STATE OF TENNESSEE

WORKERS' COMPENSATION ADVISORY COUNCIL

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COMMENTS
re:

WORKERS' COMPENSATION LEGISLATION
~2006~

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VENUE pp. 8 - 10	SB#	Sponsor	HB#	Sponsor	DESCRIPTION
	3453 p. ***8***	Harper	***3846***	West	Changes venue statute if employer is county or municipal corporation venue of suit is where employer is located or where "incident" occurred
INSURANCE & SELF-INSURANCE pp. 11 - 19	SB#	Sponsor	HB#	Sponsor	DESCRIPTION
	2568 p. 11	Cooper	***2578***	West	Requires drug free premium credit to be based on employer's annual premiums and that if the employer is paying on a schedule, the credit shall be given over the schedule dates.
	2892 p. 15	Williams	***3471***	Curtiss	Changes some of the requirements for sponsoring trade that authorize pooling work comp liability
	2899 p. 17	Woodson	***3506***	Tindell	Exempts governmental entities with power to tax property from posting security as a self-insured employer

MEDICAL FEE SCHEDULE [MFS] pp. 20 - 27	SB#	Sponsor	HB#	Sponsor	DESCRIPTION
	2957 p. 20	Cooper	***3335***	McCord	Requires DOLWD Comm'r to hold rulemaking hearing on any changes to the MFS and requires annual review to include report on adequacy of provider networks and requires annual report to be filed with Joint Committee
	3261 p. 23	Burchett	***3351***	West	Authorizes DOLWD Comm'r to impose fines on providers who refuse to repay to a payor amounts paid that exceed the MFS
	3993 p. 25	Cooper	***4055***	Turner, M	**Note**: Bill is identical to SB2957/HB3335 Requires DOLWD Comm'r to hold rulemaking hearing on any changes to the MFS and requires annual review to include report on adequacy of provider networks and requires annual report to be filed with Joint Committee

WCAC pp. 28 - 29	SB#	Sponsor	HB#	Sponsor	DESCRIPTION
	3628 p. 28	Haynes	***3892***	Hargrove	Removes statutory requirement for Advisory Council's annual report to contain statistics; changes due date for case law report to on/before January 15
WORKERS' COMPENSATION BENEFITS & SPECIALISTS' ORDERS pp. 30 - 40	SB#	Sponsor	HB#	Sponsor	DESCRIPTION
	3228 p. 30	Burchett	***2886***	Turner, M	Provides state benefits to employees, beneficiaries or survivors for occupational diseases that are compensable under Federal legislation enacted in 2000 that compensates DOE employees who have certain diseases (beryllium disease, silicosis, etc.) - Exempts SIF, state, county and municipal employees
	3631 p. 36	Bryson	***3670***	Curtiss	Grants right to file "Request for Reconsideration" regarding Specialist's order
	3632 p. 40	Bryson	***3671***	Curtiss	Permits recovery from Second Injury Fund if a court finds that the employee was not entitled to benefits ordered by Specialist

ADMINISTRATION BILLS pp. 41 - 48	SB#	Sponsor	HB#	Sponsor	DESCRIPTION
	3890 p. 41	Kyle	***4004***	McMillan	(1)Allows "Administrator of Second Inj Fund to request MIRR Exam; (2) changes words "self-insured employer" to "employer" in section permitting penalties assessed by specialist; (3) requires employer, insurer or self-insured pool to file wage statement (for 52 weeks) w/in 15 days of date of injury unless parties stipulate max. comp rate applies -failure to file allows specialist to deem comp rate to be the maximum; (4) changes code section permitting parties to waive a BRC (not amended in 04)
	3900 p. 46	Kyle	***4032***	McMillan	Extends life of Part B of SIF statute 6 months til 12-31-06

SB 3453 by HARPER / HB 3846 by WEST

Present Law

TCA §50-6-225(a)(2) provides that if the parties are not able to reach a compromise of the claim at the benefit review conference then either party may file a civil action in the circuit court or the chancery court in the county in which the employee resides or in which the alleged injury occurred. If the injury occurs out of state and the employee resides outside the state, suit must be filed in any county where the employer maintains an office.

TCA §29-20-101, *et seq.* Is the "Tennessee Governmental Tort Liability Act". While that act generally regulates all actions against a governmental entity, *TCA* §29-20-308 is the venue section of the law and provides that suits must be brought in the county in which the incident occurred or the county in which the governmental entity is located [if operating in more than one county, then in the county of its principal office]. However, *TCA* §29-20-106 provides that the "Governmental Tort Liability Act" shall not apply to any action brought by an employee under the workers' compensation law.

The Tennessee Supreme Court recently held in *Lanius v. Nashville Electric Service*, 181 SW3d 661 (Tenn., December 2, 2005), that if a governmental entity has accepted the provisions of the Workers' Compensation Act, as permitted by that Act, then the governmental entity is bound by the venue provisions of the Workers' Compensation Act.

Proposed Change

SB 3453 / HB 3846 adds a specific subdivision to *TCA* §50-6-225(a)(2) that addresses venue in those cases in which the employer is a county or municipal corporation. The proposed amendment would limit the venue to the county in which the governmental entity is located or in the county in which the injury occurred if the claim is not resolved by the benefit review process.

Practical Effect

Obviously, this proposed change is intended to reverse the Supreme Court's decision in *Lanius.* The proposal grants those counties/municipal corporations who accept the provisions of the Workers'

SB 3453 / HB 3846, continued.

Practical Effect, cont.

Compensation Act greater rights than those given to a general employer. Also, the employee of a governmental employer will be more restricted as to where a lawsuit can be filed than those employed by a non-governmental entity employer.

Informational Note

The bill changes the venue provisions of the Workers' Compensation Act that were enacted in 1999 after the Workers' Compensation Advisory Council studied the venue issue and the issue of "forum shopping". Prior to 1999, the statute permitted suit to be filed by either party in the county in which the "petitioner" resides or in which the injury occurred. This permitted an employer to file suit in the county in which it was located, even it that location was not the county in which the worker was employed.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYEE REPRESENTATIVES:

Jerry Lee: Mr. Lee stated that the purpose of having venue in the county where the employee lives is that if the employee is seriously injured, it is easier to obtain his medical treatment. This current venue statute favors the injured employee because of the nature of his injuries.

Othal Smith: Mr. Smith stated that NES, who employs persons who reside in the counties that are adjacent to Nashville, is trying to gain an advantage with the bill because they think the awards in Davidson County are more conservative than the awards in the adjacent counties. He said that historically the worker has always been able to file suit in the county where the employee lives in order to avoid forum shopping by the employer. In his opinion, NES is seeking to do a little forum shopping that they feel would be to their advantage.

SB 3453 / HB 3846, continued.

Jack Gatlin: Mr. Gatlin stated if you are going to lean toward where the company is located surely it should also include the county of the employee's residence.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts stated:

- local governments probably consider the workers' compensation venue statute to be a unique imposition since the venue rule in the Governmental Tort Liability Act is different;
- "venue shopping" is an argument that can be made; but since benefit review conferences are now mandatory, the issue of "forum shopping" will decline substantially. As a result, it may be time to revisit the issue; and
- since governmental entities have an option as to whether they participate in the workers' compensation program or not, if the issue of venue is a factor for a governmental entity not to accept the workers' compensation law, this is not the direction one wants to see governmental entities go.

ATTORNEY REPRESENTATIVES:

Kitty Boyte (TDLA): Ms. Boyte pointed out that other governmental entities may not be as interested in changing the venue statute to require workers' compensation cases to be filed in the county of the governmental entity, especially those counties that are considered to be less conservative than Davidson County.

Gregg Ramos (TBA): Mr. Ramos observed that it would be a good idea for the language of this bill to track the language of the Governmental Tort Liability Act which states that suits may be brought in:

- the county in which the governmental entity is located;
- the county in which the accident/incident occurred giving rise to the cause action;
- the county where the principal office is found if the governmental entity is operating in more than one county.

SB 2568 by COOPER / HB 2578 by WEST

Present Law

TCA §50-6-418 requires the Department of Commerce & Insurance to approve rating plans for workers' compensation insurance that give specific identifiable consideration in the setting of rates to employers that implement a drug-free workplace program (implemented pursuant to the Department of Labor/Workforce Development rules). The plans must be actuarially sound and must state the savings anticipated to result from such drug testing. The credit must be at least 5% unless the Commissioner of C&I determines the 5% to be actuarially unsound.

The Department of Labor/WFD implemented Rules of the Drug Free Workplace Program, effective April 11, 1998. Rule 0800-1-12-.02(5) provides that the insurance company or self-insured pool program administrator must apply the premium credit upon receipt of notification from the Department of Labor/WFD that the employer has implemented a certified drug-free workplace program or make payment for the credit effective after the annual premium audit has been completed.

In 1998, the NCCI, the designated rate service organization, submitted a filing [Item 04-TN-98 - Revised Tennessee Drug-free Workplace Program] at the request of the Department of Commerce & Insurance that relates to the computation of the drug-free workplace credit. The Department was concerned that as a result of the inclusion of the employer's experience rating offset in the calculation [as was being done prior to 1998], some employers would receive a "net" credit that may be less than 5%. Therefore, the NCCI submitted revised basic manual rules, which are still in effect, that require the credit to be calculated before application of the experience modification, any other premium surcharge, premium discounts and expense constants.

An amendment to *TCA* §50-6-418 in 2005 requires the credit to be applied separately to each individual company for an employer having more than one company under one workers' compensation insurance policy.

SB 2568 / HB 2578, continued.

Proposed Change

SB 2568 / HB 2578 requires the drug-free workplace premium credit:

- to be based upon the employer's total annual premiums;
- to take effect upon approval of eligibility for the credit; and
- to be credited equally over the employer's payment schedule, if any.

Practical Effect

The current NCCI Basic Manual for Tennessee Workers' Compensation contains a premium algorithm by which an employer's **estimated annual premium** is calculated. Currently, the drug-free workplace credit is applied **after** the manual premium is determined (by multiplying the payroll by the loss costs/rate) but **before** application of the employer's experience mod factor, schedule rating, premium discount, terrorism risk load or domestic terrorism charge. The Department of Labor/WFD's rules permit an insurance company to apply the credit when it receives notification that the employer has a certified program **OR** after the completion of the premium audit.

The bill would change the premium algorithm and require the NCCI to submit a new filing related to the Tennessee drug-free workplace credit program. The drug-free workplace premium credit would not be applied until **after** the application of all the other factors. It would be the last calculation before the actual premium is determined.

The bill also addresses those employers who pay their premiums on an installment plan. The bill would require the drug-free workplace premium credit to be given equally over the payment schedule. This provision would necessitate a change in the rules of the drug-free workplace program.

Informational Note:

The language of the bill appears to have two inconsistent sentences. While the first sentence states the credit shall be based on total annual premiums, the third sentence requires the credits to be applied equally over any payment schedule applicable to the policy. The term "total annual premium" usually refers to the final premium the employer is determined to have been required to

SB 2568 / HB 2578, continued.

pay and is determined after a premium audit. Workers' Compensation insurance policies provide that the insurer may audit the policy within 90 days after the expiration of the policy period. Thus, at the time the policy is issued, the premium is estimated (this is consistent with the language of the algorithm). Thus, it appears an employer's total annual premium is not capable of calculation until either the expiration of 90 days following the end of the policy term or until the premium audit is completed.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS:

Scott White: Mr. Scott White, Deputy Commissioner, Department of Commerce & Insurance, distributed a sample algorithm that showed the calculation of the premium with a drug-free workplace credit under current law and the calculation under the proposed bill. He stated that calculations by the NCCI and by the Department indicate the change in premiums will not be significant. The bill will result in between a +0.7% increase in premiums or a -0.1% decrease in premiums depending on how the companies apply their other premium credits. This would result in a change in workers' compensation premium taxes between an increase of $39,000 in premium taxes to a $4400 decrease in premium taxes.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts made the following comments concerning the bill:

- He doubts Chairman West, the House sponsor, intends to put a program in place that gives employers the premium credit money up front since from the estimates he has seen it will cost the business community $2 Million dollars in additional premiums because of apparent drafting problems in the bill.
- The bill changes the current algorithm for calculation of the drug-free premium credit and this change is totally inconsistent with what the insurance industry does in most states.

SB 2568 / HB 2578, continued.

- A part of the problem is that even though the legislation gives the premium discount up front, you still have to deal with a potential clean-up as a result of the premium audit. While you can give a premium discount on an estimated premium, it is impossible or improper to give an advance credit on a final total premium that cannot be determined until after final audit.
- When an employer changes carriers in the midst of the policy period and is using third party finance companies - this will results in an almost impossible process to get a third party finance company into the rebate business. The insurance company, not the finance company, should do this.

Mr. Pitts said he believes the intent of the Chairman West is to get timely consideration for the premium discount. He noted the business community has no problem with the part of the bill that gives timely consideration for the premium credit. However, he stated he believes there is a drafting problem that would appear to cost the business community more in additional premiums than will be realized in timely credits. Therefore, he suggested the insurance industry and the Department of Commerce & Insurance meet with Chairman West to see if they could assist in developing language that will prevent this proposal from becoming a convoluted nightmare.

INSURANCE COMPANY REPRESENTATIVES:

Jerry Mayo: Mr. Mayo noted that both insurance companies and third party finance companies finance premiums. He stated if the bill is pursued it should also address the finance company aspect. He stated that the bill is giving a discount on largely pass through items, as opposed to real premiums; therefore, you are discounting items that were never intended to be discounted. The current calculation method is the actuarially sound way to calculate the premium discount.

SB 2892 by WILLIAMS / HB 3471 by CURTISS

***THE DEPARTMENT OF COMMERCE & INSURANCE SUBMITTED A PROPOSED AMENDMENT TO THE BILL. THE COUNCIL CONSIDERED THE AMENDMENT.**

Present Law

TCA §50-6-405(c)(1) permits employers to pool their workers' compensation liability, with the permission of a trade or professional association. The statute also provides that the "pool" continues only as long as the sponsoring association deems the pool is operating in compliance with the associations's constitution/bylaws/ rules. The statute sets other qualifications for a group of pooling employers.

Proposed Change

SB 2892 / HB 3471 deletes language in *TCA* §50-6-405(c) that grants the sponsoring association the power to terminate the pooling arrangement if the pool is not in compliance with the association's constitution/bylaws/rules. The bill then adds specific requirements/qualifications for a group of pooling employers that pertain to the relationship with the sponsoring association. The new provisions:

- require the participants in the pool to be and remain members of the sponsoring trade association;
- permit the trade association to determine whether the pool shall remain in existence;
- requires the pool members to provide information requested by the trade association; and
- provides that the sponsoring association shall not bear any liability for the act/omission of the pool.

Proposed Department Amendment

The amendment proposed by the Department of Commerce & Insurance would add a sentence to subparagraph (6) that requires the sponsoring association to confirm (at least annually) that the participants in the pool are still members of the sponsoring association. The amendment also adds a subparagraph (10) that gives the commissioner authority to promulgate rules/regs establishing civil penalties for violation of the statute or the rules.

SB 2892 / HB 3471, continued.

Practical Effect

The proposed bill and amendment:

- more specifically defines the relationship between a sponsoring trade or professional association and the "pool" formed by 10 or more employers of the same group;
- establishes that the association has the power to determine if the pool remains in existence;
- establishes that the association is not legally responsible for the acts or omissions of the "pool";
- requires annual reporting that the members of the pool are still members of the sponsoring association; and
- creates authority for the commissioner to establish monetary penalties against either the sponsoring association or the pool for violations of the newly created subdivision in *TCA* §50-6-405(c).

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts noted most, if not all, of the sponsoring associations and the Department of Commerce & Insurance are in support of the bill.

SB 2899 by WOODSON / HB 3506 by TINDELL

Present Law

TCA §50-6-106 provides that the Workers' Compensation Law does **not** apply to the state of Tennessee, counties or municipal corporations **unless** they accept the provisions of the Law by filing written notice of acceptance with the Division of Workers' Compensation.

TCA §50-6-405 requires every employer under the Tennessee Workers' Compensation Law to either:

- insure the employer's work comp liability;
- possess a valid "certificate of authority" from the Commissioner of Commerce & Insurance to self-insure its liability; or
- enter into an agreement to pool their workers' compensation liability with permission of a trade or professional association (employers of the same group).

TCA §50-6-405(b)(1) requires an authorized self-insured employer to file and maintain security in an amount (determined by the Commissioner of Commerce & Insurance) **not less than $500,000**.

Proposed Change

SB 2899 / HB 3506 adds a new section to *TCA* §50-6-405(b)(1) that exempts Tennessee governmental entities who wish to self-insure their workers' compensation liability from the security requirements established by the statute. To be eligible for the exemption the governmental entities must:

- have the statutory power to tax real and personal property within their boundaries and
- maintain at lease two credit ratings of "A" or better (or the equivalent) for general obligation debt from a nationally recognized major credit rating agency.

Practical Effect

The proposed bill would eliminate the $500,000 (or greater) security requirement of certain governmental entities (to be provided to the Commissioner of Commerce & Insurance) in order to be authorized to self-insure its workers' compensation liability.

SB 2899 / HB 3506, continued.

Informational Note

The Department of Commerce & Insurance currently has 22 self-insured governmental entities.

The Advisory Council Staff is not clear as to where the proposed language is intended to be inserted in the current statute. The bill states it is to be added immediately preceding the last sentence of TCA 50-6405(b)(1). However, the last sentence of that subsection is (b)(1)(K), which requires the security to be filed on an approved form, etc. It appears the proposed language might be more appropriately added as a new subdivision (b)(1)(L).

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS:

Scott White: Mr. White, Deputy Commissioner, Department of Commerce & Insurance noted the Department has concerns regarding the proposed bill. He stated:

- The $500,000 security required by the statute is a minimum.
- Currently, the Department's policy is to allow self-insured governmental entities to post only the minimum security of $500,000.
- The Department thinks this $500,000 minimum for these entities needs to remain in effect. Governments can and have gone bankrupt and have run into financial problems.
- If something goes financially wrong with one of the self-insured governmental entities, the $500,000 minimum amount of money will be available to allow payments to injured employees while the governmental entities are working on ways to raise revenue.
- The Department is permitting a governmental entity to use its own resources as a pledge for securing its workers' compensation liability. The department is not requiring the entity to purchase a separate security bond.

SB 2899 / HB 3506, continued.

James G. Neeley: Commissioner Neeley stated that with the experiences the Department has had it would be detrimental not to require this $500,000 minimum security.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts noted he tends to support the view of the Department of Commerce & Insurance, because there is always a question of what governmental entities have revenue raising capabilities. There have been two or three governmental entity funds that have had some problems and this is probably not a good time to venture down this path.

LOCAL GOVERNMENT REPRESENTATIVES:

Kenny McBride: Mayor Mr. McBride noted when Carroll County was self-insured, they had a million dollars in a separate fund for workers' compensation. While the interest went into the general fund, the million dollars was pledged for workers' compensation.

EMPLOYEE REPRESENTATIVES:

Jerry Lee: After the statements of the Department of Commerce & Insurance Mr. Pitts, Mr. Lee announced the three employee representatives concur with the general consensus of the statements made.

SB 2957 by COOPER / HB 3335 by McCORD

Present Law

TCA §50-6-204(I) is the statute that authorized the Commissioner of Labor/WFD to establish by rule a comprehensive medical fee schedule and related system. The Department has three sets of "Public Necessity" rules/regulations currently in effect that govern the medical fee schedule. These "Public Necessity" rules expire on June 30 and will be replace by permanent rules.

TCA §50-6-204(i)(3) required the Commissioner to submit the proposed rules to the Medical Care and Cost Containment Committee (MCCC) and to the Advisory Council by December 1, 2004. These two entities were to provide comment concerning the rules to the Commissioner and to the Joint Committee on Workers' Compensation.

TCA §50-6-204(i)(6) requires the Commissioner, in consultation with the MCCC and the Advisory Council, to annually review the medical fee schedules and, where appropriate, to revise them.

Proposed Change

SB 2957/ HB 3335 adds a provision to *TCA* §50-6-204(i)(3) to require the Commissioner to:

- submit any proposed changes to the rules to the MCCC and the Advisory Council;
- hold a public hearing; and
- provide "proper notice" as part of the rulemaking process.

The bill also adds a provision to *TCA* §50-6-204(i)(6) to require the Commissioner's annual review of the medical fee schedule to include a report on the adequacy of the "health care provider networks" across the state providing care in workers' compensation cases. It also requires the Commissioner to file an annual report on the impact of the medical fee schedule and its revisions based on the findings of the "department, cost containment committee and advisory council". The annual report is to be filed with the special joint committee on workers' compensation.

SB 2957/ HB 3335, continued.

Practical Effect

The bill adds a statutory requirement that the department conduct rulemaking hearings each time there is a proposed change to the medical fee schedule. [The UAPA requires a hearing only if one is requested.] Also, the bill will require the department to determine what providers are participating in workers' compensation claims and to report annually on the impact of the medical fee schedule.

Informational Note:

The bill uses the term " health care provider networks". *TCA* §50-6-122 refers to health maintenance organizations and preferred provider organizations. *TCA* §50-6-204 refers only to "attending physician", "physicians or surgeons", "doctor of chiropractic". There does not appear to be any definition of "health care provider networks".

Most people think of "health care provider networks" as referring to preferred provider organizations (PPOs). If the sponsor wants the department to report on all physicians, surgeons, chiropractors who treat workers' compensation claimants then consideration might be given to changing the language of the bill.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS

James G. Neeley	Commissioner Neeley stated the Department has no problem with the bill's requirement to submit potential changes to the medical fee schedule to the Medical Care and Cost Containment Committee and the Advisory Council; to conduct public hearings; and to provide notice through the normal process of the Register.

SB 2957/ HB 3335, continued.

Commissioner Neeley noted the bill should define the term "health care networks" as the Department would need to know specifically what providers the Department is to monitor and that the sponsor consider changing the language to coincide with current law.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts stated he thought the sponsor was interested in requiring the Department to report on the adequacy and sufficiency of health care providers in Tennessee who are treating injured employees who have workers' compensation claims.

MEDICAL REPRESENTATIVES:

Sam Murrell, M.D.: Dr. Murrell suggested monitoring the number of doctors or networks who are accepting discounts off the medical fee schedule as he has heard of an undercurrent in the medical community of doctors electing not to treat workers' compensation patients if they do not receive the medical fee schedule rate.

CHAIR

Treasurer Dale Sims: Mr. Sims cautioned that a vicious cycle may result if the bill requires another public hearing following every change to the rules that is made as a result of a public hearing. He stated this is the reason why we designate an official to finally determine the rules that will be made permanent rules.

SB 3261 by BURCHETT / HB 3351 by WEST

Present Law

TCA §50-6-204(i) is the statute that authorized the Commissioner of Labor/WFD to establish by rule a comprehensive medical fee schedule and related system. The Department has three sets of "Public Necessity" rules/regulations currently in effect that govern the medical fee schedule. These "Public Necessity" rules expire on June 30 and will be replaced by permanent rules that have already been promulgated.

The rules/regulations establish a procedure by which a provider or insurer can recover payments that are in excess of or less than required by the medical fee schedule.

TCA §50-6-233 grants unlimited rulemaking authority (in addition to *TCA* §50-6-118) to the Commissioner of Labor/WFD to promulgate rules to implement the provisions of Chapter 6. The statute specifies seven (7) specific rules/regs the Commissioner is required to promulgate.

Proposed Change

SB 3261/ HB 3351 adds a new subdivision to *TCA* §50-6-233 that authorizes the Commissioner of Labor/WFD to establish a civil penalty to be assessed, at the Commissioner's discretion, against a provider who refuses to repay an amount it received from a payor in excess of the medical fee schedule, provided appeals are exhausted. The bill also provides that the civil penalty shall not be assessed **solely** for receiving payment from a payor that exceeds the medial fee schedule.

Practical Effect

The proposed bill prohibits any civil penalty against a provider who merely receives a payment from a payor that exceeds the applicable medical fee schedule; however, it permits a penalty if the provider refuses to repay monies received from a payor that exceed the applicable medical fee schedule, after "all appeals" are exhausted.

SB 3261/ HB 3351, continued.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS:

James G. Neeley: Commissioner Neeley announced that to trigger penalties to be assessed by the Department for violation of the medical fee schedule there must be a pattern and practice of activity. This applies to billing matters also.

CHAIR

Treasurer Dale Sims: Mr. Sims noted the Workers' Compensation Fraud Act is still in effect and it also requires a pattern and practice of activity to constitute a violation of the act.

Commissioner Neeley responded that the Department has been discussing the issue of fraud in the broadest sense and the Department has determined if it becomes aware of potential fraud that the Department intends to investigate.

SB 3993 by COOPER / HB 4055 by TURNER, M.

***NOTE: THIS BILL IS IDENTICAL TO SB2957; THEREFORE, THE ANALYSIS IS IDENTICAL.**

Present Law

TCA §50-6-204(i) is the statute that authorized the Commissioner of Labor/WFD to establish by rule a comprehensive medical fee schedule and related system. The Department has three sets of "Public Necessity" rules/regulations currently in effect that govern the medical fee schedule. These "Public Necessity" rules expire on June 30 and will be replace by permanent rules.

TCA §50-6-204(i)(3) required the Commissioner to submit the proposed rules to the Medical Care and Cost Containment Committee (MCCC) and to the Advisory Council by December 1, 2004. These two entities were to provide comment concerning the rules to the Commissioner and to the Joint Committee on Workers' Compensation.

TCA §50-6-204(i)(6) requires the Commissioner, in consultation with the MCCC and the Advisory Council, to annually review the medical fee schedules and, where appropriate, to revise them.

Proposed Change

SB 3993/ HB 4005 adds a provision to *TCA* §50-6-204(i)(3) to require the Commissioner to:

- submit any proposed changes to the rules to the MCCC and the Advisory Council;
- hold a public hearing; and
- provide "proper notice" as part of the rulemaking process.

The bill also adds a provision to *TCA* §50-6-204(i)(6) to require the Commissioner's annual review of the medical fee schedule to include a report on the adequacy of the "health care provider networks" across the state providing care in workers' compensation cases. It also requires the Commissioner to file an annual report on the impact of the medical fee schedule and its revisions based on the findings of the "department, cost containment committee and advisory council". The annual report is to be filed with the special joint committee on workers' compensation.

SB 3993/ HB 4005, continued.

Practical Effect

The bill adds a statutory requirement that the department conduct rulemaking hearings each time there is a proposed change to the medical fee schedule. [The UAPA requires a hearing only if one is requested.] Also, the bill will require the department to determine what providers are participating in workers' compensation claims and to report annually on the impact of the medical fee schedule.

Informational Note:

The bill uses the term " health care provider networks". *TCA* §50-6-122 refers to health maintenance organizations and preferred provider organizations. *TCA* §50-6-204 refers only to "attending physician", "physicians or surgeons", "doctor of chiropractic". There does not appear to be any definition of "health care provider networks".

Most people think of "health care provider networks" as referring to preferred provider organizations (PPOs). If the sponsor wants the department to report on all physicians, surgeons, chiropractors who treat workers' compensation claimants then consideration might be given to changing the language of the bill.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS

James G. Neeley	Commissioner Neeley stated the Department has no problem with the bill's requirement to submit potential changes to the medical fee schedule to the Medical Care and Cost Containment Committee and the Advisory Council; to conduct public hearings; and to provide notice through the normal process of the Register.

SB 3993/ HB 4005, continued.

Commissioner Neeley noted the bill should define the term "health care networks" as the Department would need to know specifically what providers the Department is to monitor and that the sponsor consider changing the language to coincide with current law.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts stated he thought the sponsor was interested in requiring the Department to report on the adequacy and sufficiency of health care providers in Tennessee who are treating injured employees who have workers' compensation claims.

MEDICAL REPRESENTATIVES:

Sam Murrell, M.D.: Dr. Murrell suggested monitoring the number of doctors or networks who are accepting discounts off the medical fee schedule as he has heard of an undercurrent in the medical community of doctors electing not to treat workers' compensation patients if they do not receive the medical fee schedule rate.

CHAIR

Treasurer Dale Sims: Mr. Sims cautioned that a vicious cycle may result if the bill requires another public hearing following every change to the rules that is made as a result of a public hearing. He stated this is the reason why we designate an official to finally determine the rules that will be made permanent rules.

SB 3628 by HAYNES / HB 3892 by HARGROVE

Present Law

TCA §50-6-121(c) requires the Advisory Council to include the following in its annual report (due on or before July 1 of each year):

- a summary of significant court decisions relating to workers' compensation and an explanation of their impact on existing policy and
- a summary of all permanency awards broken down by judicial district.

TCA §50-6-121(f) requires the Advisory Council to develop evaluations, statistical reports and other information from which the general assembly may evaluate the Reform Acts of 1992 and 1996 and subsequent changes.

TCA §50-6-121 (g) requires the Advisory Council to include a report on activities and outcomes of the Workers' Compensation Fraud Act (*TCA* §56-47-101, *et seq*.).

Proposed Change

SB 3628/ HB 3892 changes three subsections of the statute related to the Advisory Council by:

- deleting the requirement that the Annual Report contain the significant cases report and the list of PPD awards by judicial districts;
- deleting the requirement that the Annual Report contain a report on the Fraud Act;
- changing from mandatory to permissive the statute regarding the development of evaluations and statistical reports that evaluate the reform acts;
- requiring the date the report regarding significant court decisions is due to on or before January 15 of each year.

SB 3628/ HB 3892, continued.

Practical Effect

The Advisory Council has included statistics in its Annual Report for the last five years, but only in the last report has it been statutorily mandated that PPD awards by judicial district be included. The bill deletes the mandatory statistical reporting. However, the Advisory Council still would have the right to report statistics or other information from which the general assembly can evaluate the impact of legislative changes if it wishes to do so.

The TBI Fraud Unit was dissolved several years ago and fraud statistics have not been included in either the 2003 or 2004 Annual Report. The deletion of this section removes a statutory duty of the Council as it is now impossible to gather accurate fraud data from any source.

The bill also conforms the statute to the Advisory Council's practice of sending the case law summary to the general assembly shortly before the beginning of session instead of including it in the Annual Report mid-year.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

CHAIR:

Treasurer Dale Sims: Chairman Sims noted this bill was filed on behalf of the Advisory Council.

SB 3228 by BURCHETT / HB 2886 by TURNER, M.

*THE ADVISORY COUNCIL ALSO REVIEWED THE AMENDMENT SUBMITTED BY SPONSORS: The proposed amendment is not substantive. It changes the term "Second Illness Fund" to "Second Injury Fund" and changes the second paragraph numbered (6) to (7).

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 3228 / HB2886, as amended, 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.

SB 3228 / HB2886, continued.

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.

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.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

INSURANCE COMPANY REPRESENTATIVE:

Jerry Mayo: Mr. Mayo questioned whether the attorney fees permitted by the federal program is significantly less than allowed by Tennessee workers' compensation law. Chairman Sims stated if the federal claim is uncontested, attorney fees are 2% of the award and if the federal claim is contested, the attorney fees are 5% of the award.

Mr. Mayo stated since the bill eliminates the burden of proving causation then the he questioned why the state attorney fees should be so much higher. He suggested that the fees in the state claim should be the same as are allowed in the federal claims.

SB 3228 / HB2886, continued.

EMPLOYEE REPRESENTATIVES:

Othal Smith: Mr. Smith stated the Tennessee workers' compensation law compensates the attorney for work done, up to 20% of the award, and he does not think a law should be passed that compensates the attorney for money not earned. He suggested the sponsor consider a provision to limit attorney fees in these cases since the statute of limitations and notice defenses cannot be raised by the employer and the employee's attorney does not have to prove causation.

Mr. Smith further explained he thinks in this type of case and throughout the workers' compensation recovery process, lawyers should be paid for the work that they do. In those cases in which a lawyer spends a lot of time, energy and effort to obtain a benefit for a party, then that attorney should be paid more than an attorney who has a case that is resolved with very little effort. He stated there should be some recognition of this. Nobody wants to take anything away from an attorney who is helping an injured employee obtain these benefits however, he does not want to help the attorney who signs up 300 cases and take a portion of the money without the same amount of effort by the attorney. There should be some recognition that this has and could happen again.

Mr. Smith noted the Federal government provides benefits to veterans and the workers at these nuclear facilities should also be provided for.

ATTORNEY REPRESENTATIVES:

Tony Farmer: Mr. Farmer was unable to attend the meeting; he submitted his comments via letter. Mr. Farmer supports this bill and a copy of the letter will be provided to the recipients of this report.

SB 3228 / HB2886, continued.

Gregg Ramos: After a majority of the discussion, Mr. Ramos noted while he does not know anything about this particular Federal program, he has had experience in cases requiring coordination of federal and state benefits. He said these cases are very complicated and often require a great deal more work on the part of the attorney than the typical workers' compensation case. He suggested care should be exercised and one should not assume pursuing the state claim will be easy and straightforward.

Mr. Ramos stated, after listening to much of the discussion concerning the federal program, that the program appears it will a complicated process, not one that is simple and straightforward. He said he feels the determination as to attorney's fees in each individual case is a difficult process best left to the trial judge who has the statutory responsibility to make certain the fee is commensurate with the work done by the attorney.

Kitty Boyte: Ms. Boyte questioned why the state program is needed if the federal program compensates the employee. She stated the bill takes away the requirement that the employee must prove notice and causation and creates a "silver platter" program for state benefits. Ms. Boyte stated that more understanding is needed concerning the federal program.

Ms. Boyte inquired as to whether the employee must be permanently totally disabled to receive the federal benefits. If they are still working, then there would appear to be some potential liability for the second injury fund if the employee sustains a subsequent injury of a different type.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts stated that this is this is probably one of the most aggravating, difficult, complex subjects the Council has ever considered. He then gave an historical perspective of the issues:

The nuclear program was largely a secret operation run in this country 50-60 years ago and after lots of political bantering, the federal government has decided it should do something for workers who were probably victims of the work environment that they put into place in this country. As a result,

SB 3228 / HB2886, continued.

legislation was passed so the worker could get medical care and some level of compensation. However, there was a great deal of delay in getting the benefits to these workers.

The records and documentation are bad and from a social point of view it would appear that there is a good chance that if you make application you will receive consideration from the federal program. The Energy Department operates under contracts with vendors/contractors over time. Just like they have no records, the contractors that were operating in Oak Ridge are no longer in existence in Tennessee. If the Federal government had agreed to accept the entire liability, we would not be fretting as to how Tennessee is to put equity into this subject area.

Mr. Pitts suggested it appears that once an employee is approved for benefits by the Federal program, there is not a whole lot for the attorney or employee to do other than to line up and receive state workers' compensation benefits. Therefore, it raises the issue as to whether the attorneys are actually doing any work of any consequence for these workers.

Mr. Pitts said he has never seen anything so difficult to get comfortable with that you have so little factual information with which to make a decision. Proponents of the bill argue that to the extent employees are paid benefits, the current contractors will receive full reimbursement from the Department of Energy. The employers who are going to be paying the state workers' compensation benefits argue just a strongly that Federal reimbursement is not guaranteed as it must go through the Federal appropriation process and the contract prices have not been increasing. Therefore, Federal contractors, including the University of Tennessee, that had absolutely nothing to do with creating these injuries are at peril of what it is going to cost from their bottom line. He questioned where is the equity in penalizing a subsequent contractor who had nothing to with the injury period.

Mr. Pitts stated he has reached the point that he does not know who to believe; however, he does not believe anybody has it exactly right. He said he has problems with:

SB 3228 / HB2886, continued.

- penalizing people who had nothing to with the sins of the past when they should be going back to Congress seeking responsible relief to the problems created by the Department of Energy;
- putting existing contractors in peril for sins of the past;
- making a lot of lawyers rich for something that is a cakewalk if the bill passes; and
- if the employees get the Federal money first, which makes their state case, he does not believe there is an offset against the state money that is to be paid out in the workers' compensation claim.

Mr. Pitts explained while everyone should be concerned about the wrongs of the past, he is not convinced the passage of this bill in its present form provides any more justice to all the affected parties than we presently have today.

EX OFFICIO MEMBERS:

James G. Neeley: Commissioner Neeley stated that as the bill was drafted in 2005, the second injury fund could be liable; as currently drafted the bill excludes the second injury fund for liability; therefore, the Department has no problem with the bill.

SB 3631 by BRYSON / HB 3670 by CURTISS

*THE ADVISORY COUNCIL ALSO REVIEWED AN AMENDMENT SUBMITTED BY SENATOR BRYSON: The amendment changed the original bill's language that required the administrator to conduct an informal hearing to language requiring the administrator to conduct an informal conference with the affected parties. The analysis includes the changes made by the amendment in subsections (d)(1) and (d)(2) of the original bill.

Present Law

TCA §50-6-238(a) permits a workers' compensation specialist to order initiation, continuation or reinstitution or retroactive payment of temporary disability benefits by an employer or the employer's insurer and has the authority to order the provision of medical benefits. There is no statutory or regulatory procedure to permit appeal of the order of a specialist.

TCA §50-6-238(d) provides that if an insurer, self-insured employer or self-insured pool fails to comply with an order issued by a specialist within 15 days of receipt of the order, the Commissioner of Labor/WFD shall issue a $10,000 penalty. If proof is not received within 21 days of receipt of the order that the order has been complied with, the penalty increases by $1000 for each day of non-compliance. The statute does provide the right to appeal (pursuant to the UAPA) the penalty assessed for failure to comply with the order.

TCA §50-6-238(d) also provides that if there is non-compliance with the order for 30 days, the Commissioner of Labor/WFD is required to report the non-compliance to the Commissioner of Commerce & Insurance. Authority is granted to the Commissioner of C&I to consider the non-compliance as sufficient grounds to revoke the employer's status as a self-insured employer or self-insured pool and subjects an insurer to penalty provisions under the insurance statute.

Proposed Change (including Amendment)

SB 3631 / HB 3670 provides a mechanism by which a party against whom a specialist has issued an order to provide benefits may request the Administrator of the Division of Workers' Compensation to reconsider the specialist's order. The written request has to be submitted to the Administrator within 10 calendar days of receiving the order. The request has to be in a format specified by the Administrator.

SB 3631 / HB 3670, continued.

If no written request to reconsider the order is submitted to the Administrator, the party against whom the order has been issued must comply with the order within 15 calendar days of receiving the order. If a written request is submitted to the Administrator, then the Administrator is to schedule an informal conference with the affected parties within 21 calendar days of the date the Administrator receives the written request. Within 5 calendar days following the informal conference, the Administrator is to issue a written order that either affirms, modifies or withdraws the order of the specialist. If the order affirms or modifies the specialist's decision, the party is to comply with the order within 10 days of receipt of the Administrator's order.

Subsections (d)(3) and (d)(40 are subsections of the original bill that were not amended. These subsections relate to time when a penalty will attach for non-compliance with the order of either the specialist or Administrator and relate to when the notification to the Commissioner of Commerce & Insurance must occur. A party has 15 days to comply with the specialist's order when an informal conference has not been held; the party has 10 days to comply with the order of the Administrator following the informal conference. If the order of either the specialist or Administrator is not complied with within 30 days, the Commissioner of Labor/WFD must notify the Commissioner of Commerce & Insurance.

Practical Effect of Amendment

The bill, as amended, changes the current law by providing a mechanism by which a party can have the order of a specialist reviewed by the Administrator of the Division of Workers' Compensation. The amendment clarifies the Administrator is to hold an informal conference with the affected parties. The language of the bill and amendment made the necessary changes to other sections of the statute to reflect the necessary time frames within which a party must comply with an order of a specialist or an order of the Administrator.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS:

James G. Neeley: Commissioner Neeley stated the Department has no problem with the bill other than he would request that the Administrator or the Administrator's designee be permitted to hold the informal conference to be sure the conferences are conducted in a timely fashion..

SB 3631 / HB 3670, continued.

Commissioner Neeley stated for the record that it is the intent of the Department to have an expedited process and if the issue is medical, it will probably take priority.

EMPLOYEE REPRESENTATIVES:

Othal Smith: Mr. Smith expressed concerns that the amendment will add an additional 30 days until the order is final. He stated while this might not be a problem in all cases, it could be a real problem when medical treatment is being sought. He said the 1992 Act that set up the specialist program was designed to err on the side of injured workers and, in his opinion, a mechanism was established whereby the employer could get their money back if the specialist made an error.

EMPLOYER REPRESENTATIVES:

Bob Pitts: Mr. Pitts stated he supports this proposed legislation but also stated this issue should be addressed both in the short term and in the long term. He said from his vantage point, he does not seek to further bog down the system; however, everybody on all sides needs to think about a system that has the best chance for uniformity, fairness and equity to all parties. Mr. Pitts explained that in the past years Tennessee has gone from a voluntary system to a mandatory system and a lot of new staff has been hired and it is inevitable that in this process of growth there will be a struggle about fairness and consistency. He stated there needs to be, even in an administrative system, a mechanism to allow for appeal and it needs to be done timely and quickly and this is the only way to keep confidence in the program for the long term.

ATTORNEY REPRESENTATIVES:

Kitty Boyte: Ms. Boyte said the issue of erroneous specialists' orders is one that needs to be addressed because, even though the specialists are of very high quality, they are human and they make mistakes. Therefore, there needs to be a review process.

SB 3631 / HB 3670, continued.

Ms. Boyte reminded the members that the current statute provides an employer gets money back from the second injury fund only if the claim is later determined by a court to be noncompensable. Therefore, if the issue before the specialist is not a compensability issue, but is rather a temporary disability issue, then the employer cannot get its money back if the specialist makes an error.

Gregg Ramos: Mr. Ramos suggested the language of the bill should allow both an employer and an employee to seek reconsideration. He said there are times when a specialist has determined the injury is not compensable and the employee would need the ability to seek reconsideration also.

Note: The members were in agreement to request the sponsors to consider amending the bill to permit the reconsideration process to be open to either party, employee or employer.

SB 3632 by BRYSON / HB 3671 by CURTISS

Present Law

TCA §50-6-238(a) permits a workers' compensation specialist to order initiation, continuation or reinstitution or retroactive payment of temporary disability benefits by an employer or the employer's insurer and has the authority to order the provision of medical benefits.

TCA §50-6-238(b) provides if a specialist has ordered benefits and a court finds the injury to be noncompensable, then the employer or insurer is entitled to a refund of all amounts paid pursuant to an order from the Second Injury Fund.

Proposed Change

SB 3632 / HB 3671 permits the entity or person who paid benefits pursuant to a specialist's order to recover those benefits from the Second Injury Fund if a court finds the employee was not entitled to the ordered benefits.

Practical Effect

The bill changes the law by permitting recovery of benefits paid pursuant to a specialist's order even in a compensable workers' compensation case if a court determines the employee was not entitled to the benefits. Under current law, if a court determines the employee was not entitled to benefits ordered by a specialist (for example, temporary total benefits or medical bills for a specific treatment) but finds the injury to be compensable, the employer or insurer would not be entitled to a refund of those payments.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

ATTORNEY REPRESENTATIVES:

Kitty Boyte: Ms. Boyte suggested consideration should be given to language that permits recovery from the second injury fund only if an offset against the employee's permanent disability benefits is not available.

SB 3890 by KYLE / HB 4004 by McMILLAN

***NOTE**: SB 3890 / HB 4004 appears to be "housekeeping legislation" from the Department of Labor/WFD; therefore, the analysis of each section of the bill will be separately presented..

Present Law - Section 1

TCA §50-6-102(1) defines "Administrator" as the chief administrative officer of the division of workers' compensation. *TCA* §50-6-206 requires in settlement proceedings or any other workers' compensation court proceeding that involve a subsequent injury where the employee is claiming compensation from the Second Injury Fund that the Administrator be made a party defendant, represented by an attorney representing the Department of Labor/WFD under the supervision of the attorney general.

TCA §50-6-204(d)(5), enacted in 2004, provides "(w)hen a dispute as to the degree of medical impairment exists, either party may request an independent medical examiner from the commissioner's registry". The word "party" is not defined in *TCA* §50-6-102, nor in any other section of the code. According to the definitions contained in the Medical Impairment Rating Registry rules, the term "party":

- is any person or entity which could be liable for payment of workers' compensation benefit;
- is a person who has a potential right to receive workers' compensation benefits;
- includes a legal representative of a party.

Proposed Change - Section 1

Section 1 of the bill amends *TCA* §50-6-208 [Second Injury Fund statute] by adding a new section that states the terms "party" or "parties" referenced in *TCA* §50-6-204(d)(5) [the MIRR statute] shall include the "administrator of the second injury fund".

Practical Effect - Section 1

The intent of Section 1 appears to be to permit the second injury fund to request a MIRR medical examination that would require the employer to pay for the examination. The language of the bill permits the "administrator of the second injury fund" to request a MIRR examination; however, there is no such person or entity identified in the Tennessee Workers' Compensation Act.

SB 3890 / HB 4004, continued.

Present Law - Section 2

TCA §50-6-208 is the "Second Injury Fund Statute". The statute refers to the "administrator of the division of workers' compensation" and "administrator" when referring to the premium taxes collected and distribution of benefits from the second injury fund.

TCA §50-6-238(d) provides that if an insurer, self-insured employer or self-insured pool fails to comply with an order issued by a specialist within 15 days of receipt of the order, the Commissioner of Labor/WFD shall issue a $10,000 penalty. If proof is not received within 21 days of receipt of the order that the order has been complied with, the penalty increases by $1000 for each day of non-compliance. The statute does provide the right to appeal (pursuant to the UAPA) the penalty assessed for failure to comply with the order.

TCA §50-6-238(d) also provides that if there is non-compliance with the order for 30 days, the Commissioner of Labor/WFD is required to report the non-compliance to the Commissioner of Commerce & Insurance. Authority is granted to the Commissioner of C&I to consider the non-compliance as sufficient grounds to revoke the employer's status as a self-insured employer or self-insured pool and subjects an insurer to penalty provisions under the insurance statute.

Proposed Change - Section 2

Section 2 of the bill amends *TCA* §50-6-238(d) by deleting the words "self-insured employer" wherever it occurs and substituting the word "employer".

Practical Effect - Section 2

Section 2 changes the term "self-insured employer" to employer. While this would include a non-compliant employer, it would then permit a penalty to be assessed against an insured employer. As currently written, a penalty could not be assessed against an insured employer. In addition, the change proposed by this section of the bill significantly alters the original intent of *TCA* §50-6-238(d)(2) that permits the Commissioner of Commerce & Insurance to consider non-payment of a penalty by self-insured employer sufficient to revoke self-insured status.

SB 3890 / HB 4004, continued.

Present Law - Section 3

TCA §50-6-102(3) defines "average weekly wage" as the earnings of the injured employee ...during the period of 52 weeks immediately preceding the date of injury divided by 52. The section also clarifies how the "average weekly wage" is to be computed when the employee had worked less than 52 weeks or when the employee had lost more than 7 days during the computation period. In addition it states that allowances made in lieu of wages are deemed to be part of the employee's earnings.

TCA §50-6-225(c) states that within 60 days of filing an action in a workers' compensation lawsuit, unless required earlier by discovery requests, the employer is required to file a wage statement with the court detailing the employee's wages for the previous 52 weeks unless the employer stipulates the maximum weekly workers' compensation rate applies in a particular action.

Proposed Change - Section 3

Section 3 of the bill adds a new provision to *TCA* §50-6-201 [the Notice of Injury statute]. The additional language requires, within 15 days of the date of injury, the insurer, employer or self-insured pool to file a wage statement (on department promulgated form) detailing the employee's wages for the previous 52 weeks unless the employer stipulates the maximum weekly workers' compensation rate applies. If the employer fails to timely file the wage statement, a workers' compensation specialist shall have the authority to deem the employee's compensation rate to be the maximum workers' compensation rate effective on the date of injury.

Practical Effect - Section 3

Section 3 would require an insurer, employer or self-insured pool to file a "wage statement form" within 15 days of the date of injury or risk the possibility that a late filing would result in a specialist "deeming" the maximum compensation rate" to be applicable to the claim. [Note: while the section requires the insurer, employer or self-insured employer to file the "wage statement form", only the employer's failure to do so triggers the specialist's authority to deem the compensation rate to the be the maximum.

SB 3890 / HB 4004, continued.

Present Law - Section 4

Pursuant to *TCA* §50-6-234(d) when an injured employee reaches maximum medical improvement, a permanent impairment rating is given and compensability has not be contested, payments of temporary disability payments are to continue until the earlier of:

- employee accepts or rejects a job offer by the employer at a wage equal to or greater than the pre-injury wage; or
- the parties agree to waive holding a benefit review conference; or
- a benefit review conference is held and the report of the conference is filed.

[Note: the employer gets credit for continued payments against any PPD/PTD benefits paid.]

Proposed Change - Section 4

Section 4 deletes the language referring to agreement to waive holding a benefit review conference.

Practical Effect - Section 4

This change makes *TCA* §50-6-234(d) consistent with the 2004 Reform Act which prohibits waiver of benefit review conferences.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS:

James G. Neeley: Commissioner Neeley commented that the Department considers this bill to be housekeeping and it will look at what changes may need to be made in the language used in portions of the bill.

SB 3890 / HB 4004, continued.

EMPLOYEE REPRESENTATIVES:

Othal Smith: Regarding Section 3, Mr. Smith stated the penalty of using the maximum compensation rate as it provides an incentive for the wage statement to be filed timely.

EMPLOYER REPRESENTATIVES:

Kitty Boyte: Regarding Section 3, Ms. Boyte suggested using the hourly wage and number of hours worked per week as reported on the First Report of Injury instead of using the maximum compensation rate if a wage statement is not filed. She stated this will be closer to the accurate compensation rate, especially if there are issues of overtime or undertime.

SB 3900 by KYLE / HB 4032 by McMILLAN

***NOTE**: Analysis of similar and related sections will be grouped.

Present Law - Sections 1 & 2

TCA §50-6-208(b)(1)(D) and (b)(2)(A) provide that claims made under section (b) of the Second Injury Fund Statute [that section permits recovery from the SIF when the injured employee has received or will receive PPD work comp awards that total or exceed 100%] will not apply to injuries on or after July 1, 2006.

Proposed Change - Sections 1 & 2

Sections 1 & 2 changes SIF section (b) claims to be applicable to injuries that arise on or before December 31, 2006 and not be applicable to injuries arising on or after January 1, 2007.

Practical Effect - Sections 1 & 2

Sections 1 & 2 amend pertinent sections of the code to delays for six months the elimination of SIF section (b) claims.

Present Law - Section 3

TCA §50-6-208(f), enacted in 1992, authorized a pilot project to retain private attorneys to defend the Administrator of the Workers' Compensation Division in actions claiming benefits from the Second Injury Fund.

Proposed Change & Practical Effect - Section 3

Section 3 deletes *TCA* §50-6-208(f) and renumbers subsequent subsections.

SB 3900 / HB 4032, continued.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EX OFFICIO MEMBERS:

James G. Neeley: Commissioner Neeley explained this issue is one about which the Administration feels strongly because an analysis of the liability of the second injury fund revealed there to be an $56 million unfunded liability and a second analysis conducted 1 ½ half years later revealed the unfunded liability had increased to $79 million. He stated this is a serious issue.

EMPLOYEE REPRESENTATIVES:

Othal Smith: Mr. Smith stated that the part (b) of the second injury fund was designed to protect employers from having to pay for an employee who had a previous injury with a significant previous disability; it was to encourage them to hire handicapped workers who had received on the job injuries and not have to be responsible for paying for all the disability, especially where you have rehabilitated workers. He stated that bill should not be passed.

Mr. Smith stated if the bill is passed, it should be amended to make it abundantly clear that the employer is not being relieved of the liability for the last injury. He said if all that is being done by the bill is to transfer the liability to the employer from the second injury fund he has no problem with the bill. However, if the bill is eliminating a benefit, then he is against the bill. He said he would like for the General Assembly to state that it is not the intent to eliminate a benefit but rather to reallocate it to the last employer.

ATTORNEY REPRESENTATIVES:

Kitty Boyte: Ms. Boyte stated this provision was added to the 2004 Reform Act without much opportunity for discussion. She agreed the intent of the second injury fund was to encourage employers to hire people who had already had previous injuries and now with the American with Disabilities Act (ADA) an employer is not permitted to ask if the employee has had prior injuries. She stated in her opinion it is a terrible idea to do away with this provision of the law - it is bad for employers and bad for employees.

SB 3900 / HB 4032, continued.

Ms. Boyte said she thinks the changes in the benefit structure made in the 2004 Reform Act will make a huge difference in the amount of money that will be paid by the second injury fund under part (b), which is the only part being eliminated.

Gregg Ramos: Mr. Ramos stated he concurs with Mr. Smith as the whole idea of the second injury fund was to encourage the hiring of disabled people and this law should not be terminated.