Legislative Committee on Workers' Compensation

Legislative Counsel Bureau

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STUDY OF THE LEGISLATIVE COMMITTEE ON WORKERS' COMPENSATION

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SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMITTEE ON WORKERS' COMPENSATION (NRS 218.5375)

The Legislative Committee on Workers' Compensation recommends that the 69th Session of the Nevada Legislature consider the following changes to Nevada's workers' compensation laws:

ADMINISTRATION

1. **Amend *Nevada Revised Statutes* (NRS) 616C.020 to reduce from 90 the number of days within which an injured employee must seek medical treatment.**

2. **Amend Chapter 616A of NRS to add a requirement that an insurer provide policy information to a policyholder within a reasonable period of time after such information is requested. This provision is designed to prevent an insurer from deliberately withholding information requested by a policyholder that may be required by the Commissioner of Insurance for consideration of an application for self-insurance.**

3. **Allow electronic transmission of the Employer's Report of Industrial Injury or Occupational Disease (C-3 form), Employee's Claim for Compensation/Report of Initial Treatment (C-4 form), medical bills, and other documents.**

4. **Amend NRS 616B.018 and NRS 616C.020 to allow insurers greater access to medical and claim information from other insurers.**

5. **Amend NRS 616C.020 and NRS 616C.025 to clarify reporting requirements.**

6. **Amend NRS 616C.065 to clarify that an insurer shall take certain actions within 30 *working* days after being notified of an industrial accident and having *received a claim for compensation*.**

7. **Amend NRS 616C.235 to clarify that an insurer may dispose of a claim file six months after the date of automatic closure.**

8. **Amend NRS 616C.475 to clarify that a certification of disability shall not be given for dates that are prior to the date of the physician's examination of the injured employee.**

9. **Amend subsection 5 of NRS 616C.490 so that it is consistent with *Nevada Administrative Code* (NAC) 616C.103 which allows 30 days for an employer to notify the employee of the compensation to which he is entitled. The statute currently allows only 14 days.**

10. **Amend subsection 9 of NRS 612.265 to allow self-insured employers to participate in the program designed to identify persons who are simultaneously receiving unemployment compensation and workers' compensation benefits. Also, clarify in the statute that both the Employment Security Division of the Department of Employment, Training and Rehabilitation and insurers have authority to investigate persons suspected of violating the law by simultaneously obtaining benefits under both the unemployment compensation and workers' compensation programs.**

COMPENSATION PAYMENT

11. **Correct a conflict between NRS 616C.060 and 616C.475 regarding the number of days within which an insurer must begin paying compensation. Subsection 1 of NRS 616C.060 requires that an insurer commence payment of an accepted claim within 30 days after the insurer has been notified of an industrial accident. Subsection 3 of NRS 616C.475 requires that an insurer make the first payment within 14 working days after receiving the initial certification of disability.**

12. **Amend the law to disallow any person from receiving workers' compensation benefits if that person has falsified citizenship documents to obtain employment.**

COVERAGE

13. **Amend Chapter 616 to allow (but not require) coverage of a student in a "volunteer" Schools to Careers related situation.**

14. **Develop a specific provision that requires a teacher's employer to continue coverage while the teacher is in a temporary location in an approved Schools to Careers activity.**

HEARINGS AND APPEALS

15. **Provide peer review or management review of hearing and appeals officers of the Department of Administration to help ensure consistency of decisions. Also require training of hearing and appeals officers at the National Judicial College in Reno.**

16. **Evaluate prior commitments made by the Department of Administration regarding scheduling of hearings and related matters.**

PENSIONS AND ANNUITIES

17. **Amend Chapter 616 to specify that insurers may purchase annuities.**

PERMANENT PARTIAL DISABILITIES

18. **Consider studying alternatives to the current permanent partial disability (PPD) rating system such as implementing a schedule of benefits for most injuries to take out some subjective areas such as range of motion. If this review cannot be completed during the 1997 Legislative Session, continue the statutory committee and charge the committee with commissioning an independent study of PPD awards. The results of the study, along with recommendations of the committee, are to be presented to the 1999 Legislature.**

19. **Address the issue of PPD awards for dental problems.** (Note: NRS 616C.485 and NAC 616C.508 govern payment of PPD awards for loss of or permanent damage to a tooth.)

20. **Amend NRS 616C.090 to provide that an injured employee be allowed to choose a doctor from the rotating list for a PPD evaluation at any time.**

21. **Amend NRS 616C.090 to provide that if an injured employee's claim is being administered by the State Industrial Insurance System (SIIS) and the injured employee requests a doctor from the rotating list, and the injured employee is assigned a doctor who is employed by SIIS, then the injured employee is entitled to request another doctor from the rotating list.**

22. **Amend NRS 616C.090 to provide that the doctor who shall rate the claimant for a PPD shall be the claimant's treating physician.**

REGULATION OF WORKERS' COMPENSATION INSURANCE

23. **Consider changing the law to place responsibility for adoption of an experience rating plan with the Commissioner of Insurance.**

24. **Correct a perceived conflict between NRS 616D.200 and the regulation adopted by SIIS regarding the "three times penalty" imposed for failure of an employer to secure or maintain workers' compensation insurance.**

25. **Amend NRS 616C.260 to change the benchmark for the medical fee schedule.**

26. **Identify which regulatory responsibilities should be delegated to the Commissioner of Insurance and/or DIR in anticipation of workers' compensation coverage being provided by private carriers beginning July 1, 1999.**

SAFETY AND HEALTH

27. **Amend subsection 1(d) of NRS 616C.230 to strengthen provisions for an insurer to deny a workers' compensation claim if an injured employee tests positive for a controlled substance. Refusal to take a drug test would have the same presumption of "under the influence" as in the case of driving under the influence of alcohol. Termination of employment for failing a drug test or refusing to take a drug test would disqualify an injured employee from benefits.**

SOLVENCY ASSESSMENT AND THE ROLE OF SIIS

28. **Currently, NRS 616B.110 provides that the Commissioner of Insurance may declare SIIS to be insolvent if the agency must liquidate its invested assets or real property in order to pay its outstanding obligations as they mature in the regular course of business. Such a declaration would trigger imposition of a solvency assessment. Amend NRS 616B.110 to require that the decision to impose the assessment be made by the Legislative Committee on Workers' Compensation after it has considered all other available options.**

29. **Amend NRS 616B.110 so that if an assessment is imposed, it is based on a percentage of paid claims of all employers. Consider allowing exemptions for special circumstances such as cancer, heart, and lung coverage provided by certain governmental entities.**

REPORT TO THE 69TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMITTEE ON WORKERS' COMPENSATION

I. INTRODUCTION

Under the provisions of Sections 120-123 of Senate Bill 458 (Chapter 587, *Statutes of Nevada 1995*), the Legislature established a Legislative Committee on Workers' Compensation to review issues related to workers' compensation.[1] Section 122 of S.B. 458 specifically allows the committee to:

- Study the desirability of establishing a preferred worker program to provide incentives for employers to hire injured workers; and
- Review the manner used by the Division of Industrial Relations (DIR), Department of Business and Industry, to rate physical impairments of injured employees.

In addition, Section 122 of S.B. 458 requires that the committee:

- Review and study the financial condition of SIIS;
- Determine the extent of any apparent insolvency of SIIS; and
- Establish a formula which will be applied to calculate a surcharge that is equal in amount to any deficiency in the cumulative amount of premiums paid by an employer who is subject to Section 33 of S.B. 458.

Section 33 of the bill[2] requires that the surcharge, if imposed, be applied to:

- Each employer who was insured by the Nevada Industrial Commission (NIC) or SIIS at any time during the period beginning on July 1, 1979, and ending on July 1, 1995;
- Each employer who is insured by SIIS at any time after July 1, 1995;
- Each self-insured employer; and
- Each association of self-insured public or private employers.

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[1]Sections 120-123 of S.B. 458 are codified as Sections 218.5375 through 218.5378 of *Nevada Revised Statutes* (NRS). See Appendix A.

[2]Section 33 of S.B. 458 is codified as Section 616B.110 of NRS. See Appendix B.

Eight legislators were appointed as members of the committee. Four members were appointed by the Senate Majority Floor Leader in consultation with the Minority Floor Leader of the Senate from members of the Senate standing Committee on Commerce and Labor. Four members were appointed by the Speakers of the Assembly from the Assembly Committee on Labor and Management. The committee members selected their chairman and vice chairman from among their members.

The following legislators served on the Legislative Committee on Workers' Compensation:

Assemblyman Lynn C. Hettrick, Chairman
Senator Randolph J. Townsend, Vice Chairman
Senator Kathy Augustine
Senator Joseph M. Neal, Jr.
Senator Ann O'Connell
Assemblyman David E. Goldwater
Assemblywoman Saundra Krenzer
Assemblyman Dennis Nolan

Legislative Counsel Bureau (LCB) staff services for the committee were provided by Vance A. Hughey, Senior Research Analyst, Research Division; Jan K. Needham, Principal Deputy Legislative Counsel, Legal Division; Sue S. Matuska, Deputy Legislative Counsel, Legal Division; and Nenita Wasserman, Research Secretary, Research Division.

Beginning in November 1995 and concluding in December 1996, the committee held seven meetings to obtain expert and public testimony. Following are the dates and locations of each meeting of the committee:

- November 8, 1995;
- December 19, 1995;
- January 9, 1996;
- May 23, 1996;
- September 12, 1996;
- November 7, 1996; and
- December 3, 1996

All of the meetings were held in Las Vegas and, except for the November 7, 1996, meeting, were video conferenced to Carson City.

During the course of this study, the committee reviewed existing laws and implementation of the workers' compensation legislation enacted by the 1995 Legislature. It received comments and recommendations from employers, injured employees, medical providers,

vocational rehabilitation specialists, claimants' attorneys, third-party administrators, State agency executives, local government officials, and representatives of various self-insured employers, business groups, and labor organizations. In addition, the committee heard testimony by a national workers' compensation expert from the Workers Compensation Research Institute.

At its work session, the committee considered 66 proposed recommendations. It adopted 29 recommendations on the following topics:

- Administration;
- Compensation Payment;
- Coverage;
- Managed Care;
- Pensions and Annuities;
- Permanent Partial Disabilities;
- Regulation of Workers' Compensation Insurance;
- Reopening;
- Safety and Health; and
- Solvency Assessment and the Role of SIIS.

In this document, the committee has attempted to present its findings and recommendations in a concise form. A great amount of information was gathered during the course of this study, and much of it was provided in exhibits that became a part of the minutes of the committee's meetings. All supporting documents and minutes are on file with the LCB Research Library. This report also contains background information on Nevada's workers' compensation program and the financial condition of SIIS.

The committee wishes to thank the many individuals who contributed to this study through their correspondence or testimony at the public hearings. The committee members also recognize the cooperation and assistance provided by the staffs of the Hearing and Appeals Division, Department of Administration; the Workers' Compensation Fraud Unit, Office of the Attorney General; DIR; the Division of Insurance; the Nevada Attorney for Injured Workers; and SIIS.

II. OVERVIEW OF WORKERS' COMPENSATION

Following is historical and other background information on the development of workers' compensation in the United States and Nevada. Included is a discussion of the recent financial problems of SIIS and major legislative reforms enacted beginning in 1991.

A. Background Information

Workers' compensation insurance is specialized insurance purchased by employers to provide medical care, disability compensation (indemnity) payments, and rehabilitation services for workers who are injured on the job or who contract occupational diseases in the course of their employment. Workers' compensation was the first social insurance system in the United States. It developed as a consequence of the high rate of industrial accidents in the 19th and early 20th centuries.

Under common law, 19th century employers were required to provide a reasonably safe place for their employees to work. If an injury occurred, however, and the employer did not voluntarily pay compensation, then the employee had to take his case to court. The litigation which arose out of this situation proved to be an unsatisfactory means of caring for injured workers. Uncertainty of outcome and the costs associated with the delay in compensating injured workers under a common law system were instrumental in the formation of the workers' compensation system.

Even if the employee could afford legal assistance, the employer had several defenses that made it difficult for the employee to collect damages. The employer might plead contributory negligence, suggesting that the employee was at fault to some degree. The employer might attempt to prove that the real fault was lodged with a fellow worker—the so-called fellow-servant doctrine. An employer also might apply what is called the "doctrine of assumption of risk." Under this doctrine, the employee was assumed to have had knowledge that he was engaged in a dangerous occupation and, therefore, if he still chose to work in that occupation, he had to assume the known risks of being injured.

American policymakers looked to Europe where the idea of workers' compensation had originated in Germany in the 1800s and later was adopted in France, Great Britain, and other countries. Under a workers' compensation insurance program, the right to bring legal action against an employer on the grounds of negligence was exchanged for a system whereby benefits were paid for all injuries arising out of and in the course of employment. The costs of the work-related injuries were allocated to the employer, not because of any presumption that he was to blame for every individual injury, but because the inherent hazards of employment were considered to be a cost of production.

This "no-fault" approach to insuring employers soon became popular throughout the United States. Between 1911 and 1920, all but six states passed universal workers' compensation statutes. Eventually, the remaining states also enacted such laws.

B. Workers' Compensation in Nevada

Nevada was one of the first states to enact a compulsory workers' compensation law. The original industrial insurance act was adopted in 1913, and a complete revision was drafted in 1947. The State's industrial insurance laws have been amended during every regular legislative session since 1913.

Recent legislative sessions have brought major changes to the statutes relating to workers' compensation. During the 1979 Session, self-insurance was authorized for qualified employers. The self-insurance option became effective on January 1, 1980. Prior to that time, NIC had been the only provider of workers' compensation insurance in the State.

The 1979 Legislature removed the hearings process for contested claims from NIC and placed it in a new Hearings Division within the Department of Administration. The Hearings Division is responsible for the hearings and appeals process.

In 1981, the Legislature completely revised the NIC structure. Effective July 1, 1982, NIC ceased to exist and SIIS began operation as the state-run workers' compensation insurance carrier. Also on that date, the Department of Industrial Relations (DIR) began operation as the primary regulator of the State's workers' compensation program.[3] The DIR regulatory umbrella includes SIIS and self-insured employers, the medical fee schedule, panels of treating and rating physicians, and the State's Occupational Safety and Health Administration (OSHA) program.

The Commissioner of Insurance reviews and approves SIIS premium rates and is responsible for certifying self-insured employers who meet certain statutory qualifications. The Division of Insurance also regulates third-party administrators of self-insured programs and managed care organizations.

The Nevada Attorney for Injured Workers (NAIW),[4] a state agency separate from SIIS, represents claimants free of charge at the Hearings Division's appeals level, in the State's district courts, and before Nevada's Supreme Court.

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[3]The Commissioner of Insurance retained authority to approve premium rates charged by SIIS. In 1993, both the Department of Insurance and DIR were made divisions of the new Department of Business and Industry.

[4]Originally created in 1977 as the State Industrial Claimants' Attorney, in 1991, the Legislature changed the agency's name to the Nevada Attorney for Injured Workers.

C. Emerging Problems in Nevada's Workers' Compensation Program and Early Legislative Responses

During the early- and mid-1980s, workers' compensation did not generate an inordinate amount of legislative interest in Nevada. Available information seemed to suggest that there were no major problems within the workers' compensation program. From 1984 through 1988, SIIS paid over $50 million in dividends to policyholders.[5] Additionally, from 1985 through 1988, SIIS did not request approval for any increases in premium rates charged to its policyholders.[6] During the 1980s and early-1990s, Nevada's compensation benefits were among the best in the Western States and premium rates were among the lowest.[7]

Beginning in 1988, SIIS instituted the first in a series of premium rate increases. Also at about that time, injured workers began to express more concerns about the manner in which their claims were being handled by SIIS and self-insured employers. In 1989, the Legislature enacted Assembly Bill 1 (Chapter 856, *Statutes of Nevada 1989*). This bill directed the Legislative Auditor to conduct a performance audit of Nevada's workers' compensation program. The audit covered five aspects of the program:

- Medical Benefits to Injured Workers;
- Compensation and Other Benefits to Injured Workers;
- Hearings and Appeals Process;
- State Industrial Insurance System; and
- Department of Industrial Relations.

In 1991, the Legislature enacted S.B. 7 (Chapter 723, *Statutes of Nevada 1991*) to resolve many of the issues identified by the legislative audit. This measure reflected the Legislature's intent to reform the workers' compensation system in the following ways:

1. Lower Nevada's high rate of industrial injuries by promoting safety on the job;

2. Serve Nevada's injured employees by streamlining the process for filing, hearing, and appealing claims. The object was to make certain that injured employees and their health care providers received compensation as soon as possible. In addition, the injured employees were to receive appropriate medical care and rehabilitation to allow them to return to work as soon as possible; and

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[5] *State Industrial Insurance System Business Plan*, June 1992, p. 61.

[6] *Ibid.*, p. 60.

[7] *Rate and Benefit Comparison: Nevada and Surrounding States*, State Industrial Insurance System, April 2, 1993.

3. Serve employers by protecting against fraudulent claims and by returning injured employees to work as soon as possible.

This bill also established an interim Legislative Committee on Industrial Insurance. The purpose of this committee was to study Nevada's laws concerning industrial insurance and to prepare a report for submission to the Governor and the 1993 Legislature. Eight legislators were appointed as members of the committee. The committee held eight meetings, including a two-day work session, to obtain expert and public testimony. The committee considered 188 proposed recommendations. It adopted 62 of them covering a variety of topics including:

- Determination and payment of benefits;
- Medical care, compensation, and other benefits to injured workers;
- Fraud in workers' compensation;
- The organization of SIIS;
- Employer options for industrial insurance;
- Hearings and appeals of contested claims;
- Occupational safety and health; and
- Legislative oversight concerning industrial insurance.

Many of those 62 recommendations were subsequently adopted with the enactment of Senate Bill 316 (Chapter 265, *Statutes of Nevada 1993*), which is discussed later in this report.

D. SIIS's Financial Difficulties

At the April 9, 1992, meeting of the Legislative Committee on Industrial Insurance, SIIS announced that it was experiencing financial difficulty and presented a *Financial Forecast and Strategic Plan*. The newly appointed manager of SIIS reported that invested assets were being sold to cover current expenses. In the months following that meeting, a financial audit conducted for SIIS by KPMG Peat Marwick (independent auditors) concluded that SIIS's unfunded liability as of June 30, 1992, was approximately $1.4 billion. This audit was followed by a Department of Insurance report that estimated SIIS's unfunded liability at $2.2 billion. Much of the difference between the two estimates of the level of the unfunded liability was due to differences in accounting methods. The auditors used "generally accepted accounting principles" while the Department of Insurance used the more conservative "statutory accounting principles."

Regardless of which figure more accurately reflected SIIS's financial condition at that time, it was clear that SIIS was on the brink of insolvency. In fact, on November 23, 1992, SIIS reported that without large increases in premium rates to

employers and/or major changes in Nevada's laws governing industrial insurance, the agency would be unable to pay claims by early Fiscal Year (FY) 1997.[8]

E. 1993 Legislative Reforms

During the 1993 Session, the Legislature addressed many workers' compensation issues, including SIIS's financial difficulties. After many months of hearings (at which testimony was received from employees, employers, health care providers, trial lawyers, agency officials, and others), S.B. 316 and Assembly Bill 374 (Chapter 587, *Statutes of Nevada 1993*) were enacted.

Senate Bill 316 was a comprehensive measure that reformed Nevada's workers' compensation programs and enacted cost savings provisions to deal with the financial situation of SIIS. Some of the changes in the State's industrial insurance laws included provisions relating to benefit decisions, fraud, limiting or reducing the payment of compensation benefits, limits on reopening claims, SIIS management procedures, and subrogation recovery.

Contained in S.B. 316 were other major revisions to the State's workers' compensation laws, including provisions to:

- Simplify and clarify the procedures for reporting an injury. Require employer notification to the insurer of an accident only if it has required treatment or compensation for industrial insurance.

- Clarify prohibited fraudulent acts and establish a special fraud unit in the Office of the Attorney General with authority to investigate and prosecute criminal fraud for industrial insurance by employees, employers, and providers.

- Strengthen various penalties and administrative fines and establish an administrative procedure for violations of industrial insurance laws and regulations.

- Authorize SIIS to charge uninsured employers three times the amount of premium that would have been due for the period the employer was without industrial insurance, but not to exceed six years.

- For two years, freeze the average monthly wage used for calculating the payment of temporary total disability benefits.

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[8] *Pro Forma Projections of Financial Conditions: An Analytical Modeling of the Impacts of Cost Containment Measures, Alternative Rate Scenarios, and Financial Restructuring*, State Industrial Insurance System, November 23, 1992, p. 9.

- Prohibit payment of compensation if an employee has a preexisting condition or sustains a subsequent injury that is not the primary cause of the resulting disability.

- Reduce compensation for permanent partial disabilities by revising the factor from 0.6 percent to 0.54 percent of the average monthly wage for each degree of impairment.

- Require an injured worker who disagrees with a permanent partial disability rating, and who requests a second determination, to choose the next rating physician in rotation from the list maintained by DIR. Furthermore, require hearing and appeals officers, when ordering new permanent partial disability ratings, to select rating physicians from the rotating list, unless the insurer and the injured worker agree otherwise.

- Extend various deadlines regarding the hearings and appeals process for contested claims and eliminate the deadline for hearing or appeals officers granting stays. In addition, provide that parties represented by legal counsel may stipulate to forego a hearing before a hearing officer and proceed directly to the appeals officer hearing. Furthermore, authorize the Director of the Department of Administration to appoint hearing officers who serve in the unclassified service and at the pleasure of the Director.

- Make it unlawful for any person who is not an attorney admitted to practice law in Nevada to represent an employee before an appeals officer. Limit the categories of persons who may be licensed to represent employers at hearings of contested cases.

- Require the State's workers' compensation laws to be interpreted according to the plain meaning of the statutes.

- Allow SIIS to contract with managed care organizations (MCOs) and establish requirements for the selection of MCOs by the manager of SIIS.

- Limit the ability of any MCO to provide care to not more than 25 percent of the employees insured by SIIS in Clark County and to not more than 34 percent of the employees insured by SIIS in Washoe County. Furthermore, require that SIIS contract with no fewer than seven MCOs in Clark County and no fewer than five MCOs in Washoe County. Prohibit MCO contracts based solely on the number of employees receiving services. Provide that the principal owner of an MCO in Clark or Washoe County, or any member of the owner's immediate family, may not be a principal owner of another MCO in the same county.

- Provide for independent evaluations of MCOs and other medical care providers. The manager of SIIS is required to contract with a private person to conduct evaluations of the utilization review procedures of MCOs.

- Freeze the medical fee schedule until October 1, 1995, unless SIIS signs contracts with MCOs or the Governor approves an increase in the fee schedule. Allow DIR to increase or decrease the medical fee schedule and authorize increases above the medical care component of the Consumer Price Index if approved by the DIR Advisory Council.

- Authorize self-insured employers to contract with MCOs.

- Require injured employees to choose their treating physician or chiropractor according to the terms of a contract which their insurer has made with an MCO.

- Provide that disputed decisions relating to accident benefits must, before going to an appeals officer, be appealed through the procedure for resolving complaints established by an MCO, if the insurer has contracted with an MCO.

- Prohibit, in most cases, a physician or chiropractor from referring an injured employee to a health service or facility in which a member of the physician's or chiropractor's immediate family has a financial interest. Exceptions are made for rural areas, certain arrangements with health maintenance organizations, group practices, surgical centers for ambulatory patients, and in cases where the financial interest represents an investment in publicly traded securities.

- Limit stress as a compensable injury. Provide that stress may be compensable if the employee proves by clear and convincing evidence that he has a mental injury caused by extreme stress in time of danger and the employment was the primary cause of the injury. Stress is not compensable if it is caused by gradual mental stimulus.

- Limit rehabilitation maintenance payments, limit eligibility for vocational rehabilitation, and require the use of private and public rehabilitation counselors.

- Allow SIIS to provide vocational rehabilitation services if it can do so at a cost lower than the services available from private or public counselors, but prohibit SIIS from developing a majority of the vocational rehabilitation plans in any one year. Limit eligibility for vocational rehabilitation to injured employees who return to work at less than 80 percent of their past wage, and provide 90 days of job placement assistance for injured workers who possess marketable skills. Other vocational rehabilitation benefits are limited as follows:

1. Six months of benefits for an injured worker with a permanent physical impairment of less than 6 percent;

2. Nine months of benefits for an injured worker with a permanent physical impairment of 6 percent or more, but less than 11 percent; and

3. Twelve months of benefits for an injured worker with a permanent physical impairment of 11 percent or more.

- Extensions in the length of the vocational rehabilitation programs and benefits may be granted for exceptional circumstances.

- Require that certified vocational rehabilitation counselors must supervise and review the work of counselors who are not certified.

- Require each employer to establish a written safety program and implement its operation within 90 days and increase the maximum penalty from 3 percent to 15 percent of premium for violations of this requirement by employers insured by SIIS.

- Require the SIIS manager to adopt a plan for reviewing employers who have excessive losses and allow the imposition of disincentives on such employers. Provide for procedures to terminate an employer's participation in such a plan.

- Authorize groups of five or more public and private employers to form associations for self-insurance effective July 1, 1995.

- Abolish the SIIS Board of Directors and allow the Governor to control SIIS until July 1, 1997. Require the Governor to report on the results of reforms to the Legislature early in the 1995 Session.

- Require SIIS to operate more like a private insurance company, remove it from the State Budget Act, and establish clearer and stronger regulatory controls by the Commissioner of Insurance.

- For employers insured by SIIS, establish an employer-paid deductible of up to $100 for the payment of medical benefits and provide an optional program for additional deductible coverage at reduced premium. Require employers who have excessive losses to pay a deductible of up to $1,000 for medical benefits for their employees. Require SIIS to bill employers for the amount of any deductible that is owed to the system.

- Limit the application of the subsequent injury fund to self-insured employers and authorize SIIS to manage its own subsequent injury claims.

- Increase from $400 to $600 the monthly compensation for each person entitled to receive benefits for a permanent total disability or a death benefit for an industrial injury or occupational disease which occurred before July 1, 1980.

Assembly Bill 374 was the "trailer" legislation to S.B. 316. This bill added certain provisions and made technical changes and corrections to S.B. 316.

The measure authorized licensed health care providers to form an organization for managed care under a common agreement to provide comprehensive medical and health care services for industrial injuries. Procedures and fees were specified for such providers to apply for and obtain permits from the Commissioner of Insurance. The Commissioner is required to evaluate and regulate these agreements.

Employers insured by SIIS were allowed to select an organization for managed care in a manner prescribed by the manager of SIIS and pursuant to the law.

Other changes contained in A.B. 374 included provisions to:

- Establish criteria for the manager to identify an employer with excessive losses.

- Clarify that any party to a dispute, not just the employee, may file a notice of appeal in cases involving MCO dispute resolution proceedings.

- Require that an application to reopen a claim be supported by medical evidence demonstrating an objective change in the claimant's medical condition.

- Clarify the entitlement of compensation for dependents of an employee injured before July 1, 1980.

- Remove a conflict in the bill relating to the placement of hearing officers in the unclassified service.

- Authorize public agencies and nonprofit medical facilities to enter into cooperative agreements concerning industrial insurance.

- Clarify the primary cause language of the stress provision to relate to the course of employment rather than the conditions at the place of employment.

- Clarify that an insurer may, without limitation, extend an injured worker's program for vocational rehabilitation.

- Reduce the period of time pertaining to the criteria for wage reimbursement for a program of on-the-job training from one year to 90 days for the employer and six months for the employee.

- Correct the sanctions for fraud violators to apply to any person, not just a claimant, and to include liability for the costs of the Office of the Attorney General as well as the insurer.

- Delete an erroneous reference to certification under Chapter 695F of NRS for a managed care organization and revise the population threshold language for the provision of managed care services.

- Change the references from "evaluations" to "additional independent utilization reviews" and add certain prohibitions on such contracts by the manager.

- Clarify the procedure on final determinations for disputes.

- Allow an employer representative, in hearings of contested cases, to include a licensee who is not a third-party administrator.

F. SIIS's Improving Financial Condition

On November 15, 1994, SIIS released a report of its financial condition for FY 1994. According to the *Financial Statements*, the total accumulated deficit (unfunded liability) of SIIS decreased by $44.1 million during the fiscal year that ended June 30, 1994. The independent accounting firm KPMG Peat Marwick conducted the audit of SIIS's financial records and concluded:

> Although SIIS experienced income from underwriting activities during the year ended June 30, 1994, and the accumulated deficit decreased from $2,097,124,000 at June 30, 1993 to $2,053,047,000 at June 30, 1994, such accumulated deficit will need to be recovered from future revenues, operating efficiencies or from other resources to be provided to SIIS.

This improvement in SIIS's financial condition still left the agency with an unfunded liability of more than $2 billion. However, it is now clear that workers' compensation reforms enacted by the Legislature in 1991 and 1993 helped to reverse SIIS's negative financial trends.

G. 1995 Legislative Reforms

Workers' compensation reform was a major topic of discussion during the 1995 Legislative Session, as it was in 1993. However, unlike the 1993 Session, the threatened

financial collapse of SIIS, while still a concern, did not dictate the focus of legislative attention in 1995. Instead, a variety of topics were addressed that resulted in the enactment of the following bills:

Senate Bill 458 (Chapter 587, *Statutes of Nevada 1995*)—While the reforms enacted in 1993 helped to improve the financial condition of SIIS, the Legislature determined that additional reforms were necessary. With S.B. 458, the Legislature clarified provisions regarding exclusive remedy, created separate boards to administer subsequent injury programs of self-insured employers, revised provisions regarding confidentiality of records, clarified the definition of an employee leasing company, and exempted real estate brokers and salesmen from the mandatory coverage requirements of the Nevada Industrial Insurance Act. The Legislature also clarified provisions regarding eligibility for more than one program for vocational rehabilitation, created a legislative committee on workers' compensation, and authorized collection of a solvency surcharge from certain employers if SIIS is declared insolvent by the Commissioner of Insurance.

Assembly Bill 57 (Chapter 194, *Statutes of Nevada 1995*)—This bill extends workers' compensation benefits for heart and lung disorders to forensic specialists and correctional officers employed by the State's Mental Hygiene and Mental Retardation Division at facilities for mentally disordered offenders. This measure also provides these benefits to forensic specialists employed by the Department of Prisons.

Assembly Bill 59 (Chapter 127, *Statutes of Nevada 1995*)—This bill allows the Attorney General to determine the propriety of submitted evidence concerning an employer taking money out of an employee's paycheck to pay workers' compensation premiums. In addition, the measure provides that, if the amount of a benefit obtained or sought in a fraudulent manner is less than $250, a person convicted of such an offense is guilty of a misdemeanor. The bill also allows the Attorney General, in workers' compensation fraud cases, to subpoena records from a financial institution without notifying the pertinent customer.

Assembly Bill 61 (Chapter 497, *Statutes of Nevada 1995*)—Further adjustments to the penalty provisions of the workers' compensation statutes were made with A.B. 61, including a new provision to allow certain fines to be paid directly to an injured worker, and more severe penalties to be assessed on insurers that violate prohibitions against certain claims management practices.

Assembly Bill 498 (Chapter 578, *Statutes of Nevada 1995*)—During the 1995 Session, the Legislature enacted several measures that provide employers with industrial insurance options. Group self-insurance was authorized in 1993, effective July 1, 1995. However, the Legislature reviewed existing statutes and concluded that changes were necessary to clarify the types of businesses that would be allowed to join insurance groups. In addition, the Legislature clarified provisions regarding financial requirements of groups

and their members, provided for regulation of solicitors, and made other changes to help ensure that self-insurance groups will be financially viable. These provisions are included in A.B. 498.

Assembly Bill 552 (Chapter 580, *Statutes of Nevada 1995*)—The Legislature also passed A.B. 552 to allow private carriers to offer workers' compensation insurance beginning July 1, 1999 (so-called three-way insurance). The four-year delay in establishing three-way insurance will give SIIS an opportunity to further improve its financial condition so that it can effectively operate in a competitive market. The delay also will give the Commissioner of Insurance time to implement any necessary regulatory controls.

Assembly Bill 587 (Chapter 544, *Statutes of Nevada 1995*)—Assembly Bill 587 was enacted to enhance the ability of the Workers' Compensation Fraud Unit to investigate and prosecute employees, medical providers, and employers who engage in fraudulent activities. The bill also increases penalties for committing certain violations. In addition, A.B. 587 revises provisions relating to payment of an award for permanent partial disability in a lump sum to an employee who is the subject of a criminal action.

III. DISCUSSION OF RECOMMENDATIONS

Financial problems at SIIS have their beginnings in the early- to mid-1980s when the agency's loss ratios[9] rose significantly in the face of an increasing number of registered claims, rising costs of those incurred claims, and stable premium rates from 1985 through 1988. These trends are documented in a July 15, 1992, SIIS report entitled, "Financial Forecast and Strategic Plan." The most recent reserve study prepared for SIIS by Tillinghast-Towers Perrin includes the following statistics regarding historical loss ratios:

Fiscal Accident Year	Projected Ultimate Loss Ratio (in percent)
1982	103
1983	112-115
1984	127-131
1985	141-144
1986	175-179
1987	181-185
1988	192-201
1989	190-197
1990	171-176
1991	160-166
1992	145-154
1993	111-120
1994	80-90
1995	78-88
1996	79-93

According to the Tillinghast-Towers Perrin reserve study, the estimated break-even loss ratio currently is 110 percent. Loss ratios significantly in excess of the current breakeven ratio coincide with the period during which SIIS did not increase premium rates to its policyholders during the mid- to late-1980s. While the loss ratios have shown

[9]A loss ratio is calculated as ultimate losses divided by earned premiums for a fiscal accident year.

improvements since 1989, they remained well above breakeven levels until 1993. Since 1994, SIIS loss ratios are below breakeven levels.

When SIIS's financial problems were first revealed by SIIS in 1991, it was unclear just how serious the problem was. The first actuarial report to indicate that SIIS did not have sufficient assets to pay its incurred liabilities was prepared by Joseph T. Flynn and Associates on October 23, 1991. That report indicated that SIIS had an unfunded liability as of June 30, 1991, of $199.3 million before unrealized gains on equity securities. Taking into account the unrealized gains on equity securities of $5.6 million, the deficit was $193.7 million.

An actuarial review covering the same period was conducted by Tillinghast-Towers Perrin in June 1992 and confirmed that SIIS was experiencing financial difficulties. However, the Tillinghast report estimated the value of the unfunded liability to be $377.6 million on a fully discounted basis, and $608.6 million on a partially discounted basis. (Partial discounting reflected that fact that approximately 33 percent of SIIS's discounted loss reserves were not supported by assets.)

Tillinghast-Towers Perrin also conducted an actuarial review of SIIS for the fiscal year ended June 30, 1992. According to that report, dated November 24, 1992, SIIS had an undiscounted unfunded liability of $1,623 million. (The figure booked by SIIS in its *Financial Statements* that year was $1,413 million.)

In January 1993, the Department of Insurance released a report entitled, "Solvency Investigation of the Nevada State Industrial Insurance System." In that report, the Department of Insurance concluded that SIIS had an accumulated deficit as of June 30, 1992, in excess of $2.2 billion.

Due in large part to the reforms enacted by the Legislature in 1991 and 1993, the financial position of SIIS has improved dramatically in recent years. The following five-year financial summary documents this improvement:

State Industrial Insurance System
Five-Year Financial Summary

(dollars in thousands)	1996	1995	1994	1993	1992
Net Premium Income	$ 458,979	$ 451,243	$ 419,103	$ 378,146	$ 338,682
Claims Expense	248,529	266,288	322,628	428,522	435,266
Net Investment Income	76,736	50,831	49,617	57,479	54,003
Net Realized Investment Gains	32,643	11,652	13,586	18,688	6,664
Net Income (Loss)	363,470	276,664	98,718	(699,797)	(1,260,273)
Total Assets	1,409,444	981,545	734,721	710,042	748,359
Total Liabilities	2,761,732	2,713,185	2,787,768	2,807,166	2,161,291
Total Accumulated Deficit	(1,352,288)	(1,731,640)	(2,053,047)	(2,097,124)	(1,412,932)

Source: SIIS *1996 Annual Report*

Particularly noteworthy in the above figures are the improvements in net income, reductions in claims expense, and reduction in the unfunded liability (accumulated deficit). Net income increased by 31.4 percent from FY 1995 to FY 1996. Claims expenses fell by 6.7 percent in FY 1996 and by nearly 43 percent since FY 1993. The unfunded liability has decreased from $2,097 million in FY 1993 to $1,352 million in FY 1996. More recent estimates provided to the committee by the SIIS manager indicate that the unfunded liability as of October 31, 1996, may be approximately $1,259 million.[10]

Even though the turnaround of SIIS's financial condition has been dramatic, concerns exist among members of the committee that the agency may not be able to continue to improve its financial condition as it faces increased competition from individual and group self-insurance, and from private carriers beginning July 1, 1999.

According to the Division of Insurance, SIIS is continuing to lose business as employers exercise their options to self-insure. As of December 1, 1996, the Division of Insurance had on file 254 active certificates of individual self-insurance covering approximately 328,900 employees. The Division also had certified nine self-insurance groups (one public and eight private). These group self-insurance certificates represent approximately 327 individual former policyholders of SIIS and cover approximately 17,700 employees.

Charles B. Knaus, Actuary, Division of Insurance, reported to the committee that SIIS estimates that it could lose as much as $125 million of its current $450 million premium base when private carriers enter Nevada's workers' compensation market for the first time on July 1, 1999. Mr. Knaus further indicated that if SIIS's financial condition deteriorated to the point where it was again experiencing negative cash flow, he did not think that the agency could "recover to a better financial position than just prior to the onset of negative cash flow."[11]

The concern expressed by Mr. Knaus is similar to the concern expressed by the Nevada Legislature when it created the Legislative Committee on Workers' Compensation and gave it a responsibility to review and study the financial condition of SIIS, determine the extent of any apparent insolvency of SIIS, and establish a solvency formula. In addition, however, the committee was given authority to considered many other issues related to Nevada's workers' compensation program. Following is a discussion of the recommendations adopted by the committee at its December 3, 1996, work session in Las Vegas. The recommendations as approved by the committee are denoted by bullets and text in bold print.

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[10]See unaudited SIIS *Financial Statements* included as Appendix C of this report.

[11]See a November 26, 1996, memorandum from Charles B. Knaus to Vance Hughey which is included in this report as Appendix D.

A. Administration

During the course of its study, the committee received considerable testimony regarding administration of the workers' compensation program. For example, NRS 616C.020 provides that an injured employee must file a claim for compensation with the insurer within 90 days after an accident if either (a) the employee has sought medical treatment for an injury arising out of and in the course of his employment, or (b) the employee was off work as a result of an injury arising out of and in the course of his employment. Testimony was provided to the committee by employers and third-party administrators (TPAs) contending that 90 days was too long a period of time within which to seek medical treatment for an industrial injury. They suggested that if treatment was sought sooner, many medical conditions could be resolved more quickly and at a lower cost. To address this concern, the committee made the following recommendation to the 1997 Legislature:

1. **Amend NRS 616C.020 to reduce from 90 the number of days within which an injured employee must seek medical treatment.**

A company that assists employers seeking to become members of associations of self-insured employers expressed concern that insurers may be reluctant to provide certain information in a timely manner to a policyholder who is considering some form of self-insurance. The information referred to is required to be supplied to the Commissioner of Insurance for consideration of a policyholder's application for a certificate of self-insurance. The company that raised this issue felt that a delay in providing information might be used either to allow an insurer an opportunity to try to convince the employer to keep his coverage with the insurer, or to keep the policyholder account for as long as possible before it becomes self-insured. To minimize the chance of such delays occurring, the committee made the following recommendation:

2. **Amend Chapter 616A of NRS to add a requirement that an insurer provide policy information to a policyholder within a reasonable period of time after such information is requested.**

Representatives of employers and TPAs testified that a number of changes in certain provisions in the statutes would help streamline the administration of claims. The committee agreed with those representatives and adopted the following recommendations:

3. **Allow electronic transmission of the Employer's Report of Industrial Injury or Occupational Disease (C-3 form), Employee's Claim for Compensation/Report of Initial Treatment (C-4 form), medical bills, and other documents.**

4. **Amend NRS 616B.018 and NRS 616C.020 to allow insurers greater access to medical and claim information from other insurers.**

5. **Amend NRS 616C.020 and NRS 616C.025 to clarify reporting requirements.**

6. **Amend NRS 616C.065 to clarify that an insurer shall take certain actions within 30 *working* days after being notified of an industrial accident and having *received a claim for compensation*.**

7. **Amend NRS 616C.235 to clarify that an insurer may dispose of a claim file six months after the date of automatic closure.**

8. **Amend NRS 616C.475 to clarify that a certification of disability shall not be given for dates that are prior to the date of the physician's examination of the injured employee.**

9. **Amend subsection 5 of NRS 616C.490 so that it is consistent with *Nevada Administrative Code* (NAC) 616C.103 which allows 30 days for an employer to notify the employee of the compensation to which he is entitled. The statute currently allows only 14 days.**

10. **Amend subsection 9 of NRS 612.265 to allow self-insured employers to participate in the program designed to identify persons who are simultaneously receiving unemployment compensation and workers' compensation benefits. Also, clarify in the statute that both the Employment Security Division of the Department of Employment, Training and Rehabilitation and insurers have authority to investigate persons suspected of violating the law by simultaneously obtaining benefits under both the unemployment compensation and workers' compensation programs.**

Suggested wording changes to the statutes referred to in recommendations three through ten are included as Appendix E to this report.

B. Compensation Payment

Subsection 1 of NRS 616C.060 requires that an insurer commence payment of an accepted claim within 30 days after the insurer has been notified of an industrial accident. However, subsection 3 of NRS 616C.475 requires that an insurer make the first payment within 14 working days after receiving the initial certification of disability. It was pointed out to the committee that an insurer may be required to make the first payment of temporary total disability before it has completed its investigation of the compensability of a claim for compensation. If an insurer ultimately determines that the claim is not compensable under the Nevada Industrial Insurance Act, the injured employee will have received a payment to which he or she is not entitled. To avoid this situation from occurring, the committee made the following recommendation:

11. Correct a conflict between NRS 616C.060 and 616C.475 regarding the number of days within which an insurer must begin paying compensation.

A self-insured employer provided the committee with information regarding a case where one of its employees had falsified documents to obtain employment. The employee had used a false Social Security number and a forged resident alien card to complete her I-9 form at the time of employment. The employee filed a workers' compensation claim just prior to the discovery of the falsified documents. The employer argued that it is wrong for a person who has entered this country illegally and produced false documents in order to obtain employment to be able to receive workers' compensation benefits. The committee made the following recommendation:

12. Amend the law to disallow any person from receiving workers' compensation benefits if that person has falsified citizenship documents to obtain employment.

C. Coverage

A representative of the Schools to Careers Council explained to the committee that student participants in programs administered by a school district, a licensed private school, or a post secondary educational institution designed to provide exposure, training, or work experience are not covered by workers' compensation insurance even though they are subject to risks similar to those faced by employees of the participating companies. In addition, when a teacher participates in an unpaid "externship," where he or she works at a business for a few weeks during the summer or between school sessions, the teacher cannot be covered by the school district's workers' compensation insurance. Because teachers in these circumstance also cannot be paid by an external source for such activities, they cannot be covered under the business's workers' compensation policy. In order to address these school to careers issues, the committee voted to have a separate bill drafted that will include the following recommendations:

13. Amend Chapter 616 to allow (but not require) coverage of a student in a "volunteer" Schools to Careers related situation.

14. Develop a specific provision that requires a teacher's employer to continue coverage while the teacher is in a temporary location in an approved Schools to Careers activity.

D. Hearings and Appeals

Employers and TPAs expressed concern that many decisions rendered by hearing officers and appeals officers of the Department of Administration lack consistency when the facts of the cases suggest otherwise. They further complained that prior commitments

regarding scheduling of hearings and related matters have not been adhered to by the Department of Administration. In an effort to deal with these issues, the committee made the following recommendations for legislative action:

15. **Provide peer review or management review of hearing and appeals officers of the Department of Administration to help ensure consistency of decisions. Also require training of hearing and appeals officers at the National Judicial College in Reno.**

16. **Evaluate prior commitments made by the Department of Administration regarding scheduling of hearings and related matters.**

E. Pensions and Annuities

The committee received testimony that suggested that Nevada's workers' compensation laws are not clear regarding whether an insurer may purchase an annuity to satisfy its obligation to provide long term benefits in certain cases. Self-insured employers testified that they currently purchase annuities in some cases. In order to clarify the Legislature's position regarding the purchase of annuities by workers' compensation insurers, the committee made the following recommendation:

17. **Amend Chapter 616 to specify that insurers may purchase annuities.**

F. Permanent Partial Disabilities

At the May 23, 1996, meeting of the committee, Dr. Richard Victor, Executive Director, Workers Compensation Research Institute (WCRI), Cambridge, Massachusetts, made a presentation regarding PPD benefit structures and delivery systems.[12] The WCRI is a nonpartisan, not-for-profit research institute that specializes in conducting research on workers' compensation issues.

Dr. Victor's presentation highlighted the adversarial nature of many PPD benefit delivery systems which leads to litigation, delay of benefit payments, and distrust between injured employees and insurers. He outlined the following key system features that can improve PPD benefit delivery systems:

- Rules that generate predictable payments;

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[12]Dr. Victor's slide presentation is included in this report as Appendix F.

- Practices that encourage nonpartisan experts;
- A system that fosters early payment;
- Agencies that help parties (especially injured employees) navigate the system; and
- An adjudication process that deters litigation.

Dr. Victor explained that injured employees often retain attorneys merely to obtain information, not necessarily to dispute decisions affecting their claims. He noted that a less complex system that generates more predictable outcomes probably would lead to fewer disputes and less litigation. In addition, he advised workers' compensation agencies to seek ways of improving communication with their clients.

Return-to-work strategies can help minimize economic losses to both employees and employers. According to Dr. Victor, the primary factors that shape return-to-work outcomes include the following:

- Economic incentives, including benefit levels and reemployment wage levels;
- Return to preinjury employer;
- Worker attributes reflected in unstable employment history; and
- Return to work in six months or less.

"Laboratory studies" from California demonstrate the subjectivity associated with PPD ratings that can contribute to disputes regarding the amount of benefits to which an injured employee may be entitled. Dr. Victor explained that even asymptomatic individuals (those persons with no industrial injuries) are likely to have measurable impairments, and that the amount of impairment increases with age (from 2 percent on average for a young person to nine percent on average for an older person).

Dr. Victor also noted that when benefit levels are relatively high, incentives exist for injured employees to contest even small differences in impairment ratings. He cautioned, however, that policy makers must balance equity issues (such as the adequacy of compensation for work-related impairments) with cost savings associated with lower benefit levels and reduced litigation.

Mr. Hughey and Ron Swirczek, Administrator, DIR, presented the results of a 50-state survey on PPD awards with the assistance of Deb Braun, Chief Administrative Officer,

DIR, and Ruth Ryan, Management Analyst, DIR.[13] The survey compared the amount of PPD awards in different states under several assumptions regarding the wage of a hypothetical injured employee and the severity of the employee's injury.

After considerable deliberations regarding alternative methods of determining appropriate benefits for permanent partial impairments, the committee made the following recommendations:

18. **Consider studying alternatives to the current PPD rating system such as implementing a schedule of benefits for most injuries to take out some subjective areas such as range of motion. If this review cannot be completed during the 1997 Legislative Session, continue the statutory committee and charge the committee with commissioning an independent study of PPD awards. The results of the study, along with recommendations of the committee, are to be presented to the 1999 Legislature.**

19. **Address the issue of PPD awards for dental problems.** (Note: NRS 616C.485 and NAC 616C.508 govern payment of PPD awards for loss of or permanent damage to a tooth.)

20. **Amend NRS 616C.090 to provide that an injured employee be allowed to choose a doctor from the rotating list for a PPD evaluation at any time.**

21. **Amend NRS 616C.090 to provide that if an injured employee's claim is being administered by SIIS and the injured employee requests a doctor from the rotating list, and the injured employee is assigned a doctor who is employed by SIIS, then the injured employee is entitled to request another doctor from the rotating list.**

22. **Amend NRS 616C.090 to provide that the doctor who shall rate the claimant for a PPD shall be the claimant's treating physician.**

G. Regulation of Workers' Compensation Insurance

Many of the public comments during the first two meetings of the committee were in the form of complaints regarding a regulatory change to the formula used by SIIS to calculate experience modification factors.[14] The concern expressed by these SIIS policyholders was that the new formula is unfairly discriminatory because it results in:

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[13]The results of the survey are included in this report as Appendix G.

[14]The credibility formula was changed by SIIS from C = E / (1.1E + 40,000) to C = E / (E + 100,000), where C=credibility and E=expected losses.

1. An increase in standard premiums for policyholders with better than average loss experience; and

2. A reduction in standard premiums for policyholders with worse than average experience.

At the second meeting of the committee, Mr. Hughey gave a presentation on experience rating and the effects of a change to the experience rating formula adopted by SIIS.[15] Mr. Hughey explained that experience rating is a pricing tool that distinguishes each employer as better than, equal to, or worse than his or her industry average in terms of controlling losses. Two primary goals of experience rating are "predictive accuracy" and "safety incentive." In addition, credibility is used to gauge the level of confidence that an insurer has in the available data as an indicator of a policyholder's future losses.

The basic formula for calculating experience modification factors (e-mods) has been part of the *Nevada Administrative Code* (NAC) since at least 1983. The SIIS did not change this basic formula, although it did revise the credibility component of the formula. The change in the formula caused concern among many policyholders, especially smaller policyholders with e-mods less than one that also experienced stable or declining losses during the preceding year. Employers who had better than average loss experience and less than $600,000 in expected losses, complained that their premiums were increased as a result of the change in the e-mod formula, while premiums were reduced for employers who had worse than average premiums and less than $600,000 in expected losses.

Robert Conger, a consulting actuary with Tillinghast-Towers Perrin, explained the changes to the experience modification plan and discussed some of the difficulties the agency had to address in making those changes. He stated that experience rating may help turn an employer with poor claims experience into a good policyholder by:

1. Establishing a premium charge that is adequate to cover the risks of that employer;

2. Providing a mechanism to encourage the commercial market to provide coverage for an employer with worse than average claims experience. With the benefit of experience rating, the commercial market or SIIS may be interested in writing coverage for that employer; and

3. Providing an incentive to the employer to improve its claims experience.

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[15]Mr. Hughey's slide presentation is included in this report as Appendix H.

He also explained that an experience rating plan is not the cause of all premium increases. An employer's premium may increase due to growth in payroll or changes to any of the following other factors:

1. Operation or type of business;

2. Claims experience of the employer's industry; and

3. The employer's own claims experience.

According to Mr. Conger, changes to the experience rating formula recently adopted by SIIS include:

1. An increase in the "eligibility requirement" to be experience rated;

2. A change to the credibility formula. Credibility factors for most employers were reduced;

3. An increase in the dollar cap on individual claims; and

4. An offsetting 6 percent reduction in manual premium rates.

After considering the testimony and recognizing that neither the committee nor the Commissioner of Insurance had jurisdiction over the regulation adopted by SIIS, the committee made the following recommendation.

23. Consider changing the law to place responsibility for adoption of an experience rating plan with the Commissioner of Insurance.

Public testimony was received from the owner of a custom wood working company regarding a "three times" penalty (NRS 616D.200) imposed by SIIS for a period of time when the company was uninsured in Nevada. The owner explained to the committee that his Nevada employees were covered by a California policy during the period of time for which SIIS imposed the penalty. He argued that the regulation adopted by SIIS provided the agency with no discretion to wave or reduce the amount of the penalty in cases such as his. He contended that the regulation was contrary to the Legislature's intent to provide SIIS with discretion in imposing the penalty. The committee made the following recommendation regarding penalties for failure of an employer to secure or maintain workers' compensation insurance:

24. Correct a perceived conflict between NRS 616D.200 and the regulation adopted by SIIS regarding the "three times penalty" imposed for failure of an employer to secure or maintain workers' compensation insurance.

Mr. Swirczek testified regarding the annual review of the medical fee schedule. Such a review is required by subsection 2 of NRS 616C.260. The committee discussed the issue of setting maximum fees and how the medical fee schedule worked in conjunction with managed care organizations (MCOs) who typically require physicians on their provider panels to agree to substantial discounts from the approved medical fee schedule. The committee agreed to make the following recommendation:

25. Amend NRS 616C.260 to change the benchmark for the medical fee schedule.

The committee spent a considerable amount of time discussing the role of various entities involved in the workers' compensation program, especially in view of private carriers entering the market beginning July 1, 1999. The committee received testimony that currently certain regulatory functions are performed by SIIS (such as imposing a penalty for failure of an employer to secure or maintain workers' compensation insurance). In addition, employers complained that the regulatory responsibilities of DIR and the Commissioner of Insurance are often duplicative and confusing. In an effort to clarify regulatory responsibilities in a more competitive insurance environment, the committee made the following recommendation:

26. Identify which regulatory responsibilities should be delegated to the Commissioner of Insurance and/or DIR in anticipation of workers' compensation coverage being provided by private carriers beginning July 1, 1999.

H. Safety and Health

Testimony was provided to the effect that employees sometimes prevail upon appeal in cases involving a claim by an employer that an injured worker was injured as a result of being under the influence of a controlled substance. Employers explained that it is difficult to prove that an employee was intoxicated or "under the influence" at the time of an industrial injury because no levels have been established for controlled substances as they have for alcohol. The committee was advised of a position taken by the Employment Security Division (ESD), Department of Employment, Training, and Rehabilitation, in similar cases involving eligibility determinations for unemployment compensation. According to testimony, if an employee is terminated by an employer for violating a written drug policy, the ESD upholds the denial of unemployment compensation benefits. The agency does not address the issue of whether the employee was under the influence at the time of the termination of employment, but rather upholds state laws that prohibit the use of illegal substances. This position was upheld in a recent case decided by the Supreme Court of Nevada (*Nevada Employment Security Department*

v. Cynthia Holmes) in a claim against the San Remo Hotel in Las Vegas. The committee adopted the following recommendation:

27. **Amend subsection 1(d) of NRS 616C.230 to strengthen provisions for an insurer to deny a workers' compensation claim if an injured employee tests positive for a controlled substance. Refusal to take a drug test would have the same presumption of "under the influence" as in the case of driving under the influence of alcohol. Termination of employment for failing a drug test or refusing to take a drug test would disqualify an injured employee from benefits.**

I. Solvency Assessment and the Role of SIIS

Chairman Hettrick offered several proposals regarding the solvency assessment formula. First, he suggested that the mechanism for determining if and when a solvency assessment is to be imposed be changed. Currently, NRS 616B.110 provides that the Commissioner of Insurance may declare SIIS to be insolvent if the agency must liquidate its invested assets or real property in order to pay its outstanding obligations as they mature in the regular course of business. Such a declaration would trigger imposition of the solvency assessment. Chairman Hettrick stated his opinion that the Commissioner could make such a declaration at any time, which would require that a solvency assessment immediately be imposed on employers. He expressed concern that automatically imposing an assessment before considering other available options to deal with SIIS's financial difficulties might not be in the best interest of Nevada's workers' compensation program. Chairman Hettrick instead suggested that the decision to impose the assessment be made by the committee after it has considered all other available options.

Second, Chairman Hettrick suggested that if the assessment must be imposed, that it be an assessment on all insurers in the amount of 4 percent of paid claims. He noted that an analysis by the Division of Insurance suggested that a 4 percent assessment on paid claims likely would be adequate if it became necessary to impose an assessment. He also stated that the figure of 4 percent could be higher or lower depending upon the extent of any insolvency of SIIS at the time a decision is made to impose an assessment. Chairman Hettrick argued that by placing the decision to impose an assessment with the committee, the most recent financial information could be considered before setting the assessment rate.

The committee discussed several options regarding the base upon which an assessment should be applied including premiums, employees, and paid claims. Chairman Hettrick explained that using paid claims had several advantages over the other options. First, the current formula used by DIR to assess insurers for the administrative expenses of

regulating workers' compensation insurance is based on paid claims. From an administrative standpoint, appending a solvency assessment to the current DIR assessment formula would be relatively easy. Second, basing a solvency assessment on paid claims provides an incentive for employers to improve workplace safety and to provide return to work opportunities for their injured employees. Under such a plan, a company with no paid claim costs would not pay an assessment. Likewise, an employer with high losses would pay a larger share of the assessment.

Representatives of governmental entities in Clark County suggested that the committee consider excluding from the solvency assessment formula payments for cancer, heart, and lung claims under NRS 617.453, 617.455, and 617.457. These sections of Nevada's occupational disease statutes provide a conclusive presumption that cancer, heart, and lung diseases arise out of and in the course of employment for fire fighters and police officers. The local government representatives argued that city and county governments are uniquely affected by these statutory provisions. They explained that they can neither prevent such claims nor defend against them. Because the law prohibits requiring that injured employees afflicted with these conditions return to work in alternative positions, there is little that a local government can do to mitigate costs of such claims.

After much deliberation, the committee considered and adopted the following recommendations regarding the solvency assessment issue:

28. **Amend NRS 616B.110 to require that the decision to impose the assessment be made by the Legislative Committee on Workers' Compensation after it has considered all other available options.**

29. **Amend NRS 616B.110 so that if an assessment is imposed, it is based on a percentage of paid claims of all employers. Consider allowing exemptions for special circumstances such as cancer, heart, and lung coverage provided by certain governmental entities.**

IV. CONCLUSIONS

> All reform efforts are experimental and represent innovation on the part of the states who have undertaken them. Cost containment mechanisms, particularly managed care programs which have been used for years in other health care systems, are just beginning to be tested in workers' compensation. When the old answers no longer work, it takes leadership and creative thinking to institute reforms—and this is the tack that many states have taken.[16]

The Nevada Legislature is faced with the difficult task of dealing with the potential insolvency of SIIS, the State's largest workers' compensation insurance carrier, while providing for obligations of SIIS to pay benefits to injured employees. In addition, the Legislature is faced with problems of promoting a business environment that is conducive to creating and maintaining high quality employment opportunities to Nevada's workers, while attempting to ensure the future funding of liabilities incurred by SIIS at least a decade ago.

The reasons for SIIS's financial problems are varied and complex. Successful resolution of those problems are likely to be the same. The recommendations contained in this report, and the bill draft requests included in Appendix I are designed to minimize the chance that drastic measures will need to be taken in the future. Even so, future Nevada Legislatures will likely face additional challenges in their attempts to maintain a cost-effective, comprehensive program of industrial insurance that is fair to employers and injured employees alike.

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[16] *The State of Workers' Compensation*, National Conference of State Legislatures, January 1994, p. 78.

V. APPENDICES

Appendix A

NRS 218.5375 through 218.5378

LEGISLATIVE COMMITTEE ON WORKERS' COMPENSATION

218.5375 Creation; membership; chairman and vice chairman; vacancies.

1. There is hereby created a legislative committee on workers' compensation. The committee consists of:

(a) Four members appointed by the majority leader of the senate, in consultation with the minority leader of the senate, from the membership of the senate standing committee on commerce and labor during the immediately preceding session of the legislature.

(b) Four members appointed by the speaker of the assembly from the membership of the assembly standing committee on labor and management during the immediately preceding session of the legislature. The members must represent each political party represented in the assembly in the approximate proportion that they are represented in that house, but at least one member must be chosen from each political party.

2. The members of the committee shall elect a chairman and vice chairman from among their members. The chairman must be elected from one house of the legislature and the vice chairman from the other house. After the initial election of a chairman and vice chairman, each of those officers holds office for a term of 2 years commencing on July 1 of each odd-numbered year. If a vacancy occurs in the chairmanship or vice chairmanship, the members of the committee shall elect a replacement for the remainder of the unexpired term.

3. Any member of the committee who is not a candidate for reelection or who is defeated for reelection continues to serve until the convening of the next session of the legislature.

4. Vacancies on the committee must be filled in the same manner as original appointments.

(Added to NRS by 1995, 2162)

218.5376 Meetings; compensation of members.

1. The members of the committee shall meet at least quarterly and at the times and places specified by a call of the chairman. The research director of the legislative counsel bureau or a person he has designated shall act as the nonvoting recording secretary. Five members of the committee constitute a quorum, and a quorum may exercise all the power and authority conferred on the committee.

2. Except during a regular or special session of the legislature, the members of the committee are entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding session, the per diem allowance provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207 for each day or portion of a day of attendance at a meeting of the committee and while engaged in the business of the committee. The salaries and expenses of the members of the committee and any other expenses incurred by the committee in carrying out its duties must be paid from assessments imposed pursuant to NRS 232.680.

(Added to NRS by 1995, 2163)

218.5377 Powers and duties. The committee:

1. May review issues related to workers' compensation.

2. May study the desirability of establishing a preferred employee program which provides exemptions from the payment of premiums and other financial incentives for employers who provide suitable employment for injured employees and any other program for returning injured employees to work.

3. May review the manner used by the division of industrial relations of the department of business and industry to rate physical impairments of injured employees.

4. Shall, to ensure the solvency of the state industrial insurance system:

(a) Review and study the financial condition of the state industrial insurance system;

(b) Determine the extent of any apparent insolvency of the system; and

(c) Establish a formula which will be applied to calculate a surcharge that is equal in amount to any deficiency in the cumulative amount of premiums paid by an employer who is subject to the provisions of NRS 616B.110.

5. May conduct investigations and hold hearings in connection with carrying out its duties pursuant to this section.

6. May direct the legislative counsel bureau to assist in its research, investigations, hearings and reviews.

(Added to NRS by 1995, 2163)

218.5378 Fees and mileage for witnesses. Each witness who appears before the committee by its order, except a state officer or employee, is entitled to receive for his attendance the fees and mileage provided for witnesses in civil cases in the courts of record of this state. The fees and mileage must be audited and paid upon the presentation of proper claims sworn to by the witness and approved by the chairman of the committee.

(Added to NRS by 1995, 2164)

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Appendix B

NRS 616B.110

616B.110 Solvency surcharge: Collection by administrator; credit of money received to account for solvency surcharges; cessation of collection when system is no longer insolvent; civil liability for failure to pay.

1. If, after conducting an examination of the affairs, transactions, accounts, funds, records and assets of the system, the commissioner determines that the system is insolvent, he shall give written notice of his determination to the manager and administrator.

2. Except as otherwise provided in this subsection, upon receipt of such a notice, the administrator shall impose and collect a solvency surcharge from:

(a) Each employer who was insured by the Nevada industrial commission or the system at any time during the period beginning on July 1, 1979, and ending on July 1, 1995;

(b) Each employer who is insured by the system at any time after July 1, 1995;

(c) Each self-insured employer; and

(d) Each association of self-insured public or private employers,

in an amount calculated to produce the revenue that is required to pay the outstanding obligations of the system as they become due. The formula used by the administrator to calculate the surcharge must be approved by the legislative committee on workers' compensation created pursuant to NRS 218.5375. The surcharge must be paid in the manner prescribed by the administrator. The manager shall collect the surcharge imposed against those employers who are insured by the system at any time after July 1, 1995.

3. All money received by the administrator and manager from any surcharge imposed pursuant to this section must be credited on the records of the system to the account for solvency surcharges, which is hereby created in the state insurance fund. The money in the account:

(a) Constitutes a part of the assets of the state insurance fund.

(b) Must be used solely to pay the operating expenses of the system and any obligations of the system as they become due. The money in the account may not be used by the system to incur any additional obligations.

4. If, at any time after the imposition of a surcharge pursuant to this section, the manager determines that the system is no longer insolvent, he shall file a request with the commissioner to cease the collection of any surcharge imposed pursuant to this section. Upon the receipt of the request, the commissioner shall, for the purpose of determining the financial condition of the system, conduct an examination of the affairs, transactions, accounts, funds, records and assets of the system. If, after conducting the examination, the commissioner determines that the system is no longer insolvent, the commissioner shall approve the request.

5. Any employer, self-insured employer or association of self-insured public or private employers that fails to pay any surcharge imposed pursuant to this section is liable in a civil action commenced by the administrator for:

(a) The amount owed pursuant to this section;

(b) The reasonable expenses incurred by the administrator in enforcing this section; and

(c) Payment of interest on the amount due at the rate fixed pursuant to NRS 99.040 for the period from the date upon which the surcharge was due to the date upon which the surcharge is paid.

Any money collected by the administrator pursuant to this subsection must be deposited into the account for solvency surcharges.

6. For the purposes of this section, the system is insolvent if the system is required to sell or otherwise liquidate any of the invested assets or real property of the system for the purpose of paying its outstanding obligations as they mature in the regular course of business.

(Added to NRS by 1995, 2128)

Appendix C

Unaudited SIIS *Financial Statements* as of October 31, 1996.

State Industrial Insurance System

Unaudited Interim Financial Statements for the Period Ending October 31, 1996

Prepared by:
State Industrial Insurance System
For Internal Use Only

STATE INDUSTRIAL INSURANCE SYSTEM

Table of Contents

October 31, 1996

STATE INDUSTRIAL INSURANCE SYSTEM
Balance Sheet
As of October 31, 1996 and June 30, 1996

(In thousands)

	As of 31-Oct-96	As of 30-Jun-96	Changes
ASSETS			
Investment Securities (note 2):			
Marketable Equity Securities	$ 370,536	$ 339,030	$ 31,506
Bonds	396,464	308,793	87,671
Mortgages	307,153	293,968	13,185
Total Investment Securities	1,074,152	941,791	132,361
Cash and cash equivalents	220,239	297,303	(77,064)
Cash held in escrow (note 3):	2,807	3,405	(598)
Premiums receivable	86,350	100,350	(14,000)
Accrued interest and dividends receivable	5,265	5,276	(11)
Due from brokers for security sales	14,978	26,221	(11,243)
Property, Plant & Equipment (note 4):			
Land	3,779	3,779	-
Buildings	15,378	15,302	76
Furniture & Equipment	27,289	26,937	352
Systems in development	9,698	6,859	2,839
	56,144	52,877	3,267
Less Accumulated Depreciation	23,094	22,528	566
Net Property, Plant & Equipment	33,050	30,349	2,701
Other assets	4,897	4,749	148
	$ 1,441,739	$ 1,409,444	$ 32,295
LIABILITIES AND ACCUMULATED DEFICIT			
Liability for incurred but unpaid claims and claims adjustment expense (note 5 and 8)	$ 2,443,000	$ 2,443,000	$ -
Reserve for retrospective rating plans	18,500	18,500	
Policyholders premium deposit	42,881	48,692	(5,811)
Accounts Payable and other liabilities	17,526	17,211	315
Pending security purchases	170,196	222,851	(52,655)
Obligations under capital leases	8,581	11,478	(2,897)
Total Liabilities	2,700,683	2,761,732	(61,049)
Commitments and contingencies (notes 6 and 9)			
Accumulated deficit	(1,345,763)	(1,420,533)	74,770
Net unrealized gain on investment	86,819	68,245	18,574
Total accumulated deficit	(1,258,944)	(1,352,288)	93,344
	$ 1,441,739	$ 1,409,444	$ 32,295

** See accompanying notes*

STATE INDUSTRIAL INSURANCE SYSTEM
Statement of Operations and Changes in Accumulated Deficit
For the period July 1, 1996 to October 31, 1996

(In thousands)

	Period Ending 31-Oct-96	Current Month Oct-96
Net premium income (note 7 and 8)	$ 141,252	$ 37,258
Operating expenses		
Claims expense	66,451	16,280
Change in reserve for claims	-	-
MCO fees (note 10)	1,405	(428)
Salaries and benefits (note 11)	13,524	3,226
Operating	9,827	1,701
Administrative expense	1,967	437
Depreciation and amortization	982	251
	94,158	21,467
Underwriting income (loss)	47,095	15,791
Other income		
Miscellaneous income	884	184
Delinquent penalties	646	181
Other	1,784	417
	3,313	782
Net investment income (note 2):		
Interest and dividend income	14,024	2,664
Net realized investment gain	10,337	3,637
	24,361	6,300
Net income (loss)	$ 74,770	$ 22,874
Accumulated deficit beginning of period	1,420,533	1,368,637
Accumulated deficit end of period	$ 1,345,763	$ 1,345,763

** See accompanying notes*

STATE INDUSTRIAL INSURANCE SYSTEM
Statement of Cash Flows
For the period July 1, 1996 to October 31, 1996

(In thousands)

	Period ending 31-Oct-96
Cash flow from operating activities:	
Premiums received	$ 153,493
Claims paid	(68,183)
MCO expense	(1,405)
Salaries and benefits paid to employees	(12,236)
Deductible income-net	1,363
Operating and other expenses paid	(18,019)
Other operating receipts	4,733
Net cash provided by operating activities	59,746
Cash flows from capital and related financing activities	
Systems in development	(2,838)
Acquisitions of property and equipment, net	(845)
Payments on obligations under capital leases	(2,897)
Net cash used in capital and related financing activities	(6,581)
Cash flows from investing activities:	
Purchases	(776,906)
Sales	632,044
Interest & dividends received	14,036
Net cash provided by investing activities	(130,826)
Net increase/(decrease) in cash	(77,661)
Cash and cash equivalents, beginning of year	300,707
Cash and cash equivalents, year to date	$ 223,047
Reconciliation of underwriting gain to net cash used in operating activities:	
Underwriting income	$ 47,095
Adjustments to reconcile underwriting income to net cash provided by operating activities:	
Depreciation and amotization	982
Changes in operating assets & liabilities:	
Premiums receivable	14,000
Allowance for uncollectible accounts	-
Accounts payable and other liabilities	315
Other income	3,312
Other assets	(148)
Premium deposits	(5,811)
Liability for incurred but unpaid claims	-
Net cash provided by (used in) operating activities	$ 59,746

** See accompanying notes*

STATE INDUSTRIAL INSURANCE SYSTEM
Notes to Financial Statements
October 31, 1996

(Dollar amounts in thousands)

(1) **Basis of Accounting**

As a separate self-supporting agency of the State of Nevada, SIIS follows the Accrual basis of accounting. Revenues are recognized when earned regardless of when received and expenses are recognized when incurred regardless of when paid. For purposes of financial presentation, SIIS has adopted Governmental Accounting Standards Board Opinion 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues* . Interim financial statements are prepared internally, are unaudited, and are intended only for internal use.

(2) **Investment Securities**

Investment securities are carried at market value. The resulting unrealized gains and losses on these securities are reported as a separate component of the balance sheet. Realized gains or losses are recognized as income upon the maturity or disposition of the investment or when a decline in value is considered other than temporary. For purposes of computing gains and losses, the cost of bonds and mortgages sold is determined by specific identification. The cost of marketable equity securities sold is determined on the average cost method.

On an interim basis an estimated accrual of investment activities is booked. This estimate includes: dividend income, interest income, mortgage principal, security lending income, and unrealized gain.

Market value for investment securities is determined from prices quoted on national exchanges as of October 31, 1996. Market values for investment securities that are not traded on national exchanges are determined based upon quotes from several licensed securities brokers as of October 31, 1996.

(3) **Cash Held In Escrow**

Cash held in escrow represents the balance of monies held in escrow for the claims document imaging project. Payments made on accepted deliverables are paid from the escrow account to Unisys Corporation.

Beginning Balance	Current Month	Year to date Disbursements	Balance
$ 3,405	0	598	$2,807

(4) **Property, Plant and Equipment**

Property, plant, equipment and externally developed software costs are stated at cost, less accumulated depreciation. Lease obligations for which SIIS assumes substantially all the property rights and risks of ownership are capitalized and reported as furniture and equipment. Maintenance, repairs and minor renovations are charged to expense as costs are incurred.

On an interim basis, property, plant and equipment purchased is booked based on the date placed in service.

Property and equipment is depreciated using the straight-line method over the estimated useful lives of the assets:

Buildings and improvements	5 to 40 years
Furniture, equipment and software	4 to 7 years

Leasehold improvements and assets under capital leases are amortized using the straight-line method over the lives of the leases or the estimated useful lives of the assets, whichever is shorter.

Systems in development represents the claims document imaging project currently under development (notes 3 and 6). Acceptable deliverables are paid from the escrow account and are capitalized to Systems in development. Interest expense ($127 year to date) from the lease obligation and interest income ($72 year to date) from an escrow account incurred during the development of the project are also capitalized, in accordance with Statements of Financial Accounting Standards pronouncement 34.

(5) **Incurred but Unpaid Claims**

Claims expenses, on an interim basis, are recorded as paid. The liabilities for incurred but unpaid claims and loss adjustment expenses is based on the estimated ultimate cost of settling the claims. An external actuarial review was conducted as of June 30, 1996.

Incurred but unpaid claims and claims adjustment expense represents: (a) individual case estimates for reported claims, (b) bulk reserve estimates for reported and unreported claims based on past experience modified for current trends, and (c) estimates of expenses for investigating and settling claims. The total of such items is reduced by estimated future employer deductibles and subrogation recoveries.

(6) **Lease Obligations**

SIIS has entered into noncancelable lease agreements for computer equipment and related maintenance contracts. Ownership of the computer equipment will be transferred to SIIS at the end of the lease term. The estimated capital lease and operating payments are $5,805 and $1,272 respectively for fiscal year 1997. The future minimum lease payments under capital and operation leases are as follows:

		Capital	Operating
Fiscal Year:			
1998	$	2,338	1,008
1999		2,338	1,021
2000		2,206	898
2001		--	898
Thereafter		--	3,299
Total minimum lease payments		6,882	7,124
Less amount representing interest		659	
Total future minimum lease payments	$	6,223	8,396

In July 1995, SIIS entered into a capital lease for the imaging system which includes: computer equipment, software, and development for $9,282, to be amortized over five years. As part of the imaging lease the finance company advanced the full amount of monies, $9,282, to an escrow account (see note 3). Imaging development and materials costs are paid from the escrow account.

(7) **Premiums**

Premiums are based on individual employers' reported payroll using predetermined insurance rates based on the employee risk classifications and are recognized as income over the coverage period. In addition to regular premium plans, a retrospective premium rating plan under which premiums are adjusted annually for four years following the plan year based on individual employers' loss experience is available. Adjustments to the original premiums are paid to or collected from the employers approximately six months after the end of each plan year. Policyholders' premiums due to SIIS are recorded as premiums receivable, net of reserve for uncollectible accounts.

Premium income, on an interim basis, is an estimate of premium income earned for the current month. This estimate is based on the premium activity of the preceding three months seasonalized over the prior year's activities. The premium income is only an internal estimate and is not a function of an actuarial review.

(8) **Reinsurance**

In the ordinary course of business, the System cedes premiums for purposes of risk diversification and limiting maximum loss exposure from catastrophic events through contractual agreements with reinsurers.

The following amounts have been deducted in the accompanying financial statements as a result of reinsurance ceded:

		1996
Gross liability for incurred but unpaid claims and claims adjustment expense	$	2,450,000
Reinsurance recoverable on unpaid claims and claims adjustment expense		(7,000)
Liability for incurred but unpaid claims and claims adjustment expense	$	2,443,000
Premium income	$	142,418
Ceded premiums		(1,166)
Net premium income	$	141,252

The System's reinsurance program provides coverage for loss occurrences involving one person subject to a limit of $7,000 in excess of a $3,000 retention. Reinsurance for loss occurrences involving two or more persons is subject to a limit of $125,000 in excess of a $3,000 retention.

(9) **Commitments**

An agreement for a Policyholder Services Business Process Analysis and a Policyholder Services Computer System has been entered into with an outside contractor. The contract began in February 1996 and is scheduled for completion in February 1999. The expected cost for fiscal year 1997 is $14,965, which is allocated to the following functions:

Operational consulting	$	9,910
Computer consulting		925
Computer hardware		930
Computer software		3,200

The agency has entered into an agreement with an outside contractor to provide for the implementation of a Claims Business Process Analysis. The contract was entered into in January 1996 and is scheduled for completion in September 1996. The expected cost for fiscal year 1997 is $6,209.

(10)**Managed Care Organization Fees**

The managed care organizations (MCO) manage claims by arranging to provide medical and health care services. The expense is based on the number of claims accepted and closed while managed by the MCO. On an interim basis, the SIIS prepares an estimate of fees that have accrued for the current period. This estimate is based on historical activity.

(11)**Salary and Benefit Expense**

Salary and benefit expense for the interim periods includes an accrual for expenses incurred yet not paid as of the end of the interim period.

Appendix D

Memorandum from Charles B. Knaus to Vance Hughey, dated November 26, 1996, regarding "Answers to Questions Posed During S.B. 458 Meeting Held on November 7, 1996."

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE

MEMORANDUM

TO: Vance Hughey, Senior Research Analyst
Legislative Counsel Bureau

FROM: Charles B. Knaus, Actuary III
Division of Insurance

DATE: November 26, 1996

SUBJECT: Answers to Questions Posed During SB 458 Meeting held on November 7, 1996

****

For the purposes of continuity, I have elected to answer the questions in a different order than they were presented.

QUESTION: WHAT IS THE AMOUNT OF THE UNINSURED EMPLOYER FUND? (Question 2)

ANSWER: The balance in the uninsured employer fund is $4,533,092.06 (as of 10-30-96). Claims are paid as they come due and monies are added to the fund quarterly, but an employer may pay on an annual basis. Source: Ms. Debbie Braun, Division of Industrial Relations, 684-8024.

QUESTION: WOULD THE SIIS BE CONSIDERED INSOLVENT? HOW WOULD THE DIVISION OF INSURANCE MAKE THAT DETERMINATION? IS THAT ANY DIFFERENT FROM ANY OTHER FUND? (Question 3)

ANSWER: There are different insolvency triggers for the SIIS from those for insurers licensed pursuant to chapter 680A of NRS. In fact, NRS 680A.120 defines capital and surplus requirements for the licensed insurers.

The Life and Health Guaranty statutes in chapter 687C of NRS and the Guaranty Association statutes in chapter 687A of NRS control insolvency proceedings for licensed insurers. Chapter 687A of NRS would control workers' compensation by licensed insurers because it is defined as casualty insurance (NRS 681A.020(1)(c)).

The Commissioner has an implied statutory duty (NRS 687A.107) to hold a hearing for the purpose of determining whether an insurer is insolvent pursuant to NRS 687A.035(2). In my opinion, the grounds for holding such a hearing would be the determination that an insurer is unlikely to have the capital and surplus required by NRS 680A.120.

It is an easy determination that the SIIS does not have the required capital and surplus. The information which substantiated this fact includes the SIIS financial statements dated 1992-1996 and the 1993 examination report. (The examination was conducted by Douglas D. Dirks, then an independent contract examiner for the Division of Insurance.)

As noted above, there is a different trigger than NRS 680A.120 for the SIIS. NRS 616B.110(6) is the controlling provision, and negative cash flow from operations is the requisite trigger. SIIS is not insolvent according to NRS 616B.110(6).

QUESTION: IF THE COMMITTEE'S RESPONSIBILITIES WERE NOT IN PLACE, WHAT WOULD BE THE RESPONSIBILITY AND JURISDICTION OF THE DIVISION OF INSURANCE? ALSO, PLEASE EXPLAIN THE GUARANTY FUND SITUATION. (Question 1)

ANSWER: The SIIS is a governmental entity and, therefore, not part of the Guaranty Association. Insurers could not be assessed through the guaranty association for SIIS insolvency.

Pursuant to NRS 687A.020, effective until July 1, 1999, the Guaranty applies to all direct insurance except:

. . .

(9) Any insurance provided by or guaranteed by a governmental agency.

Under current law, the commissioner has responsibility/jurisdiction over the SIIS as follows: NRS 616B.110 allows the commissioner to conduct an examination of SIIS and to establish insolvency pursuant to NRS 616B.110(6). If insolvency is determined, the commissioner must give written notice to the manager and the administrator.

The following points do not apply to the commissioner's responsibility/jurisdiction over the SIIS. They apply to **licensed insurers only.**

1. Issue the financial examination report showing the insurer to be insolvent;

2. Hold a hearing to have oral and written testimony on record to confirm the insolvency;

3. Issue an order declaring the insurer to be insolvent;

4. Apply to the court of jurisdiction for an order appointing the commissioner as receiver;

5. Take possession of the assets of the insurer and then, as receiver, either conduct the business of the insurer or take the authorized statutory steps for the purpose of rehabilitating, liquidating, or conserving the affairs or assets of the insurer.

6. File with the court the reports of the insurers' affairs including progress toward accomplishing the objectives of the receivership;

7. With respect to the SIIS operations over the past few years, the current General Manager has accomplished very acceptable variations of steps 5 and 6 above. His reports, however, are to parties other than a court.

QUESTION: WHAT WOULD THE DIVISION OF INSURANCE NEED TO DO TO DETERMINE IF THE SIIS QUALIFIES FOR CONSERVATORSHIP VERSUS LIQUIDATION? (Question 5)

ANSWER: To decide if the SIIS best qualifies for conservatorship (run as an ongoing business for as long as practical) or liquidation (sale of both assets and liabilities), the Commissioner would consider the information presented at the insolvency hearing. The most relevant information would be the schedule of maturity of claims liabilities as compared to projected flow of income. In my opinion, the

SIIS could not sustain negative cash flow for any period of time and then recover to a better financial position than just prior to the onset of negative cash flow.

QUESTION: IF THE SIIS IS DETERMINED TO BE INSOLVENT, WHAT IS THE RESPONSIBILITY OF THE DIVISION OF INSURANCE? (Question 4)

ANSWER: The Commissioner has responsibility/jurisdiction over the SIIS as follows: NRS 616B.110 allows the commissioner to conduct an examination of SIIS and to establish insolvency pursuant to NRS 616B.110(6). If insolvency is determined, the commissioner must give written notice to the manager and the administrator.

QUESTION: IS THE INSURANCE DIVISION COMFORTABLE WITH ASSEMBLYMAN HETTRICK'S PROPOSAL OF A 4 PERCENT ASSESSMENT TO PAY OFF THE UNFUNDED LIABILITY? WHAT ABOUT THE BENEFITS FOR HEART-LUNG DISEASE WHICH ARE NOT TO BE FUNDED BY THE ASSESSMENT? (Question 6)

ANSWER: Given that certain specified benefits such as heart-lung disease would not be funded by assessments (that is, not paid for by the SIIS), the following analysis explains how I would determine whether a 4 percent assessment on claims paid would generate sufficient funds to pay off the unfunded liability of $1.35 billion.

Listed below are my observations:

1. The $1.35 billion number used to define the unfunded liability is a projection into the future. It is, in fact, an estimate which would better be represented as a range. For the purpose of this writing, I will assume it to be an exact number.

2. I previously mentioned the schedule of maturity of SIIS liabilities as compared to projected flow of income. From consultation with Mr. Dirks, it does not appear there is an unforeseen or unusual front end maturity of liabilities;

3. It is very possible that the SIIS assets such as bonds and real estate might have to be sold in an unfavorable environment. This possibility, as much as any other assumption, may actually determine if the SIIS will be unable to pay claims;

4. The base for the assessment is the aggregate of paid claims for all self-insureds and the SIIS for a fiscal year. Information from the Administrative Services Unit of the Division of Industrial Relations is that for the fiscal year ending 6-30-95, this aggregate was $338,107,486.20. Contact person is Ms. Mary Keating, telephone number 687-3308.

5. A 4 percent assessment on a base of $340 million produces $13.6 million annually. I expect that the growth of Nevada will increase this number by 3 to 5 percent per year.

6. Assuming that assessments would begin and continue for 40 years, the average annual collection will be about $18 million.

   An average assessment of $18 million over 40 years is the amount to balance against the estimate of the unfunded liability. The aggregate assessment amount projects to $720 million (excluding any investment income the accumulation might earn). Thus, if the unfunded liability of $1.35 billion (as of June 30, 1996) is correct, then there is an apparent short fall as measured by the difference between $1.35 billion and $720 million.

7. The $1.35 billion represents "full value" of the claims. If the reserve liability could be discounted according to usual actuarial tables, the true unfunded liability is very probably in the range of $1 billion. This suggests a short fall of $280 million. However, if interest income on the accumulated assessments is factored in, the $280 million tends to disappear over time and the 4 percent assessment is plausible.

8. It is apparent that any of several alternative scenarios might play out. I represent that item 7 above, where interest accrues on the assessment money to the extent that all liability is funded, is a very likely outcome. The worst case is that SIIS will run out of money in about the year 2016 due to the estimated unfunded liability being much higher than $1.35 billion.

   The best case outcome is reflected by examining the value of compound interest. If left untouched, the first assessment of $13.6 million, would accumulate to over $36 million at 5 percent over a 20 year period. It is similarly true that an extra increment of either current unfunded liability

(this makes the outcome worse) or overstatement of unfunded liability (this makes the outcome better) would accumulate under compound interest.

9. The best control available to the legislature and other influential persons is that the professional staff of the SIIS, including their consulting actuary, will continue to provide periodic updated reports of the unfunded liability. The yearly report of the consulting actuary for the period ending June 30, 2001 will, in all probability, define how the current estimate of unfunded liability relates to any assessments collected. Stated another way, it will very likely be apparent by late 2001 whether the SIIS has sufficient assets to fund past liabilities.

QUESTION: WHAT IS THE POTENTIAL LOSS OF PREMIUM TO SIIS DUE TO "3-WAY" AND HOW WOULD THIS BE FACTORED INTO THE 4 PERCENT FORMULA? (Question 7)

ANSWER: The effect of "3-Way" as of July 1, 1999 will certainly be to reduce SIIS premium revenue. The $450 million could easily drop by over $125 million as of July 1, 1999. This $125 million figure is an estimate based on information available at the current time, as provided by Mr. Dirks to Mr. Knaus.

NRS requires that each SIIS rate filing address the "provision for contingencies." The last SIIS rate filing thus projected a $31 million dollar addition to the "provision for contingencies." To the extent that a reduced premium base will generally require a smaller dollar provision for contingencies," there could be a smaller amount left to accrue as a valid asset of the SIIS. Such accruals will reduce the unfunded liabilities. In this context, any proposed addition to the "provision for contingencies" must relate to SIIS operations and cannot be an artificially high amount.

The most important consideration, in my opinion, is that the SIIS have adequate rates in a the "3-Way" environment. This would mean that, at worst, the unfunded liability will not increase due to the continuing insurance underwriting operation.

QUESTION: IS THERE A WAY TO CREATE A LINE ITEM TO PAY UNFUNDED LIABILITY? (Question 8)

ANSWER: Currently, the rate law does not allow for a line item in the SIIS rate filings for unfunded liability. However, it is within the legislative prerogative to create such a line item for future SIIS and/or NCCI rate filings.

CBK/pd

cc: Alice A. Molasky, Commissioner
Claudia K. Cormier, Director
Douglas D. Dirks, Manager
Ron Swirczek, Administrator

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Appendix E

Suggested wording regarding administrative proposals (Recommendation Nos. 3 through 10), provided by Larry Zimmerman, President, CDS of Nevada.

STATE OF NEVADA

JOHN P. COMEAUX
Director

BRYAN A. NIX
Senior Appeals Officer

DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION
Appeals Officer
555 E. Washington Avenue
Suite 3300
Las Vegas, Nevada 89101
(702) 486-2525 • Fax (702) 486-2555

April 23, 1996

Larry Zimmerman
CDS of Nevada
3700 Grant Drive #C
Reno, NV 89509

Re: NOTICE OF INJURY

Dear Larry:

I have discovered a couple of problems with the provisions of NRS 616C.020 and 616C.025 which should be addressed next session. NRS 616C.025 provides exceptions to the requirement that a claim be reported within 7 days. Section 1 of this statute provides that

> "Except as otherwise provided in subsection 2, an employee or, in the event of the death of the employee, his dependent, is barred from recovering compensation pursuant to the provisions of chapters 616A to 616D, inclusive of NRS if he fails to file a notice of injury pursuant to NRS 616C.015 **or** a claim for compensation pursuant to NRS 616C.020."

The use of the word **or** rather than **and** means that either the notice pursuant to 616C.015 OR the claim pursuant to 616C.020 is sufficient to satisfy this requirement. While I believe it was the legislative intent to require both, the plain meaning of this language does cause confusion.

Next the wording of subsection 1 of NRS 616C.020 requires an injured employee to file a claim for compensation within 90 days **if**:

> "(a) The employee has sought medical treatment for an injury...; **or**
> (b) The employee was off work as a result of an injury..."

In cases where the employee neither sought treatment nor was off work as a result, must that employee comply with this section? While I believe it was the legislative intent to require the filing of a claim within 90 days in all cases, the language of this

section is confusing on its face. This section should be redrafted to make the intent of this section clear.

As always I am available to discuss any issue concerning the interpretation of these statutes. While I may disagree with how these sections are occasionally interpreted, I have no independent authority to direct appeals officers to interpret these according to my view. The best approach is to draft these provisions in a clear and simple manner capable of application in the event of litigation. If I can assist you in this regard please do not hesitate to contact me.

Very Truly Yours,

Bryan A. Nix, Esq.

1

L.R. Zimmerman
cds of nevada

Certain laws in our state will have to be changed for insurers, administrators, employers and medical providers to exchange data electronically. Some suggestions are as follows. I have also enclosed copies of NRs 616D.380 as NAC 616.5985 and NAC 616.562 for discussion.

616A. NEW "EDI defined.
EDI means electronic data interchange.

616C.NEW
All forms, bills and reports required by this section and section NRS617 may be transmitted by EDI. The division shall adopt regulations for the development and implementation of an EDI system for the transmission of forms and reports required.

TREATMENT AND RATING OF INJURED EMPLOYEES

NRS 616C.130 Insurer's payment to physician or chiropractor attending injured employee conditioned upon receipt of itemized statement.[**and certificate.**]

The insurer shall not authorize the payment of any money to a physician or chiropractor for services rendered by him in attending an injured employee until an itemized statement for the services has been received by the insurer [**accompanied by a certificate of the physician or chiropractor stating that a duplicate of the itemized statement has been mailed or personally delivered to the employer of the injured employee**].

(Added to NRS by 1957, 232; A 1981, 1167, 1471; 1985, 1543)--(Substituted in revision for NRS 616.353)

REPORTS OF INJURIES AND CLAIMS FOR COMPENSATION
NRS 616C.045 Duty of employer to complete and mail report of injury or disease; form; contents; completion of report by employee of system prohibited; exceptions; penalty.

1. Within 6 working days after the receipt of a claim for compensation from a physician or chiropractor, an employer shall complete and **[mail]** ***send*** to his insurer or third-party administrator an employer's report of industrial injury or occupational disease.

2. The report must:

(a) Be on a form prescribed by the administrator;

(b) Be signed by the employer or his designee;

(c) Contain specific answers to all questions required by the regulations of the administrator; and

(d) Be accompanied by a statement of the wages of the employee if the claim for compensation received from the treating physician or chiropractor indicates that the injured employee is expected to be off work for 5 days or more.

(e) If the report is sent by EDI, the original report containing the signature of the employer must be sent within 30 days.

3. An employee of the system shall not complete the report required by subsection 1 or any other form relating to the accident on behalf of the employer unless the employer:

(a) Is not in business;

(b) Has not been located by the system within 5 working days after receipt of a claim for compensation; or

(c) Refuses to complete the report.

4. The administrator shall impose an administrative fine of not more than $1,000 on an employer for each violation of this section.

(Added to NRS by 1993, 661; A 1995, 649)--(Substituted in revision for NRS 616.5013)

REPORTS OF INJURIES AND CLAIMS FOR COMPENSATION
NRS 616C.040 Duty of treating physician or chiropractor to complete and **[mail]** ***send*** claim for compensation; form; contents; duty to maintain supply of forms; penalty.

1. A treating physician or chiropractor shall, within 3 working days after he first treats an injured employee for a particular injury, complete and **[mail]** ***send*** to the employer of the injured employee and to the employer's insurer, a claim for compensation. If the employer is a self-insured employer, the treating physician or chiropractor shall **[mail]** ***send*** the claim for compensation to the employer's third-party administrator. ***If the claim for compensation is sent by EDI, the original claim for compensation form containing the injured workers' and physician's signatures must be sent by mail within 30 days.***

2. A claim for compensation required by subsection 1 must be on a form prescribed by the administrator.

3. If a claim for compensation is accompanied by a certificate of disability, the certificate must include a description of any limitation or restrictions on the injured employee's ability to work.

4. Each physician, chiropractor and medical facility that treats injured employees, each insurer, third-party administrator and employer, and the division shall maintain at their offices a sufficient supply of the forms prescribed by the administrator for filing a claim for compensation.

5. The administrator shall impose an administrative fine of not more than $1,000 on a physician or chiropractor for each violation of subsection 1.

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(Added to NRS by 1993, 661; A 1995, 649)--(Substituted in revision for NRS 616.5012)

FRAUDULENT PRACTICES

NRS 616D.380 Invoices containing false information; signature required; presumption.

1. Each invoice for payment for accident benefits provided to an injured employee must:

(a) Contain a statement that all matters stated therein are true and accurate; and

(b) Be signed by a natural person who is the provider of health care or is authorized to act for the provider of health care.

2. A person who, by any act or omission, signs or submits, or causes to be signed or submitted, the statement required by subsection 1, knowing that the invoice contains information which is false, in whole or in part, is guilty of a gross misdemeanor.

3. For the purposes of this section, a person who signs on behalf of a provider of health care is presumed to have the authorization of the provider of health care and to be acting at his direction.

4. As used in this section, to "sign" means to affix a signature directly or indirectly by means of handwriting, a typewriter, a stamp, a computer impulse or other means.

(Added to NRS by 1993, 681)--(Substituted in revision for NRS 616.679)

GENERAL PROVISIONS
NRS 616B.018 Index of claims: Preparation; use; fee. [Effective until July 1, 1999.]

1. The administrator shall establish a method of indexing claims for compensation that will make information concerning the claimants of one insurer available to other insurers.
2. Every self-insured employer, association of self-insured public or private employers and the system shall provide information as required by the administrator for establishing and maintaining the index of claims.
3. If an employee files a claim ***for compensation*** with an insurer, the insurer is entitled to receive from the administrator a list of the prior claims of the employee. If the insurer desires to inspect the files ***of other insurers*** related to the prior claims, he must **[obtain the written consent of the employee]** ***provide the insurer with a copy of the claim for compensation.***
4. Any information obtained from the index of claims must be admitted into evidence in any hearing before an appeals officer, a hearing officer or the administrator.
5. The division may assess and collect a reasonable fee for its services provided pursuant to this section. The fee must be payable monthly or at such other intervals as determined by the administrator.

(Added to NRS by 1991, 352; A 1993, 702, 1859; 1995, 531, 539)--(Substituted in revision for NRS 616.1925)

616b.018

REPORTS OF INJURIES AND CLAIMS FOR COMPENSATION
NRS 616C.020 Claim for compensation: Requirements for injured employee, his dependent or his representative to file claim; form.

1. Except as otherwise provided in subsection 2, an injured employee, or a person acting on his behalf, shall file a claim for compensation with the **[insurer within 90 days after an accident if:**

(a) The employee has sought medical treatment for an injury arising out of and in the course of his employment; or

(b) The employee was off work as a result of an injury arising out of and in the course of his employment.] ***initial treating physician at time of first treatment. Treatment if needed, must be sought within 90 days after the accident.***

2. In the event of the death of the injured employee resulting from the injury, a dependent of the employee, or a person acting on his behalf, shall file a claim for compensation with the insurer within 1 year after the death of the injured employee.

3. The claim for compensation must be filed on a form prescribed by the administrator.

4. The form prescribed by the administrator shall include a provision for a medical release section. The injured employee's signature on this form shall constitute his authorization for any insurer, medical provider, employer or other agency to release to each other any medical or other information acquired.

(Added to NRS by 1993, 661)--(Substituted in revision for NRS 616.501)

REPORTS OF INJURIES AND CLAIMS FOR COMPENSATION
NRS 616C.025 Recovery of compensation barred if notice of injury **[or]** ***and*** claim for compensation **[is]** ***are*** not filed; exceptions.

1. Except as otherwise provided in subsection 2, an employee or, in the event of the death of the employee, his dependent, is barred from recovering compensation pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS if he fails to file a notice of injury pursuant to NRS 616C.015 **[or]** ***and*** a claim for compensation pursuant to NRS 616C.020.

2. An insurer may excuse the failure to file a notice of injury or a claim for compensation pursuant to the provisions of this section if:

(a) The injury to the employee or another cause beyond his control prevented him from providing the notice or claim;

(b) The failure was caused by the employee's or dependent's mistake or ignorance of fact or of law;

(c) The failure was caused by the physical or mental inability of the employee or the dependent; or

(d) The failure was caused by fraud, misrepresentation or deceit.

(Added to NRS by 1993, 661)--(Substituted in revision for NRS 616.5011)

616C.025

REPORTS OF INJURIES AND CLAIMS FOR COMPENSATION
NRS 616C.065 Insurer to commence payment of claim or deny claim within certain time after insurer notified of industrial accident; notification of claimant and administrator of denial of claim; penalty for unreasonable delay or refusal to pay claim. [Effective July 1, 1999.]

1. Within 30 ***working*** days after the insurer has been notified of an industrial accident ***and received a claim for compensation***, every insurer shall:

(a) Commence payment of a claim for compensation; or

(b) Deny the claim and notify the claimant and administrator that the claim has been denied.Payments made by an insurer pursuant to this section are not an admission of liability for the claim or any portion of the claim.

2. If an insurer unreasonably delays or refuses to pay the claim within 30 ***working*** days after the insurer has been notified of an industrial accident ***and received a claim for compensation,*** the insurer shall pay upon order of the administrator an additional amount equal to three times the amount specified in the order as refused or unreasonably delayed. This payment is for the benefit of the claimant and must be paid to him with the compensation assessed pursuant to chapters 616A to 617, inclusive,
of NRS.

(Added to NRS by 1995, 2001, effective July 1, 1999)

DETERMINATION AND PAYMENT OF BENEFITS
NRS 616C.235 Closure of claim by insurer: Notice required; right to request resolution of dispute; effect of notice; service of decision of hearing officer; automatic closure of claims with medical benefits of less than $500.

1. Except as otherwise provided in subsection 2:

(a) When the insurer determines that a claim should be closed before all benefits to which the claimant may be entitled have been paid, the insurer shall send a written notice of its intention to close the claim to the claimant by first-class mail addressed to the last known address of the claimant. The notice must include a statement that if the claimant does not agree with the determination, he has a right to request a resolution of the dispute pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive. A suitable form for requesting a resolution of the dispute must be enclosed with the notice. The closure of a claim is not effective unless notice is given as required by this subsection.

(b) If the insurer does not receive a request for the resolution of the dispute, it may close the claim.

(c) Notwithstanding the provisions of NRS 233B.125, if a hearing is conducted to resolve the dispute, the decision of the hearing officer may be served by first-class mail.

2. If the medical benefits required to be paid for a claim are less than $500, the claim closes automatically if the claimant does not receive medical treatment for the injury for at least 6 months. The claimant may not appeal the closing of such a claim. ***Six months after the date of automatic closure the insurer may dispose of the file of the claim.***

(Added to NRS by 1979, 707; A 1981, 1140, 1492; 1989, 333; 1991, 2421; 1993, 746)--(Substituted in revision for NRS 616.567)

CONTESTED CLAIMS
NRS 616C.390 Reopening claim: Procedure; limitations; applicability.

1. If an application to reopen a claim to increase or rearrange compensation is made in writing more than 1 year after the date on which the claim was closed, the insurer shall reopen the claim if:
(a) A change of circumstances warrants an increase or rearrangement of compensation during the life of the claimant;
(b) The primary cause of the change of circumstances is the injury for which the claim was originally made; and
(c) The application is accompanied by the certificate of a physician or a chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation.
2. After a claim has been closed, the insurer, upon receiving an application and for good cause shown, may authorize the reopening of the claim for medical investigation only. ***A hearing officer or appeals officer may not order a claim be reopened under medical investigation.*** The application must be accompanied by a written request for treatment from the physician or chiropractor treating the claimant, certifying that the treatment is indicated by a change in circumstances and is related to the industrial injury sustained by the claimant.
3. If a claimant applies for a claim to be reopened pursuant to subsection 1 or 2 and a final determination denying the reopening is issued, the claimant shall not reapply to reopen the claim until at least 1 year after the date on which the final determination is issued.
4. Except as otherwise provided in subsection 5, if an application to reopen a claim is made in writing within 1 year after the date on which the claim was closed, the insurer shall reopen the claim only if:
(a) The application is supported by medical evidence demonstrating an objective change in the medical condition of the claimant; and
(b) There is clear and convincing evidence that the primary cause of the change of circumstances is the injury for which the claim was originally made.
5. An application to reopen a claim must be made in writing within 1 year after the date on which the claim was closed if:
(a) The claimant was not off work as a result of the injury; and
(b) The claimant did not receive benefits for a permanent partial disability.
If an application to reopen a claim to increase or rearrange compensation is made pursuant to this subsection, the insurer shall reopen the claim if the requirements set forth in paragraphs (a), (b) and (c) of subsection 1 are met.
6. If an employee's claim is reopened pursuant to this section,

he is not entitled to vocational rehabilitation services or benefits for a temporary total disability if, before his claim was reopened, he:

(a) Retired; or

(b) Otherwise voluntarily removed himself from the work force, for reasons unrelated to the injury for which the claim was originally made.

7. One year after the date on which the claim was closed, an insurer may dispose of the file of a claim authorized to be reopened pursuant to subsection 5, unless an application to reopen the claim has been filed pursuant to that subsection.

8. An increase or rearrangement of compensation is not effective before an application for reopening a claim is made unless good cause is shown. The insurer shall, upon good cause shown, allow the cost of emergency treatment the necessity for which has been certified by a physician or a chiropractor.

9. A claim that automatically closes pursuant to subsection 2 of NRS 616C.235 may not be reopened pursuant to this section.

10. The provisions of this section apply to any claim for which an application to reopen the claim or to increase or rearrange compensation is made pursuant to this section, regardless of the date of the injury or accident to the claimant. If a claim is reopened pursuant to this section, the amount of any compensation or benefits provided must be determined in accordance with the provisions of NRS 616C.425.

[56:168:1947; 1943 NCL Sec. 2680.56] + [57:168:1947; 1943 NCL Sec. 2680.57]--(NRS A 1971, 770; 1981, 1198, 1831; 1983, 285, 1294; 1985, 1547; 1993, 741, 2441; 1995, 2152)--(Substituted in revision for NRS 616.545)

616C.390

COMPENSATION FOR INJURIES AND DEATH
Temporary Total Disability
NRS 616C.475 Amount and duration of compensation; limitations.

1. Except as otherwise provided in this section, NRS 616C.175 and 616C.390, every employee in the employ of an employer, within the provisions of chapters 616A to 616D, inclusive, of NRS, who is injured by accident arising out of and in the course of employment, or his dependents, is entitled to receive for the period of temporary total disability, 66 2/3 percent of the average monthly wage.

2. Except as otherwise provided in NRS 616B.185, an injured employee or his dependents are not entitled to accrue or be paid any benefits for a temporary total disability during the time the injured employee is incarcerated. The injured employee or his dependents are entitled to receive such benefits when the injured employee is released from incarceration if he is certified as temporarily totally disabled by a physician or chiropractor.

3. If a claim for the period of temporary total disability is allowed, the first payment pursuant to this section must be issued by the insurer within 14 working days after receipt of the initial certification of disability and regularly thereafter.

4. Any increase in compensation and benefits effected by the amendment of subsection 1 is not retroactive.

5. Payments for a temporary total disability must cease when:

(a) A physician or chiropractor determines that the employee is physically capable of any gainful employment for which the employee is suited, after giving consideration to the employee's education, training and experience;

(b) The employer offers the employee light-duty employment or employment that is modified according to the limitations or restrictions imposed by a physician or chiropractor pursuant to subsection 7; or

(c) Except as otherwise provided in NRS 616B.185, the employee is incarcerated.

6. Each insurer may, with each check that it issues to an injured employee for a temporary total disability, include a form approved by the division for the injured employee to request continued compensation for the temporary total disability.

7. A certification of disability issued by a physician or chiropractor must:

(a) Include the period of disability and a description of any physical limitations or restrictions imposed upon the work of the employee;

(b) Specify whether the limitations or restrictions are permanent or temporary; and

(c) Be signed by the treating physician or chiropractor authorized pursuant to NRS 616B.515 or 616B.527.

8. If certification of disability specifies that the physical limitations or restrictions are temporary, the employer of the employee at the time of his accident is not required to comply with NRS 616C.545 to 616C.575, inclusive, and 616C.590 or the regulations adopted by the division governing vocational rehabilitation services if the employer offers the employee a position that is substantially similar to the employee's position at the time of his injury in relation to the location of the employment, the hours he is required to work and the salary he will be paid.

9. A certification of disability shall not be given for dates which are prior to the date of the physicians examination of the injured employee.

[Part 59:168:1947; A 1949, 659; 1951, 485; 1953, 292; 1955, 901]--(NRS A 1957, 72; 1959, 201; 1963, 837; 1965, 226; 1966, 43; 1969, 472; 1971, 322; 1973, 531; 1975, 253; 1983, 1295; 1985, 1548; 1991, 2422; 1993, 747, 1870, 2442; 1995, 579, 2155)--(Substituted in revision for NRS 616.585)

616C.475

COMPENSATION FOR INJURIES AND DEATH
Permanent and Temporary Partial Disabilities
NRS 616C.490 Permanent partial disability: Compensation.

1. Except as otherwise provided in NRS 616C.175, every employee, in the employ of an employer within the provisions of chapters 616A to 616D, inclusive, of NRS, who is injured by an accident arising out of and in the course of employment is entitled to receive the compensation provided for permanent partial disability. As used in this section, "disability" and "impairment of the whole man" are equivalent terms.

2. Within 30 days after receiving from a physician or chiropractor a report indicating that the injured employee may have suffered a permanent disability and is stable and ratable, the insurer shall schedule an appointment with a rating physician or chiropractor to determine the extent of the employee's disability. The insurer shall select a physician or chiropractor from a group of rating physicians and chiropractors designated by the administrator, to determine the percentage of disability in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the division pursuant to NRS 616C.110. Rating physicians and chiropractors must be selected in rotation from the list of qualified physicians and chiropractors designated by the administrator, according to their area of specialization and the order in which their names appear on the list.

3. At the request of the insurer, the injured employee shall, before an evaluation by a rating physician or chiropractor is performed, notify the insurer of:

(a) Any previous evaluations performed to determine the extent of any of the employee's disabilities; and

(b) Any previous injury, disease or condition sustained by the employee which is relevant to the evaluation performed pursuant to this section.The notice must be on a form approved by the administrator and provided to the injured employee by the insurer at the time of the insurer's request.

4. Unless the regulations adopted pursuant to NRS 616C.110 provide otherwise, a rating evaluation must include an evaluation of the loss of motion, sensation and strength of an injured employee if the injury is of a type that might have caused such a loss. No factors other than the degree of physical impairment of the whole man may be considered in calculating the entitlement to compensation for a permanent partial disability.

5. The rating physician or chiropractor shall provide the insurer with his evaluation of the injured employee. After receiving the evaluation, the insurer shall, within **[14]** ***30*** days, provide the employee with a copy of the evaluation and notify the employee:

(a) Of the compensation to which he is entitled pursuant to this section; or

(b) That he is not entitled to benefits for permanent partial disability.

6. Each 1 percent of impairment of the whole man must be compensated by a monthly payment:

(a) Of 0.5 percent of the claimant's average monthly wage for injuries sustained before July 1, 1981;

(b) Of 0.6 percent of the claimant's average monthly wage for injuries sustained on or after July 1, 1981, and before June 18, 1993; and

(c) Of 0.54 percent of the claimant's average monthly wage for injuries sustained on or after June 18, 1993.

Compensation must commence on the date of the injury or the day following the termination of temporary disability compensation, if any, whichever is later, and must continue on a monthly basis for 5 years or until the claimant is 70 years of age, whichever is later.

7. Compensation benefits may be paid annually to claimants who will be receiving less than $100 a month.

8. Where there is a previous disability, as the loss of one eye, one hand, one foot, or any other previous permanent disability, the percentage of disability for a subsequent injury must be determined by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury.

9. The division may adopt schedules for rating permanent disabilities resulting from injuries sustained before July 1, 1973, and reasonable regulations to carry out the provisions of this section.

10. The increase in compensation and benefits effected by the amendment of this section is not retroactive for accidents which occurred before July 1, 1973.

11. This section does not entitle any person to double payments for the death of an employee and a continuation of payments for a permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal.

[63:168:1947; A 1949, 659; 1953, 292]--(NRS A 1959, 204; 1966, 46; 1967, 691; 1969, 475; 1971, 326; 1973, 531; 1975, 605; 1977, 1006; 1979, 1057; 1981, 1170, 1493, 1653; 1983, 428, 1295; 1985, 308, 374; 1987, 78; 1991, 493, 2423, 2424; 1993, 748, 1871; 1995, 579, 2156)--(Substituted in revision for NRS 616.605)

616C.490

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Modify NRS 612.265 as follows.

Delete [Effective until July 1, 1999] and [Effective July 1, 1999]

Modify subsection 9 to read as follows..

9. **[The manager of the state industrial insurance system]** ***An insurer for the purposes of chapters 616 and 617 of NRS*** shall submit to the administrator a list containing the name of each person who received benefits pursuant to chapters 616A to 616D, inclusive or 617 of NRS during the preceding month and request that he compare the information so provided with the records of the division regarding persons claiming benefits pursuant to chapter 612 of NRS for the same period. The information submitted by the **[manager]** ***insurer*** must be in a form determined by the administrator and must contain the social security number of each such person. Upon receipt of such a request, the administrator shall make such a comparison and provide to the **[manager]** ***insurer*** a list containing the name, address and social security number of each person who appears, from the information submitted, to be simultaneously claiming benefits under chapter 612 of NRS and under chapters 616A to 616D, inclusive, or 617 of NRS. ***Upon request, the administrator shall make available to the insurer a copy of any form used to claim unemployment compensation submitted by any person on the list.*** The administrator shall charge a fee to cover the actual costs of any related administrative expenses. The **[manager]** ***insurer*** shall use the information obtained pursuant to this subsection only to further a current investigation. The **[manager]** ***insurer*** shall not disclose the information for any other purpose.

612.265

Appendix F

Slide presentation entitled "PPD Benefit Structures and Delivery Systems: Lessons from WCRI Research," by Dr. Richard Victor, Executive Director, Workers Compensation Research Institute, Cambridge, Massachusetts.

PPD Benefit Structures and Delivery Systems

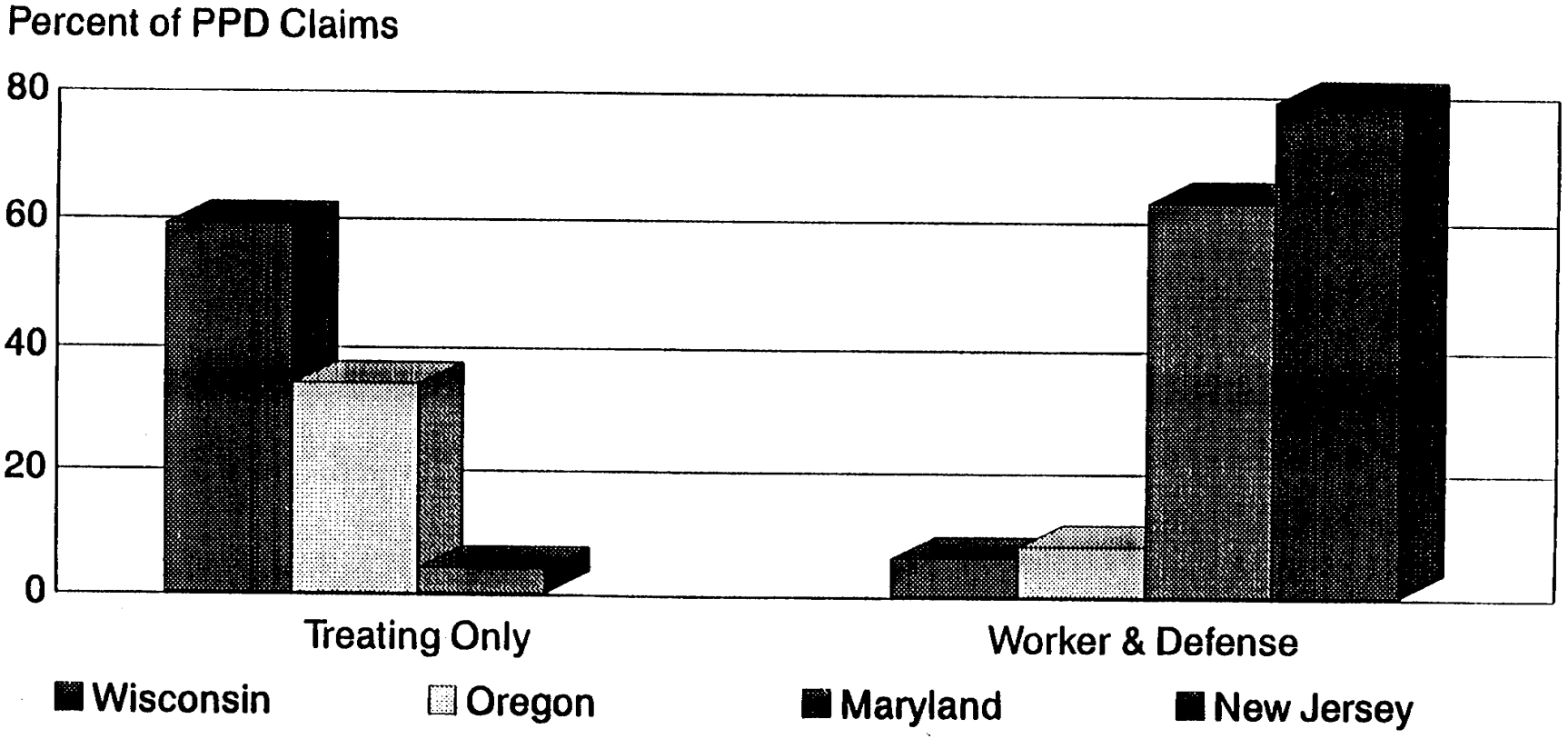
Lessons from WCRI Research

Outline

- Disability Evaluation is Often Adversarial But Not Necessarily
- Use of AMA Guides Intends to Reduce Adversariness, But Not Necessarily
- System Design Can Improve Outcomes, But Not Guides Alone
- Return to Work is the Key to Success
- Benchmarking the Nevada Fee Schedule

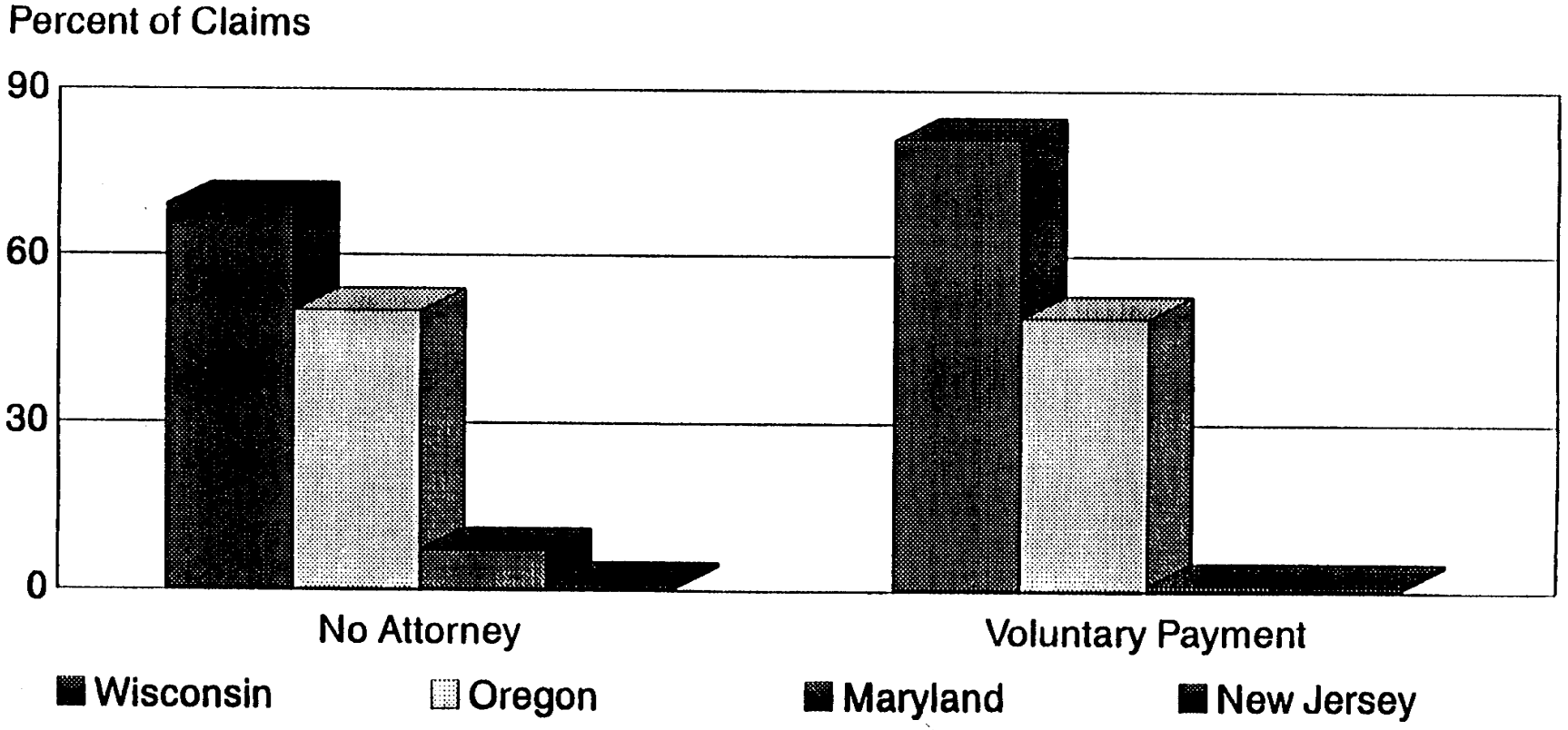
Disability Evaluation Often Adversarial

Disputes Can be Prevented



Voluntary Payment of PPD Possible

System Features Shape Outcomes



Key System Features

- Rules Generate Predictable Payments
- Practices Encourage Non-Partisan Experts
- Agency Fosters Early Payment
- Agency Helps Parties Navigate the System
- Adjudication Process Deters Litigation

Key System Features

Wisconsin

- Treating MD Ratings
- Minimum PPD Ratings
- "Final Offer" Adjudication
- Active Administrative Oversight
- Workers Kept Informed

Key System Features

Oregon

- Initial Evaluations by Treating Physicians
- State-Employed Evaluators
- Objective PPD Guidelines
- Benefits Often Paid Early
- Litigation Moderate

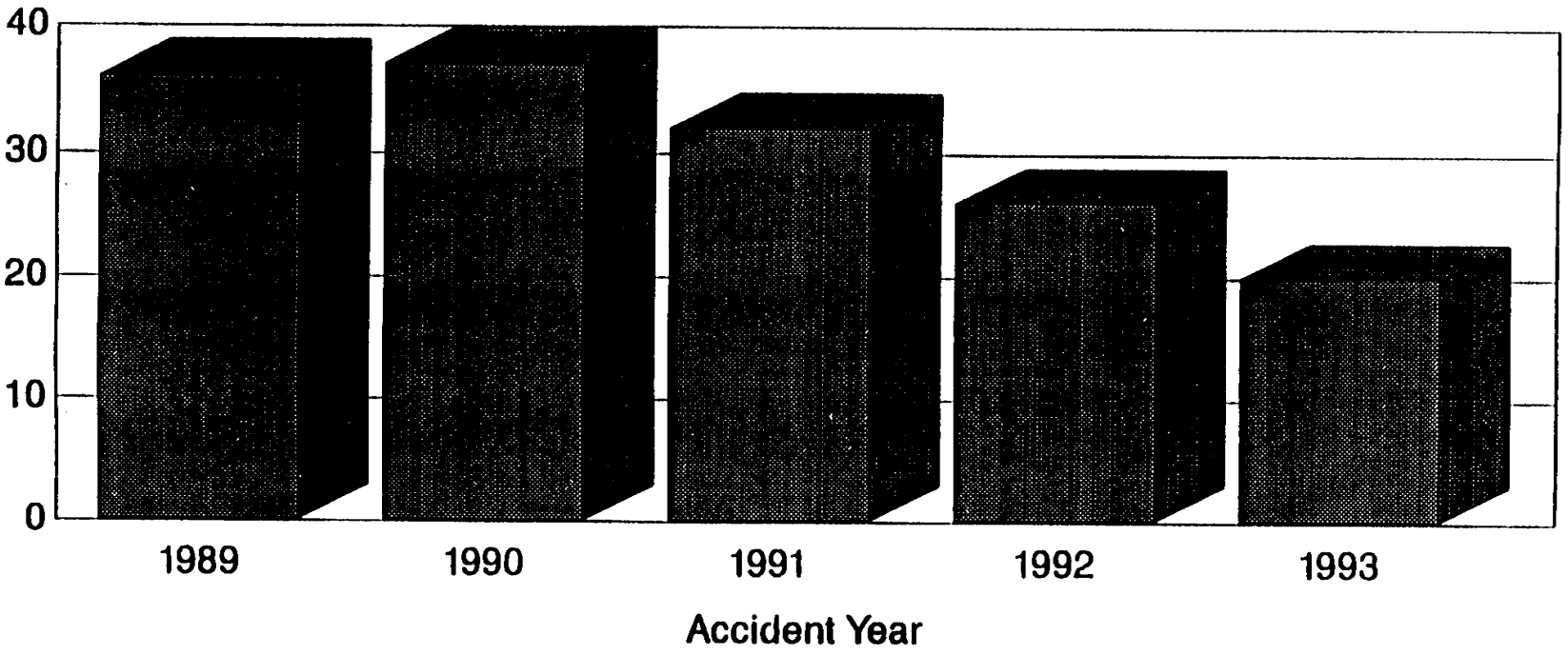
A Model for Nevada?

- Design Must be Appropriate to Setting
- Features Must Work Together
- Active Oversight Essential

California Has Made Changes to Reduce Adversariness

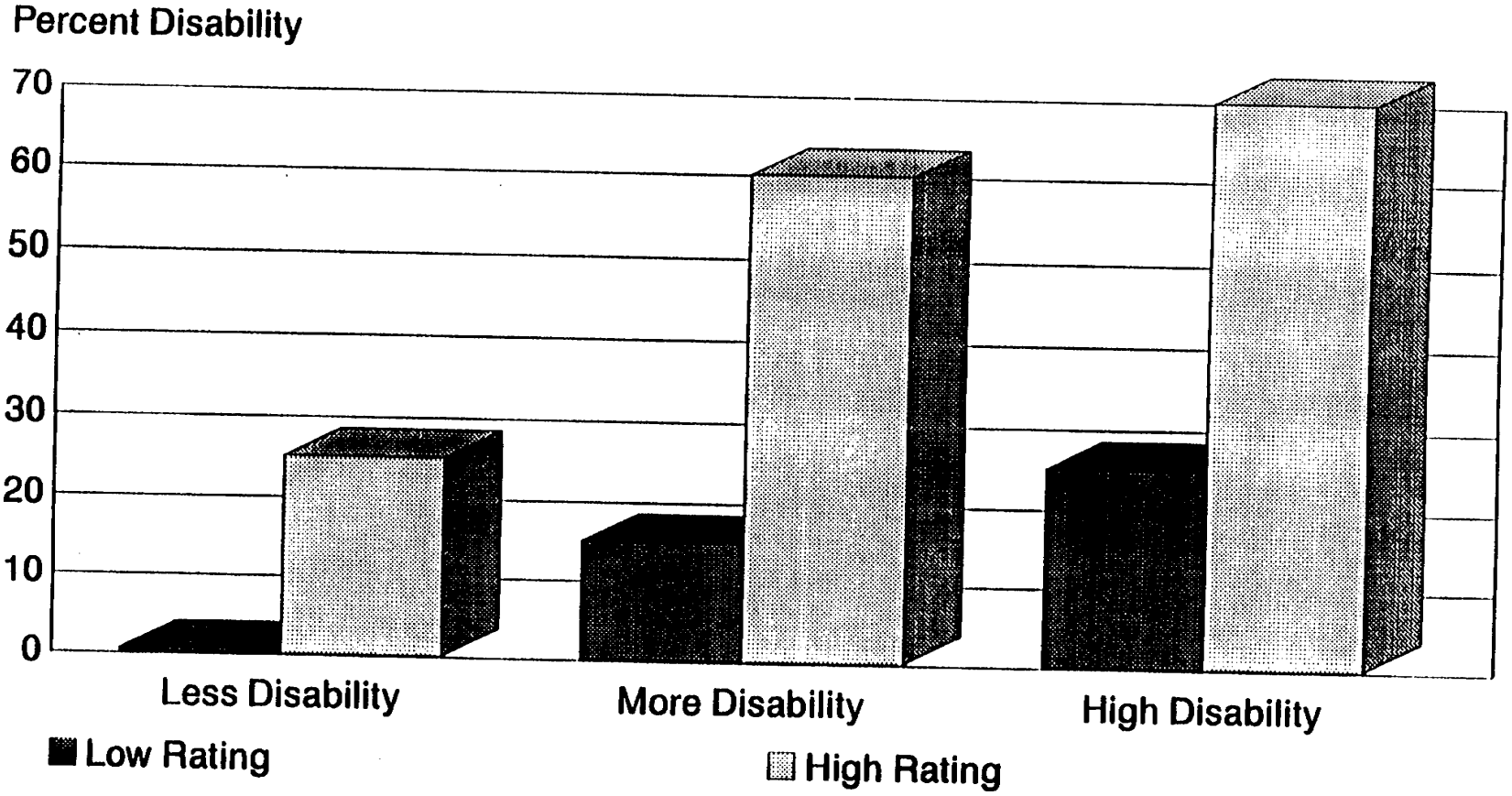
Non-Partisan Experts	Treating MDs, QMEs, IMEs, Med-legal Fees
Requiring Early Payment	80% of PPD
Information Provision	Benefit Notice Letters
Adjudicator Behavior	"Baseball Arbitration," but not well-used
Predictable Payments	?????

Some Success Evident: "Dueling Docs" Declined



Wide Variability in Ratings

Case Reports Using CA Schedule



Important Issues Remain

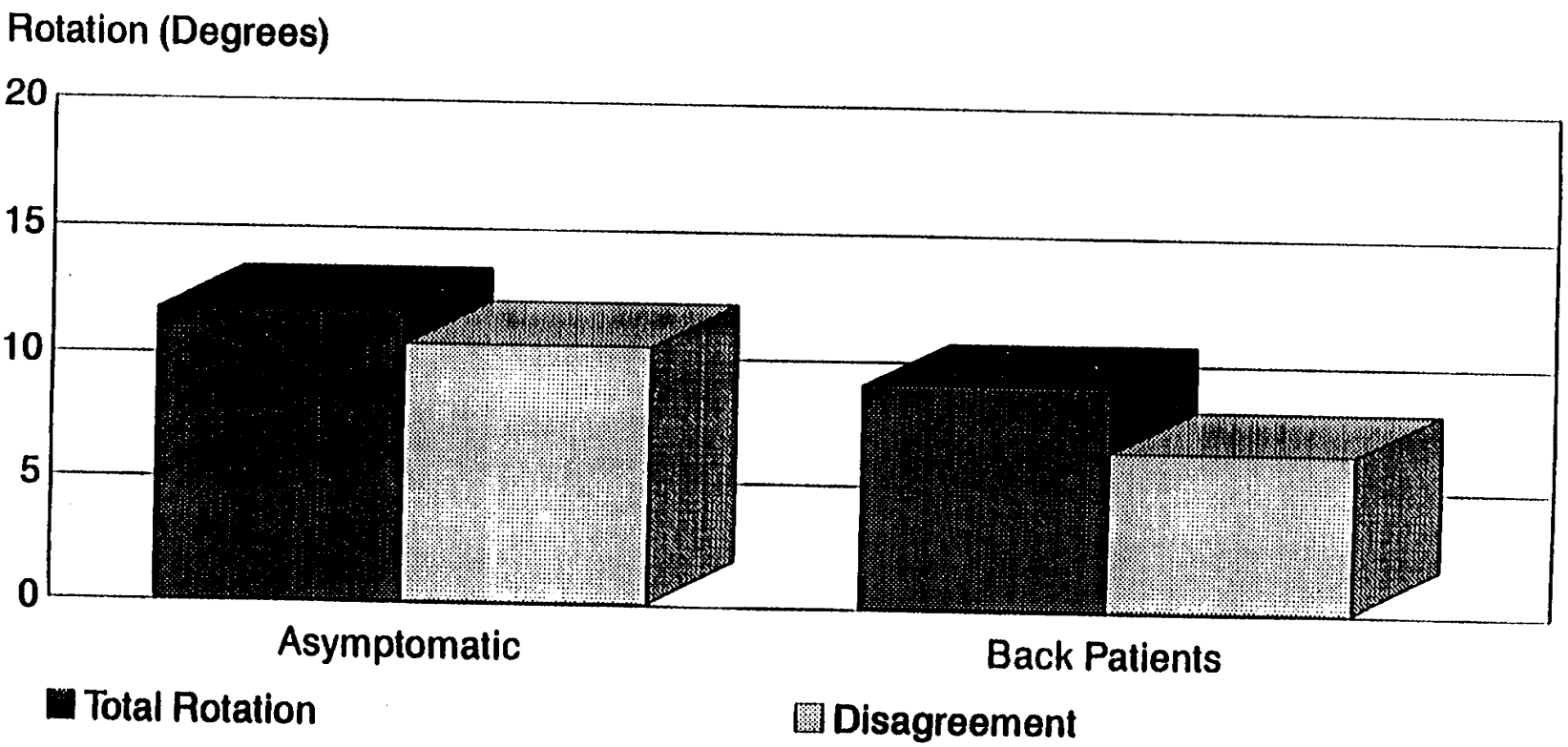
- Providing Clarity in PPD Owed Clear Impairment Guidelines
- Training Treating Physicians
- Making "Baseball Arbitration" Happen
- Providing Needed Information in Most Useful Form

Are AMA-Guides Ratings Consistent?

- Somewhat
- Examples: Range of Motion
  - Laboratory Studies
  - Maryland and Oregon

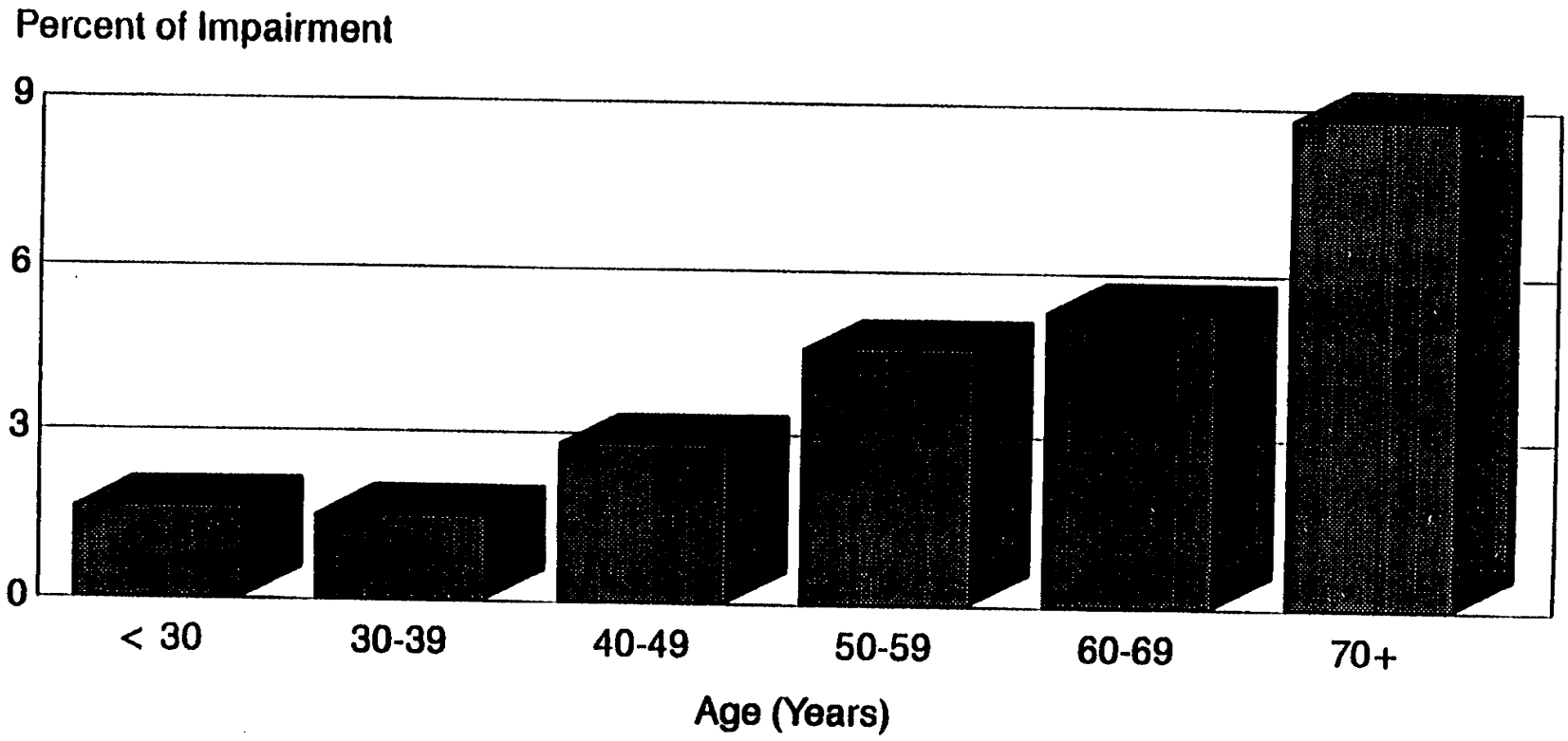
Large Disagreements about Rotation

Laboratory Study

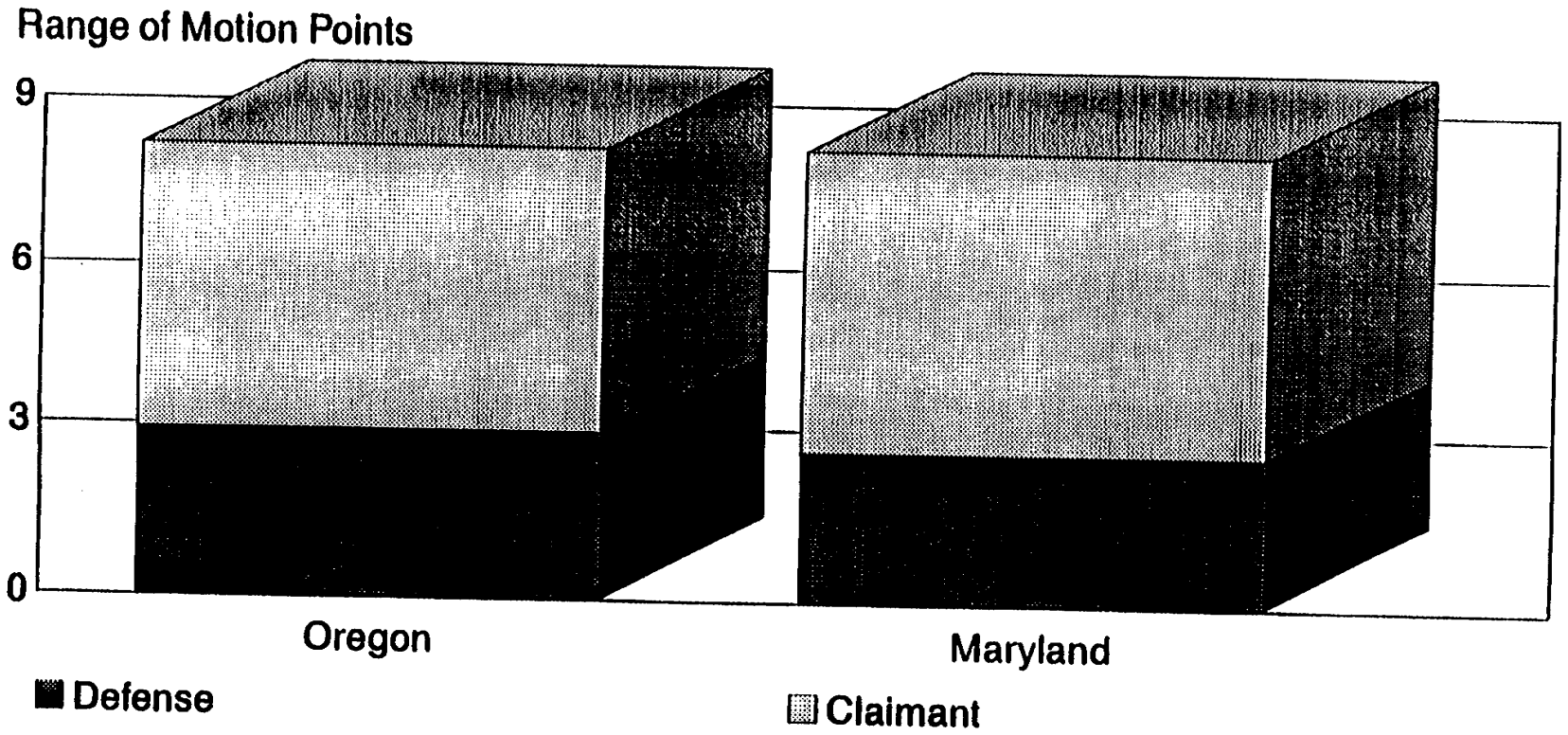


Lumbar Impairment Increases with Age

Asymptomatic Volunteers



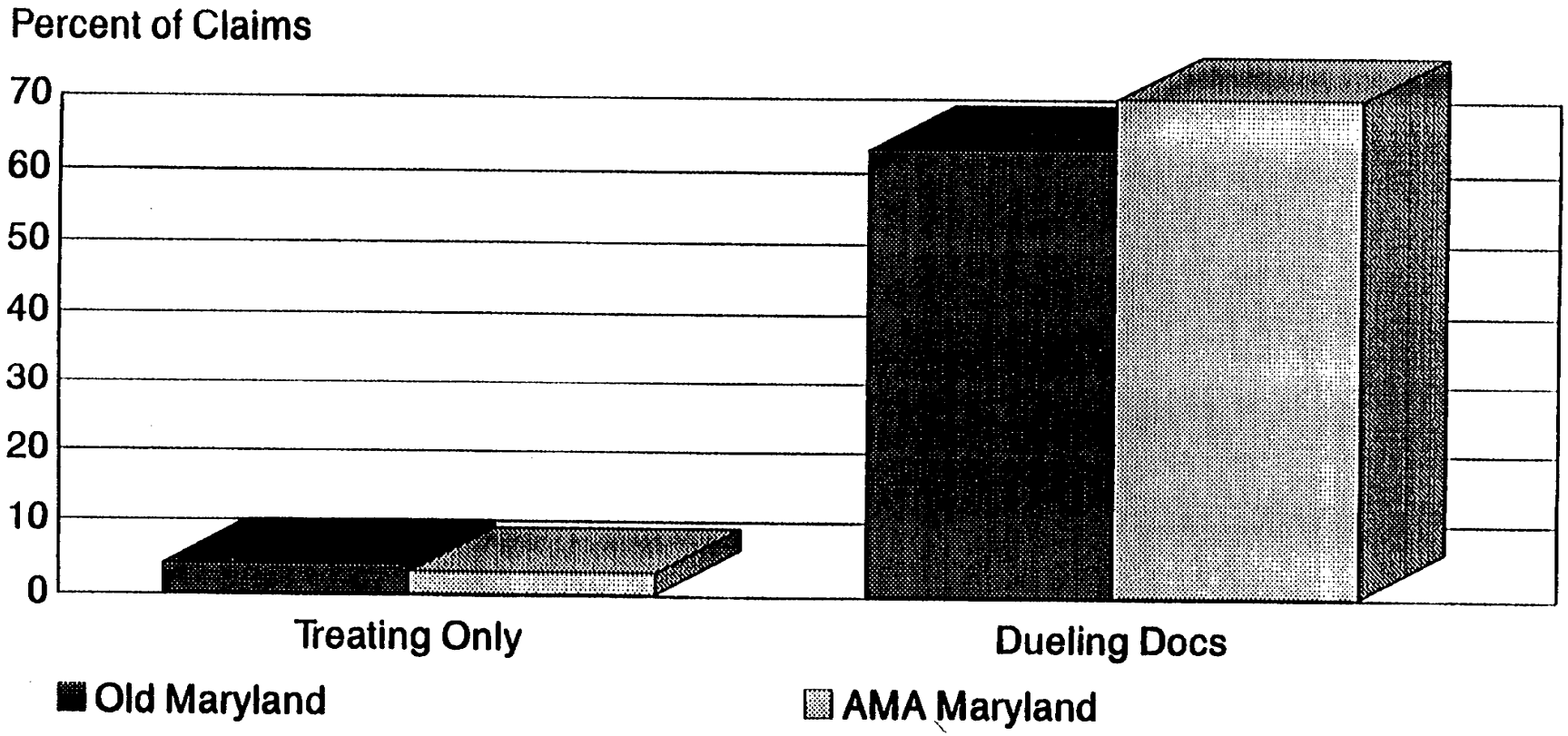
Range of Motion Disagreements Similar



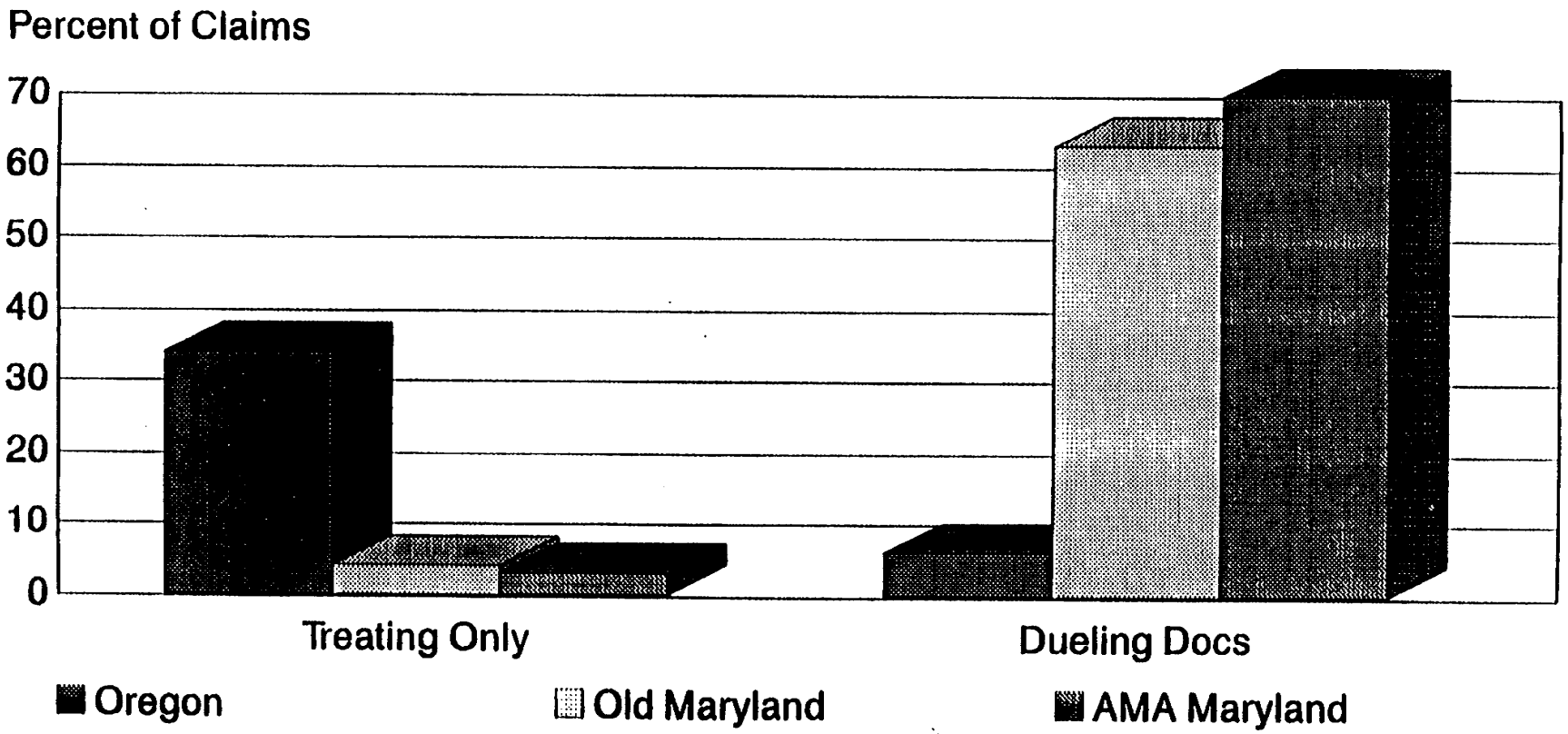
Maryland: Impact of AMA Guides

- All Evaluators Use Same Rules
- Evaluation Still Adversarial
- Maryland Still Litigious

Adversarial Evaluation Still Common



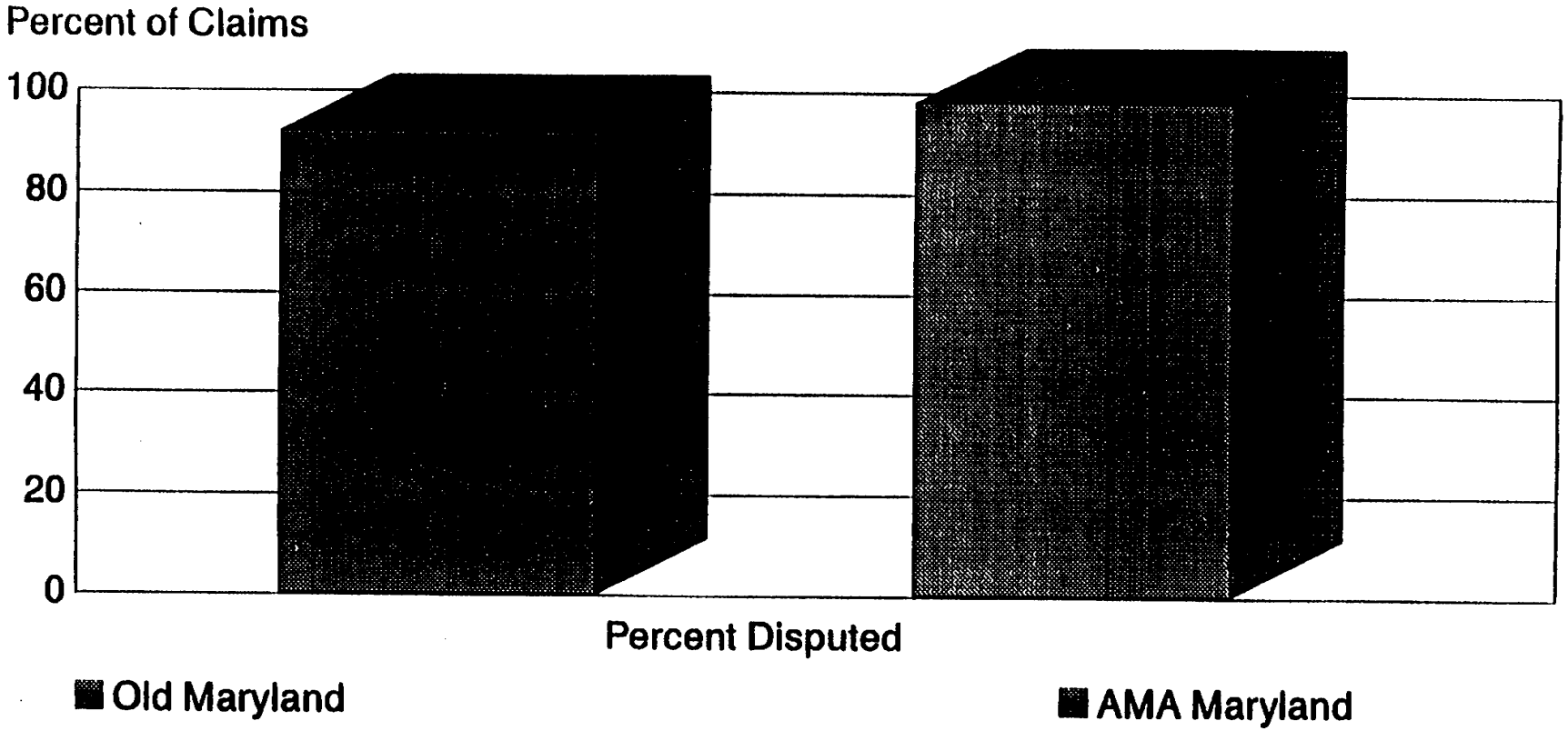
PPD Evaluations: Benchmarked on Oregon



Why Still Adversarial?

- Subjective Add-Ons
- Non-Partisan Evaluations Not Encouraged
- Adjudicators Still Split the Difference

Attorney Involvement Still High



AMA Guides

Summary

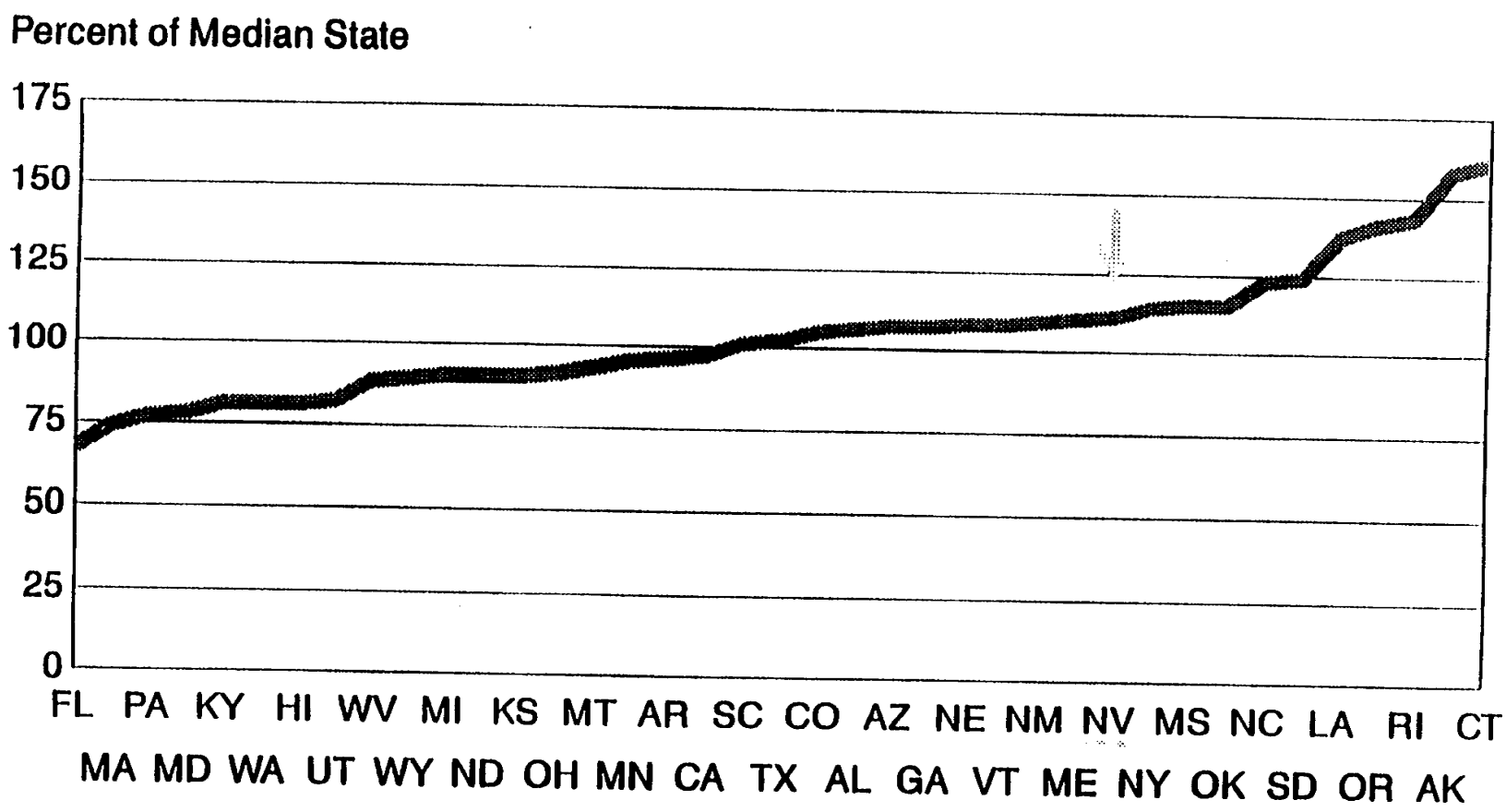
- Impairment Guides Can => Predictability
- Guides Must be Clear
- But Uncertainty Will Remain
- Guides Alone Do Not Work
- Adjudication Process Critical
- Adequacy and Equity Not Assured

Factors Shaping Return to Work

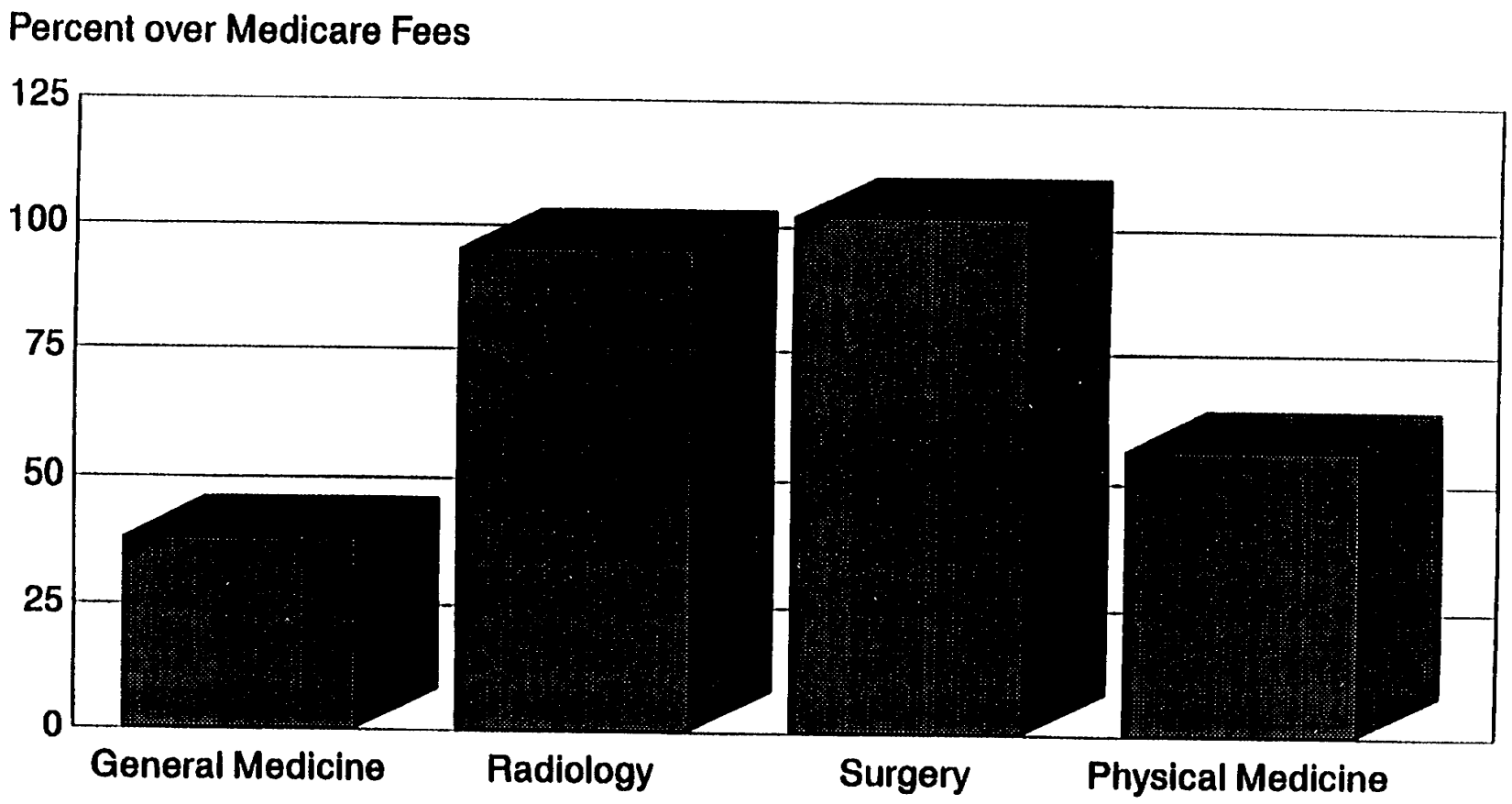
- Economic Incentives
  - Benefit Levels
  - Reemployment Wage Levels
- Return to Preinjury Employer
- Worker Attributes Reflected in Unstable Employment History
- Return to Work in 6 Months Or Less is Important

Nevada Medicare Fee Schedule

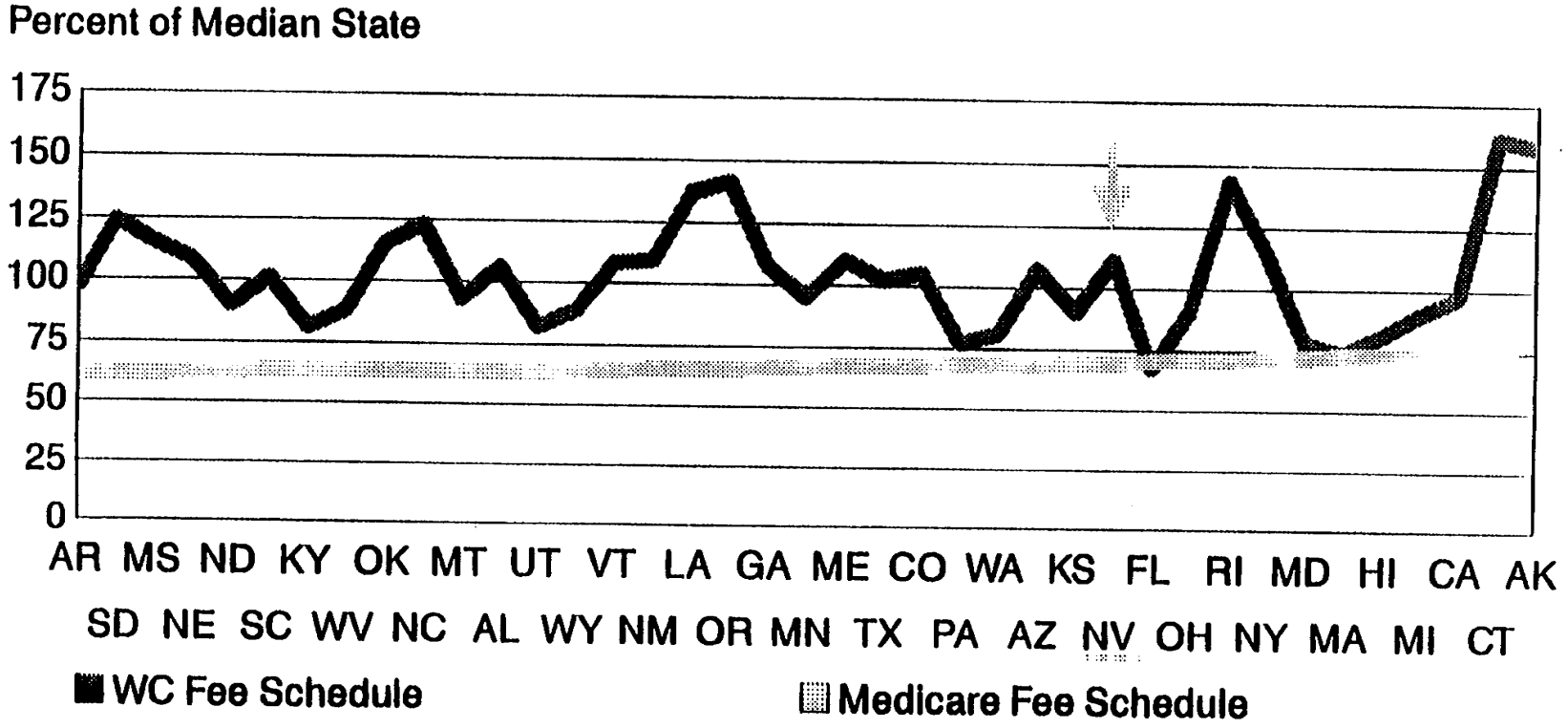
11th Highest of 39 States



Premium Over Medicare



Fee Schedule Pays 57% Over Medicare



Appendix G

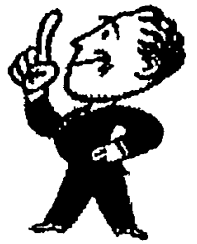
Slide presentation entitled "Permanent Partial Disability Survey," dated September 12, 1996, by Division of Industrial Relations, Department of Business and Industry, and Research Division, Legislative Counsel Bureau.

Permanent Partial Disability Survey

Prepared by:
Division of Industrial Relations,
Department of Business and Industry and
Research Division,
Legislative Counsel Bureau
September 12, 1996

Essential Task of Workers' Compensation Programs

An essential task of a workers' compensation program is to pay appropriate benefits to employees who have been injured while in the course and scope of employment.



Permanent Partial Disability Defined

Workers' compensation programs pay injured employees for permanent physical impairment or loss of physical functioning that results from an injury incurred in the course and scope of employment or that results from an occupational disease. This compensation is called a permanent partial disability (PPD) award.

Permanent Partial Disability

In Nevada, a permanent partial disability benefit is awarded to an injured employee who:

1. Sustains a work-related injury or disease and
2. As a result of that injury or disease incurs a permanent physical impairment.

NRS 616C.490.

Economic Impairment Theories

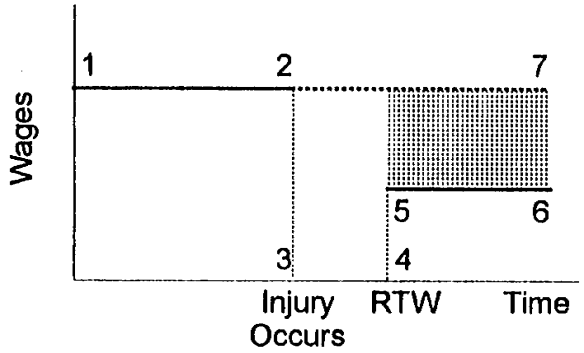
Reason for compensating for injury:

1. **Actual wage loss; or**
2. **Loss of earning capacity.**

Economic Impairment Theories

Actual Wage Loss--Under this method of compensation, a comparison of actual postinjury and preinjury wages would be made. A payment would then be made to the employee for the appropriate period of time during which actual earnings were either zero or less than preinjury earnings.

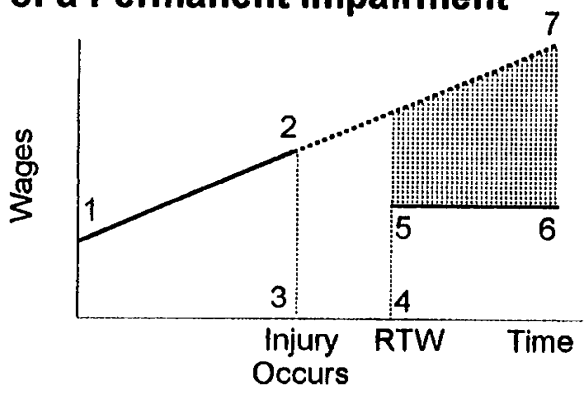
Actual Wage Loss Consequence of a Permanent Impairment



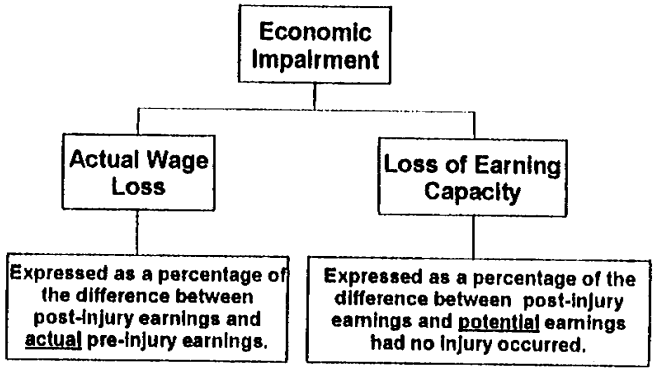
Economic Impairment Theories

Loss of Earning Capacity--This theory holds that an injured employee should be compensated for the loss of earning capacity that stems from a work-related physical impairment.

Earning Capacity Consequence of a Permanent Impairment



Summary



Physical Impairment Theories

Under a physical impairment theory, an injured employee is compensated for a physical impairment regardless of the effect of the impairment on current wages or future earning capacity.

Physical Impairment Theories

Basis of determining amount of compensation:

1. **Scheduled injury;**
2. **Nonscheduled injury; or**
3. **Combination.**

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Physical Impairment

Scheduled Injuries--A specific dollar amount or number of weeks of benefit payments for an accident or disease causing a permanent loss or a permanent loss of use of a specified body part.

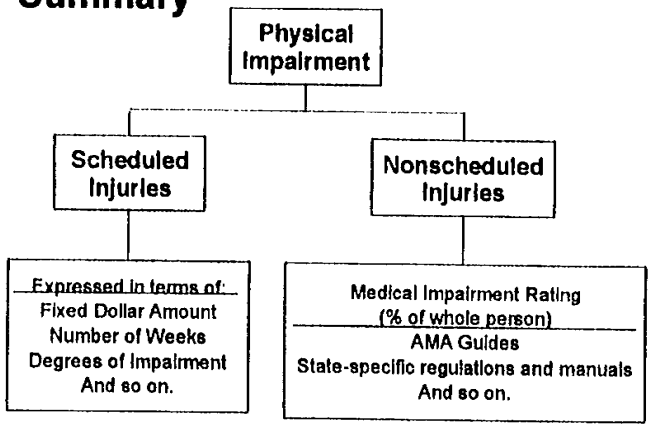
Physical Impairment

Nonscheduled Injuries--Physical impairments or functional limitations that are consequences of work-related injuries are rated as a percentage of total disability.

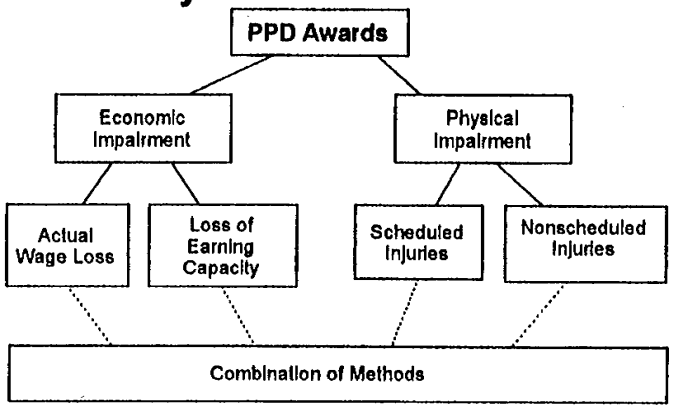
Physical Impairment

Combination--Some jurisdictions provide for compensation of certain injuries using a schedule. Other injuries are compensated on the basis of a formula.

Summary



Summary



Measuring Physical Impairment in Nevada: An Historical Perspective

1913 actual wage loss provision:

For partial disability, one-half the difference between the wages earned before the injury and wages which injured is able to earn thereafter, but not more than $40 a month for a period not to exceed sixty months.

1913 physical impairment provision

Specific payments of injuries as per the following schedule, subject to a maximum of $60 and a minimum of $20 per month:

- Loss of thumb--50% of average monthly wage during 15 months;
- Loss of a first (index) finger--50% of average monthly wage during 9 months;
- Loss of a second finger--50% of average monthly wage during 7 months;
- And so on.

1915 actual wage loss provision

For *temporary* partial disability, one-half the difference between the wages earned before the injury and wages which injured is able to earn thereafter, but not more than $40 a month for a period not to exceed sixty months.

1915 nonscheduled injury provision

In all cases of permanent partial disability, not otherwise specified in the foregoing schedule, the disability shall be determined according to the percentage thereof, taking into account, among other things, any previous disability, the occupation of the injured employee, the nature of the physical injury or disfigurement, and the age of the employee at the time of the injury;

1915 nonscheduled injury provision

and the compensation paid therefor shall be the percentage of the disability caused by the injury times fifty percent of the average monthly wage (but not more than fifty dollars a month) for not exceeding 100 months during the life of the injured employee.

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1917 clarification for nonscheduled injuries

In all cases of permanent partial disability, not otherwise specified in the foregoing schedule, the percentage of disability to the total disability shall be determined. For the purpose of computing compensation for a disability that is partial in character but permanent in quality, the sum of sixty dollars per month for a period of one hundred months shall represent a one hundred percent disability.

Measuring Physical Impairment in Nevada: An Historical Perspective

Between 1919 and 1971, only relatively minor changes to the PPD statutes were enacted by the Legislature.

Measuring Physical Impairment in Nevada: An Historical Perspective

In 1973, the Legislature repealed the statutory schedule of benefits and adopted a new method of determining compensation for a PPD that involved an impairment determination made by a physician designated by the Commission in accordance with the current edition of the *AMA Guides*.

Measuring Physical Impairment in Nevada: An Historical Perspective

In 1981, the Legislature changed from 0.5% to 0.6% the factor used to calculate the amount of a PPD award.

In 1983, the Legislature enacted a schedule that gradually increased from 65 to 70 the age at which a PPD award ceases.

Measuring Physical Impairment in Nevada: An Historical Perspective

In 1993, the Legislature changed the factor used to calculate the amount of a PPD award for injuries sustained on or after June 18, 1993, from 0.6% to 0.54%.

Research Methodology

1. Identify major research topics;
2. Draft written survey instrument (Appendix 1);
3. Distribute written survey instrument to all states;
4. Telephone follow-up for clarification of responses; and
5. Compile comparative results and report to Committee.

Survey Response

Thirty-eight (38) states responded to the 50-state survey. The response rate was 76 percent.

These responses include the following western states:

Arizona	California	Colorado
Idaho	Montana	New Mexico
Oregon	Utah	Washington
Wyoming		

PPD Survey Topics

Four major topics were addressed in the survey:

1. **Methodology and theories** used to determine PPD benefits.
2. **Methods of payment** of PPD awards.
3. **Extent of litigation** relating to the determination and/or payment of PPD awards.
4. **Six examples of workers with injuries:** Specific PPD awards.

PPD Survey Topics

Other topics addressed by the survey for DIR and LCB informational purposes were:

1. Methods available to employers for providing workers' compensation insurance; and
2. Copies of statutes, regulations, organizational charts, bill summaries, and so on.

Survey Findings

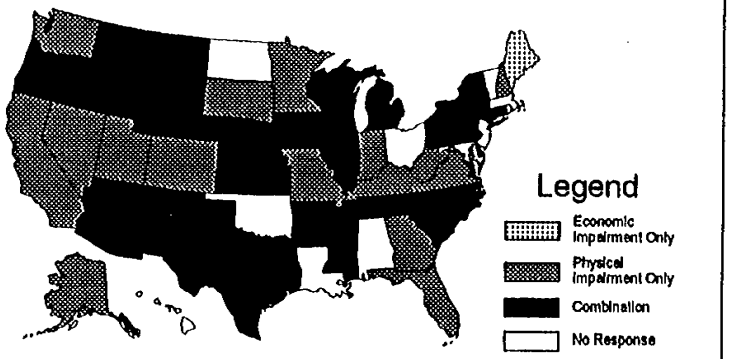
1. Methodology and theories

Physical Impairment Methods →
- ✓ Scheduled Injuries Only
- ✓ Combination of Scheduled and Nonscheduled Injuries
- ✓ Medical Impairment Rating

Economic Impairment Methods →
- ✓ Loss of Earning Capacity
- ✓ Actual Wage Loss
- ✓ Other

Survey Findings

1. Methodology and theories



Survey Findings

Examples of Elements Considered by Other States When Calculating a PPD Award

Age, Wage, Date of Injury, Job Description, Education, Number of Dependents, Medical Impairment (objective factors), Marital Status, Employment History, Work Restrictions Upon Release to Return to Work, Pain Level (subjective factors), Compensability of the Injury, Labor Market, and Full Time vs. Part Time Employment at Time of Injury.

Survey Findings

Elements Considered by Nevada When Calculating a PPD Award

Age, Wage, and Medical Impairment.

Survey Findings

2. Methods of payment

Installments--Weekly, Biweekly, Monthly, Bimonthly, Quarterly, Annually

Lump Sums--Under certain conditions

Annuities--Under certain conditions

Survey Findings

3. Extent of litigation
   State of Washington findings:

- "...closure of indemnity claims (especially those involving a disputed degree of permanent partial disability) continues to be a major problem..."
- There do not appear to be any available formulas or statistical techniques for measuring litigiousness. According to the WCRI, this is due to a lack of adequate data.

Survey Findings

State of Washington findings (cont.):

- A general conclusion of the Washington analysis is that "attending physician impairment ratings are an essential factor in obtaining non-adversarial initial ratings, and ultimately contribute significantly to reducing disputes and litigation."
- Reforms that work in one state to reduce litigation may not work in another state. Also, some reforms may be more effective if they are part of a package of related reforms.

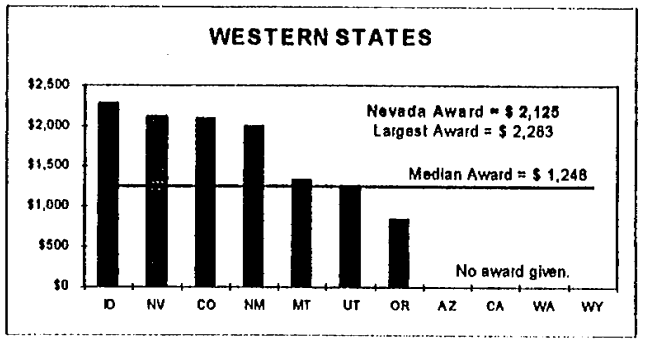
Survey Findings

4. Six examples of workers with injuries

	INJURIES		
WORKERS	Minor Cervical Strain/Sprain--2% Whole Person Impairment	Moderate Right Rotator Cuff Tear--10% Whole Person Impairment	Major Lumbar Fusion/Discectomy--20% Whole Person Impairment
Worker A $1200 per month Dishwasher/Busboy	Example 1	Example 2	Example 3
Worker B $3000 per month Office Manager	Example 4	Example 5	Example 6

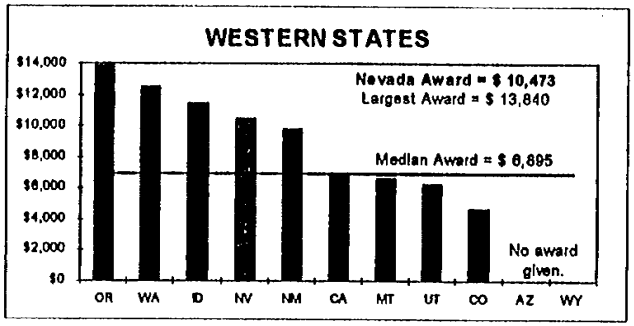
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 1--Low wage employee, minor injury--no wage loss upon return to work



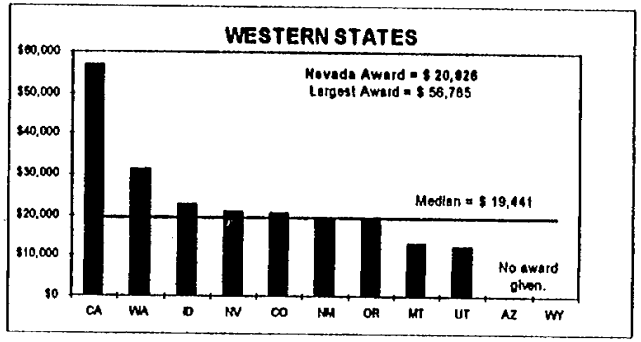
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 2--Low wage employee, moderate injury--no wage loss upon return to work



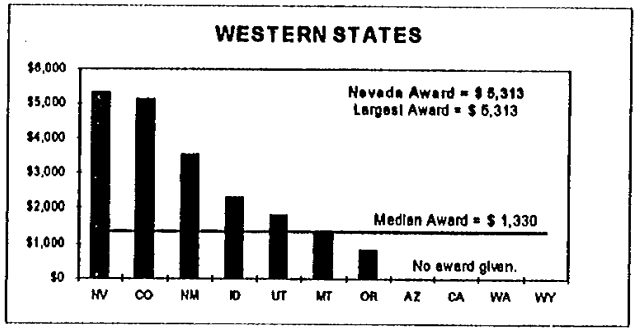
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 3--Low wage employee, major injury--no wage loss upon return to work



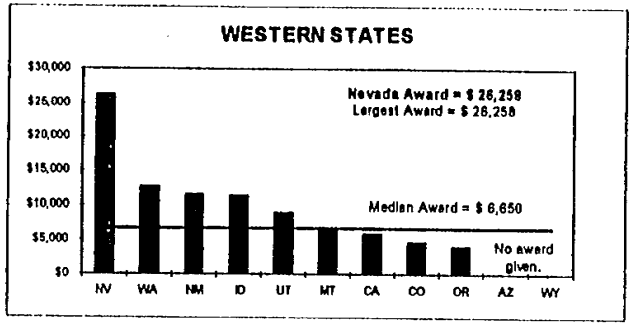
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 4--Higher wage employee, minor injury--no wage loss upon return to work



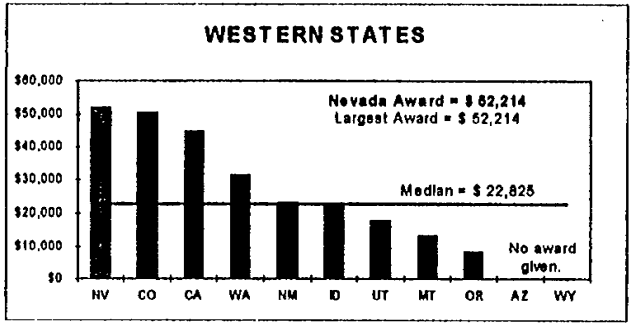
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 5--Higher wage employee, moderate injury--no wage loss upon return to work



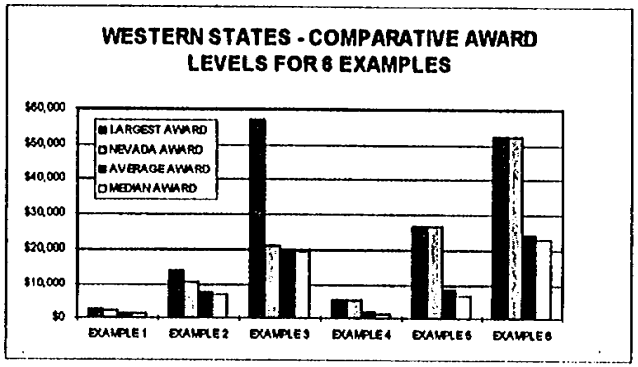
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 6--Higher wage employee, major injury--no wage loss upon return to work



This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Summary--no wage loss upon return to work



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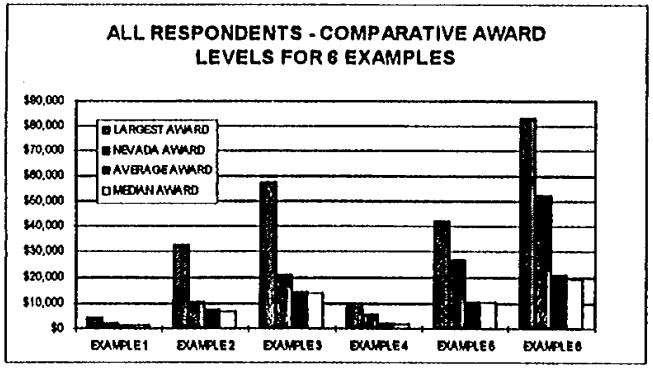
Summary--no wage loss upon return to work

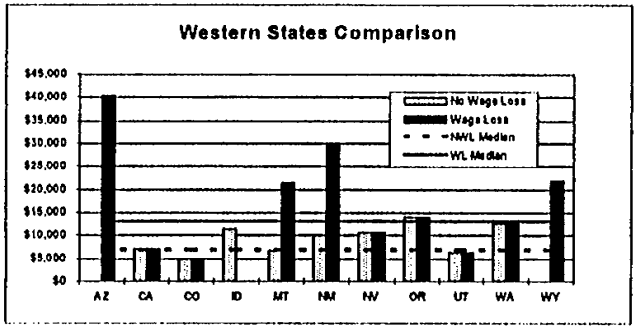


Wage Loss

For the purposes of this study, the term "wage loss" refers to a situation in which an injured employee returns to the work force at a wage lower than that which he earned at the time of injury. "No wage loss" refers to a situation in which an injured employee returns to the work force at a wage equal to or higher than that which he earned at the time of the injury.

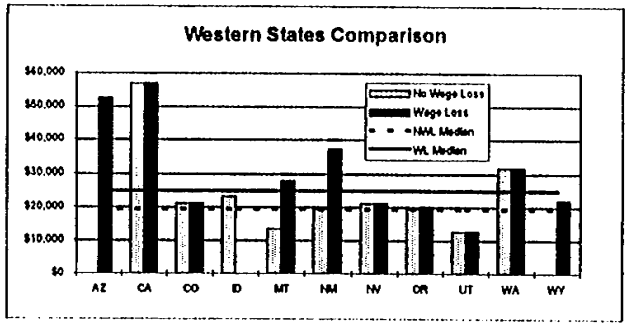
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 2--Low wage worker, moderate injury--wage loss upon return to work vs. no wage loss



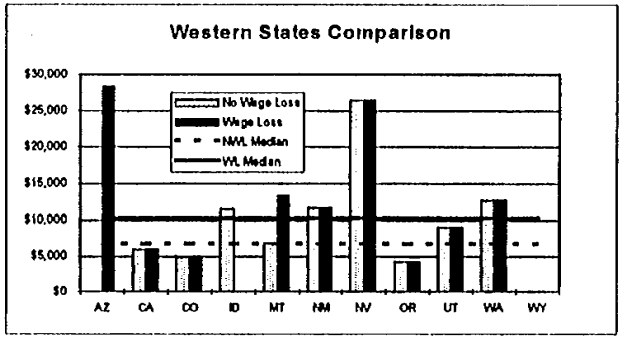
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 3--Low wage worker, major injury--wage loss upon return to work vs. no wage loss



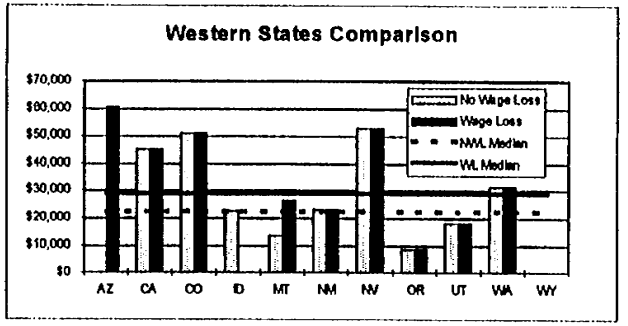
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 5--Higher wage worker, moderate injury--wage loss upon return to work vs. no wage loss



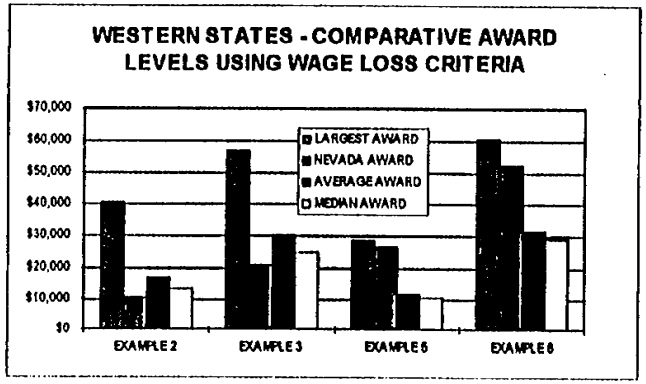
This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Example 6--Higher wage worker, major injury--wage loss upon return to work vs. no wage loss



This chart depicts values reported by respondents and are unaudited. Due to the number and variety of elements used to calculate PPD awards in each state, DIR cautions that generalizations cannot be made from individual charts.

Summary (Wage Loss)



Concluding Remarks

- The scope of this study was limited to comparing PPD awards paid in Nevada to those in other states for specific workers with specific injuries. It was not designed to be an analysis of all components and types of permanent partial disability benefits in Nevada and other states. It was not designed to compare other compensation benefits which could impact PPD such as temporary total disability, vocational rehabilitation, reopening, or medical benefits. What the study does depict is a limited view of PPD awards of a limited number of examples;

Concluding Remarks

- The data received from the responding states was not audited to determine if the calculations were made in accordance with each state's laws and regulations; and

- Even though we categorized states by type of PPD system, each state is unique. Comparisons can be misleading and should be viewed with caution as all relevant factors regarding PPD must be taken into consideration.

Appendix H

Slide presentation entitled "Experience Rating Presentation,"
dated December 19, 1995, by Vance A. Hughey, Senior Research Analyst,
Research Division, Legislative Counsel Bureau

Experience Rating

Prepared by:
Research Division
Legislative Counsel Bureau
December 19, 1995

Experience Rating

Workers' compensation experience rating is designed to provide a mechanism to charge higher than average premiums to policyholders with higher than average losses and to charge lower than average premiums to policyholders with lower than average losses.

Example A:

Policyholder A has average experience and an experience modification factor of 1.00. If the manual premium rate for this policyholder was $5.00 per $100 of payroll, this policyholder would pay a standard premium rate of $5.00.

Example B:

Policyholder B has better than average experience and an experience modification factor of 0.80. If the manual premium rate for this employer was $5.00 per $100 of payroll, this employer would pay a standard premium rate of $4.00.

Primary Goals of Experience Rating

- **Predictive Accuracy**--To the extent that the experience modification factor helps predict future loss experience of a policyholder, it allows the premium to be tailored more closely to each policyholder's own loss potential. This is the equity contribution of experience rating.
- **Safety Incentive**--By charging a policyholder for incurred costs of accidents that occur, a financial incentive for safety is added to other incentives that may exist.

Credibility

Conceptually, if past experience was a perfect indicator of future experience, the experience modification factor could be derived by dividing actual losses by expected losses. Because past experience is not a perfect indicator of future experience, a credibility factor is used in the experience rating formula. This factor represents an estimate of the predictive power of the policyholder's past loss experience.

Credibility

The statistical "law of large numbers" suggests that a larger data base generally has better predictive power than a smaller data base. Consequently, the credibility assigned to a policyholder's experience is a function of the size of the policyholder (in terms of expected losses):

- The larger a policyholder is, the more weight will be given to its own experience, other things being equal. This allows for deeper discounts from the manual premium rate through lower experience modification factors, or higher standard premiums through higher experience modification factors for larger policyholders.
- The smaller a policyholder is, the more reliance is placed on the manual premium rate, other things being equal.

Experience Rating Formula

(*Nevada Administrative Code* 616.298)

$$E\text{-}Mod = ([A / E] \times C) + (1 - C)$$

where:
A=Actual Losses
E=Expected Losses
C=Credibility

Credibility Formulas

Previous Credibility Formula (NAC 616.298)

$$C = E / (1.1E + 40{,}000)$$

where:
E = Expected Losses

New Credibility Formula (SIIS Regulation 95-5)

$$C = E / (E + 100{,}000)$$

where:
E = Expected Losses

Effect of New Credibility Formula

Some policyholders have observed that if a policyholder's 1996 experience modification factor would have been less than one under the previous formula, it will go up under the new formula.

Likewise, if a policyholder's 1996 experience modification factor would have been greater than one under the previous formula, it will go down under the new formula.

This relationship has been observed for any policyholder with expected losses under $600,000. At expected loss levels higher than $600,000, the effect is reversed.

Effect of New Credibility Formula

Example A:

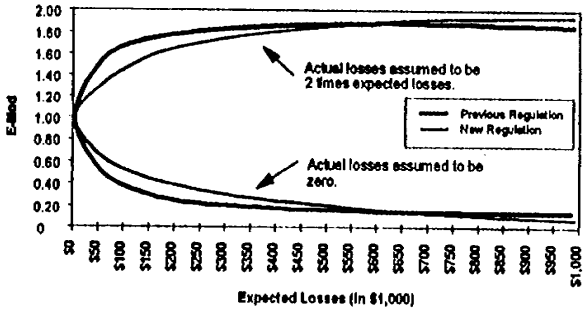
Company A has no actual losses and $10,000 of expected losses. Under the previous formula, Company A would expect to receive an experience modification factor of 0.80. Under the new formula, Company A receives an experience modification factor of 0.91.

Example B:

Company B has $20,000 of actual losses and $10,000 of expected losses. Under the previous formula, Company B would expect to receive an experience modification factor of 1.20. Under the new formula, Company B receives an experience modification factor of 1.09.

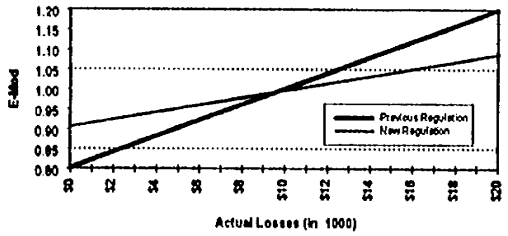
	Previous Formula	New Formula
Company A	0.80	0.91
Company B	1.20	1.09

Comparison Under Previous and New Experience Modification Formulas



Comparison Under Previous and New Experience Modification Formulas

Based on $10,000 of Expected Losses



Appendix I

Suggested Legislation

SUMMARY—Makes various changes to provisions governing administration and payment of benefits for industrial insurance. (BDR 53-952)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to industrial insurance; providing for the electronic transmission of documents related to claims; clarifying the authority of insurers to purchase annuities for the payment of claims; clarifying the prohibition against recovering benefits unless a notice of injury and a claim for compensation are filed; prohibiting an injured employee from recovering benefits for an industrial injury or occupational disease unless he receives medical treatment for the injury or disease; revising the training requirements for hearing and appeals officers; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 612.265 is hereby amended to read as follows:

612.265 1. Except as otherwise provided in this section, information obtained from any employing unit or person pursuant to the administration of this chapter and any determination as to the benefit rights of any person is confidential and may not be disclosed or be open to public inspection in any manner which would reveal the person's or employing unit's identity.

2. Any claimant or his legal representative is entitled to information from the records of the division, to the extent necessary for the proper presentation of his claim in any proceeding pursuant to this chapter. A claimant or an employing unit is not entitled to information from the records of the division for any other purpose.

3. Subject to such restrictions as the administrator may by regulation prescribe, the information obtained by the division may be made available to:

(a) Any agency of this or any other state or any federal agency charged with the administration or enforcement of an unemployment compensation law, public assistance law, workman's compensation or labor law, or the maintenance of a system of public employment offices;

(b) Any state or local agency for the enforcement of child support;

(c) The Internal Revenue Service of the Department of the Treasury;

(d) The department of taxation; and

(e) The state contractors' board in the performance of its duties to enforce the provisions of chapter 624 of NRS.

Information obtained in connection with the administration of the employment service may be made available to persons or agencies for purposes appropriate to the operation of a public employment service or a public assistance program.

4. Upon written request made by a public officer of a local government, the administrator shall furnish from the records of the division the name, address and place of employment of any person listed in the records of employment of the division. The request must set forth the social security number of the person about whom the request is made and contain a statement signed by proper authority of the local government certifying that the request is made to allow the proper authority to enforce a law to recover a debt or obligation owed to the local government. The information obtained by the local government is confidential and may not be used or disclosed for any purpose other than the collection of a debt or obligation owed to that local government. The administrator may charge a reasonable fee for the cost of providing the requested information.

5. The administrator may publish or otherwise provide information on the names of employers, their addresses, their type or class of business or industry, and the approximate number of employees employed by each such employer, if the information released will assist unemployed persons to obtain employment or will be generally useful in developing and diversifying the economic interests of this state. Upon request by a state agency which is able to demonstrate that its intended use of the information will benefit the residents of this state, the administrator may, in addition to the information listed in this subsection,

disclose the number of employees employed by each employer and the total wages paid by each employer. The administrator may charge a fee to cover the actual costs of any administrative expenses relating to the disclosure of this information to a state agency. The administrator may require the state agency to certify in writing that the agency will take all actions necessary to maintain the confidentiality of the information and prevent its unauthorized disclosure.

6. Upon request therefor the administrator shall furnish to any agency of the United States charged with the administration of public works or assistance through public employment, and may furnish to any state agency similarly charged, the name, address, ordinary occupation [,] and employment status of each recipient of benefits and the recipient's rights to further benefits pursuant to this chapter.

7. To further a current criminal investigation, the chief executive officer of any law enforcement agency of this state may submit a written request to the administrator that he furnish, from the records of the division, the name, address and place of employment of any person listed in the records of employment of the division. The request must set forth the social security number of the person about whom the request is made and contain a statement signed by the chief executive officer certifying that the request is made to further a criminal investigation currently being conducted by the agency. Upon receipt of such a request, the administrator shall furnish the information requested. He may charge a fee to cover the actual costs of any related administrative expenses.

8. In addition to the provisions of subsection 5, the administrator shall provide lists containing the names and addresses of employers, the number of employees employed by each employer and the total wages paid by each employer to the department of taxation, upon request, for use in verifying returns for the business tax. The administrator may charge a fee to cover the actual costs of any related administrative expenses.

9. [The manager of the state industrial insurance system] *Each insurer* shall submit to the administrator a list containing the name of each person who received benefits pursuant to chapters 616A to 616D, inclusive, or 617 of NRS during the preceding month and request that [he] *the administrator* compare the information so provided with the records of the division regarding persons claiming benefits pursuant to chapter 612 of NRS for the same period. The information submitted by [the manager] *an insurer* must be in a form determined by the administrator and must contain the social security number of each such person. Upon receipt of such a request, the administrator shall make such a comparison and provide to the [manager] *insurer* a list containing the name, address and social security number of each person who appears, from the information submitted, to be simultaneously claiming benefits under chapter 612 of NRS and under chapters 616A to 616D, inclusive, or 617 of NRS. *Upon receipt of a request therefor, the administrator shall provide to the insurer a copy of the form used by any person whose name appears on the list to claim benefits under chapter 612 of NRS.* The administrator shall charge a fee to cover the actual costs of any related administrative expenses. The [manager] *insurer* shall use the

information obtained pursuant to this subsection only to further a current investigation. The [manager] *insurer* shall not disclose the information for any other purpose. *As used in this subsection, "insurer" has the meaning ascribed to it in NRS 616A.270.*

10. The administrator may request the Comptroller of the Currency of the United States to cause an examination of the correctness of any return or report of any national banking association rendered pursuant to the provisions of this chapter, and may in connection with the request transmit any such report or return to the Comptroller of the Currency of the United States as provided in Section 3305(c) of the Internal Revenue Code of 1954.

11. If any employee or member of the board of review or the administrator or any employee of the administrator, in violation of the provisions of this section, discloses information obtained from any employing unit or person in the administration of this chapter, or if any person who has obtained a list of applicants for work, or of claimants or recipients of benefits pursuant to this chapter uses or permits the use of the list for any political purpose, he is guilty of a gross misdemeanor.

12. All letters, reports or communications of any kind, oral or written, from the employer or employee to each other or to the division or any of its agents, representatives or employees are privileged and must not be the subject matter or basis for any lawsuit if the letter, report or communication is written, sent, delivered or prepared pursuant to the requirements of this chapter.

Sec. 2. Chapter 616A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in chapters 616A to 617, inclusive, of NRS, a form, notice, claim, bill or other document required to be filed, mailed or delivered pursuant to the provisions of those chapters, or any regulations adopted pursuant thereto, may be filed or delivered by electronic transmission.

2. For the purposes of the provisions of chapters 616A to 617, inclusive, of NRS, and any regulations adopted pursuant thereto, a signature on a form, notice, claim, bill or other document that is filed or delivered by electronic transmission has the same legal effect as the original signature.

3. The administrator may adopt such regulations as are necessary to provide for the filing or delivery of such documents by electronic transmission.

Sec. 3. Chapter 616B of NRS is hereby amended by adding thereto the provisions set forth as sections 4 and 5 of this act.

Sec. 4. *An insurer shall, within 10 days after receiving from an employer a written request for information relating to the employer's policy of industrial insurance, provide to the employer the information requested if that information is in the possession of, or reasonably available to, the insurer.*

Sec. 5. *An insurer may purchase an annuity in any form to ensure the payment of a claim filed with the insurer pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS.*

Sec. 6. NRS 616B.012 is hereby amended to read as follows:

616B.012 1. Except as otherwise provided in this section and in NRS 616B.015, 616B.021 and 616C.205, information obtained from any insurer, employer or employee is confidential and may not be disclosed or be open to public inspection in any manner which would reveal the person's identity.

2. Any claimant or his legal representative is entitled to information from the records of the insurer, to the extent necessary for the proper presentation of a claim in any proceeding under chapters 616A to 616D, inclusive, of NRS.

3. *An insurer, the administrator, an employer or a provider of health care is entitled to any medical or other information released by an injured employee pursuant to subsection 3 of NRS 616C.020 or subsection 3 of NRS 617.344.*

4. The division and administrator are entitled to information from the records of the insurer which is necessary for the performance of their duties. The manager may, by regulation, prescribe the manner in which otherwise confidential information may be made available to:

(a) Any agency of this or any other state charged with the administration or enforcement of [workers' compensation law,] *laws relating to industrial insurance,*

unemployment compensation , [law,] public assistance [law] or labor [law;] *and industrial relations;*

(b) Any state or local agency for the enforcement of child support;

(c) The Internal Revenue Service of the Department of the Treasury;

(d) The department of taxation; and

(e) The state contractors' board in the performance of its duties to enforce the provisions of chapter 624 of NRS.

Information obtained in connection with the administration of a [workers' compensation] program *of industrial insurance* may be made available to persons or agencies for purposes appropriate to the operation of a [workers' compensation program.

4.] *program of industrial insurance.*

5. Upon written request made by a public officer of a local government, the manager shall furnish from the records of the insurer, the name, address and place of employment of any person listed in the records of the insurer. The request must set forth the social security number of the person about whom the request is made and contain a statement signed by proper authority of the local government certifying that the request is made to allow the proper authority to enforce a law to recover a debt or obligation owed to the local government. The information obtained by the local government is confidential and may not be used or disclosed for any purpose other than the collection of a debt or obligation owed

to that local government. The manager may charge a reasonable fee for the cost of providing the requested information.

[5.] *6.* To further a current criminal investigation, the chief executive officer of any law enforcement agency of this state may submit a written request to the manager that he furnish from the records of the insurer, the name, address and place of employment of any person listed in the records of the insurer. The request must set forth the social security number of the person about whom the request is made and contain a statement signed by the chief executive officer certifying that the request is made to further a criminal investigation currently being conducted by the agency. Upon receipt of a request, the manager shall furnish the information requested. He may charge a reasonable fee to cover any related administrative expenses.

[6.] *7.* The manager shall provide lists containing the names and addresses of employers, the number of employees employed by each employer and the total wages paid by each employer to the department of taxation, upon request, for its use in verifying returns for the business tax. The manager may charge a reasonable fee to cover any related administrative expenses.

[7.] *8.* If the manager or any employee of the manager, in violation of this section, discloses information obtained from files of claimants or policyholders, or if any person who has obtained a list of claimants or policyholders under chapters 616A to 616D,

inclusive, of NRS uses or permits the use of the list for any political purposes, he is guilty of a gross misdemeanor.

[8.] *9.* All letters, reports or communications of any kind, oral or written, from the insurer, or any of its agents, representatives or employees are privileged and must not be the subject matter or basis for any lawsuit if the letter, report or communication is written, sent, delivered or prepared pursuant to the requirements of chapters 616A to 616D, inclusive, of NRS.

Sec. 7. NRS 616B.018 is hereby amended to read as follows:

616B.018 1. The administrator shall establish a method of indexing claims for compensation that will make information concerning the claimants of one insurer available to other insurers.

2. Every self-insured employer, association of self-insured public or private employers and the system shall provide information as required by the administrator for establishing and maintaining the index of claims.

3. If an employee files a claim [with an insurer,] *for compensation, or if a claim for compensation is filed on behalf of an employee,* the insurer is entitled to receive from the administrator a list of the prior claims of the employee. If the insurer desires to inspect the files *of another insurer that are* related to *one or more of* the prior claims, he must [obtain the written consent] *provide the other insurer with a copy of the claim for compensation filed by or on behalf* of the employee.

4. Any information obtained from the index of claims must be admitted into evidence in any hearing before an appeals officer, a hearing officer or the administrator.

5. The division may assess and collect a reasonable fee for its services provided pursuant to this section. The fee must be payable monthly or at such other intervals as determined by the administrator.

Sec. 8. NRS 616B.021 is hereby amended to read as follows:

616B.021 1. [The insurer must] *An insurer shall* provide access to the files of claims in its offices.

2. A file is available for inspection during regular business hours by the employee or his designated agent, the employer or his designated agent and the administrator or his designated agent.

3. Upon request, the insurer [must] *shall* make copies of anything in the file and may charge a reasonable fee for this service. Copies of materials in the file which are requested by the administrator or his designated agent, or the Nevada attorney for injured workers or his designated agent must be provided free of charge.

4. [If] *Except as otherwise provided in NRS 616C.235, if* a claim has been closed for at least 1 year, the insurer may microphotograph or film any of its records relating to that claim. The microphotographs or films must be placed in convenient and accessible files, and provision must be made for preserving, examining and using the records.

5. [Nothing in this section requires] *This section does not require* the insurer to allow inspection or reproduction of material regarding which a legal privilege against disclosure has been conferred.

Sec. 9. NRS 616B.024 is hereby amended to read as follows:

616B.024 *Except as otherwise provided in NRS 616C.235:*

1. Upon written approval of the administrator, the insurer may destroy accumulated and noncurrent detail records such as payroll reports, checks, claims [,] and other records of similar importance for the period July 1, 1913, to January 1, 1947, if:

(a) Claims from January 1, 1940, and after are first microphotographed; and

(b) A brief inventory of the destroyed records is retained.

2. The insurer may dispose of or destroy any record which has been microphotographed or filmed if the procedure required by NRS 239.051 has been followed.

3. The principal records, such as the general and regular journals and the general ledgers, must be retained intact until audited and then must be microfilmed for retention until their destruction pursuant to NRS 239.051.

Sec. 10. NRS 616B.033 is hereby amended to read as follows:

616B.033 1. Every policy of insurance issued pursuant to chapters 616A to 617, inclusive, of NRS must contain a provision for the requirements of subsection 5 and a provision that insolvency or bankruptcy of the employer or his estate, or discharge therein,

or any default of the employer does not relieve the insurer from liability for compensation resulting from an injury otherwise covered under the policy issued by the insurer.

2. No statement in an employer's application for a policy of industrial insurance voids the policy as between the insurer and employer unless the statement is false and would have materially affected the acceptance of the risk if known by the insurer, but in no case does the invalidation of a policy as between the insurer and employer affect the insurer's obligation to provide compensation to claimants arising before the cancellation of the policy. If the insurer is required pursuant to this subsection to provide compensation under an invalid policy, the insurer is subrogated to the claimant's rights against the employer.

3. If an insurer or employer intends to cancel or renew a policy of insurance issued by the insurer pursuant to chapters 616A to 617, inclusive, of NRS, the insurer or employer must give notice to that effect in writing to the administrator and to the other party fixing the date on which it is proposed that the cancellation or renewal becomes effective. The notices must comply with the provisions of NRS 687B.310 to 687B.355, inclusive, and must be served personally on or sent by first-class mail *or electronic transmission* to the administrator and the other party. If the employer has secured insurance with another insurer which would cause double coverage, the cancellation must be made effective as of the effective date of the other insurance.

4. As between any claimant and the insurer, no defense based on any act or omission of the insured employer, if different from the insurer, may be raised by the insurer.

5. For the purposes of chapters 616A to 617, inclusive, of NRS, as between the employee and the insurer:

(a) Except as otherwise provided in NRS 616C.065, notice or knowledge of the injury to or by the employer is notice or knowledge to or by the insurer;

(b) Jurisdiction over the employer is jurisdiction over the insurer; and

(c) The insurer is bound by and subject to any judgments, findings of fact, conclusions of law, awards, decrees, orders or decisions rendered against the employer in the same manner and to the same extent as the employer.

Sec. 11. NRS 616B.327 is hereby amended to read as follows:

616B.327 1. Except as otherwise provided in NRS 616D.120, before any action may be taken pursuant to subsection 2, the commissioner of insurance shall arrange an informal meeting with the self-insured employer to discuss and seek correction of any conduct which would be grounds for withdrawal of the self-insured employer's certificate of self-insurance.

2. Except as otherwise provided in NRS 616D.120, before the withdrawal of the certification of any self-insured employer, the commissioner of insurance shall give written notice to that employer by certified mail *or electronic transmission* that his certification will be withdrawn 10 days after receipt of the notice unless, within that time, the employer corrects the conduct set forth in the notice as the reason for the withdrawal or submits a

written request for a hearing to the commissioner of insurance. Before requesting a hearing the employer must make the deposit required by NRS 616B.300.

3. If the employer requests a hearing:

(a) The commissioner of insurance shall set a date for a hearing within 20 days after receiving the appeal request, and shall give the employer at least 10 business days' notice of the time and place of the hearing.

(b) A record of the hearing must be kept but it need not be transcribed unless requested by the employer with the cost of transcription to be charged to the employer.

(c) Within 5 business days after the hearing, the commissioner of insurance shall either affirm or disaffirm the withdrawal and give the employer written notice thereof by certified mail [.] *or electronic transmission.* If withdrawal of certification is affirmed, the withdrawal becomes effective 10 business days after the employer receives notice of the affirmance unless within that period of time the employer corrects the conduct which was ground for the withdrawal or petitions for judicial review of the affirmance.

4. If the withdrawal of certification is affirmed following judicial review, the withdrawal becomes effective 5 days after entry of the final decree of affirmance.

Sec. 12. NRS 616B.431 is hereby amended to read as follows:

616B.431 1. Except as otherwise provided in NRS 616D.120, before any action may be taken pursuant to subsection 2, the commissioner shall arrange an informal meeting with

an association of self-insured public or private employers to discuss and seek correction of any conduct which would be grounds for withdrawal of the certificate of the association.

2. Except as otherwise provided in subsection 3 and NRS 616D.120, before the withdrawal of the certificate of any association of self-insured public or private employers, the commissioner shall give written notice to the association by certified mail *or electronic transmission* that its certificate will be withdrawn 10 days after receipt of the notice unless, within that time, the association corrects the conduct set forth in the notice as the reason for the withdrawal or submits a written request for a hearing to the commissioner.

3. The commissioner may grant additional time, not to exceed an additional 120 days, before the withdrawal of the certificate of an association if:

(a) The grounds for withdrawal of the certificate of the association are based on paragraph (d) of subsection 2 of NRS 616B.428; and

(b) The association is financially sound and capable of fulfilling its commitments.

4. If the association requests a hearing:

(a) The commissioner shall set a date for a hearing within 20 days after receiving the request and give the association at least 10 business days' notice of the time and place of the hearing.

(b) A record of the hearing must be kept, but it need not be transcribed unless requested by the association with the cost of transcription to be charged to the association.

(c) Within 5 business days after the hearing, the commissioner shall either affirm or disaffirm the withdrawal and give the association written notice thereof by certified mail [.] *or electronic transmission.* If withdrawal of certification is affirmed, the withdrawal becomes effective 10 business days after the association receives notice of the affirmance unless within that period the association corrects the conduct which was grounds for the withdrawal or petitions for judicial review of the affirmance.

5. If the withdrawal of certification is affirmed following judicial review, the withdrawal becomes effective 5 days after entry of the final decree of affirmance.

Sec. 13. NRS 616B.472 is hereby amended to read as follows:

616B.472 1. The commissioner shall suspend the authorization of a private carrier to provide industrial insurance for 1 year, if the commissioner finds that the private carrier has intentionally or repeatedly failed to comply with the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS or the regulations of the division.

2. Before the commissioner suspends the authorization of a private carrier, he shall arrange an informal meeting with the private carrier to discuss and seek correction of any conduct which would be grounds for suspension.

3. Before the suspension of the authorization, the commissioner shall give written notice to the private carrier by certified mail *or electronic transmission* that its authorization will be suspended within 10 days after it receives the notice unless, within

that time, the private carrier corrects the conduct set forth in the notice as the reason for the withdrawal or submits a written request for a hearing to the commissioner.

4. If the private carrier requests a hearing:

(a) The commissioner shall set a date for a hearing within 20 days after receiving the notice of the appeal and shall give the private carrier at least 10 business days' notice of the time and place of the hearing.

(b) A record of the hearing must be kept but it need not be transcribed unless requested by the private carrier. The cost of transcription must be charged to the private carrier.

5. Within 5 days after the hearing, the commissioner shall affirm or deny his order suspending the authorization of the private carrier and notify the private carrier by certified mail *or electronic transmission* of his decision.

6. If the private carrier does not comply with the order of the commissioner during the period of suspension of the authorization, the commissioner shall file an order prohibiting the private carrier from issuing new policies until the order has expired. A copy of the order must be sent by certified mail *or electronic transmission* to the private carrier.

Sec. 14. NRS 616C.020 is hereby amended to read as follows:

616C.020 1. Except as otherwise provided in subsection 2, an injured employee [,] *who wishes to recover compensation pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS,* or a person acting on his behalf, shall , *at the time of the employee's first*

medical examination for his injury, file a claim for compensation with the [insurer within 90 days after an accident if:

(a) The employee has sought medical treatment for an injury arising out of and in the course of his employment; or

(b) The employee was off work as a result of an injury arising out of and in the course of his employment.] *physician or chiropractor who conducts the examination. The injured employee must submit to a medical examination for his injury and file a claim for compensation within 90 days after the date of the injury.*

2. In the event of the death of the injured employee resulting from the injury, a dependent of the employee, or a person acting on his behalf, shall file a claim for compensation with the insurer within 1 year after the death of the injured employee.

3. The claim for compensation must be filed on a form prescribed by the administrator. *The form must include a provision which, if signed by the injured employee, authorizes the release of any medical or other information related to the claim to the insurer, the administrator, the employee's employer and any provider of health care who provides treatment to the injured employee.*

Sec. 15. NRS 616C.025 is hereby amended to read as follows:

616C.025 1. Except as otherwise provided in subsection 2, an employee or, in the event of the death of [the employee, his dependent,] *an employee, a dependent, who does not file a notice of injury pursuant to NRS 616C.015 and a claim for compensation*

pursuant to NRS 616C.020 is barred from recovering compensation pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS . [if he fails to file a notice of injury pursuant to NRS 616C.015 or a claim for compensation pursuant to NRS 616C.020.]

2. An insurer may excuse the failure to file a notice of injury or a claim for compensation pursuant to the provisions of this section if:

(a) The injury to the employee or another cause beyond his control prevented him from providing the notice or claim;

(b) The failure was caused by the employee's or dependent's mistake or ignorance of fact or of law;

(c) The failure was caused by the physical or mental inability of the employee or the dependent; or

(d) The failure was caused by fraud, misrepresentation or deceit.

Sec. 16. NRS 616C.040 is hereby amended to read as follows:

616C.040 1. A treating physician or chiropractor shall, within 3 working days after he first [treats] *examines* an injured employee for a particular injury, complete and [mail to] *file with* the employer of the injured employee and [to] the employer's insurer, [a] *the* claim for compensation [.] *filed with the physician or chiropractor by the injured employee pursuant to NRS 616C.020.* If the employer is a self-insured employer, the treating physician or chiropractor shall [mail] *file* the claim for compensation [to] *with* the employer's third-party administrator. *If the physician or chiropractor files the claim for*

compensation by electronic transmission, he shall, upon request, mail to the insurer or third-party administrator the form that contains the original signatures of the injured employee and the physician or chiropractor. The form must be mailed within 7 days after receiving such a request.

2. [A claim for compensation required by subsection 1 must be on a form prescribed by the administrator.

3.] If a claim for compensation is accompanied by a certificate of disability, the certificate must include a description of any limitation or restrictions on the injured employee's ability to work.

[4.] *3.* Each physician, chiropractor and medical facility that treats injured employees, each insurer, third-party administrator and employer, and the division shall maintain at their offices a sufficient supply of the forms prescribed by the administrator for filing a claim for compensation.

[5.] *4.* The administrator shall impose an administrative fine of not more than $1,000 on a physician or chiropractor for each violation of subsection 1.

Sec. 17. NRS 616C.045 is hereby amended to read as follows:

616C.045 1. Within 6 working days after the receipt of a claim for compensation from a physician or chiropractor, an employer shall complete and [mail to] *file with* his insurer or third-party administrator an employer's report of industrial injury or occupational disease.

2. The report must:

(a) Be on a form prescribed by the administrator;

(b) Be signed by the employer or his designee;

(c) Contain specific answers to all questions required by the regulations of the administrator; and

(d) Be accompanied by a statement of the wages of the employee if the claim for compensation received from the treating physician or chiropractor indicates that the injured employee is expected to be off work for 5 days or more.

3. An employee of the system shall not complete the report required by subsection 1 or any other form relating to the accident on behalf of the employer unless the employer:

(a) Is not in business;

(b) Has not been located by the system within 5 working days after receipt of a claim for compensation; or

(c) Refuses to complete the report.

4. *An employer who files the report required by subsection 1 by electronic transmission shall, upon request, mail to the insurer or third-party administrator the form that contains the original signature of the employer or his designee. The form must be mailed within 7 days after receiving such a request.*

5. The administrator shall impose an administrative fine of not more than $1,000 on an employer for each violation of this section.

Sec. 18. NRS 616C.060 is hereby amended to read as follows:

616C.060 An insurer shall accept or deny responsibility for compensation under chapters 616A to 616D, inclusive, of NRS within 30 working days after [claims] *a claim* for compensation [are] *is* received pursuant to [both NRS 616C.020 and] *NRS* 616C.040.

Sec. 19. NRS 616C.130 is hereby amended to read as follows:

616C.130 The insurer shall not authorize the payment of any money to a physician or chiropractor for services rendered by him in attending an injured employee until an itemized statement for the services has been received by the insurer accompanied by a certificate of the physician or chiropractor stating that a duplicate of the itemized statement has been [mailed or personally delivered to] *filed with* the employer of the injured employee.

Sec. 20. NRS 616C.150 is hereby amended to read as follows:

616C.150 1. An injured employee or his dependents are not entitled to receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS unless [the] :

(a) The employee submits to a medical examination for an injury arising out of and in the course of his employment within 90 days after the date of that injury; and

(b) The employee or his dependents establish by a preponderance of the evidence that the employee's injury arose out of and in the course of his employment.

2. For the purposes of chapters 616A to 616D, inclusive, of NRS, if the employee files a notice of an injury pursuant to NRS 616C.015 after his employment has been terminated for any reason, there is a rebuttable presumption that the injury did not arise out of and in the course of his employment.

Sec. 21. NRS 616C.220 is hereby amended to read as follows:

616C.220 1. An employee may receive compensation from the uninsured employers' claim fund if:

(a) He was hired in this state or he is regularly employed in this state;

(b) He suffers an accident or injury in this state which arises out of and in the course of his employment;

(c) [He files a] *His* claim for compensation *is filed* with the system pursuant to NRS [616C.020;] *616C.040;*

(d) He files written notice with the division; and

(e) He makes an irrevocable assignment to the division of a right to be subrogated to the rights of the injured employee pursuant to NRS 616C.215.

2. If the system receives a claim pursuant to subsection 1, the system shall immediately:

(a) Notify the employer of the claim; and

(b) Deliver to the division any evidence regarding the claim and any evidence indicating that the employer was uninsured.

3. For the purposes of this section, the employer has the burden of proving that he provided mandatory industrial insurance coverage for the employee or that he was not required to maintain industrial insurance for the employee.

4. Any employer who has failed to provide mandatory coverage required by the provisions of chapters 616A to 616D, inclusive, of NRS is liable for all payments made on his behalf, including any benefits, administrative costs or attorney's fees paid from the uninsured employers' claim fund or incurred by the division.

5. The division:

(a) May recover from the employer the payments made by the division that are described in subsection 4 and any accrued interest by bringing a civil action in district court.

(b) In any civil action brought against the employer, is not required to prove that negligent conduct by the employer was the cause of the employee's injury.

(c) May enter into a contract with any person to assist in the collection of any liability of an uninsured employer.

(d) In lieu of a civil action, may enter into an agreement or settlement regarding the collection of any liability of an uninsured employer.

6. The division shall:

(a) Determine whether the employer was insured within 30 days after receiving notice of the claim from the employee.

(b) Assign the claim to the system for administration of the claim, payment of benefits and reimbursement of costs of administration and benefits paid to the system.

Upon determining that a claim is invalid, the system shall notify the claimant, the named employer and the division that the claim will not be assigned for benefits from the uninsured employers' claim fund.

7. Any party aggrieved by a decision regarding the administration of an assigned claim or a decision made by the division or by the system regarding any claim made pursuant to this section may appeal that decision within 60 days after the decision is rendered to the hearings division of the department of administration in the manner provided by NRS 616C.305 and 616C.315 to 616C.385, inclusive.

8. All insurers shall bear a proportionate amount of a claim made pursuant to chapters 616A to 616D, inclusive, of NRS, and are entitled to a proportionate amount of any collection made pursuant to this section as an offset against future liabilities.

9. An uninsured employer is liable for the interest on any amount paid on his claims from the uninsured employers' claim fund. The interest must be calculated at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date of the claim, plus 3 percent, compounded monthly, from the date the claim is paid from the fund until payment is received by the division from the employer.

10. Attorney's fees recoverable by the division pursuant to this section must be:

(a) If a private attorney is retained by the division, paid at the usual and customary rate for that attorney.

(b) If the attorney is an employee of the division, paid at the rate established by regulations adopted by the division.

Any money collected must be deposited to the uninsured employers' claim fund.

11. In addition to any other liabilities provided for in this section, the administrator may impose an administrative fine of not more than $10,000 against an employer if the employer fails to provide mandatory coverage required by the provisions of chapters 616A to 616D, inclusive, of NRS.

Sec. 22. NRS 616C.235 is hereby amended to read as follows:

616C.235 1. Except as otherwise provided in subsection 2:

(a) When the insurer determines that a claim should be closed before all benefits to which the claimant may be entitled have been paid, the insurer shall send a written notice of its intention to close the claim to the claimant by first-class mail addressed to the last known address of the claimant. The notice must include a statement that if the claimant does not agree with the determination, he has a right to request a resolution of the dispute pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive. A suitable form for requesting a resolution of the dispute must be enclosed with the notice. The closure of a claim is not effective unless notice is given as required by this subsection.

(b) If the insurer does not receive a request for the resolution of the dispute, it may close the claim.

(c) Notwithstanding the provisions of NRS 233B.125, if a hearing is conducted to resolve the dispute, the decision of the hearing officer may be served by first-class mail.

2. If the medical benefits required to be paid for a claim are less than $500, the claim closes automatically if the claimant does not receive medical treatment for the injury for at least 6 months. The claimant may not appeal the closing of such a claim. *The insurer may, not less than 6 months after a claim is closed pursuant to this subsection, destroy the records relating to the claim.*

Sec. 23. NRS 616C.285 is hereby amended to read as follows:

616C.285 1. If an employer requests a hearing concerning the withdrawal of approval pursuant to NRS 616C.280, the administrator shall set a date for a hearing within 20 days after receiving the request, and shall give the employer at least 10 business days' notice of the time and place of the hearing.

2. A record of the hearing must be kept but it need not be transcribed unless it is requested by the employer and he pays the cost of transcription.

3. Within 5 business days after the hearing, the administrator shall either affirm or disaffirm the withdrawal of approval and give the employer written notice thereof by certified mail [.] *or electronic transmission.*

Sec. 24. NRS 616C.295 is hereby amended to read as follows:

616C.295 The chief of the hearings division of the department of administration shall:

1. Prescribe by regulation [the] :

(a) The qualifications and training required before a person may, pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS, serve as a hearing officer. Training for a hearing officer must include [techniques] :

(1) Techniques of mediation [.] ; *and*

(2) Instruction at the National Judicial College in Reno, Nevada, in the administrative procedures and substantive law relating to contested cases for compensation under chapters 616A to 617, inclusive, of NRS, if such instruction is available at the college.

(b) Procedures to ensure that the decisions of hearing officers are consistent with prior decisions issued by hearing officers for similar claims.

2. Provide for the expediting of the hearing of cases that involve the termination or denial of compensation.

Sec. 25. NRS 616C.340 is hereby amended to read as follows:

616C.340 1. The governor shall appoint one or more appeals officers to conduct hearings in contested claims for compensation pursuant to NRS 616C.360. Each appeals officer shall hold office for 2 years from the date of his appointment and until his successor is appointed and has qualified. Each appeals officer is entitled to receive an annual salary in an amount provided by law and is in the unclassified service of the state.

2. Each appeals officer must be an attorney who has been licensed to practice law before all the courts of this state for at least 2 years. Except as otherwise provided in NRS 7.065, an appeals officer shall not engage in the private practice of law.

3. *The chief of the hearings division of the department of administration shall prescribe by regulation:*

(a) The training required before a person may, pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS, serve as an appeals officer. Training for an appeals officer must include instruction at the National Judicial College in Reno, Nevada, in the administrative procedures and substantive law relating to contested cases for compensation under chapters 616A to 617, inclusive, of NRS, if such instruction is available at the college.

(b) Procedures to ensure that the decisions of appeals officers are consistent with prior decisions issued by appeals officers for similar claims.

4. If an appeals officer determines that he has a personal interest or a conflict of interest, directly or indirectly, in any case which is before him, he shall disqualify himself from hearing the case and the governor may appoint a special appeals officer who is vested with the same powers as the regular appeals officer would possess. The special appeals officer is entitled to be paid at an hourly rate, based upon the appeals officer's salary.

[4.] *5.* The decision of an appeals officer is the final and binding administrative determination of a claim for compensation under chapters 616A to 616D, inclusive, or

chapter 617 of NRS, and the whole record consists of all evidence taken at the hearing before the appeals officer and any findings of fact and conclusions of law based thereon.

Sec. 26. NRS 616C.550 is hereby amended to read as follows:

616C.550 1. Except as otherwise provided in this section, if benefits for a temporary total disability will be paid to an injured employee for more than 90 days, a vocational rehabilitation counselor shall, within 30 days after being assigned to the claim, make a written assessment of the injured employee's ability or potential to return to:

(a) The position he held at the time that he was injured; or

(b) Any other gainful employment.

2. Before completing the written assessment, the counselor shall:

(a) Contact the injured employee and:

(1) Identify the injured employee's educational background, work experience and career interests; and

(2) Determine whether the injured employee has any existing marketable skills.

(b) Contact the injured employee's treating physician or chiropractor and determine:

(1) Whether the employee has any temporary or permanent physical limitations;

(2) The estimated duration of the limitations;

(3) Whether there is a plan for continued medical treatment; and

(4) When the employee may return to the position that he held at the time of his injury or to any other position. The treating physician or chiropractor shall determine whether an employee may return to the position that he held at the time of his injury.

3. The written assessment must contain a determination as to whether the employee is eligible for vocational rehabilitation services pursuant to NRS 616C.590. If the insurer, with the assistance of the counselor, determines that the employee is eligible for vocational rehabilitation services, a plan for a program of vocational rehabilitation must be completed pursuant to NRS 616C.555.

4. The division may, by regulation, require a written assessment to include additional information.

5. If an insurer determines that the written assessment required by this section is impractical because of the expected duration of the employee's total temporary disability, the insurer shall:

(a) Complete a written report which specifies his reasons for the decision; and

(b) Review the claim at least once every 60 days.

6. The insurer shall [mail] *deliver* a copy of the written assessment or the report completed pursuant to subsection 5 to the injured employee, his employer, the treating physician or chiropractor and the injured employee's attorney or representative, if applicable.

7. For the purposes of this section, "existing marketable skills" include, but are not limited to:

(a) Completion of:

(1) A program at a trade school;

(2) A program which resulted in an associate's degree; or

(3) A course of study for certification,

if the program or course of study provided the skills and training necessary for the injured employee to be gainfully employed on a reasonably continuous basis in an occupation that is reasonably available in this state.

(b) Completion of a 2-year or 4-year program at a college or university which resulted in a degree.

(c) Completion of any portion of a program for a graduate's degree at a college or university.

(d) Skills acquired in previous employment, including those acquired during an apprenticeship or a program for on-the-job training.

The skills set forth in paragraphs (a) to (d), inclusive, must have been acquired within the preceding 7 years and be compatible with the physical limitations of the injured employee to be considered existing marketable skills.

Sec. 27. NRS 616C.560 is hereby amended to read as follows:

616C.560 1. A program for vocational rehabilitation developed pursuant to subsection 3 of NRS 616C.555 may be extended:

(a) Without condition or limitation, by the insurer at his sole discretion; or

(b) In accordance with this section if:

(1) The injured employee makes a written request to extend the program within 30 days after he receives written notification that he is eligible for vocational rehabilitation services; and

(2) There are exceptional circumstances which make it unlikely that the injured employee will obtain suitable gainful employment as a result of vocational rehabilitation which is limited to the period for which he is eligible.

An insurer's determination to grant or deny an extension pursuant to paragraph (a) may not be appealed.

2. If an injured employee has incurred a permanent physical impairment of less than 11 percent:

(a) The total length of the program, including any extension, must not exceed 1 year.

(b) "Exceptional circumstances" shall be deemed to exist for the purposes of paragraph (b) of subsection 1, if:

(1) The injured employee lacks work experience, training, education or other transferable skills for an occupation which he is physically capable of performing; or

(2) Severe physical restrictions as a result of the industrial injury have been imposed by a physician which significantly limit the employee's occupational opportunities.

3. If an injured employee has incurred a permanent physical impairment of 11 percent or more:

(a) The total length of the program, including any extension, must not exceed 2 years.

(b) "Exceptional circumstances" shall be deemed to exist for the purposes of paragraph (b) of subsection 1, if the injured employee has suffered:

(1) The total and permanent loss of sight of both eyes;

(2) The loss by separation of a leg at or above the knee;

(3) The loss by separation of a hand at or above the wrist;

(4) An injury to the head or spine which results in permanent and complete paralysis of both legs, both arms or a leg and an arm;

(5) An injury to the head which results in a severe cognitive functional impairment which may be established by a nationally recognized form of objective psychological testing;

(6) The loss by separation of an arm at or above the elbow and the loss by separation of a leg at or above the knee;

(7) An injury consisting of second or third degree burns on 50 percent or more of the body, both hands or the face;

(8) A total bilateral loss of hearing;

(9) The total loss or significant and permanent impairment of speech; or

(10) A permanent physical impairment of 50 percent or more determined pursuant to NRS 616C.490, if the severity of the impairment limits the injured employee's gainful employment to vocations that are primarily intellectual and require a longer program of education.

4. The insurer shall [mail] *deliver* a copy of its decision granting or denying an extension to the injured employee and the employer. Except as otherwise provided in this section, the decision shall be deemed to be a final determination of the insurer for the purposes of NRS 616C.315.

Sec. 28. NRS 616C.590 is hereby amended to read as follows:

616C.590 1. Except as otherwise provided in this section, an injured employee is not eligible for vocational rehabilitation services, unless:

(a) The treating physician or chiropractor approves the return of the injured employee to work but imposes permanent restrictions that prevent the injured employee from returning to the position that he held at the time of his injury;

(b) The injured employee's employer does not offer employment that the employee is eligible for considering the restrictions imposed pursuant to paragraph (a); and

(c) The injured employee is unable to return to gainful employment at a gross wage that is equal to or greater than 80 percent of the gross wage that he was earning at the time of his injury.

2. If the treating physician or chiropractor imposes permanent restrictions on the injured employee for the purposes of paragraph (a) of subsection 1, he shall specify in writing:

(a) The medically objective findings upon which his determination is based; and

(b) A detailed description of the restrictions.

The treating physician or chiropractor shall [mail] *deliver* a copy of the findings and the description of the restrictions to the insurer.

3. If there is a question as to whether the restrictions imposed upon the injured employee are permanent, the employee may receive vocational rehabilitation services until a final determination concerning the duration of the restrictions is made.

4. Vocational rehabilitation services must cease as soon as the injured employee is no longer eligible for the services pursuant to subsection 1.

5. An injured employee is not entitled to vocational rehabilitation services solely because the position that he held at the time of his injury is no longer available.

6. An injured employee or his dependents are not entitled to accrue or be paid any money for vocational rehabilitation services during the time the injured employee is incarcerated.

7. Any injured employee eligible for compensation other than accident benefits may not be paid those benefits if he refuses counseling, training or other vocational rehabilitation services offered by the insurer. Except as otherwise provided in NRS

616B.185, an injured employee shall be deemed to have refused counseling, training and other vocational rehabilitation services while he is incarcerated.

8. If an insurer cannot locate an injured employee for whom it has ordered vocational rehabilitation services, the insurer may close his claim 21 days after the insurer determines that the employee cannot be located. The insurer must make a reasonable effort to locate the employee.

9. The reappearance of the injured employee after his claim has been closed does not automatically reinstate his eligibility for vocational rehabilitation benefits. If the employee wishes to reestablish his eligibility for such benefits, he must file a written application with the insurer to reinstate his claim. The insurer shall reinstate the employee's claim if good cause is shown for the employee's absence.

Sec. 29. NRS 616D.200 is hereby amended to read as follows:

616D.200 1. If the manager finds that an employer within the provisions of NRS 616B.633:

(a) Has failed to provide and secure compensation as required by the terms of chapters 616A to 616D, inclusive, of NRS; or

(b) Has provided and secured such compensation but has failed to maintain that compensation,

he shall make a determination thereon and [may] charge the employer an amount of not more than three times the premiums that would otherwise have been owed to the system

pursuant to the terms of chapters 616A to 616D, inclusive, of NRS for the period that the employer was doing business in this state without providing, securing or maintaining that compensation, but not to exceed 6 years.

2. The manager shall [mail] *deliver* a copy of his determination to the employer. An employer who is aggrieved by the manager's determination may appeal from the determination pursuant to subsection 2 of NRS 616D.220.

3. Any employer within the provisions of NRS 616B.633 who fails to provide, secure or maintain compensation as required by the terms of chapters 616A to 616D, inclusive, of NRS, is:

(a) For the first offense, guilty of a gross misdemeanor.

(b) For a second or subsequent offense committed within 7 years after the previous offense, guilty of a felony, punishable by imprisonment in the state prison for a definite term of not less than 1 year nor more than 5 years or by a fine of not more than $10,000, or by both fine and imprisonment. A person who is sentenced to imprisonment becomes eligible for parole when he has served one-third of the definite term for which he has been sentenced, less any credit earned to reduce his sentence pursuant to chapter 209 of NRS.

Any criminal penalty imposed must be in addition to the amount charged pursuant to subsection 1.

Sec. 30. NRS 616D.220 is hereby amended to read as follows:

616D.220 1. If the manager finds that any employer or any employee, officer or agent of any employer has knowingly:

(a) Made a false statement or has knowingly failed to report a material fact concerning the amount of payroll upon which a premium is based; or

(b) Misrepresented the classification or duties of an employee,

he shall make a determination thereon and charge the employer's account an amount equal to three times the amount of the premium due. The manager shall [mail] *deliver* a copy of his determination to the employer.

2. An employer who is aggrieved by the manager's determination may appeal from the determination by filing a request for a hearing. The request must be filed within 30 days after the date on which a copy of the determination was [mailed] *delivered* to the employer. The manager shall hold a hearing within 30 days after he receives the request. The determination of the manager made pursuant to a hearing is a final decision for the purposes of judicial review.

3. A person who knowingly:

(a) Makes a false statement or representation or who knowingly fails to report a material fact concerning the amount of payroll upon which a premium is based; or

(b) Misrepresents the classification or duties of an employee,

is guilty of a gross misdemeanor. Any criminal penalty imposed must be in addition to the amount charged pursuant to subsection 1.

Sec. 31. NRS 616D.440 is hereby amended to read as follows:

616D.440 1. An insurer may withhold any payment due a provider of health care pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, in whole or in part, upon receipt of reliable evidence that the provider of health care knowingly made a false statement or representation or knowingly concealed a material fact to obtain the payment. The insurer may withhold such a payment without first notifying the provider of health care of its intention to do so.

2. The insurer shall, within 5 days after withholding such a payment, send notice of the withholding to the provider of health care by certified mail [.] *or electronic transmission.* The notice must:

(a) Set forth the factual basis for the withholding, but need not disclose specific information regarding the insurer's investigation;

(b) Indicate that the payment is being withheld pursuant to the provisions of this section;

(c) Indicate that the payment is being withheld temporarily, as set forth in subsection 4, and describe the circumstances under which the withholding will be terminated;

(d) Specify the charge submitted by the provider of health care for which the payment is being withheld; and

(e) Notify the provider of health care of his right to appeal the withholding.

3. A provider of health care may appeal the decision of the insurer to withhold payment to an appeals officer pursuant to NRS 616C.360.

4. Any payment withheld pursuant to the provisions of this section must be made to the provider of health care if:

(a) The insurer or the attorney general determines that there is insufficient evidence to prove that the provider of health care knowingly made a false statement or representation or knowingly concealed a material fact to obtain the payment; or

(b) A final judgment or decree was rendered in favor of the provider of health care in a criminal proceeding arising out of the alleged misconduct.

Sec. 32. NRS 617.344 is hereby amended to read as follows:

617.344 1. Except as otherwise provided in subsection 2, an employee who has incurred an occupational disease [,] *and wishes to recover compensation pursuant to the provisions of this chapter,* or a person acting on his behalf, shall , *at the time of the employee's first medical examination for his occupational disease,* file a claim for compensation with the [insurer] *physician or chiropractor who conducts the examination. The employee must submit to a medical examination for that disease and file a claim for compensation* within 90 days after the employee has knowledge of the disability and its relationship to his employment.

2. In the event of the death of the employee resulting from the occupational disease, a dependent of the employee, or a person acting on his behalf, shall file a claim for compensation with the insurer within 1 year after the death of the employee.

3. The claim for compensation must be filed on a form prescribed by the administrator. *The form must include a provision which, if signed by the employee, authorizes the release of any medical or other information related to the claim to the insurer, the administrator, the employee's employer and any provider of health care who provides treatment to the employee.*

Sec. 33. NRS 617.346 is hereby amended to read as follows:

617.346 1. Except as otherwise provided in subsection 2, an employee or, in the event of the death of [the employee, his dependent,] *an employee, a dependent, who does not file a notice of an occupational disease pursuant to NRS 617.342 and a claim for compensation pursuant to 617.344* is barred from recovering compensation pursuant to the provisions of this chapter. [if he fails to file a notice of an occupational disease pursuant to NRS 617.342 or a claim for compensation pursuant to NRS 617.344.]

2. An insurer may excuse the failure to file a notice of an occupational disease or claim for compensation pursuant to the provisions of this section if:

(a) The employee's disease or another cause beyond his control prevented him from providing the notice or the claim;

(b) The failure was caused by the employee's or dependent's mistake or ignorance of fact or of law;

(c) The failure was caused by the physical or mental inability of the employee or the dependent; or

(d) The failure was caused by fraud, misrepresentation or deceit.

Sec. 34. NRS 617.352 is hereby amended to read as follows:

617.352 1. A treating physician or chiropractor shall, within 3 working days after he first [treats] *examines* an employee who has incurred an occupational disease, complete and [mail to] *file with* the employer of the employee and [to] the employer's insurer, [a] *the* claim for compensation [.] *filed with the physician or chiropractor by the employee pursuant to NRS 617.344.* If the employer is a self-insured employer, the treating physician or chiropractor shall [mail] *file* the claim for compensation [to] *with* the employer's third-party administrator. *If the physician or chiropractor files the claim for compensation by electronic transmission, he shall, upon request, mail to the insurer or third-party administrator the form that contains the original signatures of the employee and the physician or chiropractor. The form must be mailed within 7 days after receiving such a request.*

2. [A claim for compensation required by subsection 1 must be on a form prescribed by the administrator.

3.] If a claim for compensation is accompanied by a certificate of disability, the certificate must include a description of any limitation or restrictions on the employee's ability to work.

[4.] *3.* Each physician, chiropractor and medical facility that treats employees who have incurred occupational diseases, each insurer, third-party administrator and employer, and the division shall maintain at their offices a sufficient supply of the forms prescribed by the administrator for filing a claim for compensation.

[5.] *4.* The administrator shall impose an administrative fine of not more than $1,000 against a physician or chiropractor for each violation of subsection 1.

Sec. 35. NRS 617.354 is hereby amended to read as follows:

617.354 1. Within 6 working days after the receipt of a claim for compensation from a physician or chiropractor, an employer shall complete and [mail to] *file with* his insurer or third-party administrator an employer's report of industrial injury or occupational disease.

2. The report must:

(a) Be on a form prescribed by the administrator;

(b) Be signed by the employer or his designee;

(c) Contain specific answers to all questions required by the regulations of the department; and

(d) Be accompanied by a statement of the wages of the employee if the claim for compensation received from the treating physician or chiropractor indicates that the employee is expected to be off work for 5 days or more.

3. An employee of the system shall not complete the report required by subsection 1 or any other form relating to the occupational disease on behalf of the employer unless the employer:

(a) Is not in business;

(b) Has not been located by the system within 5 working days after receipt of a claim for compensation; or

(c) Refuses to complete the report.

4. *An employer who files the report required by subsection 1 by electronic transmission shall, upon request, mail to the insurer or third-party administrator the form that contains the original signature of the employer or his designee. The form must be mailed within 7 days after receiving such a request.*

5. The administrator shall impose an administrative fine of not more than $1,000 against an employer for each violation of this section.

Sec. 36. NRS 617.356 is hereby amended to read as follows:

617.356 An insurer shall accept or deny responsibility for compensation under this chapter within 30 working days after [claims] *a claim* for compensation [are] *is* received pursuant to [both NRS 617.344 and] *NRS* 617.352.

Sec. 37. NRS 617.358 is hereby amended to read as follows:

617.358 1. An employee or his dependents are not entitled to receive compensation pursuant to the provisions of this chapter unless [the] :

(a) The employee submits to a medical examination for an occupational disease that arose out of and in the course of his employment within 90 days after the employee has knowledge of the disability and its relationship to his employment; and

(b) The employee or his dependents establish by a preponderance of the evidence that the employee's occupational disease arose out of and in the course of his employment.

2. If the employee files a notice of an occupational disease pursuant to NRS 617.342 after his employment has been terminated for any reason, there is a rebuttable presumption that the occupational disease did not arise out of and in the course of his employment.

Sec. 38. NRS 617.401 is hereby amended to read as follows:

617.401 1. An employee may receive compensation from the uninsured employers' claim fund if:

(a) He was hired in this state or he is regularly employed in this state;

(b) He contracts an occupational disease as a result of work performed in this state;

(c) [He files a] *His* claim for compensation *is filed* with the system pursuant to NRS [617.344;] *617.352;*

(d) He files a written notice with the division; and

(e) He makes an irrevocable assignment to the division of a right to be subrogated to the rights of the employee pursuant to NRS 616C.215.

2. If the system receives a claim pursuant to subsection 1, the system shall immediately:

(a) Notify the employer of the claim;

(b) Deliver to the claimant any forms necessary to make a claim pursuant to this section; and

(c) Notify the division of the claim by sending a copy of the claim, any evidence regarding the claim and any evidence indicating that the employer was uninsured.

3. For the purposes of this section, the employer has the burden of proving that he provided mandatory coverage for occupational diseases for the employee or that he was not required to maintain industrial insurance for the employee.

4. Any employer who has failed to provide mandatory coverage required by the provisions of this chapter is liable for all payments made on his behalf, including, but not limited to, any benefits, administrative costs or attorney's fees paid from the uninsured employers' claim fund or incurred by the division.

5. The division:

(a) May recover from the employer the payments made by the division that are described in subsection 4 and any accrued interest by bringing a civil action in district court.

(b) In any civil action brought against the employer, is not required to prove that negligent conduct by the employer was the cause of the occupational disease.

(c) May enter into a contract with any person to assist in the collection of any liability of an uninsured employer.

(d) In lieu of a civil action, may enter into an agreement or settlement regarding the collection of any liability of an uninsured employer.

6. The division shall:

(a) Determine whether the employer was insured within 30 days after receiving notice of the claim from the employee.

(b) Assign the claim to the system for administration of the claim, payment of benefits and reimbursement of costs of administration and benefits paid to the system.

Upon determining that a claim is invalid, the system shall notify the claimant, the named employer and the division that the claim will not be assigned for benefits from the uninsured employers' claim fund.

7. Any party aggrieved by a decision regarding the administration of an assigned claim or a decision made by the division or by the system regarding any claim made pursuant to this section may appeal that decision within 60 days after the decision is rendered to the hearings division of the department of administration in the manner provided by NRS 616C.305 and 616C.315 to 616C.385, inclusive.

8. All insurers shall bear a proportionate amount of a claim made pursuant to this chapter, and are entitled to a proportionate amount of any collection made pursuant to this section as an offset against future liabilities.

9. An uninsured employer is liable for the interest on any amount paid on his claims from the uninsured employers' claim fund. The interest must be calculated at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date of the claim, plus 3 percent, compounded monthly, from the date the claim is paid from the fund until payment is received by the division from the employer.

10. Attorney's fees recoverable by the division pursuant to this section must be:

(a) If a private attorney is retained by the division, paid at the usual and customary rate for that attorney.

(b) If the attorney is an employee of the division, paid at the rate established by regulations adopted by the division.

Any money collected must be deposited to the uninsured employers' claim fund.

11. In addition to any other liabilities provided for in this section, the administrator may impose an administrative fine of not more than $10,000 against an employer if the employer fails to provide mandatory coverage required by the provisions of this chapter.

Sec. 39. Section 1 of chapter 580, Statutes of Nevada 1995, at page 1997, is hereby amended to read as follows:

Section 1. NRS 612.265 is hereby amended to read as follows:

612.265 1. Except as otherwise provided in this section, information obtained from any employing unit or person pursuant to the administration of this chapter and any determination as to the benefit rights of any person is confidential and may not be disclosed or be open to public inspection in any manner which would reveal the person's or employing unit's identity.

2. Any claimant or his legal representative is entitled to information from the records of the division, to the extent necessary for the proper presentation of his claim in any proceeding pursuant to this chapter. A claimant or an employing unit is not entitled to information from the records of the division for any other purpose.

3. Subject to such restrictions as the administrator may by regulation prescribe, the information obtained by the division may be made available to:

(a) Any agency of this or any other state or any federal agency charged with the administration or enforcement of [an] *laws relating to* unemployment compensation, [law,] public assistance [law, workman's], *workers'* compensation or labor [law,] *and industrial relations,* or the maintenance of a system of public employment offices;

(b) Any state or local agency for the enforcement of child support;

(c) The Internal Revenue Service of the Department of the Treasury;

(d) The department of taxation; and

(e) The state contractors' board in the performance of its duties to enforce the provisions of chapter 624 of NRS.

Information obtained in connection with the administration of the employment service may be made available to persons or agencies for purposes appropriate to the operation of a public employment service or a public assistance program.

4. Upon written request made by a public officer of a local government, the administrator shall furnish from the records of the division the name, address and place of employment of any person listed in the records of employment of the division. The request must set forth the social security number of the person about whom the request is made and contain a statement signed by proper authority of the local government certifying that the request is made to allow the proper authority to enforce a law to recover a debt or obligation owed to the local government. The information obtained by the local government is confidential and may not be used or disclosed for any purpose other than the collection of a debt or obligation owed to that local government. The administrator may charge a reasonable fee for the cost of providing the requested information.

5. The administrator may publish or otherwise provide information on the names of employers, their addresses, their type or class of business or industry, and the approximate number of employees employed by each such employer, if

the information released will assist unemployed persons to obtain employment or will be generally useful in developing and diversifying the economic interests of this state. Upon request by a state agency which is able to demonstrate that its intended use of the information will benefit the residents of this state, the administrator may, in addition to the information listed in this subsection, disclose the number of employees employed by each employer and the total wages paid by each employer. The administrator may charge a fee to cover the actual costs of any administrative expenses relating to the disclosure of this information to a state agency. The administrator may require the state agency to certify in writing that the agency will take all actions necessary to maintain the confidentiality of the information and prevent its unauthorized disclosure.

6. Upon request therefor the administrator shall furnish to any agency of the United States charged with the administration of public works or assistance through public employment, and may furnish to any state agency similarly charged, the name, address, ordinary occupation and employment status of each recipient of benefits and the recipient's rights to further benefits pursuant to this chapter.

7. To further a current criminal investigation, the chief executive officer of any law enforcement agency of this state may submit a written request to the administrator that he furnish, from the records of the division, the name, address

and place of employment of any person listed in the records of employment of the division. The request must set forth the social security number of the person about whom the request is made and contain a statement signed by the chief executive officer certifying that the request is made to further a criminal investigation currently being conducted by the agency. Upon receipt of such a request, the administrator shall furnish the information requested. He may charge a fee to cover the actual costs of any related administrative expenses.

8. In addition to the provisions of subsection 5, the administrator shall provide lists containing the names and addresses of employers, the number of employees employed by each employer and the total wages paid by each employer to the department of taxation, upon request, for use in verifying returns for the business tax. The administrator may charge a fee to cover the actual costs of any related administrative expenses.

9. Each insurer shall submit to the administrator a list containing the name of each person who received benefits pursuant to chapters 616A to 616D, inclusive, or 617 of NRS during the preceding month and request that the administrator compare the information so provided with the records of the division regarding persons claiming benefits pursuant to chapter 612 of NRS for the same period. The information submitted by an insurer must be in a form determined by the administrator and must contain the social security number of each such person.

Upon receipt of [such a] *the* request, the administrator shall make such a comparison and [provide to the insurer a list containing the name, address and social security number of each person who appears,] , *if it appears* from the information submitted [, to be] *that a person is* simultaneously claiming benefits under chapter 612 of NRS and under chapters 616A to 616D, inclusive, or 617 of NRS [.] , *the administrator shall notify the attorney general or any other appropriate law enforcement agency.* Upon receipt of a request therefor, the administrator shall provide to the insurer a copy of the form used by any person whose name appears on the list to claim benefits under chapter 612 of NRS. The administrator shall charge a fee to cover the actual costs of any related administrative expenses. The insurer shall use the information obtained pursuant to this subsection only to further a current investigation. The insurer shall not disclose the information for any other purpose. As used in this subsection, "insurer" has the meaning ascribed to it in NRS 616A.270.

10. The administrator may request the Comptroller of the Currency of the United States to cause an examination of the correctness of any return or report of any national banking association rendered pursuant to the provisions of this chapter, and may in connection with the request transmit any such report or return to the Comptroller of the Currency of the United States as provided in Section 3305(c) of the Internal Revenue Code of 1954.

11. If any employee or member of the board of review or the administrator or any employee of the administrator, in violation of the provisions of this section, discloses information obtained from any employing unit or person in the administration of this chapter, or if any person who has obtained a list of applicants for work, or of claimants or recipients of benefits pursuant to this chapter uses or permits the use of the list for any political purpose, he is guilty of a gross misdemeanor.

12. All letters, reports or communications of any kind, oral or written, from the employer or employee to each other or to the division or any of its agents, representatives or employees are privileged and must not be the subject matter or basis for any lawsuit if the letter, report or communication is written, sent, delivered or prepared pursuant to the requirements of this chapter.

Sec. 40. Section 54 of chapter 580, Statutes of Nevada 1995, at page 2011, is hereby amended to read as follows:

Sec. 54. NRS 616B.012 is hereby amended to read as follows:

616B.012 1. Except as otherwise provided in this section and in NRS 616B.015, 616B.021 and 616C.205, information obtained from any insurer, employer or employee is confidential and may not be disclosed or be open to public inspection in any manner which would reveal the person's identity.

2. Any claimant or his legal representative is entitled to information from the records of the insurer, to the extent necessary for the proper presentation of a claim in any proceeding under chapters 616A to 616D, inclusive, of NRS.

3. An insurer, the administrator, an employer or a provider of health care is entitled to any medical or other information released by an injured employee pursuant to subsection 3 of NRS 616C.020 and subsection 3 of NRS 617.344.

4. The division and administrator are entitled to information from the records of the insurer which is necessary for the performance of their duties. The [manager] *administrator* may, by regulation, prescribe the manner in which otherwise confidential information may be made available to:

(a) Any agency of this or any other state charged with the administration or enforcement of laws relating to industrial insurance, unemployment compensation, public assistance or labor and industrial relations;

(b) Any state or local agency for the enforcement of child support;

(c) The Internal Revenue Service of the Department of the Treasury;

(d) The department of taxation; and

(e) The state contractors' board in the performance of its duties to enforce the provisions of chapter 624 of NRS.

Information obtained in connection with the administration of a program of industrial insurance may be made available to persons or agencies for purposes appropriate to the operation of a program of industrial insurance.

5. Upon written request made by a public officer of a local government, the manager shall furnish from the records of the insurer, the name, address and place of employment of any person listed in the records of the insurer. The request must set forth the social security number of the person about whom the request is made and contain a statement signed by proper authority of the local government certifying that the request is made to allow the proper authority to enforce a law to recover a debt or obligation owed to the local government. The information obtained by the local government is confidential and may not be used or disclosed for any purpose other than the collection of a debt or obligation owed to that local government. The manager may charge a reasonable fee for the cost of providing the requested information.

6. To further a current criminal investigation, the chief executive officer of any law enforcement agency of this state may submit a written request to the [manager] *administrator* that he furnish from the records of the insurer, the name, address and place of employment of any person listed in the records of the insurer. The request must set forth the social security number of the person about whom the request is made and contain a statement signed by the chief executive officer

certifying that the request is made to further a criminal investigation currently being conducted by the agency. Upon receipt of a request, the [manager] *administrator* shall furnish the information requested. He may charge a reasonable fee to cover any related administrative expenses.

7. The [manager] *administrator* shall provide lists containing the names and addresses of employers, the number of employees employed by each employer and the total wages paid by each employer to the department of taxation, upon request, for its use in verifying returns for the business tax. The [manager] *administrator* may charge a reasonable fee to cover any related administrative expenses.

8. If the [manager or] *administrator,* any employee of the [manager,] *division or the commissioner* in violation of this section, discloses information obtained from files of claimants or policyholders, or if any person who has obtained a list of claimants or policyholders under chapters 616A to 616D, inclusive, of NRS uses or permits the use of the list for any political purposes, he is guilty of a gross misdemeanor.

9. All letters, reports or communications of any kind, oral or written, from the insurer, or any of its agents, representatives or employees are privileged and must not be the subject matter or basis for any lawsuit if the letter, report or

communication is written, sent, delivered or prepared pursuant to the requirements of chapters 616A to 616D, inclusive, of NRS.

Sec. 41. Section 55 of chapter 580, Statutes of Nevada 1995, at page 2012, is hereby amended to read as follows:

Sec. 55. NRS 616B.018 is hereby amended to read as follows:

616B.018 1. The administrator shall establish a method of indexing claims for compensation that will make information concerning the claimants of one insurer available to other insurers.

2. Every [self-insured employer, association of self-insured public or private employers and the system] *insurer* shall provide information as required by the administrator for establishing and maintaining the index of claims.

3. If an employee files a claim for compensation, or if a claim for compensation is filed on behalf of an employee, the insurer is entitled to receive from the administrator a list of the prior claims of the employee. If the insurer desires to inspect the files of another insurer that are related to one or more of the prior claims, he must provide the other insurer with a copy of the claim for compensation filed by or on behalf of the employee.

4. Any information obtained from the index of claims must be admitted into evidence in any hearing before an appeals officer, a hearing officer or the administrator.

5. The division may assess and collect a reasonable fee for its services provided pursuant to this section. The fee must be payable monthly or at such other intervals as determined by the administrator.

Sec. 42. Section 56 of chapter 580, Statutes of Nevada 1995, at page 2012, is hereby amended to read as follows:

Sec. 56. NRS 616B.021 is hereby amended to read as follows:

616B.021 1. An insurer shall provide access to the files of claims in its offices.

2. A file is available for inspection during regular business hours by the employee or his designated agent, the employer or his designated agent and the administrator or his designated agent.

3. Upon request, the insurer shall make copies of anything in the file and may charge a reasonable fee for this service. Copies of materials in the file which are requested by the administrator or his designated agent, or the Nevada attorney for injured workers or his designated agent must be provided free of charge.

4. Except as otherwise provided in NRS 616C.235, if a claim has been closed for at least 1 year, the insurer may microphotograph or film any of its records relating to that claim. The microphotographs or films must be placed in convenient and accessible files . [, and provision must be made for preserving, examining and using the records.

5. This section does not require the]

5. The administrator shall adopt regulations concerning the:

(a) Maintenance of records in a file on current or closed claims;

(b) Preservation, examination and use of records which have been microphotographed or filmed by an insurer; and

(c) Location of a file on a closed claim.

6. This section does not require an insurer to allow inspection or reproduction of material regarding which a legal privilege against disclosure has been conferred.

Sec. 43. Section 104 of chapter 580, Statutes of Nevada 1995, at page 2032, is hereby amended to read as follows:

Sec. 104. NRS 616D.200 is hereby amended to read as follows:

616D.200 1. If the [manager] *administrator* finds that an employer within the provisions of NRS 616B.633:

(a) Has failed to provide and secure compensation as required by the terms of chapters 616A to 616D, inclusive, of NRS; or

(b) Has provided and secured such compensation but has failed to maintain that compensation,

he shall make a determination thereon *based on any information that is within his possession or that may come within his possession* and charge the employer an

amount of not more than three times the premiums that would otherwise have been owed to the system *if he had been insured by the system* pursuant to the terms of chapters 616A to 616D, inclusive, of NRS for the period that the employer was doing business in this state without providing, securing or maintaining that compensation, but not to exceed 6 years. *Any money collected by the administrator pursuant to this subsection must be deposited into the uninsured employers' claim fund.*

2. [The manager shall deliver a copy of his determination to the employer.] *If the manager is not satisfied with the amount of a premium required to be paid to the system by any person, he may compute and determine the amount required to be paid on the basis of any information within his possession or which may come into his possession. One or more determinations of a deficiency may be made of the amount due for one or more periods.*

3. Except for a determination made pursuant to subsection 1, a notice of a determination of a deficiency issued by the manager must be served personally or mailed within 3 years after the last day of the calendar month following the period for which the amount that is proposed to be determined is due. An employer who is aggrieved by [the manager's] *a* determination *made pursuant to this section or NRS 360.300* may appeal from the determination pursuant to subsection 2 of NRS 616D.220.

[3.] *4.* Any employer within the provisions of NRS 616B.633 who fails to provide, secure or maintain compensation as required by the terms of chapters 616A to 616D, inclusive, of NRS, is:

(a) For the first offense, guilty of a gross misdemeanor.

(b) For a second or subsequent offense committed within 7 years after the previous offense, guilty of a felony, punishable by imprisonment in the state prison for a definite term of not less than 1 year nor more than 5 years or by a fine of not more than $10,000, or by both fine and imprisonment. A person who is sentenced to imprisonment becomes eligible for parole when he has served one-third of the definite term for which he has been sentenced, less any credit earned to reduce his sentence pursuant to chapter 209 of NRS.

Any criminal penalty imposed must be in addition to the amount charged pursuant to subsection 1.

Sec. 44. Section 106 of chapter 580, Statutes of Nevada 1995, at page 2033, is hereby amended to read as follows:

Sec. 106. NRS 616D.220 is hereby amended to read as follows:

616D.220 1. If the [manager] *administrator* finds that any employer or any employee, officer or agent of any employer has knowingly:

(a) Made a false statement or has knowingly failed to report a material fact concerning the amount of payroll upon which a premium is based; or

(b) Misrepresented the classification or duties of an employee,

he shall make a determination thereon and charge the employer's account an amount equal to three times the amount of the premium due. The [manager] *administrator* shall deliver a copy of his determination to the employer.

2. An employer who is aggrieved by the [manager's] *administrator's* determination may appeal from the determination by filing a request for a hearing. The request must be filed within 30 days after the date on which a copy of the determination was delivered to the employer. The [manager] *administrator* shall hold a hearing within 30 days after he receives the request. The [determination] *decision* of the [manager] *administrator* made pursuant to a hearing is a final decision for the purposes of judicial review. *The amount of the determination as finally decided by the administrator becomes due within 30 days after the decision is served on the employer.*

3. A person who knowingly:

(a) Makes a false statement or representation or who knowingly fails to report a material fact concerning the amount of payroll upon which a premium is based; or

(b) Misrepresents the classification or duties of an employee,

is guilty of a gross misdemeanor. Any criminal penalty imposed must be in addition to the amount charged pursuant to subsection 1.

Sec. 45. The amendatory provisions of sections 20 and 37 of this act must not be applied to reduce the amount of compensation and benefits of an employee who is receiving compensation and benefits for an industrial injury or an occupational disease before October 1, 1997, or to reduce the amount of the compensation and benefits of the dependents of such an employee.

Sec. 46. 1. This section and sections 1 to 9, inclusive, 11, 12 and 14 to 45, inclusive, of this act become effective on October 1, 1997.

2. Sections 10 and 13 of this act become effective at 12:01 a.m. on July 1, 1999.

SUMMARY—Makes various changes to provisions governing eligibility for and payment of benefits for workers' compensation. (BDR 53-953)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to industrial insurance; expanding the circumstances under which an employee and his dependents are barred from recovering compensation; requiring an employee with a permanent partial disability to select his rating physician; expanding the circumstances under which an employee's use of a controlled substance is presumed to be the proximate cause of his injury; prohibiting a physician or chiropractor from issuing a certification of disability for any period preceding the date of an injured employee's examination; revising the standard for determining fees and charges for accident benefits; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616C of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *An employee or, in the event of the death of the employee, his dependent, is barred from recovering compensation pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS if the employee misrepresented or falsified any document or information submitted to his employer as evidence that he has been lawfully admitted for residency in the United States.*

Sec. 3. *An employee or, in the event of the death of the employee, his dependent, is barred from recovering compensation pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS if, in violation of a written policy of his employer, the employee was discharged from the employment out of which his injury arose for:*

1. Refusing to submit to a test conducted for the purpose of determining the presence of a controlled substance in his system; or

2. Testing positive after submitting to such a test.

Sec. 4. NRS 616C.060 is hereby amended to read as follows:

616C.060 [An] *Except as otherwise provided in NRS 616C.490, an* insurer shall accept or deny responsibility for compensation under chapters 616A to 616D, inclusive, of NRS within 30 working days after claims for compensation are received pursuant to both NRS 616C.020 and 616C.040.

Sec. 5. NRS 616C.065 is hereby amended to read as follows:

616C.065 1. [Within] *Except as otherwise provided in NRS 616C.490, within* 30 *working* days after [the] *an* insurer has been notified of an industrial accident [, every] *and has received a claim for compensation pursuant to NRS 616C.040, the* insurer shall:

(a) Commence payment of a claim for compensation; or

(b) Deny the claim and notify the claimant and administrator that the claim has been denied.

Payments made by an insurer pursuant to this section are not an admission of liability for the claim or any portion of the claim.

2. If an insurer unreasonably delays or refuses to pay the claim within [30 days after the insurer has been notified of an industrial accident,] *the time set forth in subsection 1,* the insurer shall pay upon order of the administrator an additional amount equal to three times the amount specified in the order as refused or unreasonably delayed. This payment is for the benefit of the claimant and must be paid to him with the compensation assessed pursuant to chapters 616A to 617, inclusive, of NRS.

Sec. 6. NRS 616C.100 is hereby amended to read as follows:

616C.100 1. If an injured employee disagrees with the percentage of disability determined by a physician or chiropractor, the injured employee may obtain a second determination of the percentage of disability. [If] *Except as otherwise provided in this subsection, if* the employee wishes to obtain such a determination, he must select the next physician or chiropractor in rotation from the list of qualified physicians or chiropractors

maintained by the administrator pursuant to subsection 2 of NRS 616C.490. *If the next physician or chiropractor in rotation from the list has entered into a contract with the insurer to provide medical and health care services to employees with industrial injuries or occupational diseases, the injured employee may select the next physician or chiropractor in rotation from the list of qualified physicians or chiropractors who has not entered into such a contract with the insurer, according to the area of specialization required.* If a second determination is obtained, the injured employee shall pay for the determination.

2. The results of a second determination made pursuant to subsection 1 may be offered at any hearing or settlement conference.

Sec. 7. NRS 616C.230 is hereby amended to read as follows:

616C.230 1. Compensation is not payable pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS for an injury:

(a) Caused by the employee's willful intention to injure himself.

(b) Caused by the employee's willful intention to injure another.

(c) Proximately caused by the employee's intoxication. If the employee was intoxicated at the time of his injury, intoxication must be presumed to be a proximate cause unless rebutted by evidence to the contrary.

(d) Proximately caused by the employee's use of a controlled substance. [If the employee had] *The use of a controlled substance must be presumed to be a proximate cause of an injury if the employee:*

(1) Refuses to submit to a test conducted for the purpose of determining the presence of a controlled substance in his system at the time of his injury; or

(2) Had any amount of a controlled substance in his system at the time of his injury for which the employee did not have a current and lawful prescription issued in his name, [the controlled substance must be presumed to be a proximate cause] unless *the presumption is* rebutted by evidence to the contrary.

For the purposes of paragraphs (c) and (d), the affidavit of an expert or other person described in NRS 50.315 is admissible to prove the existence of any alcohol or the existence, quantity or identity of a controlled substance in an employee's system. If the affidavit is to be so used, it must be submitted in the manner prescribed in NRS 616C.355.

2. No compensation is payable for the death, disability or treatment of an employee if his death is caused by, or insofar as his disability is aggravated, caused or continued by, an unreasonable refusal or neglect to submit to or to follow any competent and reasonable surgical treatment or medical aid.

3. If any employee persists in an unsanitary or injurious practice that imperils or retards his recovery, or refuses to submit to such medical or surgical treatment as is necessary to promote his recovery, his compensation may be reduced or suspended.

4. An injured employee's compensation, other than accident benefits, must be suspended if:

(a) A physician or chiropractor determines that the employee is unable to undergo treatment, testing or examination for the industrial injury solely because of a condition or injury that did not arise out of and in the course of his employment; and

(b) It is within the ability of the employee to correct the nonindustrial condition or injury.

The compensation must be suspended until the injured employee is able to resume treatment, testing or examination for the industrial injury. The insurer may elect to pay for the treatment of the nonindustrial condition or injury.

Sec. 8. NRS 616C.260 is hereby amended to read as follows:

616C.260 1. All fees and charges for accident benefits must not [:

(a) Exceed] *be:*

(a) Less than the fees and charges [usually paid in the state for similar treatment.

(b) Be unfairly] *established by the administrator pursuant to subsection 2.*

(b) Unfairly discriminatory as between persons legally qualified to provide the particular service for which the fees or charges are asked.

2. The administrator shall, giving consideration to the fees and charges being paid in the state, establish a schedule of [reasonable] *the lowest* fees and charges allowable for accident benefits provided to injured employees whose insurers have not contracted with an organization for managed care pursuant to NRS 616B.515. *The lowest fees and charges allowable must be equal to 50 percent of the fees and charges usually paid in the state for*

similar treatment. The administrator shall review and revise the schedule on or before October 1 of each year. The administrator may increase or decrease the schedule, but shall not increase the schedule by any factor greater than the corresponding annual increase in the Consumer Price Index (Medical Care Component), unless the advisory council of the division approves such an increase.

3. The administrator may request a health insurer, health maintenance organization or provider of accident benefits, an agent or employee of such a person, or an agency of the state, to provide the administrator with such information concerning fees and charges paid for similar services as he deems necessary to carry out the provisions of subsection 2. The administrator shall require a person or entity providing records or reports of fees charged to provide interpretation and identification concerning the information delivered. The administrator may impose an administrative fine of $500 for each refusal to provide the information requested pursuant to this subsection.

4. The division may adopt reasonable regulations necessary to carry out the provisions of this section. The regulations must include provisions concerning:

(a) Standards for the development of the schedule of fees and charges;

(b) The periodic revision of the schedule; and

(c) The monitoring of compliance by providers of benefits with the adopted schedule of fees and charges.

5. The division shall adopt regulations requiring the utilization of a system of billing codes as recommended by the American Medical Association.

Sec. 9. NRS 616C.330 is hereby amended to read as follows:

616C.330 1. The hearing officer shall:

(a) Within 5 days after receiving a request for a hearing, set the hearing for a date and time within 30 days after his receipt of the request;

(b) Give notice by mail or by personal service to all interested parties to the hearing at least 15 days before the date and time scheduled; and

(c) Conduct hearings expeditiously and informally.

2. The notice must include a statement that the injured employee may be represented by a private attorney or seek assistance and advice from the Nevada attorney for injured workers.

3. [If] *Except as otherwise provided in this subsection, if* necessary to resolve a medical question concerning an injured employee's condition, the hearing officer may refer the employee to a physician or chiropractor chosen by the hearing officer. If the medical question concerns the rating of a permanent disability, the hearing officer may [refer] *require* the employee to *select* a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians and chiropractors maintained by the administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and injured employee otherwise agree to a rating physician or

chiropractor [.] *or the next physician or chiropractor in rotation from the list has entered into a contract with the insurer to provide medical and health care services to employees with industrial injuries and occupational diseases. If the next physician or chiropractor in rotation from the list has entered into such a contract with the insurer, the injured employee may select the next physician or chiropractor in rotation from the list of qualified physicians or chiropractors who has not entered into such a contract, according to the area of specialization required.* The insurer shall pay the costs of any medical examination requested by the hearing officer.

4. The hearing officer may allow or forbid the presence of a court reporter and the use of a tape recorder in a hearing.

5. The hearing officer shall render his decision within 15 days after:

(a) The hearing; or

(b) He receives a copy of the report from the medical examination he requested.

6. The hearing officer shall render his decision in the most efficient format developed by the chief of the hearings division of the department of administration.

7. The hearing officer shall give notice of his decision to each party by mail. He shall include with the notice of his decision the necessary forms for appealing from the decision.

8. Except as otherwise provided in NRS 616C.380, the decision of the hearing officer is not stayed if an appeal from that decision is taken unless an application for a stay is submitted by a party. If such an application is submitted, the decision is automatically

stayed until a determination is made on the application. A determination on the application must be made within 30 days after the filing of the application. If, after reviewing the application, a stay is not granted by the hearing officer or an appeals officer, the decision must be complied with within 10 days after the refusal to grant a stay.

Sec. 10. NRS 616C.360 is hereby amended to read as follows:

616C.360 1. A stenographic or electronic record must be kept of the hearing before the appeals officer and the rules of evidence applicable to contested cases under chapter 233B of NRS apply to the hearing.

2. The appeals officer must hear any matter raised before him on its merits, including new evidence bearing on the matter.

3. [If] *Except as otherwise provided in this subsection, if* necessary to resolve a medical question concerning an injured employee's condition, the appeals officer may refer the employee to a physician or chiropractor chosen by the appeals officer. If the medical question concerns the rating of a permanent disability, the appeals officer may [refer] *require* the employee to *select* a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians or chiropractors maintained by the administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor [.] *or the next physician or chiropractor in rotation from the list has entered into a contract with the insurer to provide medical and health care services to employees*

with industrial injuries or occupational diseases. If the next physician or chiropractor in rotation from the list has entered into such a contract with the insurer, the injured employee may select the next physician or chiropractor in rotation from the list of qualified physicians or chiropractors who has not entered into such a contract, according to the area of specialization required. The insurer shall pay the costs of any examination requested by the appeals officer.

4. Any party to the appeal or the appeals officer may order a transcript of the record of the hearing at any time before the seventh day after the hearing. The transcript must be filed within 30 days after the date of the order unless the appeals officer otherwise orders.

5. The appeals officer shall render his decision:

(a) If a transcript is ordered within 7 days after the hearing, within 30 days after the transcript is filed; or

(b) If a transcript has not been ordered, within 30 days after the date of the hearing.

6. The appeals officer may affirm, modify or reverse any decision made by the hearing officer and issue any necessary and proper order to give effect to his decision.

Sec. 11. NRS 616C.475 is hereby amended to read as follows:

616C.475 1. Except as otherwise provided in this section, NRS 616C.175 and 616C.390, every employee in the employ of an employer, within the provisions of chapters 616A to 616D, inclusive, of NRS, who is injured by accident arising out of and in the

course of employment, or his dependents, is entitled to receive for the period of temporary total disability, 66 2/3 percent of the average monthly wage.

2. Except as otherwise provided in NRS 616B.185, an injured employee or his dependents are not entitled to accrue or be paid any benefits for a temporary total disability during the time the injured employee is incarcerated. The injured employee or his dependents are entitled to receive such benefits when the injured employee is released from incarceration if he is certified as temporarily totally disabled by a physician or chiropractor.

3. If a claim for the period of temporary total disability is allowed, the first payment pursuant to this section must be issued by the insurer within [14] *30* working days after receipt of the initial certification of disability and regularly thereafter.

4. Any increase in compensation and benefits effected by the amendment of subsection 1 is not retroactive.

5. Payments for a temporary total disability must cease when:

(a) A physician or chiropractor determines that the employee is physically capable of any gainful employment for which the employee is suited, after giving consideration to the employee's education, training and experience;

(b) The employer offers the employee light-duty employment or employment that is modified according to the limitations or restrictions imposed by a physician or chiropractor pursuant to subsection 7; or

(c) Except as otherwise provided in NRS 616B.185, the employee is incarcerated.

6. Each insurer may, with each check that it issues to an injured employee for a temporary total disability, include a form approved by the division for the injured employee to request continued compensation for the temporary total disability.

7. A certification of disability issued by a physician or chiropractor must:

(a) Include the period of disability and a description of any physical limitations or restrictions imposed upon the work of the employee;

(b) Specify whether the limitations or restrictions are permanent or temporary; and

(c) Be signed by the treating physician or chiropractor authorized pursuant to NRS 616B.515 or 616B.527.

8. If *a* certification of disability specifies that the physical limitations or restrictions are temporary, the employer of the employee at the time of his accident is not required to comply with NRS 616C.545 to 616C.575, inclusive, and 616C.590 or the regulations adopted by the division governing vocational rehabilitation services if the employer offers the employee a position that is substantially similar to the employee's position at the time of his injury in relation to the location of the employment, the hours he is required to work and the salary he will be paid.

9. A physician or chiropractor shall not issue a certification of disability for any period preceding the date on which the physician or chiropractor examined the injured employee.

Sec. 12. NRS 616C.485 is hereby amended to read as follows:

616C.485 *1.* The administrator shall adopt, by regulation, a schedule which, in his judgment, is best calculated to compensate fairly and adequately an injured employee for the loss of, or permanent damage to, a tooth. The administrator shall review the schedule at least once every 2 years to ensure the fairness and adequateness of the schedule.

2. An injured employee whose tooth has been repaired to a condition that is equal to or better than the condition of his tooth before his injury, and the dependent of such an employee, is not entitled to receive compensation for a permanent partial disability pursuant to NRS 616C.490 unless the employee or his dependent establishes by a preponderance of the evidence that the employee suffered a permanent disability.

Sec. 13. NRS 616C.490 is hereby amended to read as follows:

616C.490 1. Except as otherwise provided in NRS 616C.175 [,] *and 616C.485,* every employee, in the employ of an employer within the provisions of chapters 616A to 616D, inclusive, of NRS, who is injured by an accident arising out of and in the course of employment is entitled to receive the compensation provided for permanent partial disability. As used in this section, "disability" and "impairment of the whole man" are equivalent terms.

2. Within 30 days after receiving from a physician or chiropractor a report indicating that the injured employee may have suffered a permanent disability and is stable and ratable, the insurer shall schedule an appointment with a rating physician or chiropractor to determine the extent of the employee's disability. The [insurer] *employee* shall select a

physician or chiropractor from a group of rating physicians and chiropractors designated by the administrator, to determine the percentage of disability in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the division pursuant to NRS 616C.110. [Rating] *Except as otherwise provided in this subsection, rating* physicians and chiropractors must be selected in rotation from the list of qualified physicians and chiropractors designated by the administrator, according to their area of specialization and the order in which their names appear on the list. *If the next physician or chiropractor in rotation from the list has entered into a contract with the insurer to provide medical and health care services to employees with industrial injuries and occupational diseases, the injured employee may select the next physician or chiropractor in rotation from the list of qualified physicians or chiropractors who has not entered into such a contract with the insurer, according to the area of specialization required.*

3. At the request of the insurer, the injured employee shall, before an evaluation by a rating physician or chiropractor is performed, notify the insurer of:

(a) Any previous evaluations performed to determine the extent of any of the employee's disabilities; and

(b) Any previous injury, disease or condition sustained by the employee which is relevant to the evaluation performed pursuant to this section.

The notice must be on a form approved by the administrator and provided to the injured employee by the insurer at the time of the insurer's request.

4. Unless the regulations adopted pursuant to NRS 616C.110 provide otherwise, a rating evaluation must include an evaluation of the loss of motion, sensation and strength of an injured employee if the injury is of a type that might have caused such a loss. No factors other than the degree of physical impairment of the whole man may be considered in calculating the entitlement to compensation for a permanent partial disability.

5. The rating physician or chiropractor shall provide the insurer with his evaluation of the injured employee. After receiving the evaluation, the insurer shall, within [14] *30* days, provide the employee with a copy of the evaluation and notify the employee:

(a) Of the compensation to which he is entitled pursuant to this section; or

(b) That he is not entitled to benefits for permanent partial disability.

6. Each 1 percent of impairment of the whole man must be compensated by a monthly payment:

(a) Of 0.5 percent of the claimant's average monthly wage for injuries sustained before July 1, 1981;

(b) Of 0.6 percent of the claimant's average monthly wage for injuries sustained on or after July 1, 1981, and before June 18, 1993; and

(c) Of 0.54 percent of the claimant's average monthly wage for injuries sustained on or after June 18, 1993.

Compensation must commence on the date of the injury or the day following the termination of temporary disability compensation, if any, whichever is later, and must continue on a monthly basis for 5 years or until the claimant is 70 years of age, whichever is later.

7. Compensation benefits may be paid annually to claimants who will be receiving less than $100 a month.

8. Where there is a previous disability, as the loss of one eye, one hand, one foot, or any other previous permanent disability, the percentage of disability for a subsequent injury must be determined by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury.

9. The division may adopt schedules for rating permanent disabilities resulting from injuries sustained before July 1, 1973, and reasonable regulations to carry out the provisions of this section.

10. The increase in compensation and benefits effected by the amendment of this section is not retroactive for accidents which occurred before July 1, 1973.

11. This section does not entitle any person to double payments for the death of an employee and a continuation of payments for a permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal.

Sec. 14. Chapter 617 of NRS is hereby amended by adding thereto a new section to read as follows:

An employee or, in the event of the death of the employee, his dependent, is barred from recovering compensation pursuant to the provisions of this chapter if the employee misrepresented or falsified any document or information submitted to his employer as evidence that he has been lawfully admitted for residency in the United States.

Sec. 15. The provisions of sections 2, 3 and 14 of this act must not be applied to reduce the amount of compensation and benefits of an employee who is receiving compensation and benefits for an industrial injury or an occupational disease before October 1, 1997, or to reduce the amount of compensation and benefits of the dependents of such an employee.

Sec. 16. 1. This section and sections 1 to 4, inclusive, and 6 to 15, inclusive, of this act become effective on October 1, 1997.

2. Section 5 of this act becomes effective at 12:01 a.m. on July 1, 1999.

SUMMARY—Provides for industrial insurance coverage for certain pupils and teachers participating in program to provide pupils with skills to make transition from school to work. (BDR 53-954)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to industrial insurance; requiring a school district or community college to insure itself against liability for the industrial injuries and occupational diseases of a teacher who, as part of the program to provide pupils with the skills to make the transition from school to work, works without pay for an employer other than the school system or community college with which the teacher is employed; authorizing industrial insurance coverage for a pupil who works without pay as part of the program; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *Any teacher who, as part of the program to provide pupils with the skills to make the transition from school to work established pursuant to NRS 388.368, works without pay for an employer other than the school district or community college with which the teacher is employed shall be deemed for the purposes of chapters 616A to 616D, inclusive, of NRS to be an employee of the school district or community college with which he is employed at his normal monthly wage, and is entitled to the benefits of those chapters.*

Sec. 3. *1. A pupil who, as part of the program to provide pupils with the skills to make the transition from school to work established pursuant to NRS 388.368, works without pay for an employer shall be deemed for the purposes of chapters 616A to 616D, inclusive, of NRS to be an employee if:*

(a) The employer for whom the pupil works;

(b) The school district or community college the pupil attends; or

(c) Any other person,

pays the premium rate for industrial insurance established by an insurer pursuant to subsection 2.

2. An insurer who provides industrial insurance for such pupils shall, for the purposes of determining and fixing the premium rate for that insurance, place the pupils in a separate class, the premium rates of which must be sufficient to provide an adequate fund

for the payment of the proportionate administrative expense and compensation on account of injuries and death of pupils of this class.

3. A pupil who is deemed to be an employee pursuant to subsection 1 shall be deemed to work at the wage of $5 per day and is entitled to the benefits of chapters 616A to 616D, inclusive, of NRS.

Sec. 4. NRS 616A.025 is hereby amended to read as follows:

616A.025 As used in chapters 616A to 616D, inclusive, of NRS, unless the context otherwise requires, the words and terms defined in NRS 616A.030 to 616A.360, inclusive, *and sections 2 and 3 of this act,* have the meanings ascribed to them in those sections.

Sec. 5. NRS 616A.230 is hereby amended to read as follows:

616A.230 "Employer" means:

1. The state, and each county, city, school district, and all public and quasi-public corporations therein without regard to the number of persons employed.

2. Every person, firm, voluntary association, and private corporation, including any public service corporation, which has in service any person under a contract of hire.

3. The legal representative of any deceased employer.

4. The Nevada rural housing authority.

5. Any person who pays the premium established by an insurer pursuant to section 3 of this act for a pupil who, as part of the program to provide pupils with the skills to make

the transition from school to work established pursuant to NRS 388.368, works without pay for an employer.

Sec. 6. NRS 617.110 is hereby amended to read as follows:

617.110 "Employer" means:

1. The state and each county, city, school district, and all public and quasi-public corporations therein, without regard to the number of persons employed.

2. Every person, firm, voluntary association, and private corporation, including any public service corporation, which has in service any employee under a contract of hire.

3. The legal representative of any deceased employer.

4. The Nevada rural housing authority.

5. Any person who pays the premium established by an insurer pursuant to section 3 of this act for a pupil who, as part of the program to provide pupils with the skills to make the transition from school to work established pursuant to NRS 388.368, works without pay for an employer.

Sec. 7. The provisions of subsection 1 of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 8. This act becomes effective upon passage and approval.

SUMMARY—Revises requirements for imposition of solvency surcharge for state industrial insurance system. (BDR 53-955)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to industrial insurance; transferring the authority to impose a surcharge to ensure the solvency of the state industrial insurance system to the legislative committee on workers' compensation; requiring the committee to establish the formula to calculate the surcharge based on a percentage of the total amount of claims paid for certain industrial injuries or occupational diseases; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 616B.110 is hereby amended to read as follows:

616B.110 1. If, after conducting an examination of the affairs, transactions, accounts, funds, records and assets of the system, the commissioner determines that the

system is insolvent, he shall give written notice of his determination to the [manager and administrator.

2. Except as otherwise provided in this subsection, upon] *legislative committee on workers' compensation.*

2. The legislative committee shall review the determination of the commissioner at its next scheduled meeting or at a meeting specified by a call of the chairman of the committee. If, after considering all other reasonable methods for ensuring the solvency of the system, the committee determines that the imposition of a solvency surcharge is necessary, it shall give written notice to the administrator requiring him to collect a solvency surcharge pursuant to the provisions of this section.

3. Upon receipt of such a notice, the administrator shall [impose and] collect a solvency surcharge from [:

(a) Each employer who was insured by the Nevada industrial commission or the system at any time during the period beginning on July 1, 1979, and ending on July 1, 1995;

(b) Each employer who is insured by the system at any time after July 1, 1995;

(c) Each self-insured employer; and

(d) Each association of self-insured public or private employers,

in an amount calculated to produce the revenue that is required to pay the outstanding obligations of the system as they become due.] *each employer doing business in this state.* The formula used by the administrator to calculate the surcharge *required to be paid* must

be [approved] *established* by the legislative committee on workers' compensation [created pursuant to NRS 218.5375.] *based on a percentage of the total amount of claims paid for industrial injuries or occupational diseases to the employer's employees and their beneficiaries during the immediately preceding calendar quarter. Any claims paid for a disease of the heart or lungs pursuant to NRS 617.455 or 617.457 must not be included in the calculation. Each employer shall provide to the administrator such information as the administrator deems necessary to determine the amount of any surcharge required to be collected pursuant to this section.*

4. The administrator shall collect the surcharge quarterly until he receives notice to cease the collection of the surcharge pursuant to subsection 6. The surcharge must be paid in the manner prescribed by the administrator. [The manager shall collect the surcharge imposed against those employers who are insured by the system at any time after July 1, 1995.

3.] *5.* All money received by the administrator [and manager] from any surcharge imposed pursuant to this section must be credited on the records of the system to the account for solvency surcharges, which is hereby created in the state insurance fund. The money in the account:

(a) Constitutes a part of the assets of the state insurance fund.

(b) Must be used solely to pay the operating expenses of the system and any obligations of the system as they become due. The money in the account may not be used by the system to incur any additional obligations.

[4. If, at any time after the imposition of a surcharge pursuant to this section, the manager determines that the system is no longer insolvent, he shall file a request with the commissioner to cease the collection of any surcharge imposed pursuant to this section. Upon the receipt of the request, the commissioner shall, for the purpose of determining the financial condition of the system, conduct an examination of the affairs, transactions, accounts, funds, records and assets of the system. If, after conducting the examination, the commissioner determines that the system is no longer insolvent, the commissioner shall approve the request.

5.] *6. If the manager wishes to continue the collection of a surcharge imposed pursuant to this section, he shall, not later than January 15 of the year following the imposition of the surcharge, and annually thereafter, file a request with the legislative committee on workers' compensation to continue the collection of the surcharge. If such a request is filed, the commissioner shall, for the purpose of determining the financial condition of the system, conduct an examination of the affairs, transactions, accounts, funds, records and assets of the system and report his findings to the legislative committee on workers' compensation. The legislative committee shall give written notice to the administrator ordering him to cease the collection of the solvency surcharge if:*

(a) A request for the continuation of the collection of the surcharge is not filed by the manager as required by this subsection; or

(b) After reviewing the findings of the commissioner, the legislative committee determines that the imposition of a solvency surcharge is no longer necessary.

7. Any employer [, self-insured employer or association of self-insured public or private employers that] *who* fails to pay any surcharge imposed pursuant to this section is liable in a civil action commenced by the administrator for:

(a) The amount owed pursuant to this section;

(b) The reasonable expenses incurred by the administrator in enforcing this section; and

(c) Payment of interest on the amount due at the rate fixed pursuant to NRS 99.040 for the period from the date upon which the surcharge was due to the date upon which the surcharge is paid.

Any money collected by the administrator pursuant to this subsection must be deposited into the account for solvency surcharges.

[6.] *8.* For the purposes of this section, the system is insolvent if the system is required to sell or otherwise liquidate any of the invested assets or real property of the system for the purpose of paying its outstanding obligations as they mature in the regular course of business.

Sec. 2. NRS 218.5377 is hereby amended to read as follows:

218.5377 The committee:

1. May review issues related to workers' compensation.

2. May study the desirability of establishing a preferred employee program which provides exemptions from the payment of premiums and other financial incentives for employers who provide suitable employment for injured employees and any other program for returning injured employees to work.

3. May review the manner used by the division of industrial relations of the department of business and industry to rate physical impairments of injured employees.

4. Shall, to ensure the solvency of the state industrial insurance system:

(a) Review and study the financial condition of the state industrial insurance system;

(b) Determine the extent of any apparent insolvency of the system; and

(c) Establish a formula [which will be applied to calculate a surcharge that is equal in amount to any deficiency in the cumulative amount of premiums paid by an employer who is subject] *to be used to calculate any solvency surcharge required to be paid pursuant* to the provisions of NRS 616B.110.

5. May conduct investigations and hold hearings in connection with carrying out its duties pursuant to this section.

6. May direct the legislative counsel bureau to assist in its research, investigations, hearings and reviews.

Sec. 3. This act becomes effective upon passage and approval.

BILL DRAFT REQUEST (BDR)
53-956

WAS NOT AVAILABLE AT TIME OF PRINTING

Please contact committee staff
for BDR status.

SUMMARY—Requires legislative committee on workers' compensation to contract with private party to conduct study of system for providing compensation for permanent partial disabilities. (BDR S-957)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to industrial insurance; requiring the legislative committee on workers' compensation to contract with a private party to conduct a study of the system in this state for providing to injured employees compensation for permanent partial disabilities; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. 1. The legislative committee on workers' compensation created pursuant to NRS 218.5375 shall cause to be conducted a study of the system in this state for providing workers' compensation for permanent partial disabilities.

2. The study must include:

(a) An evaluation of the system for determining the amount of compensation to be paid for permanent partial disabilities.

(b) A comparison of that system and the systems in other states for determining the amount of compensation to be paid for permanent partial disabilities.

(c) An evaluation of the rating system used in this state to determine the extent of an employee's permanent partial disability.

(d) An evaluation of the manner in which rating physicians and chiropractors are selected.

(e) Such other information as the legislative committee on workers' compensation deems appropriate.

Sec. 2. 1. The legislative committee on workers' compensation shall, not later than March 1, 1998, enter into a contract with a private person to conduct the study required by section 1 of this act.

2. The legislative committee on workers' compensation shall ensure that a copy of the study is submitted to the director of the legislative counsel bureau for transmittal to the 70th session of the Nevada Legislature.