**South Carolina General Assembly**
117th Session, 2007-2008

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**A111, R163, S332**

## STATUS INFORMATION

General Bill
Sponsors: Senators Martin, Ritchie and Vaughn
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Introduced in the Senate on January 24, 2007
Introduced in the House on April 11, 2007
Last Amended on June 20, 2007
Passed by the General Assembly on June 20, 2007
Governor's Action: June 25, 2007, Signed

Summary: Workers' compensation reform

## HISTORY OF LEGISLATIVE ACTIONS

| Date | Body | Action Description with journal page number |
|---|---|---|
| 1/24/2007 | Senate | Introduced and read first time SJ-10 |
| 1/24/2007 | Senate | Referred to Committee on **Judiciary** SJ-10 |
| 1/26/2007 | Senate | Referred to Subcommittee: Martin (ch), Hutto, Ritchie, Lourie |
| 3/21/2007 | Senate | Committee report: Favorable with amendment **Judiciary** SJ-11 |
| 4/3/2007 | Senate | Special order, set for April 3, 2007 SJ-32 |
| 4/4/2007 | Senate | Committee Amendment Adopted and Amended SJ-26 |
| 4/4/2007 | Senate | Debate interrupted SJ-26 |
| 4/5/2007 | Senate | Amended SJ-38 |
| 4/5/2007 | Senate | Read second time SJ-38 |
| 4/10/2007 | Senate | Read third time and sent to House SJ-19 |
| 4/11/2007 | House | Introduced and read first time HJ-13 |
| 4/11/2007 | House | Referred to Committee on **Labor, Commerce and Industry** HJ-15 |
| 5/9/2007 | House | Committee report: Favorable with amendment **Labor, Commerce and Industry** HJ-4 |
| 5/15/2007 | House | Requests for debate-Rep(s). Cato, Thompson, White, Clemmons, Chellis, Leach, Hagood, Bannister, Bedingfield, JR Smith, Haskins, Hamilton, Witherspoon, Hardwick, Shoopman, Haley, and Jefferson HJ-25 |
| 5/16/2007 | House | Amended HJ-45 |
| 5/16/2007 | House | Debate interrupted HJ-69 |
| 5/16/2007 | House | Amended HJ-160 |
| 5/16/2007 | House | Read second time HJ-190 |
| 5/16/2007 | House | Roll call Yeas-110 Nays-0 HJ-190 |
| 5/17/2007 | | Scrivener's error corrected |

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|---|---|---|
| 5/17/2007 | House | Read third time and returned to Senate with amendments HJ-49 |
| 5/17/2007 | House | Roll call Yeas-101 Nays-0 HJ-51 |
| 5/23/2007 | Senate | Non-concurrence in House amendment SJ-81 |
| 5/24/2007 | House | House insists upon amendment and conference committee appointed Reps. Chellis, Cato, and Haley HJ-8 |
| 5/29/2007 | Senate | Conference committee appointed Martin, Hutto, and Ritchie SJ-51 |
| 6/19/2007 | Senate | Conference report adopted SJ-50 |
| 6/20/2007 | House | Conference report adopted HJ-21 |
| 6/20/2007 | House | Roll call Yeas-117 Nays-0 HJ-30 |
| 6/20/2007 | Senate | Ordered enrolled for ratification SJ-56 |
| 6/20/2007 | | Ratified R 163 |
| 6/25/2007 | | Signed By Governor |
| 7/2/2007 | | Copies available |
| 7/2/2007 | | Effective date See Act for Effective Date |
| 7/6/2007 | | Act No. 111 |

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**VERSIONS OF THIS BILL**

1/24/2007
3/21/2007
4/4/2007
4/5/2007
5/9/2007
5/16/2007
5/17/2007
6/20/2007

(Text matches printed bills. Document has been reformatted to meet World Wide Web specifications.)

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(A111, R163, S332)

**AN ACT TO AMEND SECTION 1-23-600, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO HEARINGS AND PROCEEDINGS OVER WHICH AN ADMINISTRATIVE LAW JUDGE SHALL PRESIDE, SO AS TO PROVIDE THAT AN APPEAL FROM THE WORKERS' COMPENSATION COMMISSION IS TO THE COURT OF APPEALS INSTEAD OF THE CIRCUIT COURT; TO AMEND SECTION 14-8-200, AS AMENDED, RELATING TO THE JURISDICTION OF THE COURT OF APPEALS, SO AS TO INCLUDE WITHIN ITS JURISDICTION APPEALS FROM FINAL DECISIONS OF THE WORKERS' COMPENSATION COMMISSION; TO AMEND SECTION 38-55-530, RELATING TO DEFINITIONS USED IN THE OMNIBUS INSURANCE FRAUD AND REPORTING IMMUNITY ACT, SO AS TO CLARIFY THE DEFINITION OF "FALSE STATEMENT OR MISREPRESENTATION"; TO AMEND SECTION 38-55-540, RELATING TO CRIMINAL PENALTIES FOR MAKING A FALSE STATEMENT OR MISREPRESENTATION, SO AS TO INCREASE PENALTIES AND CREATE ADDITIONAL CATEGORIES FOR VIOLATIONS; TO AMEND SECTION 38-55-560, RELATING TO THE INSURANCE FRAUD DIVISION CREATED**

**WITHIN THE OFFICE OF THE ATTORNEY GENERAL, SO AS TO AUTHORIZE THE ATTORNEY GENERAL TO HIRE A FORENSIC ACCOUNTANT TO BE ASSIGNED TO THE INSURANCE FRAUD DIVISION; TO AMEND SECTION 42-1-160, AS AMENDED, RELATING TO THE DEFINITION OF "INJURY" AND "PERSONAL INJURY", SO AS TO FURTHER DEFINE THESE TERMS, TO ESTABLISH A BURDEN OF PROOF FOR AN EMPLOYEE, TO FURTHER EXCLUDE CERTAIN CONDITIONS FROM "PERSONAL INJURY", TO EXCLUDE CERTAIN EVENTS FROM "ACCIDENT", AND TO DEFINE "MEDICAL EVIDENCE"; BY ADDING SECTION 42-1-172 SO AS TO ESTABLISH WHEN A REPETITIVE TRAUMA INJURY MAY BE COMPENSABLE; TO AMEND SECTION 42-1-360, RELATING TO PERSONS NOT COVERED UNDER THE WORKERS' COMPENSATION LAW, SO AS TO DELETE AND ADD CERTAIN INDIVIDUALS AND GROUPS OF INDIVIDUALS; BY ADDING SECTIONS 42-1-700 AND 42-1-705 SO AS TO REQUIRE CERTAIN SPECIFICITY ON FORM 50 AND FORM 51 (EMPLOYEE'S NOTICE OF CLAIM AND/OR REQUEST FOR HEARING AND EMPLOYEE'S ANSWER TO REQUEST FOR HEARING FORMS); TO AMEND SECTION 42-3-20, RELATING TO THE WORKERS' COMPENSATION COMMISSION, SO AS TO PROVIDE FOR THE APPOINTMENT OF A DEPUTY COMMISSIONER AND AN INTERIM CHAIRMAN UNDER CERTAIN CIRCUMSTANCES AND DELETE A PROVISION REGARDING REVIEWS BEING CONDUCTED TEMPORARILY WHEN A COMMISSIONER IS INCAPACITATED OR A VACANCY EXISTS; TO AMEND SECTION 42-3-60, RELATING TO THE AUTHORIZATION FOR EACH COMMISSIONER TO EMPLOY A SECRETARY AND COURT REPORTER, SO AS TO DELETE THIS AUTHORITY AND AUTHORIZE EACH COMMISSIONER TO EMPLOY AN ADMINISTRATIVE ASSISTANT, TO SERVE AT THE COMMISSIONER'S PLEASURE; BY ADDING SECTION 42-3-175 SO AS TO PROVIDE FOR THE PAYMENT OF CLAIMANT'S ATTORNEY'S FEES AND COSTS OF ENFORCING THE ORDER OF THE COMMISSION IF IT IS SHOWN THAT AN INSURER, A SELF-INSURED EMPLOYER, A SELF-INSURED FUND, OR AN ADJUSTER, WITHOUT GOOD CAUSE, FAILED TO AUTHORIZE MEDICAL TREATMENT AND/OR PAY BENEFITS WHEN ORDERED TO DO SO BY THE COMMISSION; TO AMEND SECTION 42-3-230, RELATING TO THE DESTRUCTION OF INACTIVE FILES, SO AS TO AUTHORIZE THE FILES TO BE KEPT IN EITHER PAPER OR ELECTRONIC FORM; TO AMEND SECTION 42-5-40, RELATING TO THE PENALTY FOR THE FAILURE TO SECURE PAYMENT FOR COMPENSATION UNDER TITLE 42, SO AS TO INCREASE THE PENALTY FOR SECURING COMPENSATION FOR AN EMPLOYEE AND TO PROVIDE FOR WHAT CONSTITUTES TOTAL AND PERMANENT DISABILITY AND IS NOT SUBJECT TO THE FIVE-HUNDRED-WEEK LIMITATION OR RECEIPT OF BENEFITS; BY ADDING SECTION 42-9-5 SO AS TO REQUIRE AN AWARD MADE PURSUANT TO TITLE 42 MUST BE BASED UPON SPECIFIC AND WRITTEN DETAILED FINDINGS OF FACT SUBSTANTIATING THE AWARD; TO AMEND SECTION 42-9-10, RELATING TO COMPENSATION PAID TO AN EMPLOYEE BECAUSE OF INCAPACITY RESULTING FROM AN INJURY WHICH IS A TOTAL DISABILITY, SO AS TO ADD THE LOSS OF BOTH SHOULDERS AND HIPS TO THE LIST OF BODY PARTS WHICH CONSTITUTES TOTAL AND PERMANENT DISABILITY; TO AMEND SECTION 42-9-30, AS AMENDED, RELATING TO THE AMOUNT OF COMPENSATION AND PERIOD OF DISABILITY FOR CERTAIN INJURIES, SO AS TO PROVIDE FOR THE LOSS OF A SHOULDER, A HIP, AND TOTAL AND PARTIAL LOSS OF THE BACK, AND PROVIDE FOR A REBUTTABLE PRESUMPTION IN CERTAIN CASES; BY ADDING SECTION 42-9-35 SO AS TO PROVIDE THAT THE EMPLOYEE SHALL ESTABLISH BY THE PREPONDERANCE OF THE EVIDENCE, INCLUDING MEDICAL EVIDENCE, THAT THE SUBSEQUENT INJURY AGGRAVATED THE PREEXISTING CONDITION OR PERMANENT PHYSICAL IMPAIRMENT OR THE PREEXISTING CONDITION OR THE PERMANENT PHYSICAL IMPAIRMENT AGGRAVATES THE SUBSEQUENT INJURY, TO PROVIDE THE COMMISSION MAY AWARD COMPENSATION BENEFITS TO AN EMPLOYEE UNDER CERTAIN CONDITIONS WHEN THE EMPLOYEE INCURS A SUBSEQUENT DISABILITY FROM AN INJURY ARISING OUT OF AND IN THE**

**SCOPE OF HIS EMPLOYMENT FOR THE RESULTING DISABILITY OF THE PERMANENT PHYSICAL IMPAIRMENT OR PREEXISTING CONDITION AND THE SUBSEQUENT INJURY, TO PROVIDE FOR THE BENEFIT IF THE SUBSEQUENT INJURY IS LIMITED TO A SINGLE BODY PART, TO PROVIDE EXCEPTIONS, AND TO DEFINE "MEDICAL EVIDENCE"; TO AMEND SECTION 42-9-60, RELATING TO THE PROHIBITION ON PAYING COMPENSATION IF THE INJURY OR DEATH WAS OCCASIONED BY THE INTOXICATION OF THE EMPLOYEE OR THE WILFUL INTENTION OF THE EMPLOYEE TO INJURE OR KILL HIMSELF OR ANOTHER, SO AS TO PROVIDE THAT IF A PERSON CLAIMS THAT THE PROVISIONS OF THIS SECTION ARE APPLICABLE, THE BURDEN OF PROOF IS UPON THAT PERSON; TO AMEND SECTION 42-9-150, RELATING TO AN EMPLOYEE WHO HAS A PERMANENT DISABILITY OR HAS SUSTAINED A PERMANENT INJURY IN THE SERVICE OF THE ARMY OR NAVY OF THE UNITED STATES OR IN ANOTHER EMPLOYMENT OTHER THAN THAT IN WHICH HE RECEIVES SUBSEQUENT PERMANENT INJURY BY ACCIDENT, SO AS TO CORRECT BOTH ARCHAIC AND OTHER REFERENCES; TO AMEND SECTION 42-9-170, RELATING TO THE AMOUNT OF COMPENSATION AN EMPLOYEE MAY RECEIVE IF HE RECEIVES A PERMANENT INJURY AND THEN SUSTAINS ANOTHER PERMANENT INJURY IN THE SAME EMPLOYMENT, SO AS TO PROVIDE THE MANNER IN WHICH THE COMPENSATION MUST BE PAID; TO AMEND SECTION 42-9-390, RELATING TO VOLUNTARY SETTLEMENTS, SO AS TO DELETE PROVISIONS WHICH REQUIRE THE SETTLEMENT AGREEMENT TO BE FILED BY THE EMPLOYER AND WITH ONE MEMBER OF THE COMMISSION IF THE EMPLOYEE IS NOT REPRESENTED BY AN ATTORNEY, AND TO SUBSTITUTE A PROVISION TO REQUIRE THE EMPLOYER TO FILE THE SETTLEMENT AGREEMENT WITH THE COMMISSION IF EACH PARTY IS REPRESENTED BY AN ATTORNEY AND IF THE EMPLOYEE IS NOT REPRESENTED BY AN ATTORNEY, THE EMPLOYER MUST FILE A COPY AND IT MUST BE APPROVED BY A MEMBER OF THE COMMISSION; TO AMEND SECTION 42-11-10, RELATING TO THE DEFINITION OF "OCCUPATIONAL DISEASE", SO AS TO ESTABLISH EMPLOYEE'S BURDEN OF PROOF, TO FURTHER DEFINE WHAT CONSTITUTES AN OCCUPATIONAL DISEASE, TO EXCLUDE CERTAIN CONDITIONS, TO DEFINE "MEDICAL EVIDENCE", AND TO PROVIDE COMPENSATION IS NOT PAYABLE UNLESS THE CLAIMANT SUFFERS PERMANENT OR PARTIAL DISABILITY; TO AMEND SECTION 42-15-20, RELATING TO THE REQUIREMENT THAT NOTICE MUST BE GIVEN BY THE EMPLOYEE FOR A REPETITIVE TRAUMA INJURY, SO AS TO REQUIRE NOTICE BE GIVEN NO LATER THAN NINETY DAYS AFTER AN EMPLOYEE COULD HAVE DISCOVERED THAT THE CONDITION IS COMPENSABLE; TO AMEND SECTION 42-15-40, AS AMENDED, RELATING TO THE RIGHT TO COMPENSATION BEING BARRED UNDER THIS TITLE UNLESS A CLAIM IS FILED WITHIN A CERTAIN TIME, SO AS TO BAR A CLAIM FOR A REPETITIVE TRAUMA INJURY UNLESS THE CLAIM IS FILED WITHIN A CERTAIN TIME; TO AMEND SECTION 42-15-60, RELATING TO AN EMPLOYER'S RESPONSIBILITY TO FURNISH MEDICAL TREATMENT AND SUPPLIES, SO AS TO ESTABLISH THAT AFTER TEN WEEKS AFTER DATE OF AN EMPLOYEE'S INJURY, AN EMPLOYEE MUST ESTABLISH BY MEDICAL RECORDS OR EXPERT MEDICAL TESTIMONY THAT ADDITIONAL TIME IS NEEDED TO LESSEN THE EMPLOYEE'S DEGREE OF IMPAIRMENT AND TO CLARIFY THAT AN EMPLOYER'S DUTY TO AN EMPLOYEE TERMINATES WHEN THERE IS NO FURTHER MEDICAL CARE THAT WOULD LESSEN THE DEGREE OF MEDICAL IMPAIRMENT AND IN NO CASE WOULD MEDICAL BENEFITS EXTEND FOR MORE THAN ONE YEAR FROM THE DATE OF FULL PAYMENT OF THE SETTLEMENT UNLESS STATED OTHERWISE ON APPROPRIATE FORMS, TO PROVIDE THAT EACH AWARD OF PERMANENCY AS ORDERED BY A SINGLE COMMISSIONER OR BY THE COMMISSION MUST CONTAIN A FINDING AS TO WHETHER OR NOT FURTHER MEDICAL TREATMENT OR MODALITIES MUST BE PROVIDED TO THE EMPLOYEE, TO PROVIDE THAT AN EMPLOYER IS NOT REQUIRED TO PROVIDE MEDICAL TREATMENT OR MODALITIES IN ANY CASE WHERE THERE HAS BEEN A LAPSE IN TREATMENT OF THE**

**EMPLOYEE BY AN AUTHORIZED PHYSICIAN IN EXCESS OF ONE YEAR, AND TO PROVIDE EXCEPTIONS; TO AMEND SECTION 42-15-80, RELATING TO PHYSICAL EXAMINATIONS AND FACTS LEARNED BY DOCTORS DURING THESE PROCEDURES ARE NOT PRIVILEGED AND THE REFUSAL OF AN EMPLOYEE TO SUBMIT TO AN EXAMINATION MAY SUSPEND HIS RIGHTS TO COMPENSATION AND RIGHT TO PROSECUTE A PROCEEDING UNDER THIS TITLE, SO AS TO PROVIDE FOR REGULATIONS ESTABLISHING THE ROLE OF REHABILITATION PROFESSIONALS AND OTHER SIMILARLY SITUATED PROFESSIONALS IN WORKERS' COMPENSATION CASES WITH CONSIDERATION GIVEN TO THESE PERSONS' DUTIES TO BOTH EMPLOYER AND EMPLOYEE AND THE STANDARDS OF CARE APPLICABLE TO THESE PERSONS; TO AMEND SECTION 42-15-95, AS AMENDED, RELATING TO THE RELEASE OF MEDICAL INFORMATION IN WORKERS' COMPENSATION CLAIMS, SO AS TO PROVIDE THAT AN EMPLOYEE SEEKING TREATMENT IS CONSIDERED TO HAVE GIVEN CONSENT FOR RELEASE OF MEDICAL RECORDS AND TO PROVIDE COMMUNICATION OPTIONS AMONG INTERESTED PARTIES; TO AMEND SECTION 42-17-60, AS AMENDED, RELATING TO THE CONCLUSIVENESS OF THE AWARD BY THE COMMISSION, SO AS TO PROVIDE THAT AN APPEAL TO THE AWARD MUST BE TO THE COURT OF APPEALS INSTEAD OF THE COURT OF COMMON PLEAS, PROVIDE FOR THE MANNER OF THE PAYMENTS AND COMPENSATION, AND PROVIDE THAT INTEREST ACCRUES ON AN UNPAID PORTION OF THE AWARD AT THE LEGAL RATE OF INTEREST PROVIDED FOR JUDGMENTS; TO AMEND SECTION 42-17-90, RELATING TO THE REVIEW OF AN AWARD ON THE CHANGE OF CONDITIONS, SO AS TO AUTHORIZE THE COMMISSION TO REVIEW THE AWARD BASED ON PROOF BY A PREPONDERANCE OF THE EVIDENCE THAT THERE HAS BEEN A CHANGE OF CONDITION CAUSED BY THE ORIGINAL INJURY, AFTER THE LAST PAYMENT OF COMPENSATION, AND TO ESTABLISH A ONE-YEAR PERIOD FOR CHANGE OF CONDITION IN CASES INVOLVING REPETITIVE TRAUMA OR OCCUPATIONAL DISEASE; TO REPEAL SECTIONS 42-1-350, 42-1-370, AND 42-1-375 ALL RELATING TO EXEMPTIONS OF RAILWAYS AND EXPRESS COMPANIES, CASUAL AND OTHER EMPLOYEES, AND REAL ESTATE SALES PERSONS FROM THE PROVISIONS OF TITLE 42; TO REPEAL SECTION 42-9-80 RELATING TO THE BURDEN OF PROOF ON PERSONS BRINGING CLAIMS UNDER THE PROVISIONS OF SECTIONS 42-9-50, 42-9-60, AND 42-9-70; TO AMEND SECTION 38-73-495, RELATING TO THE AUTHORITY OF THE DIRECTOR OF INSURANCE TO DISAPPROVE PREVIOUSLY APPROVED RATE OF CLASSIFICATION OF WORKERS' COMPENSATION INSURANCE, THE REASSIGNMENT OF THE CLASSIFICATION, AND TIME FOR FILING APPEALS TO THE DEPARTMENT OF INSURANCE, SO AS TO ACCOUNT FOR THIRD-PARTY REIMBURSEMENTS IN EXPERIENCE MODIFICATION; TO AMEND SECTION 42-7-310, AS AMENDED, RELATING TO THE SECOND INJURY FUND, SO AS TO REDUCE THE ASSESSMENT FORMULA TO ONE HUNDRED AND THIRTY-FIVE PERCENT; TO AMEND SECTION 42-9-400, AS AMENDED, RELATING TO THE MANNER IN WHICH AN EMPLOYER OR INSURANCE CARRIER MUST BE REIMBURSED FROM THE SECOND INJURY FUND WHEN A DISABILITY RESULTS FROM A PREEXISTING IMPAIRMENT AND SUBSEQUENT INJURY, SO AS TO ELIMINATE THE REQUIREMENT THAT THE EMPLOYER OR CARRIER SHALL ESTABLISH THAT, IN ORDER TO OBTAIN REIMBURSEMENT FOR MEDICAL EXPENSES FOLLOWING THE SUBSEQUENT INJURY, THE LIABILITY FOR MEDICAL PAYMENT IS SUBSTANTIALLY GREATER BY REASON OF THE COMBINED EFFECT OF THE PREEXISTING IMPAIRMENT AND SUBSEQUENT INJURY, TO ELIMINATE ARTHRITIS AND ANY OTHER PREEXISTING DISEASE, CONDITION, OR IMPAIRMENT WHICH IS PERMANENT IN NATURE FROM THE LIST OF PRESUMPTIONS FOR PERMANENT IMPAIRMENT, AND TO PROVIDE FOR WRITTEN NOTICE OF POSSIBLE CLAIMS; TO AMEND SECTION 42-7-200, AS AMENDED, RELATING TO THE ESTABLISHMENT OF THE SOUTH CAROLINA WORKERS' COMPENSATION UNINSURED EMPLOYERS' FUND TO ENSURE PAYMENT OF WORKERS' COMPENSATION BENEFITS TO INJURED EMPLOYEES WHOSE**

**EMPLOYERS HAVE FAILED TO ACQUIRE NECESSARY COVERAGE FOR EMPLOYEES, SO AS TO TRANSFER ALL FUNCTIONS, POWERS, DUTIES, OBLIGATIONS, RESPONSIBILITIES, ENTITIES, EMPLOYEES, FUNDS, PROPERTY, AND CONTRACTUAL RIGHTS OF THE FUND TO THE SOUTH CAROLINA WORKERS' COMPENSATION UNINSURED EMPLOYERS' FUND, WHICH IS ESTABLISHED WITHIN THE OFFICE OF THE STATE ACCIDENT FUND, EFFECTIVE JULY 1, 2013, TO PROVIDE THE PURPOSE OF THE FUND AND ITS ADMINISTRATION; BY ADDING SECTION 42-7-320 SO AS TO PROVIDE THAT EFFECTIVE JULY 1, 2013, THE PROGRAMS AND APPROPRIATIONS FOR THE SECOND INJURY FUND ARE TERMINATED, TO PROVIDE FOR THE CLOSURE OF THE FUND BY THE STATE BUDGET AND CONTROL BOARD, AND TO PROVIDE FOR A SCHEDULE OF TIMES AFTER WHICH CLAIMS FOR REIMBURSEMENT MAY NOT BE ACCEPTED; TO REQUIRE THE CODE COMMISSIONER, BEFORE JANUARY 15, 2014, TO PREPARE A REPORT TO THE PRESIDENT PRO TEMPORE OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES CONTAINING REFERENCES AND CROSS-REFERENCES WHICH HE CONSIDERS IN NEED OF CORRECTION, MODIFICATION, OR REPEAL WITH REGARD TO AFFECTING THE CODE OF LAWS OF SOUTH CAROLINA, 1976, AND TO SPECIFY WHAT MUST BE IN THE REPORT; TO AMEND SECTION 38-73-520, AS AMENDED, RELATING TO FILING OF RATES BY AN INSURER, SO AS TO PROVIDE THAT THE FILING EXEMPTION DOES NOT APPLY TO THE MULTIPLIER FOR EXPENSES, ASSESSMENTS, PROFIT, AND CONTINGENCIES AND ANY MODIFICATIONS TO LOSS COSTS USED BY A WORKERS' COMPENSATION INSURER TO BE APPLIED TO APPROVED LOSS COSTS TO DEVELOP THE INSURER'S RATES AS PROVIDED IN SECTION 38-73-525; BY ADDING SECTION 38-73-525 SO AS TO PROVIDE THAT AT LEAST THIRTY DAYS BEFORE USING NEW RATES, EVERY INSURER WRITING WORKERS' COMPENSATION MUST FILE ITS MULTIPLIER FOR EXPENSES, ASSESSMENTS, PROFITS, AND CONTINGENCIES AND ANY INFORMATION RELIED UPON BY THE INSURER TO SUPPORT THE MULTIPLIER AND ANY MODIFICATION TO LOSS COSTS, TO REQUIRE TO WHOM COPIES MUST BE PROVIDED, THE CONTENTS OF THE FILING AND ITS REQUIREMENTS, INCLUDING REVIEW BY AN ACTUARY IN THE DEPARTMENT BEFORE RATES MAY BE EFFECTIVE; TO AMEND SECTION 38-73-960, RELATING TO THE EFFECTIVE DATE OF RATE FILINGS, SO AS TO MAKE THE FILINGS SUBJECT TO THE PROVISIONS OF SECTION 38-73-965; BY ADDING SECTION 38-73-965 SO AS TO PROVIDE THAT A FILING MADE PURSUANT TO SECTION 38-73-525 IS GOVERNED BY THE EFFECTIVE DATES SPECIFIED IN THAT SECTION; TO AMEND SECTION 38-73-990, RELATING TO DISAPPROVAL OF A FILING, SO AS TO PROVIDE AN EXCEPTION TO SECTION 38-73-995; BY ADDING SECTION 38-73-995 SO AS PROVIDE THAT THE DIRECTOR OF INSURANCE MAY DISAPPROVE THE LOSS COST MULTIPLIER OF A WORKERS' COMPENSATION INSURER IF HE DETERMINES THAT IT DOES NOT MEET THE REQUIREMENTS OF CHAPTER 73, TITLE 38; AND BY ADDING SECTION 38-73-526 SO AS TO REQUIRE THE DIRECTOR TO ISSUE A REPORT TO THE GENERAL ASSEMBLY BY THE FIRST OF JANUARY OF EACH YEAR AND TO REQUIRE CERTAIN MATERIAL IN THE REPORT.**

Be it enacted by the General Assembly of the State of South Carolina:

PART I

General Provisions

**Jurisdiction of administrative law judge**

SECTION 1. Section 1-23-600(D) of the 1976 Code, as last amended by Act 387 of 2006, is further amended to read:

"(D) An administrative law judge also shall preside over all appeals from final decisions of contested cases pursuant to the Administrative Procedures Act, Article I, Section 22, Constitution of the State of South Carolina, 1895, or another law, except that an appeal from a final order of the Public Service Commission and the State Ethics Commission is to the Supreme Court or the Court of Appeals as provided in the South Carolina Appellate Court Rules, an appeal from the Procurement Review Panel is to the circuit court as provided in Section 11-35-4410, an appeal from the Workers' Compensation Commission is to the Court of Appeals as provided in Section 42-17-60, and an appeal from the Employment Security Commission is to the circuit court as provided in Section 41-35-750."

**Jurisdiction of Court of Appeals**

SECTION 2. Section 14-8-200(a) of the 1976 Code, as last amended by Act 387 of 2006, is further amended to read:

"(a) Except as limited by subsection (b) and Section 14-8-260, the court has jurisdiction over any case in which an appeal is taken from an order, judgment, or decree of the circuit court, family court, a final decision of an agency, a final decision of an administrative law judge, or the final decision of the Workers' Compensation Commission. This jurisdiction is appellate only, and the court shall apply the same scope of review that the Supreme Court would apply in a similar case. The court has the same authority to issue writs of supersedeas, grant stays, and grant petitions for bail as the Supreme Court would have in a similar case. The court, to the extent the Supreme Court may by rule provide for it to do so, has jurisdiction to entertain petitions for writs of certiorari in post-conviction relief matters pursuant to Section 17-27-100."

**Definition clarified**

SECTION 3. Section 38-55-530(D) of the 1976 Code is amended to read:

"(D) 'False statement or misrepresentation' means a statement or representation made by a person that is false, material, made with the person's knowledge of the falsity of the statement and made with the intent of obtaining or causing another to obtain or attempting to obtain or causing another to obtain an undeserved economic advantage or benefit or made with the intent to deny or cause another to deny any benefit or payment in connection with an insurance transaction, and such shall constitute fraud. 'False statement or misrepresentation' specifically includes, but is not limited to, an intentional:

(1) false report of business activities;

(2) miscount or misclassification by an employer of its employees;

(3) failure to timely reduce reserves;

(4) failure to account for Second Injury Fund reimbursements or subrogation reimbursements; or

(5) failure to provide verifiable information to public or private rating bureaus and the Department of Insurance.

An undeserved economic benefit or advantage includes, but is not limited to, a favorable insurance premium, payment schedule, insurance award, or insurance settlement."

**Penalties increased, addition of categories**

SECTION 4. Section 38-55-540 of the 1976 Code is amended to read:

"Section 38-55-540. (A) A person who knowingly makes a false statement or misrepresentation, and any other person knowingly, with an intent to injure, defraud, or deceive, or who assists, abets, solicits, or conspires with a person to make a false statement or misrepresentation, is guilty of a:

(1) misdemeanor, for a first offense violation, if the amount of the economic advantage or benefit received is less than one thousand dollars. Upon conviction, the person must be fined not less than one hundred nor more than five hundred dollars or imprisoned not more than thirty days;

(2) misdemeanor, for a first offense violation, if the amount of the economic advantage or benefit received is one thousand dollars or more but less than ten thousand dollars. Upon conviction, the person must be fined not less than two thousand nor more than ten thousand dollars or imprisoned not more than three years, or both;

(3) felony, for a first offense violation, if the amount of the economic advantage or benefit received is ten thousand dollars or more but less than fifty thousand dollars. Upon conviction, the person must be fined not less than ten thousand nor more than fifty thousand dollars or imprisoned not more than five years, or both;

(4) felony, for a first offense violation, if the amount of the economic advantage or benefit received is fifty thousand dollars or more. Upon conviction, the person must be fined not less than twenty thousand nor more than one hundred thousand dollars or imprisoned not more than ten years, or both;

(5) felony, for a second or subsequent violation, regardless of the amount of the economic advantage or benefit received. Upon conviction, the person must be fined not less than twenty thousand nor more than one hundred thousand dollars or imprisoned not more than ten years, or both.

(B) In addition to the criminal penalties set forth in subsection (A), a person convicted pursuant to the provisions of this section must be ordered by the court to make full restitution to a victim for any economic advantage or benefit which has been obtained by the person as a result of that violation, and to pay the difference between any taxes owed and any taxes the person paid, if applicable."

**Forensic accountant may be hired**

SECTION 5. Section 38-55-560 of the 1976 Code is amended by adding at the end:

"(E) The Office of the Attorney General is authorized to hire, employ, and reasonably equip one forensic accountant, and this forensic accountant must be assigned to the Insurance Fraud Division of the Office of the Attorney General. A person is not qualified to be hired and the Insurance Fraud Division may not hire a forensic accountant unless he possesses and maintains a current license to engage in the practice of accounting pursuant to the provisions of Chapter 2, Title 40."

**Definitions**

SECTION 6. Section 42-1-160 of the 1976 Code, as last amended by Act 424 of 1996, is further amended to read:

"Section 42-1-160. (A) 'Injury' and 'personal injury' mean only injury by accident arising out of and in the course of employment and shall not include a disease in any form, except when it results naturally and unavoidably from the accident and except such diseases as are compensable under the provisions of Chapter 11 of this title. In construing this section, an accident arising out of and in the course of employment includes

employment of an employee of a municipality outside the corporate limits of the municipality when the employment was ordered by a duly authorized employee of the municipality.

(B) Stress, mental injuries, and mental illness arising out of and in the course of employment unaccompanied by physical injury and resulting in mental illness or injury are not considered a personal injury unless the employee establishes, by a preponderance of the evidence:

(1) that the employee's employment conditions causing the stress, mental injury, or mental illness were extraordinary and unusual in comparison to the normal conditions of the particular employment; and

(2) the medical causation between the stress, mental injury, or mental illness, and the stressful employment conditions by medical evidence.

(C) Stress, mental injuries, heart attacks, strokes, embolisms, or aneurisms arising out of and in the course of employment unaccompanied by physical injury are not considered compensable if they result from any event or series of events which are incidental to normal employer/employee relations including, but not limited to, personnel actions by the employer such as disciplinary actions, work evaluations, transfers, promotions, demotions, salary reviews, or terminations, except when these actions are taken in an extraordinary and unusual manner.

(D) Stress, mental injuries, and mental illness alleged to have been aggravated by a work-related physical injury may not be found compensable unless the aggravation is:

(1) admitted by the employer/carrier;

(2) noted in a medical record of an authorized physician that, in the physician's opinion, the condition is at least in part causally-related or connected to the injury or accident, whether or not the physician refers the employee for treatment of the condition;

(3) found to be causally-related or connected to the accident or injury after evaluation by an authorized psychologist or psychiatrist; or

(4) noted in a medical record or report of the employee's physician as causally-related or connected to the injury or accident.

(E) In medically complex cases, an employee shall establish by medical evidence that the injury arose in the course of employment. For purposes of this subsection, 'medically complex cases' means sophisticated cases requiring highly scientific procedures or techniques for diagnosis or treatment excluding MRIs, CAT scans, x-rays, or other similar diagnostic techniques.

(F) The word 'accident' as used in this title must not be construed to mean a series of events in employment, of a similar or like nature, occurring regularly, continuously, or at frequent intervals in the course of such employment, over extended periods of time. Any injury or disease attributable to such causes must be compensable only if culminating in a compensable repetitive trauma injury pursuant to Section 42-1-172 or an occupational disease pursuant to the provisions of Chapter 11 of this title.

(G) As used in this section, 'medical evidence' means expert opinion or testimony stated to a reasonable degree of medical certainty, documents, records, or other material that is offered by a licensed health care provider."

**Definitions**

SECTION 7. Chapter 1, Title 42 of the 1976 Code is amended by adding:

"Section 42-1-172. (A) 'Repetitive trauma injury' means an injury which is gradual in onset and caused by the cumulative effects of repetitive traumatic events. Compensability of a repetitive trauma injury must be determined only under the provisions of this statute.

(B) An injury is not considered a compensable repetitive trauma injury unless a commissioner makes a specific finding of fact by a preponderance of the evidence of a causal connection that is established by medical evidence between the repetitive activities that occurred while the employee was engaged in the regular duties of his employment and the injury.

(C) As used in this section, 'medical evidence' means expert opinion or testimony stated to a reasonable degree of medical certainty, documents, records, or other material that is offered by a licensed and qualified medical physician.

(D) A 'repetitive trauma injury' is considered to arise out of employment only if it is established by medical evidence that there is a direct causal relationship between the condition under which the work is performed and the injury.

(E) Upon reaching maximum medical improvement, the employee may be entitled to benefits pursuant to Section 42-9-10, 42-9-20, or 42-9-30. Medical benefits for compensable repetitive trauma injuries shall be as provided elsewhere in this title."

**Nonapplicability**

SECTION 8. Section 42-1-360 of the 1976 Code is amended to read:

"Section 42-1-360. This title does not apply to:

(1) a casual employee, as defined in Section 42-1-130;

(2) any person who has regularly employed in service less than four employees in the same business within the State or who had a total annual payroll during the previous calendar year of less than three thousand dollars regardless of the number of persons employed during that period;

(3) a state and county fair association, unless the employer voluntarily elects to be bound by this title, as provided by Section 42-1-380;

(4) an agricultural employee, unless the agricultural employer voluntarily elects to be bound by this title, as provided by Section 42-1-380;

(5) a railroad, railroad employee, railway express company, or railway express company employee; nor may this title be construed to repeal, amend, alter, or affect in any way the laws of this State relating to the liability of a railroad or railway express company for an injury to a respective employee;

(6) a person engaged in selling any agricultural product for a producer of them on commission or for other compensation, paid by a producer, when the product is prepared for sale by the producer;

(7) a licensed real estate sales person engaged in the sale, leasing, or rental of real estate for a licensed real estate broker on a straight commission basis and who has signed a valid independent contractor agreement with the broker;

(8) a federal employee in this State;

(9) an individual who owns or holds under a bona fide lease-purchase or installment-purchase agreement a tractor trailer, tractor, or other vehicle, referred to as 'vehicle', and who, under a valid independent contractor contract provides that vehicle and the individual's services as a driver to a motor carrier. For purposes of this item, any lease-purchase or installment-purchase of the vehicle may not be between the individual and the motor carrier referenced in this title, but it may be between the individual and an affiliate, subsidiary, or related entity or person of the motor carrier, or any other lessor or seller. Where the lease-purchase or installment-purchase is between the individual and an affiliate, subsidiary, or related entity or person of the motor carrier, or any other lessor or seller, the vehicle acquisition or financing transaction must be on terms equal to terms available in customary and usual retail transactions generally available in the State. This individual is considered an independent contractor and not an employee of the motor carrier under this title. The individual and the motor carrier to whom the individual contracts or leases the vehicle mutually may agree that the individual or workers, or both, is covered under the motor carrier's workers' compensation policy or authorized self-insurance if the individual agrees to pay the contract amounts requested by the motor carrier. Under any such agreement, the independent contractor or workers, or both, must be considered an employee of the motor carrier only for the purposes of this title and for no other purposes."

**Form 50 - specificity**

SECTION 9. Article 3, Chapter 1, Title 42 of the 1976 Code is amended by adding:

"Section 42-1-700. (A) Injured or affected body parts and conditions shall be set forth with as much specificity as possible on the commission's Employee's Notice of Claim and/or Request for Hearing form, hereinafter referred to as Form 50. A Form 50 shall not describe the injured body part(s) or condition(s) as 'whole person', 'whole body', 'all body parts', or other similar language unless the injured employee died as a result of the accident. No hearing shall be held on a Form 50 which does not conform to the requirements of this subsection.

(B) Nothing in this section prohibits a commissioner from determining the compensability of a body part or condition not listed or described on a Form 50 if:

(1) the body part or condition is proved by a preponderance of the evidence to have arisen from the injury or injuries out of and in the course of employment as set forth on the Form 50;

(2) it is proven to the satisfaction of the commissioner that the employee had no knowledge of the injury or condition on the date of the completion of the Form 50. However, the employee is required to amend the Form 50 upon discovery of the injury or condition within a reasonable time period pursuant to regulation; or

(3) in the case of a represented employee, the body part or condition is set forth on the commission's Pre-Hearing Brief form, and such pre-hearing brief is timely filed with the commission and timely served upon the parties.

(C) A Form 50 must be signed by an attorney if the employee is represented, verifying that the contents of the form are accurate and true to the best of the attorney's knowledge. If the employee is not represented, the employee who signs a Form 50 must verify that the contents of the form are accurate and true to the best of the

employee's knowledge."

**Form 51 - specificity**

SECTION 10. Article 3, Chapter 1, Title 42 of the 1976 Code is amended by adding:

"Section 42-1-705. (A) The commission's Employer's Answer to Request for Hearing form, hereinafter referred to as Form 51, must describe with as much specificity as possible the defenses to be relied upon by the defendants. A Form 51 shall not state that 'all defenses apply' or other similar language, unless such is actually the case. A Form 51 which does not conform to the requirements of this subsection shall not be considered at a hearing.

(B) Nothing in this section prohibits a commissioner from considering a defense not listed on a Form 51 if:

(1) it is proven to the satisfaction of the commissioner that the defendants had no knowledge of the facts supporting the defense on the date of the completion of the Form 51; and

(2) in the case of represented defendants, the defense omitted on the Form 51 is set forth on the commission's Pre-Hearing Brief form, and such brief is timely filed with the commission and timely served upon the parties.

(C) A Form 51 must be signed by an attorney, verifying that the contents of the form are accurate and true to the best of the attorney's knowledge. If the employer is unrepresented and completes a Form 51, the employer must sign the form, verifying that the contents are accurate and true to the best of the employer's knowledge."

**Workers' Compensation Commission, vacancies, chairman, deputy commissioner**

SECTION 11. Section 42-3-20 of the 1976 Code is amended to read:

"Section 42-3-20. (A) The commission shall consist of seven members appointed by the Governor with the advice and consent of the Senate for terms of six years and until their successors are appointed and qualify. In the event the Governor does not fill a vacancy within sixty days after the vacancy occurs, the commission by majority vote shall deputize a person with suitable experience, training, and knowledge to serve as a deputy commissioner to serve until such time as the Governor fills the vacancy. As soon as the Governor appoints a replacement who is confirmed by the Senate, the deputy commissioner shall immediately cease to serve in that office. While serving as a deputy commissioner, the deputy commissioner has the power and authority to swear or cause the witnesses to be sworn and shall transmit all testimony and shall make a recommendation to the commission for an award. The commission must determine the award based upon testimony received by the deputy commissioner and may consider the deputy commissioner's recommendation.

(B) The Governor, with the advice and consent of the Senate, shall designate one commissioner as chairman for a term of two years, and the chairman may serve two terms during his six-year term but not consecutively. At the conclusion of a commissioner's two-year term as chairman, the Governor shall appoint another chairman. If the Governor does not appoint another chairman at the expiration of the two-year term, a majority of the commission shall elect from among their members an interim chairman who shall serve until the Governor appoints another chairman other than the one last appointed. A deputy commissioner is not eligible to serve as chairman.

(C) The commissioners shall hear and determine all contested cases, conduct informal conferences when necessary, approve settlements, hear applications for full commission reviews, and handle such other matters as may come before the department for judicial disposition. Full commission reviews shall be conducted by all

commissioners, excluding the original hearing commissioner, or by three-member panels, excluding the original hearing commissioner, appointed by the chairman. The chairman, with approval of a majority of the other commissioners, shall determine which full commission reviews shall be assigned to panels. The decisions of three-member panels have the same force and effect as full commission reviews."

**Commissioner authorized an administrative assistant**

SECTION 12. Section 42-3-60 of the 1976 Code is amended to read:

"Section 42-3-60. Each commissioner shall be authorized to employ an administrative assistant to serve at the commissioner's pleasure."

**Sanctions**

SECTION 13. Chapter 3, Title 42 of the 1976 Code is amended by adding:

"Section 42-3-175. (A)(1) If a claimant brings an action before the commission to enforce an order authorizing medical treatment or payment of benefits and the commission determines that an insurer, a self-insured employer, a self-insured fund, or an adjuster, without good cause, failed to authorize medical treatment and/or pay benefits when ordered to do so by the commission, the insurer, the self-insured employer, the self-insured fund, or the adjuster must pay the claimant's attorneys' fees and costs of enforcing the order. The commission may impose sanctions for wilful disobedience of an order, including, but not limited to, a fine of up to five hundred dollars for each day of the violation.

(2) The commission must notify the Department of Insurance of an insurer's or an adjuster's failure to authorize and pay benefits for medical treatment. If the Director of the Department of Insurance or his or her designee determines that there has been a violation of any provision of Title 38, he may impose penalties for each violation, including, but not limited to, administrative penalties pursuant to Section 38-2-10.

(B)(1) If the commission discovers a pattern of an insurer failing to pay benefits pursuant to an award, as defined in item (2), the chairman must notify the Director of the Department of Insurance. The director or his or her designee must hold a hearing to determine if the insurer had good cause for nonpayment. If the director or his or her designee determines that nonpayment was intentional three or more times within a two-year period, the director may revoke the license of the insurer to do business in this State. If the director or his or her designee revokes the license of the insurer, he must take any steps he considers necessary for the protection of the insurer's policyholders in this State.

(2) For purposes of this section, a pattern is established upon an insurer's failure to pay an award at least three times within a two-year period by failing to pay:

(a) for individual claims;

(b) for a claim in which the claimant had to request enforcement of an award; or

(c) any combination of subitems (a) and (b).

(3) All fines collected pursuant to this section must be submitted to the general fund."

**Files**

SECTION 14. Section 42-3-230 of the 1976 Code is amended to read:

"Section 42-3-230. The commission may from time to time, as it may consider advisable, destroy any of its inactive files that are at least fifteen years old. The commission may maintain these files in either paper or electronic form. No files of the commission shall be considered inactive until the commission is satisfied that the files will be of no further use."

**Penalty**

SECTION 15. Section 42-5-40 of the 1976 Code is amended to read:

"Section 42-5-40. Any employer required to secure the payment of compensation under this title who refuses or neglects to secure such compensation shall be punished by a fine of one dollar for each employee at the time of the insurance becoming due, but not less than ten dollars nor more than one hundred dollars for each day of such refusal or neglect, and until the same ceases, and he shall be liable during continuance of such refusal or neglect to an employee either for compensation under this title or at law in an action instituted by the employee or his personal representative against such employer to recover damages for personal injury or death by accident and in any such action such employer shall not be permitted to defend upon any of the grounds mentioned in Section 42-1-510.

The fine provided in this section may be assessed by the commission in an open hearing with the right of review and appeal as in other cases. All fines collected pursuant to this section must be submitted to the general fund."

**Award**

SECTION 16. Chapter 9, Title 42 of the 1976 Code is amended by adding:

"Section 42-9-5. Any award made pursuant to this title must be based upon specific and written detailed findings of fact substantiating the award."

**Compensation for certain injuries**

SECTION 17. Section 42-9-10 of the 1976 Code is amended to read:

"Section 42-9-10. (A) When the incapacity for work resulting from an injury is total, the employer shall pay, or cause to be paid, as provided in this chapter, to the injured employee during the total disability a weekly compensation equal to sixty-six and two-thirds percent of his average weekly wages, but not less than seventy-five dollars a week so long as this amount does not exceed his average weekly salary; if this amount does exceed his average weekly salary, the injured employee may not be paid, each week, less than his average weekly salary. The injured employee may not be paid more each week than the average weekly wage in this State for the preceding fiscal year. In no case may the period covered by the compensation exceed five hundred weeks except as provided in subsection (C).

(B) The loss of both hands, arms, shoulders, feet, legs, hips, or vision in both eyes, or any two thereof, constitutes total and permanent disability to be compensated according to the provisions of this section.

(C) Notwithstanding the five-hundred-week limitation prescribed in this section or elsewhere in this title, any person determined to be totally and permanently disabled who as a result of a compensable injury is a paraplegic, a quadriplegic, or who has suffered physical brain damage is not subject to the five-hundred-week limitation and shall receive the benefits for life.

(D) Notwithstanding the provisions of Section 42-9-301, no total lump sum payment may be ordered by the commission in any case under this section where the injured person is entitled to lifetime benefits."

**Schedule**

SECTION 18. Section 42-9-30 of the 1976 Code, as last amended by Act 412 of 1988, is further amended to read:

"Section 42-9-30. In cases included in the following schedule, the disability in each case is considered to continue for the period specified and the compensation paid for the injury is as specified:

(1) for the loss of a thumb sixty-six and two-thirds percent of the average weekly wages during sixty-five weeks;

(2) for the loss of a first finger, commonly called the index finger, sixty-six and two-thirds percent of the average weekly wages during forty weeks;

(3) for the loss of a second finger, sixty-six and two-thirds percent of the average weekly wages during thirty-five weeks;

(4) for the loss of a third finger, sixty-six and two-thirds percent of the average weekly wages during twenty-five weeks;

(5) for the loss of a fourth finger, commonly called the little finger, sixty-six and two-thirds percent of the average weekly wages during twenty weeks;

(6) the loss of the first phalange of the thumb or any finger is considered to be equal to the loss of one half of such thumb or finger and the compensation must be for one half of the periods of time above specified;

(7) the loss of more than one phalange is considered the loss of the entire finger or thumb; provided, however, that in no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand;

(8) for the loss of a great toe, sixty-six and two-thirds percent of the average weekly wages during thirty-five weeks;

(9) for the loss of one of the toes other than a great toe, sixty-six and two-thirds percent of the average weekly wages during ten weeks;

(10) the loss of the first phalange of any toe is considered to be equal to the loss of one half of such toe and the compensation must be for one half the periods of time above specified;

(11) the loss of more than one phalange is considered as the loss of the entire toe;

(12) for the loss of a hand, sixty-six and two-thirds percent of the average weekly wages during one hundred and eighty-five weeks;

(13) for the loss of an arm, sixty-six and two-thirds percent of the average weekly wages during two hundred twenty weeks;

(14) for the loss of a shoulder, sixty-six and two-thirds percent of the average weekly wages during three hundred weeks;

(15) for the loss of a foot, sixty-six and two-thirds percent of the average weekly wages during one hundred forty weeks;

(16) for the loss of a leg, sixty-six and two-thirds percent of the average weekly wages during one hundred ninety-five weeks;

(17) for the loss of a hip, sixty-six and two-thirds percent of the average weekly wages during two hundred eighty weeks;

(18) for the loss of an eye, sixty-six and two-thirds percent of the average weekly wages during one hundred forty weeks;

(19) for the complete loss of hearing in one ear, sixty-six and two-thirds percent of the average weekly wages during eighty weeks; and for the complete loss of hearing in both ears, sixty-six and two-thirds percent of the average weekly wages during one hundred sixty-five weeks, and the commission, by regulation, shall provide for the determination of proportional benefits for total or partial loss of hearing based on accepted national medical standards;

(20) total loss of use of a member or loss of vision of an eye is considered as equivalent to the loss of the member or eye. The compensation for partial loss of or for partial loss of use of a member or for partial loss of vision of an eye is the proportion of the payments provided in this section for total loss as such partial loss bears to total loss;

(21) for the loss of use of the back in cases where the loss of use is forty-nine percent or less, sixty-six and two-thirds percent of the average weekly wages during three hundred weeks. In cases where there is fifty percent or more loss of use of the back, sixty-six and two-thirds percent the average weekly wages during five hundred weeks. The compensation for partial loss of use of the back shall be such proportions of the periods of payment herein provided for total loss as such partial loss bears to total loss, except that in cases where there is fifty percent or more loss of use of the back the injured employee shall be presumed to have suffered total and permanent disability and compensated under paragraph two of Section 42-9-10. The presumption set forth in this item is rebuttable;

(22) for the total or partial loss of, or loss of use of, a member, organ, or part of the body not covered in this section and not covered under Section 42-9-10 or 42-9-20, sixty-six and two-thirds of the average weekly wages not to exceed five hundred weeks. The commission, by regulation, shall prescribe the ratio which the partial loss or loss or partial loss of use of a particular member, organ, or body part bears to the whole man, basing these ratios on accepted medical standards and these ratios determine the benefits payable under this subsection;

(23) proper and equitable benefits must be paid for serious permanent disfigurement of the face, head, neck, or other area normally exposed in employment, not to exceed fifty weeks. Where benefits are paid or payable for injury to or loss of a particular member or organ under other provisions of this title, additional benefits must not be paid under this item, except that disfigurement also includes compensation for serious burn scars or keloid scars on the body resulting from injuries, in addition to any other compensation.

The weekly compensation payments referred to in this section all are subject to the same limitations as to maximum and minimum as set out in Section 42-9-10."

**Evidence to be established**

SECTION 19. Chapter 9, Title 42 of the 1976 Code is amended by adding:

"Section 42-9-35. (A) The employee shall establish by a preponderance of the evidence, including medical evidence, that:

(1) the subsequent injury aggravated the preexisting condition or permanent physical impairment; or

(2) the preexisting condition or the permanent physical impairment aggravates the subsequent injury.

(B) The commission may award compensation benefits to an employee who has a permanent physical impairment or preexisting condition and who incurs a subsequent disability from an injury arising out of and in the course of his employment for the resulting disability of the permanent physical impairment or preexisting condition and the subsequent injury. However, if the subsequent injury is limited to a single body part or member scheduled in Section 42-9-30, except for total disability to the back as provided in Section 42-9-30(21), the subsequent injury must impair or affect another body part or system in order to obtain benefits in addition to those provided for in Section 42-9-30.

(C) As used in this section, 'medical evidence' means expert opinion or testimony stated to a reasonable degree of medical certainty, documents, records, or other material that is offered by a licensed health care provider.

(D) The provisions of this section apply whether or not the employer knows of the preexisting permanent disability.

(E) On and after the effective date of this section, an employee who suffers a subsequent injury which affects a single body part or member injury set forth in Section 42-9-30 is limited to the recovery set forth in that section."

**Intoxication, insuring self**

SECTION 20. Section 42-9-60 of the 1976 Code is amended to read:

"Section 42-9-60. No compensation shall be payable if the injury or death was occasioned by the intoxication of the employee or by the wilful intention of the employee to injure or kill himself or another. In the event that any person claims that the provisions of this section are applicable in any case, the burden of proof shall be upon such person."

**References corrected**

SECTION 21. Section 42-9-150 of the 1976 Code is amended to read:

"Section 42-9-150. If an employee has a permanent disability or has sustained a permanent injury that resulted from serving in the United States Armed Forces or in another employment other than that in which he receives a subsequent permanent injury by accident, such as specified in Section 42-9-30 or the second paragraph of Section 42-9-10, he shall be entitled to compensation only for the degree of disability which would have resulted from the later accident if the earlier disability or injury had not existed, except that such employee may receive further benefits if his subsequent injury qualifies for additional benefits under Section 42-9-35."

**Manner in which compensation paid**

SECTION 22. Section 42-9-170 of the 1976 Code is amended to read:

"Section 42-9-170. (A) If an employee receives a permanent injury as specified in Section 42-9-30 or the second paragraph of Section 42-9-10 after having sustained another permanent injury in the same employment, he is entitled to compensation for both injuries, but the total compensation must be paid by extending the period and not by increasing the amount of weekly compensation, and in no case exceeding five hundred weeks. If an employee previously has incurred permanent partial disability through the loss of a hand, arm, shoulder, foot, leg, hip, or eye and by subsequent accident incurs total permanent disability through the loss of another member, the employer's liability is for the subsequent injury only, except that the employee may receive further benefits as provided by Sections 42-7-310, 42-9-400, and 42-9-410 if his subsequent injury qualifies for additional benefits provided in those sections. This subsection is effective until June 30, 2008.

(B) If an employee receives a permanent injury as specified in Section 42-9-30 or the second paragraph of Section 42-9-10 after having sustained another permanent injury in the same employment, he is entitled to compensation for both injuries, but the total compensation must be paid by extending the period and not by increasing the amount of weekly compensation, and in no case exceeding five hundred weeks. If an employee previously has incurred permanent partial disability through the loss of a hand, arm, shoulder, foot, leg, hip, or eye and by subsequent accident incurs total permanent disability through the loss of another member, the employer's liability is for the subsequent injury only, except that the employee may receive further benefits as provided under the provisions of Section 42-9-35. This subsection is effective on July 1, 2008."

**Voluntary settlements**

SECTION 23. Section 42-9-390 of the 1976 Code is amended to read:

"Section 42-9-390. Nothing contained in this chapter may be construed so as to prevent settlements made by and between an employee and employer as long as the amount of compensation and the time and manner of payment are in accordance with the provisions of this title. The employer must file a copy of the settlement agreement with the commission if each party is represented by an attorney. If the employee is not represented by an attorney, a copy of the settlement agreement must be filed by the employer with the commission and approved by one member of the commission."

**Occupational disease**

SECTION 24. Section 42-11-10 of the 1976 Code is amended to read:

"Section 42-11-10. (A) 'Occupational disease' means a disease arising out of and in the course of employment that is due to hazards in excess of those ordinarily incident to employment and is peculiar to the occupation in which the employee is engaged. A disease is considered an occupational disease only if caused by a hazard recognized as peculiar to a particular trade, process, occupation, or employment as a direct result of continuous exposure to the normal working conditions of that particular trade, process, occupation, or employment. In a claim for an occupational disease, the employee shall establish that the occupational disease arose directly and naturally from exposure in this State to the hazards peculiar to the particular employment by a preponderance of the evidence.

(B) No disease shall be considered an occupational disease when it:

(1) does not result directly and naturally from exposure in this State to the hazards peculiar to the particular

employment;

(2) results from exposure to outside climatic conditions;

(3) is a contagious disease resulting from exposure to fellow employees or from a hazard to which the workman would have been equally exposed outside of his employment;

(4) is one of the ordinary diseases of life to which the general public is equally exposed, unless such disease follows as a complication and a natural incident of an occupational disease or unless there is continuous exposure peculiar to the occupation itself which makes such disease a hazard inherent in such occupation;

(5) is any disease of the cardiac, pulmonary, or circulatory system not resulting directly from abnormal external gaseous pressure exerted upon the body or the natural entrance into the body through the skin or natural orifices thereof of foreign organic or inorganic matter under circumstances peculiar to the employment and the processes utilized therein; or

(6) is any chronic disease of the skeletal joints.

(C) As used in this section, 'medical evidence' means expert opinion or testimony stated to a reasonable degree of medical certainty, documents, records, or other material that is offered by a licensed health care provider.

(D) No compensation shall be payable for any occupational disease unless the employee suffers a disability as described in Section 42-9-10, 42-9-20, or 42-9-30."

**Notice required**

SECTION 25. Section 42-15-20 of the 1976 Code is amended to read:

"Section 42-15-20. (A) Every injured employee or his representative immediately shall on the occurrence of an accident, or as soon thereafter as practicable, give or cause to be given to the employer a notice of the accident and the employee shall not be entitled to physician's fees nor to any compensation which may have accrued under the terms of this title prior to the giving of such notice, unless it can be shown that the employer, his agent, or representative, had knowledge of the accident or that the party required to give such notice had been prevented from doing so by reason of physical or mental incapacity or the fraud or deceit of some third person.

(B) Except as provided in subsection (C), no compensation shall be payable unless such notice is given within ninety days after the occurrence of the accident or death, unless reasonable excuse is made to the satisfaction of the commission for not giving timely notice, and the commission is satisfied that the employer has not been prejudiced thereby.

(C) In the case of repetitive trauma, notice must be given by the employee within ninety days of the date the employee discovered, or could have discovered by exercising reasonable diligence, that his condition is compensable, unless reasonable excuse is made to the satisfaction of the commission for not giving timely notice, and the commission is satisfied that the employer has not been unduly prejudiced thereby."

**Compensation barred**

SECTION 26. Section 42-15-40 of the 1976 Code, as last amended by Section 15C, Part II, Act 612 of

1990, is further amended to read:

"Section 42-15-40. The right to compensation under this title is barred unless a claim is filed with the commission within two years after an accident, or if death resulted from the accident, within two years of the date of death. However, for occupational disease claims the two-year period does not begin to run until the employee concerned has been diagnosed definitively as having an occupational disease and has been notified of the diagnosis. For the death or injury of a member of the South Carolina National Guard, as provided for in Section 42-7-67, the time for filing a claim is two years after the accident or one year after the federal claim is finalized, whichever is later. The filing required by this section may be made by registered mail, and the service within the time periods set forth in this section constitutes timely filing. For a 'repetitive trauma injury' as defined in Section 42-1-172, the right to compensation is barred unless a claim is filed with the commission within two years after the employee knew or should have known that his injury is compensable but no more than seven years after the last date of injurious exposure. This section applies regardless of whether the employee was aware that his repetitive trauma injury was the result of his employment."

**Employer responsibilities**

SECTION 27. Section 42-15-60 of the 1976 Code is amended to read:

"Section 42-15-60. (A) The employer shall provide medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be required, for a period not exceeding ten weeks from the date of an injury, to effect a cure or give relief and for an additional time as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty. In addition to it, the original artificial members as reasonably may be necessary must be provided by the employer. During any period of disability resulting from the injury, the employer, at his own option, may continue to furnish or cause to be furnished, free of charge to the employee, and the employee shall accept, an attending physician and any medical care or treatment that is considered necessary by the attending physician, unless otherwise ordered by the commission for good cause shown. The refusal of an employee to accept any medical, hospital, surgical, or other treatment or evaluation when provided by the employer or ordered by the commission bars the employee from further compensation until the refusal ceases and compensation is not paid for the period of refusal unless in the opinion of the commission the circumstances justified the refusal, in which case the commission may order a change in the medical or hospital service. If in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the commission.

(B)(1) When a claim is settled on the commission's Agreement for Permanent Disability/Disfigurement Compensation form, the employer is not required to provide further medical treatment or medical modalities after one year from the date of full payment of the settlement unless the form specifically provides otherwise.

(2) Each award of permanency as ordered by the single commissioner or by the commission must contain a finding as to whether or not further medical treatment or modalities must be provided to the employee. If the employee is entitled to receive such benefits, the medical treatment or modalities to be provided must be set forth with as much specificity as possible in the single commissioner's order or the commission's order.

(3) In no case shall an employer be required to provide medical treatment or modalities in any case where there is a lapse in treatment of the employee by an authorized physician in excess of one year unless:

(a) the settlement agreement or commission order provides otherwise; or

(b) the employee has made reasonable attempts to obtain further treatment or modality from an authorized physician, but through no fault of the employee's own, is unable to obtain such treatment or modalities.

(C) In cases in which total and permanent disability results, reasonable and necessary nursing services, medicines, prosthetic devices, sick travel, medical, hospital, and other treatment or care shall be paid during the life of the injured employee, without regard to any limitation in this title including the maximum compensation limit. In cases of permanent partial disability, prosthetic devices shall be furnished during the life of the injured employee or for as long as such devices are necessary."

**Examination by physician**

SECTION 28. Section 42-15-80 of the 1976 Code is amended to read:

"Section 42-15-80. (A) After an injury and so long as he claims compensation, the employee, if so requested by his employer or ordered by the commission, shall submit himself to examination, at reasonable times and places, by a qualified physician or surgeon designated and paid by the employer or the commission. The employee has the right to have present at the examination any qualified physician or surgeon provided and paid by him. A fact communicated to or otherwise learned by any physician or surgeon who may have attended or examined the employee, or who may have been present at any examination, is not privileged, either in hearings provided for by this title or any action at law brought to recover damages against an employer who may have accepted the compensation provisions of this title. If the employee refuses to submit himself to or in any way obstructs the examination requested by and provided for by the employer, his right to compensation and his right to take or prosecute a proceeding under this title must be suspended until the refusal or objection ceases and compensation is not payable at any time for the period of suspension unless in the opinion of the commission the circumstances justify the refusal or obstruction. The employer or the commission may require in any case of death an autopsy at the expense of the person requesting it.

(B) The commission shall promulgate regulations establishing the role of rehabilitation professionals and other similarly situated professionals in workers' compensation cases with consideration given to these persons' duties to both the employer and the employee and the standards of care applicable to the rehabilitation professional or other similarly situated professional as the case may be."

**Consent**

SECTION 29. Section 42-15-95 of the 1976 Code, as last amended by Act 468 of 1994, is further amended to read:

"Section 42-15-95. (A) Any employee who seeks treatment for any injury, disease, or condition for which compensation is sought under the provisions of this title shall be considered to have given his consent for the release of medical records relating to such examination or treatment under any applicable law or regulation. All information compiled by a health care facility, as defined in Section 44-7-130, or a health care provider licensed pursuant to Title 40 pertaining directly to a workers' compensation claim must be provided to the insurance carrier, the employer, the employee, their respective attorneys or certified rehabilitation professionals, or the South Carolina Workers' Compensation Commission, within fourteen days after receipt of written request. A health care facility and a health care provider may charge a fee for the search and duplication of a medical record in accordance with regulations promulgated by the Workers' Compensation Commission. Fee schedules established through regulations of the Workers' Compensation Commission shall apply only to claims under Title 42. If a health care provider fails to send the requested information within thirty days after receipt of the request, the person or entity making the request may apply to the commission for an appropriate penalty payable to the commission, not to exceed two hundred dollars.

(B) A health care provider who provides examination or treatment for any injury, disease, or condition for which compensation is sought under the provisions of this title may discuss or communicate an employee's medical history, diagnosis, causation, course of treatment, prognosis, work restrictions, and impairments with the insurance carrier, employer, their respective attorneys or certified rehabilitation professionals, or the commission without the employee's consent. The employee must be:

(1) notified by the employer, carrier, or its representative requesting the discussion or communication with the health care provider in a timely fashion, in writing or orally, of the discussion or communication and may attend and participate. This notification must occur prior to the actual discussion or communication if the health care provider knows the discussion or communication will occur in the near future;

(2) advised by the employer, carrier, or its representative requesting the discussion or communication with the health care provider of the nature of the discussion or communication prior to the discussion or communication; and

(3) provided with a copy of the written questions at the same time the questions are submitted to the health care provider. The employee also must be provided with a copy of the response by the health care provider.

Any discussion or communication must not conflict with or interfere with the employee's examination or treatment.

Any discussions, communications, medical reports, or opinions obtained in accordance with this section will not constitute a breach of the physician's duty of confidentiality.

(C) Any discussions, communications, medical reports, or opinions obtained in violation of this section must be excluded from any proceedings under the provisions of this title."

**Review of award**

SECTION 30. Section 42-17-60 of the 1976 Code, as last amended by Act 439 of 1990, is further amended to read:

"Section 42-17-60. The award of the commission, as provided in Section 42-17-40, if not reviewed in due time, or an award of the commission upon the review, as provided in Section 42-17-50, is conclusive and binding as to all questions of fact. However, either party to the dispute, within thirty days from the date of the award or within thirty days after receipt of notice to be sent by registered mail of the award, but not after, whichever is the longest, may appeal from the decision of the commission to the court of appeals. Notice of appeal must state the grounds of the appeal or the alleged errors of law. In case of an appeal from the decision of the commission on questions of law, the appeal does not operate as a supersedeas and, after that time, the employer is required to make weekly payments of compensation and to provide medical treatment ordered by the commission involved in the appeal or certification until the questions at issue have been fully determined in accordance with the provisions of this title. Interest accrues on an unpaid portion of the award at the legal rate of interest as established in Section 34-31-20(B) during the pendency of an appeal."

**Review of award**

SECTION 31. Section 42-17-90 of the 1976 Code is amended to read:

"Section 42-17-90. (A) On its own motion or on the application of a party in interest on the ground of a change in condition, the commission may review an award and on that review may make an award ending,

diminishing, or increasing the compensation previously awarded, on proof by a preponderance of the evidence that there has been a change of condition caused by the original injury, after the last payment of compensation. An award is subject to the maximum or minimum provided in this title, and the commission immediately shall send to the parties a copy of the order changing the award. The review does not affect the award as regards any monies paid and the review must not be made after twelve months from the date of the last payment of compensation pursuant to an award provided by this title.

(B) A motion or application for change in condition involving a repetitive trauma injury must be made within one year from the date of the last compensation payment for the repetitive trauma injury. Any filing not made within this one-year period shall be considered untimely and shall not be reviewed.

(C) A motion or application for change in condition involving an occupational disease must be made within one year from the date of the last compensation payment for the occupational disease. Any filing not made within this one-year period shall be considered untimely and shall not be reviewed."

**Repeal**

SECTION 32. Sections 42-1-350, 42-1-370, 42-1-375, and 42-9-80 of the 1976 Code are repealed.

PART II

Second Injury Fund

**Power of Director of Insurance, rates**

SECTION 1. Section 38-73-495 of the 1976 Code is amended to read:

"Section 38-73-495. The director or his designee may:

(1) disapprove a previously approved rate for any classification for workers' compensation insurance upon a finding that the rate for that classification is excessive, inadequate, or unfairly discriminatory;

(2) require the division of a particular classification into separate classifications, or the joining of separate classifications into one classification, upon a finding that such action is in the public interest;

(3) direct that a particular risk be classified in a particular classification upon a finding that a risk is classified incorrectly;

(4) disapprove an experience modification rate for workers' compensation insurance upon a finding that the rate is excessive, inadequate, or unfairly discriminatory. This includes an experience modification rate that fails to account for third party reimbursements, including the Second Injury Fund. Appeals regarding experience modification rates must first be exhausted through the National Council on Compensation Insurance's dispute resolution process prior to appealing with the Department of Insurance.

Appeals to the department must be filed within one year of policy expiration date or cancellation date, whichever comes first."

**Equitable assessments**

SECTION 2. Section 42-7-310(d)(2) of the 1976 Code, as last amended by Act 73 of 2003, is further

amended to read:

"(2) equitable assessments upon each carrier which, as used in this section, includes all insurance carriers, self-insurers, and the State Accident Fund. Each carrier shall make payments to the fund in an amount equal to that proportion of one hundred thirty-five percent of the total disbursement made from the fund during the preceding fiscal year less the amount of net assets in the fund as of June thirtieth of the preceding fiscal year which the normalized premium of each carrier bore to the normalized premium of all carriers during the preceding calendar year. Each insurance carrier, self-insurer, and the State Accident Fund shall make payment based upon workers' compensation normalized premiums during the preceding calendar year. The charge to each insurance carrier is a charge based upon normalized premiums. An employer who has ceased to be a self-insurer shall continue to be liable for any assessments into the fund on account of any benefits paid by him during such calendar year. Any assessment levied or established in accordance with this section constitutes a personal debt of every employer or insurance carrier so assessed and is due and payable to the Second Injury Fund when payment is called for by the fund. In the event of failure to pay any assessment upon the date determined by the fund, the employer or insurance carrier immediately may be assessed a penalty in an amount not exceeding ten percent of the unpaid assessment. If the employer or insurance carrier fails to pay the assessment and penalty, they shall be barred from any recovery from the fund on all claims without exception until the assessment and penalty are paid in full. The director may file a complaint for collection against the employer or insurance carrier in a court of competent jurisdiction for the assessment, penalty, and interest at the legal rate, and the employer/carrier is responsible for attorney's fees and costs. The penalty and interest under this subsection are payable to the Second Injury Fund. At the time of the filing of the complaint, the fund also shall notify the South Carolina Department of Insurance and the South Carolina Workers' Compensation Commission, and these government agencies shall take the appropriate legal and administrative action immediately."

**Subsequent disabilities**

SECTION 3. Section 42-9-400 of the 1976 Code, as last amended by Act 73 of 2003, is further amended to read:

"Section 42-9-400. (a) If an employee who has a permanent physical impairment from any cause or origin incurs a subsequent disability from injury by accident arising out of and in the course of his employment, resulting in compensation and medical payments liability or either, for disability that is substantially greater and is caused by aggravation of the preexisting impairment than that which would have resulted from the subsequent injury alone, the employer or his insurance carrier shall pay all awards of compensation and medical benefits provided by this title; but such employer or his insurance carrier shall be reimbursed from the Second Injury Fund as created by Section 42-7-310 for compensation and medical benefits in the following manner:

(1) reimbursement of all compensation benefit payments payable subsequent to those payable for the first seventy-eight weeks following the injury;

(2) reimbursement of fifty percent of medical payments in excess of three thousand dollars during the first seventy-eight weeks following the injury and then reimbursement of all medical benefit payments payable subsequent to the first seventy-eight weeks following the injury; provided, however, in order to obtain reimbursement for medical expense during the first seventy-eight weeks following the subsequent injury, an employer or carrier must establish that his liability for medical payments is substantially greater by reason of the aggravation of the preexisting impairment than that which would have resulted from the subsequent injury alone.

(b) If the subsequent injury of such an employee shall result in the death of the employee, and it shall be

determined that the death would not have occurred except for such preexisting permanent physical impairment, the employer or his insurance carrier shall in the first instance pay the compensation prescribed by this title; but he or his insurance carrier shall be reimbursed from the Second Injury Fund created by Section 42-7-310, for all compensation payable in excess of seventy-eight weeks.

(c) In order to qualify under this section for reimbursement from the Second Injury Fund, the employer must establish when claim is made for reimbursement thereunder, that the employer had knowledge of the permanent physical impairment at the time that the employee was hired, or at the time the employee was retained in employment after the employer acquired such knowledge. However, the employer may qualify for reimbursement hereunder upon proof that he did not have prior knowledge of the employee's preexisting physical impairment because the existence of the condition was concealed by the employee.

(d) As used in this section, 'permanent physical impairment' means any permanent condition, whether congenital or due to injury or disease, of such seriousness as to constitute a hindrance or obstacle to obtaining employment or to obtaining reemployment if the employee should become unemployed.

When an employer establishes his prior knowledge of the permanent impairment, then there shall be a presumption that the condition is permanent and that a hindrance or obstacle to employment or reemployment exists when the condition is one of the following impairments:

(1) Epilepsy;

(2) Diabetes;

(3) Cardiac disease;

(4) Amputated foot, leg, arm, or hand;

(5) Loss of sight of one or both eyes or partial loss of uncorrected vision of more than seventy-five percent bilateral;

(6) Residual disability from Poliomyelitis;

(7) Cerebral Palsy;

(8) Multiple Sclerosis;

(9) Parkinson's disease;

(10) Cerebral vascular accident;

(11) Tuberculosis;

(12) Silicosis;

(13) Psychoneurotic disability following treatment in a recognized medical or mental institution;

(14) Hemophilia;

(15) Chronic Ostemyelitis;

(16) Ankylosis of joints;

(17) Hyperinsulinism;

(18) Muscular Dystrophy;

(19) Arteriosclerosis;

(20) Thrombophlebitis;

(21) Varicose veins;

(22) Heavy metal poisoning;

(23) Ionizing radiation injury;

(24) Compressed air sequelae;

(25) Ruptured intervertebral disc;

(26) Hodgkins disease;

(27) Brain damage;

(28) Deafness;

(29) Cancer;

(30) Sickle-Cell Anemia;

(31) Pulmonary disease;

(32) Mental retardation provided the employee's intelligence quotient is such that he falls within the lowest percentile of the general population. However, it shall not be necessary for the employer to know the employee's actual intelligence quotient or actual relative ranking in relation to the intelligence quotient of the general population.

(e) The Second Injury Fund shall not be bound as to any question of law or fact by reason of any compensation agreement, settlement, award, and adjudication to which it was not a party, or in relation to which it was not notified at least twenty days prior to a hearing on liability that it might be subject to liability for the injury or death.

(f) An employer or his carrier must notify the Workers' Compensation Commission and the Director of the Second Injury Fund in writing of any possible claim against the fund as soon as practicable but in no event later than after the payment of the first seventy-eight weeks of compensation. This written notice must provide the:

(i) date of accident;

(ii) employee's name;

(iii) employer's name and address;

(iv) insurance carrier's name, address, and the National Council on Compensation Insurance code; and

(v) insurance carrier's claim number, policy number, and policy effective date. The carrier claim number is the unique identifier a carrier uses throughout the life of a claim to report that claim to the National Council on Compensation Insurance. Failure to comply with the provisions of this subsection shall bar an employer or his carrier from recovery from the fund.

(g) If the employee has a permanent physical impairment, as defined in this section and the prerequisites for reimbursement have been met, and if it can be shown that the subsequent injury most probably would not have occurred 'but for' the presence of the prior impairment, then reimbursement will be granted as provided in this section even if the subsequent injury does not cause the employer's liability for compensation and medical benefits to be substantially greater than that which would have resulted from the subsequent injury alone.

(h) When a third party is deemed to be an employer for the purposes of paying workers' compensation benefits, that third party will be entitled to reimbursement from the Second Injury Fund if either he or the employer of record have met the knowledge requirements outlined in this section, as well as all other requirements.

(i) The Second Injury Fund is entitled to a credit for sums recovered by the employer or his workers' compensation carrier from third parties, after the employer or his workers' compensation carrier have been reimbursed for the monies paid out by them and not reimbursed by the fund.

(j) The Second Injury Fund can enter into compromise settlements at the discretion of the director with approval of a majority of the Workers' Compensation Commission, provided a bona fide dispute exists.

(k) Any employer operating in violation of Section 42-5-20 is not eligible for reimbursement from the South Carolina Second Injury Fund.

(l) As a prerequisite to reimbursement from the fund, the insurer shall be required to certify that the medical and indemnity reserves have been reduced to the threshold limits of reimbursement and report in accordance with the National Council on Compensation Insurance Workers' Compensation Statistical Plan.

(m) The Second Injury Fund Director must quarterly submit to the National Council on Compensation Insurance information regarding Second Injury Fund accepted claims.

(n) The National Council on Compensation Insurance must submit a report of any discrepancies pursuant to regulations established by the Department of Insurance. The Department of Insurance is directed to establish regulations concerning Second Injury Fund discrepancies."

**Workers' Compensation Uninsured Employers' Fund**

SECTION 4. Section 42-7-200 of the 1976 Code, as last amended by Act 459 of 1994, is further amended to read:

"Section 42-7-200. (A)(1) There is hereby established, within the office of the Second Injury Fund, the South Carolina Workers' Compensation Uninsured Employers' Fund. This fund is created to ensure payment of workers' compensation benefits to injured employees whose employers have failed to acquire necessary coverage for employees in accordance with provisions of this section. The fund must be administered by the

Director of the Second Injury Fund, who shall establish procedures to implement this section, until June 30, 2013. Effective July 1, 2013, all functions within the Second Injury Fund related to the Uninsured Employers' Fund, including all allied, advisory, affiliated, or related entities, as well as the employees, funds, property, and all contractual rights and obligations associated with the Uninsured Employers' Fund, is transferred to the South Carolina Workers' Compensation Uninsured Employers' Fund, and all powers, duties, obligations, and responsibilities of the Second Injury Fund that relate to the Uninsured Employers' Fund are devolved upon the South Carolina Workers' Compensation Uninsured Employers' Fund in accordance with the State Budget and Control Board's plan for the closure of the Second Injury Fund. This item is effective until July 1, 2013.

(2) There is hereby established, within the office of the State Accident Fund, the South Carolina Workers' Compensation Uninsured Employers' Fund. This fund is created to ensure payment of workers' compensation benefits to injured employees whose employers have failed to acquire necessary coverage for employees in accordance with provisions of this section. The fund must be administered by the Director of the State Accident Fund, who shall establish procedures to implement this section. This item is effective as of July 1, 2013.

(B) When an employee makes a claim for benefits pursuant to Title 42 and the State Workers' Compensation Commission determines that the employer is subject to Title 42 and is operating without insurance or as an unqualified self-insurer, the commission shall notify the fund of the claim. The fund shall pay or defend the claim as it considers necessary in accordance with the provisions of Title 42.

(C) When the fund is notified of a claim, the fund may place a lien on the assets of the employer by way of lis pendens or otherwise so as to protect the fund from payments of costs and benefits. If the fund is required to incur costs or expenses or to pay benefits, the fund has a lien against the assets of the employer to the full extent of all costs, expenses, and benefits paid and may file notice of the lien with the clerk of court or register of deeds of any county in which the employer has assets in the same manner as the filing of South Carolina tax liens and with the Secretary of State in the same manner as utilized under Title 36 (Uniform Commercial Code). Any of the employer's assets sold or conveyed during the litigation of the claim must be sold or conveyed subject to the lien.

(D) The fund has all rights of attachment set forth in Section 15-19-10 and has the right to proceed otherwise in the collection of its lien in the same manner as the Department of Revenue is allowed to enforce a collection of taxes generally pursuant to Section 12-49-10, et seq. When all benefits due the claimant, as well as all expenses and costs of litigation, have been paid, the fund shall file notice of the total of all monies paid with the clerk of court in any county in which the employer has assets and with the Secretary of State. This notice constitutes a judgment against the employer and has priority as a first lien in the same manner as liens of the Department of Revenue, subject only to the lien of the Department of Revenue pursuant to Section 12-49-10, et seq. If the employer files for bankruptcy or otherwise is placed into receivership, the fund becomes a secured creditor to the assets of the employer in the same manner as the Department of Revenue has priority for unpaid taxes, subject only to the lien of the Department of Revenue. The fund otherwise has all rights and remedies afforded the Department of Revenue as set forth in Section 12-54-10, et seq.

(E) Nothing in this section precludes the South Carolina Workers' Compensation Uninsured Employers' Fund from entering into an agreement for the reimbursement of expenses, costs, or benefits paid by the fund. If an agreement is entered into subsequent to the filing of a lien, the lien may be canceled by the fund. Provided, however, an agreement between the fund and an employer under this section may provide that in the event the employer breaches the terms or conditions of the agreement, the fund may file or reinstate a lien, as the case may be. For purposes of this section, the term 'costs' includes reasonable administrative costs which must be set by the director of the fund, subject to the approval of the Workers' Compensation Commission.

(F) To establish and maintain the South Carolina Workers' Compensation Uninsured Employers' Fund, there must be earmarked from the collections of the tax on insurance carriers and self-insured persons provided for in

Sections 38-7-50 and 42-5-190 an amount sufficient to establish and annually maintain the fund at a level of not less than two hundred thousand dollars. In addition, the State Treasurer may deposit to the account of the fund monies authorized to be paid to the Workers' Compensation Commission under Section 42-9-140 upon determination additional funds are needed for the operation of the fund.

(G) When an employee makes a claim for benefits pursuant to Title 42 and the records of the South Carolina Workers' Compensation Commission indicate that the employer is operating without insurance, the South Carolina Workers' Compensation Uninsured Employers' Fund or any person designated by the director may subpoena the employer or its agents and require the production of any documents or records which the fund considers relevant to its investigation of the claim. The subpoena shall be returnable at the office of the fund or any place designated by it. In the case of refusal to obey a subpoena issued to any person or agent of any employer, a court of common pleas upon application of the fund may issue an order requiring the person or agent of an employer to appear at the fund and produce documentary evidence or give other evidence concerning the matter under inquiry."

**Second Injury Fund terminated**

SECTION 5. Article 3, Chapter 7, Title 42 of the 1976 Code is amended by adding:

"Section 42-7-320. (A) Except as otherwise provided in this section, on and after July 1, 2013, the programs and appropriations of the Second Injury Fund are terminated. The State Budget and Control Board must provide for the efficient and expeditious closure of the fund with the orderly winding down of the affairs of the fund so that the remaining liabilities of the fund are paid utilizing assessments, accelerated assessments, annuities, loss portfolio transfers, or such other mechanisms as are reasonably determined necessary to fund any remaining liabilities of the fund. The Department of Insurance and the Workers' Compensation Commission may submit comments and suggestions to be considered by the State Budget and Control Board in planning for the closure of the fund. The State Budget and Control Board shall cause all necessary actions to be taken to provide appropriate staffing of the fund until such time as the staff services are no longer required to administer the obligations of the fund. The fund's administrative costs, including employee salaries and benefits, shall be paid from the Second Injury Fund Trust if the interest from the trust becomes insufficient to pay these obligations.

(B) After December 31, 2011, the Second Injury Fund shall not accept a claim for reimbursement from any employer, self-insurer, or insurance carrier. The fund shall not consider a claim for reimbursement for an injury that occurs on or after July 1, 2008.

(1) An employer, self-insurer, or insurance carrier must notify the Second Injury Fund of a potential claim by December 31, 2010. Failure to submit notice by December 31, 2010, shall bar an employer, self-insurer, or insurance carrier from recovery from the fund.

(2) An employer, self-insurer, or insurance carrier must submit all required information for consideration of accepting a claim to the Second Injury Fund by June 30, 2011. Failure to submit all required information to the fund by June 30, 2011, so that the claim can be accepted, compromised, or denied shall bar an employer, self-insurer, or insurance carrier from recovery from the fund.

(3) Insurance carriers, self-insurers, and the State Accident Fund remain liable for Second Injury Fund assessments, as determined by the State Budget and Control Board, in order to pay accepted claims. The fund shall continue reimbursing employers and insurance carriers for claims accepted by the fund on or before December 31, 2011."

**Report of Code Commissioner**

SECTION 6. On or before January 15, 2014, the Code Commissioner shall prepare and deliver a report to the President Pro Tempore of the Senate and the Speaker of the House of Representatives of all code references and cross-references which he considers in need of correction, modification, or repeal insofar as the 1976 Code has been affected by this act. The Code Commissioner also is directed to include in his report how to provide adequate notice to alert code users to the status of the provisions concerning the Second Injury Fund as the fund continues to do business pending its termination.

PART III

Loss Cost Multiplier

**Exemption not to apply**

SECTION 1. Section 38-73-520 of the 1976 Code, as last amended by Act 300 of 2002, is further amended to read:

"Section 38-73-520. Every insurer must file with the department, except as to exempt commercial policies, every manual of classifications, rules, and rates, every rating plan, and every modification of any of these which it proposes to use. The filing exemption shall not apply to loss cost filings by advisory or rating organizations or to the multiplier for expenses, assessments, profit, and contingencies and any modifications to loss costs used by a workers' compensation insurer to be applied to approved loss costs to develop the insurer's rates as provided in Section 38-73-525. Every filing must state the proposed effective date and indicate the character and extent of the coverage contemplated."

**Filing of multiplier for expenses, etc.**

SECTION 2. Article 5, Chapter 73, Title 38 of the 1976 Code is amended by adding:

"Section 38-73-525. At least thirty days prior to using new rates, every insurer writing workers' compensation must file its multiplier for expenses, assessments, profit, and contingencies and any information relied upon by the insurer to support the multiplier and any modifications to loss costs. A copy of the filing must be provided simultaneously to the Consumer Advocate. The filing must contain, at a minimum, the following information: commission expense; other acquisition expense; general expense; expenses associated with recoveries from the Second Injury Fund; guaranty fund assessments; other assessments; premium taxes; miscellaneous taxes, licenses, or fees; and provision for profit and contingencies. Rate filings must be reviewed by an actuary employed or retained by the department who is a member of the American Academy of Actuaries or an associate or fellow of the Casualty Actuarial Society. Within the thirty-day period, if the director or his or her designee believes the information filed is not complete, the director or his or her designee must notify the insurer of additional information to be provided. Within fifteen days of receipt of the notification, the insurer must provide the requested information or file for a hearing challenging the reasonableness of the director's or his or her designee's request. The burden is on the insurer to justify the denial of the additional information.

Unless a hearing has been requested, upon expiration of the thirty-day period or the fifteen-day period, whichever is later, the insurer may use the rates developed using the multiplier of expenses, assessments, profit, and contingencies."

**Review of filings**

SECTION 3. Section 38-73-960 of the 1976 Code is amended to read:

"Section 38-73-960. The director or his or her designee must review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter. Subject to the exceptions specified in Sections 38-73-965, 38-73-970, and 38-73-980, each filing must be on file for a waiting period of sixty days before it becomes effective. This period may be extended by the director or his or her designee for an additional period not to exceed sixty days if he or she gives written notice within the waiting period to the insurer or rating organization which made the filing that he or she needs additional time for the consideration of the filing. Upon written application by the insurer or rating organization, the director or his or her designee may authorize a filing which he or she has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing meets the requirements of this chapter unless disapproved by the director or his or her designee within the waiting period or any extension thereof."

**Filing - effective date**

SECTION 4. Article 9, Chapter 73, Title 38 of the 1976 Code is amended by adding:

"Section 38-73-965. A filing made pursuant to Section 38-73-525 is governed by the effective dates specified in that section."

**Disapproval of filings**

SECTION 5. Section 38-73-990 of the 1976 Code is amended to read:

"Section 38-73-990. Except as provided in Section 38-73-995, if within the waiting period or any extension thereof as provided in Section 38-73-960 the director or his or her designee finds that a filing or a part of a filing does not meet the requirements of this chapter, he or she must send to the insurer or rating organization which made the filing written notice of disapproval of the filing or part of a filing specifying therein in what respects he or she finds the filing or part thereof fails to meet the requirements of this chapter and stating that the filing or the part may not become effective."

**Disapproval by director**

SECTION 6. Article 9, Chapter 73, Title 38 of the 1976 Code is amended by adding:

"Section 38-73-995. An insurer's workers' compensation rates developed using its most recent multiplier for expenses, assessments, profit, and contingencies and any modifications to loss costs may be disapproved at any time after they become effective if the director or his or her designee determines that they do not meet the requirements of this chapter."

**Report**

SECTION 7. Article 5, Chapter 73, Title 38 of the 1976 Code is amended by adding:

"Section 38-73-526. The director or his or her designee must issue a report to the General Assembly by the first of January each year that evaluates the state of the workers' compensation insurance market in this State. The report must contain an analysis of the availability and affordability of workers' compensation coverage and document that the department has complied with the provisions of Sections 38-73-430 and 38-73-525 with regard to both workers' compensation loss cost filings submitted by an advisory or rating organization and multiplier filings submitted by every insurer writing workers' compensation insurance."

PART IV

Severability and Time Effective

**Severability**

SECTION 1. If any section, subsection, item, subitem, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, item, subitem, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one of more other sections, subsections, items, subitems, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

**Time effective**

SECTION 2. Except as otherwise provided for in this act, this act takes effect July 1, 2007, or, if ratified after July 1, 2007, and except otherwise stated, upon approval by the Governor and applies to injuries that occur on or after this date.

Ratified the 20th day of June, 2007.

Approved the 25th day of June, 2007.

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