STATE OF TENNESSEE

WORKERS' COMPENSATION ADVISORY COUNCIL

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ANALYSES AND COMMENTS
re:
WORKERS' COMPENSATION LEGISLATION
~2007~

PROVIDED TO:
SENATE COMMERCE AND AGRICULTURE COMMITTEE
AND
HOUSE CONSUMER AND EMPLOYEE AFFAIRS COMMITTEE

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March, 2007

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TABLE OF CONTENTS

NUMERICAL INDEX OF SENATE BILLS

NUMERICAL INDEX OF HOUSE BILLS

TABLE OF BILLS - AMENDMENTS EXPECTED or CAPTION BILLS

[Analyses Of These Bills Begin On Page 66.]

At the meeting of the Advisory Council on Friday, March 16, 2007, either a sponsor of the bill or a representative of the interested party who is supporting the bill indicated amendments were expected if the bill was pursued or that the bill was a caption bill. Therefore, the members of the Advisory Council decided it would be best to defer specific comments on the following bills. The Advisory Council requested its Executive Director to include in the report to the Standing Committees the description and analysis of the bills, as currently drafted, for the benefit of those who may be interested in the current bills.

BILLS FOR WHICH AMENDMENT IS EXPECTED - Sen. Ketron & Rep. Mumpower pp. 66 - 78	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
	1745 p. 66	Ketron	1646	Mumpower	>Requires a sole proprietor or partner to file written notice with the Division of Work Comp as to decision to be covered or not covered as an employee >For those in construction industry, they must file election not to be covered by workers comp to be exempt from the law
.	1746 p. 68	Ketron	1642	Mumpower	Changes criteria for determining whether one is employee or independent contractor -conclusive presumption of independent contractor if certain documents are provided; but, maintains statutory criteria if unable to provide the documents
	1748 p. 72	Ketron	1645	Mumpower	Requires sole proprietors and partners to carry workers compensation insurance on themselves

	1749 p, 73	Ketron	1644	Mumpower	Provides principal or general contractor not liable for injuries to sole proprietor or partners who fail to elect to be covered for work comp purposes; requires "certification of noncoverage" from dept which is conclusive proof of noncoverage;
	1747 p. 75	Ketron	1643	Mumpower	Creates "Workers Compensation Insurance Board" to hear appeals of complaints by those "aggrieved" by application of the work comp rating system after first considered by the insurer. Appeals from Board decision go to Commissioner
BILL INDICATED AS "CAPTION BILL" BY TN. HOSPITAL ASSOCIATION REPS - Sen. Burchett & Rep. Overbey pp. 79 - 80	496 p. 79	Burchett	1603	Overbey	Requires Comm'r of Labor/WFD to promulgate rules to establish civil penalty against provider found to have fraudulently billed and collected amount in excess of the medical fee schedule

Senator Ketron was present and discussed the five (5) bills he and Rep. Mumpower are sponsoring:

SB 1745 / HB 1646;
SB 1746 / HB 1642;
SB 1748 / HB 1645;
SB 1749 / HB 1644 ; and
SB 1747 / HB 1643.

Senator Ketron explained the first four bills pertain to the issue of independent contractors and how they are treated for workers' compensation purposes - by the insurance industry, by the courts and by the administrative agencies. Senator Ketron stated the first four bills present four different methods of dealing with the problem. He said he and Rep. Mumpower want to continue working with the interested parties on this issue and, therefore, these four bills will probably be replaced with an amendment to address the problem about which the interested parties can agree.

Senator Ketron stated SB 1747 / HB 1643, which creates a Workers' Compensation Appeals Board, will be amended after an opportunity to meet with the Department of Commerce and Insurance. The members of the Advisory Council agreed the issue of "independent contractors" is a big issue that needs to be addressed. The members directed staff to include the description and analysis of these bills in the report to the Standing Committees with the notation that the Advisory Council will be available to consider any proposed amendment after the sponsors have had an opportunity to meet with the industry and departments to determine the best way to address the problem.

With regard to SB 1747 /HB 1643, the Advisory Council agreed to defer discussion and consideration of the bill until the sponsors have an opportunity to meet with Department of Commerce & Insurance personnel to craft an amendment.

With regard to SB 496(Burchett)/HB1603(Overbey), representatives of the Tennessee Hospital Association stated at the Advisory Council meeting that this bill was filed as a "caption bill".

TABLE OF BILLS REVIEWED BY ADVISORY COUNCIL

(BY SUBJECT MATTER)

NOTE: The description of the bill in the following table is a limited description and does not describe all aspects of the bill.

INSURANCE & INSURANCE RATES pp. 13 - 18	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
	149 p. 13	Southerland	1319	West	Prohibits combining business entities for purposes of determining experience ratings based on percentage of ownership interest or supervisory control.
	1762 p. 15	Kyle	1862	Shepard	Authority of Comm'r Commerce & Ins. to promulgate rules limited to subsection (c) - intent is to make rulemaking authority applicable to only work comp instead of all property & casualty insurance.
	2171 p. 16	Kyle	1813	McDonald	Eliminates repeal of advisory prospective loss costs
	2241 p. 17	Kyle	2322	Odom	Includes any filing affecting rates mandated by federal law in definition of "advisory prospective loss costs"; requires these filings to be referred to WCAC
COVERAGE pp. 19 - 28	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
	253 p. 19	Haynes	73	Turner, M	Prohibits "illegal" aliens from receipt of workers' compensation benefits
	366 p. 24	Southerland	655	Hawk	Prohibits "illegal" aliens from receipt of workers' compensation benefits

MEDICAL RECORDS pp. 29 - 30	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
	313 p. 29	Finney, R	247	Hensley	Increases charge for medical report from $10.00 to $20.00
	1474 p. 30	McNally	1518	Hackworth	Adds "other approved provider" as entities protected from liability for producing medical records without consent of employee/patient
MEDICAL FEE SCHEDULE pp. 31 - 33	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
	445 p. 31	Burchett	454	Hackworth	Prohibits negotiated commercial health insurance contracts to be applied in workers' compensation.
WORKERS' COMPENSATION BENEFITS pp. 34 -52	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
	322 p. 34	Haynes	1818	Hackworth	Permits Comm'r of Labor/WFD or designee to order work comp benefits paid equally by 2 carriers (self-insureds) when claim is compensable and there is dispute as to had coverage
	425 p. 37	Crutchfield	1822	Buck	Prohibits social security offset from applying to death benefits; requires copies of all information available to specialist related to request for assistance to be provided to the parties

	849 p. 39	Kilby	1073	Turner, M	Beryllium - Makes occupational diseases covered by 2000 federal act [parts (B)(D)(E)] a compensable state work comp claim (all presumptions, etc of federal act are to be used in state claim); >positive determination in federal case to be conclusive proof of causation in state claim; >exempts second injury fund, state employees and municipal and county employees (if accepted work comp law) >excludes medical benefits >provides claims not to be included in experience rating for employer
	857 p. 41	Kilby	643	Turner, M	Beryllium - same as SB849, except part (D) not included [part (D) no longer in the Federal Act]
	1044 p. 43	Finney, L	1081	Turner, M	Changes definition of maximum total benefit to be 400 times 100% of state's average weekly wage except in instances of TTD and PTD
	1672 p. 45	Ramsey	278	Mumpower	Deletes reference to subsection (13) of 50-6-102 as definition of "maximum total benefit"
	1775 p. 46	Southerland	2128	Fitzhugh	Multiplier caps applicability to be measured by whether employee returned to work at any job at same/equal pay

	1797 p. 49	Southerland	2129	Fitzhugh	>Changes 2004 act language related to inability of employee to settle issue of future medicals-will permit court or dept to permit settlement if "in best interests of all parties to do so"; >Adds definition of "repetitive injury" - >For repetitive injuries burden of proof changed to clear and convincing evidence instead of preponderance of evidence
LABOR & WFD SPECIALISTS, MIRR PROGRAM pp. 53 - 58	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
	1477 p. 53	Tracy	1568	Curtiss	Prohibits additional information to be considered by administrator or designee when specialist order is "reconsidered"; requires administrator/designee to determine if specialist's order was correct and, if not, to issue order stating correct resolution; prohibits remand of matter to specialist; provides any party can re-submit request for assistance based on new or additional information
	1805 p. 55	Tracy	1569	Curtiss	>Prohibits specialist from ordering temporary or medical benefits unless order is issued determining injury to be compensable or that benefits are required by prior court order or settlement >Amends statute regarding MIRR >Requires department to advise employee of the right to request MIRR >Requires Commissioner of Labor/WFD to amend current rules

LABOR & WFD BILL	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
pp. 59 - 60	2259 p. 59	Kyle	2397	Turner, M.; Odom	Makes certain technical corrections to remove outdated references; changes law to permit specialist to approve attorney fees above the current statutory maximum for dept. approval - makes 20% fee deemed "reasonable".
WORKERS' COMPENSATION ADVISORY COUNCIL	**SB#**	**Sponsor**	**HB#**	**Sponsor**	**DESCRIPTION**
pp. 61 - 65	446 p. 61	Burchett	1635	Ferguson	Requires one employer representative on Advisory Council to be representative from self-insured pools
	1043 p. 62	Finney, L	595	Turner, M	Makes chairs (or co-chairs) of standing committees ex officio members of Advisory Council; deletes chair/co-chair of Joint Committee as ex officio members
	1222 p. 63	Cooper	1571	Curtiss	Deletes the four ex officio members of the Advisory Council (chair and co-chair of special joint committee on workers' compensation, commissioner of labor and workforce development and commissioner of commerce and insurance) AND requires filing of rate service organization's rules with the Advisory Council
	1473 p. 64	Tracy	1563	Curtiss	Makes housekeeping changes to workers' compensation statute
	1884 p. 65	Jackson	1138	Buck	Requires Commissioner of Labor/WFD to submit proposed revisions to claims handling standards to Advisory Council and Joint Committee - Council has 45 days to comment

***SB 149 by Southerland / HB 1319 by West**

Present Law

There is no current statute that is applicable to the exact subject matter of this bill.

TCA §56-5-320 authorizes the Commissioner of Commerce and Insurance to designate a rate service organization to assist in gathering, compiling and reporting relevant workers' compensation insurance statistical information. Tennessee's designated rate service organization is the National Council on Compensation Insurance (NCCI). The statute requires each workers' compensation insurer to:

- be a member of NCCI;
- report its workers' compensation insurance experience to NCCI;
- adhere to the policy forms and rating rules filed by NCCI;
- adhere to the uniform classification system and uniform experience and retrospective rating plans filed by NCCI and approved by the Commissioner.

In addition, subject to the approval of the Commissioner, NCCI is required to develop and file rules reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan and the uniform classification system.

The NCCI's experience rating plan rules include a provision for the combination of businesses with the same majority ownership to determine the experience rating modification factor that is used in the calculation of workers' compensation premiums.

Proposed Change

SB 149 / HB 1319 adds a new section to Title 56 (Insurance), Chapter 5 (Rates and Rating Organizations, Part 3 (General Provisions). The bill requires the experience rating of each business to be based on the nature of the business, the business' loss run history and any other factor relevant to the business. The bill prohibits combining business entities (based on the percentage of ownership interest or upon supervisory control exercised over the businesses) for purposes of determining experience ratings.

Practical Effect

The bill statutorily amends the experience rating plan rules, originally filed in 1940, by the Tennessee authorized rate service organization, NCCI, and which are approved by the Commissioner of Commerce and Insurance. As a result, the bill, by implication, amends *TCA* §56-5-320 which requires each insurer to follow the experience rating rules.

SB 149 / HB 1319,continued.

Informational Note

The NCCI is the designated rate service organization in 33 of the states. Four states have a monopolistic fund for workers' compensation insurance instead of a competitive market and the other states have an independent rating bureau within state government. NCCI is the designated rate service organization for the states surrounding Tennessee, with the exception of North Carolina which has its own rating bureau.

The NCCI's "combining of entities" rule is in place to prevent employers from taking action for the purpose of avoiding an experience rating modification or to apply in situations where actions are taken for otherwise legitimate business reasons but nevertheless result in improper application of the experience rating modification.

The NCCI representative, Ms. Cathy Booth, stated this rule is approved in all states where the NCCI is the authorized rate making entity. Ms. Booth indicated if the bill is passed it will cause problems for Tennessee employers who have an "interstate policy for their workers' compensation insurance.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYEE REPRESENTATIVES:

Othal Smith: Mr. Smith stated he does not support the bill".

INSURANCE COMPANY REPRESENTATIVE:

Jerry Mayo Mr. Mayo stated the bill confuses the issue and the industry is opposed to this bill.

EX OFFICIO MEMBERS

James Neeley: Commissioner Neeley indicated the issue is a lot broader than just workers' compensation regarding the position it puts the state in.

SB 1762 by Kyle / HB 1862 by Shepard

Present Law

In 2006, Public Chapter 536 added subsections (c) and (d) to *TCA* §56-5-320.

Subsection (c) permits the Commissioner of Commerce and Insurance, after a UAPA hearing, to impose civil penalties up to $10,000 against an workers' compensation insurer for assessing, without any lawful basis, a premium for individuals who are not employees or for assessing a premium on the basis of improper classification of employees.

Subsection (d) grants the Commissioner of Commerce and Insurance authority to promulgate rules, including public necessity rules, to effectuate the provisions "of this section". As written and codified, Public Chapter granted rulemaking authority related to *TCA* §56-5-320, which applies to all property and casualty insurance carriers and is not limited to workers' compensation.

Proposed Change

SB 1762 / HB 1862 restricts the rulemaking authority granted by subsection (d) to rules implementing ONLY subsection (c), i.e., applicable to only workers' compensation. It deletes language that gave the Commissioner authority to promulgate rules "to effectuate the provisions of this section", i.e., the entire section 320 (all property and casualty insurance).

Practical Effect

This bill appears to be a correction of language of last year's Public Chapter - to make it clear the Commissioner has rulemaking authority related to the assessing of the civil penalties provided in subsection (c) - which is limited to only workers' compensation insurance. Therefore, the bill deletes the Commissioner's power to promulgate rules related to entire property and casualty business in the instance of classification of employees.

Informational Note

Mr. John Morris, Deputy Commissioner of the Department of Commerce and Insurance, explained the Department had recently held a public hearing on proposed rules for the appeal of complaints relating to the premiums assessed by insurance carriers. After some negative comments that the proposed rules were not very relevant to the entire property and casualty market the Department withdrew the proposed rules. He indicated the Department wants to work with the sponsors of the legislation to improve the language of the bill.

SB 2171 by Kyle / HB 1813 by McDonald

Present Law

In 1996, the General Assembly enacted Public Chapter 944 which made significant changes to various laws governing Tennessee workers' compensation, including the pricing of workers' compensation insurance. As a result, since 1996, the workers' compensation insurance market in Tennessee has been a competitive pricing system - specifically, the "advisory prospective loss costs" system. The implementation of the loss costs competitive pricing system was accomplished by amending various portions of both the workers' compensation law (Title 50, Chapter 6, Part 4) and the insurance laws (Title 50, Chapter 5).

The 1996 Act also included a provision that repealed the sections of the Act that created the loss costs system. The repeal provision was not codified in the Tennessee Code. As a result of the "repeal" provision, the old law of administered insurance pricing was revived as of July 1, 2001. In 2001, to prevent the repeal of the "loss costs" workers' compensation insurance pricing system, the General Assembly enacted Public Chapter 192 to extend the "loss costs" system. Public Chapter 192 simply amended the language of Public Chapter 944 (1996) to create a new repeal date of July 1, 2007. As in 1996, the repeal provision included in Public Chapter 192 was not codified in the Tennessee Code.

Therefore, as a result of these two Public Chapters, the loss costs system is repealed as of July 1, 2007 and the old "administered pricing" system becomes law again.

Proposed Change

SB 2141/ HB 1813 eliminates the "repeal provisions" of the Public Acts of 1996 and 2001.

Practical Effect

The bill eliminates any repeal provisions related to the advisory prospective loss costs system in Tennessee. Thus, the competitive pricing system for the workers' compensation insurance market in Tennessee will continue without any automatic repeal provisions.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

All the Council members favor the continuation of the advisory prospective loss costs system.

SB 2241 by Kyle / HB 2322 by Odom

Present Law

Section 302 of Title 56 (Insurance), Chapter 5 (rates and rating organizations) is the definition section. Subdivision (12) defines "advisory prospective loss costs": "...historical aggregate losses and loss adjustment expenses projected through development to their ultimate value and through trending to a future point in time...". The subdivision also states what is not included in the definition: it does not include provisions for profit or for expenses other than loss adjustment expenses.

TCA §50-6-402 requires the Commissioner of Commerce and Insurance to consult with the Workers' Compensation Advisory Council before approving any workers' compensation loss costs filing made by the designated rate service organization.

Proposed Change

SB 2241 / HB 2322 adds language to the definition of advisory prospective loss costs to include "any other filing concerning or affecting rates and ratemaking purposes that are mandated by federal law". The bill also amends §50-6-402 to require consultation with the Advisory Council concerning loss costs filings or "other such other filings include in the definition of advisory prospective loss cost filing.

Practical Effect

The bill would include federally mandated filings - such as the terrorism filing mandated after the events of September 11, 2001- in the definition of advisory prospective loss costs and would require the Commissioner of Commerce and Insurance to consult with the Advisory Council before approving any federally mandated filing.

Informational Note

In the past there has been a question whether the terrorism filing was actually a "loss costs filing" that required the Commissioner to consult with the Advisory Council. This bill clears any remaining questions about that issue.

Advisory Council staff suggests there are possible drafting errors in section 2 of the bill that should be considered before the bill is passed: (1) the added phrase should begin with either "or other such filings" **OR** "or such other filings"; (2) the definition used in TCA 56-5-301(12) is advisory prospective loss costs **NOT** "advisory prospective loss cost filing" and (3) the phrase should probably be added after only the first time the word "filing" appears in the sentence, instead of after both words.

SB 2241 / HB 2322 , continued.

Informational Note, cont.

If the bill is enacted as drafted, the first sentence of the subsection will read as follows:

> (b) Before approving any workers' compensation loss cost filing **or other such other filings included in the definition of advisory prospective loss cost filing** made by the designated rate service organization pursuant to this part or title 56, the commissioner of commerce and insurance shall consult with the advisory council on workers' compensation concerning such filing **or other such other filings included in the definition of advisory prospective loss cost filing**.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS

Leslie Newman: Mr. John Morris, Deputy Commissioner of the Department of Commerce and Insurance, indicated it was the department's opinion that federally mandated filings are "loss costs filings" but this bill makes it clear statutorily they will be included in the definition.

All the members of the Advisory Council spoke favorably toward the bill.

SB 253 by Haynes / HB 73 by Turner, M.

Note: This bill is identical to SB366(Southerland)/HB655 (Hawk).

Present Law

TCA §50-6-102(10)(A) defines "employee" to include every person, including a minor, whether lawfully or unlawfully employed. (Prior to 1961, the law did not include the words "whether lawfully or unlawfully employed" following the word "minor".) In addition, the definition section states when the employee is dead, any reference to an "employee" shall include the employee's legal representatives, dependents and other persons to whom compensation may be payable under the workers' compensation law.

TCA §50-6-103 requires every employee that is subject to the workers' compensation law to accept compensation without regard to fault as a cause of the injury or death. *TCA* §50-6-106 and 107 include certain employments that are not covered by Tennessee workers' compensation law:

- common carriers in interstate business that are federally regulated;
- casual employments (one not employed in the usual course of trade, business, profession or occupation of the employer);
- farm or agricultural laborers and employers of such laborers;
- those employers who regularly employ less than 5 employees - except for those in the construction industry (1 employee) or coal mining (1 employee);
- state, county or municipal employees, unless the entity has accepted the provisions of the workers' compensation law;
- voluntary ski patrol person who receive no compensation other than meals, lodging or use of the ski lift facilities.

Proposed Change

SB 253 / HB 73 amends the code section that lists the types of employments not covered by Tennessee workers' compensation law to provide that Tennessee workers' compensation law does not apply to an alien - unless the alien was:

- lawfully admitted for permanent residence at the time "such services" were performed;
- lawfully present for the purposes of performing "such services"; or
- was permanently residing in the United States "under color of law" at the time the "services" were performed.

SB 253 / HB 73, continued.

***Proposed Change*, cont.**

The bill also provides that any data or information that is required of persons applying for benefits to determine eligibility must be required of all applicants of benefits and declares that in order to deny benefits, the decision must be based on a preponderance of the evidence.

Practical Effect

It has been public policy in Tennessee since the implementation of the workers' compensation statute in 1919 that the exclusive remedy for an employee injured on the job is workers' compensation benefits. This bill, if enacted, goes outside the exclusive remedy public policy of Tennessee.

The bill prohibits payment of workers' compensation benefits to an injured employee who is not lawfully in the United States. The bill will deny benefits even though the employer may have purchased workers' compensation insurance coverage that included the "undocumented" or "illegal" employee in the payroll on which the premium was based. Assuming the Tennessee employer was unaware the employee was not legally in the United States, the bill results in the following:

- the employer will have paid workers' compensation premiums to an insurance company that will not have to pay benefits under the insurance policy;
- the employer is subject to being sued by the employee in tort as the exclusive remedy of workers' compensation will no longer apply and the liability insurance companies will have to defend tort actions filed against the employers and pay any judgments;
- there will be uncompensated medical care to injured workers which will have to be managed by the medical community or other public resources;
- although unintended, the result may be to encourage employers to hire workers whom they know are undocumented/illegal workers.

Tennessee law creates an incentive for an employer to bring injured workers back to work by limiting the amount of permanent partial disability benefits payable to the worker (1.5 times the impairment rating). If the employer does not bring the injured worker back to work the employee can obtain permanent disability benefits up to 6 times the impairment rating. The employer is faced with a real problem if it is learned for the first time after injury that the worker is undocumented/illegal. The employer is not permitted - by Federal law - to bring the employee back to the pre-injury job. Thus, the employer is not permitted to limit its liability for PPD benefits to 1.5 times the impairment rating. Some states have restricted the right to rehabilitation services in these situations.

SB 253 / HB 73, continued.

Informational Note

The language of the bill tracks almost exactly the language in Title 50, Chapter 7 related to unemployment insurance law. Tennessee unemployment benefits are not payable to aliens who are not lawfully in the United States.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYEE REPRESENTATIVES:

Jerry Lee:

Othal Smith: Mr. Smith stated, in his opinion, this is a "bad bill" because if it passes and the employee is permitted to sue the employer in tort, and this opens a tremendous amount of exposure for the employer. In addition, it is a problem already for ordinary English speaking employees to successfully prosecute a workers' compensation claim, let alone a tort action. He stated, "They (illegal aliens) are here; they are working; they should get workers' compensation benefits; the employer pays premium based on the wages paid to the employee and it does not matter where they come from.

Mr. Smith did not agree with Mr. Pitts' concerns regarding the PPD caps because he thought the employer should have a reason to look at the people they hire at the front end of the employment relationship. He does not favor an easy out on the disability caps issue. He stated he did not think the difference between a 1.5 multiplier cap and a 6 multiplier cap will make much difference in the system. Mr. Smith also stated the employers should be more careful to check the employee's documents prior to hiring the worker. He contended the bill is drafting a "fault bases" system into the "no-fault" workers' compensation system.

SB 253 / HB 73, continued.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts stated his concerns with the bill is that if an undocumented worker solicits employment from an employer, knowing they are illegal and not eligible for employment and submits documents that appear valid, the employer - when it is learned following the injury that the worker is undocumented and cannot be employed - the employer will not be permitted to limit his exposure for permanent partial disability benefits (using the 1.5 multiplier cap) by returning the injured worker to the pre-injury employment.

ATTORNEY REPRESENTATIVES:

Gregg Ramos (TBA): Mr. Ramos stated, in his opinion, the Tennessee workers' compensation law, since 1961, has included the words, "whether lawfully or unlawfully employed" following the words "any person". He stated he has successfully argued for years that this phrase mandates workers' compensation coverage for all immigrants working in Tennessee, whether documented or undocumented.

Mr. Ramos pointed out that if this bill is passed, the employer will lose the exclusive remedy rule and will lose protection from punitive damages. Also, the bill encourages employers to hire undocumented workers and pressure them not to submit claims for injuries on the job.

Mr. Ramos also stated the employer pays insurance premiums and the claim will be denied by carriers and this underscores a windfall to insurance companies. He said the insurance company should screen the employee's status at the beginning when the insurance is purchased by the employer.

Mr. Ramos agreed that Mr. Pitts had a legitimate concern with the application of the PPD caps when the employer is not permitted under Federal law to return the employee to pre-injury employment.

SB 253 / HB 73, continued.

ATTORNEY REPRESENTATIVES, cont.

Mr. Ramos, cont. — With regard to the issue of the "multiplier caps", Mr. Ramos said employers can introduce evidence of undocumented worker status as evidence of a decrease in the employee's permanent partial disability.

INSURANCE COMPANY REPRESENTATIVE:

Jerry Mayo — Mr. Mayo stated the insurance company will not reap a windfall for insurance provided to the employer of an undocumented worker. Whatever is not paid for workers' compensation benefits will be paid for defense costs on the tort side.

Mr. Mayo said the industry opposes the bill. He indicated this bill addresses a political issue and a federal issue that the sponsors are trying to solve by amending the workers' compensation law. Mr. Mayo indicated he agreed, if the employer is paying premiums for the worker, the employer should get the coverage and the worker should get the benefits.

HEALTH CARE PROVIDER REPRESENTATIVES:

Sam Murrell, M.D.: — Dr. Murrell stated the health care community is not in favor of the bill.

EX OFFICIO MEMBERS

James Neeley: — Commissioner Neeley expressed reservations about the bill because public policy in Tennessee, since the adoption of workers' compensation, has been that workers' compensation is the exclusive remedy for a worker injured on the job.

SB 366 by Southerland / HB 655 by Hawk

Note: As this bill is identical to SB253/HB73, the analysis will be identical.

Present Law

TCA §50-6-102(10)(A) defines "employee" to include every person, including a minor, whether lawfully or unlawfully employed. (Prior to 1961, the law did not include the words "whether lawfully or unlawfully employed" following the word "minor".) In addition, the definition section states when the employee is dead, any reference to an "employee" shall include the employee's legal representatives, dependents and other persons to whom compensation may be payable under the workers' compensation law.

TCA §50-6-103 requires every employee that is subject to the workers' compensation law to accept compensation without regard to fault as a cause of the injury or death. *TCA* §50-6-106 and 107 include certain employments that are not covered by Tennessee workers' compensation law:

- common carriers in interstate business that are federally regulated;
- casual employments (one not employed in the usual course of trade, business, profession or occupation of the employer);
- farm or agricultural laborers and employers of such laborers;
- those employers who regularly employ less than 5 employees - except for those in the construction industry (1 employee) or coal mining (1 employee);
- state, county or municipal employees, unless the entity has accepted the provisions of the workers' compensation law;
- voluntary ski patrol person who receive no compensation other than meals, lodging or use of the ski lift facilities.

Proposed Change

SB 253 / HB 73 amends the code section that lists the types of employments not covered by Tennessee workers' compensation law to provide that Tennessee workers' compensation law does not apply to an alien - unless the alien was:

- lawfully admitted for permanent residence at the time "such services" were performed;
- lawfully present for the purposes of performing "such services"; or
- was permanently residing in the United States "under color of law" at the time the "services" were performed.

SB 366 / HB655 , continued.

***Proposed Change*, cont.**

The bill also provides that any data or information that is required of persons applying for benefits to determine eligibility must be required of all applicants of benefits and declares that in order to deny benefits, the decision must be based on a preponderance of the evidence.

Practical Effect

The bill also provides that any data or information that is required of persons applying for benefits to determine eligibility must be required of all applicants of benefits and declares that in order to deny benefits, the decision must be based on a preponderance of the evidence.

It has been public policy in Tennessee since the implementation of the workers' compensation statute in 1919 that the exclusive remedy for an employee injured on the job is workers' compensation benefits. This bill, if enacted, goes outside the exclusive remedy public policy of Tennessee.

The bill prohibits payment of workers' compensation benefits to an injured employee who is not lawfully in the United States. The bill will deny benefits even though the employer may have purchased workers' compensation insurance coverage that included the "undocumented" or "illegal" employee in the payroll on which the premium was based. Assuming the Tennessee employer was unaware the employee was not legally in the United States, the bill results in the following:

- the employer will have paid workers' compensation premiums to an insurance company that will not have to pay benefits under the insurance policy;
- the employer is subject to being sued by the employee in tort as the exclusive remedy of workers' compensation will no longer apply and the liability insurance companies will have to defend tort actions filed against the employers and pay any judgments;
- there will be uncompensated medical care to injured workers which will have to be managed by the medical community or other public resources;
- although unintended, the result may be to encourage employers to hire workers whom they know are undocumented/illegal workers.

Tennessee law creates an incentive for an employer to bring injured workers back to work by limiting the amount of permanent partial disability benefits payable to the worker (1.5 times the impairment rating). If the employer does not bring the injured worker back to work the employee can obtain permanent disability benefits up to 6 times the impairment rating. The employer is faced with a real problem if it is learned for the first time after injury that the worker is undocumented/illegal.

SB 366 / HB655 , continued.

Practical Effect, cont.

The employer is not permitted - by Federal law - to bring the employee back to the pre-injury job. Thus, the employer is not permitted to limit its liability for PPD benefits to 1.5 times the impairment rating. Some states have restricted the right to rehabilitation services in these situations.

Informational Note

The language of the bill tracks almost exactly the language in Title 50, Chapter 7 related to unemployment insurance law. Tennessee unemployment benefits are not payable to aliens who are not lawfully in the United States.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYEE REPRESENTATIVES:

Othal Smith: Mr. Smith stated, in his opinion, this is a "bad bill" because if it passes and the employee is permitted to sue the employer in tort, and this opens a tremendous amount of exposure for the employer. In addition, it is a problem already for ordinary English speaking employees to successfully prosecute a workers' compensation claim, let alone a tort action. He stated, "They (illegal aliens) are here; they are working; they should get workers' compensation benefits; the employer pays premium based on the wages paid to the employee and it does not matter where they come from.

Mr. Smith did not agree with Mr. Pitts' concerns regarding the PPD caps because he thought the employer should have a reason to look at the people they hire at the front end of the employment relationship. He does not favor an easy out on the disability caps issue. He stated he did not think the difference between a 1.5 multiplier cap and a 6 multiplier cap will make much difference in the system. Mr. Smith also stated the employers should be more careful to check the employee's documents prior to hiring the worker. He contended the bill is drafting a "fault bases" system into the "no-fault" workers' compensation system.

SB 366 / HB655 , continued.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts stated his concerns with the bill is that if an undocumented worker solicits employment from an employer, knowing they are illegal and not eligible for employment and submits documents that appear valid, the employer - when it is learned following the injury that the worker is undocumented and cannot be employed - the employer will not be permitted to limit his exposure for permanent partial disability benefits (using the 1.5 multiplier cap) by returning the injured worker to the pre-injury employment.

ATTORNEY REPRESENTATIVES:

Gregg Ramos (TBA): Mr. Ramos stated, in his opinion, the Tennessee workers' compensation law, since 1961, has included the words, "whether lawfully or unlawfully employed" following the words "any person". He stated he has successfully argued for years that this phrase mandates workers' compensation coverage for all immigrants working in Tennessee, whether documented or undocumented.

Mr. Ramos pointed out that if this bill is passed, the employer will lose the exclusive remedy rule and will lose protection from punitive damages. Also, the bill encourages employers to hire undocumented workers and pressure them not to submit claims for injuries on the job.

Mr. Ramos also stated the employer pays insurance premiums and the claim will be denied by carriers and this underscores a windfall to insurance companies. He said the insurance company should screen the employee's status at the beginning when the insurance is purchased by the employer.

Mr. Ramos agreed that Mr. Pitts had a legitimate concern with the application of the PPD caps when the employer is not permitted under Federal law to return the employee to pre-injury employment.

SB 366 / HB655 , continued.

ATTORNEY REPRESENTATIVES, cont.

Mr. Ramos, cont. — With regard to the issue of the "multiplier caps", Mr. Ramos said employers can introduce evidence of undocumented worker status as evidence of a decrease in the employee's permanent partial disability.

INSURANCE COMPANY REPRESENTATIVE:

Jerry Mayo — Mr. Mayo stated the insurance company will not reap a windfall for insurance provided to the employer of an undocumented worker. Whatever is not paid for workers' compensation benefits will be paid for defense costs on the tort side.

Mr. Mayo said the industry opposes the bill. He indicated this bill addresses a political issue and a federal issue that the sponsors are trying to solve by amending the workers' compensation law. Mr. Mayo indicated he agreed, if the employer is paying premiums for the worker, the employer should get the coverage and the worker should get the benefits.

HEALTH CARE PROVIDER REPRESENTATIVES:

Sam Murrell, M.D.: — Dr. Murrell stated the health care community is not in favor of the bill.

EX OFFICIO MEMBERS

James Neeley: — Commissioner Neeley expressed reservations about the bill because public policy in Tennessee, since the adoption of workers' compensation, has been that workers' compensation is the exclusive remedy for a worker injured on the job.

SB 313 by Finney, R. / HB 247 by Hensley

Present Law

TCA §50-6-204(a)(1) requires a physician to furnish to the employer, insurer, employee or employee's attorney, upon request, a complete medical report at a charge not to exceed $10.00 if the report is 20 pages or less in length. If it is longer than 20 pages, the charge is limited to 25 cents per page.

Proposed Change

SB 313 / HB 247 changes the minimum charge from $10.00 to $20.00.

Practical Effect

The bill increases the charges for a medical report.

Informational Note

A charge for the medical report required by this section of the workers' compensation law was added in 1988 by Public Chapter 525 (effective March 3, 1988). The charge was set at $5.00 for the first 20 pages plus 25 cents per page after the first 20 pages. Prior to that no charge was set by statute. In 1989, the amount of the charge for the initial 20 pages of a report was increased to $10.00 (Public Chapter 446, effective May 29, 1989). The amount per page over 20 pages remained at 25 cents per page.

SB 1474 by McNally / HB 1518 by Hackworth

Present Law

TCA §50-6-204(a)(2)(B) provides that the employee's consent is not required to produce medical records related to a workers' compensation claim at the request of the employer, insurer, employee or employee's attorney. A physician or hospital is protected from liability for producing the medical records without consent.

Proposed Change

SB 1474 / HB 1518 adds "or other approved provider" to the protection from liability afforded to physicians and hospitals.

Practical Effect

The bill clarifies that any approved medical care provider is going to be protected from liability if they produce medical records without the employee's consent.

SB 445 by Burchett / HB 454 by Hackworth

Present Law

TCA §50-6-204(i), enacted in 2004, authorized the Commissioner of Labor/WFD to establish a Medical Fee Schedule. The Medical Fee Schedule has been in effect since 2005 and it sets an amount per service that is a cap - i.e., the employer/insurer may negotiate to pay less than the amount authorized by the Medical Fee Schedule. However, a medical care provider cannot charge more than the Medical Fee Schedule and the employer/insurer is not permitted to pay more than the Medical Fee Schedule authorized charge.

Proposed Change

SB 445 / HB 454 prohibits payment of fees lower than the Medical Fee Schedule unless there is a specific contract between the health care provider and the employer, trust, pool or insurer. It prohibits the assigning of the negotiated rates in the contract to any other party. If there is no contract between the specific medical care provider and the insurer/employer then the payment will be at the rates established by the Medical Fee Schedule. The bill specifically prohibits fees paid to a workers' compensation medical provider that are based on a contract or agreement negotiated on a commercial health insurance product line - UNLESS the contract clearly states the rates payable under commercial health insurance will also apply to workers' compensation services.

Practical Effect

The bill, as drafted, requires the contract for reimbursement for services to be directly between the employer/pool, etc. and the health care provider. This bill would, therefore, prohibit long established, on-going contractual arrangements where the employer/trust/pool or employer has contracted with a preferred provider organization to pay medical claims based on a contract negotiated between the third party PPO and health care providers regarding the amounts they will charge for their services.

The bill does make it clear that insurance companies and employers (trust or pool) are not permitted to apply a contract for general health services negotiated with a health care provider to workers' compensation services unless the contract specifically permits the action.

SB 445 / HB 454, continued.

Informational Note

Anecdotal evidence indicates there are insurance companies that have been using contracts they have negotiated for reimbursement in the general health insurance arena for reimbursement of workers' compensation services even though no contract to do so exists with the medical care provider. This has become a problem for providers who receive payments based on negotiated "health insurance" networks and this reimbursement is often lower than the Medical Fee Schedule reimbursement rates.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

ATTORNEY REPRESENTATIVES:

Tony Farmer (TTLA): Mr. Farmer stated he believes the bill is intended to address an ongoing problem in Knox County where an employer authorizes a physician to provide treatment to an injured worker and the physician bills for the services at the maximum rate allowed by the medical fee schedule. The insurance company then refuses to pay the maximum rate and says it has not authorized payment of the maximum rate. He believes the bill provides that unless the employer or insurer has an different agreement with the physician, then the employer/insurer has to pay the maximum rate authorized by the medical fee schedule. He does agree there may be some unintended ramifications as outlined by Commissioner Neeley and other council members related to third party contracts.

INSURANCE COMPANY REPRESENTATIVE:

Jerry Mayo Mr. Mayo says the bill will hurt self-insured employers as it prevents utilization of PPOs.

SB 445 / HB 454, continued.

COMMENTS OF ADVISORY COUNCIL MEMBERS, cont.

HEALTH CARE PROVIDER REPRESENTATIVES:

Sam Murrell, M.D.: Dr. Murrell says this is a real problem for the medical care providers. The insurance companies are reimbursing a doctor/provider based on a negotiated network contract that applies to general health and the provider has not agreed to accept less than the amount allowed under the medical fee schedule. Dr. Murrell also noted a problem with reimbursement for the correct charge for a board certified physician; the carriers are reimbursing at rates permitted for non-board certified physicians.

Dr. Murrell also stated there is a problem where a network is developed for health treatment in non-workers compensation matters and the network wants to apply that contract to any later developed networks later developed for workers' compensation.

EX OFFICIO MEMBERS

James Neeley: Commissioner Neeley stated he believes the bill addresses "silent PPOs" (lot of individuals in health care industry in third tier below the medical fee schedule and trying to eliminate these individuals.

SB 322 by Haynes / HB 1818 by Hackworth

Present Law

There is currently no provision in the Tennessee Workers' Compensation law that requires disputing carriers to pay equally the benefits to the employee and resolve the question of who had coverage at the end of the claim.

The Department indicated when the Department is made aware of a situation where two carriers are disputing who has liability for an injury, the Department will begin its investigation and obtain relevant information from which it can make a decision. If there is a dispute about compensability, the Department will first determine that issue. If the injury is not in dispute, after proper investigation, the Department issues an order (binding only for administrative purposes) as to which carrier has the liability. If the carrier that is ordered to pay the benefits disagrees, the carrier can go to court to obtain a final determination of which carrier is liable and if the Department's decision was in error, the other carrier is reimbursed from the Second Injury Fund the amounts it paid pursuant to the order.

Proposed Change

SB 322 / HB 1818 adds a new section to the workers' compensation statute. If the following conditions are met, the Commissioner of Labor/WFD or designee is authorized to order benefits to be paid on an equal basis by carriers/self-insured employers:

- compensability is not disputed or a specialist has determined the claim to be compensable AND
- there is a dispute as to which entity is responsible to pay benefits to the injured workers when the
    - employer has changed carriers;
    - the employer was self-insured and is now insured; or
    - the employer who was insured, becomes self-insured

In addition, the bill provides that - upon agreement of the parties OR a court order as to which entity is responsible to pay benefits - the one responsible shall reimburse the party who was not responsible to pay benefits, all amounts paid to the employee plus interest.

SB 322 / HB 1818 , continued.

Practical Effect

The bill will permit an employee to receive payment of workers' compensation benefits before the conclusion of the case when there is a dispute as to which employer or carrier had coverage at the time of the injury. The employers/carriers in question will pay the benefits equally and upon resolution of the issue, the one who had coverage must repay the other, with interest.

Informational Note

As drafted, either the parties must finally agree as to who had coverage or a court must make the decision.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYEE REPRESENTATIVES:

Othal Smith: Mr. Smith said this can be very detrimental to an injured worker when two carriers/self-insured employers are disputing who is responsible for payment of the claim.

ATTORNEY REPRESENTATIVES:

Kitty Boyte (TDLA): Ms. Boyte indicated there may be a problem when two carriers are arguing over a gradual injury - under this circumstance which panel is to apply. It is unclear how you split the responsibilities of the employer.

Tony Farmer (TTLA): Mr. Farmer stated it is a problem for employees because it often takes the Department several months to obtain the information it feels is needed in order to make a decision as to which entity is liable to pay the workers' compensation benefits. In the meantime, the employee goes without medical treatment or indemnity benefits even though the injury is not being contested. He said a worker can lose their house while waiting for a decision from the Department.

SB 322 / HB 1818 , continued.

ATTORNEY REPRESENTATIVES, cont.

Gregg Ramos (TBA): Mr. Ramos said he likes this concept although the issue as to whose medical panel is to be used may need to be addressed.

INSURANCE COMPANY REPRESENTATIVE:

Jerry Mayo Mr. Mayo said injured workers should not be denied benefits when there is no doubt of the compensability. He suggested the bill should be amended to also provide for reimbursement of all medical expenses paid and all loss adjustment expenses incurred by the carrier/self-insured employer in addition to the benefits paid to the employee. He also expressed concern if one of the

SB 425 by Crutchfield / HB 1822 by Buck

Present Law

Re: Section 1

TCA §50-6-207(4)(A)(I) provides that permanent total disability benefits are to be paid to the employee until the employee reaches the age to be eligible for full social security benefits; or if the employee is 60+ years old at the time of injury, the payment of benefits is for 260 weeks. The benefits are reduced by the amount of any old age insurance benefit payments attributable to employer contribution (i.e., 50%). The Tennessee Supreme Court has held the social security setoff to be applicable to employees over age 60 who receive permanent partial disability benefits and to death benefits received by a spouse.

Re: Section 2

The operating procedures of the Division of Workers' Compensation prohibit the parties from discovering the documents provided by the other party to a workers' compensation specialist in those instance where assistance is being sought regarding medical or temporary benefits.

Proposed Change

Section 1 of SB 425 / HB 1822 prohibits the social security offset from applying to death benefits.

Section 2 of the bill requires copies of all information available to a workers' compensation specialist when considering medical or temporary disability benefits to be provided to all parties, upon request. The bill make it clear this is not applicable to medication situations when information may be held confidential upon request of a party.

Practical Effect

Section 1 of the bill addresses the Supreme Court's recent application of the social security offset to death benefits and determines the public policy of Tennessee is contrary to the Supreme Court's interpretation of the statute.

Regarding the discovery of information the specialist is considering when determining temporary or medical issues, section 2 of the bill makes certain all parties are on the same playing field by requiring the sharing of the information which the specialist is considering when making the decision as to whether to order benefits. It permits both employees and employers an opportunity to provide the specialist with full information upon which to make a determination of the issue.

SB 425 / HB 1822, continued.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

ATTORNEY REPRESENTATIVES:

Kitty Boyte (TDLA): Ms. Boyte said the social security offset is to prevent the receipt of double benefits.

Tony Farmer (TTLA): Mr. Farmer says it is a real handicap for both sides in the procedures for the department to make a decision when a Request for Assistance has been submitted. Each side will present its position but has no idea what the other party has said about the claim. This causes significant fairness problems for both sides. The current process provides no transparency.

Gregg Ramos (TBA): Mr. Ramos said he is in favor of both sections of the bill as they will improve the entire system.

EX OFFICIO MEMBERS

James Neeley: Commissioner Neeley stated there are approximately 5000 requests for assistance received by the department annually. The average file is about 45 pages. Therefore, there is a fiscal impact to the department as a result of Section 2.

SB 849 by Kilby / HB 1073 by Turner, M.

Present Law

TCA §50-6-302 pertains to occupational diseases. The current law does not have any language regarding specific occupational diseases except for coal worker's pneumoconiosis.

Proposed Change

SB 857 / HB643 applies only to occupational diseases involving a disease or condition covered by the federal "Energy Employees Occupational Illness Compensation Program Act of 2000, parts (B), (D) or (E)". The bill makes these diseases or conditions compensable as an occupational disease for Tennessee state workers' compensation benefits. The bill makes positive determination findings pursuant to the Federal Act conclusive proof as to causation for a state claim and prohibits an employer from raising issues related to: notice, causation, statute of limitations.

The bill provides that it is not applicable to workers' compensation claims made by a state employee or by a municipal or county employee, whether it has accepted the Workers' Compensation Act or not. The bill also provides:

- neither the employee, employee's survivors/beneficiaries nor the employer shall be entitled to make a claim for benefits against the Second Injury Fund;
- there shall be no entitlement to medical benefits (past, present or future) for these diseases or conditions pursuant to *TCA* §50-6-204;
- state workers' compensation awards paid by reason of this law are not to be included in the employer's experience factors for changes in the employer's loss history to the extent the employer is reimbursed or indemnified by the federal government for benefits paid.

Practical Effect

For those employees (usually an employee of a DOE facility or the employee's survivors or beneficiaries) who receive a positive determination in the federal claim for benefits due to illnesses contracted as a result of work at the employer, it is conclusively presumed that the illness or condition is causally related to the employee's occupation and the employer shall be prohibited from raising the defenses of notice, causation or statute of limitations in a claim for state workers' compensation benefits.

SB 849 / HB 1073 , continued.

Practical Effect, cont.

The bill makes it clear that an employee or employer is prohibited from seeking any recovery against the Second Injury Fund and that employees of the State of Tennessee or counties/municipalities are not entitled to state workers' compensation benefits for these diseases or conditions. Finally, the bill provides that to the extent an employer is reimbursed or indemnified for state workers' compensation benefits paid pursuant to this law, the payments are not to be considered in the employer's loss history for computation of the experience modification factors.

SB 857 by Kilby / HB 643 by Turner, M.

NOTE: This bill is the same as SB 849 (Kilby)/HB1073(Turner, M.) except this bill does not have a reference to Part (D) of the Federal Act. Part(D) no longer is in the Federal Act. However, the general analysis of the bill remains the same as in the previous bill. Therefore, the analysis will be repeated here.

Present Law

TCA §50-6-302 pertains to occupational diseases. The current law does not have any specific language regarding specific occupational diseases except for coal worker's pneumoconiosis.

Proposed Change

SB 857 / HB643 applies only to occupational diseases involving a disease or condition covered by the federal "Energy Employees Occupational Illness Compensation Program Act of 2000, parts (B), (D) or (E)". The bill makes these diseases or conditions compensable as an occupational disease for Tennessee state workers' compensation benefits. The bill makes positive determination findings pursuant to the Federal Act conclusive proof as to causation for a state claim and prohibits an employer from raising issues related to: notice, causation, statute of limitations.

The bill provides that it is not applicable to workers' compensation claims made by a state employee or by a municipal or county employee, whether it has accepted the Workers' Compensation Act or not. The bill also provides:

- neither the employee, employee's survivors/beneficiaries nor the employer shall be entitled to make a claim for benefits against the Second Injury Fund;
- there shall be no entitlement to medical benefits (past, present or future) for these diseases or conditions pursuant to *TCA* §50-6-204;
- state workers' compensation awards paid by reason of this law are not to be included in the employer's experience factors for changes in the employer's loss history to the extent the employer is reimbursed or indemnified by the federal government for benefits paid.

Practical Effect

For those employees (usually an employee of a DOE facility or the employee's survivors or beneficiaries) who receive a positive determination in the federal claim for benefits due to illnesses

SB 857 / HB 643 , continued.

Practical Effect, cont.

contracted as a result of work at the employer, it is conclusively presumed that the illness or condition is causally related to the employee's occupation and the employer shall be prohibited from raising the defenses of notice, causation or statute of limitations in a claim for state workers' compensation benefits.

The bill makes it clear that an employee or employer is prohibited from seeking any recovery against the Second Injury Fund and that employees of the State of Tennessee or counties/municipalities are not entitled to state workers' compensation benefits for these diseases or conditions. Finally, the bill provides that to the extent an employer is reimbursed or indemnified for state workers' compensation benefits paid pursuant to this law, the payments are not to be considered in the employer's loss history for computation of the experience modification factors.

SB 1044 by Finney, L. / HB 1081 by Turner, M.

Present Law

TCA §50-6-102(14)(C) defines "maximum total benefit" as the sum of all weekly benefits to which an employee may be entitled and for injuries on/after 7-1-1992, the maximum total benefit equals 400 weeks times the maximum weekly benefit except in instances of permanent total disability.

The Supreme Court held in 2005 that the maximum total benefit limitation is applicable not only to permanent partial disability benefits but also to temporary total disability benefits. The maximum total benefits calculated by the Court was 400 times the employee's weekly compensation rate.

Proposed Change

SB 1044 / HB 1081 amends *TCA* §50-6-102(14)(C) by adding a new provision to apply to injuries occurring on/after 7-1-2007. It defines "maximum total benefit" to be 400 times 100 % of the state's average weekly wage (SAWW) which is set annually by the Division of Workers' Compensation. In addition, the bill excludes both temporary total disability and permanent partial disability from the definition of "maximum total benefit".

Practical Effect

This bill addresses the Supreme Court's decision, *Wausau Ins. Co. v. Dorsett*, 172 S.W.3d 538 (Tenn. 2005), that held temporary total disability benefits are to be included in the calculation of "maximum total benefit". In the *Dorsett* case, the Supreme Court stated: "...this Court has no authority to alter the statutory definition of maximum total benefit. Whether this statutory definition should be revised to exclude temporary total disability from the 400-week limitation is a question for the legislature, not the judiciary." In *Dorsett* the employee had never reached maximum medical improvement before the expiration of 400 weeks of temporary total disability benefits. Thus, she would not have been entitled to any permanent partial disability at the time she reached maximum medical improvement.

The bill can be viewed as increasing the maximum total benefit from that which has been interpreted by the Supreme Court in recent years (i.e, 400 weeks times the employee's compensation rate). The bill can also be viewed as returning the law to the original intent of the definition of "maximum total benefit" as it existed before the maximum weekly benefit was tied to the state's average weekly wage.

SB 1044 / HB 1081, continued.

Practical Effect, cont.

For instance, *TCA* §50-6-102(14)(A) states the maximum total benefit for injuries occurring between 7-1-90 and 6-30-91 is $109,200. *TCA* §50-6-102(15) states the maximum weekly for that same time period is $273.00. Therefore, it appears if you multiply the maximum weekly benefit of $273 times 400, the result is $109,200.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYEE REPRESENTATIVES:

Othal Smith: Mr. Smith says he believes the bill places the law as it was prior to 1992 and the bill will help only those most seriously injured workers.

ATTORNEY REPRESENTATIVES:

Tony Farmer (TTLA): Mr. Farmer stated this bill will impact a very, very small percentage of claims (significantly less than 1% of the claims made annually in Tennessee) and of the people it does impact, it only effects the most seriously injured workers who are eligible for TTD and PPD for an extended period of time. It protects Tennessee's most seriously injured workers.

EX OFFICIO MEMBERS

James Neeley: Commissioner Neeley stated that he remembers when the maximum benefits were based on the maximum weekly benefit and the reforms did not change the law; rather, the courts' interpretation has changed the law from the state's maximum weekly rate to the employee's weekly compensation rate.

SB 1672 by Ramsey / HB 278 by Mumpower

Present Law

TCA §50-6-205(b)(1) references "maximum total benefit" provided in §50-6-102(13). That section is no longer the section that defines "maximum total benefit".

Proposed Change

SB 1672 / HB 278 deletes the reference to a specific subdivision of §50-6-102 and references only the section.

Practical Effect

The bill corrects an incorrect reference to the definition of "maximum total benefit".

SB 1775 by Southerland / HB 2128 by Fitzhugh

Present Law

TCA §50-6-241 sets maximum permanent partial disability benefits an employee may receive when the pre-injury employer returns the employee to work at a job making the same or higher pay as when the injury occurred. For injuries that occurred on/after August 1, 1992 and before July 1, 2004, the maximum is 2.5 times the medical impairment rating. For injuries that occur on or after July 1, 2004, the maximum is 1.5 times the medical impairment rating. If the pre-injury employer does not return the employee to work at same or greater pay, the maximum permanent partial benefits is capped at 6 times the medical impairment rating.

For injuries [August 1, 1992 - June 30, 2004] that are subject to this "cap", if the employee subsequent loses his/her job with the pre-injury employer within 400 weeks he/she may seek reconsideration of the permanent partial disability benefits. For injuries on or after July 1, 2004 the employee may seek reconsideration of permanent partial disability benefits [within 400 weeks if it was a body as a whole injury; number of weeks of benefits for schedule member injuries covered by the schedule] if he/she loses their job UNLESS the loss of employment is due to voluntary resignation or retirement (not related to the injury) or due to employee's misconduct connected to employment.

Proposed Change

SB 1775 / HB 2128 makes changes to various sections of *TCA* §50-6-241 to make the caps apply in situations where the employee acquires any employment at the same or greater pay - deleting the requirement that the pre-injury employer return the employee to work. The bill applies these multiplier changes to both the 1992 Act and the 2004 Act.

In addition, the bill also amends the sections applicable to reconsideration of the disability benefits when the employee is no longer employed by the pre-injury employer. The bill changes those sections by permitting the employee to seek reconsideration within 400 weeks (or the applicable number of weeks depending on the body part injured) from the day the employee acquires employment.

Practical Effect

The bill retroactively changes the applicable maximum permanent disability benefits an employee may receive - by removing the requirement that the pre-injury employer return the employee to work

SB 1775 / HB 2128, continued.

Practical Effect, cont.

and substituting instead the employee's acquiring of employment at the same or higher pay. This would apply to all claims that are still pending in which the injury occurred at any time since August 1, 1992. In addition, the bill changes dramatically the time within which an employee can seek reconsideration.

Informational Note

It may be an unintended consequence of the bill to remove any incentive for the pre-injury employer to return the employee to work at the same or higher pay. With regard to capping PPD when the employee finds work at any job paying the same or higher, the bill appears to leave it up to the employee as to whether he/she finds employment. Also, the language of the bill that addresses reconsideration is very confusing - - as drafted, it appears the time within which an employee can seek reconsideration begins with the day the employee acquires employment at the same or higher pay. If the employee does not acquire employment, then the time limit on reconsideration appears never to run.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYEE REPRESENTATIVES:

Othal Smith: Mr. Smith stated the intent of the 1992 Reform Act that added the PPD caps was to give the employer who is willing to bring the injured employee back to work a break - lower PPD benefits.

ATTORNEY REPRESENTATIVES:

Kitty Boyte (TDLA): Ms. Boyte stated there should be no difference in the amount of PPD benefits awarded to an injured employee depending on whether the employer brings the employer back to work or the employee finds a job with another employer.

SB 1775 / HB 2128, continued.

Comments of Advisory Council Members, cont.

Tony Farmer (TTLA) ; Mr. Farmer stated the intent of the PPD caps is to give an incentive to the employer to return the employee to the pre-injury employment.<

Gregg Ramos (TBA): Mr. Ramos suggested the current law regarding the time within which an action to seek reconsideration can be filed should remain one (1) year from the loss of the job, as provided in current law.

SB 1797 by Southerland / HB 2129 by Fitzhugh

Present Law

TCA §50-6-206(a)(2), enacted by the 2004 Reform Act, prohibits the settlement of future medical benefits for a period of 3 years from the date on which the settlement is approved. The statute prohibits an employee who is permanently totally disabled from settling the employee's right to future medical benefits.

TCA §50-6-102(13) defines "injury" and "personal injury" as an injury by accident, an occupational disease or a mental injury that arises out of and in the course of employment that causes either disablement or death of the employee. Tennessee case law has held gradually occurring injuries to be compensable.

Case law has also held the burden of proof in a workers' compensation case is upon the employee to prove - by a preponderance of the evidence - that the injury occurred in the course and scope of employment and by a preponderance of expert medical testimony that the injury caused a permanent condition. The Tennessee courts have held that when work duties exacerbate a pre-existing condition, the resulting injury is compensable.

Proposed Change

SB 1797 / HB 2129 deletes the provision of the 2004 Reform Act that prohibits the settlement of future medical benefits in permanent partial disability benefit cases for 3 years and prohibits the settlement of medical benefits in permanent total disability cases.

The bill also adds a definition of "repetitive injury" to the statute - "injury directly and solely caused by repetitive use of the affected body part". The bill requires the employee to prove he/she sustained a repetitive injury by clear and convincing evidence by competent ergonomic and medical evidence, that the injury is not the result of the aging process or the result of a congenital or developmental disorder.

SB 1797 / HB 2129, continued.

Practical Effect

The public policy considerations behind the 2004 Reform Act's provision that future medical benefits cannot be settled for a three year period following the date of the settlement included:

- not to induce an injured employee to settle the claim, with medical benefits included, before the employee has an opportunity to understand the long term ramifications of their condition. injury;
- many times it is not clear to employee that their medical insurance will not cover these expenses, if it can be shown the expenses incurred in the future;
- a three year period is not an excessive amount of time in a permanent partial disability case to make someone wait to consider whether to close future medical benefits;
- if the employees are permitted to close the medical benefits and need medical treatment later, that potentially falls back to the State and the citizens in general to fund these expenses as opposed to the employer at the time of the injury - the same rationale holds true - to a greater degree - for situations involving permanent total disability.

Section 1 of the bill permits the parties to settle any claim for future medical benefits provided the court or the Department determines the settlement to be in the best interests of all parties. This includes the settlement of the future medical benefits to which an employee who is permanently totally disabled would be entitled.

The remaining sections of the bill restrict the workers' compensation benefits an employee may receive for gradually occurring injuries such as carpal tunnel, tendinitis, etc. by requiring both ergonomic and medical evidence by clear and convincing proof. In addition, the bill changes case law that recognizes compensability when the work advances an underlying condition that may be a result of the natural aging process or a congenital anomaly.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYEE REPRESENTATIVES:

Jerry Lee: Mr. Lee stated during the discussions regarding the 2004 Reform Act, a five year period was originally proposed and a reasonable compromise was reached to limit the time to three

SB 1797 / HB 2129, continued.

Comments of Advisory Council Members, cont.

years. He indicated he still believes the three year period is a reasonable amount of time.

ATTORNEY REPRESENTATIVES:

Kitty Boyte (TDLA): Ms. Boyte agreed there are many situations where future medical benefits should not be closed but stated there are also situations where it is silly to keep the medical benefits open - for example, amputated finger, broken arm. She stated she did not think the bill is encouraging the closure of future medical benefits - instead it is allowing closure in situations where it is clear they should be closed.

Tony Farmer (TTLA): Mr. Farmer said another public policy consideration to retain the prohibition against closing future medical benefits occurs in situations involving permanent total disability, it would be an impossible burden for employees of the Department of Labor and Workforce Development to attempt to advise claimants who are closing the right to future medical benefits about their obligations to Medicare in creating Medicare Set Aside Trusts that have to be created any time a third party's liability for medical benefits in the future has been terminated. The Set Aside involves application of a very sophisticated formula/process at the time of closure to determine how much money has to be paid to Medicare at the time of closure for Medicare's obligation in the future to provide medical treatment.

Gregg Ramos (TBA): Mr. Ramos agreed with the points raised by Mr. Farmer with respect to permanent total disability benefits. Mr. Ramos stated that from a practical standpoint with respect to permanent partial disability cases, from a defense standpoint, more cases would be settled - especially highly disputed cases - if the parties were permitted to compromise the claim including the closure of future medical benefits. Mr. Ramos suggested the dollar threshold on claims that can close future medical benefits be increased.

SB 1797 / HB 2129, continued.

Comments of Advisory Council Members, cont.

EX OFFICIO MEMBERS

James Neeley: Commissioner Neeley stated during the last two years the Department has seen a number of cases that future medical benefits are being held open and all it does is require the insurance industry to keep its files open. He said there are certain cases where there is no impact to the employee if the future medical benefits are closed.

CHAIR:

Dale Sims: Mr. Sims stated the difficulty arises in determining what the threshold should be for which claims can and cannot settle future medical benefits. He explained the original intent of the three year period was to avoid building in an incentive - in a borderline case - to induce, with dollars, an employee to take an action that is adverse to them and that the review process would not catch this situation. He said the proponents of this provision to prohibit settlement of future medical benefits was to avoid placing an employee in that position.

SB 1477 by Tracy / HB 1568 by Curtiss

Present Law

TCA §50-6-238(d) creates a procedure by which an employee or employer who disagrees with the order of a workers' compensation specialist can request the administrator of the division of workers' compensation to reconsider the specialist's order. The statute provides after the receipt of the "request for reconsideration", the administrator, or designee, is to conduct an informal conference with the parties within 10 days of the receipt of the request for reconsideration. Then, within 7 days following the informal conference the administrator/designee is to issue an order and if it orders the payment of benefits to the employee, the party against whom the order is issued shall comply with the order within 10 days of receipt of the order.

Proposed Change

SB 1477 / HB 1568 clarifies the procedures to be used by the administrator/designee in reconsidering a specialist's order. The bill restricts the review to only the information that was available to the specialist who issued the order; requires the administrator/designee to determine whether the specialist's order was correct under the law; requires the issuance of a written order that fully resolves the issues in dispute. The administrator/designee is prohibited from sending the matter back to the specialist for further action on the issue. The bill requires the following:

- if the specialist's order is deemed to be correct, the order shall affirm the order and order the same action as contained in the specialist's order;
- if the specialist's order is deemed to be incorrect, the order shall reverse the specialist's order and include an order of the correct resolution of the issues - so the administrator/designee's order becomes the definitive order on the issue.

The bill makes it clear that any party may submit a new request for assistance following the resolution of the request for reconsideration by the administrator/designee based on new or additional information, facts or documents not originally considered by the specialist when the original order was issued.

Practical Effect

The bill clarifies the procedure to be used by the department in processing "requests for reconsideration" of a specialist's order. It assures the administrator/designee's role is to determine if the specialist erred in the original order based on the information available to the specialist and

SB 1477 / HB 1568, continued.

Practical Effect, cont.

in the department's files. The bill makes it clear the review by the administrator/designee is not an additional fact finding hearing, instead it is a review of the workers' compensation law applied to the facts/information known to the specialist at the time the specialist issued the original order. The bill creates a very specific mechanism by which the administrator can review the effectiveness of the workers' compensation specialist program in handling requests for assistance filed by either the employee or employer and to correct any errors made by the specialist in deciding whether or not to order benefits based on the facts/information available to the specialist at the time of the request.

Informational Note

Since this statute was passed last year, several stakeholders feel the use of the term "reconsideration" of a specialist's order has led to confusion with the "reconsideration" of permanent partial disability when an employee whose original award of permanent partial disability benefits has been capped and he/she subsequently is no longer employed by the pre-injury employer. Perhaps "reconsideration" could be replaced by "review" or perhaps the Department has a suggestion of a different title for this process.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

ATTORNEY REPRESENTATIVES:

Gregg Ramos (TBA): Mr. Ramos agreed another word needs to be used other than "reconsideration" and the word "review" is fine with him. He said it is important that this process not be confused with reconsideration of permanent partial disability .

SB 1805 by Tracy / HB 1569 by Curtiss

Present Law

TCA §50-6-204 requires the employer/insurer to provide the employee with the medical treatment and services "made necessary by accident as defined in this chapter". The employer/insurer is required to provide the injured employee a panel of physicians (and/or specialists) from which the employee selects the treating physician.

TCA §50-6-238 authorizes a workers' compensation specialist to order the initiation, continuation, retroactive payment of or reinstitution of temporary disability benefits; to order the employer/insurer to provide medical benefits, including the authority to order specific medical treatment recommended by a treating physician and the authority to require the employer to provide the appropriate panel of physicians or specialists.

TCA §50-6-204(d)(5) provides when a dispute as to the degree of medical impairment exists, either party may request an independent medical examiner from a registry established by the Commissioner of Labor/WFD. If the parties are not able to agree on the selection of the independent examiner from the registry, then the employer is required to request, in writing, the Commissioner to assign a list of three doctors from the registry from which the parties select the examiner. The statute creates a rebuttable presumption (rebuttable by clear and convincing evidence) that the impairment rating given by the Registry Physician is the accurate rating. The employer bears the cost of the Registry examination and report.

The Commissioner promulgated rules/regs, as permitted by the statute, to establish the independent medical registry. The rules adopted by the Department prohibit the use of the registry by the parties unless there are two (2) impairment ratings given by two doctors that are in dispute prior to requesting the examination by a Registry Physician. This rule requires, in most instances, the injured employee to pay for an independent medical examination before using the Commissioner's registry.

Proposed Change

SB 1805 / HB 1569 requires a workers' compensation specialist to make a determination that the injury sustained by the employee is a compensable workers' compensation injury (or that a prior order requires the benefits) prior to ordering the employer to provide either temporary disability benefits or medical benefits, specific medical treatment or a panel choice of physicians to the employee.

SB 1805 / HB 1569, continued.

Proposed Change, cont.

The bill deletes the current statute regarding the independent medical examiners registry and re-drafts the language by outlining in specific terms the conditions under which a party can request an examiner from the registry. The bill provides:

- employee may request the examination by a registry physician if the employer has provided the appropriate panel for the selection of a treating physician and the treating physician is either unwilling or unable to provide an impairment rating;
- employee may request the examination by a registry physician if the employee disagrees with an impairment rating given by the treating physician - chosen from the panel provided by the employer - and the employee has not also obtained an independent medical examination at his/her own expense;
- employee or employer may request the examination by a registry physician if the treating physician has issued an impairment rating and the employee has obtained his own independent evaluation;
- employer may request the examination by a registry physician if the employer has permitted the employee to select his own treating physician, without use of a panel, provided the employer has not had an independent evaluation conducted on the employee that resulted in an impairment rating.

The bill also requires the Department to advise employees - in plain and understandable language at the time the employee is first contacted following a report of a work-related injury - of the employee's rights to use the registry and that the department can assist in this request. The bill also requires the Commissioner of Labor/WFD to amend the current rules governing the independent medical examiners registry to be effective on January 1, 2008. The Commissioner is required to provide proposed rules to the Advisory Council before the proposed rules are sent to the Attorney General for review. The Council has 30 days from receipt to provide written comment. The Commissioner is required to provide the Council with any changes to the proposed rules suggested by the Attorney General prior to submitting the proposed rules to the Secretary of State.

Practical Effect

The bill makes it clear that a workers' compensation specialist cannot order medical or disability benefits, including a panel choice of physicians, unless the specialist enters an order that the

SB 1805 / HB 1569, continued.

Practical Effect, cont.

employee's claim is compensable under the workers' compensation law. The bill also makes it clear that the intent of the independent medical examiners registry is to provide a mechanism by which a party may obtain an impairment rating without the expense of hiring an independent medical examiner before asking to use the registry.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

ATTORNEY REPRESENTATIVES:

Kitty Boyte (TDLA): Ms. Boyte stated the 2004 Reform Act made the MIRR program applicable to only injuries that occurred on or after July 1, 2005. She questioned whether the bill changes the injury dates to which the MIRR program would be applicable.

Note: The Executive Director reviewed the 2004 Reform Act (Public Chapter 962) after the meeting of the Advisory Council. Section 51 of Public Chapter 962 is the enacting clause and it states: "Section 24 (which is the section that required the establishment of a independent medical impairment registry) shall apply to injuries on or after July 1, 2005..." It is apparent the date is tied to giving the Department the time to promulgate the rules for the registry.

With regard to the portion of the bill related to the authority of the specialist to order a panel of physicians to be provided, Ms. Boyte noted the intent of the bill is to prohibit current practice of the workers' compensation specialists to order the employer to provide a panel of physicians so the physician can determine if the injury was work-related.

SB 1805 / HB 1569, continued.

Comments of Advisory Council Members, cont.

EX OFFICIO MEMBERS

James Neeley:

With regard to the section of the bill regarding the specialists' ability to order medical or disability benefits, Commissioner Neeley noted the 2004 Reform Act provides that if a specialist makes a mistake then the Second Injury Fund reimburses the benefits paid by the party who was ordered to pay benefits.

Commissioner Neeley also noted when you open up the MIRR MIRR registry to anyone - even though the employer is required to pay for the Registry physician ($1,000) - this will cause a lot more people to be involved than has been before.. He indicated the Department had submitted a fiscal note regarding this bill.

SB 2259 by Kyle / HB 2307 by Turner, M./Odom

Present Law

TCA §50-6-204 has a reference to a payment to be made to the Second Injury Fund in death cases although this requirement has been deleted in other sections of the law.

TCA §50-6-226 pertains to fees of attorneys. Subdivision (a)(1) provides that fees of attorneys for services to employees are subject to the approval of either the Commissioner of Labor/WFD or the court. The subdivision states fees charged for by attorneys representing employers are subject to review for reasonableness and subject to approval by a court when the fee exceeds $10,000 [now $14,388.17 due to application of subdivision (a)(2)(E)].

Subdivision (a)(2) (B) permits the department to approve attorney fees in cases submitted to the department for settlement approval if the attorney's fee is less than $10,000 [note, this section was enacted in 1992 as a $10,000 cap with an escalator equal to the amount the state's average weekly wage increased each year - the $14,388.17 is the amount in effect from July 1, 2006 through June 30, 2007]. If the attorney's fee is over that amount, the attorney's fee must be approved by a court.

If the case proceeds to trial, *TCA* §50-6-226(a)(2)(C) requires the trial court to make specific findings as to the factors that justify an employee's attorney's fee in excess of $14,388.17 as provided in Supreme Court Rule 8, RPC 1.5. For cases that result in death, plaintiff attorney fees are limited to reasonable payment for actual time and expenses incurred when the employer makes a voluntary settlement offer in writing to pay all the benefits provided under the law.

Proposed Change

SB 2259 / HB 2397 removes the references to payments to the Second Injury Fund in death cases. The bill also removes the monetary threshold for attorney fees the department can approve and removes subdivision (a)(2)(E) which mandates an escalation clause for the $10,000 limit on approval of attorney fees.

Practical Effect

The removal of the reference to a monetary payment to the Second Injury Fund is housekeeping legislation to correct a section of the law that is no longer applicable.

SB 2259 / HB 2307, continued.

Practical Effect, cont.

The bill eliminates those situations where the commissioner/specialist approves a settlement agreement but are unable to approve the attorney fees in the case if the fees are in excess of the threshold. In those cases, the attorneys are required to go to court even though the settlement has been approved at the department level. The bill will permit the commissioner/specialist to approve all attorney fees - presuming 20% is reasonable.

Informational Note

The bill does not address all portions of the statute that reference the $10,000 ($14,388.17) threshold. It appears an unintended consequence of the deletion of subdivision (a)(2)(E) without any changes to subdivision (a)(1) and subdivision (a)(2)(C) is to eliminate the escalator or indexing of the attorney fees threshold. In other words, the court's authority will revert to $10,000 and all cases that go to court will require the attorney to file an application for approval of the fee in excess of $10,000.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

ATTORNEY REPRESENTATIVES:

Tony Farmer (TTLA): Mr. Farmer noted the practical effect of the section permitting the Department to approve all attorney fees is the elimination of additional court costs and attorney fees paid by the employer and delay and inconvenience to the parties and attorneys. The current law that requires attorney fees above the threshold to be approved by a court causes additional expenses and delays for no practical purposes.

Gregg Ramos (TBA): Mr. Ramos stated the $10,000 threshold amount for attorney fees should continue to be indexed annually based on change in the increase in the state's average weekly wage.

SB 446 by Burchett / HB 1635 by Ferguson

Present Law

TCA §50-6-121 creates an advisory council on workers' compensation. The voting members include three (3) who represent employees and three (3) who represent employers. The statute provides that in making appointments of the employer representatives, the4 appointing authorities (Governor, Lt. Governor/Speaker of the Senate and Speaker of the House of Representatives) are to strive to ensure a balance of a commercially insured employer, self-insured employer or an employer who operates a small business.

Proposed Change

SB 446 / HB 1635 requires one employer representative to be a representative from self-insured pools.

Practical Effect

While the bill will require one representative from "self-insured pools", the bill does not provide a definition of "self-insured pools".

TCA §50-6-405 provides for authorized self-insured employers and authorized groups of 10 or more employers, with the permission of a trade or professional association board of directors, to pool their liabilities for the purpose of qualifying as as self-insurers. Both are authorized by the Commissioner of Commerce and Insurance.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

The Council members noted it is unclear what is meant by "self-insured pool". In the Advisory Council's history, there has always been a member of the Council that insured their workers' compensation liability through a pool.

SB 1043 by Finney, L. / HB 595 by Turner, M.

Present Law

TCA §50-6-121 provides the chair and co-chair of the special joint legislative committee on workers' compensation (*TCA* §50-6-130) serve as ex officio, nonvoting members of the Workers' Compensation Advisory Council.

Proposed Change

SB 1043 / HB 595 deletes the chair and co-chair as ex officio, non voting members of the Advisory Council and substitutes the chair or co-chair of the standing committees of the House and Senate as ex officio, nonvoting members of the Council.

Practical Effect

The bill places the "chair or co-chair" (Rep. Turner has indicated he will amend the bill to say chair and vice-chair) of the House Consumer and Employee Affairs Committee and the Senate Commerce, Labor and Agriculture as ex officio, nonvoting members of the Council in place of the chair and co-chair of the Joint Committee.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

The Advisory Council defers to the General Assembly on the issue addressed by the bill.

SB 1222 by Cooper / HB 1571 by Curtiss

Present Law

TCA §50-6-121(a)(1)(f) provides the following are to be ex officio, nonvoting members of the Advisory Council: chair and co-chair of the joint legislative committee on workers' compensation; the commissioner of commerce and insurance and the commissioner of labor and workforce development.

TCA §56-5-320(d) authorizes the rate service organization, subject to the approval of the commissioner of commerce and insurance, to develop and file rules reasonably related t the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan and the uniform classification system.

Proposed Change

Section 1 of SB 1222/HB 1571 eliminates all ex officio, nonvoting members of the Workers' Compensation Advisory Council.

Section 2 of SB 1222/HB 1571 requires the rate service organization to file rules related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan and the uniform classification system with the Advisory Council before approval by the Commissioner of Commerce and Insurance.

Practical Effect

The practical effect of the bill is as outlined in the proposed change.

SB 1473 by Tracy / HB 1563 by Curtiss

Present Law

TCA § 50-6-204(c) references payment of an assessment to the Second Injury Fund in death cases that was repealed years ago.

TCA § 50-6-205(b)(1) references the incorrect subdivision of the definition section of the workers' compensation law (*TCA* § 50-6-102).

TCA § 50-6-208(f) is a section that authorized a pilot project for hiring outside attorneys to defend the Second Injury Fund. The pilot project is no longer in operation.

Proposed Change

SB 1473 / HB 1563 deletes the references outlined above.

Practical Effect

The practical effect is the same as the proposed change.

SB 1884 by Jackson / HB 1138 by Buck

Present Law

TCA §50-6-419 (enacted in 1996) requires the Commissioner of Labor/WFD to promulgate claims handling standards. These claims handling standards became effective on February 28, 1998.

Proposed Change

SB 1884 / HB 1138 adds a new subsection to *TCA* §50-6-419 that requires the Commissioner of Labor/WFD to deliver any proposed revisions of the claims handling standards to the Advisory Council for comment within 45 days and requires the Commissioner to provide the special joint committee on workers' compensation with the proposed revisions for comment. These requirements will apply to any revision of the claims handling standards after July 1, 2007.

Practical Effect

The bill requires consultation with the Advisory Council and the Joint Committee prior to any changes by the department to the claims handling standards.

Informational Note

The claims handling standards (Rule 0800-2-14) are out of date and conflict with several provisions of the 2004 Reform Act.

BILLS NOT CONSIDERED BY COUNCIL

[SPONSORS OR INTERESTED PARTIES INDICATED BILL WOULD NOT BE PURSUED IN PRESENT FORM]

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SB 1745 by Ketron / HB 1646 by Mumpower

Present Law

SECTION 1: *TCA* §50-6-102(10)(B) defines "employee" to include a sole proprietor or partner who devotes full time to the proprietorship or partnership and elects to be included in the definition of "employee" by filing written notice with the division of workers' compensation at least 30 days before an injury or death. The acceptance may be withdrawn by giving notice of withdrawal to the division.

The Department of Labor/WFD has 2 forms related to this issue: Form I-4 "Election of Sole Proprietor or Partner To Come Within the Provisions of the Tennessee Workers' Compensation Law" and Form I-5 "Notice of Withdrawal of Sole Proprietor or Partner Election".

SECTION 2: *TCA* §50-6-113(f)(1) requires any person engaged in the construction industry to carry workers' compensation insurance except sole proprietors and partners are not required to carry insurance on themselves.

Proposed Change

SECTION 1: The first section of SB 1745 / HB 1646 amends *TCA* §50-6-102(10)(B) by redrafting the entire subdivision. The proposed amendment states that a sole proprietor or partner who devotes full time to the proprietorship or partnership **and elects either to be covered or not to be covered as an "employee" under the operation of the Workers Compensation Law shall** file a written notice with the division at least 30 days prior to injury/death and permits withdrawal of election by giving notice of the change to the division.

SECTION 2: This section addresses sole proprietors/partners in the construction industry - the amendment states they are not required to carry workers' compensation on themselves **if they elect not to be covered pursuant** *TCA* §50-6-102(10)(B).
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SB 1745 / HB 1646, continued.

Practical Effect

SECTION 1: This section appears to require each and every sole proprietor or partner who devotes full time to the business to file a form with the division of workers' compensation stating whether they do or do not want to be covered by workers' compensation. The amendment does use the word "shall" in describing the filing of the form while the current statute does not. However, the Supreme Court has held notice provisions in the workers' compensation law to be directory, rather than mandatory. (See, Informational Note below)

SECTION 2: This portion of the bill changes current law by making *TCA* §50-6-102(10)(B) applicable to a sole proprietor or partner in the construction industry even though they may not devote full time to the business.

Informational Note

On February 28, 2007, the Tennessee Supreme Court held insurance coverage for a sole proprietor existed under a workers' compensation policy despite his failure to fully comply with the 30 day notice requirement of the statute. (*Scheele v. Hartford Underwriters Insurance Company*, February 28, 2007, No. E2006-01050-SC-R3-WC.) Relying on prior Supreme Court cases dating back several decades, the Supreme Court held the notice requirement of *TCA* §50-6-102(10)(B) is directory, not mandatory and thus requires only substantial compliance with the statute. Mr. Scheele had filed the form, paid his premium and was injured before 30 days had expired from the date the form was received by the division. The court held there was insurance coverage.

SB 1746 by Ketron / HB 1642 by Mumpower

Present Law

TCA §50-6-102(11) lists the factors to be considered in determining whether an individual is an "employee", "subcontractor" or "independent contractor":

1. The right to control the conduct of the work;
2. The right of termination;
3. The method of payment;
4. The freedom to select and hire helpers;
5. The furnishing of tools and equipment;
6. Self scheduling of working hours; and
7. The freedom to offer services to other entities.

The listed criteria were codified in 1991; case law had long listed these criteria as the factors to be considered when an issue arose as to whether a person was an employee - and thus entitled to workers' compensation benefits- or an independent contractor. The Supreme Court has held in many cases that while the right to control is the primary test for determining whether a person is an employee or independent contractor, it is not the sole test. Additionally, the Court has stated the criteria are not absolute, the criteria must not be applied abstractly, and no one criteria standing alone is conclusive.

Proposed Change

SB 1746 / HB 1642 changes the defined criteria that are to be considered when resolving the "employee/independent contractor" issue. The bill makes the subdivision applicable to only sole proprietors and partners. It creates a conclusive presumption of independent contractor status IF the person produces the following documents:

a. Business license;
b. Tax identification number or employer identification number;
c. General liability insurance in the name of the sole proprietor or partnership;
d. Contractor's license - if such license is offered by the State for the trade practiced;
e. Invoice from sole proprietor or partner detailing work performed and fee charged for services; **and**

SB 1746 / HB 1642 , continued.

Proposed Change, cont.

f. Copy of prior year's federal income tax returns with schedule K or other schedule attached showing the sole proprietor or partner's income was not reported as an employee.

In addition, the bill states that if the sole proprietor or partner has employees, they are required to produce proof of [a] workers' compensation policy covering the employees.

The bill also provides if the sole proprietor or partner is unable to provide the documents outlined, then the 7 factors (listed in current statute and outlined in case law) shall be considered.

Practical Effect

SB 1746 / HB 1642 changes *TCA* §50-6-102(11) in the following ways:

- by making it applicable to only sole proprietors and partners;
- by designating certain documents as conclusive proof of independent contractor status; and
- by permitting the 7 listed criteria to be "considered" **only** when the sole proprietor or partner is not able to produce required the documents.

If this bill becomes law, neither a court, nor the departments of commerce and insurance and labor/wfd, nor any other entity may look beyond the face of the documents produced to make a decision as to whether the actual facts of the specific situation are as the documents would indicate.

Under the current law, these documents can be used as proof of status, but they are not conclusive proof. Under current law, a person could have all of these documents and still be held to be an "employee" because someone else had the right to control the work to be performed, whether or not actual control was exercised.

The bill appears to apply equally to any and all entities who consider issues related to the status of a person as an independent contractor or employee - including insurance companies who perform audits after the policy has expired to see if the correct premium was paid - and departments of state government who have regulatory authority to assess fines for improper classification of employees.

SB 1746 / HB 1642 , continued.

Informational Note

The employee/independent contractor issue is a very complex one. This issue has become more intense since the Department of Labor and Workforce Development discontinued use of its "I-18 Form" on September 7, 2004. Prior to that time, the Department accepted the filing of a form that permitted a person to declare themselves as an independent contractor. While the form stated it was not to be used for audit purposes and it was not controlling in court, many thought employers used it to show non-coverage when indeed the person should have been covered as an employee.

When the Department discontinued the form, which had initially been promulgated at the request of the insurance industry, the insurance industry was not pleased. Issues continued to ferment around the determination of correct workers' compensation premiums and employers became concerned the auditors of policies were being compensated by how many independent contractors could be re-classified as employees for additional premium. The problems persisted and on June 1, 2005, the Commissioner of Commerce and Insurance issued a "BULLETIN" to all workers' compensation insurers, self-insured insurance pools and insurance producers (i.e., agents and brokers).

The stated purpose of the BULLETIN was "to communicate the Department's position regarding the responsibility of insurance companies and employers to determine whether an individual is an employee or an independent contractor for the purposes of obtaining and maintaining workers' compensation coverage for that individual." The Commissioner declared that if an employer designated a person as an independent contractor, rather than an employee, then it was incumbent on the insurance carrier to either document any basis for disagreement with the classification (based on the 7 criteria listed in the Code) or accept the employer's classification. In addition, the Commissioner cautioned the insurance companies not to rely upon the procurement of a minimum premium insurance policy to evidence the lack of an employer-employee relationship. Instead, the BULLETIN made it clear the insurance carriers should conduct an analysis of the factors outlined in the statute in making underwriting decisions.

Thus, it appears the current bill is designed to establish a way in which the insurance carriers will not be required to conduct this analysis. However, staff notes there are potential problems with the listed documentation that equals "conclusive proof" of independent contractor status:

>the bill does not require recently dated documents - as written, a person could produce outdated documents and meet requirement of document production;

>the invoice to be produced appears to be generic - and unrelated to the specific relationship at issue;

SB 1746 / HB 1642 , continued.

Informational Note, cont.

>a copy of a prior tax return does not prove the individual is still in the same business and that the type of work being conducted is the same;

>the "contractor's license" document is very narrow - not all independent contractors are in the contracting business (example: nail technicians, hair stylists, car detailers, etc.)

>the bill does not indicate to whom the documents are to be provided; and

>the bill does not indicate in what circumstances the documents are relevant - are the documents binding on a court or workers' compensation specialist's determination regarding the ordering of workers' compensation benefits?

>it is unclear whether the language at the top of the second page of the bill is to be included in the required documents for conclusive presumption status.

SB 1748 by Ketron / HB 1645 by Mumpower

Present Law

TCA §50-6-113(f)(1) requires any person who is engaged in the construction industry (principal contractors, intermediate contractors, or subcontractors) to carry workers' compensation insurance even if they have fewer than 5 employees. The section does exempt sole proprietors, partners and those who build for personal use from the requirement to carry workers' compensation coverage.

Proposed Change

SB 1748 / HB 1645 amends the third sentence of the statute by making it mandatory for sole proprietors and partners to carry workers' compensation insurance.

Practical Effect

The bill would require sole proprietors and partners to carry workers' compensation insurance on themselves. Thus, only those building for personal use would be exempt from workers' compensation coverage if engaged in the construction industry.

Informational Note

While the current statutory language does not state the "sole proprietor" and "partner" must be engaged in the construction industry for the exemption to apply - it might be prudent to amend the bill to state "sole proprietors and partners engaged in the construction industry shall also be required...".

NOTE: This bill conflicts with SB1745(Ketron)/HB1646(Mumpower) that requires a sole proprietor or partner in the construction industry to file an election not to be covered by workers' compensation in order to be exempt from the law. If this bill (SB1748/HB1645) passes, they would no longer have a choice to be exempt.

SB 1749 by Ketron / HB 1644 by Mumpower

Present Law

TCA §50-6-102(10)(B) defines "employee" to include a sole proprietor or partner who devotes full time to the proprietorship or partnership and elects to be included in the definition of "employee" by filing written notice with the division of workers compensation at least 30 days before an injury or death. The acceptance may be withdrawn by giving notice of withdrawal to the division.

TCA §50-6-113(a, e) provide that a principal or intermediate contractor, or subcontractor is liable for workers' compensation benefits to any employee who is injured while employed by any of the subcontractors of the principal, intermediate contractor or subcontractor. The statute does permit the subcontractor under contract to a general contractor to elect to be covered under the workers' compensation policy insuring the general contractor, with the general's permission. The general contractor then has the obligation to file written notice of the election with the Department of Labor/WFD. *TCA* §50-6-113(f)(1) requires any person engaged in the construction industry to carry workers' compensation insurance except sole proprietors and partners are not required to carry insurance on themselves.

Proposed Change

SB 1749 / HB 1644 adds new subsections to *TCA* §50-6-113. First, the bill provides that when a sole proprietorship or partnership fails to elect to cover himself/herself, the principal or general contractor is not liable to the sole proprietor or partner provided they are not actual employees of the principal or general contractor.

Second, the bill creates a "certification of noncoverage" to be provided by the Division of Workers' Compensation. The Commissioner is authorized to promulgate rules/regs regarding the procedures for issuing and renewing the "certification of noncoverage". A fee of $50.00 is permitted for each application for the "certification of noncoverage" or renewals and the "certification"is valid for two years.

Third, the bill provides that delivery of a current "certification of noncoverage" to the principal or general contractor by a sole proprietor or partners of a partnership constitutes a conclusive presumption that the sole proprietor/partner is not covered by the workers' compensation law. The bill provides the insurer of the principal or general contractor is not liable for injuries to a sole proprietor/partner who produce a "certification of noncoverage" and directs the carrier not to include compensation paid to the sole proprietor/partner in computing the insurance premium of the principal

SB 1749 / HB 1644 , continued.

Proposed Change, cont.

or general contractor. The employees of the sole proprietor/partners are not affected by the "certification of noncoverage" and can still seek workers' compensation benefits from the principal/general contractor.

Fourth, the bill classifies as a Class D felony any act by the principal/general contractor to force a sole proprietor/partner to obtain a "certification of noncoverage" or who, after being presented with a "certification of noncoverage" compels the sole proprietor/partner to pay for or contribute to workers' compensation coverage for the sole proprietor/partner. Also, any applicant who makes false statements when applying for a "certification of noncoverage" commits a Class D felony.

Practical Effect

The bill creates a new procedure by which a sole proprietor/partner can assure contractors that they are not required to have workers' compensation coverage on themselves. It deems the "certification of noncoverage" to be conclusive proof that the person is not an employee and that the principal/general is not liable for workers' compensation benefits. This is a change from current law because current questions about liability for injuries to sole proprietors/partners would be governed by the preponderance of evidence rule when determining whether a principal/general contractor is liable for benefits to a sole proprietor/partner who is working for a subcontractor.

Informational Note

This procedure is very similar to the former "I-18" form that has been discontinued by the Department of Labor/WFD. The bill does not indicate whether the Department is to investigate whether the applicant is being truthful on the application for a "certification of noncoverage" or whether the certification is given upon receipt of an application.

SB 1747 by Ketron / HB 1643 by Mumpower

Present Law

TCA §56-5-309(b) requires every insurer and rate service organization to provide a mechanism in the State of Tennessee by which any person who is "aggrieved" by the application of the insurance company's (and rate service organization's) insurance rating system may request (in writing) the insurer/organization to review the manner in which the rating system was applied to the insurance purchased. This section is applicable to any type of insurance; it is not restricted to only workers' compensation.

If the request is rejected or not granted within 30 days, then the matter proceeds as if the request for review has been rejected. The "aggrieved" person may within 30 days appeal to the Commissioner of Commerce and Insurance. The Commissioner is required to conduct a hearing and is authorized to ("may") affirm, modify or reverse the action of the insurer/organization.

The statute was amended in 2006 and authorizes the Commissioner to promulgate rules to effectuate the provisions of *TCA* §56-5-309 and specifically authorizes the Commissioner to assess the charges by the Secretary of State for any administrative hearing conducted under the section.

Proposed Change

SB 1747 / HB 1643 makes *TCA* §56-5-309(b) applicable to only non-workers' compensation insurers and enacts a new subsection (c) that is to govern application to the workers' compensation rating system. First, the "aggrieved" person shall be heard by the insurer upon written request. Then, if the person is still unhappy with the insurance company's decision, the person may appeal to a newly created "Workers' Compensation Appeals Board" which is required (shall) after a hearing to affirm, modify or reverse the action of the insurer. The hearing must conform to the provisions of the Uniform Administrative Procedures Act.

The bill creates a "Workers' Compensation Appeals Board" whose characteristics include:

- MEMBERSHIP
  - a. 5 voting members and 1 non-voting advisor
  - b. the 5 voting members include the following:
    - (1) one member from the Department of Labor and Workforce Development;
    - (2) one member from the Association of General Contractors;

SB 1747 / HB 1643, continued.

Proposed Change, cont.

(3) three members "from the private sector" who shall be referred to as "public members" :

>>at least one to be a private sector employer or a representative of a private sector employer located within the State;

>>at least one to be affiliated with a local chamber of commerce, small business federation or similar business association within the State;

>>at least one to be an employee of an insurance company, insurance broker, insurance agent, law firm, actuary or association of such entities;

>>two of the public members are to be appointed by the Commissioner of Commerce and Insurance and one is to be appointed by the Commissioner of Labor and Workforce Development; and

>>no two of the public members are to be affiliated with the same business organization, affiliated group, business league or labor organization;

c. each member's term shall be for three (3) years - - however, the public member's initial terms are staggered with one member serving 1 year, one serving 2 years and one serving 3 years;

d. the term of each "appeals board" shall commence on May 1 and expire on April 30 the following year;

e. the non-voting advisor is required to be an employee from the NCCI, with another "salaried employee" as an alternate and while the NCCI representative may participate in the discussion he/she has no vote in determining the appeal board's decisions;

f. the NCCI representative is required to attend each meeting, serve as technical and business resource, provide advice on issues related to experience modification factors, classification assignments, and other rules.

- MEETINGS

a. required to be held in Tennessee;

b. at beginning of each term, board must meet either in person or by teleconference to elect a chair who is responsible for organizing the agenda of each meeting and each hearing;

c. meetings must be quarterly and **"in accordance with the provisions of state law**";

SB 1747 / HB 1643, continued.

Proposed Change, cont.

- HEARINGS
  a. upon receipt of a grievance, a hearing is to be set on next available hearing date unless it is within 10 days of the next meeting and if so, it is to be scheduled for next quarterly meeting, unless parties agree otherwise;
  b. written notice of the hearing is required to be sent within 15 days of receipt of grievance, but not less than 10 days prior to the hearing;
  c. require a simple majority quorum present via person or teleconference
- DECISIONS
  a. must affirm, modify or reverse the action of the insurer;
  b. must be by majority vote of members present;
  c. must be supported by written memorandum stating reasons for decision;
  d. must be sent to both parties and the Commissioner of Commerce and Insurance;
  e. must advise of rights of appeal and the procedure to be followed.

Practical Effect

The bill creates an intermediate appeals process for grievances before requiring a formal administrative hearing by the Commissioner of Commerce and Insurance.

Informational Note

For many years prior to 2005, the Department of Commerce and Insurance operated an informal, intermediate appeals mechanism for grievances in lieu of direct appeal to the Commissioner that was called the "Workers' Compensation Appeals Panel". Its responsibility was similar to the responsibilities of the "Workers' Compensation Appeals Board" created by this bill, although it operated in a much less formal way as it did not operate under the UAPA rules. If the person who had filed the grievance disagreed with the decision of the "Panel" they could appeal to the Commissioner as permitted by *TCA* §56-5-309. An employee of NCCI staffed the "Panel" and kept minutes of the meetings, which occurred as often as the number of grievances dictated.

SB 1747 / HB 1643, continued.

Informational Note, cont.

The bill appears to create, by statute, an intermediate appeal process similar to one that previously functioned for years in the Department informally. However, the bill establishes a much more restricted mode of operation - especially since it mandates only 4 meetings per year and requires the meetings to be conducted "in accordance with the provisions of state law" which could be construed to be a very formalized hearing process.

There are sections of the bill and language within the bill that are somewhat confusing and could be troublesome to interpret if the bill is enacted:

A. the bill does not designate which of the "public members" are to be appointed by each of the commissioners - it simply says 2 are to be appointed by the commerce commissioner and 1 by the labor/wfd commissioner;

B. the language describing the third public member is written such that it may require the member to be an employee of an insurance broker or insurance agent instead of permitting a solo insurance agent/broker to serve;

C. there is no voting member from the Department of Commerce and Insurance - the entity that regulates workers' compensation insurance rates and carriers; instead, the bill states the voting member shall be from the Department of Labor/WFD;

D. with regard to the non-voting advisor member - - the bill could be interpreted as permitting an advisor member and an alternate - - and the term "salaried employee" describes only the alternate and the phrase is not defined;

E. terms of members section is confusing - - there is no beginning date and ending date of each term; terms are to be 3 years, yet staggered terms of 1, 2 and 3 years;

F. the May 1 - April 30 "term of the appeals board" is included in the section that discusses terms of members;

G. the appeals board is limited to only 4 meetings per year - there appears to be no authority to meet more often if the number of grievance appeals are too large to be handled in only 4 meetings each year; and

H. the term "in accordance with the provisions of state law" is much too broad to be a meaningful requirement for board meetings.

SB 496 by Burchett / HB 1603 by Overbey

Note: Representatives of the Tennessee Hospital Association stated at the Advisory Council meeting on March 16, 2007, that this bill was filed as a "caption bill".

Present Law

TCA §50-6-233 is the statute that outlines the power of the Commissioner of Labor/WFD to enforce the provisions of the workers' compensation law. Subdivision (c)(8) requires the rules promulgated by the Commissioner to include rules and regulations to establish a civil penalty, assessed at the discretion of the Commissioner, against a provider who refuses(after proper notification and appropriate time to respond) to repay a payor (insurer/employer/TPA) for payments made in excess of the rates set by the Medical Fee Schedule. The law also states that no provider is to be assessed a penalty solely for receiving a payment in excess of the Medical Fee Schedule.

The pertinent rule of the Department (0800-2-18-.15 "Penalties For Violations of Fee Schedules") states that no provider shall accept and no employer/carrier shall pay an amount for health care services in excess of the maximum permitted by the medical fee schedule. The provider or payor has 90 days from receipt or payment to correct the error without there being a violation of the rules. Further, a monetary penalty cannot be assessed unless a "pattern or practice of such activity" is found.

Proposed Change

SB 496 / HB 1603 amends the statute by deleting the discretionary nature of the penalty to be assessed by the Commissioner and changes the action for which a penalty can be assessed. The bill permits a penalty against a provider who, **after proper notification and appropriate time to respond,** has been found to have **fraudulently billed and collected** an amount that exceeds the Medical Fee Schedule.

Practical Effect

The bill will restrict the circumstances in which the Commissioner may issue a penalty against a provider. Under the language of the bill, the Commissioner is no longer permitted to penalize a provider who fails to repay a payor the amounts received in excess of the Medical Fee Schedule. Now, under the proposed change, the only way the Commissioner can penalize a provider is to find the provider fraudulently billed and collected an amount higher than the amount authorized by the Medical Fee Schedule - after proper notification and appropriate time to respond.

SB 496 / HB 1603, continued.

Informational Note

Commissioner Neeley reported to the members of the Advisory Council that no penalties have been assessed by the Commissioner against any medical provider under this provision of the law.