 312-week entitlement, compensation is 66-2/3% of the employee's average weekly wage at the time of the injury, limited as follows:

(a) compensation per week may not be more than 85% of the state average weekly wage at the time of the injury;

(b) (i) subject to Subsection (2)(b)(ii), compensation per week may not be less than the sum of \$45 per week and:

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

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

(ii) the amount calculated under Subsection (2)(b)(i) may not exceed:

(A) the maximum established in Subsection (2)(a); or

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

(c) after the initial 312 weeks, the minimum weekly compensation rate under Subsection (2)(b) is 36% of the current state average weekly wage, rounded to the nearest dollar.

...

**SB 64** was:

- Passed by the first chamber on February 20, 2018
- Included in NCCI's March 2, 2018 *Legislative Activity Report* (RLA-2018-09)
- Passed by the second chamber on March 7, 2018

**SB 64** amends *sections 34A-2-107, 34A-2-407, and 34A-2-705* of the Utah Workers Compensation Act as follows:

**34A-2-107. Appointment of workers' compensation advisory council—Composition—Terms of members—Duties—Compensation.**

(1) The commissioner shall appoint a workers' compensation advisory council composed of:

...

(b) the following nonvoting members:

...

(iv) the Utah insurance commissioner or the insurance commissioner's designee; ~~and~~

(v) the commissioner or the commissioner's designee; and

(vi) a representative of hospitals.

...

~~(7) The council shall study how hospital costs may be reduced for purposes of medical benefits for workers' compensation. By no later than November 30, 2017, the council shall submit, in accordance with Section 68-3-14, a written report to the Business and Labor Interim Committee containing the council's recommendations.~~

(7) (a) The council shall:

(i) study how to reduce hospital costs for purposes of medical benefits for workers' compensation;

(ii) study hospital billing and payment trends under Subsection 34A-2-407(11)(c);

(iii) study hospital fee schedules used in other states; and

(iv) collect information from third-party hospital review companies in the state or region, to identify an average reimbursement

rate that represents the approximate rate at which a workers' compensation insurance carrier or self-insured employer should expect to reimburse a hospital for billed hospital fees for covered medical services in the state.

(b) In accordance with Section 68-3-14, the council shall submit a written report to the Business and Labor Interim Committee no later than September 1, 2019, 2020, and 2021. The council's written report shall include:

(i) recommendations on how to reduce hospital costs for purposes of medical benefits or workers' compensation;

(ii) aggregate data on hospital billing and payment trends under Subsection 34A-2-407(11)(c);

(iii) the results of the council's study of hospital fee schedules from other states; and

(iv) the approximate rate at which a workers' compensation insurance carrier or self-insured employer should expect to reimburse a hospital for billed hospital fees for covered medical services, calculated in accordance with Subsection (7)(a)(iv).

(c) For each report described in Subsection (7)(b), the commission may contract with a third-party expert to assist with the council's duties described in Subsections (7)(a) and (b).

...

#### **34A-2-407. Reporting of industrial injuries—Regulation of health care providers.**

...

(11) (a) As used in this Subsection (11):

...

(c) Subject to Subsection (11)(d), for the time period beginning on May ~~10, 2016~~ 8, 2018, and ending on July 1, ~~2018~~ 2021, a workers' compensation insurance carrier or self-insured employer that is reimbursing a hospital ~~that has not entered into a contract described in Subsection (11)(b) shall reimburse the hospital for covered medical services at 85% of the billed hospital fees for the covered medical services. shall reimburse the hospital:~~

(i) in accordance with a contract described in Subsection (11)(b); or

(ii) (A) if the hospital is located in a county of the first, second, or third class, as classified in Section 17-50-501, at 75% of the billed hospital fees for the covered medical services; or

(B) if the hospital is located in a county of the fourth, fifth, or sixth class, as classified in Section 17-50-501, at 85% of the billed hospital fees for the covered medical services.

...

#### **34A-2-705. Industrial Accident Restricted Account.**

...

(4) (a) From money appropriated by the Legislature from the account to the commission and subject to the requirements of this section, the commission may fund:

(i) the activities of the Division of Industrial Accidents described in Section 34A-1-202;

(ii) the activities of the Division of Adjudication described in Section 34A-1-202; and

(iii) the activities of the commission described in Section 34A-2-1005[-]; and

(iv) the activities of the commission described in Subsection 34A-2-107(7)(c), up to \$50,000 for each of the three reports described in Subsection 34A-2-107(7)(b).

...

## **West Virginia**

**HB 4628** was:

- Passed by the first chamber on February 28, 2018
- Included in NCCI's March 9, 2018 *Legislative Activity Report* (RLA-2018-10)
- Passed by the second chamber on March 9, 2018

**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** was:

- Passed by the first chamber on February 27, 2018
- Included in NCCI's March 9, 2018 **Legislative Activity Report** (RLA-2018-10)
- Passed by the second chamber on March 9, 2018

**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 625** was:

- Passed by the first chamber on February 27, 2018
- Included in NCCI's March 9, 2018 **Legislative Activity Report** (RLA-2018-10)
- Amended and passed by the second chamber on March 9, 2018

**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.

**BILLS PASSING FIRST CHAMBER**

The following workers compensation-related bills passed the first chamber within the one-week period ending March 9, 2018.

**Alabama**

**HB 401** amends *sections 27-42-3, 27-42-5, 27-42-8, 27-42-11, and 27-42-12* of the Alabama Insurance Code, in part, as follows:

**Section 27-42-3**

**Applicability of chapter.**

This chapter shall apply to all kinds of direct insurance, ~~except life, annuities, disability, accident and health, title, surety, credit, mortgage guaranty, and ocean marine insurance.~~ excluding all of the following:

(1) Life, annuity, health, or disability insurance.

(2) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(3) Fidelity or surety bonds, or any other bonding obligations.

(4) Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction.

(5) Insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement, or service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits.

(6) Title insurance.

(7) Ocean marine insurance.

(8) Any insurance provided by or guaranteed by the government.

**Section 27-42-5**

**Definitions.**

As used in this chapter, the following terms shall have the following meanings, respectively, unless the context clearly indicates otherwise:

...

(4) CLAIMANT. Any insured making a first party claim or any person instituting a liability claim. The term does not include a person who is an affiliate of an insolvent insurer.

...

~~(6)~~ (7) COVERED CLAIM. An unpaid claim, including one of unearned premiums, which arises out of, and is within the coverage and not in excess of, the applicable limits of an insurance policy to which this chapter applies, issued by an insurer, if such insurer becomes an insolvent insurer after January 1, 1981, and (i) the claimant or insured is a resident of this state at the time of the insured event; or (ii) the property from which the claim arises is permanently located in this state. "Covered claim" shall The term does not include any of the following:

a. Any amount due any reinsurer, insurer, insurance pool, self-insurer, or underwriting association, as subrogation recoveries or otherwise, nor shall "covered claim" include any .

b. Any first party claims by a "high net worth insured."

c. Any amount awarded as punitive or exemplary damages except for punitive damages awarded under the Alabama Wrongful Death Act.

d. Any amount sought as a return of premium under any retrospective rating plan.

...

(10) INSURED. Any named insured, additional insured, vendor, lessor, or other party identified as an insured under a policy.

...

#### **Section 27-42-8**

##### **Powers and duties.**

a) The association shall:

(1)a. Be obligated to the extent of the pay covered claims existing prior to the determination of insolvency and order of liquidation arising within 30 days after the determination of insolvency order of liquidation, or before the policy expiration date if less than 30 days after the determination, on order of liquidation, or before the insured replaces the policy or causes its cancellation, if he or she does so within 30 days of the determination, but the association's obligation shall include only that amount of each covered claim which is in excess of one hundred dollars (\$100) and is less than one hundred fifty thousand dollars (\$150,000), except that the association shall pay the full amount of any covered employee benefit claim arising under Section A of workers' compensation policy. In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises. order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

1. The full amount of a covered claim for benefits under a workers' compensation insurance coverage.

2. An amount not exceeding ten thousand dollars (\$10,000) per policy for a covered claim for the return of unearned premium.

3. An amount not exceeding three hundred thousand dollars (\$300,000) or the policy limits, whichever is less, per claim for all covered claims. For purposes of this limitation, all claims of any kind whatsoever arising out of, or related to, bodily injury or death to any one person shall constitute a single claim, regardless of the number of claims made or the number of claimants.

b. In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises.

c. Notwithstanding any other provisions of this chapter, a covered claim shall not include any claim filed with the guaranty fund association after the earlier of:

1. Twenty-five months after the date of the order of liquidation.

2. The final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

d. Any obligation of the association to defend an insured on a covered claim shall cease upon the association's

1. payment, by settlement releasing the insured or on a judgment, of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit or

2. tender of such amount.

e. If the association determines that there may be more than one claimant having a covered claim or allowed claim against the association or any associations similar to the association in other states, under the policy or policies of any one insolvent insurer, the association may establish a plan to allocate amounts payable by the association in such manner as the association deems equitable.

...

(b) The association may:

...

(7) Bring an action against any third party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all claims information including, but not limited to, files, records, and electronic data related to an insolvent company that are appropriate or necessary for the association, or a similar association in other states, to carry out its duties under this chapter. In such a suit, the association shall have the absolute right through emergency equitable relief to obtain custody and control of all claims information in the custody or control of the third party administrator, agent, attorney, or other representative of the insolvent insurer, regardless of where the claims information may be physically located. In bringing such an action, the association shall not be subject to any defense, lien, possessory or otherwise, or other legal or equitable ground whatsoever for refusal to surrender claims information that might be asserted against the liquidator of the insolvent insurers. To the extent that litigation is required for the association to obtain custody of the claims information requested and litigation results in the relinquishment of claims information to the association after refusal to provide the same in response to a written demand, the court shall award the association its costs, expenses, and reasonable attorneys' fees incurred in bringing the action. This section shall have no effect on the rights and remedies that the custodian of such claims information may have against the insolvent insurers, so long as such rights and remedies do not conflict with the rights of the association to custody and control of the claims information under this chapter.

...

#### **Section 27-42-11**

**Settlement and payment of claims; recovery.**

...

(i) The association and any association similar to the association in another state shall be recognized as claimants in the liquidation of an insolvent insurer for any amounts paid by them on covered claims obligations as determined under this chapter, or similar laws in other states, and shall receive dividends and any other distributions at the priority set forth for policyholder claims in the liquidation proceeding. The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by determinations of covered claim eligibility under this chapter and by settlements of claims made by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this chapter against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

**Section 27-42-12**

**Exhaustion of rights; nonduplication of recovery.**

(a) Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first his rights under such policy. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under such insurance policy. An insurance policy, whether or not it is a policy issued by a member insurer, where the claim under the other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the association, shall be required first to exhaust all coverage provided by any such policy. Any amount payable on a covered claim under this chapter shall be reduced by the full applicable limits stated in the other insurance policy and the association shall receive a full credit for the stated limits, or, where there are no applicable stated limits, the claim shall be reduced by the total recovery. Notwithstanding the foregoing, no person shall be required to exhaust any right under the policy of an insolvent insurer.

(1) A claim under a policy providing liability coverage to a person who may be jointly and severally liable with, or a joint tortfeasor with, the person covered under the policy of the insolvent insurer that gives rise to the covered claim, shall be considered to be a claim arising from the same facts, injury, or loss that gave rise to the covered claim against the association.

(2) A claim under an insurance policy shall also include, for purposes of this section:

a. A claim against a health maintenance organization, a hospital plan corporation, or a professional health service corporation.

b. Any amount payable by or on behalf of a self-insurer.

(3) To the extent that the association's obligation is reduced by the application of this section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount.

(b) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he or she shall seek recovery first from the association of the location of the property and if it is a workmen's workers' compensation claim, he or she shall seek recovery first from the association of the residence of the claimant at the time of the accident giving rise to the claim. Any recovery under this chapter shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

**Hawaii**

**SB 2364 SD2** adds a new section to the Hawaii Workers Compensation Law as follows:

**§ 386- Payment by employer; duty to service provider; disagreement with service provider; resolution procedures.**

(a) Notwithstanding any other law to the contrary, the employer shall pay for all medical services required by the employee for the compensable injury and the process of recovery. The employer shall not be required to pay for care unrelated to the compensable injury.

(b) The employer shall not dispute a claim for services:

(1) Without reasonable cause; or

(2) While the claim is pending investigation; provided that a claim shall be presumed compensable when submitted by an employee who is excluded from health care coverage under chapter 393, the Hawaii Prepaid Health Care Act.

(c) If an employer disputes a claim for services rendered or a bill received, the employer shall notify the provider of services of that fact within thirty calendar days of receipt of the claim for services or bill. Failure by the employer to submit timely notice to the provider of services shall render the employer liable for the services provided or bill received until the employer satisfies the notice requirement and except as provided in subsection (d).

(d) Any employer who has received a claim for services rendered or a bill from a provider of services shall be liable for the claim or bill and, within sixty calendar days of receipt of the claim or bill, shall pay all charges listed in the claim for services rendered or the bill, except for items for which there is reasonable disagreement. After expiration of the sixty-calendar-day time period for payment, the provider of services may increase the total outstanding balance owed for undisputed services or charges by one per cent per month.

(e) If reasonable disagreement occurs, the employer shall:

(1) Pay all undisputed charges;

(2) Notify the provider of services of the denial of payment of any disputed charges and the reason for the denial within thirty calendar days of receipt of the bill or claim for services rendered; and

(3) Provide a copy of the denial to the employee.

The employer's denial shall include a statement as follows:

"IF THE PROVIDER OF SERVICES DOES NOT AGREE WITH THE EMPLOYER'S STATED REASON FOR DENIAL OF PAYMENT, THE PROVIDER OF SERVICES MAY FILE A BILL DISPUTE REQUEST WITH THE DIRECTOR OF THE HAWAII DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS. THE BILL DISPUTE REQUEST SHALL BE CLEARLY IDENTIFIED AS 'BILL DISPUTE REQUEST' IN CAPITAL LETTERS AND IN NO LESS THAN TEN POINT FONT ON THE FRONT OF THE FIRST PAGE OF THE REQUEST AND ON THE FRONT OF THE ENVELOPE IN WHICH THE REQUEST IS SENT. ANY BILL DISPUTE REQUEST SHALL BE FILED WITHIN THIRTY CALENDAR DAYS AFTER THE POSTMARK DATE OF THE EMPLOYER'S DENIAL OF PAYMENT. IF THE PROVIDER OF SERVICES FAILS TO SUBMIT A TIMELY BILL DISPUTE REQUEST, THE PROVIDER SHALL FORFEIT THE RIGHT TO DISPUTE THE EMPLOYER'S DENIAL OF PAYMENT."

(f) Upon receipt of a bill dispute request, the director shall send notice to the parties and the parties shall negotiate to resolve the disputed services or charges during the thirty-one calendar days following the date of the notice from the director. If the parties fail to enter into an agreement within the thirty-one calendar days, then within fourteen calendar days thereafter, either party may file a request in writing to the director to review the bill dispute request; provided that the requesting party shall send a notice of the request to the non-requesting party. Upon receipt of the request for review, the director shall send the parties a second notice requesting each party to file a position statement with the director, including substantiating documentation that describes the services and amounts in dispute and all actions taken to resolve the dispute during the thirty-one calendar day period of negotiation under this subsection. The director shall review the positions of the parties and render an administrative decision without a hearing. The director may assess a fine of up to \$1,000 payable to the general fund against any party if the director finds that the party has failed to negotiate in good faith. Denial of payment without reasonable cause shall be considered a failure to negotiate in good faith.

(g) An employee shall be liable for reimbursement of benefits or payments received under this section for any disputed claim that is found to be not compensable, whether received from an employer, insurer, or the special compensation fund. Reimbursement shall be made to the source from which the compensation was received, and may include recoupment by the insurer of all payments made for medical care, medical services, vocational rehabilitation services, and all other services rendered for payment under this section.

**SB 2660** 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 such amounts as authorized by this chapter and rules adopted by the department.

**§ 386- Medical care, services, and supplies for firefighters suffering from cancer.** If a claim for leukemia, multiple myeloma, non-Hodgkin's lymphoma, or cancer of the lung, brain, stomach, esophagus, intestines, rectum, kidney, bladder, prostate, or testes filed by a firefighter with five or more years of service as a firefighter is accepted or determined to be compensable, section 386-21 remains applicable; provided that the employer shall be liable for medical care, services, and supplies not to exceed one hundred thirty-seven percent 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.

## Kentucky

**HB 323**, in part, amends *sections 304.47-020* and *532.350* of the Kentucky Revised Statutes as follows:

**304.47-020 Fraudulent insurance acts—Penalties—Compensatory damages—Application of section.**

1) For the purposes of this subtitle, a person or entity commits a "fraudulent insurance act" if he or she engages in any of the following, including but not limited to matters relating to workers' compensation:

(a) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, Kentucky Claims Commission, Special Fund, or any agent thereof; 7

1. Any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or from a "self-insurer" as defined by KRS Chapter 342, knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim; or

~~(b) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, Kentucky Claims Commission, or any agent thereof;~~

2. Any statement as part of, or in support of, an application for an insurance policy, for renewal, reinstatement, or replacement of insurance, or in support of an application to a lender for money to pay a premium, knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the application;

~~(b) (e)~~ Knowingly and willfully transacts any contract, agreement, or instrument which violates this title;

~~(c) (d)~~ Knowingly and with intent to defraud or deceive; 7

1. Receives money for the purpose of purchasing insurance, and fails to obtain insurance;

~~(e) Knowingly and with intent to defraud or deceive,~~

~~2. Fails to make payment or disposition of money or voucher as defined in KRS 304.17A-750, as required by agreement or legal obligation, that comes into his or her possession while acting as a licensee under this chapter;~~

~~3. Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or to the commissioner, any statement, knowing that the statement contains any false, incomplete, or misleading information concerning any material fact or thing, as part of, or in support of one (1) or more of the following:~~

~~a. The rating of an insurance policy;~~

~~b. The financial condition of an insurer;~~

~~c. The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one (1) or more lines of insurance in all or part of this Commonwealth by an insurer; or~~

~~d. A document filed with the commissioner; or~~

~~4. Engages in any of the following:~~

~~a. Solicitation or acceptance of new or renewal insurance risks on behalf of an insolvent insurer; or~~

~~b. Removal, concealment, alteration, tampering, or destruction of money, records, or any other property or assets of an insurer;~~

~~(d) (f) Issues or knowingly presents fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, insurance binders, or any other documents that purport to evidence insurance;~~

~~(e) (g) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer;~~

~~(f) (h) Engages in unauthorized insurance, as set forth defined in KRS 304.11- 030;~~

~~(i) Knowingly and with intent to defraud or deceive, presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or to the commissioner, any statement, knowing that the statement contains any false, incomplete, or misleading information concerning any material fact or thing, as part of, or in support of one (1) or more of the following:~~

~~1. The rating of an insurance policy;~~

~~2. The financial condition of an insurer;~~

~~3. The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one (1) or more lines of insurance in all or part of this Commonwealth by an insurer; or~~

~~4. A document filed with the commissioner;~~

~~(j) Knowingly and with intent to defraud or deceive, engages in any of the following:~~

~~1. Solicitation or acceptance of new or renewal insurance risks on behalf of an insolvent insurer; or~~

~~2. Removal, concealment, alteration, tampering, or destruction of money, records, or any other property or assets of an insurer; or~~

~~(g) (k) Assists, abets, solicits, or conspires with another to commit a fraudulent insurance act in violation of this subtitle.~~

~~(2) (a) Except as provided in paragraphs (b) and (c) of this subsection, A person convicted of a violation of subsection (1) of this section shall be guilty of a Class A misdemeanor unless where the aggregate of the claim, benefit, or money referred to in subsection (1) of this section is less than or equal to five hundred dollars (\$500), and shall be punished by:~~

~~1. Ten thousand dollars (\$10,000) or more but less than one hundred thousand dollars (\$100,000), in which case it is a Class D felony imprisonment for not more than one (1) year;~~

~~2. One hundred thousand dollars (\$100,000) or more but less than one million dollars (\$1,000,000), in which case it is a Class C felony A fine, per occurrence, of not more than one thousand dollars (\$1,000) per individual nor five thousand dollars (\$5,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or~~

~~3. One million dollars (\$1,000,000) or more, in which case it is a Class B felony Both imprisonment and a fine as set forth in subparagraphs 1. and 2. of this paragraph.~~

~~(b) A Except as provided in paragraph (c) of this subsection, where the claim, benefit, or money referred to in subsection (1) of this section exceeds an aggregate of five hundred dollars (\$500), a person convicted of a violation of subsection (1) of this section shall be guilty of a felony and shall be punished by:~~

~~1. Imprisonment for not less than one (1) nor more than five (5) years;~~

~~2. A fine, per occurrence, of not more than ten thousand dollars (\$10,000) per individual nor one hundred thousand dollars (\$100,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or~~

~~3. Both imprisonment and a fine as set forth in subparagraphs 1. and 2. of this paragraph.~~

~~(c) Any person, with the purpose of establishing or maintaining to establish or maintain a criminal syndicate, or to facilitate any of its activities, convicted of doing any act as set forth in KRS 506.120(1), shall be guilty of engaging in organized crime, a Class B felony.~~

~~(c) A person convicted of a crime set forth in this section, and shall be punished by:~~

~~1. Imprisonment for a term:~~

~~a. Not to exceed the period set forth in KRS 532.090 if the crime is a Class A misdemeanor; or~~

~~b. Within the periods set forth in KRS 532.060 if the crime is a Class D, C, or B felony not less than ten (10) years nor more than twenty (20) years;~~

~~2. A fine, per occurrence, of:~~

- a. For a misdemeanor, not more than one thousand dollars (\$1,000) per individual nor five thousand dollars (\$5,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or
- b. For a felony, not more than ten thousand dollars (\$10,000) per individual nor one hundred thousand dollars (\$100,000) per corporation, or twice the amount of gain received as a result of the violation; whichever is greater; or
3. Both imprisonment and a fine, as set forth in subparagraphs 1. and 2. of this paragraph.
- (d) In addition to imprisonment, the assessment of a fine, or both, a person convicted of a violation of paragraph (a) ~~or~~, (b), ~~or~~ (c) of subsection (2) of this section may be ordered to make restitution to any victim, including an insurer that has contracted to indemnify a victim, who suffered a monetary loss due to any actions by that person which resulted in the adjudication of guilt, and to the division for the cost of any investigation. The amount of restitution shall equal the monetary value of the actual loss or twice the amount of gain received as a result of the violation, whichever is greater.
- (3) Any person damaged as a result of a violation of any provision of this section ~~when there has been a criminal adjudication of guilt~~ shall have a cause of action to recover compensatory damages, plus all reasonable investigation and litigation expenses, including attorneys' fees, at the trial and appellate courts.

...

**532.350 Definitions for chapter.**

- (1) (a) "Restitution" means any form of compensation paid by a convicted person to a victim or an insurer as defined in KRS 304.1-040 that has contracted to indemnify the victim for counseling, medical expenses, lost wages due to injury, ~~or~~ property damage, ~~or~~ and other expenses and losses suffered by a victim because of a criminal act;

...

**HB 388** amends *sections 342.0011, 342.122, 342.1221, 342.1223, 342.1231, 342.1242, and 342.1243* of the Kentucky Workers Compensation Law as follows:

**342.0011 Definitions for chapter.**

As used in this chapter, unless the context otherwise requires:

...

- (25) (a) "Premiums received" for policies effective on or after January 1, 1994, for insurance companies means direct written premiums as reported in the annual statement to the Department of Insurance by insurance companies, except that "premiums received" includes premiums charged off or deferred, and, on insurance policies or other evidence of coverage with provisions for deductibles, the calculated cost for coverage, including experience modification and premium surcharge or discount, prior to any reduction for deductibles. The rates, factors, and methods used to calculate the cost for coverage under this paragraph for insurance policies or other evidence of coverage with provisions for deductibles shall be the same rates, factors, and methods normally used by the insurance company in Kentucky to calculate the cost for coverage for insurance policies or other evidence of coverage without provisions for deductibles, except that, for insurance policies or other evidence of coverage with provisions for deductibles effective on or after January 1, 1995, the calculated cost for coverage shall not include any schedule rating modification, debits, or credits. The cost for coverage calculated under this paragraph by insurance companies that issue only deductible insurance policies in Kentucky shall be actuarially adequate to cover the entire liability of the employer for compensation under this chapter, including all expenses and allowances normally used to calculate the cost for coverage. For policies with provisions for deductibles with effective dates of May 6, 1993, through December 31, 1993, for which the insurance company did not report premiums and remit special fund assessments based on the calculated cost for coverage prior to the reduction for deductibles, "premiums received" includes the initial premium plus any reimbursements invoiced for losses, expenses, and fees charged under the deductibles. The special fund assessment rates in effect for reimbursements invoiced for losses, expenses, or fees charged under the deductibles shall be those percentages in effect on the effective date of the insurance policy. For policies covering leased employees as defined in KRS 342.615, "premiums received" means premiums calculated using the experience modification factor of each lessee as defined in KRS 342.615 for each leased employee for that portion of the payroll pertaining to the leased employee. For policies with provisions for deductibles with effective dates on or after January 1, 2019, assessments shall be imposed on premiums as calculated by the deductible program adjustment.

...

- (c) "Premium," for policies effective on or after January 1, 1994, for insurance companies means all consideration, whether designated as premium or otherwise, for workers' compensation insurance paid to an insurance company or its representative, including, on insurance policies with provisions for deductibles, the calculated cost for coverage, including experience modification and premium surcharge or discount, prior to any reduction for deductibles. The rates, factors, and methods used to calculate the cost for coverage under this paragraph for insurance policies or other evidence of coverage with provisions for deductibles shall be the same rates, factors, and methods normally used by the insurance company in Kentucky to calculate the cost for coverage for insurance policies or other evidence of coverage without provisions for deductibles, except that, for insurance policies or other evidence of coverage with provisions for deductibles effective on or after January 1, 1995, the calculated cost for coverage shall not include any schedule rating modifications, debits, or credits. The cost for coverage calculated under this paragraph by insurance companies that issue only deductible insurance policies in Kentucky shall be actuarially adequate to cover the entire liability of the employer for compensation under this chapter, including all expenses and allowances normally used to calculate the cost for

coverage. For policies with provisions for deductibles with effective dates of May 6, 1993, through December 31, 1993, for which the insurance company did not report premiums and remit special fund assessments based on the calculated cost for coverage prior to the reduction for deductibles, "premium" includes the initial consideration plus any reimbursements invoiced for losses, expenses, or fees charged under the deductibles. For policies with provisions for deductibles with effective dates on or after January 1, 2019, large risk alternative rating options and schedule rating modifications shall be subject to assessment.

..  
(e) "Deductible program adjustment" means the method of calculating premium and premiums received on a gross basis for any schedule rating modifications, debits, or credits as if the deductible contract is not being used to calculate coverage;

...

#### **342.122 Special fund assessments—Annual adjustments—Reports—Central claim registry.**

...

(2) (a) These assessments shall be paid quarterly not later than the thirtieth day of the month following the end of the quarter in which the premium is received. Receipt shall be considered timely through actual physical receipt or by postmark of the United States Postal Service. Employers carrying their own risk and employers defined in KRS 342.630(2) shall pay the annual assessments in four (4) equal quarterly installments.

(b) Beginning on January 1, 2020, all assessments shall be electronically remitted to the funding commission quarterly not later than the thirtieth day of the month following the end of the quarter in which the premium is received. Receipt shall be considered timely when filed and remitted using the appropriate electronic pay system as prescribed by the funding commission. Employers carrying their own risk and employers defined in KRS 342.630(2) shall pay the annual assessments in four (4) equal quarterly installments.

...

#### **342.1221 Penalty and interest on late payment of assessments—Waiver.**

Assessments levied and expenses owed pursuant to KRS 342.122 and Sections 6 and 7 of this Act and unpaid on the date on which they are due and payable shall bear interest at the rate specified in KRS 131.183 plus a penalty of one and one-half percent (1.5%) per month or portion thereof without proration from the date on which the assessment or expenses are ~~was~~ due and payable. The funding commission shall have the authority to waive part or all of the penalty, but not the interest, where it is shown to the satisfaction of the commission that failure to timely pay assessments is due to reasonable cause. This authority shall extend to the coal workers' pneumoconiosis fund until it ceases to exist.

#### **342.1223 Kentucky Workers' Compensation Funding Commission—Commission's relationship with Office of Financial Management within the Finance and Administration Cabinet.**

...

(2) The commission shall:

...

(b) Act as a fiduciary, as defined in KRS Chapter 386, in exercising its power over the funds collected pursuant to KRS 342.122, and may invest association funds through one (1) or more banks, trust companies, or other financial institutions with offices in Kentucky in good standing with the Department of Financial Institutions, in investments described in KRS Chapter 386, except that the funding commission may, at its discretion, invest in ~~non-dividend-paying~~ equity securities;

...

#### **342.1231 Procedure for protesting special fund assessments—Expenses of audits, how paid.**

(1) The funding commission may mail to the assessment payer ~~taxpayer~~ a notice of any assessment assessed by it. The assessment shall be final if not protested in writing to the funding commission within thirty (30) days from the date of notice. Payment for the assessment, penalty and interest, and expenses shall be received by the funding commission within thirty (30) days from the date the notice becomes final. The protest shall be accompanied by a supporting statement setting forth the grounds upon which the protest is made. Upon written request, the funding commission may extend the time for filing the supporting statement if it appears the delay is necessary and unavoidable. The refusal of such extension may be reviewed in the same manner as a protested assessment.

(2) After a timely protest has been filed, the assessment payer ~~taxpayer~~ may request a conference with the funding commission. The request shall be granted in writing stating the date and time set for the conference. The assessment payer ~~taxpayer~~ may appear in person or by representative. Further conferences may be held by mutual agreement.

(3) After considering the assessment payer's ~~taxpayer's~~ protest, including any matters presented at the final conference, the funding commission shall issue a final ruling on any matter still in controversy, which shall be mailed to the assessment payer ~~taxpayer~~. The ruling shall state that it is a final ruling of the funding commission, generally state the issues in controversy, the funding commission's position thereon and set forth the procedure for prosecuting an appeal to the Kentucky Claims Commission pursuant to KRS 49.220.

- (4) The ~~assessment payer taxpayer~~ may request in writing a final ruling at any time after filing a timely protest and supporting statement. When a final ruling is requested, the funding commission shall issue such ruling within sixty (60) ~~thirty (30)~~ days or at the next board of directors meeting, whichever is later, from the date the request is received by the funding commission.
- (5) After a final ruling has been issued, the ~~assessment payer taxpayer~~ may appeal to the Kentucky Claims Commission pursuant to KRS 49.220.
- (6) The expenses incurred by the funding commission in conducting audits required in this chapter shall be paid by the audited entities ~~insurance companies~~ in accordance with administrative regulations promulgated by the funding commission
- (7) Notwithstanding any provision to the contrary, a notice of assessment under subsection (1) of this section shall not be collected unless the notice of assessment is mailed to the assessment payer not later than five (5) years from the due date of the quarterly premium report or the date the amended quarterly premium report is filed, whichever is later. A quarterly premium report shall not be amended later than one (1) year after the due date of the quarterly premium report.
- (8) Assessment payers shall preserve, retain, and provide all documents relevant to quarterly premium reports and subject to audits to the funding commission upon request during the completion of the audit.
- (9) (a) The funding commission may mail the assessment payer notice of a refund amount to be returned to an insured. The insurance carrier shall pay the amount of the refund to the insured within sixty (60) days from the date of notice sent by the funding commission. If, after good faith efforts, the refund cannot be returned to the insured, the refund amount shall be remitted to the funding commission within thirty (30) days from the last date of attempting the refund.
- (b) If a refund amount to an insured is unpaid on the date on which it is due, then that amount shall bear a penalty of one and one-half percent (1.5%) per month from that due date. The funding commission shall have the authority to waive part or all of the penalty where failure to pay is shown, to the satisfaction of the funding commission, to be for a reasonable cause.
- (10) "Assessment payer" ~~"Taxpayer"~~ as used in this section means insurance carrier, self-insured group, and self-insured employer.

**342.1242 Kentucky coal workers' pneumoconiosis fund—Liability for and manner of making payments for awards for coal workers' pneumoconiosis—Assessments to finance fund—When assessments cease.**

...

(4) All assessments imposed by this section shall be paid to the Kentucky Workers' Compensation Funding Commission and shall be transferred to the Kentucky Employers' Mutual Insurance Authority, which is administering the coal workers' pneumoconiosis fund. In addition, the powers and responsibilities of the Kentucky Workers' Compensation Funding Commission including its fiduciary duties and responsibilities relating to assessments collected for the special fund pursuant to KRS 342.122, Section 3 of this Act, 342.1222, 342.1223, 342.1226, 342.1229, and 342.1231 shall apply to assessments collected for the Kentucky coal workers' pneumoconiosis fund created pursuant to this section. Each entity subject to assessments for the Kentucky coal workers' pneumoconiosis fund shall provide any and all information requested by the Kentucky Workers' Compensation Funding Commission necessary to carry out its powers and responsibilities relating thereto.

...

(9) The Kentucky Employers' Mutual Insurance Authority shall reimburse the funding commission for any expenses incurred with regard to the collection of assessments for the coal workers' pneumoconiosis fund and other incurred expenses related to the coal workers' pneumoconiosis fund.

**342.1243 Transfer of the administration, assets, and liabilities of the Kentucky coal workers' pneumoconiosis fund—assessments on employers.**

...

(8) When the Kentucky Workers' Compensation Funding Commission and the Kentucky Employers' Mutual Insurance Authority have determined final audits are closed and the liability of the fund is fully funded ~~that the Kentucky coal workers' pneumoconiosis fund has fully funded its liabilities~~, then the authority for imposing assessment rates assessments pursuant to this section and KRS 342.1242 shall cease to exist, ~~and the Kentucky coal workers' pneumoconiosis fund shall be abolished~~. Any remaining assessments received following the exhaustion of liabilities shall be refunded pro rata to all employers who have paid an assessment in the year that liabilities are fully funded. When all claim payouts are completed, the Kentucky coal workers' pneumoconiosis fund shall be abolished.

## Maryland

SB 575 amends *sections 1-204, 27-402, 27-801 and 27-802* of the Maryland Insurance Code as follows:

**§ 1-204. Application of article to workers' compensation insurance**

~~For~~ Except for provisions governing the reporting and investigation of workers' compensation insurance fraud claims under § 2-201, Title 2, Subtitle 4, And Title 27, Subtitles 4 And 8 of this article, the purpose of workers' compensation insurance, this article does not apply to an employer who:

- (1) participates in a governmental self-insurance group under § 9-404 of the Labor and Employment Article; or
- (2) self-insures under § 9-405 of the Labor and Employment Article.

**§ 27-402. Scope of subtitle**

The provisions of this subtitle that apply to insurers also apply to:

- ...
- (13) a governmental self-insurer group formed in accordance with § 9-404 of the labor and employment article;
- (14) an employer who self-insures or participates in a self-insurance group in accordance with § 9-405 of the labor and employment article; and
- ~~13}~~ (15) an agent, employee, or representative of an entity described in items (1) through ~~(12)~~ (14) of this section.

**§ 27-801. Definitions**

- ...
- (c) "Insurance fraud" means:
- ...
- (2) theft, as set out in §§ 7–101 through 7–104 of the Criminal Law Article:
  - (i) from a person regulated under this article; or
  - (ii) by a person regulated under this article or an officer, director, agent, or employee of a person regulated under this article; ~~or~~
- (3) a violation of § 9-1106 of the labor and employment article; or
- ~~(3)}~~ (4) any other fraudulent activity that is committed by or against a person regulated under this article and is a violation of:
- ...

**§ 27-802. Reporting suspected insurance fraud**

- (a)... (4) A governmental self-insurance group formed in accordance with § 9-404 of the labor and employment article or an employer who self-insures or participates in a self-insurance group in accordance with § 9-405 of the labor and employment article shall meet the reporting requirement of this subsection by reporting suspected insurance fraud in writing to the fraud division.
- (b) In addition to any protection provided under Title 4, Subtitle 4, Part IV of the General Provisions Article, any information, documentation, or other evidence provided under this section by an insurer, its employees, fund producers, or insurance producers, a viatical settlement provider, a viatical settlement broker, an independent insurance producer, ~~or~~ a registered premium finance company, a governmental self-insurance group, or an employer who self-insures or participates in a self-insurance group to the Commissioner, the Fraud Division, or a federal, State, or local law enforcement authority in connection with an investigation of suspected insurance fraud is not subject to public inspection for as long as the Commissioner, Fraud Division, or law enforcement authority considers the withholding to be necessary to complete an investigation of the suspected fraud or to protect the person investigated from unwarranted injury.
- ...

**Missouri**

**HB 2062** adds new **section 44.098** to the Missouri Annotated Statutes, relating to mutual aid agreements with Kansas and Oklahoma, as follows:

**44.098.**

1. As used in this section, the following terms mean:

- (1) "Critical incident", an incident that could result in serious physical injury or loss of life;
- (2) "Kansas border county", the county of Cherokee;
- (3) "Law enforcement mutual aid region", the counties of Jasper and Newton, including the Joplin metropolitan area, and the Kansas border county and Oklahoma border county as defined in this section;
- (4) "Oklahoma border counties", the counties of Ottawa and Delaware;
- (5) "Missouri border counties", the counties of Jasper and Newton.

2. All law enforcement officers in the law enforcement mutual aid region shall be permitted in critical incidents to respond to lawful requests for aid in any other jurisdiction in the law enforcement mutual aid region.

3. The on-scene incident commander, as defined by the National Incident Management System, shall have the authority to make a request for assistance in a critical incident and shall be responsible for on-scene management until command authority is transferred to another person.

4. In the event that an officer makes an arrest or apprehension outside his or her home state, the offender shall be delivered to the first officer who is commissioned in the jurisdiction in which the arrest was made.

5. For the purposes of liability, all members of any political subdivision or public safety agency responding under operational control of the requesting political subdivision or public safety agency are deemed employees of such responding political subdivision or public safety agency and are subject to the liability and workers' compensation provisions provided to them as employees of their respective political subdivision or public safety agency. Qualified immunity, sovereign immunity, official immunity, and the public duty rule shall apply to the provisions of this section as interpreted by the federal and state courts of the responding agency.

6. If the director of the Missouri department of public safety determines that the state of Kansas has enacted legislation or the governor of Kansas has issued an executive order or similar action that permits Kansas border counties to enter into a similar mutual-aid agreement as described under this section, then the director shall execute and deliver to the governor, the speaker of the house of representatives, and the president pro tempore of the senate a written certification of such determination. Upon the execution and delivery of such written certification and the parties receiving such certification providing a unanimous written affirmation, the provisions of this section shall be effective unless otherwise provided by law.

7. If the director of the Missouri department of public safety determines that the state of Oklahoma has enacted legislation or the governor of Oklahoma has issued an executive order or similar action that permits Oklahoma border counties to enter into a similar mutual-aid agreement as described under this section, then the director shall execute and deliver to the governor, the speaker of the house of representatives, and the president pro tempore of the senate a written certification of such determination. Upon the execution and delivery of such written certification and the parties receiving such certification providing a unanimous written affirmation, the provisions of this section shall be effective unless otherwise provided by law.

8. The director of the Missouri department of public safety shall notify the revisor of statutes of any changes that would render the provisions of this section effective.

**SB 600** adds nine new sections to **chapter 285** of the Missouri Annotated Statutes, creating the “Professional Employer Organization Act” to provide, in part, that:

- The responsibility to obtain workers compensation coverage shall be specifically allocated in the professional employer agreement to either the PEO or the client
- If the coemployment relationship between a PEO and a client is terminated, the client shall utilize an experience modification rating that reflects its individual experience. The PEO shall provide a client its workers compensation information within five business days of receiving or giving notice that the relationship has been terminated
- A client may request its workers compensation information at any time and the PEO shall provide such information to the client within five business days of receiving such request. Such information shall also be provided to any future client insurer if requested by such client
- A client is additionally required to provide prospective insurers with its workers compensation information upon receiving such information from the PEO. A client is further required to disclose to a prospective insurer its current or previous relationship with a PEO. Violation of either of these provisions is subject to a Class A misdemeanor
- If a third party requests verification of a client’s experience modification factor for a client in certain types of insurance policies from a PEO, the PEO shall, within five business days of receipt of receiving the client’s consent, provide the information to the third party. If the client refuses to grant consent to a request for information, the PEO shall notify the requesting third party that the client has refused to consent to the disclosure of the information

## New Hampshire

**SB 351** amends **section 281-A:23-a** of the New Hampshire Workers’ Compensation Law as follows:

### **281-A:23-a Managed Care Programs.—...**

V. Every managed care program shall include a sufficient number of injury management facilitators, including resident injury management facilitators, who shall be qualified by reason of education, training, and experience to manage the injured employee’s medical, hospital and remedial care, vocational rehabilitation, modified duty, and return to work plans. An injury management facilitator shall work with the injured employee, employer, and medical, hospital and other providers to ensure that the injured employee receives effective, timely, and appropriate services in order to achieve maximum medical improvement and an expeditious return to work. Any person ~~employed operating~~ as an injury management facilitator ~~by in conjunction with~~ a managed care program under this section shall be approved by the commissioner with ratification by the workers’ compensation advisory council. The commissioner shall, in consultation with the advisory council, by rule determine the number of facilitators which shall be sufficient.

## Oklahoma

**HB 2993** amends **sections 85A-97, 85A-98, and 85A-99** of the Oklahoma Administrative Workers’ Compensation Act as follows:

### **§85A-97. Self-insurance Guaranty Fund.**

A. The Self-insurance Guaranty Fund shall be for the purpose of continuation of workers’ compensation benefits due and unpaid or interrupted due to the inability of a self-insurer to meet its compensation obligations because its financial resources, security deposit, guaranty agreements, surety agreements and excess insurance are either inadequate or not immediately accessible for the payment of benefits. Monies in the fund, including interest, are not subject to appropriation and shall be expended to compensate employees for eligible benefits for a compensable injury under the Administrative Workers’ Compensation Act, pay outstanding workers’ compensation obligations of the impaired self-insurer, and for all claims for related administrative fees, operating costs of the Self-insurance Guaranty Fund Board, attorney fees, and other costs reasonably incurred by the Board in the performance of its duties.

B. Monies transferred pursuant to Section 99 of this title may be expended by the Board to provide a credit against the assessment required to be paid by each private self-insurer and group self-insurer association pursuant to Section 98 of this title.

C. Expenditures from the fund shall be made on warrants issued by the State Treasurer against claims as prescribed by law. The fund shall be subject to audit in the same manner as state funds and accounts, the cost for which shall be paid for from the fund.

**§85A-98. Funds to be transferred to Self-insurance Guaranty Fund.**

The Self-insurance Guaranty Fund shall be derived from the following sources:

...

(2)... c. Failure of a self-insurer to pay, or timely pay, an assessment required by this paragraph, or to report payment of the same to the Commission within ten (10) days of payment, shall be grounds for revocation by the Commission of the self-insurer's permit to self-insure in this state, after notice and hearing. A former self-insurer failing to make payments required by this paragraph promptly and correctly, or failing to report payment of the same to the Commission within ten (10) days of payment, shall be subject to administrative penalties as allowed by law, including but not limited to, a fine in the amount of Five Hundred Dollars (\$500.00) or an amount equal to one percent (1%) of the unpaid amount, whichever is greater, to be paid and deposited to the credit of the Workers' Compensation Commission Revolving Fund created in Section ~~28~~ 28.1 of this title. It shall be the duty of the Tax Commission to collect the assessment provided for in this paragraph. The Tax Commission is authorized to bring an action for recovery of any delinquent or unpaid assessments, and may enforce payment of the assessment by proceeding in accordance with Section 79 of this title.

...

e. The Tax Commission shall determine the fund balance as of March 1 and September 1 of each year, and when otherwise requested by the Workers' Compensation Commission, and shall advise the Workers' Compensation Commission in writing within thirty (30) days of each such determination; ~~and~~

3. Any interest accruing on monies paid into the fund; and

4. Monies transferred pursuant to Section 99 of this title.

**§85A-99. Impaired self-insurer.**

A. On determination by the Workers' Compensation Commission that a self-insurer has become an impaired self-insurer, the Commission shall secure release of the security required by Section 38 of this title and advise the Self-insurance Guaranty Fund Board of the impairment. Claims administration, including processing, investigating and paying valid claims against an impaired self-insurer under the Administrative Workers' Compensation Act, may include payment by the surety that issued the surety bond or be under a contract between the Commission and an insurance carrier, appropriate state governmental entity or an approved service organization, as approved by the Commission.

B. Excess proceeds from the security remaining after each claim for benefits of an impaired self-insurer has been paid, settled or lapsed, and associated costs of administration of such claim have been paid, shall be transferred to the Self-insurance Guaranty Fund and may be used as a credit against the assessment required to be paid by each private self-insurer and group self-insurer association pursuant to Section 98 of this title, as determined by the Self-insurance Guaranty Fund Board.

**SB 1411** amends **section 40-418** of the Oklahoma Labor Code as follows:

**§40-418. Payments to Commission—Refunds—Collection of payments—Disposition of funds.**

...

(5) ~~The~~ Except as otherwise provided in paragraph 7 of this section, the Oklahoma Tax Commission shall, monthly, as the same are collected, pay to the State Treasurer of this state, to the credit of the Special Occupational Health and Safety Fund, all monies collected under the provisions of this section. Monies shall be paid out of said Fund exclusively for the operation and administration of the Oklahoma Occupational Health and Safety Standards Act and for other necessary expenses of the Department of Labor pursuant to appropriations by the Oklahoma Legislature.

...

(7) In no event shall the total fiscal year amount paid to the credit of the Special Occupational Health and Safety Fund pursuant to this section exceed the 3-year average of the total fiscal year amounts apportioned fiscal years 2015, 2016 and 2017. Any amount in excess of the 3-year average shall be placed to the credit of the General Revenue Fund.

## 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, NM, VA, WV	David Benedict	804-380-3005
CO, FL	Dawn Ingham	561-893-3165
CT, ME, NH, RI	Justin Moulton	860-969-7903
HI, UT, VT	Laura Backus Hall	802-454-1800
AL, GA, LA, MS	Laura Hart Bryan	225-618-8168
AR, IL, TX	Terri Robinson	501-333-2835
Federal Issues	Tim Tucker	202-403-8526
AK, ID, MT, OR	Todd Johnson	503-892-8919

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