ADOPTED REGULATION OF THE ADMINISTRATOR OF THE

DIVISION OF INDUSTRIAL RELATIONS OF THE

DEPARTMENT OF BUSINESS AND INDUSTRY

LCB File No. R149-09

Effective October 23, 2013

EXPLANATION – Matter in ***italics*** is new; matter in brackets [~~omitted material~~] is material to be omitted.

AUTHORITY: §1, NRS 616A.400; §§2-7, NRS 616A.400 and 616D.120.

A REGULATION relating to industrial insurance; adopting criteria by which the Division of Industrial Relations of the Department of Business and Industry may refuse to recommend approval of certain applications for a certificate of registration as an administrator; adopting provisions relating to untimely payments to injured workers; establishing certain provisions relating to employee leasing companies; and providing other matters properly relating thereto.

Section 1. Chapter 616A of NAC is hereby amended by adding thereto a new section to read as follows:

1. The Division may refuse to recommend for final approval an application for a certificate of registration as an administrator pursuant to subsection 3 of NRS 683A.08524 because:

(a) A principal of the applicant was formerly a principal of a third-party administrator or insurer which has an outstanding debt owing to the Division or an injured employee;

(b) The information in the application reveals that the applicant does not maintain, based on the experience, caseload and number of clients of its adjuster, a sufficient number of experienced and qualified persons to properly administer claims; or

(c) Any other reason the Division determines may hinder the prompt and efficient payment of compensation to injured employees.

2. As used in this section:

(a) "Debt" includes, without limitation, an administrative fine, a benefit penalty or a penalty imposed pursuant to subsection 4 of NRS 616C.065.

(b) "Principal" means an owner, manager, officer, proprietor or any other person having a significant degree of control over the administration of claims.

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

1. For the purposes of paragraph (h) of subsection 1 of NRS 616D.120, to determine whether an insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company has engaged in a pattern of untimely payments to injured workers, the Administrator will consider:

(a) The reasons given by the insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company for making the payments after the time set forth in the applicable statute or regulation;

(b) The efforts made by the insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company to make the payments within the time set forth in the applicable statute or regulation;

(c) The date the payments were made;

(d) The number of injured employees who have received untimely payments;

(e) The number of untimely payments;

(f) The length of the time period in which the untimely payments occurred;

(g) Whether the amount of any payments due, or any portion of that amount, was unknown, unclear or ambiguous, and whether the insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company took action or exercised reasonable diligence to determine the unknown amounts or to clarify the uncertainty or ambiguity and to make the payments due within the time set forth in the applicable statute or regulation or at any time thereafter;

(h) Whether the insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company was advised, in writing, by the affected injured employee or a representative thereof that payments could be delayed pending the outcome of any further negotiations relating to the compensation that was due;

(i) Whether successive or numerous untimely payments have been made to a single injured employee;

(j) Whether the untimely payments involved the same form of compensation, such as temporary total disability;

(k) Whether the insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company knew or reasonably should have known of the circumstances resulting in or likely to result in multiple untimely payments to one or more injured employees;

(l) Whether the insurer, organization for managed care, health care provider or third-party administrator established the policies and procedures required by NAC 616D.311 and complied with those policies and procedures;

(m) Whether the untimely payments were the result of error, lack of good faith or diligence, neglect or another cause within the control of the insurer, organization for

managed care, health care provider, third-party administrator, employer or employee leasing company; and

(n) Any other circumstance which the Administrator deems relevant to determine whether untimely payments to one or more injured employees constitute a pattern of untimely payments that warrants awarding a benefit penalty to an injured employee.

2. Timeliness of payments must be determined by the statute or regulation specifically applicable to the type of payment involved.

3. The insurer or third party administrator shall record in the claim file the date on which any payment of compensation or other relief pursuant to chapters 616A to 617, inclusive, of NRS is made to an injured employee or other person or has been deposited for mailing to the injured employee or other person. This information must be provided to the Administrator upon request.

Sec. 3. NAC 616D.315 is hereby amended to read as follows:

616D.315 For the purposes of paragraph (c) of subsection 1 of NRS 616D.120, to determine whether an insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer ***or employee leasing company*** has unreasonably delayed payment to an injured employee of compensation found to be due him by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the Division when carrying out its duties pursuant to chapters 616A to 617, inclusive, of NRS, the Administrator will consider:

1. The reasons given by the insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer ***or employee leasing company*** for making the payment after the time set forth in paragraph (c) of subsection 1 of NRS 616D.120;

2. The efforts made by the insurer, organization for managed care, health care provider, third-party administrator *,* [or] employer ***or employee leasing company*** to make the payment within the time set forth in paragraph (c) of subsection 1 of NRS 616D.120, if any;

3. The date the payment was made;

4. Whether the amount of compensation due, or any portion of that amount, was unclear or ambiguous and whether the insurer, organization for managed care, health care provider, third-party administrator *,* [or] employer ***or employee leasing company*** took action or exercised reasonable diligence to clarify the uncertainty or ambiguity and to pay the compensation due within the time set forth in paragraph (c) of subsection 1 of NRS 616D.120, or at any time thereafter;

5. Whether the amount of compensation due, or any portion of that amount, was unknown or could have been determined through the exercise of reasonable diligence within the time set forth in paragraph (c) of subsection 1 of NRS 616D.120, or at any time thereafter;

6. Whether the insurer, organization for managed care, health care provider, third-party administrator *,* [or] employer ***or employee leasing company*** was advised, in writing, by the injured employee or his representative that payment of the compensation due could be delayed pending the outcome of any further negotiations relating to the compensation that was due;

7. Whether the insurer, organization for managed care, health care provider or third-party administrator established the policies and procedures required by NAC 616D.311 and complied with those policies and procedures;

8. Whether the delay in the payment of the compensation due, or any portion thereof, was the result of error, lack of good faith or diligence, neglect or another cause within the control of

the insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer [;] ***or employee leasing company;*** and

9. Any other circumstance which the Administrator deems relevant to determine whether a delay in the payment of compensation due was reasonable.

Sec. 4. NAC 616D.400 is hereby amended to read as follows:

616D.400 1. For the purposes of subsection 2 of NRS 616D.120 and except as otherwise provided in chapters 616A to 617, inclusive, of NRS, or in any regulation adopted pursuant thereto, an insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer ***or employee leasing company*** commits a "minor violation" of any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS, or a regulation adopted pursuant thereto, if the violation is a single, unintentional violation and the insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer ***or employee leasing company*** agrees, in writing, to correct the violation during the course of an investigation or audit conducted pursuant to those chapters.

2. Except as otherwise provided in this subsection, if an insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer ***or employee leasing company*** agrees, in writing, to correct a single, unintentional violation during the course of an investigation or audit, the Administrator will issue a notice of correction for that violation. The Administrator will not issue a notice of correction pursuant to this subsection if the violation does not require correction or the correction is unnecessary or moot.

3. If an insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer ***or employee leasing company*** does not agree, in writing, to correct a single, unintentional violation during the course of an investigation or audit, the Administrator

may impose an administrative fine in an amount not to exceed those amounts set forth in subsection 2 of NRS 616D.120 or order a plan of corrective action to be submitted to the Administrator, or both.

Sec. 5. NAC 616D.405 is hereby amended to read as follows:

616D.405 1. For the purposes of NRS 616D.120, an insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer ***or employee leasing company*** commits an "intentional violation" of any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS, or any regulation adopted pursuant thereto, if he or she acts with purpose or design, otherwise acts to cause the consequences, desires to cause the consequences or believes that the consequences are substantially certain to result from the violation.

2. The Administrator may consider two or more violations of the same or similar provisions of chapters 616A to 617, inclusive, of NRS, or any regulations adopted pursuant thereto, as evidence of an intentional violation. If the Administrator determines that two or more violations constitute an intentional violation, the Administrator will impose an administrative fine as required by subsection 1 of NRS 616D.120 and, if appropriate, order a plan of corrective action to be submitted to the Administrator.

Sec. 6. NAC 616D.411 is hereby amended to read as follows:

616D.411 1. To determine the amount of a benefit penalty required to be paid pursuant to subsection 3 of NRS 616D.120, the Administrator will determine that the violation caused physical or economic harm to the injured employee or his or her dependents if he or she finds, by a preponderance of the evidence, that:

(a) The harm would not have occurred but for the violation;

(b) The violation was a substantial factor in bringing about the harm; and

(c) There is no supervening cause that is responsible for bringing about the harm.

2. Physical harm must be established by a preponderance of objective medical evidence in the form of existing medical records or medical records furnished by the claimant.

3. The Administrator will determine the amount of a benefit penalty required to be paid pursuant to subsection 3 of NRS 616D.120 according to the following schedule. In addition to the required minimum benefit penalty of $5,000, a claimant will be awarded ~~[$1,625]~~ ***$2,250*** for each point assessed, but in no event will the amount of the benefit penalty be greater than ~~[$37,500.]~~ ***$50,000.***

Points assessed for physical harm:

Temporary minor harm .... 2 points

Temporary major harm .... 5 points

Permanent minor harm .... 5 points

Permanent major harm .... ~~[10]~~ ***15*** points

Death .... ~~[20]~~ ***25*** points

Points assessed for the amount of compensation found to be due the claimant:

Amount of compensation

$3,001 - $5,000 .... 1 point

$5,001 - $7,000 .... 2 points

$7,001 - $9,000 .... 3 points

$9,001 - $11,000 .... 4 points

$11,001 - $13,000 .... 5 points

$13,001 - $15,000 .... 6 points

$15,001 - $17,000 .... 7 points

$17,001 - $19,000 .... 8 points

$19,001 - $21,000 .... 9 points

An amount that is greater than $21,000 .... 10 points

Points assessed for prior violations:

~~[One prior violation .... 1 point~~

~~Two prior violations .... 3 points~~

~~More than two prior violations .... 5 points]~~

Average number of claims handled in the past 3 years of 4,000 or more

Five or less prior violations .... 0 points

Six prior violations .... 1 point

Seven prior violations .... 2 points

Eight prior violations .... 4 points

Nine or more prior violations .... 6 points

Average number of claims handled in the past 3 years of less than 4,000 but more than 1,500

Three or less prior violations .... 0 points

Four prior violations .... 1 point

Five prior violations .... 2 points

Six prior violations .... 4 points

Seven or more prior violations .... 6 points

Average number of claims handled in the past 3 years of 1,500 or less

One prior violation ....0 points

Two prior violations.. 1 point

Three prior violations...2 points

Four prior violations ....4 points

Five or more prior violations ....6 points

Points assessed for economic harm:

Amount of economic harm

$6,001 - $7,000... 1 point

$7,001 - $8,000...2 points

$8,001 - $9,000...3 points

$9,001 - $10,000...4 points

$10,001 - $11,000...5 points

$11,001 - $12,000...6 points

$12,001 - $13,000...7 points

$13,001 - $14,000...8 points

$14,001 - $15,000...9 points

More than $15,000 ....10 points

4. To determine the number of prior violations of an insurer, organization for managed care, health care provider, third-party administrator ***,*** ~~[or]~~ employer ~~[,]~~ ***or employee leasing company,*** the Administrator will ~~[consider]~~ ***:***

(a) Consider only those fines and benefit penalties imposed pursuant to paragraphs (a) to (e), inclusive, [~~and~~] (h) ***and (i)*** of subsection 1 of NRS 616D.120 [~~in the immediately preceding 5 years.~~] ***using the 3 most recent complete years of available data.***

(b) Not consider those benefit penalties imposed pursuant to paragraph (b) of subsection 3 of NRS 616D.120.

5. ***To determine the average number of claims handled in the past 3 years, the Administrator will consider the 3 most recent complete years of available data.***

6. As used in this section:

(a) "Dependent" means a person who:

(1) At the time of the violation, is:

(I) The spouse of the injured employee;

(II) A child of the injured employee and is under 18 years of age; or

(III) A child of the injured employee, is 18 years of age or older and is physically or mentally incapacitated and unable to earn a wage; or

(2) Is a parent of the injured employee, a child of the injured employee who is 18 years of age or older, a stepchild of the injured employee or a sibling of the injured employee if that person's dependency upon the injured employee is established by a federal income tax return of the injured employee or by any other reliable evidence.

(b) "Economic harm" includes:

(1) The loss of money or an item of monetary value; and

(2) The deprivation of a reasonable expectation of a financial or monetary advantage.

(c) ***"Number of claims handled" means the total number of claims accepted, denied or reopened during a 1-year period.***

(d) "Permanent major harm" means physical harm that:

(1) Results in a complete or significant loss of the ability to engage in activities of daily living, including, without limitation, caring for oneself, performing manual tasks, walking, standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually, and engaging in normal recreational and social activities; and

(2) Is unlikely to be alleviated in spite of medical treatment that a reasonable person is willing to undergo.

~~[(d)]~~ ***(e)*** "Permanent minor harm" means physical harm that:

(1) Does not result in a complete or significant loss of the ability to engage in activities of daily living, including, without limitation, caring for oneself, performing manual tasks, walking, standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually, and engaging in normal recreational and social activities; and

(2) Is unlikely to be alleviated in spite of medical treatment that a reasonable person is willing to undergo.

~~[(e)]~~ ***(f)*** "Physical harm" means death or any physiological disorder or condition, cosmetic disfigurement or anatomic loss affecting one or more of the following body systems:

(1) The neurological system.

(2) The musculoskeletal system.

(3) Special sense organs.

(4) The respiratory system, including, without limitation, speech organs.

(5) The cardiovascular system.

(6) The reproductive system.

(7) The digestive system.

(8) The genitourinary system.

(9) The hemic and lymphatic system.

(10) The skin.

(11) The endocrine system.

~~[(f)]~~ ***(g)*** "Temporary major harm" means physical harm that:

(1) Results in a complete or significant loss of the ability to engage in activities of daily living, including, without limitation, caring for oneself, performing manual tasks, walking, standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually, and engaging in normal recreational and social activities; and

(2) Is likely to be alleviated with or without medical treatment.

~~[(g)]~~ ***(h)*** "Temporary minor harm" means physical harm that:

(1) Does not result in a complete or significant loss of the ability to engage in activities of daily living, including, without limitation, caring for oneself, performing manual tasks, walking, standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually, and engaging in normal recreational and social activities; and

(2) Is likely to be alleviated with or without medical treatment.

Sec. 7. NAC 616D.415 is hereby amended to read as follows:

616D.415 Except as otherwise provided in chapters 616A to 617, inclusive, of NRS, or in any regulation adopted pursuant thereto:

1. If the Administrator determines that:

(a) An insurer or third-party administrator has failed to comply or has complied in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS, or any

regulation adopted pursuant thereto, that requires the insurer or third-party administrator to make a determination regarding the acceptance or denial of a claim for compensation;

(b) An insurer or third-party administrator has failed to comply or has complied in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS, or any regulation adopted pursuant thereto, that requires the insurer or third-party administrator to make a payment of benefits to an injured employee;

(c) An insurer or employer has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616B.460 or 616B.461 or NAC 616B.124 to 616B.136, inclusive;

(d) An insurer, organization for managed care, provider of health care, third-party administrator ***,*** ~~[or]~~ employer ***or employee leasing company*** has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616A.475, 616B.006, 616B.009 or 617.357 or NAC 616A.410;

(e) A treating physician or chiropractor has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616C.020, 616C.040, subsection 7 of NRS 616C.475 or NRS 617.352, or any regulations adopted pursuant thereto, that require the treating physician or chiropractor to complete a claim for compensation; or

(f) An employer has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616C.045 or 617.354, or any regulation adopted pursuant thereto, that require the employer to complete a report of industrial injury or occupational disease,

➥ and the Administrator determines that the violation was not an intentional violation, the Administrator may impose an administrative fine in an amount not to exceed those amounts set forth in subsection 2 of NRS 616D.120 or order a plan of corrective action to be submitted to the Administrator, or both.

2. If the Administrator determines that an insurer, organization for managed care, health care provider, third-party administrator ***,*** [or] employer ***or employee leasing company*** has committed two or more violations of the same or similar provisions of chapters 616A to 617, inclusive, of NRS, or any regulation adopted pursuant thereto, the Administrator may impose an administrative fine in an amount not to exceed those amounts set forth in subsection 2 of NRS 616D.120 or order a plan of corrective action to be submitted to the Administrator, or both.

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS

IN THE MATTER OF THE ADOPTION OF PERMANENT REGULATIONS ADDING EMPLOYEE LEASING COMPANIES TO CHAPTER 616D ENFORCEMENT; PROVISIONS CONCERNING THE DETERMINATION OF AN UNTIMELY PATTERN OF PAYMENTS PURSUANT TO NRS 616D.120(1); QUALIFICATIONS FOR AN ADMINISTRATOR SEEKING A CERTIFICATE OF REGISTRATION TO GAIN AN APPROVAL RECOMMENDATION FROM THE DIVISION OF INDUSTRIAL RELATIONS; AND FACTORS TO BE CONSIDERED IN CALCULATING AND IMPOSING BENEFIT PENALTIES

LCB FILE NO. R149-09

AMENDED INFORMATIONAL STATEMENT

1. A clear and concise explanation of the need for the adopted regulation.

Sections 1, 2 and 6, adding a new provisions to Chapter 616A and 616D, NAC and amending NAC 616D.411, are necessary to comply with the language of Senate Bill 195 (2009). Sections 3, 4, 5, 6 and 7, amending NAC 616D.315, 616D.400, 616D.405, 616D.411 and 616D.415, respectively, are necessary to comply with the language of Senate Bill 361 (2009).

2. A description of how comments were solicited from the public and affected businesses, a summary of responses from the public and affected businesses and an explanation of how other interested persons may obtain a copy of the summary.

Section 13.8 of Senate Bill 361 (2009) added employee leasing companies to the list of violators that may be fined by the Division or ordered to pay a benefit penalty pursuant to NRS 616D.120. NRS 616D.120(1)(h) prohibits an insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company from "engaging in a pattern of untimely payments to injured employees." Section 1.5 of Senate Bill 195 (2009) required the Division Administrator to adopt regulations detailing recommendation criteria for insurance administrator certificate applicants which once satisfied would be forwarded to the Insurance Commissioner for final approval consideration. Section 19 of Assembly Bill 496 (2007) revised provisions relating to the factors to be considered in calculating and imposing a benefit penalty, while section 10 of Senate Bill 195 (2009) revised provisions governing the imposition of administrative fines for certain violations by an insurer, organization for managed care, health

care provider, and third-party administrator by introducing a requirement that the Administrator consider the number of previous benefit penalty violations in light of the number of claims handled.

Accordingly, the Division held workshops on **July 12, 2007** and **July 17, 2009** to hear public comment on these matters. In addition the Division conducted a public hearing on **February 16, 2010**, on the draft regulations. In conjunction with providing notice to the public and interested parties of the workshop and public hearing, the Division prepared the Small Business Impact Statement required by NRS 233B. The Division submitted the draft regulation and Small Business Impact Statement to the Legislative Counsel Bureau pursuant to NRS 233B.

A summary of the responses from the public and affected businesses is included in Response 2 below of this Amended Informational Statement and may be obtained by contacting the Division of Industrial Relations' Workers' Compensation Section at the following locations:

Workers' Compensation Section	Workers' Compensation Section
1301 N. Green Valley Pkwy., #200	400 W. King St., #400
Henderson, NV 89074	Carson City, NV 89703
Telephone: (702) 486-9080	Telephone: (775) 684-7270

3. The number of persons who attended the workshop, testified at each workshop, and submitted written statements to the agency.

The workshops and hearing were conducted on, **July 12, 2007**, **July 17, 2009** and **February 16, 2010** at two sites via videoconference: The main site was at the Sawyer Building in Las Vegas; the other site was at Legislative Building, Room 2135, 401 South Carson Street, Carson City, Nevada. The workshop attendance and testimony totals are as follows: **July 12, 2007**, in Las Vegas, **74** people attended and **1**5 testified; in Carson City, **30** attended and **3** testified. **July 17, 2009**, in Las Vegas, **43** people attended and **9** testified; in Carson City, **24** attended and **4** testified. The pertinent oral testimony on these matters is presented as follows for the areas indicated:

Concerning the determination of an untimely pattern of payments pursuant to NRS 616D.120(1)

The hearing was conducted on **February 16, 2010**, at two sites via videoconference: the main site was at the Sawyer Building in Las Vegas; the other site was at the Legislative Building in Carson City. In Las Vegas, **36** people attended and **13** testified; in Carson City, **15** attended and **5** testified. The pertinent oral testimony is presented as follows:

George Ross, Nevada Self-Insured Association, Snell & Wilmer,3883 Howard Hughes Pkwy., #1100, Las Vegas, Nevada 89169, (702)784-5200: We believe that the phrase "reasonably should have known of the circumstances" is too broad and should be tightened up a bit. The quote "any other circumstances, which the administrator deems relevant to determine..." is also too broad and allows a tremendous amount of discretion in that respect.

Also we are concerned about how the WCS is going to consider compliance with this section [3.3]. Whether it's going to be noting the date of the check, when it was issued, whether it was mailed in claim notes, check copy, and how to determine that with checks mailed to employees from out-of-state. I think you're familiar with other situations where they had a lot of controversy on whether something was mailed or received, and we just think that probably would be safe to define this a little more carefully.

Charles Verre, DIR: One of the issues with that is that instead of an actual document, a check face, that shows when the payment was made and when it was sent. What we have been seeing is these printouts of when the checks were cut, and so on, and that really doesn't show us what we need to see which is to determine the timeliness of this kind of stuff. So what we are driving at here is we want to get something that we can actually look at it to be sure that the payment to the injured person was made on time. We understand that we are in the computer age, and we understand that there are electronic payments and those kinds of things going on, but we are looking for and would appreciate hearing any input in regarding that, a way to show that the payments have been made positively. We just want to clarify that when our auditors go look at those files.

Nancyann Leeder, Attorney, NAIW, 1000 W. William Street, Carson City, Nevada 89701, (775) 684-7555: The notice which has to be sent to a claimant indicating a closure was changed a couple of sessions ago to require a certificate of mailing. If you require a certificate of mailing on the payment then you would certainly know the date that the checks were actually sent as opposed to one that was stated that it was sent in the record of the insured.

Barbara Gruenwald, Nevada Justice Association, Anderson & Gruenewald, 439 Marsh Avenue, Reno, Nevada 89509, (775) 322-3366: I think everything listed in here is excellent. There is a lot of controversy regarding untimely payments to the injured worker and I agree that printouts of the payments are not good enough. Because the printout may show the date the instruction was sent by the claims examiner to the company to make the payment, but it doesn't show exactly the date when the payment was made. The payment could be made two weeks later, so we really do appreciate that you leave the regulations the way that you have them written.

Ann Davison: Nelson Davison Administrators: Re: Ms. Leeder's comments, we strongly disagree with her suggestion on a certificate of mailing. That's an issue now, that isn't a process that is smooth. There is also a lot of debate on it.

There was **1** written set of comments submitted by the **March 8, 2010** deadline announced at the hearing. These comments are as follows:

Jennifer Kruger, Nevada Self-Insured Association

Sec. 7
1K. "Reasonably should have known of the circumstances" is much too broad and subject to arbitrary and personal interpretation.

In "any other circumstances which the administrator deems relevant to determine" is again much too broad and can enable arbitrary, and inconsistent, and personal interpretations.

3. NSIA is concerned with how the WCS is going to measure compliance with this action. Will WCS note the date a check was issued and mailed in the claim notes, will require writing the mailing date on the check copy, etc.? How will check receipt dates be determined on checks mailed out of state?

Concerning qualifications for an administrator seeking a certificate of registration to gain an approval recommendation from the Division of Industrial Relations

July 17, 2009 Workshop

Robin A Drew, Injured Worker: I am submitting this suggestion now. If you are considering a certification and you are looking at issues such as a debt, a reputation, conduct of employees or the conduct of a corporation or organization and you notice that an injured worker hasn't been paid, you might want to send that injured worker a letter or a postcard.

Sam McMullan, Nevada Self-Insured Association (NSIA): My comments on this legislation are there a couple of words that I suggest you think about revising. I think that it's a little bit [unintelligible word] to say that a debt to the division includes an unpaid benefit penalty or administrative fine, although that is probably right. It might be just smarter to not use two words. To use debt and unpaid benefit penalty, but to speak directly to the fact that there is an unpaid benefit penalty or an administrative fine. Collapse that a little bit, I am assuming that there may be other debts that are owed, specifically in terms of assessments or other things like that wouldn't be specifically unpaid benefit penalties or administrative fines. So, maybe it's all three of those, owes the debt, or has an unpaid benefit penalty or unpaid administrative fine. Refer to as 1(a).

Move down to 1(c). It's great to look at the general business or personal reputation of any person but I think that you may want to relate that, in terms of the license being requested that is quite general, so I would put some relational language that makes sure that the personal business reputation would be related to the ability to conduct the business of and the activities of an administrator, otherwise it could be overly broad and just make it more clear.

Robin A Drew, Injured Worker: In fact, I would ask for (a) to be broadened out so that we talk about all of the different ways third-party administrators have basically skipped town without fixing certain problems, including monetary issues, benefit penalties, administrative fines, other assessments, and they can be listed very clearly. I see no reason why they wouldn't be listed very clearly. I would certainly like to see this narrowed down.

There were **0** pertinent written comments submitted by the **July 24, 2009** deadline announced at the hearing.

The hearing was conducted on **February 16, 2010**, at two sites via videoconference: the main site was at the Sawyer Building in Las Vegas; the other site was at the Legislative Building in Carson City. In Las Vegas, **36** people attended and **13** testified; in Carson City, **15** attended and **5** testified. The pertinent oral testimony is summarized as follows:

George Ross, NSIA: Section l(b) on page 100, we are concerned about the phraseology "adequate staffing." We are concerned about, what would be the criteria for adequate staffing, who would be the person to decide that?

In 2(b), where it refers to the word "principal," it defines principal. We believe that the principal should be the officers or owners of the company. We believe that saying any other person having a significant degree of control over the administration of claims is too broad. The person applying for this license could have been a claims manager or supervisor of a prior TPA.

In Section 3, we noticed that your regs referred to AB 24, and sometime about now, they are supposed to be smoothly written into the NRS, so we presumed that the final version will reflect the overall NRS, correct?

Robin A. Drew, Injured Worker: I would like to comment specifically about the certification process and the process of revoking the certification. Anyone who has a significant role in administering a claim no matter what the title is if they have a significant role in the decision that is being made by the self-insured employer or the decisions being made by the third party administrator you darn better check and see what their record has been. So I would not like to remove language that says someone who has a significant role in the administration of claims should be looked at.

Susan Sayegh, Sierra Nevada Administrators, P.O. Box 15750, Las Vegas, Nevada 89114, (702) 240-8935: Section l(b), in regards to the language of "adequate staffing", obviously we prefer that that language be changed, but if it isn't we ask that you define "adequate staffing." Are we looking at the number of claims per claims examiner, the number of clients per TPA? If you can just specify exactly what you mean by "adequate staffing" should you decide not to change the language.

There was **1** written comment submitted by the **March 8, 2010** deadline announced at the hearing. This comment is as follows:

Jennifer Kruger, NSIA

SB 195 (2009) adopt criteria by which the DIR may refuse to recommend approval of an application for a certificate of registration as an administrator (Sections 1 - 3, pp. 99 -100)

1(b). NSIA is concerned with how "adequate staffing" is to be determined and with who would determine that staffing is adequate to administer claims properly. As drafted, this regulation gives great discretion to an audit or, supervisor, or any other state employee involved. The criteria for "adequate staffing" should be clearly defined as should the level of state employee who is qualified to interpret the new regulation. NSIA believes that DIR should strive for

consistency, rationality, and common sense and limit the chance of arbitrary and capricious interpretations.

2(b). The term "principal" should include only the officers or owners of the company. The phrase "any other person having a significant degree of control over the administration of claims" is too broad.

Factors to be considered in calculating and imposing benefit penalties

<u>July 12, 2007 Workshop</u>

No pertinent oral comments received on this issue. Additionally, the Division received no pertinent written comments by the submission deadline.

<u>July 17, 2009 Workshop</u>

<u>Susan Sayegh, Sierra Nevada Administrators</u>: What about pending fines or administrative fines? If we as a TPA are going to be assessed based on prior history and yet a year or two later we end up winning that litigation; we are paying these fines based on inaccurate information.

<u>Jim Werbeckes, EMPLOYERS, 10375 Professional Circle, Reno, Nevada 89521-4802, (775) 327-2458</u>: Keeping the standard minimum $,5000 penalty in place, increasing the points from 1625 to 2030. The way that we arrived at that figure that is the same percentage of change from the $37,500 to $50,000. We believe that the claimant already received the check, the difference should be the interest owed from the date it should have been paid to the day that the injured worker received it. That is what that injured worker is out.

Further down, we deleted the points, 1 prior, 2 prior, and more than 2 prior, we deleted that completely, and reinstated that later on with additional points assessed for prior violations, and this is where we get to our apportionment provision. In the event of a prior violation exceeding any 2-year period the following percentages, additional points shall be used in calculating the benefit penalty. The percent is based on "the percentage shall be calculated by using the total number of prior benefit penalty violations, divided by total number of accepted claims administered during the prescribed period. Now, we haven't described a prescribed period; we don't know if you want to make that a one year period, a two-year period--that's left open at this point in time. But, if you are 99% compliant, but 1% off, then get hit with 1 point. If you were 98% then get 3 points, 97% compliant that's how we arrived at our apportionment.

<u>Sam McMullan, Nevada Self-Insured Association</u>: My comments are we at least focus on which time period to use. We all universally agree on the one-year period but we need some concurrence as a term of the period in which you measure the benefit penalties and the period in which you measure the claims in terms of the number of claims. It may take some time for the benefit penalty to be adjudicated and that may not be in the same calendar year as the year in which the behavior happened that instituted the BP. The intent is to have some relationship to the number of the claims handled during that concurrent period. It didn't necessarily need to be

the most current time period as much as the most accurate, complete indicator of conduct that lead to a benefit penalty.

Second, in terms of claims handled, it's worth the comment that an administrator or anyone that handles claims, handles all of them whether they are denied or other actions or issues. They are part of the work load and should be considered. Things need to be handled on a current basis not necessarily on an historical basis.

Bob Ostrovsky, EMPLOYERS: In response to Ms. Grunewald, the legislature increased the maximum penalty at the same time it took a policy position in this statute that the regulation should in fact reflect volume of claims payments in determining the exact level of that penalty. The making of and withdrawing of proposals before the legislature should not be a consideration of this Department in the drafting of this regulation. There was an increase in penalties, but also, a balancing provision on volume.

The last thing, it was recommended that (g) be included as a benefit penalty item. The statute specifically designates those behaviors which are subject to a penalty; (g) is not included in that and I would ask that Division to carefully read the statute and reflect what the statute says not what any of the parties, myself included, would like it to say. I know you will do that.

Robin A Drew, Injured Worker: I would take out one or more untimely payments and put one untimely payment and each untimely payment would be looked at as a separate problem.

On same section, item 3, or any other money compensation, is the word "compensation" and just say "money."

There were **4** pertinent written comments submitted by the July 24, 2009 deadline announced at the hearing. These comments are summarized as follows:

Barbara Gruenwald, Attorney

1. Points Assessed. We request that the points assessed remain as set forth in NAC 616D.411. Specifically, we do not want the points reduced, as that action would be contrary to the intent of the 2009 Nevada Legislature.

2. Insurer Violation Amount of Compensation to be Paid to the Claimant. The changes proposed by Bob Ostrovsky and Jim [Werbeckes] were that if a Benefit Penalty is assessed, the amount of compensation that the Claimant would receive would be solely limited to the amount of interest assessed for the delayed payment. We strongly object to this proposed change. We request that the assessment of the Benefit Penalty remain as is. We object, because the proposed change would be contrary to the intent of the 2009 Nevada Legislature.

3. Period of Time for Identifying Violations. We agree to a 12 month period of time, whether it be (a) the most recent 12 month period, or (b) a 12 month calendar year (January 1st to December 31st, or July 1st to June 30th) .

4. Include (g) from NRS 616D.120(1) in NAC 616D 411 We request that DIR include paragraph (g) of NRS 616D.120(l).

"(g) Failed to provide or unreasonably delayed payment to an injured employee, or reimbursement to an Insurer pursuant to NRS 616C.165;

We agree to the remainder of the proposed regulation for Senate Bill 195, Section 10. Thank you.

Samuel Sorich, Property Casualty Insurers Association of America, 2600 South River Road, Des Plaines, Illinois 60018-3286

PCI has reviewed the proposed revision to NAC 616D.411 and believe that three issues in the proposal merit further consideration.

First, references to five years as the time frame for consideration of past claims should be deleted because the five-year time frame was deleted from the underlying statute by SB 195. The appropriate time frame is a consecutive 12-month period for which data is available.

Second, the proper manner for calculating the amount of compensation due to a claimant when the benefit penalty is solely for a delay in payment should be the amount of interest payable to the claimant.

Third, a key element in SB 195 is the provision that in determining the amount of a penalty, the number of claims handled by an insurer in relation to the number of benefit penalties previously imposed must be considered. This critical concept needs to be expressly recognized in NAC 616D.411.

Jim Werbeckes, EMPLOYERS:

The new language provided in NAC616D.411 falls short of achieving the intent of the legislature to create a system which takes into account the number of benefit penalties in relation to the number of claims handled by the insurer or third party administrator. While we agree the increase in the per point assessment from $1,625 to $2,000 is appropriate. Any reference to "5 years" in NAC 616D.411 should be removed due to the deletion of this reference in NRS 616D.120(4).

In subsection 4 of our draft, we defined the prescribed period to be a consecutive 12 months period tor which data is available. We also inserted new language which addresses the enhanced benefit penalty for multiple violations. The percentage used in this provision shall be calculated using the total benefit penalties divided by the number of claim handed. This section addresses the intent of the legislation to look at the number of claims handle in relation to the benefit penalties awarded. An insurance carrier or third party administrator who is 99.5% compliant would be required to pay the minimum penalty ($5,000) plus 1 point ($2,030) for a second benefit penalty in a rolling 12 months. On the other hand an insurance carrier or third party administrator who is 98% compliant would be required to pay the minimum penalty ($5,000)

plus 5 point ($10,150) for a total benefit penalty of $15,150. In addition, these figures do not take into account the economic and physical harm the DIR may award on top of these figures. It is our conviction that our proposal reflects the objective of the legislature to punish carriers for not complying but at the same time take into account the volume of claims being handled as a percentage of their business.

Tina Sanchez, Nevada Self-Insured Association, MGM Mirage, 3260 Industrial Road, Bldg. B, Las Vegas, Nevada 89109, (702) 401-8637

A) First and foremost, we specifically object to and oppose the doubling of the value per point [effectively doubling all awards immediately] and the increase in points for "Permanent major harm" (from 10 to 15) and for "Death" (from 20 to 25), all included in the amendment to NAC 616D.411(4). We are not aware of any discussion in the legislature or otherwise, and we would not have agreed to any proposal to do so if it had been raised, about increasing the benefit penalty levels. Not only is this change inconsistent with the legislative intent of this year (and interested parties agreement to allow a reasonable adjustment based on proportional claims), it is clearly not addressed in any legislation amending NRS 616D.120 either in specific allowance or any express language at all. Accordingly, we suggest that the payment levels for physical harm and point value not be changed and stay as in the current regulation.

B) With respect to legislative intent, it was to do away with the automatic ratcheting of benefit penalties up without any relation to claims handled or severity of violations, hence the language removed in NRS 616D.120 and the new language requiring some consideration for number of claims "handled." Based on the deletion in statute, the reference to "five (5) years" as a period seems unnecessary in the current regulation and should be deleted. It will be more appropriately handled by the changes made to implement the legislation considered in the other proposed language.

C) Second, claims "handled" should not be just those accepted and we object to this limitation. We want to reiterate that the claims handled in the defined measurement period should be the complete number, including all filed, as they all relate to the work load and true "proportionality" for purposes of the measure of claims load as each takes effort and action, no matter what the length or disposition.

D) There seems to be consensus that the measurement period be for one year and we agree as well. Most importantly, we want to reiterate that not only must the measurement period be "concurrent" for the total claims and benefit penalties—i.e., the year for violation calculation must match exact period for measuring total claims handled.

E) We also concur that the violation should at least be adjudicated by the Division, not just as alleged or benefit penalty claims, and unless stayed upon application to the court upon appeal, it can be counted for purposes of defining the number of benefit penalties in the measurement period, so long as it is specifically related back to the time of the alleged violation or conduct (not the date of its adjudication).

F) But also, we want to emphasize that accuracy may require the measurement period to be a prior year so that "final" decisions on claimed violation facts may be made and then correlated to the claims year for the measurement period, and this may not allow it to be the current/immediately preceding year as proposed in the regulation. Reason seems to dictate that processing of benefit penalty claims may require a period of time for adjudicating them, so correlating them to the correct measurement period may have to be for a prior year. If this is what is intended from the reference that it is dependent on data received from TPA or Insurer, then it should clearly be stated. If not, a prior year which allows such accurate correlation should be clearly defined in the regulation (e.g., first (or second) fiscal year period immediately preceding).

H) Based on the above comments, and an understanding of the underpinnings which got us to the point of discussing proportionality as a factor in adjusting benefit penalties, we would like to respectfully request that a specific task force of interested parties be convened to see if concepts initially discussed in the legislative session could be developed and matured into a consensus which could form the basis for a regulation with as complete as possible agreement across the parties who might contest the provisions. Such a task force, given the progress which was made in the last days of the legislature, could yield a compatible result in a short period to meet the Division's time frames without any delay, but even if not, could greatly enhance the chances of a broadly-supported regulation implementing some significant changes to benefit penalty provisions more easily for the Division. We would be willing to call and coordinate such an effort if the Division thinks it might be helpful, at whatever time frame it thinks appropriate.

Benefit Penalty Proportionality Proposal

# of Claims	% of Deduction on BP
0 to 1000	0%
1001 to 3000	5% per thousand
3001 to 5000	1% per thousand
5001 and up	10% per thousand

All reductions totaled cannot exceed a maximum deduction of 70% of the total value of the benefit penalty. This means the insurer, TPA or employer would always be required to pay a minimum of 30% of the total BP assessed. Reductions do not apply in cases where pattern in practice have been determined.

Pattern in practice is defined as three or more of the same offenses in a calendar year.

Offenses are defined as a payment or nonpayment of individual types of benefit categories (i.e. PPD, TTD, TPD, VRMA, Medical or Expense Reimbursement).

In the case of three or more offenses, the Insurer, TPA or Employer will not be allowed to utilize the reduction factors.

Criteria for deciding number of claims:

All claims filed in the year that the benefit penalty became measurable. This means the total number of claims filed in the year that the action or inaction took place.

Example: In 2006, a TPA/Insurer issues a payment for TTD late by three weeks. In 2008, DIR audits the file and finds this late issuance and finds a BP. The matter is litigated and, in 2009, found to be a valid and finable offense. The number of claims used would be the total number of claims filed with that TPA/Insurer in 2005 (not 2009), the full calendar year preceding the offense.

Were using the preceding year of the offense because if the offense occurs in the current calendar year and a BP is assessed, the total number of claims for the current year have not yet been filed by the time the BP payment is due.

February 16, 2010 Hearing

The hearing was conducted on **February 16, 2010**, at two sites via videoconference: the main site was at the Sawyer Building in Las Vegas; the other site was at the Legislative Building in Carson City. In Las Vegas, **36** people attended and **13** testified; in Carson City, **15** attended and **5** testified. The oral testimony is summarized as follows:

Jim Werbeckes, EMPLOYERS: We have several sections in here that deal with NAC 616D.411, I am going to concentrate on page 116. This provision came out in Senate Bill 195, the 2009 session, it was an agreement between the trial bar to take a look at the three violations in five years that was very punitive to the large carriers which handle a large volume of claims. The insurers and the trial bar agreed to remove that provision, that was removed in Senate Bill 195, and we agreed to adopt regulations at that time to take into account the size of the carrier versus the benefit penalties were imposed.

During the workshop back in July, I brought a proposal which had a concept. If a carrier with 99.5% compliant, they would only have a $5,000 penalty imposed. That didn't gain a lot of traction at that hearing, and we went back and retooled what we took out of that from both the trial bar and from folks who had discussed this. And that is a proposal that we have here on page 116 and 117, which Bob Ostrovsky, and I drafted. The new concept looks at three different tiers, which are also based on two-year average number of claims handled as well as two years averaged benefit penalties.

In order to have some good data on this for the DIR to use this, we have excluded the most recent years. So from this example of where looking at 2010 to implement this we would exclude the data from 2009 because that data is probably not true data at this point in time. So we would end up using a 2007 and 2008 to determine the average number of claims handled and the average number of benefit penalties imposed. (See examples in packet.)

This takes us out of that re-occurring function. When we put these tiers together, these tiers were developed to looking at carriers with a first benefit penalty imposed with an additional kicker.

The carrier would be 99.8% compliance, that carrier is doing a pretty good job when they are getting their first benefit penalty at 99.8% compliance. This is also just one provision within this section, the DIR also has other items that they can charge to increase the benefit penalty, but that overall is our concept and I will entertain any questions.

Robin Drew, Injured Worker: I am concerned about any attempt to change the structure of developing enhancement assessments. When I hear the testimony that says suppose an insurer is 98% compliant, there is a compliance issue problem already. We don't know how compliant the insurer is we have no way of knowing how compliant the insurer is, we only know how many times the insurer has been caught. We only know how many times the Division has had to be ordered to find a violation. So I can't ever accept the idea that an insurer is a certain percentage compliant unless I know that there is someone who is forensically going through the insurer's files and making sure the insurer is compliant.

Barbara Gruenwald, Nevada Justice Association: This regulation states that the DIR will use the two most complete years. When we were in negotiations with Employers during the last session of the legislature, it was our understanding that it would be three or four years, so we would ask for four, but if DIR wants to compromise with three then we would really appreciate that.

Secondly, there is no data upon which to base this point system, so we don't know whether the point system that EMPLOYERS has submitted here will work. What we would like to do is ask DIR to compile some data so that we might be able to see how this regulation is going to work or whether it is going to work and ask that the regulation be reviewed two years from now after the next session of the legislature.

The third point is the problem with this point system is that the worst offenders, in our experience over the last several years, have been large insurers who have received multiple violations for systemic errors, not just the errors of individual adjusters. I'm not sure whether this point system will help the claimant because these systemic errors might not be corrected by expanding this point system.

This point system provides more of an incentive for insurers to try and slip in under the wire and continue these systemic errors. We are asking that this body review the point system and not make it as liberal as it is.

There were **2** written comments submitted by the **March 8, 2010** deadline announced at the hearing. These comments are presented as follows:

Jim Werbeckes, EMPLOYERS

The added language in this section was to address the Nevada Legislature directive to take into account the size of an insurer in relation to the number of benefit penalties assessed. The proposal developed in this section creates a three tier point system based on the number of claims handled over the past two complete years. This proposal provides an incentive over the current system for an insurer or third-party administrator not to incur a benefit penalty thus resulting in

better service to the injured worker. The Nevada Trial Lawyers Association indicates at the hearing that the look back period should be three to five years. During the negotiations of Senate Bill 195 the only time frame discussed was two years. Lastly, the tiers in this proposal were developed to impose an additional benefit penalty above the standard $5,000.00 on insurers or third-party administrators who exceed a compliance rate of 99.998%. We feel this is a very substantial bar for any business to maintain.

Marvin Gross, Nevada Justice Association, King, Gross, & Sutcliffe, 3017 W. Charleston Blvd., #50, Las Vegas, Nevada 89102, (702) 870-3555

First, since none of us are particularly good at mathematics, we couldn't tell whether or not the "look back period" for purposes of determining the average number of prior years violations was two years or three. Perhaps the language in this regard could be clearer. Additionally, our concern was that by utilizing a shorter period of time than the five years previously specified, the insurance industry was being allowed to absolve themselves of their prior violations too quickly. We would suggest a longer duration such as three to four years before the prior violations would no longer be taken into account.

The other major concern which we had is that the proposed regulation seems to imply that the more claims an entity has, the more likely they are to commit errors, and as a result, they should be given greater latitude before the number of violations begin to accrue additional benefit penalty points. We wanted to know whether or not there was any empirical data to substantiate this assumption one way or the other. Further, some of the worst offenders in our experience over the last several years have been large insurers who have received multiple violations for systemic errors, not the errors of individual adjusters. Since these systemic errors were business decisions made by the insuring entity, it doesn't seem appropriate to award that type of behavior with further insulation from additional benefit penalties.

Finally, since Mr. Badger and I have distinct memories of sitting in on the meetings concerning the adoption of the point enhancement system, and since neither he nor I have ever had it utilized in any of our cases, we were wondering whether there is any data as to the number of times that this type of additional penalty has been used, and to what extent.

4. For each person identified in paragraphs (b) and (c) of number 3 above, the following information if provided to the agency conducting the hearuing

(a) Name;
(b) Telephone number;
(c) Business address;
(d) Business Telephone number;
(e) Electronic mail address; and
(f) Name of entity or organization represented.

To the extent the requested information was provided to the agency, this information was included in the Response 3 immediately above.

5. A description of how comment was solicited from affected businesses, a summary of their responses and an explanation of how other interested persons may obtain a copy of the summary.

The Division publicly posted Notices of each of the workshops held on **July 12, 2007** and **July 17, 2009,** as well distributing these Notices via e-mail to each of the individuals who enrolled with the Division for electronic notification. The Division publicly posted notices of the public hearing held on **February 16, 2010**, as well distributing this notice via e-mail to each of the individuals who enrolled with the Division for electronic notification.

A summary of the responses from the public and affected businesses is included in Response 2 below of this Amended Informational Statement and may be obtained by contacting the Division of Industrial Relations' Workers' Compensation Section at the following locations:

Workers' Compensation Section
1301 N. Green Valley Pkwy., #200
Henderson, NV 89074
Telephone: (702) 486-9080

Workers' Compensation Section
400 W. King St., #400
Carson City, NV 89703
Telephone: (775) 684-7270

6. If the regulations were adopted without changing any part of the proposed regulations, a summary of the reasons for adopting the regulations without changes.

The Division did change the wording of the proposed regulations based on suggestions provided by the oral testimony during the workshop and hearing and the written comments submitted by the announced deadlines.

The Division did not change the wording of the proposed changes to NAC 616D.315; 616D.400; 616D.405. These regulation amendments adding employer leasing companies are required to implement SB 361 (2009) legislation.

In the matter of untimely payments, the Division did not change the wording as suggested by the oral testimony during the hearing and the written comments submitted by the announced deadline. A subsequent review of the draft language by Division Counsel determined that the proposed language was sufficient, including ancillary issues of tracking payment issuance and receipt.

In the matter of the Division recommendation to the insurance commissioner, the Division did change the wording as suggested by the oral testimony during the workshop and hearing and the written comments submitted by the announced deadline. Wording in section 1(b) was changed to better define staffing requirements.

However, the Division chose to stay with the more expansive definition of "principal" (2(b)) as well use "debt" as defined in 2(a), which is worded purposely not to be all inclusive.

As for factors to be considered in calculating and imposing benefit penalties, wording in section 3 was changed to reflect increased maximum penalties authorized by the legislature (SB 195,

Sec. 10)(2009). Also, the benefit penalty exclusion criteria conforms to legislative intent promulgated in 2007 legislation (AB 496. Sec. 19) which created a two-tier benefit penalty structure. In addition, employee leasing companies were added to the list of possible benefit penalty violators pursuant to AB 24, Sec. 13.8 (2009).

The Division did change the wording as suggested by the oral testimony during the workshop and hearing and the written comments submitted by the announced deadline. The three-tier benefit penalty levels were adopted after review of various point scales submitted and internal Division review. The decision to use a three-year look back to gauge claim activity level is a consensus compromise based on comments received.

However, the Division deemed the suggestion to convene a special task force to further study this matter unfeasible and unnecessary. Also, it was noted that the legislature deleted language in the statute for a 5-year review of past benefit penalty offenses and the regulation should follow suit.

7. The estimated economic effect of the adopted regulations on the businesses which it is to regulate, and on the public.

(a) Estimated economic effect on the business which they are to regulate.

(b) Estimated economic effect on the public which they are to regulate.

Concerning qualifications for an administrator seeking a certificate of registration to gain an approval recommendation from the division of industrial relations

Adverse: The Division believes that there is an adverse economic effect of the regulations on regulated businesses, both immediate and long-term, if administrators fail to meet the newly established criteria and qualifications.

Beneficial: The Division believes that there are beneficial effects, both immediate and long-term, for injured employees via improved claim handling.

The regulations also do not impose any significant regulatory burdens associated with compliance.

Adding employee leasing companies to Chapter 616D, NAC enforcement provisions

Adverse: The Division believes that there are no adverse economic effects of the regulations on regulated businesses or the public, both immediate and long-term.

Beneficial: The Division believes that there are some beneficial effects, both immediate and long-term, for injured employees whose rights or benefits have been violated or delayed by an employee leasing organization.

The regulations also do not impose any significant regulatory burdens associated with compliance.

Concerning the determination of an untimely pattern of payments pursuant to NRS 616D.120(1)(h).

Adverse: The Division believes that there are no adverse economic effects of the regulations on regulated businesses, both immediate and long-term, which should already be making required payments in a timely matter.

Beneficial: The Division believes that there are beneficial effects, both immediate and long-term, for injured employees through improved delivery of timely compensation.

The regulations also do not impose any significant regulatory burdens associated with compliance.

Concerning factors to be considered in calculating and imposing benefit penalties under NAC 616D.411.

Adverse: The Division believes that there is an adverse economic effect of the regulations on injured employees, both immediate and long-term, if multiple "mini - BP" violations accumulate and reduce overall benefit penalty compensation but in turn do not motivate lawful and expeditious claim administration to avoid benefit penalties. Introducing the notion of proportionality in assessing and levying benefit penalties may have adverse effects, both immediate and long term, to injured employees who may receive reduced benefit penalty compensation.

Beneficial: The Division believes that the beneficial economic effect of the regulations on business is minimal. There are beneficial effects, immediate and long-term, for benefit penalty violators assessed "mini - BPs" per NRS 616D.120(3)(b) who avoid more substantial and costly "regular" benefit penalties. Introducing the notion of proportionality in assessing and levying benefit penalties may have beneficial effects, both immediate and long term, for insurers and third-party administrators by payouts to injured employees.

The regulations also do not impose any significant regulatory burdens associated with compliance.

8. The estimated cost to the agency for enforcement of the adopted regulations.

The Division estimates that the costs of the enforcing and administering these regulations will be minimal.

9. A description of any regulations of other state or government agencies, which the proposed regulations overlap or duplicate, and a statement explaining why the duplication or overlapping is necessary. If the regulations overlap or duplicate a federal regulation, the name of the regulating federal agency.

The Division believes that the proposed regulations do not overlap or duplicate any existing state, federal or other government regulations.

10. If the regulations include provisions which are more stringent than a federal regulation which regulates the same activity, a summary of such provisions.

There is no federal regulation that regulates the same activity.

11. If the regulations provide a new fee or increase in existing fees, the total annual amount the agency expects to collect and the manner in which the money will be used.

The regulations do not provide for ongoing new fees or an increase in existing fees.

Dated this 25th day of September, 2013.

By:

/s/

Charles J. Verre, CAO
Department of Business and Industry
Division of Industrial Relations
Workers' Compensation Section
1301 N. Green Valley Pkwy., #200
Henderson, NV 89074