



May 5, 2017

RLA-2017-17

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 April 28, 2017.

Nebraska

LB 444 was:

- Passed by the legislature on April 24, 2017
- Enacted on April 27, 2017, with a projected effective date of September 2, 2017

LB 444, in part, amends **section 48-101.01 Mental injuries and mental illness; first responder; compensation; when** of the Nebraska Revised Statutes as follows:

48-101.01 Mental injuries and mental illness; first responder; compensation; when

(1) Personal injury includes mental injuries and mental illness unaccompanied by physical injury for an employee who is a first responder or frontline state employee if such first responder or frontline state employee:

- (a) Establishes, by a preponderance of the evidence, that the employee's employment conditions causing the mental injury or mental illness were extraordinary and unusual in comparison to the normal conditions of the particular employment; and
- (b) Establishes, by a preponderance of the evidence, the medical causation between the mental injury or mental illness and the employment conditions by medical evidence.

(2) For purposes of this section, mental injuries and mental illness 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 and 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.

(3) For purposes of this section: ~~first~~

(a) First responder means a sheriff, a deputy sheriff, a police officer, an officer of the Nebraska State Patrol, a volunteer or paid firefighter, or a volunteer or paid individual licensed under a licensure classification in subdivision (1) of section 38-1217 who provides medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury; -

(b) Frontline state employee means an employee of the Department of Correctional Services or the Department of Health and Human Services whose duties involve regular and direct interaction with high-risk individuals;

(c) High-risk individual means an individual in state custody for whom violent or physically intimidating behavior is common, including, but not limited to, a committed offender as defined in section 83-170, a patient at a regional center as defined in section 71-911, and a juvenile committed to the Youth Rehabilitation and Treatment Center-Kearney or the Youth Rehabilitation and Treatment Center-Geneva; and

(d) State custody means under the charge or control of a state institution or state agency and includes time spent outside of the state institution or state agency.

BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending April 28, 2017.

Oklahoma

HB 1462 was:

- Passed by the first chamber on March 20, 2017
- Included in NCCI's March 31, 2017 *Legislative Activity Report* (RLA-2017-12)
- Amended and passed by the second chamber on April 26, 2017

HB 1462 deletes, amends, and adds numerous provisions to the Oklahoma Statutes to:

- Delete, amend, and add numerous definitions of the Administrative Workers' Compensation Act (AWCA). Notably, the definition of *cumulative trauma* is modified to allow claims for cumulative trauma to be valid regardless of an employee's tenure.
- Bar any claim for compensation under the AWCA when a claim has been brought in another jurisdiction or benefits were awarded in another jurisdiction for the same injury.
- Provide that an employer may be subject to an intentional tort claim if the employer does not secure workers compensation insurance or self-insured status.
- Transfer authority to hear retaliation claims from the Workers' Compensation Commission (WCC) to any district court in the state and establish a \$100,000 limit on the amount of punitive damages that may be awarded.
- Establish new guidelines for determining when heart-related accidents, lung-related accidents, and strokes are considered a compensable injury.
- Recognize the Office of Disability Guidelines as the mandatory standard of reference for determining medically necessary services.
- Allow the notice telling a health care provider that an injury is work-related and payment for the services should not be billed to the injured employee to be delivered by fax, email, or any other electronic means with confirmation of receipt.
- Strike language that provided for the replacement and substitution of disqualified commissioners.
- Provide that the WCC does not have the power to determine the constitutionality of workers compensation laws.
- Modify the qualifications for an administrative law judge (ALJ) by removing the requirement that an appointee have at least three years of workers compensation experience.
- Remove the requirement that commissioners take an oath of office.
- Strike existing language that outlines the notice procedure for changes to rules, regulations, and forms established by the WCC. Instead, the WCC is directed to comply with the Administrative Procedures Act for rulemaking.
- Establish a \$1,000 annual fee payable to the WCC for each insurer writing workers compensation policies.
- Delete notice requirements relating to the Multiple Injury Trust Fund and Compsource.
- Allow persons exempt from being covered under the AWCA to execute an Affidavit of Exempt Status. Execution of the affidavit establishes a rebuttable presumption that the executor is not an employee and therefore is not eligible to seek workers compensation benefits against any contractor.
- Direct the WCC to charge no more than \$50 to apply for an affidavit and establish penalties for knowingly providing false information on a notarized affidavit.
- Clarify the ability to sue a third party for injuries or deaths and modify guidelines for the distribution of any amount recovered as a result of a third-party suit.
- Increase the monetary threshold for temporary total disability (TTD) benefits from 70% of the state average weekly wage (SAWW) to the SAWW.
- Clarify that TTD benefits may be extended because of a subsequent injury if the subsequent injury is a direct result of the injury or medical treatment to the part of the body that was originally injured.
- Strike language allowing termination of TTD benefits if three or more consecutive medical treatments are missed.
- Modify how compensation for temporary partial disability (TPD) is determined and limit total compensation for TPD to no more than the TTD rate.
- Modify how permanent partial disability (PPD) benefits are determined if an injured employee reaches maximum medical improvement (MMI). The formula is 70% of the employee's average weekly wage up to \$350 per week for 3.5 weeks for each percentage point of impairment up to the earlier of 350 weeks or the date of the injured employee's death.
- Strike language that allows for deferral of PPD awards when an injured employee returns to work.
- Prohibit PTD benefits and PPD benefits for the same injury and allow an employee to commute the remainder of a PPD award.
- Strike language relating to the revival of a claim for PTD after the employee dies.

- Establish new guidelines to allow for vocational rehabilitation, job retraining, and job placement services provided by a vocational-technical center, public secondary school, or member institution of higher education. Injured employees may also be eligible for reimbursement of reasonable costs for board, lodging, travel, tuition, books, and other necessary equipment to attend the training.
- Modify the compensation for amputations or permanent total loss of use of a scheduled member. The compensation is 70% of the employee's average weekly wage, up to \$350 for a specified number of weeks depending on the affected area.
- Strike an exemption for hernia injuries when an employee refuses to have a recommended surgical operation and that refusal is taken into consideration when determining benefits.
- Give employers additional flexibility when selecting the treating and replacement physician. When an employee makes a request to change the treating physician, the only requirement for the list of three replacement physicians is that they be licensed and accredited to perform the necessary treatment.
- Extend, from 8 to 12, the number of weeks that benefits may be received for soft tissue injuries and clarify that there is no limit on the number of epidural steroid injections that may be administered for soft tissue injuries.
- Clarify that compensation for an occupational disease is limited to the proportion of the occupational disease that is compensable.
- Reduce, from 30 to 15, the number of days that an employee must report an injury for it to be automatically considered work-related. After 15 days with no notice, there is a rebuttable presumption that the injury is not a compensable injury.
- Set the statutes of limitation for occupational disease, cumulative trauma, and death at two years from the date of injury or death and the deadline for filing for additional compensation at three months after the date that the last benefits were received.
- Establish a timeline for hearing claims by requiring a prehearing conference to be scheduled within 7 days from the notice of a claim for compensation and a trial date to be set no later than 60 days from the prehearing conference.
- Allow notice of a judgment to be delivered by fax, email, or other electronic means with confirmation of receipt.
- Establish procedures on the conduct of hearings and the introduction of evidence.
- Authorize the chair of the WCC to appoint an ALJ to the en blanc panel when a commissioner is not able to preside on the panel. The panel is responsible for hearing appeals of a judgment, decision, or award made by an ALJ.
- Reduce, from 20 to 15, the percentage of attorney fees allowed for PPD, PTD, or death compensation.
- Restrict the ability of the WCC to approve a joint petition or settlement that provides for the payment of benefits in a lump sum.
- Increase, from 1% to 2%, the assessment levied against a self-insurer when the balance of the Self-insurance Guaranty Fund is less than \$800,000.
- Establish procedures for the maintenance of securities transferred to the Self-insurance Guaranty Fund Board.
- Direct the WCC to mail information about the workers compensation ombudsman program upon request.
- Allow employees to challenge a denial of benefits by filing an Employee's First Notice of Claim for Compensation.
- Repeal various sections of law relating to workers compensation.

HB 1572 was:

- Passed by the first chamber on March 21, 2017
- Included in NCCI's March 31, 2017 **Legislative Activity Report** (RLA-2017-12)
- Amended and passed by the second chamber on April 25, 2017

HB 1572 amends **sections 85A-22. Administration of act—Additional powers and duties, 85A-38. Securing compensation, 85A-98. Funds to be transferred to Self-insurance Guaranty Fund, and 85A-99. Impaired self-insurer** of the Oklahoma Statutes, in part, as follows:

§ 85A-22. Administration of act—Additional powers and duties.

...
C. Additionally, the Commission shall have the following powers and duties:

...
4. ~~To contract with an appropriate state governmental entity, insurance carrier or approved service organization to process, investigate and pay valid claims against an impaired self-insurer which fails, due to insolvency or otherwise, to pay its workers' compensation obligations, charges for which shall be paid from the proceeds of security posted with the Commission as provided in Section 38 of this act;~~

...

§ 85A-38. Securing compensation.

A. An employer shall secure compensation to employees under ~~this act~~ the Administrative Workers' Compensation Act in one of the following ways:

1. By insuring and keeping insured the payment of compensation with any stock corporation, mutual association, or other concerns authorized to transact the business of workers' compensation insurance in this state. When an insurer issues a policy to provide workers' compensation benefits under the provisions of ~~this act~~ the Administrative Workers' Compensation Act, it shall file a notice with the Workers' Compensation Commission containing the name, address, and principal occupation of the employer, the number, effective date, and expiration date of the policy, and such other information as may be required by the Commission. The notice shall be filed by the insurer within thirty (30) days after the effective date of the policy. Any insurer who does not file the notice required by this paragraph shall be subject to a fine by the Commission of not more than One Thousand Dollars (\$1,000.00);

...

3. By furnishing satisfactory proof to the Commission of the employer's financial ability to pay the compensation. The Commission, ~~under rules adopted by the Insurance Department~~, shall require any employer that has:

a. less than one hundred employees or less than One Million Dollars (\$1,000,000.00) in net assets to:

(1) deposit with the Commission securities, an irrevocable letter of credit or a surety bond payable to the state, in an amount determined by the Commission which shall be at least an average of the yearly claims for the last three (3) years, or

(2) provide proof of excess coverage with such terms and conditions as is commensurate with their ability to pay the benefits required by the provisions of this act, and

b. one hundred or more employees and One Million Dollars (\$1,000,000.00) or more in net assets to:

(1) secure a surety bond payable to the state, or an irrevocable letter of credit, in an amount determined by the Commission which shall be at least an average of the yearly claims for the last three (3) years, or

(2) provide proof of excess coverage with terms and conditions that are commensurate with their ability to pay the benefits required by the provisions of this act;

...

C. An employer who does not fulfill the requirements of this section is not relieved of the obligation to pay compensation under ~~this act~~ the Administrative Workers' Compensation Act. The security required under this section, including any interest, shall be maintained by the ~~Commission~~ Self-insurance Guaranty Fund Board as provided in ~~this act~~ Section 99 of this title until each claim for benefits is paid, settled, or lapses under ~~this act~~ the Administrative Workers' Compensation Act, and costs of administration of such claims are paid.

D. Failure on the part of any employer to secure the payment of compensation provided in ~~this act~~ the Administrative Workers' Compensation Act shall have the effect of enabling the ~~Commission~~ Self-insurance Guaranty Fund Board to assert the rights of an injured employee against the employer.

...

§ 85A-98. Funds to be transferred to Self-insurance Guaranty Fund.

The Self-insurance Guaranty Fund shall be derived from the following sources:

...

2. ~~Until the Self-insurance Guaranty Fund contains Two Million Dollars (\$2,000,000.00) or in~~ In the event the amount in the net fund balance falls below One Million Dollars (\$1,000,000.00) Seven Hundred Fifty Thousand Dollars (\$750,000.00), the Workers' Compensation Commission shall make an assessment against each private self-insurer and group self-insurance association based on an assessment rate to be determined by the commissioners, not exceeding ~~one percent (1%)~~ two percent (2%) per annum of actual paid losses of the self-insurer during the preceding calendar year, payable to the Tax Commission for deposit to the fund. The assessment against private self-insurers shall be determined using a rate equal to the proportion that the deficiency in the fund attributable to private self-insurers bears to the actual paid losses of all private self-insurers for the year period of January 1 through December 31 preceding the assessment. The assessment against group self-insurance associations shall be determined using a rate equal to the proportion that the deficiency in excess of the surplus of the Group Self-Insurance Association Guaranty Fund at the date of the transfer attributable to group self-insurance associations bears to the actual paid losses of all group self-insurance associations cumulatively for any calendar year preceding the assessment. Each self-insurer shall provide the Workers' Compensation Commission with such information as the Commission may determine is necessary to effectuate the purposes of this paragraph. For purposes of this paragraph, "actual paid losses" means all medical and indemnity payments, including temporary disability, permanent disability, and death benefits, and excluding loss adjustment expenses and reserves.

...

3. Any excess funds, including interest thereon, transferred to the Self-insurance Guaranty Fund as provided in Section 99 of this title; and

...

§ 85A-99. Impaired self-insurer.

A. On determination by the Workers' Compensation Commission that a self-insurer has become an impaired self-insurer, the Commission shall promptly secure release of the security required by Section 38 of this title ~~and~~ advise the Self-insurance Guaranty Fund Board of the impairment. ~~Claims administration, including processing, investigating and paying valid claims against~~

~~an impaired self-insurer under the Administrative Workers' Compensation Act, may include payment by the surety that issued the surety bond or be under a contract between the Commission and an insurance carrier, appropriate state governmental entity or an approved service organization, as approved by the Commission, and transfer the proceeds of the security to the Self-insurance Guaranty Fund Board to be maintained in a segregated account for administering workers' compensation obligations of the impaired self-insurer. The Self-insurance Guaranty Fund Board shall be the fiduciary of the account.~~

~~B. Proceeds from the released security shall be used for administering the workers' compensation obligations of the impaired self-insurer. Claims administration includes, but is not limited to, processing, investigating, and paying claims; actuarial studies; attorney fees incurred for filing a proof of claim in the bankruptcy of the impaired self-insurer; and a pro rata portion of the staff expenses of the Self-insurance Guaranty Fund Board.~~

~~C. Except as otherwise provided by law or agreement of the parties, excess proceeds from the security remaining after each claim for benefits of an impaired self-insurer has been paid, settled, or lapsed under the Administrative Workers' Compensation Act, and costs of administration of such claims have been paid, as determined by the Self-insurance Guaranty Fund Board, shall be transferred to the Self-insurance Guaranty Fund by the Commission or Board, as appropriate.~~

HB 2242 was:

- Passed by the first chamber on March 23, 2017
- Included in NCCI's March 31, 2017 *Legislative Activity Report* (RLA-2017-12)
- Amended and passed by the second chamber on April 26, 2017

HB 2242 amends *section 85A-36. Liability other than immediate employer* of the Oklahoma Statutes as follows:

§ 85A-36. Liability other than immediate employer.

~~A. If a subcontractor an individual or business entity fails to secure compensation required by this act title, the prime contractor party for whom work is being performed shall be liable for compensation to the employees of the subcontractor individual or business entity unless there is an intermediate subcontractor individual or business entity who has workers' compensation coverage.~~

~~B. 1. Any contractor or the contractor's party for whom work is being performed or the party's insurance carrier who shall become liable for the payment of compensation on account of injury to or death of an employee of his or her subcontractor an individual or business entity may recover from the subcontractor individual or business entity the amount of the compensation paid or for which liability is incurred.~~

~~2. The claim for the recovery shall constitute a lien against any monies due or to become due to the subcontractor individual or business entity from the prime contractor party for whom work is being performed.~~

~~3. A claim for recovery shall not affect the right of the injured employee or the dependents of the deceased employee to recover compensation due from the prime contractor party for whom work is being performed or his or her insurance carrier.~~

~~C. 1. a. When a sole proprietorship or partnership fails to elect to cover the sole proprietor or partners under this act, the prime contractor is not liable under this act for injuries sustained by the sole proprietor or partners if the sole proprietor or partners are not employees of the prime contractor.~~

~~b. (1) A sole proprietor or the partners of a partnership who do not elect to be covered by this act and be deemed employees thereunder and who deliver to the prime contractor a current certification of noncoverage issued by the Commission shall be conclusively presumed not to be covered by the law or to be employees of the prime contractor during the term of his or her certification or any renewals thereof.~~

~~(2) A certificate of noncoverage may not be presented to a subcontractor who does not have workers' compensation coverage.~~

~~(3) This provision shall not affect the rights or coverage of any employees of the sole proprietor or of the partnership.~~

~~2. The prime contractor's insurance carrier shall not be liable for injuries to the sole proprietor or partners described in this section who have provided a current certification of noncoverage, and the carrier shall not include compensation paid by the prime contractor to the sole proprietor or partners described above in computing the insurance premium for the prime contractor.~~

~~3. a. Any prime contractor who after being presented with a current certification of noncoverage by a sole proprietor or partnership compels the sole proprietor or partnership to pay or contribute to workers' compensation coverage of that sole proprietor or partnership shall be guilty of a misdemeanor.~~

~~b. Any prime contractor who compels a sole proprietor or partnership to obtain a certification of noncoverage when the sole proprietor or partnership does not desire to do so shall be guilty of a misdemeanor.~~

~~c. Any applicant who makes a false statement when applying for a certification of noncoverage or any renewals thereof shall be guilty of a felony.~~

~~D. 1. A certification of noncoverage issued by the Commission shall be valid for two (2) years after the effective date stated thereon. Both the effective date and the expiration date shall be listed on the face of the certificate by the Commission. The certificate shall expire at midnight two (2) years from its issue date, as noted on the face of the certificate.~~

~~2. The Commission may assess a fee not to exceed Fifty Dollars (\$50.00) with each application for a certification of noncoverage or any renewals thereof.~~

3. Any certification of noncoverage issued by the Commission shall contain the social security number and notarized signature of the applicant. The notarization shall be in a form and manner prescribed by the Commission.

4. The Commission may prescribe by rule forms and procedures for issuing or renewing a certification of noncoverage.

E. If work is performed by an independent contractor on a single family residential dwelling occupied by the owner, or the premises of such dwelling, or for a farmer whose cash payroll for wages, excluding supplies, materials and equipment, for the preceding calendar year did not exceed One Hundred Thousand Dollars (\$100,000.00), such owner or farmer shall not be liable for compensation under this act for injuries to the independent contractor or his or her employees. Any individual or business entity that is not required to be covered under a workers' compensation insurance policy or other plan for the payment of workers' compensation may execute an Affidavit of Exempt Status under the Administrative Workers' Compensation Act. The affidavit shall be a form prescribed by the Workers' Compensation Commission and shall be available on the Commission's website. The Commission may assess a fee not to exceed Fifty Dollars (\$50.00) for each Affidavit executed.

D. Execution of the affidavit shall establish a rebuttable presumption that the executor or executor's agent is not an employee for purposes of the Administrative Workers' Compensation Act and that an individual or company possessing the affidavit is in compliance and shall not be responsible for workers' compensation claims made by the executor.

E. The execution of an affidavit shall not affect the rights or coverage of any employee of the individual executing the affidavit.

F. 1. Knowingly providing false information on a notarized Affidavit of Exempt Status under the Administrative Workers' Compensation Act shall constitute a misdemeanor punishable by a fine not to exceed One Thousand Dollars (\$1,000.00).

2. Affidavits shall conspicuously state on the front thereof in at least ten-point, bold-faced print that it is a crime to falsify information on the form.

3. The Commission shall immediately notify the Workers' Compensation Fraud Unit in the Office of the Attorney General of any violations or suspected violations of this section. The Commission shall cooperate with the Fraud Unit in any investigation involving affidavits executed pursuant to this section.

G. Fees collected pursuant to subsection C of this section shall be deposited in the State Treasury to the credit of the Workers' Compensation Commission Revolving Fund.

H. If any employer relies in good faith on proof of a valid workers' compensation insurance policy issued to a contractor of any tier or on proof of an Affidavit of Exempt Status under this section, the employer shall not be liable for injuries of any employees of the contractor.

SB 737 Committee Substitute was:

- Passed by the first chamber on March 23, 2017
- Included in NCCI's March 31, 2017 **Legislative Activity Report** (RLA-2017-12)
- Amended and passed by the second chamber on April 24, 2017

Engrossed **SB 737** modifies various provisions relating to workers' compensation. The measure:

- Deletes, amends and adds numerous definitions of the Administrative Workers' Compensation Act (AWCA). Notably, the definition of cumulative trauma is modified to allow claims for cumulative trauma to be valid regardless of an employee's tenure. The current definition requires an employee to have completed at least 180 days of continuous active employment with the employer to be eligible for benefits relating to cumulative trauma. This provision was ruled unconstitutional by the Oklahoma Supreme Court in *Torres v. Seaboard Foods LLC*;
- Bars any claim for compensation under the AWCA when a claim has been brought in another jurisdiction or benefits were awarded in another jurisdiction for the same injury;
- Transfers authority to hear retaliation claims from the Workers' Compensation Commission (WCC) to any district court in the state and establishes a \$100,000 limit on the amount of punitive damages that may be awarded;
- Establishes new guidelines for determining when heart-related accidents, lung-related accidents and strokes are considered a compensable injury;
- Recognizes the Office of Disability Guidelines as the mandatory standard of reference for determining medically necessary services;
- Allows notice to a health care provider to be delivered by fax, e-mail or any other electronic means with confirmation of receipt. The notice tells the provider that an injury is work-related and payment for the services should not be billed to the injured employee;
- Modifies the procedures and requirements to appoint WCC commissioners;
- Strikes language that provided for the replacement and substitution of disqualified commissioners;
- Provides that the WCC does not have the power to determine the constitutionality of workers' compensation laws;
- Modifies the qualifications for an administrative law judge (ALJ) by removing the requirement that an appointee have at least 3 years of workers' compensation experience;
- Strikes existing language that outlines the notice procedure for changes to rules, regulations and forms established by the WCC. Instead, the WCC is directed to comply with the Administrative Procedures Act for rulemaking;
- Deletes notice requirements relating to the Multiple Injury Trust Fund and Compsource;

- Allows persons exempt from being covered under the AWCA to execute an Affidavit of Exempt Status. Execution of the affidavit establishes a rebuttable presumption that the executor is not an employee and therefore is not eligible to seek workers' compensation benefits against any contractor.
- Directs the WCC to charge no more than \$50 to apply for an affidavit and establishes penalties for knowingly providing false information on a notarized affidavit;
- Clarifies the ability to sue a third party for injuries or deaths and modifies guidelines for the distribution of any amount recovered as a result of a third party suit;
- Increases the monetary threshold for temporary total disability (TTD) benefits to the state average weekly wage (SAWW). Currently, the threshold is 70 percent of the SAWW;
- Clarifies that TTD benefits may be extended because of a subsequent injury if the subsequent injury is a direct result of the injury or medical treatment to the part of the body that was originally injured;
- Strikes language allowing termination of TTD benefits if 3 or more consecutive medical treatments are missed;
- Modifies how compensation for temporary partial disability (TPD) is determined and limits total compensation for TPD to no more than the TTD rate;
- Modifies how permanent partial disability (PPD) benefits are determined if an injured employee reaches maximum medical improvement (MMI). The formula is 70 percent of the employee's average weekly wage up to \$350 * 3.5 weeks * impairment percentage;
- Strikes languages that allows for deferral of permanent partial disability (PPD) awards when an injured employee returns back to work. This provision was ruled unconstitutional by the Oklahoma Supreme Court in *Maxwell v. Sprint PCS*;
- Prohibits PTD benefits and PPD benefits for the same injury and allows an employee to commute the remainder of a PPD award;
- Establishes new guidelines to allow for vocational rehab, job retraining and job placement services provided by a vo-tech center, public secondary school or member institution of higher ed. Injured employees may also be eligible for reimbursement of reasonable costs for board, lodging, travel, tuition, books and other necessary equipment to attend the training;
- Modifies the compensation for amputations or permanent total loss of use of a scheduled member. The compensation is 70 percent of the employee's average weekly week, up to \$350 for a specified number of weeks depending on the affected area;
- Gives employers additional flexibility when selecting the treating and replacement physician. When an employee makes a request to change the treating physician, the only requirement for the list of three replacement physicians is that they be licensed and accredited to perform the necessary treatment;
- Increases, from 2 to 3, the number of medical appointments that may be missed without good cause before benefits are terminated;
- Extends, from 8 to 12, the number of weeks that benefits may be received for soft tissue injuries and clarifies that there is no limit on the number of epidural steroid injections that may administered for soft tissue injuries;
- Clarifies that compensation for an occupation disease is limited to the proportion of the occupational disease that is compensable;
- Reduces, from 30 to 15, the number of days that an employee must report an injury for it to be automatically considered work-related. After 15 days with no notice, there is a rebuttable presumption that the injury is not a compensable injury;
- Set the statutes of limitation for occupational disease, cumulative trauma and death at 2 years from the date of injury or death and the deadline for filing for additional compensation at 90 months after the date that the last benefits was received;
- Establishes a timeline for hearing claims by requiring a prehearing conference to be scheduled within 7 days from the notice of a claim for compensation and a trial date to be set no later than 60 days from the prehearing conference;
- Allows notice of a judgment to be delivered by fax, e-mail or other electronic means with confirmation of receipt;
- Authorizes the chair of the WCC to appoint an ALJ to the en blanc panel when a commissioner is not able to preside on the panel. The panel is responsible for hearing appeals of a judgment, decision or award made by an ALJ;
- Reduces, from 20 to 15, the percentage of attorney fees allowed for PPD, PTD, or death compensation;
- Restricts the ability of the WCC to approve a joint petition or settlement that provides for the payment of benefits in a lump sum;
- Increases, from 1 to 2 percent, the assessment levied against self-insurer when the balance of the Self-insurance Guaranty Fund contains less than \$800,000;
- Establishes procedures for the maintenance of securities transferred to the Self-insurance Guaranty Fund Board;
- Directs the WCC to publish information about the workers' compensation ombudsman program on its website;
- Allows employees to challenge a denial of benefits by filing an Employee's First Notice of Claim for Compensation;
- Modifies the procedure for selecting and assigning independent medical examiners to review cases; and
- Repeals various sections of law relating to workers' compensation.

Fiscal Analysis

The engrossed version of **SB 737** upon review by the WCC (a statutorily appropriated agency) is believed to require the agency to hire an additional 2 Administrative Law Judges.

The bill upon review by the Court of Existing Claims is said to have a \$60,000 loss to the non-appropriated agency: "This bill has changes under Section 33 (85A O.S. Supp. 2016, Section 120) which could have the effect of unconstitutionally passing the right to collect search fees on searching Court of Existing Claims Cases from the Court of Existing Claims to the Workers' Compensation Commission. This would impact the Court with a probable loss of \$60,000.00 annually for the Court."

The measure, which alters language regarding the workers' compensation system in Oklahoma, does affect state government agencies and their employees. The extent to which is contingent upon how many employees file cases and which agencies are involved.

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Tennessee

SB 1214 was:

- Passed by the first chamber on April 17, 2017
- Included in NCCI's April 28, 2017 *Legislative Activity Report* (RLA-2017-16)
- Passed by the second chamber on April 27, 2017

SB 1214 makes various changes to the Tennessee Workers' Compensation Law as follows:

- Renames the Second Injury Fund the Subsequent Injury and Vocational Recovery Fund.
- Authorizes a sole proprietor, a partner, and members of a Limited Liability Company (LLC) who devote full time to the company to elect to be a covered employee for workers compensation purposes by filing written notice of the election with the partnership, proprietorship, or LLC; and requires that the election be filed with the insurer. Such a sole proprietor, a partner, or member of an LLC may at any time withdraw the election by giving notice of the withdrawal to the partnership, proprietorship, or LLC.
- Specifies, with regard to an officer of a corporation electing to be exempt from the Workers' Compensation Law, that notice of such election will not be effective until filed with the corporation; and adds provisions regarding the revocation of the exemption.
- Requires that only the employer must be provided the notice and affidavit. Present law authorizes corporate officers, other than corporate officers engaged in the construction industry, to elect exemption from the Workers' Compensation Law by providing notice of the election to the bureau and the officer's employer along with an affidavit affirming that the election was not advised, counseled, or encouraged by the employer.
- Requires that an employer with less than five regular employees who wants to opt into the law must purchase a workers compensation insurance policy rather than provide notice to the bureau. Present law generally exempts nonconstruction services employers who have less than five regular employees from the Workers' Compensation Law; and any such exempt employer may opt into the law by filing a notice with the bureau.
- Authorizes any employee who has exhausted eligibility for permanent partial disability benefits and, following a workers compensation injury, has not returned to work with any employer or has returned to work and is receiving wages or a salary that is less than 100% of the wages or salary the employee received from the employee's pre-injury employer on the date of injury, to request vocational recovery assistance from the subsequent injury and vocational recovery fund. Vocational recovery assistance may include, but is not limited to, vocational assessment, employment training, job analysis, vocational testing, GED classes and testing, and education through a public Tennessee higher education institution, including books and materials required for courses. All vocational recovery assistance is subject to the maximum limit of \$5,000 per eligible employee in a fiscal year, not to exceed a total sum of \$20,000 per employee who participates in the program for all years. The total aggregate amount to be paid from the subsequent injury and vocational recovery fund as to all eligible employees will be limited to a total of \$500,000 in a calendar year. The administrator of the bureau will determine whether to grant requests for vocational recovery assistance. Sets financial parameters for use of the monies in the subsequent injury and vocational recovery fund for vocational recovery assistance. Deletes the present law requirement that the administrator cause the bureau of workers' compensation to refer all feasible cases for vocational rehabilitation to the department of education. The provisions described here are limited to injuries that occur on or after July 1, 2018, but before July 1, 2021
- Specifies that oral argument may be heard for appeals to the workers compensation appeals board; deletes from present law the authorization for the workers compensation appeals board to reverse or modify and remand the decision of a workers compensation judge when the rights of any party have been prejudiced because findings, inferences, conclusions, or decisions of a workers compensation judge:

(A) Violate constitutional or statutory provisions;

- (B) Exceed the statutory authority of the workers' compensation judge;
 - (C) Do not comply with lawful procedure;
 - (D) Are arbitrary, capricious, characterized by abuse of discretion, or clearly an unwarranted exercise of discretion; or
 - (E) Are not supported by evidence that is both substantial and material in the light of the entire record
- Requires that a statistical data form must be filed for a settlement for initial benefits, a settlement for increased benefits, and a settlement for closure of future medical benefits that remained open pursuant to a prior order, even if a statistical data form was filed at the time of submission of the prior order; removes present law language that prohibits entry of a settlement or trial order in a workers compensation claim if the statistical data form is not filed; authorizes the administrator to assess a civil penalty of \$100 to \$1,000 against an employer or employer's agent who fails to fully complete and timely file the statistical data form within 10 business days of the date of a compensation hearing order. Present law generally requires that a statistical data form be filed with the bureau for workers' compensation claims that are resolved by trial or settlement; if the administrator determines that an insurer or self-insured employer fails to complete substantially and file the statistical data more than five times, the administrator may assess a monetary penalty up to \$100 against the insurance company for the employer or against the employer, if self-insured. Under present law, a statistical data form is not required for reconsideration of a prior settlement or trial judgment order for which a statistical data form was filed at the time of submission of the prior order, or when the only issue resolved by an order is the closing of future medical benefits that remained open pursuant to a prior order for which a statistical data form was filed at the time of submission of the prior order.
 - Requires any employer of a construction services provider to, upon request by the bureau, provide proof of valid workers' compensation insurance coverage at the employer's place of business and at job sites where the employer is providing construction services; authorizes the administrator to assess a penalty of \$50 to \$5,000 per violation for failure to provide proof of valid workers' compensation insurance coverage, and the administrator may assess not less than \$50 nor more than \$5,000 per violation for subsequent violations.
 - Authorizes the administrator to assess a penalty of \$50 to \$5,000 per violation against any person or representative of an entity who knowingly enters or directs a party to enter false or unauthorized information on a construction services provider's application to the secretary of state. Present law generally requires all construction services providers to carry workers compensation insurance; provided, that a construction service provider who meets certain criteria may apply to the secretary of state for an exemption.
 - Requires insurers to advise policy holders who are construction services providers about the availability of electronic downloads of policy information to facilitate field inspection of proof of workers compensation coverage.

Vermont

HB 515 was:

- Passed by the first chamber on March 29, 2017
- Included in NCCI's April 7, 2017 **Legislative Activity Report** (RLA-2017-13)
- Amended and passed by the second chamber on April 28, 2017

HB 515, in part, amends **Title 21, Chapter 009, section 711. Workers' Compensation Administration Fund** of the Vermont Statutes Annotated as follows:

§ 711. Workers' Compensation Administration Fund

(a) A Workers' Compensation Administration Fund is created pursuant to 32 V.S.A. chapter 7, subchapter 5 to be expended by the Commissioner for the administration of the workers' compensation and occupational disease programs. The Fund shall consist of contributions from employers made at a rate of ~~1.75~~ **1.4** percent of the direct calendar year premium for workers' compensation insurance, one percent of self-insured workers' compensation losses, and one percent of workers' compensation losses of corporations approved under this chapter. Disbursements from the Fund shall be on warrants drawn by the Commissioner of Finance and Management in anticipation of receipts authorized by this section.

...

SB 56 was:

- Passed by the first chamber on March 1, 2017
- Amended and passed by the second chamber on April 28, 2017

SB 56, in part, requires the following reports and studies:

Workers Compensation; Industries and Occupations with High Risk, High Premiums, and Few Policy Holders; Study; Report

(a) The Commissioner of Financial Regulation, in consultation with the Commissioner of Labor, the National Council on Compensation Insurance, and other interested stakeholders, shall identify and study industries and occupations in Vermont that experience a high risk of workplace and on-the job injuries and whose workers' compensation insurance is characterized by high premiums and few policy holders in the insurance pool. The industries and occupations addressed in the study shall include, among others, logging and log hauling, as well as arborists, roofers, and occupations in saw mills and wood manufacturing operations. In particular, the Commissioner shall: (1) examine difference in the potential for loss, premium rates, and experience and

participation in the workers' compensation marketplace between the industries and occupations identified, and the average for all industries and occupations in Vermont;

(2) study potential methods for reducing workers' compensation premium rates and costs for high-risk industries and occupations, including risk pooling between multiple high-risk industries or occupations, creating self-insured trusts; creating voluntary safety certification programs, and programs or best practices employed by other states; and (3) model the potential impact on workers' compensation premiums and costs from each of the methods identified pursuant to subdivision (2) of this subsection.

(b) On or before January 15, 2018, the Commissioner of Financial Regulation shall submit a written report to the House Committee on Commerce and Economic Development and the Senate Committee on Finance regarding his or her findings and any recommendations for legislative action to reduce the workers' compensation premium rates and costs for the industries identified in the study.

Short-Term Workers Compensation Policies; Study; Report

The Commissioner of Financial Regulation, in consultation with the Commissioner of Labor, shall examine potential measures to encourage the creation of affordable seasonal and short-term workers' compensation policies and measures to reduce the cost of workers' compensation insurance coverage for small employers in seasonal occupations. On or before January 15, 2018, the Commissioner shall report to the House Committee on Commerce and Economic Development and the Senate Committee on Finance regarding his or her finding and any recommendations for legislative action.

Regional Assigned Risk Pool; Study; Report

The Commissioner of Financial Regulation shall examine potential mechanisms for joining with neighboring states to create a regional assigned risk pool for workers' compensation insurance and whether the creation of a regional assigned risk pool could reduce the cost of administering Vermont's assigned risk pool. On or before January 15, 2018, the Commissioner shall submit a written report to the House Committee on Commerce and Economic Development and the Senate Committee on Finance with his or her findings and any recommendations for legislative action related to the implementation of a regional assigned risk pool for workers' compensation insurance.

Administration of Assigned Risk Pool; Study; Report

The Commissioner of Financial Regulation shall examine whether any premium savings or reductions in costs could be realized if the assigned risk pool for workers' compensation was administered directly by the Department of Financial Regulation rather than through a third-party. On or before January 15, 2018, the Commissioner shall submit a written report to the House Committee on Commerce and Economic Development and the Senate Committee on Finance with his or her findings and any recommendations for legislative action.

Emergency Personnel Post-Traumatic Stress Disorder; Study of Experience and Costs; Report

(a) The Commissioner of Labor, in consultation with the Secretary of Administration, the Commissioner of Financial Regulation, the Vermont League of Cities and Towns, and the National Council on Compensation Insurance, shall examine claims for workers' compensation made pursuant to 21 V.S.A. § 601(11)(I) and (J) between July 1, 2017 and January 1, 2020, including: (1) the number of claims made; (2) the cost of the workers compensation benefits provided for those claims; and (3) any changes in administrative and premium costs associated with those claims.

(b) On or before January 15 of each year from 2018 through 2020, the Commissioner shall report to the House Committees on Appropriations, on Commerce and Economic Development, and on Health Care, and the Senate Committees on Appropriations, on Finance, and on Health and Welfare regarding its findings and any recommendations for legislative changes.

SB 56, in part, also amends *section 601 Definitions* of Title 21 of the Vermont Statutes Annotated as follows:

§ 601 Definitions

Unless the context otherwise requires, words and phrases used in this chapter shall be construed as follows:

...

(11) "Personal injury by accident arising out of and in the course of employment" includes an injury caused by the willful act of a third person directed against an employee because of that employment.

...

(I)(i) In the case of police officers, rescue or ambulance workers, or firefighters, post-traumatic stress disorder that is diagnosed by a mental health professional shall be presumed to have been incurred during service in the line of duty and shall be compensable, unless it is shown by a preponderance of the evidence that the post-traumatic stress disorder was caused by nonservice connected risk factors or nonservice-connected exposure.

(ii) A police officer, rescue or ambulance worker, or firefighter who is diagnosed with post-traumatic stress disorder within three years of the last active date of employment as a police officer, rescue or ambulance worker, or firefighter shall be eligible for benefits under this subdivision (11).

(iii) As used in this subdivision (11)(I):

(I) "Firefighter" means a firefighter as defined in 20 V.S.A. § 3151(3) and (4).

(II) "Mental health professional" means a person with professional training, experience, and demonstrated competence in the treatment and diagnosis of mental conditions, who is certified or licensed to provide mental health care services and for whom diagnoses of mental conditions are within his or her scope of practice, including a physician, nurse with recognized psychiatric specialties, psychologist, clinical social worker, mental health counselor, or alcohol or drug abuse counselor.

(III) "Police officer" means a law enforcement officer who has been certified by the Vermont Criminal Justice Training Council pursuant to 20 V.S.A. chapter 151.

(IV) "Rescue or ambulance worker" means ambulance service, emergency medical personnel, first responder service, and volunteer personnel as defined in 24 V.S.A. § 2651.

(J)(i) A mental condition resulting from a work-related event or work-related stress shall be considered a personal injury by accident arising out of and in the course of employment and be compensable if it is demonstrated by the preponderance of the evidence that:

(I) the work-related event or work-related stress was extraordinary and unusual in comparison to pressures and tensions experienced by the average employee across all occupations; and

(II) the work-related event or work-related stress, and not some other event or source of stress, was the predominant cause of the mental condition.

(ii) A mental condition shall not be considered a personal injury by accident arising out of and in the course of employment if it results from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer.

Note: SB 56 was not included in any of NCCI's previous *Legislative Activity Reports*.

BILLS PASSING FIRST CHAMBER

The following workers compensation-related bills passed the first chamber within the one-week period ending April 28, 2017.

Alaska

HB 69 amends various provisions of the Alaska Statutes as follows:

23.30.005 Alaska Workers' Compensation Board

...

(n) The board, in its administrative capacity, shall make available, upon request, the decisions and orders of the former Workers' Compensation Appeals Commission. Unless reversed or modified by a court, decisions of the former Workers' Compensation Appeals Commission have the force of legal precedent and shall stand instead of the order of the board from which review was taken.

23.30.107 Release of Information

...

(b) Medical or rehabilitation records, and the employee's name, address, social security number, electronic mail address, and telephone number contained on any record, in an employee's file maintained by the division or held by the board ~~or the commission~~ are not public records subject to public inspection and copying under AS 40.25.100–40.25.295. This subsection does not prohibit

(1) the reemployment benefits administrator, the division, the board, ~~the commission~~, or the department from releasing medical or rehabilitation records in an employee's file, without the employee's consent, to a physician providing medical services under AS 23.30.095(k) or 23.30.110(g), a party to a claim filed by the employee, or a governmental agency; or

(2) the quoting or discussing of medical or rehabilitation records contained in an employee's file during a hearing on a claim for compensation or in a decision or order of the board ~~or commission~~.

23.30.108 Prehearings on discovery matters; objections to requests for release of information; sanctions for noncompliance

...

(d) If the employee files a petition seeking a protective order to recover medical and rehabilitation information that has been provided but is not related to the employee's injury, and the board or the board's designee grants the protective order, the board or the board's designee granting the protective order shall direct the division, the board, ~~the commission~~, and the parties to return to the employee, as soon as practicable following the issuance of the protective order, all medical and rehabilitation information, including copies, in their possession that is unrelated to the employee's injury under the protective order.

(e) If the board or the board's designee limits the medical or rehabilitation information that may be used by the parties to a claim, either by an order on the record or by issuing a written order, the division, the board, ~~the commission~~, and a party to the claim may request and an employee shall provide or authorize the production of medical or rehabilitation information only to the extent of the limitations of the order. If information has been produced that is outside of the limits designated in the order, the board or the

board's designee shall direct the party in possession of the information to return the information to the employee as soon as practicable following the issuance of the order.

23.30.155 Payment of Compensation

(f) If compensation payable under the terms of an award is not paid within 14 days after it becomes due, there shall be added to that unpaid compensation an amount equal to 25 percent of the unpaid installment. The additional amount shall be paid at the same time as, but in addition to, the compensation, unless ~~there is a review of the compensation order making the award as provided under AS 23.30.126 and a court orders a stay of payments as 23.30.008 and an interlocutory injunction staying payments is allowed by the court.~~ The additional amount shall be paid directly to the recipient to whom the unpaid compensation was to be paid.

39.50.200 Definitions

...
(b) In this chapter "state commission or board" means the
...
(31) Workers' Compensation Board (AS 23.30.005) ~~and workers' compensation appeals commission (as 23.30.007);~~
...

HB 69 also adds the following new sections to Alaska Statutes as follows:

23.30.126. Review of a board decision and order.

(a) A decision and order of the board becomes effective when filed in the office of the board under AS 23.30.110. A decision and order of the board may be modified under AS 23.30.130 or reconsidered under AS 44.62.540. A party may seek review of a decision and order of the board by filing with the superior court a notice of appeal under AS 44.62.560 or a petition for review under the Alaska Rules of Appellate Procedure.

(b) A decision and order is not automatically stayed pending judicial review.

A court may order a stay, in whole or in part, if a party

(1) applies for a stay;

(2) files a supersedeas bond, if required, in conformance with the Alaska Rules of Appellate Procedure;

(3) for a stay involving continuing future periodic compensation payments, shows irreparable harm and the probability that the appeal will be decided adversely to the recipient on the merits; and

(4) for a stay involving a lump sum compensation payment, shows irreparable harm and serious and substantial questions regarding the merits of the case.

(c) A finding of fact made by the board as part of a decision and order shall be conclusive for a reviewing court if supported by substantial evidence in light of the whole record. To the extent that it does not conflict with the provisions of this chapter, AS 44.62.570 applies to judicial review.

(d) The director may intervene in an appeal or petition for review. If a party is not represented by an attorney and a compensation order concerns an unsettled question of law, the director may file an appeal or petition for review to obtain a ruling.

HB 69 also repeals Rules 201.1, 401.1, and 501.1 of the Alaska Rules of Appellate Procedure and the following Alaska Statutes: AS 23.30.007, 23.30.008, 23.30.009, 23.30.125, 23.30.127, 23.30.128, 23.30.129, 23.30.395(10); AS 39.25.110 (40); AS 44.64.020(a)(12), and 44.64.020(a)(13) are repealed.

HB 69 also adds the following new sections to the uncodified law of the State of Alaska as follows:

Indirect Court Rule Amendments

(a) The provisions of AS 23.30.126, added by sec. 5 of this Act, and the repeal of AS 23.30.007, 23.30.008, 23.30.009, 23.30.125, 23.30.127, 23.30.128, and 23.30.129 in sec. 9 of this Act, have the effect of changing Rules 202(a), 204(a)-(c), 210(e), and 601(b), Alaska Rules of Appellate Procedure, by repealing the Alaska Workers' Compensation Appeals Commission and providing that appeals and petitions for review from decisions of the Alaska Workers' Compensation Board be brought in superior court.

(b) AS 23.30.126, added by sec. 5 of this Act, has the effect of amending Rules 602(c) and (h), Alaska Rules of Appellate Procedure, by permitting the director of the division of workers' compensation to file an appeal or petition for review in the superior court under specified circumstances or intervene in an appeal or petition for review in the superior court.

(c) AS 23.30.126, added by sec. 5 of this Act, has the effect of amending Rule 603(a), Alaska Rules of Appellate Procedure, by establishing a standard for seeking a stay of compensation payments in an appeal filed in the superior court from a final decision of the Alaska Workers' Compensation Board.

Applicability

(a) AS 23.30.005, 23.30.007, 23.30.008, 23.30.009, 23.30.107(b), 23.30.108(d), 23.30.108(e), 23.30.125, 23.30.127, 23.30.128, 23.30.129, 23.30.155(f), 23.30.395(10), AS 39.25.110(40), AS 39.50.200(b)(31), and AS 44.64.020(a)(12) and (13), as those statutes

read on the day before the effective date of this Act, continue to apply to appeals, petitions for review, and other proceedings pending before the Workers' Compensation Appeals Commission on or before December 1, 2017. Appeals, petitions for review, and other proceedings under this subsection shall be continued in the Workers' Compensation Appeals Commission on or before December 1, 2017.

(b) AS 23.30.126, added by sec. 5 of this Act, and AS 23.30.155(f), as amended by sec. 6 of this Act, do not apply to appeals, petitions for review, or other proceedings under (a) of this section.

(c) AS 23.30.129, as it read on the day before the effective date of this Act, applies to appeals to the Alaska supreme court from final decisions of the Workers' Compensation Appeals Commission issued on or before December 1, 2017, and to petitions for review from interlocutory decisions of the Workers' Compensation Appeals Commission issued on or before December 1, 2017.

Transitional Provisions

(a) Appeals, petitions for review, and other proceedings that seek review of decisions and orders of the Alaska Workers' Compensation Board and that have not been filed before the Workers' Compensation Appeals Commission before the effective date of this Act, shall be filed in the superior court on or after June 1, 2017, in accordance with AS 23.30.126, added by sec. 5 of this Act, and the filing deadlines in AS 44.62.560 and Rule 602(a)(2), Alaska Rules of Appellate Procedure.

(b) A party seeking review of a final Workers' Compensation Appeals Commission decision issued on or before December 1, 2017, shall file an appeal to the Alaska supreme court under AS 23.30.129, and the Alaska Rules of Appellate Procedure, as that statute and those rules read on the day before the effective date of this Act. A party who seeks review of an interlocutory decision of the Workers' Compensation Appeals Commission issued on or before December 1, 2017, shall file a petition for review with the Alaska supreme court under AS 23.30.129, and the Alaska Rules of Appellate Procedure, as that statute and those rules read on the day before the effective date of this Act. Cases in which a party seeks review of a final Alaska Workers' Compensation Board decision and order issued after a remand from the Workers' Compensation Appeals Commission must be filed in the superior court on or after June 1, 2017, in accordance with AS 23.30.126, added by sec. 5 of this Act.

(c) The Workers' Compensation Appeals Commission's power to order reconsideration under AS 23.30.128(f), as that section read on the date before the effective date of this Act, expires on December 2, 2017. Requests for reconsideration pending before the Workers' Compensation Appeals Commission shall be automatically denied on December 2, 2017, and, notwithstanding AS 23.30.128(g), as that section read on the day before the effective date of this Act, the decision of the Workers' Compensation Appeals Commission becomes final on December 2, 2017. If the Workers' Compensation Appeals Commission ordered reconsideration but did not issue a decision on reconsideration on or before December 1, 2017, reconsideration shall be automatically denied on December 2, 2017, and, notwithstanding AS 23.30.128(g), as that section read on the day before the effective date of this Act, the original decision of the Workers' Compensation Appeals Commission becomes final on December 2, 2017. A party whose request for reconsideration was denied under this subsection and who seeks further review shall file an appeal in the Alaska supreme court under AS 23.30.129, as that section read on the day before the effective date of this Act, and in accordance with the Alaska Rules of Appellate Procedure.

(d) On December 2, 2017, the Workers' Compensation Appeals Commission shall transfer the files of all appeals, petitions for review, and other proceedings that were pending before June 1, 2017, and were not completed on or before December 1, 2017, to the superior court, which shall assume jurisdiction under AS 22.10.020, and Rules 604(b) and 609, Alaska Rules of Appellate Procedure. The Workers' Compensation Appeals Commission shall provide notice to all parties of record 30 days before it transfers a pending case, advising parties of the transfer of jurisdiction and the effective date of the transfer. The Workers' Compensation Appeals Commission shall prepare each record in accordance with Rule 604(b), Alaska Rules of Appellate Procedure, and mail or hand deliver the record in the pending case to the superior court in the judicial district where the Alaska Workers' Compensation Board issued the contested decision and order. If the superior court determines that the record does not comply with Rule 604(b), Alaska Rules of Appellate Procedure, the court may return the record to the Alaska Workers' Compensation Board and direct the Alaska Workers' Compensation Board to conform the record as may be necessary.

Transition: Terms Of Commissioners.

Notwithstanding AS 23.30.007(e), as repealed by sec. 9 of this Act, the terms of the members appointed to the Workers' Compensation Appeals Commission expire December 31, 2017.

Conditional Effect

This Act takes effect only if secs. 8 and 10 of this Act, receive the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

Florida

HB 837, in part, amends *sections 631.021 Jurisdiction of delinquency proceeding; venue; change of venue; exclusiveness of remedy; appeal, 631.191 Special deposit claims and secured claims and 631.397 Use of certain marshaled assets* of the Florida Statutes as follows:

631.021 Jurisdiction of delinquency proceeding; venue; change of venue; exclusiveness of remedy; appeal; construction

- (1) The circuit court shall have original jurisdiction of any delinquency proceeding under this chapter, and any court with jurisdiction is authorized to make all necessary or proper orders to carry out the purposes of this chapter. Any delinquency proceeding in this chapter is in equity.
- (2) The venue of a delinquency proceeding or summary proceeding against a domestic, foreign, or alien insurer shall be in the Circuit Court of Leon County.
- (3) A delinquency proceeding pursuant to this chapter constitutes the sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving an insurer. ~~A No court may not shall~~ entertain a petition for the commencement of such a proceeding unless the petition has been filed in the name of the state on the relation of the department. The Florida Insurance Guaranty Association, Incorporated, the Florida Workers' Compensation Insurance Guaranty Association, Incorporated, the Florida Health Maintenance Organization Consumer Assistance Plan, and the Florida Life and Health Guaranty Association, Incorporated, shall be given reasonable written notice by the department of all hearings ~~that which~~ that which pertain to an adjudication of insolvency of a member insurer.
- (4) An appeal shall lie to the District Court of Appeal, First District, from an order granting or refusing rehabilitation, liquidation, or conservation and from every order in a delinquency proceeding having the character of a final order as to the particular portion of the proceeding embraced therein.
- (5) No service of process against the department in its capacity as receiver shall be effective unless served upon a person designated by the receiver and filed with the circuit court having jurisdiction over the delinquency proceeding. The designated person shall refuse to accept service if acceptance would violate a stay against legal proceedings involving an insurer that is the subject of delinquency proceedings or would violate any orders of the circuit court governing a delinquency proceeding. The person denied service may petition the circuit court having jurisdiction over the delinquency proceeding for relief from the receiver's refusal to accept service. This subsection shall be strictly construed, and any purported service on the receiver or the department that is not in accordance with this subsection shall be null and void.
- (6) The domiciliary court acquiring jurisdiction over persons subject to this chapter may exercise exclusive jurisdiction to the exclusion of all other courts, except as limited by the provisions of this chapter. Upon the issuance of an order of conservation, rehabilitation, or liquidation, the Circuit Court of Leon County ~~has shall have~~ shall have exclusive jurisdiction ~~over all with respect to~~ over all assets or property of ~~the any insurer, wherever located, including property located outside the territorial limits of the state subject to such proceedings and claims against said insurer's assets or property.~~ the any insurer, wherever located, including property located outside the territorial limits of the state
- (7) This chapter constitutes this state's insurer receivership laws, and these laws must be construed as consistent with each other. If there is a conflict between this chapter and any other law, this chapter prevails.

631.191 Special deposit claims; ~~and~~ secured claims; administration of workers' compensation large deductible policies and insured collateral

- (1) Special Deposit Claims The owners of special deposit claims against an insurer against which a liquidation order has been entered in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.
- (2) Secured Claims
- (a) The owner of a secured claim against an insurer against which a liquidation order has been entered in this or any other state may surrender her or his security and file her or his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this chapter, or if it has been adjudicated by a court of competent jurisdiction in a proceeding in which the domiciliary receiver has had notice and an opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.
- (b) The value of any security held by a secured creditor shall be determined under supervision of the court by:
1. Converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditor; or
 2. If no such agreement exists, the court shall determine the value in the event the creditor and the receiver cannot agree upon same.
- (3) Administration of Workers' Compensation Large Deductible Policies and Insured Collateral
- (a) Definitions. —As used in this subsection, the term:
1. "Collateral" means cash, a letter of credit, a surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured's obligation under a large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay the insurer as may be required for other secured obligations.

2. "Deductible claim" means any claim that is within the deductible under a large deductible policy, including a claim for loss and defense and cost containment expense, unless such expense is excluded by the terms of the policy.

3.a. "Large deductible policy" means a combination of one or more workers' compensation policies and endorsements issued to an insured, and contracts or security agreements entered into between an insured and the insurer, in which the insured has agreed with the insurer to:

(I) Pay directly the initial portion of any claim under the policy up to a specified dollar amount or the expenses related to any claim;
or

(II) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

b. The term also includes policies that contain an aggregate limit on the insured's liability for all deductible claims in addition to a per-claim deductible limit. A policy must meet the current guidelines for large deductible workers' compensation filings as defined by the office, including the eligibility standards regarding the minimum standard premium and the minimum deductible to be deemed a large deductible policy.

c. The term does not include policies, endorsements, or agreements providing that the initial portion of any covered claim must be self-insured and that the insurer has no payment obligation within the self-insured retention.

d. The term does not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder's large deductible obligations.

4. "Other secured obligations" means obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations, the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy.

(b) Applicability.—

1. This subsection applies to workers' compensation large deductible policies issued by an insurer that is subject to delinquency proceedings under this chapter. This subsection does not apply to first-party claims, or to covered claims funded by a guaranty association above the deductible unless paragraph (c) applies. Large deductible policies must be administered in accordance with the terms of the policy, except to the extent such terms conflict with this subsection.

2. This subsection applies to all delinquency proceedings that commence on or after July 1, 2017.

(c) Handling of large deductible claims.—Unless otherwise agreed to by the responsible guaranty association, all large deductible claims that are also covered claims as defined by an applicable guaranty association law, including those that may have been funded by an insured before liquidation, must be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim pursuant to an agreement by the guaranty fund or otherwise, the insured's funding or payment of a deductible claim extinguishes the obligations, if any, of the receiver and any guaranty association to pay such claim. A charge may not be made against the receiver or a guaranty association on the basis of an insured's funding or payment of a deductible claim.

(d) Deductible claims paid by a guaranty association.—

1. To the extent a guaranty association pays any deductible claim for which an insurer would have been entitled to reimbursement from an insured, a guaranty association is entitled to the amount of reimbursements received or collateral available, subject to paragraph (g). Reimbursements paid to the guaranty association pursuant to this paragraph may not be treated as distributions under s. 631.271 or as early access payments under s. 631.397(1).

2. To the extent that a guaranty association pays a deductible claim that is not reimbursed from collateral or by insured payments, or the guaranty association incurred expenses in connection with large deductible policies that are not reimbursed under this subsection, the guaranty association is entitled to assert a claim for those amounts in the delinquency proceeding.

3. This paragraph does not limit any right of the receiver or a guaranty association which may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses.

(e) Collections.—

1. The receiver may collect reimbursements owed for deductible claims as provided in this paragraph, and must use reasonable efforts to collect such reimbursements from the insured or the party that is obligated to pay the deductible as specified in the large deductible policy or other agreement. The receiver may bill insureds and others for reimbursement of deductible claims that are:

a. Paid by the insurer before the commencement of delinquency proceedings;

b. Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or

c. Paid or allowed by the receiver.

2. If the insured or other party does not make payment within the time specified in the large deductible policy, or, if no time is specified, within a reasonable time after the date of billing, the receiver may take reasonable steps to collect any reimbursements owed.

3. The insolvency of the insurer or its inability to perform any of its obligations under the large deductible policy may not be a defense to the insured's reimbursement obligation under the large deductible policy.

4. An allegation of improper handling or payment of a deductible claim by the receiver or a guaranty association may not be a defense to the insured's reimbursement obligations under the large deductible policy.

(f) Collateral.—

1. Subject to this paragraph, the receiver shall use collateral, when available, to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or payment obligations. A guaranty association is entitled to collateral as provided for in this paragraph to the extent needed to reimburse a guaranty association for the payment of a deductible claim. Any distributions made to a guaranty association pursuant to this paragraph may not be treated as distributions under s. 631.271 or as early access payments under s. 631.397(1).

2. The receiver shall draw down collateral to the extent necessary in the event the insured fails to:

- a. Perform its funding or payment obligations under any large deductible policy;
- b. Pay deductible claim reimbursements within the time specified in the large deductible policy, or, if no time is specified, within 60 days after the date of the billing;
- c. Pay amounts due to the estate for preliquidation obligations;
- d. Timely fund any other secured obligation; or
- e. Timely pay expenses.

3. Claims that are validly asserted against the collateral must be satisfied in the order in which such claims are received by the receiver. However, if more than one creditor has a valid claim against the same collateral and the available collateral, along with billing collection efforts and to the extent that the collateral is subject to other known secured obligations, are together insufficient to pay each creditor in full, the receiver may prorate payments based on the ratio of the amount of claims each creditor has to the total claims paid by all such creditors.

4. Excess collateral may be returned to the insured, as determined by the receiver, after a periodic review of claims paid, outstanding case reserves, and a factor for claims that were incurred but not reported.

(g) Receiver's expenses.—The receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements as provided pursuant to s. 631.271.

(h) Construction.—This subsection does not limit or adversely affect any rights or powers a guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association under policies of the insolvent insurer, or for related expenses the guaranty association incurs.

631.397 Use of certain marshaled assets

~~(1) Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, The department, as receiver, may shall apply to the court for approval of a proposal to disburse assets out of such insurer's marshaled assets, as such assets become available, to each association entitled thereto or, if there are no assets available for such disbursement, then for approval of such proposal as the receiver deems appropriate. For the purposes of this section, the term "association" includes the Florida Insurance Guaranty Association, Incorporated, the Florida Workers' Compensation Insurance Guaranty Association, and any entity or person performing a function in another state similar to that performed in this state by the Florida Insurance Guaranty Association, Incorporated, or the Florida Workers' Compensation Insurance Guaranty Association, provided the Florida Insurance Guaranty Association, Incorporated, or the Florida Workers' Compensation Insurance Guaranty Association, is entitled to like payment under the laws of the association's state of domicile in respect to insolvent companies doing business in that state.~~

...

~~(4) Notice of such application shall be given by the department to the associations in, and to the commissioners of insurance of, each of the states to which disbursement may be made. Such notice shall be made by certified mail, first-class postage prepaid, at least 15 days prior to submission of such application to the court. Such notice shall be deemed to have been made when deposited in the mail.~~

~~(5) Action on the application may be taken by the court if notice has been given pursuant to subsection (4) and the department's proposal complies with subsection (2).~~

Illinois

HB 2525 amends the Illinois Compiled Statutes Annotated as follows:

- Provides that a rate is excessive if it is likely to produce a long-run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to the services rendered.
- Repeals provisions regarding presumptions that a competitive market exists, determining whether a competitive market exists, and disapproval of rates under specified circumstances.
- Provides that accidental injuries sustained while traveling to or from work do not arise out of and in the course of employment.
- Defines "in the course of employment" and "arising out of the employment."

- Permits an employer to file with the Illinois Workers' Compensation Commission a workers compensation safety program or a workers compensation return-to-work program implemented by the employer.
- Provides that the Commission may certify any such safety program as a bona fide safety program after reviewing the program.
- Provides that, in a provision concerning compensation for the period of temporary total incapacity for work resulting from an accidental injury, (i) injuries to the shoulder must be considered injuries to part of the arm and (ii) injuries to the hip must be considered injuries to part of the leg.
- Contains, among other things, provisions concerning:
 - Repetitive and cumulative injuries
 - Permanent partial disability determinations
 - Electronic claims
 - Annual reports by the Commission concerning the state of self-insurance for workers compensation in Illinois
 - Duties of the Workers' Compensation Premium Rates Task Force

HB 2622 amends section **215 ILCS 5/416 Illinois Workers' Compensation Commission Operations Fund Surcharge** of the Illinois Compiled Statutes Annotated as follows:

215 ILCS 5/416 Illinois Workers' Compensation Commission Operations Fund Surcharge

...

(h) After the effective date of this amendatory Act of the 100th General Assembly, the Director shall make a loan to the Illinois Employers Mutual Insurance Company of \$10,000,000 from the Illinois Workers' Compensation Commission Operations Fund for the start-up funding and initial capitalization of the Illinois Employers Mutual Insurance Company. The Board of Directors of the Illinois Employers Mutual Insurance Company shall make an application to the Director for the loans, stating the amount to be loaned to the Illinois Employers Mutual Insurance Company. The Illinois Employers Mutual Insurance Company shall repay the loans in full within 5 years after issuance, plus any interest that would have accrued thereon had the loan not occurred.

HB 2622 also creates a new Article to the Illinois Compiled Statutes Annotated entitled the Illinois Employers Mutual Insurance Company as follows:

215 ILCS 5/1700. Purpose.

The purpose of this Article is to establish the Illinois Employers Mutual Insurance Company as a nonprofit, independent public corporation to insure Illinois employers against liability for workers' compensation and occupational disease coverage.

215 ILCS 5/1705. Definitions.

As used in this Article:

"Board" means the board of directors of the Illinois Employers Mutual Insurance Company.

"Board director" means a member of the board of directors of the Company.

"Company" means the Illinois Employers Mutual Insurance Company created by this Article.

215 ILCS 5/1710. Establishment of the Company.

(a) There is hereby created the Illinois Employers Mutual Insurance Company, which shall be a nonprofit, independent public corporation. The Company shall be operated as a domestic mutual insurance company, subject to all applicable provisions of this Code.

(b) The Company shall issue insurance for workers' compensation and occupational disease. The Company shall not provide any other type of insurance.

(c) The Company shall provide workers' compensation coverage to employers at the highest level of service and savings consistent with reasonable applicable actuarial standards and shall maintain the financial integrity of the Company. The Company shall foster employer involvement in safety initiatives and the creation of workplace safety plans set forth in Section 1740 of this Article.

(d) The Company shall not be considered a State agency or instrumentality of the State for any purpose. Employees of the Company are not employees of the State and are not subject to the Personnel Code. The Company shall not receive any State appropriations or funds, except for an initial loan or loans made pursuant to Section 416 of this Code. The State shall not borrow or otherwise appropriate funds from the Company. The Company or its liabilities shall not be deemed to constitute a debt or a liability of the State or a pledge of the full faith and credit of the State.

215 ILCS 5/1715. Board of directors.

(a) The Company shall be managed by a 7-member board of directors. The board of directors shall be appointed by the Governor with the advice and consent of the Senate. For the initial set of appointments, 2 Board directors shall be appointed to a term ending July 1, 2019, 2 Board directors shall be appointed to a term ending July 1, 2020, 2 Board directors shall be appointed to a term ending July 1, 2021, and one Board director shall be appointed to a term ending July 1, 2022. All initial appointments shall be made by the Governor within 30 days after the effective date of this amendatory Act of the 100th General Assembly. Thereafter, all appointments or reappointments shall be for a 5-year term ending on July 1 of the fifth year. The appointment and

reappointment of Board directors by the Governor shall be subject to the provisions of Article 3A of the Illinois Governmental Ethics Act.

(b) A Board director appointed by the Governor must meet all of the following qualifications:

(1) he or she does not have any interest as a stockholder, employee, attorney, agent, broker, or contractor of an insurance entity that writes workers' compensation insurance or whose affiliates write workers' compensation insurance; however, nothing in this Section shall be construed to prohibit an individual who previously had an interest in an insurance entity that writes workers' compensation insurance or whose affiliates write workers' compensation insurance from being appointed to the Board;

(2) he or she is not the spouse or an immediate family member living with a person who has an interest as a stockholder, employee, attorney, agent, broker, or contractor of an insurance entity that writes workers' compensation insurance or whose affiliates write workers' compensation insurance; however, nothing in this Section shall be construed to prohibit an individual who previously had an interest in an insurance entity that writes workers' compensation insurance or whose affiliates write workers' compensation insurance from being appointed to the Board;

(3) he or she is a resident of the State of Illinois;

(4) he or she is of good moral character and has never pleaded guilty to, or been found guilty of, a felony; and

(5) he or she is not a registered lobbyist under the Lobbyist Registration Act.

(c) The Board directors shall elect a chairman from the Board.

(d) The Board is vested with the full power, authority, and jurisdiction over the Company and may perform any necessary or convenient act in the exercise of its power. The Board shall discharge its duties with the care, skill, prudence, and diligence as that of prudent directors acting in a similar enterprise and purpose. The powers of the Board include, but are not limited to:

(1) the ability to enter into contracts;

(2) the purchase of reinsurance; and

(3) the declaration of dividends.

(e) The Board shall develop bylaws which shall be subject to the restrictions set forth in this Article. The bylaws shall provide for a schedule of at least quarterly meetings and set forth rules specifically relating to the conduct of meetings and voting procedures.

(f) The Board shall reflect the ethnic, cultural, and geographical diversity of the State.

215 ILCS 5/1720. Ratemaking.

The Board shall have full power and authority to establish rates to be charged by the Company for insurance, subject to the applicable provisions of this Code. The Board shall contract for the services of or hire an independent actuary, who is a member in good standing with the American Academy of Actuaries, to develop and recommend actuarially sound rates. Rates shall be set at amounts sufficient, when invested, to carry all claims to maturity, meet the reasonable expenses of conducting the business of the Company, and maintain a reasonable surplus.

215 ILCS 5/1725. Guaranty fund.

The Company shall be subject to Article XXXIV of this Code and shall pay any assessments required for members of the Illinois Insurance Guaranty Fund.

215 ILCS 5/1730. Chief executive officer.

(a) The Board shall hire a chief executive officer who shall serve at the pleasure of the Board. The chief executive officer shall not be a member of the Board and must be qualified by education and experience to manage an organization with financial and operational obligations to policyholders and claimants. The compensation of the chief executive officer shall be determined by the Board.

(b) The chief executive officer shall be responsible for conducting the day-to-day operations of the Company, including the hiring of personnel. The chief executive officer shall also maintain an Internet website for the Company, which shall include information regarding the purchase of policies from the Company, as well as any reports required to be published under this Article.

(c) The chief executive officer shall present a proposed operating budget for the Company to the Board for its approval on an annual basis. The operating budget shall include a description of administrative and personnel costs.

215 ILCS 5/1735. Liability.

The Board and its employees shall not be personally liable for acts performed in good faith, without the intent to defraud, and made in an official capacity.

215 ILCS 5/1740. Workplace safety plan.

(a) The chief executive officer shall formulate, implement, and monitor a workplace safety plan for all policyholders. This plan shall include written guidance to reduce workplace accidents, prevent injuries, and promote safe working conditions. Each plan shall have clearly stated safety objectives for the policyholder.

(b) Employees of the Company shall have access to the premises of any policyholder for the purpose of examining the safety conditions of the workplace. The Company may terminate a policy if there is a refusal by the policyholder to permit on-site

examinations by the Company or if the policyholder disregards or fails to comply with the safety objectives set forth by the Company in the workplace safety plan.

215 ILCS 5/1745. Investments.

(a) The Company shall formulate and adopt an investment policy that safeguards the value of all assets and maximizes investment potential. All investments by the Company shall be subject to the applicable restrictions for domestic mutual insurers set forth in this Code.

(b) The Company may retain an independent investment counsel who shall be subject to standards applicable to fiduciaries responsible for safeguarding the assets of a corporation.

215 ILCS 5/1750. Dividends.

(a) The Company may declare a dividend in accordance with the requirements set forth in this Code.

(b) Dividends may be distributed in the form of premium discounts, dividends, or a combination of dividends and discounts.

(c) In addition to any requirements for dividends set forth in this Code, dividends may only be distributed if:

(1) the initial funding of the Company has been repaid in full;

(2) an independent actuarial report of the prior year's operations has been completed and reviewed by the Board;

(3) the Company has met all expenses for administration and claims for the prior year; and

(4) adequate reserves exist to pay all claims.

215 ILCS 5/1755. Sale of policies.

The Company shall administer the sale of policies for workers' compensation and occupational disease coverage. The Company shall utilize the Internet and other technologies to the greatest extent possible in order to facilitate the purchase of a policy for employers in this State.

215 ILCS 5/1760. Auditing requirements.

(a) The Company shall be subject to all examinations and audits required under this Code.

(b) The Board shall retain a competent and independent firm of certified public accountants to perform an annual audit of the performance and management of the Company and an audit of the accounts, funds, and securities of the Company. The costs of these audits shall be paid for by the Company. The audits shall be published on the Company's Internet website.

215 ILCS 5/1765. Annual report.

(a) On July 1, 2018, the Board shall prepare and submit a report to the Governor, the President of the Senate, the Minority Leader of the Senate, the Speaker of the House, and the Minority Leader of the House. This report shall describe the progress of the Company to date in establishing its operations as a domestic mutual insurance company in this State providing workers' compensation and occupational disease coverage. This report shall include the information required in subsection (b) of this Section, if available.

(b) Beginning July 1, 2019 and continuing every July 1 thereafter, the Board shall prepare and submit a report to the Governor, the President of the Senate, the Minority Leader of the Senate, the Speaker of the House, and the Minority Leader of the House. This report shall contain, at a minimum, the following information:

(1) a summary of the most recent audits performed pursuant to Section 1760 of this Code;

(2) statistical and actuarial data related to the determination of premium rate levels; and

(3) the incidence of work-related injuries and costs related to those injuries.

(c) The reports required under this Section shall be submitted electronically and posted on the Internet website of the Company.

Nevada

AB 83 adds to, revises, and repeals various provisions of the Nevada Revised Statutes including, but not limited to the following:

- **Section 35** of this bill defines the term "large-deductible agreement" as certain agreements in which the policyholder must bear the risk of loss of a specified amount of \$25,000 or more per claim or occurrence covered under the policy of industrial insurance
- **Section 37** of this bill limits the applicability of **Sections 38** and **39** to policies of industrial insurance with large-deductible agreements that are issued by insurers with both ratings below specified levels and surpluses below specified amounts
- **Section 37** further specifies that **Sections 38** and **39** only apply to policies of industrial insurance issued or renewed on or after January 1, 2018, and which are not issued to a governmental entity
- **Section 38** of this bill requires full collateralization of the outstanding obligations owed under a large-deductible agreement and limits the size of the policyholder's obligations under the large-deductible agreement
- **Section 39** of this bill generally prohibits an insurer from issuing or renewing a policy of industrial insurance that includes a large-deductible agreement if the insurer is in a hazardous financial condition

- **Section 166** of this bill revises the definition of the term “tangible net worth” in relation to industrial insurance, specifically self-insured employers and associations of self-insured employers

AB 267 amends various provisions of the Nevada Revised Statutes as follows:

Section 1. 616C.400 Minimum duration of incapacity.

1. Temporary compensation benefits must not be paid under chapters 616A to 616D, inclusive, of NRS for an injury which does not incapacitate the employee for at least 5 consecutive days, or 5 cumulative days within a 20-day period, from earning full wages, but if the incapacity extends for 5 or more consecutive days, or 5 cumulative days within a 20-day period, compensation must then be computed from the date of the injury.
2. The period prescribed in this section does not apply to:
 - (a) Accident benefits, whether they are furnished pursuant to NRS 616C.255 or 616C.265, if the injured employee is otherwise covered by the provisions of chapters 616A to 616D, inclusive, of NRS and entitled to those benefits.
 - (b) Compensation paid to the injured employee pursuant to subsection 1 of NRS 616C.477.
 - (c) A claim which is filed pursuant to NRS 617.453, 617.455 or 617.457.

Section 2. 617.420 Minimum duration of incapacity; payment of medical benefits.

1. No compensation may be paid under this chapter for temporary total disability which does not incapacitate the employee for at least 5 cumulative days within a 20-day period from earning full wages, but if the incapacity extends for 5 or more days within a 20-day period, the compensation must then be computed from the date of disability.
2. The limitations in this section do not apply to medical benefits, including, without limitation, medical benefits pursuant to NRS 617.453, 617.455 or 617.457, which must be paid from the date of application for payment of medical benefits.

Section 3. 617.454 Physical examinations: required tests.

1. Any physical examination administered pursuant to NRS 617.455 or 617.457 must include:
 - (a) A thorough test of the functioning of the hearing of the employee; and
 - (b) A purified protein derivative skin test to screen for exposure to tuberculosis.
2. Except as otherwise provided in subsection 8 of NRS 617.457, the tests required by this section must be paid for by the employer.
3. Except as otherwise provided by the provisions governing privacy in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations, or an employee’s collective bargaining agreement, whichever is more restrictive:
 - (a) The results of a physical examination administered pursuant to NRS 617.455 or 617.457 may only be provided to:
 - (1) The examining physician;
 - (2) The employee;
 - (3) The employer’s officer who is responsible for risk management or human resources or a similar position; and
 - (4) If the employee has filed a claim pursuant to NRS 617.455 or 617.457, the insurer.
 - (b) A person who receives the results of a physical examination pursuant to paragraph (a) may only use the results for the purposes of:
 - (1) Complying with the requirements of NRS 617.455 or 617.457, as applicable; or
 - (2) Creating a report pursuant to paragraph (c).
 - (c) The employer’s officer who is responsible for risk management or human resources or a similar position may create and release a report that is based on the results of a physical examination administered pursuant to NRS 617.455 or 617.457 to any person whom the employer’s officer determines has a need to know the information in the report. The report must only contain the following information:
 - (1) The name of the employee who was the subject of the physical examination; and
 - (2) A statement that the employee, as applicable:
 - (I) Satisfies the physical qualifications required for his or her employment; or
 - (II) Does not satisfy the physical qualifications required for his or her employment.

Section 4. 617.455 Lung diseases as occupational diseases of firefighters, police officers and arson investigators.

- ...
10. Except as otherwise provided in this subsection, if an employer, insurer or third-party administrator denies a claim that was filed pursuant to this section and the claimant ultimately prevails, the employer, insurer or third-party administrator, as applicable, must pay all the claimant’s reasonable attorney’s fees and associated costs. Such fees and costs are payable in addition to any benefits to which the claimant is entitled under the claim and any fines and penalties imposed by the Administrator pursuant to NRS 616D.120. If a hearing before a hearing officer is requested pursuant to NRS 616C.315 and held pursuant to NRS 616C.330, such fees and costs do not include any attorney’s fees and associated costs that are incurred by the claimant on or before the date of the hearing before the hearing officer.

Section 5. 617.457 Heart diseases as occupational diseases of firefighters, arson investigators and police officers.

...

15. Except as otherwise provided in this subsection, if an employer, insurer or third-party administrator denies a claim that was filed pursuant to this section and the claimant ultimately prevails, the employer, insurer or third-party administrator, as applicable, must pay all the claimant's reasonable attorney's fees and associated costs. Such fees and costs are payable in addition to any benefits to which the claimant is entitled under the claim and any fines and penalties imposed by the Administrator pursuant to NRS 616D.120. If a hearing before a hearing officer is requested pursuant to NRS 616C.315 and held pursuant to NRS 616C.330, such fees and costs do not include any attorney's fees and associated costs that are incurred by the claimant on or before the date of the hearing before the hearing officer.

AB 267 also includes the following language:

The amendatory provisions of sections 1, 2, 4 and 5 of 41 this act apply only to claims filed on or after October 1, 2017.

North Carolina

SB 489 amends sections **58-36-105 Certain workers' compensation insurance policy cancellations prohibited** and **58-2-255 Electronic insurance communications and records** of the North Carolina General Statutes as follows:

58-36-105 Certain workers' compensation insurance policy cancellations prohibited

...

(b) Any cancellation permitted by subsection (a) of this section is not effective unless written notice of cancellation has been given to the insured not less than 15 days before the proposed effective date of cancellation. The notice may be given by registered or certified mail, return receipt requested, to the insured and any other person designated in the policy to receive notice of cancellation at their addresses shown in the policy or, if not indicated in the policy, at their last known addresses. The notice shall state the precise reason for cancellation. Whenever notice of intention to cancel is given by registered or certified mail, no cancellation by the insurer shall be effective unless and until such method is employed and completed. Notice of intent to cancel given by registered or certified mail shall be conclusively presumed completed three days after the notice is sent if, on the same day that the notice is sent by registered or certified mail, the insurer also provides notice by first-class mail and by electronic means if available as defined in G.S. 58-2-255(a) to the insured and any other person designated in the policy to receive notice. Any such supplemental notice given by electronic means shall be effective for the limited purpose of establishing this conclusive presumption, notwithstanding G.S. 58-2-255(b). Within three (3) business days of cancellation, the insurer shall provide notice by first-class mail to any person to whom the insurer has provided a certificate of insurance pursuant to G.S. 97-19. Notice of cancellation, termination, or nonrenewal may also be given by any method permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure. Failure to send this notice, as provided in this section, to any other person designated in the policy to receive notice of cancellation invalidates the cancellation only as to that other person's interest.

58-2-255 Electronic insurance communications and records.

...

(b) ~~When any insurance law of this State, except for cancellation, termination, or nonrenewal of workers' compensation policies pursuant to G.S. 58-36-105(b), State requires a communication to be provided to a party in writing, signed by a party, provided by means of a specific delivery method, or retained by an insurer, those requirements are satisfied if the insurer complies with Article 40 of Chapter 66 of the General Statutes.~~

...

Texas

HB 919 adds **section 88.126** of the Texas Education Code to read as follows:

Section 88.126. Workers' Compensation Insurance Coverage: Intrastate Fire Mutual Aid System and Regional Incident Management Teams.

(a) In this section:

(1) "Intrastate fire mutual aid system team" means an intrastate fire mutual aid system team established under the state emergency management plan under Section 418.042, Government Code, or the statewide mutual aid program for fire emergencies under Section 418.110, Government Code, and coordinated by the Texas A&M Forest Service to assist the state with fire suppression and all-hazard emergency response activities before and following a natural or man-made disaster.

(2) "Local government employee member" means a member employed by a local government, as defined by Section 102.001, Civil Practice and Remedies Code.

(3) "Member" means an individual, other than an employee of The Texas A&M University System, who has been officially designated as a member of an intrastate fire mutual aid system team or a regional incident management team.

(4) "Nongovernment member" means a member who is not a state employee member, a local government employee member, or an employee of The Texas A&M University System.

(5) "Regional incident management team" means a regional incident management team established under Section 88.122 or under the state emergency management plan under Section 418.042, Government Code, and coordinated by the Texas A&M Forest Service to assist the state with managing incident response activities before and following a natural or man-made disaster.

(6) "State employee member" means a member employed by an agency of the state other than a component of The Texas A&M University System.

(b) Notwithstanding any other law, during any period in which an intrastate fire mutual aid system team or a regional incident management team is activated by the Texas Division of Emergency Management, or during any training session sponsored or sanctioned by the Texas Division of Emergency Management for an intrastate fire mutual aid system team or a regional incident management team, a participating nongovernment member or local government employee member is included in the coverage provided under Chapter 501, Labor Code, in the same manner as an employee, as defined by Section 501.001, Labor Code.

(c) Service with an intrastate fire mutual aid system team or a regional incident management team by a state employee member who is activated is considered to be in the course and scope of the employee's regular employment with the state.

(d) Service with an intrastate fire mutual aid system team or a regional incident management team by an employee of The Texas A&M University System is considered to be in the course and scope of the employee's regular employment with The Texas A&M University System.

HB 919 also amends *Section 408.0445 Average Weekly Wage for Members of State Military Forces and Texas Task Force 1, Section 501.001 Definitions*, and *Section 501.002 Application of General Workers™ Compensation Laws; Limit on Actions and Damages* of the Texas Labor Code as follows:

Sec. 408.0445. Average Weekly Wage For Members of State Military Forces, ~~And~~ Texas Task Force 1, Intrastate Fire Mutual Aid System Teams, and Regional Incident Management Teams.

...

(c) For purposes of computing income benefits or death benefits under Section 88.126, Education Code, the average weekly wage of an intrastate fire mutual aid system team member or a regional incident management team member, as defined by Section 88.126, Education Code, who is engaged in authorized training or duty is an amount equal to the sum of the member's regular weekly wage at any employment, including self-employment, that the member holds in addition to serving as a member of an intrastate fire mutual aid system team or a regional incident management team, as applicable, except that the amount may not exceed 100 percent of the state average weekly wage as determined under Section 408.047. A member for whom an average weekly wage cannot be computed shall be paid the minimum weekly benefit established by the division.

Section 501.001 Definitions

...

(5) "Employee" means a person who is:

(A) in the service of the state pursuant to an election, appointment, or express oral or written contract of hire;

(B) paid from state funds but whose duties require that the person work and frequently receive supervision in a political subdivision of the state;

(C) a peace officer employed by a political subdivision, while the peace officer is exercising authority granted under:

(i) Article 2.12, Code of Criminal Procedure; or

(ii) Articles 14.03(d) and (g), Code of Criminal Procedure;

(D) a member of the state military forces, as defined by Section 437.001, Government Code, who is engaged in authorized training or duty; ~~or~~

(E) a Texas Task Force 1 member, as defined by Section 88.301, Education Code, who is activated by the Texas Division of Emergency Management or is injured during training sponsored or sanctioned by Texas Task Force 1; or

(F) an intrastate fire mutual aid system team member or a regional incident management team member, as defined by Section 88.126, Education Code, who is activated by the Texas Division of Emergency Management or is injured during training sponsored or sanctioned by the Texas Division of Emergency Management on behalf of an intrastate fire mutual aid system team or a regional incident management team, as applicable.

Section 501.002 Application of General Workers™ Compensation Laws; Limit on Actions and Damages

...

(g) For purposes of this chapter and Section 88.126, Education Code, the Texas A&M Forest Service shall perform all duties of an employer in relation to an intrastate fire mutual aid system team member or a regional incident management team member who is injured and receives benefits under this chapter.

HB 919 also states the following:

The change in law made by this Act applies only to a claim for workers' compensation benefits based on a compensable injury that occurs on or after the effective date of this Act. A claim based on a compensable injury that occurs before the effective date of this

Act is governed by the law in effect on the date the compensable injury occurred, and the former law is continued in effect for that purpose.

HB 1983 adds **Section 504.019** to the Texas Labor Code as follows:

Sec. 504.019. COVERAGE FOR POST-TRAUMATIC STRESS DISORDER FOR CERTAIN FIRST RESPONDERS.

(a) In this section:

(1) "First responder" means an individual employed by a political subdivision of this state who is:

(A) a peace officer under Article 2.12, Code of Criminal Procedure;

(B) a person licensed under Chapter 773, Health and Safety Code, as an emergency care attendant, emergency medical technician, emergency medical technician-intermediate, emergency medical technician-paramedic, or licensed paramedic; or

(C) a firefighter subject to certification by the Texas Commission on Fire Protection under Chapter 419, Government Code, whose principal duties are firefighting and aircraft crash and rescue.

(2) "Post-traumatic stress disorder" means a disorder that meets the diagnostic criteria for post-traumatic stress disorder specified by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, or a later edition adopted by the commissioner of workers' compensation.

(b) Post-traumatic stress disorder suffered by a first responder is a compensable injury under this subtitle only if it is based on a diagnosis that:

(1) the disorder is caused by an event occurring in the course and scope of the first responder's employment; and

(2) the preponderance of the evidence indicates that the event was a substantial contributing factor of the disorder.

HB 1983 also amends **Section 408.006 Mental Trauma Injuries** of the Texas Labor Code as follows:

Section 408.006 Mental Trauma Injuries

...

(b) Notwithstanding Section 504.019, a A mental or emotional injury that arises principally from a legitimate personnel action, including a transfer, promotion, demotion, or termination, is not a compensable injury under this subtitle.

HB 1983 also states the following:

The change in law made by this Act applies only to a claim for workers' compensation benefits based on a compensable injury that occurs on or after the effective date of this Act. A claim based on a compensable injury that occurs before that date is governed by the law as it existed on the date the compensable injury occurred, and the former law is continued in effect for that purpose.

HB 1989 amends **section 407.045 Withdrawal from Self-Insurance** of the Texas Labor Code as follows:

407.045 Withdrawal from Self-Insurance

...

(a-1) For purposes of Subsection (a), an adequate program includes a program in which the certified self-insurer has insured or reinsured all workers' compensation obligations incurred by the self-insurer with an authorized insurer under an agreement that is filed with and approved in writing by the commissioner. The obligations incurred include:

(1) all known claims and expenses associated with those claims; and

(2) all incurred but not reported claims and expenses associated with those claims.

...

HB 2326 amends Subchapter B, Chapter 408 of the Texas Labor Code by adding Section 408.0273 to read as follows:

408.0273. Medical Causation Narrative Report

(a) In this section, “medical causation narrative report” means an original report created by a doctor that explains a causal connection, if any, between a compensable workplace injury and the diagnoses or conditions specified in the insurance carrier’s plain language notice disputing the extent of the injured employee’s compensable injury.

(b) On receipt of a plain language notice from the insurance carrier disputing the extent of an injured employee’s compensable injury, if the employee does not agree with the statements in the plain language notice, the injured employee may request a medical causation narrative report addressing the extent of the employee’s compensable injury from:

(1) the treating doctor; or

(2) a doctor to whom the treating doctor has previously referred the injured employee and who has treated the injured employee.

(c) An insurance carrier is only required to provide reimbursement for one medical causation narrative report for each plain language notice disputing the extent of the injured employee’s compensable injury.

(d) The commissioner shall adopt rules implementing this section to ensure the efficient use of medical causation narrative reports and resolution of disputes regarding the extent of an injured employee’s compensable injury.

HB 2326 also states the following:

The change in law made by this Act applies to a medical causation narrative report requested in response to a plain language notice disputing the extent of the injured employee’s compensable injury that is issued on or after the effective date of this Act, regardless of whether the compensable injury occurred before, on, or after that date.

HB 2546 amends *section 408.025 Reports and Records Required from Health Care Providers* of the Texas Labor Code as follows:

408.025 Reports and Records Required from Health Care Providers

...

(a-1) A treating doctor may delegate to a physician assistant who is licensed to practice in this state under Chapter 204, Occupations Code, the authority to complete and sign a work status report regarding an injured employee’s ability to return to work. The delegating treating doctor is responsible for the acts of the physician assistant under this subsection.

...

SB 877 amends *section 504.053 Election* of the Texas Labor Code as follows:

504.053 Election

...

(e) Nothing in this chapter waives sovereign immunity or creates a new cause of action, ~~except that a political subdivision that self-insures either individually or collectively is liable for attorney’s fees as provided by Section 417.003.~~

SB 1895 amends *section 415.021 Assessment of Administrative Penalties* of the Texas Labor Code as follows:

415.021 Assessment of Administrative Penalties

...

(c) In assessing an administrative penalty:

(1) the commissioner shall consider:

(A) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(B) the history and extent of previous administrative violations;

(C) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(D) the penalty necessary to deter future violations; ~~and~~

(E) whether the administrative violation has negative impact on the delivery of benefits to an injured employee;

(F) the history of compliance with electronic data interchange requirements; and

(G) other matters that justice may require; and

(2) the commissioner shall, to the extent reasonable, consider the economic benefit resulting from the prohibited act.

(c-1) The commissioner shall adopt rules that require the division, in the assessment of an administrative penalty against a person, to communicate to the person information about the penalty, including:

(1) the relevant statute or rule violated;

(2) the conduct that gave rise to the violation; and

(3) the factors considered in determining the penalty.

SB 1895 also states the following:

Section 415.021(c), Labor Code, as amended by this Act, applies only to an administrative violation that occurs on or after the effective date of this Act.

The commissioner of workers’ compensation shall adopt rules under Section 415.021(c-1), Labor Code, as added by this Act, as soon as practicable after the effective date of this Act.

FEDERAL ISSUES

Issue	Update
Congress	Congress will be in session through the Memorial Day holiday, focusing on major public policy issues including changes to the Affordable Care Act, tax reform, and infrastructure funding. The House Financial Services Committee held a hearing in late April proposing changes to the Dodd-Frank Wall Street Reform and Consumer Protection Act. The Creating Hope & Opportunity for Investors, Consumers, and Entrepreneurs (CHOICE Act) includes a provision that would combine the Federal Insurance Office (FIO) with the independent insurance member of the Federal Stability Oversight Council (FSOC) to create a new Office of the Independent Insurance Advocate.
TRIPRA Data Collection—Federal Insurance Office (FIO)	FIO has promulgated regulations for the collection of terrorism data from the industry related to Section 111 of the Terrorism Risk Insurance Program Reauthorization Act (TRIPRA) of 2015. For 2017, FIO will collect high-level terrorism insurance data by May 15 and the remaining required data elements by October 15. NCCI and the California Workers' Compensation Insurance Rating Bureau (WCIRB) have been designated as the sole reporters of workers compensation data. Individual carriers will not be required to submit workers compensation data; however, carriers must still provide reinsurance information as required by the Data Call for all covered lines (including workers compensation).
TRIPRA Data Collection—NAIC	NCCI is engaged with the National Association of Insurance Commissioner's (NAIC) Terrorism Insurance Implementation Working Group (TIIWG) regarding the scope and timing of the 2017 Data Call for terrorism coverage. The scope of data requested in 2017 will be the same as last year. NCCI will once again this year submit the workers compensation data for NCCI states and coordinate with the independent rating bureau states to submit data to the NAIC through the New York State Department of Financial Services portal. As a result of NCCI's coordination with the NAIC, individual carriers were not required to respond to the Data Call for workers compensation coverage.
Private Sector Alternatives to TRIPRA	<p>The Federal Insurance Office (FIO) Advisory Committee on Risk-Sharing Mechanisms (ACRSM) is continuing its work to develop recommendations for private sector alternatives to the current federal backstop approach to insurable losses from large-scale terrorist attacks. At its recent meeting, the ACRSM heard presentations from four stakeholders on the impact of the current Terrorism Risk Insurance Program (TRIP) on direct insurers and large commercial policyholders.</p> <p>The ACRSM heard presentation from a mono line workers compensation carrier on the importance of TRIPRA to the workers compensation line. It has been requested that NCCI provide the ACRSM with additional background information on several questions raised by committee members regarding workers compensation premium charges and the impact of legislative changes to TRIPRA on terrorism insurance rates. ACRSM committee members continue to highlight the need to consider the unique impact of the terrorism peril on workers compensation in any alternative approaches to the current federal backstop.</p>

The bills included in the following section have been filed, but have not yet passed the first chamber.

STATE LEGISLATIVE ACTIVITY

State	Update
Maine	LD 1274 establishes a single-payer health care system in the state, to become effective July 1, 2020. This system would finance health care services for most Maine residents. The bill also proposes that employees whose employers are required under the Maine Workers' Compensation Act of 1992 to provide workers compensation insurance for their employees assume responsibility for payment of all reasonable and necessary medical expenses incurred by workers who suffer injuries or illnesses arising out of and during their employment.
Texas	<p>HB 1983 proposes to expand compensable injuries for certain first responders to include post-traumatic stress disorder. Firefighter and police officer organizations are supporting the bill, which is expected to go to a vote in the House soon.</p> <p>HB 2326 requires carriers to pay doctors the cost of drawing up a medical causation narrative report, which has been estimated at \$150 to \$350. Injured workers tend to request these reports when a carrier disputes the extent of a compensable injury and to avoid unnecessary causation reports. A subsequent amendment to the bill clarified that the compensable report is specifically limited to cases where a carrier sends notice disputing the extent of the compensable injury. This amendment resolved the objections raised by industry representatives, and the bill was moved to the fast-track agenda.</p>

STATE COMMITTEE ACTIVITY

State	Update
Idaho	Idaho's Advisory Committee on Workers Compensation will discuss rule-making related to medical fees and electronic reporting when it meets May 10 in Boise. In addition to a review of recently passed legislative measures, the agenda includes updates on the Commission's ongoing Electronic Data Interchange Claims Release 3.0 efforts and on negotiated rulemaking regarding a study of medical fees.
South Dakota	On April 26, 2017, the South Dakota Department of Labor proposed amendments to increase base unit values and reimbursement amounts within fee schedules impacting hospital and medical services. It will hold a public hearing on May 15, 2017, to consider the adoption and amendment of the proposed changes.

OTHER ITEMS OF INTEREST

State	Update
Missouri	In <i>Gattenby v. Treasurer of the State of Missouri—Custodian of the Second Injury Fund</i> , the Missouri Court of Appeals, Western District, ruled that although the employee's last compensable injury was in March 2014, the Second Injury Fund (SIF) liability provision for injuries occurring after January 1, 2014, did not apply because the appellate court interpreted this provision as requiring both the preexisting and primary/last compensable injury to have occurred after January 1, 2014. In this case, the preexisting injuries occurred prior to 2014. Instead, SIF liability for the employee's permanent total disability (PTD) was based on the provision referring to all cases of permanent disability where there has been previous disability due to injuries occurring prior to January 1, 2014, with respect to the employee's PTD arising from his March 2014 work injury and pre-existing injuries. A request has been made to the state Supreme Court to accept appeal.
South Carolina	On March 8, 2017, the state Supreme Court issued a decision related to PTD in the case of <i>Clemmons v. Lowe's Home Centers</i> . Since 2007, there has been a rebuttable presumption of PTD for injured workers with more than 50% impairment to the back. This recent Supreme Court decision overrules a 2012 Court of Appeals decision by finding that an employee's return to work is not, by itself, enough to rebut the presumption. A Petition for Rehearing was filed on April 7. NCCI is monitoring this case and its potential impact on South Carolina loss costs and rates.
Virginia	Actuarial consulting firm Oliver Wyman delivered the preliminary approved medical fee schedule to the Virginia Medical Fee Schedule Advisory Panel on April 10, 2017. The fee schedule has been posted on the Virginia Workers Compensation Commission's (WCC) website. Public review of the medical fee schedule and comment period via the Commission's website was set for April 10, 2017, to May 10, 2017. A public hearing is scheduled for May 23, 2017, at the WCC office in Richmond. The medical fee schedule will be implemented on January 1, 2018.

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
FL, ID, MT, NV, OR	Peter Burton	610-964-8852
AL, GA, KY, LA, MS	Laura Hart Bryan	225-618-8168
AK, AZ, CO, NM, UT	Maggie Karpuk	818-707-8374
DC, MD, VA, WV	David Benedict	804-380-3005
HI	Carolyn Pearl	808-524-6239
IN, NC, SC, TN	Amy Quinn	803-356-0851
AR, IL, KS, TX	Terri Robinson	501-333-2835
IA, MO, NE, OK, SD	Carla Townsend	314-843-4001
Federal Issues	Tim Tucker	202-403-8526

This report is informational and is not intended to provide an interpretation of state and federal legislation.