



State or Federal Issues Contacts: Please refer to the list of State Relations Executives at the end of this report.

LEGISLATIVE ACTIVITY—LEGISLATIVE SESSION UPDATES

This report contains descriptions and/or excerpts of relevant bills that passed the first chamber, passed the second chamber, or were enacted during the specific periods. In addition, a recap of significant legislative and judicial activity impacting the workers compensation system will be included in the first report published each month. This report is issued on a weekly basis throughout the legislative season, and it provides updates on the content of these bills if and when they progress through the legislative process. This report includes bills from states where NCCI provides ratemaking services (see state list under Contact Information) and the US Congress.

BILLS ENACTED

The following workers compensation-related bill was enacted within the one-week period ending February 17, 2017.

Arkansas

HB 1262 was:

- Passed by the first chamber on January 31, 2017
- Included in NCCI's February 10, 2017 **Legislative Activity Report** (RLA-2017-05)
- Passed by the second chamber on February 9, 2017
- Included in NCCI's February 17, 2017 **Legislative Activity Report** (RLA-2017-06)
- Enacted on February 10, 2017, with a projected effective date of July 30, 2017

HB 1262 amends **section 11-14-101(b)**. **Legislative intent** of the Arkansas Code as follows:

§ 11-14-101. Legislative intent.

...

(b)(1) If an employer implements a drug-free workplace program ~~in accordance with~~ under this chapter that includes notice, education, and procedural requirements for testing for drugs and alcohol ~~pursuant to~~ under rules developed by the Workers' Health and Safety Division of the Workers' Compensation Commission, the covered employer may require the employee to submit to a test for the presence of drugs or alcohol, and if a drug or alcohol is found to be present in the employee's system at a level prescribed by statute or by rule adopted ~~pursuant to~~ under this chapter as excessive, the employee may be terminated and may be precluded from workers' compensation medical and indemnity benefits.

(2) However, a drug-free workplace program ~~must~~ shall require the covered employer to notify all employees that it is a condition of employment for an employee to refrain from reporting to work or working with the presence of drugs or alcohol in the employee's body, and if an injured employee refuses to submit to a test for drugs or alcohol, the employee may be precluded from workers' compensation medical and indemnity benefits. ~~In the event of termination, an employee shall be entitled to contest the test results before the Department of Labor.~~

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending February 17, 2017.

Virginia

HB 1571 was:

- Passed by the first chamber on January 18, 2017
- Included in NCCI's January 27, 2017 **Legislative Activity Report** (RLA-2017-03)
- Passed by the second chamber on February 16, 2017

HB 1571 amends **Section 65.2-605. Liability of employer for medical services ordered by Commission; fee schedules for medical services; malpractice; assistants-at-surgery; coding** of the Code of Virginia as follows:

§ 65.2-605. Liability of employer for medical services ordered by Commission; fee schedules for medical services; malpractice; assistants-at-surgery; coding

A. As used in this section, unless the context requires a different meaning:

...
“Codes” means, as applicable, CPT codes, HCPCS codes, ~~or~~ DRG classifications, or revenue codes.

...
“Health Care Common Procedure Coding System codes” or “HCPCS codes” means the medical coding system, including all subsets of codes by alphabetical letter, used to report hospital outpatient and certain physician services as published by the National Uniform Billing Committee, including Temporary National Code (Non-Medicare) S0000-S-9999.

...
“Medical service provided for the treatment of a serious burn” includes any professional service rendered during the dates of service of the admission or transfer to a burn center.

“Medical service provided for the treatment of a traumatic injury” includes any professional service rendered during the dates of service of the admission or transfer to a Level I or Level II trauma center.

...
“New type of technology” means an item resulting or derived from an advance in medical technology, including an implantable medical device or an item of medical equipment, that is supplied by a third party, provided that the item has been cleared or approved by the federal Food and Drug Administration (FDA) after the transition date and prior to the date of the provision of the medical service using the item.

...
“Professional service” means any medical or surgical service required to be provided to an injured person pursuant to this title that is provided by a physician or any health care practitioner licensed, accredited, or certified to perform the service consistent with state law.

...
“Revenue codes” means a method of coding used by hospitals or health care systems to identify the department in which medical service was rendered to the patient or the type of item or equipment used in the delivery of medical services.

...
B. The pecuniary liability of the employer for a:

...
3. Medical service provided on or after the transition date ~~is~~ for the treatment of a traumatic injury or serious burn, regardless of the date of injury, shall be limited to:

...
E. The maximum pecuniary liability of the employer for a fee scheduled medical service that is not included in a Virginia fee schedule when it is provided shall be determined by the Commission. The Commission’s determination of the employer’s maximum pecuniary liability for such fee scheduled medical service shall be effective until the Commission sets a maximum fee for the fee scheduled medical service and incorporates such maximum fee into an adjusted Virginia fee schedule adopted pursuant to subsection D. If the fee scheduled medical service is not included in a Virginia fee schedule because it is:

1. A new type of technology, ~~including an implantable medical device or item of medical equipment, that is supplied by a third party, provided that such technology has been cleared or approved by the federal Food and Drug Administration (FDA) prior to the date of the provision of the medical service~~, the employer’s maximum pecuniary liability shall not exceed 130 percent of the provider’s invoiced cost for such device, as evidenced by a copy of the invoice. If the new type of technology has not been cleared or approved by the FDA prior to such date, then the provider shall not be entitled to payment or reimbursement therefor unless the employer or its insurer agree; or

...
F. The Commission shall:

...
2. Utilize a 10-member regulatory advisory panel to assist in the development of regulations adopting initial Virginia fee schedules pursuant to subsection C ~~and~~ in adjusting initial Virginia fee schedules pursuant to subsection D, and on all matters involving or related to the fee schedule as deemed necessary by the Commission. One member of the regulatory advisory panel shall be selected by the Commission from each of the following: (i) the American Insurance Association; (ii) the Property and Casualty Insurers Association of America; (iii) the Virginia Self-Insurers Association, Inc.; (iv) the Medical Society of Virginia; (v) the Virginia Hospital and Healthcare Association; (vi) a Type One teaching hospital; (vii) the Virginia Orthopaedic Society; (viii) the Virginia Trial Lawyers Association; (ix) a group self-insurance association representing employers; and (x) a local government group self-insurance pool formed under Chapter 27 (Section 15.2-2700 et seq.) of Title 15.2. The Commission shall meet with the regulatory advisory panel and consider the recommendations of its members in its development of the Virginia fee schedules pursuant to subsections C and D.

...

H. When the total charges of a hospital or Type One teaching hospital, based on such provider's charge master, for inpatient hospital services covered by a DRG code exceed the charge outlier threshold, then the Commission shall establish the maximum fee for such scheduled inpatient hospital services at an amount equal to the total of (i) the maximum fee for the service as set forth in the applicable fee schedule and (ii) initially equal to 80 percent of the provider's total charges for the service in excess of the charge outlier threshold. The charge outlier threshold for such services initially shall equal ~~150~~ 300 percent of the maximum fee for the service set forth in the applicable fee schedule; however, the Commission, in consultation with the firm retained pursuant to subdivision C 4, is authorized on a biennial basis to ~~decrease~~ adjust such percentage if it finds that the number of such claims for which the total charges of the hospital or Type One teaching hospital exceed the charge outlier threshold is less than five percent or to increase such percentage if such number is greater than 10 percent of all such claims.

...

In addition, **HB 1571** extends the deadline by which the regulatory advisory panel is required to meet, review, and make recommendations to the Virginia Workers' Compensation Commission from July 1, 2017, to July 1, 2018.

HB 1659 was:

- Passed by the first chamber on January 30, 2017
- Included in NCCI's February 10, 2017 *Legislative Activity Report* (RLA-2017-05)
- Passed by the second chamber on February 16, 2017

HB 1659 Substitute amends *Section 65.2-309. Lien against settlement proceeds or verdict in third party suit; subrogation of employer to employee's rights against third parties; evidence; recovery; compromise* of the Code of Virginia as follows:

§ 65.2-309. Lien against settlement proceeds or verdict in third party suit; subrogation of employer to employee's rights against third parties; evidence; recovery; compromise

...

E. Any arbitration held by the employer in the exercise of such right of subrogation (i) shall be limited solely to arbitrating the amount and validity of the employer's lien, (ii) shall not affect the employee's rights in any way, and (iii) shall not be held unless:

1. Prior to the commencement of such arbitration the employer has provided the injured employee and his attorney, if any, with an itemization of the expenses associated with the lien that is the subject of the arbitration;

2. Upon receipt of the itemization of the lien, the employee shall have 21 days to provide a written objection to any expenses included in the lien to the employer, and if the employee does not do so any objections to the lien to be arbitrated shall be deemed waived;

3. The employer shall have 14 days after receipt of the written objection to notify the employee of any contested expenses that the employer does not agree to remove from the lien, and if the employer does not do so any itemized expense objected to by the employee shall be deemed withdrawn and not included in the arbitration; and

4. Any contested expenses remaining shall have been submitted to the Commission for a determination of their validity and the Commission has made such determination of validity prior to the commencement of the arbitration.

SB 1201 was:

- Passed by the first chamber on January 27, 2017
- Included in NCCI's February 3, 2017 *Legislative Activity Report* (RLA-2017-04)
- Passed by the second chamber on February 17, 2017

SB 1201 amends *section 65.2-603. Duty to furnish medical attention, etc., and vocational rehabilitation; effect of refusal of employee to accept* of the Code of Virginia as follows:

§ 65.2-603. Duty to furnish medical attention, etc., and vocational rehabilitation; effect of refusal of employee to accept.

A. Pursuant to this section:

1. As long as necessary after an accident, the employer shall furnish or cause to be furnished, free of charge to the injured employee, a physician chosen by the injured employee from a panel of at least three physicians selected by the employer and such other necessary medical attention. Where such accident results in the amputation or loss of use of an arm, hand, leg, or foot or the enucleation of an eye or the loss of any natural teeth or loss of hearing, the employer shall furnish prosthetic or orthotic appliances, as well as wheelchairs, walkers, canes, or crutches, proper fitting and maintenance thereof, and training in the use thereof, as the nature of the injury may require.

In awards entered for incapacity for work, under this title, upon determination by the treating physician and the Commission that the same is medically necessary, the Commission may ~~require~~:

a. Require that the employer either (i) furnish and maintain ~~(i)~~ modifications to or equipment for the employee's automobile or (ii) if there is a loss of function to either or both feet, legs, hands, or arms and if the Commission determines that modifications to or equipment for the employee's automobile pursuant to clause (i) are not technically feasible, will not render the automobile operable by the employee, or will cost more than is available for such purpose after payment for any items provided under

subdivision b, order that the balance of funds available under the aggregate cap of \$42,000 be applied towards the purchase by the employee of a suitable automobile or to furnish or maintain modifications to such automobile; and

~~b. Require that the employer furnish and maintain~~ bedside lifts, adjustable beds, and modification of the employee's principal home consisting of ramps, handrails, or any appliances prescribed by the treating physician and doorway alterations, ~~provided that the~~

The aggregate cost of all such items and modifications required to be furnished pursuant to ~~clauses (i) subdivisions a and (iii) b~~ on account of any one accident shall not exceed \$42,000.

The employee shall accept the attending physician, unless otherwise ordered by the Commission, and in addition, such surgical and hospital service and supplies as may be deemed necessary by the attending physician or the Commission.

...

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending February 17, 2017.

Arizona

SB 1331 amends *section 20-359. Deviations from filed workers' compensation rates* and adds *section 20-359.01. Requirements for workers' compensation tiered rate filings* to the Arizona Revised Statutes as follows:

20-359. Deviations from filed workers' compensation rates

A. Every insurer shall adhere to the filings made by the rating organization of which it is a member, except that any member insurer may file with the director:

1. A uniform percentage decrease or increase in any rate filing to be applied to the statewide rate portion of ~~the rating organization's~~ that rate filing.
2. A subclassification rate related rule that deviates from the rules or any schedule rating plan filed by the insurer's rating organization. An insurer shall not apply a deviation and a schedule rating plan within the same ~~insurance company~~ rate filing.

20-359.01. Requirements for workers' compensation tiered rate filings

A. Subject to the other provisions of this article, an insurer transacting workers' compensation insurance may file with the director a rate filing for workers' compensation insurance that provides for a plan with more than one rate tier for that insurer or a group of insurers under common management if the filing complies with the following requirements:

1. Each tier is established consistent with underwriting rules that are based on criteria that would lead to a logical distinguishing of potential risk.
2. Supporting actuarial analysis or other information is provided that shows a clear distinction between the following for each tier:
 - (a) Expected losses and expenses.
 - (b) Actual losses and expenses.

B. An insurer filing tiered ratings pursuant to this section shall file with the director an update of the actuarial analysis or other information required under subsection A, paragraph 2 of this section at least every three years.

C. An insurer using tiered ratings may apply underwriting expertise and judgment in the tier placement process if the underwriting expertise and judgment:

1. Is applied in a consistent manner.
2. When applied, is fair, reasonable and fully documented.

Kentucky

HB 75 amends *sections 342.650 Exemptions of particular classes of employees from coverage* and *342.630 Coverage of employers* of the Kentucky Revised Statutes as follows:

342.650 Exemptions of particular classes of employees from coverage.

The following employees are exempt from the coverage of this chapter:

- ...
- (2) Any person employed, for not exceeding twenty (20) consecutive work days, to do maintenance, repair, remodeling, lawn services, or similar work in or about the private home of the employer, or if the employer has no other employees subject to this chapter, in or about the premises where that employer carries on his or her trade, business, or profession;

342.630 Coverage of employers.

The following shall constitute employers mandatorily subject to, and required to comply with, the provisions of this chapter:

- (1) Any person, ~~other than one engaged solely in agriculture~~, that has in this state one (1) or more employees subject to this chapter, except:
 - (a) A person engaged solely in agriculture;

- (b) A private homeowner who hires a person for a period of time not exceeding twenty (20) work days to do maintenance, repair, remodeling, lawn service, or similar work in or about his or her private home;
- (c) A person with no other employees who hires a person for a period of time not exceeding twenty (20) work days to do maintenance, repair, remodeling, lawn service, or similar work in or about the premises where he or she carries out his or her trade, business, or profession;
- (d) A person who hires as a domestic servant in his or her private home who has less than two (2) employees each regularly employed forty (40) or more hours a week in domestic servant employment.
- ...

North Carolina

HB 26 amends *section 97-90 Legal and medical fees to be approved by Commission; misdemeanor to receive fees unapproved by Commission, or to solicit employment in adjusting claims; agreement for fee or compensation* of the North Carolina General Statutes as follows:

...

§ 97-90 Legal and medical fees to be approved by Commission; misdemeanor to receive fees unapproved by Commission, or to solicit employment in adjusting claims; agreement for fee or compensation.

~~(f) The if a dispute arises between an employee's current and past attorney or attorneys regarding the division of a fee as approved by the Commission pursuant to this section, the Commission shall hear and determine any dispute between an employee's current and past attorney or attorneys regarding the division of a fee as approved by the Commission pursuant to this section. any dispute after the Commission has approved the settlement agreement. The Commission shall give notice to each of the employee's current and past attorneys of the total amount of the approved fee prior to determining how the fee shall be divided between those attorneys. An attorney who is a-an interested party to an action under this subsection shall have the same rights of appeal as outlined in subsection (c) of this section.~~

...

Utah

SB 92 creates, repeals, and amends numerous sections of the Utah Code to, in part:

- Repeal the statute creating the Workers' Compensation Fund
- Remove statutory references to the Workers' Compensation Fund
- Address the obligation to write workers' compensation insurance and residual market mechanisms
- Provide for the Workers' Compensation Fund's transition to a mutual corporation
- Modify membership on the workers' compensation advisory council
- Address methods to obtain workers' compensation insurance
- Amend the provision addressing penalty for failure to obtain workers' compensation
- Modify the provision addressing exemptions for employees temporarily in state

SB 120 amends section **34A-2-702. Employers' Reinsurance Fund—Injury causing death—Burial expenses—Payments to dependents** of the Utah Code, in part, as follows:

34A-2-702. Employers' Reinsurance Fund—Injury causing death—Burial expenses—Payments to dependents.

....

(5) (a) If injury causes death within a period of 312 weeks from the date of the accident, the employer or insurance carrier shall pay:

- (i) the burial expenses of the deceased as provided in Section 34A-2-418; and
- (ii) benefits in the amount and to a person provided for in this Subsection (5).

(b) (i) If there is a wholly dependent person at the time of the death, the payment by the employer or ~~its~~ the employer's insurance carrier shall be:

(A) subject to Subsections (5)(b)(i)(B) and (C), 66-2/3% of the decedent's average weekly wage at the time of the injury;

(B) not more than a maximum of 85% of the state average weekly wage at the time of the injury per week; and

(C) (I) not less than a minimum of \$45 per week, plus:

(Aa) ~~\$5~~ \$20 for a dependent spouse; and

(Bb) ~~\$5~~ \$20 for each dependent minor child under the age of 18 years, up to a maximum of four such dependent minor children; and

(II) not exceeding:

(Aa) the average weekly wage of the employee at the time of the injury; and

(Bb) 85% of the state average weekly wage at the time of the injury per week.

...

Contact Information

If you have any questions about the legislation or proposals mentioned, please contact the appropriate NCCI state relations executive (listed below) or a representative of your local insurance trade association.

State	State Relations Executive	Phone Number
CT, ME, NH, RI, VT	Laura Backus Hall	802-454-1800
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AK, AZ, CO, NM, UT	Maggie Karpuk	818-707-8374
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AR, IL, KS, TX	Terri Robinson	501-333-2835
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This report is informational and is not intended to provide an interpretation of state and federal legislation.