# STATE OF TENNESSEE

## WORKERS' COMPENSATION ADVISORY COUNCIL

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***ADVISORY COUNCIL COMMENTS***

***re:***

***WORKERS' COMPENSATION LEGISLATION***

***2008***

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**Dale Sims, State Treasurer, Chair**

**M. Linda Hughes, Executive Director**

# WORKERS' COMPENSATION ADVISORY COUNCIL

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## *ADVISORY COUNCIL COMMENTS*
## *re:*
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| Jack Gatlin | Voting Member | Employees |
| Jerry Lee | Voting Member | Employees |
| Stewart Meadows | Voting Member | Employers |
| Bob Pitts | Voting Member | Employers |
| Gary Selvy | Voting Member | Employers |
| Kitty Boyte | Nonvoting Member | Tennessee Defense Lawyers Association (TDLA) |
| Kenny McBride | Nonvoting Member | Local Governments |
| Jerry Mayo | Nonvoting Member | Insurance Companies |
| Sam Murrell, M.D. | Nonvoting Member | Health Care Providers |
| A. Gregory Ramos | Nonvoting Member | Tennessee Bar Association (TBA) |
| David Stout | Nonvoting Member | Health Care Providers |
| James G. Neeley, Commissioner<br>Dept. Labor/WFD | Ex-Officio Member | |
| Leslie Newman, Commissioner<br>Dept. Commerce & Insurance | Ex-Officio Member | |
| Sen. Joe Haynes<br>Chair, Joint Committee | Ex-Officio Member | |
| Rep. Randy Rinks<br>Co-Chair, Joint Committee | Ex-Officio Member | |
| Vacant | Nonvoting Member | TN Association For Justice (Formerly Tennessee Trial Lawyers Association) |

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*SB2902 (Stanley) has been placed in General Subcommittee; however, since the companion bill - HB 3699 (Cobb, C.) is currently proceeding in the House committees, the Advisory Council did review the bill.

NOTE: SB 3071 (Kyle)/HB3814 (Fitzhugh)]: Senator Kyle's office notified the Executive Director of the Advisory Council that the bill would not be pursued; therefore, the Advisory Council did not review this bill

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*NOTE: Re: HB 3814 (Fitzhugh) / SB3071 (Kyle)
Senator Kyle's office notified the Executive Director of the Advisory Council that the bill would not be pursued; therefore, the Advisory Council did not review this bill

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| | 3117 p. 15 | Burchett | 3988 | Brooks, H | Changes proximate cause ("due to") standard of proof in cases where employee tests positive for drugs/alcohol to "contributing cause of injury". |
| | 3271 p. 18 | McNally | 3710 | Fitzhugh | changes liability of employer in recreational activities cases - no liability unless employer has expressly required participation or employer derives substantial direct benefit from activity (intangible value of improving employee's health and morale is not sufficient). |
| | 3862 p. 21 | Norris | 3801 | Curtiss | Revises definition of injury - injury does not arise out of and in course of employment if the injury occurs while employee is in the employee's residence or on employee's property unless employee is actively engaged in a defined work activity within an established immediate work area. |

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| | 3890<br><br>p. 35 | Marrero, B | 3843 | Turner, M | Permits psychologist to give expert opinion regarding impairment rating by any appropriate method used and accepted by medical or psychological community. |
| **UTILIZATION REVIEW**<br><br>pp. 37 - 39 | **SB#** | **Sponsor** | **HB#** | **Sponsor** | **DESCRIPTION** |
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| | 3177<br><br>p. 42 | Johnson | 3712 | Fitzhugh | permits compensation to be paid in lump sum without court determination that it is in employee's best interest and employee has ability to manage lump sum; deletes provision permitting lump sum attorney fees; requires commutation to be equal to value of all future installments calculated on 6% basis (4% basis if coal worker's pneumoconiosis. |
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**AMENDED** ***SB 2989 by Herron / HB 4160 by Ferguson**

***Present Law***

*TCA* §50-6-103 requires every employer subject to the workers' compensation law to pay compensation for injuries/death that are caused by accident arising out of and in the course of employment without regard to fault. *TCA* §50-6-102(12) defines employer as any individual or entity who uses the services of not less than five (5) persons for pay, with two exceptions. An employer engaged in the mining and production of coal and a person engaged in the construction industry (*TCA* §50-6-113) with one (1) employee are subject to the workers' compensation law.

***Proposed Change***

The Advisory Council discussed the original bill at its meeting on February 15, 2008 and the consensus of the members included suggesting the bill be tied more closely to the Federal Social Security exemption and suggesting all employees, religious sect members and non-sect members, be counted for purposes of determining whether the employer is required to purchase workers' compensation coverage. These comments were communicated to the sponsor and an amendment was submitted to the Council for consideration at its meeting on February 29, 2008.

**Amended** SB 1811 / HB 287 adds a new section to Title 50, Chapter 6, Part 1. The amendment permits an employer to file an application with the Department of Labor/WFD to be excepted from the workers' compensation law in respect to certain employees. The application shall include:

(1) a written waiver by the employee of all benefits under the workers' compensation law;
(2) an affidavit from the employee that he/she is a member of a sect or division and an adherent to established tenets or teachings such that the employee is opposed to acceptance of any benefits of public or private insurance.

The department is to promulgate a form to be used for the waiver and affidavit.

The application is to be granted by the Department if it finds proof that the employee has an approved exemption from the federal internal revenue service Form 4029 (which must accompany the application for exemption). The federal exemption is to be considered by the Department as prima facie proof of compliance with the provisions of the law.

***SB 2989 by Herron / HB 4160 by Ferguson, continued.**

***Proposed Change, cont.***

If the employee is a minor, the waiver and affidavit may be made by a guardian of the minor. The exception granted as to a specific employee shall be valid for all future years unless such employee or sect ceases to meet the requirements of the section.

Additionally, the amendment provides that any employee exempted from the provisions of the workers' compensation law shall still be counted when determining whether an individual or entity is an "employer" under the Tennessee workers' compensation law.

***Practical Effect***

The amended bill creates a mechanism by which employers can exempt themselves from paying workers' compensation benefits to certain employees who meet the criteria set out in the bill. A guardian can submit the waiver and affidavit on behalf of a minor. The amendment addresses two of the concerns expressed by all the Advisory Council members when the original bill was reviewed on February 15, 2008: tying the Tennessee law more closely to the Federal Social Security exemption and counting all employees for purposes of determining whether the employer is required to purchase workers' compensation insurance.

***Comments of Advisory Council Members re: Amendment***

Commissioner Neeley (Ex Officio Member) stated if the exemption is tied to the Federal requirement it will be fairly clear who will qualify and who will not and the other requirement that all employees be counted in determining whether the employer must have workers' compensation coverage, then the bill is clear to the Department.

Mr. Farmer (Employee Representative) stated as a representative of employees he is opposed to endorsing any waiver of benefits by an employee when the waiver is being negotiated between the employer and the employee, which is on its face an uneven bargaining position. In addition, he does not support permitting a parent to waive the rights of a minor when the waiver may be based on the parent's religious belief but not the minor's religious beliefs.

***SB 2989 by Herron / HB 4160 by Ferguson, continued.**

***Comments of Advisory Council Members re: Original Bill***

**NOTE: The Advisory Council reviewed the original bill on February 15, 2008. The following are general comments that are related to the original bill that were not addressed by the Amendment or reiterated during the discussion at the meeting on February 29, 2008.**

Mr. Ramos (TBA Representative) stated there is nothing in the law to require an employee to accept workers' compensation benefits. He questioned whether the intent of the proposed law is to reduce the amount the employer is required to pay for workers' compensation insurance coverage.

Mr. Farmer (Employee Representative) stated the bill creates an enormous potential for abuse as an employer could require every employee to sign the waiver in order to continue employment. It creates an opportunity to take advantage of an uninformed and possibly uneducated employee and as an employee representative does not see how he could favor anything that reduces coverage of workers' compensation for Tennessee's workers. He also pointed out there is nothing in the law that requires an employee to accept workers' compensation benefits and questioned what would happen if an employee who is a member of the religious sect changes his mind as to the need for benefits because of the severity of the injury. Mr. Farmer stated the bill creates an unequal bargaining position between the employer and employee.

Mr. Lee (Employee Representative - Voting Member) expressed concerns regarding a religious group or member of the group forcing a relative to sign the waiver and thereby be prohibited from receiving workers' compensation benefits.

***SB 2990 by Herron / HB 4140 by McDonald**

***Present Law***

*TCA* §50-6-405 requires every employer who is subject to the workers' compensation law to either purchase insurance or qualify as a self-insured employer. *TCA* §50-6-406 requires each employer or insurer to file notice with the division of workers' compensation that it has complied with the law and if the employer fails to comply the employer is either liable to the injured employee for workers' compensation benefits or for damages in tort.

*TCA* §50-6-412 establishes **mandatory** monetary penalties for an employer who is subject to the workers' compensation act but has failed to obtain insurance. The monetary penalties are based on what the employer's insurance premium would have been for the time period the employer was not in compliance - calculated using the appropriate assigned risk plan advisory prospective loss cost and multiplier.

*TCA* §50-6-118 requires the division of workers' compensation, by rule, to establish and collect penalties for:

(1) failure of a covered employer to provide work comp coverage or qualify as self-insured;
(2) late filing of
- accident reports
- notice of denial of a claim
- notice of a change in benefit payments
- notice of filing of a lawsuit;

(3) bad faith denial of claims; and
(4) failure to file judgments

The penalties for failure to obtain insurance or qualify as self-insured are to be paid into and become a part of the uninsured employers fund. The other penalties are paid into the second injury fund.

***Proposed Change***

SB 2990 / HB 4140 adds a new subsection (d) to *TCA* §50-6-118. It would give the Commissioner of Labor/WFD sole discretion to reduce or waive fines/penalties arising out of the employer's failure to provide workers compensation insurance coverage or qualify as a self-insured employer provided the employer had paid all medical and other workers' compensation benefits available to the injured employee under the workers' compensation law.

***SB 2990 by Herron / HB 4140 by McDonald, continued.**

***Practical Effect***

The bill creates an incentive for an employer not to carry workers' compensation insurance in violation of the law. The bill undermines the rationale for the 1999 enactment of significant penalties for failure to comply with the workers' compensation law. Prior to the enactment of *TCA* §50-6-412, which mandates specific monetary penalties based on the premiums that the employee should have paid during the time of noncompliance, there was no significant deterrent to employers who failed to obtain workers' compensation insurance coverage.

***Informational Note***

The statute requiring specific penalties for noncompliance with the workers' compensation law has been in effect since 2000.

***Comments of Advisory Council Members***

Commissioner Neeley (Ex Officio Member) indicated it is much easier today with electronic reporting for the Department to determine whether an employer has workers' compensation insurance. He questioned the fairness of a system that would penalize an employer who does not have insurance yet no employees have sustained any work related injuries. He stated the current system is straightforward and it is working well - when you get into discretion, the question is how much discretion. The current system is consistent - everybody knows what will happen if they are caught without coverage.

Mr. Farmer (Employee Representative - Voting Member) stated the bill is an incentive for an employer not to have insurance. It would permit an employer to take a risk and then file bankruptcy if an employee has a significant injury.

Ms Boyte (TDLA Representative) stated the bill favors the richer employer over the poorer employer.

It was the consensus of all the Advisory Council members that the current system is working well.

***SB 3117 by Burchett / HB 3988 by Brooks, H.**

***Present Law***

*TCA* §50-6-110(a) provides that no compensation shall be allowed for an injury or death **due to**

- the employee's willful misconduct;
- the employee's intentional self-inflicted injury';
- the employee's intoxication or illegal drug usage; or
- the employee's willful failure to use a safety appliance or perform a duty required by law.

*TCA* §50-6-110(c)(1) provides in those instances where the employer has implemented a drug-free workplace (DFWP) pursuant to Title 50, Chapter 9, it the injured employee has, at the time of injury, a blood alcohol greater than .08% for non-safety sensitive positions or .04% for safety-sensitive positions OR if the injured employee has a positive test for drugs (as defined in the DFWP Act) it is presumed that the drug or alcohol was the **proximate cause** of the injury. The presumption can be rebutted by the employee by a preponderance of the evidence that such drug or alcohol was not the **proximate cause** of the injury.

***Proposed Change***

SB 3117 / HB 3988 rewrites *TCA* §50-6-110(a) in its entirety and deletes the first two sentences in *TCA* §50-6-110(c)(1).

The bill, as drafted, eliminates the provision of *TCA* §50-6-110(a) that does not allow compensation for injury/death due to an employee's willful failure to use a safety appliance or perform a duty required by law. The bill also changes the standard related to when compensation is denied if the employee is intoxicated or has positive drug tests for illegal drugs.

The new language of *TCA* §50-6-110(a) would read:

"No compensation shall be allowed for an injury or death due to the employee's willful misconduct or intentional self-inflicted injury, or in which the employee's intoxication or illegal drug usage was a contributing cause of the injury."

The bill changes the presumption in *TCA* §50-6-110(c)(1) from "the proximate cause of the injury" to a "contributing cause of the injury".

***SB 3117 by Burchett / HB 3988 by Brooks, H., continued.**

***Practical Effect***

The bill changes the standard by which compensation can be denied in circumstances where an employee tests positive for drugs or alcohol. While current law requires proof that the intoxication /drugs proximately caused the injury, the new law will prohibit payment of compensation if the employee's intoxication/drug use contributed to the injury.

***Informational Note***

The bill appears to be a reaction to the Supreme Court's opinion in *Interstate Mechanical Contractors, Inc. v. McIntosh*, 229 S.W.3d 674 (Tenn. 2007) which held the employee's injury must be caused by the drug or alcohol use in order to deny benefits; drug use alone does not defeat a claim for benefits. In that case there was testimony that the employee's marijuana use may have slowed his reaction time and prevented his ability to avoid his injuries but there was also testimony that there was no time for him to react before the machine, activated by an employee in training, crushed his hand.

***Comments of Advisory Council Members***

Mr. Mayo (Insurance Companies Representative) suggested the bill be amended to re-instate the provision of current law that does not allow compensation for injury/death due to an employee's willful failure to use a safety appliance or perform a duty required by law.

Mr. Farmer stated it is important to understand that "proximate cause" is a well defined, well understood critical term understood in the law. Lawyers and judges know what the term means. However, "contributing cause", could mean a hundred different things to a hundred different people. Mr. Farmer stated in the *Interstate Mechanical* case, the fact the employee smoked marijuana three days before the injury had absolutely nothing to do with his injuries and no one could demonstrate that it did. If "contributing cause" had been the standard applied to that case, then it is totally likely the employee would have received no workers' compensation benefits because there is no legal definition of "contributing cause".

***SB 3117 by Burchett / HB 3988 by Brooks, H., continued.**

***Comments of Advisory Council Members, cont.***

Mr. Ramos (TBA Representative) said "contributing cause" is a vague term that could be anywhere from 1 percent (1%) to 100 percent (100%); if the intoxication is 1% under the terms of the bill the employee would receive no benefits.

Ms. Boyte (TDLA Representative) stated this bill appears to be an attempt to redress a situation where someone disagreed with a Supreme Court decision and attorneys could probably do that every day. In reality, cases are going to be determined by the trier of fact and you cannot legislate that - it must be determined by the trier of fact - what is the causal connection to the injury.

Mr. Lee (Employee Representative - Voting Member) stated marijuana will stay in a person's system for thirty (30) days. If you are injured - it should be the amount of impairment to the employee that impacts the decision not whether the employee tested positive for drug use that occurred some time ago prior to the injury.

It was pointed out by the members of the Advisory Council that the defense of intoxication is currently available to any employer, whether they operate under the Department approved drug free workplace program, whether they have an internal drug use policy or whether they have no policy related to drug use. Proximate cause (that drug use caused the injury) is required under present law. Under the proposed bill, benefits would be denied if the drug use was a contributing cause of the injury.

Mr. Pitts (Employer Representative) noted the decision is one of public policy - you either want to permit award of workers' compensation benefits that require proof that the intoxication or drug use caused the injury OR you want to deny all workers' compensation benefits if the employee tests positive for drugs or alcohol in the workplace without there being any causal connection between the injury and the drug use.

***SB 3271 by McNally / HB 3710 by Fitzhugh**

***Present Law***

*TCA* §50-6-103 requires the employer to pay for personal injury or death by accident arising out of and in the course of employment without regard to fault. There is no other statute that specifically addresses the compensability of injuries incurred during recreational activities. Tennessee courts have dealt with this issue and have found some injuries during recreational activities to be compensable and some not to be - depending on the specific facts of each case.

*TCA* §50-6-110 is the statute that addresses when injuries are not covered: injuries due to willful misconduct; intentional self-inflicted injury; intoxication or drug use; or refusal to use a safety appliance or perform a duty required by law.

***Proposed Change***

SB 3271 / HB 3710 adds a provision to *TCA* §50-6-110. Under the bill, injuries incurred during an employee's recreational activities are not compensable unless

- the employer expressly required participation or made the activity part of the services of the employee; or
- the employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health or morale.

***Practical Effect***

The bill adds injuries that will not be held compensable to the workers' compensation law - injuries that are incurred during recreational activities at work.

***Informational Note***

The bill is in response to the Supreme Court's holding in *Gooden v. Coors Technical Ceramic Co.,* 236 S.W.3d 151, Tenn. 2007, that the death of the employee due to exertion from playing basketball during a work break to be compensable because the employer knew the employees played on break and the employees were not permitted to leave the employer's premises during breaks. The Court held that each case involving injuries during recreational activities is decided on the individual facts of each case.

***SB 3271 by McNally / HB 3710 by Fitzhugh, continued**

***Informational Note, cont.***

In *Gooden*, the employer did not permit the employees to leave the employer's premises during their breaks; a basketball goal was erected by the employees on the employer's premises and each night during break, the employees, including supervisors, would play basketball. The employee, Mr. Gooden, had a heart attack as a result of the exertion of the basketball game. The Supreme Court upheld the award of death benefits based on the facts of the case: employees were not permitted to leave during break; the employer was aware of the basketball games; supervisors participated in the basketball games.

In other recreational cases workers' compensation benefits have been denied to an employee who was injured during a recreational activity. One case, *McCammon v. Neubert*, 651 S.W.2d 702 (Tenn. 2005) involved an injury to an employee while participating in a three leg race at the employer-sponsored company picnic. The Court held the injury did not occur during the course of employment as the picnic was held on Saturday outside work hours, at a public park and not on the employer's premises.

***Comments of Advisory Council Members***

Mr. Ramos (TBA Representative) stated the decision in the *Gooden* case was factually driven. He questioned the provision in the bill that requires the employer to expressly require participation in a recreational activity in order to be compensable. Often, there is subtle pressure on an employee to participate in certain recreational activities - playing on a baseball team, in a basketball game, etc.

Ms. Boyte (TDLA) noted cases involving injuries during recreational activities have come up for years. She stated you cannot legislate what people can and cannot do on their breaks, at company picnics, on company retreats, in workout rooms, the real issue is what is the definition of an "on the job injury" - did the accident occur when the employee was doing an activity he/she was paid to do. As long as there are workout rooms, basketball goals in parking lots, these cases will continue to arise until the "What is an on the job injury"" issue is resolved.

Mr. Farmer (Employee Representative) stated there has never been a "bright line" rule on recreational injuries in Tennessee workers' compensation law. It has always been the role of the Court to interpret each fact situation individually and make a determination on an individual basis.

***SB 3271 by McNally / HB 3710 by Fitzhugh, continued**

***Comments of Advisory Council Members, cont.***

Mr. Farmer (Employee Representative) said in his opinion it serves both employers and employees best to allow the Court to look at each situation individually. This type legislation could discourage the employer from providing services that are valuable to both the employer or employee. The response to one fact-driven case should not be to make a change in the law itself. There are numerous examples where a court has decided both for and against the employee in a recreational injury case and the response of the losing party each time a new case is decided should not be to change the law to address this specific case. It is hard to argue the Supreme Court has not done a fair job of looking at each situation over the last 50 years. This legislation would deprive the Court of making important decisions in this very difficult area of the law.

Mr. Pitts (Employer Representative) noted it appears the Supreme Court is in a new era of accepting appeal of certain workers' compensation cases before the case is heard by the Special Appeals Panel. The *Gooden* case was such a case and the employer community feels *Gooden* broadens employer liability in recreational settings. He said there are employers who have invested lots of money in recreational facilities for their employees who are very concerned as to whether they should drop their wellness programs and/or remove their exercise facilities to avoid any potential liability for recreational activities that are not under the direction of the employer. Mr. Pitts stated that this is a far reaching case in employers' minds and there is great interest in some clarification of the law to identify general principals that will apply so everyone knows what cases are and are not compensable in the realm of recreational activities.

Mr. Farmer (Employee Representative) noted the primary issue is a changing workplace and rather than reacting to an individual case perhaps the issue should be reviewed in a broader sense - changing the definition of accidental injury - instead of legislating a response to one individual case instead of looking at the changing workplace.

***SB 3862 by Norris / HB 3801 by Curtiss**

***Present Law***

*TCA* §50-6-102(13) defines "injury" and "personal injury" as an injury by accident that arises out of and in the course of employment that causes disablement or death; the definition includes occupational injuries and mental injuries. "Mental injury" is further defined in *TCA* §50-6-102(16).

***Proposed Change***

SB 3862 / HB 3801 adds a qualifying phrase to the definition of "injury" and "personal injury" to provide that an injury/personal injury does not arise out of and in the course of employment under the following circumstance:

- while the employee is in the employee's residence or on the employee's property;
- UNLESS the employee is engaged in a defined work activity within an established immediate work area.

***Practical Effect***

The proposed change prohibits the recovery of workers' compensation benefits for an employee who is either a "telecommuter" who works from the employee's home or who is performing work at home unless the injury occurs when the employee is engaged in a specific work activity within the employee's immediate work area. The bill also applies to any property of the employee, not just the residence.

***Informational Note***

The bill appears to be a response to the recent Supreme Court opinion in *Wait v. Travelers Indem. Co. of Illinois*, 240 S.W.3d 220 (Tenn. 2007), which was issued in November, 2007. In that case the Supreme Court held the injuries suffered by an employee who worked from a home office, with permission of the employer, as a result of a physical assault by an acquaintance during the employee's lunch break DID arise in the course and scope of her employment but DID NOT arise out of her employment. Therefore, the Court held the employee was not entitled to receive workers' compensation benefits.

***SB 3862 by Norris / HB 3801 by Curtiss, continued.**

***Comments of Advisory Council Members***

Mr. Farmer (Employee Representative) suggested the issues raised by this bill and the bill related to recreational injuries are important issues that deserve and need to immediate study. He suggested that the General Assembly consider allowing a group such as the Advisory Council to study the definition of accidental injury as it relates to the changing workplace and to report suggestions to the General Assembly as to how these issues can be addressed.

Mr. Mayo (Insurance Companies Representative) stated the issues are basically identical - a changing workplace and concurred in the suggestion that the Advisory Council study the issue.

***SB 2902 by Stanley / HB 3699 by Cobb, C.**

***Present Law***

*TCA* §50-6-405 requires each employer in Tennessee to either purchase workers' compensation insurance, obtain a certificate of authority to self-insure from the Commissioner of Commerce and Insurance or be a member of workers' compensation pool for the purpose of qualifying as self-insured employers. The Commissioner of Commerce and Insurance has the authority to promulgate rules and regulations necessary for the administration of this section of the law. Chapter 0780-1-83 are the rules applicable to self-insured single employers and Chapter 0780-1-81 are rules regulating the person(s) who administer workers' compensation benefits for employers that self-insure (both single employers and those who are members of a pool).

*TCA* §50-6-405(b) requires the Commissioner of Commerce and Insurance to require each self-insured employer to maintain security in an amount to be determined by the Commissioner (not less than $500,000) to secure payment of the benefits to injured employees of the self-insured employer. The security can be in the form of negotiable securities, surety bond, certificate of deposit or letter of credit. Each type of security is to be held by the Commissioner and is required to be conditioned to run solely and directly for the benefit of the employees of the self-insured employer.

In addition, the self-insured employer is required to provide the department an annual certified financial statement that includes a statement of assets and liabilities, statement of profit and loss, and a detailed accounting for reserves for outstanding losses that have been incurred in connection with its workers' compensation self-insurance. The statute also requires the employer's losses and adequacy of reserves to be certified biennially by an actuary. These filings are deemed to be confidential and not public records.

***Proposed Change***

SB 2902 / HB 3699 authorizes the Commissioner of Commerce and Insurance to promulgate rules for an alternative security system for self-insured single employers to collectively secure all or a portion of their aggregate liabilities through a self-insurers security fund.

***SB 2902 by Stanley / HB 3699 by Cobb, C., continued.**

***Practical Effect***

The proposed law would permit a single self-insured employer to effectively "pool" its liabilities with other single self-insured employers. Thus, the liability of each individual employer would be spread to other self-insured employers. The bill does not contain specifics as to the requirements of a "self-insurers security fund" - that would be left to the Commissioner through rule-making.

***Informational Note***

*TCA* §56-12-101, et seq. establishes a Tennessee Insurance Guaranty Association. Its purpose, as determined by the General Assembly and set out in the statute is "to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers." No similar guaranty association has been established for self-insured employers.

***Comments of Advisory Council Members***

**NOTE:** At the February 29, 2008 meeting of the Advisory Council, Deputy Commissioner John Morris, Department of Commerce and Insurance spoke regarding the background of the proposed bill. Commissioner Morris explained that the Department has taken a more conservative approach regarding the security required from self-insured employers because Tennessee, unlike a lot of other states, does not have a backstop for self-insuring employers in the event of insolvency. Insurance companies have the Guaranty Fund and self-insured pools have joint and several liability, but the self-insured single employer has no backstop, unlike the situation in several other states. As a result of the Department's proposed rules regulating the required security for self-insured employers the Department began discussions with the Tennessee Chamber and other interested parties regarding the possibility of creating a type guaranty fund for self-insured Tennessee employers and he believes the bill is the attempt by interested parties to begin the discussion of putting a guaranty fund structure in place in Tennessee to eliminate the more stringent bond requirements for self-insured employers. He indicated the Department is prepared to continue working on this possible guaranty structure. He did state that a statutory

***SB 2902 by Stanley / HB 3699 by Cobb, C., continued.**

***Comments of Advisory Council Members, cont.***

change will be required if such a fund is enacted into law, but does not believe any statutory change is necessary at present to enable the Department to continue discussions on the topic. Commissioner Morris also stated it is probably not realistic to expect anything to be finalized this legislative session.

None of the members had any comments given the remarks of Commissioner Morris.

***SB 2944 by Haynes / HB 3400 by Cobb,C.**

***Present Law***

*TCA* §50-6-405(c) permits ten (10) or more employers, with the permission of a trade or professional association, to pool their workers' compensation liabilities for the purpose of qualifying as self-insurers. *TCA* §50-6-405(c)(6) requires the sponsoring trade association to provide an annual confirmation that the participants in the pool comply with *TCA* §50-6-405(c).

***Proposed Change***

SB 2944 / HB 3400 removes the requirement that the sponsoring associations provide to the Commissioner of Commerce and Insurance confirmation that employer participants in the pool are in compliance with requirements for qualifying as self-insurers.

***Practical Effect***

The bill will remove a requirement that the sponsoring association verify that each member of the pool has complied with the statute permitting self-insurance via a pool arrangement. Each of the member employers is required to provide annually to the Commissioner a statement of financial condition audited by an independent certified public accountant. The individual member's financial statements and supporting documents are confidential and not public records. [see *TCA* §50-6-405(c)(3)(4)].

***Comments of Advisory Council Members***

Mr. Pitts (Employer Representative) stated the history of this bill originated a couple of years ago when a bill was passed in response to a situation involving an association-sponsored fund trying to leave the association's oversight. He stated this bill in no way weakens the pool/trust's responsibilities regarding the self-insured pool; the bill pertains only to the sponsoring association's responsibilities.

***SB 2668 by Burks / HB 2490 by Fincher**

***Present Law***

*TCA* §50-6-206(a)(1) provides that in all cases (settlements or any other court proceedings for workers' compensation) that involve a subsequent injury where the employee would be entitled to receive benefits - or is claiming compensation - from the second injury fund, the administrator of the division of workers' compensation shall be made a party defendant in any action filed either by the employer or injured employee.

Tennessee Rules of Civil Procedure permit a plaintiff to file a voluntary dismissal of a lawsuit and the Savings Statute (*TCA* §28-1-105) permits the claim to be re-filed within a year of the voluntary dismissal unless the claim is against the state or city and they have not waived immunity.

***Proposed Change***

SB 2668 / HB 2490 deems a claim timely filed – or re-filed – against an employer or insurer to be timely filed against the second injury fund (SIF) if the SIF is joined at the time of the original filing or joined later pursuant to the Tennessee Rules of Civil Procedure or pursuant to the Savings Statute. In addition, the bill adds language to the workers' compensation act to specify that sovereign immunity is waived for all purposes for any claims against the SIF.

***Practical Effect***

The bill changes the law that the Supreme Court addressed in *Davidson v. Lewis Bros. Bakery*, 227 S.W.3d 17 (Tenn. 2007). In that case the Supreme Court held a claim against the Second Injury Fund cannot be voluntarily dismissed and re-filed because the savings statute does not contain a waiver of the Fund's sovereign immunity.

***Comments of Advisory Council Members***

**NOTE:** Representative Fincher attended the meeting of the Advisory Council on February 29, 2008, to discuss the bill. He said many times attorneys find themselves adding the Second Injury Fund to a case needlessly because they do not know if the SIF will be needed later on. The intent of the bill was to extend the statute of limitations to file against the SIF until the time the liability of the Fund was put into issue as long as the original suit was timely filed. There was discussion with representatives of the Department of Labor/WFd regarding their estimate of the fiscal impact of the bill.

***SB 2668 by Burks / HB 2490 by Fincher, continued.**

***Comments of Advisory Council Members, cont.***

Mr. Farmer (Employee Representative) suggested to prevent the employee or employer who takes a voluntary dismissal of the lawsuit for a valid reason from re-filing the suit against the Second Injury Fund within the Savings Statute period creates a great inequity.

Mr. Ramos (TBA Representative) agreed that if the Second Injury Fund is already a party to the lawsuit and there is a legitimate reason for a nonsuit, the statute of limitations should be preserved against the Second Injury Fund also.

***SB 2882 by Haynes / HB 2494 by Fincher**

**NOTE:** Representative Fincher attended the meeting of the Advisory Council on February 29, 2008 and explained the purpose of the bill is to address those workers' compensation cases that have been filed (by attorneys representing employees) in court after the effective date of *TCA* §50-6-203(a) before the benefit review conference process has been exhausted. In some cases, the employer/insurer filed a motion to dismiss at the time the lawsuit was filed; in others, the employer/insurer did not file the motion to dismiss until after the parties participated in a benefit review conference (mediation). Some courts have dismissed the lawsuit for lack of jurisdiction; other courts have not. He restricted the bill to workers' compensation actions filed by the employee to prevent the jumpsuit by the employer.

***Present Law***

*TCA* §50-6-203(a) provides that "No claim for compensation under Workers' Compensation Law...shall be filed with a court...until the parties have exhausted the benefit review conference process."

***Proposed Change***

SB 2882 / HB 2494 prohibits a lawsuit that has been filed by an employee before the BRC process has been exhausted from being dismissed by the court. Under the bill, the lawsuit would be stayed until a benefit review conference is held at the request of the employer. Also, the bill states any other action should be dismissed upon a properly filed motion requesting such dismissal.

***Practical Effect***

This bill effectively eliminates one of the important aspects of the 2004 Reform Act that required the parties to participate in mediation prior to filing the lawsuit. The bill will permit the employee to file the lawsuit before mediation has occurred and requires the court to stay the action until the employer requests a BRC (mediation).

***SB 2882 by Haynes / HB 2494 by Fincher, continued.**

***Informational Note***

There have been reports that several courts in Tennessee are permitting attorneys to file workers' compensation lawsuits before a Benefit Review Conference has been held contrary to the specific language of *TCA* §50-6-203(a). Some courts have dismissed the lawsuits shortly after suit is filed; others have developed a local practice of permitting the filing of the lawsuits but staying any court action pending participation in the mediation process and others have dismissed the case after the parties have participated in mediation, failed to reach a settlement and have tried the case. This has created problems for workers in Tennessee - especially in instances where the employee's statute of limitation has run during the time between the filing of the lawsuit and the dismissal of the lawsuit. Therefore, it is suggested there are two policy choices regarding the lawsuits that have been filed: that the suit should be dismissed because the statute prohibits suits being filed before exhaustion of the BRC process or to permit the continued filing of the suits but require the court to stay any court action until the BRC has been conducted.

***Comments of Advisory Council Members***

Mr. Ramos (TBA Representative) suggested since the employer is permitted to file a workers' compensation claim the employer should also have the right to file the lawsuit before the BRC process has been exhausted.

Ms. Boyte (TDLA) Representative stated the bill would permit judges to ignore the legislative intent in the 2004 Reform Act that no suit shall be filed prior to a BRC.

Mr. Pitts stated that in his opinion as one who went through the reforms in 2004, there is no question as to what the legislative intent was - - there would be a full benefit review conference before any action can be filed in court. He stated the 2004 Reform Act struck a balance between those interests that want a full administrative system and those who want only a court based system. If you allow a person to file suit in court before participating in mediation, this may have a chilling effect on the mediation process and will gut the 2004 Reform Act.

Commissioner Neeley (Ex Officio Member) stated as a participant in the workers' compensation process in Tennessee for over 30 years, he feels this bill will effectively destroy the Department's mediation process.

***SB 2882 by Haynes / HB 2494 by Fincher, continued.**

***Comments of Advisory Council Members, cont.***

Mr. Farmer (Employee Representative) stated he believes the sponsors of the bill are addressing a real dilemma that exists - a genuine number of cases are pending in the system where judges have allowed lawsuits to be filed without a BRC being conducted prior to the suit being filed; in some instances the BRC has been conducted post-suit and there are pending motions to dismiss the lawsuits. He said there is merit to the bill in addressing those who are in limbo because lawsuits have been filed before a BRC and there is uncertainty as to whether the requirement of BRC before suit is procedural or jurisdictional. To do otherwise may punish innocent workers because lawyers may not know what they are doing and judges may tolerate it.

**AMENDED** **SB 2650 by Ketron / HB 2571 by Curtiss**

**NOTE:** Rep. Curtiss supplied the Executive Director of the Advisory Council with a copy of an amendment to this bill. It is this amendment that the Advisory Council discussed at the meeting on February 29, 2008 and the amendment that will be analyzed below.

***Present Law***

*TCA* §50-6-102(2) defines "AMA Guides" as the most recent edition of the American Medical Association guides to the Evaluation of Permanent Impairment, American Medical Association. The section also provides that if a new edition is published, it becomes effective as of January 1 following year of publication and states that the edition that is in effect on the date of the employee's injury is to apply.

*TCA* §50-6-204(d)(3) - enacted in 1992 - states: "...to provide uniformity and fairness for all parties in determining the degree of anatomical impairment sustained by the employee, the doctor/chiropractor who is permitted to give expert testimony shall utilize the **most recent** edition of the AMA Guides in determining the impairment rating". In the 2004 Reform Act the language was changed to state the expert must use applicable edition as provided in *TCA* §50-6-102. In addition *TCA* §50-6-204(d)(3)(C) was added to require the administrator of the division of workers' compensation to determine the date on which the most recent edition of the AMA Guides became effective and to maintain the effective date on the division's website.

***Proposed Amendment***

The amendment re-defines the "AMA Guides" by citing the full title of the publication and by deleting the reference to "most recent edition" and continues the law that the edition in effect on date of injury is applicable to the claim.

The amendment also amends *TCA* §50-6-204(d)(3)(C). The proposed amendment:

- permits the Commissioner of Labor/WFD to delay implementation of a new edition of the AMA Guides for up to six months following the date a new edition is published;
- requires the Commissioner to study the effect of the new edition on the workers' compensation system during the six months delay period;
- permits the Commissioner to decide whether the new edition should be implemented or whether to further delay implementation; and

**AMENDED** ***SB 2650 by Ketron / HB 2571 by Curtiss, continued.**

***Proposed Amendment, cont.***

- requires the Commissioner to
  - inform the Joint Committee and the Advisory Council of the Commissioner's decision regarding implementation as soon as the decision is made (or within a reasonable time immediately preceding the end of the six month period);
  - share as much information concerning the results of the study with the Joint Committee and Advisory Council; and
  - share the reasons for the decision to further delay implementation as the Commissioner deems appropriate.

***Practical Effect***

The amendment removes the statutory requirement that any impairment rating be based on the "most recent" edition of the AMA Guides (in effect on date of injury).

The amendment permits the Commissioner of Labor/WFD to decide any new edition of the AMA Guides should not be implemented. If the Commissioner's decision is to delay implementation, the amendment requires the Commissioner to study the impact of the new edition on the workers' compensation system during the 6 month delay before making a decision to implement or delay implementation indefinitely. The amendment requires the Commissioner to report the implementation decision to both the Joint Committee and the Advisory Council and to share information from the results of the study and the reason for any decision to delay implementation.

***Informational Note***

The AMA published the 6th Edition of the AMA Guides in December, 2007, and as a result of the current law, the 6th Edition became effective on January 1, 2008. Current law specifies the 6th Edition is applicable to injuries sustained on or after January 1, 2008.

As drafted, the amendment gives the Commissioner authority to delay implementation upon publication of a new edition of the AMA Guides - therefore, it appears the Commissioner will not have the authority to delay implementation until a new edition is published.

**AMENDED** ***SB 2650 by Ketron / HB 2571 by Curtiss, continued.**

***Informational Note, cont.***

When a new edition of the AMA Guides is published the actual book does not contain an exact date of publication - only the month and year are given. Therefore, it will be impossible for the participants in the system to determine when the six (6) months have expired to determine the date by which the Commissioner must decide whether to implement the new edition.

***Comments of Advisory Council Members***

Commissioner Neeley (Ex Officio Member) stated the Department's concerns regarding the 6th Edition of the AMA Guides arose as a result of its publication in December, 2007 and it would go into effect in less than a month without any time to analyze to see if it would increase costs or not. He stated Tennessee is not the only state that has concerns regarding the 6th Edition.

Dr. Murrell (Health Care Providers Representative) stated the amendment will have no effect on the 6th Edition of the Guides as they are currently in effect and are not "new".

Mr. Pitts (Employer Representative) suggested the effective date of the bill should be a specific date rather than "upon passage" and that consideration be given to including a date specific by which the Commissioner is required to conclude the study of a new edition and make a determination whether to implement a new edition of the AMA Guides or not. Without specific dates, or at least references to quarters or semi-annual reviews, etc. there will be no order to the chaos of a non-specific bill as it pertains to effective dates.

***SB 3890 by Marrero, B. / HB 3843 by Turner, M.**

***Present Law***

*TCA* §50-6-204 (a)(1) requires the employer to furnish to the employee "...such...psychological services ordered by the attending physician". Under present case law, a psychologist is not permitted to give expert testimony regarding permanent impairment. The only medical professionals who are permitted to render an opinion regarding impairment are physicians and chiropractors under the Tennessee Rules of Evidence as they do not qualify as experts. *TCA* §50-6-204 (d)(3) requires "... a physician, chiropractor or medical practitioner who is permitted to give expert testimony in a Tennessee court of law ..." to utilize the applicable edition of the AMA Guides or in cases not covered by the Guides the impairment rating may by assigned using any appropriate method used and accepted by the medical community.

***Proposed Change***

SB 3890 / HB 3841 permits psychologists to provide an impairment rating for an injured employee and the impairment rating shall be determined using any appropriate method used and accepted by the medical or psychological community.

***Practical Effect***

The bill would permit, for the first time in Tennessee, a psychologist to render an opinion as to the impairment rating resulting from the employee's injury. The bill does not require the use by the psychologist of a specific manual, treatise or psychological guideline in determining the impairment rating.

***Informational Note***

The bill does not specifically grant a psychologist the right to give expert testimony in a court of law. Currently, the psychologist can testify as to factual matters regarding the treatment of the employee, but only a medical doctor or chiropractor can give opinion testimony. This is also true as to physical therapists - they are not permitted to render expert opinion in court in Tennessee.

***SB 3890 by Marrero, B. / HB 3843 by Turner, M., continued.**

***Comments of Advisory Council Members***

The Advisory Council members were in consensus that psychologists do not have the training to render a decision related to a permanent impairment rating under the AMA Guides. Mr. Farmer (Employee representative) noted there is currently a controversy regarding the impairment of psychological injuries but psychologists have not demonstrated qualifications to testify. A psychologist is permitted to testify concerning treatment and diagnosis but not the assessment of permanent medical impairment because they are not trained or qualified to make that decision.

Mr. Sims (Chair) noted the bill permits the psychologist to determine a permanent impairment rating - by any appropriate, accepted method - but the bill does not address the issue of whether the psychologist is permitted to testify in court concerning the impairment rating.

***SB 2975 by Norris / HB 3807 by Lollar**

***Present Law***

In 1992, the General Assembly enacted comprehensive reform of the Tennessee workers' compensation law. *TCA* §50-6-122 through *TCA* §50-6-124 contain one component of the reform related to providing quality medical care to injured employees while also controlling increasing medical costs. The statute states that the cost control mechanisms were to be a program of medical case management and a program to review utilization and quality of medical care services. *TCA* §50-6-122 permits an employer to use health maintenance organizations (HMO) or preferred provider organizations (PPO) and that the HMO or PPO was authorized to contract with medical contracts as permitted by law. In addition, the statute provided the contracts were authorized to use the following managed care methodologies: (1) medical bill review; (2) establishment of medical practice guidelines; (3) case management - subject to the provisions of *TCA* §50-6-123; (4) utilization review - subject to the provisions of *TCA* §50-6-124; and (5) peer review programs.

*TCA* §50-6-124 required the Commissioner of Labor and Workforce Development to establish a system of utilization review of selected outpatient and inpatient health care providers to employees claiming workers' compensation benefits by providers qualified pursuant to law or the utilization review accreditation commission.

The General Assembly also enacted a definition of "utilization review" in 1992. *TCA* §50-6-102(18) defines utilization review to mean "the evaluation of the necessity, appropriateness, efficiency and quality of medical care services provided to an injured or disabled employee based on medically accepted standards and an objective evaluation of the medical care services provided; provided, that "utilization review" does not include the establishment of approved payment levels or a review of medical charges or fees."

The Department of Labor and Workforce Development was authorized by *TCA* §50-6-124 to contract with an independent utilization review organization to provide utilization review, including peer review. The statute also authorized the Commissioner to order the forfeiture of payment for services found to be excessive; the authority to assess a monetary penalty against any health care provider found to have provided excessive or inappropriate services or to; and the authority to temporarily or permanently suspend the health care provider's right to provide medical services to injured workers provided there was a pattern of violations.

***SB 2975 by Norris / HB 3807 by Lollar continued.**

***Present Law, cont.***

The department promulgated rules for the utilization review program - Chapter 0800-2-6. The rules require each insurer and each self-insured employer to provide for a system of utilization review for cases involving compensable injuries. The rules also require utilization review conducted by the insurer/employer to comply with *TCA* §56-6-701, et seq., the "Health Care Service Utilization Review Act", also enacted in 1992.

*TCA* §56-6-703(4)(A) defines utilization review as "a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an individual within this state". This is different from the definition cited above contained in the workers' compensation act. The Utilization Review Act, which is not limited to workers' compensation, requires a utilization review agent (a person or entity who performs utilization review) to be certified by the Department of Commerce and Insurance and to meet the minimum standards contained in *TCA* §56-6-705. Under that act, any utilization review agent who has received accreditation by the utilization review accreditation commission is exempt from meeting the minimum standards contained in *TCA* §56-6-705.

***Proposed Change***

SB 2975 / HB 3807, which amends only *TCA* §50-6-124, requires all utilization review of medical services to be completed by a physician who is licensed in Tennessee and who is board certified in the same speciality as the physician providing the medical services.

***Practical Effect***

The bill changes the requirements of any utilization review in workers' compensation cases from the present system that does not require the utilization review agent to be a physician who is board certified in the same specialty as the treating physician.

***SB 2975 by Norris / HB 3807 by Lollar continued.**

***Comments of Advisory Council Members***

Ms. Boyte (TDLA Representative) noted if the reason for utilization review is cost containment that issue is addressed by the medical fee schedule; if the reason for utilization review is the necessity of care, the standard under the Tennessee medical malpractice law is that an opinion can be rendered by any physician who practices in a state contiguous to Tennessee. She suggested broadening the scope of the bill as it may be difficult to find medical doctors licensed in Tennessee who are willing to perform utilization review of their peers' decisions.

Dr. Murrell (Health Care Providers Representative) suggested the review by a licensed physician who practices the same *or equivalent* speciality as the treating physician should be permitted as this would allow a neurosurgeon to review the treatment recommended by a board certified orthopedic.

**AMENDED** ***SB 3155 by Southerland / HB 3711 by Fitzhugh**

***Present Law***

*TCA* §50-6-206(a)(2), enacted in 2004, prohibits the closing of future medical benefits for a period of three years after a settlement of a claim unless the injury is to a schedule member injury not subject to *TCA* §50-6-241(d)(1)(A), the multiplier caps statute.

*TCA* §50-6-206(a)(2)(C) prohibits the settlement of future medical benefits at any time if the employee is permanently totally disabled.

*TCA* §50-6-206(b) permits the closing of future medical benefits in specified cases: there must be a dispute between the parties on the issue of compensability or the issue of the amount of disability and the amount paid to the employee cannot exceed 50 times the minimum weekly benefit rate (currently, $5,347.50). In those instances the statute provides the employees are not entitled to any future medical benefits.

***Proposed Amendment***

Section 1 of the Amendment provided to the Council provides if a claim is settled by the parties the parties cannot agree to compromise and settle the issue of medical benefits for a period of three (3) years from the date of settlement approval, except as provided in the new (a)(2)(C). In addition, the amendment provides an employee who is determined to be permanently totally disabled shall not be allowed to compromise and settle the employee's right to future medical benefits.

Section 2 of the Amendment deletes the current language of (a)(2)(C) and substitutes language granting the trial court authority, upon application of the parties, to terminate the right to future medical benefits upon a finding there is clear and convincing evidence that compensability is a contested issue, raised in good faith as a potentially valid defense AND, when required, the Center for Medicare and Medicaid Services has approved the employer's submission of a Medicare set aside allocation. The amendment makes it clear the "clear and convincing evidence" decision is not to be made by the Department of Labor/WFD specialist..

**AMENDED** ***SB 3155 by Southerland / HB 3711 by Fitzhugh, continued.**

***Practical Effect***

It appears the amendment would permit the court to terminate the right to future medical benefits upon application of the parties. It is not clear from the wording of the amendment if this can be a result of a proposed settlement or whether it is limited to claims that have proceeded to trial. It is not clear whether Section 2 negates the provision of Section 1 that prohibits an employee who is permanently totally disabled from settling the right to future medical benefits; it may be that Section 2 will permit a judge, following a trial, to terminate the future medical benefits of a permanently totally disabled employee.

***Informational Note***

The Council received testimony at the February 29, 2008 meeting that the current language of the proposed amendment does not adequately address the issue that was intended to be addressed. The intent was to address an issue that arises in claims in which the employee is severely injured (i.e., the employee is permanently totally disabled) and the employer adamantly contests whether the injury is compensable under Tennessee law. It may be in the best interest for both the employee and employer to settle this type claim instead of litigating the issue. Each party has substantial risk in pursuing resolution through the court system. The employee attorney is afraid the court will determine the injury is not work related, resulting in the employee (and attorney) receiving no workers' compensation benefits. The employer/insurance carrier and the employer's attorney are afraid if the court finds the injury to be compensable, the amount of money due the employee will be substantial. Therefore, each wants to cut their "potential losses" by settlement.

***Comments of Advisory Council Members***

Mr. Ramos (TBA Representative) believes if the intent of the bill is to promote settlement in permanent total disability cases then it worthy of consideration.

**AMENDED** ***SB 3177 by Johnson / HB 3712 by Fitzhugh**

***Present Law***

*TCA* §50-6-229 permits the court, upon the motion of one of the parties, to order amounts of periodic compensation to be commuted to one (1) or more lump sum payments that must be equal all future installments of compensation. The statute requires the court to consider whether the commutation is in the best interest of the employee and whether the employee has the ability to wisely manage and control the commuted award. The court is also authorized to pay attorneys' fees as a partial lump sum from any award.

***Proposed Amendment***

The amendment permits compensation payable periodically through settlement or through judgments - to be commuted to one or more lump sums. The court of the department must find the lump sum **award** to be in the best interest of the employee and that the employee has the ability to wisely manage the lump sum **award** (emphasis added by Council staff). The amendment also states in making such commutation the lump sum, the payment shall, in the aggregate, amount to a sum equal to the value of all future installments of compensation calculated on a six-percent (6%) basis [4% basis if the matter involves cases of coal worker's pneumoconiosis]. Attorney fees for lump sum settlements shall be paid in a lump sum calculated at a maximum of 20% of the lump sum amount.

***Practical Effect***

The amendment permits either the court or the department to approve commutation of settlements or judgments to one or more lump sums if the court/department finds the commutation is in the best interest of the employee and the employee has the ability to wisely manage the lump sum award. The amendment continues the current law that permits payment of attorney fees in a lump sum (not to exceed 20%.

***Informational Note***

There is case law that states an **award** refers to a judgment of a court as a result of a trial. Thus the use of the word "award" is not applicable to a settlement of a workers' compensation claim. The language of the amendment is not clear whether the lump sum would be equal to the present value

**AMENDED** ***SB 3177 by Johnson / HB 3712 by Fitzhugh, continued.**

***Informational Note, cont.***

calculated on a six-percent discount basis or whether the language requires the lump sum to be equal to the amount of all future installments multiplied by 6%.

***Comments of Advisory Council Members***

**NOTE: The comments made at the February 15, 2008 meeting during discussion of original bill; no additional comments were made concerning the amendment.**

Mr. Sims (Chair) noted that if the bill moves forward it would be best if it contains language that the bill be applicable to injuries sustained on or after a specific date in order to prevent confusion.

Mr. Farmer (Employee Representative) indicated the reason the law was changed in 1986 to require benefits to be paid in a lump sum that equals the aggregate of all the weekly payments was to prevent the application of a discount to a negotiated settlement. Otherwise, there is no protection for an unrepresented worker being told by an employer representative that in order to get a lump sum settlement they must agree to a 6% discount. He stated restrictions on how much a Court can commute an award might be appropriate if settlements are excluded. The practical effect of the bill would be the discounting of a negotiated settlement. Mr. Farmer said that employers already have an economic advantage to paying benefits in a lump sum by saving the administrative costs associated with payment of periodic payments. There is no reason to give employers an additional economic advantage by discounting.

Mr. Pitts (Employer Representative) suggested the real question is whether it is time to look at the entire issue of lump sum payments and to revisit the issue.

Mr. Farmer (Employee Representative) agreed the issue should be revisited, noting that the restrictions applicable to lump sum payments in permanent total disability cases has not harmed employees.

Commissioner Neeley (Ex Officio Member) noted there is significant history surrounding the change in the law in 1986 to prohibit discounting of lump sum amounts and he would hate to the see the State return to discounting.

**AMENDED** ***SB 3177 by Johnson / HB 3712 by Fitzhugh, continued.**

***Comments of Advisory Council Members, cont.***

Ms. Boyte (TDLA Representative) stated if the bill moves forward she would suggest the 6% be limited to a specific number of weeks that are being commuted to a lump sum (for example, lump sums in excess of 200 weeks), taking into account the present value of money. This would put a floor and ceiling to the issue.

***SB 3466 by Marrero, B. / HB 3676 by Turner, M.**

***Present Law***

*TCA* §50-6-241 contains provisions limiting the employee's recovery of permanent partial disability benefits. If the employer returns the employee to the work at the same or higher pay, the limit is 1.5 times the permanent impairment rating (injuries occurring on or after 7-1-2004) and if the employee is not returned to work, the limit is 6 times the impairment rating. The law also permits higher than six times the impairment rating if certain criteria are met. These limitations apply whether the injury is caused by a TOSHA violation or not.

***Proposed Change***

SB 3466 / HB 3676 adds a new subsection to *TCA* §50-6-241 that mandates the multiplier to be 6 times the impairment rating in cases where the accident or injury is caused by a TOSHA violation.

***Practical Effect***

The bill applies to all cases in which the injury was caused by a TOSHA violation whether or not the employer returns the employee to work at the same or higher wage.

***Informational Note***

The bill does not address the manner by which the injury is proven to be caused by a TOSHA violation - whether there has to be a determination by the Department of Labor/WFD that a TOSHA violation has occurred - or whether the court can determine under the facts of the case that a TOSHA violation occurred despite no determination by the department. In addition, if the employer is insured, the insurer will be required to pay the additional benefits, not the employer who was guilty of a TOSHA violation.

***Comments of Advisory Council Members***

Mr. Mayo (Insurance Companies Representative) questioned how the bill will be an incentive to the employer to reduce TOSHA violations when the bill will result in the insurance company paying the increased amount of benefits to the employee. He stated the punitive nature of the bill against the insurance company is hard to understand.

***SB 3466 by Marrero, B. / HB 3676 by Turner, M., continued.**

***Comments of Advisory Council Members, cont.***

Mr. Farmer (Employee Representative) stated if the bill goes forward it should include a requirement that the TOSHA violation be the proximate cause of the employee's injury in order for the increased benefits to be awarded.

Mr. Pitts (Employer Representative) said the workers' compensation program and the TOSHA law are two independent programs and each has penalties attached and they should stand on separate footing.

**AMENDED** **SB 3350 by Jackson / * HB 3170 by Buck**

***Present Law***

TCA §50-6-204(a)(1) requires the employer to furnish - free of charge - such medical and surgical treatment as may be reasonably required.

TCA §50-6-204(a)(4)(A) requires the employee to accept the medical benefits afforded under the statute **provided** the employer shall designate a group of three (3) or more reputable physicians or surgeons ...from which the employee shall have the privilege of selecting the operating surgeon or the attending physician.

If the injury is a back injury, then the panel of three (3) physicians or surgeons must also include a doctor of chiropractic. If the injury requires the treatment of a physician or surgeon who practices orthopedic or neuroscience medicine, the employer is permitted to appoint a panel of physicians or surgeons who practice orthopedic or neuroscience medicine required to be designated pursuant to subdivision (a)(4)(A) consisting of five (5) physicians, with no more than four (4) who are affiliated in practice; if this panel is provided then the employee is entitled to a second opinion on the issue of surgery, impairment and diagnosis from the same panel.

***Proposed Amendment***

The amendment to SB 3350 / HB 3170 changes the entire subject matter of the original bill. The amendment requires an employer (insurer/TPA/self-insured pool) to provide a panel of three physicians and a panel of three surgeons in the event the employee requires surgical intervention as a result of the injury.

***Practical Effect***

The bill makes it clear that if an employee requires surgery he/she is entitled to receive a panel of three specialists (surgeons) from which to select the operating physician.

**AMENDED** **SB 3350 by Jackson / * HB 3170 by Buck, continued.**

***Comments of Advisory Council Members***

Ms. Boyte (TDLA Representative) stated the law is unclear on the issue of what happens after the original panel is given and the employee requires further specialized treatment. The decisions of whether the employer is required to give an additional panel of specialists vary from court to court. There is no consensus on the issue. The bill is attempting to create a consistent decision on this issue.

Ms Head (Administrator of Division of Workers' Compensation) stated several years ago the Attorney General issued an informal opinion that the law requires only one panel be given to the employee and when treatment by a specialist is recommended there is no requirement the employer provide a second panel of specialists. She said the Department would have no problem with additional panels.

Mr. Farmer (Employee Representative) believes the intent of the law is that whenever treatment is required then the panel should be provided to the employee so the employee can choose the treating doctor. Therefore, since uncertainty appears to exist on this issue, the law should be changed to require a panel of surgeons should be provided when a recommendation for surgery has been made.

**AMENDED** ***SB 3939 by McNally / HB 3783 by Hackworth**

***Present Law***

TCA §50-6-204(i), enacted in 2004, required the Commissioner of Labor/WFD to establish, by rule, a Medical Fee Schedule. The statute permits the Commissioner to consider any and all reimbursement systems and methodologies in developing the fee schedule. Subdivision (i)(6) requires the Commissioner to review the adopted fee schedules on an annual basis and to revise the fee schedule as necessary. That subdivision also states it is the intent of the general assembly that the annual review consider, among other factors, the medical consumer price index. In 2007, language was added to TCA §50-6-204(i)(1) to prohibit bifurcated reimbursement schedules for physical therapy depending on the ownership interest of the therapy center.

The "Rulemaking Hearing Rules" promulgated by the Department of Labor/WFD that amend the current Medical Fee Schedule Rules go into effect on March 4, 2008. A portion of the rules are as follows:

> ...
> The Medical Fee Schedule of the Tennessee Division of Workers' Compensation ("TDWC") is a Medicare-based system, but with multiple conversion factors. These Medical Fee Schedule Rules apply to all injured employees claiming benefits under the Tennessee Workers' Compensation Act. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration's) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' relative value units ("RVUs") which must be adjusted for the Tennessee Geographic Practice Index ("GPCI") and the Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation in these Rules.
> ...
> The Medical Fee Schedule maximum reimbursement amount for professional services is calculated for any specific CPT code by multiplying the CMS relative value units ("RVUs") by CMS' Tennessee specific Geographic Practice Cost Index ("GPCI") to establish Tennessee specific RVUs, then multiplying the adjusted Tennessee total RVUs by the appropriate Medical Fee Schedule conversion factor. Whether one uses the facility or nonfacility RVUs is determined using the current, effective Medicare guidelines and is dependent upon the location at which the service is provided.
> ...

**AMENDED** ***SB 3939 by McNally / HB 3783 by Hackworth, continued.**

***Proposed Amendment***

The amendment to SB 3939 / HB 3783 changes the entire subject matter of the original bill (dealt with provision of medical reports to family members of employee). The amendment pertains to the reimbursement rates under the Tennessee medical fee schedule and re-writes TCA §50-6-204(i)(1). The 2007 provision related to physical therapy becomes TCA §50-6-204(i)(1)(A) and additional language is added as (B),(C) and (D).

Proposed TCA §50-6-204(i)(1)(B) prohibits the Geographic Practice Cost Index (GPCI - pronounced "gypsy") adjusted Medicare RVUs [relative value units] from falling below the effective January 1, 2008 Medicare RVUs for Tennessee. It also prohibits the RVUs from being negatively adjusted in any subsequent year "by any means or methodology prescribed by Medicare or commercial payors so as to offset, modify or compromise the development of the RVUs contemplated herein".

Proposed TCA §50-6-204(i)(1)(C) prohibits the Tennessee conversion factors from falling below those that go into effect on March 4, 2008.

Proposed TCA §50-6-204(i)(1)(D)requires the Tennessee conversion factors to be adjusted upward annually based on the annual Medicare Economic Index adjustment.

***Practical Effect***

In effect, the proposed amendment freezes the reimbursement rates at the current level so as to prohibit lowered reimbursement and mandates increased reimbursement if the annual Medicare Economic Index adjustment is a positive (+) number. The proposed amendment effectively deletes the portion of current law that requires the Commissioner of Labor/WFD to review the adopted fee schedules on an annual basis and to revise the fee schedule as necessary. The proposed amendment eliminates the Commissioner of Labor's ability to lower the reimbursement rates in the medical fee schedule in the future and requires the Commissioner to increase the reimbursement rates annually in accord with the Medicare Economic Index adjustment.

***Comments of Advisory Council Members***

Commissioner Neeley (Ex Officio) stated the Tennessee Medical Fee Schedule is near the top in reimbursement when compared to the fee schedules adopted by other states.

***SB 3886 by Crowe / HB 3848 by Mumpower**

***Present Law***

TCA §50-6-204(i)(7)(A), adopted in 2004, stated the medical fee schedule (MFS) did not prohibit an employer, trust or pool, or insurer from negotiating medical fee agreements lower than those established by the MFS. In 2007, the subdivision was amended to add the following as (7)(C):

- defined contracting agent as one in direct privity of contract with a medical provider to reimburse the provider for services rendered at rates different from the MFS;
- made it clear negotiated rates could not exceed the MFS
- as of January 1, 2008 - required a portion of any a new contract or renewal of a contract with a medical care provider to contain a section titled "assignment or assignability" or similar title that discloses whether the list of contracted providers can be sold, leased (etc.) to other payors or agents [including insurers and self-insured employers]; required the contracting agent to permit the provider to decline participation in a workers' compensation network that are sold or leased; and required the contracting agent to maintain a web page listing all the customers to whom the network is sold.
- as of January 1, 2008 - required the payor's explanation of benefits (EOB) to identify the name of the network that had the written contract with the provider showing payor can pay preferred rate for services; required the payor to demonstrate, within 30 days of a request from a provider, the payor's right to pay the contracted rate (identification of contracting agent deemed sufficient).

***Proposed Change***

SB 3886 / HB 3848 adds a provision to TCA §50-6-204(i)(7) - to become effective on January 1, 2009 - that:

- prohibits payment for medical services at less than the MFS without a direct contract between the medical provider and the employer, trust/pool, insurer, or PPO Network;
- prohibits an employer, trust/pool, and insurer from assigning (or making accessible) the contractually negotiated rates for workers' compensation services;
- prohibits a PPO Network contracted by an employer to manage its workers' compensation program from assigning or making the negotiated rates accessible to any other PPO Network;

***SB 3886 by Crowe / HB 3848 by Mumpower, continued.**

***Proposed Change, cont.***

- prohibits application of negotiated reimbursement rates for commercial health insurance to workers' compensation services UNLESS the contract clearly and expressly stipulates the commercial health insurance rates will apply to workers' compensation.

***Practical Effect***

SB 3886 / HB 3848 changes the law to require a DIRECT contract between the payor of medical services with the specific medical provider if rates lower than the MFS are to be paid. The bill effectively negates the 2007 change in the law as of January 1, 2009.

***Informational Note***

The first line of the bill references "lower fees" paid for medical services. If the sponsors intend a reference to fees less than the medical fee schedule, it might be appropriate to change the wording to: "Provided, however, that any fees lower than the comprehensive medical fee schedule paid for medical services...".

In addition, the language of the bill does not specify whether a single employer, even if insured, is required to have a contract with the provider or whether the reference to "employer" in the bill should be a reference to a self-insured employer.

***Comments of Advisory Council Members***

**NOTE:** The Advisory Council first discussed this bill at the meeting on February 15, 2008 and at the meeting on February 29, 2008, Mr. Dan Pohljeers, a constituent of the sponsors, testified concerning the problems providers are having with their contracts with one entity then being sold and resold and the reasons the bill is necessary. The members of the Advisory Council again commented on the bill at the February 29 meeting. The comments of the members from both meetings have been combined.

***SB 3886 by Crowe / HB 3848 by Mumpower, continued.**

***Comments of Advisory Council Members, cont.***

Mr. Sims (Chair) noted the issue was addressed by the legislature in 2007 (to require direct contracts between the payor and the provider) and the legislature enacted a bill requiring more disclosure to the providers when contracts are sold.

Dr. Murrell (Health Care Providers Representative) commented that he has seen commercial health insurance carriers tying their contracts with the doctors to an agreement that if they have any workers' compensation business in Tennessee in the future that the commercial health insurance contract rates will also apply to the workers' compensation cases. In addition, he stated that the proposed bill is not onerous and payments by payors have been inaccurately paid as non-board certified when the provider clearly indicated board certification on the initial paperwork submitted to the original contract holder. He suggested the Department should put teeth behind violations of the medical fee schedule when the payors are not paying in accord with the fee schedule.

Mr. Mayo (Insurance Companies Representative) suggested the bill passed in 2007, which only became effective on since January 1, 2008, has not had time to work and process through the system. He stated it would be remiss not to allow time to permit the 2007 law to work before changing the law.

**AMENDED** ***SB 3791 by Haynes / HB 3436 by Rinks**

**NOTE**: This is the bill filed as the WCAC "omnibus bill". The amendment contains changes that address issues the Commissioner of Labor/WFD raised in a letter to the Council in January, 2008 pertaining to the statute of limitations; dismissal of dormant requests for benefit review conferences, administrative review of specialist's orders and other issues.

***The analysis will be presented for each individual section of the amendment.***

**SECTION 1**
***Present Law***

*TCA* §50-6-238(a)(1) provides that with respect to the determination of whether to order temporary disability benefits or medical benefits a workers' compensation specialist shall not be an advocate for either party and shall determine the issue based solely on the information available to the specialist without favor or presumption for or against any party.

*TCA* §50-6-203 and *TCA* §50-6-203 are the sections that contain the statute of limitations provisions regarding workers' compensation injuries by accident and occupational disease cases. The statutes prohibit a claim from being filed in court until the parties have exhausted the benefit review conference process; a request for benefit review conference must be filed within one year of the accident or one year from the date the beginning of the incapacity for work due to an occupational disease (or one year from the date of death) if the claim has been denied by the employer and no benefits have been paid. If benefits have been paid, then the request for BRC must be filed within one year of the last date of payment of benefits or last authorized treatment, whichever is the latest date.

Department of Labor/WFD "Benefit Review Process Rules" permit a party to submit a Request for Assistance to resolve issues of causation and/or compensability, temporary disability and/or medical treatment. The filing of a Request for Assistance does not toll the statute of limitations; only a Request for BRC tolls the statute.

***Proposed Amendment***

The proposed amendment adds language to *TCA* §50-6-238(a)(1) stating that any party or their attorney may request the assistance of a workers' compensation specialist in determining whether temporary disability or medical benefits are appropriate. The amendment also provides if the Request for Assistance is filed within the time limitations contained in the statute of limitations

**AMENDED** ***SB 3791 by Haynes / HB 3436 by Rinks, continued.**

**SECTION 1, *Proposed Amendment, cont.***

sections of the Act, then the time to file a Request for Benefit Review Conference shall not expire before 60 days from the issuance of a benefit review report by the specialist who makes the determination on the request for assistance. The amendment also provides that the parties shall not have less time to file the BRC request than is contained in the applicable statute of limitations statutes.

***Practical Effect***

The practical effect of the amendment is that the filing of a Request for Assistance will toll the statute of limitations for purposes of protecting an employee's claim. This should resolve the problem of having to file a Request for BRC before the employee has reached maximum medical improvement or before the specialist has determined whether the claim is compensable on a Request for Assistance.

***Informational Note***

There are reports of employees who are not represented by an attorney who file a Request for Assistance and do not realize this action does not toll the statute of limitations and they run the risk of being precluded from receipt of benefits because they do not file the Request for BRC. Also, there are reports of attorneys who file the Request for Assistance and do not realize this does not toll the statute of limitations.

**SECTION 2**
***Present Law***

*TCA* §50-6-238(d) establishes a process by which a person aggrieved by a specialist's order can request the Administrator of the Division of Workers' Compensation or his/her designee to reconsider the specialist's order. *TCA* §50-6-241, which is the statute that limits recovery for permanent partial disability when the employee returns to work for the pre-injury employer, also permits the employee to ask a court to "reconsider" the permanent partial disability (PPD) award in the event the employee loses his/her job within specified periods of time.

**AMENDED** ***SB 3791 by Haynes / HB 3436 by Rinks, continued.**

**SECTION 2,** ***Proposed Amendment, cont.***

The Amendment changes the words "reconsider" and "reconsideration" *TCA* §50-6-238(d) to "administratively review".

***Practical Effect***

The change to the words "administratively review" resolves the confusion that has existed between reconsideration of a specialist's order and reconsideration of a prior permanent partial disability award/settlement pursuant to *TCA* §50-6-241. The Department of Labor/WFD suggested this change would make things easier administratively.

**SECTION 3**

***Present Law***

*TCA* §50-6-238(d) establishes a process by which a person aggrieved by a specialist's order can request the Administrator of the Division of Workers' Compensation or his/her designee to reconsider the specialist's order. *TCA* §50-6-238(d)(2)(A) requires the administrator's designee to have been an employee of the benefit review section of the division of workers' compensation for five (5) years and not the specialist who issue the original order.

***Proposed Amendment***

The amendment deletes the requirement the designee be have been a workers' compensation specialist for five (5) years. The amendment requires, instead, that the designee be a Tennessee licensed attorney who has a minimum of five (5) years experience with Tennessee workers' compensation law and shall not be the specialist who issued the order.

***Practical Effect***

The amendment permits the Department to appoint a designee who is not a workers' compensation specialist (a specific Department of Personnel position) provided the person is an attorney who has at least 5 years of experience with Tennessee workers' compensation.

**AMENDED** ***SB 3791 by Haynes / HB 3436 by Rinks, continued.**

**SECTION 4**
***Present Law***

*TCA* §50-6-239(b) requires the parties to a dispute to attend and participate in a benefit review conference as a condition precedent to filing suit in court.

The Department's Benefit Review Process Rules include circumstances in which the parties will be deemed to have exhausted the benefit review conference process without attending a mediation. For example: (1) a specialist has determined the claim is not compensable (via a Request for Assistance); (2) the department has issued a written waiver of mediation; or (3) the parties have conducted mediation by private Rule 31 mediation.

***Proposed Amendment***

The amendment adds the following language at the beginning of the subsection: "Unless the benefit review conference process is otherwise exhausted pursuant to rules promulgated by the commissioner," .

***Practical Effect***

The amendment clarifies when a benefit review conference is not required before suit can be filed.

**SECTION 5**
***Present Law***

*TCA* §50-6-239(c) grants the division of workers' compensation the authority to schedule a specific date for a Benefit Review Conference but requires the division to endeavor to work with the parties to schedule a date convenient to the parties. If the parties cannot agree on a date within 45 days of the request for a BRC or the date the employee reaches maximum medical improvement (whichever is later), then the division is required to schedule the conference on a specific date.

***Proposed Amendment***

The amendment adds a provision that gives the division the authority to schedule a specific date for a BRC and to give notice to the parties at their last know address in those circumstances where the request for a BRC is on file for over one year.

**AMENDED** ***SB 3791 by Haynes / HB 3436 by Rinks, continued.**

**SECTION 5,** ***Practical Effect, cont.***

The division feels this amendment will permit it to clear up cases in which the parties or attorneys do not take steps to set the BRC.

**SECTION 6**

***Present Law***

*TCA* §50-6-246 provides that in a request for medical records under *TCA* §50-6-204, a physician or hospital shall include a medical or anatomical impairment rating if such record is available. The statute prohibits an additional or separate cost for providing the impairment rating as a part of the request for medical records.

***Proposed Amendment***

The amendment addresses the when and how the anatomical impairment rating for an employee is determined and the amount of money the physician can charge for the impairment rating.

The amendment provides:

- a medical provider shall determine the employees anatomical impairment rating within 10 calendar days of the employee's last visit or the date the provider determines the employee has reached maximum medical improvement, whichever first occurs;
- requires the provider to enter the anatomical impairment rating in the employee's medical records at the time the rating is determined and requires the provider, physician or hospital to include the portion of the records containing the impairment rating when medical records are requested pursuant to *TCA* §50-6-204;
- requires the medical provider to report the anatomical impairment rating to the division of workers' compensation on a "final medical report" form within 10 days of the last visit or when the employee reaches maximum medical improvement, whichever first occurs; and
- permits the provider to charge no more than $150.00 for the service of timely determining the anatomical impairment rating, completing and filing the "final medical report" and provides that violation of this provision shall constitute a violation of the Medical Fee Schedule rules and subject the provider to penalties pursuant to *TCA* §50-6-204.

**AMENDED** ***SB 3791 by Haynes / HB 3436 by Rinks, continued.**

**SECTION 6,** ***Practical Effect, cont.***

The amendment makes it clear the medical provider has an obligation to determine the impairment rating for an employee, to include it in the employee's medical records and to report the rating to the division of workers' compensation. In addition, the amendment makes it clear that the provider may charge for the determination of the impairment rating and filing the report but restricts the charge to no more than $150

***Informational Note***

The division has received reports of the authorized treating physician charging $1000 to determine the employees' anatomical impairment rating and reports of physicians who have determined the rating but who refuse to include it in the medical reports without additional compensation.

**SECTION 7**

***Present Law***

*TCA* §50-6-121(a)(1)(D) requires the Governor to appoint an attorney member of the Advisory Council from a list of three attorneys submitted by the Tennessee Trial Lawyers Association.

***Proposed Amendment***

The amendment changes "Tennessee Trial Lawyers Association" to "Tennessee Association for Justice", the new name of the organization.

***Practical Effect***

The change is a technical correction of the statute.

**AMENDED** ***SB 3791 by Haynes / HB 3436 by Rinks, continued.**

**SECTION 8**

***Present Law***

*TCA* §50-6-203(f) permits the Commissioner of Labor/WFD to dismiss an employee's claim if he/she fails to appear at the benefit review conference after sending a copy of the order of dismissal "by certified mail with return receipt requested, signed by the employee, to the employee's last known address".

***Proposed Amendment***

The amendment deletes the phrase "signed by the employee" in *TCA* §50-6-203(f)

***Practical Effect***

The change is a technical correction to delete words that are not needed.

***Comments of Advisory Council Members***

Dr. Murrell (Health Care Providers Representative) suggested the requirement of Section 6 that requires the physician to provide an impairment rating within 10 days of the last visit or date of maximum medical improvement - whichever first occurs - may be problematic especially in those instances where the patient has been noncompliant with the doctor's instructions and recommendations and may not have returned to see the physician as directed. In those instances, the physician assumes the patient is at maximum medical improvement but more than 10 days will have elapsed since the last visit.

**Consensus of Members:** It was suggested by the members of the Advisory Council that an effective date for each section of the bill be provided for clarity as some portions of the bill will require specific effective dates.