



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 30, 2018.

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
- Included in NCCI's March 30, 2018 **Legislative Activity Report** (RLA-2018-13)
- Enacted on March 29, 2018, with a projected effective date of July 21, 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 ~~no~~ not later than thirty days ~~from~~ after the date of the inquiry. Thereafter, the carrier, self-insured employer or commission may request ~~no~~ not more than once every two months that the physician ~~perform~~ perform additional inquiries to obtain a patient utilization report regarding the employee from the Arizona state board of pharmacy controlled substances prescription monitoring program's central database tracking system.

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

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

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

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

...

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

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

J. For the purposes of this section:

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

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

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

(c) A return to gainful employment.

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

2. "Inconsistent results" means:

...

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

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

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

SB 1111 also includes the following language:

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

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

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

Florida

SB 376 was:

- Passed by the first chamber on March 3, 2018
- Passed by the second chamber on March 5, 2018
- Included in NCCI's March 16, 2018 **Legislative Activity Report** (RLA-2018-11)
- Enacted on March 27, 2018, with an effective date of October 1, 2018

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

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

...

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

1. The posttraumatic stress disorder resulted from the first responder acting within the course of his or her employment as provided in s. 440.091; and
 2. The first responder is examined and subsequently diagnosed with such disorder by a licensed psychiatrist who is an authorized treating physician as provided in chapter 440 due to one of the following events:
 - a. Seeing for oneself a deceased minor;
 - b. Directly witnessing the death of a minor;
 - c. Directly witnessing an injury to a minor who subsequently died before or upon arrival at a hospital emergency department;
 - d. Participating in the physical treatment of an injured minor who subsequently died before or upon arrival at a hospital emergency department;
 - e. Manually transporting an injured minor who subsequently died before or upon arrival at a hospital emergency department;
 - f. Seeing for oneself a decedent whose death involved grievous bodily harm of a nature that shocks the conscience;
 - g. Directly witnessing a death, including suicide, that involved grievous bodily harm of a nature that shocks the conscience;
 - h. Directly witnessing a homicide regardless of whether the homicide was criminal or excusable, including murder, mass killing as defined in 28 U.S.C. s. 530C, manslaughter, self-defense, misadventure, and negligence;
 - i. Directly witnessing an injury, including an attempted suicide, to a person who subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience;
 - j. Participating in the physical treatment of an injury, including an attempted suicide, to a person who subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience; or
 - k. Manually transporting a person who was injured, including by attempted suicide, and subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience.
- (b) Such disorder must be demonstrated by clear and convincing medical evidence.
- (c) Benefits for a first responder under this subsection:
1. Do not require a physical injury to the first responder; and
 2. Are not subject to:
 - a. Apportionment due to a preexisting posttraumatic stress disorder;
 - b. Any limitation on temporary benefits under s. 440.093; or
 - c. The 1-percent limitation on permanent psychiatric impairment benefits under s. 440.15(3).
- (d) The time for notice of injury or death in cases of compensable posttraumatic stress disorder under this subsection is the same as in s. 440.151(6) and is measured from one of the qualifying events listed in subparagraph (a)2. or the manifestation of the disorder, whichever is later. A claim under this subsection must be properly noticed within 52 weeks after the qualifying event.

(e) As used in this subsection, the term:

1. "Directly witnessing" means to see or hear for oneself.

2. "Manually transporting" means to perform physical labor to move the body of a wounded person for his or her safety or medical treatment.

3. "Minor" has the same meaning as in s. 1.01(13).

(f) The Department of Financial Services shall adopt rules specifying injuries qualifying as grievous bodily harm of a nature that shocks the conscience for the purposes of this subsection.

(6) An employing agency of a first responder, including volunteer first responders, must provide educational training related to mental health awareness, prevention, mitigation, and treatment.

SB 376 also includes the following clause:

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

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

Indiana

SB 290 was:

- Passed by the first chamber on January 29, 2018.
- Included in NCCI's February 9, 2018 **Legislative Activity Report** (RLA-2018-06).
- Passed by the second chamber on February 19, 2018.
- Included in NCCI's March 2, 2018 **Legislative Activity Report** (RLA-2018-09).
- Enacted on March 25, 2018, with an effective date of July 1, 2018, except for section 17 of the bill urging the Legislative Council to assign a task to an interim study committee referenced in the last bullet below. Section 17 is effective on February 19, 2018, and expires on January 1, 2019.

SB 290 adds to and amends various provisions of the Indiana Labor and Safety code to:

- Establish a time frame for the payment of compensation under a settlement agreement, a permanent partial impairment agreement, and an award of compensation ordered by a single hearing member of the Worker's Compensation Board (board). It provides that an employer that fails to make a timely payment is subject to a civil penalty
- Require an employer that has mobile or remote employees to convey information about workers compensation coverage to the employer's employees in an electronic format or in the same manner as the employer conveys other employment-related information. It allows the electronic filing of certain documents with the board
- Provide that a permanently, totally disabled worker must reapply to the second injury fund for a wage replacement benefit every three years instead of every 150 weeks
- Require the reporting of workplace injuries needing medical attention beyond first aid instead of injuries causing an absence from work for more than one day. It provides that reporting requirements for workplace injuries are intended to be consistent with the recording requirements set out in the United States Occupational Safety and Health Administration's regulations
- Change the civil penalty for an employer's failure to provide proof of workers compensation coverage from \$50 per employee to \$100 per day
- Revise the definition of employer to include corporations, limited liability companies, limited liability partnerships, and other entities that have common control and ownership
- Establish the assigned risk plan (plan) administered by the Worker's Compensation Rating Bureau (bureau). It provides that the plan may be substantially modified or eliminated only as the General Assembly provides by statute. The bill removes the requirement for representation in the management of the bureau by stock companies and nonstock companies
- Make conforming amendments for occupational diseases compensation
- Urge the Legislative Council to assign to an appropriate interim study committee the task of studying increases to the benefit schedules for workers compensation and occupational diseases compensation

SB 369 was:

- Passed by the first chamber on February 6, 2018
- Included in NCCI's February 16, 2018 **Legislative Activity Report** (RLA-2018-07)
- Amended and passed by the second chamber on February 27, 2018
- Included in NCCI's March 9, 2018 **Legislative Activity Report** (RLA-2018-10)
- Enacted on March 25, 2018, with a projected effective date of July 1, 2018

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

22-3-3-4.7:

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

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

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

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

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

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

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

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

- (1) send the request to a third party that is certified by the Utilization Review Accreditation Commission to make a determination concerning the request; and
- (2) notify the prescribing physician and the injured employee of the third party's determination not more than five (5) business days after receiving the request.

(f) If an employer fails to provide the notice required by subsection (e)(2), the prescribing physician's request under subsection (d) is considered approved, and reimbursement of the "N" drug prescribed for use by the injured employee is authorized.

(g) If the third party's determination under subsection (e) is to deny the prescribing physician's request to permit the use of an "N" drug:

- (1) the employer shall notify the prescribing physician and the injured employee; and
- (2) the injured employee may apply to the worker's compensation board for a final determination concerning the third party's determination under subsection (e).

(h) Notwithstanding subsections (c) through (f), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is an "N" drug according to the formulary.

22-3-7-17.6:

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

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

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

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

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

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

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

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

- (1) send the request to a third party that is certified by the Utilization Review Accreditation Commission to make a determination concerning the request; and
- (2) notify the prescribing physician and the disabled employee of the third party's determination not more than five (5) business days after receiving the request.

(f) If an employer fails to provide the notice required by subsection (e)(2), the prescribing physician's request under subsection (d) is considered approved, and reimbursement of the "N" drug prescribed for use by the disabled employee is authorized.

(g) If the third party's determination under subsection (e) is to deny the prescribing physician's request to permit the use of an "N" drug:

(1) the employer shall notify the prescribing physician and the disabled employee; and

(2) the disabled employee may apply to the worker's compensation board for a final determination concerning the third party's determination under subsection (e).

(h) Notwithstanding subsections (c) through (f), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is an "N" drug according to the formulary.

*NCCI is currently analyzing enacted **IN SB 369** for potential system cost impact.*

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
- Included in NCCI's March 30, 2018 **Legislative Activity Report** (RLA-2018-13)
- Enacted on March 30, 2018, with a projected effective date of July 13, 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.

*NCCI is currently analyzing enacted **KY HB 2** for potential system cost impact.*

West Virginia

SB 82 was:

- Passed by the first chamber on February 27, 2018
- Included in NCCI’s March 9, 2018 **Legislative Activity Report** (RLA-2018-10)
- Passed by the second chamber on March 9, 2018
- Included in NCCI’s March 16, 2018 **Legislative Activity Report** (RLA-2018-11)
- Enacted on March 27, 2018, with an effective date of June 7, 2018

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

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

- ...
- (g) No award ~~shall~~ may be made under the provisions of this chapter for any occupational disease contracted prior to July 1, 1949. An employee ~~shall be considered to have~~ has contracted an occupational disease within the meaning of this subsection if the disease or condition has developed to such an extent that it can be diagnosed as an occupational disease.
- (h) (1) For purposes of this chapter, a rebuttable presumption that a professional firefighter who has developed a cardiovascular or pulmonary disease or sustained a cardiovascular injury or who has developed leukemia, lymphoma, or multiple myeloma arising out of and in the course of employment as a firefighter has received an injury or contracted a disease arising out of and in the course of his or her employment exists if: (A) The person has been actively employed by a fire department as a professional firefighter for a minimum of two years prior to the cardiovascular injury or onset of a cardiovascular or pulmonary disease or death; ~~and~~ (B) the injury or onset of the disease or death occurred within six months of having participated in firefighting or a training or drill exercise which actually involved firefighting; and (C) in the case of the development of leukemia, lymphoma, or multiple myeloma the person has been actively employed by a fire department as a professional firefighter for a minimum of five years in the state prior to the development of leukemia, lymphoma, or multiple myeloma, has not used tobacco products for at least 10 years, and is not over the age of 65 years. When the above conditions are met, it shall be presumed that sufficient notice of the injury, disease, or death has been given and that the injury, disease, or death was not self inflicted.
- ~~(2) The Insurance Commissioner shall study the effects of the rebuttable presumptions created in this subsection on the premiums charged for workers’ compensation for professional municipal firefighters; the probable effects of extending these presumptions to volunteer firefighters; and the overall impact of the risk management programs, wage replacement, premium calculation, the number of hours worked per volunteer, treatment of nonactive or “social” members of a volunteer crew and the feasibility of combining various volunteer departments under a single policy on the availability and cost of providing workers’ compensation coverage to volunteer firefighters. The Insurance Commissioner shall file the report with the Joint Committee on Government and Finance no later than December 1, 2008.~~
- (2) The amendments made to this section during the 2018 regular session of the Legislature to include leukemia, lymphoma, or multiple myeloma arising out of and in the course of employment as a firefighter as a rebuttable presumption shall expire on July 1, 2023, unless extended by the Legislature.
- (i) Claims for occupational disease as defined in §23-4-1(f) of this code, except occupational pneumoconiosis for all workers and pulmonary disease and cardiovascular injury and disease for professional firefighters, shall be processed in like manner as claims for all other personal injuries.
- ~~(j) On or before January 1, 2004, the Workers’ Compensation Commission shall adopt standards for the evaluation of claimants and the determination of a claimant’s degree of whole body medical impairment in claims of carpal tunnel syndrome.~~

SB 625 was:

- Passed by the first chamber on February 27, 2018
- Included in NCCI's March 9, 2018 **Legislative Activity Report** (RLA-2018-10)
- Amended and passed by the second chamber on March 9, 2018
- Included in NCCI's March 16, 2018 **Legislative Activity Report** (RLA-2018-11)
- Amended and passed by the first chamber with second chamber concurrence on March 10, 2018
- Enacted on March 27, 2018, with an effective date of June 8, 2018

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

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

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

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

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

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

...

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

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

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

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

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

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

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

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

...

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

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

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

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending March 30, 2018.

Alabama

HB 192 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 27, 2018

HB 192, in part, amends *sections 25-5-60, 25-5-66, 25-5-68, and 25-5-69* of the Alabama Industrial Relations and Labor Code as follows:

Section 25-5-60 Compensation for death.

...

(1) Persons Entitled to Benefits; Amount of Benefits.

...

e. Except as provided in subdivision (3), if compensation is being paid under this article to any dependent, the compensation shall cease upon the death or marriage of the dependent, unless otherwise provided in this article.

...

(2) Maximum and Minimum Compensation Awards. The compensation payable in case of death to persons wholly dependent shall be subject to a maximum and minimum weekly compensation as stated in Section 25-5-68, but if at the time of injury the employee receives earnings of less than the minimum stated in Section 25-5-68, then the compensation shall be the full amount of such earnings per week. The compensation payable to partial dependents shall be subject to a maximum and minimum weekly compensation as stated in Section 25-5-68, but if the income loss of the partial dependents by the death is less than the minimum weekly compensation stated in Section 25-5-68, then the dependents shall receive the full amount of their income loss. This compensation shall be paid during dependency, not exceeding 500 weeks, except as provided in subsection (f) of Section 25-5-68. Payments shall be made at the intervals when the earnings were payable, as nearly as may be, unless the parties otherwise agree.

(3) If a dependent is the surviving spouse of a law enforcement officer or firefighter killed as a result of injuries received while engaged in the performance of his or her duties, the compensation does not cease upon remarriage.

Section 25-5-66 Disposition of compensation upon remarriage of widow of employee who has another dependent.

(a) In case of the remarriage of a widow the surviving spouse of an employee who has another dependent, the unpaid balance of compensation, which would otherwise become due her, shall be paid to the dependent or may, on approval by the court, be paid to some suitable person designated by the court for the use and benefit of the dependent. Payment to that person shall discharge the employer from any further liability.

(b) Subsection (a) does not apply to the surviving spouse of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties.

Section 25-5-68 Maximum and minimum weekly compensation.

...
(d) In no event, except as provided for permanent total disability in subdivision (a)(4) of Section 25-5-57 or except for compensation benefits payable for permanent partial and temporary total disability in connection with a disability scheduled in subdivisions (1) and (3) of subsection (a) of Section 25-5-57 or except as provided in subsection (f), shall the total amount of compensation payable for an accident or an occupational disease exceed the product of 500 times the maximum weekly benefit applicable on the date of the accident.

...
(f) Notwithstanding any other provision of this article, the compensation benefits payable to a surviving dependent child of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties shall not discontinue at least until the dependent child reaches the age of 18 years.

Section 25-5-69 Compensation to cease upon death or marriage of dependent; proportional benefits for dependents.

¶ Except when the dependent is the surviving spouse of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties, if compensation is being paid under this article to any dependent, such compensation shall cease upon the death or marriage of such dependent. Where compensation is being paid under this chapter to any dependent, in no event shall such dependent receive more than the proportion which the amount received of the deceased employee's income during his or her life bears to the compensation provided under this article.

Arizona

HB 2047 was:

- Passed by the first chamber on February 6, 2018
- Included in NCCI's February 16, 2018 **Legislative Activity Report** (RLA-2018-07)
- Amended and passed by the second chamber on March 28, 2018

HB 2047 amends **section 23-901. Definitions** of the Arizona Revised Statutes, in part, as follows:

23-901. Definitions

In this chapter, unless the context otherwise requires:

...
6. "Employee", "workman", "worker" and "operative" means:

...
(q) A working member of a limited liability company who owns less than fifty percent of the membership interest in the limited liability company.

(r) A working member of a limited liability company who owns fifty percent or more of the membership interest in the limited liability company may be deemed to be an employee entitled to the benefits provided by this chapter on the written acceptance, by endorsement, of an application for coverage by the working member at the discretion of the insurance carrier for the limited liability company. The basis for computing wages for premium payments and compensation benefits for the working member is an assumed average monthly wage of six hundred dollars or more but not more than the maximum wage provided in section 23-1041 and is subject to the discretionary approval of the insurance carrier. Any compensation for permanent partial or permanent total disability payable to the working member is computed on the lesser of the assumed monthly wage agreed to by the insurance carrier on the acceptance of the application for coverage or the actual average monthly wage received by the working member at the time of injury.

(s) A working shareholder of a corporation who owns less than fifty percent of the beneficial interest in the corporation.

(t) A working shareholder of a corporation who owns fifty percent or more of the beneficial interest in the corporation may be deemed to be an employee entitled to the benefits provided by this chapter on the written acceptance, by endorsement, of an application for coverage by the working shareholder at the discretion of the insurance carrier for the corporation. The basis for computing wages for premium payments and compensation benefits for the working shareholder is an assumed average monthly wage of six hundred dollars or more but not more than the maximum wage provided in section 23-1041 and is subject to the discretionary approval of the insurance carrier. Any compensation for permanent partial or permanent total disability payable to the working shareholder is computed on the lesser of the assumed monthly wage agreed to by the insurance carrier on the acceptance of the application for coverage or the actual average monthly wage received by the working shareholder at the time of injury.

...

Kentucky

HB 323 was:

- Passed by the first chamber on March 9, 2018
- Included in NCCI's March 16, 2018 **Legislative Activity Report** (RLA-2018-11)

- Amended and passed by the second chamber on March 27, 2018

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The rating of an insurance policy;

b. The financial condition of an insurer;

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

d. A document filed with the commissioner; or

4. Engages in any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

...

(3) Any person damaged as a result of a violation of any provision of this section ~~when there has been a criminal adjudication of guilt~~ shall have a cause of action to recover compensatory damages, plus all reasonable investigation and litigation expenses, including attorneys’ fees, at the trial and appellate courts.

...

Maryland

HB 205 was:

- Passed by the first chamber on March 17, 2018
- Included in NCCI's March 30, 2018 **Legislative Activity Report** (RLA-2018-13)
- Passed by the second chamber on March 30, 2018

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.

HB 1499 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 30, 2018

HB 1499 repeals and reenacts, with amendments, **sections 1-204, 27-402, 27-801, and 27-802** of the Maryland Insurance Code as follows:

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

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

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

§ 27-402. Scope of subtitle

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

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

§ 27-801. Definitions

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

§ 27-802. Reporting suspected insurance fraud

(a)

...

(4) A governmental self-insurance group formed in accordance with § 9-404 of the Labor and Employment Article or an employer who self-insures or participates in a self-insurance group in accordance with § 9-405 of the Labor and Employment Article shall meet the reporting requirement of this subsection by reporting suspected insurance fraud in writing to the fraud division.

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

...

HB 1500 was:

- Passed by the first chamber on March 15, 2018
- Included in NCCI’s March 23, 2018 **Legislative Activity Report** (RLA-2018-12)
- Passed by the second chamber on March 30, 2018

HB 1500 repeals and reenacts, with amendments, **section 9-902** of the Maryland Labor and Employment Code as follows:

§ 9-902. Action against third party after award or payment of compensation

...

(e) If the covered employee or the dependents of the covered employee recover damages, the covered employee or dependents:

- (1) first, may deduct the costs and expenses of the covered employee or dependents for the action;
- (2) next, subject to subsection (g) of this section, shall reimburse the self-insured employer, insurer, Subsequent Injury Fund, or Uninsured Employers’ Fund for:

- (i) the compensation already paid or awarded; and
- (ii) any amounts paid for medical services, funeral expenses, or any other purpose under Subtitle 6 of this title; and

...

(g) In determining reimbursement under subsection (e)(2) of this section, if the self-insured employer, insurer, or uninsured employers’ fund has not waived third-party reimbursement:

- (1) first, the self-insured employer, insurer, or uninsured employers’ fund shall be reimbursed; and
- (2) next, the subsequent injury fund shall be reimbursed.

HB 1500 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 action filed before the effective date of this Act.

Tennessee

SB 1615 was:

- Passed by the first chamber on March 19, 2018
- Included in NCCI’s March 30, 2018 **Legislative Activity Report** (RLA-2018-13)
- Passed by the second chamber on March 26, 2018

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.~~

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending March 30, 2018.

Colorado

SB 178 amends **section 40-11.5-102** of the Colorado Revised Statutes as follows:

~~**40-11.5-102. Lease provisions—definitions—rules.**~~

...

(5) (a) Any lease or contract executed pursuant to this section ~~shall~~ must provide for coverage under workers' compensation or a ~~private occupational accident~~ insurance policy that provides similar coverage.

(a.5) If an operator of a commercial vehicle, as defined in section 42-4-235 (1)(a)(l)(b), obtains similar coverage pursuant to this subsection (5), then the operator:

(I) Is excluded from the definition of employee for purposes of section 8-40-202 (2);

(II) Shall notify the division of workers' compensation in the department of labor and employment of the election, in a manner determined by the director of the division of workers' compensation by rule; and

(III) Shall, along with the motor carrier and contract carrier, provide proof of the similar coverage upon request to interested parties, including the carrier's workers' compensation insurance provider, the division of workers' compensation, and the division of insurance.

(b) for purposes of this subsection (5), "similar coverage":

(I) Means ~~disability insurance for on and off the job injury, health insurance, and life insurance~~ benefits designed for independent contractors and sole proprietors who reject workers' compensation coverage and elect, pursuant to this subsection (5), coverage providing medical, temporary and permanent disability, death and dismemberment, and survivor benefits that are subject to regulation by the division of insurance in the department of regulatory agencies. The specifications of ~~such~~ the insurance, including ~~the amount of any deductible, shall~~ coverages, exclusions, policy limits, and the amount, if any, of any deductibles or copayments, must be filed with the division of insurance. The specifications must meet or exceed standards set by the division of insurance in the department of regulatory agencies, and such the standards ~~shall~~ must specify that the benefits offered by ~~such~~ the insurance coverage ~~shall~~ must be at least comparable to the benefits offered under the workers' compensation system.

(II) For services performed by operators of commercial vehicles, as defined in section 42-4-235 (1)(a)(l)(b), means insurance benefits defined in subsection (5)(b)(I) of this section. The specifications of the insurance, including minimum thresholds for coverage and the amount, if any, of any deductibles or copayments, must meet or exceed the standards set, by rule, by the division of insurance in the department of regulatory agencies.

(d) Notwithstanding any other law, if an operator of a commercial vehicle, as defined in section 42-4-235 (1)(a)(l)(b), a motor carrier, or a contract carrier obtains similar coverage pursuant to this subsection (5), articles 40 to 47 of title 8 do not apply.

(e) The commissioner of insurance in the division of insurance in the department of regulatory agencies shall promulgate rules establishing the minimum coverages for benefits under an occupational accident policy under this subsection (5).

Louisiana

HB 370 creates new *chapter 19* in the Louisiana Insurance Code to read:

CHAPTER 19. ELECTRONIC DELIVERY OF INSURANCE DOCUMENTS AND NOTICES

§2461. Definitions

As used in this Chapter, the following definitions apply:

(1) "Delivered by electronic means" means either of the following:

(a) Delivery to an electronic mail address at which a party has consented to receive notices or documents.

(b) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet, or any other electronic device, together with separate notice of the posting provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party.

(2) "Party" means any recipient of any notice or document required as part of an insurance transaction, including but not limited to an applicant, an insured, a policyholder, or an annuity contract holder.

§2462. Electronic delivery of insurance documents and notices

A. Subject to the requirements of this Section, any notice to a party or any other document required by law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means if the electronic means meet the requirements of the Louisiana Uniform Electronic Transactions Act, R.S. 9:2601 et seq.

B. Delivery of a notice or document in accordance with this Section shall be considered equivalent to and have the same effect as any delivery method required by law, including delivery by first class mail, first class mail with postage prepaid, certified mail, certificate of mail, or certificate of mailing.

C. A notice or document may be delivered by electronic means by an insurer to a party pursuant to this Section if all of the following apply:

(1) The party has affirmatively consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means to which the party has given consent, and the party has not withdrawn the consent.

(2) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of all of the following:

(a) The hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(b) The types of notices and documents to which the party's consent would apply.

(c) The right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn.

(d) The procedures a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the party's electronic mail address.

(e) The right of a party to have a notice or document delivered, upon request, in paper form.

D. An insurer shall take all measures reasonably calculated to ensure that delivery by electronic means pursuant to this Section results in receipt of the notice or document by the party.

§2463. Change in hardware or software requirements

After the consent of a party is given, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies, the insurer shall not deliver a notice or document to the party by electronic means unless the insurer complies with R.S. 22:2462 and provides the party with a statement that describes all of the following:

(1) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(2) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

§2464. Applicability

A. The provisions of this Section shall not be construed to affect requirements related to content or timing of any notice or document required by any other provision of law.

B. If a provision of this Title or other applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

C. This Chapter shall not apply to a notice or document delivered by an insurer in an electronic form before the effective date of this Chapter to a party who, before that date, has consented to receive the notice or document in an electronic form otherwise allowed by law.

§2465. Contracts and policies not affected

The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party shall not be denied solely because of the failure of the insurer to obtain electronic consent or confirmation of consent of the party in accordance with the provisions of this Chapter.

§2466. Withdrawal of consent

A. A withdrawal of consent by a party shall not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

B. A withdrawal of consent by a party shall be effective within a reasonable period of time after receipt of the withdrawal by the insurer.

C. Failure by an insurer to comply with any provision of R.S. 22:2462 or 20 2463 may be treated, at the election of the party, as a withdrawal of consent for purposes of this Chapter.

§2467. Prior consent to receive notices or documents in an electronic form

If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before the effective date of this Chapter, and an insurer intends to deliver additional notices or documents to the party in an electronic form pursuant to this Chapter, then prior to delivering the additional notices or documents electronically, the insurer shall comply with the provisions of 28 R.S. 22:2462 and shall provide the party with a statement that describes both of the following:

(1) The notices or documents that shall be delivered by electronic means that were not previously delivered electronically.

(2) The party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

§2468. Alternative method of delivery required

An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if either of the following occurs:

(1) The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party.

(2) The insurer becomes aware that the electronic mail address provided by the party is no longer valid.

§2469. Limitation of liability

An insurance producer shall not be subject to civil liability for any harm or injury that occurs because of a party's election to receive any notice or document by electronic means or by an insurer's failure to deliver or a party's failure to receive a notice or document by electronic means.

HB 451 amends and reenacts **section RS 22:337** in the Louisiana Insurance Code to read:

§337. Refusal, suspension, and revocation of certificate of authority

A. The commissioner of insurance may refuse, suspend, or revoke the certificate of authority of a foreign or alien insurer ~~whenever he shall find~~ upon finding that such the insurer:

...

(17) Fails to maintain a claims office for processing workers' compensation insurance claims in this state, as required by R.S. 23:1161.1, or to retain the services of ~~Louisiana domiciled independent licensed workers' compensation claims adjusters domiciled in this state~~. This Paragraph shall not apply to reinsurers licensed or accredited to do business in the state.

...

Missouri

SB 666 adds new sections to **chapter 285** of the Missouri Annotated Statutes, creating the "Professional Employer Organization Act" to provide, in part, that:

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

SB 981 amends **sections 287.127, 287.690, and 287.715** of the Missouri Workers' Compensation Law as follows:

287.127. Notice, employer to post, contents—division to provide notice, when—penalty.—

...

2. The division of workers' compensation shall develop the notice to be posted ~~and shall~~, distribute such notice free of charge to employers and insurers upon request, and publish the notice on the website of the department of labor and industrial relations. Failure to request such notice does not relieve the employer of its obligation to post the notice. If the employer carries workers' compensation insurance, the carrier shall provide the notice, in paper or electronic format, to the insured within thirty days of the insurance policy's inception date. A carrier who elects to provide the notice in electronic format shall direct the insured to the notice available on the website of the department of labor and industrial relations.

...

287.690. Premium tax on insurance carriers, purpose, rate, how determined—use of funds for employers mutual insurance company, purpose.—

1. Prior to December 31, 1993, for the purpose of providing for the expense of administering this chapter and for the purpose set out in subsection 2 of this section, every person, partnership, association, corporation, whether organized under the laws of this or any other state or country, the state of Missouri, including any of its departments, divisions, agencies, commissions, and boards or any political subdivisions of the state who self-insure or hold themselves out to be any part self-insured, company, mutual company, the parties to any interindemnity contract, or other plan or scheme, and every other insurance carrier, insuring employers in this state against liability for personal injuries to their employees, or for death caused thereby, under this chapter, shall pay, as provided in this chapter, tax upon the net deposits, net premiums or net assessments received, whether in cash or notes in this state, or on account of business done in this state, for such insurance in this state at the rate of two percent in lieu of all other taxes on such net deposits, net premiums or net assessments, which amount of taxes shall be assessed and collected as herein provided. Beginning October 31, 1993, and every year thereafter, the director of the division of workers' compensation shall estimate the amount of revenue required to administer this chapter and the director shall determine the rate of tax to be paid in the following calendar year pursuant to this section commencing with the calendar year beginning on January 1, 1994. If the balance of the fund estimated to be on hand on December thirty-first of the year each tax rate determination is made is less than one hundred ten percent of the previous year's expenses plus any additional revenue required due to new statutory requirements

given to the division by the general assembly, then the director shall impose a tax not to exceed two percent in lieu of all other taxes on net deposits, net premiums or net assessments, rounded up to the nearest one-half of a percentage point, which amount of taxes shall be assessed and collected as herein provided. The net premium equivalent for individual self-insured employers ~~and any group of political subdivisions of this state qualified to self-insure their liability pursuant to this chapter as authorized by section 537.620~~ shall be based on average rate classifications calculated by the department of insurance, financial institutions and professional registration as taken from premium rates filed by the twenty insurance companies providing the greatest volume of workers' compensation insurance coverage in this state. For employers qualified to self-insure their liability pursuant to this chapter, the rates filed by such group of employers in accordance with subsection 4 of section 287.280 shall be the net premium equivalent. Any group of political subdivisions of this state qualified to self-insure their liability pursuant to this chapter as authorized by section 537.620 may choose either the average rate classification method or the filed rate method, provided that the method used may only be changed once without receiving the consent of the director of the division of workers' compensation. Every entity required to pay the tax imposed pursuant to this section and section 287.730 shall be notified by the division of workers' compensation within ten calendar days of the date of the determination of the rate of tax to be imposed for the following year. **Net premiums, net deposits or net assessments** are defined as gross premiums, gross deposits or gross assessments less cancelled or returned premiums, premium deposits or assessments and less dividends or savings, actually paid or credited.

...
287.715. Annual surcharge required for second injury fund, amount, how computed, collection—violation, penalty—supplemental surcharge, amount.

...
2. Beginning October 31, 2005, and each year thereafter, the director of the division of workers' compensation shall estimate the amount of benefits payable from the second injury fund during the following calendar year and shall calculate the total amount of the annual surcharge to be imposed during the following calendar year upon all workers' compensation policyholders and authorized self-insurers. The amount of the annual surcharge percentage to be imposed upon each policyholder and self-insured for the following calendar year commencing with the calendar year beginning on January 1, 2006, shall be set at and calculated against a percentage, not to exceed three percent, of the policyholder's or self-insured's workers' compensation net deposits, net premiums, or net assessments for the previous policy year, rounded up to the nearest one-half of a percentage point, that shall generate, as nearly as possible, one hundred ten percent of the moneys to be paid from the second injury fund in the following calendar year, less any moneys contained in the fund at the end of the previous calendar year. All policyholders and self-insurers shall be notified by the division of workers' compensation within ten calendar days of the determination of the surcharge percent to be imposed for, and paid in, the following calendar year. The net premium equivalent for individual self-insured employers ~~and any group of political subdivisions of this state qualified to self-insure their liability pursuant to this chapter as authorized by section 537.620~~ shall be based on average rate classifications calculated by the department of insurance, financial institutions and professional registration as taken from premium rates filed by the twenty insurance companies providing the greatest volume of workers' compensation insurance coverage in this state. For employers qualified to self-insure their liability pursuant to this chapter, the rates filed by such group of employers in accordance with subsection 4 of section 287.280 shall be the net premium equivalent. Any group of political subdivisions of this state qualified to self-insure their liability pursuant to this chapter as authorized by section 537.620 may choose either the average rate classification method or the filed rate method, provided that the method used may only be changed once without receiving the consent of the director of the division of workers' compensation. The director may advance funds from the workers' compensation fund to the second injury fund if surcharge collections prove to be insufficient. Any funds advanced from the workers' compensation fund to the second injury fund must be reimbursed by the second injury fund no later than December thirty-first of the year following the advance. The surcharge shall be collected from policyholders by each insurer at the same time and in the same manner that the premium is collected, but no insurer or its agent shall be entitled to any portion of the surcharge as a fee or commission for its collection. The surcharge is not subject to any taxes, licenses or fees.

...

Tennessee

HB 2304 amends **section 50-6-226** of the Tennessee Workers' Compensation Law as follows:

50-6-226. Fees of attorneys and physicians, and hospital charges.

...
(d) (1) In addition to attorneys' fees provided for in this section, the court of workers' compensation claims may award reasonable attorneys' fees and reasonable costs, including, but not limited to, reasonable and necessary court reporter expenses and expert witness fees, for depositions and trials, incurred when the employer:

...
(B) Wrongfully denies a claim ~~by filing a timely notice of denial, or fails to or wrongfully~~ fails to timely initiate any of the benefits to which the employee or dependent is entitled under this chapter, including medical benefits under § 50-6-204, temporary or permanent disability benefits under § 50-6-207, or death benefits under § 50-6-210 if the workers' compensation judge makes a

finding that the benefits were owed at an expedited hearing or compensation hearing. For purposes of this subdivision (d)(1)(B), “wrongfully” means erroneous, incorrect, or otherwise inconsistent with the law or facts.

(2) Subdivision (d)(1)(B) shall apply to injuries that occur on or after July 1, 2016, but shall not apply to injuries that occur after June 30, ~~2018~~ 2020.

...

FEDERAL ISSUES

| Issue | Update |
|--|---|
| TRIPRA Implementation—Data Collection | <p>State and federal regulators are continuing to implement provisions of the Terrorism Risk Insurance Program Reauthorization Act (TRIPRA) of 2015. Annual collection of terrorism insurance data is central to the efforts of the National Association of Insurance Commissioners (NAIC) (on behalf of state insurance regulators) and the US Department of the Treasury’s Federal Insurance Office (FIO).</p> <p>In 2018, FIO and the NAIC converged their previously separate terrorism data calls for all covered TRIPRA lines of insurance, except workers compensation. However, FIO and the NAIC determined that workers compensation data would continue to be reported to the respective organizations by NCCI and the independent state rating bureaus. They decided this given the uniqueness of workers compensation data and the positive track record established in collecting and aggregating the data. Since 2016, NCCI and the independent bureaus have been aggregating and reporting industry terrorism data, which removes the requirement from individual carriers.</p> <p>NCCI and the independent bureaus delivered the 2018 data to the NAIC in March and will complete the FIO portion of the data call in May. FIO will rely on the 2018 workers compensation data to produce its Congressionally mandated report on the effectiveness of TRIPRA and the impact on the federal government. The FIO report is due to Congress by June 30, 2018. State regulators, in coordination with the NAIC, will leverage the data for its ongoing solvency and market regulation activities.</p> |
| Federal Insurance Office (FIO) Request for Comments | <p>The US Department of the Treasury’s Federal Insurance Office (FIO) has issued a request for comments regarding the impact and effectiveness of the Terrorism Risk Insurance Program (TRIP). The TRIP was created after the September 11, 2001 terrorist attacks and provides a backstop from the economic impact of insured losses from terrorist attacks. The comments FIO receives, along with data it collects from the industry, will be included in a report on TRIP, which will be sent to Congress by June 30, 2018. Specific issues FIO is requesting comments on include: whether any aspects of TRIP have the effect of discouraging insurers from providing coverage; the impact of TRIP on workers compensation; and trends in the availability and affordability of coverage, both nationally and in geographic areas. Comments are due to FIO by April 30, 2018.</p> |

The bills included in the following section have been filed, but have not yet passed the first chamber.

STATE LEGISLATIVE ACTIVITY

| State | Update |
|----------------|---|
| Alabama | <p>SB 363 was filed on March 6, 2018, to establish marketplace contractor portable benefit plans for certain contractors of marketplace platforms. The statute is permissive and does not require coverage to be established by a marketplace platform. If a marketplace platform elects to contribute to a marketplace contractor portable benefit plan and provide contractor benefits, it must provide written notice to the Department of Labor. The contractor benefits are defined as one or more of the following:</p> <ul style="list-style-type: none"> • Health benefits to cover medical care, which may include costs for hospitalization, and prescription drugs • Benefits in the event of sickness, accident, or disability • Liability insurance • Retirement benefits • Life insurance • Vision care • Dental care • Compensation during a period of leave, not to exceed 12 weeks during a 12-month period, because of any of the following: <ol style="list-style-type: none"> 1. The birth or adoption of a son or daughter 2. To care for a spouse, son, daughter, or parent 3. A serious health condition that makes the marketplace contractor unable to work |

| | |
|------------------|--|
| Alaska | <p>HB 38 increases the permanent partial disability (PPD) benefits and death benefits under certain circumstances. This bill remains in the House Rule Committee and has not passed the first chamber.</p> <p>HB 303 relates to the workers compensation benefits for rehabilitation and reemployment benefits. The bill proposes to increase the amount of reemployment benefits available depending upon the severity of the injury as measured by the permanent partial impairment rating.</p> |
| Colorado | HB 1308 establishes an exemption from the Workers Compensation Act of Colorado for an out-of-state employer whose employees are working in Colorado on a temporary basis under certain conditions. The home state's workers compensation laws would be the sole remedy for an out-of-state worker who is injured while working temporarily in Colorado. |
| Louisiana | HB 609 would enact LA R.S. 22:2013.1 to provide for the administration of large deductible workers compensation policies and collateral for such policies. Large deductible policies are defined as, among other requirements, those policies with a deductible of \$100,000 or greater. Retrospectively rated policies are not included in the definition of large deductible policies. The bill directs the handling of the claims and the related collateral under a large deductible policy subject to delinquency proceedings, including when the claims under the policies become the responsibility of the guaranty association. |
| Missouri | <p>SB 601 would create a mandate for the Division of Workers Compensation to implement a medical fee schedule.</p> <p>SB 735 eliminates monetary bonuses from being considered as payroll for workers compensation premium, up to 3% of the employee's yearly compensation from such employer, along with employer contributions to retirement accounts (which is an existing exclusion per NCCI's <i>Basic Manual</i> rules).</p> <p>SB 736 prohibits the conditioning of eligibility for certain contracts to be contingent on experience rating for state, political subdivision, and public utility contracts.</p> |
| Nebraska | LB 957 Allows for compensation payable under the Nebraska Workers' Compensation to be in the form of various payment methods including direct deposit, prepaid card, or similar electronic payment system. |

STATE COMMITTEE ACTIVITY

| State | Update |
|----------------|---|
| Idaho | The Idaho Industrial Commission held its first post-traumatic stress disorder (PTSD) subcommittee meeting on March 20, 2018, to study PTSD benefits for first responders. Additional research is being conducted by all interested stakeholders, and the next meeting is scheduled for May 30, 2018. |
| Montana | The Montana Economic Affairs Interim Committee/SJR 27 Subcommittee is continuing to hold hearings regarding the structure of the workers compensation system in Montana. There is no active discussion regarding changing benefits for injured employees. The next committee meeting is scheduled for April 27 in Helena. |

OTHER ITEMS OF INTEREST

| State | Update |
|-----------------|---|
| Oklahoma | <p>The 2014 amendment to the Workers Compensation Act limiting temporary total disability (TTD) to 104 weeks was challenged in <i>Gillispie v. Estes Express Lines</i>, where the carrier ended TTD after 104 weeks even though claimant was still under active medical care, awaiting surgery. The claimant was not considered eligible for permanent disability, as maximum medical improvement (MMI) had not yet been reached. The claimant argued that the 104-week limitation is unconstitutional or permanent total disability (PTD) benefits should be granted per 85A O.S. § 45(D)(1).</p> <p>In a unanimous opinion, the Commission said it was the intent of the Legislature, by adopting 45(D)(1), to pay PTD benefits beyond the 104 weeks, even though the worker had not reached MMI. The Commission said, “We find that the Legislature intended to avoid the gap in benefits previously experienced by workers who had exhausted TTD but were not yet eligible for PTD.”</p> <p>The employer’s argument that PTD should be paid by the Multiple Injury Trust Fund (MITF) was rejected and the Commission found the Legislature did not intend to expand the MITF liability and that the employer is solely responsible for temporary PTD benefits. The employer did not exercise its right to appeal the order of the Workers’ Compensation Commission, extending weekly payments as PTD.</p> <p>The administrative law judge (ALJ) wrote a comprehensive order that fully discussed the limitations imposed by the 104-week statute [(85A O.S. Sec. 45(A)(1))] and the remedy available for PTD while the claimant otherwise meets the requirements for TTD [(85A O.S. Sec. 45(D)(1))].</p> <p>The judge used the term “total disability” to distinguish between TTD and PTD and rejected the employer’s contention that any award of PTD, although the claimant has not reached MMI, must be based upon a finding that the claimant will be PTD after MMI. The judge wrote, “Interpreting the phrase in that manner would create a gap in benefits that would promote disparity in the way disabled workers are treated.”</p> |
| Oregon | <p>The Department of Consumer and Business Services (DCBS) Workers Compensation Division issued temporary rules effective February 21, 2018, that change the method for determining an injured employee’s average weekly wage if the earnings were irregular or changed during the 52 weeks prior to the injury. The next DCBS meeting to address the permanent rules is scheduled for April 30.</p> |

Contact Information

If you have any questions about the legislation or proposals mentioned, please contact the appropriate NCCI state relations executive (listed below) or a representative of your local insurance trade association.

| State | State Relations Executive | Phone Number |
|--------------------|---------------------------|--------------|
| IN, NC, SC, TN | Amy Quinn | 803-356-0851 |
| UT | Brett Barratt | 801-209-7443 |
| MO, NE, NV, OK, SD | Carla Townsend | 314-843-4001 |
| AZ, IA, KS, KY | Clarissa Preston | 561-945-4517 |
| DC, MD, NM, VA, WV | David Benedict | 804-380-3005 |
| CO, FL | Dawn Ingham | 561-893-3165 |
| CT, ME, NH, RI | Justin Moulton | 860-969-7903 |
| HI, VT | Laura Backus Hall | 802-454-1800 |
| AL, GA, LA, MS | Laura Hart Bryan | 225-618-8168 |
| AR, IL, TX | Terri Robinson | 501-333-2835 |
| Federal Issues | Tim Tucker | 202-403-8526 |
| AK, ID, MT, OR | Todd Johnson | 503-892-8919 |

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