MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By **CHAIRMAN CHASE HIBBARD**, on January 25, 1993, at 3:00 P.M.

ROLL CALL

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

Members Excused: None

Members Absent: None

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

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

Committee Business Summary:
Hearing: None
Executive Action: None

CHAIRMAN HIBBARD introduced **Chuck Hunter, Department of Labor and Industry,** to discuss their safety program.

Opening Statement

Chuck Hunter, representing the **Department of Labor and Industry,** distributed copies of the organizational chart entitled Safety Bureau, Research, Safety and Training Division. **EXHIBIT 1**

The safety bureau does safety inspections, enforces standards and has the ability to impose standards on public sector employers. If there are safety violations and unsafe working conditions, the bureau has the ability to require conformity with the standards.

The safety bureau also provides consultations for private sector employers. The bureau has no legal jurisdiction to enforce standards in the private sector but many private sector employers request the bureau to come in and do safety consultation and inspections. A written report is given detailing the findings

and providing recommendations.

The department is placing particular emphasis on safety consultations and inspections. Safety is one of the areas where an employer can get a handle on his workers' compensation costs by preventing accidents in the work place. The key to the safety program is for both the employer and the workers to take safety seriously.

Mr. Hunter reviewed **SENATOR HARP'S** bill which was introduced at the request of the Governor. The bureau is very supportive of the concept of the bill.

REP. HIBBARD asked **Mr. Hunter** to explain the different functions of safety as viewed by the State Fund and the bureau.

Mr. Hunter said that both the State Fund and the Department of Labor have a large interest in preventing accidents in the work place. They contemplate working with schools and various groups to establish an awareness of the need for safety in the work place.

REP. COCCHIARELLA asked **Mr. Hunter** if the FTE requested were on the chart at the present time or if they would be added. **Mr. Hunter** replied they would be added if they were included when the budget was finalized.

REP. COCCHIARELLA asked if the FTE were in the safety bill or not. **Mr. Hunter** said the four FTE were not in the safety bill - they were in the Governor's budget.

In response to a question from Rep. Driscoll, **John Maloney, Safety Bureau Chief**, responded that the mine safety inspectors, in addition to inspecting the coal mines as required four times a year, also do safety training, first aid and CPR.

REP. BERGSAGEL asked if the request in **SENATOR HARP'S** bill and the request from the agency would result in five FTE. **Mr. Maloney** said it would result in five.

Mr. Maloney said the coal mining inspector doesn't work exclusively on coal mines but it is the majority of the work.

REP. BERGSAGEL asked if there was any coordination between OSHA and the department. **Mr. Maloney** replied that each coal mine is inspected four times per year by the department and each is inspected twice per year by the federal mine inspectors (OSHA). In Montana OSHA inspects only private sector entities and the safety bureau inspects only public sector entities.

REP. EWER asked if the Department of Labor keeps statistics on injuries. **Mr. Maloney** replied affirmatively.

REP. HIBBARD asked how many of the 19 FTE were in the area of

safety consultation and how many in the area of safety inspection. **Mr. Hunter** said it's a mixture and most of the people are capable of doing both.

Mr. Maloney said under the current operation, consultation comes only upon request of the private sector. The department is funded by grants from OSHA; 10% of the budget can be spent in the on-site consultation program, so it does not consume a great deal of the department's time.

REP. EWER said the committee was very interested in knowing what type of injuries occur and asked for a breakdown on what type of claims predominate and what steps should be taken to reduce them. **Mr. Maloney** said the latest statistics on injuries by industry and types of injuries had been prepared by the Research Bureau at the Department of Labor and was available. **Mr. Maloney** said it contained all injuries but didn't break them down according to plan by injuries, lost-time injuries or how many days were missed as a result of the injury. In conclusion, **Mr. Hunter** said the statistics show how much is unknown about accidents. He also said the areas where the department would like spend significant time would be the high hazard industries.

ADJOURNMENT

Adjournment: 4:20 p.m.

Chase Hibbard

REP. CHASE HIBBARD, Chairman

Evy Hendrickson

EVY HENDRICKSON, Secretary

by Marilyn Miller

CH/eh

HOUSE OF REPRESENTATIVES

Select Workers Comp COMMITTEE

ROLL CALL VOTE

DATE 1-25-23 BILL NO. _____ NUMBER _____

MOTION: _____

NAME	~~AYE~~	NO
Chase Hibbard ✓		
~~Jerry Driscoll~~ ✓		
Steve Benedict ✓		
Ernest Bergsagel Sagel ✓		
Vicki Cocchiarella ✓		
David Ewer ✓		

SAFETY BUREAU
RESEARCH, SAFETY AND TRAINING DIVISION

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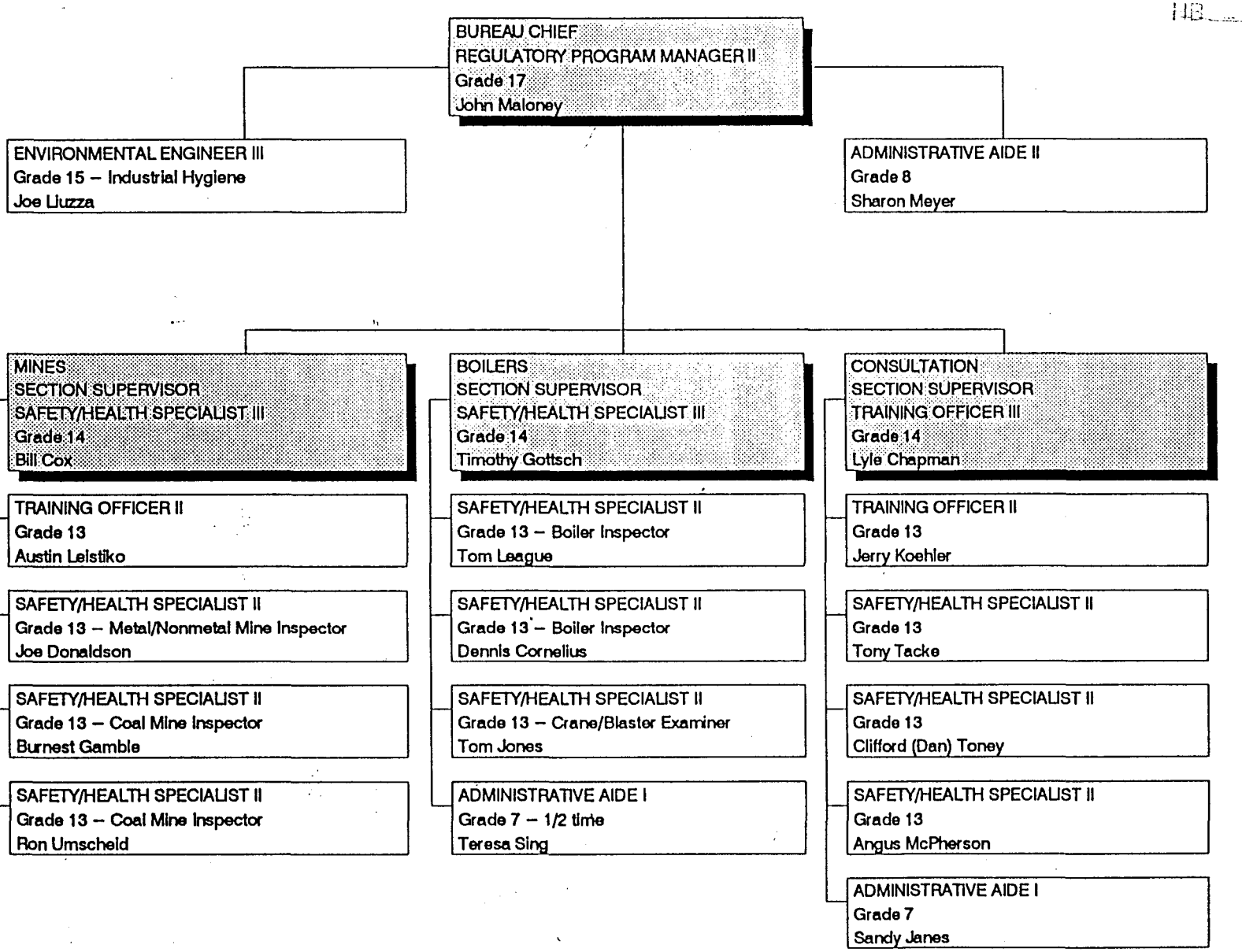
HB



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BACKGROUND OF THE "OREGON MIRACLE"

Prepared for
HOUSE JOINT SELECT COMMITTEE ON WORKERS' COMPENSATION
By Paul Verdon, Staff Researcher
January 22, 1993

The modifications in the Oregon workers' compensation system that occurred in 1988-90 resulted in a turnaround of its financial situation so dramatic that it is commonly referred to as the "Oregon Miracle".

ATTACHED IS A COPY 1990 OREGON WORKERS' COMPENSATION REFORM LAW COMPARISON WHICH OUTLINES THE CHANGES THAT CONTRIBUTED TO THE TURNAROUND

MONTANANS FIND MAJOR CHANGES IN OREGON'S COMPENSATION LAW

After visiting Oregon last year, a group of Montana State Fund executives found that a number of major changes in Oregon's workers' compensation law in 1990 stimulated the dramatic turnaround. These included:[1]

1. Development of Managed Care Organizations (MCO) which resulted in cost-effective, high-quality care for the claimant. Savings were estimated at approximately $12 million in the first year.

2. Major reforms in the laws and administrative rules: the definition of a job-related injury was changed and the claimant must have objective medical evidence that he did suffer an injury. Aggravation of a pre-existing condition is limited to the extent of the aggravation only, and to be compensable the claimant's disability has to be caused more than 50% by the aggravation.

3. Development of an early return to work program and the establishment of a fraud control and investigative unit.

4. Severe restriction on the role of chiropractic, now limited to a maximum of 12 treatments or 30 days, thereafter only at the prescription of a treating medical doctor. A chiropractor cannot declare or keep a person disabled more than 30 days.

Because SAIF is willing to defend against frivolous claims or overcharges with all its resources, those kinds of claims have dropped significantly.

The SAIF Claims Division's objective is to:

1. Accept compensable claims promptly and target 14 days.

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2. Return claimants to work as soon as possible either through an early return to work program or speedy resolution of the claim.

3. For acceptance of a claim, the burden of proof is on the claimant.

SAIF sees its first responsibility as to its customers, the policyholders, and involves the policyholder in claims handling from the beginning.

SAIF employs 1,150 people and handles about 39,000 new incident reports per year. The staff of the Montana State Fund handles about 21,000 new claims per year and would have to be more than doubled to approximate Oregon's staffing pattern.

SAIF'S ANTI-FRAUD CAMPAIGN

By 1988, phony claims, bogus medical bills and other problems in Oregon's workers' compensation system had burdened Oregon with the eighth highest rates in the nation. SAIF Corporation, the state's largest workers' compensation insurance carrier, was suffering losses of $1 million a week. But SAIF turned itself around in two years and in 1990 made nearly $46.5 million, lowered rates by 10%, and paid a $20 million dividend. A crackdown on fraud played a large part in the improvement.

When a former deputy state attorney general was appointed head of SAIF in 1988 he recognized the damage fraud was causing and made fighting fraud a high priority. A Fraud/Investigations Division was created, and investigators, many of them former police officers with training in investigations, were hired and a "fraud hotline" was established. A chief architect of the anti-fraud program was an attorney who had spent 22 years as a trial lawyer defending doctors in medical malpractice cases. A staff of more than 50 people used a full range of investigative tactics including photographic surveillance and undercover agents to ferret out and prosecute cheaters.

In its first 20 months, the hotline generated more than 2,300 investigations. In the first two years, the investigators obtained more than $1 million in judgments against or settlements with 22 medical providers and actions were pending against 24 more. In some cases medical care providers were sentenced to jail, lost their licenses to practice or were barred forever from treating injured workers employed by SAIF policyholders. SAIF also successfully prosecuted nearly 40 persons for theft, perjury, and other criminal charges and filed charges against dozens more.

The war on fraud has been cost effective, receiving more in judgments, awards, settlements, and restitutions amounts than it

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was paying out in operating cost, but officials say its real value has been in the deterrent effect on others. Total claims filed with SAIF dropped 24% by the end of 1990, and the fraud program was thought to be a significant factor in the drop. The anti-fraud program gave SAIF a reputation for wanting to preserve the integrity of the insurance program and this gave it a competitive edge that contributed to $27 million in new business in 1990 and a customer retention rate of 97%.[2]

ASSIGNED RISK POOL

In 1980, an Assigned Risk Pool was established to make workers' compensation insurance available to employers unable to obtain coverage in the voluntary market. Beginning in October 1989, SAIF Corporation began the nonrenewal of policies held by approximately 10,000 employers, but the majority of the nonrenewals were not effective until 1990, when many of those employers fell into the Assigned Risk Pool. By the end of 1990, the number of policyholders in the Pool had jumped to 14,882, more than four times as many as a year earlier. Net premiums written in the pool totaled $71.9 million, up 150% from 1989, while the average premium per risk dropped from $7,874 in 1989 to $4,834 in 1990. The premiums of all employers in the Pool are subject to the ARP expense loading factor. In the first half of 1990, that factor was 1.719 and increased to 1.738 on July 1, 1990. The average factor in the voluntary market for 1990 was 1.260.

Under the Assigned Risk Plan, SAIF, Liberty Northwest, and Employers Insurance of Wausau act as service providers. ARP net operating losses are apportioned to all insurers, based on their share of workers' compensation premiums written in Oregon's voluntary market. The burden of risk pools upon the voluntary market in the 33 jurisdictions with similar pools was over 16% of voluntary written premiums in 1990. In Oregon, the burden was 7.2%, up from 3.8% in 1989. Oregon's assigned risk premiums were 9.8% of total workers' compensation premiums written by SAIF and private insurers, compared to the 24.1% pool market share for the 33 jurisdictions overall.[3]

1. INTEROFFICE MEMORANDUM, Montana State Compensation Mutual Insurance Fund, April 7, 1992

2. SAIF Corporation's Anti-fraud Campaign, memo prepared by SAIF

3. Oregon Worker' Compensation Premiums, CY 1990, Research and Analysis Section, Oregon Department of Insurance and Finance

1990 OREGON WORKERS' COMPENSATION REFORM LAW COMPARISON

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On May 7, 1990, the Oregon Legislature met in special session and passed a workers' compensation reform bill, Senate Bill 1197. The package of reforms embodied in the bill had been negotiated by an advisory committee composed of labor and management representatives. Most provisions of the bill took effect on July 1, 1990.

The following document is a summary of the major provisions of the bill. It also includes some elements of the negotiated package which were not statutory in nature, but were agreed to and implemented as part of the reforms.

NEW LAW	OLD LAW
1. DEFINITION OF A COMPENSABLE CLAIM	1. DEFINITION OF A COMPENSABLE CLAIM
A. **INJURIES**	A. **INJURIES**
The existence of an injury must be established by medical evidence supported by objective findings.	A claimant's testimony (for example, that he felt pain), without any objective evidence, was enough to establish the injury.
* * * *	* * * *
No change.	Injuries are compensable when the work activity is a material cause of the injury.
* * * *	* * * *
Conditions pre-existing an injury or developing subsequently are compensable only if the compensable injury is the major contributing (primary) cause.	Pre-existing and subsequently developing conditions were compensable whenever the injury was simply a material (enough to make a difference) cause of any worsening or was a material cause of an increase in symptoms or prolongation of condition.
* * * *	* * * *

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NEW LAW	OLD LAW
Any injury, the major cause of which was alcohol or drug use, is not compensable (unless the employer permitted, encouraged, or has actual knowledge of the alcohol or drug use).	Such injuries were compensable.
* * * *	* * * *
Injuries resulting from recreational or social activities are not compensable when the activity is primarily for the worker's benefit.	Compensable unless the activity was solely for the worker's benefit.
B. DISEASES	B. DISEASES
A disease is compensable only if the work is the major contributing (primary) cause of the disease.	Since 1987 amendments to the occupational disease law, certain occupational diseases were compensable even if the work had only a material impact.
* * * *	* * * *
Occupational diseases must be established by medical evidence with objective findings.	Claimant's testimony was sufficient to prove a disease.
C. AGGRAVATIONS	C. AGGRAVATIONS
Any aggravations (worsened conditions) relating to the original injury or disease are compensable only when established by medical evidence with objective findings.	Claimant's testimony often was sufficient.
* * * *	* * * *
An aggravation whose major contributing cause is an off-work injury is not compensable.	Even if a claimant worsened a compensable condition solely because of an injury occurring off the job, it was compensable.
D. CLAIMS	D. CLAIMS
An insurer or self-insured employer is given 90 days in which to accept or deny a claim.	Acceptance or denial was required within 60 days.
* * * *	* * * *

NEW LAW	OLD LAW
A "back-up" denial (the denial of a previously accepted claim) is permitted within two years of claim acceptance, with any such denial subject to clear and convincing evidence by the employer.	Back-up denials were permissible only with proof of fraud, misrepresentation, or illegal activity.
* * * *	* * * *
Claims or benefits of any kind, except for medical services, are subject to compromise and release.	Compromise and release was prohibited in the absence of a bona fide dispute over compensability.
2. MEDICAL SERVICES	2. MEDICAL SERVICES
A worker's attending physician in most cases must be a medical doctor or doctor of osteopathy.	Any licensed medical provider, including chiropractors and others, qualified as attending physicians.
* * * *	* * * *
Chiropractors may treat a worker within the first 30 days of a claim or first twelve visits, whichever occurs first; however, chiropractors acting as members of a Managed Care Organization are not subject to these limits.	Chiropractors were not limited, except to the extent an employer could prove that treatment was not reasonable and necessary.
* * * *	* * * *
Managed care organizations will be permitted, subject to the following provisions: • Managed Care organizations (MCOs) can be created by health care providers (including entities that provide support services to health care providers) and must be certified by the Director. Insurers may contract with MCOs to provide medical care for injured workers. • Injured workers whose medical treatment is provided by an MCO must choose from among the MCO's service providers (although the worker may continue to treat with another provider with whom they have a history of treatment).	Managed care organizations were not available.

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NEW LAW	OLD LAW
• The MCO must include all categories of medical service providers, and must provide peer review, utilization review, and incentives to reduce service costs without sacrificing quality of service.	
* * * *	* * * *
Palliative care is not payable after a worker becomes medically stationary, except to monitor prescriptions or prosthetic devices, to enable worker to continue employment (approval required), or for PTD case.	Palliative care was unlimited and compensable.
* * * *	* * * *
Medical treatment disputes are resolved by an appointed doctor to serve as a medical arbiter. Fee disputes are be resolved summarily in many cases by the Director.	Medical services disputes were subject to the full hearing process.
* * * *	* * * *
Only the attending physician may authorize time loss or make findings regarding PPD.	No such limitation.
3. BENEFITS	3. BENEFITS
Each degree of disability for scheduled injuries (arms, legs, sight, hearing) is payable at $305.	Scheduled permanent partial disability was payable at $145 per degree.
* * * *	* * * *
Time loss (temporary total disability compensation) is not payable for a worker while in jail.	Such benefits were payable.
* * * *	* * * *
Time loss terminates when a worker is medically stationary and the claim is closed, when he/she actually returns to work, or when he/she is released to return to his regular work.	No provision for terminating time loss upon a worker's release to return to work, until he/she actually did return.
* * * *	* * * *

NEW LAW	OLD LAW
Employer or insurer may close a claim without submitting it to the Department when a worker becomes medically stationary and is released to regular or modified work.	A claim could be closed only when the worker actually returned to work.
* * * *	* * * *
A worker dissatisfied with the amount of permanent disability awarded on closure must request reconsideration before proceeding further.	Reconsideration of an extent of disability rating was permissive only and rarely used.
* * * *	* * * *
A claimant's extent of disability is rated as of the date of reconsideration, based on medical evidence at the time of reconsideration.	Extent of disability was rated as of the time of hearing, with new evidence created months or years after claim closure.
* * * *	* * * *
The rating of disability requires a strict application of the Standards for the Evaluation of Permanent Disability.	Use of the Standards was not always strictly adhered to.
* * * *	* * * *
Litigation concerning disability is limited to arguing that the Standards were applied incorrectly.	A worker was entitled to prove that the Standards did not accurately reflect his disability.
* * * *	* * * *
Disputes over extent of disability involving impairment suffered by a worker are decided by an appointed doctor or medical panel.	Referees would evaluate and determine the impairment suffered by a worker.
* * * *	* * * *

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NEW LAW	OLD LAW
Payments pending appeal, except for ongoing time loss and permanent total disability payments, are stayed pending outcome of the appeal.	All current and past time loss and other benefits, except medical services, were payable despite an appeal. All such payments were lost and could not be recovered or offset against future benefits even if the appeal was successful.
* * * *	* * * *
4. INJURED WORKER REINSTATEMENT	4. INJURED WORKER REINSTATEMENT
The definition of "available" now means that the worker must be reinstated to his/her former position "even if that position has been filled by a replacement while the injured worker was absent." The replacement worker must be removed upon the injured worker's return to work.	"Available" meant "vacant" per Knapp v. City of North Bend. When an injured worker's position was filled upon his return, he/she would have to wait for the next job opening.
* * * *	* * * *
Reinstatement rights terminate three years after the injury or whenever any of the following occur: • Attending physician or medical panel declare worker cannot return to former position of employment. • Worker is eligible and participates in vocational assistance. • Worker accepts suitable employment with another employer after becoming medically stationary. • Worker waits more than seven days to request reinstatement after being notified by the insurer or employer that his doctor has released him to return to work.	Reinstatement rights were lost only in the following circumstances: • Worker was discharged for reasons unrelated to his injuries. • Worker refused a suitable job. • Worker clearly abandoned future employment. • Worker failed to make proper or timely (5 days) demand.
* * * *	* * * *
Employers with 20 employees or less are not covered by the reinstatement statute (but employers with 6 or more employees remain subject to the obligation to provide suitable alternative work).	Employers with six or more employees were covered.

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NEW LAW	OLD LAW
5. OTHER	5. OTHER
The fund, renamed the Reemployment Assistance Reserve, encourages hiring of preferred workers through exemption from premium and assessments for three years from the date of hire. Insurers' claim costs for these workers are reimbursed from the fund. Eligible workers are issued identity cards to be presented to employers at the time of hire.	The workers Reemployment Reserve encouraged the re-hiring of disabled, injured workers ("preferred workers") by reimbursing premium costs for two years from the date of hire.
* * * *	* * * *
Attorney fees on penalties for improper claim processing are limited to one-half of the penalty.	A claimant's attorney was entitled to a separate, sometimes substantial attorney fee regardless of the amount of penalty.
* * * *	* * * *
Hearings referees are subject to annual, confidential evaluations by workers' compensation attorneys.	Comments concerning Hearings referees were not confidential and, therefore, were rarely critical.
* * * *	* * * *
Every employer with more than 10 employees, and small employers in hazardous businesses, are required to create a safety committee.	Certain large companies were required to have safety committees.
* * * *	* * * *
Office of Ombudsman for small business created to provide information and assistance to small business.	No such provision.
* * * *	* * * *
Claims Examiners must be certified.	No such provision.
* * * *	* * * *

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NEW LAW	OLD LAW
A standing Management-Labor Advisory Committee, appointed by the Governor, is established to study and report to the Legislature on workers' compensation issues.	The Director was permitted to appoint an advisory committee on Workers' Compensation issues, to report to the Director.
* * * *	* * * *
The staff of the Oregon Occupational Safety and Health Division (OR-OSHA) was increased by over 40 percent. (Negotiated provision, not specified in SB 1197.)	

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