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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2016 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/16)

JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
Alabama	HB 270	**HB 270** makes various changes to the Alabama Captive Insurers Act including, but not limited to, the following amendments: **Section 27-31B-2 Definitions** As used in this chapter, the following terms shall have the following meanings, unless the context clearly indicates otherwise: … ~~(11)~~ (12) EXCESS WORKERS' COMPENSATION INSURANCE. In the case of an employer or group of employers that has insured or self-insured its workers' compensation risks in accordance with applicable state or federal law, insurance in excess of a specified per-incident or aggregate limit established by the commissioner. … **Section 27-31B-3 Licensing** (a) Any captive insurance company, when permitted by its articles of association, charter, or other organizational document, may apply to the commissioner for a license to do any and all insurance defined in Sections 27-5-2, 27-5-4, and 27-5-5, in subdivisions (1), (2), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), and (14) of subsection (a) of Section 27-5-6, in Sections 27-5-7, 27-5-8, 27-5-9, and 27-5-10, and to grant annuity contracts as defined in Section 27-5-3, subject, however, to all of the following: … ~~(6)~~ (7) Any captive insurance company may provide excess workers' compensation insurance to its parent and affiliated companies~~,~~ and member organizations unless prohibited by the laws of the state having jurisdiction over the transaction. Any captive insurance company may reinsure workers' compensation of a qualified self-insured plan of its parent and affiliated companies.	7/1/16	No action required
Arizona	HB 2114	**HB 2114** adds ***sections 23-1601. Declaration of independent business status*** and ***23-1602. Determination of employment relationship; prohibition*** to the Arizona Revised Statutes as follows: **23-1601. Declaration of independent business status** A. Compliance with this chapter and the execution of a declaration of independent business status in compliance with this section are not mandatory in order to establish the existence of an independent contractor relationship between an employing unit and an independent contractor. The failure of a party to execute a declaration in compliance with this section does not create any presumptions and is not admissible to deny the existence of an independent contractor relationship. B. Any employing unit contracting with an independent contractor may prove the existence of an independent contractor relationship for the purposes of this title by the independent contractor executing a declaration of independent business status, as provided by this section, and by the employing unit acting in a manner substantially consistent with the declaration. Compliance with this section creates a rebuttable presumption of an independent contractor relationship between the independent contractor and the employing unit with whom the independent contractor contracts. Any declaration of independent business status shall be signed by the independent contractor, be dated and substantially comply with the following form: This declaration of independent business status is made by (contractor) in relation to services performed by the contractor for or in connection with (contracting party). The contractor states and declares the following: 1. The contractor acknowledges that the contractor operates the contractor's own independent business and is providing services for or in	8/6/16	No action required

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		connection with the contracting party as an independent contractor. 2. The contractor acknowledges that the contractor is not an employee of the contracting party and the services rendered for or in connection with the contracting party do not establish any right to unemployment benefits or any other right arising from an employment relationship. 3. The contractor is responsible for all tax liability associated with payments received from or through the contracting party and the contracting party will not withhold any taxes from payments to the contractor. 4. The contractor is responsible for obtaining and maintaining any required registration, licenses or other authorization necessary for the services rendered by the contractor. 5. The contractor acknowledges at least six of the following: (a) that the contractor is not insured under the contracting party's health insurance coverage or workers' compensation insurance coverage. (b) That the contracting party does not restrict the contractor's ability to perform services for or through other parties and the contractor is authorized to accept work from and perform work for other businesses and individuals besides the contracting party. (c) That the contractor has the right to accept or decline requests for services by or through the contracting party. (d) That the contracting party expects that the contractor provides services for other parties. (e) That the contractor is not economically dependent on the services performed for or in connection with the contracting party. (f) That the contracting party does not dictate the performance, methods or process the contractor uses to perform services. (g) That the contracting party has the right to impose quality standards or a deadline for completion of services performed, or both, but the contractor is authorized to determine the days worked and the time periods of work. (h) That the contractor will be paid by or through the contracting party based on the work the contractor is contracted to perform and that the contracting party is not providing the contractor with a regular salary or any minimum, regular payment. (i) That the contractor is responsible for providing and maintaining all tools and equipment required to perform the services performed. (j) That the contractor is responsible for all expenses incurred by the contractor in performing the services. 6. The contractor acknowledges that the terms set forth in this declaration apply to the contractor, the contractor's employees and the contractor's independent contractors. C. Subsections A and B of this section do not apply to any employing unit that is licensed or is required to be licensed pursuant to title 32, chapter 10 unless the employing unit is contracting with an independent contractor to perform services that do not require a license pursuant to title 32, chapter 10 for or in connection with the employing unit. D. Execution of a declaration of independent business status under this section is optional and this section does not require an independent contractor to execute a declaration of independent business status to be considered an independent contractor. Any employing unit or independent contractor may rely on any provision in this title for the purposes of establishing an employment or independent contractor relationship. E. The execution of a declaration of independent business status and substantial compliance with the declaration pursuant to this section does not operate to the same effect as or otherwise act as a substitute for a written agreement executed pursuant to section 23-902, subsection D. **23-1602. Determination of employment relationship; prohibition** Except for the enforcement of chapter 2, article 10 of this title, any supervision or control exercised by an employing unit to comply with any statute,		

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		rule or code adopted by the federal government, this state or a political subdivision of this state or any requirement of licensing, professional or ethical standards may not be considered for the purposes of determining the independent contractor or employment status of any relationship or individual for the purposes of this title. This section does not otherwise affect any investigatory or enforcement authority related to the determination of the independent contractor or employment status of any relationship as provided by this title or federal law. **HB 2114** also includes the following clauses: **Severability** If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this act that can be given effect without the invalid provision or application, and to this end the provisions of this act are severable. **Applicability** This act does not annul, alter, affect or exempt any employing unit or individual subject to title 23, Arizona Revised Statutes, from complying with the laws of this state, except to the extent that the laws of this state are inconsistent with any provision of this act, and then only to the extent of the inconsistency.		
Arizona	HB 2240	**HB 2240** amends ***sections 23-941. Hearing rights and procedure***, ***23-1044. Compensation for partial disability; computation***, ***23-1062. Medical, surgical, hospital benefits; translation services; commencement of compensation; method of compensation***, and ***23-1070.01. Request for early hearing; stipulation; action of commission***, and adds ***section 23-954. Payment of interest on awards*** to the Arizona Revised Statutes, as follows: **23-941. Hearing rights and procedure** A. Subject to ~~the provisions of~~ section 23-947, any interested party may file a request for a hearing concerning a claim. B. A request for a hearing shall be made in writing, be signed by or on behalf of the interested party and ~~including his~~ include the interested party's address, ~~stating~~ state that a hearing is desired, and be filed with the commission. C. The commission shall refer the request for the hearing to the administrative law judge division for determination as expeditiously as possible. The presiding administrative law judge may dismiss a request for hearing ~~when~~ if it appears to ~~his~~ the presiding administrative law judge's satisfaction that the disputed issue or issues have been resolved by the parties. Any interested party who objects to such dismissal may request a review pursuant to section 23-943. D. At least twenty days' prior notice of the time and place of the hearing shall be given to all parties in interest by mail at their last known address. In the case of a hearing concerning suspension of benefits, pursuant to section 23-1026, 23-1027 or 23-1071, only ten days' prior notice ~~need be given~~ is required. Hearings shall be held in the county where the workman resided at the time of the injury or ~~such other~~ another place selected by the administrative law judge. E. A record of all proceedings at the hearing shall be made but need not be transcribed unless a party applies to the court of appeals for a writ of certiorari pursuant to section 23-951. The record of the proceedings if not transcribed, shall be kept for at least two years but may be destroyed after ~~such~~ that time if a transcription is not requested. F. Except as otherwise provided in this section and rules ~~or~~ of procedure established by the commission, the administrative law judge is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct the hearing in any manner that will	8/6/16	No action required

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		achieve substantial justice. G. Any party shall be entitled to issuance and service of subpoenas under ~~the provisions of~~ section 23-921. Any party or ~~his~~ the party's representative may serve such subpoenas. H. Any interested party or ~~his~~ the interested party's authorized agent shall be entitled to inspect any claims file of the commission, provided that such authorization is filed in writing with the commission. I. Any interested party is entitled to one change of administrative law judge as a matter of right. To exercise the right to a change of administrative law judge, the interested party shall file a notice of change of administrative law judge. The notice of change of administrative law judge shall: 1. Be signed by the interested party or the interested party's authorized agent. 2. State the name of the administrative law judge to be changed. 3. Certify that the interested party or the interested party's authorized agent has timely filed the notice of change of administrative law judge. A notice of change of administrative law judge as a matter of right is timely if filed not more than thirty days after the date of the notice of hearing or not more than thirty days after a new administrative law judge is assigned to the claim if another interested party or the interested party's authorized agent has filed a notice of change of administrative law judge as a matter of right. 4. Certify that the interested party or the interested party's authorized agent has not previously been granted a change of administrative law judge as a matter of right for the claim. ~~I.~~ J. ~~Within thirty days after the date of notice of hearing~~ Any interested party to a hearing before the commission or the interested party's authorized agent may file an affidavit for change of administrative law judge for cause against ~~any hearing officer of the commission hearing such matters or commencing to hear such matter, setting~~ a presiding administrative law judge that sets forth any of the grounds as provided in subsection ~~J~~ K of this section. ~~, and~~ The chief administrative law judge shall immediately transfer the matter to another ~~officer of the commission who shall preside therein. Not more than one change of administrative law judge shall be granted to any one party.~~ administrative law judge. An affidavit for change of administrative law judge for cause shall be filed within the time frames provided in subsection I of this section. ~~J.~~ K. Grounds ~~which~~ that may be alleged as provided in subsection ~~I~~ J of this section for change of administrative law judge for cause are: 1. That the administrative law judge has been engaged as counsel in the hearing ~~prior to~~ before appointment as administrative law judge. 2. That the administrative law judge is otherwise interested in the hearing. 3. That the administrative law judge is of kin or otherwise related to a party to the hearing. 4. That the administrative law judge is a material witness in the hearing. 5. That the party filing the affidavit has cause to believe and does believe that on account of the bias, prejudice, or interest of the administrative law judge ~~he~~ the administrative law judge cannot obtain a fair and impartial hearing. L. For the purposes of subsections I and J of this section, the employer and the employer's insurance carrier are considered a single party unless the employer's and the employer's insurance company's interests are in conflict. ~~K.~~ M. After final disposition of the proceedings in which they are used, exhibits marked for identification or introduced as evidence at hearings or proceedings ~~which~~ that cannot be readily copied, photocopied, mechanically reproduced or otherwise preserved as a document for inclusion in the record of the proceedings may be disposed of in the following manner: 1. By written notice, the attorneys of record, or if none, the parties, shall be notified that the counsel or the party introducing ~~such~~ the exhibit may		

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		claim it at the industrial commission within sixty days. 2. After sixty days following notification, any such exhibit remaining in the custody of the industrial commission shall be disposed of as state surplus property pursuant to the direction of the department of administration~~, surplus property division~~. A written description of ~~any such~~ the exhibit shall be included in the record to preserve ~~its~~ the exhibit's identity. **23-954. Payment of interest on awards** Interest on the payment of benefits shall be paid at a rate of interest at the lesser of ten percent per annum or a rate per annum that is equal to one percent plus the prime rate as published by the board of governors of the federal reserve system in statistical release H.15 or any publication that may supersede it on the date benefits are paid. Interest shall be paid only in the following instances: 1. On an award entered by the commission or by notice of claim status awarding permanent partial disability benefits pursuant to section 23-1044, subsection B or C or permanent total disability benefits pursuant to section 23-1045, subsection B or C, if benefits are not paid within ten days after the date the award or notice becomes final. 2. On a claim for dependent benefits, if the claim is denied and subsequently accepted or found compensable by award of the commission, from the date the claim for benefits was filed. **23-1044. Compensation for partial disability; computation** A. For temporary partial disability there shall be paid during the period thereof sixty-six and two-thirds ~~per cent~~ percent of the difference between the wages earned before the injury and the wages ~~which~~ that the injured person is able to earn thereafter. Unemployment benefits received during the period of temporary partial disability ~~and fifty per cent of retirement and pension benefits received from the insured or self-insured employer during the period of temporary partial disability~~ shall be considered wages able to be earned. B. Disability shall be deemed permanent partial disability if caused by any of the following specified injuries, and compensation of fifty-five ~~per cent~~ percent of the average monthly wage of the injured employee, in addition to the compensation for temporary total disability, shall be paid for the period given in the following schedule: 1. For the loss of a thumb, fifteen months. 2. For the loss of a first finger, commonly called the index finger, nine months. 3. For the loss of a second finger, seven months. 4. For the loss of a third finger, five months. 5. For the loss of the fourth finger, commonly called the little finger, four months. 6. The loss of a distal or second phalange of the thumb or the distal or third phalange of the first, second, third or fourth finger, shall be considered equal to the loss of one-half of the thumb or finger, and compensation shall be one-half of the amount specified for the loss of the entire thumb or finger. 7. The loss of more than one phalange of the thumb or finger shall be considered as the loss of the entire finger or thumb, but in no event shall the amount received for more than one finger exceed the amount provided for the loss of a hand. 8. For the loss of a great toe, seven months.		

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		9. For the loss of a toe other than the great toe, two and one-half months. 10. The loss of the first phalange of any toe shall be considered equal to the loss of one-half of the toe and compensation shall be one-half of the amount for one toe. 11. The loss of more than one phalange shall be considered as the loss of the entire toe. 12. For the loss of a major hand, fifty months, or of a minor hand, forty months. 13. For the loss of a major arm, sixty months, or of a minor arm, fifty months. 14. For the loss of a foot, forty months. 15. For the loss of a leg, fifty months. 16. For the loss of an eye by enucleation, thirty months. 17. For the permanent and complete loss of sight in one eye without enucleation, twenty-five months. 18. For permanent and complete loss of hearing in one ear, twenty months. 19. For permanent and complete loss of hearing in both ears, sixty months. 20. The permanent and complete loss of the use of a finger, toe, arm, hand, foot or leg may be deemed the same as the loss of any such member by separation. 21. For the partial loss of use of a finger, toe, arm, hand, foot or leg, or partial loss of sight or hearing, fifty ~~per cent~~ percent of the average monthly wage during that proportion of the number of months in the foregoing schedule provided for the complete loss of use of such member, or complete loss of sight or hearing, which the partial loss of use thereof bears to the total loss of use of such member or total loss of sight or hearing. ~~In~~ For the purposes of this paragraph, "loss of use" means a loss of physical function of the affected member, sight or hearing. The effect on an employee's ability to return to the employee's occupation at the time of the injury shall not be considered in establishing the percentage of loss under this section, except that if the employee is unable to return to the work the employee was performing at the time the employee was injured due to the total or partial loss of use, compensation pursuant to this section shall be calculated based on seventy-five ~~per cent~~ percent of the average monthly wage. 22. For permanent disfigurement about the head or face, ~~which shall include~~ including injury to or loss of teeth, the commission ~~may~~, ~~in accordance with the provisions of~~ pursuant to section 23-1047, may allow such sum for compensation thereof as it deems just, in accordance with the proof submitted, for a period of not ~~to exceed~~ more than eighteen months. C. In cases not enumerated in subsection B of this section, if the injury causes permanent partial disability for work, the employee shall receive during such disability compensation equal to fifty-five ~~per cent~~ percent of the difference between the employee's average monthly wages before the accident and the amount ~~which~~ that represents the employee's reduced monthly earning capacity resulting from the disability, but the payment shall not continue after the disability ends, or the death of the injured employee, and in case the partial disability begins after a period of total disability, the period of total disability shall be deducted from the total period of compensation. D. In determining the amount ~~which~~ that represents the reduced monthly earning capacity for the purposes of subsections A and C of this section, consideration shall be given, among other things, to any previous disability, the occupational history of the injured employee, the nature and extent of the physical disability, the type of work the injured employee is able to perform ~~subsequent to~~ after the injury, any wages received for work performed ~~subsequent to~~ after the injury and the age of the employee at the time of injury. If the employee is unable to return to work or continue		

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		working in any employment after the injury due to the employee's termination from employment for reasons that are unrelated to the industrial injury, the commission may consider the wages that the employee could have earned from that employment as representative of the employee's earning capacity. A determination of earning capacity that is based on wages that could have been earned from previously terminated employment is subject to change under subsection F of this section and an employee retains the right to later establish that the employee's reduced earning capacity is related in whole or in part to the industrial injury. E. In case there is a previous disability, as the loss of one eye, one hand, one foot or otherwise, the percentage of disability for a subsequent injury shall be determined by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury. F. For the purposes of subsection C of this section, the commission, in accordance with the provisions of section 23-1047 when the physical condition of the injured employee becomes stationary, shall determine the amount ~~which~~ that represents the reduced monthly earning capacity and ~~upon~~ on such determination make an award of compensation ~~which shall be~~ that is subject to change in any of the following events: 1. ~~Upon~~ On a showing of a change in the physical condition of the employee ~~subsequent to~~ after such findings and award arising out of the injury resulting in the reduction or increase of the employee's earning capacity. 2. ~~Upon~~ On a showing of a reduction in the earning capacity of the employee arising out of such injury where there is no change in the employee's physical condition, ~~subsequent to~~ after the findings and award. 3. ~~Upon~~ On a showing that the employee's earning capacity has increased ~~subsequent to~~ after such findings and award. G. The commission may adopt a schedule for rating loss of earning capacity and reasonable and proper rules to carry out ~~the provisions of~~ this section. In all cases involving this section, except for cases under subsection B of this section, or in cases involving a request pursuant to section 23-1061, subsection J for disability compensation, if any issue is raised regarding whether the injured employee has suffered a loss of earning capacity because of an inability to obtain or retain suitable work, the following apply: 1. The employer or carrier may present evidence showing that the inability to obtain suitable work is due, in whole or in part, to economic or business conditions, or other factors unrelated to the industrial injury. The injured employee may present evidence showing that the inability to obtain suitable work is due, in whole or in part, to the industrial injury or limitations resulting from the injury. The administrative law judge shall consider all such evidence in determining whether and to what extent the injured employee has sustained any loss of earning capacity. 2. In cases involving loss of employment, the employer or carrier may present evidence showing that the injured employee was terminated from employment or has not obtained suitable work, or both, due, in whole or in part, to economic or business conditions, or other factors unrelated to the injury. The injured employee may present evidence showing that such termination or inability to obtain suitable work is due, in whole or in part, to the industrial injury or limitations resulting from the injury. The administrative law judge shall consider all such evidence in determining whether and to what extent the injured employee has sustained any loss or additional loss of earning capacity. H. Any single injury or disability that is listed in subsection B of this section and that is not converted into an injury or disability compensated under subsection C of this section by operation of this section shall be treated as scheduled under subsection B of this section regardless of its actual effect on the injured employee's earning capacity. **23-1062. Medical, surgical, hospital benefits; translation services; commencement of compensation; method of compensation**		

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		A. Promptly, on notice to the employer, every injured employee shall receive medical, surgical and hospital benefits or other treatment, nursing, medicine, surgical supplies, crutches and other apparatus, including artificial members, reasonably required at the time of the injury, and during the period of disability. Such benefits shall be termed "medical, surgical and hospital benefits." B. Medical, surgical and hospital benefits include translation services, if needed. A carrier, self-insurance pool or employer that does not direct care pursuant to section 23-1070 may choose the translator if the translator is certified by an outside agency and is not an employee of the carrier, self-insurance pool or employer. If the carrier, self-insurance pool or employer is unable to locate a certified translator for the particular language or dialect needed, the parties may agree on a translator who is not a certified translator. ~~B.~~ C. The first installment of compensation is to be paid no later than the twenty-first day after written notification by the commission to the carrier of the filing of a claim ~~except where~~ unless the right to compensation is denied. Thereafter, compensation shall be paid at least once each two weeks during the period of temporary total disability and at least monthly thereafter. Compensation shall not be paid for the first seven days after the injury. If the incapacity extends beyond the period of seven days, compensation shall begin on the eighth day after the injury, but if the disability continues for one week beyond such seven days, compensation shall be computed from the date of the injury. ~~C.~~ D. Compensation shall be made by negotiable instrument, payable immediately on demand or, at the election of the employee and if offered by the employer or carrier, by another commonly accepted method for transferring money by banking institutions, including electronic fund transfers to the employee's account or a prepaid debit card account that is established for the purpose of making direct electronic payment to the employee. **23-1070.01. Request for early hearing; stipulation; action of commission** A. If a request for hearing filed in connection with a change of physician under section 23-1070 alleges, by affidavit, that immediate and irreparable injury, loss or damage will result if ~~such~~ the hearing is not held ~~prior to~~ before the times otherwise prescribed by article 3 of this chapter or if all interested parties, in person or by counsel, stipulate in ~~such~~ the request for hearing that ~~such~~ the hearing should be held ~~prior to~~ before the times otherwise prescribed by article 3 of this chapter, the commission shall: 1. Immediately issue a notice to all parties setting a hearing date not more than fifteen days later. 2. Require that the administrative law judge, who shall not be subject to the notice or affidavit for change prescribed by section 23-941, subsection I or J, determine the matter and make an award, if any, within five days after completion of the hearing. B. All other procedures prescribed for subsequent actions with regard to ~~such~~ the hearing or award shall be as otherwise prescribed by law. **HB 2240** also includes the following language: **Industrial commission of Arizona; workers' compensation fraud; self-insured employers; recommendations** A. The industrial commission of Arizona shall research and make recommendations on ways to allow for investigations into the act or practice of workers' compensation fraud impacting self-insured employers in a manner consistent with section 20-466, Arizona Revised Statutes, as applicable, but not duplicative of the functions of another state agency, including the department of insurance. B. The industrial commission of Arizona shall make recommendations on or before December 31, 2016, to the governor, the speaker of the house of representatives, the president of the senate and chairpersons of the senate commerce and workforce development committee and the house of representatives insurance committee.		

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Arizona	HB 2652	**HB 2652** adds new ***Chapter 10 Employment Relationships*** to the Arizona Revised Statutes to read: **Chapter 10** **Employment Relationships** **Article 1. General Provisions** **23-1601. Qualified marketplace contractors; definitions** A. A qualified marketplace contractor shall be treated as an independent contractor for all purposes under state and local laws, regulations and ordinances, including employment security laws prescribed in chapter 4 of this title and workers' compensation laws prescribed in chapter 6 of this title, if all of the following apply: 1. All or substantially all of the payment for the services performed by the qualified marketplace contractor is related to the performance of services or other output. 2. The services performed by the qualified marketplace contractor are governed by a written contract executed between the qualified marketplace contractor and a qualified marketplace platform. 3. The written contract required by paragraph 2 of this subsection provides for all of the following: (a) That the qualified marketplace contractor is providing services as an independent contractor and not as an employee. (b) That, pursuant to paragraph 1 of this subsection, all or substantially all of the payment paid to the contractor shall be based on the performance of services or other output. (c) That the qualified marketplace contractor is allowed to work any hours or schedules the qualified marketplace contractor chooses. If the qualified marketplace contractor elects to work specified hours or schedules, a contract may require the qualified marketplace contractor to perform work during the selected hours or schedules. (d) That the qualified marketplace contract does not restrict the contractor's ability to perform services for other parties. (e) That the qualified marketplace contractor bears all or substantially all of the qualified marketplace contractor's own expenses that are incurred by the qualified marketplace contractor in performing the services. (f) That the qualified marketplace contractor is responsible for the taxes on the qualified marketplace contractor's own income. (g) That the contract and the association created by the contract may be terminated without cause by either party to the contract at any time on reasonable notice given to the other party. B. For services performed by a qualified marketplace contractor before the effective date of this section, the qualified marketplace contractor shall be treated as an independent contractor for all purposes under state and local laws, regulations and ordinances, including employment security laws prescribed in chapter 4 of this title and workers' compensation laws prescribed in chapter 6 of this title, if both of the following apply: 1. All or substantially all of the payment for the services performed by the qualified marketplace contractor is related to the performance of services or other output. 2. The services performed by the qualified marketplace contractor are governed by a written contract executed between the qualified marketplace contractor and a qualified marketplace platform that conforms to the requirements of subsection A, paragraph 3 of this section. C. Compliance with this section is not mandatory in order to establish the existence of an independent contractor relationship. The exclusion of any contractor or digital platform from this section does not create any presumptions and is not admissible to deny the existence of an independent	8/6/16	No action required

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		contractor relationship. D. This section does not apply to: 1. Service performed in the employ of a state, or any political subdivision of the state, or in the employ of an Indian tribe, or any instrumentality of a state, any political subdivision of a state or any Indian tribe that is wholly owned by one or more states or political subdivisions or Indian tribes, provided that such service is excluded from employment as defined in the Federal Unemployment Tax Act (26 United States Code sections 3301 and 3306(c)(7)). 2. Service performed in the employ of a religious, charitable, educational or other organization that is excluded from employment as defined in the Federal Unemployment Tax Act (26 United States Code sections 3301 through 3311), solely by reason of 26 United States Code section 3306(c)(8). E. For the purposes of this section: 1. "Qualified marketplace contractor" means any person or organization, including an individual, corporation, limited liability company, partnership, sole proprietor or other entity, that enters into an agreement with a qualified marketplace platform to use the qualified marketplace platform's digital platform to provide services to third-party individuals or entities seeking those services. Qualified marketplace contractor does not include any contractor when the services performed consist of transporting freight, sealed and closed envelopes, boxes or parcels or other sealed and closed containers for compensation. 2. "Qualified marketplace platform" means an organization, including, but not limited to, a corporation, limited liability company, partnership, sole proprietor or any other entity, that both: (a) Operates a digital website or digital smartphone application that facilitates the provision of services by qualified marketplace contractors to individuals or entities seeking such services. (b) Accepts service requests from the public only through its digital website or digital smartphone application, and does not accept service requests by telephone, by facsimile or in person at physical retail locations. Qualified marketplace platform does not include any digital website or smartphone application where the services facilitated consist of transporting freight, sealed and closed envelopes, boxes or parcels or other sealed and closed containers for compensation.		
Arizona	SB 1323	**SB 1323** amends ***section 23-941.02. Vexatious litigants; designation; definitions*** of the Arizona Revised Statutes as follows: **23-941.02. Vexatious litigants; designation; definitions** A. In a workers' compensation case before the commission, on the motion of a party, the chief administrative law judge or an administrative law judge designated by the chief administrative law judge may designate a pro se litigant a vexatious litigant. The pro se litigant shall respond within thirty days after the motion. The chief administrative law judge, or administrative law judge if designated by the chief administrative law judge, shall issue an order within thirty days after the pro se litigant's response is received or the time for response has elapsed. The vexatious litigant designation applies only to the claim at issue before the administrative law judge. B. A pro se litigant who is designated a vexatious litigant may not file a new request for hearing, pleading, motion or other document without prior leave of the administrative law judge. C. A pro se litigant is a vexatious litigant if the commission finds the pro se litigant engaged in vexatious conduct. A designation of vexatious litigant is suspended during the period in which the litigant is represented by legal counsel. D. For the purposes of this section:	7/23/16	No action required

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		1. "vexatious conduct" includes any of the following: (a) repeated filing of requests for hearing, pleadings, motions or other documents solely or primarily for the purpose of harassment. (b) unreasonably expanding or delaying commission proceedings. (c) bringing or defending claims without substantial justification. (d) engaging in abuse of discovery or conduct in discovery that has resulted in the imposition of sanctions against the pro se litigant. (e) a pattern of making unreasonable, repetitive and excessive requests for information. (f) repeated filing of documents or requests for relief that have been the subject of previous rulings by the commission in the same claim. 2. "without substantial justification" has the same meaning prescribed in section 12-349.		
Arkansas	HB 1010/ SB 13	**HB 1010/SB 13** amend various sections of the Arkansas workers compensation law as follows: **11-9-303. Payment of tax by carrier.** (a)(1) In addition to the premium taxes collected from carriers, the carriers shall pay annually to the Workers' Compensation Commission a tax, at the rate to be determined as provided in § 11-9-306 but not to exceed three percent (3%), on all written manual premiums resulting from the writing of workers' compensation insurance on risks within the state. (2) Upon the final payment of the liabilities of the Death and Permanent Total Disability Trust Fund under § 11-9-502, the tax rate under this section shall not exceed one and five-tenths percent (1.5%). … **11-9-304. Payment of tax by self-insurer.** (a)(1) ~~It shall be the duty of the~~ The Workers' Compensation Commission ~~to~~ shall collect a tax from every self-insured employer at a rate to be determined as provided by § 11-9-306 but not to exceed three percent (3%) of the written manual premium which would have to be paid under § 11-9-303 by a carrier if the self-insured employer were insured by a carrier. (2) Upon the final payment of the liabilities of the Death and Permanent Total Disability Trust Fund pursuant to § 11-9-502, the tax rate under this section shall not exceed one and five-tenths percent (1.5%). … **11-9-305. Payment of tax by public employer.** (a)(1)(A) ~~It shall be the duty of the~~ The Workers' Compensation Commission ~~to~~ shall collect a tax from every public employer providing workers' compensation coverage to its employees at a rate to be determined as provided by § 11-9-306 but not to exceed three percent (3%) of the written manual premium which an insurance carrier would have to pay under § 11-9-303 if the public employer were insured by a carrier. (B) Upon the final payment of the liabilities of the Death and Permanent Total Disability Trust Fund under § 11-9-502, the tax rate under this section shall not exceed one and five-tenths percent (1.5%). … **11-9-306. Determination of surplus and rate of taxation.**	8/21/16	***Tax and Assessment Directory*** revisions completed

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		(a) (1) The Workers' Compensation Commission, on or before December 31 of each year, shall determine the surplus, if any, in the Workers' Compensation Fund, together with the additional amounts necessary to properly administer this chapter for the ensuing year. (2) The commission shall determine the rate of taxation for collections for that year on or before March 1 of the following year. (b) (1) The commission, on or before December 31 of each year, shall determine the surplus, if any, in the Second Injury Trust Fund, together with the additional amounts necessary to properly administer this chapter for the ensuing year. (2) The commission shall determine the rate of taxation for collections for that year on or before March 1 of the following year. (c) (1) The commission, on or before December 31 of each year, shall determine the surplus, if any, in the Death and Permanent Total Disability Trust Fund, together with the additional amounts necessary to properly administer this chapter for the ensuing year. (2) The commission shall determine the rate of taxation for collections for that year on or before March 1 of the following year. (d)(1) The total rate of taxation for all three (3) funds when added together shall not exceed three percent (3%). (2) Upon the final payment of the liabilities of the Death and Permanent Total Disability Trust Fund under § 11-9-502, the tax rate under this section shall not exceed one and five-tenths percent (1.5%). … **11-9-502. Limitations on compensation—Exceptions.** … (b)(1)(A) For injuries occurring on or after March 1, 1981, but on or before December 31, 2007, and a claim for death or permanent total disability benefits filed on or before June 30, 2019, the first seventy-five thousand dollars ($75,000) of weekly benefits for death or permanent total disability shall be paid by the employer or its insurance carrier in the manner provided in this chapter. (B) For injuries occurring on or after January 1, 2008, and a claim for death or permanent total disability benefits filed on or before June 30, 2019, the employer or its insurance carrier shall pay weekly benefits for death or permanent total disability not to exceed three hundred twenty-five (325) times the maximum total disability rate established for the date of the injury under this chapter. (2)(A) An employee or a dependent of an employee who has filed a claim for death or permanent total disability benefits on or before June 30, 2019, and who receives a total of seventy-five thousand dollars ($75,000) in weekly benefits for injuries sustained on or before December 31, 2007, shall be eligible to continue to draw benefits at the rates prescribed in this chapter, but all benefits in excess of seventy-five thousand dollars ($75,000) shall be payable from the Death and Permanent Total Disability Trust Fund. (B) An employee or a dependent of an employee who has filed a claim for death or permanent total disability benefits on or before June 30, 2019, and who receives the maximum amount specified in subdivision (b)(1)(B) of this section shall be eligible to continue to draw benefits at the rates prescribed by this chapter payable from the trust fund. … (c)(1) A claim against the Death and Permanent Total Disability Trust Fund shall not be filed later than June 30, 2019, regardless of the date of injury or death, or otherwise. (2) The Death and Permanent Disability Trust Fund is not liable for a claim for permanent total disability or death filed after June 30, 2019. (3) For a claim for permanent total disability or death filed after June 30, 2019, the employer at the time of the employee's compensable injury is		

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		liable for permanent total disability or death benefits under this chapter, excluding this section and any claim pending under § 11-9-525 on June 30, 2019. (4) Upon satisfaction of the liabilities of the Death and Permanent Total Disability Trust Fund, the Death and Permanent Total Disability Trust Fund shall be terminated.		
Colorado	SB 16-198	**SB 16-198** amends ***section 8-44-102. Contract for insurance subject to workers' compensation act*** of the Colorado Revised Statutes as follows: **8-44-102. Contract for insurance subject to workers' compensation act** … (2) (a) (I) Except as specified in subparagraph (III) of this paragraph (a), Eevery carrier providing workers' compensation insurance that is authorized to conduct business in Colorado shall submit an annual report to the commissioner of insurance listing any policy forms ~~endorsements, riders, letters, notices, or other documents affecting an insurance policy or contract issued or delivered to any policyholder in Colorado~~ as may be requested by the commissioner. The listing must be submitted no later than July 1 of each year and must contain a certification by an officer of the carrier that, to the best of the officer's knowledge, each policy form ~~endorsement, rider, letter, notice, or other document affecting an insurance policy or contract~~ in use complies with Colorado law. The commissioner shall determine the necessary elements of the certification. (II) (A) An advisory organization as defined in section 10-4-402 (1), C.R.S., or a rating organization as defined in section 10-4-402 (3), C.R.S., shall submit an annual report to the commissioner of insurance listing any policy forms as may be requested by the commissioner. The listing must be submitted no later than July 1 of each year and must contain a certification by an officer of the organization that, to the best of the officer's knowledge, each policy form listed complies with Colorado law. The commissioner shall determine the necessary elements of the certification. (B) As used in this section, "form" may include any endorsement, rider, letter, notice, or other document affecting an insurance policy or contract issued or delivered to any policyholder in Colorado. (III) If a carrier uses, in their entirety and without modification, forms prepared by an advisory organization as defined in section 10-4-402 (1), C.R.S., or a rating organization as defined in section 10-4-402 (3), CR.S., the carrier shall notify the commissioner of insurance that it adopts the annual report filed by the advisory organization or rating organization under subparagraph (ii) of this paragraph (a) and, if it so notifies the commissioner, it need not submit the certification required by subparagraph (i) of this paragraph (a). If a carrier uses forms that deviate from the forms listed by the advisory organization or rating organization, or if it uses forms other than those listed by the advisory organization or rating organization, the carrier shall submit the annual listing of forms and certification as required by subparagraph (i) of this paragraph (a). (b) In addition to submitting the documentation required under paragraph (a) of this subsection (2) and except as specified in subparagraph (iii) of this paragraph (b): (I) Every carrier providing workers' compensation insurance that is authorized to conduct business in Colorado, every advisory organization as defined in section 10-4-402 (1), C.R.S., and every rating organization as defined in section 10-4-402 (3), C.R.S., shall ~~also~~ submit to the commissioner a list of any new or revised policy forms ~~endorsements, riders, letters, notices, or other documents~~ as may be requested by the commissioner at least thirty-one days before ~~using~~ a carrier uses the ~~policy~~ forms. ~~endorsements, riders, letters, notices, or other documents.~~ Unless a carrier notifies the division of insurance otherwise, policy forms submitted on behalf of a member of an advisory organization or rating organization are deemed to	6/8/16	See update to ***Filing Guide for Rates and Forms***

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		be automatically adopted by the carrier without modification. (II) The listing must also contain a certification by an officer of the carrier or an officer of the advisory or rating organization that, to the best of the officer's knowledge, each new or revised policy form, endorsement, rider, letter, notice, or other document proposed to be used complies with Colorado law. The commissioner shall determine the necessary elements of the certification. (III) If an advisory organization or rating organization certifies a form as required by subparagraph (II) of this paragraph (b) and a carrier is a member of that organization and uses the form in its entirety, the carrier need not list that form as required by subparagraph (I) of this paragraph (b) or submit a certification for that form as required by subparagraph (II) of this paragraph (b). (c) The commissioner may examine and investigate workers' compensation carriers authorized to conduct business in Colorado to determine whether workers' compensation policy forms ~~endorsements, riders, letters, notices, or other forms~~ as may be requested by the commissioner comply with the certification of the carrier and statutory mandates.		
Colorado	SB 16-217	**SB 16-217** amends ***sections 8-42-112. Acts of employees reducing compensation, 8-43-203. Notice concerning liability—notice to claimants—notice of rights and claims process—rules***, and ***8-43-404. Examination—refusal—personal responsibility—physicians to testify and furnish results—injured worker right to select treating physicians—injured worker right to third-party communications—definitions—rules*** of the Colorado Revised Statutes as follows: **8-42-112. Acts of employees reducing compensation.** … (3) An admission of liability reducing compensation under this section must include a statement by a representative of the employer listing the specific facts on which the reduction is based. (4) If the insurer or self-insured employer admits liability for the claim, any party may request an expedited hearing on the issue of whether the employer or insurer may reduce compensation under this section if the application for hearing is filed within forty-five days after the date of the admission reducing compensation under this section. The director shall set any expedited matter for hearing within sixty days after the date of the application. The time schedule for an expedited hearing is subject to the extensions set forth in section 8-43-209. If the party elects not to request an expedited hearing under this subsection (4), the time schedule for hearing the matter is as set forth in section 8-43-209. (5) Nothing in this section limits the right of a party to submit evidence at a hearing scheduled under this section or section 8-43-209. (6) Nothing in this section precludes a party from requesting a hearing pursuant to the time schedule set forth in section 8-43-209. **8-43-203. Notice concerning liability—notice to claimants—notice of rights and claims process—rules.** (1) (a) The employer or, if insured, the employer's insurance carrier shall notify in writing the division and the injured employee or, if deceased, the decedent's dependents within twenty days after a report is, or should have been, filed with the division pursuant to section 8-43-101, whether liability is admitted or contested; except that, for the purpose of this section, any knowledge on the part of the employer, if insured, is not knowledge on the part of the insurance carrier. The employer or the employer's insurance carrier may notify the division electronically. Unless exempted by the director pursuant to rule because of a small number of filings or a showing of financial hardship, beginning July 1, 2006, all notices of contest shall be filed electronically. The rejection of an electronically filed notice by the division for a technical error shall not affect the validity of the notice to the claimant. If the insurance carrier or self-insured employer denies liability for the claim, the claimant may request an expedited	7/1/16	No action required

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		hearing on the issue of compensability if the application therefor is filed within forty-five days after the date of mailing of the notice of contest. The director shall set any such expedited matter for hearing within ~~forty~~ sixty days after the date of the application, when the issue is liability for the disease or injury. The time schedule for such an expedited hearing is subject to the extensions set forth in section 8-43-209. If a claimant elects not to request an expedited hearing pursuant to this subsection (1), the time schedule for hearing the matter shall be as set forth in section 8-43-209. … **8-43-404. Examination—refusal—personal responsibility—physicians to testify and furnish results—injured worker right to select treating physicians—injured worker right to third-party communications—definitions—rules.** … (5) (a) (I) (D) Except as otherwise provided by sub-subparagraph (E) of this subparagraph (I), any party may request an expedited hearing on the issue of whether the employer or insurer provided a list in compliance with this subsection (5) if the application for expedited hearing is filed within forty-five days after the claimant provides notice of the injury to the employer. (E) If the insurer or self-insured employer admits liability for the claim, any party may request an expedited hearing on the issue of whether the employer or insurer provided a list in compliance with this subsection (5) if the application for expedited hearing is filed within forty-five days after the initial admission of liability for the claim. The director shall set any expedited matter for hearing within sixty days after the date of the application. The time schedule for an expedited hearing is subject to the extensions set forth in section 8-43-209. If the party elects not to request an expedited hearing under this subsection (5), the time schedule for hearing the matter is as set forth in section 8-43-209. … (VI) (A) In addition to the one-time change of physician allowed in subparagraph (III) of this paragraph (a), upon written request to the insurance carrier or to the employer's authorized representative if self-insured, an injured employee may procure written permission to have a personal physician or chiropractor treat the employee. The written request must be completed on a form that is prescribed by the director. If permission is neither granted nor refused within twenty days after the date of the certificate of service of the request form, the employer or insurance carrier shall be deemed to have waived any objection to the employee's request. Objection shall be in writing on a form prescribed by the director and shall be ~~deposited in the United States mail or hand-delivered to~~ served on the employee or, if represented, the employee's authorized representative within twenty days after the date of the certificate of service of the request form. An insurance carrier, or an employer's authorized representative if self-insured, shall track how often an injured employee requests to change his or her physician and how often such change is granted or denied and shall report such information to the division upon request. Upon the proper showing to the division, the employee may procure the division's permission at any time to have a physician of the employee's selection treat the employee, and in any nonsurgical case the employee, with such permission, in lieu of medical aid, may procure any nonmedical treatment recognized by the laws of this state as legal. The practitioner administering the treatment shall receive fees under the medical provisions of articles 40 to 47 of this title as specified by the division. (B) If an injured employee is permitted to change physicians under sub-subparagraph (A) of this subparagraph (VI) resulting in a new authorized treating physician who will provide primary care for the injury, then the previously authorized treating physician providing primary care shall continue as the authorized treating physician providing primary care for the injured employee until the injured employee's initial visit with the newly authorized treating physician, at which time the treatment relationship with the previously authorized treating physician providing primary care is		

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		terminated. (C) Nothing in this subparagraph (VI) precludes any former authorized treating physician from performing an examination under subsection (1) of this section. (D) If an injured employee is permitted to change physicians pursuant to sub-subparagraph (A) of this subparagraph (VI) resulting in a new authorized treating physician who will provide primary care for the injury, then the opinion of the previously authorized treating physician providing primary care regarding work restrictions and return to work controls unless that opinion is expressly modified by the newly authorized treating physician. …		
Connecticut	SB 101	**SB 101** amends ***section 31-286a Insurance requirements for contractors on public works projects and renewals of state business licenses*** of the Connecticut Workers Compensation Act as follows: **31-286a Insurance requirements for contractors on public works projects and renewals of state business licenses.** (a) Notwithstanding any provision of any general statute, special act, charter or ordinance, neither the state, or its agents, nor any political subdivision of the state, or its agents, may enter into any contract on or after October 1, 1986, for the construction, remodeling, refinishing, refurbishing, rehabilitation, alteration or repair of any public works project before receiving from each of the other parties to such contract (1) sufficient evidence of compliance with the workers' compensation insurance and self-insurance requirements of subsection (b) of section 31-284, and (2) a current statement from the State Treasurer that, to the best of his knowledge and belief, as of the date of the statement, the particular party was not liable to the state for any workers' compensation payments made pursuant to section 31-355, except that any sole proprietor who is a party to such contract shall not be subject to the provisions of this section, provided such sole proprietor (A) does not utilize any subcontractor in performing such contract, (B) is not acting as a principal employer, (C) has not accepted the provisions of chapter 568 in accordance with subdivision (10) of section 31-275, and (D) has liability insurance in lieu of workers' compensation insurance. …	10/1/16	No action required
District of Columbia	B21-0388	**DC B21-0388** amends ***section 32-1535*** of the District of Columbia Official Code to require that if a person entitled to workers compensation institutes proceedings and recovers an amount against a third person, court costs and attorney fees shall be proportionally shared between the person entitled to the compensation and the employer, relative to the amount each received in the settlement against the third person. ***** Once District of Columbia bills are passed by the DC Council, they must be sent to Congress for a period of 30 days before becoming effective as law (or 60 days for certain criminal legislation).	5/12/16	No action required
Florida	HB 613	**HB 613** amends various provisions of the Florida workers compensation law including, but not limited to: • Providing for a 25% penalty credit for certain employers • Establishing a deadline for employers to file certain documentation to receive a penalty reduction • Reducing the imputed payroll multiplier related to penalty calculations from 2 times to 1.5 times the statewide average weekly wage • Requiring employers to simply notify their insurers of their employee's coverage exemption, rather than requiring that a copy of the exemption be provided	10/1/16	No action required

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		• Eliminating a three-day response requirement applicable to employer held exemption information • Removing the requirement that construction employers maintain written exemption acknowledgements • Deleting a requirement that exemption revocations be filed by mail only • Removing unnecessary information from the exemption application • Relieving employers of the obligation to notify the Department of Financial Services (DFS) by telephone or telegraph within 24 hours of any work-related death and relying instead on other existing reporting requirements • Removing insurers and employers from the medical reimbursement dispute provision since they meet their adjustment, disallowance, and provider violation reporting duties through other provisions of law • Eliminating fees collected by the DFS related to new insurer registrations and Special Disability Trust Fund notices of claim and proofs of claim • Revising the method for selecting an expert medical examiner • Eliminating the Preferred Worker Program		
Florida	SB 828	**SB 828** amends ***section 631.914 Assessments*** of the Florida Statutes as follows: **631.914 Assessments** (1)(a) To the extent necessary to secure the funds for the payment of covered claims, and also to pay the reasonable costs to administer the same, the Office of Insurance Regulation ~~department~~, upon certification by the board, shall levy assessments on each insurer initially estimated in the proportion that the insurer's net direct written premiums in this state bears to the total of said net direct written premiums received in this state by all such workers' compensation insurers for the preceding calendar year. Assessments levied against insurers and self-insurance funds pursuant to this paragraph must be computed and levied on the basis of the full policy premium value on the net direct written premium amount as set forth in the state for workers' compensation insurance without consideration of any applicable discount or credit for deductibles. Insurers and self-insurance funds must report premiums in compliance with this paragraph. Assessments shall be remitted to and administered by the board of directors in the manner specified by the approved plan of operation and paragraph (d). ~~The board shall give each insurer so assessed at least 30 days' written notice of the date the assessment is due and payable.~~ Each assessment shall be a uniform percentage applicable to the net direct written premiums of each insurer writing workers' compensation insurance. ~~1. Beginning July 1, 1997,~~ Assessments levied against insurers and ~~, other than~~ self-insurance funds~~,~~ shall not exceed in any calendar year more than 2 percent of that insurer's net direct written premiums in this state for workers' compensation insurance ~~during the calendar year next preceding the date of such assessments~~. (b) Member insurers shall collect surcharges at a uniform percentage rate on new and renewal policies issued and effective during the period of 12 months beginning on January 1, April 1, July 1, or October 1, whichever is the first day of the following calendar quarter as specified in an order issued by the office directing insurers to pay an assessment to the association. The surcharge may not begin until 90 days after the board of directors certifies the assessment. ~~2. Beginning July 1, 1997, assessments levied against self insurance funds shall not exceed in any calendar year more than 1.50 percent of that self-insurance fund's net direct written premiums in this state for workers' compensation insurance during the calendar year next preceding the date of such assessments.~~ ~~3. Beginning July 1, 2003, assessments levied against insurers and self-insurance funds pursuant to this paragraph are computed and levied on the~~	7/1/16	***Tax and Assessment Directory*** revisions completed Item Filing has been approved Approval Circular FL-2016-04

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		~~basis of the full policy premium value on the net direct premiums written in the state for workers' compensation insurance during the calendar year next preceding the date of the assessment without taking into account any applicable discount or credit for deductibles. Insurers and self-insurance funds must report premiums in compliance with this subparagraph.~~ ~~(b) Assessments shall be included as an appropriate factor in the making of rates.~~ (c)~~1. Effective July 1, 1999,~~ If assessments otherwise authorized in paragraph (a) are insufficient to make all payments on reimbursements then owing to claimants in a calendar year, then upon certification by the board, the office ~~department~~ shall levy additional assessments of up to 1.5 percent of the insurer's net direct written premiums in this state ~~during the calendar year next preceding the date of such assessments against insurers to secure the necessary funds~~. (d) The association may use an installment method to require the insurer to remit the assessment as premium is written or may require the insurer to remit the assessment to the association before collecting the policyholder surcharge. If the assessment is remitted before the surcharge is collected, the assessment remitted must be based on an estimate of the assessment due based on the proportion of each insurer's net direct written premium in this state for the preceding calendar year as described in paragraph (a) and adjusted following the end of the 12-month period during which the assessment is levied. 1. If the association elects to use the installment method, the office may, in the order levying the assessment on insurers, specify that the assessment is due and payable quarterly as premium is written throughout the assessment year. Insurers shall collect surcharges at a uniform percentage rate specified by order as described in paragraph (b). Insurers are not required to advance funds if the association and the office elect to use the installment option. Assessments levied under this subparagraph are paid after policy surcharges are collected, and the recognition of assets is based on actual premium written offset by the obligation to the association. 2. If the association elects to require insurers to remit the assessment before surcharging the policyholder, the following shall apply: a. The levy order shall provide each insurer so assessed at least 30 days written notice of the date the initial assessment payment is due and payable by the insurer. b. Insurers shall collect surcharges at a uniform percentage rate specified by the order, as described in paragraph (b). c. Assessments levied under this subparagraph are paid before policy surcharges are billed and result in a receivable for policy surcharges to be billed in the future. The amount of billed surcharges, to the extent it is likely that it will be realized, meets the definition of an admissible asset as specified in the National Association of Insurance Commissioners' Statement of Statutory Accounting Principles No. 4. The asset shall be established and recorded separately from the liability. If an insurer is unable to fully recoup the amount of the assessment, the amount recorded as an asset shall be reduced to the amount reasonably expected to be recouped. 3. Insurers must submit a reconciliation report to the association within 120 days after the end of the 12-month assessment period and annually thereafter for a period of three years. The report must indicate the amount of the initial payment or installment payments made to the association and the amount of written premium pursuant to paragraph (a) for the assessment year. If the insurer's reconciled assessment obligation is more than the amount paid to the association, the insurer shall pay the excess surcharges collected to the association. If the insurer's reconciled assessment obligation is less than the initial amount paid to the association, the association shall return the overpayment to the insurer. (2) Assessments levied under this section are not premium and are not subject to any premium tax, fees, or commissions. Insurers shall treat the failure of an insured to pay assessment-related surcharges as a failure to pay premium. An insurer is not liable for any uncollectible assessment-		

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		related surcharges. (3) Assessments levied under this section may be levied only upon insurers. This section does not create a cause of action by a policyholder with respect to the levying of an assessment or a policyholder's duty to pay assessment-related surcharges. ~~2. To assure that insurers paying assessments levied under this paragraph continue to charge rates that are neither inadequate nor excessive, each insurer that is to be assessed pursuant to this paragraph, or a licensed rating organization to which the insurer subscribes, may make, within 90 days after being notified of such assessments, a rate filing for workers' compensation coverage pursuant to ss. 627.072 and 627.091. If the filing reflects a percentage rate change equal to the difference between the rate of such assessment and the rate of the previous year's assessment under this paragraph, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of ss. 627.072 and 627.091.~~ (4) ~~(2)~~(a) The board may exempt any insurer from an assessment if, in the opinion of the office ~~department~~, an assessment would result in such insurer's financial statement reflecting an amount of capital or surplus less than the minimum amount required by any jurisdiction in which the insurer is authorized to transact insurance. (b) The board may temporarily defer, in whole or in part, assessments against an insurer if, in the opinion of the office ~~department~~, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the case of a self-insurance fund, the trustees of the fund determined to be endangered must immediately levy an assessment upon the members of that self-insurance fund in an amount sufficient to pay the assessments to the corporation. (c) The board may allow an insurer to pay an assessment on a quarterly basis.		
Florida	SB 1402	**SB 1402** ratifies Rule 69L-7.020, F.A.C. The *Florida Workers' Compensation Health Care Provider Reimbursement Manual* (manual), 2015 Edition, sets out the policies, guidelines, codes, and maximum reimbursement allowances for services and supplies furnished by health care providers under the workers' compensation statutes. The manual provides the reimbursement policies and payment methodologies for pharmacists and medical suppliers pertaining to workers' compensation. The current manual was adopted by Rule 67-7.020, F.A.C. The rule was adopted on July 16, 2015, and submitted for ratification on November 3, 2015. The bill authorizes the rule to go into effect. The scope of the bill is limited to this rulemaking condition and does not adopt the substance of any rule into the statutes.	7/1/16	See "Legislative Analysis" section on NCCI's Legislative Activity page on **ncci.com** for cost impact analysis
Georgia	HB 402	**HB 402** adds several new sections to the Official Code of Georgia Annotated as follows: **33-9-40.3** (a) For each policy of workers' compensation insurance issued or renewed in the state on and after July 1, 2016, there may be granted by the insurer up to a 5 percent reduction in the premium for such policy if the insured has been certified by the State Board of Education to the State Board of Workers' Compensation as a work based learning employer pursuant to Article 12 of Chapter 9 of Title 34 and has notified its insurer in writing of such certification. (b) If granted, the premium discount provided by this Code section shall be applied to an insured's policy of workers' compensation insurance pro rata as of the date the insured receives such certification and shall continue for as long as the insured maintains the certification; provided, however, that an insurer shall not be required to credit the actual amount of the premium discount to the account of the insured until the final premium audit under such policy. Certification of an insured shall be required for each year in which a premium discount is granted. (c) If it is determined that an insured misrepresented its qualifications for certification pursuant to Article 12 of Chapter 9 of Title 34, the workers'		Item Filing has been approved Approval Circular GA-2015-03

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		compensation insurance policy of such insured may be subject to an additional premium for the purposes of reimbursement of a previously granted premium discount and to cancellation in accordance with the provisions of the policy. (d) Each insurer shall make an annual report, in accordance with guidelines established by the Commissioner, to the rating and statistical organization designated by the Commissioner illustrating the total dollar amount of the premium discounts applied pursuant to this Code section. (e) The Commissioner shall conduct a study to determine the impact of the premium discounts provided pursuant to this Code section in encouraging employers to provide work based learning opportunities for students age 16 or older. (f) The Commissioner shall be authorized to promulgate rules and regulations necessary for the implementation and enforcement of this Code section. **34-9-2.4** (a) As used in this Code section, the term: (1) 'Work based learning placement' or 'placement' shall have the same meaning as in Code Section 34-9-430. (2) 'Work based learning student' or 'student' shall have the same meaning as in Code Section 34-9-430. (b) Notwithstanding the provisions of paragraph (2) of Code Section 34-9-1: (1) A work based learning student in a paid work based learning placement for an employer shall be deemed an employee of such employer for purposes of workers' compensation coverage; and (2) A work based learning student in an unpaid work based learning placement for an employer shall be deemed an employee of such employer for purposes of workers' compensation coverage unless all of the following conditions apply: (A) The placement, even though it includes actual operation of the facilities of the employer, is similar to training which would be given in an educational environment; (B) The placement is for the benefit of the student; (C) The student does not displace regular employees, but works under close supervision of existing staff; (D) The employer that provides the training derives no immediate advantage from the activities of the student; and on occasion its operations may actually be impeded; (E) The student is not necessarily entitled to a job at the conclusion of the placement; and (F) The employer and the student understand that the student is not entitled to wages for the time spent in the placement. **34-9-430** As used in this article, the term: (1) 'Employer' means a person or entity that is subject to the provisions of this chapter but shall not include the state or any department, agency, or instrumentality of the state; any county; any county or independent school system; any municipal corporation; or any employer which is self-insured for the purposes of this chapter. (2) 'Employer member of a group self-insurance fund' means any employer who is a member of a fund certified pursuant to Code Section 34-9-153. (3) 'Self-insured employer' means any employer certified pursuant to Code Section 34-9-127.		

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		(4) 'Work based learning coordinator' means a school employee who coordinates and supervises students in work based learning placements. (5) 'Work based learning employer' means an employer who provides work based learning placements in accordance with this article. (6) 'Work based learning placement' or 'placement' means an arrangement between a business or industry partner and a local school system in which students are released for a portion of the school day for structured learning at an employer's job site in either a paid or unpaid position while receiving academic credit. Work based learning placements include, but are not limited to, employability skill development, service learning, cooperative education, internship, youth apprenticeship, and clinical experiences. (7) 'Work based learning student' means a student age 16 or older in a work based learning placement for an employer. **34-9-431** (a) A work based learning employer that has been certified pursuant to this Code section may be eligible for a premium discount under such employer's workers' compensation insurance policy pursuant to Code Section 33-9-40.3. (b) The State Board of Education shall certify to the State Board of Workers' Compensation that a work based learning employer meets the following requirements: (1) Enters into a training agreement with one or more work based learning students, the student's parent or guardian, and the school's work based learning coordinator; (2) Develops, in conjunction with the school's work based learning coordinator, a detailed training plan for the work based learning student that focuses on development of technical skills and employability skills; (3) Assigns a mentor to the work based learning student and assist in monitoring the progress of such student; (4) Provides workers' compensation insurance coverage for the work based learning student; (5) Complies with all federal, state, and local laws and regulations regarding the employment of students; and (6) Complies with the rules and regulations of the State Board of Education. **34-9-432** A self-insured employer or an employer member of a group self-insurance fund that provides work based learning placements for one or more work based learning students substantially in accordance with Code Section 34-9-431 and that complies with all other provisions of this article required of employers in order to qualify for insurance premium discounts may be certified by the State Board of Education to the State Board of Workers' Compensation as a work based learning employer in compliance with this article. **HB 402** also contains the following clause: All laws and parts of laws in conflict with this Act are repealed.		
Georgia	HB 818	**HB 818** amends numerous sections of the Official Code of Georgia Annotated as follows: **§ 34-9-47. Trial division and appellate division created; composition; sessions** ... (c) The trial division shall be composed of administrative law judges appointed by the board who shall serve as hearing officers and exercise judicial	7/1/16	See "Legislative Analysis" section on NCCI's Legislative Activity page on

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		functions in implementing this chapter. ~~Administrative law judges~~ An administrative law judge shall have the power to subpoena witnesses and administer oaths and may take testimony in those cases brought before the board. An administrative law judge hearing a case shall make an award, subject to review and appeal as provided in this chapter. An administrative law judge shall be subject to the Georgia Code of Judicial Conduct. … **§ 34-9-121. Duty of employer to insure in licensed company or association or to deposit security, indemnity, or bond as self-insurer, application to out-of-state employers, and membership in mutual insurance company** (a) Unless otherwise ordered or permitted by the board, every employer subject to the provisions of this chapter relative to the payment of compensation shall secure and maintain full insurance against such employer's liability for payment of compensation under this article, such insurance to be secured from some person, corporation, association, or organization licensed by law to transact the business of workers' compensation insurance in this state or from some mutual insurance association formed by a group of employers so licensed; or such employer shall ~~furnish~~ provide the board with sufficient information for the board to make an adequate assessment of the employer's workers' compensation exposure and liabilities and shall further provide evidence satisfactory ~~proof~~ to the board of such employer's financial ability to pay the compensation directly in the amount and manner and when due, as provided for in this chapter. In the latter case, the board may, in its discretion, require the deposit of acceptable security, indemnity, or bond to secure the payment of compensation liabilities as they are incurred; provided, however, that it shall be satisfactory proof of the employer's financial ability to pay the compensation directly in the amount and manner when due, as provided for in this chapter, and the equivalent of acceptable security, indemnity, or bond to secure the payment of compensation liabilities as they are incurred, if the employer shall show the board that such employer is a member of a mutual insurance company duly licensed to do business in this state by the Commissioner of Insurance, as provided by the laws of this state, or of an association or group of employers so licensed and as such is exchanging contracts of insurance with the employers of this and other states through a medium specified and located in their agreements with each other, but this proviso shall in no way restrict or qualify the right of self-insurance as authorized in this Code section. Nothing in this Code section shall be construed to require an employer to place such employer's entire insurance in a single insurance carrier. … **§ 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 ~~$550.00~~ $575.00 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		**ncci.com** for cost impact analysis

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		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 ~~$367.00~~ $383.00 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, and 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 ~~$220,000.00~~ $230,000.00. … **§ 34-9-380. Purpose of article** It is the purpose of this article through the establishment of a guaranty trust fund to provide for the continuation of workers' compensation benefits due and unpaid, excluding penalties, fines, and attorneys' fees assessed against a participant, when ~~a self-insured employer becomes insolvent~~ such participant becomes an insolvent self-insurer. **§ 34-9-381. Definitions** As used in this article, the term: (1) 'Applicant' means an employee entitled to workers' compensation benefits. (2) 'Board' means the State Board of Workers' Compensation. (3) 'Board of trustees' means the board of trustees of the fund. (4) 'Company' means a corporation, association, partnership, proprietorship, firm, or other form of business organization. ~~(4)~~ (5) 'Fund' means the Self-insurers Guaranty Trust Fund established by this article. ~~(5)~~ (6) 'Insolvent self-insurer' means a self-insurer: (A) ~~a self-insurer who~~ Who files for relief under the federal Bankruptcy Act~~, a~~ ; (B) ~~self-insurer against~~ Against whom involuntary bankruptcy proceedings are filed~~, a~~ ; (C) ~~self-insurer for~~ For whom a receiver is appointed in a federal or state court of this state or any other jurisdiction, ~~or a self-insurer who~~ ; (D) Who is in default on workers' compensation obligations; or (E) Who is determined by the board to be in ~~default of its~~ noncompliance with workers' compensation obligations or requirements ~~according to~~ under the laws of this state and the rules and regulations ~~promulgated by the board of trustees and approved by~~ of the board. ~~(6)~~ (7) 'Participant' means a self-insurer who is a member of the fund ~~and exclusive of those entities described in Article 5 of this chapter~~. ~~(7)~~ (8) 'Self-insurer' means a private employer, including any hospital authority created pursuant to the provisions of Article 4 of Chapter 7 of Title 31, the 'Hospital Authorities Law,' that has been authorized to self-insure its payment of workers' compensation benefits pursuant to this chapter~~,~~ ~~except any~~ . The term 'self-insurer' shall not mean or include any of the following:		

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		(A) Any governmental ~~self-insurer or other~~ employer authorized by the board to self-insure; (B) Any employer who elects to group self-insure pursuant to Code Section 34-9-152~~, captive~~ ; (C) Captive insurers as provided for in Chapter 41 of Title 33~~, or employers~~ ; (D) Any employer who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter; or (E) Any individual or company who: (i) Enters into a contract or agreement with an employer under which the employer outsources its workers' compensation risks, responsibilities, obligations, or liabilities to such individual or company; and (ii) Pursuant to such contract or agreement, is required to provide workers' compensation benefits to an injured employee even though no common-law master-servant relationship or contract of employment exists between the injured employee and the individual or company providing the benefits. ~~(8)~~ (9) 'Trustee' means a member of the Self-insurers Guaranty Trust Fund board of trustees. **§ 34-9-382 Establishment of Self-insurers Guaranty Trust Fund, use of fund, and application to be accepted in fund** (a) There is established a Self-insurers Guaranty Trust Fund for the sole purpose of making payments in accordance with this article. The fund shall be administered by an administrator appointed by the chairperson of the board of trustees with the approval of the board of trustees. All moneys in the fund shall be held in trust and shall not be money or property of the state or the participants and shall be exempt from levy, attachment, garnishment, or civil judgment for any claim or cause of action other than for not making payments in accordance with this article. ~~The board of trustees shall be authorized to invest the moneys of the fund in the same manner as provided by law for investments in government backed securities~~ The fund assets shall be invested only in obligations issued or guaranteed by the United States government. … (c) As a condition of self-insurance, all private employers, except ~~any governmental self-insurer or other employer who elects to group self-insure pursuant to Code Section 34-9-152, captive insurers as provided for in Chapter 41 of Title 33, or employers who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter, must~~ those precluded from membership in the fund pursuant to subsection (d) of this Code section, shall make application to and be accepted in the Self-insurers Guaranty Trust Fund. (d) Membership in the fund shall not be permitted for any of the following: (1) Any governmental employer authorized by the board to self-insure; (2) Any employer who elects to group self-insure pursuant to Code Section 34-9-152; (3) Captive insurers as provided for in Chapter 41 of Title 33; (4) Any employer who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter; or (5) Any individual or company who: (A) Enters into a contract or agreement with an employer under which the employer outsources its workers' compensation risks, responsibilities,		

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		obligations, or liabilities to such individual or company; and (B) Pursuant to such contract or agreement, is required to provide workers' compensation benefits to an injured employee even though no common-law master-servant relationship or contract of employment exists between the injured employee and the individual or company providing the benefits. **§ 34-9-384. General powers of board of trustees** … (2)(A) The board of trustees shall meet not less than quarterly and shall meet at other times upon the call of the chairperson, issued to the trustees in writing not less than 48 hours prior to the day and hour of the meeting, or upon a request for a meeting presented in writing to the chairperson not less than 72 hours prior to the proposed day and hour of the meeting and signed by at least a majority of the trustees, whereupon the chairperson shall provide notice issued in writing to the trustees not less than 48 hours prior to the meeting and shall convene the meeting at the time and place stated in the request~~;~~ . (B) Any trustee may participate in a meeting of the board of trustees by telephone conference or similar communications technology which allows all individuals participating in the meeting to hear and speak with each other. Participation in a meeting pursuant to this subparagraph shall constitute presence in person at such meeting. … **§ 34-9-385. Bankruptcy of participants** (a) Any participant who files for relief under the federal Bankruptcy Act or against whom bankruptcy proceedings are filed or for whom a receiver is appointed shall file written notice of such fact with the board and the board of trustees within 30 days of the occurrence of such event. (b) Any ~~person~~ individual who files an application for adjustment of a claim against a participant who is ~~in default or has filed for relief under the federal Bankruptcy Act or against whom bankruptcy proceedings have been filed or for whom a receiver has been appointed must~~ or becomes an insolvent self-insurer shall file a written notice of such ~~fact~~ participant's status with the board and the board of trustees within 30 days of such ~~person's~~ individual having knowledge of the ~~event~~ participant becoming an insolvent self-insurer. (c) Upon receipt of any notice as provided in subsection (a) or (b) of this Code section, the board shall determine whether the participant is an insolvent ~~or in default according to procedures established by the board of trustees and approved by the board~~ self-insurer. Such determination shall be made within a reasonable time after the date the board and board of trustees receive notification as provided in subsection (a) or (b) of this Code section. (d) When a participant is determined to be ~~in default or~~ an insolvent self-insurer, the board of trustees is empowered to and shall assume on behalf of the participant its outstanding workers' compensation obligations excluding penalties, fines, and claimant's attorneys' fees assessed against the participant pursuant to subsection (b) of Code Section 34-9-108 and shall take all steps necessary to collect, recover, and enforce all outstanding security, indemnity, insurance, or bonds furnished by such participant guaranteeing the payment of compensation provided in this chapter for the purpose of paying outstanding and continuing obligations of the participant. The board of trustees shall convert and deposit into ~~the fund~~ a separate account established within the fund such security and any amounts received under agreements of surety, guaranty, insurance, or otherwise on		

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		behalf of the participant. Any amounts remaining from such security, indemnity, insurance, bonds, guaranties, and sureties, following payment of all compensation costs and related administrative expenses and fees of the board of trustees including attorneys' fees, and following collection of all amounts assessed and received pursuant to subsections (a) and (d) of Code Section 34-9-121 and any applicable rule of the board may be refunded by the fund as directed by the board of trustees, subject to the approval of the board, to the appropriate party one year from the date of final payment and closure of all claims, provided no outstanding self-insured liabilities remain against the fund and ~~the~~ all applicable ~~statute~~ statutes of ~~limitations has~~ limitation have run. … **§ 34-9-386. Assessment of participants, liability of fund and participants for claims, and revocation of participant's authority to be self-insured** … (5) Funds obtained by such assessments shall be used only for the purposes set forth in this article and shall be deposited upon receipt by the board of trustees into the fund. If payment of any assessment, penalty, or fine made under this article is not made within 30 days of the sending of the notice to the participant, the board of trustees is authorized to do any or all of the following: (A) Levy fines or penalties; (B) Proceed in court for judgment against the participant, including the amount of the assessment, fines, penalties, the costs of suit, interest, and reasonable attorneys' fees; (C) Proceed directly against the security pledged by the participant for the collection of same; or (D) Seek revocation of the participant's ~~insured~~ self-insured status. (b)(1) The fund shall be liable for claims arising out of injuries occurring after January 1, 1991; provided, however, that no claim may be asserted against the fund until the funding level has reached $1.5 million. (2) All active participants shall be required to maintain surety bonds or the board of trustees may, in its discretion, accept ~~any~~ an irrevocable letter of credit ~~or other acceptable forms of security~~ in the amount of no less than $250,000.00. In addition, each active participant shall be required to purchase excess insurance for statutory limits with a self-insured retention specified by the board, and the excess policy shall include the bankruptcy endorsement required by the board and board of trustees. For participants who are no longer active, security in an amount commensurate with their remaining exposure, as determined by the board, shall be required until all self-insured claims have been closed and all applicable statutes of limitation have run. (c) A participant who ceases to be a self-insurer shall be liable for any and all assessments, penalties, and fines made pursuant to this Code section for so long as indemnity or medical benefits are paid for claims which originated when the participant was a self-insurer. Assessments of such a participant shall be based on the indemnity and medical benefits paid by the participant during the previous calendar year. (d) Upon refusal to pay assessments, penalties, or fines to the fund or upon refusal to comply with a board order ~~increasing security~~, the fund may treat the self-insurer as being in default with this chapter and the self-insurer shall be subject to revocation of its board authorization to self-insure and forfeiture of its security. **§ 34-9-387. Reimbursement and security deposit from participant for compensation obligations**		

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		… (c) The board of trustees shall be a party in interest in any action or proceeding to obtain the security deposit of a participant for the payment of the participant's compensation obligations, in any action or proceeding under the participant's excess insurance policy, and in any other action or proceeding to enforce an agreement of any security deposit or captive or excess insurance carrier and from any other guarantee to satisfy such obligations. The fund is authorized to file a claim against ~~a bankrupt~~ an insolvent participant or the participant's agents and seek reimbursement for any payments made by the fund on behalf of the participant pursuant to this chapter. The fund is subrogated to the claim of any employee whose benefits are paid by the fund. Further, the fund shall have a lien against any reimbursement payments the participant is entitled to from the Subsequent Injury Trust Fund in an amount equal to the payments made by the fund to satisfy the participant's liability for workers' compensation benefits. **§ 34-9-388. Reports of participant's insolvency, participant's audits, review of applications for self-insurance and recommendations thereon** … (b) The board shall, at the inception of a participant's self-insured status and at least annually thereafter, so long as the participant remains self-insured, furnish the board of trustees with a complete, original bound copy of each participant's ~~audit~~ audited annual financial statement performed in accordance with generally accepted accounting standards by an independent certified public accounting firm, three to five years of loss history, name of the ~~person~~ individual or company to administer claims, and any other pertinent information submitted to the board to authenticate the participant's self-insured status. The board of trustees may contract for the services of a qualified certified public accountant or firm to review, analyze, and make recommendations on these documents. All financial information submitted by a participant shall be considered confidential and not public information. **HB 818** also contains the following clause: All laws and parts of laws in conflict with this Act are repealed. *NCCI estimates that **HB 818** will result in an impact of +1.5% on total workers compensation system costs in Georgia.*		

Hawaii	HB 2363 HD1 SD1 CD1	**HB 2363 HD1 SD1 CD1** amends various provisions of the Hawaii Revised Statutes related to workers compensation and temporary disability insurance coverage to:
		• Exclude the following from providing temporary disability insurance coverage for services they provide for themselves:
		  o Sole proprietors
		  o Individual partners of a partnership
		  o Partners of a limited liability partnership with a transferable interest of at least 50%
		  o Individual members of a limited liability company with a distributional interest of at least 50%
		  o Individuals owning at least 50% of a corporation
		• Authorize the Director of Labor and Industrial Relations to receive electronic copies of injury and other reports required under the workers compensation law
			7/1/16	No action required

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2016 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/16)

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		• Increase the maximum penalty from $2,500 to $5,000 for employers or insurance carriers who fail to make correct or timely workers compensation benefit payments or terminate such benefits without approval or statutory cause • Increase the maximum penalty from $250 to $500 for physicians who fail to timely file workers compensation injury and treatment reports • Increase the maximum penalty from $1,000 to $5,000 for employers who fail to furnish workers compensation medical reports or allow inspection and copying of requested medical depositions • Increase the penalty for employers who fail to provide workers compensation coverage for employees from the greater of at least $250 or $10 per employee per day of failure to the greater of at least $500 or $100 per employee per day of failure • Increase the maximum penalty from $2,500 to $5,000 for employers who deduct workers compensation premium payments from an employee's wages • Increase the penalty for employers who fail to provide temporary disability insurance coverage for employees from the greater of at least $25 or $1 per employee per day of failure to the greater of at least $500 or $100 per employee per day of failure		
Idaho	HB 501	**HB 501** amends ***section 72-301. Security for payment of compensation*** of the Idaho Code as follows: **§ 72-301. Security for payment of compensation** **…** (2) No insurer shall be permitted to transact worker's compensation insurance covering the liability of employers under this law unless it shall have been authorized to do business under the laws of this state and until it shall have received the approval of the commission. To the end that the workers secured under this law shall be adequately protected, the commission shall require such insurer to deposit and maintain in a custodial account with the state treasurer money or acceptable security instruments ~~of the United States~~ in an amount equal to the total amounts of all outstanding and unpaid compensation awards against such insurer. Acceptable security instruments are bonds, treasury bills, interest-bearing notes or other obligations of the United States for which the full faith and credit of the United States is pledged for the payment of principal and interest. Acceptable security instruments also include municipal bonds issued by the state of Idaho, its subdivisions, counties, cities, towns, villages and school districts. The insurer shall have the responsibility to monitor the ratings for its bonds. Bonds held by worker's compensation insurers in support of insurance obligations must have been assigned a credit rating grade not less than "single A minus" by one (1) or more credit rating providers registered with the United States securities and exchange commission as a nationally recognized statistical rating organization (NRSRO) . If the credit rating assigned to the bond by the NRSRO is downgraded below "single A minus," the worker's compensation insurer shall within thirty (30) days of the downgrade replace the bond with one (1) that meets the credit quality requirement specified in this section. In lieu of such money or security instruments, the commission may allow or require such insurer to file or maintain with the state treasurer a surety bond of some company or companies authorized to do business in this state for and in the amounts equaling the total unpaid compensation awards against such insurer. …	3/30/16	No action required
Idaho	HB 554	**HB 554** amends ***sections 72-102. Definitions*** and ***72-438. Occupational Diseases*** of the Idaho Code as follows: **72-102. Definitions**. Words and terms used in the worker's compensation law, unless the context otherwise requires, are defined in the subsections which follow: …	5/24/16	No action required

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		(12) "Employee" is synonymous with "workman" and means any person who has entered into the employment of, or who works under contract of service or apprenticeship with, an employer. It does not include any person engaged in any of the excepted employments enumerated in section 72-212, Idaho Code, unless an election as provided in section 72-213, Idaho Code, has been filed. It does, however, include a volunteer firefighter for purposes of section 72-438 (12) and (14), Idaho Code. Any reference to an employee who has been injured shall, where the employee is dead, include a reference to his dependents as herein defined, if the context so requires, or, where the employee is a minor or incompetent, to his committee or guardian or next friend. (13) (a) "Employer" means any person who has expressly or impliedly hired or contracted the services of another. It includes contractors and subcontractors. It includes the owner or lessee of premises, or other person who is virtually the proprietor or operator of the business there carried on, but who, by reason of there being an independent contractor or for any other reason, is not the direct employer of the workers there employed. It also includes, for purposes of section 72-438 (12) and (14), Idaho Code, a municipality, village, county or fire district that utilizes the services of volunteer firefighters. If the employer is secured, it means his surety so far as applicable. (b) "Professional employer" means a professional employer as defined in chapter 24, title 44, Idaho Code. (c) "Temporary employer" means the employer of temporary employees as defined in section 44-2403(7), Idaho Code. (d) "Work site employer" means the client of the temporary or professional employer with whom a worker has been placed. (14) "Farm labor contractor" means any person or his agent or subcontractor who, for a fee, recruits and employs ~~farm workers~~ farmworkers and performs any farm labor contracting activity. … (31) "United States," when used in a geographic sense, means the several states, the District of Columbia, the Commonwealth of Puerto Rico~~, the Canal Zone~~ and the territories of the United States. (32) "Volunteer emergency responder" means a firefighter or peace officer, or publicly employed certified personnel ~~as that term is defined in section 56-1012, Idaho Code,~~ who is a bona fide member of a legally organized law enforcement agency, a legally organized fire department or a licensed emergency medical service provider organization who contributes services. … **72-438. Occupational diseases**. Compensation shall be payable for disability or death of an employee resulting from the following occupational diseases: … (2) Carbon monoxide poisoning or chlorine poisoning in any process or occupation involving direct exposure to carbon monoxide or chlorine in buildings, sheds, or ~~inclosed~~ enclosed places. … (6) Radium poisoning by or disability due to radioactive properties of substances or to ~~Roentgenray~~ roentgen ray (X-ray) in any occupation involving direct contact therewith, handling thereof, or exposure thereto. … (12) Cardiovascular or pulmonary or respiratory diseases of a ~~paid fireman~~ firefighter, employed by or volunteering for a municipality, village or fire		

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		district as a regular member of a lawfully established fire department, caused by overexertion in times of stress or danger or by proximate exposure or by cumulative exposure over a period of four (4) years or more to heat, smoke, chemical fumes or other toxic gases arising directly out of, and in the course of, his employment. … (14) Firefighter occupational diseases: (a) As used in this subsection, "firefighter" means an employee whose primary duty is that of extinguishing or investigating fires as part of a fire district, fire department or fire brigade. (b) If a firefighter is diagnosed with one (1) or more of the following diseases after the period of employment indicated in subparagraphs (i) through (xi) of this paragraph, and the disease was not revealed during an initial employment medical screening examination that was performed according to such standards and conditions as may be established at the sole discretion of the governing board having authority over a given fire district, fire department, or fire brigade, then the disease shall be presumed to be proximately caused by the firefighter's employment as a firefighter: (i) Brain cancer after ten (10) years; (ii) Bladder cancer after twelve (12) years; (iii) Kidney cancer after fifteen (15) years; (iv) Colorectal cancer after ten (10) years; (v) Non-Hodgkin's lymphoma after fifteen (15) years; (vi) Leukemia after five (5) years; (vii) Mesothelioma after ten (10) years; (viii) Testicular cancer after five (5) years if diagnosed before the age of forty (40) years with no evidence of anabolic steroids or human growth hormone use; (ix) Breast cancer after five (5) years if diagnosed before the age of forty (40) years without a breast cancer 1 or breast cancer 2 genetic predisposition to breast cancer; (x) Esophageal cancer after ten (10) years; and (xi) Multiple myeloma after fifteen (15) years. (c) The presumption created in this subsection may be overcome by substantial evidence to the contrary. If the presumption is overcome by substantial evidence, then the firefighter or the beneficiaries must prove that the firefighter's disease was caused by his or her duties of employment. (d) The presumption created in this subsection shall not preclude a firefighter from demonstrating a causal connection between employment and disease or injury by a preponderance of evidence before the Idaho industrial commission. (e) The presumption created in this subsection shall not apply to any specified disease diagnosed more than ten (10) years following the last date on which the firefighter actually worked as a firefighter as defined in paragraph (a) of this subsection. Nor shall the presumption apply if a firefighter or a firefighter's cohabitant has regularly and habitually used tobacco products for ten (10) or more years prior to the diagnosis. (f) The periods of employment described in paragraph (b) of this subsection refer to periods of employment within the state of Idaho. Recognizing that additional toxic or harmful substances or matter are continually being discovered and used or misused, the above enumerated		

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		occupational diseases are not intended to be exclusive, but such additional diseases shall not include hazards ~~which~~ that are common to the public in general and ~~which~~ that are not within the meaning of section 72-102 (22) (a), Idaho Code, and the diseases enumerated in subsection (12) of this section pertaining to ~~paid firemen~~ firefighters shall not be subject to the limitations prescribed in section 72-439, Idaho Code. **HB 554** also includes the following language: The provisions of this act shall be null, void and of no force and effect on and after July 1, 2021.		
Illinois	HB 6225	**HB 6225** amends ***sections 215 ILCS 113/25 Record keeping and reporting requirement*** and ***215 ILCS 113/30 Responsibility for policy issuance and continuance*** of the Illinois Compiled Statutes Annotated as follows: **215 ILCS 113/25 Record keeping and reporting requirement** (a) A lessor shall maintain accounting and employment records relating to all employee leasing arrangements for a minimum of 4 calendar years. A lessor shall maintain the address of each office it maintains in this State, at its principal place of business. (b) A lessor shall maintain sufficient information in a manner consistent with a licensed rating organization's data submission requirements to permit the rating organization licensed under Section 459 of the Illinois Insurance Code to calculate an experience modification factor for the lessee. (c) Upon written request of a lessee with an annual payroll attributed to it in excess of $200,000, the lessor shall provide the lessee's experience modification factor to the lessee within 30 days of the request. (d) Upon request of a lessee with an annual payroll attributed to it of less than $200,000, the lessor shall provide the loss information required to be maintained by this Section to the lessee within 30 days of the request. (e) Nothing in this Section shall preclude a licensed rating organization from calculating the experience modification factor for each lessee nor an insurer from maintaining and furnishing on behalf of the lessor, such information as required by this Section. (f) In the event that a lessee's experience modification factor exceeds the lessor's experience modification factor by 50% at the inception of the employee leasing arrangement, the lessee's experience modification factor shall be utilized to calculate the premium or costs charged to the lessee for workers' compensation coverage for a period of 2 years. Thereafter, the premium charged by the insurer for inclusion of a lessee under a lessor's policy may be calculated on the basis of the lessor's experience modification factor. (g) A lessor that does not provide workers' compensation insurance coverage for leased employees of a lessee under an employee leasing arrangement shall not be subject to compliance with subsections (b) through (f) of this Section. **215 ILCS 113/30 Responsibility for policy issuance and continuance** (a) Either a lessor or lessee may provide workers' compensation insurance coverage for leased employees under an employee leasing arrangement. When a workers' compensation policy written to cover leased employees is issued to the lessor as the named insured, the lessee shall be identified thereon by the attachment of an appropriate endorsement indicating that the policy provides coverage for leased employees. The endorsement shall, at a minimum, provide for the following: (1) Coverage under the endorsement shall be limited to the named insured's employees leased to the lessees. (2) The experience of the employees leased to the particular lessee shall be separately maintained by the lessor as provided in Section 25. …	1/1/17	Item Filing has been approved Approval Circular IL-2016-07

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		(f) When the lessee provides workers' compensation coverage for leased employees under an employee leasing arrangement, the lessor shall notify the Department in a manner specified by the Department to ensure proper and timely notification of coverage to the Department.		
Indiana	HB 1136	**HB 1136**, in part, amends ***section 27-9-1-2. Definitions***, and adds ***section 27-9-3-34.5*** to the Indiana Code relating to large deductible workers compensation policies, as follows: **27-9-1-2. Definitions** … (b) "Collateral", for purposes of IC 27-9-3-34.5, means cash, a letter of credit, a surety bond, or another form of security posted by an insured, a captive insurer, or reinsurer, to secure the insured's obligation to: (1) pay deductible claims or to reimburse the insurer for deductible claim payments under a large deductible policy; or (2) reimburse or pay the insurer as required for other secured obligations. (c) "Commercially reasonable" means: (1) acting in good faith according to prevailing industry practices; and (2) making all reasonable efforts considering the facts and circumstances of a matter. … (f) "Deductible claim" means a claim under a large deductible policy that does not exceed the deductible. The term includes a claim for loss, defense, and (unless excluded) cost containment expense. … (q) "Large deductible policy" means a combination of worker's compensation policies or endorsements, or both, issued to an insured and contracts or security agreements entered into between the insured and insurer in which the insured has agreed to pay directly, or reimburse the insurer for the insurer's payment of, the: (1) initial part of a claim under the policy; or (2) expenses related to a claim; up to a specified dollar amount. The term includes a policy that contains, in addition to a per claim limit, an aggregate limit on the insured's liability for all deductible claims. The term also includes a policy with a deductible of at least fifty thousand dollars ($50,000). The term does not include a policy, an endorsement, or an agreement under which the initial part of a claim is self-insured and the insurer is not obligated to pay any part of the self-insured retention. The term also does not include a policy that provides for retrospectively rated premium payments or a reinsurance agreement, except to the extent that a reinsurance agreement assumes, secures, or pays the insured's large deductible obligations. (r) "Other secured obligations", for purposes of IC 27-9-3-34.5, means obligations of an insured to an insurer other than obligations under a large deductible policy. The term includes obligations under a reinsurance agreement or another agreement that involves retrospective premium obligations the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy. … **27-9-3-34.5** Sec. 34.5. (a) This section:	7/1/16, for the amendments to ***section 27-9-1-2. Definitions*** and for new ***section 27-9-3-34.5***	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		(1) applies to a worker's compensation large deductible policy issued by an insurer that is subject to this chapter; and (2) does not apply to first party claims or claims funded by the guaranty association net of the deductible. (b) To the extent that the terms of a large deductible policy conflict with this section, the policy must be administered in accordance with this section. (c) Unless otherwise agreed by the guaranty association, all deductible claims that are covered claims (as defined in IC 27-6-8-4), including claims funded by an insured before liquidation, must be referred to the guaranty association for processing. To the extent an insured funds or pays a deductible claim under an agreement with the guaranty association or otherwise, the insured's funding or payment of the deductible claim extinguishes any obligation of the receiver or the guaranty association to pay the claim. A charge may not be made against the receiver or the guaranty association on the basis of an insured's funding or payment of a deductible claim. (d) The following apply when the guaranty association pays a deductible claim: (1) If the guaranty association pays a deductible claim for which the insurer would have been entitled to reimbursement from the insured, the guaranty association is entitled to the full amount of the reimbursement and available collateral to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association under this subsection are not early access payments under section 32 of this chapter or distributions under section 40 of this chapter. (2) If the guaranty association pays: (A) a deductible claim that is not reimbursed: (i) from collateral; or (ii) by payment by the insured; or (B) an incurred expense in connection with a large deductible policy that is not reimbursed; the guaranty association is entitled to assert a claim for the payments in the delinquency proceeding. (e) Subsection (d) does not limit the receiver's or guaranty association's rights under other applicable law to obtain reimbursement from an insured for claim payments made by the guaranty association: (1) under the policies of the insurer; or (2) for the guaranty association's related expenses; including payments described in IC 27-6-8-11.5 or under another state's similar law. (f) A receiver shall do the following: (1) Upon receipt by the receiver of notice from the guaranty association of reimbursable payments for which the guaranty association has not been reimbursed, bill an insured for reimbursement of deductible claims: (A) paid by the insurer before the commencement of delinquency proceedings; (B) paid by the guaranty association; or (C) paid or allowed by the receiver. (2) If an insured that is billed under subdivision (1) does not make payment within: (A) the time specified in the large deductible policy; or (B) if no time is specified in the large deductible policy, sixty (60) days after the date of billing;		

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		the receiver shall pursue all commercially reasonable actions to collect the payment. (g) The following do not relieve an insured from the insured's reimbursement obligation under a large deductible policy and this chapter: (1) An insurer's insolvency. (2) An insurer's inability to perform the insurer's obligations. (3) An allegation of improper processing or payment of a deductible claim, except for gross negligence, by the: (A) insurer; (B) receiver; or (C) guaranty association. (h) With respect to collateral, the following apply: (1) A receiver shall use available collateral to secure: (A) an insured's obligation to fund or reimburse deductible claims; and (B) other secured obligations or payment obligations. The guaranty association is entitled to collateral to the extent needed to reimburse the guaranty association for the guaranty association's payment of a deductible claim. A distribution to the guaranty association under this subdivision is not an early access payment under section 32 of this chapter or a distribution under section 40 of this chapter. (2) A receiver shall pay all claims against collateral in the order received, and a claim of the receiver, including claims described in this subsection, does not supersede any other claim against the collateral as described in subdivision (4). (3) A receiver shall draw down collateral to the extent necessary if the insured fails to do any of the following: (A) Perform the insured's funding or payment obligations under the large deductible policy. (B) Pay a deductible claim reimbursement within the time specified in subsection (f)(2). (C) Pay amounts due to the insurer estate for pre-liquidation obligations. (D) Fund any other secured obligation within: (i) the time specified in the large deductible policy; or (ii) another reasonable period. (E) Pay expenses within the time specified in subsection (f)(2). (4) A receiver shall pay all claims that are validly asserted against the collateral in the order in which the claims are received by the receiver. (5) A receiver shall return to an insured any excess collateral, as determined by the receiver after a periodic review of claims paid, outstanding case reserves, and a factor for incurred but not reported claims.		
Indiana	SB 20	**SB 20**, in part, includes the following language: (a) As used in this Section, "legislative council" refers to the legislative council established by IC 2-5-1.1-1. (b) The legislative council is urged to assign to the interim study committee on employment and labor established by IC 2-5-1.3-4 or another appropriate interim study committee during the 2016 legislative interim the topics of: (1) employee misclassification; (2) payroll fraud; and	7/1/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		(3) the use of independent contractor status. (c) If the topics described in subsection (b) are assigned to an interim study committee, the interim study committee shall issue a final report to the legislative council containing the interim study committee's findings and recommendations, including any recommended legislation, in an electronic format under IC 5-14-6 not later than November 1, 2016. (d) This Section expires December 31, 2016.		
Kansas	HB 2617	**HB 2617** amends several sections of the Kansas workers compensation law as follows: **44-510i—Medical benefits; appointment of medical administrator; maximum medical fee schedule; advisory panel.** (a) Subject to the approval of the secretary, ~~T~~the director shall contract with or appoint~~, subject to the approval of the secretary,~~ a specialist in health services delivery, who shall be referred to as the medical administrator. The medical administrator shall be a person licensed to practice medicine and surgery in this state and, if appointed, shall be in the unclassified service under the Kansas civil service act. … **44-534. Proceedings; time limitations.** (a) Whenever the employer, worker, Kansas workers compensation fund or insurance carrier cannot agree upon the worker's right to compensation under the workers compensation act or upon any issue in regard to workers compensation benefits due the injured worker thereunder, the employer, worker, Kansas worker's compensation fund or insurance carrier may apply in writing to the director for a determination of the benefits or compensation due or claimed to be due. The application shall be filed in the form prescribed by the rules and regulations of the director, including requirements for electronic filing, and the application shall set forth the substantial and material facts in relation to the claim. Whenever an application is filed under this section, the matter shall be assigned to an administrative law judge. The director shall forthwith mail a certified copy of the application to the adverse party. The administrative law judge shall proceed, upon due and reasonable notice to the parties, which shall not be less than 20 days, to hear all evidence in relation thereto and to make findings concerning the amount of compensation, if any due to the worker. … (c) After implementation of rules and regulations by the director, if the workers compensation electronic filing system is inaccessible on the last day for filing, then the time for filing shall be extended to the first accessible day that is not a Saturday, Sunday or legal holiday. As used in this subsection: (1) "Last day" means: (A) For electronic or facsimile filing, at midnight in the division's time zone on the final day for filing; and (B) for filing by other means, at 5 p.m. in the division's time zone on the final day for filing; and (2) "legal holiday" means any day declared a holiday by the president of the United States, the congress of the United States or the legislature of this state, or any day observed as a holiday by order of the governor. A half holiday shall be treated as other days and not as a holiday. **44-536a. Signing of pleadings, motions and other papers; liability for frivolous filings.** (a) Every pleading, motion and other ~~paper~~ document provided for by the workers compensation act of any party, who is represented by an	7/1/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		attorney, shall be signed by at least one attorney of record in the attorney's individual name, and the attorney's address ~~and~~, telephone number, fax number, email address and supreme court registration number shall be stated. Signature by electronic means, when utilizing the workers compensation electronic filing system, satisfies the requirements for signing. A pleading, motion or other ~~paper~~ document provided for by the workers compensation act of any party who is not represented by an attorney shall be signed by the party in writing or electronically, when utilizing the workers compensation electronic filing system, and shall state the party's name, address, telephone number, fax number and email address, if applicable. (b) Except when otherwise specifically provided by rule and regulation of the director, pleadings need not be verified or accompanied by an affidavit. The signature of a person constitutes a certificate by the person; (1) That the person has read the pleading~~,~~; (2) that to the best of the person's knowledge, information and belief formed after reasonable inquiry, the pleading is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification or reversal of existing law~~,~~; and (3) that the pleading is not imposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of resolving disputed claims for benefits. (c) If any pleading, motion or other ~~paper~~ document provided for by the workers compensation act is not signed, such pleading, motion or other ~~paper~~ document shall not be accepted and shall be void unless it is signed promptly after the omission is called to the attention of the pleader or movant. (d) If a pleading, motion or other ~~paper~~ document provided for by the workers compensation act is signed in violation of this section, the administrative law judge, director or board, upon motion or upon its own initiative upon notice and after opportunity to be heard, shall impose upon the person who signed such pleading or a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion or other ~~paper~~ document, including reasonable attorney fees. ... **44-550b. Records open to public inspection, exceptions.** (a) All records provided to be maintained under K.S.A. 44-550, and amendments thereto, and not withstanding the provisions of K.S.A. 45-215 et seq., and amendments thereto, shall be open to public inspection, except: ... (4) medical records, forms collected pursuant to ~~subsection (b) of~~ K.S.A. 44-567(b), and amendments thereto, accident reports maintained under K.S.A. 44-550, and amendments thereto, and social security numbers pertaining to an individual which shall not be disclosed except: ... (D) to federal or state governmental agencies for purposes of fraud and abuse investigations and child support enforcement, except that such disclosure shall not then be open to public inspection; ...		
Louisiana	HB 476	**HB 476** amends ***section 22:890 Certificates of insurance*** of the Louisiana Revised Statutes, in part, as follows: **§890. Certificates of insurance** A. For the purposes of this Section:	8/1/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		(1) "Certificate" or "certificate of insurance" means any document, instrument, or record, including an electronic record, no matter how titled or described, which is prepared by an insurer or insurance producer and issued to a third person not a party to the subject insurance contract, as evidence of property and casualty insurance coverage. "Certificate" or "certificate of insurance" shall not mean an insurance binder. (2) "Certificate holder" means any person, other than a policyholder, that is designated on a certificate of insurance as a "certificate holder" or any person, other than a policyholder, to whom a certificate of insurance has been issued by an insurer or insurance producer at the request of the policyholder. (3) "Electronic record" shall have the meaning defined in R.S. 9:2602 (7). (4) "Insurance" shall have the meaning defined in R.S. 22:46 (9). (5) "Insurance producer" shall have the same definition as set forth in R.S. 22:1542. (6) "Insurer" means an insurer as defined in R.S. 22:46 (10) and any other person engaged in the business of making property and casualty insurance contracts, including but not limited to self-insurers, syndicates, risk purchasing groups, and similar risk transfer entities. "Insurer" shall not mean any person self-insured for purposes of workers' compensation, including any group self-insurance fund authorized pursuant to R.S. 23:1195 et seq., any interlocal risk management agency authorized pursuant to R.S. 33:1341 et seq., or any self-insured employer authorized pursuant to R.S. 23:1168 et seq. (7) "Lender" means an individual, partnership, corporation, limited liability company, association, federally insured depository institution, or other entity, agent, loan agent, servicing agent, or loan or mortgage broker, who makes, owns, or services a loan. … C. No person, other than a lender, wherever located, may prepare, issue, or request the issuance of a certificate of insurance for risks located in this state unless the ~~form has been filed with and approved by the commissioner of insurance. No person, wherever located, may alter or modify an approved certificate of insurance form unless the alteration or modification has been approved by the commissioner of insurance~~ certificate is issued on standard certificate of insurance forms promulgated by the insurer, the Association for Cooperative Operations Research and Development (ACORD), the American Association of Insurance Services (AAIS), or the Insurance Services Office (ISO). D. ~~The commissioner of insurance shall disapprove a form filed under this Section or withdraw approval of a form if that form:~~ ~~(1) Is unfair, misleading, or deceptive, or violates public policy.~~ ~~(2) Violates any state statute or regulation validly promulgated by the commissioner of insurance.~~ ~~(3) Requires certification of insurance coverages that are not available.~~ ~~E. The commissioner may approve a certificate of insurance form that does not state that the form is provided for information only or similar language, provided that the form states that the certificate of insurance does not confer any rights or obligations other than those conveyed by the policy and that the terms of the policy control. Further, use of such a form shall not be, in and of itself, cause for disapproval by the commissioner under the provisions of Subsection D of this Section.~~ ~~F.(1) The commissioner of insurance shall approve or disapprove certificate of insurance forms filed pursuant to this Section in writing within forty-five days of receipt of the form.~~ ~~(2) Standard certificate of insurance forms promulgated by the Association for Cooperative Operations Research and Development (ACORD), the American Association of Insurance Services (AAIS), or the Insurance Services Office (ISO) shall be filed, but are deemed approved by the~~		

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2016 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/16)

JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		~~commissioner of insurance, provided these forms comply with the provisions of this Section.~~ ~~G.~~ No person shall demand or request the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference. ~~H.~~ E.(1)(a) No person may ~~prepare, issue, or~~ request an insurance producer prepare or issue, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document or correspondence, instrument, or record, including an electronic record~~, that is inconsistent with this Section;~~ . (b) The provisions of Subparagraph (a) of this Paragraph shall not apply to lenders, as defined in this Section, or to certificates of insurance required or requested by a lender from a policyholder. (2)(a) ~~however,~~ A person may request that an insurer ~~or insurance producer may~~ prepare or issue an addendum that clarifies, explains, summarizes, or provides a statement of the coverages provided by a policy of insurance and otherwise complies with the requirements of this Section. (b) Notwithstanding Subparagraph (a) of this Paragraph, a lender may request that an insurer or insurance producer prepare or issue an addendum that clarifies, explains, summarizes, or provides a statement of the coverages provided by a policy of insurance and otherwise complies with the requirements of this Section. … ~~J.~~ G. A certificate of insurance form which has been ~~approved by the commissioner~~ issued in accordance with this Section and properly executed and issued by a property and casualty insurer or an insurance producer, shall constitute a confirmation that the referenced insurance policy has been issued or that coverage has been bound notwithstanding the inclusion of "for information purposes only" or similar language on the face of the certificate. A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy or any validly executed endorsements of insurance provides. ~~K.~~ H. No certificate of insurance shall contain references to legal or insurance requirements contained in any contracts ~~other than the underlying contracts of insurance~~, including but not limited to construction or service contracts. The certificate of insurance may list only the specific forms or endorsements contained in the underlying contracts of insurance. No certificate holder or other interested party may require an interpretation of those forms or endorsements from the insurance agent. The provisions of this Subsection shall not apply to lenders, as defined in this Section, or to certificates of insurance required or requested by a lender from a policyholder.		
Louisiana	SB 44	**SB 44** amends ***section 23:1103. Damages; apportionment of between employer and employee in suits against third persons; compromise of claims; credit*** of the Louisiana Revised Statutes as follows: **§1103. Damages; apportionment of between employer and employee in suits against third persons; compromise of claims; credit** … D. An insurer shall grant its insured a dollar-for-dollar credit for any amount on any claim paid pursuant to this Chapter on the employer's behalf and recovered in the current year, less any reasonable expenses incurred in the recovery by the insurer, in an action or compromise pursuant to this Section and R.S. 23:1102. The credit shall be used by the insurer in the calculation~~, including but not limited to loss experience ratios,~~ of the loss experience modifier promulgated by and in accordance with the rules of the National Council on Compensation Insurance, to be applied in determining the annual premium paid by the employer for workers' compensation insurance under this Chapter. The group self-insurance fund shall	8/1/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		apply the loss experience modifier authorized by R.S. 23:1196.		
Maine	LD 1553	**LD 1553** makes various changes to the Maine Workers' Compensation Act of 1992 to: • Increase the Workers' Compensation Board's assessment cap starting in fiscal year 2017–18 to $13 million • Establish that appeals to the Law Court from the Workers' Compensation Board are from decisions of the Workers' Compensation Board's Appellate Division and not an individual administrative law judge • Require the Workers' Compensation Board to study the current system for independent contractor predeterminations and report any recommended legislation to the joint standing committee of the legislature having jurisdiction over labor matters • Require the Workers' Compensation Board to consider an employer's efforts to comply with the coverage requirements of the Maine Workers' Compensation Act of 1992 when imposing a monetary penalty • Establish that criminal prosecution may be pursued only if the employer has committed a knowing violation • Establish that revocation of authority to operate pursuant to the Maine Revised Statutes, Title 39-A, section 324, subsection 3, paragraph C may be pursued only if the employer has committed a knowing violation, has failed to pay a penalty assessed pursuant to that subsection, or continues to operate without required workers compensation insurance coverage after a penalty has been assessed pursuant to that subsection	7/19/16	No action required
Maryland	HB 631	**HB 631** amends ***section 9-628. Compensation for less than 75 weeks*** of the Labor and Employment Annotated Code of Maryland by expanding the circumstances under which a Howard County deputy sheriff is considered a public safety employee, thereby making the deputy sheriff eligible for enhanced workers compensation benefits. Specifically, the bill repeals a provision that only considers a deputy sheriff a public safety employee when he or she is performing law enforcement duties expressly requested, defined, and authorized in accordance with a written memorandum of understanding executed between the Howard County Sheriff and other law enforcement agencies.	10/1/16	No action required
Maryland	HB 958	**HB 958** amends ***section 11-307 Rate Filings*** of the Maryland Insurance Code as follows: **11-307 Rate Filings** **(a) Required.**— (1) Except as otherwise provided in this subsection, each authorized insurer and each rating organization that has been designated by an insurer for the filing of rates under subsection (b) of this section shall file with the Commissioner all rates and supplementary rate information and all changes and amendments of rates and supplementary information made by it for use in the State on or before the date they become effective. (2) Rates and supplementary rate information need not be filed for inland marine risks that by general custom are not written according to manual rules or rating plans. **(b) Establishing rates and supplementary rate information.**— (1) An insurer may itself establish rates and supplementary rate information based on the factors in § 11-306 of this subtitle. (2) Except for workers' compensation insurance rates, an insurer may use rates and supplementary rate information prepared and filed with the Commissioner by a rating organization of which it is a member or subscriber, with average loss factors or expense factors determined by the rating organization or with modification for its own expense and loss experience as the credibility of that experience allows. (3) If an insurer uses rates and supplementary rate information prepared by a rating organization: (i) the insurer shall notify the Commissioner that it uses rates and supplementary rate information prepared and filed with the Commissioner by a	10/1/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		designated rating organization of which it is a member or subscriber and shall provide the Commissioner with information about modifications of those rates and supplementary rate information that is necessary to inform the Commissioner fully; and (ii) subject to modifications filed by the insurer, the insurer's rates and supplementary rate information shall be those filed periodically by the rating organization, including any amendments to those filings. **(c) Public inspection.—** (1) In this subsection,"proprietary rate-related information": (i) means a rating model; and (ii) includes the formulas, algorithms, analyses, and specific weights given to variables used in the model. ~~(1)~~ (2) (i) ~~Each~~ except as provided in paragraph (3) of this subsection, each filing and any supporting information filed under this subtitle shall be open to public inspection as soon as filed. ~~(2)~~ (ii) On request and payment of a reasonable charge, a person may obtain copies of a filing and any supporting information. (3) (i) information that an insurer files with the Commissioner and identifies as proprietary rate-related information: 1. Constitutes a trade secret and confidential commercial information; 2. Subject to subparagraph (ii) of this paragraph and except as provided in subparagraph (iii) of this paragraph, shall be kept confidential by the Commissioner; and 3. Is not subject to subpoena served on the Commissioner or any recipient of proprietary rate-related information under subparagraph (iii) of this paragraph. (ii) 1. except as provided in subsubparagraph 2 of this subparagraph, if the Commissioner determines that some or all of the material that an insurer files and identifies as proprietary rate-related information does not constitute proprietary rate-related information as defined in paragraph (1) of this subsection, the Commissioner shall: A. Give the insurer written notice of that determination; and B. Make the material open to public inspection 10 business days after the date the Commissioner gives notice of the determination to the insurer. 2. The Commissioner may not disclose the material if: A. The insurer has not put the rate filing into effect; and B. Within the time period described in subsubparagraph 1b of this subparagraph, the insurer withdraws the rate filing and notifies the Commissioner that the rate filing is withdrawn. (iii) this paragraph does not prohibit the Commissioner from disclosing an insurer's proprietary rate-related information: 1. In furtherance of a regulatory or legal action that the Commissioner undertakes in performing the Commissioner's duties under this article; 2. If the recipient enters into a written agreement to maintain the confidentiality of the proprietary rate-related information, to: A. An outside consultant that the Commissioner engages to assist the Commissioner in reviewing the insurer's rate filing; B. Another state's insurance regulatory agency; C. The National Association of Insurance Commissioners; or D. A state or federal law enforcement authority, including the United States Department of Justice and the Maryland Attorney General, if acting in a		

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		law enforcement capacity; or 3. If the proprietary rate-related information is part of a homeowner's insurance or medical malpractice insurance rate filing, to the People's Insurance Counsel Division acting under § 6-306 of the state government article. (iv) 1. except as provided in subsubparagraph 2 of this subparagraph, the People's Insurance Counsel Division shall maintain the confidentiality of proprietary rate-related information disclosed to the division under subparagraph (iii)3 of this paragraph. 2. The People's Insurance Counsel Division may disclose proprietary rate-related information to an outside consultant that the division engages to assist the division in reviewing a homeowner's insurance rate filing, provided that the outside consultant enters into a written agreement to maintain the confidentiality of the proprietary rate-related information. (v) the Commissioner shall notify the insurer in writing at least 10 business days before the Commissioner discloses any of the insurer's proprietary rate-related information under subparagraph (iii) of this paragraph. (vi) in addition to any other rights an insurer may have under any other applicable law, the insurer may seek to have any disclosure of the insurer's proprietary rate-related information under subparagraph (iii)1 of this paragraph be made under seal or other protection of confidentiality. (vii) there is no waiver of any applicable privilege or claim of confidentiality with regard to any proprietary rate-related information that is disclosed under subparagraph (iii) of this paragraph. (4) This subsection may not be construed to: (i) authorize an insurer to designate the rating factors used to calculate the premium as proprietary rate-related information; or (ii) authorize the Commissioner to keep the rating factors confidential. **(d) Action by Commissioner.—** (1) The Commissioner may investigate and determine whether or not rates in the State are excessive, inadequate, or unfairly discriminatory. (2) In an investigation and determination under this subsection, the Commissioner shall give due consideration to the factors specified in § 11-306 of this subtitle.		
Maryland	HB 1408	**HB 1408** amends ***section 27-608 Premium increase for commercial insurance—Notice required*** of the Maryland Insurance Code by: • Exempting a commercial or workers compensation insurer from being required to send notice to the named insured and insurance producer, if any, when the insurer intends to increase a renewal policy premium, if the renewal policy premium is increasing by 15% or less • Repealing an exemption from the notice requirement for insurers if the renewal policy premium is greater than $1,000 and increasing by 3% or $300, whichever is less • Specifying that an insurer may not be required to comply with the notice requirement if a separate notice containing specified information is sent • Repealing a provision that considers the notice requirement to have been met when an insurer sends this separate notice The proposed amendments apply to all policies of commercial insurance and workers compensation insurance issued, delivered, or renewed in the state on or after October 1, 2016.	10/1/16	No action required
Maryland	SB 505	**SB 505** amends ***section 11-329. Workers' compensation insurers*** of the Maryland Insurance Code as follows:	10/1/16	Item Filing has been

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		§ 11-329. Workers' compensation insurers … (f) Basis for premium adjustment.— (1) Except as provided in ~~paragraph (2)~~ paragraphs (2) and (3) of this subsection, the uniform experience rating plan shall be the exclusive means of providing prospective premium adjustment based on measurement of the loss-producing characteristics of an individual insured. (2) In addition to any premium adjustment allowed under paragraph (1) of this subsection and pursuant to a filing made by a rating organization and approved by the Commissioner, an insurer may file a rating plan with the Commissioner that provides for prospective premium adjustments up to 25% based upon characteristics of a risk that are not reflected in the uniform experience rating plan. (3) (I) Except as provided in subparagraph (ii) of this paragraph, in addition to any premium adjustment allowed under paragraphs (1) and (2) of this subsection and pursuant to a filing made by a rating organization and approved by the commissioner, an insurer may file a rating plan with the commissioner that provides for a premium discount for appropriate classifications or subclassifications of a risk of up to 4% to an insured that has an alcohol- and drug-free workplace policy that may include one or more of the following programs: 1. An alcohol and drug testing program; 2. An employee education program on alcohol and drug abuse; 3. A supervisor education program on alcohol and drug abuse; 4. An employee assistance program that includes referrals of employees for appropriate diagnosis, treatment, and assistance; 5. A program requiring an employee who has caused or contributed to an accident while at work to undergo alcohol or drug testing; and 6. Any other program that the insurer deems effective to encourage an alcohol- and drug-free workplace. (ii) an insurer is not required to provide a premium discount under this paragraph if the insured is required under federal or state law to test its employees for drugs or otherwise provide an alcohol- and a drug-free workplace. (4) An insurer may file a rating plan that provides for retrospective premium adjustments based on an insured's past experience.		approved Approval Circular MD-2016-04
Mississippi	SB 2193	**SB 2193**, in part, amends ***section 83-17-401 Definitions*** of the Mississippi Code of 1972 as follows: **§ 83-17-401 Definitions** As used in this article, unless the context otherwise requires: … (e) "Workers' compensation adjuster" means an adjuster whose scope of licensure is limited to workers' compensation insurance. A workers' compensation adjuster may not represent an insured individual. A workers' compensation adjuster must comply with all licensing and continuing education requirements as are prescribed by the commissioner pursuant to this article. …	7/1/16	No action required
Missouri	HB 1763	**HB 1763** adds new ***section 375.1605*** to the Missouri Annotated Statutes to read as follows: **375.1605** 1. The provisions of this section shall apply to workers' compensation large deductible policies issued by an insurer subject to delinquency proceedings under this chapter. This section shall not apply to first party claims or to claims funded by a guaranty association net of the deductible unless subsection 3 of this section applies. Large deductible policies shall be administered in accordance with their terms, except to the extent such	9/14/16	No action required

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		terms conflict with the provisions of this section. 2. For purposes of this section, the following terms mean: (1) "Collateral", any cash, letters of credit, surety bond, or any other form of security posted by the insured or by a captive insurer or reinsurer to secure the insured's obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay the insurer as may be required for other secured obligations; (2) "Commercially reasonable", to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter; (3) "Deductible claim", any claim, including a claim for loss and defense and cost containment expense, unless such expenses are excluded, under a large deductible policy that is within the deductible; (4) "Delinquency proceeding", shall have the same meaning ascribed to it in section 375.1152; (5) "Guaranty association", the Missouri property and casualty insurance guaranty association created by sections 375.771 to 375.779, as amended, and any other similar entities created by the laws of any other state for the payment of claims of insolvent insurers; (6) "Large deductible policy", any combination of one or more workers' compensation policies and endorsements issued to an insured and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to: (a) Pay directly the initial portion of any claim under the policy up to a specified dollar amount or the expenses related to any claim; or (b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible. The term "large deductible policy" also includes policies that contain an aggregate limit on the insured's liability for all deductible claims in addition to a per-claim deductible limit. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer. Large deductible policies do not include policies, endorsements, or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insured shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder's large deductible obligations; (7) "Other secured obligations", obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations, the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy; (8) "Receiver", shall have the same meaning ascribed to it in section 375.1152. 3. Unless otherwise agreed by the responsible guaranty association, all large deductible claims which are also "covered claims", as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim pursuant to an agreement by the guaranty fund or otherwise, the insured's funding or payment of a deductible claim will extinguish the obligations, if any, of the receiver or any guaranty association to pay such claim. No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured's funding or payment of a deductible claim.		

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		4. To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Such reimbursements and collateral shall be subject to any reasonable and actual expenses recovered by the receiver as provided for under subsection 7 of this section. Reimbursements paid to the guaranty association under this subsection shall not be treated as distributions under section 375.1218 or as early access payments under section 375.1205. To the extent that a guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, or incurred expenses in connection with large deductible policies that are not reimbursed under this section, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding. Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses such as those affording the guaranty association the right to recover for claims payments made to or on behalf of high net worth insureds or claimants. 5. (1) The receiver shall have the obligation to collect reimbursements owed for deductible claims as provided for herein and shall take all commercially reasonable actions to collect such reimbursements. The receiver shall promptly bill insureds for reimbursement of deductible claims: (a) Paid by the insurer prior to the commencement of delinquency proceedings; (b) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or (c) Paid or allowed by the receiver. (2) If the insured does not make payment within the time specified in the large deductible policy, or within sixty days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed. (3) Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured's reimbursement obligation under the large deductible policy. (4) Except for gross negligence, an allegation of improper handling or payment of a deductible claim by the insurer, the receiver, or any guaranty association shall not be a defense to the insured's reimbursement obligations under the large deductible policy. 6. (1) Subject to the provisions of this subsection, the receiver shall utilize collateral if available to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payments of a deductible claim. Any distributions made to a guaranty association under this subsection shall not be treated as distributions under section 375.1218 or as early access payments under section 375.1205. (2) All claims against the collateral shall be paid in the order received and no claim of the receiver, including those described in this subsection, shall supersede any other claim against the collateral as described in subdivision (4) of this subsection. (3) The receiver shall draw down collateral to the extent necessary in the event that the insured fails to: (a) Perform its funding or payment obligations under any large deductible policy; (b) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty days after the date of the billing if no time is specified; (c) Pay amounts due the estate for preliquidation obligations;		

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		(d) Timely fund any other secured obligation; or (e) Timely pay expenses. (4) Claims that are validly asserted against the collateral shall be satisfied in the order in which such claims are received by the receiver; except that, if more than one creditor has a valid claim against the same collateral and the available collateral, along with billing collection efforts and to the extent that the collateral is subject to other known secured obligations, are together insufficient to pay each creditor in full, then the director as rehabilitator or liquidator shall prorate payments to each creditor based upon the relationship the amount of claims each creditor has paid bears to the total of all claims paid by all such creditors. (5) Excess collateral may be returned to the insured as determined by the receiver after a periodic review of claims paid, outstanding case reserves, and a factor for incurred but not reported claims. 7. The receiver shall be entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements under the provisions of this section, subject to the review and approval by the court. 8. The court having jurisdiction over the delinquency proceedings under section 375.1154 shall have jurisdiction to resolve disputes arising under the provisions of this section. 9. The provisions of this section shall apply to all delinquency proceedings that either commence on or after the effective date of this section or are open and pending on the effective date of this section, provided that, the provisions of this section shall not affect any delinquency proceeding for which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction prior to the effective date of this section. 10. Nothing in this section is intended to limit or adversely affect any rights or powers a guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association under policies of the insolvent insurer, or for related expenses the guaranty association incurs.		
Missouri	HB 1936	**HB 1936** amends, in part, ***section 57.111 May act in adjoining county, when*** of the Missouri Annotated Statutes as follows: **57.111 May act in adjoining county, when** Whenever any sheriff or deputy sheriff of any county in this state is expressly requested, in each instance, by a sheriff ~~of an adjoining county~~ of this state to render assistance, such sheriff or deputy shall have the same powers of arrest in such county as he or she has in his or her own jurisdiction. Any sheriff, or deputy sheriff that a responding sheriff sends, of a county responding to a request for assistance in another county of the state shall be deemed an employee of the sending sheriff's office and shall be subject to the workers' compensation, overtime, and expense reimbursement provisions provided to him or her as an employee of the sending sheriff's office.	8/28/16	No action required
Missouri	HB 2194	**HB 2194**, in part, amends ***section 287.955. Insurers to adhere to uniform classification system, plan—director to designate advisory organization, purpose, duties—risk premium modification plan, requirements*** of the Missouri Annotated Statues as follows: **287.955. Insurers to adhere to uniform classification system, plan—director to designate advisory organization, purpose, duties—risk premium modification plan, requirements.** … 6. (1) A workers' compensation insurer may develop an individual risk premium modification rating plan which prospectively modifies premium	8/28/16	No action required

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		based upon individual risk characteristics which are predictive of future loss. Such rating plan shall be filed thirty days prior to use and may be subject to disapproval by the director. (2) Premium modifications under this subsection may be determined by an underwriter assessing the individual risk characteristics and applying premium credits and debits as specified under a schedule rating plan. Alternatively, an insurer may utilize software or a computer risk modeling system designed to identify and assess individual risk characteristics and which systematically and uniformly applies premium modifications to similarly situated employers. The rating plan shall establish objective standards for measuring variations in individual risks for hazards or expense or both. ~~The rating plan shall be actuarially justified and shall not result in premiums which are excessive, inadequate, or unfairly discriminatory.~~ The rating plan shall not utilize factors which are duplicative of factors otherwise utilized in the development of rates or premiums, including the uniform classification system and the uniform experience rating plan. ~~The premium modification factors utilized under the rating plan shall be applied on a statewide basis, with no premium modifications~~ No premium modification factors shall be based solely upon the geographic location of the employer. (a) Premium modifications resulting from a schedule rating plan, with an underwriter determining individual risk characteristics, shall be limited to plus or minus twenty-five percent. Up to an additional ten percent credit may be given for a reduction in the insurer's expenses. (b) Premium modifications resulting from a risk modeling system shall be limited to plus or minus fifty percent. Premium modifications resulting from a risk modeling system shall be reported separately under the uniform statistical plan from premium modifications resulting from a schedule rating plan. (c) Changes in premium modification factors may occur if there is a change in the insurer, the insurer amends or withdraws the rating plan, or if there is a change in the insured employer's operations or risk characteristics underlying the premium modification factor. (3) Within thirty days of a request, the insurer shall clearly disclose to the employer the individual risk characteristics which result in premium modifications. However, this disclosure shall not in any way require the release to the insured employer of any trade secret or proprietary information or data used to derive the premium modification and that meets the definitions of, and is protected by, the provisions of chapter 417. ~~(4) (a) Premium modifications under this subsection may be determined by an underwriter assessing the individual risk characteristics and applying premium credits and debits as specified under a schedule rating plan. Alternatively, an insurer may utilize software or a computer risk modeling system designed to identify and assess individual risk characteristics and which systematically and uniformly applies premium modifications to similarly situated employers.~~ ~~(b) Premium modifications resulting from a schedule rating plan, with an underwriter determining individual risk characteristics, shall be limited to plus or minus twenty-five percent. An additional ten percent credit may be given for a reduction in the insurer's expenses.~~ ~~(c) Premium modifications resulting from a risk modeling system shall be limited to plus or minus fifty percent. Premium modifications resulting from a risk modeling system shall be reported separately under the uniform statistical plan from premium modifications resulting from a schedule rating plan.~~ ~~(d) Premium credits or reductions shall not be removed or reduced unless there is a change in the insurer, the insurer amends or withdraws the rating plan, or unless there is a corresponding change in the insured employer's operations or risk characteristics underlying the credit or reduction.~~		
Missouri	SB 613	**SB 613** adds new section *287.245* and amends ***sections 287.957. Experience rating plan, contents*** and ***287.975. Pure premium rate, schedule of rates, filed with director, when—payroll differential, advisory organization to collect data, when, purpose*** of the Missouri Workers Compensation	8/28/16	Item Filing has been approved

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		Law as follows: **287.245** 1. As used in this section, the following terms shall mean: (1) "Association", volunteer fire protection associations as defined in section 320.300; (2) "State fire marshal", the state fire marshal selected under the provisions of sections 320.200 to 320.270; (3) "Volunteer firefighter", the same meaning as in section 287.243. 2. Any association may apply to the state fire marshal for a grant for the purpose of funding such association's costs related to workers' compensation insurance premiums for volunteer firefighters. 3. Subject to appropriations, the state fire marshal shall disburse grants to each applying volunteer fire protection association according to the following schedule: (1) Associations which had zero to five volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for two thousand dollars in grant money; (2) Associations which had six to ten volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand five hundred dollars in grant money; (3) Associations which had eleven to fifteen volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand dollars in grant money; (4) Associations which had sixteen to twenty volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for five hundred dollars in grant money. 4. Grant money disbursed under this section shall only be used for the purpose of paying for the workers' compensation insurance premiums of volunteer firefighters. **287.957 Experience rating plan, contents.** The experience rating plan shall contain reasonable eligibility standards, provide adequate incentives for loss prevention, and shall provide for sufficient premium differentials so as to encourage safety. The uniform experience rating plan shall be the exclusive means of providing prospective premium adjustment based upon measurement of the loss-producing characteristics of an individual insured. An insurer may submit a rating plan or plans providing for retrospective premium adjustments based upon an insured's past experience. Such system shall provide for retrospective adjustment of an experience modification and premiums paid pursuant to such experience modification where a prior reserved claim produced an experience modification that varied by greater than fifty percent from the experience modification that would have been established based on the settlement amount of that claim. The rating plan shall prohibit an adjustment to the experience modification of an employer if the total medical cost does not exceed ~~one thousand dollars~~ twenty percent of the current split point of primary and excess losses under the uniform experience rating		Approval Circular MO-2016-02

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		plan, and the employer pays all of the total medical costs and there is no lost time from the employment, other than the first three days or less of disability under subsection 1 of section 287.160, and no claim is filed. An employer opting to utilize this provision maintains an obligation to report the injury under subsection 1 of section 287.380. **287.975 Pure premium rate, schedule of rates, filed with director, when—payroll differential, advisory organization to collect data, when, purpose.** 1. The advisory organization shall file with the director every pure premium rate, every manual of rating rules, every rating schedule and every change or amendment, or modification of any of the foregoing, proposed for use in this state no more than thirty days after it is distributed to members, subscribers or others. 2. The advisory organization which makes a uniform classification system for use in setting rates in this state shall collect data for two years after January 1, 1994, on the payroll differential between employers within the construction group of code classifications, including, but not limited to, payroll costs of the employer and number of hours worked by all employees of the employer engaged in construction work. Such data shall be transferred to the department of insurance, financial institutions and professional registration in a form prescribed by the director of the department of insurance, financial institutions and professional registration, and the department shall compile the data and develop a formula to equalize premium rates for employers within the construction group of code classifications based on such payroll differential within three years after the data is submitted by the advisory organization. 3. The formula to equalize premium rates for employers within the construction group of code classifications established under subsection 2 of this section shall be the formula in effect on January 1, 1999. This subsection shall become effective on January 1, 2014. 4. For the purposes of calculating the premium credit under the Missouri contracting classification premium adjustment program, an employer within the construction group of code classifications may submit to the advisory organization the required payroll record information for the first, second, third, or fourth calendar quarter of the year prior to the workers' compensation policy beginning or renewal date, provided that the employer clearly indicates for which quarter the payroll information is being submitted.		
Missouri	SB 700	**SB 700** adds new section ***287.245*** and amends ***sections 287.090. Exempt employers and occupations—election to accept—withdrawal—notification required of insurance companies, 287.957. Experience rating plan, contents,*** and ***287.975. Pure premium rate, schedule of rates, filed with director, when—payroll differential, advisory organization to collect data, when, purpose*** of the Missouri Workers Compensation Law as follows: **287.245.** 1. As used in this section, the following terms shall mean: (1) "Association", volunteer fire protection associations as defined in section 320.300; (2) "State fire marshal", the state fire marshal selected under the provisions of sections 320.200 to 320.270; (3) "Volunteer firefighter", the same meaning as in section 287.243. 2. Any association may apply to the state fire marshal for a grant for the purpose of funding such association's costs related to workers' compensation insurance premiums for volunteer firefighters. 3. Subject to appropriations, the state fire marshal shall disburse grants to each applying volunteer fire protection association according to the	8/28/16	See "Legislative Analysis" section on NCCI's Legislative Activity page on **ncci.com** for cost impact analysis Item Filing has been approved Approval Circular MO-2016-02

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		following schedule: (1) Associations which had zero to five volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for two thousand dollars in grant money; (2) Associations which had six to ten volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand five hundred dollars in grant money; (3) Associations which had eleven to fifteen volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand dollars in grant money; (4) Associations which had sixteen to twenty volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for five hundred dollars in grant money. 4. Grant money disbursed under this section shall only be used for the purpose of paying for the workers' compensation insurance premiums of volunteer firefighters. **287.090. Exempt employers and occupations—election to accept—withdrawal—notification required of insurance companies.** 1. This chapter shall not apply to: … (4) Except as provided in section 287.243, volunteers of a tax-exempt organization which operates under the standards of Section 501(c)(3) or Section 501(c)(19) of the federal Internal Revenue Code, where such volunteers are not paid wages, but provide services purely on a charitable and voluntary basis; … **287.957. Experience rating plan, contents.** The experience rating plan shall contain reasonable eligibility standards, provide adequate incentives for loss prevention, and shall provide for sufficient premium differentials so as to encourage safety. The uniform experience rating plan shall be the exclusive means of providing prospective premium adjustment based upon measurement of the loss-producing characteristics of an individual insured. An insurer may submit a rating plan or plans providing for retrospective premium adjustments based upon an insured's past experience. Such system shall provide for retrospective adjustment of an experience modification and premiums paid pursuant to such experience modification where a prior reserved claim produced an experience modification that varied by greater than fifty percent from the experience modification that would have been established based on the settlement amount of that claim. The rating plan shall prohibit an adjustment to the experience modification of an employer if the total medical cost does not exceed ~~one thousand dollars~~ twenty percent of the current split point of primary and excess losses under the uniform experience rating plan, and the employer pays all of the total medical costs and there is no lost time from the employment, other than the first three days or less of		

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		disability under subsection 1 of section 287.160, and no claim is filed. An employer opting to utilize this provision maintains an obligation to report the injury under subsection 1 of section 287.380. **287.975. Pure premium rate, schedule of rates, filed with director, when—payroll differential, advisory organization to collect data, when, purpose.** 1. The advisory organization shall file with the director every pure premium rate, every manual of rating rules, every rating schedule and every change or amendment, or modification of any of the foregoing, proposed for use in this state no more than thirty days after it is distributed to members, subscribers or others. 2. The advisory organization which makes a uniform classification system for use in setting rates in this state shall collect data for two years after January 1, 1994, on the payroll differential between employers within the construction group of code classifications, including, but not limited to, payroll costs of the employer and number of hours worked by all employees of the employer engaged in construction work. Such data shall be transferred to the department of insurance, financial institutions and professional registration in a form prescribed by the director of the department of insurance, financial institutions and professional registration, and the department shall compile the data and develop a formula to equalize premium rates for employers within the construction group of code classifications based on such payroll differential within three years after the data is submitted by the advisory organization. 3. The formula to equalize premium rates for employers within the construction group of code classifications established under subsection 2 of this section shall be the formula in effect on January 1, 1999. This subsection shall become effective on January 1, 2014. 4. For the purposes of calculating the premium credit under the Missouri contracting classification premium adjustment program, an employer within the construction group of code classifications may submit to the advisory organization the required payroll record information for the first, second, third, or fourth calendar quarter of the year prior to the workers' compensation policy beginning or renewal date, provided that the employer clearly indicates for which quarter the payroll information is being submitted.		
Missouri	SB 732	**SB 732** amends various sections of the Missouri Annotated Statutes including, but not limited to, ***section 44.023 Disaster volunteer program established, agency's duties—expenses—immunity from liability, exception*** as follows: **Disaster volunteer program established, agency's duties—expenses—immunity from liability, exception.** **44.023. 1.** The Missouri state emergency management agency shall establish and administer an emergency volunteer program to be activated in the event of a disaster whereby volunteer architects, ~~and professional~~ engineers ~~registered~~ licensed under chapter 327, any individual including, but not limited to, building officials and building inspectors employed by local governments, qualified by training and experience, who has been certified by the state emergency management agency, and who performs his or her duties under the direction of an architect or engineer licensed under chapter 327, and construction contractors, equipment dealers and other owners and operators of construction equipment may volunteer the use of their services and equipment, either manned or unmanned, for up to ~~three~~ five consecutive days for in-state deployments as requested and needed by the state emergency management agency. 2. In the event of a disaster, the enrolled volunteers shall, where needed, assist local jurisdictions and local building inspectors to provide essential demolition, cleanup or other related services and to determine whether ~~buildings~~ structures affected by a disaster: (1) Have not sustained serious damage and may be occupied;	8/28/16	No action required

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		(2) Must be ~~vacated temporarily~~ restricted in their use pending repairs; or (3) ~~Must be demolished in order to avoid hazards to occupants or other persons~~ Are unsafe and shall not be occupied pending repair or demolition. 3. Any person when utilized as a volunteer under the emergency volunteer program shall have his or her incidental expenses paid by the local jurisdiction for which the volunteer service is provided. Enrolled volunteers under the emergency volunteer program shall be provided workers' compensation insurance by the state emergency management agency during their official duties as authorized by the state emergency management agency. 4. Emergency volunteers who are certified by the state emergency management agency shall be considered employees of the state for purposes of the emergency mutual aid compact under section 44.415 and shall be eligible for out-of-state deployments in accordance with such section. 5. Architects, ~~and professional~~ engineers, individuals including, but not limited to, building officials and building inspectors employed by local governments, qualified by training and experience, who have been certified by the state emergency management agency, and who perform their duties under the direction of an architect or engineer licensed under chapter 327, construction contractors, equipment dealers and other owners and operators of construction equipment and the companies with which they are employed, working under the emergency volunteer program, shall not be personally liable either jointly or separately for any act or acts committed in the performance of their official duties as emergency volunteers except in the case of willful misconduct or gross negligence. ~~5.~~ 6. Any individuals, employers, partnerships, corporations or proprietorships, that are working under the emergency volunteer program providing demolition, cleanup, removal or other related services, shall not be liable for any acts committed in the performance of their official duties as emergency volunteers except in the case of willful misconduct or gross negligence. In addition, **SB 732** adds new section ***287.245*** to the Missouri Workers Compensation Law to read: **287.245** 1. As used in this section, the following terms shall mean: (1) "Association", volunteer fire protection associations as defined in section 320.300; (2) "State fire marshal", the state fire marshal selected under the provisions of sections 320.200 to 320.270; (3) "Volunteer firefighter", the same meaning as in section 287.243. 2. Any association may apply to the state fire marshal for a grant for the purpose of funding such association's costs related to workers' compensation insurance premiums for volunteer firefighters. 3. Subject to appropriations, the state fire marshal shall disburse grants to each applying volunteer fire protection association according to the following schedule: (1) Associations which had zero to five volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for two thousand dollars in grant money; (2) Associations which had six to ten volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand five hundred dollars in grant money;		

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		(3) Associations which had eleven to fifteen volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for one thousand dollars in grant money; (4) Associations which had sixteen to twenty volunteer firefighters receive workers' compensation benefits from claims arising out of and in the course of the prevention or control of fire or the underwater recovery of drowning victims in the preceding calendar year shall be eligible for five hundred dollars in grant money. 4. Grant money disbursed under this section shall only be used for the purpose of paying for the workers' compensation insurance premiums of volunteer firefighters.		
New Hampshire	HB 1459	**HB 1459** amends ***sections 412:3. Definitions***, ***412:15. Rate Standards***, and ***412:16. Rate Filings*** of the New Hampshire Statutes as follows: **412:3. Definitions** … XI. "Large commercial policyholder" means an insurance contract holder that is a corporation, partnership, trust, sole proprietorship, or other business or public entity and that has certified that it meets: (a)At least ~~2~~ one of the following ~~3~~ 4 criteria: (1)A net worth of $10,000,000 as certified by a certified public accountant or public accountant authorized to do business in this state; (2) Net revenue or sales of $5,000,000 as certified by a certified public account or public accountant authorized to do business in this state; or (3) A total of more than 25 employees per individual company or more than 50 employees per holding company~~.~~;~~ and~~ (4) Aggregate property and casualty insurance premiums, excluding workers' compensation, medical malpractice, life, health, and disability insurance premiums of $50,000 or more. (b) ~~The following criteria~~ ~~(1) The use of an employed or retained risk manager to procure insurance. For the purposes of this section, "risk manager" means a chartered property and casualty underwriter, a certified insurance counselor, an associate in risk management, a certified risk manager or a licensed insurance consultant; and~~ ~~(2) Aggregate property and casualty insurance premiums, excluding workers' compensation, medical malpractice, life, health, and disability insurance premiums of $30,000 or more.~~ ~~(c)~~ "Large commercial policyholder" also includes a nonprofit or public entity with an annual budget or assets of $25,000,000 or more that meets the criteria listed in subparagraph ~~(b)~~(a)(4), and a municipality with a population of 20,000 or more that meets the premium criteria listed in subparagraph ~~(b)(2)~~(a)(4). ~~(d) A commercial policyholder that meets the premium criteria listed in subparagraph (b)(2), but that does not meet 3 of the qualifying criteria listed in either subparagraph (a) or subparagraph (b)(1) may petition the commissioner for a waiver of the remaining criteria. The commissioner may grant a waiver if the commissioner determines that the applicant for a waiver is sufficiently qualified to act as a large commercial policyholder.~~ (c) In this section, "risk manager" means a chartered property and casualty underwriter, certified insurance counselor, an associate in risk management, certified risk manager or a licensed insurance consultant. …	7/19/16	No action required

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		412:15. Rate Standards … IV. The commissioner may permit insurers to use appropriate systems of schedule rating filed by any insurer or rating bureau approved by the commissioner, subject to rules adopted under RSA 541-A, to assure the uniform and impartial application of such rating. Such ratings shall be: (a) Based on an insured's management, safety, and loss control policies and record; (b) No greater than plus or minus 40 percent of the insurer's base rates. V. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer, advisory organization and statistical agent may exchange information and experience data with insurance supervisory officials, insurers and advisory organizations in other states and may consult with them with respect to the application of rating systems and the collection of statistical data. **412:16. Rate Filings** … II. Every insurer shall file with the commissioner, except as to inland marine risks which are not written according to manual rates or rating plans, every manual, predictive models or telematics models or other models that pertain to the formulation of rates and/or premiums, minimum premium, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing which it proposes to use. Personal lines filings shall include underwriting rules used by insurers or a group of affiliated insurers to the extent necessary to determine the applicable rate and/or policy premium for an individual insured or applicant. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by RSA 412:23. Every such filing shall state the effective date, and shall indicate the character and extent of the coverage contemplated. Information contained in the underwriting rules that does not pertain to the formulation of rates and/or premiums shall be identified by the filer as proprietary and shall be kept confidential by the department and shall not be subject to the provisions of RSA 91-A. … VII(b) For all commercial risk policies, except policies issued to a large commercial policyholder, and except as provided in this chapter, the rates and supplementary rating information that will be used in this state shall be filed for informational purposes only within 30 days of the effective date. … VIII. In a noncompetitive market, subject to the exceptions specified in RSA 412:16, IX and X, and RSA 412:28, each filing shall be on file for a waiting period of 30 days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed ~~30~~ 60 days if written notice is given within such waiting period to the insurer or advisory organization which made the filing that additional time is needed for the consideration of the filing. Upon written application by the insurer, the commissioner may authorize a filing that has been reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof. Failure of the insurer or advisory organization to provide the requested information within the waiting period or the extension thereof shall be deemed a request to withdraw the filing from further consideration. Failure of the commissioner to act within the waiting period or the extension thereof shall result in the filing being deemed to meet		

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		the requirements of this chapter. Neither the insurer nor the commissioner may waive the timeliness requirements of the provisions in this section. …		
New Hampshire	SB 203	**SB 203** amends ***section 281-A:48. Review of Eligibility for Compensation*** of the New Hampshire Statutes as follows: I. Any party at interest with regard to an injury occurring after July 1, 1965, may petition the commissioner to review a denial or an award of compensation made pursuant to RSA 281-A:40 by filing a petition with the commissioner not later than the fourth anniversary of the date of such denial or the last payment of compensation under such award or pursuant to RSA 281-A:40, as the case may be, upon the ground of a change in conditions, mistake as to the nature or extent of the injury or disability, fraud, undue influence, or coercion. This section shall not apply to requests for extensions of medical and hospital benefits, or other remedial care, which shall be governed solely by those sections of this chapter relating thereto. This section shall not apply to lump sum agreements, except upon the grounds of fraud, undue influence, or coercion. I-a. Any party at interest with regard to an injury occurring after January 1, 2016, where medical treatment for that injury is purposefully and intentionally postponed for medical reasons beyond the fourth anniversary of the date of denial or the last payment of compensation, may petition the commissioner to review such denial or award of compensation made pursuant to RSA 281-A:40 by filing a petition with the commissioner no later than 180 days after the date of the postponed treatment. A written acknowledgment by the employee and notification to the workers' compensation carrier shall be included in the worker's medical record including the medical reason for postponing the medical procedure. Any award or denial of indemnity payments made under this paragraph shall not extend the time frame under paragraph I. **…**	9/19/16	No action required
New Hampshire	SB 409	**SB 409** amends ***section 281-A:32-a First Responder's Critical Injury Benefit*** of the New Hampshire Statutes as follows: **281-A:32-a First Responder's Critical Injury Benefit** I. In addition to other payments made under RSA 281-A, a group II retirement system member may request additional compensation under this section. If the impairment to a group II retirement system member resulting from an injury is partial, with a determination by the department of labor that the employee has reached maximum medical improvement and that such maximum medical improvement is less than 100 percent, the governor may draw a warrant, with approval by the executive council, from funds not otherwise appropriated for payments in addition to benefits payable under this chapter for an award to be paid to such employees in amounts provided by RSA 281-A:28 for the number of weeks set forth in this section for permanent bodily loss or impairment: (a) Permanent loss or impairment of heart, lung, or brain 208 (b) Permanent loss or impairment of other internal organs 104 (c) Permanent loss or impairment of speech, touch, taste, or smell 104 II. Payments awarded under this section shall be subject to all other provisions of RSA 281-A. Total compensation payments for all additional compensation claims paid under this section shall not exceed $125,000 per claimant. No payments shall be made after July 1, ~~2016~~ 2018. Benefits paid under this section for all claimants shall not exceed $500,000. **SB 409** also extends the prospective repeal of the first responder's critical injury benefit from June 30, 2016, to June 30, 2018. Additionally, **SB 409** includes the following language:	6/21/16	No action required

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		I. There is established a committee to study soft tissue injuries for purposes of workers' compensation permanent impairment awards. (a) The members of the committee shall be as follows: (1) One member of the senate, appointed by the president of the senate. (2) Three members of the house of representatives, appointed by the speaker of the house of representatives. (b) Members of the committee shall receive mileage at the legislative rate when attending to the duties of the committee. II. The committee shall study soft tissue injuries for purposes of workers' compensation permanent impairment awards. III. The members of the study committee shall elect a chairperson from among the members. The first meeting of the committee shall be called by the senate member. The first meeting of the committee shall be held within 45 days of the effective date of this section. IV. The committee shall report its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2016.		
New Mexico	SB 214	**SB 214** amends ***sections 52-1-11. Injuries due to intoxication, willfulness or intention of worker are noncompensable*** and ***52-1-12.1. Reduction in compensation when alcohol or drugs contribute to injury or death*** and repeals ***section 52-1-12. Compensation prohibited when worker under influence of certain drugs*** of the New Mexico Statutes Annotated as follows: **52-1-11. Injuries ~~due to intoxication~~ caused by the willfulness or intention of worker are noncompensable** No compensation shall become due or payable from any employer under the terms of the Workers' Compensation Act in the event such injury was ~~occasioned by the intoxication of such worker or~~ willfully suffered by ~~him~~ the worker or intentionally inflicted by ~~himself~~ the worker. **52-1-12.1. Reduction in compensation when alcohol or drugs contribute to injury or death** ~~The compensation otherwise payable a worker pursuant to the Workers' Compensation Act shall be reduced ten percent in cases in which the injury to or death of a worker is not occasioned by the intoxication of the worker as stated in Section 52-1-11 NMSA 1978 or occasioned solely by drug influence as described in Section 52-1-12 NMSA 1978, but voluntary intoxication or being under the influence of a depressant, stimulant or hallucinogenic drug as defined in the New Mexico Drug, Device and Cosmetic Act or under the influence of a narcotic drug as defined in the Controlled Substances Act, unless the drug was dispensed to the person upon the prescription of a practitioner licensed by law to prescribe the drug or administered to the person by any person authorized by a licensed practitioner to administer the drug, is a contributing cause to the injury or death. Test results used as evidence of intoxication or drug influence shall not be considered in making a determination of intoxication or drug influence unless the test and testing procedures conform to the federal department of transportation "procedures for transportation workplace drug and alcohol testing programs" and the test is performed by a laboratory certified to do the testing by the federal department of transportation.~~ A. As used in this section, "intoxication" or "influence" means a temporary state or condition of impaired physical, mental or cognitive function by means of alcohol, a drug, a controlled substance or a combination of two or more substances at the time of injury or death. "Drug" or "controlled substance" pursuant to this section does not include medications prescribed to a worker by the worker's licensed health care provider and taken in accordance with directions of the prescribing health care provider or dispensing pharmacy, unless such medication is combined with alcohol or a non-prescribed drug or controlled substance to cause intoxication or influence. B. Except as otherwise provided in this section, compensation benefits otherwise due and payable from an employer to the worker under the terms of the Workers' Compensation Act shall be reduced by the degree to which the intoxication or influence contributes to the worker's injury or death;	5/18/16	See "Legislative Analysis" section on NCCI's Legislative Activity page on **ncci.com** for cost impact analysis

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		provided that the reduction shall be a minimum of ten percent but no more than ninety percent. C. Test results relied on as evidence of a worker's intoxication or influence shall not be considered in making a reduction in compensation determination unless the test and testing procedures conform with standard testing procedures generally accepted in the medical community and the test is performed by a laboratory certified to do the testing by an organization nationally recognized to do such certification. Testing may include testing methods for urine, breath or blood. D. The director shall adopt rules regarding tests, testing and the cutoff levels for intoxication or influence. E. If a post-accident test pursuant to Subsection C of this section is required of a worker and the worker refuses to submit to the test or to release the post-accident test results to the employer, no compensation otherwise payable from an employer under the terms of the Workers' Compensation Act shall be paid to the worker claiming compensation. F. Testing shall be at the employer's expense and shall not be used as evidence in a criminal proceeding against the worker. Test samples shall be taken as a split sample. One part of the sample shall be held by the testing facility for twelve months from the date of the original test. Within this twelve-month period, the worker has the right to request a second test of the original sample at the worker's expense. G. An employer shall be barred from claiming a reduction in compensation pursuant to this section if, before the accident, the employer has actual or constructive knowledge of the worker's intoxication or influence and a reasonable opportunity to take appropriate measures in response to the intoxication or influence but fails to take those measures. H. An employer shall be barred from claiming a reduction in compensation pursuant to this section if the employer fails to implement a written policy that declares a drug- and alcohol-free workplace, which may include post-accident testing in accordance with this section, and that gives its employees notice that workers' compensation benefits may be reduced in the event intoxication or influence contributes to a workplace injury. I. Reduction or denial of compensation benefits authorized under this section shall not affect payment of medical benefits provided for pursuant to Section 52-1-49 NMSA 1978. J. Reduction or denial of compensation benefits authorized under this section shall not affect payments of benefits to the dependents of a deceased worker pursuant to Section 52-1-46 NMSA 1978. ~~**52-1-12 . Compensation prohibited when worker under influence of certain drugs.**~~ ~~No compensation is payable from any employer under the provisions of the Workers' Compensation Act [52-1-1 NMSA 1978] if the injury to the person claiming compensation was occasioned solely by the person being under the influence of a depressant, stimulant or hallucinogenic drug as defined in the New Mexico Drug, Device and Cosmetic Act [26-1-1 NMSA 1978] or under the influence of a narcotic drug as defined in the Controlled Substances Act [30-31-1 NMSA 1978] unless the drug was dispensed to the person upon the prescription of a practitioner licensed by law to prescribe the drug or administered to the person by any person authorized by a licensed practitioner to administer the drug.~~ *NCCI estimates that **SB 214** may result in a negligible decrease in overall workers compensation system costs in New Mexico. The resulting impact, if any, would be realized in future experience and reflected in subsequent NCCI loss cost filings in New Mexico. Depending upon how various aspects are interpreted, this bill could result in increased frictional costs and litigation.*		
Oklahoma	SB 1083	**SB 1083** amends ***section 1151.22. A. Any contract entered into under the Roofing Contractor Registration Act shall include a statement that all***	11/1/16	No action required

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		individuals performing work under the contract are covered by workers' compensation insurance of the Oklahoma Statutes as follows: **1151.22. A. Any contract entered into under the Roofing Contractor Registration Act shall include a statement that all individuals performing work under the contract are covered by workers' compensation insurance** … B. If ~~the individuals performing work under the contract are not covered by~~ an affidavit of exemption for workers' compensation insurance~~, the contractor shall provide a written statement to the homeowner advising that the individuals performing work under the contract are not covered by workers' compensation insurance, which~~ is used by a legitimately exempt person, it shall be ~~signed by all parties to the contract and~~ attached to the contract and it shall be used only for residential construction projects. All commercial projects shall require all individuals performing work on such project to be covered by workers' compensation insurance as employees of the person registered under the Roofing Contractor Registration Act. However, any day laborer who can show proof of being covered by workers' compensation insurance under the temporary labor agency for whom he or she is hired-out may provide an affidavit from the temporary labor agency to meet the requirement of this section for authority to use an affidavit of exemption. No roofing contractor required to be registered under the Roofing Contractor Registration Act shall hire any out-of-state company or person or use any person or independent contractor that is not registered under the Roofing Contractor Registration Act with the required workers' compensation insurance or who is not deemed his or her employee for purposes of workers' compensation insurance. C. In no event shall a homeowner be held liable in the workers' compensation administrative system for injury or death to any person who performs work under a contract with a person required by law to be registered under the Roofing Contractor Registration Act and have workers' compensation on all persons performing work on the roofing project.		
Rhode Island	HB 8058 Substitute A	**HB 8058 Substitute A** amends ***section 44-17-1 Companies required to file—Payment of tax—Retaliatory rates*** of the State of Rhode Island General Laws as follows: **§44-17-1 Companies required to file—Payment of tax—Retaliatory rates—**(a) Every domestic, foreign, or alien insurance company, mutual association, organization, or other insurer, including any health maintenance organization, as defined in § 27-41-1, any medical malpractice insurance joint underwriters association as defined in § 42-14.1-1, any nonprofit dental service corporation as defined in § 27-20.1-2 and any nonprofit hospital or medical service corporation, as defined in chapters 27-19 and 27-20, except companies mentioned in § 44-17-6, and organizations defined in § 27-25-1, transacting business in this state, shall, on or before March 1 in each year, file with the tax administrator, in the form that he or she may prescribe, a return under oath or affirmation signed by a duly authorized officer or agent of the company, containing information that may be deemed necessary for the determination of the tax imposed by this chapter, and shall at the same time pay an annual tax to the tax administrator of two percent (2%) of the gross premiums on contracts of insurance, except for ocean marine insurance, as referred to in § 44-17-6, covering property and risks within the state, written during the calendar year ending December 31st next preceding. (b) Qualifying insurers for purposes of this subsection means every domestic, foreign, or alien insurance company, mutual association, organization, or other insurer and excludes: (1) Health maintenance organizations, as defined in §27-41-2; (2) Nonprofit dental service corporations as defined in §27-20.1-2; and (3) Nonprofit hospital or medical service corporations, as defined in §§27-19-1 and 27-20-1.	9/7/16	Currently analyzing for potential ***Tax and Assessment Directory*** revision

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		(c) For tax years 2018 and thereafter, the rate of taxation may be reduced as set forth below and, if so reduced, shall be fully applicable to qualifying insurers instead of the two percent (2%) rate listed in subsection (a) above. ~~but in~~ In the case of foreign or alien companies, except as provided in § 27-2-17(d), the tax ~~is~~ shall not be less in amount than is imposed by the laws of the state or country under which the companies are organized upon like companies incorporated in this state or upon its agents, if doing business to the same extent in the state or country. The tax rate shall not be reduced for gross premiums written on contracts of health insurance as defined in §42-14-5(c) but shall remain at two percent (2%) or the appropriate retaliatory tax rate, whichever is higher. (d) For qualifying insurers the premium tax rate may be decreased based upon Rhode Island jobs added by the industry as detailed below: (1) A committee shall be established for the purpose of implementing tax rates using the framework established herein. The committee shall be comprised of the following persons or their designees: the secretary of commerce, the director of the department of business regulation, the director of the department of revenue, and the director of the office of management and budget. No rule may be issued pursuant to this section without the prior, unanimous approval of the committee. (2) On the timetable listed below the committee shall determine whether qualifying insurers have added new qualifying jobs in this state in the preceding calendar year. A qualifying job for purposes of this section is one in which a person is employed for consideration for at least thirty-five (35) hours a week earning no less than the median hourly wage as reported by the United States Bureau of Labor Statistics for the state of Rhode Island. (3) If the committee determines that there has been a sufficient net increase in qualifying jobs in the preceding calendar year(s) to offset a material reduction in the premium tax, it shall calculate a reduced premium tax rate. Such rate shall be determined via a method selected by the committee and designed such that the estimated personal income tax generated by the increase in qualifying jobs is at least one-hundred and twenty-five percent (125%) of the anticipated reduction in premium tax receipts resulting from the new rate. For purposes of this calculation, the committee may consider personal income tax withholdings or receipts, but in no event may the committee include for the purposes of determining revenue neutrality income taxes that are subject to segregation pursuant to section 44-48.3-8(f) of the general laws or that are otherwise available to the general fund. (4) Any reduced rate established pursuant to this section must be established in a rulemaking proceeding pursuant to chapter 35 of title 42, subject to the following conditions: (i) Any net increase in qualifying jobs and the resultant premium tax reduction and revenue impact shall be determined in any rulemaking proceeding conducted under this section and shall be set forth in a report included in the rulemaking record, which report shall also include a description of the data sources and calculation methods used. The first such report shall also include a calculation of the baseline level of employment of qualifying insurers for the calendar year 2015. (ii) Notwithstanding any provision of the law to the contrary, no rule changing the tax rate shall take effect until one hundred and twenty (120) days after notice of the rate change is provided to the speaker of the house, the president of the senate, the house and senate fiscal advisors, and the auditor general, which notice shall include the report required under the preceding provision. (5) For each of the first three (3) rulemaking proceedings required under this section, the tax rate may remain unchanged or be decreased consistent with the requirements of this section, but may not be increased. These first three (3) rulemaking proceedings shall be conducted by the division of taxation and occur in the following manner:		

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		(i) The first rulemaking proceeding shall take place in calendar year 2017. This proceeding shall establish a rule that sets forth (A) a new premium tax rate, if allowed under the requirements of this section, which rate shall take effect in 2018, and (B) a method for calculating the number of jobs at qualifying insurers. (ii) The second rulemaking proceeding shall take place in calendar year 2018. This proceeding shall establish a rule that sets forth (A) a new premium tax rate, if allowed under the requirements of this section, which rate shall take effect in 2019, and (B) the changes, if any, to the method for calculating the number of jobs at qualifying insurers. (iii) The third rulemaking proceeding shall take place in calendar year 2019. This proceeding shall establish a rule that sets forth (A) a new premium tax rate, if allowed under the requirements of this section, which rate shall take effect in 2020, and (B) the changes, if any, to the method for calculating the number of jobs at qualifying insurers. (5) The tax rate established in the regulation following regulatory proceedings that take place in 2019 shall remain in effect through and including 2023. In calendar year 2023 the department of business regulation will conduct a rulemaking proceeding and issue a rule that sets forth (A) a new premium tax rate, if allowed under the requirements of this section, which rate shall take effect in 2024, and (B) the changes, if any, to the method for calculating the number of jobs at qualifying insurers. A rule issued by the department of business regulation may decrease the tax rate if the requirements for a rate reduction contained in this section are met, or it may increase the tax rate to the extent necessary to achieve the overall revenue level sought when the then existing tax rate was established. Any rate established shall be no lower than one percent (1%) and no higher than two percent (2%). This proceeding shall be repeated every three (3) calendar years thereafter, however, the base for determination of job increases or decreases shall remain the number of jobs existing during calendar year 2022. (7) No reduction in the premium tax rate pursuant to this section shall be allowed absent a determination that qualifying insurers have added in this state at least three hundred fifty (350) new, full-time, qualifying jobs above the baseline level of employment of qualifying insurers for the calendar year 2015. (8) Notwithstanding any provision of this section to the contrary, the premium tax rate shall never be set lower than one percent (1%). (9) The division of taxation may adopt implementation guidelines, directives, criteria, rules and regulations pursuant to chapter 35 of title 42 as are necessary to implement this section. (10) The calculation of revenue impacts under this section is at the sole discretion of the committee established under subsection (d)(1) of this section. Notwithstanding any provision of law to the contrary, any administrative action or rule setting a tax rate pursuant to this section or failing or declining to alter a tax rate pursuant to this section shall not be subject to judicial review under chapter 35 of title 42. **HB 8058 Substitute** also creates the following new sections in Chapter 27-1 "Domestic Insurance Companies" and Chapter 27-2 "Foreign Insurance Companies": **§ 27-1-45. Determination of premium tax rate.—**The department of business regulation may participate in proceedings under §44-17-1(d) to implement guidelines, directives, criteria, and may promulgate additional resulting rules and regulations pursuant to chapter 35 of title 42 as are necessary to implement §44-17-1(d). **§ 27-2-28. Determination of premium tax rate.—**The department of business regulation may participate in proceedings under §44-17-1(d) to		

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		implement guidelines, directives, criteria, and may promulgate additional resulting rules and regulations pursuant to chapter 35 of title 42 as are necessary to implement §44-17-1(d).		
Rhode Island	HB 8203 Substitute A/SB 2945 Substitute A	**HB 8203 Substitute A/SB 2945 Substitute A** amend ***sections 28-30-22. Medical advisory board***, ***28-33-18.3 Continuation of benefits—Partial incapacity***, ***28-33-39. Transportation costs for medical examination***, ***28-33-41. Rehabilitation of injured persons***, and ***28-53-7. Payments to employees of uninsured employers***; and creates ***section 42-16.1-19. Cost of legal and audit fees*** of the Rhode Island General Laws as follows: **§ 28-30-22. Medical advisory board.** (a) The chief judge of the workers' compensation court, in consultation with the appropriate medical or professional association, shall appoint a medical advisory board that shall serve at the chief judge's pleasure and consist of eleven (11) members in the following specialties: one orthopedic surgeon; one neurologist; one physiatrist; one chiropractor; one physical therapist; one internist; one psychiatrist or psychologist; and four (4) ad hoc physician members appointed at the discretion of the chief judge. Members of the board shall be reimbursed ~~three hundred dollars ($300)~~ five hundred dollars ($500) per day served in the discharge of the board's duties, not to exceed six thousand dollars ($6,000) per member in any year. The chief judge shall designate the chairperson of the board. … **§ 28-33-18.3. Continuation of benefits—Partial incapacity.** (a) (1) For all injuries occurring on or after September 1, 1990, in those cases where the employee has received a notice of intention to terminate partial incapacity benefits pursuant to § 28-33-18, the employee, or his or her duly authorized representative, may file with the workers' compensation court a petition for continuation of benefits on forms prescribed by the workers' compensation court. In any proceeding before the workers' compensation court on a petition for continuation of partial incapacity benefits, where the employee demonstrates by a fair preponderance of the evidence that his or her partial incapacity poses a material hindrance to obtaining employment suitable to his or her limitation, partial incapacity benefits shall continue. For injuries on and after July 1, ~~2021~~ 2023, "material hindrance" is defined to include only compensable injuries causing a greater than sixty-five percent (65%) degree of functional impairment and/or disability. Any period of time for which the employee has received benefits for total incapacity shall not be included in the calculation of the three hundred and twelve-week (312) period. (2) The provisions of this subsection apply to all injuries from Sept. 1, 1990, to July 1, ~~2021~~ 2023. (b) (1) Where any employee's incapacity is partial and has extended for more than three hundred and twelve (312) weeks and the employee has proved an entitlement to continued benefits under subsection (a) of this section, payments made to these incapacitated employees shall be increased annually on the tenth (10th) day of May thereafter so long as the employee remains incapacitated. The increase shall be by an amount equal to the total percentage increase in the annual Consumer Price Index, United States City Average for Urban Wage Earners and Clerical Workers, as formulated and computed by the Bureau of Labor Statistics of the United States Department of Labor for the period of March 1 to February 28 each year. (2) "Index", as used in this section, refers to the Consumer Price Index, United States City Average for Urban Wage Earners and Clerical Workers, as that index was formulated and computed by the Bureau of Labor Statistics of the United States Department of Labor. (3) The annual increase shall be based upon the percentage increase, if any, in the Consumer Price Index for the month of a given year, over the index for February, the previous year. Thereafter, increases shall be made on May 10 annually, based upon the percentage increase, if any, in the	7/13/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		Consumer Price Index for the period of March 1 to February 28. (4) The computations in this section shall be made by the director of labor and training and promulgated to insurers and employers making payments required by this section. Increases shall be paid by insurers and employers without further order of the court. If payment payable under this section is not mailed within fourteen (14) days after the employer or insurer has been notified by publication in a newspaper of general circulation in the state it becomes due, there shall be added to the unpaid payment an amount equal to twenty percent (20%) of it, to be paid at the same time as, but in addition to, the payment. (5) This section applies only to payment of weekly indemnity benefits to employees as described in subdivision (1) of this subsection and does not apply to specific compensation payments for loss of use or disfigurement or payment of dependency benefits or any other benefits payable under the workers' compensation act. (c) No petitions for commutation shall be allowed or entertained in those cases where an employee is receiving benefits pursuant to this section. **§ 28-33-39. Transportation costs for medical examination.** The reasonable costs of transportation to and from the office of any examiner requested by the employer or of any impartial examiner appointed as provided in § 28-33-35 shall be charged to the employer and, if paid for by the employee, he or she shall be reimbursed in full for this expenditure by his or her employer, upon presentation of a receipt or other evidence of expenditure. The reasonable cost of transportation that occurs on or after July 1, 2016, is the rate equal to the per-mile rate allowed by the Internal Revenue Service for use of a privately owned automobile for business miles driven, as from time to time amended, for a private motor vehicle or the reasonable cost incurred for transportation, from the employee's point of departure, whether from the employee's home or place of employment, and return. **§ 28-33-41. Rehabilitation of injured persons.** … (d) The employer shall bear the expense of rehabilitative services agreed to or ordered pursuant to this section. If those rehabilitative services require residence at or near or travel to a rehabilitative facility, the employer shall pay the employee's reasonable expense for board, lodging, and/or travel. The reasonable cost of transportation on or after July 1, 2016, is the rate equal to the per-mile rate allowed by the Internal Revenue Service for use of a privately owned automobile for business miles driven, as from time to time amended, for a private motor vehicle or the reasonable cost incurred for transportation, from the employee's point of departure, whether from the employee's home or place of employment, and return. … **§ 28-53-7. Payments to employees of uninsured employers.** (a) Where it is determined that the employee was injured in the course of employment while working for an employer who fails to maintain a policy of workers' compensation insurance as required by § 28-36-1 et seq., the uninsured employers fund shall pay the benefits to which the injured employee would be entitled pursuant to chapters 29 to 38 of this title subject to the limitations set forth herein. (b) The workers' compensation court shall hear all petitions for payment from the fund pursuant to § 28-30-1 et seq., provided, however, that the		

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		uninsured employers fund and the employer shall be named as parties to any petition seeking payment of benefits from the fund. (c) Where an employee is deemed to be entitled to benefits from the uninsured employers fund, the fund shall pay benefits for disability and medical expenses as provided pursuant to chapters 29 to 38 of this title except that the employee shall not be entitled to receive benefits for loss of function and disfigurement pursuant to the provisions of § 28-33-19. (d) The fund shall pay cost, counsel and witness fees, as provided in § 28-35-32, to any employee who successfully prosecutes any petitions for compensation; petitions for medical expenses; petitions to amend a pretrial order or memorandum of agreement; and all other employee petitions; and to employees who successfully defend, in whole or in part, proceedings seeking to reduce or terminate any and all workers' compensation benefits; provided, however, that the attorney's fees awarded to counsel who represent the employee in petitions for lump sum commutation filed pursuant to § 28-33-25, or in the settlement of disputed cases pursuant to § 28-33-25.1, shall be limited to the maximum amount paid to counsel who serve as court-appointed attorneys in workers' compensation proceedings as established by rule or order of the Rhode Island supreme court. (e) In the event that the uninsured employer makes payment of any monies to the employee to compensate the employee for lost wages or medical expenses, the fund shall be entitled to a credit for all such monies received by or on behalf of the employee against any future benefits payable directly to the employee. (f) This section shall apply to injuries that occur on or after ~~January~~ July 1, 2017. **§ 42-16.1-19. Cost of legal and audit fees.** The director is hereby authorized and may in their discretion recover the reasonable cost of legal services and audit fees for services provided by in-house attorneys and/or other personnel of the department of labor and training or outside auditors and incurred by the department in matters pertaining to fraud investigations and examinations. Nothing in this section shall limit the power of the director to retain legal counsel to recover the costs of such legal counsel and auditors pursuant to other provisions of the general laws.		
South Carolina	HB 3576	**HB 3576** adds new ***section 41-1-120*** to the South Carolina Code of Laws as follows: **Section 41-1-120.** (A) Notwithstanding another provision of law, a written agreement between a nonprofit youth sports organization and a coach which specifies that the coach is an independent contractor and not an employee of the nonprofit youth sports organization and also which otherwise satisfies the requirements of this subsection constitutes conclusive evidence that the relationship between the nonprofit youth sports organization and the coach is that of an independent contractor relationship rather than an employment relationship for the purposes of this section, and that the nonprofit youth sports organization consequently is not obligated to: (1) secure compensation for the coach pursuant to the workers' compensation law; and (2) withhold federal and state income taxes from money paid to the coach for services he provides to the organization pursuant to the contract. (B) A written agreement provided in subsection (A) must contain a conspicuously located disclosure appearing in bold-faced, underlined, or large type. This agreement must be acknowledged by the parties as indicated by their signatures, initials, or other means to evince that the parties have read and understand the disclosure. This disclosure clearly must state that the coach is: (1) an independent contractor and not an employee of the nonprofit youth sports organization for the purposes listed in (A)(1) and (2); (2) not entitled to workers' compensation benefits in connection with his or her contract with the nonprofit youth sports organization; and	4/21/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		(3) obligated to pay federal and state income tax on any money paid pursuant to the contract for coaching services, and that as a consequence the nonprofit youth sports organization will not withhold any amounts from the coach for purposes of satisfying the coach's income tax liability. (C) A written agreement between a nonprofit youth sports organization and a coach formed pursuant to this subsection may not, in and of itself, be construed as conclusive evidence that an independent contractor relationship exists for purposes of required coverage under the state unemployment compensation law or any civil action instituted by a third party. (D) As used in this section, 'nonprofit youth sports organization' means an organization that is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and is primarily engaged in conducting organized sports programs for persons under twenty-one years of age.		
South Carolina	SB 1064	**SB 1064** amends ***sections 38-73-525 Filing of multiplier for expenses by insurers writing workers' compensation*** and ***38-73-1210 Members of rating organization not required to file individually; rates for members in first year; collection, compilation and dissemination of premium data*** of the South Carolina Code of Laws as follows: **Section 38-73-525 Filing of multiplier for expenses by insurers writing workers' compensation** (A) Each insurer writing workers' compensation insurance shall adopt the most recent loss costs within sixty days after approval of these loss costs. This loss costs adoption must become effective no later than one hundred twenty days after the effective date of the approved loss costs. An insurer must notify the department of its adoption of the most recently approved loss costs by filing a notification on a form and in a manner prescribed by the director or his designee. The notification filing required by this subsection does not constitute a rate filing and is not subject to prior approval. (B)(1) At least ~~thirty~~ sixty days ~~prior to~~ before using a new ~~rates, every~~ multiplier for expenses, assessments, profits, and contingencies, each insurer writing workers' compensation ~~must~~ shall file its multiplier for expenses, assessments, profit, and contingencies and any information relied upon by the insurer to support the multiplier and any modifications to loss costs. A copy of the filing must be provided simultaneously to the consumer advocate. (2) ~~The filing~~ Filings submitted pursuant to item (1) must be filed on a form and in the manner prescribed by the director or his designee and must contain, at a minimum, the following information: commission expense; other acquisition expense; general expense; expenses associated with recoveries from the Second Injury Fund; guaranty fund assessments; other assessments; premium taxes; miscellaneous taxes, licenses, or fees; ~~and~~ a provision for profit and contingencies, and the date of approval of the loss costs to which the multiplier is applied, which must be the most recently approved loss costs. (3) ~~Rate~~ Filings submitted pursuant to item (1) are subject to approval of the director or his designee and must be reviewed by an actuary employed or retained by the department who is a member of the American Academy of Actuaries or an associate or fellow of the Casualty Actuarial Society. (4)(a) Within the ~~thirty-day~~ sixty-day period, if the director or his ~~or her~~ designee believes the information filed is not complete, the director or his ~~or her~~ designee ~~must~~ shall notify the insurer of additional information to be provided. Within fifteen days of receipt of the notification, the insurer ~~must~~ shall provide the requested information or file for a hearing challenging the reasonableness of the director's or his ~~or her~~ designee's request. The burden is on the insurer to justify the denial of the additional information. (b) Unless a hearing ~~has been~~ is requested, upon expiration of the ~~thirty-day~~ sixty-day period or the fifteen-day period, whichever is later, the insurer may use the ~~rates developed using the multiplier of expenses, assessments, profit, and contingencies~~ multiplier for expenses, assessments, profit, and contingencies.	6/2/16	See update to ***Filing Guide for Rates and Forms***

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		Section 38-73-1210 Members of rating organization not required to file individually; rates for members in first year; collection, compilation and dissemination of premium data (A)(1) This item applies to property and casualty insurance but does not apply to workers' compensation insurance. An insurer may satisfy its obligation to make required filings by becoming a member of, or a subscriber to, a licensed rating organization which makes filings and by authorizing the director or his designee to accept the filings on its behalf. However, notwithstanding ~~any other provisions~~ another provision of this article, ~~no~~ a member or subscriber ~~may~~, within twelve months after its membership or subscribership, may not file to adopt ~~any~~ a rate approved for use for the rating organization if the rate is more than the rate in use by the member or subscriber ~~prior to~~ before its membership or subscribership in the rating organization. Further, notwithstanding the provisions of Sections 38-73-1300~~,~~ and 38-73-1310, ~~and 38-73-1320, no~~ a member or subscriber, within twelve months after its membership or subscribership, may not be granted an upward deviation from its rate in use when becoming a member or subscriber. However, if a rate increase for the rating organization is approved within twelve months after an insurer becomes a member or subscriber, the member or subscriber may increase its rates by the same percentage of increase granted the rating organization. Nothing contained in this chapter may be construed ~~as requiring any~~ to require an insurer to become a member of or a subscriber to ~~any~~ a rating organization. (2) This item applies to workers' compensation insurance. An insurer may satisfy its obligation to make required filings by becoming a member of, or a subscriber to, a licensed rating organization that makes filings and by authorizing the director or his designee to accept the filings on its behalf. However, a licensed rating organization may not satisfy the insurer's obligation to make filings required pursuant to Section 38-73-525. (B) In addition to other activities not prohibited by this chapter, a rating organization may collect, compile, and disseminate to insurers compilations of past and current premiums of insurers.		
South Dakota	HB 1084	**HB 1084** adds and amends various sections of the South Dakota Codified Laws related to when concurrent employment may be used to calculate earnings in workers compensation cases. The bill amends the following sections to read: **58-20-3.1. Premiums on wages for vacations, holidays, or sick leave prohibited.** Premiums for workers' compensation insurance may not be based on wages paid to employees while they are on vacation, holidays, or sick leave or on wages received from employment not performed for the insured employer. **62-1-1 Definitions** … (6) "Earnings," the amount of compensation for the number of hours commonly regarded as a day's work for the employment in which the employee was ~~engaged~~ working at the time of ~~his~~ the employee's injury. It includes payment for all hours worked, including overtime hours at straight-time pay, and does not include any sum which the employer has been accustomed to pay the employee to cover any special expense entailed by ~~him~~ the employee by the nature of ~~his~~ the employment; wherever allowances of any character made to an employee in lieu of wages are specified as a part of the wage contract, ~~they~~ the allowances shall be deemed a part of ~~his~~ the employee's earnings; …	7/1/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		A new section is added to ***Chapter 62-1*** to read: For a workers' compensation claim arising before May 6, 2015, an employee's earnings up to the claimed date of injury are calculated exclusively on the wages earned at the place of employment where the injury occurred. For a workers' compensation claim arising after May 5, 2015, if an employee was working for more than one employer, the employee's earnings used to calculate the employee's average weekly wage in §§ 62-4-24, 62-4-25, or 62-4-26 shall include the amount of compensation for the number of hours commonly regarded as a day's work for each employer in which the person was concurrently employed at the time of the person's injury; however, an employee's earnings from concurrent employment are aggregated only if the injury occurred when the employee was actively working in the concurrent employment and when the injury prevents the employee from performing the employee's duties at the employee's other concurrent employment. A new section is added to ***Chapter 62-6*** to read: An employer which complies with this title shall produce, if demanded by any employer or insurer against whom an injured employee has made a workers' compensation claim, the work-related records referring to its employee available for the fifty-two weeks preceding the employee's claimed dates of injury, such as: (1) The weeks in which the employee performed services; (2) The earnings the employee received for the services, as defined in subdivision 62-1-1(6); (3) Interruptions in employment if the employee was rehired or seasonally employed; (4) Changes in the employee's grade of employment; (5) The employee's job description; and (6) Federal or state tax deductions. The employer receiving this demand shall produce the employee's work-related records in ten business days, and may charge a fee for the production of the records. The fee for the production of the employee's work-related records may not exceed fifteen dollars. An employee waives any right to privacy to these work-related records when the employee makes a claim for workers' compensation benefits and the employee consents to the release of these work-related records to the employer or insurer against which the employee is making a claim for workers' compensation benefits. A new section is added to ***Chapter 62-2*** to read: The Workers' Compensation Advisory Council shall include in its annual report data about the average amount of disability or fatality benefits paid for a claim over the most recent calendar years, the ratio of disability and fatality benefits to overall benefits paid, and any changes in premium base rates directly attributable to including concurrent earnings in benefits. It shall report to the 2019 Legislature the impact of this Act.		

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2016 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/16)

JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		HB 1084 also includes the following language: The Legislature finds that the aggregation of wages from concurrent employment was not within the Legislature's intent when it enacted the definition of earnings in subdivision 62-1-1(6). Therefore, the holding in Wheeler v. Cinna Baker LLC, 2015, 864 N.W. 2d, regarding the aggregation of wages is abrogated.		
TN	SB 1758	**SB 1758** adds a new subsection to ***section 50-6-215. Rental and assignment of PPO network rights.*** of the Tennessee Code as follows: **50-6-215. Rental and assignment of PPO network rights. [Applicable to injuries occurring both prior to and on and after July 1, 2014.]** … (e)(1) A written complaint alleging a violation of this section by individuals or entities licensed by the department of commerce and insurance may be filed with the bureau of workers' compensation. The bureau may investigate complaints made under this subsection (e) and shall direct all such complaints, along with any investigatory materials, to the department of commerce and insurance. The commissioner of commerce and insurance may take appropriate action in accordance with § 56-2-305. (2) A written complaint alleging a violation of this section by individuals or entities not licensed by the department of commerce and insurance may be filed with the bureau. The bureau may investigate all complaints made under this subsection (e) and shall have the authority to establish and collect penalties for violations of this section in accordance with § 50-6-118. In addition, **SB 1758** adds the following new appropriately designated subsection to ***section 50-6-118. Penalties.*** of the Tennessee Code as follows: ***50-6-118. Penalties. [Applicable to injuries occurring on and after July 1, 2014.]*** (a) The bureau of workers' compensation shall, by rule promulgated pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, establish and collect penalties for the following: ( ) Any violation of § 50-6-215 by an individual or entity not licensed by the department of commerce and insurance; **SB 1758** also contains the following clause: This act shall take effect July 1, 2016, and shall apply to all claims submitted to a medical provider on or after that date.	7/1/16	No action required
TN	SB 2563	**SB 2563** amends various sections of the Tennessee Workers' Compensation Law to: • Add members of limited liability companies to the definition of employee for the purposes of workers compensation law • Require workers compensation settlement agreements to be reduced to writing and approved by the Court of Workers' Compensation Claims • Clarify the procedures for approval of settlements by the Court of Workers' Compensation Claims • Provide that the Court of Workers' Compensation Claims will determine the right of an employee to receive compensation from the Second Injury Fund • Require a lump-sum settlement under Tenn. Code Ann. § 50-6-229 to be approved by the Court of Workers' Compensation Claims and not chancery, circuit, or criminal courts • Provide that any current or retired Tennessee judge or chancellor, workers compensation judge, or the governor of Tennessee may swear in judges of the Court of Workers' Compensation Claims	4/14/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		• Require costs of administering claims for benefits under Tenn. Code Ann. § 50-6-801 to be paid from the Uninsured Employers Fund		
TN	SB 2582	**SB 2582** amends various sections of the Tennessee Code as follows: Section 1 **50-6-201. Notice of Injury** (a) (1) Every injured employee or the injured employee's representative shall, immediately upon the occurrence of an injury, or as soon thereafter as is reasonable and practicable, give or cause to be given to the employer who has no actual notice, written notice of the injury, and the employee shall not be entitled to physician's fees or to any compensation that may have accrued under this chapter, from the date of the accident to the giving of notice, unless it can be shown that the employer had actual knowledge of the accident. No compensation shall be payable under this chapter, unless the written notice is given to the employer within fifteen (15) ~~thirty (30)~~ days after the occurrence of the accident, unless reasonable excuse for failure to give the notice is made to the satisfaction of the tribunal to which the claim for compensation may be presented. (2) The notice of the occurrence of an accident by the employee required to be given to the employer shall state in plain and simple language the name and address of the employee and the time, place, nature, and cause of the accident resulting in injury or death. The notice shall be signed by the claimant or by some person authorized to sign on the claimant's behalf, or by any one (1) or more of the claimant's dependents if the accident resulted in death to the employee. (3) No defect or inaccuracy in the notice shall be a bar to compensation, unless the employer can show, to the satisfaction of the workers' compensation judge before which the matter is pending, that the employer was prejudiced by the failure to give the proper notice, and then only to the extent of the prejudice. (4) The notice shall be given personally to the employer or to the employer's agent or agents having charge of the business at which the injury was sustained by the employee. (b) In those cases where the injuries occur as the result of gradual or cumulative events or trauma, then the injured employee or the injured employee's representative shall provide notice of the injury to the employer within fifteen (15) ~~thirty (30)~~ days after the employee: (1) Knows or reasonably should know that the employee has suffered a work-related injury that has resulted in permanent physical impairment; or (2) Is rendered unable to continue to perform the employee's normal work activities as the result of the work-related injury and the employee knows or reasonably should know that the injury was caused by work-related activities. Section 2 **50-6-226. Fees of attorneys and physicians, and hospital charges. [Applicable to injuries occurring on and after July 1, 2014.]** … ~~(d) In addition to any attorneys' fees provided for in this section, the Court of Workers' Compensation Claims may award attorneys' fees and reasonable costs, including reasonable and necessary court reporter expenses and expert witness fees for depositions and trials incurred when the employer fails to furnish appropriate medical, surgical and dental treatment or care, medicine, medical and surgical supplies, crutches, artificial members and other apparatus to an employee provided for in a settlement or judgment under this chapter.~~ (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 reasonable and necessary court reporter expenses and expert witness fees, for depositions and trials incurred when	7/1/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		the employer: (A) Fails to furnish appropriate medical, surgical, and dental treatment or care, medicine, medical and surgical supplies, crutches, artificial members, and other apparatus to an employee provided for in a settlement, expedited hearing order, compensation hearing order, or judgment under this chapter; or (B) Wrongfully denies a claim by filing a timely notice of denial, or fails to timely initiate any of the benefits to which the employee is entitled under this chapter, including medical benefits under § 50-6-204 or temporary or permanent disability benefits under § 50-6-207, if the workers' compensation judge makes a finding that such benefits were owed at an expedited hearing or compensation hearing. (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. Section 3 **50-9-101. Legislative Intent.** (a) It is the intent of the general assembly to promote drug-free workplaces in order that employers in this state be afforded the opportunity to maximize their levels of productivity, enhance their competitive positions in the marketplace and reach their desired levels of success without experiencing the costs, delays and tragedies associated with work-related accidents resulting from drug or alcohol abuse by employees. It is further the intent of the general assembly that drug and alcohol abuse be discouraged and that employees who choose to engage in drug or alcohol abuse face the risk of unemployment and the forfeiture of workers' compensation benefits. It is also the intent of the general assembly that employers obtaining certification as a drug-free workplace under rules promulgated by the bureau should be able to renew that certification on an annual basis without requiring repeated annual training of existing employees; provided, however, the employer certifies on a form prescribed by the bureau that all existing employees have undergone training at least once and have acknowledged annually in writing the existence of the employer's drug-free workplace policy. Section 4 **50-9-111. Rules and regulations—Guidelines for state testing program.** … (d) The administrator is authorized to set education program requirements for drug-free workplaces by rules promulgated in accordance with the requirements of the Uniform Administrative Procedures Act. The requirements shall not be more stringent than the federal requirements for workplaces regulated by the United States Department of Transportation rules. The requirements shall not require an employer to provide annual education or awareness training for each employee if all existing employees have undergone such training at least once and have acknowledged annually in writing the existence of the employer's drug-free workplace policy. Section 5 **50-6-216 Ombudsman program. [Applicable to injuries occurring on and after July 1, 2014.]** … (e) (1) Any party that is not represented by legal counsel may request the services of a workers' compensation ombudsman by contacting the office		

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		of mediation services. (2) The ombudsman's authority shall include, but not be limited to, the following: (A) Meet with and provide information to unrepresented parties about the unrepresented party's rights and responsibilities under the law; (B) Explain the administrative process for resolving workers' compensation claims; (C) Investigate claims and attempt to resolve disputes without resort to alternative dispute resolution and court proceedings; (D) Communicate with all parties and providers in the claim; (E) Assist the parties in the completion of forms; ~~and~~ (F) Facilitate the exchange of medical records~~.~~; and (G) Approve a settlement between an employer and employee who are not represented by an attorney in the claim as authorized by §50-6-240(f). ~~(3) An ombudsman shall not provide legal advice.~~ (3) An ombudsman who is not a licensed attorney shall not provide legal advice; however, an ombudsman who is a licensed attorney may provide limited legal advice but shall not represent any party as the party's attorney. No ombudsman shall make attorney referrals. **SB 2582** also includes the following clause: This act shall take effect July 1, 2016, the public welfare requiring it, and Sections 1, 2, and 5 shall apply to injuries that occur on or after that date.		
Utah	HB 96	**HB 96** creates new ***Chapter 3*** in ***Title 63F*** of the Utah Code Annotated to read: **Chapter 3. Single Sign-On Database** **63F-3-101. Title.** This chapter is known as "Single Sign-On Database." **63F-3-102. Definitions.** As used in this chapter: (1) "Business data" means data collected by the state about a person doing business in the state. (2) "Business database" means the database described in Subsection 63F-3-103(1). (3) "Database" means an electronic means of storing information. (4) "Single sign-on web portal" means the web portal described in Subsection 63F-3-103(2). (5) "Web portal" means an Internet webpage that can be accessed by an individual where the individual enters the individual's unique user information in order to access secure information. **63F-3-103. Single sign-on database—Creation.** (1) The department shall, in consultation with the entities described in Subsection (4), design and create a prototype of a single database, and associated data entry screens, that stores business data agreed upon by the entities described in Subsection (4) that is: (a) secure; (b) centralized; and	5/9/16	No action required

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		(c) interconnected. (2) The department shall create a web portal that allows a person doing business in the state to access, at a single point of entry, all relevant state-collected business data about the person, including information related to: (a) business registration; (b) workers' compensation; (c) tax liability and payment; and (d) other information collected by the state that the department determines is relevant to a person doing business in the state. (3) The department shall develop the business database and the single sign-on web portal: (a) using an open platform that: (i) facilitates participation in the database and web portal by a state entity; and (ii) allows for optional participation by a political subdivision of the state; and (b) in a manner that anticipates expanding the database and web portal to include: (i) a database for data collected by the state on an individual; and (ii) a web portal for an individual to access all relevant data collected by the state on the individual. (4) In developing the business database and the single sign-on web portal, the department shall consult with: (a) the Department of Commerce; (b) the State Tax Commission; (c) the Labor Commission; (d) the Department of Workforce Services; (e) the Governor's Office of Management and Budget; (f) the Utah League of Cities and Towns; (g) the Utah Association of Counties; and (h) the business community that is likely to use the business database and single sign-on web portal. **63F-3-104. Report.** The department shall report to the Public Utilities and Technology Interim Committee: (1) no later than November 30, 2016, with an initial design and prototype of the business database and the single sign-on web portal, together with a minimum two-year plan, including projected cost, for the initial implementation phase of the project; and (2) before November 30 of each year beginning in 2017 until the development of the business database and the single sign-on web portal is complete, regarding the progress the department has made in developing the business database and the single sign-on web portal.		
Utah	HB 116	**HB 116**, in part, amends section ***34A-2-103. Employers enumerated and defined—Regularly employed—Statutory employers—Exceptions.*** of the Utah Code Annotated as follows: **34A-2-103. Employers enumerated and defined—Regularly employed—Statutory employers—Exceptions.** …	5/9/16	No action required

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		(10) (a) For purposes of this Subsection (10), "federal executive agency" means an executive agency, as defined in 5 U.S.C. Sec. 105, of the federal government. (b) For purposes of determining whether two or more persons are considered joint employers under this chapter or Chapter 3, Utah Occupational Disease Act, an administrative ruling of a federal executive agency may not be considered a generally applicable law unless that administrative ruling is determined to be generally applicable by a court of law, or adopted by statute or rule. (11) (a) As used in this Subsection (11): (i) "Franchise" means the same as that term is defined in 16 C.F.R. Sec. 436.1. (ii) "Franchisee" means the same as that term is defined in 16 C.F.R. Sec. 436.1. (iii) "Franchisor" means the same as that term is defined in 16 C.F.R. Sec. 436.1. (b) For purposes of this chapter, a franchisor is not considered to be an employer of: (i) a franchisee; or (ii) a franchisee's employee. (c) With respect to a specific claim for relief under this chapter made by a franchisee or a franchisee's employee, this Subsection (11) does not apply to a franchisor under a franchise that exercises a type or degree of control over the franchisee or the franchisee's employee not customarily exercised by a franchisor for the purpose of protecting the franchisor's trademarks and brand. …		
Utah	SB 76	**SB 76** adds new ***section 34A-2-104.5. Nongovernment entity volunteers*** to the Utah Code Annotated to read as follows: **34A-2-104.5. Nongovernment entity volunteers.** (1) As used in this section: (a) (i) "Intern" means a student or trainee who works without pay at a trade or occupation in order to gain work experience. (ii) Notwithstanding Subsection (1)(a)(i), "intern" does not include an intern described in Section 53A-29-103 or 53B-16-403. (b) "Nongovernment entity" means an entity or individual that: (i) is an employer as provided in Section 34A-2-103; and (ii) is not a government entity. (c) "Utah minimum wage" means the highest wage designated as Utah's minimum wage under Title 34, Chapter 40, Utah Minimum Wage Act. (d) (i) "Volunteer" means an individual who donates service without pay or other compensation except expenses actually and reasonably incurred as approved by the supervising nongovernment entity. (ii) "Volunteer" includes an intern of a nongovernment entity. (iii) "Volunteer" does not include an individual participating in human subjects research to the extent that the participation is governed by federal law or regulation inconsistent with this chapter. (2) A volunteer for a nongovernment entity is not an employee of the nongovernment entity for purposes of this chapter and Chapter 3, Utah Occupational Disease Act, unless the nongovernment entity elects in accordance with this section to provide coverage under this chapter and Chapter 3, Utah Occupational Disease Act. (3) (a) A nongovernment entity may elect to secure coverage for all of the nongovernment entity's volunteers by obtaining coverage for the	5/9/16	No action required

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		volunteers in accordance with Section 34A-2-201 under the same policy it uses to cover the nongovernment entity's employees. (b) If a nongovernment entity obtains coverage under Section 34A-2-201 for the nongovernment entity's volunteers, for purposes of receiving benefits under this chapter and Chapter 3, Utah Occupational Disease Act: (i) a volunteer is considered an employee of the nongovernment entity; and (ii) these benefits are the exclusive remedy of the volunteer in accordance with Section 34A-2-105 for an industrial injury or disease covered by this chapter and Chapter 3, Utah Occupational Disease Act. (4) A nongovernment entity shall keep sufficient records of the nongovernment entity's volunteers and the volunteers' duties to determine compliance with this section. (5) To compute the disability compensation benefits under Subsection (3), the disability compensation shall be calculated in accordance with Part 4, Compensation and Benefits, with the average weekly wage of the nongovernment volunteer assumed to be the Utah minimum wage at the time of the industrial accident or occupational disease that is the basis for the volunteer's workers' compensation claim. (6) A workers' compensation insurer shall calculate the premium for a nongovernment entity's volunteer on the basis of the Utah minimum wage on the actual hours the volunteer provides service to the nongovernment entity, except that a workers' compensation insurer may assume 30 hours worked per week if the nongovernment entity does not provide a record of actual hours worked. The imputed wages shall be assigned to the class code on the policy that best describes the volunteer's duties. (7) The failure or refusal of a nongovernment entity to make an election under this section in regard to volunteers does not alter, have an effect on, or give rise to any implication or presumption regarding: (a) the nongovernment entity's duties or liabilities with respect to volunteers; or (b) the rights of volunteers. (8) Subject to Subsection (3)(b)(ii), nothing in this section affects a volunteer's right to seek remedies available to the volunteer through a personal insurance policy that the volunteer obtains for the volunteer in addition to any workers' compensation benefits obtained under this section ~~(8)~~ (9) A nongovernment entity shall notify a volunteer of an election under Subsection (3)(a) by posting: (a) printed notices where volunteers are likely to see the notices in conspicuous places about the nongovernment entity's place of business; and (b) notices on a website that the nongovernment entity uses to recruit or provide information to volunteers.		
Utah	SB 127	**SB 127** amends ***sections 34A-2-416. Additional benefits in special cases*** and ***34A-2-703. Payments from Employers' Reinsurance Fund.*** of the Utah Code Annotated as follows: **34A-2-416. Additional benefits in special cases** ~~(1)~~ Benefits received by a wholly dependent person under this chapter or Chapter 3, Utah Occupational Disease Act, extend indefinitely if at the termination of the benefits: ~~(a)~~ (1) the wholly dependent person is still in a dependent condition; and ~~(b)~~ (2) under all reasonable circumstances the wholly dependent person should be entitled to additional benefits. ~~(2) If benefits are extended under Subsection (1):~~ ~~(a) the liability of the employer or insurance carrier involved may not be extended; and~~ ~~(b) the additional benefits allowed shall be paid out of the Employers' Reinsurance Fund created in Subsection 34A-2-702(1).~~	5/9/16	No action required

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		34A-2-703. Payments from Employers' Reinsurance Fund. If an employee, who has at least a 10% whole person permanent impairment from any cause or origin, subsequently incurs an additional impairment by an accident arising out of and in the course of the employee's employment during the period of July 1, 1988, to June 30, 1994, inclusive, and if the additional impairment results in permanent total disability, the employer or its insurance carrier and the Employers' Reinsurance Fund are liable for the payment of benefits as follows: …. (4) If it is determined that the employee is permanently and totally disabled, the employer or its insurance carrier shall be given credit for all prior payments of temporary total, temporary partial, and permanent partial disability compensation made as a result of the industrial accident. ~~Any~~ An overpayment by the employer or its insurance carrier shall be reimbursed by the Employers' Reinsurance Fund under Subsection (5). (5) (a) (i) Upon receipt of a duly verified petition, the Employers' Reinsurance Fund shall reimburse the employer or its insurance carrier for the Employers' Reinsurance Fund's share of medical benefits and compensation paid to or on behalf of an employee. (ii) A request for Employers' Reinsurance Fund reimbursements shall be accompanied by satisfactory evidence of payment of the medical or disability compensation for which the reimbursement is requested. ~~Each~~ (iii) A request is subject to review as to reasonableness by the administrator. The administrator may determine the manner of reimbursement. (b) A decision of the administrator under Subsection (5)(a) may be appealed in accordance with Part 8, Adjudication. (c) An employer or its insurance carrier shall submit to the Employers' Reinsurance Fund, by June 30, 2018, a request for reimbursement related to medical benefits or compensation paid on or before July 1, 2016. (d) An employer or its insurance carrier shall submit to the Employers' Reinsurance Fund a request for reimbursement related to medical benefits or compensation paid after July 1, 2016, within 24 months of the later of: (i) the date the benefits or compensation are paid by the employer or its insurance carrier; or (ii) the date the Employers' Reinsurance Fund is determined to be liable. (e) Requests for reimbursement not submitted in accordance with Subsection (5)(c) or (5)(d) are considered untimely and the Employers' Reinsurance Fund may not reimburse the benefits or compensation paid. …		
Utah	SB 146	**SB 146** amends ***section 34A-2-413. Permanent total disability—Amount of payments—Rehabilitation*** of the Utah Code Annotated, in part, as follows: **34A-2-413. Permanent total disability—Amount of payments—Rehabilitation** … (1) (a) In the case of a permanent total disability resulting from an industrial accident or occupational disease, the employee shall receive compensation as outlined in this section. (b) To establish entitlement to permanent total disability compensation, the employee shall prove by a preponderance of evidence that: (i) the employee sustained a significant impairment or combination of impairments as a result of the industrial accident or occupational disease that gives rise to the permanent total disability entitlement;	5/9/16	No action required

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		(ii) the employee has a permanent, total disability; and (iii) the industrial accident or occupational disease is the direct cause of the employee's permanent total disability. (c) To establish that an employee has a permanent, total disability the employee shall prove by a preponderance of the evidence that: (i) the employee is not gainfully employed; (ii) the employee has an impairment or combination of impairments that reasonably limit the employee's ability to do basic work activities; …		
Utah	SB 216	**SB 216** amends the workers' compensation and occupational disease acts in the Utah Code Annotated, relating to reimbursement of hospitals, in part, as follows: **34A-2-107. Appointment of workers' compensation advisory council—Composition—Terms of members—Duties—Compensation.** … (7) The council shall study how hospital costs may be reduced for purposes of medical benefits for workers' compensation. The council shall report to the Business and Labor Interim Committee the council's recommendations by no later than November 30, 2017. … **34A-2-407. Reporting of industrial injuries—Regulation of health care providers.** … (11) (a) As used in this Subsection (11): (i) "Balance billing" means charging a person, on whose behalf a workers' compensation insurance carrier or self-insured employer is obligated to pay medical benefits under this chapter or Chapter 3, Utah Occupational Disease Act, for the difference between what the workers' compensation insurance carrier or self-insured employer reimburses the hospital for covered medical services and what the hospital charges for those covered medical services. (ii) "Covered medical services" means medical services provided by a hospital that are covered by workers' compensation medical benefits under this chapter or Chapter 3, Utah Occupational Disease Act. (iii) "Health benefit plan" means the same as that term is defined in Section 31A-22-619.6. (iv) "Self-insured employer" means the same as that term is defined in Section 34A-2-201.5. (b) Subject to Subsection (11)(d), a workers' compensation insurance carrier or self-insured employer may contract, either in writing or by mutual oral agreement, with a hospital to establish reimbursement rates. (c) Subject to Subsection (11)(d) for the time period beginning on May 10, 2016, and ending on July 1, 2018, a workers' compensation insurance carrier or self-insured employer that is reimbursing a hospital that has not entered into a contract described in Subsection (11)(b) shall reimburse the hospital for covered medical services at 85% of the billed hospital fees for the covered medical services. (d) A hospital may not engage in balance billing. (e) Covered services paid under a health benefit plan are subject to coordination of benefits in accordance with Sections 31A-22-619.6 and 34A-2-213. ~~(11)~~ (12) (a) Subject to appellate review under Section 34A-1-303, the commission has exclusive jurisdiction to hear and determine:	5/9/16	See "Legislative Analysis" section on NCCI's Legislative Activity page on **ncci.com** for cost impact analysis

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		(i) whether goods provided to or services rendered to an employee are compensable pursuant to this chapter or Chapter 3, Utah Occupational Disease Act, including: (A) medical, nurse, or hospital services; (B) medicines; and (C) artificial means, appliances, or prosthesis; (ii) except for amounts charged or paid under Subsection (11), the reasonableness of the amounts charged or paid for a good or service described in Subsection ~~(11)~~ (12)(a)(i); and (iii) collection issues related to a good or service described in Subsection ~~(11)~~ (12)(a)(i). (b) Except as provided in Subsection ~~(11)~~ (12)(a), Subsection 34A-2-211(6), or Section 34A-2-212, a person may not maintain a cause of action in any forum within this state other than the commission for collection or payment for goods or services described in Subsection ~~(11)~~ (12)(a) that are compensable under this chapter or Chapter 3, Utah Occupational Disease Act. **34A-2-418. Awards—Medical, nursing, hospital, and burial expenses—Artificial means and appliances.** (1) In addition to the compensation provided in this chapter or Chapter 3, Utah Occupational Disease Act, and subject to Subsection 34A-2-407(11), the employer or the insurance carrier shall pay reasonable sums for medical, nurse, and hospital services, for medicines, and for artificial means, appliances, and prostheses necessary to treat the injured employee. … **34A-2-801. Initiating adjudicative proceedings—Procedure for review of administrative action.** … (c) A person providing goods or services described in Subsections 34A-2-407~~(11)~~(12) and 34A-3-108~~(12)~~(13) may file an application for hearing in accordance with Section 34A-2-407 or 34A-3-108. … **34A-3-108. Reporting of occupational diseases—Regulation of health care providers.** … (11) (a) As used in this Subsection (11): (i) "Balance billing" means charging a person, on whose behalf a workers' compensation insurance carrier or self-insured employer is obligated to pay medical benefits under this chapter or Chapter 2, Workers' Compensation Act, for the difference between what the workers' compensation insurance carrier or self-insured employer reimburses the hospital for covered medical services and what the hospital charges for those covered medical services. (ii) "Covered medical services" means medical services provided by a hospital that are covered by workers' compensation medical benefits under this chapter or Chapter 2, Workers' Compensation Act. (iii) "Health benefit plan" means the same as that term is defined in Section 31A-22-619.6.		

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		(iv) "Self-insured employer" means the same as that term is defined in Section 34A-2-201.5. (b) Subject to Subsection (11)(d), a workers' compensation insurance carrier or self-insured employer may contract, either in writing or by mutual oral agreement, with a hospital to establish reimbursement rates. (c) Subject to Subsection (11)(d), for the time period beginning on May 10, 2016, and ending on July 1, 2018 , a workers' compensation insurance carrier or self-insured employer that is reimbursing a hospital that has not entered into a contract described in Subsection (11)(b), shall reimburse the hospital for covered medical services at 85% of the billed hospital fees for the covered medical services. (d) A hospital may not engage in balance billing. (e) Covered services paid under a health benefit plan are subject to coordination of benefits in accordance with Sections 31A-22-619.6 and 34A-2-213. ~~(11)~~ (12) (a) An application for a hearing to resolve a dispute regarding an occupational disease claim shall be filed with the Division of Adjudication. (b) After the filing, a copy shall be forwarded by mail to: (i) (A) the employer; or (B) the employer's workers' compensation insurance carrier; (ii) the applicant; and (iii) the attorneys for the parties. ~~(12)~~ (13) (a) Subject to appellate review under Section 34A-1-303, the commission has exclusive jurisdiction to hear and determine: (i) whether goods provided to or services rendered to an employee is compensable pursuant to this chapter and Chapter 2, Workers' Compensation Act, including the following: (A) medical, nurse, or hospital services; (B) medicines; and (C) artificial means, appliances, or prosthesis; (ii) except for amounts charged or paid under Subsection (11), the reasonableness of the amounts charged or paid for a good or service described in Subsection ~~(12)~~ (13)(a)(i); and (iii) collection issues related to a good or service described in Subsection ~~(12)~~ (13)(a)(i). (b) Except as provided in Subsection ~~(12)~~ (13)(a), Subsection 34A-2-211(6), or Section 34A-2-212, a person may not maintain a cause of action in any forum within this state other than the commission for collection or payment of goods or services described in Subsection ~~(12)~~ (13)(a) that are compensable under this chapter or Chapter 2, Workers' Compensation Act.		
Vermont	HB 872	**HB 872** adjusts certain Executive Branch fees regarding the Workers' Compensation Fund including, but not limited to, the following: **Workers' Compensation Rate of Contribution** For fiscal year 2017, after consideration of the formula in 21 V.S.A. § 711(b) and historical rate trends, the General Assembly has established that the rate of contribution for the direct calendar year premium for workers' compensation insurance shall be set at the rate of 1.45 percent established in 2015 Acts and Resolves No. 57, Sec. 25, notwithstanding 21 V.S.A. § 711(a). The contribution rate for self-insured workers' compensation losses and workers' compensation losses of corporations approved under 21 V.S.A. chapter 9 shall remain at one percent.	7/1/16 for the language included in this entry	***Tax and Assessment Directory*** revisions completed
Virginia	HB 44	**HB 44** amends ***section 65.2-105. Presumption that certain injuries arose out of and in the course of employment*** of the Code of Virginia as follows:	7/1/16	No action required

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		§ 65.2-105. Presumption that certain injuries arose out of and in the course of employment. In any claim for compensation, where the employee (i) is physically or mentally unable to testify as confirmed by competent medical evidence, (ii) dies with there being no evidence that he ever regained consciousness after the accident, (iii) dies at the accident location or nearby, or (iv) is found dead where he is reasonably expected to be as an employee, and where the factual circumstances are of sufficient strength from which the only rational inference to be drawn is that the accident arose out of and in the course of employment, it shall be presumed the accident arose out of and in the course of employment, unless such presumption is overcome by a preponderance of competent evidence to the contrary.		

Virginia	HB 378/ SB 631	**HB 378/SB 631** make various changes to the Code of Virginia, as it relates to workers compensation medical fee schedules, as described below:
		• Directs the Workers' Compensation Commission (the Commission) to adopt regulations that will become effective January 1, 2018. It establishes fee schedules setting the maximum pecuniary liability of the employer for medical services provided to an injured person pursuant to the Virginia Workers' Compensation Act, in the absence of a contract under which the provider has agreed to accept a specified amount for the medical service.
		• The Commission is required to retain a firm to assist it in establishing the initial fee schedules. It will set amounts based on a reimbursement objective constituting the average of all amounts paid to providers in the same category of providers for the medical service in the same medical community.
		• Reimbursements for medical services provided to treat traumatic injuries and serious burns are excluded from the fee schedules, and liability for their treatment costs will be based, absent a contract, on 80% of the provider's charges. However, the required reimbursement will be 100% of the provider's charges if the employer unsuccessfully contests the compensability of the claim.
		• The Commission is required to review and revise the fee schedules in the year after they become effective and biennially thereafter.
		• The liability of the employer for certain medical services not included in a fee schedule will be set by the Commission.
		• A stop-loss feature allows hospitals to receive payments or reimbursements that exceed the fee schedule amount for certain claims when the total charges exceed a charge outlier threshold, which initially is 150% of the maximum fee for the service set forth in the applicable fee schedule. Providers are prohibited from using a different charge master or schedule of fees for any medical service provided for workers compensation patients than the provider uses for health care services provided to patients who are not claimants.
		• When determining whether the employee's attorney's work, with regard to a contested claim, resulted in an award of benefits that inure to the benefit of a third-party insurance carrier or health care provider (and in determining the reasonableness of the amount of any fee awarded to an attorney), the measure requires the Commission:
		  o To consider only the amount paid by the employer or insurance carrier to the third-party insurance carrier or health care provider for medical services rendered to the employee through a certain date
		  o Not to consider additional amounts previously paid to a health care provider or reimbursed to a third-party insurance carrier
		• The Commission shall have an independent, peer-reviewed study conducted every two years. The existing peer review provisions are repealed.
		• The regulations setting fee schedules are exempt from the Administrative Process Act if the Commission utilizes a regulatory advisory panel to assist in the development of such regulations and provides an opportunity for public comment on the regulations prior to adoption.
		• The measure prohibits certain practices involving the use by third parties of contracts, such as:
		  o When a provider agrees to accept payment of less than the fee scheduled amount—including restricting the sale, lease, or other
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		dissemination of information regarding the payment amounts or terms of a provider contract—without the express written consent and prior notification of all parties to the provider contract o When an employer shops for the lowest discount for a specific provider among the provider contracts held in multiple preferred provider organization networks • The regulatory advisory panel is directed to make recommendations to the Commission prior to July 1, 2017, on workers compensation issues relating to: o Pharmaceutical costs not previously included in the fee schedules o Durable medical equipment costs not previously included in the fee schedules o Certain awards of attorney fees o Peer review of medical costs o Prior authorization for medical services o Other issues that the Commission assigns to it		
Virginia	HB 1108	**HB 1108** amends ***sections 2.2-4302.1. Process for competitive sealed bidding*** and ***2.2-4302.2. Process for competitive negotiation*** of the Code of Virginia as follows: **§ 2.2-4302.1. Process for competitive sealed bidding.** The process for competitive sealed bidding shall include the following: 1. Issuance of a written Invitation to Bid containing or incorporating by reference the specifications and contractual terms and conditions applicable to the procurement. Unless the public body has provided for prequalification of bidders, the Invitation to Bid shall include a statement of any requisite qualifications of potential contractors. <u>No Invitation to Bid for construction services shall condition a successful bidder's eligibility on having a specified experience modification factor.</u> When it is impractical to prepare initially a purchase description to support an award based on prices, an Invitation to Bid may be issued requesting the submission of unpriced offers to be followed by an Invitation to Bid limited to those bidders whose offers have been qualified under the criteria set forth in the first solicitation; … 5. Award to the lowest responsive and responsible bidder. When the terms and conditions of multiple awards are so provided in the Invitation to Bid, awards may be made to more than one bidder. <u>For the purposes of subdivision 1, "experience modification factor" means a value assigned to an employer as determined by a rate service organization in accordance with its uniform experience rating plan required to be filed pursuant to subsection D of Section 38.2-1913.</u> **Section 2.2-4302.2. Process for competitive negotiation.** A. The process for competitive negotiation shall include the following: 1. Issuance of a written Request for Proposal indicating in general terms that which is sought to be procured, specifying the factors that will be used in evaluating the proposal, indicating whether a numerical scoring system will be used in evaluation of the proposal, and containing or incorporating by reference the other applicable contractual terms and conditions, including any unique capabilities, specifications or qualifications that will be required. In the event that a numerical scoring system will be used in the evaluation of proposals, the point values assigned to each of the evaluation	7/1/16	No action required

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JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
		criteria shall be included in the Request for Proposal or posted at the location designated for public posting of procurement notices prior to the due date and time for receiving proposals. No Request for Proposal for construction authorized by this chapter shall condition a successful offeror's eligibility on having a specified experience modification factor; … For the purposes of subdivision A 1, "experience modification factor" means a value assigned to an employer as determined by a rate service organization in accordance with its uniform experience rating plan required to be filed pursuant to subsection D of Section 38.2-1913. In addition, **HB 1108** adds the following new section to read: **§ 11-9.8. Construction of certain terms of offer to contract; use of experience modification factor prohibited.** A. As used in this section: "Contract" means an agreement for the provision of construction services under which the contractor will be required to have and maintain a policy of insurance as defined in Section 38.2-119. "Experience modification factor" means a value assigned to an employer as determined by a rate service organization in accordance with its uniform experience rating plan required to be filed pursuant to subsection D of Section 38.2-1913. "Offer to contract" means a solicitation of bids, Request for Proposals, or similar invitation to enter into a contract that is extended to potential contractors for construction services. "Person" means any individual; firm; cooperative; association; corporation; limited liability company; trust; business trust; syndicate; partnership; limited liability partnership; joint venture; receiver; trustee in bankruptcy; club, society, or other group or combination acting as a unit; or public body, including but not limited to (i) the Commonwealth; (ii) any other state; and (iii) any agency, department, institution, political subdivision, or instrumentality of the Commonwealth or any other state. B. A term of an offer to contract issued that requires that the successful bidder have a specified experience modification factor is prohibited. C. Any contract or offer to contract that requires the contractor or bidder responding to the offer to contract to have a specified experience modification factor is prohibited. … **HB 1108** also contains the following clause: That the provisions of this act shall apply to any offer to contract, as defined in § 11-9.8 of the Code of Virginia, as created in this act; Invitation to Bid; or Request for Proposal for construction services issued on or after July 1, 2016.		
West Virginia	HB 128	**HB 128** amends ***section 33-3-33a. Excess moneys of Fire Protection Fund deposited into Volunteer Fire Department Workers' Compensation Premium Subsidy Fund; other funding; special report from State Fire Marshal by December 15, 2015; termination of program June 30, 2016*** of the Code of West Virginia to provide for the: • Deposit of monies into the Volunteer Fire Department Workers' Compensation Premium Subsidy Fund until June 30, 2017 • Expiration and closure of the Volunteer Fire Department Workers' Compensation Premium Subsidy Fund on June 30, 2017 • Transfer of any remaining monies in the Volunteer Fire Department Workers' Compensation Premium Subsidy Fund upon closure of such fund	6/14/16	No action required

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2016 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/16)

JURISDICTION	BILL	SUMMARY	EFFECTIVE	NCCI ACTION
West Virginia	HB 4228	**HB 4228** creates new ***Article 29. Transportation Network Companies*** in ***Chapter 17. Roads and Highways*** of the Code of West Virginia which, in part, includes ***section 17-29-11. Limitation on transportation network companies.*** to read: **§17-29-11. Limitation on transportation network companies.** (a) Drivers are independent contractors and not employees of the transportation network company if all of the following conditions are met: (1) The transportation network company does not prescribe specific hours during which a transportation network company driver must be logged into the transportation network company's digital network; (2) The transportation network company imposes no restrictions on the transportation network company driver's ability to utilize digital networks from other transportation network companies; (3) The transportation network company does not assign a transportation network company driver a particular territory in which to operate; (4) The transportation network company does not restrict a transportation network company driver from engaging in any other occupation or business; and (5) The transportation network company and transportation network company driver agree in writing that the driver is an independent contractor of the transportation network company. (b) A transportation network company operating under this article is not required to provide workers' compensation coverage to a transportation network company driver that is classified as an independent contractor pursuant to this section.	7/1/16	No action required
West Virginia	SB 621	**SB 621** amends ***section 23-2-1. Employers subject to chapter; elections not to provide certain coverages; notices; filing of business registration certificates*** of the Code of West Virginia as follows: **§23-2-1. Employers subject to chapter; elections not to provide certain coverages; notices; filing of business registration certificates.** (a) The State of West Virginia and all governmental agencies or departments created by it, including county boards of education, political subdivisions of the state, any volunteer fire department or company and other emergency service organizations as defined by article five, chapter fifteen of this code, and all persons, firms, associations and corporations regularly employing another person or persons for the purpose of carrying on any form of industry, service or business in this state, are employers within the meaning of this chapter and are required to subscribe to and pay premium taxes into the Workers' Compensation Fund for the protection of their employees and are subject to all requirements of this chapter and all rules prescribed by the Workers' Compensation Commission with reference to rate, classification and premium payment*: Provided,* That rates will be adjusted by the commission to reflect the demand on the compensation fund by the covered employer. (b) The following employers are not required to subscribe to the fund, but may elect to do so: … (8) Taxicab drivers of taxicab companies operating under article two, chapter twenty-four-a of this code, who provide taxicab service pursuant to a written or electronic agreement that identifies the taxicab driver as an independent contractor consistent with the United States Internal Revenue code requirements for persons acting as independent contractors: Provided, That any such taxicab driver identified as an independent contractor shall not be eligible for workers' compensation benefits under this chapter as an employee of the taxicab company.; ~~(8)~~ (9) Any employer whose employees are eligible to receive benefits under the federal Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §901, *et seq*., but only for those employees eligible for those benefits. …	6/27/16	No action required

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

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