MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By **CHAIRMAN CHASE HIBBARD**, on March 10, 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: Susan Fox, Legislative Council
Evy Hendrickson, Committee Secretary

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

Committee Business Summary:
Hearing: SB 347
Executive Action: SB 347, HB 504, SB 394, HB 587, HB 628

HEARING ON SB 347

Opening Statement by Sponsor:

SENATOR JOHN HARP, Senate District 4, Kalispell, summarized SB 347, an act generally revising workers' compensation law to attain better medical cost containment; revising an injured worker's freedom of choice of physicians; amending medical definitions; distinguishing between primary and secondary medical services; revising provisions regarding payment for prescription drugs; providing for managed care and a preferred providers organization; requiring the injured worker to comply with recommended medical treatment; regulating domiciliary care; limiting physician self-referral; creating medical advisory committees; amending certain sections and providing an effective date and a retroactive applicability date. **EXHIBIT 1**

SEN. HARP said his amendments address the goal of medical cost

containment and also ensures that everyone who wants to be a participant in this program can be.

SEN. HARP distributed and reviewed his amendments dated March 10, 1993. **EXHIBIT 2**

Proponents' Testimony:

Terry Mitton, representing the **Coalition for Workers' Compensation System Improvement (CWCSI),** said they represent over 50,000 employers and employees and businesses in the state of Montana. They support SB 347.

Jim Puttman, representing the **Coalition for Workers' Compensation System Improvement,** asked the committee to remember that the Coalition, from the very beginning, has been a coalition of workers and employers, the two primary elements in workers' compensation. As amended, this is an outstanding bill. It provides adequate supervision by the Department of Labor; remains cost effective while providing appropriate care; and provides flexibility.

Rick Hill, representing **Governor Racicot's Office,** said the concept of managed care is familiar to most people with medical insurance. This measure would bring proven techniques to the workers' compensation arena. He noted that **SEN. HARP** has spent many hours evaluating the real world of medical costs and medical care as it relates to the workers' compensation situation in Montana. This bill is a Montana solution to the situation. The Governor is an enthusiastic supporter of managed care and asks the committee to give SB 347 a do pass recommendation.

Pat Sweeney, representing the **State Fund,** said they have spent $37 million on medical expenses in FY92 and that medical expenses accounted for over half of the 20% rate increase taken by the State Fund at the beginning of FY93. The cost of workers' compensation insurance is not going to stabilize or decrease if we don't make medical cost containment part of the effort to address the problems facing the system. This bill gives the State Fund and all other insurers the tool to help contain the rise in cost of medical care while providing effective and timely care for insured workers. He added that **Mr. Strizich** of the State Fund has worked on the concepts contained in this bill for over a year and will present specifics on how the bill will work.

Mr. P.J. Strizich, from the **State Fund,** distributed written testimony and charts and gave his presentation. **EXHIBIT 3**

James Tutwiler, representing the **Montana Chamber of Commerce, the Montana Retail Association, Montana Hardware and Implement Dealers,** said they believe SB 347 is a very important piece of legislation aimed at containing medical costs. Employers are being restricted in their ability to provide jobs and pay and

salary increases because of the cost of workers' compensation. **Mr. Tutwiler** said since FY88 the employers in the state have paid about $64 million to support the system, and we are going to have to continue that payroll tax for an indefinite period.

Bill Crivello, Branch Manager for **Crawford Health and Rehabilitation,** representing the **Rehabilitation Association of Montana**, presented written testimony. **EXHIBIT 4**

Harlee Thompson, Manager of Intermountain Truss, and a delegate from the **Montana Building Industry Association** to the **Coalition for Workers' Compensation System Improvement (CWCSI),** submitted written testimony and asked to go on record as recommending a do pass on SB 347. **EXHIBIT 5**

Mike Micone, representing **Montana Motor Carriers Association (MMCA),** said the association would reiterate testimony similar to **Mr. Sweeney** and said they support passage of this bill.

Jacqueline Lenmark, representing the **American Insurance Association (AIA),** said she wanted to address specific concerns AIA has with SB 347 as it is presently drafted and then convey their strong support for the bill. Ms. Lenmark said AIA had one major concern with the bill as it is presently drafted and that goes back to the comments that **SEN. HARP** made about competition. **Ms. Lenmark** commented on the article distributed to the committee members. **EXHIBIT 6** She said that allowing only medical care providers to set up managed care organizations puts control in the hands of the people who have a vested interest in making money in the system rather than allowing competition from all sorts of entities, especially insurers who have a vested interest in keeping costs down. **Ms. Lenmark** then referred to AIA-recommended amendments; reviewed them section by section and asked the committee to add them to the bill. **EXHIBIT 7** She said with these amendments, AIA would support passage of SB 347.

Chuck Hunter, representing the **Department of Labor and Industry (DLI),** said they support SB 347 and outlined the department's role in the bill on managed care. He said this bill would require the department to write rules regarding who may provide managed care and what has to be covered under a managed care plan. He said the statute is quite specific and thinks it is crafted in such a way as to maintain the quality of care that's currently contemplated under the law while providing cost containment and allowing the department to deal with the managed care organization that subsequently does not provide what is intended under the law.

Mr. Hunter said he did not think **Ms. Lenmark's** amendments were needed to get the rules in place.

Bill Egan, representing the **Montana Conference of Electrical Workers (MCEW),** said they rise in support of this bill only if it is amended as proposed by the Senate Labor Committee, and with

the AFL-CIO amendments pertaining to the co-payment which MCEW feels violates the fundamental principle of what workers' comp is and is supposed to be, the secondary medical treatment issue, and also on some parts of the manage care issue.

Riley Johnson, representing **National Federation of Independent Business (NFIB),** said they strongly support SB 347 and the amendments suggested by the sponsor.

Oliver Goe, representing the **Montana Municipal Insurance Authority (MMIA),** the **Montana School Groups Insurance Authority (MSGIA), and the Montana Association of Counties (MACO),** said the groups he represents are pools that have been put together by the various public entities for the purpose of providing workers' compensation coverage. **Mr. Goe** said they keep very close tabs on all costs, including medical. He said this bill gives them the necessary tools to make a determination about the necessity of different types of care and allows the professionals to make their determinations based upon the information provided.

Jerry Loendorf, representing the **Montana Medication Association,** said they support the bill and specifically want to go on record as supporting Section 12. They would suggest an additional improvement and that being, when an injured worker is referred to a preferred provider, notice is given to the injured worker. **Mr. Loendorf** said notice should be given to the treating physician as well; the reason for this is if the injured worker returns to the treating physician, the treating physician will know he's no longer authorized to provide treatment. If the injured worker does not return but does not notify the treating physician that he has received notice to go to a preferred provider, the treating physician will not be trying to find him for needed treatment.

Mr. Loendorf said if a treating physician has information that is important to the continued treatment of the injured worker, he knows who to pass that information on to. Also, diagnostic procedures and tests can be passed on to the preferred provider to avoid duplicate costs of evaluations and diagnoses.

Tom Ebzery, representing the **Montana Associated Physicians Inc.,** distributed written testimony and addressed the committee. **EXHIBIT 8**

Russ Ritter, representing **Washington Corporations, Missoula,** said they have 13 different companies throughout the state with over 3,000 workers. Managed care, in their judgement, is the key plan in workers' comp reform. He said they strongly support this bill. **Mr. Ritter** said of those 3,000 workers, some 800 are with Montana Rail Link (MRL); since they are all covered under FELA, they would not be covered under workers' comp.

REP. HOWARD TOOLE, House District 60, Missoula, said he supports this bill and said his bill has some of the same goals but takes

a slightly different approach. He said there are some things in his bill that could be incorporated into SB 347 and wants the committee to be aware that there is a difference in the terminology between HB 628 which talks about medical care plans on an individualized basis for the injured worker. **REP. TOOLE** said after reviewing the two bills, they both address different subjects and different portions of the problem and he offered to participate in a merger of the two bills.

Mr. Bob Olsen, representing the **Hospital Association,** said they want to be on record as supporting SB 347.

Bruce Coen, representing the **Montana Optometric Association (MOA),** which represents over 90 optometrists throughout the state of Montana, submitted his written testimony to the committee and stated their support of SB 347. **EXHIBIT 9**

Sam Hubbard, representing the **Deaconess Medical Center of Billings,** said they believe very strongly in the managed care concept contained in this bill and for that reason they urge support of SB 347.

Keith Olsen, Executive Director of the Montana Logging Association, said the state fund work comp rate in Idaho is $28.00; in Montana it is $48.00. Therefore, Montana is not competitive in bidding for federal contracts along our common border. **Mr. Olsen** said Montana needs substantial reform in our system to benefit employers and employees. They believe this bill addresses that, and they urge a do pass.

George Wood, Executive Secretary for the Montana Self Insurers Association, said they support the legislation as amended by the sponsor and recommend a do pass.

Opponents' Testimony:

Roger Tippy, representing the **Montana Pharmaceutical Association,** said they are only opposed to one part of the bill contained in Section 4, page 17 & 18. He distributed his written testimony and discussed it. **EXHIBIT 10**

Don Judge, representing the **Montana State AFL-CIO,** said they believe the legislation is driven by panic founded upon the old workers' compensation debt and it is not the same problem we currently have in the new workers' compensation system. **Mr. Judge** said we have a system that has projected a $42 million deficit based on a 20-year projection and there is currently over $200 million cash in the account of the new fund. He said one of the biggest reasons for rising costs in the system is the cost of health care. He suggested that the committee approach the course of correction with caution.

Mr. Judge said that in the next 20 years, there will be some form

of national health care and perhaps some form of unified, universal state health care program. He said this will significantly reduce the cost of workers' compensation across the country as well as Montana. **Mr. Judge** said the AFL-CIO testified in the Senate and supported this legislation. He said managed care systems are good as long as the injured worker has the initial choice of determining which system they want to use among those managed care providers certified by state government and subsequent disputes would be solved by the Department of Labor.

Mr. Judge said if the employer is paying money to the insurer and the insurer contracts to pay money to the medical care providers, they, in essence, become the company doctor. He said that is not in the best interest of the system or the injured worker. **Mr. Judge** said under this plan the injured worker would go to the company doctor. Regarding co-pays, he said Montana is the only state in the country currently having co-pays.

Barbara Downing, from **Billings,** said she is representing herself and she gave her oral and written testimony to the committee. **EXHIBIT 11** **Ms. Downing** told **SEN. HARP** that she would like to go back to work if she was physically able to. She has 15 years before she can retire and cannot make it on $119.00 a week on workers' comp.

Dan Edwards, Representative, Oil, Chemical & Atomic Workers International Union, AFL-CIO, Billings, gave his written and oral testimony to the committee. **EXHIBIT 12**

Russell B. Hill, representing the **Montana Trial Lawyers Association (MTLA),** submitted his oral and written testimony to the committee. **EXHIBIT 13**

Janice S. VanRiper, Attorney in Helena, said her practice consists mainly of representing workers who are injured, and she has a legitimate concern about these people in the state of Montana. **Ms. VanRiper** said the problem with this bill is it goes too far in decreasing benefits to injured workers and giving unilateral control, in many instances, to the insurance companies. **Ms. VanRiper** submitted her proposed amendments to the committee and reviewed them section by section. **EXHIBIT 14**

Dan Shea, representing himself as an interested citizen, said the co-payment provision of this law is absolutely unfair. He said **SEN. HARP** indicated that it would be $10 a visit or 20%, whichever is less. **Mr. Shea** said if a person goes to physical therapy and it is $50.00 a treatment, for three treatments a week the co-payment would be $30.00 week so, that would be $120.00 a month coming out of their compensation in order to pay for their own physical therapy. He said if it was figured at 20%, it would come out to exactly the very same thing; therefore, that is unfair. **Ms. Shea** said this treats all people the same as to the percentages of what they have to pay without regard to the compensation they are receiving. A high wage earner would be

better able to handle co-payments. **Ms. Shea** said he didn't think there should be a co-payment; but if the committee decides to include them, there should be a sliding scale based on the compensation people are receiving.

Roxanne Verworn, representing herself as a claimant, said the problem she sees with managed care is that we are initially putting the doctors in and keeping them in the insurance companies' pockets. **Ms. Verworn** said when they can recommend who your doctor is going to be, you have a severe problem, especially in Montana where we don't have a lot of competent medical professionals who really care about the injured worker getting back to work. She said she has fought a seven-year battle with workers' comp and still has to have a second back surgery and workers' comp continues to push off what is still an old injury as a new injury. **Ms. Verworn** said the co-payment is absurd and when she was drawing comp benefits she received $122.01 a week. She said she was going to the doctor twice a week and physical therapy five times a week for four months. Her benefits were cut to $45.76 a week without notification and her comp carrier referred her to another physician. **Ms. Verworn** said after receiving the results of the test, the physician told her exactly the opposite of what the test showed. She informed her attorney about the misinformation but, in the meantime, the physician had left town. **Ms. Verworn** said managed care and the co-payment will not handle this situation.

Ms. Dot Stevens, representing herself as a concerned citizen, said there is fraud going on. She said we need more medical training for doctors and we need to get the state involved in ensuring a safe work place. She said when you give an insurer the right to send someone to a physician, they should review the claim to make sure that physician is appropriate for the kind of injury sustained and not send an injured worker to an orthopedic surgeon if they have chemical poisoning.

Jerome Connolly from Billings said he graduated from the Mayo Clinic School of Physical Therapy 21 years ago. **Mr. Connolly** submitted his written and oral testimony on how the current bill functions. **EXHIBIT 15**

Gary Lusin, representing the **Montana Chapter of the American Physical Therapy Association,** submitted his written testimony. **EXHIBIT 16**

Lorin Wright, physical therapist from Red Lodge, thanked **SEN. HARP** for his amendments on the preferred provider organization section. He said Section 6 is too vague and puzzling where it indicates a workers' compensation insurer being contracted with other entities to use the other entities of preferred provider organizations.

Kirk Hanson said he is a self-employed physical therapist representing the **Montana Association of Private Practice Physical**

Therapists. They fully support cost containment and the principles of managed care, but they object to hospitals and large clinics being set up to corner the health care market for injured workers. **Mr. Hanson** said in its present form, SB 347 will not allow self-employed physical therapists to treat injured workers at all, and this will result in the closure of these small businesses. **Mr. Hanson** submitted his written testimony. **EXHIBIT 17**

Richard Smith, self-employed physical therapist in Missoula, said SB 347 promotes the formation of managed care organizations by large corporate institutions. He suggested putting small businesses back in the system, increase the competition and the results will be the costs will go down and quality will go up.

Ann Lawson, owner of a small physical therapy clinic in Kalispell, said competition usually produces a better product. She said currently her costs in Kalispell in providing therapy to an injured worker run about 55% of what it would cost in the hospital in Kalispell and Whitefish. **Ms. Lawson** said her concern is not being able to compete and not even being allowed a chance to treat the workers who self-refer to them because of their reputation. **Ms. Lawson** said she is in opposition to the bill as it's written and is very much in favor of **SEN. HARP'S** amendment on preferred providers.

Questions From Committee Members and Responses:

REP. DRISCOLL asked **Mr. Strizich** to refer to Sections 3 and 5. He said unless the injured worker went to work, he would lose some wages; he asked whether, if the employee was injured at noon, he could go to the doctor. **Mr. Strizich** said he does not put the same interpretation on that. **REP. DRISCOLL** said the injured worker could choose any doctor he wants except he may not choose your doctor unless he's a member of a managed care operation. If the injury results in a total loss of wages for any duration -- for instance, if he lost four hours of wages -- then there would be some loss of wages and if he chose to go to a doctor who is not a member of manage care organization, he couldn't go? **Mr. Strizich** said no, there is an option. It's not 100% required that an employee report to a managed care organization. He said there is an option for the insurer. **Mr. Strizich** said it is optional on managed care. At the point in time when the initial choice physician says the worker is disabled, he has to lose wages, that's when it kicks in, not because someone had to take a half-day off to go to the doctor.

REP. DRISCOLL said that is not what it says. He said after the injured person is treated and has an infection in his arm and the doctor prescribes a brace, is that considered an appliance medically necessary for medical stability? **Mr. Strizich** said yes, if the doctor prescribes it. **REP. DRISCOLL** asked if the doctor prescribes it, then it is not secondary medical services.

Mr. Strizich responded no.

REP. DRISCOLL asked who makes the decision when it's primary and secondary. **Mr. Strizich** said the way the legislation is intended is all the players understand exactly what their role is, and the language goes to the providers. He said if a person has reached stability and their services have nothing to do with impairment or secondary treatment, it might not be allowed by the insurer. **REP. DRISCOLL** asked what medical stability means. **Mr. Strizich** responded that the person has reached maximum medical improvement and there is no expectation that they are going to get any better from medical treatment. **REP. DRISCOLL** asked what is the difference between that and MMI. **Mr. Strizich** said it is essentially the same thing.

REP. DRISCOLL referred to page 6, lines 6 through 8, and said if it means the same thing, then the same words might as well be put back in. **Mr. Strizich** said the old definition was stricken and the new definition is an expansion of that.

REP. DRISCOLL referred to page 11 where it states that the insurer will only pay travel if it is incurred at the request of the insurer, and he asked for clarification. **Mr. Strizich** said if a person had to travel to the nearest medical provider, the insurer would probably pay the travel. He said people will not be stranded because they live in remote areas.

After some discussion, **Mr. Strizich** said the injured person does not attach the deductible to the first visit to the physical therapist or physician. **REP. DRISCOLL** said there needs to be some clarifying language put in the bill because that is not what it states now.

REP. EWER referred to page 5 of the bill and asked **SEN. HARP** what it means that disability does not mean a purely medical condition. **SEN. HARP** said there is an acknowledgment that disability may include something other than a medical condition. **REP. EWER** asked if pain can be a debilitating phenomenon and is that part of the definition of disability. **SEN. HARP** said he could not address the matter in the way it has been described by **REP. EWER.**

REP. EWER asked **SEN. HARP** to respond to **Mr. Judge's** comments on page 11 of the bill. **SEN. HARP** said there are a lot of increased costs in medical service under the current law. At some point, the person paying the bill should have the ability, along with the managed care organization, to show clear evidence that it's cost effective to actually help that injured worker return to work. He said the primary goal of this bill is to help the injured worker through the process to ultimately return to work.

SEN. HARP said he is a union contractor and employs over 100 employees. His policy is when there is an injured worker at any given time, the workers get together and match hours of work. He

said his employees all earn at least $15.00 per hour and if they match four hours, he matches four hours. He described one injury that the company matched over $10,000.

REP. EWER said there is some terminology used in this bill for which the committee doesn't have definitions and he feels that is important. He then reviewed page 15 of the bill and asked if there is much opportunity for a worker to go to an emergency room and have that payable by the State Fund or an insurer, given that this bill is so much of the physician's discretion with the insurer. He also referred to page 18 and said one of the essential points of this bill is, does an injured worker have a choice and can they use their own physician subject to Subsection 3.

SEN. HARP said at the time of the first visit when the injured worker can work outside of managed care and it is the treating physician that he chooses, he doesn't see any problem. He said that 75% of all claims will be excluded from this bill and only about 25% will actually ever see managed care. **SEN. HARP** then referred the question to **Mr. Strizich** with the State Fund.

Mr. Strizich said he understands the concerns but said he doesn't envision any of these kicking in the minute the injured worker walks into the doctor's office. He said after three or four months into a treatment program, if the physician feels there might be permanent impairment, at that point in time managed care comes in. **REP. EWER** then referred to page 21, Section 9, and said there is a lot of terminology in this bill that is not defined. He asked if a health care provider could be a treating physician. **Mr. Strizich** responded yes.

REP. EWER asked if a treating physician jumped through the hoops could he be a managed care provider under this bill. **Mr. Strizich** said yes, it is possible if he can meet all the requirements and certification which entails providing all the necessary medical services.

REP. EWER said his interpretation of this bill is that of trying to ensure that people aren't getting duplicate services, and that is one of the opponents' central problem with this bill. **Mr. Strizich** said if you have two or three things equal, and if the employee has the right to choose between them, you defeat the purpose of preferred providers. **REP. EWER** asked if it is possible to have two preferred providers in the same town. **Mr. Strizich** responded absolutely. He said the purpose of the bill is to allow the insurer to make arrangements to provide all of the necessary medical care and get the best deal they can for it; that is the preferred provider concept.

REP. BENEDICT asked **SEN. HARP** if it was his intent that, if there was not an agreement in place in a small town, the reimbursement rates would be the average wholesale price plus. **SEN. HARP** said definitely, and there was also language added in the Senate

dealing with out-of-state mail order prescription drugs.

CHAIRMAN HIBBARD said a lot of Montana is more than 100 miles from any urban area where a managed care organization would exist, and he asked **SEN. HARP** what his thinking was on that. **SEN. HARP** said managed care will be set up in urban areas. He said in rural Montana, as we know it today, life will continue the way it is has for the injured worker seeing his local physician in most cases. He said the only time that may change is if the treating physician in that community recognizes that there are managed care organizations close to where he might refer that injured worker in rural Montana. In most cases, he doesn't see anything in this bill that would not allow latitude of the insurer. He said they can work outside managed care, and they can work out of an organized group, either PPO or MCO. He said there is flexibility under this bill because rural Montana is recognized. **SEN. HARP** said not every claim and incident in this bill is going to kick in even though **REP. EWER** went through the list.

CHAIRMAN HIBBARD said one of the recurring themes among the opponents was that we may be endangering the exclusive remedy through the 20%, $10.00 charge and more importantly the co-payment provisions and asked for **SEN. HARP's** comments. **SEN. HARP** explained that under work comp there are conditions where employees do not get maximum wages, they get 66 2/3; and there are conditions where it isn't 100% on the benefit side. He said he recognizes the exposure of the small co-payment and it is a matter of saying everybody should have an investment in managed care and medical costs because of the increasing costs.

REP. DRISCOLL referred to page 18, Section 5, lines 18 through 21, and asked for a clarification. If an injured person doesn't ask to change, and he gets to stay with the doctor he wants until you decide he should go to a preferred provider, and you tell him which preferred provider he has to go to, if the claimant doesn't go to them, you don't have to pay the non-preferred provider? **SEN. HARP** said that is correct. **REP. DRISCOLL** asked if the preferred provider is also the managed care person or then do you order me down to Section 7 to a managed care system. **SEN. HARP** said it could be one or the other. If you have a managed care system that is certified and the insurer is contracted with him, you may be directed to them. **REP. DRISCOLL** said he can't see where the person can be ordered to go to a managed care system but they can be ordered to a preferred provider. **SEN. HARP** referred to Section 5 that deals with what happens if a choice is made by the insurer. He said the language reads that the insurer has the choice. He said the insurer cannot direct the person to a managed care organization if there is none, but they can direct to a preferred provider if they have set one up in that particular area.

REP. DRISCOLL said he has a list that is 20 pages long that shows how much money was paid out. In 1992 St. Vincent's Hospital was

paid $2.7 million with a grand total of $20 million paid to medical care providers. He said these are the same people that want to become the managed care people. **REP. DRISCOLL** said they haven't been managing anything now so what is going to force them to manage. There is nothing stated in this bill that forces them to manage. **SEN. HARP** said he disagrees and if we paid $20 million now and the concern is having no control, the law now says we provide reasonable medical services which has been determined by the courts. He said now we are defining what those reasonable services are. **SEN. HARP** said if he finds that St. Vincent's Hospital is overcharging on their services, he will not use them as an insurer.

REP. DRISCOLL asked **SEN. HARP** if he would be willing to amend the bill to say if you order the injured party to one of your doctors, I don't have to pay the $10.00 and they will pay the $10.00 as long as they stay with their physician. He further asked if the person goes to a physician that is not a preferred provider and your preferred provider is going to be cheaper, you are going to save money and then charge me $10.00. **SEN. HARP** said he is not the person to ask if he would support the amendment as this portion of the bill is not his bill. He further said he agreed with **REP. DRISCOLL** but he is not in control of some of those things. **SEN. HARP** then referred to page 15, line 21 of the bill.

REP. DRISCOLL asked if that section means if you request me to go to a managed care system or preferred provider system, I don't pay the deductible? **SEN. HARP** said he did not think so and it deals strictly with examinations.

REP. DRISCOLL asked **SEN. HARP** if he would be willing to amend the bill to say that as long as the injured worker stays with the doctor of his choice, he will pay the deductible, and once he is ordered into managed care or preferred provider, there no longer is a deductible? **SEN. HARP** said that is a good point and he would support that.

REP. COCCHIARELLA referred to page 12, line 9 and asked if medical stability has been defined somewhere or who defines it. **Mr. Strizich** said page 6, line 12 states the definition. He then explained briefly page 12 starting from F.

(Tape 3)

REP. COCCHIARELLA said medical stability to her doesn't mean that person is well and can go back to work. She asked how a person moves on from medical stability. **Mr. Strizich** said if a person is going to a chiropractor and at some point in time the chiropractor says they have reached maximum medical healing, which is the same as medical stability, that may entitle the worker to get his impairment award. He said this bill does not intend to say the injured worker is not entitled to the monthly chiropractic treatment.

REP. EWER asked **Mr. Strizich** if an injured person has to go to the emergency room and there is an attending physician there, is that his first choice. **Mr. Strizich** said the courts have already stated that going to an emergency room is not the injured person's choice of a treating physician and the injured person does not pay the $25.00 for that. He said this is designed to encourage people who may only need a prescription filled or a non-emergency situation to think twice before they rush off to the emergency room.

Closing by Sponsor:

SEN. HARP said he was surprised by the people opposing this bill and the concern about the injured worker that somehow we are affecting the injured worker's ability to receive benefits. He said there is nothing in the bill that lists benefit schedules or where benefits will be reduced with this bill. He said this bill allows quality early return to work in a fair way. He said he views this bill as a pendulum and the pendulum in work comp is completely to one side and out of control. He said this bill is trying to move the pendulum to the middle. **SEN. HARP** said they are trying to look at every avenue in cost containment. He said this bill passed the Senate 48-0.

EXECUTIVE ACTION ON SB 347

Motion: **REP. BENEDICT SB 347 BE CONCURRED IN** and offered amendments. **EXHIBIT 2**

Discussion: **REP. BENEDICT** offered the amendments that **SEN. HARP** provided to the committee. He said that **SEN. HARP** has stayed within his main goal of cost containment to deal with the out of control situation of medical costs in workers' comp. He said he is very appreciative of the work that has been done on this bill.

Vote: Motion to adopt amendments carried unanimously. **EXHIBIT 18**

Motion: **REP. DRISCOLL** moved the amendments dated March 10, 1993. **EXHIBIT 19**

Discussion: **REP. DRISCOLL** discussed the amendments dated March 10, 1993 by Susan Fox. **REP. EWER** said the committee knows what the intention is and they rely on the legislative staff to clean it up. **REP. DRISCOLL** said he would support the amendments and with the concurrence of **SEN. HARP** they are good amendments.

Motion/Vote: **REP. BENEDICT** called the question.

Vote: Motion to adopt amendments carried with **REP. COCCHIARELLA** voting no. **EXHIBIT 20**

Motion: **REP. DRISCOLL** moved the amendments dated March 19, 1993.

Discussion: **REP. DRISCOLL** reviewed the amendments dated March 19, 1993 prepared by **Susan Fox** section by section.

Mona Jamison, representing the **Montana Chapter of the Physical Therapy Association (MCPTA),** was asked to expand on Section 6 of the amendments. She asked the committee to notice that, with the authorization of a treating physician, before this can actually occur where the injured worker is immediately seeing the physical therapist, the treating physician is authorizing that. She said this means that immediate physical therapy is sound and will help get the injured worker back to work quickly. She said there is no need to put this worker into managed care when the treating physical therapist determines this will best serve the injured worker. She said this section will keep costs down.

REP. DRISCOLL continued reviewing the amendments.

SEN. HARP said with the amendments he offered, if the treating physician has an interest in the facility, unless it's in a small community, they will no longer be allowed to treat the injured person unless the insurer authorizes this. He said there is flexibility and in some cases it would be allowable.

REP. DRISCOLL said he would withdraw that amendment. He then asked if the insurer says it's okay for this person to take X-ray's, blood tests, etc., then it's paid for; if they started using it, then they could say no, we're not paying for anything inside your office except your office call?

Mona Jamison said amendments number 11, 12 and 14 on page 2 now being discussed that were prepared by **Ms. Fox** should be stricken. She said they have been taken care of through other amendments.

CHAIRMAN HIBBARD said numbers 3, 5, 8, 10, 11, 12, 13, 14, 15 & 16 have been stricken. He said 1 & 2 go together and 4, 6, 7 & 9 remain.

REP. BENEDICT said the committee has gone as far as possible to try to make this a perfect bill for everyone.

Motion/Vote: **REP. DRISCOLL** called for the question. Motion failed 3 to 3 with **CHAIRMAN HIBBARD AND REPS. BENEDICT AND BERGSAGEL** voting no. **EXHIBIT 21**

Tape 4. Side 1

Motion/Vote: **REP. BENEDICT** called the question on the motion **SB 347 BE CONCURRED IN AS AMENDED.** Voice vote. Motion carried unanimously.

HEARING ON HB 504 AMENDMENTS

Discussion:

CHAIRMAN HIBBARD said the committee had begun the hearing on these amendments on Monday and the bill was moved. **REP. BENEDICT'S** amendments were discussed and passed and the committee will now hear information on **REP. DRISCOLL's** amendments. He called on representatives from the Department of Revenue to speak to **REP. DRISCOLL's** amendments and the idea about bringing in employments that are not contemplated to be covered under the .5% scheme.

Charlotte Maharg, from the **Department of Revenue,** said she was asked to provide a response to **REP. DRISCOLL's** indication of the $7.3 million non-farm wage and salary income under HJR 3 -- what would be available to tax under the payroll tax, and if there was available income, what would be the tax impact on that income. She said, in addition, the department was asked to provide the number of civilian, federal and military employees, the number of interstate railroad workers and the number of sole proprietors and working partners, under **REP. DRISCOLL's** amendments and what would possibly be covered by the payroll tax.

Ms. Maharg said because of their partnership with the Department of Labor in collecting and administering the payroll tax, she referred **REP. DRISCOLL's** amendments to them to review to see if they were in agreement that it did bring the sole proprietors and the working partners under the umbrella of the payroll tax. She has not received a response from them. She said **Chuck Hunter** has not had an opportunity to look at the amendments.

Ms. Maharg introduced **Dr. Phil Brooks, Senior Economist** with the **Department of Revenue.** He reviewed the handout of three tables he put together of Montana Nonfarm Wages and Salaries, Reconciliation of Workers' Compensation Payroll Tax Base & Nonfarm Wage & Salary Income, & Montana Employment, 1991, **EXHIBIT 22**

CHAIRMAN HIBBARD asked what base was used for the $5 million figure at the rate of .5%. **Dr. Brooks** said it was roughly $1 billion. He took the column 1041 and took out the voluntary ones, which are $30 to $40 million and said that brings it down to about $1 billion. He said he didn't expect there would be a big increase in 1995 so he held it constant and took the .5% times $1 billion. He said the reason it won't increase much is that he computed that based on current law, minimum contributions or minimum wage base that's in the current law for the voluntary program which is $10,800 per year.

REP. BENEDICT said this is exactly what he was looking for the other day. If they put the .28%, which is what is considered in the amendments, and extended it to what we are not getting right now, we still can't get there. **REP. BENEDICT** asked **John Fine**

if, under these amendments, they could extend the .28% payroll tax far enough to capture enough people to fund the unfunded liability. He also asked if right now the .28% payroll tax will bring in the coming year about $15 million. **Mr. Fine** agreed with that.

REP. BENEDICT stated that if the railroads could be brought in and all the self-employed, we still couldn't get close to what we need in order to service the debt under this cash flow scenario, which is around $50 million a year. **Mr. Fine** said it wouldn't be close. He said it appears if they went with a 10-year scenario and these numbers that **Dr. Brooks** provided, that the payroll tax on employers with full time and part time numbers which are different, would be somewhere between .78% and .71%. He said these are rough calculations that he made.

Dr. Brooks said the $1 billion was on the self-employed side and on the payroll side. In 1991, what was excluded was roughly $784 million and of that the federal government was $527 million, which left $257 million and that seemingly could be added in and there are current exemptions in effect that could be repealed. He said he would not expect that $257 million to grow very much between now and 1994. He said most of it is railroad wages and salary. He said the 1994 projection of nonfederal government exclusions could use $275 million and that would yield a few hundred thousand more than the .28%. **REP. DRISCOLL** said he wants to know how many millions and he asked **Dr. Brooks** what he would call a life insurance agent's commission check. **Dr. Brooks** said he would include it in the entity that's called wages and salaries. **REP. DRISCOLL** asked the department to find out how much is on the total gross on schedule C's income tax. **Dr. Brooks** said for 1991, households with a gain of $525 million and households with a loss of $68 million so the net is $457 million in terms of what is filed on schedule C for sole proprietors. **REP. DRISCOLL** asked if that category would include finance, insurance and real estate? **Dr. Brooks** said yes, those individual proprietors in that economic sector. He said he has an estimate of 9,133 that are of the self-employed for real estate. He said real estate is exempt in the current law. **Dr. Brooks** said there are roughly 4,900 total employees, both wage and salary and self-employed people in the insurance agent sector so there would be about 3,700 self-employed insurance agents.

REP. DRISCOLL asked how many self-employed finance people there are. **Dr. Brooks** said there are about 1,064 total employees in that sector of which 618 are wage and salary workers, so there are about 400 self-employed securities and commodity dealers/ brokers. He said there are not too many banks that are sole proprietorship. **REP. DRISCOLL** said they had better start auditing because there are 3,500 railroaders making $159 million and 13,308 making $500 million. He asked why they get away and don't have to pay. He said all we have to do is say the gross on schedule C's have to pay. Railroads would have to pay.

REP. DRISCOLL said under the bill as written, if a person was in finance, real estate or insurance, they would pay once and if they didn't, they would pay nothing. He asked **Dr. Brooks** when there are 3,500 railroad people making $159 million and 15,000 people are only making $500 million, does that add up? **Dr. Brooks** said the $500 million is for all the nonfarm sole proprietors and so it's self-employed miners, construction businesses, manufactures and so forth. **REP. DRISCOLL** suggested that there is something wrong with the tax laws for those people to get away with this.

REP. BENEDICT asked if **REP. DRISCOLL** had moved his amendment and the committee suspended it.

CHAIRMAN HIBBARD said **REP. DRISCOLL** moved his amendment and he was attempting to identify some other sources of payroll tax that are not currently taxes and additional information was requested because it was apparent that the committee was making guesses and didn't have the information.

REP. BENEDICT said he agreed with **REP. DRISCOLL** that there are not enough people in the payroll tax but he doesn't think through his amendments we can achieve where we want to go. He said even if every self-employed person could be pulled in, we couldn't put a payroll tax on people that are not on payroll and there would have to be an income tax surcharge on them. He said we still wouldn't get close with the .28%, which the amendments call for, to fund the $500 million a year and so for that reason he opposes the amendment.

Motion/Vote: **REP. DRISCOLL** moved adoption of the amendments as discussed. Motion failed 3 to 3 with **REPS. DRISCOLL, COCCHIARELLA** and **EWER** voting aye. **EXHIBIT 23**

EXECUTIVE ACTION ON HB 504

Motion: **REP. BENEDICT MOVED HB 504 DO PASS AS AMENDED**

Discussion: **REP. DRISCOLL** said if we have to tax minimum wage, such as hotel restaurant workers and we cannot tax stockbrokers, he is not voting for this bill.

REP. BENEDICT said he is not voting for this bill because he doesn't like any of the alternatives. He said they have wrestled with this bill for two years as part of the Joint Select Committee on Workers' Compensation and this is the best they could come up with.

REP. COCCHIARELLA said on the issue of tax increases, the point she is going to make is that the public employees who work for our government are taxpayers too and what we have done essentially with this bill is a major cut in pay for the public employees in this state, probably the biggest cut they have ever

taken. She said regarding the pay issue, if members don't support a pay increase, they are adding more to the burden because of the cost of inflation in public employment. She said minimum wage earners and public employees in the state of Montana are eating it big time and she hates this bill.

REP. DRISCOLL said there is a list of people they cannot tax because it is too hard for the department to find these people who are lawyers, stockbrokers, insurance agents, real estate people and doctors. He said if a person is injured, the lawyer is right there and they will help the insurance company. He said the guys that help the insurance company get up to $200 per hour and don't not pay in but the hotel restaurant worker who makes minimum wage is going to pay .5% out of his check and then if they get injured and go to the doctor they pay $10.00. He said they can be found for income tax but they only report $525 million and that is criminal. He summed up by saying it is unfair that railroads won't be taxed and other occupations are not taxed because supposedly they are too hard to find.

CHAIRMAN HIBBARD asked **REP. DRISCOLL** if he was on the joint interim committee and he responded he was. **CHAIRMAN HIBBARD** asked when looking at the various funding sources for the committee if they considered ways to get at the list of people who do not pay. **REP. DRISCOLL** said the committee offered many ideas, for instance, punch board, pull tabs and magi-buck poker machines and **SEN. HARRY FRITZ** said no, he wanted that for the university system. **REP. DRISCOLL** said at one time they looked at the total wage and salaries of this line item in the revenue estimate but there was no interest so that idea was dropped. He said the amendment made at the last meeting was amended by **REP. DOLEZAL.**

CHAIRMAN HIBBARD said the .28% payroll tax was put into effect in 1987 and the joint interim committee had two years to work on this but the problem has gotten worse and we have to find a funding source. He said the committee should go ahead and pass this and try to figure out a way to bring some of the others in.

REP. BENEDICT said the joint interim committee looked at the old coal tax too. He said there isn't any way to get there and not one of the options seem to work.

REP. EWER said it seems to be the consensus that people are very concerned about increasing the base but right now there is not a vehicle to increase the base. He said if this committee is sincere about trying to increase the base, there is still some time.

CHAIRMAN HIBBARD asked if he was referring to the committee bill we have already discussed. **REP. EWER** said no, we are talking about finding a way to increase the base and we can't do it with **REP. BENEDICT's** bill because it won't allow amending of the title because of the Schedule C business.

REP. BENEDICT said even if we could increase the base clear up to anyone that is making money in the state of Montana, we still could not tax enough at .28% to get there. He said if we put an income tax surcharge on the billion dollars that is still left out there, and pulled in the self-employed and the railroads and all the other people, we still could not come close. He said he would like to see some other funding source and challenged **REP. DRISCOLL** to vote for this bill. He said the committee has to get something out on the floor to debate and he would work with any of the committee members to come up with something.

After further discussion, **REP. BENEDICT** called the question.

Vote: HB 504 DO PASS AS AMENDED. Motion carried 4 to 2 with **REPS. DRISCOLL AND COCCHIARELLA** voting no. **EXHIBIT 24**

Motion/Vote: REP. EWER MOVED THAT THIS COMMITTEE ASK FOR LATE INTRODUCTION OF THIS BILL so the payroll tax base can be increased to whatever mechanism needed, be it using income tax schedules or whatever.

Discussion: CHAIRMAN HIBBARD said he would talk with the Speaker after this meeting. He said he honestly didn't know if the committee could introduce a bill at this time.

REP. BENEDICT said he would support this motion just to look into it.

REP. EWER said the conclusion that is made regardless of what the base is, we can get out of here on the status quo and he challenged that notion. He said the bigger the base, the more equitable it is and that's a good argument.

REP. BENEDICT said when **REP. EWER** talked about fairness, he assumed that his motion would include bringing employers and employees into the base. **REP. EWER** said the issue is finding a larger base; stockbrokers, self-employed people, the upper end people who are escaping payroll tax.

Motion/Vote: REP. EWER MOVED FOR A LATE INTRODUCTION OF THE BILL SO AN INCREASED PAYROLL TAX BASE CAN BE CHECKED INTO. Voice vote taken. Motion carried unanimously.

EXECUTIVE ACTION ON SB 394 AMENDMENTS

Motion: REP. BENEDICT MOVED SB 394 BE CONCURRED IN.

Discussion: REP. COCCHIARELLA moved adoption of the amendment dated March 8, 1993. She asked that **Nancy Butler, State Fund** and **Jan VanRiper** tell the committee the difference between the two amendments and see if there is a controversy. **EXHIBIT 25**

CHAIRMAN HIBBARD said he also has another amendment by **SEN. HARP**

dated March 8, 1993. **EXHIBIT 26**

Nancy Butler representing the **State Fund** said what **REP. COCCHIARELLA's** amendment does is for an attorney representing a party other than the claimant like an insurance company. Their fees are limited to $75.00 an hour and subject to a maximum fee of $7,500. **Ms. Butler** said it wasn't clear if that is per case or per attorney. She said the problem with that is a defense attorney's work is on an hourly basis all the time and they don't work on a contingency basis. She said when they get hired to defend a case, if they win the case, they don't get any of the money that goes to the worker so it's always on an hourly basis. She said the claimant's attorney works on a contingency basis with their clients; but when it comes to the workers' compensation court, the court awards fees on an hourly basis to the claimant's attorney as well. Now the law reads that there is no limit on the number of hours or on the hourly fee unless the judge determines there should be a limit on the rate and hours. **Ms. Butler** said this bill deals with the relationship between the claimant and the attorney only. She said this amendment puts the defense attorneys in the picture.

Ms. Butler said **SEN. HARP's** amendment limits a defense attorney to no more than $95.00 per hour; but if the workers' compensation judge is going to award these to the claimant's attorney, they are also limited to $95.00 per hour. She said to put a cap on a defense attorney means you are going to get $7,500 into a case and have to stop working or give it to another attorney who then gets to put $7,500 into it. She said the workers' compensation act provides for an award of fees to a claimant's attorney from an insurance company; but if the insurance company wins, they do not get their fees paid by the claimant.

REP. DRISCOLL asked how much the claimant's attorney receives if they lose. **Ms. Butler** said right now the rules read that the attorney has to get something through separately and if he does, he gets the fee. If he loses, he doesn't earn anything. She said defense attorneys are paid their hourly rate on how many hours they put into the case. She said the difference is the claimant's attorney often works on a contingency basis and it doesn't matter how many hours they put in, they get a percentage.

REP. DRISCOLL asked how much the State Fund outside lawyers get. **Ms. Butler** said in FY92, outside defense counsel was paid $340,000.

REP. COCCHIARELLA asked **Jan VanRiper** to explain her views on the amendments.

Mr. VanRiper said **REP. COCCHIARELLA's** amendment basically puts both claimant's attorneys and defense attorneys on the same basis, $75.00 per hour and $7,500 per case. She said that also requires defense attorneys to submit their attorney fee contracts to the department. She said on **SEN. HARP's** amendments there is

no reporting requirement so there's nothing to monitor what the defense is doing and there is a discrepancy that allows the defense attorneys to charge $95.00 per case with no maximum at all versus what the claimant's attorneys are allowed to charge. She said she cannot see the rationale for that.

Ms. VanRiper said she doesn't think it was the original intent of **REP. COCCHIARELLA's** amendment to envision a situation where the defense attorney would chalk up $7,500 worth of fees and then hand the case over to another lawyer to chalk up an additional $7,500.

REP. COCCHIARELLA said the amendment proposed by **SEN. HARP** gets at a small part of this and he said they could talk about the $95.00 amount. She said under her amendment it says every attorney in the situation is treated exactly the same. She said if the department has to use in-house attorneys, they only get to use them up to a certain point and they will have to find a way to limit that. She said she didn't think we need to be paying attorneys $95.00 per hour and this will limit costs.

REP. BENEDICT said if there are three attorneys working in a firm and one attorney uses up their $7,500, under **REP. COCCHIARELLA's** amendments they could still hand it to another attorney in the same firm and let them also run up $7,500. He said it needs to be spelled out that it is the maximum that can be charged for a particular case.

REP. COCCHIARELLA asked that **Susan Fox** change the amendment so that it means a maximum per case.

Ms. Fox said the amendment uses the same language that is in the bill so if there is a problem with the amendment, there is a problem with the bill as well.

REP. BENEDICT said he would support **REP. COCCHIARELLA's** amendment with the added suggestion.

SEN. HARP said his intent was per claim and that is how it was discussed in the Senate.

CHAIRMAN HIBBARD said he did not have a problem with **REP. COCCHIARELLA's** amendment.

Motion/Vote: **REP. BENEDICT** called for the question. Motion carried unanimously. Voice vote taken.

EXECUTIVE ACTION ON SB 394

Motion/Vote: **REP. BENEDICT MOVED SB 394 BE CONCURRED IN AS AMENDED.** Motion carried with **REPS. EWER AND DRISCOLL** voting no. **EXHIBIT 27**

EXECUTIVE ACTION ON HB 587

Motion: **REP. BENEDICT** moved adoption of the amendments.

Discussion: **REP. BENEDICT** read his amendments and said he had worked on them with **Steve Brown** and other interested parties.

Ms. Fox reviewed the amendments section by section.

CHAIRMAN HIBBARD asked if this is consistent with unemployment insurance hearings. **REP. BENEDICT** said he wasn't sure because he had never been through an unemployment insurance hearing but it is an informal process and that's what he wants to get at. He said we have an informal process, then we go to a formal process, then those records are available to the board.

CHAIRMAN HIBBARD said he did not have a problem with this.

REP. EWER asked if this vote is on the amendments. **CHAIRMAN HIBBARD** said yes.

Vote: **REP. DRISCOLL** called for the question. Motion carried unanimously. **EXHIBIT 28**

Motion/Vote: **REP. BENEDICT MOVED HB 587 DO PASS AS AMENDED.** Motion carried unanimously. **EXHIBIT 29**

EXECUTIVE ACTION ON HB 628 REP. TOOLE'S AMENDMENTS #1

Motion: **REP. BENEDICT** moved Rep. Toole's amendments #1 but intends to offer a table motion after discussion.

Discussion: **REP. TOOLE** said this bill does not mandate the selection of treating physicians but it does allow that to be changed if there are problems. He said this allows the change not to be made by the insurer but by the department upon application by the insurer. He reviewed the amendments section by section.

Vote: **REP. EWER** called for the question. Motion carried with **REP. BENEDICT** voting no and **REP. BERGSAGEL** abstaining. **EXHIBIT 30**

EXECUTIVE ACTION ON HB 628 REP. TOOLE'S AMENDMENTS #2

Motion: **REP DRISCOLL MOVED HB 628 DO PASS AS AMENDED.**

Discussion: **REP. TOOLE** said this bill has two subjects. The last section deals with rates and rate structure but the primary thrust of the bill is managed care. He said he would like the committee to pass this bill and allow it to be coordinated with the concepts of **SEN. HARP's** bill. He said he would support

amending the NCCI out of the bill if it would help the bill's progress.

Susan Fox asked if the intention is to take all of Section 7 out of this bill. **REP. TOOLE** said yes.

CHAIRMAN HIBBARD said he intends to support **REP. EWER's** motion as the bill deals with two very different subjects; one is managed care and one is NCCI rates. He said the managed care is the most important part of the bill.

REP. BENEDICT said he also intends to support **REP. EWER** and that one of his main concerns is the NCCI rates.

Motion/Vote: **REP. EWER** moved to delete all reference to using NCCI rates in this bill. Amendment passed unanimously. **EXHIBIT 31**

EXECUTIVE ACTION ON HB 628

Motion: **REP. DRISCOLL MOVED HB 628 DO PASS AS AMENDED.**

Discussion: **CHAIRMAN HIBBARD** said, as a matter of clarification, if the committee should pass this bill we then have managed care which conflicts with the managed care in the bill the committee passed earlier today. He asked how to handle that.

REP. TOOLE said this bill provides the managed care program on a case-by-case approach and the focus of the managed care is on the individual workers' compensation injuries. He said this is the guts of a managed care program.

CHAIRMAN HIBBARD asked **SEN. HARP** if he had a chance to look at this managed care bill. He responded no and he did not know how it would coordinate with his.

Vote: **REP. BENEDICT** called the question. Motion carried with **REPS. BENEDICT** and **BERGSAGEL** voting no. **EXHIBIT 32**

EXECUTIVE ACTION ON HB 456

Motion: **REP. BENEDICT MADE A MOTION TO RECONSIDER ACTION ON HB 456 AS AMENDED. (Jacqueline Lenmark's privatization bill)**

Discussion: **REP. BENEDICT** said he feels this bill is a very important part of the package, has been discussed, and he would like to get the bill out of the committee.

Vote: **REP. BERGSAGEL** called for the question. Motion failed with **REPS. DRISCOLL, COCCHIARELLA AND EWER** voting no. **EXHIBIT 33**

Questions From Committee Members and Responses:

REP. DRISCOLL observed that, out of all the bills that have passed out of this committee with a do pass as part of the package, HB 361 is still in committee.

CHAIRMAN HIBBARD said it has been the intent all along that all the bills will become part of a package which will go forward to the Labor Committee.

REP. BENEDICT said HB 361 was passed out of the committee as part of the package. He asked **REP. DRISCOLL** if it was his impression that the committee was going to vote on all the bills as one package out of the committee before they were moved to the Labor Committee.

REP. DRISCOLL said it was his impression when the committee started there was going to be some compromising and there hasn't been. He said whenever there was a bill that had a Democrat's name on it or had anything to do with giving the worker benefits, it was dead. He said when a bill came up to tax the rich people, it died. He said it is his full intent that HB 361 is a dead bill.

After some discussion on this subject, it was decided that the secretary would type verbatim discussion and votes on HB 361 for the committee to read on Friday.

REP. BENEDICT said he doesn't feel that employees are the only people being asked to take some restrictions on trying to bring the system into balance. He said the employers in this state, through cooperative efforts of members of this committee, have been asked to police themselves. He said we have some very severe anti-fraud programs and safety programs that some employers will not like and there are a lot of things that employers are going to have to go along with, especially employers who have been trying to defraud the system the same as health care providers or as employees. **REP. BENEDICT** said the committee has done a good job in trying to work through all of our different values and philosophies and come together with something that will work and make the system better.

REP. DRISCOLL said he found out from attorneys that to prove fraud on an employer is a much higher standard than proving fraud on an employee. He said to prove fraud on an employer, one has to go to the criminal statutes.

ADJOURNMENT

Adjournment: 9:00 p.m.

REP. CHASE HIBBARD, Chairman

EVY HENDRICKSON, Secretary

CH/ev

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL DATE 3-10-93

NAME	PRESENT	ABSENT	EXCUSED
CHASE HIBBARD, CHAIRMAN	✓		
JERRY DRISCOLL, VICE CHAIRMAN	✓		
STEVE BENEDICT	✓		
ERNEST BERGSAGEL	✓		
VICKI COCCHIARELLA	✓		
DAVID EWER	✓		

HR:1993
wp.rollcall.man

HOUSE SELECT COMMITTEE REPORT

March 11, 1993
Page 1 of 1

Speaker: We, the select committee on Workers' Compensation
mmend that Senate Bill 347 (third reading copy -- blue) do
oncurred in as amended, and that the House refer the bill
amendments to the House Committee on Labor and Employment
tions for its consideration as part of the Workers'
ensation package.

Signed: _____
Chase Hibbard, Chair

that such amendments read:

age 15, line 6.
owing: "for"
rt: "20%, but not to exceed"
owing: "$10"
rt: ","

age 15, line 8.
owing: "disease"
rt: ", unless the visit is to a medical service provider in a
managed care organization as requested by the insurer or is
a visit to a preferred provider as requested by the insurer"

age 20, lines 3 and 4.
owing: "~~or~~" on line 3
ke: the remainder of line 3 through "pharmacies," on line 4

age 20, line 5.
owing: "goods"
ke: ","
owing: "and"
ke: "other"

age 27, line 8.
owing: "prohibition."
ke: "A"
rt: "Unless authorized by the insurer, a"

age 27, lines 9 and 10.
owing: "facility" on line 9
ke: the remainder of line 9 through "practice" on line 10

ittee Vote:
5, No 1.

551221SC.Hpf

HOUSE SELECT COMMITTEE REPORT

March 11, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that Senate Bill 394 (third reading copy -- blue) do be concurred in as amended, and that the House refer the bill with amendments to the House Committee on Labor and Employment Relations for its consideration as part of the Workers' Compensation package.

Signed: Chase Hibbard
Chase Hibbard, Chair

And that such amendments read:

1. Page 1, line 12.
Following: "claimant"
Insert: ", an employer,"

2. Page 1, line 17.
Strike: "claimant"
Insert: "party"

3. Page 1, line 18.
Following: "(2)"
Insert: "Fees charged by an attorney representing a claimant are limited as provided by subsections (2) through (5)."

4. Page 1, line 23.
Following: "$7500"
Insert: "per claim"

5. Page 3, line 12.
Following: line 11
Insert: "(6) Fees charged by an attorney representing a party other than a claimant may not exceed $75 an hour, subject to a maximum fee of $7,500 per claim. The fee arrangement is subject to approval by the department."
Renumber: subsequent subsections

6. Page 3, lines 13 and 14.
Following: "arrangement" on line 13
Strike: the remainder of line 13 through "claimant" on line 14.

Committee Vote:
Yes 11, No 2.

551247SC.Hpf

7. Page 3, line 16.
Page 3, line 17.
Strike: "claimant"
Insert: "party"

8. Page 4, lines 2 and 3.
Following: "benefits" on line 2
Strike: the remainder of line 2 through "attorney" on line 3
Insert: "paid"

HOUSE SELECT COMMITTEE REPORT

March 11, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that House Bill 587 (first reading copy -- white) do pass as amended, and that the House refer the bill as amended to the House Committee on Labor and Employment Relations for its consideration as part of the Workers' Compensation package.

Signed: Chase Hibbard
Chase Hibbard, Chair

And, that such amendments read:

1. Title, line 9.
Strike: "GUIDELINES NOT SUBJECT TO"
Insert: "PROCEDURES OF"

2. Page 3, line 15.
Strike: "employers"
Insert: "an employer"
Strike: "are"
Insert: "is"
Following: "by"
Insert: "either a"

3. Page 3, line 16.
Strike: "carriers and"
Insert: "carrier or"

4. Page 4, line 11.
Following: line 10
Insert: "(6) Documents and other information concerning the committee's actions must be made available for public review in the office of the commissioner of insurance."

5. Page 4, line 19.
Following: line 18
Insert: "(b) make the final determination regarding the establishment of all classifications;"
Renumber: subsequent subsections

Committee Vote:
Yes 4, No 0.

551345SC.Hpf

6. Page 5, lines 12 through 17.
Following: "subsection" on line 12
Strike: the remainder of line 12 through line 17
Insert: "(1)(e) must be an informal proceeding as provided in 2-4-604."

7. Page 5, line 18 through page 6, line 4.
Strike: subsections (b) and (c) in their entirety
Insert: "(b) A party aggrieved by a decision of the committee rendered after a hearing conducted pursuant to subsection (2)(a) may petition for judicial review of the decision pursuant to Title 2, chapter 4, part 7."

EXHIBIT 1
DATE 3-10-93
SB 347

TESTIMONY ON SENATE BILL 347
By Senator John Harp

House Select Committee on Workers' Compensation
March 10, 1993

This bill represents the first comprehensive revision of the medical delivery system under the Workers' Compensation Act. The Workers' Compensation Act provides an injured worker with payment of "reasonable" medical expenses. This bill affords the Legislature the opportunity to determine what are "reasonable" medical services, instead of leaving it up to the courts to make that decision. Cost containment is the principle upon which the bill is based but its purpose also is to provide timely and effective medical services to injured workers.

MANAGED CARE

A key component of this bill is managed care. Managed care is defined in section 8 as:

> A program organized to serve the medical needs of injured workers in an efficient and cost effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to section 6 through appropriate health care professionals.

The managed care organization is to provide <u>all</u> primary medical services to an injured worker who loses wages for any duration, has permanent impairment, needs referral to a specialist for treatment or requires special, and costly diagnostic procedures. The insurer will have the right to designate the managed care organization and will not be liable for medical services obtained outside the managed care organization, unless the insurer authorizes the care, or emergency care is necessary. The designated treating physician in the managed care organization then becomes the worker's treating physician.

The Department of Labor will establish criteria pursuant to section 9 to certify managed care organizations. Once certified, insurers may contract with the

organizations to provide medical services for injured workers. Insurers will be required to give written notice to workers regarding managed care organizations. Reimbursement for travel has been restricted by this bill unless the travel is incurred at the request of the insurer. As managed care will be at the request of the insurer when the worker is subject to managed care, travel related to treatment from the managed care organization will be reimbursable. Managed care organizations, based on the size and population distribution in Montana, will likely only be established in the state's largest cities.

FREEDOM OF CHOICE

Freedom of choice of the treating physician has been deleted for workers' compensation insurance from Title 33. Treating physician is defined in the bill. However, if a worker is subject to managed care, the managed care organization then designates the physician who becomes the worker's treating physician and becomes primarily responsible for the worker's treatment. If a worker is not subject to managed care, or if the insurer authorizes the care, a worker may chose and continue to receive care from the worker's choice of initial treating physician. However, a worker may receive immediate emergency care from a physician and then chose an initial treating physician, unless the worker then becomes subject to managed care.

PREFERRED PROVIDERS

Use of preferred provider organizations by insurers is encouraged under this bill to promote cost containment of medical care. Insurers may establish such arrangements with medical providers. A preferred provider organization may be established with the managed care organization or a preferred provider organization may be established independently of a managed care organization with any providers. A worker receiving care from a managed care organization might be directed to a preferred provider organization for medical goods, however a managed care organization could be a managed care preferred provider.

PRIMARY AND SECONDARY MEDICAL SERVICES

A distinction is made between "primary" and "secondary" medical services and puts restrictions tied to cost effectiveness, on those services which are not necessary to achieve medical stability. Secondary medical services will be paid by the insurer if it is demonstrated they are cost effective in returning the worker to employment. Both services are defined in the bill. The secondary services definition was amended to reflect programs addressing disability and for this section a definition of disability was added to the bill.

PALLIATIVE AND MAINTENANCE CARE MEDICAL SERVICES

Restrictions are also placed on "palliative" and "maintenance care", unless, it clearly enhances employment, or is for a permanently totally disabled worker to monitor medication or monitor the status of a prosthetic device.

ROLE OF DEPARTMENT OF LABOR

The Department of Labor's functions are important to this bill as it fulfills a neutral regulatory role in regards to medical services that are provided to injured workers by the insurers. Their functions in this bill are to certify managed care organizations after establishing the criteria and rules, develop utilization and treatment standards in conjunction with standing medical advisory committees, establish physician panels and review requests for approval of palliative or maintenance care, establish rates for hospital services, adopt rules excluding from compensability medical treatment that is unscientific, unproved, outmoded, or experimental and provides hearings for disputes between an insurer and a medical service provider.

It is intended that the medical advisory committees would be established either with all representatives from the same provider group or in various appropriate combinations.

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GENERIC DRUGS

This legislation calls for reestablishing reimbursement rates for prescription drugs similar to the methods used by Medicaid, and also requires generic drugs to be used unless unavailable.

HOSPITAL RATES

Hospital reimbursement rates established by the Department of Labor may be based on a per diem or diagnostic-related groups. These methods are those used by other types of insurers and a delayed effective date to January 1, 1995 is provided for in order for the Department of Labor to properly establish this process. The rates effective 1/1/95 may not be less than Medicaid reimbursement rates, and it is contemplated that the Department of Labor will use a system similar to Medicaid's. Currently, the bill's intent is to allow the Department of Labor to follow their current rate setting process, subject to 39-71-704(4), without regard to the Medicaid reimbursement rates. Time for the Department of Labor to change the process is necessary, and it also gives insurers time to reprogram computers.

COMPLIANCE WITH MEDICAL TREATMENT

Compliance with medical treatment is required under this bill, and an insurer may terminate benefits upon 14 days notice for failure to cooperate with the managed care organization or the treating physician, submit to medical treatment except for invasive procedures or provide access to health care information. This section is intended to be an option available to insurers, and in addition to or instead of any remedies provided for in 39-71-605 and 607.

DOMICILIARY CARE

Domiciliary care is also addressed in this bill. The criteria for domiciliary care is placed in the law and requires the care to be provided by a nurse if professional nursing care is required. Care that is required on a 24-hour basis but does not require the services of a professional nurse may be provided by a family

member but is limited to the statewide daily average reimbursement rate for nursing homes by Medicaid. The average rate right now is $67.15 per day. Currently a family member may be reimbursed up to $180.00 per day. Domiciliary care required for less than 24 hours a day by a family member is limited to the primary wage and a maximum of 8 hours per day. The prevailing wage, based on the level of care provided could potentially range from minimum wage to approximately $7.50 per hour.

CO-PAYMENT

This bill has unique provision on a co-payment by a worker. After the initial treatment, a worker is liable for $10.00 for every visit, and visit is defined in the bill. The worker will also be liable for $25.00 of every visit to a hospital emergency department after the initial treatment. My understanding is that workers' compensation insurance is the only form of medical insurance without a deductible or co-payment provision. Medical payment prior to the early 70s was limited as to time and dollar amount. This provision is not inconsistent with other workers' compensation benefits in that a deduction exists in the 6-day waiting period to receive wage loss compensation benefits, the wage rate itself is 66 and 2/3 of the worker's average weekly wage and permanent partial and permanent total benefits have statutory limits. The Workers' Compensation Act currently in its declaration of public policy states wage loss benefits are not intended to make a worker whole but are intended to assist a worker at a reasonable cost to the employer.

SELF REFERRAL

This bill also contains a provision on self referral by physicians. If a provider is referring a claimant to a health care facility outside the physician's office and the physician does not directly provide the services there and the physician has an investment interest in the facility, the insurer is not liable for charges incurred. An exception is if there is a demonstrated need in the community for the facility and

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alternative financing is not available. This provision is consistent with the recent resolution by the American Medical Association.

FREEDOM OF CHOICE - RETROACTIVELY

This bill's amendment of the "freedom of choice" provision in §33-22-111, MCA, is also applicable because of the recent Workers' Compensation court decision in *Wieland v. State Fund*, WCC No. 9208-6554. In the *Wieland* case, the Court directly contradicted a 1978 Supreme Court decision *Garland v. Anaconda Co.*, 177 Mont. 260 (1978) that had upheld the Department of Labor rule concerning choice of physicians, in spite of an argument in *Garland* that the freedom of choice statute rendered the rule invalid.

Garland held that a claimant must have prior authorization from an insurer to change physicians. A Department of Labor rule, 24.29.1403, also requires authorization from the insurer to change physicians.

Section 33-22-111, MCA, allows for freedom of choice under the Workers' Compensation Act (amended in SB 347, p. 2, and then separately defines treating physician on p. 9).

The impact of this case is that a claimant does not need approval from the insurer to change doctors, therefore ability to seek treatment from different physicians would be unlimited. The curative legislative, section 16, is necessary to resolve the conflict in the Workers' Compensation Court's interpretation.

The Workers' Compensation Court currently has the case on a request for a rehearing. It may reconsider its decision, or the Supreme Court may very well reverse.

The National Council on Compensation Insurance, NCCI, is an organization of which the State Fund and the private insurers must belong. One of their actuaries priced this bill for the State Fund and determined that bill would save approximately $7 to $8 million annually for the Sate Fund.

Oregon used managed care and other concepts which this Legislature is also addressing in this and other bills, in the reform of their workers' compensation system with positive results. Montana should do no less. I urge this Committee to pass this bill.

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SB 347

EXHIBIT 2
DATE 3-10-93
~~HB~~ SB 347

Amendments to SB 347
Third Reading

House Select Committee on Workers' Compensation
Requested by Senator John Harp
March 10, 1993

1. Page 15, line 6.
Following: "for"
Insert: "20%, but not to exceed"

2. Page 15, line 6.
Following: "$10"
Insert: ","

3. Page 20, lines 3 and 4.
Following: "~~or~~"
Strike: the remainder of line 3 through "pharmacies," on line 4

4. Page 20, line 5.
Following: "and"
Strike: "other"

5. Page 27, line 8
Following: "prohibition."
Strike: "A"
Insert: "Unless authorized by the insurer, a"

6. Page 27, line 9 and 10.
Following: "facility"
Strike: "the remainder of line 9 through "practice" on line 10

EXHIBIT 3
DATE 3-10-93
HB SB 347

Testimony in support of SB347 P. J. Strizich - State Fund

I would like to give you a quick glance at the reasons we feel the reforms presented in this bill are necessary. I would like to give an illustration which represents a glaring example of the issue of medical care to injured workers under the current statutes.

The charts I have handed to you represent figures published in the annual report to the governor by the Department of Labor and Industry and the State Fund. The first chart reflects the number of injuries reported, industry wide, for fiscal years 81 through 92. The second chart reflects the total medical benefits paid for the same periods. The third chart represents the average cost of medical services per accident. The average cost per accident has increased 402% over the 11 year period. This amounts to over 36% per year.

During the same period, the state's average weekly wage, which is a reflection on the overall economic status of Montana's workers, and is used to determine the maximum compensation rates paid to injured workers, rose from $219.00 in FY81 to $336.00 in FY 92, for a total increase of 65%. The yearly average increase is less than 6%. The simple truth is that medical costs have increased six time faster than compensation rates. Up until now, insurers have been obligated to deliver "reasonable" medical services to injured workers. If the increases just demonstrated are reasonable, then this bill in unnecessary.

According the State Fund's actuary, more than half of the most recent rate increase by the State Fund is attributable to the uncontrolled increases in medical benefit payments.

One of the areas representing the greatest waste in the system is duplication of services. It is not unusual to observe case files where the injured worker has been given two or three of the same diagnostic test, such as MRI's, by the same or two or three providers involved in treatment. Each one costs a thousand bucks. It is not unusual to see the same conservative treatment modalities, such as physical therapy, prescribed two or three times. If the first one was ineffective, does it make any sense to continue to try it? Each time the patient is sent can cost two or three thousand bucks. These abuses will be eliminated under this proposal.

Another area of waste is the delays in services. If a treating physician refers the patient to a specialist, an orthopedic surgeon perhaps, everything is on hold just waiting for the appointment, which may be six or eight weeks down the road. If the patient is receiving the maximum compensation rate payable today of $349.00 per week, six weeks amounts to almost $2,100.00. The managed care proposal in this bill is designed to prevent delays in treatment.

You no doubt will hear opposition to this bill, from troughers, who have many reasons to object to all or parts of this legislation. You will probably have requests to amend the language so that their special interests are addressed. Chiropractors may have the feeling that they have been singled out for exclusion. They have not. They are treated no differently than any other physician, including orthopedists, neurosurgeons or any other provider not part of a managed care organization. There is nothing in this bill to prevent physicians, chiropractors, optometrists, or any other provider from becoming a part of a managed care organization.

Physical Therapists, particularly those with independent practices, have expressed concerns that managed care will prevent them from treating workers' compensation patients. Again, there is nothing in this bill to prevent them from affiliating with managed care organizations. Physical Therapy will still be necessary. Currently, a prescription from the attending physician is necessary for them to treat injured workers. The same will be true under this bill. There is no reason to use this legislation as a vehicle for the advancement of special interests.

As the largest single payer of medical benefits under the workers' compensation system, the State Fund is aware of these concerns. In evaluating the respective opposition to this bill, please bear in mind that the purpose of the legislation is to provide a systematic, defined method to deliver medical services to all injured workers in Montana, whether they have been severely burned or have a foreign body in their eye, whether they suffer from a hernia or have a simple back strain, whether they require surgery or not. The managed care system created by this bill will provide the necessary, quality treatment to all injured workers in the most cost effective manner.

For the first time in our history, you have been asked to address, by way of a major reform, the system which delivers medical care to injured workers. The State Fund encourages a do pass vote from this committee.

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DATE 3/10/93
SB 347

Amendments to SB 347
Third Reading

House Select Committee on Workers' Compensation
Requested by Senator John Harp
March 10, 1993

1. Page 15, line 6.
Following: "for"
Insert: "20%, but not to exceed"

2. Page 15, line 6.
Following: "$10"
Insert: ","

3. Page 20, lines 3 and 4.
Following: "~~or~~"
Strike: the remainder of line 3 through "pharmacies," on line 4

4. Page 20, line 5.
Following: "and"
Strike: "other"

5. Page 27, line 8
Following: "prohibition."
Strike: "A"
Insert: "Unless authorized by the insurer, a"

6. Page 27, line 9 and 10.
Following: "facility"
Strike: "the remainder of line 9 through "practice" on line 10

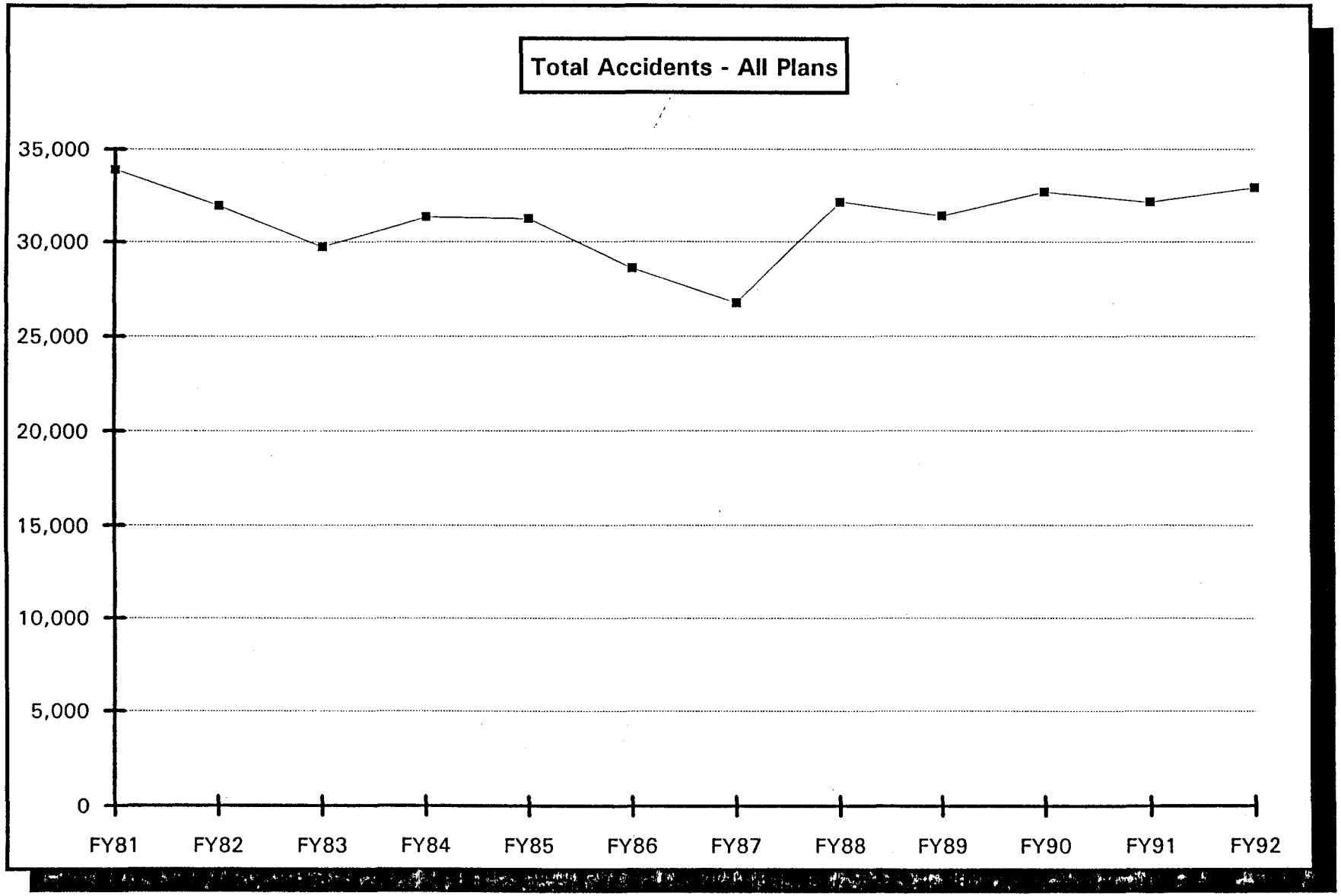


EXHIBIT 3
DATE 3/10/93
SB 347

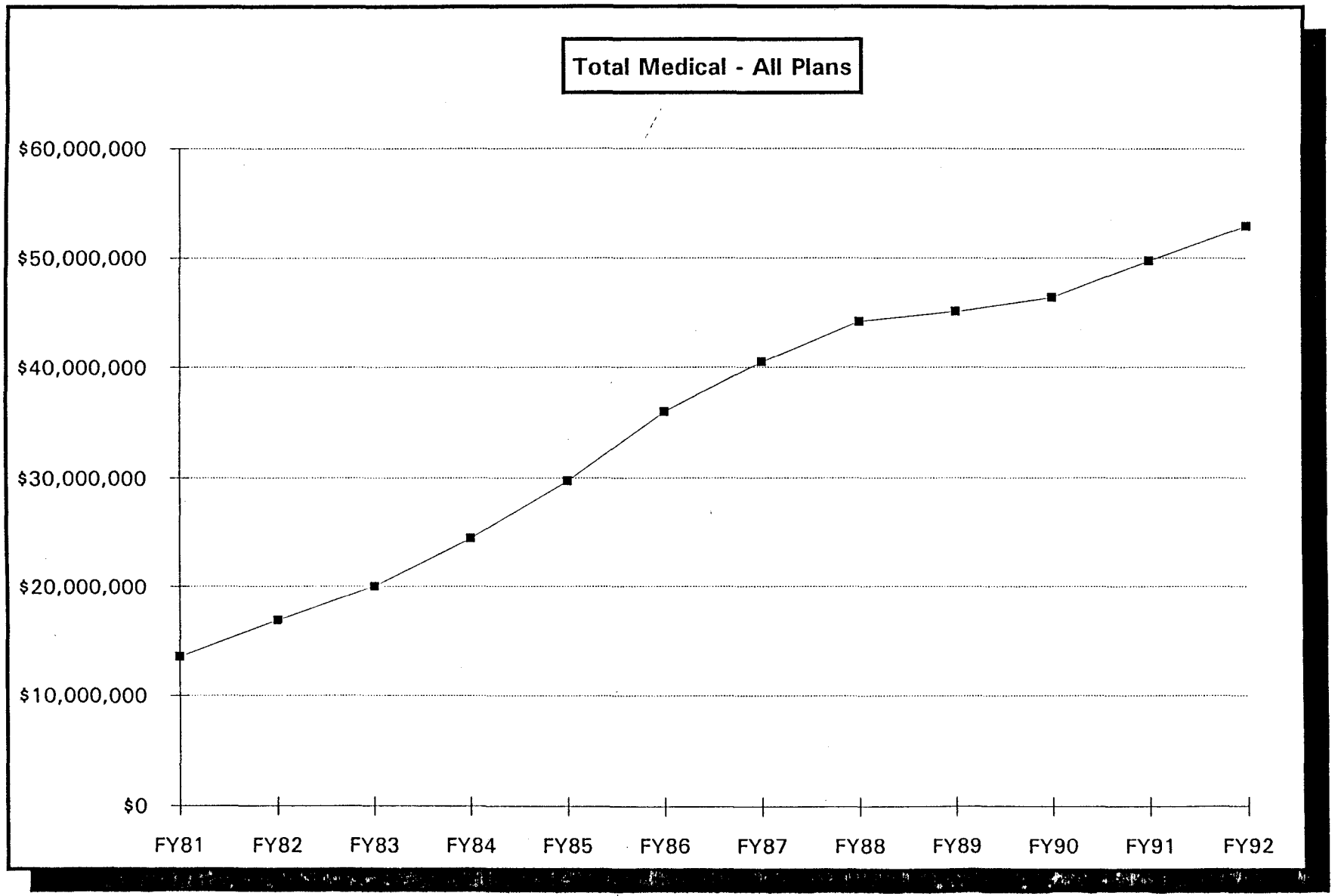
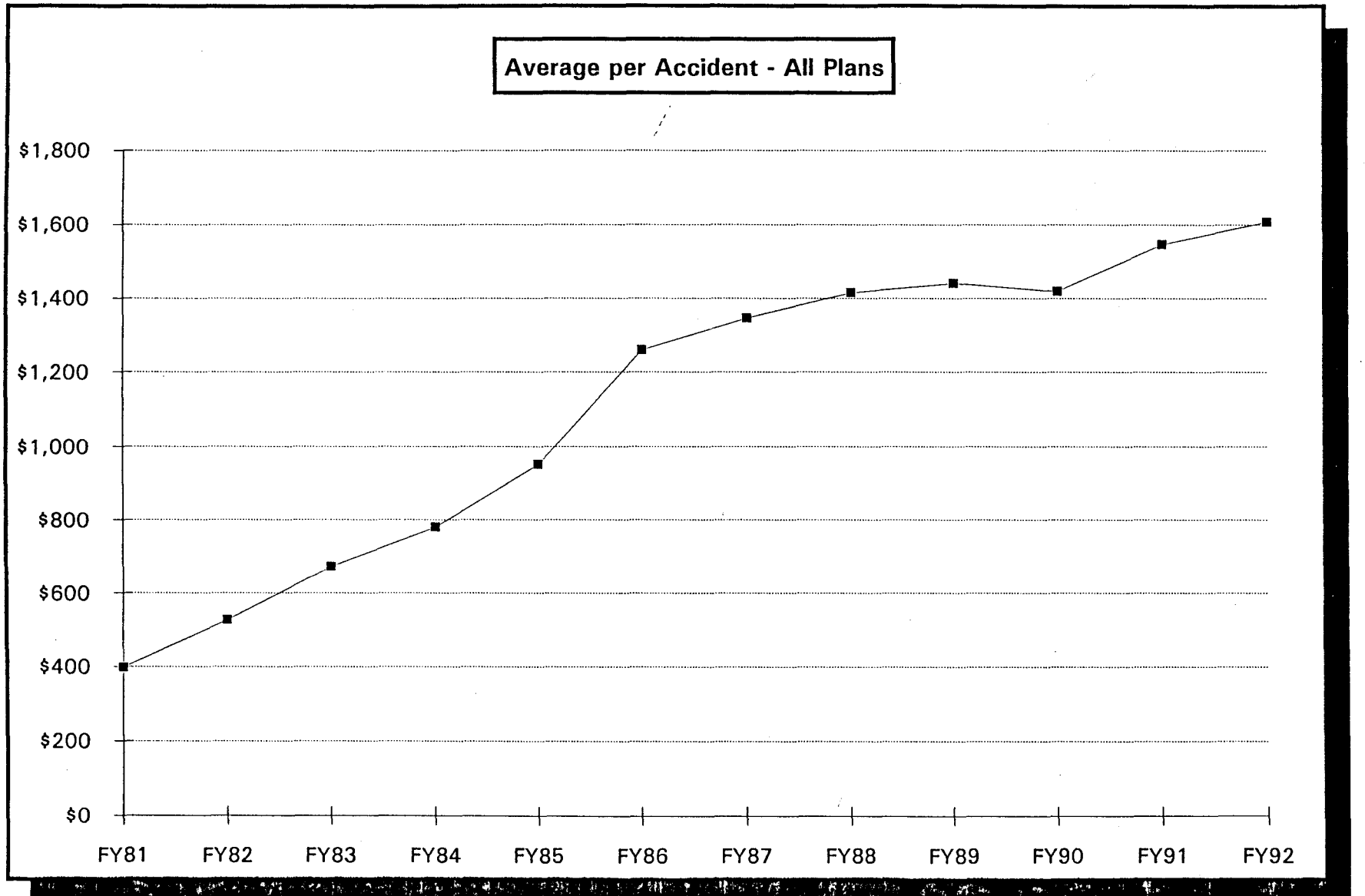


EXHIBIT 3
DATE 3/10/93
SB 347



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SB 347

EXHIBIT 4
DATE 3-10-93
HB SB 347

RAM
Rehabilitation Association of Montana

March 10, 1993

Mr. Chairman, Members of the Committee:

For the record, my name is Bill Crivello. I am a Branch Manager for Crawford Health & Rehabilitation, and I am also representing the Rehabilitation Association of Montana. In the interest of time, I am providing written testimony which I would request that you please take the time to review. In particular, I would like to draw your attention to my written remarks as a manager for Crawford Health & Rehabilitation, and my specific concerns and recommendations as they relate to your intentions regarding what type of managed care programs will be allowed to participate in the workers' compensation arena.

The Rehabilitation Association of Montana supports the concept of cost containment through the provision of managed care. We feel that Senate Bill 347 is a move in the right direction. However, we also wish to express our opinion that existing managed care and medical case management programs in the private sector which utilize nurse medical coordinators and case managers should be an optional model for utilization in the workers' compensation field. The language of Senate Bill 347 substantially focuses on a model which places managed care responsibility in the hands of treating physicians. We recognize that the Bill was rewritten with language intended to broaden the scope of potential alternative managed care efforts, and we draw attention to the specific language on Page 24, lines 6 and 7, where it reads ". . . a group of medical service providers or an entity with a managed care organization. . ." can provide managed care under specific provisions of the Bill.

While we have stopped short of opposing this Bill, we encourage the Committee to either consider amendments which would more clearly allow insurers the option to select an appropriate managed care program, or to establish a clear legislative record with regard to this intent.

We also note that when Senate Bill 347 was passed out of the Senate, additional language was written into it on Page 5, providing a definition of "disability". This definition appears to incorporate vocational terminology in defining disability, and we would like to request clarification as to its purpose for being included. Thank you.

Sincerely,

Bill Crivello

Bill Crivello, Legislative Chairman
REHABILITATION ASSOCIATION OF MONTANA

EXHIBIT 4
DATE 3/10/93
SB 347

Crawford
CRAWFORD & COMPANY
HEALTH AND REHABILITATION

WILLIAM J. CRIVELLO
BRANCH MANAGER

March 3, 1993

Mr. Chairman, Members of the Committee:

For the record, my name is Bill Crivello. I am a Branch Manager for Crawford Health & Rehabilitation. Our firm is a nationally-based health care management firm with seven offices in the state of Montana.

I would like to preface my remarks by first stating that I've known Senator Harp for several years, having worked with him several years ago when I resided in the Flathead Valley. I have a great respect for his integrity, and more specifically, I fully support his intentions and hopes with regard to the objectives of Senate Bill 347. Further, I have worked closely with Mr. Pete Strizich at the State Fund for the past several years, and I know that he, too, is faithfully and professionally committed with regard to the intentions and objectives underlying his drafting for language contained in this Bill. Senator Harp allowed me the opportunity on a number of occasions to meet with him and Mr. Strizich, as well as others, in an effort to refine some of the language and the fine points of this Bill. My initial involvement in discussions was admittedly non-supportive, as I had professional difference of opinion with regard to the physician/gatekeeper model outlined in the managed care component of this Bill.

To put it simply, and in an effort to keep my remarks brief, the type of managed care postulated in this Bill is not the type of managed care which our company promotes and provides. To the credit of Senator Harp, I, and a number of other individuals who are not directly involved in providing managed care, was successful in having alternative language placed into this Bill which would at least theoretically allow existing managed care organizations such as ours to operate within the scope of managed care in workers' compensation. I refer you, specifically, to Page 23, line 6 and 7, where it reads ". . . a group of medical service providers or an entity with a managed care organization . . ." can provide managed care under certain provisions.

In retrospect, and having analyzed the Bill in more detail, I am not convinced that the type of managed care which we presently provide will be certifiable under the Department of Labor requirements outlined in Section 9. Like most managed care systems throughout the country, Crawford Health Care Management provides a Nurse-Case Manager model, and is not physician-based, as is contemplated throughout the various managed care sections of this Bill. While I fully appreciate and wholeheartedly support the goal of containing medical costs through managed care, I still do not believe that the physician/gatekeeper model

is the one and only solution to address the issues inherent to the system. My goal here is merely to insure that insurers have the freedom to select the model which they feel will work for them.

Yesterday, by way of example, I had occasion to review a case which we were closing with regard to medical case management. This case was referred to us by a Workers' Compensation Claims Adjuster in the Fall of 1991. The Adjuster was plagued with repeated instances of the injured worker going to the Emergency Room for treatment, and being unnecessarily hospitalized for continued pain and symptomology. Despite indications from the attending physician that the costly Emergency Room visits and hospitalizations were not necessary, the physician did nothing to circumvent the problem, or identify more appropriate solutions. The situation went uncontrolled, with costs continuing to soar with each new hospitalization. Our Nurse/Case Manager was asked to intervene, and to become involved directly with the physician, to formulate a more viable treatment plan. Subsequently, the claimant was encouraged, counseled, and finally directed not to utilize the Emergency Room and hospitalizations for treatment. By obtaining the commitment to this treatment plan from her attending physician, the insurer was able to eliminate the inappropriate hospitalizations, and they have now gone 14 months with no hospitalizations. Additionally, we have assisted in discontinuing repeated physical therapy and work hardening, which had been ongoing, despite lack of progress for the claimant. In the alternative, the claimant has been enrolled in a health club program, and is now involved in home exercise and health club conditioning, in lieu of the more expensive physical therapy, which had not resulted in any significant benefit. The medical cost savings realized as a result of our intervention was in excess of $13,000, for the past year alone. If the claimant continues to follow the revised treatment plan, and unnecessary hospitalizations continue to be avoided, additional savings of approximately $5,000 per year will be realized. This type of savings is not unusual with regard to the type of managed care which we presently provide for workers' compensation cases. And, it is certainly found to be desirous by many insurers.

I fully recognize that the State Fund is committed to implementation of the physician/gatekeeper managed care model. However, numerous clients that we presently serve have indicated that they would like to continue utilizing our type of managed care in workers' compensation, and they do not plan to utilize the physician-based model. It is my hope that you will allow us to continue providing managed care, and to do it within the scope of the workers' compensation managed care legislation.

I am offering several amendments here which I believe will allow the Department of Labor to exercise reasonable and fair judgement with regard to managed care application which we or others might present to them. It is my belief that these amendments will allow the Department to establish the required rules for

application and certification, but allow for the potential certification of managed care programs which are not necessarily physician based.

If you see fit to accept these amendments, or--IN THE ALTERNATIVE--if you can clearly document in the Legislative Record that it is not your intention to exclude managed care efforts which are non-physician-based, I believe you will broaden the perspective of managed care within workers' compensation and will allow insurers to exercise an element of selection with regard to how they feel they can best provide managed care and realize the resultant cost savings. Thank you for your consideration.

Respectfully submitted,

William J Crivello

William J. Crivello, M.S., C.R.C.
Branch Manager
CRAWFORD HEALTH & REHABILITATION SERVICES

WJC/kv

ENCLOSURE: PROPOSED AMENDMENTS

EXHIBIT 4
DATE 3/10/93
SB 347

EXHIBIT 4
DATE 3/10/93
SB 347

3/10/93

PROPOSED AMENDMENTS TO SENATE BILL 347

1. PAGE 18, LINE 25, NEW SECTION - SECTION 5, AFTER WORD "OF",

   INSERT: "OR COORDINATING SERVICES WITH"

   LINE SHOULD READ: AS A TREATING PHYSICIAN, BUT WHO IS NOT A MEMBER OF OR COORDINATING SERVICES WITH A MANAGED

2. PAGE 19, LINE 14, NEW SECTION - SECTION 5, AFTER WORD "FROM"

   INSERT: "OR THROUGH"

   LINE SHOULD READ: INSURER, RECEIVE MEDICAL SERVICES FROM OR THROUGH THE MANAGED CARE

3. PAGE 19, LINE 16, NEW SECTION - SECTION 5, AFTER WORD "PHYSICIAN"

   INSERT: "WORKING WITH OR"

   LINE SHOULD READ: THE DESIGNATED TREATING PHYSICIAN WORKING WITH OR IN THE

4. PAGE 22, LINE 2, NEW SECTION - SECTION 9, AFTER WORD "PROVIDER"

   INSERT: "OR HEALTH CARE MANAGEMENT ORGANIZATION"

   LINE SHOULD READ: THEN A HEALTH CARE PROVIDER OR HEALTH CARE MANAGEMENT ORGANIZATION

5. PAGE 22, LINE 14, NEW SECTION - SECTION 9, AFTER WORD "INDIVIDUAL"

   INSERT: "OR IDENTIFY THE TYPES OF INDIVIDUALS"

   LINE SHOULD READ: A LIST OF NAMES OF EACH INDIVIDUAL OR IDENTIFY THE TYPES OF INDIVIDUALS WHO WILL PROVIDE

6. PAGE 22, LINE 19, NEW SECTION - SECTION 9, AFTER WORD "INDIVIDUALS"

   INSERT: "OR IDENTIFY THE TYPES OF INDIVIDUALS"

   LINE SHOULD READ: NAMES OF THE INDIVIDUALS OR IDENTIFY THE TYPES OF INDIVIDUALS WHO WILL BE DESIGNATED AS

RATIONALE

Crawford Health & Rehabilitation Services, a national Health Care Management organization, has been providing vocational and medical case management services in Montana for several years. Medical case management provided by private sector firms such as ours has become more and more commonplace in the workers' compensation arena, and is utilized by private insurers, self-insurers, and the State Compensation Mutual

Insurance Fund for cost-containment purposes. While the State Fund has expressed definite commitment toward utilizing the physician/gatekeeper model for medical case management and managed care, many of our clients--workers' compensation insurers--have expressed concern and apprehension with regard to utilization of the physician-based managed care model. Private managed care organizations have had an excellent track record in providing medical case management services for workers' compensation cases. Our nurse case managers have the experience and training necessary to continue to provide managed care, without requiring insurers to consider only a physician-based model. Recognizing that different workers' compensation insurers may wish to select different types of managed care efforts, these amendments will allow them continued use of this model, or other alternatives, within the parameters and intent of the proposed legislation.

We believe that the amendments offered do not detract from the intent of this legislation, but will allow the Department of Labor to certify current managed care programs, such as ours, to continue to provide this type of service in the area of workers' compensation.

EXHIBIT 4
DATE 3-10-93
SB 347

Homebuilders Assoc. of Billings
252-7533

Montana Home Builders Assoc.
581-7181

Great Falls Homebuilders Assoc.
452-HOME

Flathead Home Builders Assoc.
752-2522

Missoula Chapter of NAHB
273-0314

Helena Chapter of NAHB
449-7275

Montana
BUILDING INDUSTRY
ASSOCIATION

Nancy Lien Griffin, Executive Director
Suite 4D Power Block Building • Helena, Montana 59601 • (406) 442-4479

EXHIBIT 5
DATE 3-10-93
HB SB 347

SB 347

Workers Comp Medical Cost Containment

Recommend:

Do Pass

Mr. Chairman, members of the committee:

I am Harlee Thompson, manager of Intermountain Truss, and a delegate from the Montana Building Industry Association to the Coalition for Work Comp System Improvement (CWCSI).

No one usually argues that one of the major problems in the Worker's Comp system is the lack of specific injury definition. This has left the matter to the jurisdiction of medical practitioners who tend to over treat to avoid liability; lawyers who are eager to ask the court for an interpretation of the injury; and confused claims examiners who deal with a variety of diverse court interpretations.

The Coalition for Work Comp System Improvement believes that the creation of stricter injury definitions will not limit benefits--only provide clear instructions for all, whether they be claimants, medical providers, employer or insurers.

The definitions of injuries contained in SB 347 gained bipartisan support during the recent election and are an important step in eliminating vagueness in current law.

SB 347 also will help eliminate another costly area of the current system. With the creation of preferred provider organizations and the ability of insurers to contract with managed care organizations the costly practice of duplicating of services should be eliminated. This should also speed up the process in which the injured worker receives treatment and will hasten their return to work.

We urge a do pass committee recommendation.

IW
INS WEEK

EXHIBIT 6
DATE 3-10-93
HB SB 347

FEBRUARY 22, 1993

WORKERS' COMPENSATION

WORKERS' COMPENSATION

A Private Insurer's Perspective of Oregon's Reforms

Be Careful to Note What Has Worked — and What Has Not

By Richard Rambeck
Editor

Editor's note: Last year, InsuranceWeek, *as part of our 1992 look at workers' compensation, presented the story of the turnaround at Salem, Ore.-based Saif Corp., the quasi-public non-profit entity that serves as Oregon's state workers'-comp. fund and is the state's largest workers'-comp. carrier.*

This year, in the interests of equal time and to gain a private insurer's perspective of the Oregon workers'-comp. market, we present the story of Saif's seemingly eternal and very bitter rival, Portland-based Liberty Northwest Insurance Corp., the state's largest private workers'-comp. carrier

Steve Beckham professes no desire to play the role of revisionist historian. Beckham, the manager of government affairs for Portland-based Liberty Northwest Insurance Corp., readily concedes that legislative reforms enacted during the past few years have transformed the Oregon workers'-compensation market from profoundly dysfunctional to proudly functional.

But Beckham cautions that it is necessary to read the fine print of this success story, as well as to analyze the reforms and their impacts — and what hasn't been done.

Beckham notes that the much-praised reforms of 1990, passed by the state Legislature during a one-day special session, are merely the final pieces in a puzzle of change that took several legislative sessions to complete. But the 1990 legislative package coalesced all the other reforms into a system that has drawn praise nationally and spawned the sincerest form of flattery in many states.

"We did a lot of right things, but you have to look at what we did, honestly, and ask, 'What's working and what isn't?'" Beckham says.

What's working?

- Oregon has had three consecutive years of double-digit percentage workers'-comp. premium decreases.
- The costs of vocational rehabilitation and palliative care — the relief of pain or discomfort without a true "cure" — have dropped dramatically.
- Beckham says the reform legislation, particularly 1990's Senate Bill 1197, has significantly increased efficiency and reduced costs by "narrowing the funnel" of what constitutes compensable claims, reducing the time injured workers spend in the system, and reducing re-entry to the system by restricting workers' rights to claim aggravated injuries.

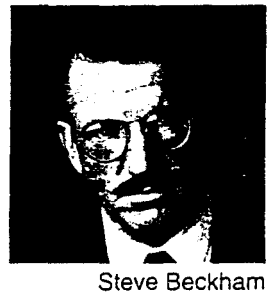
What isn't working?

- Efforts to reduce medical, curative costs, according to Beckham.

Failings of SB 1197

The Liberty Northwest official leaves no doubt that one aspect of SB 1197 left him cold: a provision preventing workers'-comp. carriers from owning or having any interest in managed-care organizations (MCOs).

"MCOs in Oregon are dominated by medical-service providers, which charge us [workers'-comp. carriers] fees — and that adds to our costs," Beckham says. "That's been one of the great fallacies of the Oregon system, the effectiveness of MCOs in reducing costs."


Steve Beckham

Beckham has a warning for insurance officials from other states — and there are apparently a lot of them — who believe they would be best served by copying the Oregon system: "You have all these states cloning Oregon's MCOs, and they're cloning the wrong thing.

"There were some real accomplishments with the reform, but what worked and was appropriate for the Oregon system won't necessarily work and be appropriate in other jurisdictions."

If Liberty Northwest, which wrote $180 million in premium last year and covered 10,000 Oregon businesses with an aggregate total of 250,000 employees, has its way, the Oregon system will continue to spawn copycats.

The Wave of the Future?

Oregon has become the laboratory to test a prototype of what is

known as 24-hour care, which combines workers'-compensation and group medical programs into one plan. The state Department of Insurance and Finance has received a grant of more than $330,000 to fund a 24-hour pilot program, which will include some yet-to-determined Oregon businesses.

Liberty is also interested in 24-hour care, but would need legislation, which undoubtedly would hinge on the success of the DIF's pilot program, to enact such a program as a private insurer.

Beckham, however, says that regardless of what the Legislature does or doesn't do regarding 24-hour care, Liberty will begin late this year integrating the administrative aspects of workers'-comp. and group health coverages for those Liberty clients that could fit under such a plan.

"It would be just an extension of what we already offer our policyholders," he says. "Many of them [employers] have asked us to do this. ... We plan to move slowly, incrementally into this combined administration function because we don't want to lose that quality service that we provide."

UnSaif at Any Speed

One thing Liberty apparently will never lose is its antipathy for Saif, to which Beckham usually refers as "the state fund." (Saif President Katherine Keene disses Liberty by calling it "Brand X.")

The two carriers have butted heads on virtually every issue, and harsh words are spoken at virtually every opportunity. "Saif denies too many claims," says Liberty. "Liberty denies too few claims," says Saif.

The facts, according to a DIF investigation last year, show that Saif is two and a half times more likely (29 percent to 12 percent) to deny a claim than is Liberty.

"We believe this report shows that the difference between our denial rate and that of other insurance companies is appropriate given the vigilant approach we have to claims management," said Brian Steffel, senior vice president and chief claims officer for Saif, after the DIF released its findings a year ago.

Said Stan Long, former Saif president and chief executive officer, who is now a cost-containment executive with AIG, "We *manage* claims, we don't *process* them."

Nothing makes Beckham's corporate blood boil more than hearing about Saif's claims process.

"I get real tired of someone saying my claims process is lousy," says Beckham, who didn't say "lousy."

"It's so preposterous. It's so off the wall. It simply cannot be true that Saif and only Saif implemented the [1990] law correctly.

"In Oregon," Beckham says, "people are saying, 'This [reform] has been a tremendous, tremendous windfall for insurers.' No. It has been a tremendous windfall for Saif."

Liberty isn't exactly hurting. The carrier has grown a hundredfold in the last decade, from a five-employee entity in 1983 to its present 500-person staff. And the company is trying to position itself to be on the cutting edge of the future — 24-hour care.

Beckham sounds optimistic about what is to come, but in the same breath, he admits of the past, "It's been quite a ride."

And quite a story. ■

EXHIBIT 1
DATE 3-10-93
SB 347

Amendments to Senate Bill No. 347
Third Reading Copy

Prepared by Jacqueline Lenmark
American Insurance Association
March 10, 1993

1. Page 19.
Following: line 11
Insert: "(4) a worker whose injury is subject to the provisions of subsection (3) may procure the services of any qualified medical service provider:

(a) for emergency treatment if a treating physician in the managed care organization is not available for any reason;

(b) for conditions the worker in good faith believes are not related to the compensable injury; or

(c) when a worker living in a rural area would be unduly burdened by traveling to a managed care organization treating physician."
Renumber: subsequent subsection

2. Page 19.
Following: line 22
Insert: "(5) a worker whose injury is subject to the provisions of subsection (3) may not be required to use a managed care organization if none is established in reasonable geographic proximity to the worker's residence and the worker may choose his treating physician under the provisions of [Section 5(1) and (2).]."

3. Page 20, line 7.
Following: "organizations."
Insert: "PREFERRED PROVIDER ORGANIZATIONS ESTABLISHED UNDER THIS SECTION MUST MEET THE SAME CRITERIA AS THOSE ESTABLISHED FOR MANAGED CARE ORGANIZATIONS UNDER [SECTION 9]."

4. Page 20, line 24.
Following: "department"
Strike: "may"
Insert: "SHALL"

5. Page 21, line 2.
Following: "workers."
Insert: "insurers or self-insured employers may form groups in contracting for managed health care services with medical service providers."

6. Page 21, line 18.
Following: "providers,"
Insert: "self-insured employer or insurer,"

7. Page 21, line 24.
Following: "Montana."
Strike: the remainder of line 24 through page 22, line 3.

8. Page 23.
Following: line 13
Insert: "(b) allows a selection by the worker from more than one medical service provider in the health care specialty required for treating the specific problem of the injured worker.

EXHIBIT 7
DATE 3/10/93
SB 347

EXHIBIT 8
DATE 3-10-93
HB SB 347

Mr. Chairman & Members of the Committee

I am Tom Ebzery ~~of~~ a Billings attorney and I rise on behalf of Montana Associated Physicians Inc, a group of approximately 120 physicians ~~of~~ in Billings. My testimony is limited to language in Sec. 6 p. 20 - specifically the Harp Amendments #3 & #4 - as to who can participate in PPO Organization.

As Senator Harp has mentioned for reasons still unclear physicians & physician groups were those removed from those eligible to participate and left "clinics" in.

As a physicians group but not a clinic MAPI wishes to participate and supports the Harp Amendments 3 & 4 which will restore physicians, hospitals, clinics, pharmacies etc. to those eligible to participate. They will be back in the bill as ~~a~~ "medical providers" in line 5.

Senator Harp has described his desire for competition & to correct the oversight. We strongly support Amendments 3 & 4 and SB 34

EXHIBIT 9
DATE 3-10-93
HB SB 347

MONTANA OPTOMETRIC ASSOCIATION
36 SOUTH LAST CHANCE GULCH, SUITE A • HELENA, MT 59601 • TELEPHONE (406) 443-1160 • FAX (406) 443-4614

SENATE BILL 347

Mr. Chairman and Members of the Committee, for the record my name is Bruce Coen. I am an optometrist residing in Helena and am a past president and member of the Montana Optometric Association. I am appearing before you today on behalf of the Montana Optometric Association.

We support Senate Bill 347. We believe it is a good bill that addresses an important issue of worker's compensation--that is, the problem of medical cost containment.

We do have an amendment that we would like the committee to consider. The purpose of our amendment is to add "optometrist" to the definition of "treating physician", on page 10, line 17 of the bill.

We believe it is important to include optometrists as treating physicians because it is cost effective. The most common type of workers' comp injury treated by an optometrist is removal of a foreign body from the eye. Optometrist's fees range from $30 to $60 for this procedure. This is less expensive that if this same procedure is performed in a hospital emergency room or by a specialist. Most small hospitals do not even have the necessary equipment--i.e., a slit lamp--so they either then refer to an optometrist, in some cases borrow the optometrist's equipment, or use a magnifying glass (a less desirable treatment method).

Recognizing the cost effectiveness of optometric treatment, Doctors of Optometry are defined as physicians for purposes of participation in the Medicare program with respect to providing any service they are authorized to perform by state law or regulation.

We urge the Committee to pass SB 347 and respectfully request that the Committee adopt our proposed amendment.

Proposed Amendment to Senate Bill No. 347:

Page 10 - Line 17, add:

(f) an optometrist licensed by the state of Montana under Title 37, chapter 10.

March 10, 1993

EXHIBIT 10
DATE 3-10-93
HB SB 347

Tippy & McCue

ATTORNEYS AT LAW

1215 Eleventh Avenue
P.O. Box 543
Helena, Montana 59624
406·442·4448 FAX 406·442·8018

Roger Tippy
Mary Kelly McCue

March 8, 1993

Nancy Butler, General Counsel
State Compensation Mutual Insurance Fund
5 S. Last Chance Mall
Helena, Mont.

Re: SB 347 (third reading), Sec. 4

Dear Nancy,

The language of the bill is confusing to pharmacists, particularly where it amends existing subsec. (2) of code sec. 39-71-727. We must assume that pharmacies not designated as PPOs will be dispensing prescription drugs to injured workers in at least two situations: (1) at the outset of injury in all cases, before the insurer gives written notice of a PPO to the worker (page 20, lines 9-12), and (2) in those areas of the state where distance may make it impractical to designate a PPO (the "Ekalaka effect").

The immediate question is, what is the "reimbursement rate" for the generic drug which the nonpreferred provider bills the insurer? It is either the PPO's rate under subsec. (5), A.W.P. plus dispensing fee, or it is set by Labor & Industry under the schedule of fees for medical nonhospital services (page 13, lines 12-13). As the term "reimbursement rate" is not used elsewhere in the bill, other than in subsec. (5) of Sec. 4, it is reasonable to read that intent into the change to subsec. (2) of Sec. 4.

Under that reading, how would the Fund communicate the reimbursement rate to all pharmacies, so they know how much to bill for the medication? Would that be the reimbursement rate in Ekalaka and other regions without PPO designations?

Under the other interpretation, where the Department sets a schedule of fees for generic drugs under 39-71-704 (2), as it would be amended on page 13 of the bill, would that be payable to the nonpreferred pharmacy even if it was lower than the PPO's reimbursement rate? I note that the rule changes the Department held hearings on last Feb. 18 do not set any schedules for prescription drugs, noting that they are regulated under 39-71-727. How would the Department set such a schedule if that is the intent to the bill--by surveying pharmacists' usuals and customaries, or by starting from A.W.P.? Among the many areas in which a Statement of Intent (which would seem to be required for a bill like this anyway) would be helpful is this area.

Going back to PPOs and Sec. 6, pharmacists should have a concern with this sentence on page 20, lines 9-12: "After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers." Who eats the loss if the Fund tells a worker after his third refill of a prescription that he now has to go to a PPO pharmacy, but he goes back to the same nonpreferred pharmacy for his fourth and fifth refill anyway? Does the pharmacy have to ask the worker each time whether he has heard anything about a preferred provider from the Fund? What if the worker lies or doesn't receive the notice? Is the pharmacy stuck anyway?

I understand that you want to have some incentives for pharmacies to bid low on the dispensing fee in order to get the business. The bigger a share of the market they can see, the lower they'll bid the fee. It may be a dollar or two. However, the reimbursement of the nonpreferred provider is going to be very complicated under the current language of the bill, for the reasons I have noted. I would suggest the following concept: a nonpreferred pharmacy, dispensing to a worker who has been told to go to a preferred pharmacy, can only receive the A.W.P. without any dispensing fee. That would require inserting "except as provided under 39-71-727" after "providers" on page 20, line 12, and then amending 39-71-727 (2) on page 17 to extend its principle to dealing with a nonpreferred pharmacy. A new sentence something like this: "If an injured worker prefers obtaining the generic drug from a pharmacy which is not party to an agreement under [section 6] after the insurer has notified the worker to use a preferred provider pharmacy, the worker may pay directly to the pharmacist the difference between the average wholesale price of the drug and the pharmacist's retail price, and the pharmacist may only bill the insurer for the average wholesale price of the generic-name drug."

With this change we would know what reimbursement rate means, we would not have to worry about how to fit drugs into the fee schedule, and the pharmacist would not worry about getting burned in the after-PPO-notification. If this is seen as still eroding the cost-saving effects of the bill in the prescription area, I surely hope you can tell me how that would happen.

It's too bad your claims management is so far behind Medicaid's--the way to save some serious money on drug benefits is with a drug utilization review process like they are setting up. But I realize you have to tackle these things a step at a time.

Sincerely,

Roger

Roger Tippy/Montana State Pharmaceutical Assn.
cc: Sen. Harp, House Select Committee members

EXHIBIT 10
DATE 3/10/93
SB 347

March 9, 1993

Roger Tippy
Montana State Pharmaceutical Assn.
P. O. Box 543
Helena MT 59624

Re: SB 347, Section 4

Dear Roger,

Senator Harp has asked that I respond to the concerns you expressed in your letter of March 8, 1993, to Nancy Butler, General Counsel.

Section 39-71-727 (2) is an indication to the provider that the insurer is responsible only for the cost equivalent of the generic product. They should bill the A.W.P. for the generic product, and charge the claimant the difference between that and the A.W.P. for the brand name product. Then add the dispensing fee to the insurers bill.

Pharmacies know very well what the A.W.P. for products are at the time of dispensing. There is no need for the "Fund", or any other insurer, to communicate that information. The rates would be the same in Ekalaka as in any other location. The Department does not set a schedule of fees for generic or any other product. They set schedules for services, not for products. The reimbursement rates you a concerned about will be set by statute, i.e.; A.W.P. plus the dispensing fee.

It will be incumbent upon the insurer to notify the pharmacy, as well as the patient, in the event written notice is given of a preferred provider agreement with another vendor. Where the State Fund is concerned, the pharmacy would know about such agreements since we would need to do an RFP prior to establishing any preferred providers. The language you suggested is more in line with the "willing provider" concept, which Senator Harp has resisted. A drug utilization review process would be great to have, but it has nothing to do with reimbursement rates, which are addressed by this bill.

Sincerely,

P. J. Strizich
Assistant Vice President - Benefits

PJS/s
CC: John Harp
Nancy Butler

to 39-71-605."

Section 4. Section 39-71-727, MCA, is amended to read:

"39-71-727. Payment for prescription drugs -- limitations. (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless the physician specifies no substitutions or the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the cost reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the cost reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the physician specified no substitutions or that the generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section 7 6] are limited to the average wholesale price of the product at the time of

dispensing, plus a dispensing fee not to exceed $5.50 per product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

(5)(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

(9) AN INSURER MAY NOT REQUIRE A WORKER RECEIVING BENEFITS UNDER THIS CHAPTER TO OBTAIN MEDICATIONS FROM AN OUT-OF-STATE MAIL SERVICE PHARMACY."

NEW SECTION. **Section 5.** Choice of physician by worker -- change of physician -- receipt of care from managed care organization. (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed

EXHIBIT 11
DATE 3-10-93
HB SB 347

Good afternoon Mr. Chairman and members of the Committee, my name is Barbara Downing and I am from Billings. I have been a waitress for 33 years and have been employed by the Radisson Northern Hotel for the last 14 years.

Approximately a year and a half ago I fell in the kitchen at the hotel and fractured my spine. Ultimately I underwent surgery and intensive physical therapy.

During the last year that I was employed, I worked 32 hours a week and made $6018.00 in wages and $1867.00 in tips for a grand total of $7885.00. Based on that income my current weekly Workers Compensation benefit is $119.34. From this paltry sum I must pay for my own health insurance and pay cab fair to and from physical therapy and doctor appointments. Cab fair is now $9.50 one way from my house; and for a long time I was attending therapy 5 days a week.

I would like to ask you for just one moment to imagine what it is like for me to try and pay my regular monthly bills and living expenses. It is impossible. I have had to give up every luxury and cut my budget to the bare essentials. If SB 347 is passed I will then be required to take out money to help pay the medical bills. It is not fair to make me pay more when I am already trying to make it on less.

Please vote no one SB 347.

Thank you.

Barbara Downing
355 Naylor
Billings, Montana 59101

OCAW
Oil, Chemical & Atomic Workers
International Union, AFL-CIO

Dan C. Edwards
International Representative
P.O. Box 21635
Billings, MT 59104
406 / 669-3253 (Home)

EXHIBIT 12
DATE 3-10-93
~~HB~~ SB 347

SB 347

Testimony of:

Dan C. Edwards, International Representative
Oil, Chemical & Atomic Workers Int'l Union, AFL-CIO
P.O. Box 21635
Billings, MT 59104 669-3253

Testifying before the House Select Committee on Workers' Compensation[1], March 10, 1993, 3:00 p.m., Room 312-3.

****

THE DEAL IS DEAD

If this Bill, and its companion bills HB 604 and HB 504, become law the historic "deal" that brought about workers' compensation programs many decades ago is dead.

Workers' compensation laws are designed to provide an equitable system for handling work related injuries, illness and disabilities, and in so-doing protect the employer from law suits from injured employees. The U.S. Department of Labor describes workers' compensation as follows:

> "Workmen's compensation was devised to assure that benefits would be paid to workers injured on the job, and that they would be paid promptly, with a minimum of legal formality, and without the necessity of fixing the blame for injury. Under laws the cost of work injuries is considered part of the cost of production."

Workers' compensation is a compromise, no-fault, system. It is not, and was not, intended to be totally satisfying to the worker or the employer. The injured worker does not receive his/her full remuneration for loss of wages, but they are entitled to immediate medical care and a percentage of their wages without delay.

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[1]. Copy of this testimony will also be provided to the members of the full House Labor and Employment Relations Committee.

The devastating attack that this session of the Montana legislature has seen on workers' compensation has only one victim -- the injured worker. This unrelenting attack is truly a case of "blame the victim".

It should be obvious to everyone concerned about Montana's workers' compensation crisis, that at least one of the major reasons for our dilemma is that far too many workers are being injured on-the-job. The State and employers must promote job safety which will result in fewer accidents and ultimately lower job injury insurance premiums. Job safety is good business for the employer as well as for the employee, his/her family, and the community. SB 163 promotes this concept and should be supported.

I would like to highlight some of the major problems with the Bill before you today:

Worker "fees" and premiums: This flies in the face of the entire workers' compensation concept. Immediate medical care at the employer's expense, and paid for by employers, is the major benefit for which workers gave up the right to sue. To ask employees to now pay a portion of the costs for workplace injuries, either through fees or premiums, must not be allowed. Not one of the 50 other states allow such fees, nor does any other state require employees to pay any portion of what is legitimately and morally the employer's workers' compensation premium.

Return to the "company doctor": Despite what some would have you believe, SB 347 returns the workers' compensation program to the days of sending the employee to the "company doctor", whose interest is far more likely to be beholding to the employer who pays his/her salary than to the injured employee. Color it any way you wish, you can not get around the fact that by forcing employees to only go to medical providers with whom the insurance carrier has a "contract", is a return to company doctorism.

Deny secondary medical services to permanently "partially" disabled workers: This provision, which denies secondary medical services to the permanently "partially" disabled unless there is a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment, is simply barbaric. This would "cast out" those injured workers who may need help the most. Who decides what is "cost effective? I'll bet it's not the injured worker!

One concept of SB 347, "managed care" is supported by labor to facilitate lower costs. HB 628 provides managed care in a fair manner and should be resurrected.

Good legislation, as well as good administration, depends on sophisticated cooperation among all parties. The current wholesale attack on the working men and women of this great State, is not the way to "fix" Montana's workers' compensation problems.

In closing, I urge this select committee, and the full House Labor and Employment Relations Committee, to reject the several Bills that totally do away with the original objectives of workers' compensation. Instead, methods that promote workplace safety and reward those employers with good safety and health programs, and other programs which deal with the staggeringly high accident rate in some Montana industries, must be found. Likewise, fair "managed care" should be adopted.

Please give SB 347 a do not pass.

Thank you. I will be glad to answer any questions at the conclusion of the hearing. I would also be pleased to discuss this matter with any Legislator at your convenience.

######

EXHIBIT 12
DATE 3/10/93
SB 347

EXHIBIT 13
DATE 3-10-93
HB SB 347

Montana Trial Lawyers ASSOCIATION

Executive Office
#1 Last Chance Gulch
Helena, Montana 59601
Tel: 443-3124

March 10, 1993

Rep. Chase Hibbard, Chair
House Select Committee on Workers Compensation
Room 325, State Capitol
Helena, MT 59620

RE: SB 347

Mr. Chair, Members of the Committee:

Thank you for this opportunity to express MTLA's opposition to portions of SB 347, which revises workers compensation law regarding medical benefits. MTLA opposes numerous provisions of SB 347:

1. The bill reflects an underlying assumption that current law guarantees excessive medical benefits to injured workers. That assumption is incorrect. Current law may indeed provide medical benefits to injured workers inefficiently, and MTLA supports efforts to reduce wasteful and duplicative medical services. But instead of repairing certain problems, SB 347 concludes that they are irreparable and amputates them:

* Instead of correcting mismanaged care for pain, the bill denies injured workers treatment for pain altogether unless such treatment contributes to something called "medical stability" (Section 2, page 8, lines 11-13; page 9, lines 3-11; Section 3, page 12, beginning with line 7).

* Instead of correcting mismanaged maintenance care, the bill denies virtually all maintenance care for injured workers--even those with permanent total disabilities. Injured workers will only be entitled to maintenance care "to monitor administration of prescription medication" or "to monitor the status of a prosthetic device"--if they need maintenance care to feed, dress, or otherwise care for themselves, they also need permission from the insurer (Section 3, page 12, beginning with line 7).

* Instead of correcting mismanaged domiciliary care, the bill denies injured workers important domiciliary care (Section 11, pages 25-27).

2. SB 347 requires injured workers to pay for medical treatments (i.e., Section 3, page 15, lines 5-20) without regard to their ability to pay and even when those treatments are ordered by a doctor unilaterally selected by the insurer (i.e., Section 5, pages 18-19). Apparently without a written legal opinion, and on the basis of analogies to indemnity benefits, SB 347 seeks to insert a fundamental change into Montana's workers compensation system, a change which no other state in the nation has enacted. MTLA believes that requiring injured workers to pay for medical treatments violates the underlying bargain between employers and employees and seriously jeopardizes the exclusive remedy enjoyed by employers.

3. SB 347 reflects an underlying assumption that workers compensation insurers are trustworthy and deserve virtually unlimited discretion while injured workers and their medical providers use their discretion to exploit the system. For example:

* Section 10 authorizes an insurer to terminate any compensation benefits, not just when an injured worker in fact unreasonably refuses to cooperate but also whenever the insurer believes that the worker has unreasonably refused to cooperate (page 25, line 13).

* Section 11 drastically limits the situations in which an insurer must provide domiciliary care and even then requires such care, not from the date when the claimant needs it but from the date when the insurer knows, by a "preponderance of credible medical evidence" and "with a reasonable degree of particularity," that the claimant needs it (page 25, line 24 through page 26, line 6).

* Section 12 (page 27) declares that insurers are not liable for charges by self-referring medical providers, but it neglects to extend that admittedly reasonable protection to injured workers.

MTLA urges this committee to distinguish between provisions of SB 347 which challenge inefficiencies and provisions which surrender to such inefficiencies. MTLA urges this committee to reject the latter provisions.

Thank you for considering these comments. If I can provide additional information or assistance, please contact me.

Respectfully,

Russell B. Hill
Executive Director

EXHIBIT 13
DATE 3/10/93
SB 347

EXHIBIT 14
DATE 3-10-93
HB SB 347

Proposed Amendments to Senate Bill 347
Third Reading Bill (Blue Copy)
By: Janice S. VanRiper

1. Page 11, lines 23-24.
Leave statute as is.

2. Page 15, lines 5-20.
Strike: lines 5-20

3. Page 27, line 5.
Strike: "and the insurer is not liable for more than 8 hours of care per day.

4. Page 28, line 7.
After "The Providers", add: NEW SECTION:
NEW SECTION. **Section 14. Rule Making Authority.**
(1) The Department of Labor and Industry shall adopt rules as follows:
(a) Providing for timely administrative procedures for resolving disputes arising under _____, with specific provision for expedited procedures in cases of emergency; and,
(b) Assuring that claimants receive timely information regarding their rights and responsibilities under _____. This may include requirements that insurers provide certain information to claimants on forms approved by the Department.

5. NEW SECTION. **Section 15. Insurers to pay claims within 30 days of receipt - exceptions - providers not to bill claimants.**
(1) Upon receipt of a medical bill for a claimant, an insurer must either:
(a) Authorize the bill for payment to the State Auditor within 30 days; or,
(b) If more information is needed to determine compensability, within 14 days, issue a specific written request for the necessary information and provide a copy of the request to the claimant or health care provider, as the case may be; or
(c) Deny the bill, providing written reasons for the denial to the claimant and health care provider.

(2) Upon receipt of information as provided in (1)(b), the insurer must exercise option as provided in (1)(a) or (c).

(3) Health care providers may not bill a claimant directly for services alleged by a claimant to be covered under a workers' compensation or occupational disease claim without a written denial of liability for the bill from a claimant's workers' compensation carrier.

6. NEW SECTION:
Section 39-71-605 is repealed.

EXHIBIT 14
DATE 3/10/93
SB 347

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SB 347

that occur on or after [the effective date of this act]." Effective July 1, 1991.

Cross-References
"Division" defined, 39-71-116.
"Insurer" defined, 39-71-116.
"Physician" defined, 39-71-116.
"Injury" or "injured" defined, 39-71-119.

39-71-605. Examination of employee by physician — effect of refusal to submit to examination — report and testimony of physician — cost. (1) (a) Whenever in case of injury the right to compensation under this chapter would exist in favor of any employee, he shall, upon the written request of the insurer, submit from time to time to examination by a physician or panel of physicians, who shall be provided and paid for by such insurer, and shall likewise submit to examination from time to time by any physician or panel of physicians selected by the department.

(b) The request or order for such examination shall fix a time and place for the examination, with regard for the employee's convenience, his physical condition, and his ability to attend at the time and place that is as close to the employee's residence as is practical. The employee shall be entitled to have a physician present at any such examination. So long as the employee, after such written request, shall fail or refuse to submit to such examination or shall in any way obstruct the same, his right to compensation shall be suspended. Any physician or panel of physicians employed by the insurer or the department who shall make or be present at any such examination may be required to testify as to the results thereof.

(2) In the event of a dispute concerning the physical condition of a claimant or the cause or causes of the injury or disability, if any, the department, at the request of the claimant or insurer, as the case may be, shall require the claimant to submit to such examination as it may deem desirable by a physician or panel of physicians within the state or elsewhere who have had adequate and substantial experience in the particular field of medicine concerned with the matters presented by the dispute. The physician or panel of physicians making the examination shall file a written report of findings with the claimant and insurer for their use in the determination of the controversy involved. The requesting party shall pay the physician or panel of physicians for the examination.

(3) This section does not apply to impairment evaluations provided for in 39-71-711.

History: (1)En. Sec. 13, Ch. 96, L. 1915; re-en. Sec. 2906, R.C.M. 1921; re-en. Sec. 2906, R.C.M. 1935; amd. Sec. 16, Ch. 23, L. 1975; Sec. 92-609, R.C.M. 1947; (2)En. Sec. 10, Ch. 234, L. 1957; amd. Sec. 27, Ch. 23, L. 1975; Sec. 92-814.1, R.C.M. 1947; R.C.M. 1947, 92-609, 92-814.1; amd. Sec. 1, Ch. 422, L. 1985; amd. Sec. 15, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 5, Ch. 558, L. 1991.

Compiler's Comments

1991 Amendment: In (1)(b), at end of first sentence, provided that place of examination be "as close to the employee's residence as is practical"; in (2), in second to last sentence, substituted "claimant and insurer" for "department" and in last sentence, at beginning, substituted "requesting party" for "department" and at end deleted "and shall be reimbursed by the party who requested it"; and made minor changes in style. Amendment effective July 1, 1991.

Applicability: Section 15, Ch. 558, L. 1991, provided: "[This act] applies to injuries that occur on or after [the effective date of this act]." Effective July 1, 1991.

Cross-References

Procedural rules on physical and mental exams, Rule 35, M.R.Civ.P. (see Title 25, ch. 20).

Ex. # 14A
DATE 3-10-93
SB-347

March 4, 1993

Montana Legislature
Workers Compensation Special Comittee
State Capitol
Helena, MT 59620

Chairman Hibbard and Comittee Members:

I have chosen to write to you regarding the problems with the Workers Compensation Division. I have been up to the Capitol for several of the meetings. I have listened to various press coverage as well. I think that it is time for someone to speak on behalf of the claimant. I think it's about time for you to hear what really goes on with the comp. system from someone who's been drug through it.

I am a former claimant. In fact, I have two claims filed on me, and both were filed with one employer. The first was for bilateral carpal tunnel and the second for a severe back injury. Both claims resulted in surgeries. My comp carrier was also through a third party insurance company. I had no idea of what sort of fiasco I was in for.

I was diagnosed with carpal tunnel in December of 1985. My physician instructed me to have my employer file an industrial accident claim because he was going to send the bill to comp. This is where I encountered the start of my battle. My employer refused to file a claim. It didn't seem to matter that my doctor had recommended this. This left me having to go up to Workers Comp. after work that afternoon and file my own claim. At least I knew then that my employer would have no alternative but to fill out a claim form.

I had the first surgery done the first week of February '86 and the second surgery 6 weeks later. I returned to work in mid April. My employer had stated to the comp carrier that I would be in a non-keying position, meaning I would not be doing any data entry. This was hardly the case. I spent only a half hour a day not keying. The rest of my time was spent on the computer.

I made a complaint to my claims adjuster regarding the false statement of my employer as to my job description. My claims adjuster supposedly went to my work place to see what my job entailed. I found this to be very interesting since she never came there while I was working. Since I was the only one doing the job I had, I would think that she would have come there when I was working. How else are you really going to know what a claimant is doing at their job?

Within six months of my having surgeries, seven other people in our

data entry group were diagnosed with carpal tunnel. Since there were only ten data entry personnel to begin with, that meant 80% were all diagnosed with the same thing. We also had two of the three people in the mail room with the same diagnosis.

The management of our office always seemed to blame these problems on the employees instead of where the blame should be--with the management. The company bought everything cheaply. They never once took care as to whether or not the work stations would be adequate for the type of work being done. To this company, the only thing that was important was that we made them money.

When I injured my back in August of 1987, it was due to direct negligence of my employer. I had tripped in a hole in the middle of the hallway that had been there for the entire two and a half years that we had been in business. The hole was an old floor safe from the previous tenant. It was approximately 6 inches in diameter and 1 1/2 to 2 inches deep. When our company took over the building and remodeled, instead of leveling the hole, they laid the carpet down in it. I was not the first to trip in it, and many complaints had been made over sprained ankles. However, I was hurt the worst.

I didn't really think I had hurt myself, until I tried to stand up. The pain felt like someone had just poured gas on my back and lit a match. I reported what had happened 30 minutes before, to my immediate supervisor. I left work and tried to get into the orthopaedic clinic. I was informed that they were not taking any comp claims until October. This was the 24th of August. There was no way in hell I could sit around in the shape I was in for 2 months. They recommended that I contact my family doctor.

I saw the family doctor late that afternoon. He ran a series of x-rays, put me on a bunch of drugs, and recommended bed rest for the next 10 days. During my confinement to bed, I decided to call my claims adjuster to make sure the claim had been filed. That's when I discovered that no one seemed to know who was going to pay for this. Apparently my employer had been dropped by the previous comp carrier due to high risk. There seemed to be an uncertainty as to who had the coverage when I was injured.

After the completion of bed rest, it was off to physical therapy, 5 days a week; an intensive back class, 5 days a week; and seeing the doctor, once a week. This wonderful lifestyle went on for nine weeks. It was time to see if I could tollerate going back to work. Still I had no word as to what was happening with the comp end of things and I was getting highly annoyed with the claims adjuster and my employer. It had been nine weeks since I'd had a pay check. It seemed like no one cared that I had bills to pay each month.

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I returned to work for only 2 hours a day. I still continued to see the doctor, now every 2 weeks; and physical therapy still 5 days a week. After 3 months of this routine, I asked my doctor to have a CT-Scan done on my low back. He was insistant that I was only suffering from a lumbar strain and didn't feel the CT-Scan was necessary. I was insistant that I had injured a disk. But what do I know? I'm not the one with an "M.D." after my name.

This ridiculous vicious circle continued for 16 months. Several more times I begged the doctor to run a CT-Scan and still he denied me until I had a relaps in January '89. It still took me an act of God to get this guy to run a simple test. I had to make him mad before I finally got what I wanted. A test that could have saved the insurance company probably $20,000+ in that 16 months. The scan proved what I had been trying to tell him all along. I made him immediately refer me to someone who could help me. He referred me to one of the local orthopaedics.

I had surgery a month and a half later for a herniated disk. I was looking at a minimum healing time of six months. I was now entering the orthopaedic twilight zone!

I was still battling with my comp carrier. I would only receive checks when the mood seemed to strike them. There would be six week stretches where I wouldn't see any money at all. Because of this I was forced into getting an attorney to preserve my rights.

I ended up receiving the same circle jerk from the orthopaedic as I had from the previous doctor. There are specific things I told this doctor that never made it into my records, however they can be verified by the notes and records kept by my physical therapist.

One month post-op I had my first visit with the orthopod. I explained to him that the pain I had been previously experiencing on the left side was now appearing on my right. This was a concern to me since I was under the impression that I would be just fine after having the surgery. I was told that it was probably scar tissue and nothing to worry about. I was sent to physical therapy where they tore the adhesions.

Six months later, the symptoms had continued to increase. Again, I continued to express this concern to the orthopod. I asked him to run a CT-Scan or MRI to see what was happening. Once again I was informed that this was not necessary...it was probably just the bones compressing and there's nothing that can be done for that except eventually a spinal fussion.

In November of '90, my comp carrier sent me to one of their doctors for an evaluation because I was still unable to return to work.

The only good thing that came about from this was the fact that their doctor would not do an evaluation until he had current tests and ordered a CT-Scan. The scan showed there were postoperative changes suggestive of a recurrent disk. It also showed a buldge on the disk above. I had received a copy of the report the day after I had the test done. It took the comp doctor 2 weeks to get back to me. When he finally did, he left a message on my phone machine stating the exact opposite of what the report said. He stated that there were no signs of a recurrent disk or buldges on any other disk. This is the type of B.S. that requires claimants to seek out an attorney. I find it very interesting that when my attorney phoned him and asked how he came to his conclusion, because the report clearly states something different, he stated he read CT-Scans differently than anyone else. I invite you to figure that one out. I also find it very interesting that this doctor left town just a few weeks later.

I could go on and on with this, since this kind of garbage continued until I finally settled out in mid '92. I wanted to give you some kind of background as to what is really going on out in the world of Workers Compensation.

I am sick to death of hearing that the claimant is the one ruining the system. I'm here to say that we are not. The biggest rapers of the system are the medical professionals. The biggest offenders are certain employers across this state.

The only way to fix the system is to start where it begins-the work place. Because of the scarcity of jobs in this state, places are getting away with horrendous conditions. The place where I sustained my injuries ran like a data entry sweat shop.

I think the fact that the employer has three choices of how he wishes to insure, is a bad move. You could keep better track of things if everyone paid into the state fund and this would hopefully generate more revenues for investing. My former employer is on their 4th or 5th comp insurer. They are habitual. There has never been an investigation into this company. This is something the Dept. of Labor & Industry should be investigating and doing something about. There should be some stiff fines implemented on companies like this. Infact the best remedy would be to make them have to cover the injured themselves. If an employer is someone who has 40% of their employees injured, they should pay. In otherwords, they would be paying as if the employee was still there. Granted this is reaching to conceive this idea. However, if it happened once or twice, you might see the working environment improve. If the work place is improved and conditions are better, you have happier employees. You also have less injuries. Less injuries mean a more stable comp fund.

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There has got to be a data base system implemented between Labor & Industry and Work Comp. I must say that I am appalled at the fact that there isn't one. How can Labor & Industry and the Work Comp. Div. keep track of anything? There is no need to farm our comp problem out to some private entity. We have the resources here to fix it. We just need to improve the way things are currently done. We would be much better off spending a few million on a data base rather than spend 34.5 million to pay a private entity to take over the problem with no guarantee that they can do any better or even correct the problem. Where is the justification to farm it out? We hosed it up, I think it's time we fix our own problems. Let the others get rich off of someone else.

We need to generate funds, but you're not generating them by cutting benefits to the injured workers. A watch dog system has got to be set up. There needs to be claims people that know what they are doing and have some idea of as to what kind of testing needs to be done for various injuries. Your best bet in that area would be to hire former claimants. There isn't anyone of us that have suffered a 'real' injury that doesn't know every symptom there is to it and how it feels. Who better qualified where claimant fraud is suspected. Someone has got to be watching out for the injured person but not persecuting them as if all of the claimants are out to take the system on a ride. All claims should be watched and gone over with fine tooth combs for at least the first six months.

The 30 day limit recommended in a HB 628 for head or multiple injuries, just isn't a realistic call. You cannot expect the doctors to give a 10% impairment within a 30 day period. That could be disastrous for the claimant. My back was a multiple injury. It took 9 weeks for things to settle down and the pain to centralize. It wouldn't have been conceivably possible for my doctor to give any kind of impairment rating. Where head injuries are concerned, it would depend on the severity of the injury.

There is a definate need for a time period for treatments of injuries, placed on all doctors. If a claimant hasn't shown significant improvement within the first 3 months, then the comp system should step in and provide them with a list of names of other doctors throughout the state that specialize in their specific needs. These are not contracted medical. It would be a list of anyone and everyone. This would be for a mandatory second opinion. You would be saving the system and any other insurers some great costs. You are also still giving the claimant his freedom of choosing another doctor. That is a right that cannot be taken away. It would be different if we lived in an area where we had many superior medical professionals. Unfortunately, in Montana, that's just not the case. Instead there is too much

motivation by money.

I listened to a neuro-surgeon from Great Falls testify that claimants do nothing but basically bounce from one doctor to another. Or they request tests that he felt weren't necessary. This just is not true. Until these doctors have to live with the pain and in your body, they have no right to tell you that if you request something specifically, that they feel it's not necessary. Diagnostics are an important part to any injury or illness. If you don't do the proper testing, then you never know what the real problem is. This is just another example of how the doctors are in the pockets of the insurers. They don't want to run any tests yet they don't want to turn you loose either.

You have to pull teeth to get the authorization for a second opinion especially where the third party carriers are concerned. Sometimes it may take 5 or 6 doctors before you find one that is competent and truly wants to help you get better. As the consumer, the patient has the right to be treated with respect. They should not be treated like they have no idea of what they are talking about simply because they don't hold a degree in medicine. If you aren't getting better and you get nowhere with a doctor, you should be able to seek another doctor's opinion without all the hassle.

By making a second opinion mandatory, you are beginning the process of taking the medical field out of the pocket of insurance companies. There would really be no need for a comp evaluations which, for the most part, are a joke. An example is stated previously with what I went through where the doctor lied to me outright. The concern for the well-being of the claimant seems to go out the window. Getting the injured person back to work as soon as possible is good in theory but not always practical.

If you let the claimant go for a six month period, he has been tagged as a chronic pain person. It doesn't matter that the claimant hasn't been correctly diagnosed, as in my case. There is a stigma that follows anyone tagged as chronic pain. You suddenly get treated like the pain is all in your head. No one seems to take your problems seriously at this point.

There definately should be some price standards set for the medical field. They seem to go crazy where comp is concerned. An example is billing for procedures that weren't performed. When I received the bill from my back surgery, I was charged for physical therapy which I never received. There were also durable medical goods that were billed that I never received or used. Or they prescribe various anti-inflammitories or physical therapy which hasn't done any good in the past. So why keep prescribing it? These bills need to be scrutenized before they are ever paid and if something

locks questionable, then ask, don't just send a check. Track those files with procedures that have been done before or appear questionable. Talk to the claimant. Find out first hand how the treatment is really going. You won't know until that claimant is contacted. Follow up with those claimants!

I also don't agree with a co-payment for the claimant. Some people, infact most, don't make enough money on comp to pay for the basics, muchless have the money to be paying a co-payment. How can you justify a co-payment to someone who's hurt because of their employer? Would you want to pay for something that you are not liable for and you wouldn't be incurring the bills from if it hadn't been for someone else? You cannot continue to victimize the injured worker. The financial stress that you incur when out on an injury is a tremendous one. Why add another burden to the injured worker?

Also, if a claimant has a long-term injury and it looks like they will not be able to re-enter the work force, there needs to be steps made to get them of the comp system and on to disability or SSI. Especially where there are severe injuries. Why keep dragging them through the state system when there are federal programs out there for this purpose? If it's a permanent injury, comp should be willing to help assist these people in other programs. Get them off of a system that was not designed to support people for the rest of their lives.

If the claimant has a long-term injury and they have future problems concerning the injury, the "pat" response from the comp carrier is always the same. Instead of taking the responsibility for the problems or changes, the carriers always try to claim it's a 'new' injury instead of it being changes from the old injury. This is a most frustrating battle. This is something I have been dealing with since my back surgery. It doesn't seem to matter that I have medical tests that state 'post-surgical changes.' That's not a new injury, it's a problem with the old. Somewhere, someone has got to be out there helping the claimant to avoid this kind of run around.
There needs to be an advocate for the injured worker.

Another misconception that needs to be gotten rid of, is the idea that the claimant is getting rich off the system. This may have been true 10 years ago, but since the changes in 1987, this just is not the case. I didn't even recover 50% of my lost wages. I couldn't even pursue my employer because my right to sue him for negligence was taken away from me due to changes in the comp laws. My injuries, especially my back, have cost me personally, a tremendous amount of money and a certain quality of life.

They say that if an injured person hasn't returned to work within

2 years, he probably never will. I think this is a very discouraging statement. I have been off of work for 4 years. I'm only 34 years old and hardly ready to throw in the towel or be a non-productive part of society. For the long-term injured who have the want and need to go back to work, there needs to be something set up for them that rebuilds ones self-esteem for starters. That's the biggest obsticle to overcome when you have been out of the work force for so long. Self confidence needs to be built back up before you can even consider any kind of retraining program. It's bad enough that your skills have been on hold for a long length of time. It's an intimidating feeling going back out into the world. You cannot just cut someone off of the system and throw them to the wolves.

Alot of claimants aren't aware of the fact that the are specific programs available to retrain them or send them to school. It's obvious that not all comp carriers care to pass this information along. This is information that should be given to all injured persons at the time of their injuries. This way, there is no chance of misinforming or not informing the claimant at all, as to the options available.

A critical change that needs to be amended in the current laws is the status of carpal tunnel. I would like someone to explain to me how you can legally call this ever increasing problem a 'job disease' instead of an industrial accident. A disease is something that attacks a part of a system in the body or an organ. Carpal tunnel is something caused by repetitive work. It is a build-up of scar tissue on the nreves in one's hands and wrists. It is not and never has been a disease.

There should be a comittee set up to oversee the entire system. However, it should not be comprised of just administration and medical professionals. There needs to be direct imput from past and present claimants. A comittee or board made up of a Wk Comp, Dept. of Labor and Industry, Dept. of Justice, medical professionals (only in the capacity of review and consulting), and claimants. All the involved entities need to work together--not seperately.

These are just a few of the things I have seen and lived through and some of the ideas I have had for several years now. I have tried to give you examples of severe abuse to the system which is totalling big money every single day. I wanted to make you aware of the fact that the claimant isn't the dog stealing the bone here. Your "I don't care" employers and the medical profession are. Yes, attorneys are also getting rich. But until something is done to correct this program in particularly things like getting paid benefits on time and getting second opinions, the need to retain an

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attorney will always be there.

I want to especially thank Reps. Hibbard, Driscoll and Cocchiarella, who have taken time out previously, to speak with me personally. I appreciate the fact that you listened to what I was telling you. I thank all of the comittee for taking the time to read this lengthy letter. Be thankful there are people out there like me, that do have the best interests of this situation at heart and take the time to become involved with it. Sad thing is, there aren't enough of us. I do however, appreciate all that you are trying to do and wish you all the best of luck in trying to solve this problem.

Sincerely,

Roxianne Verworn
1239 Boulder Ave.
Helena, MT 59601
406)442-8048

EXHIBIT 15
DATE 3-10-93
HB SB 347

SB 347 -- Testimony 3/10/93

Mr Chairman--Members of the Committee:

For the record, my name is Jerome Connolly. I am a physical therapist from Billings. Twenty one years ago I graduated from the Mayo Clinic School of Physical Therapy. I chose to return to my native state to practice my new profession. Subsequently, I took risk and started a private practice and chose to use my education, training and expertise in rehabilitating injured workers. Work injury management is only a portion of our practice in Billings, Laurel and Red Lodge, but we have associated professionals skilled in work injury management, ergonomics, functional capacity testing, prevention of work injury, and the Americans with Disabilities Act (ADA).

SB 347 has some good concepts but is wrought with problems.

1. It is not good for the injured worker because it is abundant with language that gives the insurer excuses to deny care and terminate benefits.
2. It does not embrace aggressive case management.
3. It contains no emphasis -- nothing-- on keeping the injured worker on the job.
4. It contains some pitfalls that if not corrected will actually cost insurers (State) more instead of saving money.
5. It does nothing to improve the administration and management of the State Fund which many providers, employers and workers and even legislators agree is the crux of our work comp woes in MT.
6. It eliminates PPPTs--self employed business people

See Algorithm I -- SB 347 -- Blue Bill

Connelly SB347 (2)

Physical therapy is performed upon physician referral in worker's compensation cases. This bill requires all referrals to go to the managed care organization (MCO). Since self employed PTs are not likely to be invited into a hospital or clinic MCO (competition), the bill in effect prevents us from doing work injury management--years of education, training, experience not to mention investment down the drain. The IRONY? Private PTs are lower cost provider than hospitals. (E.g Rx @ FPT $65 brings $103 at Billings Deaconess Hospital).

The second algorithm depicts PTs amendments and offers a system that allows the private PTs some ***LIMITED*** participation. Not full participation--if we were asking for FULL participation we would be asking for treating physician status which would solve the whole problem. But we are not asking for that.

The changes we offer will create a better system for the insurer and injured worker alike. No insurer control is sacrificed in fact more is interposed. A much more conventional managed care system (one with an established track record in MT) will result.

Amendment 1 proposes an addition to page 18, line 24 of the blue bill. This language is taken from the Coalition for Worker's Compensation System Improvement (CWCSI) Report of the Medical Committee adopted on 12/17/92. It has been slightly modified to require referral of treating physician and allows physical therapy treatment of 12 visits or 30 days which ever occurs first. This enables early intervention to keep the injured worker on the job. It is important to note that this physician referral is not required by any other law in the state of MT. And this proposal allows the PTs **limited** involvement.

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By the way, the motion to accept the Coalition Medical Committee report which contained this concept and language was made by the senate sponsor of SB 347, Senator Harp.

Through my personal involvement in the Coalition and the Billings Chamber of Commerce Work Comp task force, I recognize this bill as being important for work comp reform.

However, it falls far short, in my estimation, of accomplishing meaningful reform and without substantial revision, I just can't support it and would ask that the committee not either.

Thank you for allowing me the opportunity to share my views.

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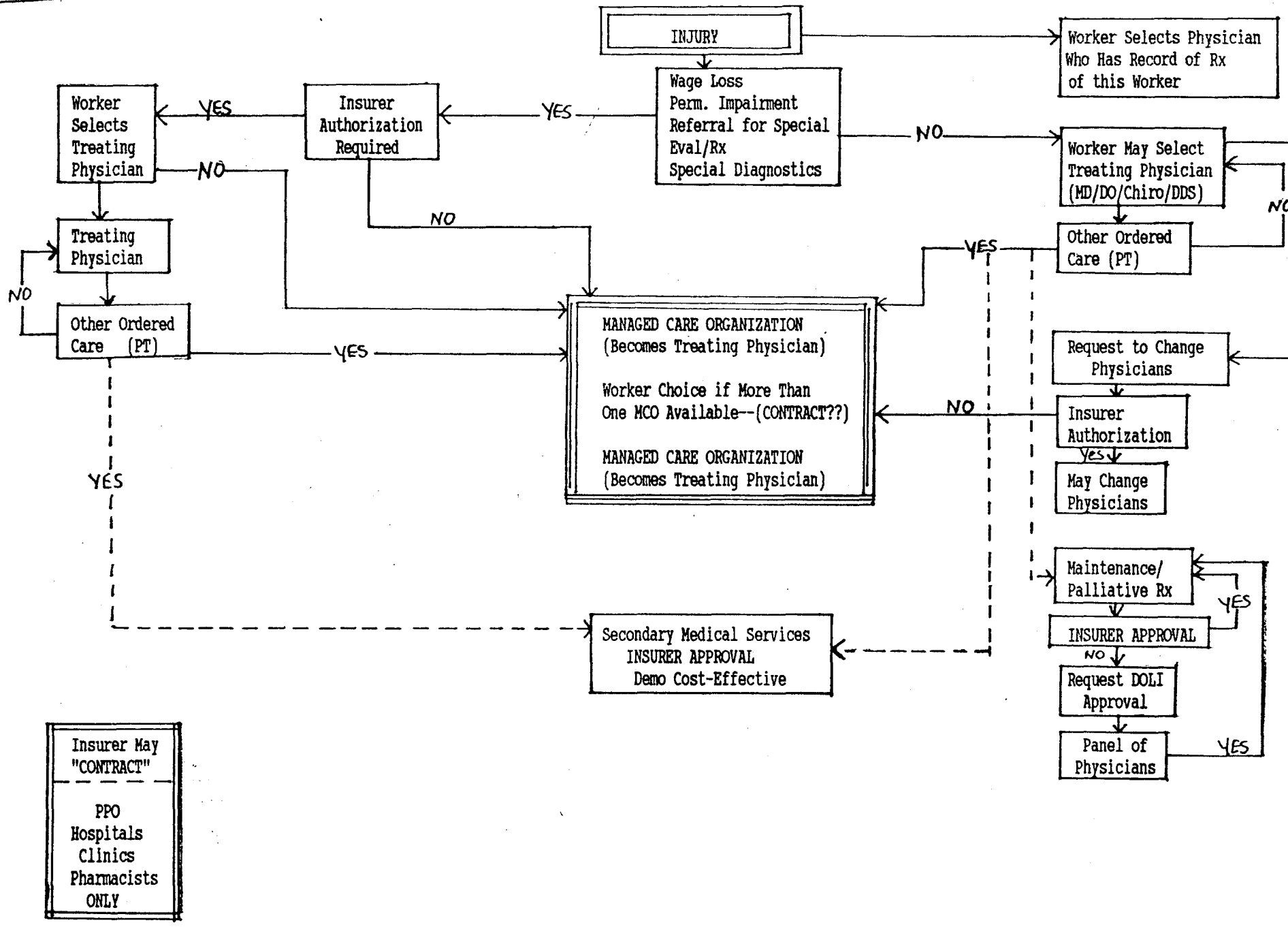
SB 347 -- Blue



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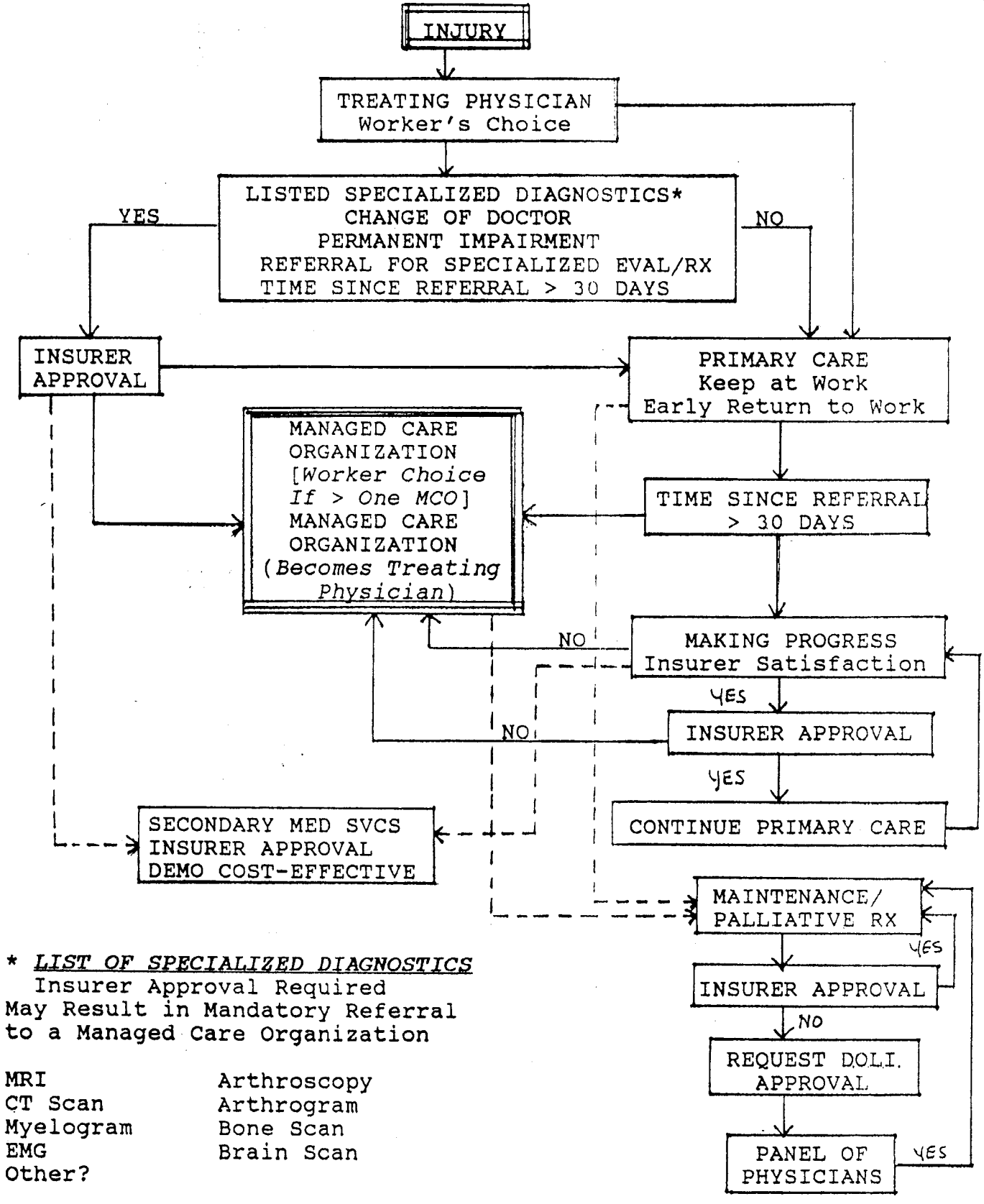
SB 347
Work Injury Management Algorithm
Physical Therapist Amendments



* ***LIST OF SPECIALIZED DIAGNOSTICS***
Insurer Approval Required
May Result in Mandatory Referral
to a Managed Care Organization

MRI	Arthroscopy
CT Scan	Arthrogram
Myelogram	Bone Scan
EMG	Brain Scan
Other?	

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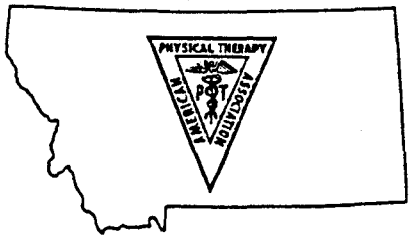

MONTANA CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

TO: House Select Workers Compensation Committee
Hearing - March 10, 1993

RE: SENATE BILL 347 (blue)

BY: Gary Lusin, MS,ATC,PT

I have two specific points to make on Senate Bill 347. These points will be included in the package of amendments submitted by the Montana Chapter of the American Physical Therapy Association.

1: Amendment 3 of the amendment package proposes a change on page 24, section 9 (4) (f), line 12 where specific reference is made to physical therapy. As it reads it attaches physical therapy to specialized treatment. Physical therapy has been identified as being a primary medical service as defined earlier in the bill. There is no definition in this language indicating what specialized treatment is. It seems very unusual to me that physical therapy would be singled out as the example of specialized treatment within this language.

This proposed language is another clear example of how self-employed physical therapists or even perhaps physical therapists working in a hospital that is not part of a managed care organization has been excluded from the opportunity to provide care to injured workers.

The phrase "including physical therapy" is totally unnecessary and I submit should not be considered a form of specialized treatment and this language should be deleted.

2: Amendment 2 on your amendment's sheet proposes a change on page 21, line 2. The amendment we are proposing clarifies an amendment already made in the Senate which indicates "a worker who is subject to managed care may chose from managed care organizations in the worker's community that have a contract with the insurer

responsible for the worker's medical services". The language we are proposing clarifies that if there is more than one certified MCO in the area that those certified MCO's also have full opportunity to have a contract with the insurer.

The language we are proposing clarifies that the so called contract between the insurer and MCO is not intended to be an exclusive contract thus allowing for not only the certification of more than one managed care organization in an area but the contracting of different managed care organizations within the same area.

Thank you for your serious consideration of these amendments.

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GENERAL REMARKS ABOUT SENATE BILL 347

Presented by

Gary Lusin, MS, ATC, PT

Physical therapists of this state are on record as supporting the concept of managed care. Managed care literally can take many many forms. I have read Senate Bill 347 very closely many times and have also been studying and trying to learn exactly what managed care is.

I believe there are some fundamental questions that all of us need to ask ourselves as we look to create a managed care system for Worker's Compensation in this state.

1: What do we all know individually, or as a group, about what managed care really is?

2: Can we individually, or as a group, make the critical decision as to what is good managed care language and what is bad managed care language? There are many many examples of failed managed care attempts across this country and there are also a few examples of relatively effective managed care organizations so what makes the difference between those organizations?

3: Who is the primary author both in concept and written design of this language? Is it for the most part the same people that have been writing Worker's Compensation Law for the past several years? Does the plan before us, even if amended, provide the highest possible guarantee that this state will have an effective and efficient, and dynamic, managed care system?

4: Are we attempting to pass managed care legislation simply for the sake of having a managed care law or are we trying to create a managed care system that has the best opportunity to first provide good management of care to injured workers and also to provide that care in the most cost effective manner possible?

5: Where in this language does it indicate what the responsibilities are of the insurers in actually <u>managing the care of injured workers?</u>

6: Who and how will fund the necessary computer software, personnel, and training to establish all that is necessary in an effective managed care organization?

Many, many questions need to be asked regarding managed care. There are too many examples of failed managed care organization attempts that we must learn from and not repeat those mistakes.

I would like to read some brief statements from at least one book available by experts in managed care. I present this in the sincere effort to help develop a good managed care system and not one that is designed around the "good old boy network" which in effect is doomed to fail.

I hope that these comments will challenge everyone's thinking so that we critically analyze exactly what it is we are creating with a managed care organization as it is written in Senate Bill 347 but perhaps more importantly how, why, and for whom it is being written.

EXHIBIT 17
DATE 3-10-93
SB 347

Montana Association
of Private Practice
Physical Therapists

March 8, 1993

Representative Chase Hibbard, Chair
Select Worker's Comp Subcommittee
Capitol Station
Helena, Mt 59620

Re: SB 347

Dear Representative Hibbard,

I am writing to share with you how SB 347 will impact the self employed physical therapists in this state. In its present form, SB 347 will not allow self employed physical therapists to treat injured workers at all. This will result in these small businesses going under.

Senate bill 347 accomplishes this by setting up managed care organizations around hospitals and large multi-specialty clinics. The MCO's are given exclusive control of where, when and who the injured worker sees for medical treatment. Since the hospital and clinic based MCO's have their own physical therapists will be completely left out of the care of the injured worker.

Self-employed physical therapists are small business owners. Our fees are demonstrably lower than either hospitals or large clinics. All treatment of injured workers is done on physician referral only. This bill will require referral to the MCO for treatment. This will produce a monopoly on health care provided to Montana's injured workers. The MCO's are set up to be both the gatekeeper and the provider. This situation defeats both the cost control/ utilization and quality maintenance objectives of the bill.

We fully support cost containment and the principles of managed care. What I object to is the hospitals and large clinics being set up to corner the health care market to injured workers. Yes, we need utilization guidelines. Yes, we need treatment parameters. Yes, we need uniform reimbursement controls. But we don't need the conflict of interest position this bill encourages hospitals and large clinics to take. Studies in California and Florida Worker's Comp Systems show that when there is a financial interest in a facility by the gatekeeper, both cost and utilization of services goes up.

Also please delete the section requiring a $10.00 co-pay each time an injured worker visits a provider. How is a worker making only two thirds of regular pay expected to bear this burden as well? It will only result in treatment delays and inadequacies and therefore defeats the purpose of getting the worker back to work as soon as possible.

Sincerely,

Kirk Hanson P.T.

Kirk Hanson, P.T.
143 Humboldt Loop
Helena MT 59555

EXHIBIT 18
DATE 3-10-93
HB SB 347

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. SB 347 NUMBER

MOTION: Benedict Move to concur with amendment Senate Jt. Res. (Tabled Pending March 10th) Carried -

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 19
DATE 3/10/93
HB SB 347

Amendments to Senate Bill No. 347
Third Reading Copy

For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 10, 1993

1. Page 11, lines 12 through 15.
Strike: subsection (b) in its entirety
Renumber: subsequent subsections

2. Page 12, line 19.
Strike: "(1)(f)"
Insert: "(1)(e)"

3. Page 15, lines 5 through 24.
Strike: subsection (7) in its entirety

4. Page 18, line 15.
Strike: "subsection"
Insert: "subsections"
Following: "(3)"
Insert: "and (4)"

5. Page 19, line 2.
Following: "the"
Strike: "insurer"
Insert: "department"

6. Page 19, line 12.
Following: line 11
Insert: "(4) A medical service provider who is not a member of a managed care organization and who is not qualified to be a treating physician may provide services to the injured worker for 30 days from the date of referral or for 12 visits, whichever occurs first, with the authorization of a treating physician. Thereafter, medical services provided to an injured worker without the written authorization of the insurer are not compensable."
Renumber: subsequent subsection

7. Page 19, line 12.
Strike: "A"
Insert: "Except as provided in subsection (4), a"

8. Page 20, lines 7 through 9.
Following: "organizations."
Strike: the remainder of line 7 through "organizations." on line 9
Insert: "A preferred provider arrangement with a hospital, clinic, or treating physician may not include physical therapy services."

9. Page 21, lines 5 and 6.

Following: "HAVE" on line 5
Strike: the remainder of lines 5 and 6
Insert: "been certified by the department. Subsequent referrals must be approved by the insurer. A dispute between the claimant and the insurer regarding subsequent referrals must be resolved through the process provided by the department."

10. Page 21, line 17.
Strike: ","
Insert: "or"

11. Page 21, lines 18 and 19.
Following: "providers" on line 18
Strike: the remainder of line 18 through "organization" on line 19

12. Page 23, lines 6 and 7.
Following: "providers"
Strike: the remainder of line 6 through "organization" on line 7

13. Page 24, line 12.
Strike: ", including physical therapy,"

14. Page 25, line 1.
Following: "provider"
Strike: ", a group of medical service providers,"

15. Page 27, lines 9 through 11.
Following: "facility"
Strike: the remainder of line 9 through "services" on page 11
Following: "has"
Strike: "an investment"
Insert: "a financial"

16. Page 27, line 16.
Following: "."
Insert: "This prohibition is not intended to prevent treating physicians from providing diagnostic services in their offices."

EXHIBIT 20
DATE 3-10-93
HB SB 347

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. SB-347 NUMBER

MOTION: Benedict - I move DO PASS as amended -

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA		✓
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 21
DATE 3-10-93
~~HB~~ SB 347

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. SB 347 NUMBER

MOTION: Adopt HA Amendments -
Rep. Driscoll moved. Fails - 3-3 vote -

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN		✓
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT		✓
ERNEST BERGSAGEL		✓
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 22
DATE 3-10-93
HB 504

MONTANA NONFARM WAGES AND SALARIES

YEAR	NONFARM WAGES & SALARIES (millions $)
1987	4,743
1988	5,013
1989	5,304
1990	5,627
1991	5,996
1992	6,332
1993	6,635
1994	6,987
1995	7,354

Sources: Bureau of Economic Analysis, U.S. Department of Commerce;
Bureau of Business & Economic Research, University of Montana;
and House Joint Resolution 3, Third Reading

Prepared by the Office of Research & Information, Montana Dept. of Revenue

EXHIBIT 22
DATE 3/10/93
HB 504

RECONCILIATION OF WORKERS' COMPENSATION PAYROLL TAX BASE & NONFARM WAGE & SALARY INCOME

ECONOMIC SECTOR	1991 NONFARM WAGES & SALARIES (millions $)	1991 CURRENT LAW WORKERS' COMP POTENTIAL NONFARM PAYROLL BASE (millions $)	DIFFERENCE (millions $)	1991 POTENTIAL FULL/PART-TIME SELF-EMPLOYED WAGE INCOME TAX BASE (millions $)	1991 POTENTIAL FULL-TIME SELF-EMPLOYED WAGE INCOME TAX BASE (millions $)	1991 CURRENT LAW POTENTIAL TAX BASE WITH ALL SELF-EMPLOYED (millions $)	1991 CURRENT LAW POTENTIAL TAX BASE WITH FULL-TIME SELF-EMPLOYED (millions $)
Agriculture				257		287	
Mining	214	214		9		223	
Construction	277	277		96		373	
Manufacturing	530	530		27		557	
Transportation/Communications/Utilities	598	439		48		487	
Interstate Railroads	159	Exempt	159				
Other Transp., Communications, Utilities	439	439					
Wholesale & Retail Trade	1,143	1,113		160		1,273	
Undocumented Tips on Meals	30	Exempt	30				
Other Wholesale/Retail Trade	1,113	1,113					
Finance/Insurance/Real Estate	309	279		50		329	
Employed Licensed Real Estate Agents	30	Exempt	30				
Other Finance/Insurance/Real Estate	279	279					
Other Private Services	1,360	1,322		394		1,716	
Household & Domestic Employment	13	Exempt	13				
Undocumented Tips on Meals/Cleaning etc.	22	Exempt	22				
Direct Sellers to Households	3	Exempt	3				
Other Services	1,322	1,322					
Government Services	1,565	1,038				1,038	
Federal-Civilian	387	Exempt	387				
Federal-Military	140	Exempt	140				
State & Local Government	1,038	1,038					
TOTAL	5,996	5,212	784	1,041	465	6,283	5,677
Reported Nonfarm Payroll Tax Base		4,970					
Non-Compliance, Underground Economy, Estimation Errors, Exempt Newpaper Carriers/Free-Lance Correspondents, Exempt Athletic Event Officials		242					

Sources: Bureau of the Census and Bureau of Economic Analysis, U.S. Department of Commerce; Montana Department of Labor & Industry and Department of Revenue

Prepared by the Office of Research and Information, Montana Department of Revenue 3-10-93

EXHIBIT 22
DATE 3/10/93
HB 504

MONTANA EMPLOYMENT, 1991

ECONOMIC SECTOR	1991 WAGE & SALARY EMPLOYMENT	1991 FULL/PART-TIME SELF-EMPLOYED
Agriculture	6,960	23,758
Mining	5,883	829
Construction	12,051	8,922
Manufacturing	21,898	2,506
Transportation/Communications/Utilities	20,724	4,458
Interstate Railroads	3,500	0
Other Transp., Communications, Utilities	17,224	4,458
Wholesale & Retail Trade	84,082	14,819
Finance/Insurance/Real Estate	14,468	13,722
Employed Licensed Real Estate Agents		9,133
Other Finance/Insurance/Real Estate		4,589
Other Private Services	86,635	36,512
Household & Domestic Employment	2,534	0
Direct Sellers to Households	271	
Other Services	83,830	
Government Services	80,463	0
Federal-Civilian	13,204	0
Federal-Military	10,504	0
State & Local Government	56,755	0
TOTAL	333,164	105,526

Sources: U.S. Bureau of Economic Analysis, and Montana Dept. of Labor & Industry

Prepared by the Office of Research & Information, Montana Dept. of Revenue, 3-10-93

EXHIBIT 23
DATE 3-10-93
HB 504

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. HB 504 NUMBER

MOTION: Revised Amendments - Eliot

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN		✓
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT		✓
ERNEST BERGSAGEL		✓
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 24
DATE 3-10-93
HB 504

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO HB 504 NUMBER

MOTION: Benedict - move Bill - Concur -

4-2-

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN		✓
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA		✓
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 25
DATE 3-10-93
HB 504

Amendments to Senate Bill No. 394
Third Reading Copy

Requested by Rep. Cocchiarella
For the Select Committee on Workers' Compensation

Prepared by Susan B. Fox
March 8, 1993

1. Page 1, line 12.
Following: "claimant"
Insert: ", an employer,"

2. Page 1, line 17.
Strike: "claimant"
Insert: "party"

3. Page 1, line 18.
Following: "(2)"
Insert: "Fees charged by an attorney representing a claimant are limited as provided by subsections (2) through (5)."

4. Page 3, line 12.
Following: line 11
Insert: "(6) Fees charged by an attorney representing a party other than a claimant may not exceed $75 an hour, subject to a maximum fee of $7,500. The fee arrangement is subject to approval by the department."
Renumber: subsequent subsections

5. Page 3, lines 13 and 14.
Following: "arrangement" on line 13
Strike: the remainder of line 13 through "claimant" on line 14.

6. Page 3, line 16.
Page 3, line 17.
Strike: "claimant"
Insert: "party"

7. Page 4, lines 2 and 3.
Following: "benefits" on line 2
Strike: the remainder of line 2 through "attorney" on line 3
Insert: "paid"

EXHIBIT 26
DATE 3-10-93
HB 504

Amendments to Senate Bill No. 394

1. Page 1, line 20.
Strike: "15%"
Insert: "20% (or 25% if the case goes to hearing before the workers' compensation judge or the state supreme court)"

2. Page 1, line 23.
Strike: "The attorney fee may not exceed $7500."

3. Page 2, line 3.
Strike: "15%"
Insert: "20% (or 25% if the case goes to hearing before the workers' compensation judge or the state supreme court)"

4. Page 2, line 4.
Strike: ", up to the"
Strike: lines 5 and 6
and on line 7, strike: "the state supreme court"

5. Page 3, line 4.
Strike: "$75"
Insert: "$90"

6. Page 3, line 13.
Following: "and"
Insert: "for contingency agreements under subsections (2) and (3) above,"

7. Page 3, line 22.
After line 22
Insert: "(8) For good cause shown, the department may approve a variance providing for fees in excess of the guidelines of fees as set forth in subsections (3) and (4).
(a) To obtain approval of a variance, an attorney has the burden of providing clear and convincing evidence of entitlement to a greater fee by documenting the following factors in regard to the specific claimant and the specific case:
(i) The anticipated time and labor required to perform the legal service properly.
(ii) The novelty and difficulty of legal issues involved in the matter.
(iii) The fees customarily charged for similar legal services.
(iv) The possible total recovery if successful.
(v) The time limitations imposed by the client or circumstances of the case."

Renumber subsequent subsections

EXHIBIT 27
DATE 3-10-93
HB 504

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. SB 394 NUMBER

MOTION: Benedict moved Bill as amended - Concurred - 4-2-

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN		✓
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA	✓	
DAVID EWER		✓

HR:1993
wp:rlclvote.man

EXHIBIT 28
DATE 3-10-93
HB 504

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. ~~HB~~ 587 NUMBER

MOTION: Amendment 3-10-93
1st Reading - Do Pass as Amd

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 29
DATE 3-10-93
HB 504

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. HB587 NUMBER

MOTION: Benedict moved as amended - Approved.

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 30
DATE 3-10-93
HB 628

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE H BILL NO. 628 NUMBER

MOTION: Tobe Am #1

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT		✓
ERNEST BERGSAGEL abstain		
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 31
DATE 3-10-93
HB 628

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. 628 NUMBER

MOTION: ~~Move HB 628 as amended~~ Todd Amendment #2 to Strike Section 7

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	
	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 32
DATE 3-10-93
HB 628

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. HB-628 NUMBER

MOTION: Do pass as amended

4-2

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT		✓
ERNEST BERGSAGEL		✓
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 33
DATE 3-10-93
HB 456

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 - BILL NO. HB 456 NUMBER _____

MOTION: Move HB 456 -

(Not passed)

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN		✓
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA		✓
DAVID EWER		✓

HR:1993
wp:rlclvote.man

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Select Workers Comp COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) SEN. HARP

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Gail Wheatley	MT Phys Ther. Assoc		✓
Ridley Johnson	NFIB	X	
Rich Hill	Gov. Office	X	
Dorothy Bradley	self		X
Chuck Hunter	DOLI	X	
Wm Egan	MT Comp Elect Wkrs	Amend	
Lenore Ranf	MT. Med Assn	X	
Tom Ebzery	MT Associated Physicians Inc	X	
Russ Ritter	Wash Corp	X	
Keith L. Olson	MT. Logging Assn	✓	
Don Allen	[illegible]	✓	
Russell B Hill	MT Trial Lawyers		✓
Michael S. Mizenko	MT. St. Assn Plumbers & Pipefitters MT. St. Bldg & Const. Council		✓
Delores Mills	St. Employee		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Select Workers Comp COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) Harp

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Gary Lusin	Physical Therapists		X
Tony Putman / Jason Putman	Coalition for WC System Improvement	X	
Jim Tutwiler	MT Chamber	✓	
Lorin Wright	Physical Therapists		✓
George Wood	Mt Self Insurers Assn	✓	
Mike Micone	MMCA	✓	
Charles R. Brooks	MT Retail Assoc	✓	
Samuel T. Hubbard	Deaconess Medical Center of Billings	✓	
Richard Smith	Montana Chapter American Physical Therapy Association		✓
Clarisse Landry	Valley P.T.		✓
Veronica Brown	H. ERG St. Council		✓
Oliver Goe	MMIA - MACO - MSCIA	✓	
Ole Meninguich	MT Opt. Assn	✓	
Dan Shea	Interested Citizen		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Select Workers Comp COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) Harp

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Terry Mutton Cd. Falls	Coalition for WC System Improvement	✓	
KIRK HANSON	MAPP		✓
Bill Crivello	Retail Assn + Crawford + Co	✓	
Jan Van Riper	Self		✓
DAN C EDWARDS	O.C.B.W.		✓
JERRY CONWOLLY	MT Chapter American Physical Therapy Assn		✓
Joyce Dougan	Valley Physical Therapy		✓
BARBARA DOWNING	BLGS Mt.		✓
HARLee Thompson	MBIA	X	
Bruce Coen	Montana Optometric Association	X	
Bob Olsen	MT. Hospital Assoc.	X	
Ann Lamm	Mt Chapter Amer. Phys. Therapy Assn		✓
Carla Torgerson	Mont. Headquarters Assn Mont Wool Growers Assn	X	
Jacqueline Denmark	Am. Fed. Assoc.	W/ amdts	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Select Workers Comp. COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) J. Harp

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
PETE STRIZICH	STATE FUND	✓	
Mona Jamison	MT. PT Assoc.		✓
Don Judge	MT STATE AFL-CIO		✓
Rick Hull	Gov. Office	✓	
Darlene Staver			✓
[redacted]	[redacted]		
Roger Tippy	Mt State Pharmaceutical Assn		(sort of)

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Select Workers Comp COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) Harp

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Carrie Gajdosik Missoula	Physical Therapist		Unless amended

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.