MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION
SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By **CHAIRMAN CHASE HIBBARD,** on January 6, 1993, 3:00 p.m., Room 325.

ROLL CALL

Members Present:
Rep. Chase Hibbard, Chairman (R)
Rep. Jerry Driscoll, Vice Chairman (R)
Rep. Ernest Bergsagel (R)
Rep. Vicki Cocchiarella (D)
Rep. David Ewer (D)

Members Excused: Rep. Steve Benedict

Members Absent: None

Staff Present: Paul Verdon, Legislative Council
Evy Hendrickson, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are condensed and paraphrased.

Committee Business Summary:
Hearing: None
Executive Action: None

CHAIRMAN CHASE HIBBARD reported that no bills have been scheduled for this committee as yet. The time allotted will be used to have informational presentations on Workers' Compensation.

George Wood, Executive Secretary of the Montana Self Insurers Organization, represents employers who self insure their workers' compensation obligation. Since its establishment in 1915, the worker's compensation system in Montana has allowed employers three choices for insuring their risks:

Plan 1: Self insurance.
Plan 2: Coverage by private insurance companies.
Plan 3: State Compensation Mutual Insurance Fund, (State Fund) which is required to provide coverage to any Montana employer who requests it and is the insurer of last resort.

A misconception is that the workers' comp system is in trouble. That is untrue. The problems that exist in the system are in Plan 3.

From 1915 to about 1980 the State Fund insured about 45% of the employers in Montana, and Plans 1 and 2 covered about 55%.

In 1980 the State Fund had a surplus approaching $100 million. From 1980 to 1992 the rates have been inadequate. The old fund has a deficit of $426 million. The new fund has a deficit of $42 million.

Court decisions in the 1980's increased the exposure of the State Fund for the payment of benefits. Benefit changes were made in 1987, 1989 and 1991. When 1987 amendments reduced the amount of benefits, it was envisioned that there would be a decrease in rates. At that time it was also decided to make the old fund a debt of the whole state of Montana and a new State Fund was created on July 1, 1990.

The State Fund was intended to operate as an insurance company, with a board of directors and the authority needed to run it. This lasted five months. The new fund had a liability reported on July 1990 to be $42 million. Total premium is about $125 million per year.

The management of the fund cannot be blamed for all the problems. The actuary used the 1987 reforms in constructing rates. The Supreme Court then overturned those portions of the 1987 reform which would have saved money. The actuary's figures were based on the law that existed at the time he set the figures but not at the time the losses started appearing. The actuary could not have foreseen the court decisions.

A payroll tax of .028% was enacted and bonds were issued. This raised about $15 million a year. There had been a loan from the new fund to the old fund that has been repaid from the bond issue of about $150 million. There is another loan that's been approved to take it up to June 30, 1993. The new fund was started July 1, 1990, with $12 million capitalization starter money.

Because the State Fund's rates were too low, private insurance companies could not write insurance competitively in Montana. The large employers that do business in several states have one policy with an all-state endorsement which provides coverage in any state where the employer operates.

Solutions to the new fund problem:

1. Dissolve the new fund and privatize the State Fund. This creates a problem because of the availability of coverage and the need to start an assigned risk pool. Every state that has an assigned risk pool has a problem. The Montana Self-insurers Association would oppose any attempt to do away with the State Fund.

Twenty states have state funds; the other 30 do not. A business can self-insure in every state except North Dakota and Wyoming. An assurance of the adequacy of rates is needed, but this is difficult to determine.

The medical payout is going up at the rate of about 15% to 17% a year. Thirty years ago about 75% of the benefits were paid out in indemnity compensation and weekly benefits to injured workers. The percentage has changed to 60% in benefits to the injured worker and 40% to the medical. If it reaches 50 and 50, the name of the fund may have to be changed from Workers' Compensation to Workers' Compensation and Medical Vendors Act. Another way to assure adequacy of rates would be by using the rate recommendations of the National Council of Compensation Insurers (NCCI).

The State Fund operates cheaper than an insurance company. They have no acquisition costs. In a private company, 15% to 17% of premium goes to acquisition costs, agents' commissions and bookkeeping. The State Fund does not pay the premium tax paid by insurance companies.

To cure the problem with the $42 million deficit and allow sufficient money for the State Fund to pay the bills as incurred will require a large rate increase or reduction of benefit levels. Benefit levels can be reduced by restricting who can get into the system.

The Supreme Court decision opened up who was eligible for benefits to a wider group than contemplated by the rates. The temporary total rate is now $336 a week. That money is spent on basic necessities. If benefits were inadequate, the program would have to be subsidized by food stamps, welfare, etc. If the Supreme Court rules that stress is compensable, based on experience in California, a 17% to 20% increase in rates may be expected each year.

One solution might be to require the employee to pay part of the cost. Other changes might include eligibility for benefits, amount of benefits, duration of benefits, permanent or partial disability payments, medical deductible, or that the employee pay 25% of the cost of medical until it reaches $250 and then the insurer will pay the balance.

Questions From Committee Members and Responses:

REP. DRISCOLL asked who was the administrator in 1980 when things were going bad? **Mr. Wood** replied that **Norm Grosfield** was the previous administrator.

REP. DRISCOLL asked **Mr. Wood** if he made the statement that 60% of the benefits go to the injured worker and that 40% goes to medical; he pointed out he had forgotten the administrative cost.

Mr. Wood said he was talking about the money available for benefits. The administrative costs of the State Fund are not out of line.

REP. DRISCOLL asked if **Mr. Wood** did not get the benefit of rate reduction because they don't pay rates, but they did get the benefit of the decrease in the amount of money that an injured worker can get by the 1987 law and the 1991 laws?

Mr. Wood said they don't pay rates as do people who are not self-insured but the rate they pay for their reinsurance is based on the rate of NCCI for Montana. As that rate escalates, they pay a percentage of that for their reinsurance, so the rate increase does affect them.

REP. DRISCOLL asked, in total dollars paid out on injuries by self-insurers, what is that total compared to what **Mr. Wood** was paying out prior to 1987.

Mr. Wood replied that that adjustment couldn't be made for the simple reason of the number of accidents. They would be paying out more dollars now than prior to 1987 because the exposure is greater.

REP. DRISCOLL said that, of the 46 self-insurers that existed in 1986, all but one still exist. He asked whether they got the benefit of the reduction in benefit payments to injured workers. **Mr. Wood** replied they did. He said the insurance companies and the State Fund had the same reduction in benefits paid. There was a benefit to them under the 1987 reforms until the courts took them back.

REP. EWER asked **Mr. Wood** to give his views as to other areas that would need to be looked at for addressing the new fund. **Mr. Wood** replied that he thought the big area in which they said their costs were less than anybody else was due to their safety. There is compulsory safety in all the plants and, in fact, the guaranty fund will not approve self-insurers who do not have a safety program and safety engineer. Fraud has always been a word used loosely, but he didn't think that it exists as much. Fraud indicates that you've taken some illegal action, i.e., filing a false claim. Abusing the system, that is staying off work longer than you should, is not fraud - it's using the system to the utmost.

He said he would like to see an adequate medical fee schedule and believed it would be something that could control costs. If the fee schedule was properly established and increased only by the same percentage as the compensation increased each year, he thought there would be some equity.

REP. DRISCOLL requested written comments for the committee to look at as to how his employees do not abuse the system - going back to work and taking responsibility so people do not abuse the self-insured employers.

Mr. Wood said some of the reasons they are in a better position than the State Fund is the communities in which they operate have

better salaries. The jobs at the plants are desirable. In addition, because of pension benefits, health and accident perks that are available which are not available other places - this creates an incentive for the injured worker to return to work.

Most of the plants have rigid safety rules and the standards are such that they can and do terminate employment if necessary. If an employee is injured, the supervisors are told to visit the person in the hospital and encourage them. If they are able to return to work, they will have their job back.

REP. BERGSAGEL asked what was done for rehabilitation services, whether retraining and rehabilitation are actively pursued for a partial injury.

Mr. Wood replied they were one of the better ones in that sense but the other thing was they have a spread of jobs in their plants that allows less than 100% to work. If it doesn't conflict with union contracts, they can transfer people within the plant. If a job in the plant is not available, rehabilitation would then be necessary. That is another problem. Rehabilitation is cost effective.

REP. EWER asked if premiums were based on hours worked as opposed to the actual wages and were there any disincentives to pay higher wages if the employers have to shoulder more premium. **Mr. Wood** replied that the state of Washington does not base premium on payroll; it is based on hours worked. It can be done either way, but the purpose of the rates is to collect the volume of money necessary to pay the losses incurred. It wouldn't make any difference where you put it, on net payroll or gross payroll; if you have to raise $400,000 to pay debts, you have to raise it.

REP. EWER asked about reducing costs by requiring employees to pay part of the costs through medical deductible or some other mechanism. Would that jeopardize the exclusive remedy which exempts employers from tort claims?

Mr. Wood believed a legitimate argument against requiring the employee to pay any part of the cost is the erosion of the exclusive remedy. As far as the exclusive remedy is concerned, in the United States it's eroding as fast as the old State Fund's liability. If the company makes the machinery on which the employee is injured, then the employee can get his compensation and also sue the government.

It used to be that the exclusive remedy started at the time the man was injured and went on during his convalescence and payment of benefits. Now basically, the exclusive remedy is from the time he gets injured to the time he is transported elsewhere. If he is transported in a company vehicle and there's damage, then the exclusive remedy is eroded. There is a problem and the question is, is it worth it.

REP. COCCHIARELLA asked about the lower percentage of injuries among **Mr. Wood's** workers and if he knew what the difference was between the percentage of self-insured and the State Fund to which **Mr. Wood** replied he did not know.

REP. COCCHIARELLA asked if he believed there were trends in injuries; for example, the state has an increase of injuries per month of more than 100 over what it was before. **Mr. Wood** did not see that trend. Trends develop usually after there is a Supreme Court decision. There are trends - about the time hunting season starts there are more injuries.

REP. COCCHIARELLA asked **Mr. Wood** if he had said if state employees were paid more, they would be back to work sooner. **Mr. Wood** responded that he had not said that and felt he was often misquoted.

Pat Sweeney, President of the State Fund, made his presentation and said he was also suspicious of the $42 million deficit in the new fund and believed the number was too high. The State Fund had $92 million in the bank. The old fund had $4.5 million in the bank and the money would run out the end of January.

REP. HIBBARD asked what the unfunded liability was and what it means. **Mr. Sweeney** said the old unfunded liability was, for example, $400 million and the money is in the bank, $4.5 million to pay that $400 million. There must be additional revenue to pay liabilities into the future. At the end of January when the old fund runs out of cash, the new fund would loan money through June 30. That would allow sufficient time for an additional revenue source to be identified and be used in the future to pay those claims.

If all claims were due today, it would cost $400 million non-discounted figure. If there were corresponding assets on a balance sheet, the claims would be discounted.

REP. HIBBARD asked if a lot of the claims would be medical claims and wage loss claims ongoing over a ten-year period. **Mr. Sweeney** said fatalities, permanent totals, and other claims would be paid into the year 2020, very lengthy payouts.

REP. HIBBARD asked if it was $1,000 a year for 10 years ($10,000); were they bringing that $10,000 back to the present and saying that's the unfunded liability? **Mr. Sweeney** responded that was correct.

REP. HIBBARD stated they were not discounting that to a present value of that $10,000, to which **Mr. Sweeney** responded that was absolutely correct. On other factors and court decisions, there was an expansion of benefits during the years that had a significant impact on the old fund.

In states that do not have a State Fund, there is an assigned

risk pool. There is not one that is not in trouble, with deficits that make the old fund deficit pale in comparison. The State Fund is an alternative for workers' compensation. It's not the only alternative. People get confused and think of Workers' Comp as the State Fund.

Over the years the State Fund has become the only vehicle in Montana for the purposes of workers' comp coverage because the private carriers have left the state. **Mr. Wood** attributes that to the State Fund having artificially low rates.

Mr. Sweeney didn't see it as that. If the private carriers had been able to make a dollar in the late 70's, they would still be here but they could not. They pulled out because of judicial decisions. There was no predictability in rates. The tail was starting to beat them up, the tail being the claims that occurred in years prior that were now being affected by court decisions. Private carriers will not come back into the state until they see significant reform. Access to the system has to be suppressed and there must be cost containment in medical. The State Fund is providing a valuable service to the businesses of the state. It is probably the only vehicle right now for insuring workers' comp. The State Fund has accomplished a number of things in the last couple of years:

In the safety program, there are 7 field consultants for 27,000 policyholders and they conducted 2,389 on-site consultations. During this legislative session additional people in this area will be requested.

Premium auditors verify premiums. In fiscal year 1992, 1,348 audits were verified which generated $750,000 in additional premiums and they verified the collection of over $10 million in earned premium. Approximately 2 to 3% of the State Fund policyholders were subject to audit within a given fiscal year.

In claims, there were 22,491 job-related accidents last fiscal year, an increase of 695 from the previous year. There were 4,444 lost time claims, an increase of 645 over the previous year.

One of the goals of the new fund in the claims administration area is medical cost containment. The utilization of a computer system which analyzes each medical field reduces it to the amount allowed under the fee schedule, eliminates duplicate billing, and generates the necessary data to pay the bill. Before bills are paid, examiners review each bill to verify that treatment is related to a workers' comp injury.

Private rehabilitation nurses have been assigned to serious and problem injuries to provide appropriate quality treatment. They also employ, on a part-time basis, consultants in the medical field who are available to the claims examiners to assist in the management of medical treatment and decisions. They have

approximately seven consultants on a part-time basis, orthopedic physician, general practitioner, chiropractor, physical therapist, oral surgeon, pharmacist, so they do utilize the services of the experts.

Vocational rehabilitation has been a significant cost to the system. In 1990 the average rehabilitation cost per closed claim was $1,771. This has been reduced to $1,021. The system needs protection from fraud. It needs the ability to investigate and prosecute when fraud is detected. A bill will be introduced in this session dealing with safety. It is modeled after the Oregon safety bill which has proven to be effective.

Workers' comp is the last form of insurance known with first dollar paid on medical coverage unlimited. It is time co-payments be looked at. With a worker's 20% co-payment on the first $1,000 and a 10% co-payment on the next $4,000, the tangible savings projected for the State Fund would be close to $2 million a year in medical benefits.

James T. (Tom) Harrison Jr., Chairman of the Board of Directors of the State Fund, presented his testimony and said the five-member board has the obligation to run the Fund as a private business and on an actuarially sound basis. The dilemma is to determine how high the premiums should be and the outcry of the people who pay the premiums who want them low.

Mr. Harrison disagreed with **Mr. Wood's** statement that there's not a problem with insurance companies. He said this is a national problem. He referred to an article from Ontario, Canada, where the unfunded liability is $10.3 billion in workers' comp. In California in April 1992, the unfunded liability was $2 billion.

A lot of attention has focused on management of the State Fund, which costs around $12 million. Assuming that the most skilled staff could be hired and 10% could be saved on costs, it would only result in $1 million saved.

Mr. Harrison then outlined the medical fee schedule.

He also stated three substantial advantages for Self Insurers:

1. Salaries to get back to work (higher pay)
2. Stability of employers (not laying off workers, etc.)
3. Slot for rehabilitation.

The State Fund is victimized by the actuary who does not give credit for the implementation of changes in the law or administration or how the benefits are parceled out until it comes to the bottom line.

He pointed out several accomplishments of the board:

Implemented a 50% limit in any one year on premium increases.

The premium levels are set in big numbers. The actuary says the fund needs $10 million extra which translates into an 8% rate. Within that overall figure there are variations all over the board. Some people may get zero increase and others will go up 50%. The board recognizes occupations with high claims.

Mr. Harrison had a list of the potential legislative changes that would be introduced in this session. The board was part of two interim committees that studied this matter.

Mr. Harrison read from a letter from Center Re Insurance. Over $900,000 of claims have been yielded to the State Fund, about $300,000 in actual cash recovered in third party suits and $600,000 in offsets at the time of settlement of the state claim. They are trying to buy the old fund and trying to convince the legislature it would be a good deal.

Mr. Harrison reviewed the 1991 auditor's report. The report had only four recommendations and they were minor. He said 1992's audit included four recommendations as well. The third year audit was not out as yet. These are objective documents that the board members can look at and ask management how they are doing.

Mr. Harrison concluded that this was a national problem with a huge tail. This will be run on an actuarially sound basis as required by law.

<u>Questions From Committee Members and Responses:</u>

REP. DRISCOLL referred to the 60-40 split, and said he disagreed on terms. Last year **Mr. Harrison** said they had $120 million in premium income and $12 million went to administration. **REP. DRISCOLL** asked if that was a benefit for workers. **Mr. Harrison** responded it was not.

REP. DRISCOLL also questioned **Mr. Harrison** about spending money on outside lawyers and asked if that was a benefit to workers in their bookkeeping scheme and whether it's a part of the $12 million. **Mr. Harrison** replied yes.

REP. DRISCOLL asked what rehabilitation is in the bookkeeping.

Mr. Harrison said that is a benefit to the worker.

REP. DRISCOLL pointed out that lawyers are administrative costs, so last year in the new fund they spent $25 million. That was called benefits to workers and $22 million was spent for doctors and hospitals according to the report. He said his definition of benefit for workers was the temporary total, permanent partial or permanently totally disabled payment. He asked what else **Mr. Sweeney** called benefits to workers and how much of that is rehab money. **Mr. Sweeney** responded he would work that number up.

REP. DRISCOLL asked if temporary total, permanent partial, permanent total, and surviving spouse payments were less than 50% of the total premium dollars for one of the four categories. **Mr. Sweeney** said he would have to look up the numbers.

REP. DRISCOLL asked **Mr. Sweeney** how he could justify that they want to cut benefits again. They took a 30% reduction last session so the medical community got a raise; now they want workers to co-pay to the medical community. How could that be justified?

REP. DRISCOLL also pointed out that Mr. Sweeney had said that access to the system would be limited because they would have to pay something. Would an employee let a crane fall on him because it might cost $400? How did he reach that scenario? If it was an accident on the job, now he's not going to report it to the employer if he got hurt on the job because it might cost him 20% of his first thousand.

Mr. Sweeney said he didn't believe the crane was going to fall on his head because of the co-pay; but if he stubbed his toe, nothing would prevent him from going to the emergency room to have his toe checked and charge it back to the employer if it happens on the job. On the other hand if he stubbed his toe and he might have to pay $20 of the emergency room visit, he probably wouldn't go. He'd go home and put his toe in a bucket of water.

REP. DRISCOLL asked if would then be fired for not reporting an accident. **Mr. Sweeney** said he could still report it.

REP. DRISCOLL asked if he reported it, would that would still affect the employee frequency of accidents. **Mr. Sweeney** replied no. All that he'd be reporting would be an incident.

REP. BERGSAGEL asked what the old fund needed in cash flow. **Mr. Sweeney** said he didn't have the cash flow figures with him but thought over the biennium it was $100 million.

REP. BENEDICT asked the same question of **Scott Seacat** to see whether he had an answer. **Mr. Seacat** said he would address that at the Friday meeting.

REP. EWER said the committee had prepared an outline of the major issues in the old fund and new fund which was very comprehensive. He asked **Mr. Sweeney**, when he distributed the list of possible legislation, whether he could assign it to these various parts in order for the committee to get a quick sense of how proposed legislation would affect these areas. He also wanted to know whether **Mr. Sweeney** was developing any kind of business plan that would show various scenarios as to the status of the financial integrity of the new fund under the current laws. He also asked whether they have the capability of showing the committee their best estimates of what various laws were passed as far as the national integrity of the fund.

Mr. Sweeney said the legislation they would be proposing would be submitted to NCCI, and their own actuary will price it. They will determine if this legislation is passed as a package. It could have X percent effect on the system. They had not received that information back. In approximately 30-45 days they will receive it from NCCI.

REP. EWER said this was vital information because the committee needs to know the potential effect and they need a base line on likely effect.

REP. HIBBARD said the policy to limit the increase in premiums to 50% per year seems to run counter to the statutory requirement to set actuarially sound premiums. **Mr. Harrison** responded it did not, and once they set the barometer that no particular premium can go up more than 50%, then they still adopt whatever total amount is necessary in the actuary's mind in order to achieve actuarial soundness. Some rates go down, some up, overall up according to the actuary. The premium payer is picking them up, a form of subsidy.

ADJOURNMENT

Adjournment: 5:30 p.m.

REP. CHASE HIBBARD, Chairman

EVY HENDRICKSON, Secretary
by Marilyn Miller

CH/ev

HOUSE OF REPRESENTATIVES

Select Committee Workers Comp. **COMMITTEE**

ROLL CALL **DATE** 1-6-93

NAME	PRESENT	ABSENT	EXCUSED
Chase Hibbard, Chairman	✓		
Jerry Driscoll, Vice Chairman	✓		
Steve Benedict			✓
Ernest Bergsagel	✓		
Vicki Cocchiarella	✓		
David Ewer	✓		

1-8- adjourn.