



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 23, 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
- Included in NCCI's March 16, 2018 **Legislative Activity Report** (RLA-2018-11)
- Enacted on March 21, 2018, with an effective date of July 1, 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.

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
- Included in NCCI's March 16, 2018 **Legislative Activity Report** (RLA-2018-11)
- Enacted on March 21, 2018, with a projected effective date of July 12, 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
- Included in NCCI’s March 16, 2018 **Legislative Activity Report** (RLA-2018-11)
- Enacted on March 19, 2018, with an effective date of May 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 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
- Included in NCCI's March 16, 2018 **Legislative Activity Report** (RLA-2018-11)
- Amended and approved by the Conference Committee on March 8, 2018
- Enacted on March 19, 2018, with an effective date of May 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 in the state;

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

(iv) collect information from third-party hospital bill 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. Each written report shall include:

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

(ii) aggregate data on hospital billing and payment trends in the state;

(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):

...

(b) Subject to Subsection (11)(d), a workers' compensation insurance carrier or self-insured employer may contract, either in writing or by mutual oral agreement, with a hospital to establish reimbursement rates.

(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).

...

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
- Included in NCCI's March 16, 2018 *Legislative Activity Report* (RLA-2018-11)
- Enacted on March 23, 2018, with an effective date of July 1, 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 92 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 February 14, 2018
- Included in NCCI's February 23, 2018 **Legislative Activity Report** (RLA-2018-08)
- Enacted on March 19, 2018, with an effective date of May 7, 2018

SB 92 repeals and reenacts **section 34A-1-309. Attorney fees**, and amends **sections 34A-2-413. Permanent total disability—Amount of payments—Rehabilitation**, and **34A-2-801. Initiating adjudicative proceedings—Procedure for review of administrative action** of the Utah Labor Code as follows:

34A-1-309. Attorney fees.

~~(1) In a case before the commission in which an attorney is employed, the commission has full power to regulate and fix the fees of the attorney.~~

~~(2) In accordance with Title 63G, Chapter 4, Administrative Procedures Act, an attorney may file an application for hearing with the Division of Adjudication to obtain an award of attorney fees as authorized by this section and commission rules.~~

~~(3) (a) The commission may award reasonable attorney fees on a contingency basis when there is generated:~~

~~(i) disability or death benefits; or~~

~~(ii) interest on disability or death benefits.~~

~~(b) An employer or its insurance carrier shall pay attorney fees awarded under Subsection (3)(a) out of the award of:~~

~~(i) disability or death benefits; or~~

~~(ii) interest on disability or death benefits.~~

~~(4) (a) In addition to the attorney fees ordered under Subsection (3), the commission may award reasonable attorney fees on a contingency basis for medical benefits ordered paid in the same percentages for an award under Subsection (3) provided for in rule made by the commission in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, if:~~

~~(i) medical benefits are not approved by:~~

~~(A) the employer or its insurance carrier; or~~

~~(B) the Uninsured Employer's Fund created in Section 34A-2-704;~~

~~(ii) after the employee employs an attorney, medical benefits are paid or ordered to be paid;~~

~~(iii) the commission's informal dispute resolution mechanisms are reasonably used by the parties before adjudication; and~~

~~(iv) the sum of the following at issue in the adjudication of the medical benefit claim is less than \$4,000:~~

~~(A) disability or death benefits; and~~

~~(B) interest on disability or death benefits.~~

~~(b) An employer or its insurance carrier shall pay attorney fees awarded under Subsection (4)(a) in addition to the payment of medical benefits ordered.~~

For an adjudication of a workers' compensation claim where only medical benefits are at issue, reasonable attorney fees may be awarded in accordance with and to the extent allowed by rule adopted by the Utah Supreme Court and implemented by the Labor Commission.

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

...

~~(10)...(g) In accordance with Section 34A-1-309, the administrative law judge may award reasonable attorney fees to an attorney retained by an employee to represent the employee's interests with respect to reexamination of the permanent total disability finding, except if the employee does not prevail, the attorney fees shall be set at \$1,000. The attorney fees awarded shall be paid by the employer or the employer's insurance carrier in addition to the permanent total disability compensation benefits due.~~

~~(h)-(g)~~ During the period of reexamination or adjudication, if the employee fully cooperates, each insurer, self-insured employer, or the Employers' Reinsurance Fund shall continue to pay the permanent total disability compensation benefits due the employee.

(11) If any provision of this section, or the application of any provision to any person or circumstance, is held invalid, the remainder of this section is given effect without the invalid provision or application.

34A-2-801. Initiating adjudicative proceedings—Procedure for review of administrative action.

(1)...(c) A person providing goods or services described in Subsections 34A-2-407(12) and 34A-3-108(13) may file an application for hearing in accordance with Section 34A-2-407 or 34A-3-108.

(d) An attorney may file an application for hearing in accordance with Section 34A-1-309.

(2) (a) Unless all parties agree to the assignment in writing, the Division of Adjudication may not assign the same administrative law judge to hear a claim under this section by an injured employee if the administrative law judge previously heard a claim by the same injured employee for a different injury or occupational disease.

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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
- Included in NCCI's March 16, 2018 **Legislative Activity Report** (RLA-2018-11)
- Enacted on March 22, 2018, with an effective date of June 7, 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.

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending March 23, 2018.

Alabama

SB 283 was:

- Passed by the first chamber on March 13, 2018
- Included in NCCI’s March 23, 2018 *Legislative Activity Report* (RLA-2018-12)
- Passed by the second chamber on March 22, 2018

SB 283 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.

* **Note: SB 283** is identical to **HB 401**, which passed the first chamber on March 5, 2018, and was included in NCCI's March 16, 2018 **Legislative Activity Report** (RLA-2018-11).

Arizona

SB 1111 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 22, 2018

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

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

...

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

...

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

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

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

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

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

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

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

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

(a) A medication agreement, a plan for subsequent

(b) The frequency of face-to-face follow-up visits and to reevaluate the employee's continued use of opioids.

(c) Random drug testing, and

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

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

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

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

~~C. D. Within two business days of writing or dispensing an initial prescription order for at least a thirty-day supply of an opioid medication for the employee, a physician shall submit an inquiry to the Arizona state board of pharmacy requesting the employee's prescription information that is compiled under the controlled substances prescription monitoring program prescribed in title 36, chapter 28. Before prescribing an opioid analgesic or benzodiazepine controlled substance that is listed in Schedule II, III or IV for an employee and at least quarterly while that prescription remains a part of the treatment, the physician shall obtain a patient utilization report regarding the employee from the controlled substances prescription monitoring program's central database tracking system as required by section 36-2606. The physician shall report the results to the carrier, self-insured employer or commission as soon as reasonably practicable but not later than thirty days from after the date of the inquiry. Thereafter, the carrier, self-insured employer or commission may request not more than once every two months that the physician perform additional inquiries to obtain a patient utilization report regarding the employee from the Arizona state board of pharmacy controlled substances prescription monitoring program's central database tracking system.~~

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

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

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

~~1. The carrier, self-insured employer or commission is not responsible for payment for the physician's services until the physician complies with this section.~~

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

~~...~~

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

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

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

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

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

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

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

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

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

~~...~~

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

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

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

SB 1111 also includes the following language:

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

A. On or before July 1, 2019, as part of the industrial commission of Arizona’s annual review of the schedule of fees pursuant to section 23-908, Arizona Revised Statutes, as amended by this act, the industrial commission of Arizona shall review information and data, consult with physician, employee and business and industry stakeholders and hold at least one public hearing in considering whether to adopt additional reimbursement guidelines for medications dispensed in settings that are not accessible to the general public.

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

Georgia

HB 760 was:

- Passed by the first chamber on February 26, 2018
- Included in NCCI’s March 9, 2018 **Legislative Activity Report** (RLA-2018-10)
- Amended and passed by the second chamber on March 23, 2018

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

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

...

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

...

(g) An insurer shall provide a written notice of a reduction in coverage to the named insured no less than 45 days prior to the effective date of the proposed reduction in coverage; provided that such notice shall be printed in all capital letters in a separate document entitled ‘NOTICE OF REDUCTION IN COVERAGE.’ Such notice shall be delivered to the insured as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the last address of record of the insured. A reduction in coverage shall mean a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion. Reduction in coverage shall not include any change, reduction, or elimination of coverage made at the request of the insured. The correction of typographical or scrivener’s errors or the application of mandated legislative changes shall not be considered a reduction in coverage.

HB 878 was:

- Passed by the first chamber on March 1, 2018
- Included in NCCI’s March 9, 2018 **Legislative Activity Report** (RLA-2018-10)
- Amended and passed by the second chamber on March 21, 2018

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

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

(a) An insured may request cancellation of an existing insurance policy by returning the original policy to the insurer or by making a ~~written~~ request for cancellation of an insurance policy to the insurer or its duly authorized agent orally, electronically, or in writing stating a future date on which the policy is to be canceled. In the event of oral cancellation the insurer, shall, within 10 days provide such insured, electronically or in writing, confirmation of such requested cancellation. The insurer or its duly authorized agent may require that the insured provide written, electronic, or other recorded verification of the request for cancellation prior to such cancellation taking effect. Such cancellation shall be accomplished in the following manner:

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

Kentucky

HB 2 was:

- Passed by the first chamber on February 21, 2018
- Included in NCCI's March 2, 2018 *Legislative Activity Report* (RLA-2018-09)
- Amended and passed by the second chamber on March 22, 2018

HB 2 amends numerous sections of the Kentucky Workers Compensation Law to:

- Establish that, only for workers compensation insurance claims resulting in an award of permanent total disability or resulting from injuries (amputation or partial amputation of a limb, loss of hearing, or loss of vision or teeth, or permanent total or permanent partial paralysis), the employer's obligation to pay benefits continues so long as the employee is disabled, regardless of the duration of the employee's income benefits. For permanent partial disability claims not involving the above injury, the employer's obligation to pay benefits would extend for 780 weeks from date of injury or date of last exposure; thereafter, benefits would continue so long as the employee demonstrates, and an administrative law judge determines, that continued medical treatment is reasonably necessary and is related to the work injury or occupational disease.
- Require the commissioner notify an employee of the right to apply for continued benefits 754 weeks from the date of injury or last exposure, and the employee to file an application for continued benefits 75 days before the end of the 780 week benefit period. If an employee fails to apply for continued benefits or a judge determines benefits are not reasonably necessary or not related to the work injury or occupational disease, the employer's obligation to pay medical benefits would cease permanently at the end of 780 weeks (15 years).
- Limit the number of urine screenings an employer would be obligated to pay for.
- Allow waiver of utilization review under identified circumstances.
- Prohibit a provider charging a fee for an initial copy of medical records for the worker or their attorney.
- Require development or adoption of a pharmaceutical formulary.
- Deem no interest due on delayed payment of income benefits if the delay was caused by the employee.
- Limit the time to reopen a claim to 4 years after the original award or order becomes final and nonappealable.
- Bar a claim based on cumulative trauma injury, unless notice was given to the employer and application for adjustment of claim was made within 2 years from the date the employee is told by a doctor that the injury is work-related. The right to compensation for cumulative trauma injury is barred if a claim application is not filed within 5 years after the last injurious exposure to the cumulative trauma.
- Limit liability for compensation for occupational disease to the last employer in whose employment the employee was last exposed to the hazard.
- Require the payment obligor pay for spirometric testing of an employee claiming pulmonary dysfunction, unless such test results are invalid because the claimant failed to properly cooperate in the testing, in which case, the claimant's right to prosecute its claim would be suspended until they properly cooperate and no compensation would be due the claimant until the claimant did so.
- Extend the deadline for filing a claim for compensation due to the following cancers to 20 years from the last injurious exposure: bladder cancer; brain cancer; colon cancer; non-Hodgkins lymphoma, kidney cancer, liver cancer, lymphatic or hematopoietic cancer, prostate cancer, testicular cancer, skin cancer, cervical cancer, and breast cancer.
- Establish new maximum limits on employee and employer attorneys' fees.
- Establish a presumption that, where an employee's injury is due to voluntary ingestion of prescribed substances in excess of prescribed amounts, or nonprescribed substances that caused disturbance of mental or physical capacity, or willful intention of an employee to injure or kill himself or another, such action caused the employee's injury, occupational disease, or death and the employer is not liable for compensation.
- Allow an employer to recover a pro-rata share of its subrogation lien (indemnity and medical benefits) when an employee recovers a judgment against a third party for the employee's injuries that includes indemnity and medical benefits.
- Increase the percentage of Kentucky's average weekly wage that may be paid as an income benefit from 75% to 82.5% for permanent partial disability, and from 100% to 110% for temporary or permanent total disability; change the age limit on benefits to 70 years (or 4 years after injury, whichever is later); cease income benefits to dependents when the employee would have reached age 70 or 4 years after injury or exposure.
- Offset income benefit payable to certain injured employees by the amount the employee would have paid in taxes or the amount paid for temporary light duty.
- Terminate income benefits for temporary total disability to a professional athlete when their contract expires if they've been released to return to employment for which they've trained or have experience.
- Require employment for one year prior to filing a claim for hearing loss.

- Establish that, notwithstanding that certain sections and subsections of the bill are remedial and are to apply to all claims no matter the date of injury or of last exposure, no award shall be reduced or duration of medical benefits limited that have been fully and finally adjudicated.

HB 388 was:

- Passed by the first chamber on March 6, 2018
- Included in NCCI's March 16, 2018 *Legislative Activity Report* (RLA-2018-11)
- Amended and passed by the second chamber on March 22, 2018

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. For policies with provisions for deductibles with effective dates on or after January 1, 1995, assessments shall be imposed on premiums received as calculated by the deductible program adjustment. 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.

...

(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. For policies with provisions for deductibles with effective dates on or after January 1, 1995, assessments shall be imposed as calculated by the deductible program adjustment. 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.

...

(e) "Deductible program adjustment" means calculating premium and premiums received on a gross basis without regard to the following:

1. Schedule rating modifications, debits, or credits;
2. Deductible credits; or

3. Modifications to the cost of coverage from inception through and including any audit that are based on negotiated retrospective rating arrangements, including but not limited to large risk alternative rating options;

...

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 ~~nondividend-paying~~ equity securities;

...

(3) The commission shall have all of the powers necessary or convenient to carry out and effectuate the purposes for which it was established, including, but not limited to, the power:

(a) To sue and be sued, complain, or defend, in its name;

(b) To elect, appoint, or hire officers, agents, and employees, and define their duties and fix their compensation within the limits of its budget approved by the General Assembly. Notwithstanding any provision of KRS Chapter 18A to the contrary, officers and employees of the funding commission may be exempted from the classified service;

...

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.

Tennessee

SB 1967 was:

- Passed by the first chamber on February 12, 2018
- Included in NCCI's February 23, 2018 *Legislative Activity Report* (RLA-2018-08)
- Passed by the second chamber on March 19, 2018

SB 1967 adds new *Chapter 10 to Title 50 Employer and Employee* of the Tennessee Code as follows:

50-10-101.

As used in this chapter:

(1) “Marketplace contractor” means any individual, corporation, partnership, sole proprietorship, or other business entity that:
(A) Enters into an agreement with a marketplace platform to use the platform’s online-enabled application, software, website, or system to receive connections to third-party individuals or entities seeking services in this state; and

(B) In return for compensation from the third-party or marketplace platform, offers or provides services to the third-party individuals or entities upon being given an assignment or connection through the marketplace platform’s online-enabled application, software, website, or system; and

(2) “Marketplace platform” means a corporation, partnership, sole proprietorship, or other business entity operating in this state that:

(A) Offers an online-enabled application, software, website, or system that enables the provision of services by marketplace contractors to third-party individuals or entities seeking services; and

(B) Neither directly nor through any related party derives any benefit from work performed by marketplace contractors other than a subscription or use fee for placing marketplace contractors in assignments or otherwise providing connections.

50-10-102.

(a) A marketplace contractor is an independent contractor and not an employee of the marketplace platform for all purposes under state and local laws, rules, ordinances, and resolutions if the following conditions are set forth in a written agreement between the marketplace platform and the marketplace contractor:

(1) The marketplace platform and marketplace contractor agree in writing that the contractor is an independent contractor with respect to the marketplace platform;

(2) 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. If a marketplace contractor posts the contractor’s voluntary availability to provide services, the posting does not constitute a prescription of hours for purposes of this subdivision (a)(2);

(3) The marketplace platform does not prohibit the marketplace contractor from using any online-enabled application, software, website, or system offered by other marketplace platforms;

(4) The marketplace contractor may, at its discretion, enlist the help of an assistant to complete the services, and the marketplace platform may require the assistant to complete the marketplace platform’s standard registration and vetting process. If the marketplace contractor enlists the help of an assistant, the marketplace contractor, not the marketplace platform, is responsible for paying the assistant;

(5) The marketplace platform does not restrict the marketplace contractor from engaging in any other occupation or business;

(6) The marketplace platform does not require marketplace contractors to use specific supplies or equipment;

(7) The marketplace platform does not control the means and methods for the services performed by a marketplace contractor by requiring the marketplace contractor to follow specified instructions governing how to perform the services. However, the marketplace platform may require that the quality of the services provided by the marketplace contractor meets specific standards and requirements;

(8) The agreement or contract between the marketplace contractor and the marketplace platform may be terminated by either the marketplace contractor or the marketplace platform with or without cause;

(9) The marketplace platform provides no medical or other insurance benefits to the marketplace contractor, and the marketplace contractor is responsible for paying taxes on all income derived as a result of services performed to third parties from the assignments or connections received from the marketplace platform; and

(10) All, or substantially all, payment to the marketplace contractor is based on performance of services to third parties who have engaged the services of the marketplace contractor through the marketplace platform.

(b) This section does not apply to any service that is the type of service identified in 26 U.S.C. § 3306(c)(7) or (c)(8).

50-10-103.

Nothing in this chapter applies to:

(1) A transportation network company, as defined in § 65-15-301; or

(2) A construction services provider, as defined in § 50-6-901.

SB 2141 was:

- Passed by the first and second chambers on March 19, 2018

SB 2141 amends **section 50-6-106** of the Tennessee Workers’ Compensation Law as follows:

50-6-106. Employments not covered.

This chapter shall not apply to:

...

(4) Farm or agricultural laborers and employers of those laborers; Employers of farm or agricultural laborers may accept this chapter by purchasing a workers' compensation insurance policy, and may at any time withdraw that acceptance by canceling or not renewing the policy and providing notice to the employees;

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending March 23, 2018.

Maryland

HB 205 amends **section 9-628** of the Maryland Worker's Compensation Act as follows:

§ 9-628. Compensation for less than 75 weeks.

(a) "Public safety employee" defined.—In this section, "public safety employee" means:

...~~(8) an Anne Arundel County deputy sheriff or detention officer; or~~

(9) a Baltimore County deputy sheriff, but only when the deputy sheriff sustains an accidental personal injury that arises out of and in the course and scope of performing duties directly related to:

(i) courthouse security;

(ii) prisoner transportation;

(iii) service of warrants;

(iv) personnel management; or

(v) other administrative duties ; or

(10) a state correctional officer.

...

HB 205 also includes the following clause:

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

SB 851, in part, repeals and reenacts, with amendments, **section 9-212** and repeals **section 9-1015** of the Maryland Worker's Compensation Act as follows:

§ 9-212. Jockey

(a) (1) This section applies to each jockey licensed by the State Racing Commission to ride a thoroughbred horse.

(2) This section applies only at a thoroughbred racing association or training facility under the jurisdiction of the State Racing Commission.

(b) A jockey is a covered employee while performing a service in connection with ~~racing or:~~

(1) live thoroughbred racing; or

(2) training a thoroughbred race horse, if the principal earnings of the jockey are based on money earned as a jockey during live racing and not as an exercise rider.

(c) (1) For the purposes of this title, the ~~joint employers~~ employer of a jockey who is a covered employee under this section ~~while performing a service in connection with racing or training is~~ are:

~~(i) the Maryland Jockey Injury Compensation Fund, Inc.; and~~

~~(ii) each licensed owner or trainer who is subject to assessment under § 11-906 of the Business Regulation Article at the time of any occurrence for which benefits are payable to the jockey under this title.~~

~~(2) For purposes of this title, the employer of a jockey who is a covered employee under this section while performing a service in connection with training is the trainer for whom the service is performed.~~

~~(3) (2) This subsection does not affect any other provision of law or practice.~~

(d) Notwithstanding any other provision of law, this section may not be construed to bar an action by a jockey against a third party.

~~**§ 9-1015. Payment by Maryland Jockey Injury Compensation Fund, Inc**~~

~~(a) A jockey who is a covered employee under § 9-212 of this title while performing a service in connection with training or the dependents of the jockey may apply for payment from the Maryland Jockey Injury Compensation Fund, Inc. if the employer of the jockey is in default on a claim under § 9-1002(b) of this subtitle.~~

~~(b) On receipt of an application for payment, the Maryland Jockey Injury Compensation Fund, Inc. shall pay the award.~~

~~(c) (1) If the Maryland Jockey Injury Compensation Fund, Inc. makes payment under this section to a covered employee or the dependents of the covered employee as directed by the Commission, the Maryland Jockey Injury Compensation Fund, Inc. is subrogated to the rights of the covered employee or dependents against the uninsured employer.~~

~~(2) The Maryland Jockey Injury Compensation Fund, Inc. may:~~

~~(i) institute a civil action against the uninsured employer to recover the money paid under the award;~~

~~(ii) refer the matter to the Maryland Racing Commission for suspension or revocation of the occupational license of the uninsured employer;~~

~~(iii) refer the matter to the appropriate authority for prosecution under § 9-1108 of this title; or~~

~~(iv) take action under any combination or all of items (i) through (iii) of this paragraph.~~

Note: SB 851 is identical to **HB 1592**, which was included in NCCI's March 23, 2018 *Legislative Activity Report* (RLA-2018-12).

New Hampshire

HB 407 amends *sections 281-A:2* and *281-A:23* of the New Hampshire Workers' Compensation Law as follows:

281-A:2 Definitions.

Any word or phrase defined in this section shall have the same meaning throughout RSA 281-A, unless the context clearly requires otherwise:

...

I-aa. "Airborne disease" means pathogenic microorganisms that may be discharged through respiratory secretions and can cause disease in humans through inhalation or contact with a mucous membrane. In this chapter these are defined as pertussis, meningococcal disease, and tuberculosis.

...

I-d. "Bloodborne disease" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus, and human immunodeficiency virus (HIV).

I-e. "Critical exposure" means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood or body fluids, other than tears, saliva, or perspiration, unless these are visibly contaminated with blood, of a magnitude that can result in transmission of bloodborne disease.

...

V-c. "Emergency response/public safety worker" means call, volunteer, or regular firefighters; law enforcement officers certified under RSA 106-L; certified county corrections officers; and rescue or ambulance workers including ambulance service, emergency medical personnel, first responder service, and volunteer personnel.

...

XIV-a. "Post-exposure prophylaxis" means preventive medical treatment started after an identified critical exposure or unprotected exposure in order to prevent infection and the development of disease, in accordance with standards promulgated by the Centers for Disease Control and Prevention, United States Department of Health and Human Services.

XIV-b. "Unprotected exposure" includes instances of direct mouth-to-mouth resuscitation or the commingling of blood or other potentially infectious material of a source individual and an emergency response/public safety worker which is capable of transmitting a bloodborne or airborne disease.

XIV-c. "Rehabilitation provider" as used in this chapter includes any person certified as a vocational rehabilitation provider under RSA 281-A:68 or RSA 281-A:69 and who operates for the purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

...

281-A:23 Medical, Hospital, and Remedial Care.—

...

VI. An employer subject to this chapter, or the employer's insurance carrier, may furnish or cause to be furnished, testing for the presence of a bloodborne disease when a critical exposure that arises out of and in the course of employment occurs. Such testing shall be provided without prejudice as to the issue of the causal relationship of any subsequently diagnosed bloodborne disease to the employee's work and without prejudice to the compensability of the bloodborne disease as an occupational disease or an accidental injury for the purposes of RSA 281-A. Notwithstanding the foregoing, any costs for testing associated with a testing order issued pursuant to RSA 141-G:11 shall be paid for by the employer's insurance carrier or third-party administrator. Such payment shall be provided without prejudice as to the issue of the causal relationship of any subsequently diagnosed disease or injury.

VI-a. All expenses associated with the medical evaluation and recommended post-exposure prophylaxis treatment for emergency response/public safety workers shall be paid by the employer's insurance carrier or third-party administrator. Such medical evaluation and prophylaxis treatment shall be provided without prejudice as to the issue of the causal relationship of any subsequently diagnosed bloodborne disease or airborne disease to the emergency response/public safety worker's work and without prejudice to the compensability of the bloodborne disease or airborne disease as an occupational disease or an accidental injury for the purposes of this chapter.

...

NCCI analysis estimates that New Hampshire House Bill (HB) 407, if enacted in its current form, may result in a minimal increase in overall workers compensation costs in New Hampshire. Any cost impact of these changes, if enacted, would be reflected in the analysis of future claims experience contained in subsequent NCCI loss cost filings in New Hampshire.

SB 541 amends *sections 281-A:17, 281-A:60*, and *6:12*; and adds new *section 281-A:17a* to the New Hampshire Statutes to read:

Section 1

281-A:17 Firefighter and Heart, Lung, or Cancer Disease.—

...

II. Notwithstanding the provisions of RSA 281-A:2, XI and XIII, 16 and 27, there shall exist a prima facie presumption that cancer disease in a firefighter, whether a regular, call, volunteer, or retired member of a fire department, is occupationally related. In order to receive this occupational cancer disability benefit, the type of cancer involved must be a type which may be caused by exposure to heat, radiation, or a known or suspected carcinogen as defined by the International Agency for Research on Cancer, including such types and variations as colon, lung, melanoma, mesothelioma, multiple myeloma, non-melanoma skin, prostate, rectal, non-Hodgkin's lymphoma, and stomach. However:

(a) ~~A call or volunteer firefighter shall have the benefit of this prima facie presumption only if there is on record reasonable medical evidence that such firefighter was free of such disease at the beginning of his or her employment for 10 years after completion of the comprehensive medical physical. It shall be the duty of the employer of call or volunteer firefighters to provide the required reasonable medical evidence as outlined by the National Fire Protection Association standard 1582 or another evaluation mandated by the fire standards and training commission under RSA 21-P:25. If the employer fails to do so, the call or volunteer firefighter shall have the benefit of the prima facie presumption regardless of the absence of said reasonable medical evidence.~~

(b) A retired firefighter who agrees to submit to any a compliant physical examination requested by his city, town, or precinct during employment and meets all other standards pertaining to this section shall have the benefit of the prima facie presumption for a period of 20 years from the effective date of such firefighter's retirement.

(c) To qualify for treatment under this paragraph, a firefighter shall:

(1) After completion of a comprehensive medical physical determining the firefighter is cancer-free, document a tobacco-free lifestyle.

(2) Have continuously served at least 10 years in the fire service.

(3) Have completed courses and training in accordance with certification for firefighter I in accordance with RSA 21-P:25.

III. There is hereby established in the office of the state treasurer a fund to be known as the firefighters with cancer disease fund. All moneys in such fund shall be nonlapsing and continually appropriated to the commissioner to be used for the sole purpose of reimbursing costs associated with medical physicals under subparagraph II(b) and additional costs in workers' compensation coverage. The state treasurer shall disburse moneys from the fund only upon written order of the commissioner. The commissioner, with the approval of the fiscal committee of the general court, shall disburse moneys from the fund to the political subdivisions of this state and to the public risk pools covered under RSA 5-B. The commissioner shall conserve the assets of the fund. The attorney general shall appoint an employee of the department of justice to represent the fund in all proceedings brought to enforce claims against the fund. The commissioner shall adopt rules, pursuant to RSA 541-A, relative to the proper administration of the fund.

Section 2

281-A:60 Rulemaking; Powers of the Commissioner.—

I. The commissioner shall have the power to adopt rules under RSA 541-A relative to the following:

...

(bb) The administration of the fund established in RSA 281-A:17, III

...

Section 3

6:12 Application of Receipts.—

I. The requirement that the state treasurer shall establish and maintain an account or fund separately in the accounting records of the state shall be met by the department of administrative services in the following manner:

...

(b) Moneys received by the state treasurer, as provided in RSA 6:11, shall be accounted for in the state's accounting system as general revenue of the state, with the exception of the following dedicated funds or accounts:

...

(340) Moneys deposited into the firefighters with cancer disease fund, established in RSA 281-A:17, III.

Section 4

281-A:17-a Commission Established.

I. (a) There is established a commission to study the funding and operations of the presumption under workers' compensation requiring the reimbursement of costs associated with firefighters who have cancer. The members of the commission shall be as follows:

(1) One member of the senate, appointed by the president of the senate.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives.

- (3) The labor commissioner, or designee.
- (4) The commissioner of safety, or designee.
- (5) The insurance commissioner, or designee.
- (6) A representative of the New Hampshire Municipal Association, appointed by the association.
- (7) A representative of the New Hampshire Association of Counties, appointed by the association.
- (8) A fire chief, appointed by the New Hampshire Association of Fire Chiefs.
- (9) A representative of the Professional Fire Fighters of New Hampshire, appointed by that organization.
- (10) A representative of the New Hampshire Public Risk Management Exchange, appointed by that organization.
- (11) An attorney practicing in the field of workers' compensation defense, appointed by the governor.
- (b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall study:

- (1) The costs that have been incurred to date under RSA 281-A:17.
- (2) How to conclusively determine that the cause of cancer is occupationally related.
- (3) Reasonable methods and practices to screen out non-occupationally related cancers, that are a result of, including, but not limited to: other employment, genetics, and lifestyle choices made before, during, and after service.
- (4) The annual costs to provide physicals and the additional workers' compensation coverage and how they should be funded.
- (5) An appropriate, stable, and long-term funding mechanism and the costs of administering the funding mechanism.
- (6) Whether the funding mechanism should include an insurance assessment against carriers issuing certain insurance policies.
- (7) Any other issues applicable to the subject matter of RSA 281-A:17.
- (b) The commission may solicit input from any person or entity the commission deems relevant to its study.

III. The members of the commission shall elect a chairperson from among the members.

The first meeting of the commission shall be called by the senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Seven members of the commission shall constitute a quorum.

IV. On or before November 1, 2018, the commission shall submit a report of its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library.

SB 541 also includes the following language in section 5 of the bill:

5 Repeal. RSA 281-A:17-a, relative to a commission to study the funding and operations of the presumption under workers' compensation requiring the reimbursement of costs associated with firefighters who have cancer, is repealed.

Tennessee

SB 1615 repeals **section 50-6-413** of the Tennessee Workers' Compensation Law as follows:

~~**50-6-413. In-state claims office or adjuster required — Authority of office or adjuster.**~~

~~Every workers' compensation insurer that provides insurance for Tennessee workers' compensation claims, and every workers' compensation bureau approved self-insured employer, shall be required to maintain a workers' compensation claims office or to contract with a claims adjuster located within the borders of the state. The claims office or adjuster has authority to commence temporary total disability benefits and medical benefits if so ordered by the claims coordinator or by a court at a show cause hearing.~~

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.

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