FREE CONFERENCE COMMITTEE REPORT

The Free Conference Committee on **SB 201** has met as provided in the Rules of the House and Senate and hereby reports the following to be adopted:

__X__ GA _____ SCS _____ HCS

For the above-referenced bill, with these amendments (if applicable):

Committee (list by chamber and number): ___;

Floor (list by chamber and number): ___; and

The following Free Conference Committee action:

On page 1 after line 2, insert the following:

"➔Section 1. KRS 342.0011 is amended to read as follows:

As used in this chapter, unless the context otherwise requires:

(1) "Injury" means any work-related traumatic event or series of traumatic events, including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings. "Injury" does not include the effects of the natural aging process, and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment. "Injury" when used generally, unless the context indicates otherwise, shall include an occupational disease and damage to a prosthetic appliance, but shall not include a psychological, psychiatric, or stress-related change in the human organism, unless it is a direct result of a physical injury;

(2) "Occupational disease" means a disease arising out of and in the course of the employment;

(3) An occupational disease as defined in this chapter shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is

performed and the occupational disease, and which can be seen to have followed as a natural incident to the work as a result of the exposure occasioned by the nature of the employment and which can be fairly traced to the employment as the proximate cause. The occupational disease shall be incidental to the character of the business and not independent of the relationship of employer and employee. An occupational disease need not have been foreseen or expected but, after its contraction, it must appear to be related to a risk connected with the employment and to have flowed from that source as a rational consequence;

(4) "Injurious exposure" shall mean that exposure to occupational hazard which would, independently of any other cause whatsoever, produce or cause the disease for which the claim is made;

(5) "Death" means death resulting from an injury or occupational disease;

(6) "Carrier" means any insurer, or legal representative thereof, authorized to insure the liability of employers under this chapter and includes a self-insurer;

(7) "Self-insurer" is an employer who has been authorized under the provisions of this chapter to carry his own liability on his employees covered by this chapter;

(8) "Department" means the Department of Workers' Claims in the Education and Labor Cabinet;

(9) "Commissioner" means the commissioner of the Department of Workers' Claims under the direction and supervision of the secretary of the Education and Labor Cabinet;

(10) "Board" means the Workers' Compensation Board;

(11) (a) "Temporary total disability" means the condition of an employee who has not reached maximum medical improvement from an injury and has not reached a level of improvement that would permit a return to employment;

(b) "Permanent partial disability" means the condition of an employee who, due to an injury, has a permanent disability rating but retains the ability to work; and

(c) "Permanent total disability" means the condition of an employee who, due to an

injury, has a permanent disability rating and has a complete and permanent inability to perform any type of work as a result of an injury, except that total disability shall be irrebuttably presumed to exist for an injury that results in:

1. Total and permanent loss of sight in both eyes;
2. Loss of both feet at or above the ankle;
3. Loss of both hands at or above the wrist;
4. Loss of one (1) foot at or above the ankle and the loss of one (1) hand at or above the wrist;
5. Permanent and complete paralysis of both arms, both legs, or one (1) arm and one (1) leg;
6. Incurable insanity or imbecility; or
7. Total loss of hearing;

(12) "Income benefits" means payments made under the provisions of this chapter to the disabled worker or his dependents in case of death, excluding medical and related benefits;

(13) "Medical and related benefits" means payments made for medical, hospital, burial, and other services as provided in this chapter, other than income benefits;

(14) "Compensation" means all payments made under the provisions of this chapter representing the sum of income benefits and medical and related benefits;

(15) "Medical services" means medical, surgical, dental, hospital, nursing, and medical rehabilitation services, medicines, and fittings for artificial or prosthetic devices;

(16) "Person" means any individual, partnership, limited partnership, limited liability company, firm, association, trust, joint venture, corporation, or legal representative thereof;

(17) "Wages" means, in addition to money payments for services rendered, the reasonable value of board, rent, housing, lodging, fuel, or similar advantages received from the employer, and gratuities received in the course of employment from persons other than the employer as evidenced by the employee's federal and state tax returns;

(18) "Agriculture" means the operation of farm premises, including the planting, cultivation,

producing, growing, harvesting, and preparation for market of agricultural or horticultural commodities thereon, the raising of livestock for food products and for racing purposes, and poultry thereon, and any work performed as an incident to or in conjunction with the farm operations, including the sale of produce at on-site markets and the processing of produce for sale at on-site markets. It shall not include the commercial processing, packing, drying, storing, or canning of such commodities for market, or making cheese or butter or other dairy products for market;

(19) "Beneficiary" means any person who is entitled to income benefits or medical and related benefits under this chapter;

(20) "United States," when used in a geographic sense, means the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Canal Zone, and the territories of the United States;

(21) "Alien" means a person who is not a citizen, a national, or a resident of the United States or Canada. Any person not a citizen or national of the United States who relinquishes or is about to relinquish his residence in the United States shall be regarded as an alien;

(22) "Insurance carrier" means every insurance carrier or insurance company authorized to do business in the Commonwealth writing workers' compensation insurance coverage and includes the Kentucky Employers Mutual Insurance Authority and every self-insured group operating under the provisions of this chapter;

(23) (a) "Severance or processing of coal" means all activities performed in the Commonwealth at underground, auger, and surface mining sites; all activities performed at tipple or processing plants that clean, break, size, or treat coal; and all activities performed at coal loading facilities for trucks, railroads, and barges. Severance or processing of coal shall not include acts performed by a final consumer if the acts are performed at the site of final consumption.

(b) "Engaged in severance or processing of coal" shall include all individuals, partnerships, limited partnerships, limited liability companies, corporations, joint

ventures, associations, or any other business entity in the Commonwealth which has employees on its payroll who perform any of the acts stated in paragraph (a) of this subsection, regardless of whether the acts are performed as owner of the coal or on a contract or fee basis for the actual owner of the coal. A business entity engaged in the severance or processing of coal, including but not limited to administrative or selling functions, shall be considered wholly engaged in the severance or processing of coal for the purpose of this chapter. However, a business entity which is engaged in a separate business activity not related to coal, for which a separate premium charge is not made, shall be deemed to be engaged in the severance or processing of coal only to the extent that the number of employees engaged in the severance or processing of coal bears to the total number of employees. Any employee who is involved in the business of severing or processing of coal and business activities not related to coal shall be prorated based on the time involved in severance or processing of coal bears to his total time;

(24) "Premium" for every self-insured group means any and all assessments levied on its members by such group or contributed to it by the members thereof. For special fund assessment purposes, "premium" also includes any and all membership dues, fees, or other payments by members of the group to associations or other entities used for underwriting, claims handling, loss control, premium audit, actuarial, or other services associated with the maintenance or operation of the self-insurance group;

(25) (a) "Premiums received" for policies effective on or after January 1, 1994, for insurance companies means direct written premiums as reported in the annual statement to the Department of Insurance by insurance companies, except that "premiums received" includes premiums charged off or deferred, and, on insurance policies or other evidence of coverage with provisions for deductibles, the calculated cost for coverage, including experience modification and premium surcharge or discount, prior to any reduction for deductibles. The rates, factors, and methods used to

calculate the cost for coverage under this paragraph for insurance policies or other evidence of coverage with provisions for deductibles shall be the same rates, factors, and methods normally used by the insurance company in Kentucky to calculate the cost for coverage for insurance policies or other evidence of coverage without provisions for deductibles, except that, for insurance policies or other evidence of coverage with provisions for deductibles effective on or after January 1, 1995, the calculated cost for coverage shall not include any schedule rating modification, debits, or credits. For policies with provisions for deductibles with effective dates on or after January 1, 1995, assessments shall be imposed on premiums received as calculated by the deductible program adjustment. The cost for coverage calculated under this paragraph by insurance companies that issue only deductible insurance policies in Kentucky shall be actuarially adequate to cover the entire liability of the employer for compensation under this chapter, including all expenses and allowances normally used to calculate the cost for coverage. For policies with provisions for deductibles with effective dates of May 6, 1993, through December 31, 1993, for which the insurance company did not report premiums and remit special fund assessments based on the calculated cost for coverage prior to the reduction for deductibles, "premiums received" includes the initial premium plus any reimbursements invoiced for losses, expenses, and fees charged under the deductibles. The special fund assessment rates in effect for reimbursements invoiced for losses, expenses, or fees charged under the deductibles shall be those percentages in effect on the effective date of the insurance policy. For policies covering covered employees having a co-employment relationship with a professional employer organization and a client as defined in KRS Chapter 336, "premiums received" means premiums calculated using the experience modification factor of each client as defined in KRS Chapter 336 for each covered employee for that portion of the payroll pertaining to the covered employee.

(b) "Direct written premium" for insurance companies means the gross premium written less return premiums and premiums on policies not taken but including policy and membership fees.

(c) "Premium," for policies effective on or after January 1, 1994, for insurance companies means all consideration, whether designated as premium or otherwise, for workers' compensation insurance paid to an insurance company or its representative, including, on insurance policies with provisions for deductibles, the calculated cost for coverage, including experience modification and premium surcharge or discount, prior to any reduction for deductibles. The rates, factors, and methods used to calculate the cost for coverage under this paragraph for insurance policies or other evidence of coverage with provisions for deductibles shall be the same rates, factors, and methods normally used by the insurance company in Kentucky to calculate the cost for coverage for insurance policies or other evidence of coverage without provisions for deductibles, except that, for insurance policies or other evidence of coverage with provisions for deductibles effective on or after January 1, 1995, the calculated cost for coverage shall not include any schedule rating modifications, debits, or credits. For policies with provisions for deductibles with effective dates on or after January 1, 1995, assessments shall be imposed as calculated by the deductible program adjustment. The cost for coverage calculated under this paragraph by insurance companies that issue only deductible insurance policies in Kentucky shall be actuarially adequate to cover the entire liability of the employer for compensation under this chapter, including all expenses and allowances normally used to calculate the cost for coverage. For policies with provisions for deductibles with effective dates of May 6, 1993, through December 31, 1993, for which the insurance company did not report premiums and remit special fund assessments based on the calculated cost for coverage prior to the reduction for deductibles, "premium" includes the initial consideration plus any reimbursements invoiced for losses, expenses, or fees charged

under the deductibles.

(d) "Return premiums" for insurance companies means amounts returned to insureds due to endorsements, retrospective adjustments, cancellations, dividends, or errors.

(e) "Deductible program adjustment" means calculating premium and premiums received on a gross basis without regard to the following:

1. Schedule rating modifications, debits, or credits;

2. Deductible credits; or

3. Modifications to the cost of coverage from inception through and including any audit that are based on negotiated retrospective rating arrangements, including but not limited to large risk alternative rating options;

(26) "Insurance policy" for an insurance company or self-insured group means the term of insurance coverage commencing from the date coverage is extended, whether a new policy or a renewal, through its expiration, not to exceed the anniversary date of the renewal for the following year;

(27) "Self-insurance year" for a self-insured group means the annual period of certification of the group created pursuant to KRS 342.350(4) and 304.50-010;

(28) "Premium" for each employer carrying his own risk pursuant to KRS 342.340(1) shall be the projected value of the employer's workers' compensation claims for the next calendar year as calculated by the commissioner using generally-accepted actuarial methods as follows:

(a) The base period shall be the earliest three (3) calendar years of the five (5) calendar years immediately preceding the calendar year for which the calculation is made. The commissioner shall identify each claim of the employer which has an injury date or date of last injurious exposure to the cause of an occupational disease during each one (1) of the three (3) calendar years to be used as the base, and shall assign a value to each claim. The value shall be the total of the indemnity benefits paid to date and projected to be paid, adjusted to current benefit levels, plus the medical benefits paid

to date and projected to be paid for the life of the claim, plus the cost of medical and vocational rehabilitation paid to date and projected to be paid. Adjustment to current benefit levels shall be done by multiplying the weekly indemnity benefit for each claim by the number obtained by dividing the statewide average weekly wage which will be in effect for the year for which the premium is being calculated by the statewide average weekly wage in effect during the year in which the injury or date of the last exposure occurred. The total value of the claims using the adjusted weekly benefit shall then be calculated by the commissioner. Values for claims in which awards have been made or settlements reached because of findings of permanent partial or permanent total disability shall be calculated using the mortality and interest discount assumptions used in the latest available statistical plan of the advisory rating organization defined in Subtitle 13 of KRS Chapter 304. The sum of all calculated values shall be computed for all claims in the base period;

(b) The commissioner shall obtain the annual payroll for each of the three (3) years in the base period for each employer carrying his own risk from records of the department and from the records of the Department of Workforce Development, Education and Labor Cabinet. The commissioner shall multiply each of the three (3) years of payroll by the number obtained by dividing the statewide average weekly wage which will be in effect for the year in which the premium is being calculated by the statewide average weekly wage in effect in each of the years of the base period;

(c) The commissioner shall divide the total of the adjusted claim values for the three (3) year base period by the total adjusted payroll for the same three (3) year period. The value so calculated shall be multiplied by 1.25 and shall then be multiplied by the employer's most recent annualized payroll, calculated using records of the department and the Department of Workforce Development data which shall be made available for this purpose on a quarterly basis as reported, to obtain the premium for the next calendar year for assessment purposes under KRS 342.122;

(d) For November 1, 1987, through December 31, 1988, premium for each employer carrying its own risk shall be an amount calculated by the board pursuant to the provisions contained in this subsection and such premium shall be provided to each employer carrying its own risk and to the funding commission on or before January 1, 1988. Thereafter, the calculations set forth in this subsection shall be performed annually, at the time each employer applies or renews its application for certification to carry its own risk for the next twelve (12) month period and submits payroll and other data in support of the application. The employer and the funding commission shall be notified at the time of the certification or recertification of the premium calculated by the commissioner, which shall form the employer's basis for assessments pursuant to KRS 342.122 for the calendar year beginning on January 1 following the date of certification or recertification;

(e) If an employer having fewer than five (5) years of doing business in this state applies to carry its own risk and is so certified, its premium for the purposes of KRS 342.122 shall be based on the lesser number of years of experience as may be available including the two (2) most recent years if necessary to create a three (3) year base period. If the employer has less than two (2) years of operation in this state available for the premium calculation, then its premium shall be the greater of the value obtained by the calculation called for in this subsection or the amount of security required by the commissioner pursuant to KRS 342.340(1);

(f) If an employer is certified to carry its own risk after having previously insured the risk, its premium shall be calculated using values obtained from claims incurred while insured for as many of the years of the base period as may be necessary to create a full three (3) year base. After the employer is certified to carry its own risk and has paid all amounts due for assessments upon premiums paid while insured, the employer shall be assessed only upon the premium calculated under this subsection;

(g) "Premium" for each employer defined in KRS 342.630(2) shall be calculated as set

forth in this subsection; and

(h) Notwithstanding any other provision of this subsection, the premium of any employer authorized to carry its own risk for purposes of assessments due under this chapter shall be no less than thirty cents ($0.30) per one hundred dollars ($100) of the employer's most recent annualized payroll for employees covered by this chapter;

(29) "SIC code" as used in this chapter means the Standard Industrial Classification Code contained in the latest edition of the Standard Industrial Classification Manual published by the Federal Office of Management and Budget;

(30) "Investment interest" means any pecuniary or beneficial interest in a provider of medical services or treatment under this chapter, other than a provider in which that pecuniary or investment interest is obtained on terms equally available to the public through trading on a registered national securities exchange, such as the New York Stock Exchange or the American Stock Exchange, or on the National Association of Securities Dealers Automated Quotation System;

(31) "Managed health care system" means a health care system that employs gatekeeper providers, performs utilization review, and does medical bill audits;

(32) "Physician" means physicians and surgeons, ***audiologists holding a doctorate in audiology,*** psychologists, optometrists, dentists, podiatrists, and osteopathic and chiropractic practitioners acting within the scope of the license or other credentials required by his or her specialty of practice in the United States jurisdiction in which he or she is authorized to practice;

(33) "Objective medical findings" means information gained through direct observation and testing of the patient applying objective or standardized methods;

(34) "Work" means providing services to another in return for remuneration on a regular and sustained basis in a competitive economy;

(35) "Permanent impairment rating" means percentage of whole body impairment caused by the injury or occupational disease as determined by the "Guides to the Evaluation of Permanent

Impairment";

(36) "Permanent disability rating" means the permanent impairment rating selected by an administrative law judge times the factor set forth in the table that appears at KRS 342.730(1)(b); and

(37) "Guides to the Evaluation of Permanent Impairment" means, except as provided in KRS 342.262:

(a) The fifth edition published by the American Medical Association; and

(b) For psychological impairments, Chapter 12 of the second edition published by the American Medical Association."; and

Renumber subsequent sections accordingly; and

On page 9 after line 16, insert the following:

"➔Section 5. KRS 342.315 is amended to read as follows:

(1) For workers who have had injuries or occupational hearing loss, the commissioner shall contract with the University of Kentucky**,** ~~[and]~~ the University of Louisville**, *and the University of Pikeville*** medical schools to evaluate workers. For workers who have become affected by occupational diseases, the commissioner shall contract with the University of Kentucky**,** ~~[and]~~ the University of Louisville**, *and the University of Pikeville*** medical schools, or other physicians otherwise duly qualified as "B" readers who are licensed in the Commonwealth and are board-certified pulmonary specialists. Referral for evaluation may be made whenever a medical question is at issue.

(2) The physicians and institutions performing evaluations pursuant to this section shall render reports encompassing their findings and opinions in the form prescribed by the commissioner. Except as otherwise provided in KRS 342.316, the clinical findings and opinions of the designated evaluator shall be afforded presumptive weight by administrative law judges and the burden to overcome such findings and opinions shall fall on the opponent of that evidence. When administrative law judges reject the clinical findings and opinions of the designated evaluator, they shall specifically state in the order

the reasons for rejecting that evidence.

(3) The commissioner or an administrative law judge may, upon the application of any party or upon his own motion, direct appointment by the commissioner, pursuant to subsection (1) of this section, of a medical evaluator to make any necessary medical examination of the employee. Such medical evaluator shall file with the commissioner within fifteen (15) days after such examination a written report. The medical evaluator appointed may charge a reasonable fee not exceeding fees established by the commissioner for those services.

(4) Within thirty (30) days of the receipt of a statement for the evaluation, the employer or carrier shall pay the cost of the examination. Upon notice from the commissioner that an evaluation has been scheduled, the insurance carrier shall forward within seven (7) days to the employee the expenses of travel necessary to attend the evaluation at a rate equal to that paid to state employees for travel by private automobile while conducting state business.

(5) Upon claims in which it is finally determined that the injured worker was not the employee at the time of injury of an employer covered by this chapter, the special fund shall reimburse the carrier for any evaluation performed pursuant to this section for which the carrier has been erroneously compelled to make payment.

(6) Not less often than annually the designee of the secretary of the Cabinet for Health and Family Services shall assess the performance of the medical schools and render findings as to whether evaluations conducted under this section are being rendered in a timely manner, whether examinations are conducted in accordance with medically recognized techniques, whether impairment ratings are in conformity with standards prescribed by the "Guides to the Evaluation of Permanent Impairment," and whether coal workers' pneumoconiosis examinations are conducted in accordance with the standards prescribed in this chapter.

(7) The General Assembly finds that good public policy mandates the realization of the potential advantages, both economic and effectual, of the use of telehealth. The commissioner may, to the extent that he or she finds it feasible and appropriate, require the use of telehealth, as defined in KRS 211.332, in the independent medical evaluation

process required by this chapter.".

Senate Members	House Members
Robert Stivers	Josh Branscom
Phillip Wheeler	Steven Rudy
David Yates	Matt Lehman
	Mitch Whitaker

The above-named members, in separate votes by house, all concur in the provisions of this report.

DATE
March 14, 2025

For Clerk's Use:
Adopted: _____
Repassage Vote: _____