



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 includes 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 is included in the first report published each month. This report is issued on a weekly basis throughout the legislative season and provides updates on the content of these bills if and when they progress through the legislative process. This report covers bills from states where NCCI provides ratemaking services (see state list under Contact Information) and the US Congress.*

### BILLS ENACTED

There were no relevant workers compensation-related bills enacted within the one-week period ending February 23, 2018.

### BILLS PASSING SECOND CHAMBER

The following workers compensation-related bills passed the second chamber within the one-week period ending February 23, 2018.

#### Idaho

**HB 366** was:

- Passed by the first chamber on January 31, 2018
- Included in NCCI's February 9, 2018 *Legislative Activity Report* (RLA-2018-06)
- Passed by the second chamber on February 23, 2018

**HB 366** amends **section 72-205. Public Employment Generally—Coverage** of the Idaho Worker's Compensation Law to read as follows:

**72-205. Public Employment Generally—Coverage.** The following shall constitute employees in public employment and their employers subject to the provisions of this law:

...

(9) A work experience student, as that term is defined in section 72-102, Idaho Code, who does not receive wages while participating in the school's work experience program shall be covered by the school district's policy or by the Idaho higher education policy when the work experience student is not covered by the private or governmental entity that is the student's work experience employer.

#### Indiana

**SB 290** was:

- Passed by the first chamber on January 29, 2018
- Included in NCCI's February 9, 2018 *Legislative Activity Report* (RLA-2018-06)
- Passed by the second chamber on February 19, 2018

**SB 290** adds to and amends various provisions of the Indiana Labor and Safety code to:

- Establish a time frame for the payment of compensation under a settlement agreement, a permanent partial impairment agreement, and an award of compensation ordered by a single hearing member of the Worker's Compensation Board (board). It provides that an employer that fails to make a timely payment is subject to a civil penalty.
- Require an employer that has mobile or remote employees to convey information about workers compensation coverage to the employer's employees in an electronic format or in the same manner as the employer conveys other employment-related information. It allows the electronic filing of certain documents with the board.

- Provide that a permanently, totally disabled worker must reapply to the second injury fund for a wage replacement benefit every three years instead of every 150 weeks.
- Require the reporting of workplace injuries needing medical attention beyond first aid instead of injuries causing an absence from work for more than one day. It provides that reporting requirements for workplace injuries are intended to be consistent with the recording requirements set out in the United States Occupational Safety and Health Administration's regulations.
- Change the civil penalty for an employer's failure to provide proof of workers compensation coverage from \$50 per employee to \$100 per day.
- Revise the definition of employer to include corporations, limited liability companies, limited liability partnerships, and other entities that have common control and ownership.
- Establish the assigned risk plan (plan) administered by the Worker's Compensation Rating Bureau (bureau). It provides that the plan may be substantially modified or eliminated only as the General Assembly provides by statute. The bill removes the requirement for representation in the management of the bureau by stock companies and nonstock companies.
- Urge the Legislative Council to assign to an appropriate interim study committee the task of studying increases to the benefit schedules for workers compensation and occupational diseases compensation.
- Make conforming amendments for occupational diseases compensation.

## Mississippi

**SB 2311** was:

- Passed by the first chamber on January 31, 2018
- Included in NCCI's February 9, 2018 *Legislative Activity Report* (RLA-2018-06)
- Passed by the second chamber on February 21, 2018

**SB 2311**, in part, amends **section 71-3-77. Insurance policy regulations** of the Mississippi Worker's Compensation Law to read as follows:

**§ 71-3-77. Insurance policy regulations**

(1) Every contract for the insurance of the compensation herein provided, or against liability therefor, shall be deemed to be made subject to the provisions of this chapter, and provisions thereof inconsistent with this chapter shall be void. Such contract shall be allowed to offer deductibles on all liability of the assured under and according to the provisions of this chapter, notwithstanding any agreement of the parties to the contrary. However, the payments of the claims, including the deductible amounts, shall be made directly from the insurance company to the employee, except for medical benefits which shall be paid to the medical provider. A copy of such payments shall be forwarded to the employer. The insurance company shall collect the deductible from the employer as shall be provided in the contract between the employer and the insurer. No such policy shall be subject to nonrenewal, or cancelled by the insurer within the policy period, until a notice in writing shall be given to the commission and to the insured, fixing the date on which it is proposed to cancel it or declaring that the company does not intend to renew the policy upon expiration date. Notice to the insured shall be served personally or by registered or certified mail. Notice to the commission shall be provided in such manner and on such form as the commission may prescribe or direct. No such cancellation or nonrenewal shall be effective until thirty (30) days after the service of such notice on the insured and the provision of notice to the commission, unless the employer has obtained other insurance coverage, in which case such policy shall be deemed cancelled as of the effective date of such other insurance, whether or not such notice has been given. The notice requirements of this section shall not apply when a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or when transfer of an insured to a licensed affiliate providing the same or substantially similar coverage occurs. Whenever a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or when a transfer of an insured to a licensed affiliate of the insurer providing the same or substantially similar coverage occurs, documents signed by the insured are applicable to the replacement policy and to coverage being transferred, and remain valid and enforceable.

The insured may also cancel such a policy on the day that the insured either (a) returns the policy to the agent, or (b) signs and delivers to the agent a "lost policy release." If the insured desires to cancel a policy before the policy has become effective, he may cancel the policy by written notice of cancellation to the agent or company without return of the policy or a release.

Whenever a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or by a licensed affiliate insurer, such insurer shall mail or deliver to the policyholder, at least thirty (30) days in advance of the effective date of renewal, written notice of any terms or conditions that are less favorable to the policyholder.

A transferring insurer shall notify the Mississippi Insurance Department and the Mississippi Workers' Compensation Commission at least forty-five (45) days in advance of notifying a policyholder that its personal or commercial lines insurance policies will be transferred to another licensed insurer within the same insurance group or same holding company. The notice shall include the name of insurer transferring the personal or commercial lines policies and the name and financial rating of the insurer receiving the transferred personal or commercial lines policies.

A transferring insurer shall provide the policyholder written notice of the policy transfer at least thirty (30) days prior to expiration of the policy term and shall include the financial rating of the insurer receiving the transferred policy. Such notice must be provided to the policyholder with the notice of renewal premium at least thirty (30) days before the effective date of the transfer.

...

(3) As used in this section:

(a) "Affiliate transfer" is when an insurer transfers, at renewal or policy expiration, its personal or commercial lines insurance policies to an affiliated licensed insurer that is a member of the same insurance group or same holding company as the transferring insurer. The issuance of a replacement policy form providing the same or substantially similar coverage issued by the same insurer, or the transfer of personal or commercial insurance policies to a licensed affiliate insurer that will issue the same or substantially similar policy, are considered a renewal and will not be treated as a cancellation or nonrenewal. The affiliate transfer must be to a licensed affiliate insurer that has been determined by the commissioner to have the same or better financial strength as the transferring insurer. The policy transfer must be selected on a nondiscriminatory basis.

(b) "Substantially similar" means a policy that provides the same basic coverages but may add, alter or eliminate incidental coverages and may provide coverages using different textual language.

## Virginia

**HB 82** was:

- Passed by the first chamber on January 22, 2018
- Included in NCCI's February 2, 2018 *Legislative Activity Report* (RLA-2018-05)
- Passed by the second chamber on February 22, 2018

**HB 82** repeals an enactment clause in **section 65.2-1201. Financing; tax** of the Virginia Workers' Compensation Act that provides that the maximum tax rate that may be assessed on insurance carriers or self-insured employers for the purpose of funding workers compensation benefits that are awarded against uninsured employers from the Uninsured Employer's Fund will revert from 0.5% to 0.25% on July 1, 2018. Repealing the enactment will maintain the maximum rate at its current level of 0.5%.

**HB 531** was:

- Passed by the first chamber on January 24, 2018
- Included in NCCI's February 2, 2018 *Legislative Activity Report* (RLA-2018-05)
- Passed by the second chamber on February 22, 2018

**HB 531** amends and reenacts **section 65.2-804. Evidence of compliance with title; notices of cancellation of insurance** of the Virginia Workers' Compensation Act as follows:

**§ 65.2-804. Evidence of compliance with title; notices of cancellation of insurance.**

A1. Each employer subject to this title shall file with the Workers' Compensation Commission, in form prescribed by it, annually or as often as may be necessary, evidence of his compliance with the provisions of § 65.2-801 and all others relating thereto; however, if the employer secures his liability under this title pursuant to subdivision A 1 of § 65.2-801 then the insurance carrier shall make a filing on behalf of the employer, and such filing shall be made electronically in the form as prescribed and to the agent as designated by the Commission, within 30 days of the inception of the policy. Evidence of an employer's compliance with the provisions of subdivision A 1 of § 65.2-801 shall be deemed to satisfy such provisions if it includes the name and address of the insured, the insured's federal employer identification number, his policy number, dates of insurance coverage, the name and address of his insurer, and the insurer's identification number. ~~Proof of coverage information filed with the Commission by an insurance carrier or rate service organization on behalf of an employer shall in no event be aggregated by the Commission with the proof of coverage information filed by or on behalf of other employers.~~ Every employer who has complied with the foregoing provision and has subsequently cancelled his insurance or his membership in a licensed group self-insurance association shall immediately notify the Workers' Compensation Commission of such cancellation, the date thereof and the reasons therefor. Every insurance carrier or group self-insurance association shall in like manner notify the Workers' Compensation Commission immediately upon the cancellation of any policy issued by it or any membership agreement, whichever is applicable, under the provisions of this title, except that a carrier or group self-insurance association need not set forth its reasons for cancellation unless requested by the Workers' Compensation Commission.

...

**HB 558** was:

- Passed by the first chamber on January 24, 2018
- Included in NCCI's February 2, 2018 *Legislative Activity Report* (RLA-2018-05)
- Passed by the second chamber on February 22, 2018

**HB 558** amends and reenacts **sections 65.2-605. Liability of employer for medical services ordered by Commission; fee schedules for medical services; malpractice; assistants-at-surgery; coding** and **65.2-605.1. Prompt payment; limitation on claims** of the Virginia Workers' Compensation Act as follows:

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

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

...

“Medical community” means one of the following six regions of the Commonwealth:

1. Northern region, consisting of the area for which three-digit ZIP code prefixes 201 and 220 through 223 have been assigned by the U.S. Postal Service.
2. Northwest region, consisting of the area for which three-digit ZIP code prefixes 224 through 229 have been assigned by the U.S. Postal Service.
3. Central region, consisting of the area for which three-digit ZIP code prefixes 230, 231, 232, 238, and 239 have been assigned by the U.S. Postal Service.
4. Eastern region, consisting of the area for which three-digit ZIP code prefixes 233 through 237 have been assigned by the U.S. Postal Service.
5. Near Southwest region, consisting of the area for which three-digit ZIP code prefixes 240, 241, 244, and 245 have been assigned by the U.S. Postal Service.
6. Far Southwest region, consisting of the area for which three-digit ZIP code prefixes 242, 243, and 246 have been assigned by the U.S. Postal Service.

The applicable community for providers of medical services rendered in the Commonwealth shall be determined by the zip code of the location where the services were rendered. The applicable community for providers of medical services rendered outside of the Commonwealth shall be determined by the zip code of the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the zip code of the location where the Commission hearing regarding a dispute concerning the services would be conducted.

...

B. The pecuniary liability of the employer for a:

1. Medical, surgical, and hospital service herein required when ordered by the Commission that is provided to an injured person prior to the transition date, regardless of the date of injury, shall be limited absent a contract providing otherwise, to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person. As used in this subdivision, “same community” for providers of medical services rendered outside of the Commonwealth shall be deemed to be the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the location where the Commission hearing regarding the dispute is conducted;

...

**§ 65.2-605.1. Prompt payment; limitation on claims.**

...

~~G. Any health care provider located outside of the Commonwealth who provides health care services under the Act to a claimant shall be reimbursed as provided in this section, and the “same community,” as used in subdivision B 1 of § 65.2-605 for treatment provided prior to the transition date as defined in subsection A of § 65.2-605, shall be deemed to be the principal place of business of the employer if located in the Commonwealth or, if no such location exists, then the location where the Commission hearing regarding the dispute is conducted.~~

~~H.~~ The Commission, by January 1, 2016, shall establish a schedule pursuant to which employers, employers’ workers’ compensation insurance carriers, and providers of workers’ compensation medical services shall be required, by a date determined by the Commission that is no earlier than July 1, 2016, and no later than December 31, 2018, to adopt and implement infrastructure under which (i) providers of workers’ compensation medical services (providers) shall submit their billing, claims, case management, health records, and all supporting documentation electronically to employers or employers’ workers’ compensation insurance carriers, as applicable (payers) and (ii) payers shall return actual payment, claim status, and remittance information electronically to providers that submit their billing and required supporting documentation electronically. The Commission shall establish standards and methods for such electronic submissions and transactions that are consistent with International Association of Industrial Accident Boards and Commission Medical Billing and Payment guidelines. The Commission shall determine the date by which payers and providers shall be required to adopt and implement the infrastructure, which determinations shall be based on the volume and complexity of workers’ compensation cases in which the payer or provider is involved, the resources of the payer or provider, and such other criteria as the Commission determines to be appropriate.

**BILLS PASSING FIRST CHAMBER**

The following workers compensation-related bills passed the first chamber within the one-week period ending February 23, 2018.

**Alabama**

**HB 192**, in part, amends *sections 25-5-60, 25-5-66, 25-5-68, and 25-5-69* of the Alabama Industrial Relations and Labor Code as follows:

**Section 25-5-60 Compensation for death.**

...

**(1) Persons Entitled to Benefits; Amount of Benefits.**

...

e. Except as provided in subdivision (3), if compensation is being paid under this article to any dependent, the compensation shall cease upon the death or marriage of the dependent, unless otherwise provided in this article.

...

**(2) Maximum and Minimum Compensation Awards.** The compensation payable in case of death to persons wholly dependent shall be subject to a maximum and minimum weekly compensation as stated in Section 25-5-68, but if at the time of injury the employee receives earnings of less than the minimum stated in Section 25-5-68, then the compensation shall be the full amount of such earnings per week. The compensation payable to partial dependents shall be subject to a maximum and minimum weekly compensation as stated in Section 25-5-68, but if the income loss of the partial dependents by the death is less than the minimum weekly compensation stated in Section 25-5-68, then the dependents shall receive the full amount of their income loss. This compensation shall be paid during dependency, not exceeding 500 weeks, except as provided in subsection (f) of Section 25-5-68. Payments shall be made at the intervals when the earnings were payable, as nearly as may be, unless the parties otherwise agree.

(3) If a dependent is the surviving spouse of a law enforcement officer or firefighter killed as a result of injuries received while engaged in the performance of his or her duties, the compensation does not cease upon remarriage.

**Section 25-5-66 Disposition of compensation upon remarriage of widow of employee who has another dependent.**

(a) In case of the remarriage of a widow the surviving spouse of an employee who has another dependent, the unpaid balance of compensation, which would otherwise become due her, shall be paid to the dependent or may, on approval by the court, be paid to some suitable person designated by the court for the use and benefit of the dependent. Payment to that person shall discharge the employer from any further liability.

(b) Subsection (a) does not apply to the surviving spouse of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties.

**Section 25-5-68 Maximum and minimum weekly compensation.**

...

(d) In no event, except as provided for permanent total disability in subdivision (a)(4) of Section 25-5-57 or except for compensation benefits payable for permanent partial and temporary total disability in connection with a disability scheduled in subdivisions (1) and (3) of subsection (a) of Section 25-5-57 or except as provided in subsection (f), shall the total amount of compensation payable for an accident or an occupational disease exceed the product of 500 times the maximum weekly benefit applicable on the date of the accident.

...

(f) Notwithstanding any other provision of this article, the compensation benefits payable to a surviving dependent child of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties shall not discontinue at least until the dependent child reaches the age of 18 years.

**Section 25-5-69 Compensation to cease upon death or marriage of dependent; proportional benefits for dependents.**

Except when the dependent is the surviving spouse of a law enforcement officer or firefighter who was killed as a result of injuries received while engaged in the performance of his or her duties, if compensation is being paid under this article to any dependent, such compensation shall cease upon the death or marriage of such dependent. Where compensation is being paid under this chapter to any dependent, in no event shall such dependent receive more than the proportion which the amount received of the deceased employee's income during his or her life bears to the compensation provided under this article.

**Arizona**

**SB 1100 amends *section 23-941.01 Settlement of claims; full and final; exception; definitions* and adds new *section 23-941.03. Settlement of claims; supportive medical maintenance benefits; definition* of the Arizona Revised Statutes as follows:**

**23-941.01. Settlement of claims; full and final; exception; definitions**

A. The interested parties to a claim may:

1. Settle and release all or any part of an accepted claim for compensation, benefits, penalties or interest.
2. If the period of temporary disability is terminated by the carrier, special fund or self insured employer a final notice of claim status, award of the commission or stipulation of the interested parties, negotiate a full and final settlement of an accepted claim.

B. Any full and final settlement shall:

1. Be in writing.
2. Be signed by the carrier, special fund or self-insured employer or an authorized representative of the carrier, special fund or self-insured employer and the employee or the employee's authorized representative.
3. Acknowledge that the employee had the opportunity to seek legal advice and be represented by counsel.

4. Include a description of the employee's medical conditions that have been identified and contemplated at the time of the settlement agreement.
5. Have attached the information provided by the carrier, special fund or self-insured employer pursuant to subsection c, paragraphs 2 and 3 of this section.
- C. ~~If the employee is represented by counsel, the~~ A full and final settlement shall include the following signed attestations:
1. ~~The employee understands the rights settled and released by the agreement and was represented by counsel.~~
  2. ~~The employee has been provided information from the carrier, special fund or self-insured employer that outlines any reasonable anticipated future medical, surgical and hospital benefits relating to the claim, and the projected cost of those benefits, and that provides an explanation of how those projected costs were determined and a disclosure of the amount of the settlement that represents the settlement of future medical, surgical and hospital benefits.~~
  3. ~~The employee has been provided information from the carrier, special fund or self-insured employer that discloses the total amount of future indemnity benefits, the employee's rated age, if applicable, the employee's life expectancy, the source of the employee's life expectancy, the present value of future indemnity benefits, the discount rate used to calculate present value and the amount of the settlement that represents the settlement of future indemnity benefits.~~
- ~~3- 4.~~ The employee understands that monies received for future medical treatment associated with the industrial injury should be set aside to ensure that the costs of such the treatment will be paid.
- ~~4- 5.~~ The parties have considered and taken reasonable steps to protect any interests of medicare, medicaid, the Indian health service and the United States department of veterans affairs, including establishing a medicare savings account if necessary.
- ~~5- 6.~~ The parties have conducted a search for and taken reasonable steps to satisfy any identified medical liens and unpaid medical charges.
7. Coercion, duress, fraud, misrepresentation or undisclosed additional agreements have not been used to achieve the full and final settlement.
- D. ~~If the employee is not represented by counsel, the employee shall appear before an administrative law judge of the commission and the administrative law judge shall make specific factual findings regarding whether the requirements of subsection subsections B and C subsection C, paragraphs 2, 3, 4 and 5 of this section are satisfied. The administrative law judge may not approve the settlement if the requirements of subsection B of this section are not met or if the settlement is not deemed fair and reasonable to the employee. The administrative law judge shall conduct a hearing and perform a detailed inquiry into the attestations provided by the unrepresented employee pursuant to subsection C of this section. The inquiry shall include whether the unrepresented employee understands the specific rights being settled and released, the information, computation and methodology provided by the carrier, special fund or self-insured employer, and the employee's responsibility to protect the interests of other payors and ensure the payment of future treatment costs.~~
- ~~E. A full and final settlement is not valid and enforceable unless the full and final settlement is approved by the commission. When determining whether to approve a settlement, the commission shall consider whether the settlement is in the best interests of the employee based on the following criteria:~~
- ~~1. Whether the employee's injuries are stabilized.~~
  - ~~2. The permanency of the employee's injuries.~~
- ~~E. The commission may not approve a full and final settlement if the requirements of subsections B and C of this section are not met.~~
- F. ~~A lump sum full and final settlement payment shall be made to the employee within fifteen days after the award approving the settlement becomes final.~~
- ...

**23-941.03. Settlement of claims; supportive medical maintenance benefits; definition**

- A. Any final settlement agreement involving undisputed entitlement to supportive medical maintenance benefits is not valid and enforceable until the final settlement agreement is approved by the commission.
- B. The commission may approve a final settlement agreement involving undisputed entitlement to supportive medical maintenance benefits if the requirements of this section are satisfied.
- C. Subject to the following requirements, the interested parties to a claim may enter into a final settlement and release of a claim for undisputed entitlement to supportive medical maintenance benefits after the period of temporary disability is terminated by a final notice of claim status or award of the commission. The carrier, special fund or self-insured employer shall submit a summary of all reasonably anticipated future supportive medical maintenance benefits and the projected cost of the benefits for review by the employee. The summary shall also be included with the final settlement agreement filed with the commission. All medical conditions subject to the final settlement agreement must be described in the final settlement agreement. The final settlement provisions defined in this subsection shall apply only to future supportive medical maintenance benefits for the described condition.
- D. The carrier, special fund or self-insured employer shall inform the attending physician of the approval of a final settlement agreement. Unless supportive medical maintenance benefits rendered before the date of the final settlement are subject to a dispute or payment for the treatment was included in the final settlement agreement, the carrier, special fund or self-insured

employer shall remain responsible for payment for the treatment not covered by the final settlement agreement as provided by this chapter.

E. This section does not prohibit a settlement that does not constitute a final settlement.

F. For the purposes of this section, "final settlement" means a settlement in which the injured worker waives any future entitlement to supportive medical maintenance benefits for known conditions described in the agreement.

**HB 2501**, in part, creates new **section 23-1106. Posttraumatic stress disorder; first responders; presumption; definition**, and amends **sections 23-901. Definitions**, and **23-1061. Notice of accident; form of notice; claim for compensation; reopening; payment of compensation** of the Arizona Revised Statutes, as follows:

**23-1106. Posttraumatic stress disorder; first responders; presumption; definition**

A. Posttraumatic stress disorder is presumed to be an occupational disease as described in section 23-901, paragraph 13, subdivision (c), compensable pursuant to section 23-1043.01 and deemed to arise out of and in the course of employment if all of the following apply:

1. The first responder is receiving or has received licensed counseling pursuant to section 38-672.

2. The licensed mental health professional providing treatment pursuant to section 38-672 determines that the first responder has posttraumatic stress disorder resulting from the performance of the first responder's job duties.

B. The presumption provided in subsection a of this section may be rebutted by a preponderance of the evidence that there is a specific cause of the posttraumatic stress disorder other than the service-connected exposure.

C. For the purposes of this section, "first responder" means any of the following:

1. A peace officer who is eligible to receive treatment pursuant to section 38-672.

2. A firefighter who is eligible to receive treatment pursuant to section 38-672.

3. A rescue or ambulance worker who is a member of any public retirement system and who is eligible to receive treatment pursuant to section 38-672.

**23-901. Definitions**

...

13. "Personal injury by accident arising out of and in the course of employment" means any of the following:

...

(c) An occupational disease that is due to causes and conditions characteristic of and peculiar to a particular trade, occupation, process or employment, and not the ordinary diseases to which the general public is exposed, and subject to any of the following:

(i) Section 23-901.01. ~~or,~~

(ii) For heart-related, perivascular or pulmonary cases, section 23-1105.

(iii) For posttraumatic stress disorder cases, section 23-1106.

14. "Posttraumatic stress disorder" has the same meaning prescribed in the most recent edition of The Diagnostic and Statistical Manual of Mental Disorders for the American Psychiatric Association.

...

**23-1061. Notice of accident; form of notice; claim for compensation; reopening; payment of compensation**

A. Notwithstanding section 23-908, subsection E, ~~no~~ a claim for compensation ~~shall be~~ is not valid or enforceable unless the claim is filed with the commission by the employee, or if resulting in death by the parties entitled to compensation, or someone on their behalf, in writing within one year after the injury occurred or the right thereto accrued. The time for filing a compensation claim begins to run when the injury becomes manifest or when the claimant knows or in the exercise of reasonable diligence should know that the claimant has sustained a compensable injury, except an employee who is receiving active treatment pursuant to section 38-672 has one year after the date of the last licensed counseling visit pursuant to section 38-672 to file a compensation claim. Except as provided in subsection B of this section, ~~neither the commission nor any or a court shall~~ does not have jurisdiction to consider a claim ~~which that~~ is not timely filed under this subsection, except if the employee or other party entitled to file the claim has delayed in doing so because of justifiable reliance on a material representation by the commission, employer or insurance carrier or if the employee or other party entitled to file the claim is insane or legally incompetent or incapacitated at the time the injury occurs or the right to compensation accrues or during the one-year period thereafter. If the insanity or legal incompetence or incapacity occurs after the one-year period has commenced, the running of the remainder of the one-year period ~~shall be~~ is suspended during the period of insanity or legal incompetence or incapacity. If the employee or other party is insane or legally incompetent or incapacitated when the injury occurs or the right to compensation accrues, the one-year period commences to run immediately ~~upon~~ on the termination of insanity or legal incompetence or incapacity. The commission ~~upon~~ on receiving a claim shall give notice to the carrier.

...

J. The commission shall investigate and review any claim in which it appears to the commission that the claimant has not been granted the benefits to which ~~such~~ the claimant is entitled. If the commission determines that payment or denial of compensation is improper in any way, it shall hold a hearing pursuant to section 23-941 within sixty days after receiving notice of such impropriety. Any claim for temporary partial disability benefits under this subsection must be filed with the commission within two

years after the date the claimed entitlement to compensation accrued or within two years after the date on which an award for benefits encompassing the entitlement period becomes final. A claim for temporary partial disability compensation shall be deemed to accrue when the employee knew or with the exercise of reasonable diligence should have known that the carrier, self-insured employer or special fund denied or improperly paid compensation. A claim for temporary partial disability benefits shall not be deemed to have accrued any earlier than the effective date of this amendment to this subsection September 26, 2008.

...

## Georgia

**HB 789** amends ~~sections 34-1-1. Redesignated~~, and **34-8-35. Employment** of the Official Code of Georgia Annotated as follows:

### **§ 34-1-1. Redesignated.**

(a) As used in this Code section, the term:

(1) 'Customer' means a person that uses a marketplace platform to connect with a marketplace contractor to obtain services.

(2) 'Digital network' means a website or smartphone application.

(3)(A) 'Marketplace contractor' means a person that:

(i) Enters into an agreement with a marketplace platform to use such platform's digital network to receive connections to customers seeking services; and

(ii) Offers or provides services to such customers for compensation.

(B) The term shall not include any person performing services that consist of transporting freight or sealed or closed containers, envelopes, or boxes for compensation.

(4)(A) 'Marketplace platform' means a person operating in this state that:

(i) Uses a digital network to connect customers to a marketplace contractor for the purpose of providing services to customers for compensation; and

(ii) Accepts service requests from customers only through such platform's digital network and does not accept service requests in person at physical retail locations, by telephone, or by facsimile.

(B) The term shall not include any person whose digital platform accepts service requests for transporting freight or sealed or closed containers, envelopes, or boxes.

(5) 'Person' means an individual, corporation, partnership, sole proprietorship, or other entity.

(b) A marketplace contractor shall be treated as an independent contractor of a marketplace platform, and not as an employee, for all purposes under state and local laws, rules, regulations, ordinances, and resolutions, except for purposes of workers' compensation pursuant to Chapter 9 of this title, if all of the following conditions are met:

(1) The marketplace platform and marketplace contractor agree in writing that the marketplace contractor is an independent contractor with respect to the marketplace platform;

(2) The marketplace platform does not unilaterally prescribe specific hours during which the marketplace contractor must be available to accept service requests submitted by customers through the marketplace platform's digital network;

(3) The marketplace platform does not prohibit the marketplace contractor from using any digital network offered by other marketplace platforms;

(4) The marketplace platform does not restrict the marketplace contractor from engaging in any other occupation or business;

(5) The marketplace contractor bears all or substantially all of its own expenses that are incurred in performing its services;

(6) The marketplace platform does not restrict the marketplace contractor to a specific territory or geographic area; provided, however, that the marketplace platform may require the marketplace contractor to complete a registration process to provide services in a new territory or geographic area; and

(7) The marketplace platform does not permit the marketplace contractor to perform any of the service requests at or from a physical business location operated by the marketplace platform.

(c) This Code section shall not apply to:

(1) Services performed by a marketplace contractor in the employ of a marketplace platform that is a state, a political subdivision of a state, an Indian tribe, or wholly owned by one or more states, political subdivisions, or Indian tribes, provided that such services are excluded from employment as such term is defined in the Federal Unemployment Tax Act by Section 3306(c)(7) of such Act, as it existed on February 1, 2018; or

(2) Services performed by a marketplace contractor in the employ of a marketplace platform that is a religious, charitable, educational, or other organization, provided that such services are excluded from employment as such term is defined in the Federal Unemployment Tax Act by Section 3306(c)(8) of such Act, as it existed on February 1, 2018.

(d) Nothing in this Code section shall be construed to prohibit a marketplace contractor from being treated as an independent contractor and not as an employee under any other provision of law if the conditions of subsection (b) of this Code section are not met.

### **§ 34-8-35. Employment**

...

(n) The term "employment" shall not include:

...  
(19) Services performed by a marketplace contractor treated as an independent contractor of a marketplace platform pursuant to Code Section 34-1-1.

## Kentucky

**HB 2** amends numerous sections of the Kentucky Workers Compensation Law to:

- Limit the time period of payment of medical expenses for certain permanent partial disabilities to 780 weeks, but provide a mechanism to apply for extended benefits
- Limit the number of drug screens for which the employer will be liable
- Specify circumstances upon which utilization review can be waived
- Mandate promulgation of treatment guidelines and a pharmaceutical formulary
- Clarify that a fee must not be charged when an injured worker requests the initial copy of medical records
- Indicate that interest will not accrue when the delay in payment of benefits was caused by the employee
- Clarify that the four-year period in which to reopen a claim begins on the date of the original order granting or denying benefits and that subsequent orders granting or denying benefits must not be considered an original order
- Indicate that an application for adjustment of claim for compensation for a cumulative trauma injury must be made within five years of the last injurious exposure to the cumulative trauma
- Require the commissioner of the Department of Workers' Claims to promulgate regulations establishing procedures for resolution of claims
- Include pulmonary specialist as an examiner
- Change the procedure for filing occupational disease claims
- Change the calculation of attorney fees and increase limitation on the amount of fees
- Indicate that the employee must show that the voluntary introduction of a substance into his or her body that causes a disturbance of mental or physical capacities was not the proximate cause of his or her injury
- Allow the recovery in subrogation of indemnity and medical expenses paid to or on behalf of the employee, less a pro rata share of the employee's legal expenses
- Increase average weekly wage caps
- Set time limits for total disability benefits paid to certain professional athletes
- Allow payment of temporary total disability benefits to be offset by gross income minus applicable taxes paid to an employee during a period of light-duty work or work in an alternative job position
- Provide an offset against temporary total disability benefits for salary continuation or wholly employer-funded disability retirement plans
- Indicate that benefits shall terminate when a plaintiff reaches age 67, or two years after the date of injury, whichever occurs last
- Require employment for a minimum of one year to be the responsible employer in a hearing loss claim
- Set forth parameters for retraining
- Delete provisions requiring the commissioner of the Department of Workers' Claims to adopt regulations regarding the "B" reader process
- Require the commissioner of the Department of Workers' Claims to maintain a list of "B" readers who are pulmonary specialists
- Specify the applicability of substantive changes to claims arising on or after the effective date of the Act and remedial changes to all claims irrespective of the injury date

## Maryland

**SB 48** amends *section 9-628. Compensation for less than 75 weeks* of the Maryland Workers Compensation Law, related to permanent partial disability benefits, to read as follows:

**§ 9-628. Compensation for less than 75 weeks.**

...

**(a) "Public safety employee" defined.—**

In this section, "public safety employee" means:

...

(9) a Baltimore County deputy sheriff, but only when the deputy sheriff sustains an accidental personal injury that arises out of and in the course and scope of performing duties directly related to:

- (i) courthouse security;
- (ii) prisoner transportation;
- (iii) service of warrants;
- (iv) personnel management; or
- (v) other administrative duties; or

(10) a state correctional officer.

...

## New Hampshire

**HB 1740** amends **sections 141-G:15 Costs**, and **141-G:19 Rules** of the New Hampshire Public Health Code as follows:

**141-G:15 Costs.**—Subject to rules adopted by the commissioner under RSA 141-G:19, an applicant’s workers’ compensation insurance carrier shall be responsible for paying the costs relating to a testing order. ~~Subject to rules adopted by the commissioner under RSA 141-G:19, the private health or automobile insurance of an applicant who does not have access to workers’ compensation insurance which would cover medication for prophylaxis against potential bloodborne pathogens shall be responsible for paying the costs relating to a testing order of the test, including charges of the health care facility taking the blood sample and the charges of the laboratory for the analysis of the sample.~~ An applicant without insurance coverage may request testing under this subdivision, however, he or she shall be responsible for paying for the testing order and may be required to pay for testing in advance.

**141-G:19 Rules.**—

...

II. The commissioner shall adopt rules under RSA 541-A, relative to:

...

(k) Circumstances in which workers’ compensation insurance, and the government, ~~and private health or automobile insurance~~ shall be responsible for paying the costs referred to in RSA 141-G:15.

...

## Oregon

**HB 4093** creates and amends various sections of the Oregon Revised Statutes, including, but not limited to creating new **section 1** below amending **section 656.027 Who are subject workers** of the Workers Compensation Law as follows:

**Section 1.** (1) As used in this section:

(a) “Amateur athlete” means an individual who:

(A)(i) Has been declared an amateur athlete under the rules of the United States Olympic Committee or the Canadian Olympic Committee; or

(ii) Participates in training or conditioning for, and participating in, amateur sports activities, events or competitions for a team, league, club or association included in the report made available under subsection (3) of this section; and

(B) Receives no remuneration for performance of services as an athlete while actively engaged in training or conditioning for, or participating in, amateur sports activities, events or competitions other than board, room, rent, housing, lodging or other reasonable incidental subsistence allowance.

(b) “Amateur sports organization” means a group or association that fosters amateur sports activities and competitions for amateur athletes and is organized under a regional, national or international certifying authority.

(2)(a) On or before January 1 of each year, an amateur sports organization shall submit to the Director of the Department of Consumer and Business Services a report that includes the following information:

(A) A list of the names, addresses and any other contact information for the regional, national and international certifying authority that has certified the organization as an amateur sports organization; and

(B) A roster that lists the names, addresses and other contact information for each team, league, club and association that is affiliated with or governed by the amateur sports organization and that participates in amateur sports activities, events or competitions in this state.

(b) Upon request, an amateur sports organization shall make copies of the report available to interested persons.

(3) The director shall make available to the public the reports submitted to the Department of Consumer and Business Services under subsection (2) of this section.

(4) For the purposes of section 8 of this 2018 Act, the provisions of ORS 656.027 and ORS chapters 652 and 653, an individual is an amateur athlete during the time in which the individual is actively engaged in training or conditioning for, or participating in, amateur sports activities, events or competitions.

**Section 2. ORS 656.027 Who are subject workers.**

All workers are subject to this chapter except those nonsubject workers described in the following subsections:

...

(7)(a) Sole proprietors, except those described in paragraph (b) of this subsection. When labor or services are performed under contract, the sole proprietor must qualify as an independent contractor to be a nonsubject worker under this subsection.

(b) Sole proprietors actively licensed under ORS 671.525 or 701.021. When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the sole proprietor must qualify as an independent contractor to be a nonsubject worker under this subsection. Any sole proprietor licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(8) Except as provided in subsection (23) of this section, partners who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto. When labor or services are performed under contract, the partnership must qualify as an independent contractor to be a nonsubject worker under this subsection.

(9) Except as provided in subsection (25) of this section, members, including members who are managers, of limited liability companies, regardless of the nature of the work performed. However, members, including members who are managers, of limited liability companies with more than one member, while engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto, are subject workers. When labor or services are performed under contract, the limited liability company must qualify as an independent contractor to be a nonsubject worker under this subsection.

(10) Except as provided in subsection (24) of this section, corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officers, subject to the following limitations:

...  
(c) When labor or services are performed under contract, the corporation must qualify as an independent contractor to be a nonsubject worker under this subsection.

...  
~~(13) A person who has been declared an amateur athlete under the rules of the United States Olympic Committee or the Canadian Olympic Committee and who receives no remuneration for performance of services as an athlete other than board, room, rent, housing, lodging or other reasonable incidental subsistence allowance, or~~

(13)(a) An amateur athlete as defined in section 1 of this 2018 Act; or

(b) Any amateur sports official who is certified by a recognized Oregon or national certifying authority, which requires or provides liability and accident insurance for such officials. A roster of recognized Oregon and national certifying authorities will be maintained by the Department of Consumer and Business Services, from lists of certifying organizations submitted by the Oregon School Activities Association and the Oregon Park and Recreation Society.

...

**HB 4093** also includes the following clause:

Nothing in section 1 or 8 of this 2018 Act or the amendments to statutes by sections 2 to 6 of this 2018 Act is intended to apply to student athletes as defined in ORS 702.005.

## Utah

**SB 64** amends *sections 34A-2-107, 34A-2-407, and 34A-2-705* of the Utah Workers' Compensation Act as follows:

**34A-2-107. Appointment of workers' compensation advisory council—Composition—Terms of members—Duties—Compensation.**

(1) The commissioner shall appoint a workers' compensation advisory council composed of:

...

(b) the following nonvoting members:

...

(iv) the Utah insurance commissioner or the insurance commissioner's designee; ~~and~~

(v) the commissioner or the commissioner's designee; and

(vi) a representative of hospitals.

...

~~(7) The council shall study how hospital costs may be reduced for purposes of medical benefits for workers' compensation. By no later than November 30, 2017, the council shall submit, in accordance with Section 68-3-14, a written report to the Business and Labor Interim Committee containing the council's recommendations.~~

(7) (a) The council shall:

(i) study how to reduce hospital costs for purposes of medical benefits for workers' compensation;

(ii) study hospital billing and payment trends under Subsection 34A-2-407(11)(c);

(iii) study hospital fee schedules used in other states; and

(iv) collect information from third-party hospital review companies in the state or region, to identify an average reimbursement rate that represents the approximate rate at which a workers' compensation insurance carrier or self-insured employer should expect to reimburse a hospital for billed hospital fees for covered medical services in the state.

(b) In accordance with Section 68-3-14, the council shall submit a written report to the Business and Labor Interim Committee no later than September 1, 2019, 2020, and 2021. The council's written report shall include:

(i) recommendations on how to reduce hospital costs for purposes of medical benefits or workers' compensation;

(ii) aggregate data on hospital billing and payment trends under Subsection 34A-2-407(11)(c);

(iii) the results of the council's study of hospital fee schedules from other states; and

(iv) the approximate rate at which a workers' compensation insurance carrier or self-insured employer should expect to reimburse a hospital for billed hospital fees for covered medical services, calculated in accordance with Subsection (7)(a)(iv).(c) For each report described in Subsection (7)(b), the commission may contract with a third-party expert to assist with the council's duties described in Subsections (7)(a) and (b).

(c) For each report described in Subsection (7)(b), the commission may contract with a third-party expert to assist with the council's duties described in Subsections (7)(a) and (b).

...

#### **34A-2-407. Reporting of industrial injuries—Regulation of health care providers.**

...

(11) (a) As used in this Subsection (11):

...

(c) Subject to Subsection (11)(d), for the time period beginning on May 10, 2016 ~~8, 2018~~, and ending on July 1, 2018 ~~2022~~, a workers' compensation insurance carrier or self-insured employer that is reimbursing a hospital ~~that has not entered into a contract described in Subsection (11)(b) shall reimburse the hospital for covered medical services at 85% of the billed hospital fees for the covered medical services.~~ shall reimburse the hospital:

(i) in accordance with a contract described in Subsection (11)(b); or

(ii) at 77% of the billed hospital fees for the covered medical services.

(d) A hospital may not engage in balance billing.

...

#### **34A-2-705. Industrial Accident Restricted Account.**

...

(4) (a) From money appropriated by the Legislature from the account to the commission and subject to the requirements of this section, the commission may fund:

(i) the activities of the Division of Industrial Accidents described in Section 34A-1-202;

(ii) the activities of the Division of Adjudication described in Section 34A-1-202; ~~and~~

(iii) the activities of the commission described in Section 34A-2-1005[-]; ~~and~~

(iv) the activities of the commission described in Subsection 34A-2-107(7)(c), up to \$50,000 for each of the three reports described in Subsection 34A-2-107(7)(b).

...

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

## **STATE LEGISLATIVE ACTIVITY**

<b>State</b>	<b>Update</b>
<b>Florida</b>	<p>Various legislative committees have passed two previously reported measures dealing with mental injury with respect to first responders. Both measures, <b>HB 227</b> and <b>SB 376</b>, provide indemnity benefits, in addition to currently available medical benefits, in specified circumstances for post-traumatic stress disorder (PTSD) suffered by a first responder regardless of whether their PTSD is accompanied by a physical injury requiring medical treatment.</p> <p><i>NCCI estimates that the enactment of either of these bills may result in an indeterminate increase in system costs for first responder classifications in Florida. The impact on overall privately insured workers compensation system costs, however, is expected to be minimal, since data reported to NCCI shows that first responder classifications represent approximately 2% of losses in Florida.</i></p> <p>Listed below are other workers compensation-related measures passed by various legislative committees:</p> <ul style="list-style-type: none"><li>• <b>HB 1437/SB 648</b> relate to employment services for persons with disabilities; the bills specify that participants in certain disabled persons work experience activities are considered state employees for workers compensation purposes</li><li>• <b>SB 280</b> concerns telehealth; this measure was replaced by a Committee Substitute bill, which removed the provision encouraging workers compensation insurers to include telehealth services in certain rating plans</li><li>• <b>SB 1412</b> requires the salary of a judge of compensation claims to be equal to the salary of a county court judge, which is currently higher than the salary of a judge of compensation claims</li><li>• <b>SB 1568</b> provides that any statements of an employee provided to an employer/carrier containing incomplete or inaccurate information or documentation of an employee's citizenship, residency, or other</li></ul>

	<p>employment status may not constitute a basis for denying compensation or benefits under chapter 440 of the Florida Statutes</p> <ul style="list-style-type: none"> <li>• <b>SB 1866</b> authorizes the issuance of a “qualified shared underwriting result participation program” between a qualified insured and a qualified reinsurer wherein the qualified insured participates in the underwriting profit or risk associated with a base workers’ compensation insurance policy.</li> </ul>
<p><b>Illinois</b></p>	<p><b>HB 4389</b> creates the Workers’ Compensation Transparency Task Force, and provides that the Task Force must collect and review information and data on the effects of the changes in workers compensation law enacted by the General Assembly. The purpose of the collection and review of information is to make as transparent as possible all information relating to the medical treatment, legal representation, and benefits paid to injured workers in the state. It requires insurers, advisory organizations, medical providers, and attorneys involved in the provision of services to persons covered under the workers compensation laws to report data and information to the Task Force on an annual basis, some of which may not be readily available.</p> <p><b>HB 4432/SB 2863</b>, in part:</p> <ul style="list-style-type: none"> <li>• Provide 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</li> <li>• Establish prior approval of rates when deviations are filed</li> <li>• Provide that accidental injuries sustained while traveling to or from work do not arise out of and in the course of employment</li> <li>• Permit 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, and requires insurers to recalculate rates in consideration of such programs</li> <li>• Provide that (1) injuries to the shoulder must be considered injuries to part of the arm and (2) injuries to the hip must be considered injuries to part of the leg</li> <li>• These bills reintroduce provisions of <b>HB 2525</b>, which was vetoed by the governor in 2017</li> </ul> <p><b>HB 4595/SB 2973</b>, in part:</p> <ul style="list-style-type: none"> <li>• Create the Illinois Employers Mutual Insurance Company Article in the Code and establishes Illinois Employers Mutual Insurance Company (the Company) as a nonprofit, independent public corporation</li> <li>• Provide that after the effective date of the amendatory Act, the Director of Insurance must make a loan of \$10,000,000 to the Company from the Illinois Workers’ Compensation Commission Operations Fund for the start-up funding and initial capitalization of the Company</li> <li>• Provide that the Company: <ul style="list-style-type: none"> <li>a. Must be operated as a domestic mutual insurance company, subject to all applicable provisions of the Code</li> <li>b. Must issue insurance for workers compensation and occupational disease and must not provide any other type of insurance</li> <li>c. Must not be considered a state agency or instrumentality of the state for any purpose, and</li> <li>d. Must not receive any state appropriations or funds, except for an initial loan or loans</li> </ul> </li> </ul> <p>These bills reintroduce provisions of <b>HB 2622</b>, which was vetoed by the governor in 2017.</p> <p><b>HB 5050</b></p> <ul style="list-style-type: none"> <li>• Establishes compensation for certain shoulder injuries to be 253 weeks</li> <li>• Limits total compensation for all injuries to an individual employee to 500 weeks, including consideration of compensation for prior injury</li> <li>• Provides that a decision by the Illinois Workers’ Compensation Commission shall be based upon the most current edition of the American Medical Association’s <i>Guides to the Evaluation of Permanent Impairment</i></li> </ul> <p><b>HB 5354</b></p> <ul style="list-style-type: none"> <li>• Limits the scope of the term “arising out of and in the course of employment”</li> <li>• Makes changes regarding recovery when an employee is travelling</li> <li>• Increases the duration of the period of temporary total incapacity necessary for recovery</li> <li>• Provides that injuries to the shoulder and hip are considered to be injuries to the arm and leg, respectively</li> <li>• Provides for the implementation of a closed formulary for prescription medicine</li> <li>• Provides for a penalty for vexatious delay in payment of benefits</li> </ul>

	<ul style="list-style-type: none"> <li>Increases criminal penalties for specified unlawful acts</li> <li>Requires the Workers' Compensation Commission to provide annual reports to the governor and General Assembly regarding self-insurance</li> <li>Amends the Freedom of Information Act to exempt certain workers' compensation related information from the scope of that Act</li> </ul> <p><b>SB 2335</b> directs that an accidental injury that results from repetitive or cumulative trauma and that occurs within six months after the employee begins employment must not be considered by a workers compensation insurer in setting rates. Provides for contribution by prior employers with respect to awards for repetitive or cumulative injuries.</p> <p><b>SB 3091</b> provides that, except for awards for certain medical costs, an arbitrator must reduce awards based on the degree to which the work-related injury resulted from the claimant's actions or a preexisting condition.</p>
<b>Missouri</b>	<p><b>HB 1554</b> would allow medical cannabis to be used for certain ailments.</p> <p><b>HB 1656/SB 600/HB 2075</b> creates the Professional Employer Organization Registration Act that would specify definitions, registration, liability, and reporting requirements for the industry.</p> <p><b>SB 601</b> would create a mandate for the Division of Workers Compensation to implement a medical fee schedule. A hearing was conducted on February 20, 2018.</p> <p><b>SB 621</b> expands the presumption of certain occupational disease to volunteer firefighters to coincide with the same presumption for paid firefighters. The bill also broadens occupational disease to include cancer. A hearing was conducted on February 6, 2018.</p> <p><b>SB 735</b> eliminates monetary bonuses from being considered as payroll for workers compensation premium (up to 3% of the employee's yearly compensation) along with employer contributions to retirement accounts (which is an existing exclusion per NCCI's manual rules). A hearing was held January 23, 2018, where NCCI submitted its analysis for information only.</p> <p><b>SB 736</b> prohibits the conditioning of eligibility for certain contracts to be contingent on experience rating for state and utility contracts. A hearing was conducted on February 7, 2018.</p>
<b>Nebraska</b>	<p><b>LB 928</b> would amend the maximum burial benefit from \$10,000 to 14 times the state average weekly wage. A hearing was conducted February 5, 2018. <i>If enacted, NCCI estimates that overall system costs in Nebraska would increase negligibly.</i></p> <p><b>LB 1015</b> would, under the Nebraska Workers' Compensation Act, allow withholding, from the public, reports of injury that reveal an employee's identity. A hearing was conducted February 14, 2018.</p>
<b>New Hampshire</b>	<p><b>SB 508</b> has been amended to change the composition of the taskforce that would be assigned to study the prevalence of PTSD for first responders.</p>
<b>Oklahoma</b>	<p><b>SB 1340</b> proposes comprehensive reform including, but not limited to:</p> <ul style="list-style-type: none"> <li>Redefining of terms and provisions of injury and occurrence</li> <li>Codifying language resulting from previous court decisions</li> <li>Codifying the use of the Sixth Edition of the American Medical Association's <i>Guides to the Evaluation of Impairment</i></li> <li>Lifting exclusive remedy where the employer did not secure coverage</li> <li>Commutation of permanent total disability, permanent partial disability, choice of physician, and occupational disease</li> </ul> <p><b>SB 1460</b> proposes to increase the required payment from 3/4 of 1% to 1.5% of workers compensation losses to the Oklahoma Tax Commission.</p>
<b>South Dakota</b>	<p><b>SB 145</b> proposes to deem the Department of Labor and Regulation as the exclusive fact finder and assessor in workers compensation cases of determination of whether a wrongful act, omission, wrongful denial, or refusal to pay a loss was vexatious, without reasonable cause, or in bad faith; the bill removes tort action in such cases and specifies administrative oversight. After a public hearing held on February 13, 2018, the bill was deferred to the 41st legislative day.</p>
<b>Utah</b>	<p>The changes proposed by <b>HB 209</b> would amend 34A-2-102 and 34A-2-402 of the Workers' Compensation Act by:</p>

	<ul style="list-style-type: none"> <li>• Defining “first responder”</li> <li>• Establishing that the legal and medical causal connection for mental stress claims is satisfied for a first responder who is diagnosed with a mental health condition after the individual becomes a first responder</li> </ul>
<b>Vermont</b>	<p><b>HB 743</b> proposes to:</p> <ul style="list-style-type: none"> <li>• Require carriers to offer short-term and seasonal policies and to require the Commissioner of Financial Regulation to direct NCCI to create a new workers compensation class code for individuals providing homemaker and companion services</li> <li>• Create a fund to reimburse a portion of the workers compensation payments made for severe injuries sustained by workers in the nonmechanized logging industry</li> <li>• Require the Commissioner of Financial Regulation to study the feasibility of creating a fund to reimburse a portion of the workers compensation payments made for severe injuries sustained by employees of small employers in high-risk industries</li> </ul>

## STATE COMMITTEE ACTIVITY

State	Update
<b>Florida</b>	The Florida Workers Compensation Fraud Task Force met on January 31, 2018, to discuss issues related to claimant fraud and premium fraud. The next meeting of this task force is scheduled for April 27.
<b>Idaho</b>	Idaho Industrial Commission created a subcommittee to study PTSD benefits for emergency personnel. It is anticipated that legislative action on PTSD benefits will not take place until the subcommittee completes its analysis.
<b>Montana</b>	The Montana legislature is not in session in 2018. However, the Montana Economic Affairs Interim Committee/SJR 27 Subcommittee is continuing to hold hearings regarding the structure of the workers compensation system in Montana. There is no active discussion regarding changing benefits for injured employees. The next committee meeting is scheduled for April 27 in Helena.

## OTHER ITEMS OF INTEREST

State	Update
<b>Oklahoma</b>	<p>The Oklahoma State Supreme Court is scheduled to hear oral arguments on March 12, 2018, in the case of <i>Robert Hill v. American Medical Response</i>, Sup. Ct. No. 115558 regarding the use of the Sixth Edition of the <i>AMA Guides</i>.</p> <p>The Oklahoma Insurance Department has proposed an amendment to Appendix B. Oklahoma Workers’ Compensation Mandatory Optional Deductible Acceptance/Rejection Form to revoke Appendix B and re-pass to allow for input of a larger deductible amount as set forth by the applicable rule provisions, OAC 365:15-1-3.1 and 3.2.</p>
<b>Texas</b>	The Texas Department of Insurance, Division of Workers’ Compensation (TDI-DWC), is accepting comments on an informal working draft of amended 28 Texas Administrative Code (TAC) §180.26 and §180.8 until March 7, 2018, at 5 p.m. CT. The purpose of the informal working draft is to update TAC in compliance with Texas Labor Code §415.021 that Senate Bill 1895 amended in the 85th Texas Legislative Session. The statute requires that TDI-DWC considers two additional factors—whether the administrative violation has negative impact on the delivery of benefits to an injured employee and the history of compliance with electronic data interchange requirements, when assessing an administrative penalty. Texas Labor Code §415.021 also requires TDI-DWC to adopt rules to communicate to the person with the administrative penalty the relevant statute or rule violated, the conduct that gave rise to the violation, and the factors considered in determining the penalty.

**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.

<b>State</b>	<b>State Relations Executive</b>	<b>Phone Number</b>
IN, NC, SC, TN	Amy Quinn	803-356-0851
MO, NE, NV, OK, SD	Carla Townsend	314-843-4001
AZ, IA, KS, KY	Clarissa Preston	561-945-4517
DC, MD, VA, WV	David Benedict	804-380-3005
FL	Dawn Ingham	561-893-3165
CT, ME, NH, RI	Justin Moulton	860-969-7903
HI, VT	Laura Backus Hall	802-454-1800
AL, GA, LA, MS	Laura Hart Bryan	225-618-8168
AK, CO, NM, UT	Maggie Karpuk	818-707-8374
AR, IL, TX	Terri Robinson	501-333-2835
Federal Issues	Tim Tucker	202-403-8526
ID, MT, OR	Todd Johnson	503-892-8919

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