BILLS NEWLY ADDED SINCE THE LAST UPDATE ARE LISTED FIRST AND HIGHLIGHTED IN "YELLOW."

NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

PREVIOUSLY ENACTED BILLS

JURISDICTION	BILL	SUMMARY	EFFECTIVE
Alabama	HB 192	**HB 192**, in part, amends ***sections 25-5-60***, ***25-5-66***, ***25-5-68***, and ***25-5-69*** of the Alabama Industrial Relations and Labor Code as follows: **Section 25-5-60 Compensation for death.** … **(1) Persons Entitled to Benefits; Amount of Benefits.** … e. ~~If~~ Except as provided in subdivision (3), if compensation is being paid under this article to any dependent, the compensation shall cease upon the death or marriage of the dependent, unless otherwise provided in this article. … **(2) Maximum and Minimum Compensation Awards.** The compensation payable in case of death to persons wholly dependent shall be subject to a maximum and minimum weekly compensation as stated in Section 25-5-68, but if at the time of injury the employee receives earnings of less than the minimum stated in Section 25-5-68, then the compensation shall be the full amount of such earnings per week. The compensation payable to partial dependents shall be subject to a maximum and minimum weekly compensation as stated in Section 25-5-68, but if the income loss of the partial dependents by the death is less than the minimum weekly compensation stated in Section 25-5-68, then the dependents shall receive the full amount of their income loss. This compensation shall be paid during dependency, not exceeding 500 weeks, except as provided in subsection (f) of Section 25-5-68. Payments shall be made at the intervals when the earnings were payable, as nearly as may be, unless the parties otherwise agree. (3) If a dependent is the surviving spouse of a law enforcement officer or firefighter killed as a result of injuries received while engaged in the performance of his or her duties, the compensation does not cease upon remarriage. **Section 25-5-66 Disposition of compensation upon remarriage of widow of employee who has another dependent.** (a) In case of the remarriage of ~~a widow~~ the surviving spouse of an employee who has another dependent, the unpaid balance of compensation, which would otherwise become due ~~her~~, shall be paid to the dependent or may, on approval by the court, be paid to some suitable person designated by the court for the use and benefit of the dependent. Payment to that person shall discharge the employer from any further liability. (b) Subsection (a) does not apply to the surviving spouse of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties. **Section 25-5-68 Maximum and minimum weekly compensation.** … (d) In no event, except as provided for permanent total disability in subdivision (a)(4) of Section 25-5-57 or except for compensation benefits payable for permanent partial and temporary total disability in connection with a disability scheduled in subdivisions (1) and (3) of subsection (a) of Section 25-5-57 or except as provided in subsection (f), shall the total amount of compensation payable for an accident or an occupational disease exceed the product of 500 times the maximum weekly benefit applicable on the date of the accident. …	7/1/18

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		(f) Notwithstanding any other provision of this article, the compensation benefits payable to a surviving dependent child of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties shall not discontinue at least until the dependent child reaches the age of 18 years. **Section 25-5-69 Compensation to cease upon death or marriage of dependent; proportional benefits for dependents.** ~~If~~ Except when the dependent is the surviving spouse of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties, if compensation is being paid under this article to any dependent, such compensation shall cease upon the death or marriage of such dependent. Where compensation is being paid under this chapter to any dependent, in no event shall such dependent receive more than the proportion which the amount received of the deceased employee's income during his or her life bears to the compensation provided under this article.	
Alabama	SB 283	**SB 283** amends **sections *27-42-3, 27-42-5, 27-42-8, 27-42-11***, and ***27-42-12*** of the Alabama Insurance Code, in part, as follows: **Section 27-42-3** **Applicability of chapter.** This chapter shall apply to all kinds of direct insurance, ~~except life, annuities, disability, accident and health, title, surety, credit, mortgage guaranty, and ocean marine insurance.~~ excluding all of the following: (1) Life, annuity, health, or disability insurance. (2) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks. (3) Fidelity or surety bonds, or any other bonding obligations. (4) Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction. (5) Insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement, or service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits. (6) Title insurance. (7) Ocean marine insurance. (8) Any insurance provided by or guaranteed by the government. **Section 27-42-5** **Definitions.** As used in this chapter, the following terms shall have the following meanings, respectively, unless the context clearly indicates otherwise: … (4) CLAIMANT. Any insured making a first party claim or any person instituting a liability claim. The term does not include a person who is an affiliate of an insolvent insurer.	7/1/18

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		… ~~(6)~~ (7) COVERED CLAIM. An unpaid claim, including one of unearned premiums, which arises out of, and is within the coverage and not in excess of, the applicable limits of an insurance policy to which this chapter applies, issued by an insurer, if such insurer becomes an insolvent insurer after January 1, 1981, and (i) the claimant or insured is a resident of this state at the time of the insured event; or (ii) the property from which the claim arises is permanently located in this state. ~~"Covered claim" shall~~ The term does not include any of the following: a. Any amount due any reinsurer, insurer, insurance pool, self-insurer, or underwriting association, as subrogation recoveries or otherwise~~, nor shall "covered claim" include any~~ . b. Any first party claims by a "high net worth insured.~~"~~ c. Any amount awarded as punitive or exemplary damages except for punitive damages awarded under the Alabama Wrongful Death Act. d. Any amount sought as a return of premium under any retrospective rating plan. … (10) INSURED. Any named insured, additional insured, vendor, lessor, or other party identified as an insured under a policy. … **Section 27-42-8** **Powers and duties.** (a) The association shall: (1)a. Be obligated to ~~the extent of the~~ pay covered claims existing prior to the ~~determination of insolvency and~~ order of liquidation arising within 30 days after the ~~determination of insolvency~~ order of liquidation, or before the policy expiration date if less than 30 days after the ~~determination, on~~ order of liquidation, or before the insured replaces the policy or causes its cancellation, if he or she does so within 30 days of the ~~determination, but the association's obligation shall include only that amount of each covered claim which is in excess of one hundred dollars ($100) and is less than one hundred fifty thousand dollars ($150,000), except that the association shall pay the full amount of any covered employee benefit claim arising under Section A of workers' compensation policy. In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises.~~ order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows: 1. The full amount of a covered claim for benefits under a workers' compensation insurance coverage. 2. An amount not exceeding ten thousand dollars ($10,000) per policy for a covered claim for the return of unearned premium. 3. An amount not exceeding three hundred thousand dollars ($300,000) or the policy limits, whichever is less, per claim for all covered claims. For purposes of this limitation, all claims of any kind whatsoever arising out of, or related to, bodily injury or death to any one person shall constitute a single claim, regardless of the number of claims made or the number of claimants. b. In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. c. Notwithstanding any other provisions of this chapter, a covered claim shall not include any claim filed with the ~~guaranty fund~~ association after the earlier of: 1. Twenty-five months after the date of the order of liquidation.	

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		2. The final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. d. Any obligation of the association to defend an insured on a covered claim shall cease upon the association's 1. payment, by settlement releasing the insured or on a judgment, of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit or 2. tender of such amount. e. If the association determines that there may be more than one claimant having a covered claim or allowed claim against the association or any associations similar to the association in other states, under the policy or policies of any one insolvent insurer, the association may establish a plan to allocate amounts payable by the association in such manner as the association deems equitable. … (b) The association may: … (7) Bring an action against any third party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all claims information including, but not limited to, files, records, and electronic data related to an insolvent company that are appropriate or necessary for the association, or a similar association in other states, to carry out its duties under this chapter. In such a suit, the association shall have the absolute right through emergency equitable relief to obtain custody and control of all claims information in the custody or control of the third party administrator, agent, attorney, or other representative of the insolvent insurer, regardless of where the claims information may be physically located. In bringing such an action, the association shall not be subject to any defense, lien, possessory or otherwise, or other legal or equitable ground whatsoever for refusal to surrender claims information that might be asserted against the liquidator of the insolvent insurers. To the extent that litigation is required for the association to obtain custody of the claims information requested and litigation results in the relinquishment of claims information to the association after refusal to provide the same in response to a written demand, the court shall award the association its costs, expenses, and reasonable attorneys' fees incurred in bringing the action. This section shall have no effect on the rights and remedies that the custodian of such claims information may have against the insolvent insurers, so long as such rights and remedies do not conflict with the rights of the association to custody and control of the claims information under this chapter. … **Section 27-42-11** **Settlement and payment of claims; recovery.** … (i) The association and any association similar to the association in another state shall be recognized as claimants in the liquidation of an insolvent insurer for any amounts paid by them on covered claims obligations as determined under this chapter, or similar laws in other states, and shall receive dividends and any other distributions at the priority set forth for policyholder claims in the liquidation proceeding. The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by determinations of covered claim eligibility under this chapter and by settlements of claims made by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this chapter against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.	

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		Section 27-42-12 **Exhaustion of rights; nonduplication of recovery.** (a) Any person having a claim ~~against an insurer~~ under ~~any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first his rights under such policy. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under such insurance policy.~~ an insurance policy, whether or not it is a policy issued by a member insurer, where the claim under the other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the association, shall be required first to exhaust all coverage provided by any such policy. Any amount payable on a covered claim under this chapter shall be reduced by the full applicable limits stated in the other insurance policy and the association shall receive a full credit for the stated limits, or, where there are no applicable stated limits, the claim shall be reduced by the total recovery. Notwithstanding the foregoing, no person shall be required to exhaust any right under the policy of an insolvent insurer. (1) A claim under a policy providing liability coverage to a person who may be jointly and severally liable with, or a joint tortfeasor with, the person covered under the policy of the insolvent insurer that gives rise to the covered claim, shall be considered to be a claim arising from the same facts, injury, or loss that gave rise to the covered claim against the association. (2) A claim under an insurance policy shall also include, for purposes of this section: a. A claim against a health maintenance organization, a hospital plan corporation, or a professional health service corporation. b. Any amount payable by or on behalf of a self-insurer. (3) To the extent that the association's obligation is reduced by the application of this section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount. (b) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he or she shall seek recovery first from the association of the location of the property and if it is a ~~workmen's~~ workers' compensation claim, he or she shall seek recovery first from the association of the residence of the claimant at the time of the accident giving rise to the claim. Any recovery under this chapter shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.	
Alaska	HB 79	**HB 79** amends numerous sections of the Alaska Workers' Compensation Act to: • Provide for a definition of "independent contractor" by creating an eight-point test to determine whether an injured person is an employee • Phase out the second injury fund, setting an end date for the fund's acceptance of new reimbursement claims, and clarify that the fund will continue to pay reimbursement claims until all liability for previously accepted claims to the second injury fund, and claims ordered to be paid from that fund, have been satisfied • Allow the Department of Labor and Workforce Development (Department) to receive a greater percentage of the annual service fees that insurers pay • Clarify that penalties for late reports accrue to the Workers' Safety and Compensation Administration Account • Make technical changes to allow electronic filing of documents • Allow the division director to prescribe the format for reporting injuries to the division • Add publications to a list that the Department may incorporate, including future amended versions, into regulation	Various effective dates

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		• Eliminate the requirement that corporate executive officers seek the division's approval before opting out of workers compensation coverage for themselves, and clarify the requirements for opting out • Eliminate a requirement that the board approve attorney fees as part of a settlement when fees are the sole issue in the settlement that require board approval • Define "employee" • Repeal AS 23.30.050(f) and 23.30.155(q) relating to the second injury fund and methods of paying benefits • Create a Legislative Workers' Compensation Working Group to act as an interim committee to continue work and develop new legislation for consideration during the 31st Alaska State Legislature • Amend the uncodified law of the state of Alaska by adding transitional language and clarifying that subject to appropriation, the balance of the second injury fund lapses into the general fund after all liability for previously accepted claims to the second injury fund, and claims ordered to be paid from that fund, have been satisfied • Amend the uncodified law of the state of Alaska by authorizing the department to initiate the regulatory process before the effective date *NCCI estimates that the impact of closing the Alaska Second Injury Fund, and thereby shifting the full financial liability for workers compensation (WC) benefits for affected claims to the employer/insurer, may result in a minimal (i.e., +/–0.2%) impact on overall WC system costs in Alaska.*	
Alaska	HB 126	**HB 126** adds new ***section 23.30.236. Members of the organized militia as employees*** to the Alaska Workers Compensation Act to read: **Sec. 23.30.236. Members of the organized militia as employees.** (a) A member of the organized militia who has been ordered into active state service by the governor under AS 26.05.070 or ordered into training under AS 26.05.100, and who suffers an injury, disability, or death in the line of duty, is an employee of the state for purposes of this chapter. (b) The gross weekly earnings for members of the organized militia are calculated using the methods prescribed under AS 26.05.260(h). **HB 126** also amends ***section 26.05.260. Pay and allowances*** of the Military Code of Alaska as follows: **Sec. 26.05.260. Pay and allowances.** … (d) A member of the organized militia who, while performing duties under AS 26.05.070 or training under AS 26.05.100, including transit to and from the member's home of record, suffers an injury or disability in the line of duty is entitled to all compensation and benefits available under AS 23.30 (Alaska Workers' Compensation Act). For a member of the Alaska State Defense Force, compensation and benefits under this subsection are provided as though the member were a state employee. A member of the organized militia who has not been ordered into active state service by the governor under AS 26.05.070 or ordered into training under AS 26.05.100 is not entitled to compensation and benefits under AS 23.30 (Alaska Workers' Compensation Act). (e) If a member of the organized militia dies as a result of an injury or disability suffered in the line of duty while performing duties under AS 26.05.070 or training under AS 26.05.100, including transit to and from the member's home of record, death benefits shall be paid to the persons in the amounts specified in AS 23.30.215. For a member of the Alaska State Defense Force, the death benefits under this subsection are provided as	11/11/18

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		though the member were a state employee. A person is not entitled to death benefits as specified in AS 23.30.215 for a member of the organized militia who dies as a result of an injury or disability suffered in the line of duty but who had not been ordered into active state service by the governor under AS 26.05.070 or ordered into training under AS 26.05.100. ...	
Arizona	HB 2025	**HB 2025** amends ***section 20-359. Deviations from filed workers' compensation rates*** of the Arizona Revised Statutes as follows: **20-359. Deviations from filed workers' compensation rates** A. Every insurer shall adhere to the filings made by the rating organization of which it is a member, except that any member insurer may file with the director: 1. Up to six uniform percentage deviations that decrease or increase the statewide rate portion of the rating organization's rate filing. If more than one deviation is filed by an insurer, each deviation must be established consistent with the underwriting rules that are based on criteria that would lead to a logical distinction of potential risk. 2. A subclassification rate related rule that deviates from the rules or schedule rating plan filed by the insurer's rating organization. An insurer shall not simultaneously apply a deviation and a schedule rating ~~plan within~~ to the ~~insurance company~~ insured risk. B. Each deviation filed shall be on file with the director for a waiting period of at least thirty days before it becomes effective. On written application by the insurer making the filing, the director may authorize a filing to become effective before the waiting period expires. A deviation that is filed pursuant to subsection A, paragraph 1 of this section and that is not disapproved by the director expires the following December 31 at midnight in this state unless the director terminates the deviation sooner. A deviation that is filed pursuant to subsection A, paragraph 2 of this section continues until the insurer withdraws the deviation or the director determines that the deviation no longer meets the standards prescribed in section 20-356, paragraph 1. At any time the director may require an insurer to actuarially support a deviation. The insurer that files the deviation shall simultaneously send a copy of the filing to the rating organization of which it is a member and to any designated rating organization. C. A rating organization shall notify the director if the organization disapproves any deviation relating to workers' compensation insurance. The director shall notify the industrial commission of the disapproval within ten days after receipt of the disapproval from the rating organization. Sec. 2. Retroactivity **HB 2025** also includes the following clause: Section 20-359, Arizona Revised Statutes, as amended by this act, applies retroactively to workers' compensation insurance rate filings made by an insurer or an insurance rating organization from and after February 28, 2018.	2/28/18
Arizona	HB 2047	**HB 2047** amends ***section 23-901. Definitions*** of the Arizona Revised Statutes, in part, as follows: **23-901. Definitions** In this chapter, unless the context otherwise requires: ... 6. "Employee", "workman", "worker" and "operative" means: ... (q) A working member of a limited liability company who owns less than fifty percent of the membership interest in the limited liability company.	8/3/18

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		(r) A working member of a limited liability company who owns fifty percent or more of the membership interest in the limited liability company may be deemed to be an employee entitled to the benefits provided by this chapter on the written acceptance, by endorsement, of an application for coverage by the working member at the discretion of the insurance carrier for the limited liability company. The basis for computing wages for premium payments and compensation benefits for the working member is an assumed average monthly wage of six hundred dollars or more but not more than the maximum wage provided in section 23-1041 and is subject to the discretionary approval of the insurance carrier. Any compensation for permanent partial or permanent total disability payable to the working member is computed on the lesser of the assumed monthly wage agreed to by the insurance carrier on the acceptance of the application for coverage or the actual average monthly wage received by the working member at the time of injury. (s) A working shareholder of a corporation who owns less than fifty percent of the beneficial interest in the corporation. (t) A working shareholder of a corporation who owns fifty percent or more of the beneficial interest in the corporation may be deemed to be an employee entitled to the benefits provided by this chapter on the written acceptance, by endorsement, of an application for coverage by the working shareholder at the discretion of the insurance carrier for the corporation. The basis for computing wages for premium payments and compensation benefits for the working shareholder is an assumed average monthly wage of six hundred dollars or more but not more than the maximum wage provided in section 23-1041 and is subject to the discretionary approval of the insurance carrier. Any compensation for permanent partial or permanent total disability payable to the working shareholder is computed on the lesser of the assumed monthly wage agreed to by the insurance carrier on the acceptance of the application for coverage or the actual average monthly wage received by the working shareholder at the time of injury. … **HB 2047** also includes the following clause: Applicability This act applies to workers' compensation policies issued or renewed on or after July 1, 2019.	
Arizona	SB 1100	**SB 1100** amends ***section 23-941.01 Settlement of claims; exception; definitions*** and adds new ***section 23-941.03. Settlement of claims; supportive medical maintenance benefits; definition*** to the Arizona Revised Statutes, in part, as follows: **23-941.01. Settlement of claims; full and final; exception; definitions** A. The interested parties to a claim may: 1. Settle and release all or any part of an accepted claim for compensation, benefits, penalties or interest. 2. If the period of temporary disability is terminated by ~~the carrier, special fund or self-insured employer~~ a final notice of claim status, award of the commission or stipulation of the interested parties, negotiate a full and final settlement of an accepted claim. B. Any full and final settlement shall: 1. Be in writing. 2. Be signed by the carrier, special fund or self-insured employer or an authorized representative of the carrier, special fund or self-insured employer and the employee or the employee's authorized representative. 3. Acknowledge that the employee had the opportunity to seek legal advice and be represented by counsel.	8/3/18

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		4. Include a description of the employee's medical conditions that have been identified and contemplated at the time of the settlement agreement. 5. Have attached the information provided by the carrier, special fund or self-insured employer pursuant to subsection c, paragraphs 2 and 3 of this section. C. ~~If the employee is represented by counsel, the~~ A full and final settlement shall include the following signed attestations: 1. The employee understands the rights settled and released by the agreement ~~and was represented by counsel~~. 2. The employee has been provided information from the carrier, special fund or self-insured employer that outlines any reasonable anticipated future medical, surgical and hospital benefits relating to the claim, ~~and~~ the projected cost of those benefits, ~~and that provides~~ an explanation of how those projected costs were determined and a disclosure of the amount of the settlement that represents the settlement of future medical, surgical and hospital benefits. 3. The employee has been provided information from the carrier, special fund or self-insured employer that discloses the total amount of future indemnity benefits, the employee's rated age, if applicable, the employee's life expectancy, the source of the employee's life expectancy, the present value of future indemnity benefits, the discount rate used to calculate present value and the amount of the settlement that represents the settlement of future indemnity benefits. ~~3.~~ 4. The employee understands that monies received for future medical treatment associated with the industrial injury should be set aside to ensure that the costs of ~~such~~ the treatment will be paid. ~~4.~~ 5. The parties have considered and taken reasonable steps to protect any interests of medicare, medicaid, the Indian health service and the United States department of veterans affairs, including establishing a medicare savings account if necessary. ~~5.~~ 6. The parties have conducted a search for and taken reasonable steps to satisfy any identified medical liens and unpaid medical charges. 7. Coercion, duress, fraud, misrepresentation or undisclosed additional agreements have not been used to achieve the full and final settlement. D. If an administrative law judge of the commission determines that the requirements of subsection b of this section are satisfied, the attestations of subsection c of this section are present and the employee is represented by counsel, the administrative law judge shall approve the settlement. ~~D~~E. If the employee is not represented by counsel, the employee shall appear before an administrative law judge of the commission and the administrative law judge shall make specific factual findings regarding whether the requirements of ~~subsection~~ subsections B and C ~~subsection C, paragraphs 2, 3, 4 and 5~~ of this section are satisfied. ~~The administrative law judge may not approve the settlement if the requirements of subsection B of this section are not met or if the settlement is not deemed fair and reasonable to the employee.~~ The administrative law judge shall conduct a hearing and perform a detailed inquiry into the attestations provided by the unrepresented employee pursuant to subsection C of this section. The inquiry shall include whether the unrepresented employee understands the specific rights being settled and released, the information, computation and methodology provided by the carrier, special fund or self-insured employer, and the employee's responsibility to protect the interests of other payors and ensure the payment of future treatment costs. ~~E. A full and final settlement is not valid and enforceable unless the full and final settlement is approved by the commission. When determining whether to approve a settlement, the commission shall consider whether the settlement is in the best interests of the employee based on the following criteria:~~ ~~1. Whether the employee's injuries are stabilized.~~ ~~2. The permanency of the employee's injuries.~~ F. The commission may not approve a full and final settlement if the requirements of subsections B and C of this section are not met.	

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		~~F~~G. A ~~lump sum~~ full and final settlement payment shall be made to the employee within fifteen days after the award approving the settlement becomes final. … **23-941.03. Settlement of claims; supportive medical maintenance benefits; definition** A. Any final settlement agreement involving undisputed entitlement to supportive medical maintenance benefits is not valid and enforceable until the final settlement agreement is approved by the commission. B. The commission may approve a final settlement agreement involving undisputed entitlement to supportive medical maintenance benefits if the requirements of this section are satisfied. C. Subject to the following requirements, the interested parties to a claim may enter into a final settlement and release of a claim for undisputed entitlement to supportive medical maintenance benefits after the period of temporary disability is terminated by a final notice of claim status or award of the commission. The carrier, special fund or self-insured employer shall submit a summary of all reasonably anticipated future supportive medical maintenance benefits and the projected cost of the benefits for review by the employee. The summary shall also be included with the final settlement agreement filed with the commission. All medical conditions subject to the final settlement agreement must be described in the final settlement agreement. The final settlement provisions defined in this subsection shall apply only to future supportive medical maintenance benefits for the described condition. D. The carrier, special fund or self-insured employer shall inform the attending physician of the approval of a final settlement agreement. Unless supportive medical maintenance benefits rendered before the date of the final settlement are subject to a dispute or payment for the treatment was included in the final settlement agreement, the carrier, special fund or self-insured employer shall remain responsible for payment for the treatment not covered by the final settlement agreement as provided by this chapter. E. This section does not prohibit a settlement that does not constitute a final settlement. F. For the purposes of this section, "final settlement" means a settlement in which the injured worker waives any future entitlement to supportive medical maintenance benefits for known conditions described in the agreement.	
Arizona	SB 1111	**SB 1111** amends ***sections 23-908*** and ***23-1062.02*** of the Arizona Revised Statutes, in part, as follows: **23-908. Injury reports by employer and physician; schedule of fees; violation; classification** … B. The commission shall fix a schedule of fees to be charged by physicians, physical therapists or occupational therapists attending injured employees and, subject to subsection C of this section, for prescription medicines required to treat an injured employee under this chapter. Notwithstanding subsection C of this section, the schedule of fees may include other reimbursement guidelines for medications dispensed in settings that are not accessible to the general public. The commission shall annually review the schedule of fees. … **23-1062.02. Use of controlled substances; prescription of schedule II controlled substances; reports; treatment plans; monitoring program inquiries; preauthorizations; definitions**	8/3/18

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BILLS NEWLY ADDED SINCE THE LAST UPDATE ARE LISTED FIRST AND HIGHLIGHTED IN "YELLOW."

JURISDICTION	BILL	SUMMARY	EFFECTIVE
		A. A physician who prescribes a schedule ii controlled substance to an employee shall comply with title 32, chapter 32, article 4, including the provisions in that article relating to patients with traumatic injuries. ~~A.~~ B. A physician shall include in the report required under commission rule the following information pertaining to the ~~following~~: ~~1. The off-label use of a narcotic, opium-based controlled substance or schedule II controlled substance by a claimant.~~ ~~2. The use of a narcotic or opium-based controlled substance or the prescription of a combination of narcotics or opium-based controlled substances at or exceeding a one hundred twenty milligram morphine equivalent dose per day.~~ ~~3. The prescription of a long-acting or controlled release opioid for acute pain.~~ ~~B. The information required pursuant to subsection A of this section shall include the~~ use of a narcotic or opium-based controlled substance that is listed in Schedule II or the prescription of any opioid medication: 1. Justification for the use of the controlled substance, ~~and~~ including documentation of the following: (a) That a physical examination of the employee was conducted. (b) That a substance use risk assessment of the employee was conducted. (c) That the employee gave informed consent for any opioid treatment. 2. A treatment plan ~~that includes a description of~~ describing the measures that the physician will implement to monitor and prevent the development of abuse, dependence, addiction or diversion by the employee. The physician shall include in the treatment plan all of the following: (a) A medication agreement. ~~, a plan for subsequent~~ (b) The frequency of face-to-face follow-up visits ~~and~~ to reevaluate the employee's continued use of opioids. (c) Random drug testing. ~~and~~ (d) Documentation that the medication regime is providing relief that is demonstrated by clinically meaningful improvement in function. (e) Criteria and procedures for tapering and discontinuing opioid prescription or administration as part of the treatment. (f) Criteria and procedures for offering or referring the employee for treatment for dependence on or addiction to opioids. C. If the drug test of the employee reveals inconsistent results, the physician within five business days shall provide a written report to the carrier, self-insured employer or commission setting forth a treatment plan to address the inconsistent drug test results. ~~C.~~ D. ~~Within two business days of writing or dispensing an initial prescription order for at least a thirty-day supply of an opioid medication for the employee, a physician shall submit an inquiry to the Arizona state board of pharmacy requesting the employee's prescription information that is compiled under the controlled substances prescription monitoring program prescribed in title 36, chapter 28.~~ Before prescribing an opioid analgesic or benzodiazepine controlled substance that is listed in Schedule II, III or IV for an employee and at least quarterly while that prescription remains a part of the treatment, the physician shall obtain a patient utilization report regarding the employee from the controlled substances prescription monitoring program's central database tracking system as required by section 36-2606. The physician shall report the results to the carrier, self-insured employer or commission as soon as reasonably practicable but ~~no~~ not later than thirty days ~~from~~ after the date of the inquiry. Thereafter, the carrier, self-insured employer or commission may request ~~no~~ not more than once every two months that the physician ~~perform additional inquiries to~~ obtain a patient utilization report regarding the employee from the ~~Arizona state board of pharmacy~~ controlled substances prescription monitoring program's central database tracking system.	

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		~~D.~~ E. If the ~~result of an inquiry to~~ patient utilization report from the ~~Arizona state board of pharmacy~~ controlled substances prescription monitoring program's central database tracking system reveals that the employee is receiving opioids from another undisclosed health care provider, the physician shall within five business days report the results to the carrier, self-insured employer or commission. ~~E.~~ F. If the physician does not comply with this section: 1. The carrier, self-insured employer or commission is not responsible for payment for the physician's services until the physician complies with this section. 2. Except for a self-insured employer that provides medical care pursuant to section 23-1070, ~~an~~ the employer, carrier or commission may request a change of physician after making a written request to the physician to comply with this section and the request identifies the area of noncompliance. If a change of physician is ordered and the order becomes final, the employee shall select a physician ~~whose practice includes pain management and~~ who agrees to comply with this section. If other medical providers are not available in the employee's area of residence, the employer, carrier or commission shall pay in advance for the employee's reasonable travel expenses, including the cost of transportation, food, lodging and loss of pay, if applicable. … ~~H. This section does not apply to medications administered to the employee while the employee is receiving inpatient hospital treatment.~~ I. A carrier, a self-insured employer or the commission may require physician compliance with this section notwithstanding the existence of a prior award addressing medical maintenance benefits for medications. A carrier or self-insured employer is not liable for bad faith or unfair claims processing for any act taken in compliance of and consistent with this section or any act reasonably necessary to monitor or assess the appropriateness and effectiveness of an employee's opioid use. J. For the purposes of this section: 1. "Clinically meaningful improvement in function" means ~~any~~ both of the following: ~~(a) A clinically documented improvement in range of motion.~~ ~~(b)~~ (a) ~~An Increase~~ A significant improvement in the performance of activities of daily living or a reduction in work restrictions. ~~(c) A return to gainful employment.~~ (b) A reduction in dependency on continued medical treatment. 2. "Inconsistent results" means: … ~~3. "Off-label use" means use of a prescription medication by a physician to treat a condition other than the use for which the drug was approved by the United States food and drug administration.~~ 3. "Substance use risk assessment" means an evaluation of an employee's unique likelihood for addiction, misuse, diversion or another adverse consequence resulting from the employee being prescribed or receiving treatment with opioids. 4. "Traumatic injury" as used in title 32, chapter 32, article 4 means physical injury that creates a reasonable risk of death or that causes serious or permanent disfigurement, serious impairment of health or loss or protracted impairment of the function of any bodily organ or limb. **SB 1111** also includes the following language: Industrial commission of Arizona; review of medication reimbursement guidelines; delayed repeal	

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		A. On or before July 1, 2019, as part of the industrial commission of Arizona's annual review of the schedule of fees pursuant to section 23-908, Arizona Revised Statutes, as amended by this act, the industrial commission of Arizona shall review information and data, consult with physician, employee and business and industry stakeholders and hold at least one public hearing in considering whether to adopt additional reimbursement guidelines for medications dispensed in settings that are not accessible to the general public. B. This section is repealed from and after June 30, 2020.	
Colorado	HB 1308	**HB 1308** adds new ***section 8-41-212*** to the Workers' Compensation Act of Colorado as follows: **8-41-212. Exemptions—laws of other state furnish exclusive remedy—definitions.** (1) An employee who was hired or is regularly employed outside of Colorado by an out-of-state employer and the out-of-state employer of the employee are exempt from Articles 40 to 47 of this Title 8 while the employee is temporarily working for the out-of-state employer within Colorado if: (a) The out-of-state employer has furnished coverage pursuant to the workers' compensation laws of the state in which the employee was hired or is regularly employed, which coverage applies to the employee while temporarily working in Colorado; and (b) The state in which the employee is furnished coverage: (I) Is contiguous to Colorado; and (II) Recognizes this section and provides the same exemption from the application of its workers' compensation laws for Colorado employers whose employees are temporarily working in the contiguous state. (2) For an out-of-state employee and out-of-state employer to which this section applies, the benefits provided under the workers' compensation laws of the state in which the employee is furnished coverage are the exclusive remedy against the out-of-state employer for any injury, whether resulting in death or not, that the employee incurs while working for the out-of-state employer in Colorado. (3) The division may enter into an agreement with any workers' compensation division or similar agency of a contiguous state to promulgate rules consistent with this section to carry out the extraterritorial application of the workers' compensation or similar law of the agreeing state. (4) Nothing in this section contravenes the legal obligations of Colorado employers to provide workers' compensation to their employees in compliance with articles 40 to 47 of this title 8. (5) As used in this section: (a) "Out-of-state employer" means an employer that is domiciled in another state. (b) "Temporarily" or "temporarily working" means: (i) A period of sustained work that does not exceed six months; or (ii) Engaging in the interstate movement of goods or commodities.	4/30/18
Colorado	SB 178	**SB 178** amends ***section 40-11.5-102*** of the Colorado Revised Statues as follows: **40-11.5-102. Lease provisions—definitions—rules.** … (5) (a) Any lease or contract executed pursuant to this section ~~shall~~ must provide for coverage under workers' compensation or ~~a private~~ an occupational accident insurance policy that provides similar coverage.	8/8/18

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

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		(a.5) If an operator of a commercial vehicle, as defined in section 42-4-235 (1)(a)(I)(b), obtains similar coverage pursuant to this subsection (5), then the operator: (I) Is excluded from the definition of employee for purposes of section 8-40-202 (2); (II) Shall notify the division of workers' compensation in the department of labor and employment of the election, in a manner determined by the director of the division of workers' compensation by rule; and (III) Shall, along with the motor carrier and contract carrier, provide proof of the similar coverage upon request to interested parties, including the carrier's workers' compensation insurance provider, the division of workers' compensation, and the division of insurance. (b) for purposes of this subsection (5), "similar coverage": (I) Means ~~disability insurance for on and off the job injury, health insurance, and life~~ insurance benefits designed for independent contractors and sole proprietors who reject workers' compensation coverage and elect, pursuant to this subsection (5), coverage providing medical, temporary and permanent disability, death and dismemberment, and survivor benefits that are subject to regulation by the division of insurance in the department of regulatory agencies. The specifications of ~~such~~ the insurance, including ~~the amount of any deductible, shall~~ coverages, exclusions, policy limits, and the amount, if any, of any deductibles or copayments, must be filed with the division of insurance. The specifications must meet or exceed standards set by the division of insurance ~~in the department of regulatory agencies,~~ and ~~such~~ the standards ~~shall~~ must specify that the benefits offered by ~~such~~ the insurance coverage ~~shall~~ must be at least comparable to the benefits offered under the workers' compensation system. (II) For services performed by operators of commercial vehicles, as defined in section 42-4-235 (1)(a)(I)(b), means insurance benefits defined in subsection (5)(b)(I) of this section. The specifications of the insurance, including minimum thresholds for coverage and the amount, if any, of any deductibles or copayments, must meet or exceed the standards set, by rule, by the division of insurance in the department of regulatory agencies. (d) Notwithstanding any other law, if an operator of a commercial vehicle, as defined in section 42-4-235 (1)(a)(I)(b), a motor carrier, or a contract carrier obtains similar coverage pursuant to this subsection (5), articles 40 to 47 of title 8 do not apply. (e) The commissioner of insurance in the division of insurance in the department of regulatory agencies shall promulgate rules establishing the minimum coverages for benefits under an occupational accident policy under this subsection (5).	
Florida	HB 1437	**HB 1437** creates new ***sections 413.15*** and ***413.209*** in the Florida Statutes to require that participants in an adult or youth work experience activity under either the Division of Blind Services or the Division of Vocational Rehabilitation be deemed an employee of the state for the purposes of workers compensation coverage.	7/1/18
Florida	HB 7087	**HB 7087,** in part, adds new ***Chapter 451*** to the Florida Statutes as follows: **CHAPTER 451** **MARKETPLACE CONTRACTORS** **451.01. Definitions—For purposes of this chapter, the term:** (1) "Household services" means: (a) Furniture assembly; (b) Interior painting; (c) Television mounting; (d) Local moving help, such as packing, lifting, loading, and rearranging household items, but excluding transporting items;	7/1/18

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		(e) Hanging pictures, mirrors, curtains, blinds, and shelves; (f) Home cleaning; (g) Installation of in-home technology that does not require a hardwired electrical connection; or (h) Installing or replacing door hardware. Household services do not include services that require licensure under chapter 489. (2) "Marketplace contractor" means any individual who: (a) Enters into an agreement with a marketplace platform to use the platform's technology application to connect with third-party individuals or entities seeking temporary household services. (b) In return for compensation, offers or provides temporary household services to third-party individuals or entities through the marketplace platform's technology application. (3) "Marketplace platform" or "platform" means an entity operating in this state which: (a) Offers an online-enabled technology application service, website, or system that enables marketplace contractors to provide services to third-party individuals or entities seeking such temporary household services. (b) Accepts service requests from the public only through its online-enabled technology application service, website, or system. **451.02 Marketplace contractors.—** (1) A marketplace contractor must be treated as an independent contractor, and not as an employee, of the marketplace platform for all purposes under state and local laws, regulations, and ordinances, including, but not limited to, chapters 440 and 443, if all of the following conditions are met: (a) The marketplace platform does not unilaterally prescribe specific hours during which the marketplace contractor must be available to accept service requests submitted through the platform from third-party individuals or entities. (b) The marketplace platform does not prohibit the marketplace contractor from using the technology application offered by other marketplace platforms. (c) The marketplace platform does not restrict the contractor from engaging in any other occupation or business. (d) The marketplace platform and marketplace contractor agree in writing that the marketplace contractor is an independent contractor with respect to the marketplace platform. (e) The marketplace contractor bears all or substantially all of the marketplace contractor's expenses incurred by the marketplace contractor in performing the services. (f) The marketplace contractor is responsible for paying taxes on the marketplace contractor's income. (2) Subsection (1) applies to services performed by a marketplace contractor before July 1, 2018, if the conditions set forth in subsection (1) were satisfied when the services were performed. (3) Compliance with subsection (1) is not mandatory to establish the existence of an independent contractor relationship. The exclusion of any person or service from this section does not create any presumption and is not admissible to deny the existence of an independent contractor relationship. (4) Third-party individuals or entities seeking services through the marketplace platform and marketplace contractors must comply with chapter 440 in the same manner as if they had not connected through the marketplace platform.	

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		(5) This section does not apply to: (a) Services performed in the employ of the state, a political subdivision of the state, an Indian tribe, an instrumentality of a state, or any political subdivision of a state or an Indian tribe which is wholly owned by one or more states, political subdivisions, or Indian tribes, respectively, provided that such service is excluded from employment as defined in s. 3306 of the Federal Unemployment Tax Act. (b) Services performed in the employ of a religious, charitable, educational, or other organization which is excluded from employment as defined in ss. 3301-3311 of the Federal Unemployment Tax Act, solely by reason of s. 3306(c)(8) of the act.	
Florida	SB 376	**SB 376** amends ***section 112.1815*** of Title X of the Florida Statutes to read: **112.1815 Firefighters, paramedics, emergency medical technicians, and law enforcement officers; special provisions for employment-related accidents and injuries.—** … (5)(a) For the purposes of this section and chapter 440, and notwithstanding sub-subparagraph (2)(a)3. and ss. 440.093 and 440.151(2), posttraumatic stress disorder, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association, suffered by a first responder is a compensable occupational disease within the meaning of subsection (4) and s. 440.151 if: 1. The posttraumatic stress disorder resulted from the first responder acting within the course of his or her employment as provided in s. 440.091; and 2. The first responder is examined and subsequently diagnosed with such disorder by a licensed psychiatrist who is an authorized treating physician as provided in chapter 440 due to one of the following events: a. Seeing for oneself a deceased minor; b. Directly witnessing the death of a minor; c. Directly witnessing an injury to a minor who subsequently died before or upon arrival at a hospital emergency department; d. Participating in the physical treatment of an injured minor who subsequently died before or upon arrival at a hospital emergency department; e. Manually transporting an injured minor who subsequently died before or upon arrival at a hospital emergency department; f. Seeing for oneself a decedent whose death involved grievous bodily harm of a nature that shocks the conscience; g. Directly witnessing a death, including suicide, that involved grievous bodily harm of a nature that shocks the conscience; h. Directly witnessing a homicide regardless of whether the homicide was criminal or excusable, including murder, mass killing as defined in 28 U.S.C. s. 530C, manslaughter, self-defense, misadventure, and negligence; i. Directly witnessing an injury, including an attempted suicide, to a person who subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience; j. Participating in the physical treatment of an injury, including an attempted suicide, to a person who subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience; or k. Manually transporting a person who was injured, including by attempted suicide, and subsequently died before or upon arrival at a hospital emergency department if the person was injured by grievous bodily harm of a nature that shocks the conscience. (b) Such disorder must be demonstrated by clear and convincing medical evidence. (c) Benefits for a first responder under this subsection:	10/1/18

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		1. Do not require a physical injury to the first responder; and 2. Are not subject to: a. Apportionment due to a preexisting posttraumatic stress disorder; b. Any limitation on temporary benefits under s. 440.093; or c. The 1-percent limitation on permanent psychiatric impairment benefits under s. 440.15(3). (d) The time for notice of injury or death in cases of compensable posttraumatic stress disorder under this subsection is the same as in s. 440.151(6) and is measured from one of the qualifying events listed in subparagraph (a)2. or the manifestation of the disorder, whichever is later. A claim under this subsection must be properly noticed within 52 weeks after the qualifying event. (e) As used in this subsection, the term: 1. "Directly witnessing" means to see or hear for oneself. 2. "Manually transporting" means to perform physical labor to move the body of a wounded person for his or her safety or medical treatment. 3. "Minor" has the same meaning as in s. 1.01(13). (f) The Department of Financial Services shall adopt rules specifying injuries qualifying as grievous bodily harm of a nature that shocks the conscience for the purposes of this subsection. (6) An employing agency of a first responder, including volunteer first responders, must provide educational training related to mental health awareness, prevention, mitigation, and treatment. **SB 376** also includes the following clause: The Legislature determines and declares that this act fulfills an important state interest. *NCCI's analysis indicates that **SB 376** may result in an indeterminate increase on system costs for law enforcement officer, firefighter, emergency medical technician, and paramedic (collectively defined as first responders) classifications in Florida. However, the impact on overall privately insured workers compensation costs is expected to be minimal, since data reported to NCCI shows that first responder classifications represent approximately 2% of losses in Florida.*	
Georgia	HB 760	**HB 760**, in part, amends ***section 33-24-47. Notice required of termination or nonrenewal, increase in premium rates, or change restricting coverage; failure of insurer to comply*** of the Official Code of Georgia Annotated as follows: **§ 33-24-47. Notice required of termination or nonrenewal, increase in premium rates, or change restricting coverage; failure of insurer to comply** … (b) A notice of termination, including a notice of cancellation or nonrenewal, by the insurer, a notice of an increase in premiums, other than an increase in premiums due to a change in risk or exposure, including a change in experience modification or resulting from an audit of auditable coverages, which exceeds 15 percent of the current policy's premium, ~~or a notice of change in any policy provision which limits or restricts coverage~~ shall be delivered to the insured as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the last address of record of the insured, at least 45 days prior to the termination date of such policy; provided, however, that a notice of cancellation or nonrenewal of a policy of workers' compensation insurance shall be controlled by the	7/1/18

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		provisions of subsection (f) of this Code section. In those instances where an increase in premium exceeds 15 percent, the notice to the insured shall indicate the dollar amount of the increase. The insurer may obtain a receipt provided by the United States Postal Service as evidence of mailing such notice or such other evidence of mailing as prescribed or accepted by the United States Postal Service. … (g) An insurer shall provide a written notice of a reduction in coverage to the named insured no less than 45 days prior to the effective date of the proposed reduction in coverage; provided that such notice shall be printed in all capital letters in a separate document entitled 'NOTICE OF REDUCTION IN COVERAGE.' Such notice shall be delivered to the insured as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the last address of record of the insured. A reduction in coverage shall mean a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion. Reduction in coverage shall not include any change, reduction, or elimination of coverage made at the request of the insured. The correction of typographical or scrivener's errors or the application of mandated legislative changes shall not be considered a reduction in coverage.	
Georgia	HB 878	**HB 878** amends ***section 33-24-44.1—Procedure for cancellation by insured and notice*** of the Official Code of Georgia Annotated as follows: **§ 33-24-44.1. Procedure for cancellation by insured and notice** (a) An insured may request cancellation of an existing insurance policy by returning the original policy to the insurer or by making a ~~written~~ request for cancellation of an insurance policy to the insurer or its duly authorized agent orally, electronically, or in writing stating a future date on which the policy is to be canceled. In the event of oral cancellation the insurer, shall, within 10 days provide such insured, electronically or in writing, confirmation of such requested cancellation. The insurer or its duly authorized agent may require that the insured provide written, electronic, or other recorded verification of the request for cancellation prior to such cancellation taking effect. Such cancellation shall be accomplished in the following manner: (1) If only the interest of the insured is affected, the policy shall be canceled on the later of the date the returned policy or ~~written~~ request is received by the insurer or its duly authorized agent or the date specified in the ~~written~~ request; provided, however, that upon receipt of a ~~written~~ request for cancellation from an insured, an insurer may waive the future date requirement by confirming the date and time of cancellation ~~in writing~~ to the insured and the insurer shall document in its policy file the request for cancellation along with the date of the requested cancellation; …	7/1/18
Hawaii	HB 1778 HD1 SD1 CD1	**HB 1778 HD1 SD1 CD1** adds two new sections to the Hawaii Workers' Compensation Law as follows: **§ 386- Medical care, services, and supplies for controverted claims.** In the event of a controverted claim, the injured employee's private health care plan shall pay for or provide medical care, services, and supplies in accordance with the private health care contract. When the claim is accepted or determined to be compensable, the employer shall reimburse the private health care plan and the injured employee in amounts as authorized by this chapter and rules adopted by the director. **§ 386- Medical care, services, and supplies for firefighters suffering from cancer.** If a claim for leukemia, multiple myeloma, non-Hodgkin lymphoma, or cancer of the lung, brain, stomach, esophagus, intestines, rectum, kidney, bladder, prostate, or testes filed by an employee with five or more years of service as a firefighter is accepted or determined to be compensable, section 386-21 shall remain applicable; provided that the employer shall be liable for medical care, services, and supplies for a minimum of one hundred ten per cent, and not to exceed one hundred fifty per	7/5/18

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		cent of fees prescribed in the Medicare Resource Based Relative Value Scale applicable to Hawaii as prepared by the United States Department of Health and Human Services.	
Hawaii	HB 2377 HD1 SD1	**HB 2377 HD1 SD1** amends ***sections 386-25*** and ***386-71.5*** of the Hawaii Workers' Compensation Law as follows: **§386-25 Vocational rehabilitation.** ... (e) A provider shall file the employee's plan with the approval of the employee. Upon receipt of the plan from the provider, an employee shall have ten days to review and sign the plan. The plan shall be submitted to the employer and the employee and be filed with the director within two days from the date of the employee's signature. A plan shall include a statement of the feasibility of the vocational goal, using the process of: ... (4) Then providing training to obtain employment in another occupational field. When training to obtain employment in another occupational field is required, the first appropriate option among the following options shall be selected for the employee: (A) On-the-job training; (B) Short-term retraining program (less than fifty-two weeks); or (C) Long-term retraining program (more than fifty-two weeks); and (5) Lastly, if training under paragraph (4) is not feasible, then self-employment may be considered. ... **[§386-71.5] Rehabilitation unit.** There is established within the department of labor and industrial relations a rehabilitation unit. All professional and clerical employees of this unit shall be appointed and administered by the director. The rehabilitation unit shall have the duties and responsibilities provided in section 386-25. Employees of the unit shall be subject to chapter 76.	7/10/18
Hawaii	SB 2244 SD1 HD2 CD1	**SB 2244 SD1 HD2 CD1** creates new ***sections 386-A*** and ***386-B*** and amends ***section 386-21.7*** of the Hawaii Workers' Compensation Law as follows: **§386-A Opioid therapy; qualifying injured employees; informed consent process.** (a) Beginning on July 1, 2019, any health care provider authorized to prescribe opioids shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the health care provider authorized to prescribe opioids and a qualifying injured employee. (b) If the qualifying injured employee is unable to physically or mentally execute the written agreement pursuant to subsection (a), due to the injury, then the physician shall execute the agreement as soon as the employee's condition improves. At no time shall the employee be responsible for the payment of the medication prescribed. (c) The department shall make available on its website a copy of the template for an opioid therapy informed consent process agreement developed by the department of health pursuant to section 329-38.5(b). The template shall be posted to the department's website no later than December 31, 2018. (d) For the purposes of this section, "qualifying injured employee" means: (1) An injured employee requiring opioid treatment for more than three months;	7/9/18

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		(2) An injured employee who is prescribed benzodiazepines and opioids together; or (3) An injured employee who is prescribed a dose of opioids that exceeds ninety morphine equivalent doses. (e) A violation of this section shall not be subject to the penalty provisions of part IV of chapter 329. **§386-B Qualifying injured employees; initial concurrent prescriptions; opioids and benzodiazepines.** (a) Initial concurrent prescriptions for opioids and benzodiazepines shall not be for longer than seven consecutive days unless a supply of longer than seven days is determined to be reasonably needed for the treatment of: (1) Pain experienced while the qualifying injured employee is in post-operative care; (2) Chronic pain and pain management; (3) Substance abuse or opioid or opiate dependence; (4) Cancer; (5) Pain experienced while the qualifying injured employee is in palliative care; or (6) Pain experienced while the qualifying injured employee is in hospice care; provided that if a health care provider authorized to prescribe opioids issues a concurrent prescription for more than a seven-day supply of an opioid and benzodiazepine, the health care provider shall document in the qualifying injured employee's medical record the condition for which the health care provider issued the prescription and that an alternative to the opioid and benzodiazepine was not appropriate treatment for the condition. (b) After an initial concurrent prescription for opioids and benzodiazepines has been made, a health care provider authorized to prescribe opioids may authorize subsequent prescriptions through a telephone consultation with the qualifying injured employee when the health care provider deems such action to be reasonably needed for post-operative care and pain management; provided that the health care provider shall consult with a qualifying injured employee in person at least once every ninety days for the duration during which the health care provider concurrently prescribes opioids and benzodiazepines to the qualifying injured employee. (c) For the purposes of this section, "qualifying injured employee" has the same meaning as in section 386-A. **§386-21.7 Prescription drugs; pharmaceuticals.** (a) Notwithstanding any other provision to the contrary, immediately after a work injury is sustained by an employee and so long as reasonably needed, the employer shall furnish to the employee all prescription drugs as the nature of the injury requires~~.~~ ; provided that initial concurrent prescriptions for opioids and benzodiazepines shall meet the requirements of section 386-B. The liability for the prescription drugs shall be subject to the deductible under section 386-100.	
Idaho	HB 366	**HB 366** amends ***section 72-205. Public Employment Generally—Coverage*** of the Idaho Worker's Compensation Law to read as follows: **72-205. Public Employment Generally—Coverage**. The following shall constitute employees in public employment and their employers subject to the provisions of this law: …	7/1/18

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		(9) A work experience student, as that term is defined in section 72-102, Idaho Code, who does not receive wages while participating in the school's work experience program shall be covered by the school district's policy or by the Idaho higher education policy when the work experience student is not covered by the private or governmental entity that is the student's work experience employer.	
Illinois	SB 904	As amended and passed by the second chamber on May 30, 2018, **SB 904** amends ***sections 820 ILCS 305/8.2*** and ***820 ILCS 305/8.2a*** of the Illinois Workers' Compensation Act as follows: **(820 ILCS 305/8.2)** **Sec. 8.2. Fee schedule.** ... (d) When a patient notifies a provider that the treatment, procedure, or service being sought is for a work-related illness or injury and furnishes the provider the name and address of the responsible employer, the provider shall bill the employer or its designee directly. The employer or its designee shall make payment for treatment in accordance with the provisions of this Section directly to the provider, except that, if a provider has designated a third-party billing entity to bill on its behalf, payment shall be made directly to the billing entity. Providers ~~and providers~~ shall submit bills and records in accordance with the provisions of this Section. (1) All payments to providers for treatment provided pursuant to this Act shall be made within 30 days of receipt of the bills as long as the bill ~~claim~~ contains substantially all the required data elements necessary to adjudicate the bill ~~bills~~. (2) If the bill ~~claim~~ does not contain substantially all the required data elements necessary to adjudicate the bill, or the claim is denied for any other reason, in whole or in part, the employer or insurer shall provide written notification to the provider in the form of an explanation of benefits~~,~~ explaining the basis for the denial and describing any additional necessary data elements, to the provider within 30 days of receipt of the bill. The Commission, with assistance from the Medical Fee Advisory Board, shall adopt rules detailing the requirements for the explanation of benefits required under this subsection. (3) In the case (i) of nonpayment to a provider within 30 days of receipt of the bill which contained substantially all of the required data elements necessary to adjudicate the bill, (ii) of ~~or~~ nonpayment to a provider of a portion of such a bill, or (iii) where the provider has not been issued an explanation of benefits for a bill ~~up to the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section,~~ the bill, or portion of the bill up to the lessor of the actual charge or the payment level set by the Commission in the fee schedule established in this Section, shall incur interest at a rate of 1% per month payable by the employer to the provider. Any required interest payments shall be made by the employer or its insurer to the provider no~~t~~ later than ~~within~~ 30 days after payment of the bill. (4) If the employer or its insurer fails to pay interest required pursuant to this subsection (d), the provider may bring an action in circuit court to enforce the provisions of this subsection (d) against the employer or its insurer responsible for insuring the employer's liability pursuant to item (3) of subsection (a) of Section 4. Interest under this subsection (d) is only payable to the provider. An employee is not responsible for the payment of interest under this Section. The right to interest under this subsection (d) shall not delay, diminish, restrict, or alter in any way the benefits to which the employee or his or her dependents are entitled under this Act. The changes made to this subsection (d) by this amendatory Act of the 100th General Assembly apply to procedures, treatments, and services rendered on and after the effective date of this amendatory Act of the 100th General Assembly. ...	11/27/18

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

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		(820 ILCS 305/8.2a) **Sec. 8.2a. Electronic claims.** (a) The Director of Insurance shall adopt rules to do all of the following: ... (4) Ensure that health care providers have an opportunity to comply with requests for records by employers and insurers for the authorization of the payment of workers' compensation claims. (5) Ensure that health care providers are responsible for supplying only those medical records pertaining to the provider's own claims that are minimally necessary under the federal Health Insurance Portability and Accountability Act of 1996. (6) Provide that any electronically submitted bill determined to be complete but not paid or objected to within 30 days shall be subject to interest pursuant to item (3) of subsection (d) of Section 8.2. (7) Provide that the Department of Insurance shall impose an administrative fine if it determines that an employer or insurer has failed to comply with the electronic claims acceptance and response process. The amount of the administrative fine shall be no greater than $1,000 per each violation, but shall not exceed $10,000 for identical violations during a calendar year. ... (c) The rules requiring employers and insurers to accept electronic claims for payment of medical services shall be proposed on or before January 1, 2012, and shall require all employers and insurers to accept electronic claims for payment of medical services on or before June 30, 2012. The Director of Insurance shall adopt rules by January 1, 2019 to implement the changes to this Section made by this amendatory Act of this 100th General Assembly. The Commission, with assistance from the Department and the Medical Fee Advisory Board, shall publish on it its Internet website a companion guide to assist with compliance with electronic claims rules. The Medical Fee Advisory Board shall periodically review the companion guide. ...	
Illinois	SB 1737	As amended and passed by the second chamber on May 31, 2018, **SB 1737** amends, creates, and repeals numerous sections of the Illinois Compiled Statutes Annotated, including, but not limited to, the following: **(215 ILCS 5/456)** **Sec. 456. Making of rates.** (1) All rates shall be made in accordance with the following provisions: ... (d) Rates shall not be excessive, inadequate or unfairly discriminatory. A rate ~~in a competitive market is not excessive. A rate in a noncompetitive market~~ is excessive if it is likely to produce a ~~long run~~ profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to the services rendered. ...	11/27/18 for section 462a and 2/1/19 for sections 456, 457, 458, and 460

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		(215 ILCS 5/457) **Sec. 457. Rate filings.** (1) Every ~~Beginning January 1, 1983, every~~ company shall prefile ~~file~~ with the Director every manual of classifications, every manual of rules and rates, every rating plan and every modification of the foregoing which it intends to use. Such filings shall be made at least ~~not later than~~ 30 days before ~~after~~ they become effective. A company may satisfy its obligation to make such filings by adopting the filing of a licensed rating organization of which it is a member or subscriber, filed pursuant to subsection (2) of this Section, in total or, with the approval of the Director, ~~by notifying the Director in what respects it intends to~~ deviate from such filing. If a company intends to deviate from the filing of a licensed rating organization of which it is a member, the company shall provide the Director with supporting information that specifies the basis for the requested deviation and provides justification for the deviation. Any company adopting a pure premium filed by a rating organization pursuant to subsection (2) must file with the Director the modification factor it is using for expenses and profit so that the final rates in use by such company can be determined. (2) Each ~~Beginning January 1, 1983, each~~ licensed rating organization must ~~prefile~~ file with the Director every manual of classification, every manual of rules and advisory rates, every pure premium which has been fully adjusted and fully developed, every rating plan and every modification of any of the foregoing which it intends to recommend for use to its members and subscribers, at least ~~not later than~~ 30 days before ~~after~~ such manual, premium, plan or modification thereof takes effect. Every licensed rating organization shall also file with the Director the rate classification system, all rating rules, rating plans, policy forms, underwriting rules or similar materials, and each modification of any of the foregoing which it requires its members and subscribers to adhere to not later than 30 days before such filings or modifications thereof are to take effect. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated. (3) A filing and any supporting information made pursuant to this Section shall be open to public inspection as soon as filed ~~after the filing becomes effective~~. (4) A filing shall not be effective nor used until approved by the Director. A filing shall be deemed approved and legally effective if the Director fails to disapprove within 30 days after the filing. **(215 ILCS 5/458)** **Sec. 458. Disapproval of filings.** (1) If within 30 ~~thirty~~ days of any filing the Director finds that such filing does not meet the requirements of this Article, he shall send to the company or rating organization which made such filing a written notice of disapproval of such filing, specifying therein in what respects he finds that such filing fails to meet the requirements of this Article ~~and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective~~. A company or rating organization whose filing has been disapproved shall be given a hearing upon a written request made within 30 days after the disapproval order. ~~If the company or rating organization making the filing shall, prior to the expiration of the period prescribed in the notice, request a hearing, such filings shall be effective until the expiration of a reasonable period specified in any order entered thereon. If the rate resulting from such filing be unfairly discriminatory or materially inadequate, and the difference between such rate and the approved rate equals or exceeds the cost of making an adjustment, the Director shall in such notice or order direct an adjustment of the premium to be made with the policyholder either by refund or collection of additional premium. If the policyholder does not accept the increased rate, cancellation shall be made on a pro rata basis. Any policy issued pursuant to this subsection shall contain a provision that the premium thereon shall be subject to adjustment~~	

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		~~upon the basis of the filing finally approved.~~ … (4) Whenever an insurer has no legally effective rates as a result of the Director's disapproval of rates or other act, the Director shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him or her. When new rates become legally effective, the Director shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required. **~~(215 ILCS 5/460)~~** **~~Sec. 460. Competitive market; approval of rates.~~** ~~(a) Beginning January 1, 1983, a competitive market is presumed to exist unless the Director, after a hearing, determines that a reasonable degree of competition does not exist in the market and the Director issues a ruling to that effect. For purposes of this Article only, market shall mean the statewide workers' compensation and employers' liability lines of business. In determining whether a reasonable degree of competition exists, the Director shall consider relevant tests of workable competition pertaining to market structure, market performance and market conduct. Such tests may include, but need not be limited to, the following: size and number of firms actively engaged in the market, market shares and changes in market shares of firms, ease of entry and exit from a given market, underwriting restriction, and whether profitability for companies generally in the market is unreasonably high. The determination of competition involves the interaction of the various tests and the weight given to specific tests depends upon the particular situation and pattern of test results.~~ ~~In determining whether or not a competitive market exists, the Director shall monitor the degree of competition in this State. In doing so, he shall utilize existing relevant information, analytical systems and other sources; cause or participate in the development of new relevant information, analytical systems and other sources; or rely on some combination thereof. Such activities may be conducted internally within the Department of Insurance, in cooperation with other state insurance departments, through outside contractors, or in any other appropriate manner.~~ ~~(b) If the Director finds that a reasonable degree of competition does not exist in a market, he may require that the insurers in that market file supporting information in support of existing rates. If the Director believes that such rates may violate any of the requirements of this Article, he shall call a hearing prior to any disapproval. If the Director determines that a competitive market does not exist in the workers' compensation market as provided in a ruling pursuant to this Section, then every company must prefile every manual of classifications, rules, rates, rating plans, rating schedules, and every modification of the foregoing covered by such rule. Such filing shall be made at least 30 days prior to its taking effect, and such prefiling requirement shall remain in effect as long as there is a ruling in effect pursuant to this Section that a reasonable degree of competition does not exist.~~ ~~(c) The Director shall disapprove a rate if he finds that the rate is excessive, inadequate or unfairly discriminatory as defined in Section 456. An insurer whose rates have been disapproved shall be given a hearing upon a written request made within 30 days after the disapproval order.~~ ~~If the Director disapproves a rate, he shall issue an order specifying in what respects it fails to meet the requirements of this Article and stating when within a reasonable period thereafter such rate shall be discontinued for any policy issued or renewed after a date specified in the order. The order shall be issued within 30 days after the close of the hearing or within such reasonable time extension as the Director may fix. Such order may include a provision for premium adjustment for the period after the effective date of the order for policies in effect on such date.~~	

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		~~(d) Whenever an insurer has no legally effective rates as a result of the Director's disapproval of rates or other act, the Director shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interest of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him. When new rates become legally effective, the Director shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required.~~ **(215 ILCS 5/462a)** **Sec. 462a. Premium increase notice.** A policy of workers' compensation insurance issued, delivered, amended, or renewed on or after January 1, 2019 shall remain in full force and effect subject to the same terms and conditions, loss cost multipliers, and classification of the employer with regard to the payment of dividends, unless written notice is mailed or delivered by the insurer to the employer, at the address shown on the policy, and to the employer's authorized agent or broker, indicating the insurer's intention to condition renewal upon issuance of a policy that supersedes the policy previously issued and that will result in a premium in excess of 5% above the rate recommendation filed with the Department, exclusive of any premium increase generated as a result of increased loss costs or increased exposure units or as a result of experience rating, contractor credit adjustment program, large deductible, retrospective rating, or audit. The notice shall be delivered at least 30 days in advance of the expiration date of the policy, and shall set forth: (1) the amount of the premium increase or, if the amount cannot reasonably be determined as of the time the notice is provided, a reasonable estimate of the premium increase based upon the information available to the insurer at that time; and (2) the reason for the increased premium in excess of the rate recommendation filed with the Department. Nothing in this Section requires the insurer to provide notice when the employer, an agent or broker authorized by the employer, or another insurer of the employer has delivered written notice that the policy has been replaced or is no longer desired.	
Indiana	SB 290	**SB 290** adds to and amends various provisions of the Indiana Labor and Safety code to: • Establish a time frame for the payment of compensation under a settlement agreement, a permanent partial impairment agreement, and an award of compensation ordered by a single hearing member of the Worker's Compensation Board (board). It provides that an employer that fails to make a timely payment is subject to a civil penalty. • Require an employer that has mobile or remote employees to convey information about workers compensation coverage to the employer's employees in an electronic format or in the same manner as the employer conveys other employment-related information. It allows the electronic filing of certain documents with the board. • Provide that a permanently, totally disabled worker must reapply to the second injury fund for a wage replacement benefit every three years instead of every 150 weeks. • Require the reporting of workplace injuries needing medical attention beyond first aid instead of injuries causing an absence from work for more than one day. It provides that reporting requirements for workplace injuries are intended to be consistent with the recording requirements set out in the United States Occupational Safety and Health Administration's regulations. • Change the civil penalty for an employer's failure to provide proof of workers compensation coverage from $50 per employee to $100 per day.	7/1/18, except for section 17 of the bill urging the Legislative Council to assign a task to an interim study committee referenced in the last bullet below. Section 17 is effective on 2/19/18 and expires on 1/1/19.

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BILLS NEWLY ADDED SINCE THE LAST UPDATE ARE LISTED FIRST AND HIGHLIGHTED IN "YELLOW."

JURISDICTION	BILL	SUMMARY	EFFECTIVE
		• Revise the definition of employer to include corporations, limited liability companies, limited liability partnerships, and other entities that have common control and ownership. • Establish the assigned risk plan (plan) administered by the Worker's Compensation Rating Bureau (bureau). It provides that the plan may be substantially modified or eliminated only as the General Assembly provides by statute. The bill removes the requirement for representation in the management of the bureau by stock companies and nonstock companies. • Make conforming amendments for occupational diseases compensation. • Urge the Legislative Council to assign to an appropriate interim study committee the task of studying increases to the benefit schedules for workers compensation and occupational diseases compensation.	
Indiana	SB 369	**SB 369** adds new ***sections 22-3-3-4.7*** and ***22-3-7-17.6***, related to reimbursement for certain prescription medications under the Indiana workers compensation drug formulary, to the Indiana Labor and Safety code to read: **22-3-3-4.7:** Sec. 4.7. (a) As used in this section, "formulary" refers to the Official Disability Guidelines (ODG) Workers' Compensation Drug Formulary Appendix A published by MCG Health. (b) As used in this section, "medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected to result in: (1) serious jeopardy to the employee's health or bodily functions; or (2) serious dysfunction of a body part or organ. (c) Beginning January 1, 2019, reimbursement is not permitted for a claim for payment for a drug that: (1) is prescribed for use by an employee who files a notice of injury under this chapter; and (2) according to the formulary, is an "N" drug. However, if the employee begins use of the "N" drug before July 1, 2018, and the use continues after January 1, 2019, reimbursement is permitted for the "N" drug until January 1, 2020. (d) If a prescribing physician submits to an employer a request to permit use of an "N" drug described in subsection (c), including the prescribing physician's reason for requesting use of an "N" drug, and the employer approves the request, the prescribing physician may prescribe the "N" drug for use by the injured employee. (e) If the employer does not approve the prescribing physician's request under subsection (d) to permit use of an "N" drug, the employer shall: (1) send the request to a third party that is certified by the Utilization Review Accreditation Commission to make a determination concerning the request; and (2) notify the prescribing physician and the injured employee of the third party's determination not more than five (5) business days after receiving the request. (f) If an employer fails to provide the notice required by subsection (e)(2), the prescribing physician's request under subsection (d) is considered approved, and reimbursement of the "N" drug prescribed for use by the injured employee is authorized. (g) If the third party's determination under subsection (e) is to deny the prescribing physician's request to permit the use of an "N" drug:	7/1/18

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		(1) the employer shall notify the prescribing physician and the injured employee; and (2) the injured employee may apply to the worker's compensation board for a final determination concerning the third party's determination under subsection (e). (h) Notwithstanding subsections (c) through (f), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is an "N" drug according to the formulary. **22-3-7-17.6:** 17.6. (a) As used in this section, "formulary" refers to the Official Disability Guidelines (ODG) Workers' Compensation Drug Formulary Appendix A published by MCG Health. (b) As used in this section, "medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected to result in: (1) serious jeopardy to the employee's health or bodily functions; or (2) serious dysfunction of a body part or organ. (c) Beginning January 1, 2019, reimbursement is not permitted for a claim for payment for a drug that: (1) is prescribed for use by an employee who files a notice of occupational disease under this chapter; and (2) according to the formulary, is an "N" drug. However, if the employee begins use of the "N" drug before July 1, 2018, and the use continues after January 1, 2019, reimbursement is permitted for the "N" drug until January 1, 2020. (d) If a prescribing physician submits to an employer a request to permit use of an "N" drug described in subsection (c), including the prescribing physician's reason for requesting use of an "N" drug, and the employer approves the request, the prescribing physician may prescribe the "N" drug for use by the disabled employee. (e) If the employer does not approve the prescribing physician's request under subsection (d) to permit use of an "N" drug, the employer shall: (1) send the request to a third party that is certified by the Utilization Review Accreditation Commission to make a determination concerning the request; and (2) notify the prescribing physician and the disabled employee of the third party's determination not more than five (5) business days after receiving the request. (f) If an employer fails to provide the notice required by subsection (e)(2), the prescribing physician's request under subsection (d) is considered approved, and reimbursement of the "N" drug prescribed for use by the disabled employee is authorized. (g) If the third party's determination under subsection (e) is to deny the prescribing physician's request to permit the use of an "N" drug: (1) the employer shall notify the prescribing physician and the disabled employee; and (2) the disabled employee may apply to the worker's compensation board for a final determination concerning the third party's determination under subsection (e). (h) Notwithstanding subsections (c) through (f), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is an "N" drug according to the formulary.	

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Iowa	SB 2257	**SB 2257** adds new ***chapter 93*** to the Code of Iowa as follows: **93.1 Definitions.** As used in this chapter, unless the context otherwise requires: 1. "Governmental entity" means the same as defined in section 96.19. 2. "Indian tribe" means the same as defined in section 96.19. 3. a. "Marketplace contractor" means a person or organization, including an individual, corporation, limited liability company, partnership, sole proprietor, or other entity, that does all of the following: (1) Enters into a written agreement with a marketplace platform to use the marketplace platform's digital network to connect with individuals or entities that seek to obtain services from the marketplace contractor. (2) Performs services for individuals or entities upon connection through a marketplace platform's digital network in exchange for compensation or payment of a fee. (3) Does not perform the services offered by the marketplace contractor at or from a physical business location that is operated by the marketplace platform in the state. b. "Marketplace contractor" does not include a person or organization that performs services consisting of transporting freight, sealed and closed envelopes, boxes, parcels, or other sealed and closed containers for compensation. 4. "Marketplace platform" means a person or organization, including an individual, corporation, limited liability company, partnership, sole proprietor, or other entity, that operates a digital network to connect marketplace contractors to individuals or entities that seek to obtain the type of services offered by marketplace contractors. **93.2 Marketplace contractors as independent contractors—retroactivity.** 1. A marketplace contractor shall be treated as an independent contractor, and not an employee of a marketplace platform, for all purposes under state or local law, including but not limited to chapters 87 and 96, if the following conditions are met: a. The marketplace contractor and marketplace platform agree in writing that the marketplace contractor is engaged as an independent contractor and not an employee of the marketplace platform. b. The marketplace platform does not unilaterally prescribe specific hours during which the marketplace contractor must be available to accept service requests submitted through the marketplace platform's digital network. c. The marketplace platform does not prohibit the marketplace contractor from engaging in outside employment or performing services through other marketplace platforms. d. The marketplace contractor bears its own expenses incurred in performing services. 2. For services performed by a marketplace contractor prior to the effective date of this Act, a marketplace contractor shall be treated as an independent contractor and not an employee of a marketplace platform for all purposes under state or local law, including but not limited to chapters 87 and 96, if the conditions set forth in subsection 1 were satisfied at the time the services were performed. 3. When providing services that require an Iowa license, the marketplace contractor shall be responsible for obtaining the Iowa license and making such license available to the individuals or entities for whom the marketplace contractor is providing services. 4. This section shall not apply to any of the following:	7/1/18

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		a. Services performed by an individual in the employ of a governmental entity or Indian tribe, but only if the services are excluded from employment as defined in the Federal Unemployment Tax Act, 26 U.S.C. §3301-3311, solely by reason of section 3306(c)(7) of that Act. b. Services performed by an individual in the employ of a religious, charitable, educational, or other organization, but only if the services are excluded from employment as defined in the Federal Unemployment Tax Act, 26 U.S.C. §3301-3311, solely by reason of section 3306(c)(8) of that Act. c. Services performed by a real estate broker or a real estate salesperson licensed pursuant to chapter 543B.	
Kansas	HB 2184	**HB 2184** amends ***section 44-510b*** of the Kansas workers compensation act as follows: **44-510b. Compensation where death results from injury; compensation upon remarriage; apportionment; burial expenses; limitations on compensation; annual statement by surviving spouse.** Where death results from injury, compensation shall be paid as provided in K.S.A. 44-510h and 44-510i, and amendments thereto, and as follows: (a) If an employee leaves any dependents wholly dependent upon the employee's earnings at the time of the accident or injury, all compensation benefits under this section shall be paid to ~~such~~ the dependent persons. There shall be an initial payment of ~~$40,000~~ $60,000 to the surviving legal spouse or a wholly dependent child or children or both. The initial payment shall not be subject to the 8% discount as provided in K.S.A. 44-531, and amendments thereto. The initial payment shall be immediately due and payable and apportioned 50% to the surviving legal spouse and 50% to the dependent children. Thereafter, ~~such~~ the dependents shall be paid weekly compensation, except as otherwise provided in this section, in a total sum to all ~~such~~ the dependents, equal to 66 ⅔ % of the average weekly wage of the employee at the time of the accident or injury, computed as provided in K.S.A. 44-511, and amendments thereto, but in no event shall ~~such~~ the weekly benefits exceed the maximum weekly benefits provided in K.S.A. 44-510c, and amendments thereto, nor be less than a minimum weekly benefit of the dollar amount nearest to 50% of the state's average weekly wage as determined pursuant to K.S.A. 44-511, and amendments thereto, subject to the following: (1) If the employee leaves a surviving legal spouse or a wholly dependent child or children, or both, who are eligible for benefits under this section, then all death benefits shall be paid to ~~such~~ the surviving spouse or children, or both, and no benefits shall be paid to any other wholly or partially dependent persons. (2) A surviving legal spouse shall be paid compensation benefits for life, except as otherwise provided in this section. (3) Any wholly dependent child of the employee shall be paid compensation, except as otherwise provided in this section, until ~~such~~ the dependent child becomes 18 years of age, unless the child is enrolled in high school. In that event, compensation shall continue until May 30th of the child's senior year in high school or until the child becomes 19 years of age, whichever is earlier. A wholly dependent child of the employee shall be paid compensation, except as otherwise provided in this section, until ~~such~~ the dependent child becomes 23 years of age during any period of time that one of the following conditions is met: (A) The wholly dependent child is not physically or mentally capable of earning wages in any type of substantial and gainful employment; or (B) the wholly dependent child is a student enrolled full-time in an accredited institution of higher education or vocational education. (4) If the employee leaves no legal spouse or dependent children eligible for benefits under this section but leaves other dependents wholly dependent upon the employee's earnings, ~~such~~ the other dependents shall receive weekly compensation benefits as provided in this subsection until death, remarriage or so long as ~~such~~ the other dependents do not receive more than 50% of their support from any other earnings or income	7/1/18

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		or from any other source, except that the maximum benefits payable to all ~~such~~ the other dependents, regardless of the number of ~~such~~ the other dependents, shall not exceed a maximum amount of ~~$18,500~~ $100,000. (b) Where the employee leaves a surviving legal spouse and dependent children who were wholly dependent upon the employee's earnings and are eligible for benefits under this section 50% of the maximum weekly benefits payable shall be apportioned to ~~such~~ the spouse and 50% to ~~such~~ the dependent children. (c) If an employee does not leave any dependents who were wholly dependent upon the employee's earnings at the time of the injury but leaves dependents, other than a spouse or children, in part dependent on the employee's earnings, ~~such~~ the percentage of a sum equal to three times the employee's average yearly earnings but not exceeding ~~$18,500~~ $100,000 but not less than ~~$2,500~~ $25,000, as ~~such~~ the employee's average annual contributions which the employee made to the support of ~~such~~ the dependents during the two years preceding the date of the injury, bears to the employee's average yearly earnings during the contemporaneous two-year period, shall be paid in compensation to ~~such~~ the dependents, in weekly payments as provided in subsection (a), not to exceed ~~$18,500~~ $100,000 to all ~~such~~ the dependents. (d) If an employee does not leave any dependents, either wholly or partially dependent upon the employee, a lump-sum payment of ~~$25,000~~ $100,000 shall be made to the legal heirs of ~~such~~ the employee in accordance with Kansas law. If the employer procured a life insurance policy with beneficiaries designated by the employee and in an amount not less than $50,000, then the amount paid to the legal heirs under this section shall be reduced by the amount of the life insurance policy up to a maximum deduction of $100,000. However under no circumstances shall ~~such~~ the payment escheat to the state. ~~Notwithstanding the provisions of this subsection, no such payment shall be required if the employer has procured a life insurance policy, with beneficiaries designated by the employee, providing coverage in an amount not less than $18,500.~~ (e) The administrative law judge, except as otherwise provided in this section, shall have the power and authority to apportion and reapportion the compensation allowed under this section, either to wholly dependent persons or partially dependent persons, in accordance with the degree of dependency as of the date of the injury, except that the weekly payment of compensation to any and all dependents shall not exceed the maximum nor be less than the minimum weekly benefits provided in subsection (a). (f) In all cases of death compensable under this section, the employer shall pay the reasonable expense of burial not exceeding ~~$5,000~~ $10,000. Where required, the employer shall pay the costs of a court-appointed conservator not to exceed ~~$1,000~~ $2,500. (g) The marriage or death of any dependent shall terminate all compensation, under this section, to ~~such~~ the dependent except the marriage of the surviving legal spouse shall not terminate benefits to ~~such~~ the spouse. Upon the death of the surviving legal spouse or the marriage or death of a dependent child, the compensation payable to ~~such~~ the spouse or child shall be reapportioned to those, among the surviving legal spouse and dependent children, who remain eligible to receive compensation under this section. (h) Notwithstanding any other provision in this section to the contrary, the maximum amount of compensation benefits payable under this section, including the initial payment in subsection (a) to any and all dependents by the employer shall not exceed a total amount of $300,000 and when ~~such~~ the total amount has been paid the liability of the employer for any further compensation under this section to dependents, other than minor children of the employee, shall cease except that the payment of compensation under this section to any minor child of the employee shall continue for the period of the child's minority at the weekly rate in effect when the employer's liability is otherwise terminated under this subsection and shall not be subject to termination under this subsection until ~~such~~ the child becomes 18 years of age. (i) Persons receiving benefits under this section shall submit an annual statement to the insurance carrier, self-insured employer or group-funded workers compensation pool paying the benefits, in ~~such~~ the form and containing ~~such~~ the information relating to eligibility for compensation under	

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

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		this section as may be required by rules and regulations of the director. If the person receiving benefits under this section is a surviving spouse or a dependent child who has reached the age of majority, ~~such~~ the person shall personally submit an annual statement. If the person receiving benefits under this section is a dependent child subject to a conservator, the conservator of ~~such~~ the child shall submit the annual statement. If ~~such~~ the person fails to submit an annual statement, the payer of benefits may notify the director of ~~such~~ the failure and the director shall notify the person of the failure by certified mail with return receipt. If ~~such~~ the person fails to submit the annual statement or fails to reasonably provide the required information within 30 days after receipt of the notice from the director, all compensation benefits paid under this section to ~~such~~ the person shall be suspended until the annual statement is submitted in proper form to the payer of benefits.	
Kentucky	HB 2	**HB 2** amends numerous sections of the Kentucky Workers Compensation Law to: • Establish that, only for workers compensation insurance claims resulting in an award of permanent total disability or resulting from injuries (amputation or partial amputation of a limb, loss of hearing, or loss of vision or teeth, or permanent total or permanent partial paralysis), the employer's obligation to pay benefits continues so long as the employee is disabled, regardless of the duration of the employee's income benefits. For permanent partial disability claims not involving the above injury, the employer's obligation to pay benefits would extend for 780 weeks from date of injury or date of last exposure; thereafter, benefits would continue so long as the employee demonstrates, and an administrative law judge determines, that continued medical treatment is reasonably necessary and is related to the work injury or occupational disease. • Require the commissioner notify an employee of the right to apply for continued benefits 754 weeks from the date of injury or last exposure, and the employee to file an application for continued benefits 75 days before the end of the 780-week benefit period. If an employee fails to apply for continued benefits or a judge determines benefits are not reasonably necessary or not related to the work injury or occupational disease, the employer's obligation to pay medical benefits would cease permanently at the end of 780 weeks (15 years). • Limit the number of urine screenings an employer would be obligated to pay for. • Allow waiver of utilization review under identified circumstances. • Prohibit a provider charging a fee for an initial copy of medical records for the worker or their attorney. • Require development or adoption of a pharmaceutical formulary. • Deem no interest due on delayed payment of income benefits if the delay was caused by the employee. • Limit the time to reopen a claim to 4 years after the original award or order becomes final and nonappealable. • Bar a claim based on cumulative trauma injury, unless notice was given to the employer and application for adjustment of claim was made within 2 years from the date the employee is told by a doctor that the injury is work-related. The right to compensation for cumulative trauma injury is barred if a claim application is not filed within 5 years after the last injurious exposure to the cumulative trauma. • Limit liability for compensation for occupational disease to the last employer in whose employment the employee was last exposed to the hazard. • Require that the payment obligor pay for spirometric testing of an employee claiming pulmonary dysfunction, unless such test results are invalid because the claimant failed to properly cooperate in the testing, in which case the claimant's right to prosecute its claim would be suspended until they properly cooperate, and no compensation would be due the claimant until the claimant did so.	7/13/18

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		• Extend the deadline for filing a claim for compensation due to the following cancers to 20 years from the last injurious exposure: bladder cancer, brain cancer, colon cancer, non-Hodgkins lymphoma, kidney cancer, liver cancer, lymphatic or hematopoietic cancer, prostate cancer, testicular cancer, skin cancer, cervical cancer, and breast cancer. • Establish new maximum limits on employee and employer attorneys' fees. • Establish a presumption that, where an employee's injury is due to voluntary ingestion of prescribed substances in excess of prescribed amounts, or nonprescribed substances that caused disturbance of mental or physical capacity, or willful intention of an employee to injure or kill himself or another, such action caused the employee's injury, occupational disease, or death and the employer is not liable for compensation. • Allow an employer to recover a pro rata share of its subrogation lien (indemnity and medical benefits) when an employee recovers a judgment against a third party for the employee's injuries that includes indemnity and medical benefits. • Increase the percentage of Kentucky's average weekly wage that may be paid as an income benefit from 75% to 82.5% for permanent partial disability, and from 100% to 110% for temporary or permanent total disability; change the age limit on benefits to 70 years (or 4 years after injury, whichever is later); cease income benefits to dependents when the employee would have reached age 70 or 4 years after injury or exposure. • Offset income benefit payable to certain injured employees by the amount the employee would have paid in taxes or the amount paid for temporary light duty. • Terminate income benefits for temporary total disability to a professional athlete when their contract expires if they've been released to return to employment for which they've trained or have experience. • Require employment for one year prior to filing a claim for hearing loss. • Establish that, notwithstanding that certain sections and subsections of the bill are remedial and are to apply to all claims no matter the date of injury or of last exposure, no award shall be reduced or duration of medical benefits limited that have been fully and finally adjudicated.	
Kentucky	HB 220	**HB 220** adds a new section to ***Chapter 336*** of the Kentucky Labor and Human Rights law to read: (1) As used in this section: (a) "Marketplace contractor" means a person or entity that enters into an agreement with a marketplace platform to use its digital network or mobile application to receive connections to third party individuals or entities seeking services; and (b) "Marketplace platform" means a person or entity that: 1. Offers a digital network or mobile application that connects marketplace contractors to third party individuals or entities seeking the type of services offered by a marketplace contractor; 2. Accepts service requests from the public exclusively through its digital network or mobile application and does not accept service requests by telephone, facsimile or in person at a physical retail location; and 3. Does not perform the services offered by the marketplace contractor at or from a physical business location that is operated by the platform in the state. (2) A marketplace contractor shall not be deemed to be an employee of a marketplace platform for any purpose under state and local laws, regulations, and ordinances, including but not limited to KRS Chapters 336, 341, and 342, so long as:	7/13/18

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		(a) The marketplace platform and the marketplace contractor agree in writing that the marketplace contractor is an independent contractor with respect to the marketplace platform; (b) The marketplace platform does not unilaterally prescribe specific hours during which the marketplace contractor must be available to accept service requests from third party individuals or entities submitted solely through the online-enabled application, software, Web site, or system of the marketplace platform; (c) The marketplace platform does not prohibit the marketplace contractor from using any online-enabled application, software, Web site, or system offered by another marketplace platform; (d) The marketplace platform does not restrict the marketplace contractor from engaging in another occupation or business; (e) The marketplace contractor bears all or substantially all of the expenses incurred by the marketplace contractor in performing the services; and (f) The marketplace platform does not supply instrumentalities or tools for the person doing the work; (3) For services performed by a marketplace contractor prior to the effective date of this Act, the marketplace contractor shall be treated as an independent contractor of the marketplace platform and not an employee of the marketplace platform if the requirements set forth in subsection (2) of this Act were met at the time at which the services were performed. (4) This section shall not apply to: (a) Service performed in the employment of a state or any political subdivision of a state, or in the employ of an Indian tribe, or any instrumentality of a state, any political subdivision of a state or any Indian tribe that is wholly owned by one (1) or more states or political subdivisions of Indian tribes, provided such service is excluded from employment as defined in 26 U.S.C. secs. 3301 to 3311; (b) Service performed in the employment of a religious, charitable, educational, or other organization that is excluded from employment as defined in 26 U.S.C. secs. 3301 to 3311, solely by reason of 26 U.S.C. sec. 3306(c)(8); or (c) Services consisting of transporting freight, sealed envelopes, boxes or parcels, or other sealed containers for compensation. **HB 220** also includes the following clause: If any provisions of this Act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.	
Kentucky	HB 323	**HB 323**, in part, amends ***sections 304.47-020*** of the Kentucky Revised Statutes as follows: **304.47-020 Fraudulent insurance acts—Penalties—Compensatory damages—Application of section.** (1) For the purposes of this subtitle, a person or entity commits a "fraudulent insurance act" if he or she engages in any of the following, including but not limited to matters relating to workers' compensation: (a) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, Kentucky Claims Commission, Special Fund, or any agent thereof: ~~,~~ 1. Any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or from a "self-insurer" as defined by KRS Chapter 342, knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim; or	7/13/18

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		~~(b) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, Kentucky Claims Commission, or any agent thereof,~~ 2. Any statement as part of, or in support of, an application for an insurance policy, for renewal, reinstatement, or replacement of insurance, or in support of an application to a lender for money to pay a premium, knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the application; (b) ~~(c)~~ Knowingly and willfully transacts any contract, agreement, or instrument which violates this title; (c) ~~(d)~~ Knowingly and with intent to defraud or deceive: ~~,~~ 1. Receives money for the purpose of purchasing insurance, and fails to obtain insurance; ~~(e) Knowingly and with intent to defraud or deceive,~~ 2. Fails to make payment or disposition of money or voucher as defined in KRS 304.17A-750, as required by agreement or legal obligation, that comes into his or her possession while acting as a licensee under this chapter; 3. Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or to the commissioner, any statement, knowing that the statement contains any false, incomplete, or misleading information concerning any material fact or thing, as part of, or in support of one (1) or more of the following: a. The rating of an insurance policy; b. The financial condition of an insurer; c. The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one (1) or more lines of insurance in all or part of this Commonwealth by an insurer; or d. A document filed with the commissioner; or 4. Engages in any of the following: a. Solicitation or acceptance of new or renewal insurance risks on behalf of an insolvent insurer; or b. Removal, concealment, alteration, tampering, or destruction of money, records, or any other property or assets of an insurer; (d) ~~(f)~~ Issues or knowingly presents fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, insurance binders, or any other documents that purport to evidence insurance; (e) ~~(g)~~ Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer; (f) ~~(h)~~ Engages in unauthorized insurance, as set forth ~~defined~~ in KRS 304.11- 030; ~~(i) Knowingly and with intent to defraud or deceive, presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or to the commissioner, any statement, knowing that the statement contains any false, incomplete, or misleading information concerning any material fact or thing, as part of, or in support of one (1) or more of the following:~~ ~~1. The rating of an insurance policy;~~ ~~2. The financial condition of an insurer;~~ ~~3. The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one (1) or more lines of insurance in all or part of this Commonwealth by an insurer; or~~ ~~4. A document filed with the commissioner;~~	

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		~~(j) Knowingly and with intent to defraud or deceive, engages in any of the following:~~ ~~1. Solicitation or acceptance of new or renewal insurance risks on behalf of an insolvent insurer; or~~ ~~2. Removal, concealment, alteration, tampering, or destruction of money, records, or any other property or assets of an insurer;~~ or <u>(g)</u> ~~(k)~~ Assists, abets, solicits, or conspires with another to commit a fraudulent insurance act in violation of this subtitle. … (3) Any person damaged as a result of a violation of any provision of this section ~~when there has been a criminal adjudication of guilt~~ shall have a cause of action to recover compensatory damages, plus all reasonable investigation and litigation expenses, including attorneys' fees, at the trial and appellate courts. …	
Kentucky	HB 388	**HB 388** amends ***sections 342.0011, 342.122, 342.1221, 342.1223, 342.1231, 342.1242***, and ***342.1243*** of the Kentucky Workers Compensation Law as follows: **342.0011 Definitions for chapter.** As used in this chapter, unless the context otherwise requires: … (25) (a) "Premiums received" for policies effective on or after January 1, 1994, for insurance companies means direct written premiums as reported in the annual statement to the Department of Insurance by insurance companies, except that "premiums received" includes premiums charged off or deferred, and, on insurance policies or other evidence of coverage with provisions for deductibles, the calculated cost for coverage, including experience modification and premium surcharge or discount, prior to any reduction for deductibles. The rates, factors, and methods used to calculate the cost for coverage under this paragraph for insurance policies or other evidence of coverage with provisions for deductibles shall be the same rates, factors, and methods normally used by the insurance company in Kentucky to calculate the cost for coverage for insurance policies or other evidence of coverage without provisions for deductibles, except that, for insurance policies or other evidence of coverage with provisions for deductibles effective on or after January 1, 1995, the calculated cost for coverage shall not include any schedule rating modification, debits, or credits. <u>For policies with provisions for deductibles with effective dates on or after January 1, 1995, assessments shall be imposed on premiums received as calculated by the deductible program adjustment.</u> The cost for coverage calculated under this paragraph by insurance companies that issue only deductible insurance policies in Kentucky shall be actuarially adequate to cover the entire liability of the employer for compensation under this chapter, including all expenses and allowances normally used to calculate the cost for coverage. For policies with provisions for deductibles with effective dates of May 6, 1993, through December 31, 1993, for which the insurance company did not report premiums and remit special fund assessments based on the calculated cost for coverage prior to the reduction for deductibles, "premiums received" includes the initial premium plus any reimbursements invoiced for losses, expenses, and fees charged under the deductibles. The special fund assessment rates in effect for reimbursements invoiced for losses, expenses, or fees charged under the deductibles shall be those percentages in effect on the effective date of the insurance policy. For policies covering leased employees as defined in KRS 342.615, "premiums received" means premiums calculated using the experience modification factor of each lessee as defined in KRS 342.615 for each leased employee for that portion of the payroll pertaining to the leased employee. …	7/13/18

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		(c) "Premium," for policies effective on or after January 1, 1994, for insurance companies means all consideration, whether designated as premium or otherwise, for workers' compensation insurance paid to an insurance company or its representative, including, on insurance policies with provisions for deductibles, the calculated cost for coverage, including experience modification and premium surcharge or discount, prior to any reduction for deductibles. The rates, factors, and methods used to calculate the cost for coverage under this paragraph for insurance policies or other evidence of coverage with provisions for deductibles shall be the same rates, factors, and methods normally used by the insurance company in Kentucky to calculate the cost for coverage for insurance policies or other evidence of coverage without provisions for deductibles, except that, for insurance policies or other evidence of coverage with provisions for deductibles effective on or after January 1, 1995, the calculated cost for coverage shall not include any schedule rating modifications, debits, or credits. For policies with provisions for deductibles with effective dates on or after January 1, 1995, assessments shall be imposed as calculated by the deductible program adjustment. The cost for coverage calculated under this paragraph by insurance companies that issue only deductible insurance policies in Kentucky shall be actuarially adequate to cover the entire liability of the employer for compensation under this chapter, including all expenses and allowances normally used to calculate the cost for coverage. For policies with provisions for deductibles with effective dates of May 6, 1993, through December 31, 1993, for which the insurance company did not report premiums and remit special fund assessments based on the calculated cost for coverage prior to the reduction for deductibles, "premium" includes the initial consideration plus any reimbursements invoiced for losses, expenses, or fees charged under the deductibles. … (e) "Deductible program adjustment" means calculating premium and premiums received on a gross basis without regard to the following: 1. Schedule rating modifications, debits, or credits; 2. Deductible credits; or 3. Modifications to the cost of coverage from inception through and including any audit that are based on negotiated retrospective rating arrangements, including but not limited to large risk alternative rating options; … **342.122 Special fund assessments—Annual adjustments—Reports—Central claim registry.** … (2) (a) These assessments shall be paid quarterly not later than the thirtieth day of the month following the end of the quarter in which the premium is received. Receipt shall be considered timely through actual physical receipt or by postmark of the United States Postal Service. Employers carrying their own risk and employers defined in KRS 342.630(2) shall pay the annual assessments in four (4) equal quarterly installments. (b) Beginning on January 1, 2020, all assessments shall be electronically remitted to the funding commission quarterly not later than the thirtieth day of the month following the end of the quarter in which the premium is received. Receipt shall be considered timely when filed and remitted using the appropriate electronic pay system as prescribed by the funding commission. Employers carrying their own risk and employers defined in KRS 342.630(2) shall pay the annual assessments in four (4) equal quarterly installments. … **342.1221 Penalty and interest on late payment of assessments—Waiver.**	

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		Assessments levied and expenses owed pursuant to KRS 342.122 and Sections 6 and 7 of this Act and unpaid on the date on which they are due and payable shall bear interest at the rate specified in KRS 131.183 plus a penalty of one and one-half percent (1.5%) per month or portion thereof without proration from the date on which the assessment or expenses are ~~was~~ due and payable. The funding commission shall have the authority to waive part or all of the penalty, but not the interest, where it is shown to the satisfaction of the commission that failure to timely pay assessments is due to reasonable cause. This authority shall extend to the coal workers' pneumoconiosis fund until it ceases to exist. **342.1223 Kentucky Workers' Compensation Funding Commission—Commission's relationship with Office of Financial Management within the Finance and Administration Cabinet.** … (2) The commission shall: … (b) Act as a fiduciary, as defined in KRS Chapter 386, in exercising its power over the funds collected pursuant to KRS 342.122, and may invest association funds through one (1) or more banks, trust companies, or other financial institutions with offices in Kentucky in good standing with the Department of Financial Institutions, in investments described in KRS Chapter 386, except that the funding commission may, at its discretion, invest in ~~nondividend-paying~~ equity securities; … (3) The commission shall have all of the powers necessary or convenient to carry out and effectuate the purposes for which it was established, including, but not limited to, the power: (a) To sue and be sued, complain, or defend, in its name; (b) To elect, appoint, or hire officers, agents, and employees, and define their duties and fix their compensation within the limits of its budget approved by the General Assembly. Notwithstanding any provision of KRS Chapter 18A to the contrary, officers and employees of the funding commission may be exempted from the classified service; … **342.1231 Procedure for protesting special fund assessments—Expenses of audits, how paid.** (1) The funding commission may mail to the assessment payer ~~taxpayer~~ a notice of any assessment assessed by it. The assessment shall be final if not protested in writing to the funding commission within thirty (30) days from the date of notice. Payment for the assessment, penalty and interest, and expenses shall be received by the funding commission within thirty (30) days from the date the notice becomes final. The protest shall be accompanied by a supporting statement setting forth the grounds upon which the protest is made. Upon written request, the funding commission may extend the time for filing the supporting statement if it appears the delay is necessary and unavoidable. The refusal of such extension may be reviewed in the same manner as a protested assessment. (2) After a timely protest has been filed, the assessment payer ~~taxpayer~~ may request a conference with the funding commission. The request shall be granted in writing stating the date and time set for the conference. The assessment payer ~~taxpayer~~ may appear in person or by representative. Further conferences may be held by mutual agreement.	

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		(3) After considering the assessment payer's ~~taxpayer's~~ protest, including any matters presented at the final conference, the funding commission shall issue a final ruling on any matter still in controversy, which shall be mailed to the assessment payer ~~taxpayer~~. The ruling shall state that it is a final ruling of the funding commission, generally state the issues in controversy, the funding commission's position thereon and set forth the procedure for prosecuting an appeal to the Kentucky Claims Commission pursuant to KRS 49.220. (4) The assessment payer ~~taxpayer~~ may request in writing a final ruling at any time after filing a timely protest and supporting statement. When a final ruling is requested, the funding commission shall issue such ruling within sixty (60) ~~thirty (30)~~ days or at the next board of directors meeting, whichever is later, from the date the request is received by the funding commission. (5) After a final ruling has been issued, the assessment payer ~~taxpayer~~ may appeal to the Kentucky Claims Commission pursuant to KRS 49.220. (6) The expenses incurred by the funding commission in conducting audits required in this chapter shall be paid by the audited entities ~~insurance companies~~ in accordance with administrative regulations promulgated by the funding commission (7) Notwithstanding any provision to the contrary, a notice of assessment under subsection (1) of this section shall not be collected unless the notice of assessment is mailed to the assessment payer not later than five (5) years from the due date of the quarterly premium report or the date the amended quarterly premium report is filed, whichever is later. A quarterly premium report shall not be amended later than one (1) year after the due date of the quarterly premium report. (8) Assessment payers shall preserve, retain, and provide all documents relevant to quarterly premium reports and subject to audits to the funding commission upon request during the completion of the audit. (9) (a) The funding commission may mail the assessment payer notice of a refund amount to be returned to an insured. The insurance carrier shall pay the amount of the refund to the insured within sixty (60) days from the date of notice sent by the funding commission. If, after good faith efforts, the refund cannot be returned to the insured, the refund amount shall be remitted to the funding commission within thirty (30) days from the last date of attempting the refund. (b) If a refund amount to an insured is unpaid on the date on which it is due, then that amount shall bear a penalty of one and one-half percent (1.5%) per month from that due date. The funding commission shall have the authority to waive part or all of the penalty where failure to pay is shown, to the satisfaction of the funding commission, to be for a reasonable cause. (10) "Assessment payer" ~~"Taxpayer"~~ as used in this section means insurance carrier, self-insured group, and self-insured employer. **342.1242 Kentucky coal workers' pneumoconiosis fund—Liability for and manner of making payments for awards for coal workers' pneumoconiosis—Assessments to finance fund—When assessments cease.** … (4) All assessments imposed by this section shall be paid to the Kentucky Workers' Compensation Funding Commission and shall be transferred to the Kentucky Employers' Mutual Insurance Authority, which is administering the coal workers' pneumoconiosis fund. In addition, the powers and responsibilities of the Kentucky Workers' Compensation Funding Commission including its fiduciary duties and responsibilities relating to assessments collected for the special fund pursuant to KRS 342.122, Section 3 of this Act, 342.1222, 342.1223, 342.1226, 342.1229, and 342.1231 shall apply to assessments collected for the Kentucky coal workers' pneumoconiosis fund created pursuant to this section. Each entity subject to assessments for the Kentucky coal workers' pneumoconiosis fund shall provide any and all information requested by the Kentucky Workers' Compensation Funding Commission necessary to carry out its powers and responsibilities relating thereto.	

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		… (9) The Kentucky Employers' Mutual Insurance Authority shall reimburse the funding commission for any expenses incurred with regard to the collection of assessments for the coal workers' pneumoconiosis fund and other incurred expenses related to the coal workers' pneumoconiosis fund. **342.1243 Transfer of the administration, assets, and liabilities of the Kentucky coal workers' pneumoconiosis fund—assessments on employers.** … (8) When the Kentucky Workers' Compensation Funding Commission and the Kentucky Employers' Mutual Insurance Authority have determined final audits are closed and the liability of the fund is fully funded ~~that the Kentucky coal workers' pneumoconiosis fund has fully funded its liabilities~~, then the authority for imposing assessment rates ~~assessments~~ pursuant to this section and KRS 342.1242 shall cease to exist~~, and the Kentucky coal workers' pneumoconiosis fund shall be abolished~~. Any remaining assessments received following the exhaustion of liabilities shall be refunded pro rata to all employers who have paid an assessment in the year that liabilities are fully funded. When all claim payouts are completed, the Kentucky coal workers' pneumoconiosis fund shall be abolished.	
Louisiana	HB 370	**HB 370** creates new ***chapter 19*** in the Louisiana Insurance Code to read: **CHAPTER 19. ELECTRONIC DELIVERY OF INSURANCE DOCUMENTS AND NOTICES** **§2461. Definitions** As used in this Chapter, the following definitions apply: (1) "Delivered by electronic means" means either of the following: (a) Delivery to an electronic mail address at which a party has consented to receive notices or documents. (b) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet, or any other electronic device, together with separate notice of the posting provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party. (2) "Party" means any recipient of any notice or document required as part of an insurance transaction, including but not limited to an applicant, an insured, a policyholder, or an annuity contract holder. **§2462. Electronic delivery of insurance documents and notices** A. Subject to the requirements of this Section, any notice to a party or any other document required by law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means if the electronic means meet the requirements of the Louisiana Uniform Electronic Transactions Act, R.S. 9:2601 et seq. B. Delivery of a notice or document in accordance with this Section shall be considered equivalent to and have the same effect as any delivery method required by law, including delivery by first class mail, first class mail with postage prepaid, certified mail, certificate of mail, or certificate of mailing. C. A notice or document may be delivered by electronic means by an insurer to a party pursuant to this Section if all of the following apply:	8/1/18

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		(1) The party has affirmatively consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means to which the party has given consent, and the party has not withdrawn the consent. (2) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of all of the following: (a) The hardware and software requirements for access to and retention of a notice or document delivered by electronic means. (b) The types of notices and documents to which the party's consent would apply. (c) The right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn. (d) The procedures a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the party's electronic mail address. (e) The right of a party to have a notice or document delivered, upon request, in paper form. D. An insurer shall take all measures reasonably calculated to ensure that delivery by electronic means pursuant to this Section results in receipt of the notice or document by the party. **§2463. Change in hardware or software requirements** After the consent of a party is given, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies, the insurer shall not deliver a notice or document to the party by electronic means unless the insurer complies with R.S. 22:2462 and provides the party with a statement that describes all of the following: (1) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means. (2) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent. **§2464. Applicability** A. The provisions of this Section shall not be construed to affect requirements related to content or timing of any notice or document required by any other provision of law. B. If a provision of this Title or other applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt. C. This Chapter shall not apply to a notice or document delivered by an insurer in an electronic form before the effective date of this Chapter to a party who, before that date, has consented to receive the notice or document in an electronic form otherwise allowed by law. **§2465. Contracts and policies not affected** The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party shall not be denied solely because of the failure of the insurer to obtain electronic consent or confirmation of consent of the party in accordance with the provisions of this Chapter.	

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		§2466. Withdrawal of consent A. A withdrawal of consent by a party shall not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective. B. A withdrawal of consent by a party shall be effective within a reasonable period of time after receipt of the withdrawal by the insurer. C. Failure by an insurer to comply with any provision of R.S. 22:2462 or 20 2463 may be treated, at the election of the party, as a withdrawal of consent for purposes of this Chapter. **§2467. Prior consent to receive notices or documents in an electronic form** If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before the effective date of this Chapter, and an insurer intends to deliver additional notices or documents to the party in an electronic form pursuant to this Chapter, then prior to delivering the additional notices or documents electronically, the insurer shall comply with the provisions of 28 R.S. 22:2462 and shall provide the party with a statement that describes both of the following: (1) The notices or documents that shall be delivered by electronic means that were not previously delivered electronically. (2) The party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent. **§2468. Alternative method of delivery required** An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if either of the following occurs: (1) The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party. (2) The insurer becomes aware that the electronic mail address provided by the party is no longer valid. **§2469. Limitation of liability** An insurance producer shall not be subject to civil liability for any harm or injury that occurs because of a party's election to receive any notice or document by electronic means or by an insurer's failure to deliver or a party's failure to receive a notice or document by electronic means.	
Louisiana	HB 579	**HB 579**, in part, amends and reenacts ***section 40:1046 Recommendation of marijuana for therapeutic use; rules and regulations; Louisiana Board of Pharmacy and the adoption of rules and regulations relating to the dispensing of recommended marijuana for therapeutic use; the Department of Agriculture and Forestry and the licensure of a production facility*** of the Louisiana Health and Safety law to stipulate that employers and their workers compensation insurers shall not be obligated or ordered to pay for recommended or prescribed medical marijuana in claims arising under present law relative to workers compensation.	8/1/18
Maine	LD 1888	**LD 1888** amends ***section 403. Insurance by assenting employer; requirements as to self-insurers*** of the Maine Workers' Compensation Act of 1992 to:	7/17/18

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

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		• Require a group self-insurer that provides an irrevocable standby letter of credit as security to file with the Superintendent of Insurance a letter of credit and other agreements or documents relating to the employer's reimbursement obligations • Require a group self-insurer to maintain an actuarially determined fully funded trust as security for self-insurance, except that the Superintendent of Insurance may authorize an affiliated group self-insurer meeting certain requirements to secure the liabilities of each of its members • Require that if the status of a group self-insurer is terminated, the required security remains subject to the control of the Workers' Compensation Board until claims against the group self-insurer have been discharged • Remove a requirement that reinsurance contracts name the self-insurer as a coinsured with the Maine Self-Insurance Guarantee Association • Authorize a member of a group self-insurer and a successor employer of a member to apply for continuing membership in the group self-insurer	
Maryland	HB 205/ SB 48	**HB 205** amends ***section 9-628. Compensation for less than 75 weeks*** of the Maryland Workers Compensation Law, related to permanent partial disability benefits, to read as follows: **§ 9-628. Compensation for less than 75 weeks.** (a) "Public safety employee" defined.—In this section, "public safety employee" means: … (8) an Anne Arundel County deputy sheriff or detention officer; ~~or~~ (9) a Baltimore County deputy sheriff, but only when the deputy sheriff sustains an accidental personal injury that arises out of and in the course and scope of performing duties directly related to: (i) courthouse security; (ii) prisoner transportation; (iii) service of warrants; (iv) personnel management; or (v) other administrative duties ; or (10) a state correctional officer. … **HB 205** also includes the following clause: And be it further enacted, That this Act shall be construed to apply only prospectively and may not be applied or interpreted to have any effect on or application to any claims arising from events occurring before the effective date of this Act.	10/1/18
Maryland	HB 1499	**HB 1499** repeals and reenacts, with amendments, ***sections 1-204, 27-402, 27-801***, and ***27-802*** of the Maryland Insurance Code as follows: **§ 1-204. Application of article to workers' compensation insurance** ~~For~~ Except for provisions governing the reporting and investigation of workers' compensation insurance fraud claims under § 2-201, Title 2, Subtitle 4, and Title 27, Subtitles 4 and 8 of this Article, for the purpose of workers' compensation insurance, this article does not apply to an employer who: (1) participates in a governmental self-insurance group under § 9-404 of the Labor and Employment Article; or	10/1/18

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		(2) self-insures under § 9-405 of the Labor and Employment Article. **§ 27-402. Scope of subtitle** The provisions of this subtitle that apply to insurers also apply to: … (12) the Maryland Health Insurance Plan; ~~and~~ (13) a governmental self-insurer group formed in accordance with § 9-404 of the labor and Employment Article; (14) an employer who self-insures or participates in a self-insurance group in accordance with § 9-405 of the labor and employment article; and ~~(13)~~ (15) an agent, employee, or representative of an entity described in items (1) through ~~(12)~~ (14) of this section. **§ 27-801. Definitions** … (c) "Insurance fraud" means: … (2) theft, as set out in §§ 7–101 through 7–104 of the Criminal Law Article: (i) from a person regulated under this article; or (ii) by a person regulated under this article or an officer, director, agent, or employee of a person regulated under this article; ~~or~~ (3) a violation of § 9-1106 of the Labor and Employment Article; or ~~(3)~~ (4) any other fraudulent activity that is committed by or against a person regulated under this article and is a violation of: … **§ 27-802. Reporting suspected insurance fraud** (a) … (4) A governmental self-insurance group formed in accordance with § 9-404 of the Labor and Employment Article or an employer who self-insures or participates in a self-insurance group in accordance with § 9-405 of the Labor and Employment Article shall meet the reporting requirement of this subsection by reporting suspected insurance fraud in writing to the fraud division. (b) In addition to any protection provided under Title 4, Subtitle 4, Part IV of the General Provisions Article, any information, documentation, or other evidence provided under this section by an insurer, its employees, fund producers, or insurance producers, a viatical settlement provider, a viatical settlement broker, an independent insurance producer, ~~or~~ a registered premium finance company, a governmental self-insurance group, or an employer who self-insures or participates in a self-insurance group to the Commissioner, the Fraud Division, or a federal, State, or local law enforcement authority in connection with an investigation of suspected insurance fraud is not subject to public inspection for as long as the Commissioner, Fraud Division, or law enforcement authority considers the withholding to be necessary to complete an investigation of the suspected fraud or to protect the person investigated from unwarranted injury. …	

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BILLS NEWLY ADDED SINCE THE LAST UPDATE ARE LISTED FIRST AND HIGHLIGHTED IN "YELLOW."

NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

JURISDICTION	BILL	SUMMARY	EFFECTIVE
Maryland	HB 1500/ SB 979	**HB 1500** repeals and reenacts, with amendments, ***section 9-902*** of the Maryland Labor and Employment Code as follows: **§ 9-902. Action against third party after award or payment of compensation** … (e) If the covered employee or the dependents of the covered employee recover damages, the covered employee or dependents: (1) first, may deduct the costs and expenses of the covered employee or dependents for the action; (2) next, subject to subsection (g) of this section, shall reimburse the self-insured employer, insurer, Subsequent Injury Fund, or Uninsured Employers' Fund for: (i) the compensation already paid or awarded; and (ii) any amounts paid for medical services, funeral expenses, or any other purpose under Subtitle 6 of this title; and … (g) In determining reimbursement under subsection (e)(2) of this section, if the self-insured employer, insurer, or uninsured employers' fund has not waived third-party reimbursement: (1) first, the self-insured employer, insurer, or uninsured employers' fund shall be reimbursed; and (2) next, the subsequent injury fund shall be reimbursed. **HB 1500** also includes the following clause: And be it further enacted, That this Act shall be construed to apply only prospectively and may not be applied or interpreted to have any effect on or application to any action filed before the effective date of this Act.	10/1/18
Maryland	HB 1592/ SB 851	**HB 1592**, in part, repeals and reenacts, with amendments, **section *9-212*** and repeals ***section 9-1015*** of the Maryland Labor and Employment Code as follows: **§ 9-212. Jockey** (a) (1) This section applies to each jockey licensed by the State Racing Commission to ride a thoroughbred horse. (2) This section applies only at a thoroughbred racing association or training facility under the jurisdiction of the State Racing Commission. (b) A jockey is a covered employee while performing a service in connection with ~~racing or~~: (1) live thoroughbred racing; or (2) training a thoroughbred race horse, if the principal earnings of the jockey are based on money earned as a jockey during live racing and not as an exercise rider. (c) (1) For the purposes of this title, the ~~joint employers~~ employer of a jockey who is a covered employee under this section ~~while performing a service in connection with racing or training~~ is ~~are:~~ ~~(i)~~ the Maryland Jockey Injury Compensation Fund, Inc.~~; and~~ ~~(ii) each licensed owner or trainer who is subject to assessment under § 11-906 of the Business Regulation Article at the time of any occurrence for which benefits are payable to the jockey under this title.~~ ~~(2) For purposes of this title, the employer of a jockey who is a covered employee under this section while performing a service in connection with training is the trainer for whom the service is performed.~~	10/1/18

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		~~(3)~~ (2) This subsection does not affect any other provision of law or practice. (d) Notwithstanding any other provision of law, this section may not be construed to bar an action by a jockey against a third party. ~~**§ 9-1015. Payment by Maryland Jockey Injury Compensation Fund, Inc**~~ ~~(a) A jockey who is a covered employee under § 9-212 of this title while performing a service in connection with training or the dependents of the jockey may apply for payment from the Maryland Jockey Injury Compensation Fund, Inc. if the employer of the jockey is in default on a claim under § 9-1002(b) of this subtitle.~~ ~~(b) On receipt of an application for payment, the Maryland Jockey Injury Compensation Fund, Inc. shall pay the award.~~ ~~(c) (1) If the Maryland Jockey Injury Compensation Fund, Inc. makes payment under this section to a covered employee or the dependents of the covered employee as directed by the Commission, the Maryland Jockey Injury Compensation Fund, Inc. is subrogated to the rights of the covered employee or dependents against the uninsured employer.~~ ~~(2) The Maryland Jockey Injury Compensation Fund, Inc. may:~~ ~~(i) institute a civil action against the uninsured employer to recover the money paid under the award;~~ ~~(ii) refer the matter to the Maryland Racing Commission for suspension or revocation of the occupational license of the uninsured employer;~~ ~~(iii) refer the matter to the appropriate authority for prosecution under § 9-1108 of this title; or~~ ~~(iv) take action under any combination or all of items (i) through (iii) of this paragraph.~~	
Mississippi	SB 2311	**SB 2311**, in part, amends ***section 71-3-77. Insurance policy regulations*** of the Mississippi Worker's Compensation Law to read as follows: **§ 71-3-77. Insurance policy regulations** (1) Every contract for the insurance of the compensation herein provided, or against liability therefor, shall be deemed to be made subject to the provisions of this chapter, and provisions thereof inconsistent with this chapter shall be void. Such contract shall be allowed to offer deductibles on all liability of the assured under and according to the provisions of this chapter, notwithstanding any agreement of the parties to the contrary. However, the payments of the claims, including the deductible amounts, shall be made directly from the insurance company to the employee, except for medical benefits which shall be paid to the medical provider. A copy of such payments shall be forwarded to the employer. The insurance company shall collect the deductible from the employer as shall be provided in the contract between the employer and the insurer. No such policy shall be subject to nonrenewal, or cancelled by the insurer within the policy period, until a notice in writing shall be given to the commission and to the insured, fixing the date on which it is proposed to cancel it or declaring that the company does not intend to renew the policy upon expiration date. Notice to the insured shall be served personally or by registered or certified mail. Notice to the commission shall be provided in such manner and on such form as the commission may prescribe or direct. No such cancellation or nonrenewal shall be effective until thirty (30) days after the service of such notice on the insured and the provision of notice to the commission, unless the employer has obtained other insurance coverage, in which case such policy shall be deemed cancelled as of the effective date of such other insurance, whether or not such notice has been given. The notice requirements of this section shall not apply when a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or when transfer of an insured to a licensed affiliate providing the same or substantially similar coverage occurs. Whenever a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or when a transfer of an insured to a licensed affiliate of the insurer providing the same or substantially similar coverage occurs, documents signed by the insured are applicable to the replacement policy and to coverage being transferred, and remain valid and enforceable.	7/1/18

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		The insured may also cancel such a policy on the day that the insured either (a) returns the policy to the agent, or (b) signs and delivers to the agent a "lost policy release." If the insured desires to cancel a policy before the policy has become effective, he may cancel the policy by written notice of cancellation to the agent or company without return of the policy or a release. Whenever a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or by a licensed affiliate insurer, such insurer shall mail or deliver to the policyholder, at least thirty (30) days in advance of the effective date of renewal, written notice of any terms or conditions that are less favorable to the policyholder. A transferring insurer shall notify the Mississippi Insurance Department and the Mississippi Workers' Compensation Commission at least forty-five (45) days in advance of notifying a policyholder that its personal or commercial lines insurance policies will be transferred to another licensed insurer within the same insurance group or same holding company. The notice shall include the name of insurer transferring the personal or commercial lines policies and the name and financial rating of the insurer receiving the transferred personal or commercial lines policies. A transferring insurer shall provide the policyholder written notice of the policy transfer at least thirty (30) days prior to expiration of the policy term and shall include the financial rating of the insurer receiving the transferred policy. Such notice must be provided to the policyholder with the notice of renewal premium at least thirty (30) days before the effective date of the transfer. … (3) As used in this section: (a) "Affiliate transfer" is when an insurer transfers, at renewal or policy expiration, its personal or commercial lines insurance policies to an affiliated licensed insurer that is a member of the same insurance group or same holding company as the transferring insurer. The issuance of a replacement policy form providing the same or substantially similar coverage issued by the same insurer, or the transfer of personal or commercial insurance policies to a licensed affiliate insurer that will issue the same or substantially similar policy, are considered a renewal and will not be treated as a cancellation or nonrenewal. The affiliate transfer must be to a licensed affiliate insurer that has been determined by the commissioner to have the same or better financial strength as the transferring insurer. The policy transfer must be selected on a nondiscriminatory basis. (b) "Substantially similar" means a policy that provides the same basic coverages but may add, alter or eliminate incidental coverages and may provide coverages using different textual language.	
Missouri	HB 1719	**HB 1719** repeals and adds numerous sections to the Missouri Annotated Statutes, in part, creating the "Professional Employer Organization Act" to provide, in part, that: • The responsibility to obtain workers compensation coverage shall be specifically allocated in the professional employer agreement to either the professional employment organization (PEO) or the client. • If the coemployment relationship between a PEO and a client is terminated, the client shall utilize an experience modification rating that reflects its individual experience. The PEO shall provide a client its workers compensation information within five business days of receiving or giving notice that the relationship has been terminated. • A client may request its workers compensation information at any time and the PEO shall provide such information to the client within five business days of receiving such request. Such information shall also be provided to any future client insurer if requested by such client.	8/28/18

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		• A client is additionally required to provide prospective insurers with its workers compensation information upon receiving such information from the PEO. A client is further required to disclose to a prospective insurer its current or previous relationship with a PEO. Violation of either of these provisions is subject to a Class A misdemeanor. • If a third party requests verification of a client's experience modification factor for a client in certain types of insurance policies from a PEO, the PEO shall, within five business days of receipt of receiving the client's consent, provide the information to the third party. If the client refuses to grant consent to a request for information, the PEO shall notify the requesting third party that the client has refused to consent to the disclosure of the information.	
Missouri	SB 981	**SB 981** amends ***sections 287.127***, ***287.690***, and ***287.715*** of the Missouri Workers' Compensation Law as follows: **287.127. Notice, employer to post, contents—division to provide notice, when—penalty.—** ... 2. The division of workers' compensation shall develop the notice to be posted and shall, distribute such notice free of charge to employers and insurers upon request, <u>and publish the notice on the website of the department of labor and industrial relations</u>. Failure to request such notice does not relieve the employer of its obligation to post the notice. If the employer carries workers' compensation insurance, the carrier shall provide the notice<u>, in paper or electronic format,</u> to the insured within thirty days of the insurance policy's inception date. <u>A carrier who elects to provide the notice in electronic format shall direct the insured to the notice available on the website of the department of labor and industrial relations.</u> ... **287.690. Premium tax on insurance carriers, purpose, rate, how determined—use of funds for employers mutual insurance company, purpose.—** 1. Prior to December 31, 1993, for the purpose of providing for the expense of administering this chapter and for the purpose set out in subsection 2 of this section, every person, partnership, association, corporation, whether organized under the laws of this or any other state or country, the state of Missouri, including any of its departments, divisions, agencies, commissions, and boards or any political subdivisions of the state who self-insure or hold themselves out to be any part self-insured, company, mutual company, the parties to any interindemnity contract, or other plan or scheme, and every other insurance carrier, insuring employers in this state against liability for personal injuries to their employees, or for death caused thereby, under this chapter, shall pay, as provided in this chapter, tax upon the net deposits, net premiums or net assessments received, whether in cash or notes in this state, or on account of business done in this state, for such insurance in this state at the rate of two percent in lieu of all other taxes on such net deposits, net premiums or net assessments, which amount of taxes shall be assessed and collected as herein provided. Beginning October 31, 1993, and every year thereafter, the director of the division of workers' compensation shall estimate the amount of revenue required to administer this chapter and the director shall determine the rate of tax to be paid in the following calendar year pursuant to this section commencing with the calendar year beginning on January 1, 1994. If the balance of the fund estimated to be on hand on December thirty-first of the year each tax rate determination is made is less than one hundred ten percent of the previous year's expenses plus any additional revenue required due to new statutory requirements given to the division by the general assembly, then the director shall impose a tax not to exceed two percent in lieu of all other taxes on net deposits, net premiums or net assessments, rounded up to the nearest one-half of a percentage point, which amount of taxes shall be assessed and collected as herein provided. The net premium equivalent for individual self-insured employers and any group of political subdivisions of this state qualified to self-insure their liability pursuant to this chapter as authorized by section 537.620 shall be based on average	8/28/18

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		rate classifications calculated by the department of insurance, financial institutions and professional registration as taken from premium rates filed by the twenty insurance companies providing the greatest volume of workers' compensation insurance coverage in this state. For employers qualified to self-insure their liability pursuant to this chapter, the rates filed by such group of employers in accordance with subsection 4 of section 287.280 shall be the net premium equivalent. Any group of political subdivisions of this state qualified to self-insure their liability pursuant to this chapter as authorized by section 537.620 may choose either the average rate classification method or the filed rate method, provided that the method used may only be changed once without receiving the consent of the director of the division of workers' compensation. Every entity required to pay the tax imposed pursuant to this section and section 287.730 shall be notified by the division of workers' compensation within ten calendar days of the date of the determination of the rate of tax to be imposed for the following year. **Net premiums, net deposits** or **net assessments** are defined as gross premiums, gross deposits or gross assessments less cancelled or returned premiums, premium deposits or assessments and less dividends or savings, actually paid or credited. ... **287.715. Annual surcharge required for second injury fund, amount, how computed, collection—violation, penalty—supplemental surcharge, amount.** ... 2. Beginning October 31, 2005, and each year thereafter, the director of the division of workers' compensation shall estimate the amount of benefits payable from the second injury fund during the following calendar year and shall calculate the total amount of the annual surcharge to be imposed during the following calendar year upon all workers' compensation policyholders and authorized self-insurers. The amount of the annual surcharge percentage to be imposed upon each policyholder and self-insured for the following calendar year commencing with the calendar year beginning on January 1, 2006, shall be set at and calculated against a percentage, not to exceed three percent, of the policyholder's or self-insured's workers' compensation net deposits, net premiums, or net assessments for the previous policy year, rounded up to the nearest one-half of a percentage point, that shall generate, as nearly as possible, one hundred ten percent of the moneys to be paid from the second injury fund in the following calendar year, less any moneys contained in the fund at the end of the previous calendar year. All policyholders and self-insurers shall be notified by the division of workers' compensation within ten calendar days of the determination of the surcharge percent to be imposed for, and paid in, the following calendar year. The net premium equivalent for individual self-insured employers and any group of political subdivisions of this state qualified to self-insure their liability pursuant to this chapter as authorized by section 537.620 shall be based on average rate classifications calculated by the department of insurance, financial institutions and professional registration as taken from premium rates filed by the twenty insurance companies providing the greatest volume of workers' compensation insurance coverage in this state. For employers qualified to self-insure their liability pursuant to this chapter, the rates filed by such group of employers in accordance with subsection 4 of section 287.280 shall be the net premium equivalent. Any group of political subdivisions of this state qualified to self-insure their liability pursuant to this chapter as authorized by section 537.620 may choose either the average rate classification method or the filed rate method, provided that the method used may only be changed once without receiving the consent of the director of the division of workers' compensation. The director may advance funds from the workers' compensation fund to the second injury fund if surcharge collections prove to be insufficient. Any funds advanced from the workers' compensation fund to the second injury fund must be reimbursed by the second injury fund no later than December thirty-first of the year following the advance. The surcharge shall be collected from policyholders by each insurer at the same time and in the same manner that the	

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		premium is collected, but no insurer or its agent shall be entitled to any portion of the surcharge as a fee or commission for its collection. The surcharge is not subject to any taxes, licenses or fees. ...	
Nebraska	LB 953	**LB 953** amends ***sections 48-139***, ***48-2907***, and ***48-2911*** of the Nebraska Revised Statutes as follows: **48-139 Compensation; lump-sum settlement; submitted to Nebraska Workers' Compensation Court; procedure; filing of release; form; contents; payment; fees**. ... (2)(a) An application for an order approving a lump-sum settlement, signed and verified by both parties, shall be filed with the clerk of the compensation court and shall be entitled the same as an action by such employee or dependents against such employer. The application shall contain a concise statement of the terms of the settlement or agreement sought to be approved with a brief statement of the facts concerning the injury, the nature thereof, the wages received by the injured employee prior thereto, the nature of the employment, a description of the medical, surgical, or hospital expenses incurred for treatment of the injury that will remain unpaid as part of the settlement which are disputed and for which compensability has been denied by the employer, and such other matters as may be reasonably required by the compensation court. The application shall also include a statement that the parties have considered the interests of medicare and have taken reasonable steps to protect any interests of medicare. The application may provide for payment of future medical, surgical, or hospital expenses incurred by the employee. The compensation court may, on its own motion, and shall, on a motion by one of the parties, hold a hearing on the application at a time and place selected by the compensation court, and proof may be adduced and witnesses subpoenaed and examined the same as in an action in equity. (b)(i) ~~(b)~~ If the compensation court finds such lump-sum settlement is made in conformity with the compensation schedule and for the best interests of the employee or his or her dependents under all the circumstances, the compensation court shall make an order approving the same. (ii) If the expenses for medical, surgical, or hospital services provided to the employee are not paid by the employer, or if any person, other than medicaid, who has made any payment to the supplier of medical, surgical, or hospital services provided to the employee, is not reimbursed by the employer, it shall be conclusively presumed that the nonpayment or nonreimbursement of disputed medical, surgical, or hospital expenses, as set forth in the application, is in conformity with the compensation schedule and for the best interests of the employee or his or her dependents, if the employee's attorney elects to affirm and does affirm in the application that the nonpayment or nonreimbursement of disputed medical, surgical, or hospital expenses is in conformity with the compensation schedule and for the best interests of the employee or his or her dependents under all the circumstances. (iii) If the employee, at the time the settlement is executed, is eligible for medicare, is a medicare beneficiary, or has a reasonable expectation of becoming eligible for medicare within thirty months after the date the settlement is executed, and if the employee's attorney elects to affirm and does affirm in the application that the parties' agreement relating to consideration of medicare's interests set forth in such lump-sum settlement is in conformity with the compensation schedule and for the best interests of the employee or his or her dependents under all the circumstances, it shall be conclusively presumed that the parties' agreement relating to consideration of medicare's interests set forth in the application is in conformity with the compensation schedule and for the best interests of the employee or his or her dependents. (iv) If such settlement is not approved, the compensation court may dismiss the application at the cost of the employer or continue the hearing, in the discretion of the compensation court.	7/18/18

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		(c) Every such lump-sum settlement approved by order of the compensation court shall be final and conclusive unless procured by fraud. An order approving an application under this subsection shall, in any case in which the employee is represented by counsel and in which the application contains a description of the medical, surgical, or hospital expenses incurred for treatment of the injury that will remain unpaid as part of the settlement which are disputed and for which compensability has been denied by the employer, provide that the employer is not liable for such expenses. Upon paying the amount approved by the compensation court, the employer ~~(i)~~ shall be discharged from further liability on account of the injury or death, other than liability for the payment of future medical, surgical, or hospital expenses if such liability is approved by the compensation court on the application of the parties~~, and (ii) shall be entitled to a duly executed release. Upon filing the release, the liability of the employer under any agreement, award, finding, or decree shall be discharged of record~~. (d) An exclusion from coverage in any health, accident, or other insurance policy covering an employee which provides that coverage under such insurance policy does not apply if such employee is entitled to workers' compensation coverage is void as to such employee if his or her employer is not liable for medical, surgical, or hospital expenses incurred for treatment of an injury that will remain unpaid as part of the settlement pursuant to an order entered under subdivision (2)(c) of this section. ... (4) Upon the entry of an order of dismissal with prejudice, a ~~A~~ release filed with the compensation court in accordance with subsection (3) of this section shall be final and conclusive as to all rights waived in the release unless procured by fraud. Amounts to be paid by the employer to the employee pursuant to such release shall be paid within thirty days of filing the release with the compensation court. Fifty percent shall be added for payments owed to the employee if made after thirty days after the date the release is filed with the compensation court. Upon making payment owed by the employer as set forth in the release and upon the entry of an order of dismissal with prejudice, as to all rights waived in the release, such release shall be a full and complete discharge from further liability for the employer on account of the injury, including future medical, surgical, or hospital expenses, unless such expenses are specifically excluded from the release~~, and the court shall enter an order of dismissal with prejudice as to all rights waived in the release~~. ... **48-2907 Fines.** (1) In addition to any other fines or penalties provided by law, if the commissioner finds, after notice and hearing, that a contractor has violated the Employee Classification Act, the contractor shall be assessed, by the commissioner, a five-hundred-dollar fine per each misclassified individual for the first offense and a five-thousand-dollar fine per each misclassified individual for each second and subsequent offense. (2) Any contractor who has unpaid fines for a violation of the Employee Classification Act shall be barred from contracting with the state or any political subdivision until such fines are paid. **48-2911 Contracts; affidavit required; rescission.** Any contract between the state or a political subdivision and a contractor shall require that each contractor who performs construction or delivery service pursuant to the contract submit to the state or political subdivision an affidavit attesting that (1) each individual performing services for such contractor is properly classified under the Employee Classification Act, (2) such contractor has completed a federal I-9 immigration form and has such form on file for each employee performing services, (3) such contractor has complied with section 4-114, (4) such contractor has no reasonable	

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		basis to believe that any individual performing services for such contractor is an undocumented worker, and (5) as of the time of the contract, such contractor is not barred from contracting with the state or any political subdivision pursuant to section 48-2907 or 48-2912. Such contract shall also require that the contractor follow the provisions of the Employee Classification Act. A violation of the act by a contractor is grounds for rescission of the contract by the state or political subdivision.	
Nebraska	LB 957	**LB 957** amends ***section 48-125*** of the Nebraska Revised Statutes as follows: **48-125 Compensation; method of payment; delay; appeal; attorney's fees; interest.** (1) ~~(1)(a)~~ Except as hereinafter provided, all amounts of compensation payable under the Nebraska Workers' Compensation Act shall be payable periodically in accordance with the methods of payment of wages of the employee at the time of the injury or death or by a method of payment as provided in subsection (2) of this section. Such payments shall be sent directly to the person entitled to compensation or his or her designated representative except as otherwise provided in section 48-149 or subsection (2) of this section. (2)(a) After an injury or death subject to the Nebraska Workers' Compensation Act, the employer, workers' compensation insurer, or risk management pool and the employee, the other person entitled to compensation, or a legal representative acting on behalf of such employee or other person entitled to compensation may enter into a written or electronic agreement that periodic or lump-sum payments to the employee or other person entitled to compensation may be made by check or by direct deposit, prepaid card, or similar electronic payment system. (b) Payments made by direct deposit, prepaid card, or similar electronic payment system pursuant to this subsection shall not be subject to attachment or garnishment or held liable in any way for any debts, except as provided in section 48-149; and an agreement pursuant to this subsection shall include notice of this fact. If an amount is withheld pursuant to section 48-149, sufficient information to identify the jurisdiction, the case number or similar identifying information, and the amount withheld shall be provided to the employee or other person entitled to compensation or his or her legal representative at or near the time of withholding. (c) Prior to entering into an agreement pursuant to this subsection for payment by prepaid card, the employer, workers' compensation insurer, or risk management pool shall provide to the employee or other person entitled to compensation information regarding the locations where such card may be used by the employee or other person. (d) Pursuant to an agreement under this subsection, compensation may be transferred by electronic funds transfer or other electronic means to the trust account of an attorney representing the employee or other person entitled to compensation, for the benefit of such employee or other person. The payment or transfer shall include or be accompanied by information sufficient to identify the nature of the payment being made, including the employer, workers' compensation insurer, or risk management pool and the employee or other person entitled to compensation. (e) If an employer, workers' compensation insurer, or risk management pool imposes any fees or other charges relating to payment by direct deposit, prepaid card, or a similar electronic payment system, prior to entering into an agreement pursuant to this subsection the employer, workers' compensation insurer, or risk management pool shall disclose such fees or charges to the employee or other person entitled to compensation. (f) Any payment or transfer made pursuant to this subsection by direct deposit, prepaid card, or similar electronic payment system shall be in the full amount of the lump-sum or periodic payment awarded or paid pursuant to section 48-121 to the employee or other person entitled to compensation. (g) A prepaid card offered by the employer, workers' compensation insurer, or risk management pool shall:	7/18/18

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		(i) Allow the employee or other person entitled to compensation to apply, initiate, transfer, and load payments with no charge by the employer, workers' compensation insurer, or risk management pool; (ii) For the initial prepaid card, be distributed or delivered to the employee or other person entitled to compensation with no charge by the employer, workers' compensation insurer, or risk management pool; and (iii) Provide the employee or other person entitled to compensation, with respect to each payment made to the prepaid card in accordance with this subsection, at least one method of accessing the full payment without fees. (h) An employee, another person entitled to compensation, or a legal representative acting on behalf of such employee or other person entitled to compensation may elect at any time to rescind the agreement under this subsection regarding the method of payment by providing written or electronic notice of such rescission to the employer, workers' compensation insurer, or risk management pool that is a party to such agreement. If such election is made, the employer, workers' compensation insurer, or risk management pool shall change the method of payment to the method of payment of wages of the employee at the time of the injury or death under subsection (1) of this section as soon as practicable after receiving the information necessary to do so and in a manner that allows the employer, workers' compensation insurer, or risk management pool to comply with the requirements of subsection (3) of this section without making a delinquent payment. The employer, workers' compensation insurer, or risk management pool is not required to rescind any payment transaction already made or made to comply with subsection (3) of this section. (i) An employer, a workers' compensation insurer, or a risk management pool or an agent of any such entity shall not engage in unfair, deceptive, or abusive practices in relation to the method of payment. No employer, workers' compensation insurer, risk management pool, or agent of any such entity shall discharge, penalize, or in any other manner discriminate against any employee or other person entitled to compensation because such employee or other person has not consented to receive payments by check or by direct deposit, prepaid card, or a similar electronic payment system. (j) An employer, workers' compensation insurer, or risk management pool that elects to make payment using a prepaid card shall comply with the requirements of 12 C.F.R. part 1005, as such part existed on April 1, 2018. (3) ~~(b)~~ Fifty percent shall be added for waiting time for all delinquent payments after thirty days' notice has been given of disability or after thirty days from the entry of a final order, award, or judgment of the Nebraska Workers' Compensation Court, except that for any award or judgment against the state in excess of one hundred thousand dollars which must be reviewed by the Legislature as provided in section 48-1,102, fifty percent shall be added for waiting time for delinquent payments thirty days after the effective date of the legislative bill appropriating any funds necessary to pay the portion of the award or judgment in excess of one hundred thousand dollars. (4)(a) ~~(2)(a)~~ Whenever the employer refuses payment of compensation or medical payments subject to section 48-120, or when the employer neglects to pay compensation for thirty days after injury or neglects to pay medical payments subject to such section after thirty days' notice has been given of the obligation for medical payments, and proceedings are held before the compensation court, a reasonable attorney's fee shall be allowed the employee by the compensation court in all cases when the employee receives an award. Attorney's fees allowed shall not be deducted from the amounts ordered to be paid for medical services nor shall attorney's fees be charged to the medical providers. ... (5) ~~(3)~~ When an attorney's fee is allowed pursuant to this section, there shall further be assessed against the employer an amount of interest on the final award obtained, computed from the date compensation was payable, as provided in section 48-119, until the date payment is made by the employer. For any injury occurring prior to August 30, 2015, the interest rate shall be equal to the rate of interest allowed per annum under section	

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		45-104.01, as such rate may from time to time be adjusted by the Legislature. For any injury occurring on or after August 30, 2015, the interest rate shall be equal to six percentage points above the bond investment yield, as published by the Secretary of the Treasury of the United States, of the average accepted auction price for the first auction of each annual quarter of the twenty-six-week United States Treasury bills in effect on the date of entry of the judgment. Interest shall apply only to those weekly compensation benefits awarded which have accrued as of the date payment is made by the employer. If the employer pays or tenders payment of compensation, the amount of compensation due is disputed, and the award obtained is greater than the amount paid or tendered by the employer, the assessment of interest shall be determined solely upon the difference between the amount awarded and the amount tendered or paid. (6) For purposes of this section: (a) Direct deposit means the transfer of payments into an account of a financial institution chosen by the employee or other person entitled to compensation; and (b) Prepaid card means a prepaid debit card that provides access to an account with a financial institution established directly or indirectly by the employer, workers' compensation insurer, or risk management pool to which payments are transferred.	
New Hampshire	HB 407	**HB 407** amends ***sections 281-A:2*** and ***281-A:23*** of the New Hampshire Workers' Compensation Law as follows: **281-A:2 Definitions.** Any word or phrase defined in this section shall have the same meaning throughout RSA 281-A, unless the context clearly requires otherwise: … I-aa. "Airborne disease" means pathogenic microorganisms that may be discharged through respiratory secretions and can cause disease in humans through inhalation or contact with a mucous membrane. In this chapter these are defined as pertussis, meningococcal disease, and tuberculosis. … I-d. "Bloodborne disease" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus, and human immunodeficiency virus (HIV). I-e. "Critical exposure" means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood or body fluids, other than tears, saliva, or perspiration, unless these are visibly contaminated with blood, of a magnitude that can result in transmission of bloodborne disease. … V-c. "Emergency response/public safety worker" means call, volunteer, or regular firefighters; law enforcement officers certified under RSA 106-L; certified county corrections officers; and rescue or ambulance workers including ambulance service, emergency medical personnel, first responder service, and volunteer personnel. … XIV-a. "Post-exposure prophylaxis" means preventive medical treatment started after an identified critical exposure or unprotected exposure in order to prevent infection and the development of disease, in accordance with standards promulgated by the Centers for Disease Control and Prevention, United States Department of Health and Human Services.	1/1/19

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BILLS NEWLY ADDED SINCE THE LAST UPDATE ARE LISTED FIRST AND HIGHLIGHTED IN "YELLOW."

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		XIV-b. "Unprotected exposure" includes instances of direct mouth-to-mouth resuscitation or the commingling of blood or other potentially infectious material of a source individual and an emergency response/public safety worker which is capable of transmitting a bloodborne or airborne disease. XIV-c. "Rehabilitation provider" as used in this chapter includes any person certified as a vocational rehabilitation provider under RSA 281-A:68 or RSA 281-A:69 and who operates for the purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision. … **281-A:23 Medical, Hospital, and Remedial Care.—** … VI. An employer subject to this chapter, or the employer's insurance carrier, may furnish or cause to be furnished, testing for the presence of a bloodborne disease when a critical exposure that arises out of and in the course of employment occurs. Such testing shall be provided without prejudice as to the issue of the causal relationship of any subsequently diagnosed bloodborne disease to the employee's work and without prejudice to the compensability of the bloodborne disease as an occupational disease or an accidental injury for the purposes of RSA 281-A. Notwithstanding the foregoing, any costs for testing associated with a testing order issued pursuant to RSA 141-G:11 shall be paid for by the employer's insurance carrier or third-party administrator. Such payment shall be provided without prejudice as to the issue of the causal relationship of any subsequently diagnosed disease or injury. VI-a. All expenses associated with the medical evaluation and recommended post-exposure prophylaxis treatment for emergency response/public safety workers shall be paid by the employer's insurance carrier or third-party administrator. Such medical evaluation and prophylaxis treatment shall be provided without prejudice as to the issue of the causal relationship of any subsequently diagnosed bloodborne disease or airborne disease to the emergency response/public safety worker's work and without prejudice to the compensability of the bloodborne disease or airborne disease as an occupational disease or an accidental injury for the purposes of this chapter. … *NCCI analysis estimates that **HB 407** may result in a minimal increase in overall workers compensation costs in New Hampshire. Any cost impact of these changes would be reflected in the analysis of future claims experience contained in subsequent NCCI loss cost filings in New Hampshire.*	
New Hampshire	HB 1740	**HB 1740** amends ***sections 141-G:15 Costs***, and ***141-G:19 Rules*** of the New Hampshire Public Health Code as follows: **141-G:15 Costs.**—Subject to rules adopted by the commissioner under RSA 141-G:19, an applicant's workers' compensation insurance carrier shall be responsible for paying the costs ~~relating to a testing order. Subject to rules adopted by the commissioner under RSA 141-G:19, the private health or automobile insurance of an applicant who does not have access to workers' compensation insurance which would cover medication for prophylaxis against potential bloodborne pathogens shall be responsible for paying the costs relating to a testing order~~ of the test, including charges of the health care facility taking the blood sample and the charges of the laboratory for the analysis of the sample. An applicant without insurance	6/8/18

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		coverage may request testing under this subdivision, however, he or she shall be responsible for paying for the testing order and may be required to pay for testing in advance. **141-G:19 Rules.—** … II. The commissioner shall adopt rules under RSA 541-A, relative to: … (k) Circumstances in which workers' compensation insurance~~,~~ and the government~~, and private health or automobile insurance~~ shall be responsible for paying the costs referred to in RSA 141-G:15. …	
New Hampshire	SB 84	**SB 84** amends ***section 281-A:40* Memorandum of Payment** of the New Hampshire Workers' Compensation Law as follows: **281-A:40 Memorandum of Payment**. An employer or the employer's insurance carrier shall make payment of compensation in the amount and manner provided by this chapter. Payment shall be made by direct deposit 6 weeks from the date of disability if the injured worker elects this payment method. The employer or the employer's insurance carrier shall notify the injured worker in writing of his or her right to payment by direct deposit. If no election is made, payment shall be made by paper check mailed to the injured worker. The employer shall file memoranda of ~~such~~ payments with the commissioner in accordance with rules adopted by the commissioner under RSA 281-A:60.	1/1/19
New Hampshire	SB 351	**SB 351** amends ***section 281-A:23-a*** of the New Hampshire Workers' Compensation Law as follows: **281-A:23-a Managed Care Programs.—** … V. Every managed care program shall include a sufficient number of injury management facilitators, including resident injury management facilitators, who shall be qualified by reason of education, training, and experience to manage the injured employee's medical, hospital and remedial care, vocational rehabilitation, modified duty, and return to work plans. An injury management facilitator shall work with the injured employee, employer, and medical, hospital and other providers to ensure that the injured employee receives effective, timely, and appropriate services in order to achieve maximum medical improvement and an expeditious return to work. Any person employed as an injury management facilitator by a managed care program or operating as an injury management facilitator in conjunction with a managed care program under this section shall be approved by the commissioner with ratification by the workers' compensation advisory council. The commissioner shall, in consultation with the advisory council, by rule determine the number of facilitators which shall be sufficient. …	1/1/19
New Hampshire	SB 541-FN-A	**SB 541-FN-A** amends ***sections 281-A:17*** of the New Hampshire Statutes to read: **281-A:17 Firefighter and Heart, Lung, or Cancer Disease.—** … II. Notwithstanding the provisions of RSA 281-A:2, XI and XIII, 16 and 27, there shall exist a prima facie presumption that cancer disease in a firefighter, whether a regular, call, volunteer, or retired member of a fire department, is occupationally related. In order to receive this occupational cancer disability benefit, the type of cancer involved must be a type which may be caused by exposure to heat, radiation, or a known ~~or suspected~~	7/10/18

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		carcinogen, as defined by the International Agency for Research on Cancer. However: (a) A ~~call or volunteer~~ firefighter who has been a firefighter for 10 years shall have the benefit of this prima facie presumption ~~only if there is on record reasonable medical evidence that~~ as follows: (1) If a fire department follows the medical examination as outlined by the National Fire Protection Association standard 1582, the firefighter shall provide this report as evidence that ~~such~~ the firefighter was free of such disease at the beginning of his or her employment~~. It shall be the duty of the~~ and shall guarantee that he or she has lived a tobacco free life. The employer of a call or volunteer ~~firefighters to~~ firefighter shall provide the required reasonable medical evidence~~. If the employer fails to do so, the call or volunteer firefighter shall~~ to the firefighter to present as part of his or her claim. (2) If the fire department does not follow the medical examination standard, the firefighter shall guarantee that he or she has lived a tobacco free life~~,~~ and has been a firefighter for 10 years and shall be required to present after action reports filed after fire incidents which demonstrate exposure to the known carcinogens as part of the claim, but shall not have the benefit of the prima facie presumption ~~regardless of the absence of said reasonable medical evidence~~. (b) A retired firefighter who has been retired between 6 and 20 years who guarantees that he or she has lived a tobacco free life and who is receiving a pension, shall be eligible for medical payments only under this section. If a new claim is being filed, the firefighter shall be responsible for filing applicable data and after action reports if no physical report can be provided. A retired firefighter who agrees to submit to any physical examination requested by ~~his~~ the employing city, town, or precinct shall have the benefit of the prima facie presumption for a period of 20 years from the effective date of ~~such~~ the firefighter's retirement, during which time the firefighter shall be eligible to have his or her medical expenses paid for this period. (c) No active or retired firefighter shall receive the presumption benefit unless the employer voluntarily has in effect a policy that follows the fire standards and training commission curriculum requirement for best practices for use and cleaning of equipment.	
North Carolina	HB 995	**HB 995** amends ***section 58-47-60*** of ***Article 47—Workers' Compensation Self-Insurance*** of the North Carolina Insurance Code to read as follows: **§ 58-47-60. Definitions.** As used in this part: ... (14) "Third-party administrator" or "TPA" means a person engaged by a board to execute the policies established by the board and to provide day-to-day management of the group. "Third-party administrator" or "TPA" does not mean: a. An employer acting on behalf of its employees or the employees of one or more of its ~~affiliates.~~ affiliates or a municipal employer acting on behalf of the employees of a third-party entity managing a municipal transit system. ... In addition, **HB 995** includes the following language: This act applies to the City of Winston-Salem only.	6/29/18
Oklahoma	HB 2722	**HB 2722** amends ***section 85A-2*** of the Oklahoma Administrative Workers' Compensation Act, in part, as follows: **§85A-2. Definitions.**	11/1/18

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		As used in the Administrative Workers' Compensation Act: … 18… b. The term "employee" shall not include: … (2) any person who is employed in agriculture, ranching or horticulture by an employer who had a gross annual payroll in the preceding calendar year of less than One Hundred Thousand Dollars ($100,000.00) wages for agricultural, ranching or horticultural workers, or any person who is employed in agriculture, ranching or horticulture who is not engaged in operation of motorized machines. This exemption applies to any period of time for which such employment exists, irrespective of whether or not the person is employed in other activities for which the exemption does not apply. If the person is employed for part of a year in exempt activities and for part of a year in nonexempt activities, the employer shall be responsible for providing workers' compensation only for the period of time for which the person is employed in nonexempt activities, …	
Oklahoma	HB 2993	**HB 2993** amends ***sections 85A-97, 85A-98,*** and ***85A-99*** of the Oklahoma Administrative Workers' Compensation Act as follows: **§85A-97. Self-insurance Guaranty Fund.** A. The Self-insurance Guaranty Fund shall be for the purpose of continuation of workers' compensation benefits due and unpaid or interrupted due to the inability of a self-insurer to meet its compensation obligations because its financial resources, security deposit, guaranty agreements, surety agreements and excess insurance are either inadequate or not immediately accessible for the payment of benefits. Monies in the fund, including interest, are not subject to appropriation and shall be expended to compensate employees for eligible benefits for a compensable injury under the Administrative Workers' Compensation Act, pay outstanding workers' compensation obligations of the impaired self-insurer, and for all claims for related administrative fees, operating costs of the Self-insurance Guaranty Fund Board, attorney fees, and other costs reasonably incurred by the Board in the performance of its duties. B. Monies transferred pursuant to Section 99 of this title may be expended by the Board to provide a credit against the assessment required to be paid by each private self-insurer and group self-insurer association pursuant to Section 98 of this title. C. Expenditures from the fund shall be made on warrants issued by the State Treasurer against claims as prescribed by law. The fund shall be subject to audit in the same manner as state funds and accounts, the cost for which shall be paid for from the fund. **§85A-98. Funds to be transferred to Self-insurance Guaranty Fund.** The Self-insurance Guaranty Fund shall be derived from the following sources: … (2)… c. Failure of a self-insurer to pay, or timely pay, an assessment required by this paragraph, or to report payment of the same to the Commission within ten (10) days of payment, shall be grounds for revocation by the Commission of the self-insurer's permit to self-insure in this state, after notice and hearing. A former self-insurer failing to make payments required by this paragraph promptly and correctly, or failing to report payment of the same to the Commission within ten (10) days of payment, shall be subject to administrative penalties as allowed by law, including but not limited to, a fine in the amount of Five Hundred Dollars ($500.00) or an amount equal to one percent (1%) of the unpaid amount, whichever is greater, to be paid and deposited to the credit of the Workers' Compensation Commission Revolving Fund created in Section ~~28~~ 28.1 of this title. It	11/1/18

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		shall be the duty of the Tax Commission to collect the assessment provided for in this paragraph. The Tax Commission is authorized to bring an action for recovery of any delinquent or unpaid assessments, and may enforce payment of the assessment by proceeding in accordance with Section 79 of this title. … e. The Tax Commission shall determine the fund balance as of March 1 and September 1 of each year, and when otherwise requested by the Workers' Compensation Commission, and shall advise the Workers' Compensation Commission in writing within thirty (30) days of each such determination; ~~and~~ 3. Any interest accruing on monies paid into the fund; and 4. Monies transferred pursuant to Section 99 of this title. **§85A-99. Impaired self-insurer.** A. On determination by the Workers' Compensation Commission that a self-insurer has become an impaired self-insurer, the Commission shall secure release of the security required by Section 38 of this title and advise the Self-insurance Guaranty Fund Board of the impairment. Claims administration, including processing, investigating and paying valid claims against an impaired self-insurer under the Administrative Workers' Compensation Act, may include payment by the surety that issued the surety bond or be under a contract between the Commission and an insurance carrier, appropriate state governmental entity or an approved service organization, as approved by the Commission. B. Excess proceeds from the security remaining after each claim for benefits of an impaired self-insurer has been paid, settled or lapsed, and associated costs of administration of such claim have been paid, shall be transferred to the Self-insurance Guaranty Fund and may be used as a credit against the assessment required to be paid by each private self-insurer and group self-insurer association pursuant to Section 98 of this title, as determined by the Self-insurance Guaranty Fund Board.	
Oklahoma	SB 1249	**SB 1249** amends ***section 85A-36*** of the Oklahoma Administrative Workers' Compensation Act as follows: **§85A-36. Liability other than immediate employer.** A. If a subcontractor fails to secure compensation required by ~~this act~~ the Administrative Workers' Compensation Act, the prime contractor shall be liable for compensation to the employees of the subcontractor unless there is an intermediate subcontractor who has workers' compensation coverage. B. 1. Any contractor or the contractor's insurance carrier who shall become liable for the payment of compensation on account of injury to or death of an employee of his or her subcontractor may recover from the subcontractor the amount of the compensation paid or for which liability is incurred. 2. The claim for the recovery shall constitute a lien against any monies due or to become due to the subcontractor from the prime contractor. 3. A claim for recovery shall not affect the right of the injured employee or the dependents of the deceased employee to recover compensation due from the prime contractor or his or her insurance carrier. C. 1. a. When a ~~sole proprietorship or partnership fails to elect to cover the sole proprietor or partners under this act~~ a subcontractor elects not to secure compensation and is not required to secure compensation pursuant to this title, the prime contractor is not liable under ~~this act~~ the	8/1/18

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		Administrative Workers' Compensation Act for injuries sustained by the ~~sole proprietor or partners~~ subcontractor or any person working with the subcontractor who is not considered an employee of the subcontractor pursuant to Section 2 of this title, and if the ~~sole proprietor or partners are~~ injured person is not ~~employees~~ an employee of the prime contractor. b. (1) ~~A sole proprietor or the partners of a partnership who do not elect to be covered by this act and be deemed employees thereunder and who deliver to the prime contractor a current certification of noncoverage issued by the Commission~~ If a subcontractor has filed with the Commission an unexpired Affidavit of Exempt Status, the subcontractor and any person who works with the subcontractor but is not considered an employee of the subcontractor pursuant to Section 2 of this title shall be conclusively presumed not to be covered by the law or to be employees of the prime contractor during the term of ~~his or her certification or any renewals thereof~~ the affidavit. (2) ~~A certificate of noncoverage may not be presented to a subcontractor who does not have workers' compensation coverage.~~ (~~3~~) This provision shall not affect the rights or coverage of any ~~employees of the sole proprietor or of the partnership~~ employee of a subcontractor. 2. The prime contractor's insurance carrier shall not be liable for injuries to the ~~sole proprietor or partners~~subcontractor described in this section who have ~~provided a current certification of noncoverage~~ filed an unexpired Affidavit of Exempt Status, and the carrier shall not include compensation paid by the prime contractor to the ~~sole proprietor or partners~~subcontractor described above in computing the insurance premium for the prime contractor. ~~3. a. Any prime contractor who after being presented with a current certification of noncoverage by a sole proprietor or partnership compels the sole proprietor or partnership to pay or contribute to workers' compensation coverage of that sole proprietor or partnership shall be guilty of a misdemeanor.~~ ~~b. Any prime contractor who compels a sole proprietor or partnership to obtain a certification of noncoverage when the sole proprietor or partnership does not desire to do so shall be guilty of a misdemeanor.~~ ~~c. Any applicant who makes a false statement when applying for a certification of noncoverage or any renewals thereof shall be guilty of a felony.~~ ~~D. 1. A certification of noncoverage issued by the Commission shall be valid for two (2) years after the effective date stated thereon. Both the effective date and the expiration date shall be listed on the face of the certificate by the Commission. The certificate~~ Any individual or business entity that is not required to secure compensation pursuant to the requirements of the Administrative Workers' Compensation Act may execute an Affidavit of Exempt Status. The "Affidavit of Exempt Status" shall be a form prescribed by the Workers' Compensation Commission available on the Commission's website. The Commission may assess a nonrefundable fee not to exceed Fifty Dollars ($50.00) per individual or business entity for filing of an Affidavit of Exempt Status at the Commission. An Affidavit of Exempt Status executed and filed with the Commission shall expire at midnight two (2) years from its ~~issue date, as noted on the face of the certificate~~ the date filed. A new Affidavit of Exempt Status may be filed prior to expiration to renew an existing Affidavit of Exempt Status. ~~2. The Commission may assess a fee not to exceed Fifty Dollars ($50.00) with each application for a certification of noncoverage or any renewals thereof.~~ ~~3. Any certification of noncoverage issued by the Commission shall contain the social security number and notarized signature of the applicant. The notarization shall be in a form and manner prescribed by the Commission.~~ ~~4. The Commission may prescribe by rule forms and procedures for issuing or renewing a certification of noncoverage~~	

NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

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		a. Knowingly providing false information on an executed affidavit shall constitute a misdemeanor punishable by a fine not to exceed One Thousand Dollars ($1,000.00). b. In the event changed circumstances make securing compensation pursuant to the requirements of the Administrative Workers' Compensation Act necessary, the individual or business entity on whose behalf the affidavit was executed shall execute and file a Cancellation of Affidavit of Exempt Status. The Commission shall prescribe a form for cancellation of an affidavit which shall available on the Commission's website. c. Affidavits shall conspicuously state on the front thereof in at least ten-point, bold-faced print that it is a crime to falsify information on the form. d. The Commission shall immediately notify the Workers' Compensation Fraud Unit in the Office of the Attorney General of any violations or suspected violations of this section. The Commission shall cooperate with the Fraud Unit in any investigation involving affidavits executed pursuant to this section. The execution or filing of an affidavit shall not affect the rights or coverage of any employee of the affiant or business entity on whose behalf the affiant executes or files an affidavit. 3. Fees collected pursuant to this section shall be deposited in the State Treasury to the credit of the Workers' Compensation Commission Revolving Fund. E. If work is performed by an independent contractor on a single-family residential dwelling occupied by the owner, or the premises of such dwelling, or for a farmer whose cash payroll for wages, excluding supplies, materials and equipment, for the preceding calendar year did not exceed One Hundred Thousand Dollars ($100,000.00), such owner or farmer shall not be liable for compensation under ~~this act~~ the Administrative Workers' Compensation Act for injuries to the independent contractor or his or her employees. F. If an owner of a project or job enters a contract with a contractor, and the owner of the project or job does not substantively form an employment relationship with its contractor, then the owner of the project or job shall not be liable for compensation for a compensable injury to any contractor or subcontractor in any tier or employee of any contractor or subcontractor in any tier.	
Oklahoma	SB 1411	**SB 1411** amends ***section 40-418*** of the Oklahoma Labor Code as follows: **§40-418. Payments to Commission—Refunds—Collection of payments—Disposition of funds.** ... (5) ~~The~~ Except as otherwise provided in paragraph 7 of this section, the Oklahoma Tax Commission shall, monthly, as the same are collected, pay to the State Treasurer of this state, to the credit of the Special Occupational Health and Safety Fund, all monies collected under the provisions of this section. Monies shall be paid out of said Fund exclusively for the operation and administration of the Oklahoma Occupational Health and Safety Standards Act and for other necessary expenses of the Department of Labor pursuant to appropriations by the Oklahoma Legislature. ... (7) In no event shall the total fiscal year amount paid to the credit of the Special Occupational Health and Safety Fund pursuant to this section exceed the 3-year average of the total fiscal year amounts apportioned fiscal years 2015, 2016 and 2017. Any amount in excess of the 3-year average shall be placed to the credit of the General Revenue Fund.	8/1/18
Rhode Island	HB 8215 Substitute A/	**HB 8215 Substitute A/SB 2924 Substitute B** amend numerous sections of the Rhode Island General Laws—Title 28. Labor and Labor Relations as follows: **§ 28-29-19. Waiver of claim of common law rights.**	6/28/18

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	SB 2924 Substitute B	(a) Any employee~~, or corporate officer, or manager, managing member or member of a limited liability company,~~ or the parent or guardian of any minor employee, who has given notice to the employer that he or she claimed his or her right of action at common law may waive that claim by filing a notice in writing with the director and the employer or his or her agent which shall take effect five (5) days after the filing with the director. (b) Any corporate officer, or manager, managing member or member of a limited liability company who has given notice to the employer and its workers' compensation insurance carrier that they claimed their right of action at common law may waive that claim by filing a notice in writing with the director and the employer or their agent and its workers' compensation insurance carrier which shall take effect five (5) days after the filing with the director. The insurance carrier shall keep a copy of the notice consistent with the rules and regulations of the department. ~~(b)~~ (c) Any person who is appointed a corporate officer between January 1, 1999 and December 31, 2001 and was not previously an employee of the corporation may elect to become subject to chapters 29–38 of this title upon filing a notice in writing with the director and his or her employer and its workers' compensation insurance carrier which notice takes effect five (5) days after the filing of his or her notice. **§ 28-29-30. Advisory council.** (a) There is created a workers' compensation advisory council consisting of ~~sixteen (16)~~ seventeen (17) members as follows: (1) The chief judge of the workers' compensation court and ~~one~~ two (2) additional ~~judge~~ judges of the workers' compensation court and one member of the Bar who primarily represents injured workers before the workers' compensation court, both to be selected by the chief judge; … (5) Three (3) representatives from business appointed by the governor, ~~one of whom shall be a self-insured employer, and~~ one of whom shall represent cities and towns; … **§ 28-30-4. Workers' compensation administrator—Appointment—Powers and duties.** … (b) The administrator shall: … (7) Have the power to act as a notary public as provided in § 42-30-14. **§ 28-36-15. Penalty for failure to secure compensation—Personal liability of corporate officers.** … (i)…(3) Actions filed with the workers' compensation court pursuant to this section shall not be subject to a pretrial conference in accordance with § 28-35-20 but and shall be assigned consistent with the workers' compensation court rules of practice. … **CHAPTER 28-53** **~~Rhode Island Uninsured Employers Fund~~ Rhode Island Uninsured Protection Fund**	

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		§ 28-53-1. Preamble and legislative findings. … WHEREAS, Professionals providing services covered under the provisions of the Workers' Compensation Act have taken into account, in the performance of their service, the important public policy benefit of a sound and properly functioning workers' compensation system in this state, and have tirelessly committed themselves to protect and ~~maintained~~maintain the integrity of this system; and … WHEREAS, Additional reform is required to provide ~~appropriate compensation, health care and rehabilitative services~~ payments to employees who are injured while in the service of uninsured employers and to eliminate the flagrant abuse of the system by illegally uninsured employers by requiring them to accept their legal responsibility to pay the appropriate benefits to their insured employees; now, therefore be it RESOLVED, That it is declared to be the intent of the legislature that an uninsured ~~employers~~ protection fund be created to ensure that injured workers who are employed by illegally uninsured employers are not deprived of ~~workers' compensation benefits~~ payments. The fund shall have enforcement mechanisms as are necessary to induce illegally uninsured employers to acknowledge their malfeasance, provide legally mandated ~~benefits~~ payments for injured workers; and to assure that all participants in the system recognize their obligation to conduct themselves in a manner consistent with the overall integrity of the compensation system. All amounts owed to the uninsured ~~employers~~ protection fund from illegally uninsured employers are intended to be excise taxes and as such, all ambiguities and uncertainties are to be resolved in favor of a determination that such assessments are excise taxes. **§ 28-53-2. Establishment—Sources—Administration.** (a)(1) There shall be established within the department of labor and training a special restricted receipt account to be known as the Rhode Island uninsured ~~employers~~ protection fund. The department shall maintain the fund for the exclusive purpose of making payments to an injured employee otherwise entitled to benefits pursuant to chapters 29 through 38 of title 28, or in the case of death of the injured employee, to person(s) presumed wholly dependent for support upon the deceased employee, as defined in § 28-33-13, and any costs specifically associated therewith, where the employer required to secure payment of such compensation failed to insure or self-insure its liability at the time the injury took place as determined by the director and the workers' compensation court. (2) The fund shall be capitalized from excise taxes assessed against uninsured employers pursuant to the provisions of § 28-53-9 and from general revenues appropriated by the legislature. Beginning in state fiscal year ending ~~June 30, 2018~~ June 30, 2019, the legislature may appropriate up to two million dollars ($2,000,000) in general revenue funds annually for deposit into the Rhode Island uninsured ~~employers~~ protection fund. … (c) All amounts owed to the uninsured ~~employers~~ protection fund from illegally uninsured employers are intended to be excise taxes and as such, all ambiguities and uncertainties are to be resolved in favor of a determination that such assessments are excise taxes. **§ 28-53-3. Powers and duties of the fund.** The fund shall: (a) Be ~~obligated~~ authorized to pay covered claims as determined by the director ~~or~~ and the workers' compensation court pursuant to the provisions of this section and promulgate all rules and regulations necessary to effectuate the provisions and overall purpose of this chapter. The rules and	

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		regulations shall be promulgated in accordance with the administrative procedures act, chapter 35 of title 42, and shall include, but not be limited to, the filing of claim forms and other documentation supporting the claim, and proof of dependency, if relevant. All claims must contain a release necessary to allow the director to investigate the claim; ... **§ 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., in accordance with the provisions of this chapter, the uninsured ~~employers~~ protection fund ~~shall~~ is authorized to 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 uninsured ~~employers~~ protection 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~~ protection fund, the fund shall pay benefits for ~~disability and medical expenses~~ incapacity as provided pursuant to chapters 29 to 38 of this title except that the employee shall not be entitled to receive benefits for medical expenses pursuant to the provisions of § 28-33-5 or loss of function and disfigurement pursuant to the provisions of § 28-33-19. (d) The fund shall pay costs, counsel, and witness fees, as provided in § 28-35-32, to any employee who successfully prosecutes any petitions for ~~compensation; petitions for medical expenses~~ payment; 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~~ payments; 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. Any payment ordered by the court or due under this section shall not be subject to liens set forth in § 28-33-27(b), nor shall such payments be assignable or subject to assignment in any way. (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 The fund shall be entitled to full reimbursement from the uninsured employer for any and all payments made to employee as well as all costs, counsel and witness fees paid out by the fund in connection with any claim and/or petition plus any and all costs and attorney fees associated with collection and reimbursement of the fund. (f) This section shall apply to injuries that occur on or after ~~July 1, 2018~~ February 1, 2019. **§ 28-53-8. Limitations on payments to injured employees.** (a) Where the director determines by experience or other appropriate accounting and actuarial methods that the reserves in the fund are insufficient to pay all claims presented or pending, the director shall petition the workers' compensation court for an order to make appropriate, proportionate reductions in the payments being made to injured employees by the fund or to suspend all payments to injured employees until such time as the reserves maintained by the fund are sufficient to resume the payment of benefits. The matter shall be heard by the chief judge. If the	

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		court determines that the monies held by the fund are insufficient to fully ~~pay all claims~~ make payments as they fall due, the court shall issue an order directing that a proportionate reduction be made in the payments made to those employees receiving ~~benefits~~ payments from the fund. In considering the fund's request for relief, the court shall give due weight to the policy of the workers' compensation act that ~~benefits~~ payments are to be paid weekly and that the unwarranted reduction or interruption in the employee's weekly ~~compensation benefit~~ payment will impose financial hardship upon the injured worker. … (d) Payments under this chapter shall not be awarded to any injured employee or dependent if the award would directly or indirectly inure to the benefit of the uninsured employer. (e) No payment shall be awarded when the director or the court, in its discretion, determines that unjust enrichment to or on behalf of the illegally uninsured employer would result. (f) No interest shall be included in or added to payments under this chapter. (g) No payments will be awarded under this chapter to an injured employee, or in the case of death of the injured employee, to person(s) presumed wholly dependent for support upon the deceased employee, as defined in § 28-33-13, in a total amount in excess of fifty thousand dollars ($50,000) plus any attorneys' fees awarded in connection with petitions for payment from the fund. (h) Applications for payment under this chapter shall be filed with the director within the time limits set forth in § 28-35-57. **§ 28-53-9. Penalties, taxes and assessments against non-complying employers.** (a) Where it is determined that an employer has failed to maintain a policy of workers' compensation insurance as required by Rhode Island general laws § 28-36-1 et seq. and that while the employer was uninsured in violation of the statute, an employee suffered a compensable injury, the uninsured ~~employers~~ protection fund shall commence the payment of weekly ~~benefits and medical expenses necessary to cure, relieve or rehabilitate the employee from the effects of the work related injury~~ payment to the employee as set forth herein, subject to fund availability. ~~The~~ On behalf of the fund, the director shall acquire a lien against the goods and chattels of the uninsured employer to the extent of any payments made by it to the injured employee. The lien(s) shall arise and attach as of the date on which the fund makes payment to the injured employee without further action by the fund or the court. The lien shall have priority over all subsequently perfected liens and security interests. …	
South Dakota	SB 20	**SB 20** adds a new section to ***chapter 48A Emergency Management*** of ***title 34 Public Health and Safety*** of the South Dakota Codified Laws, in part, to read: The State and Province Emergency Management Assistance Memorandum of Understanding is hereby enacted into law and entered into by the State of South Dakota with all other states legally joining the agreement, in the form substantially as follows: **ARTICLE I - PURPOSE AND AUTHORITIES** The State and Province Emergency Management Assistance Memorandum of Understanding, hereinafter referred to as the compact, is made and entered into by and among such of the jurisdictions as shall enact or adopt this compact, hereinafter referred to as participating jurisdictions. For the purposes of this compact, the term, jurisdictions, may include any or all of the states of Illinois, Indiana, Ohio, Michigan, Minnesota, Montana,	7/1/18

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		North Dakota, Pennsylvania, New York, and Wisconsin, and the Canadian Provinces of Alberta, Manitoba, Ontario, and Saskatchewan, and such other states and provinces as may hereafter become a party to this compact. The term, states, means the several states, the Commonwealth of Puerto Rico, the District of Columbia, and all territorial possessions of the United States. The term, province, means the ten political units of government within Canada. The purpose of this compact is to provide for the possibility of mutual assistance among the participating jurisdictions in managing any emergency or disaster when the affected jurisdiction or jurisdictions ask for assistance, whether arising from natural disaster, technological hazard, manmade disaster, or civil emergency aspects of resource shortages. This compact also provides for the process of planning mechanisms among the agencies responsible and for mutual cooperation, including civil emergency preparedness exercises, testing, or other training activities using equipment and personnel simulating performance of any aspect of the giving and receiving of aid by participating jurisdictions or subdivisions of participating jurisdictions during emergencies, with such actions occurring outside emergency periods. … **ARTICLE VIII – WORKERS' COMPENSATION AND DEATH BENEFITS** Each participating jurisdiction shall provide, in accordance with its own laws, for the payment of workers' compensation and death benefits to injured members of the emergency contingent of that participating jurisdiction and to representatives of deceased members of those forces if the members sustain injuries or are killed while rendering aid pursuant to this compact, in the same manner and on the same terms as if the injury or death were sustained within their own jurisdiction. …	
Tennessee	HB 2304	**HB 2304** amends ***section 50-6-226*** of the Tennessee Workers' Compensation Law as follows: **50-6-226. Fees of attorneys and physicians, and hospital charges.** … **(d) (1)** In addition to attorneys' fees provided for in this section, the court of workers' compensation claims may award reasonable attorneys' fees and reasonable costs, including reasonable and necessary court reporter expenses and expert witness fees, for depositions and trials incurred when the employer: ... **(B)** Wrongfully denies a claim by filing a timely notice of denial, or fails to 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~~.	4/18/18
Tennessee	SB 1615	**SB 1615** repeals ***section 50-6-413*** of the Tennessee Workers' Compensation Law as follows: ~~**50-6-413. In-state claims office or adjuster required -- Authority of office or adjuster.**~~ ~~Every workers' compensation insurer that provides insurance for Tennessee workers' compensation claims, and every workers' compensation bureau-approved self-insured employer, shall be required to maintain a workers' compensation claims office or to contract with a claims adjuster located within the borders of the state. The claims office or adjuster has authority to commence temporary total disability benefits and medical benefits if so ordered by the claims coordinator or by a court at a show cause hearing.~~	4/12/18

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Tennessee	SB 1649	**SB 1649**, in part, adds a new section to ***Title 49 Education, Chapter 11 Career and Technical Education, Part 1—General Provisions*** of the Tennessee Code to read: (a) An employer that accepts or employs a student who is participating in workbased learning coordinated through the student's LEA or a state institution of higher education, including, but not limited to, Tennessee colleges of applied technology: (1) Shall not be liable for actions relating to that student unless the employer acted willfully or with gross negligence; and (2) May elect to provide workers' compensation insurance coverage to compensate a participating student for any injury that is covered under the Workers' Compensation Law, compiled in title 50, chapter 6. Notwithstanding subdivision (a)(1), if an employer elects to provide workers' compensation insurance coverage pursuant to this subdivision (a)(2): (A) The coverage shall serve as the participating student's exclusive remedy for any compensable injury that is covered under the Workers' Compensation Law; and (B) The employer shall not disclaim the participating student's eligibility for such coverage. (b) An LEA or state institution of higher education that coordinates work-based learning for students shall maintain liability insurance coverage for all participating students. If an employer elects to provide workers' compensation insurance coverage to a participating student pursuant to subdivision (a)(2), then the LEA or state institution of higher education shall maintain liability insurance coverage to compensate the participating student for any injury that is not covered under the Workers' Compensation Law. (c) For purposes of this section, an employer shall not be prohibited from employing a student who is under the age of eighteen (18); provided, that the employer is in compliance with state and federal law.	1/1/19 for the section listed
Tennessee	SB 1967	**SB 1967** adds new ***Chapter 10*** to ***Title 50*** **Employer and Employee** of the Tennessee Code as follows: **50-10-101.** As used in this chapter: (1) "Marketplace contractor" means any individual, corporation, partnership, sole proprietorship, or other business entity that: (A) Enters into an agreement with a marketplace platform to use the platform's online-enabled application, software, website, or system to receive connections to third-party individuals or entities seeking services in this state; and (B) In return for compensation from the third-party or marketplace platform, offers or provides services to the third-party individuals or entities upon being given an assignment or connection through the marketplace platform's online-enabled application, software, website, or system; and (2) "Marketplace platform" means a corporation, partnership, sole proprietorship, or other business entity operating in this state that: (A) Offers an online-enabled application, software, website, or system that enables the provision of services by marketplace contractors to third-party individuals or entities seeking services; and (B) Neither directly nor through any related party derives any benefit from work performed by marketplace contractors other than a subscription or use fee for placing marketplace contractors in assignments or otherwise providing connections. **50-10-102.** (a) A marketplace contractor is an independent contractor and not an employee of the marketplace platform for all purposes under state and local laws, rules, ordinances, and resolutions if the following conditions are set forth in a written agreement between the marketplace platform and the marketplace contractor:	7/1/18

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		(1) The marketplace platform and marketplace contractor agree in writing that the contractor is an independent contractor with respect to the marketplace platform; (2) The marketplace platform does not unilaterally prescribe specific hours during which the marketplace contractor must be available to accept service requests from third-party individuals or entities. If a marketplace contractor posts the contractor's voluntary availability to provide services, the posting does not constitute a prescription of hours for purposes of this subdivision (a)(2); (3) The marketplace platform does not prohibit the marketplace contractor from using any online-enabled application, software, website, or system offered by other marketplace platforms; (4) The marketplace contractor may, at its discretion, enlist the help of an assistant to complete the services, and the marketplace platform may require the assistant to complete the marketplace platform's standard registration and vetting process. If the marketplace contractor enlists the help of an assistant, the marketplace contractor, not the marketplace platform, is responsible for paying the assistant; (5) The marketplace platform does not restrict the marketplace contractor from engaging in any other occupation or business; (6) The marketplace platform does not require marketplace contractors to use specific supplies or equipment; (7) The marketplace platform does not control the means and methods for the services performed by a marketplace contractor by requiring the marketplace contractor to follow specified instructions governing how to perform the services. However, the marketplace platform may require that the quality of the services provided by the marketplace contractor meets specific standards and requirements; (8) The agreement or contract between the marketplace contractor and the marketplace platform may be terminated by either the marketplace contractor or the marketplace platform with or without cause; (9) The marketplace platform provides no medical or other insurance benefits to the marketplace contractor, and the marketplace contractor is responsible for paying taxes on all income derived as a result of services performed to third parties from the assignments or connections received from the marketplace platform; and (10) All, or substantially all, payment to the marketplace contractor is based on performance of services to third parties who have engaged the services of the marketplace contractor through the marketplace platform. (b) This section does not apply to any service that is the type of service identified in 26 U.S.C. § 3306(c)(7) or (c)(8). **50-10-103.** Nothing in this chapter applies to: (1) A transportation network company, as defined in § 65-15-301; or (2) A construction services provider, as defined in § 50-6-901.	
Tennessee	SB 2141	**SB 2141** amends ***section 50-6-106*** of the Tennessee Workers' Compensation Law as follows: **50-6-106. Employments not covered.** This chapter shall not apply to: …	4/2/18

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		(4) Farm or agricultural laborers and employers of those laborers~~;~~. Employers of farm or agricultural laborers may accept this chapter by purchasing a workers' compensation insurance policy, and may at any time withdraw that acceptance by canceling or not renewing the policy and providing notice to the employees; …	
Utah	HB 288	**HB 288** adds new ***section 34A-2-114. Unlawful interference—Penalties*** to the Utah Workers Compensation Act as follows: **34A-2-114. Unlawful interference—Penalties.** (1) An employer may not knowingly or intentionally: (a) impede or diminish an employee's efforts to make a claim or receive workers' compensation benefits under this chapter or Chapter 3, Utah Occupational Disease Act; or (b) intimidate, coerce, or harass an employee with the intent of preventing the employee from making a claim or receiving workers' compensation benefits under this chapter or Chapter 3, Utah Occupational Disease Act. (2) An employer may not suspend, discharge, discipline, threaten to discharge or discipline, or otherwise retaliate against an employee solely because the employee: (a) claims or attempts to claim workers' compensation benefits under this chapter or Chapter 3, Utah Occupational Disease Act; (b) reports an employer's noncompliance with a provision of this chapter or Chapter 3, Utah Occupational Disease Act; or (c) testifies or intends to testify in a workers' compensation proceeding. (3) In accordance with Title 63G, Chapter 4, Administrative Procedures Act, the division may impose a fine of up to $5,000 against an employer for each violation of Subsection (1) or (2). (4) The division shall deposit any money collected under this section into the Uninsured Employers' Fund created in Section 34A-2-704. (5) This section does not affect the rights or obligations of an employee or employer under common law.	5/7/18
Utah	SB 40	**SB 40** amends *sections* ***34A-2-410. Temporary disability—Amount of payments—State average weekly wage defined, 34A-2-411. Temporary partial disability—Amount of payments, 34A-2-412. Permanent partial disability—Scale of payments***, and ***34A-2-413. Permanent total disability—Amount of payments—Rehabilitation.*** of the Utah Workers Compensation Act as follows: **34A-2-410. Temporary disability—Amount of payments—State average weekly wage defined**. (1) (a) Subject to Subsections (1)(b) and (5), in case of temporary disability, so long as the disability is total, the employee shall receive 66-2/3% of that employee's average weekly wages at the time of the injury but: (i) not more than a maximum of 100% of the state average weekly wage at the time of the injury per week; and (ii) (A) subject to Subsections (1)(a)(ii)(B) and (C), not less than a minimum of $45 per week plus: (I) ~~$5~~ $20 for a dependent spouse; and (II) ~~$5~~ $20 for each dependent child under the age of 18 years, up to a maximum of four dependent children; … **34A-2-411. Temporary partial disability—Amount of payments.**	7/1/18

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		(1) If the injury causes temporary partial disability for work, the employee shall receive weekly compensation equal to: (a) 66-2/3% of the difference between the employee's average weekly wages before the accident and the weekly wages the employee is able to earn after the accident, but not more than 100% of the state average weekly wage at the time of injury; plus (b) $~~5~~ $20 for a dependent spouse and $~~5~~ $20 for each dependent child under the age of 18 years, up to a maximum of four such dependent children, but only up to a total weekly compensation that does not exceed 100% of the state average weekly wage at the time of injury. … **34A-2-412. Permanent partial disability—Scale of payments.** (1) An employee who sustained a permanent impairment as a result of an industrial accident and who files an application for hearing under Section 34A-2-417 may receive a permanent partial disability award from the commission. (2) Weekly payments may not in any case continue after the disability ends, or the death of the injured person. (3) (a) In the case of the injuries described in Subsections (4) through (6), the compensation shall be 66-2/3% of that employee's average weekly wages at the time of the injury, but not more than a maximum of 66-2/3% of the state average weekly wage at the time of the injury per week and not less than a minimum of $45 per week plus $~~5~~ $20 for a dependent spouse and ~~$5~~ $20 for each dependent child under the age of 18 years, up to a maximum of four dependent children, but not to exceed 66-2/3% of the state average weekly wage at the time of the injury per week. (b) The compensation determined under Subsection (3)(a) shall be: (i) paid in routine pay periods not to exceed four weeks for the number of weeks provided for in this section; and (ii) in addition to the compensation provided for temporary total disability and temporary partial disability. … **34A-2-413. Permanent total disability—Amount of payments—Rehabilitation.** … (2) For permanent total disability compensation during the initial 312-week entitlement, compensation is 66-2/3% of the employee's average weekly wage at the time of the injury, limited as follows: (a) compensation per week may not be more than 85% of the state average weekly wage at the time of the injury; (b) (i) subject to Subsection (2)(b)(ii), compensation per week may not be less than the sum of $45 per week and: (A) ~~$5~~ $20 for a dependent spouse; and (B) ~~$5~~ $20 for each dependent child under the age of 18 years, up to a maximum of four dependent minor children; and (ii) the amount calculated under Subsection (2)(b)(i) may not exceed: (A) the maximum established in Subsection (2)(a); or (B) the average weekly wage of the employee at the time of the injury; and (c) after the initial 312 weeks, the minimum weekly compensation rate under Subsection (2)(b) is 36% of the current state average weekly wage, rounded to the nearest dollar. …	

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Utah	SB 64	**SB 64** amends ***sections 34A-2-107***, ***34A-2-407***, and ***34A-2-705*** of the Utah Workers Compensation Act as follows: **34A-2-107. Appointment of workers' compensation advisory council—Composition—Terms of members—Duties—Compensation.** (1) The commissioner shall appoint a workers' compensation advisory council composed of: … (b) the following nonvoting members: … (iv) the Utah insurance commissioner or the insurance commissioner's designee; ~~and~~ (v) the commissioner or the commissioner's designee~~.~~; and (vi) a representative of hospitals. … ~~(7) The council shall study how hospital costs may be reduced for purposes of medical benefits for workers' compensation. By no later than November 30, 2017, the council shall submit, in accordance with Section 68-3-14, a written report to the Business and Labor Interim Committee containing the council's recommendations.~~ (7) (a) The council shall: (i) study how to reduce hospital costs for purposes of medical benefits for workers' compensation; (ii) study hospital billing and payment trends in the state; (iii) study hospital fee schedules used in other states; and (iv) collect information from third-party hospital bill review companies in the state or region, to identify an average reimbursement rate that represents the approximate rate at which a workers' compensation insurance carrier or self-insured employer should expect to reimburse a hospital for billed hospital fees for covered medical services in the state. (b) In accordance with Section 68-3-14, the council shall submit a written report to the Business and Labor Interim Committee no later than September 1, 2019, 2020, and 2021. Each written report shall include: (i) recommendations on how to reduce hospital costs for purposes of medical benefits for workers' compensation; (ii) aggregate data on hospital billing and payment trends in the state; (iii) the results of the council's study of hospital fee schedules from other states; and (iv) the approximate rate at which a workers' compensation insurance carrier or self-insured employer should expect to reimburse a hospital for billed hospital fees for covered medical services, calculated in accordance with Subsection (7)(a)(iv). (c) For each report described in Subsection (7)(b), the commission may contract with a third-party expert to assist with the council's duties described in Subsections (7)(a) and (b). … **34A-2-407. Reporting of industrial injuries—Regulation of health care providers.** … (11) (a) As used in this Subsection (11): …	5/7/18

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		(b) Subject to Subsection (11)(d), a workers' compensation insurance carrier or self-insured employer may contract, either in writing or by mutual oral agreement, with a hospital to establish reimbursement rates. (c) Subject to Subsection (11)(d), for the time period beginning on May ~~10, 2016~~ 8, 2018, and ending on July 1, ~~2018~~ 2021, a workers' compensation insurance carrier or self-insured employer that is reimbursing a hospital ~~that has not entered into a contractdescribed in Subsection (11)(b) shall reimburse the hospital~~ for covered medical services ~~at 85% of the billed hospital fees for the covered medical services.~~ shall reimburse the hospital: (i) in accordance with a contract described in Subsection (11)(b); or (ii) (A) if the hospital is located in a county of the first, second, or third class, as classified in Section 17-50-501, at 75% of the billed hospital fees for the covered medical services~~.~~; or (B) if the hospital is located in a county of the fourth, fifth, or sixth class, as classified in Section 17-50-501, at 85% of the billed hospital fees for the covered medical services. … **34A-2-705. Industrial Accident Restricted Account.** … (4) (a) From money appropriated by the Legislature from the account to the commission and subject to the requirements of this section, the commission may fund: (i) the activities of the Division of Industrial Accidents described in Section 34A-1-202; (ii) the activities of the Division of Adjudication described in Section 34A-1-202; ~~and~~ (iii) the activities of the commission described in Section 34A-2-1005~~.~~; and (iv) the activities of the commission described in Subsection 34A-2-107(7)(c), up to $50,000 for each of the three reports described in Subsection 34A-2-107(7)(b). …	
Utah	SB 75	**SB 75** amends various sections of the Utah Workers' Compensation Act as follows: **34A-1-102. Definitions.** Unless otherwise specified, as used in this title: (1) "Certified mail" means a method of mailing by any carrier that is accompanied by proof of delivery. ~~(1)~~ (2) "Commission" means the Labor Commission created in Section 34A-1-103. ~~(2)~~ (3) "Commissioner" means the commissioner of the commission appointed under Section 34A-1-201. **34A-2-206. Furnishing information to division—Employers' annual report—Rights of division—Examination of employers under oath—Penalties.** … (4) (a) The division may seek a penalty of not to exceed $500 for each offense to be recovered in a civil action brought by the commission or the division on behalf of the commission against an employer who:	5/7/18

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		(i) within a reasonable time to be fixed by the division and after the receipt of written notice signed by the director or the director's designee specifying the information demanded and served by certified mail or personal service, refuses to furnish to the division: (A) the annual statement required by this section; or (B) other information as may be required by the division under this section; or (ii) willfully furnishes a false or untrue statement. (b) All penalties collected under Subsection (4)(a) shall be paid into the Employers' Reinsurance Fund created in Section 34A-2-702. **34A-2-209. Employer's penalty for violation—Notice of noncompliance—Proof required—Admissible evidence—Criminal prosecution.** (1) (a) (i) An employer who fails to comply, and every officer of a corporation or association that fails to comply, with Section 34A-2-201 is guilty of a class B misdemeanor. (ii) Each day's failure to comply with Subsection (1)(a)(i) is a separate offense. (b) If the division sends written notice of noncompliance by certified mail or personal service to the last-known address of an employer, a corporation, or an officer of a corporation or association, and the employer, corporation, or officer does not within 10 days of the day on which the notice is delivered provide to the division proof of compliance, the notice and failure to provide proof constitutes prima facie evidence that the employer, corporation, or officer is in violation of this section. (2) (a) If the division has reason to believe that an employer is conducting business without securing the payment of compensation in a manner provided in Section 34A-2-201, the division may give notice of noncompliance by certified mail or personal service to the following at the last-known address of the following: … **34A-2-211. Notice of noncompliance to employer—Enforcement power of division—Penalty.** (1) (a) In addition to the remedies ~~specified~~ described in Section 34A-2-210, if the division has reason to believe that an employer is conducting business without securing the payment of benefits in ~~a manner provided in~~ accordance with Section 34A-2-201, the division ~~may give that employer~~ shall deliver written notice of the noncompliance to the employer by certified mail or personal service to the employer's last-known address ~~of the employer.~~ (b) If the employer does not ~~remedy the default~~ demonstrate compliance with Section 34A-2-201 to the division within 15 days after the day on which the notice is delivered, the division ~~may~~ shall issue an order requiring the employer to appear before the division and show cause why the employer should not be ordered to comply with Section 34A-2-201. (c) If the division finds that an employer has failed to ~~provide for the payment of benefits in a manner provided in~~ comply with Section 34A-2-201, the division ~~may~~ shall require the employer to comply with Section 34A-2-201. (2) (a) ~~Notwithstanding Subsection (1)~~ Except as provided in Subsection (2)(d), after the division makes a finding of noncompliance described in Subsection (1)(c), the division ~~may~~ shall, in accordance with Title 63G, Chapter 4, Administrative Procedures Act, and this Subsection (2), impose a penalty against the employer ~~under this Subsection (2):~~ . ~~(i) subject to Title 63G, Chapter 4, Administrative Procedures Act; and~~	

JURISDICTION	BILL	SUMMARY	EFFECTIVE
		~~(ii) if the division believes that an employer of one or more employees is conducting business without securing the payment of benefits in a manner provided in Section 34A-2-201~~. (b) ~~The~~ Except as provided in Subsection (2)(e), a penalty imposed under Subsection (2)(a) shall be the greater of: (i) $1,000; or (ii) three times the amount of the premium the employer would have paid for workers' compensation insurance based on the rate filing of the workers' compensation insurance carrier that provides workers' compensation insurance under Section 31A-22-1001, during the period of noncompliance. (c) For purposes of Subsection (2)(b)(ii): (i) the premium is calculated by applying rates and rate multipliers to the payroll basis under Subsection (2)(c)(ii), using the highest rated employee class code applicable to the employer's operations; and (ii) the payroll basis is 150% of the state's average weekly wage multiplied by the highest number of workers employed by the employer during the period of the employer's noncompliance multiplied by the number of weeks of the employer's noncompliance up to a maximum of 156 weeks. (d) The division may waive the penalty described in this Subsection (2) if: (i) (A) the finding of noncompliance is the first finding of noncompliance against the employer under this section; (B) the period of noncompliance was less than 180 days; (C) the employer is currently in compliance with Section 34A-2-201; and (D) no injury was reported to the division in accordance with Section 34A-2-407 during the period of noncompliance; or (ii) (A) the employer is a corporation; (B) each employee of the corporation is an officer of the corporation; and (C) the employer is currently in compliance with Section 34A-2-201. (e) (i) The division may reduce the penalty described in this Subsection (2) if: (A) the finding of noncompliance is the first finding of noncompliance against the employer under this section; (B) the employer is currently in compliance with Section 34A-2-201; (C) no injury was reported to the division in accordance with Section 34A-2-407 during the period of noncompliance; and (D) upon request from the division, the employer submits to the division the employer's payroll records related to the period of noncompliance. (ii) (A) The reduced penalty shall be an amount equal to the premium the employer would have paid for workers' compensation insurance based on the rate filing of the workers' compensation insurance carrier that provides workers' compensation insurance under Section 31A-22-1001, during the period of noncompliance. (B) The division shall calculate the amount described in Subsection (2)(e)(ii)(A) using the payroll records described in Subsection (2)(e)(i)(D). (f) The division may reinstate the full penalty amount against an employer if the Uninsured Employers' Fund is ordered to pay benefits for an injury that occurred but was not reported during the period of noncompliance for which the division waived or assessed a reduced penalty under this subsection. … (5) An administrative action issued by the division under this section shall: (a) be in writing;	

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		(b) be sent by certified mail or personal service to the last-known address of the employer; (c) state the findings and administrative action of the division; and (d) specify its effective date, which may be: (i) immediate; or (ii) at a later date. … **34A-6-303. Enforcement procedures—Notification to employer of proposed assessment—Notification to employer of failure to correct violation—Contest by employer of citation or proposed assessment—Procedure.** (1) (a) If the division issues a citation under Subsection 34A-6-302(1), it shall within a reasonable time after inspection or investigation, notify the employer by certified mail or personal service of the assessment, if any, proposed to be assessed under Section 34A-6-307 and that the employer has 30 days to notify the Division of Adjudication that the employer intends to contest the citation, abatement, or proposed assessment. (b) If, within 30 days from the receipt of the notice issued by the division, the employer fails to notify the Division of Adjudication that the employer intends to contest the citation, abatement, or proposed assessment, and no notice is filed by any employee or representative of employees under Subsection (3) within 30 days, the citation, abatement, and assessment, as proposed, is final and not subject to review by any court or agency. (2) (a) If the division has reason to believe that an employer has failed to correct a violation for which a citation has been issued within the time period permitted, the division shall notify the employer by certified mail or personal service: (i) of the failure; (ii) of the assessment proposed to be assessed under Section 34A-6-307; and (iii) that the employer has 30 days to notify the Division of Adjudication that the employer intends to contest the division's notification or the proposed assessment. …	
Utah	SB 92	**SB 92** repeals and reenacts ***section 34A-1-309. Attorney fees***, and amends **sections *34A-2-413. Permanent total disability—Amount of payments—Rehabilitation***, and ***34A-2-801. Initiating adjudicative proceedings—Procedure for review of administrative action*** of the Utah Labor Code as follows: **34A-1-309. Attorney fees.** ~~(1) In a case before the commission in which an attorney is employed, the commission has full power to regulate and fix the fees of the attorney.~~ ~~(2) In accordance with Title 63G, Chapter 4, Administrative Procedures Act, an attorney may file an application for hearing with the Division of Adjudication to obtain an award of attorney fees as authorized by this section and commission rules.~~ ~~(3) (a) The commission may award reasonable attorney fees on a contingency basis when there is generated:~~ ~~(i) disability or death benefits; or~~ ~~(ii) interest on disability or death benefits.~~ ~~(b) An employer or its insurance carrier shall pay attorney fees awarded under Subsection (3)(a) out of the award of:~~ ~~(i) disability or death benefits; or~~	5/7/18

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		~~(ii) interest on disability or death benefits.~~ ~~(4) (a) In addition to the attorney fees ordered under Subsection (3), the commission may award reasonable attorney fees on a contingency basis for medical benefits ordered paid in the same percentages for an award under Subsection (3) provided for in rule made by the commission in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, if:~~ ~~(i) medical benefits are not approved by:~~ ~~(A) the employer or its insurance carrier; or~~ ~~(B) the Uninsured Employer's Fund created in Section 34A-2-704;~~ ~~(ii) after the employee employs an attorney, medical benefits are paid or ordered to be paid;~~ ~~(iii) the commission's informal dispute resolution mechanisms are reasonably used by the parties before adjudication; and~~ ~~(iv) the sum of the following at issue in the adjudication of the medical benefit claim is less than $4,000:~~ ~~(A) disability or death benefits; and~~ ~~(B) interest on disability or death benefits.~~ ~~(b) An employer or its insurance carrier shall pay attorney fees awarded under Subsection (4)(a) in addition to the payment of medical benefits ordered.~~ For an adjudication of a workers' compensation claim where only medical benefits are at issue, reasonable attorney fees may be awarded in accordance with and to the extent allowed by rule adopted by the Utah Supreme Court and implemented by the Labor Commission. **34A-2-413. Permanent total disability—Amount of payments—Rehabilitation** … (10)…~~(g) In accordance with Section 34A-1-309, the administrative law judge may award reasonable attorney fees to an attorney retained by an employee to represent the employee's interests with respect to reexamination of the permanent total disability finding, except if the employee does not prevail, the attorney fees shall be set at $1,000. The attorney fees awarded shall be paid by the employer or the employer's insurance carrier in addition to the permanent total disability compensation benefits due.~~ ~~(h)~~ (g) During the period of reexamination or adjudication, if the employee fully cooperates, each insurer, self-insured employer, or the Employers' Reinsurance Fund shall continue to pay the permanent total disability compensation benefits due the employee. (11) If any provision of this section, or the application of any provision to any person or circumstance, is held invalid, the remainder of this section is given effect without the invalid provision or application. **34A-2-801. Initiating adjudicative proceedings—Procedure for review of administrative action.** (1)…(c) A person providing goods or services described in Subsections 34A-2-407(12) and 34A-3-108(13) may file an application for hearing in accordance with Section 34A-2-407 or 34A-3-108. (d) An attorney may file an application for hearing in accordance with Section 34A-1-309. (2) (a) Unless all parties agree to the assignment in writing, the Division of Adjudication may not assign the same administrative law judge to hear a claim under this section by an injured employee if the administrative law judge previously heard a claim by the same injured employee for a different injury or occupational disease.	

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		…	
Vermont	HB 731	**HB 731** amends various sections of the Vermont Labor Code, including, but not limited to the following: ***Section 1*** **§ 710. Unlawful discrimination** (a) No person, firm, or corporation shall refuse to employ any applicant for employment because ~~such~~ the applicant asserted a claim for workers' compensation benefits under this chapter or under the law of any state or of the United States. Nothing in this section shall require a person to employ an applicant who does not meet the qualifications of the position sought. (b) No person shall discharge or discriminate against an employee from employment because such the employee asserted or attempted to assert a claim for benefits under this chapter or under the law of any state or of the United States. ... (d) An employer shall not retaliate or take any other negative action against an individual because the employer knows or suspects that the individual has filed a complaint ~~with the Department or other authority~~, or reported a violation of this chapter, or has testified, assisted, or cooperated in any manner with the Department or other appropriate governmental agency or department in an investigation of misclassification, discrimination, or other violation of this chapter. (e) The Attorney General or a State's Attorney may enforce the provisions of this section by restraining prohibited acts, seeking civil penalties, obtaining assurances of discontinuance, and conducting civil investigations in accordance with the procedures established in 9 V.S.A. §§ 2458-2461 as though ~~discrimination under~~ a violation of this section were an unfair act in commerce. (f) The provisions against retaliation in subdivision 495(a)(8) of this title and the penalty and enforcement provisions of section 495b of this title shall apply to this ~~subchapter~~ section. In addition, **HB 731** includes the following language: ***Section 2*** **Workers' compensation rate of contribution** For fiscal year 2019, 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 remain at the rate of 1.4 percent. 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. ***Section 3*** **Potential delegation of rate setting authority; report** On or before January 15, 2019, the Commissioner of Labor shall submit a written report to the House Committees on Commerce and Economic Development and on Ways and Means and the Senate Committees on Economic Development, Housing and General Affairs and on Finance regarding the potential for delegating the authority to set the Workers' Compensation Administration Fund rate of contribution for the direct calendar year premium for workers' compensation insurance to the Commissioner of Labor. In particular, the report shall:	7/1/18, for sections 1, 2, and 3; and an effective date of 5/21/18 for section 4

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		(1) describe how the Department calculates the rate of contribution that it annually proposes to the General Assembly pursuant to 21 V.S.A. § 711(b); (2) identify any advantages and disadvantages of the General Assembly's delegating to the Commissioner of Labor authority to establish annually the rate of contribution for the direct calendar year premium for workers' compensation insurance; and (3) identify any legislative, regulatory, and administrative changes that would need to be made in order to delegate to the Commissioner the authority to establish annually the rate of contribution for the direct calendar year premium for workers' compensation insurance. ***Section 4*** 2014 Acts and Resolves No. 199, Sec. 54a is amended to read: Sec. 54a. REPEAL 21 V.S.A. § 643a shall be repealed on July 1, ~~2018~~ 2023.	
Virginia	HB 82	**HB 82** repeals an enactment clause in ***section 65.2-1201. Financing; tax*** of the Virginia Workers' Compensation Act that provides that the maximum tax rate that may be assessed on insurance carriers or self-insured employers for the purpose of funding workers compensation benefits that are awarded against uninsured employers from the Uninsured Employer's Fund will revert from 0.5% to 0.25% on July 1, 2018. Repealing the enactment will maintain the maximum rate at its current level of 0.5%.	7/1/18
Virginia	HB 531	**HB 531** amends and reenacts ***section 65.2-804. Evidence of compliance with title; notices of cancellation of insurance*** of the Virginia Workers' Compensation Act as follows: **§ 65.2-804. Evidence of compliance with title; notices of cancellation of insurance.** A1. Each employer subject to this title shall file with the Workers' Compensation Commission, in form prescribed by it, annually or as often as may be necessary, evidence of his compliance with the provisions of § 65.2-801 and all others relating thereto; however, if the employer secures his liability under this title pursuant to subdivision A 1 of § 65.2-801 then the insurance carrier shall make a filing on behalf of the employer, and such filing shall be made electronically in the form as prescribed and to the agent as designated by the Commission, within 30 days of the inception of the policy. Evidence of an employer's compliance with the provisions of subdivision A 1 of § 65.2-801 shall be deemed to satisfy such provisions if it includes the name and address of the insured, the insured's federal employer identification number, his policy number, dates of insurance coverage, the name and address of his insurer, and the insurer's identification number. ~~Proof of coverage information filed with the Commission by an insurance carrier or rate service organization on behalf of an employer shall in no event be aggregated by the Commission with the proof of coverage information filed by or on behalf of other employers.~~ Every employer who has complied with the foregoing provision and has subsequently cancelled his insurance or his membership in a licensed group self-insurance association shall immediately notify the Workers' Compensation Commission of such cancellation, the date thereof and the reasons therefor. Every insurance carrier or group self-insurance association shall in like manner notify the Workers' Compensation Commission immediately upon the cancellation of any policy issued by it or any membership agreement, whichever is applicable, under the provisions of this title, except that a carrier or group self-insurance association need not set forth its reasons for cancellation unless requested by the Workers' Compensation Commission. …	7/1/18

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

JURISDICTION	BILL	SUMMARY	EFFECTIVE
Virginia	HB 558	**HB 558** amends and reenacts ***sections 65.2-605. Liability of employer for medical services ordered by Commission; fee schedules for medical services; malpractice; assistants-at-surgery; coding*** and **65.2-605.1. Prompt payment; limitation on claims** of the Virginia Workers' Compensation Act as follows: **§ 65.2-605. Liability of employer for medical services ordered by Commission; fee schedules for medical services; malpractice; assistants-at-surgery; coding.** A. As used in this section, unless the context requires a different meaning: … "Medical community" means one of the following six regions of the Commonwealth: 1. Northern region, consisting of the area for which three-digit ZIP code prefixes 201 and 220 through 223 have been assigned by the U.S. Postal Service. 2. Northwest region, consisting of the area for which three-digit ZIP code prefixes 224 through 229 have been assigned by the U.S. Postal Service. 3. Central region, consisting of the area for which three-digit ZIP code prefixes 230, 231, 232, 238, and 239 have been assigned by the U.S. Postal Service. 4. Eastern region, consisting of the area for which three-digit ZIP code prefixes 233 through 237 have been assigned by the U.S. Postal Service. 5. Near Southwest region, consisting of the area for which three-digit ZIP code prefixes 240, 241, 244, and 245 have been assigned by the U.S. Postal Service. 6. Far Southwest region, consisting of the area for which three-digit ZIP code prefixes 242, 243, and 246 have been assigned by the U.S. Postal Service. The applicable community for providers of medical services rendered in the Commonwealth shall be determined by the zip code of the location where the services were rendered. The applicable community for providers of medical services rendered outside of the Commonwealth shall be determined by the zip code of the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the zip code of the location where the Commission hearing regarding a dispute concerning the services would be conducted. … B. The pecuniary liability of the employer for a: 1. Medical, surgical, and hospital service herein required when ordered by the Commission that is provided to an injured person prior to the transition date, regardless of the date of injury, shall be limited absent a contract providing otherwise, to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person. As used in this subdivision, "same community" for providers of medical services rendered outside of the Commonwealth shall be deemed to be the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the location where the Commission hearing regarding the dispute is conducted; … ***§ 65.2-605.1. Prompt payment; limitation on claims.*** … G. ~~Any health care provider located outside of the Commonwealth who provides health care services under the Act to a claimant shall be reimbursed as provided in this section, and the "same community," as used in subdivision B 1 of § 65.2-605 for treatment provided prior to the~~	7/1/18

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		~~transition date as defined in subsection A of § 65.2-605, shall be deemed to be the principal place of business of the employer if located in the Commonwealth or, if no such location exists, then the location where the Commission hearing regarding the dispute is conducted.~~ ~~H.~~ The Commission, by January 1, 2016, shall establish a schedule pursuant to which employers, employers' workers' compensation insurance carriers, and providers of workers' compensation medical services shall be required, by a date determined by the Commission that is no earlier than July 1, 2016, and no later than December 31, 2018, to adopt and implement infrastructure under which (i) providers of workers' compensation medical services (providers) shall submit their billing, claims, case management, health records, and all supporting documentation electronically to employers or employers' workers' compensation insurance carriers, as applicable (payers) and (ii) payers shall return actual payment, claim status, and remittance information electronically to providers that submit their billing and required supporting documentation electronically. The Commission shall establish standards and methods for such electronic submissions and transactions that are consistent with International Association of Industrial Accident Boards and Commission Medical Billing and Payment guidelines. The Commission shall determine the date by which payers and providers shall be required to adopt and implement the infrastructure, which determinations shall be based on the volume and complexity of workers' compensation cases in which the payer or provider is involved, the resources of the payer or provider, and such other criteria as the Commission determines to be appropriate.	
West Virginia	HB 4628	**HB 4628** amends and reenacts ***section 23-2C-3*** of the Code of West Virginia as follows: **§23-2C-3. Creation of employers' mutual insurance company as successor organization of the West Virginia Workers' Compensation Commission.** … (f)(3)(B) By May 1 each year, the self-insured employer community shall be assessed a cumulative total of $9 million. The methodology for the assessment shall be fair and equitable and determined by exempt legislative rule issued by the Industrial Council. The amount collected pursuant to this subdivision shall be remitted to the Insurance Commissioner for deposit in the Workers' Compensation Debt Reduction Fund created in section five, article two-d of this chapter: *Provided*, That, notwithstanding any provision of this subdivision or any other provision of this code to the contrary, if the budget shortfall, as determined by the state Budget Office as of December 1, 2015, is greater than $100 million, then the Governor may, by Executive Order, redirect deposits of the amount collected pursuant to this subdivision, for any period commencing after February 29, 2016, and ending before July 1, 2016, to the General Revenue Fund, instead of to the fund otherwise mandated in this subdivision, in article two-d, chapter twenty-three of this code or in any other provision of this code: *Provided*, *however*, That, notwithstanding any provision of this subdivision or any other provision of this code to the contrary, the Governor may, by Executive Order, redirect one-half of the deposits of the amount collected pursuant to this subdivision, for any period commencing after June 30, 2016, and ending before July 1, 2017, to the General Revenue Fund, instead of to the funds otherwise mandated in this subdivision, in article two-d, chapter twenty-three of this code or in any other provision of this code, until certification of the Governor to the Legislature that an independent actuary has determined that the unfunded liability of the Old Fund, as defined in chapter twenty-three of this code, has been paid or provided for in its entirety: *Provided further*, That, notwithstanding any provision of this subdivision or any other provision of this code to the contrary, the Governor may, by Executive Order, redirect seventy-five percent of the deposits of the amount collected pursuant to this subdivision, for any period commencing after June 30, 2017, and ending before July 1, 2018, to the General Revenue Fund, instead of to the funds otherwise mandated in this subdivision, in article two-d, chapter twenty-three of this code or in any other provision of this code, until certification of the Governor to the Legislature that an independent actuary has determined that the unfunded liability of the Old Fund, as defined in chapter twenty-three of this code, has been paid or provided for in its entirety: *And provided further*, That,	6/7/18

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		notwithstanding any provision of this subdivision or any other provision of this code to the contrary, seventy-five percent of the deposits of the amount collected pursuant to this subdivision, for any period commencing after June 30, 2018, and ending before January 1, 2019, shall be deposited into the General Revenue Fund instead of to the funds otherwise mandated in this subdivision, in article two-d, chapter twenty-three of this code or in any other provision of this code, until certification of the Governor to the Legislature that an independent actuary has determined that the unfunded liability of the Old Fund, as defined in chapter twenty-three of this code, has been paid or provided for in its entirety. … (h) Notwithstanding any other provisions of this section to the contrary, after December 31, 2018, no surcharges may be assessed under subdivision (3), subsection (f) of this section or subsection (g) of this section. Except as otherwise provided in this subsection, the provisions of subdivision (3), subsection (f) of this section and subsection (g) of this section are terminated and shall be of no force or effect beginning on and after January 1, 2019: *Provided*, that liability for surcharges assessed under subdivision (3), subsection (f) of this section for periods prior to January 1, 2019, shall continue until paid.	
West Virginia	SB 82	**SB 82**, in part, amends ***section 23-4-1*** of the Code of West Virginia as follows: **§23-4-1. To whom compensation fund disbursed; occupational pneumoconiosis and other occupational diseases included in "injury" and "personal injury"; definition of occupational pneumoconiosis and other occupational diseases; rebuttable presumption for cardiovascular injury and disease or pulmonary disease for firefighters.** … (g) No award ~~shall~~ may be made under the provisions of this chapter for any occupational disease contracted prior to July 1, 1949. An employee ~~shall be considered to have~~ has contracted an occupational disease within the meaning of this subsection if the disease or condition has developed to such an extent that it can be diagnosed as an occupational disease. (h) (1) For purposes of this chapter, a rebuttable presumption that a professional firefighter who has developed a cardiovascular or pulmonary disease or sustained a cardiovascular injury or who has developed leukemia, lymphoma, or multiple myeloma arising out of and in the course of employment as a firefighter has received an injury or contracted a disease arising out of and in the course of his or her employment exists if: (A) The person has been actively employed by a fire department as a professional firefighter for a minimum of two years prior to the cardiovascular injury or onset of a cardiovascular or pulmonary disease or death; ~~and~~ (B) the injury or onset of the disease or death occurred within six months of having participated in firefighting or a training or drill exercise which actually involved firefighting; and (C) in the case of the development of leukemia, lymphoma, or multiple myeloma the person has been actively employed by a fire department as a professional firefighter for a minimum of five years in the state prior to the development of leukemia, lymphoma, or multiple myeloma, has not used tobacco products for at least 10 years, and is not over the age of 65 years. When the above conditions are met, it shall be presumed that sufficient notice of the injury, disease, or death has been given and that the injury, disease, or death was not self inflicted. ~~(2) The Insurance Commissioner shall study the effects of the rebuttable presumptions created in this subsection on the premiums charged for workers' compensation for professional municipal firefighters; the probable effects of extending these presumptions to volunteer firefighters; and the overall impact of the risk management programs, wage replacement, premium calculation, the number of hours worked per volunteer, treatment of nonactive or "social" members of a volunteer crew and the feasibility of combining various volunteer departments under a single~~	6/7/18

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		~~policy on the availability and cost of providing workers' compensation coverage to volunteer firefighters. The Insurance Commissioner shall file the report with the Joint Committee on Government and Finance no later than December 1, 2008.~~ (2) The amendments made to this section during the 2018 regular session of the Legislature to include leukemia, lymphoma, or multiple myeloma arising out of and in the course of employment as a firefighter as a rebuttable presumption shall expire on July 1, 2023, unless extended by the Legislature. (i) Claims for occupational disease as defined in §23-4-1(f) of this code, except occupational pneumoconiosis for all workers and pulmonary disease and cardiovascular injury and disease for professional firefighters, shall be processed in like manner as claims for all other personal injuries. ~~(j) On or before January 1, 2004, the Workers' Compensation Commission shall adopt standards for the evaluation of claimants and the determination of a claimant's degree of whole-body medical impairment in claims of carpal tunnel syndrome.~~	
West Virginia	SB 625	**SB 625** amends, in part, ***section 33-3-33*** and adds new ***section 33-3-33b*** to the Code of West Virginia as follows: **§33-3-33. Surcharge on fire and casualty insurance policies to benefit volunteer and part-volunteer fire departments and emergency medical services; Public Employees Insurance Agency and municipal pension plans; special fund created; allocation of proceeds; effective date.** (a) For the purpose of providing additional revenue for volunteer fire departments, part-volunteer fire departments, and emergency medical services providers for operations, equipment, training, and workers' compensation coverage, ~~and certain retired teachers and the teachers retirement reserve fund,~~ there is hereby authorized and imposed on and after July 1, ~~1992~~ 2018, on the policyholder of any fire insurance policy or casualty insurance policy issued by any insurer, authorized or unauthorized, or by any risk retention group, a policy surcharge equal to one percent of the taxable premium for each such policy. ~~After June 30, 2005, the surcharge shall be imposed as specified in subdivisions (2) and (3) of this subsection.~~ For purposes of this section, casualty insurance may not include insurance on the life of a debtor pursuant to, or in connection with, a specific loan or other credit transaction or insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy. The policy surcharge may not be subject to premium taxes, agent commissions, or any other assessment against premiums. ~~(2) After June 30, 2005, through December 31, 2005, for the purpose of providing additional revenue for volunteer fire departments, part-volunteer fire departments and to provide additional revenue to the Public Employees Insurance Agency and municipal pension plans, there is hereby authorized and imposed on and after July 1, 2005, on the policyholder of any fire insurance policy or casualty insurance policy issued by any insurer, authorized or unauthorized, or by any risk retention group, a policy surcharge equal to one percent of the taxable premium for each such policy.~~ ~~(3) After December 31, 2005, for the purpose of providing additional revenue for volunteer fire departments and part-volunteer fire departments, there is hereby authorized and imposed on the policyholder of any fire insurance policy or casualty insurance policy issued by any insurer, authorized or unauthorized, or by any risk retention group, a policy surcharge equal to fifty-five one hundredths of one percent of the taxable premium for each such policy.~~ ~~(4) For purposes of this section, casualty insurance may not include insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction or insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy. The policy surcharge may not be subject to premium taxes, agent commissions or any other assessment against premiums.~~ …	6/8/18

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JURISDICTION	BILL	SUMMARY	EFFECTIVE
		(d)~~(1)~~ All money from the policy surcharge shall be collected by the Commissioner who shall disburse the money received from the surcharge as follows: (1) Fifty-five percent of the moneys received shall be deposited into a special account in the State Treasury, designated the Fire Protection Fund. The net proceeds of this portion of the tax and the interest thereon, after appropriation by the Legislature, shall be distributed quarterly on the first day of the months of January, April, July, and October to each volunteer fire company or department on an equal share basis by the State Treasurer. ~~After June 30, 2005, the money received from the surcharge shall be distributed as specified in subdivisions (2) and (3) of this subsection.~~ ~~(2)(A) After June 30, 2005, through December 31, 2005, all money from the policy surcharge shall be collected by the Commissioner who shall disburse one half of the money received from the surcharge into the Fire Protection Fund for distribution as provided in subdivision (1) of this subsection.~~ ~~(B) The remaining portion of moneys collected shall be transferred into the fund in the state Treasury of the Public Employees Insurance Agency into which are deposited the proportionate shares made by agencies of this state of the Public Employees Insurance Agency costs of those agencies, until November 1, 2005. After the October 31, 2005, through December 31, 2005, the remain portion shall be transferred to the special account in the state Treasury, known as the Municipal Pensions and Protection Fund.~~ (2) Twenty percent of the moneys received shall be deposited into the Volunteer Fire Department Workers' Compensation Subsidy Program, established pursuant to §12-4-14a of this code. (3) Fifteen percent of the moneys received shall be deposited into the Fire Service Equipment and Training Fund, established pursuant to §29-3-5f of this code. (4) Ten percent of the moneys received shall be deposited into the Emergency Medical Services Equipment and Training Fund, established pursuant to §16-4C-24 of this code. ~~(3) After December 31, 2005, all money from the policy surcharge shall be collected by the Commissioner who shall disburse all of the money received from the surcharge into the Fire Protection Fund for distribution as provided in subdivision (1) of this subsection.~~ … **§33-3-33b. Report regarding volunteer firefighter workers' compensation coverage.** (a) The Insurance Commissioner, in consultation with the State Fire Marshal, the State Auditor, the Legislative Auditor, and the Board of Risk and Insurance Management, shall study the feasibility of combining the volunteer fire departments in our state under a single policy for workers' compensation coverage, self-insuring workers' compensation coverage for volunteer fire departments, or other workers' compensation coverage options. Such study shall also include an evaluation of the benefit, necessity, and feasibility of expanding the current scope of workers' compensation coverage for volunteers, including, but not limited to, presumptions for cardiovascular or pulmonary disease, occupational pneumoconiosis, or other occupational disease, as well as a comparison of those proposals to other means of supplementing workers' compensation insurance through secondary insurance policies. (b) On or before July 1, 2019, the Insurance Commissioner shall submit to the Joint Committee on Government Organization a comprehensive report of the review and the Insurance Commissioner's recommendations, substantiated by the findings of the review, and steps that may be taken to meet the needs of and sustain the volunteer fire departments for their workers' compensation coverage.	

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NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.—2018 ENACTED LEGISLATION YEAR TO DATE (AS OF 12/31/18)

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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