



State or Federal Issues Contacts: Please refer to the list of State Relations Executives at the end of this report.

LEGISLATIVE ACTIVITY—LEGISLATIVE SESSION UPDATES

This report includes descriptions and/or excerpts of relevant bills that passed the first chamber, passed the second chamber, or were enacted during the specific periods. In addition, a recap of significant legislative and judicial activity impacting the workers compensation system is included in the first report published each month. This report is issued on a weekly basis throughout the legislative season and provides updates on the content of these bills if and when they progress through the legislative process. This report covers bills from states where NCCI provides ratemaking services (see state list under Contact Information) and the US Congress.

BILLS ENACTED

There were no relevant workers compensation-related bills enacted within the one-week period ending March 8, 2019.

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending March 8, 2019.

Colorado

HB 1105 was:

- Passed by the first chamber on February 11, 2019
- Included in NCCI's February 22, 2019 **Legislative Activity Report** (RLA-2019-06)
- Amended and passed by the second chamber on March 7, 2019

HB 1105 amends **section 8-42-101** of the Workers' Compensation Act of Colorado, in part, as follows:

8-42-101. Employer must furnish medical aid—approval of plan—fee schedule—contracting for treatment—no recovery from employee—medical treatment guidelines—accreditation of physicians and other medical providers—rules—repeal.

...

(3.5) (a) (I) (D) an advanced practice nurse with prescriptive authority pursuant to section 12-38-111.6 may receive level I accreditation for purposes of receiving one hundred percent reimbursement under the medical fee schedule created in accordance with subsection (3) of this section.

(E) nothing in this subsection (3.5)(a) grants any person other than a physician licensed under the "Colorado Medical Practice Act" the authority to determine that no permanent medical impairment has resulted from the injury pursuant to subsection (3.6)(b) of this section or that a claimant has attained maximum medical improvement pursuant to section 8-42-107 (8)(b)(I).

...

Mississippi

SB 2864 was:

- Passed by the first chamber on February 6, 2019
- Included in NCCI's February 15, 2019 **Legislative Activity Report** (RLA-2019-05)
- Passed by the second chamber on March 4, 2019

SB 2864 amends **sections 83-23-109** and **83-23-115** of the Mississippi Insurance Guaranty Association Law as follows:

§ 83-23-109. Definitions.

As used in this article:

...

(f) "Covered claim" means an unpaid claim, including one of unearned premiums, which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this article applies issued by an insurer, if such insurer becomes an insolvent insurer and ~~(4)~~(i) the claimant or insured is a resident of this state at the time of the insured event, provided

that for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event; or ~~(2)(ii)~~ the property from which the claim arises is permanently located in this state. "Covered claim" shall not include any amount awarded as punitive or exemplary damages; or sought as a return of premium under any retrospective rating plan; or due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise and shall preclude recovery thereof from the insured of any insolvent carrier to the extent of the policy limits. "Covered claim" shall not include any claim that would otherwise be a covered claim under this article that has been rejected or denied by any other state guaranty fund based upon that state's statutory exclusions regarding the insured's net worth.

...
(h) "Member insurer" means any person who ~~(1)(i)~~ writes any kind of insurance to which this article applies under Section 83-23-105, including the exchange of reciprocal or interinsurance contracts, and ~~(2)(ii)~~ is licensed to transact insurance in this state.
...

§ 83-23-115. Powers and duties of association.

(1) The association shall:

(a)...

In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provisions of this article, a covered claim shall not include a claim filed with the association after final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

...

Nebraska

LB 380 was passed by the legislature on March 7, 2019.*

LB 380, in part, amends *sections 44-2403, 44-2406, and 44-2407* of the Nebraska Revised Statutes to read as follows:

44-2403. Terms, defined.

As used in the Nebraska Property and Liability Insurance Guaranty Association Act, unless the context otherwise requires:

...
(4)(a) Covered claim shall mean an unpaid claim ~~which has been timely filed with the liquidator~~ as provided for in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act and which arises out of and is within the coverage of an insurance policy to which the Nebraska Property and Liability Insurance Guaranty Association Act applies issued by a member insurer that becomes insolvent after May 26, 1971, and (i) the claimant or insured is a resident of this state at the time of the insured event or (ii) the property from which the claim arises is permanently located in this state. Covered claim shall also include the policyholder's unearned premiums paid by the policyholder on an insurance policy to which the act applies issued by a member insurer that becomes insolvent on or after July 9, 1988. Nothing in this section shall be construed to supersede, abrogate, or limit the common-law ownership of accounts receivable for earned premium, unearned premium, or unearned commission;

(b) Covered claim shall not include any amount due any reinsurer, insurer, liquidator, insurance pool, or underwriting association, as subrogation recoveries or otherwise, a ~~policy deductible or self-insured portion of the claim,~~ a claim for any premium calculated on a retrospective basis, any premiums subject to adjustment after the date of liquidation, or any amount due an attorney or adjuster as fees for services rendered to the insolvent insurer. Covered claim shall also not include any amount as punitive or exemplary damages or any amount claimed for incurred but not reported damages. Covered claim shall also not include any claim filed with the guaranty fund after the earlier of twenty-five months after the date of the order of liquidation or the final date set by the court for the filing of claims against the liquidator or receiver. This subdivision ~~Subdivision (4)(b) of this section~~ shall not prevent a person from presenting the excluded claim to the insolvent insurer or its liquidator, but the claim shall not be asserted against any other person, including the person to whom benefits were paid or the insured of the insolvent insurer, except to the extent that the claim is outside the coverage or is in excess of the limits of the policy issued by the insolvent insurer;

...

44-2406. Claims; filing; determination.

(1) The association shall be obligated only to the extent of the covered claims existing prior to the date a member ~~insurer company~~ becomes an insolvent insurer or arising within thirty days after it has been determined that the insurer is an insolvent insurer, before the policy expiration date, if less than thirty days after such determination, or before the insured replaces the policy or on request effects cancellation, if he or she does so within thirty days of such dates, but such obligation shall include only ~~the that~~ amount of each covered claim that does not exceed ~~which is in excess of one hundred dollars and is less than three hundred thousand dollars,~~ except that the association shall pay the amount required by law on any covered claim arising out of a workers' compensation policy. In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the face amount of the policy from which the claim arises. The association shall be obligated on covered claims, including those under a

workers' compensation policy, for unearned premiums only for ~~the~~ that amount of each covered claim that does not exceed which is in excess of one hundred dollars and is less than ten thousand dollars per policy.

...

(4) A third party having a covered claim against any insured of an insolvent member insurer may file such claim with the director pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, and the association shall process such claim in the manner specified in subsections (2) and (3) of this section. The filing of such claim shall constitute an unconditional general release of all liability of such insured in connection with the claim unless the association thereafter denies the claim for the reason that the insurance policy issued by the insolvent ~~insurer member company~~ does not afford coverage or unless the claimant, within thirty days from the date of filing his or her claim with the director, files with the director a written demand that the claim be processed in the liquidation proceedings as a claim not covered by the Nebraska Property and Liability Insurance Guaranty Association Act.

44-2407. Association; duties; powers; enumerated.

(1) The association shall:

(a) Allocate claims paid and expenses incurred among the three accounts separately and assess member insurers separately for each account in the amounts necessary to pay the obligations of the association under section 44-2406, the expenses of handling covered claims, the cost of examinations under sections 44-2412 and 44-2413, and other expenses authorized by the Nebraska Property and Liability Insurance Guaranty Association Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of such member insurer, on the basis of the insurance in the account involved, bears to the net direct written premiums of all member insurers for the same period and in the same account for the calendar year preceding the date of the assessment the member insurer becomes an insolvent insurer. After an initial assessment has been made for an insolvency, any subsequent assessments for that insolvency may be calculated in the same manner as the initial assessment and may use the same calendar year's net direct written premiums as were used in determining the original assessment. The association may make an assessment for the purpose of meeting administrative costs and other general expenses not related to a particular impaired insurer, not to exceed fifty dollars per member ~~insurer company~~ in any one year. Each member insurer shall be notified of the assessment not later than thirty days before it is due. Except for such administrative assessment, no member insurer may be assessed in any year on any account an amount greater than one percent of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. The association may defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact business as an insurer. Deferred assessments shall be paid when such payment will not reduce capital or surplus below such required minimum amounts. Such deferred assessments when paid shall be refunded to those member ~~insurers companies~~ that received larger assessments by virtue of such deferment or, in the discretion of any such ~~insurer company~~, credited against future assessments. No member insurer may pay a dividend to shareholders or policyholders while such insurer has an unpaid deferred assessment;

(b) Handle claims through its employees or through one or more insurers or other persons designated by the association as a servicing facility, except that the designation of a servicing facility shall be subject to the approval of the director and such designation may be declined by a member insurer;

(c) Reimburse any servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and such other expenses of the association as are authorized by the Nebraska Property and Liability Insurance Guaranty Association Act; ~~and~~

(d) Issue to each insurer paying an assessment under this section a certificate of contribution in appropriate form and terms as prescribed by the director for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. The insurer may offset against its premium and related retaliatory tax liability to this state pursuant to sections 44-150 and 77-908 accrued with respect to business transacted in such year an amount equal to twenty percent of the original face amount of the certificate of contribution, beginning with the first calendar year after the year of issuance through the fifth calendar year after the year of issuance. If ~~Should~~ the association ~~recovers recover~~ any sum representing amounts previously written off by member insurers and offset against premium and related retaliatory taxes imposed by sections 44-150 and 77-908, such recovered sum shall be paid by the association to the director ~~Director of Insurance~~ who shall handle such funds in the same manner as provided in Chapter 77, article 9; -

(e) Be deemed the insolvent insurer to the extent of the association's obligation for covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer, subject to the limitations provided in the act, as if the insurer had not become insolvent, with the exception that the liquidator shall retain the sole right to recover any reinsurance proceeds. The association's rights under this section include, but are not limited to, the right to pursue and retain salvage and subrogation recoveries on paid covered claim obligations to the extent paid by the guaranty fund; and

(f) Have access to insolvent insurer records. The liquidator of an insolvent insurer shall permit access by the association or its authorized representatives, and by any similar organization in another state or its authorized representatives, to the insolvent insurer's records which are necessary for the association or such similar organization in carrying out its functions with regard to

covered claims. In addition, the liquidator shall provide the association or its representative or such similar organization with copies of such records upon the request and at the expense of the association or similar organization.

(2) The association may:

...

(d) Sue or be sued, and such power to sue shall include the power and right to intervene as a party before any court that has jurisdiction over an insolvent insurer as defined by such act;

..

(g) Bring any action against any third-party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all files, records, and electronic data related to an insolvent insurer that is appropriate or necessary for the association, or a similar organization in another state, to carry out duties under such act ~~Refund to the member insurers in proportion to the contribution of each member insurer to any account that amount by which the assets of the account exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the association in the account exceed the liabilities of that account as estimated by the board of directors for the coming year.~~

LB 380 also includes the following language:

All proceedings arising out of a claim under a policy of insurance written by an insolvent insurer shall be stayed for one hundred twenty days from the date of entry of the order of liquidation to permit proper defense by the association of all such pending causes of action. Nothing in this section shall be deemed to limit the powers of a receiver appointed pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act or to stay any proceeding brought pursuant to such act.

***Note:** Nebraska has only one chamber in its legislature. After the legislature passes a bill, it goes to the governor for consideration.

Utah

HB 55 Second Substitute was:

- Passed by the first chamber on February 21, 2019
- Included in NCCI's March 1, 2019 **Legislative Activity Report** (RLA-2019-07)
- Amended and passed by the second chamber on March 7, 2019

HB 55 Second Substitute, in part, amends the Utah Workers' Compensation Act, **section 34A-2-110. Workers' compensation insurance fraud—Elements—Penalties—Notice**, to clarify that the insurance department may investigate and enforce certain provisions of the Workers' Compensation Act.

West Virginia

SB 531 was:

- Passed by the first chamber on February 23, 2019
- Included in NCCI's March 8, 2019 **Legislative Activity Report** (RLA-2019-08)
- Amended and passed by the second chamber on March 5, 2019

SB 531 amends and reenacts **section 23-5-7** of the Code of West Virginia:

§23-5-7. Compromise and settlement.

(a) The claimant, the employer, and the Workers' Compensation Commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, may negotiate a final settlement of any and all issues in a claim wherever the claim is in the administrative or appellate processes: *Provided*, That in the settlement of medical benefits for nonorthopedic occupational disease claims, the claimant shall be represented by legal counsel: *Provided, however*, That for the purposes of this section, the term "nonorthopedic occupational disease claim" does not include an occupational hearing loss or hearing impairment claim. If the employer is not active in the claim, the commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable, may negotiate a final settlement with the claimant and the settlement shall be made a part of the claim record. Except in cases of fraud, no issue that is the subject of an approved settlement agreement may be reopened by any party, including the commission, the successor to the commission, other private insurance carriers, and self-insured employers, whichever is applicable. Any settlement agreement may provide for a lump-sum payment or a structured payment plan, or any combination thereof, or any other basis as the parties may agree. If a self-insured employer later fails to make the agreed-upon payment, the commission shall assume the obligation to make the payments and shall recover the amounts paid or to be paid from the self-insured employer and its sureties or guarantors, or both, as provided in §23-2-5 or §23-2-5a of this code.

...

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending March 8, 2019.

Georgia

SB 135 amends various sections of *Title 34. Labor and Industrial Relations, Chapter 9. Workers' Compensation* of the Official Code of Georgia Annotated to read as follows:

§ 34-9-53. Directors emeritus of board—Eligibility for appointment; procedure for appointment

(a) There is created the office of director emeritus of the board.

(b) Any director of the board ~~now or hereafter~~ in office on June 30, 2019, shall be eligible for appointment as director emeritus, ~~provided that once~~ such member of the board has reached the age of 60 years and has also attained 20 consecutive years of service in the capacity of ~~chairman~~ chairperson, director, deputy director or administrative law judge, member of the General Assembly, or a combination of consecutive service in these offices; ~~and provided, further, provided~~ that not more than five years' service in the General Assembly shall be allowed as service credit under this Code section. The Governor shall appoint to the position of director emeritus anyone eligible under this Code section who shall advise the Governor in writing that he or she desires to resign from the office of director of the board and accept appointment as director emeritus of the board, stating in such notice the date upon which the resignation as director and appointment as director emeritus shall become effective; and upon such notice the Governor shall make such appointment effective upon the date requested, and the resignation as director of the board shall be automatically effective as of the same date as the appointment as director emeritus.

(c) Notwithstanding the provisions of subsection (b) of this Code section, all persons appointed to the office of director emeritus of the board prior to June 30, 2019, shall continue to hold such office for the term and salary provided for in Code Section 34-9-54.

§ 34-9-57. Creation of administrative law judge emeritus of board; eligibility for appointment; manner of appointment; compensation

(a) There is created the office of administrative law judge emeritus of the board.

(b) Any administrative law judge, formerly known as deputy director, of the board ~~now or hereafter~~ in office on June 30, 2019, shall be eligible for appointment as administrative law judge emeritus, ~~provided he once he or she~~ has reached the age of 70 years and has either:

(1) Attained ~~attained~~ 20 years of service in the capacity of administrative law judge or deputy director; or

(2) Attained ~~attained~~ 20 years of total service, aggregating his or her service as administrative law judge or deputy director with any years of prior service as director, member of the General Assembly of Georgia or the Georgia National Guard, or as special assistant attorney general, or any combination of services in these offices.

(c) An ~~Such~~ administrative law judge emeritus shall be eligible for appointment by the Governor in the same manner as provided for appointment of a director emeritus under Code Section 34-9-53 and shall exercise the same duties as provided in Code Section 34-9-55 for a director emeritus.

(d) Notwithstanding the provisions of subsection (b) of this Code section, all persons appointed to the office of administrative law judge emeritus of the board prior to June 30, 2019, shall continue to hold such office and shall receive the annual salary provided for in subsection (e) of this Code section.

(e) All persons appointed to the office of administrative law judge emeritus as provided in this Code section shall receive an annual salary equal to one-third of the annual salary provided by law for an administrative law judge of the board at the time of appointment of the administrative law judge emeritus under this Code section, such salary to be paid by the board in semimonthly installments from funds provided by law for the operation of the board.

§ 34-9-200. Compensation for medical care, artificial members, and other treatment and supplies; effect of employee's refusal of treatment; employer's liability for temporary care

(a)

...

(3)(A) For injuries arising on or after July 1, 2013, that are not designated as catastrophic injuries pursuant to subsection (g) of Code Section 34-9-200.1, the maximum period of 400 weeks referenced in paragraph (2) of this subsection shall not be applicable to the following care, treatment, services, and items when prescribed by an authorized physician:

(i) Maintenance, repair, revision, replacement, or removal of any prosthetic device, provided that the prosthetic device was originally furnished within 400 weeks of the date of injury or occupational disease arising out of and in the course of employment;

(ii) Maintenance, repair, revision, replacement, or removal of a spinal cord stimulator or intrathecal pump device, provided that such items were originally furnished within 400 weeks of the date of injury or occupational disease arising out of and in the course of employment; and

(iii) Maintenance, repair, revision, replacement, or removal of durable medical equipment, orthotics, corrective eyeglasses, or hearing aids, provided that such items were originally furnished within 400 weeks of the date of injury or occupational disease arising out of and in the course of employment.

(B) For the purposes of this subsection, the term:

(i) 'Durable medical equipment' means an apparatus that provides therapeutic benefits, is primarily and customarily used to serve a medical purpose, and is reusable and appropriate for use in the home. Such term includes, but shall not be limited to, manual and electric wheelchairs, beds and mattresses, traction equipment, canes, crutches, walkers, oxygen, and nebulizers.

(ii) 'Prosthetic device' means an artificial device that has, in whole or in part, replaced a joint lost or damaged or other body part lost or damaged as a result of an injury or occupational disease arising out of and in the course of employment.

...

§ 34-9-261. Compensation for total disability

While the disability to work resulting from an injury is temporarily total, the employer shall pay or cause to be paid to the employee a weekly benefit equal to two-thirds of the employee's average weekly wage but not more than ~~\$575.00~~ \$675.00 per week nor less than \$50.00 per week, except that when the weekly wage is below \$50.00, the employer shall pay a weekly benefit equal to the average weekly wage. The weekly benefit under this Code section shall be payable for a maximum period of 400 weeks from the date of injury; provided, however, that in the event of a catastrophic injury as defined in subsection (g) of Code Section 34-9-200.1, the weekly benefit under this Code section shall be paid until such time as the employee undergoes a change in condition for the better as provided in paragraph (1) of subsection (a) of Code Section 34-9-104.

§ 34-9-262. Compensation for temporary partial disability

Except as otherwise provided in Code Section 34-9-263, where the disability to work resulting from the injury is partial in character but temporary in quality, the employer shall pay or cause to be paid to the employee a weekly benefit equal to two-thirds of the difference between the average weekly wage before the injury and the average weekly wage the employee is able to earn thereafter but not more than ~~\$383.00~~ \$450.00 per week for a period not exceeding 350 weeks from the date of injury.

§ 34-9-265. Compensation for death resulting from injury and other causes; penalty for death from injury proximately caused by intentional act of employer; payment of death benefits where no dependents found

...

(d) The total compensation payable under this Code section to a surviving spouse as a sole dependent at the time of death and where there is no other dependent for one year or less after the death of the employee shall in no case exceed ~~\$230,000.00~~ \$270,000.00.

...

SB 135 also includes the following language:

All laws and parts of laws in conflict with this Act are repealed.

Hawaii

SB 1210 SD1 in part, amends *sections 431:14-104, 431:14-104.5, 431:14-105, and 431:14-108* of the Hawaii Insurance Code to read as follows:

§431:14-104 Rate Filings.

(a) Every insurer shall file with the commissioner every manual of classifications, rules, and rates, every rating plan, every other rating rule, and every modification of any of the foregoing that it proposes to use; provided that filings with regard to specific inland marine risks, which by general custom of the business are not written according to manual rate or rating plans, and bail bonds, subject to section 804-62, shall not be required pursuant to this subsection.

Every filing shall:

- (1) State its proposed effective date;
- (2) Indicate the character and extent of the coverage contemplated;
- (3) Include a report on investment income; and
- (4) Be accompanied by a \$50 fee ~~[, payable to the commissioner,]~~ to be deposited in the commissioner's education and training fund.

(b) ~~[For each]~~ Each filing ~~[, an insurer]~~ shall ~~[submit]~~ be submitted to the commissioner ~~[-~~

~~(1) An electronic copy of the filing; or~~

~~(2) Two printed copies of the filing.~~

The commissioner may also request a printed version of an electronic filing to be submitted pursuant to paragraph (1); via the National Association of Insurance Commissioners' System for Electronic Rates and Forms Filing or an equivalent service approved by the commissioner.

...

(k) The following rates shall become effective when filed:

- (1) Specific inland marine ~~[rates]~~ rate filings on risks specially rated by a rating organization or an advisory organization;
- (2) Any special filing with respect to a surety or guaranty bond required by law ~~[or by]~~ 2 court or executive order 2 or ~~[by]~~ order or rule of a public body, not covered by a previous filing; and

(3) Any special filing with respect to any class of insurance, subdivision, or combination thereof that is subject to individual risk premium modification and has been agreed to by an insured under a formal or an informal bid process.

The filed rates shall be deemed ~~[to meet the requirements of this article until the time the commissioner reviews the filing and]~~ approved so long as the filing remains in effect.

...

§431:14-104.5 Loss cost filings.

When required by the commissioner, the rating organization or advisory organization shall file for approval all prospective loss costs, ~~and all supplementary rating information, and every change or , amendment, or modification of any of the foregoing thereto~~ proposed for use in this State. The filings shall be subject to ~~section sections~~ sections 431:14-104 and ~~section , 431:14-105, and 431:14-106~~ and other provisions of article 14 relating to filings made by insurers.

§431:14-105 Policy revisions that alter coverage.

(a) Any policy revisions that alter coverage in any manner shall be filed with the commissioner and shall include an analysis of the impact ~~of each revision~~ has on rates.

~~(b) A filing shall consist of either:~~

~~(1) An electronic copy of the filing; or~~

~~(2) Two printed copies of the filing.~~

The commissioner may also request a printed version of an electronic filing to be submitted pursuant to paragraph (1). or loss costs.

~~(c) (b)~~ After review by the commissioner, the commissioner shall determine whether a rate filing for the policy revision must be submitted in accordance with section 431:14-104.

§431:14-108 Deviations.

(a) Except for those lines of insurance for which the commissioner determines ~~that~~ individual rate filings shall be made, every member of or subscriber to a rating organization shall adhere to the filings the organization made on its behalf ~~by the organization, except that ; provided that~~ any insurer may ~~make written application~~ submit a rate filing to the commissioner to file a deviation from the class rates, schedules, rating plans, or rules respecting any class of insurance, ~~or class of risk within a class of insurance, or combination thereof.~~ The ~~application~~ rate filing shall specify the basis for the deviation and shall be accompanied by the data upon which the applicant relies. A The filer shall simultaneously send a copy of the application deviation and data ~~shall be sent simultaneously~~ to the rating organization.

~~(b) The commissioner shall set a time and place for a hearing at which the insurer and the rating organization may be heard, and shall give them not less than ten days' written notice thereof. In the event the commissioner is advised by the rating organization that it does not desire a hearing, the commissioner may, upon the consent of the applicant, waive the hearing.~~

~~(c) (b)~~ In considering the ~~application to file a deviation,~~ the commissioner shall give consideration to consider the available statistics and the principles for ratemaking ~~as provided in section 431:14-103.~~ The commissioner shall ~~issue an order permitting~~ approve the filing of the deviation to be filed if the commissioner finds ~~that it to be is~~ justified. The deviation shall become effective upon ~~issuance of the commissioner's order.~~ approval of the proposed effective date of the filing. The commissioner shall ~~issue an order denying/disapprove the application rate filing~~ if the commissioner finds ~~that~~ the deviation is not justified or ~~that~~ the resulting premiums would be excessive, inadequate, or unfairly discriminatory. Each deviation ~~permitted to be filed~~ shall be effective for a period of one year from the date of the order approval, unless terminated sooner with ~~the approval of by~~ the commissioner.

Illinois

SB 1596 adds and amends various sections of the Illinois Workers' Compensation Act and Workers' Occupational Diseases Act to read as follows:

(820 ILCS 305/1.2)

Sec. 1.2. Permitted civil actions.

Subsection (a) of Section 5 and Section 11 do not apply to any injury or death sustained by an employee as to which the recovery of compensation benefits under this Act would be precluded due to the operation of any period of repose or repose provision. As to any such injury or death, the employee, the employee's heirs, and any person having standing under the law to bring a civil action at law, including an action for wrongful death and an action pursuant to Section 27-6 of the Probate Act of 1975, has the nonwaivable right to bring such an action against any employer or employers.

(820 ILCS 305/5)

Sec. 5. Damages; minors; third-party liability.

(a) Except as provided in Section 1.2, no ~~No~~ common law or statutory right to recover damages from the employer, his insurer, his broker, any service organization that is wholly owned by the employer, his insurer or his broker and that provides safety service, advice or recommendations for the employer or the agents or employees of any of them for injury or death sustained by any

employee while engaged in the line of his duty as such employee, other than the compensation herein provided, is available to any employee who is covered by the provisions of this Act, to any one wholly or partially dependent upon him, the legal representatives of his estate, or any one otherwise entitled to recover damages for such injury.

...

(820 ILCS 305/11)

Sec. 11. Measure of responsibility.

Except as provided in Section 1.2, the The compensation herein provided, together with the provisions of this Act, shall be the measure of the responsibility of any employer engaged in any of the enterprises or businesses enumerated in Section 3 of this Act, or of any employer who is not engaged in any such enterprises or businesses, but who has elected to provide and pay compensation for accidental injuries sustained by any employee arising out of and in the course of the employment according to the provisions of this Act, and whose election to continue under this Act, has not been nullified by any action of his employees as provided for in this Act.

...

(820 ILCS 310/1.1)

Sec. 1.1. Permitted civil actions.

Subsection (a) of Section 5 and Section 11 do not apply to any injury or death resulting from an occupational disease as to which the recovery of compensation benefits under this Act would be precluded due to the operation of any period of repose or repose provision. As to any such occupational disease, the employee, the employee's heirs, and any person having standing under the law to bring a civil action at law, including an action for wrongful death and an action pursuant to Section 27-6 of the Probate Act of 1975, has the nonwaivable right to bring such an action against any employer or employers.

(820 ILCS 310/5)

Sec. 5. Liability inclusive; third-party liability.

(a) Except as provided in Section 1.1, there There is no common law or statutory right to recover compensation or damages from the employer, his insurer, his broker, any service organization retained by the employer, his insurer or his broker to provide safety service, advice or recommendations for the employer or the agents or employees of any of them for or on account of any injury to health, disease, or death therefrom, other than for the compensation herein provided or for damages as provided in Section 3 of this Act. This Section shall not affect any right to compensation under the "Workers' Compensation Act".

...

(820 ILCS 310/11)

Sec. 11. Measure of liability.

Except as provided in Section 1.1, the The compensation herein provided for shall be the full, complete and only measure of the liability of the employer bound by election under this Act and such employer's liability for compensation and medical benefits under this Act shall be exclusive and in place of any and all other civil liability whatsoever, at common law or otherwise, to any employee or his legal representative on account of damage, disability or death caused or contributed to by any disease contracted or sustained in the course of the employment.

New Hampshire

SB 99-FN amends *sections 281-A:2, 281-A:31, and 281-A:31-a* of the New Hampshire Workers' Compensation Law to read:

281-A:2 Definitions.—

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

...

X-a. "Gainful employment" means employment which reasonably conforms with the employee's age, education, training, temperament and mental and physical capacity to adapt to other forms of similarly remunerative labor than that to which the employee was accustomed.

...

281-A:31 Compensation for Temporary Partial Disability.—

If the disability for work resulting from an injury is partial, and the employee is able to work but has not yet reached maximum medical improvement, the employer, or the employer's insurance carrier, during such disability, but not for the first 3 days of disability unless the disability continues for 14 days or longer, shall pay to the injured employee a weekly compensation equal to 60 percent of the difference between the employee's average weekly wage before the injury and the average weekly wage which he or she is able to earn thereafter; but in no instance shall the weekly compensation exceed the amount set forth by the compensation schedule in RSA 281-A:28. Payments shall not continue after the disability ends, ~~nor longer than 262 weeks; and, if~~

~~the partial disability begins after a period of total disability, the period of total disability shall be deducted from such total period of 262 weeks.~~

281-A:31-a Compensation for Permanent Partial Disability.—

Where the disability for work resulting from an injury is permanent but partial in nature, the employee has reached maximum medical improvement, is able to return to work, and there is an impairment in accordance with the “Guides to the Evaluation of Permanent Impairment” published by the American Medical Association as set forth in RSA 281-A:32, the employer, or insurance carrier, during such disability shall pay to the injured employee a weekly compensation equal to 60 percent of the difference between his average weekly wage before the injury and the average weekly wage which he is able to earn thereafter. However, in no instance shall the weekly compensation exceed the amounts set forth by the compensation schedule in RSA 281-A:28. Payments shall not continue after the disability ends, ~~nor longer than 262 weeks; and if the partial disability begins after a period of total disability, the period of disability shall be deducted from such total period of 262 weeks.~~

NCCI estimates that the proposed changes, if enacted, could result in a significant increase (>5%) to overall workers compensation system costs in New Hampshire.

Oklahoma

HB 2271 amends **section 85A-13** of the Oklahoma Administrative Workers’ Compensation Act to read as follows:

§85A-13. Mental injury or illness.

A. 1. A mental injury or illness is not a compensable injury unless caused by a physical injury to the employee, and shall not be considered an injury arising out of and in the course and scope of employment or compensable unless demonstrated by a preponderance of the evidence; provided, however, that this physical injury limitation shall not apply to any victim of a crime of violence or to a police officer, firefighter, emergency medical technician or any other employee of an emergency service who is likely to be among the first people to arrive at and assist at the scene of an emergency and who suffers a mental injury or illness related to duties performed responding to the emergency.

...

SB 841 establishes the Prescription Access and Affordability Act in the Oklahoma Insurance Code as follows:

§36-6170.

A. This act shall be known and may be cited as the “Prescription Access and Affordability Act”.

B. The purpose of the Prescription Access and Affordability Act is to establish minimum and uniform access standards and prohibitions on restriction of the right of a patient to choose a pharmacy provider.

§36-6171.

For purposes of this act:

1. “Benefit plan” means any health benefit plan offered by a health insurance carrier, health maintenance organization, managed care entity, or any other entity that provides prescription drug benefits to covered individuals, including workers’ compensation programs, state-administered health benefit plans and self-funded benefit programs;

2. “Mail-order pharmacy” means a pharmacy licensed by this state that primarily dispenses and delivers covered drugs via common carrier;

3. “Pharmacy benefits manager” means a person, business or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a PBM in a contractual or employment relationship in the performance of pharmacy benefits management for a managed-care company, nonprofit hospital, medical service organization, insurance company, third-party payor or a health program administered by a department of this state; and

4. “Retail pharmacy network” means retail pharmacy providers contracted with the entity providing or administering a benefit plan in which the pharmacy primarily fills and sells prescriptions via a retail, storefront location.

§36-6172.

A. Retail pharmacy networks shall comply with the following access standards:

1. At least ninety percent (90%) of covered individuals in the benefit plan’s Suburban Service Area live within seven (7) miles of a retail pharmacy designated as preferred participating pharmacy in the benefit plan’s retail pharmacy network;

2. At least seventy percent (70%) of covered individuals in the benefit plan’s Rural Service Area live within fifteen (15) miles of a retail pharmacy participating in the benefit plan’s retail pharmacy network;

3. At least seventy percent (70%) of covered individuals in the benefit plan’s Rural Service Area live within eighteen (18) miles of a retail pharmacy designated as a preferred participating pharmacy in the benefit plan’s retail pharmacy network; and

4. Mail-order pharmacies shall not be used to meet access standards for retail pharmacy networks.

B. The Oklahoma Insurance Department shall promulgate any rules necessary to administer and enforce the provisions of this section.

§36-6173.

A. The Oklahoma Insurance Department shall review and approve retail pharmacy network access for all benefit plans to ensure compliance with Section 3 of this act.

B. A pharmacy benefits manager or representative of a pharmacy benefits manager shall not:

1. Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;
2. Charge a pharmacist or pharmacy a fee related to the resolution of a claim, including but not limited to a fee for:
 - a. the submission of a claim,
 - b. enrollment or participation in a retail pharmacy network,
 - c. the development or management of claims processing services, or
 - d. services or claims payment services related to participation in a retail pharmacy network;
3. Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy owned by or under common ownership with a pharmacy benefits manager for providing the same covered services. The reimbursement amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number submitted by the pharmacy benefits manager owned or affiliated pharmacy;
4. Deny a pharmacy the opportunity to participate in any pharmacy network at standard or preferred participation status if the pharmacy is willing to accept the terms and conditions that the pharmacy benefits manager has established for other pharmacies as a condition of standard network participation or preferred network participation status;
5. Impose on a covered individual a monetary advantage or penalty, including a higher cost-sharing or additional fee which would affect choices of network pharmacy by a covered person;
6. Retroactively deny or reduce reimbursement for a covered service claim after returning a paid claim response as part of the resolution of the claim, unless:
 - a. the original claim was submitted fraudulently, or
 - b. the pharmacy service provided related to the subject claim violated the Oklahoma Pharmacy Act; or
7. Fail to make any payment due to a pharmacy or pharmacist for covered services properly rendered in the event a pharmacy benefits manager terminates a pharmacy or pharmacist from a pharmacy benefits manager network.

§36-6174.

The prohibitions under this section apply to contracts between pharmacy benefit managers and pharmacists or pharmacies for participation in retail pharmacy networks.

1. A pharmacy benefits manager contract with a pharmacist or pharmacy shall not contain a provision prohibiting disclosure to patients of billed or allowed amounts, reimbursement rates or out-of-pocket costs.
2. A pharmacy benefits manager contract with a participating pharmacist or pharmacy shall not prohibit, restrict or limit disclosure of information to the Insurance Commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements under this act.

§36-6175.

A. All compensation remitted by a pharmaceutical manufacturer, developer or labeler, directly or indirectly related to a health benefit plan or pharmacy benefit plan shall be remitted to, and retained by, that health benefit plan or pharmacy benefit plan for the purposes described in Subsection B of this section.

B. All compensation received by or on behalf of a health insurer from a pharmaceutical manufacturer, developer or labeler shall be used by the health insurer to:

1. Lower health benefits plan or pharmacy benefit plan premiums for covered persons;
2. Lower copayment and coinsurance amounts for covered persons; or
3. Expand pharmacy benefit plan coverage.

C. A health insurer shall file with the commissioner, on or before March 1 each year, an annual report, in a manner and form established by the Insurance Department, demonstrating the amount and nature of how compensation received from pharmaceutical manufacturers, developers or labelers has:

1. Lowered health benefit plan or pharmacy benefit plan premiums for covered persons;
2. Lowered copayment and coinsurance amounts for covered persons; or
3. Expanded pharmacy benefit plan coverage.

D. The annual report filing requirement in subsection C of this section shall not begin until March 1, 2021.

§36-6176.

A. A health insurer's Pharmacy and Therapeutics committee shall establish a formulary.

B. A health insurer shall prohibit conflicts of interest for members of the Pharmacy and Therapeutics committee.

1. A person may not serve on a Pharmacy and Therapeutics committee if the person is:

- a. currently employed or was employed within the preceding year, by a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor, or
- b. currently receives compensation, or received compensation within the preceding year, from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.
2. A health insurer shall prohibit the Pharmacy and Therapeutics committee, and any member of the Pharmacy and Therapeutics committee, from receiving any compensation or funding from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.
- C. A health insurer shall display its formulary on its website to be publicly accessible.
1. The formulary shall be electronically searchable by drug name and any other means required by the commissioner, as established by rule.
2. The formulary shall include, at a minimum, the following:
- a. an indication of whether each drug on the formulary is preferred under the plan,
- b. an indication of whether each drug on the formulary requires prior authorization or has step therapy or quantity limit restrictions,
- c. the specific tier the drug falls under, if the health insurer's plan uses a tiered formulary,
- d. the amount of the drug copayment, if applicable,
- e. the amount of the drug coinsurance, if applicable,
- f. whether the drug is subject to a deductible, and if so, the amount of the deductible,
- g. whether the drug is included on the maximum allowable cost list of the health insurer, and if so, the price of the drug as established by the maximum allowable cost list, and
- h. for drugs not included on the maximum allowable cost list of the health insurer, the average wholesale price as established by the national pricing source.
- D. The health insurer shall update the information required in subparagraph g of paragraph 2 of subsection C of this section no less than every seven (7) days.

§36-6177.

- A. The Commissioner shall provide for the receiving and processing of individual complaints alleging violations of the provisions of this act or with provisions of Sections 357 through 360 of Title 59 of the Oklahoma Statutes.
- B. The Commissioner shall establish a Prescription Access and Affordability Advisory Committee to review complaints, hold hearings and subpoena witnesses and records, initiate prosecution, reprimand, place on probation, suspend, revoke and levy fines not to exceed Ten Thousand Dollars (\$10,000.00) for each count for which any pharmacy benefits manager has been convicted in hearings by the committee. The committee may impose as part of any disciplinary action the payment of costs expended by the Department of Insurance for any legal fees and costs, including but not limited to staff time, salary and travel expense, witness fees and attorney fees. The committee may take such actions singly or in combination, as the nature of the violation requires.
- C. The Committee shall consist of seven (7) persons appointed as follows:
1. Two persons who shall be nominated by the Oklahoma Pharmacists Association;
2. Two consumer members not employed or related to insurance, pharmacy or pharmacy benefit management nominated by the Governor's office;
3. Two persons representing the pharmacy benefits manager or Insurance Industry nominated by the Insurance Commissioner; and
4. One person representing the Attorney General's Office nominated by the Attorney General.
- D. Committee members shall be appointed for a term of five (5) years. The terms of the members of the Committee shall expire on June 30 of the year designated for the expiration of the term for which appointed but the member shall serve until a qualified successor has been duly appointed. No person shall be appointed to serve more than two consecutive terms.
- E. Hearings shall be held in the Insurance Commissioner's offices or at such other place as the Commissioner may deem convenient.
- F. The Commissioner shall issue and serve upon the pharmacy benefits manager a statement of the charges and a notice of hearing in accordance with the Administrative Procedures Act.
- G. At the time and place fixed for a hearing, the pharmacy benefits manager shall have an opportunity to be heard and to show cause why the Commissioner or his or her duly appointed hearing examiner should not revoke or suspend the license of the pharmacy benefits manager and levy administrative fines for each count, or both. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.
- H. All hearings will be public and held in accordance with, and governed by, Article II of the Administrative Procedures Act, Section 308A et seq. of Title 75 of the Oklahoma Statutes.
- I. The Commissioner, upon written request reasonably made by the licensed pharmacy benefits manager affected by the hearing, and at such expense of the pharmacy benefits manager, shall cause a full stenographic record of the proceedings to be made by a competent court reporter.
- J. If the Insurance Commissioner determines, based on an investigation of complaints, that a pharmacy benefits manager has engaged in violations of this act with such frequency as to indicate a general business practice and that the pharmacy benefits

manager should be subjected to closer supervision with respect to such practices, the Commissioner may require the pharmacy benefits manager to file a report at such periodic intervals as the Commissioner deems necessary.

§36-6178.

A. Documents, materials, reports, complaints or other information in the possession or control of the Insurance Department that are obtained by or disclosed to the Commissioner or any other person in the course of an evaluation, examination, investigation or review made pursuant to the provisions of this act shall be confidential by law and privileged, shall not be subject to open records request, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action if obtained from the Commissioner or any employees or representatives of the Commissioner.

B. Nothing in this section shall prevent the disclosure of a final order issued against a pharmacy benefits manager by the Commissioner or his or her duly appointed hearing examiner. Such orders shall be open records.

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
SC, TN	Amy Quinn	561-893-3812
HI, NM, NV, UT	Brett Barratt	801-401-6464
IL, MO, OK	Carla Townsend	561-893-3819
AZ, KS, KY	Clarissa Preston	561-945-4517
DC, MD, VA, WV	David Benedict	804-380-3005
FL	Dawn Ingham	561-893-3165
IN, NC	Michelle Smith	561-893-3016
CT, ME, NH, RI	Justin Moulton	860-969-7903
VT	Laura Backus Hall	802-454-1800
AL, GA, LA, MS	Laura Hart Bryan	225-635-4481
CO, IA, NE, SD	Stephanie Paswaters	303-200-6728
AR, TX	Terri Robinson	501-333-2835
Federal Issues	Tim Tucker	202-403-8526
AK, ID, MT, OR	Todd Johnson	561-893-3814

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