MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By **CHAIRMAN CHASE HIBBARD**, on March 12, 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: HB 672
Executive Action: HB 453, HB 455, HB 504, HB 622, HB 672

HEARING ON HB 672

Opening Statement by Sponsor:

REP. DAVID EWER, House District 45, Helena, presented HB 672. He said the purpose of this bill is to meet the anticipated cash needs of the old fund for the next biennium using an increased rate of payroll tax which would be borne by employers. **REP. EWER** said this bill makes changes to existing law, and he then reviewed the bill section by section. **REP. EWER** said this bill would enable the Board of Investments to size a bond issue based on growth of payroll tax which was not an option in the past. He said under existing statute the sizing of the bond issue is strictly limited to what has happened in the past.

REP. EWER said the payroll base has been rising close to 5% per year over the last ten years. Changes in the wording in this bill, should the payroll base fail, would enable the tax rate to go up, if required. He said the payroll base is unlike an income

tax base or property tax base. Given that there would be a modest size increase, we can expect to be safe with our assumption in the size of the bond issue.

REP. EWER concluded by saying the bill will minimize the payroll tax increase and would be sized at .38. The size of the bond issue would never be more than that. A formal fiscal note is in the process of being drawn up.

Proponents' Testimony: None

Opponents' Testimony: None

Questions From Committee Members and Responses:

REP. BENEDICT said the $220 million bond limit in the past was based on the predication that we were using a discounted figure on liabilities. We thought there was a handle on the liabilities but now, two years later, we find that the liabilities are in the neighborhood of between $300 million and $400 million. He asked **REP. EWER** how comfortable he feels with the $320 million limit.

REP. BENEDICT asked if had given any thought to a .19% employer/ employee payroll tax. **REP. EWER** said he had not. **REP. BENEDICT** asked to be taken through the scenario that under the $220 million bond limit we could only sell $140 million worth of bonds and, as he understands it, we can only bond up to 90% of the $220 million which would take us down to $185 million, so why could we only sell $140 million worth of bonds? **REP. EWER** said we did not have enough payroll tax either currently or historically to size the bond issue that would get us the $220 million. He said the maximum we had in August of 1991 was $142 million and that was the most we could get out of it with the collections to that date. He said we have to size the bond issue at 90%; we cannot take the full 100%.

REP. BENEDICT asked, on the $320 million bond limit, if that's all the bonds that are issued. **REP. EWER** said he couldn't get $320 million in cash. **REP. DRISCOLL** asked how much he could get. **REP. EWER** said we could figure approximately 7% bond size to be for reserves. He said for $1.00 worth of gross bond proceeds, he would expect to get between $.90 and $.92.

REP. DRISCOLL said the cash flow charts, according to the Legislative Auditor, have been accurate for the past three years and they are predicting $50 million in 1994 and $40 million in 1995. Why do we need $188 million if we are only talking about another two years? He asked if the amount outstanding is $140 million. **REP. EWER** said we issued $142 million and don't have that amount outstanding. He said we have approximately $135 million outstanding; we need approximately $51 million and in FY 95, we will need about $43 million.

REP. EWER said he would also presume that we would want to pay the new fund loan back which is anticipated to be $26 million. He said it is more cost effective to use bonds at 5.25. He said we need about $120 million plus a debt service reserve of $10 million so we need approximately $130 million in bonds.

He said, if this bill becomes law, under current statute there is no recourse in bonding against the new fund, and now, regardless if it is bonds or new fund, it is only $220 million.

CHAIRMAN HIBBARD asked **REP. EWER** whether the amount he is anticipating here is solely to get us through the next two years and whether he has considered how much debt we will have remaining in two years. He also asked if the intent of this is to meet our cash flow needs for the next two years and end up with some remaining obligation for the 1995 legislature. **REP. EWER** said that is correct and he thinks it is entirely legitimate. He said two months ago we heard it was $490 million and today he is hearing it is maybe $340 million. He said he is hopeful that the State Fund will be staffing up and having resources to manage correctly.

CHAIRMAN HIBBARD referred to the cash flow chart for the .5.5 payroll tax in HB 504 which has been approved, and it shows that by 1999, raising through this tax roughly $600 million total, half employer and half employee, this approximates the outside of what it might take to totally get us out of this problem. While not discrediting this approach, it is only meant to get us through two years and does not take into account the entire long range nature of the problem.

Closing by Sponsor:

REP. EWER said he would appreciate consideration of this bill.

EXECUTIVE ACTION ON HB 672

Motion: **CHAIRMAN HIBBARD** moved adoption of the amendments. **EXHIBIT 1**

Discussion: **CHAIRMAN HIBBARD** offered an amendment stating that a coordinating clause is needed; if this bill passes, it is in conflict with the funding mechanism already passed out of this committee in HB 504. He said he would suggest the following wording to legislative council: "If HB 504 is passed and approved, then [this act] is void." He said if both bills pass the House, then they would both go to the Senate and the Senate would have the option of passing one or both.

Vote: **REP. EWER** called for the question. Voice vote was taken. Motion carried unanimously.

Motion: **REP. EWER MOVED HB 672 DO PASS AS AMENDED.** Voice vote was taken. Motion carried unanimously.

EXECUTIVE ACTION ON HB 622

Motion: **REP. EWER MOVED HB 622.**

Discussion: **REP. EWER** said he had asked **Susan Fox** to categorize the amendments by subject. He said there were nine sets of amendments, and the committee would address the amendments brought by the coalition.

Jim Palmer reviewed the Coalition amendment. **EXHIBIT 2**

REP. DRISCOLL asked why the injured person is limited to 26 weeks. **Mr. Palmer** said the intent of the section is to provide an incentive to both the employer and employee to move towards returning to the work place. He said if the individual is unable to continue to work in that job position over a period of approximately six weeks, it's going to be relatively obvious that the worker is not going to be able return indefinitely. He said the individual should then go back to temporary total disability if he has not reached maximum healing or, if maximum healing has been reached, then he would move on to rehabilitation. After six months, if the individual is not able to return to work at the job at which he was injured, then in all probability he will not be able to.

Mr. Palmer said this part of the amendment is nothing more than a temporary incentive to both the employer and the employee. He said that currently there is no provision to allow for this benefit. The individual is temporarily totally disabled or, if he does return to work under the current definition of temporary total, he returns to the same or equal pay in a modified job position. He said there are situations where the employer cannot afford to pay the individual his full wages for modified work and this will allow the insurance carrier to make up the difference between what the employer can pay and what the individual's temporary total rate would be.

REP. DRISCOLL said this is very important wording; "return to job at time of injury" in the amendment because they could discontinue his workers' comp and tell him to get a job at the 7-11 store and then he would not be entitled to rehabilitation.

REP. DRISCOLL said amendment 14 talks about time of injury; that's whether or not they are going to get a rehabilitation person to write a plan and that provider has to determine whether or not the injured person can return to any type of work so the words "return to the job at the time of injury" have to be put in Amendment 14, page 19, line 20. **Susan Fox** said she would change the amendment.

Motion: **REP. DRISCOLL** moved to amend the amendments.

DISCUSSION: **REP. DRISCOLL** said instead of inserting "work" and striking "the job," he present bill says "return to the job" and we have to add the words "held at the time of injury" to the amendments.

Vote: **REP. EWER** called for the question. Voice vote. Motion carried 5-0 to amend the amendments with **REP. BERGSAGEL** not present.

DISCUSSION: **CHAIRMAN HIBBARD** suggested that the committee figure out the amendments by next Tuesday so it does not duplicate other action.

Motion: **REP. DRISCOLL** moved that amendment number 23 be removed from the first amendment.

Discussion: **Jim Palmer** said the purpose of the temporary, partial disability is to provide an incentive to both the employer and employee to return to work. He said the intent is not to exceed the temporary and total disability.

REP. DRISCOLL said the coalition's minutes clearly show that the intent of the coalition is if the worker returned, he or she would get the same money received when they were working between the new wages and comp. He said if the committee accepts this amendment, one-half the weekly wage -- which is $175.00 -- would be paid if the person returns to employment at 40 hours per hours a week, minimum wage, at $160.00 minus taxes, $175.00 from this amendment; they are not half-way whole much less made whole. **REP. DRISCOLL** said his point is, why would they take the job? It would be only because it was law and they would be forced to. He said people receiving a higher wage at the time of injury are already subject to $349.00 a week temporary total and then he would be forced to go back to a temporary, partial disability taking a job at minimum wage and give him $175.00 a week temporary, partial disability benefits. **REP. DRISCOLL** said that is not the intent of the minutes of the coalition meeting. He said welders, electricians and higher wage earning workers would really suffer under this amendment.

Jim Palmer said there is some confusion regarding the intent of the temporary, partial and he thinks until it is resolved it would be better to strike Section 14 "temporary, partial" than it would be to go ahead with the present confusion.

REP. EWER asked if the injured worker can work while on temporary, total. **REP. DRISCOLL** said they cannot because it would be fraud and they could be put in jail.

Jim Palmer said if we expand temporary, partial to exceed the current standard of two-thirds the state's average weekly wage, there is a fear that there may be a precedent set as to why we

should not exceed two-thirds of the state's weekly average wage on all the other types of benefits.

Motion: **REP. DRISCOLL** moved to adopt the amendments with the exception of #23, the average weekly wage.

Discussion: **Susan Fox** clarified amendment #5, page 9, line 24. The intent is to leave the language so that language in HB 361 would take precedence; if that is what the committee wants, we cannot strike subsection 4 in its entirety because that would remove it from law. She said what we would need to do is return it to current law status as it is now and then the amendment in HB 361 would take over and House Labor Committee would not have to deal with it.

Ms. Fox said it should say "return Subsection 4 to current language." The committee agreed.

Harlee Thompson clarified this by saying the insurer would be liable for the maximum of the $349,00, which is the two-thirds of the average weekly wage currently in effect and whatever the injured worker would earn working as long as that didn't exceed his forty hours pay. **Mr. Thompson** asked **REP. DRISCOLL** if that is what his amendment says. **REP. DRISCOLL** said it would have to say "not to exceed the state's average weekly wage," not "one-half the weekly wage." He said if he puts in a new #23, not to exceed the state's average weekly wage at the time of injury, then it would be doing what he said.

REP. DRISCOLL withdrew his motion.

Motion/Vote: **REP. DRISCOLL** moved to adopt Amendment #23 striking "one-half of" following "disabled" on line 24; insert "not to exceed the state's average weekly wage at the time of injury." Voice vote was taken. Motion carried unanimously.

Motion/Vote: **REP. DRISCOLL** moved adoption of the remaining amendments. Voice vote was taken. Motion carried unanimously.

Discussion: **Mr. Palmer** reviewed the second Coalition amendment section by section. **EXHIBIT 3**

CHAIRMAN HIBBARD asked **Ms. Butler** to explain how the amendment would work in current law and what the implications of this change would be. **Ms. Butler** said with an aggravation of a pre-existing condition, the insurer accepts that pre-existing condition along with the injury and pays benefits based on the combination of the result. After a worker meets maximum healing and he is essentially back to where he was when injured, there is leeway where the insurer is no longer liable. She said generally they take the worker as they find him until he reaches maximum healing and at that point his benefits would be reduced if he had a pre-existing condition. **Ms. Butler** said if there happened to be a prior work comp claim and it wasn't settled, but the

eligibility requirements were there and the original was fifty-fifty, the first insurer would be responsible for 50% and the second insurer responsible for the other 50%.

CHAIRMAN HIBBARD asked whether, under current law, a worker would get more benefits for a shorter period of time than this contemplates? **Ms. Butler** said under current law, a worker gets more benefits for a longer period of time. She said not only do they get benefits before maximum healing but they receive benefits after maximum healing. It's unusual to get a worker totally back to where they were before the injury and generally they stay on the entire liability so this would limit benefits compared to now.

CHAIRMAN HIBBARD said this is a fairly radical departure from what is being done now and he asked how this would be administered. **Ms. Butler** said if there was a prior insurer on the claim, it would be more difficult to administer because there would be two insurance companies. She said if there were two insurance companies involved, there would be a potential for litigation and they would be splitting the liability and have to agree on what benefits were payable. **Ms. Butler** said there would be a lot of administration difficulties.

CHAIRMAN HIBBARD said he was in a quandary as this is a fairly major departure and he wasn't really sure how he feels about it.

Ms. Fox said if the committee rejects these amendments, it may want to do a substitute amendment to strike that section in its entirety, which would return it to the status quo.

Motion/Vote: **REP. DRISCOLL** moved to amend bill by striking Section 3 in its entirety. Voice vote taken. Motion carried 4-2.

Motion: **REP. BENEDICT** moved adoption of the first Ewer amendment. **EXHIBIT 4**

Discussion: **CHAIRMAN HIBBARD** said this amendment is group purchase of workers' compensation insurance.

Mike Micone explained he had received information recently on the possibility of purchasing group insurance through the State Fund. He said this would go hand in hand with **Ms. Lenmark's** proposed amendments. It will allow groups like small trucking firms to form a group and buy a group policy. He said one other side benefit would be the possibility with the premium being kicked up because of the numbers in the group which could entice private carriers to come into the state. He said this was written almost verbatim from the Texas law. He asked that, if the committee does adopt this amendment, it delete subsection (7).

Ms. Fox clarified that section 18 (4) requires a department to adopt rules on forms criteria procedures and this requires a

statement of intent. She asked for the committee's direction to ask **Mr. Micone** to supply information on a statement of intent if this should pass.

Jacqueline Lenmark, from the **American Insurance Association (AIA)**, said **Mr. Micone** was accurate in his statement and it gives small employers the option to form a group so they might obtain compensation coverage at a better rate or it would give them some other options for carriers.

REP. COCCHIARELLA asked **Jim Murphy** to respond on how this would work in Montana. **Mr. Murphy** said no one knows how this would work. It may be very good in concept, but he said insurance companies can still turn down business and the State Fund cannot.

REP. DRISCOLL said this would have to be bought from an insurer authorized to write workers' compensation in the state and suggested that, since this concept is new, the committee could insert language that the State Fund does not have to comply with this section.

REP. BENEDICT asked if this would also give the opportunity for people who are now covered under the State Fund to get private insurance. He said they cannot get it now because maybe they are not large enough; if they get into a group of 10 or 15, they could get out of the State Fund and lose those premiums. **Mr. Murphy** said if this bill passes it would allow them to do that.

CHAIRMAN HIBBARD said they would need to find an insurance company to write their policies for them and this is an option of coverage from someone else and not opting out of coverage. **Mr. Murphy** said that is correct and assuming that the State Fund is given the option of writing or not writing it, then they would have to find someone to write it.

Mr. Micone said this amendment was not to encourage private insurers to come into the state. He said it was primarily aimed at the State Fund because there are a number of small employers who could group together and possibly get volume discounts. **Mr. Micone** said the employers being discussed are presently covered by the State Fund.

REP. DRISCOLL asked if there was a group of 10 truckers, and one individual in the group is causing all the wrecks, can he be eliminated from the group? **Mr. Micone** said he thought because they would have to form a governing body, they would be rating those individuals either in the form of higher premiums and they would have the authority to kick someone out of the group. **REP. DRISCOLL** asked if anyone can get out of the group if they want and **Mr. Micone** responded yes. He said this is very new to him but as he understands, the group would receive a base rate and companies within that group would receive volume mod factors.

Ms. Lenmark said it probably would be more appropriate to have

the plan filed with the insurance commissioner the same way it is done with the premium credit plan for the construction industry, and allow the State Fund, if they choose to participate, to develop its own plan because the private companies need to be regulated by the insurance commissioner.

REP. BENEDICT withdrew his motion.

CHAIRMAN HIBBARD said this amendment will stay on the table.

Discussion: **CHAIRMAN HIBBARD** said this amendment is requested by **Ms. Lenmark** to allow certain large deductibles. **EXHIBIT 5**

Ms. Lenmark said this amendment would provide an option for Plan 2 and Plan 3 insurers, allowing the State Fund or the private carriers to develop a plan to offer large deductibles to their policyholders. She said this is different from the deductible sections currently in law. **Ms. Lenmark** said this would allow the employer and insured to negotiate with their insurance company a deductible in some given amount. The insurance company would then be entitled to reduce the premium by some percentage amount based on the deductible negotiated. The insurance company is then on the hook for all the benefits. At the end of the year, the insurance company would collect the amount of deductible back from the employer. This is a contract between the insurer and policyholder. It does not have any impact at all on benefits or claims processing. The benefit of this particular large deductible plan is it offers some middle ground between self insurance and conventional insurance. **EXHIBIT 6**

Ms. Lenmark said this would allow an employer who is not quite large enough to self insure, but who would like to assume some of that liability, to make the arrangements to do so.

CHAIRMAN HIBBARD commented that this is one of the better options the committee has heard.

Motion/Vote: **REP. EWER** moved adoption of the amendment. **REP. BENEDICT** called for the question. Voice vote. Motion carried unanimously.

Motion: **REP. EWER** moved adoption of the second Lenmark amendment. **EXHIBIT 7**

Discussion: **Ms. Lenmark** representing AIA said the amendments were presented to the committee with **SEN. HARP's** fraud bill and it was decided that they should be held for consideration with this bill. She said this concept was developed by the Governor's task force, approved unanimously by the subcommittee chaired by **CHAIRMAN HIBBARD**, and inadvertently omitted from **SEN. HARP'S** bill.

Ms. Lenmark said this amendment would provide for the suspension of licensing discipline against professionals who abuse the

system. She referred to page 7, section 24 listing certain prohibitive activities to deter professionals and others from abusing the system. These are provider directed requirements.

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

Motion: **REP. EWER** moved adoption of the second Ewer amendment. **EXHIBIT 8**

Discussion: **REP. EWER** said the purpose of this amendment is three-fold: to increase the board from five to seven members; potential members would be selected by a panel consisting of the insurance commissioner and the leadership of the House and Senate who would recommend nominees to the Governor; the Governor would choose from that panel. Under this amendment board members would be paid $12,000 a year because this is an incredibly important board. The next major point of this amendment is the board has to adopt a business plan no later then June 30.

Ms. Fox said this would be inserted in the section that describes the duties of the board.

CHAIRMAN HIBBARD said he was somewhat nervous about the political appointments and the large salary. **REP. COCCHIARELLA** said this would give the Governor five appointments and the board should be totally balanced.

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

Motion: **REP. EWER** moved adoption of Ewer amendment #3. **EXHIBIT 9**

Discussion: **REP. EWER** said the MEA brought the amendment to him.

REP. DRISCOLL said if a person gets injured on the job, has sick leave on the books and it is negotiated, they could receive temporary total and sick leave at the same time or use their vacation time.

Vote: Voice vote was taken. Motion carried unanimously.

Motion: **REP. COCCHIARELLA** moved to strike all of the language in section 10 and return it to the status quo. **Ms. Fox** said because the committee struck section 3, that returns the injury portion back to how it exists today and by striking section 10, we would return the aggravation section for occupational disease to the status quo.

REP. DRISCOLL said currently it says the compensation payable under this chapter must be reduced and limited to such portion and medical and now they will prorate medical if the bill is left as is so "and medical" has to be removed.

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

Motion/Vote: **REP. COCCHIARELLA** moved to strike section 10, page 17, line 17. **REP. BENEDICT** called for the question. Voice vote. Motion carried unanimously.

Motion/Vote: **REP. BENEDICT** moved to strike section 4, page 11 and 12, to line 3. Voice vote. Motion carried unanimously.

Motion: **REP. COCCHIARELLA** moved to strike page 11, line 16-19.

Discussion: **REP. COCCHIARELLA** referred to page 11, line 16 and said this language, which has already amended compensation entitlement benefits for an injury or occupational disease, allows the insurer's designated agent direct access. She said this language violates every protection of privacy between a claimant and their lawyer and doctor, and that means any medical record or anything the insurer wants they can get. This would do away with a person's protection of privacy under the Montana Constitution.

Mr. Allen said other than hearing some of the discussion that went on in the coalition, this was put in the original bill and adopted after four months of discussion in various committees. **Mr. Allen** said when information is not available, it results in additional cost and the inability to process the claims in such a way that they can actually try to get at what really happened. He said if they can't get the information, they cannot make good decisions and he asked the committee not to accept that amendment.

John Shontz, representing **Vocational Rehabilitation Association (VRA)**, said there is language similar to this in SB 347. He said under current practice, VRA provides managed care using nurses and under SB 347 the nurses cannot access this information but every other medical provider can. He said VRA has asked that this language be amended to read "insurers' designated rehabilitation agent." This would provide nurses in the rehab programs with access to medical records. He suggested that the committee, rather than striking the language, change the language by adding the word "rehabilitation." **Mr. Shontz** said the sentence would read "insurers' designated rehabilitation agent."

REP. EWER asked **Ms. Butler** if she has access to the medical records of the treating physician under the current law. **Ms. Butler** said they can write the doctor and ask them to answer questions but the doctor is not bound to. **Ms. Butler** referred to the wording on page 11, line 16.

REP. EWER asked **Ms. Lenmark** how insurance companies protect the claimant's privacy but also get the information needed. **Ms. Lenmark** said the insurance company can request the information and the claimant can provide it. **Ms. Lenmark** said the intent was

to speed up the process to get benefits to the claimant, not to invade their rights.

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

Motion: **REP. BENEDICT** moved to strike subsection (8) & (9).

Discussion: **Ms. Fox** referred to subsection (8) and (9) on page 20 regarding rehabilitation benefits left out of the coalition amendments. **Ms. Butler** said it was a duplication and no longer needed.

CHAIRMAN HIBBARD said subsection (9) is in HB 361 and (8) is moved to page 19, line 4.

Vote: **REP. COCCHIARELLA** called for the question. Voice vote was taken. Motion carried unanimously.

Motion/Vote: **REP. EWER MOVED HB 622 DO PASS AS AMENDED.** Voice vote was taken. Motion carried unanimously.

EXECUTIVE ACTION ON HB 453

Motion/Vote: **REP. BENEDICT** moved to reconsider the committee's action of February 15 and moved adoption of the amendments. **EXHIBIT 10** Voice vote taken. Motion carried unanimously.

Motion/Vote: **REP. BENEDICT MOVED HB 453 DO PASS AS AMENDED.** Voice vote taken. Motion carried unanimously.

EXECUTIVE ACTION ON HB 455

Motion/Vote: **REP. BENEDICT MOVED HB 455 DO PASS AS AMENDED.** Voice vote was taken. Motion carried unanimously.

HB 455 goes directly to the floor.
HB 622 and HB 453 go with the package to the House Labor Committee.

EXECUTIVE ACTION ON HB 504

Motion: **REP. BENEDICT MOVED TO RECONSIDER ACTION ON HB 504 AND MOVED THE AMENDMENT. EXHIBIT 11**

Discussion: **Ms. Fox** said **Scott Seacat** brought up a coordination instruction problem on HB 504 that the committee adopted. She said the money is transferred for one fiscal year and the duties aren't transferred until the next fiscal year. She asked if someone could move to reconsider the action taken and remove the amendment so it can go back to the floor.

Vote: **REP. BENEDICT** called for the question. **HB 504 DO PASS AS AMENDED.** Voice vote was taken. Motion carried unanimously.

ADJOURNMENT

Adjournment: 8:20 p.m.

REP. CHASE HIBBARD, Chairman

EVY HENDRICKSON, Secretary

CH/eh

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

ROLL CALL

DATE 3-12-93

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

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HOUSE SELECT COMMITTEE REPORT

March 13, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that House Bill 455 (first reading copy -- white) do pass .

Signed: Chase Hibbard
Chase Hibbard, Chair

Committee Vote:
Yes 6, No 4.

571333SC.Hpf

HOUSE SELECT COMMITTEE REPORT

March 13, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that House Bill 504 (first reading copy -- white) do pass as amended, and that the House refer the bill as amended to its committee on Labor and Employment Relations for consideration as part of the Workers' Compensation package.

Signed: Chase Hibbard
Chase Hibbard, Chair

And, that such amendments read:

1. Title, line 7.
Following: "TAX"
Strike: "TO 1 PERCENT"
Following: "IMPOSING"
Strike: "A 1 PERCENT"
Insert: "AN"

2. Title, line 9.
Following: ";"
Insert: "PROVIDING APPROPRIATIONS;"

3. Title, line 10.
Following: "SECTIONS"
Insert: "15-30-207, 39-71-406,"

4. Page 5, line 7.
Strike: "1%"
Insert: "0.28%, plus the additional amount of payroll tax provided in [section 5],"

5. Page 5, line 11.
Strike: "1%"
Insert: "0.28%, plus the additional amount of payroll tax provided in [section 5],"

6. Page 5, lines 17 and 18.
Following: "a sole proprietor"
Strike: the remainder of lines 17 and 18 in their entirety
Insert: "or a working partner of a partnership who elects coverage under 39-71-401 shall pay only the employer's portion of

Committee Vote:
Yes 7, No 0.

571337SC.Hpf

HOUSE SELECT COMMITTEE REPORT

March 13, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that House Bill 672 (first reading copy -- white) do pass as amended, and that the House refer the bill as amended to its committee on Labor and Employment Relations for consideration as part of the Workers' Compensation package.

Signed: Chase Hibbard
Chase Hibbard, Chair

And, that such amendments read:

1. Page 9, line 10.
Following: line 9
Insert: "NEW SECTION. Section 4. Coordination instruction. If House Bill No. 504 is passed and approved, then [this act] is void."
Renumber: subsequent section

Committee Vote:
Yes 7, No 2.

571353SC.Hpf

HOUSE SELECT COMMITTEE REPORT

March 13, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that House Bill 453 (first reading copy -- white) do pass as amended, and that the House refer the bill as amended to its committee on Labor and Employment Relations for consideration as part of the Workers' Compensation package.

Signed: _____
Chase Hibbard, Chair

And, that such amendments read:

1. Title, lines 7 through 9.
Strike: "CREATING" on line 7 through "FRAUD;" on line 9

2. Title, lines 11 and 12.
Strike: "REDUCE" on line 11 through "FUND" on line 12
Insert: "SUPPORT THE INVESTIGATION AND PROSECUTION OF WORKERS' COMPENSATION FRAUD"

3. Page 2, line 10.
Following: "shall"
Insert: ": (i)"

4. Page 2, lines 11 and 12.
Following: "(3)(a)" on line 11
Strike: ":" on line 11 through "(i)" on line 12

5. Page 2, line 13.
Following: "section;"
Insert: "and"

6. Page 2, lines 14 through 20.
Strike: "to" on line 14 through "39-71-2312" on line 20
Insert: "forward any surplus money to the department of justice. The forwarded money must be used exclusively for the staffing and operation of the workers' compensation fraud investigation and prosecution office established in [section 1 of Senate Bill No. 164]."

Committee Vote:
Yes ___, No ___.

571350SC.Hpf

HOUSE SELECT COMMITTEE REPORT

March 13, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that House Bill 622 (first reading copy -- white) do pass as amended, and that the House refer the bill as amended to its committee on Labor and Employment Relations for consideration as part of the Workers' Compensation package.

Signed: _____
Chase Hibbard, Chair

And, that such amendments read:

1. Title, lines 12 through 14.
Following: "INFIRMITY;" on line 12
Strike: the remainder of line 12 through line 14 in their entirety

2. Title, lines 17 through 19.
Following: "BENEFITS;" on line 17
Strike: the remainder of line 17 through "HIRING;" on line 19

3. Title, line 20.
Following: "SELF-INSURE;"
Insert: "ALLOWING CERTAIN OPTIONAL DEDUCTIBLES TO POLICYHOLDERS; REQUIRING SUSPENSION, REVOCATION, OR DENIAL OF A PROFESSIONAL OR OCCUPATIONAL LICENSE FOR VIOLATION OF THE WORKERS' COMPENSATION LAW; REVISING THE DEFINITION OF UNPROFESSIONAL CONDUCT; PROHIBITING CERTAIN ACTIONS; PRECLUDING LIABILITY FOR REPORTING VIOLATIONS OF THE WORKERS' COMPENSATION LAW; ALLOWING AUGMENTATION OF TEMPORARY TOTAL DISABILITY BENEFITS WITH SICK LEAVE AND VACATION LEAVE; REQUIRING THE STATE FUND BOARD TO ADOPT AN ANNUAL BUSINESS PLAN;"

4. Title, line 20.
Following: "SECTIONS"
Insert: "37-1-131, 37-3-322, 37-6-310, 37-10-311, 37-12-321, 37-14-321,"

Committee Vote:
Yes 6, No 0.

14. Page 19, line 4.
Following: "plan"
Insert: "and are not subject to the lump-sum payment provisions of 39-71-741"

15. Page 19, line 20.
Following: "the job"
Insert: "held at the time of injury"

16. Page 20, line 6.
Following: "of"
Strike: the remainder of line 6
Insert: "the services and benefits available"

17. Page 20, lines 7 and 8.
Following: "to" on line 7
Strike: the remainder of line 7 through "section"
Insert: "the vocational rehabilitation provisions of the Workers' Compensation Act"

18. Page 20, lines 9 through 15.
Strike: subsections (8) and (9) in their entirety

19. Page 21, line 2.
Strike: "an attending"
Insert: "a treating"
Following: "physician"
Strike: the remainder of line 2

20. Page 21, line 18 through page 23, line 15.
Strike: sections 10 through 12 in their entirety
Renumber: subsequent sections

21. Page 25, lines 14 and 15.
Following: "worker" on line 14
Strike: "is medically"
Insert: "has a physical restriction, as determined by objective medical findings, and is"
Strike: "the same," on line 14
Insert: "a"
Following: "modified" on line 15
Strike: ","

22. Page 25, line 21.
Strike: "hourly"
Insert: "average weekly"

23. Page 25, line 24.
Following: "disabled"
Insert: ", not to exceed the state's average weekly wage at the time of injury"

24. Page 26, lines 1 through 8.
Following: "weeks" on line 1
Strike: the remainder of line 1 through line 8
Insert: ".
(4) A worker requalifies for temporary total disability benefits if the modified position is no longer available to the worker and the worker continues to be temporarily totally disabled as defined in 39-71-116."

25. Page 26, lines 14 through 19.
Strike: section 15 in its entirety
Renumber: subsequent sections

26. Page 27, page 16 and 17.
Strike: section 17 in its entirety
Insert: "NEW SECTION. Section 11. Workers' compensation and employers' liability insurance -- optional deductibles. (1) An insurer issuing a workers' compensation or an employer's liability insurance policy may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).
(2) A rating organization may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).
(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:
(a) Claimants' rights are properly protected and claimants' benefits are paid without regard to the deductible.
(b) Premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.
(c) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.
(d) Recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.
(e) The policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.
(f) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the

board determines, after a hearing as provided in subsection (2), is guilty of knowingly defrauding, abusing, or aiding in the defrauding or abusing of the workers' compensation system in violation of the provisions of Title 39, chapter 71 or 72;

~~(3)~~(4) pay to the department its pro rata share of the assessed costs of the department under 37-1-101(6);

~~(4)~~(5) consult with the department before the board initiates a program expansion, under existing legislation, to determine if the board has adequate money and appropriation authority to fully pay all costs associated with the proposed program expansion. The board may not expand a program if the board does not have adequate money and appropriation authority available."

Section 14. Section 37-3-322, MCA, is amended to read:

"37-3-322. Unprofessional conduct. As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or in securing a license or in taking the examination provided for in this chapter;

(2) performing abortion contrary to law;

(3) obtaining a fee or other compensation, either directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition of a person can be cured;

(4) employing abusive billing practices;

(5) directly or indirectly giving or receiving a fee, commission, rebate, or other compensation for professional services not actually rendered. This prohibition does not preclude the legal functioning of lawful professional partnerships, corporations, or associations.

(6) willful disobedience of the rules of the board;

(7) conviction of an offense involving moral turpitude or conviction of a felony involving moral turpitude, and the judgment of the conviction, unless pending on appeal, is conclusive evidence of unprofessional conduct;

(8) commission of an act of sexual abuse, misconduct, or exploitation related to the licensee's practice of medicine;

(9) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors, otherwise than in the course of legitimate or reputable professional practice;

(10) conviction or violation of a federal or state law regulating the possession, distribution, or use of a narcotic or hallucinatory drug, as defined by the federal food and drug administration, and the judgment of conviction, unless pending on appeal, is conclusive evidence of unprofessional conduct;

(11) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other drug or substance to the extent that the use impairs the user physically or mentally;

(12) conduct unbecoming a person licensed to practice medicine or detrimental to the best interests of the public as defined by rule of the board;

(13) conduct likely to deceive, defraud, or harm the public;

(14) making a false or misleading statement regarding the licensee's skill or the effectiveness or value of the medicine, treatment, or remedy prescribed by the licensee or at the licensee's direction in the treatment of a disease or other condition of the body or mind;

(15) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(16) use of a false, fraudulent, or deceptive statement in any document connected with the practice of medicine;

(17) practicing medicine under a false or assumed name;

(18) testifying in court on a contingency basis;

(19) conspiring to misrepresent or willfully misrepresenting medical conditions improperly to increase or decrease a settlement, award, verdict, or judgment;

(20) aiding or abetting in the practice of medicine by a person not licensed to practice medicine or a person whose license to practice medicine is suspended;

(21) allowing another person or organization to use the licensee's license to practice medicine;

(22) malpractice or negligent practice;

(23) except as provided in this subsection, practicing medicine as the partner, agent, or employee of or in joint venture with a person who does not hold a license to practice medicine within this state; however, this does not prohibit:

(a) the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4;

(b) a single consultation with or a single treatment by a person or persons licensed to practice medicine and surgery in another state or territory of the United States or foreign country; or

(c) practicing medicine as the partner, agent, or employee of or in joint venture with a hospital, medical assistance facility, or other licensed health care provider. However:

(i) the partnership, agency, employment, or joint venture must be evidenced by a written agreement containing language to the effect that the relationship created by the agreement may not affect the exercise of the physician's independent judgment in the practice of medicine;

(ii) the physician's independent judgment in the practice of medicine must in fact be unaffected by the relationship; and

(iii) the physician may not be required to refer any patient

to a particular provider or supplier or take any other action the physician determines not to be in the patient's best interest.

(24) willfully or negligently violating the confidentiality between physician and patient, except as required by law;

(25) failing to report to the board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

(26) failing to transfer pertinent and necessary medical records to another physician when requested to do so by the subject patient or by the patient's legally designated representative;

(27) failing to furnish to the board or its investigators or representatives information legally requested by the board;

(28) failing to cooperate with a lawful investigation conducted by the board;

(29) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate parts 1 through 3 of this chapter or the rules authorized by them;

(30) having been subject to disciplinary action of another state or jurisdiction against a license or other authorization to practice medicine, based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section. A certified copy of the record of the action taken by the other state or jurisdiction is evidence of unprofessional conduct.

(31) any other act, whether specifically enumerated or not, which, in fact, constitutes unprofessional conduct."

Section 15. Section 37-6-310, MCA, is amended to read:

"37-6-310. Unprofessional conduct. As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or in securing a license or in taking the examination provided for in this chapter;

(2) obtaining a fee or other compensation, either directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition of a person can be cured;

(3) willful disobedience of the rules of the board;

(4) final conviction of an offense involving moral turpitude;

(5) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors, otherwise than in the course of legitimate or reputable professional practice;

(6) final conviction of a violation of a federal or state law regulating the possession, distribution, or use of a narcotic or hallucinatory drug, as defined by the federal food and drug

administration;

(7) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other drug or substance to the extent that the use impairs the user physically or mentally;

(8) conduct unbecoming a person licensed to practice podiatry or detrimental to the best interest of the public;

(9) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(10) testifying in court on a contingency basis;

(11) conspiring to misrepresent or willfully misrepresenting medical conditions to increase or decrease a settlement, award, verdict, or judgment;

(12) aiding or abetting in the practice of medicine a person not licensed to practice medicine or a person whose license to practice medicine is suspended;

(13) gross malpractice or negligent practice;

(14) practicing podiatry as the partner, agent, or employee of or in joint venture with a person who does not hold a license to practice podiatry within this state; however, this does not prohibit the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4, nor does this apply to a single consultation with or a single treatment by a person or persons licensed to practice podiatry in another state or territory of the United States or foreign country;

(15) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate parts 1 through 3 of this chapter or the rules authorized by parts 1 through 3; or

(16) any other act, whether specifically enumerated or not, which in fact constitutes unprofessional conduct."

Section 16. Section 37-10-311, MCA, is amended to read:

"37-10-311. Revocation -- unprofessional conduct. (1) The board may revoke a certificate of registration for:

(a) physical or mental incompetence;

(b) gross malpractice or repeated malpractice;

(c) a violation of any of the provisions of this chapter or rules or orders of the board; or

(d) unprofessional conduct.

(2) Unprofessional conduct includes:

(a) obtaining a fee by fraud or misrepresentation;

(b) employing, directly or indirectly, a suspended or unlicensed optometrist to perform work covered by this chapter;

(c) directly or indirectly accepting employment to practice optometry from a person not having a valid certificate of

registration as an optometrist or accepting employment to practice optometry for or from a company or corporation;

(d) permitting another to use ~~his~~ the optometrists's certificate of registration;

(e) soliciting or sending a solicitor from house to house;

(f) treatment or advice in which untruthful or improbable statements are made;

(g) professing to cure nonocular disease;

(h) advertising in which ambiguous or misleading statements are made; ~~or~~

(i) the use in advertising of the expression "eye specialist" or "specialist on eyes" in connection with the name of an optometrist. This chapter does not prohibit legitimate or truthful advertising by a registered optometrist; or

(j) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or a claim for benefits under Title 39, chapter 71 or 72.

(3) Before a certificate is revoked, the holder shall be given a notice and an opportunity for a hearing.

(4) Any optometrist convicted a second time for violation of the provisions of this chapter or whose certificate of registration or examination has been revoked a second time shall not be permitted to practice optometry in this state."

Section 17. Section 37-12-321, MCA, is amended to read:

"37-12-321. Unprofessional conduct. As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or securing a license or in taking the examination provided for in this chapter;

(2) obtaining any form of compensation, directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition can be cured;

(3) practicing chiropractic under a false or assumed name or impersonating another practitioner of like or different name;

(4) knowingly disobeying a rule of the board;

(5) conviction of a criminal offense involving moral turpitude. A certified copy of the judgment of conviction is conclusive evidence of the conviction. This subsection is subject to chapter 1, part 2, of this title.

(6) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other substance to the extent that such use impairs the user's physical or mental professional capability;

(7) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors;

(8) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(9) testifying in court on a contingency basis;

(10) conspiring to misrepresent or knowingly misrepresenting physical conditions in order to increase or decrease a settlement or award;

(11) aiding or abetting in the practice of chiropractic a person not licensed to practice chiropractic or a person whose license is suspended;

(12) practicing chiropractic as the partner, agent, or employee of or in joint venture with a person not licensed to practice chiropractic in this state. However, this does not prohibit incorporation as a professional service corporation under Title 35, chapter 4, or prevent a single consultation with or a single treatment by a person licensed to practice chiropractic in another state or territory of the United States or a foreign country.

(13) violating, attempting or conspiring to violate, or aiding or abetting in the violation of this chapter or the rules adopted under it; or

(14) conduct unbecoming a person licensed to practice chiropractic or detrimental to the best interests of the public."

Section 18. Section 37-14-321, MCA, is amended to read:

"37-14-321. Revocation or suspension of license or permit. A license or permit may be suspended for a fixed period or may be revoked, or such technologist or technician may be censured, reprimanded, or otherwise disciplined as determined by the board if, after a hearing before the board, it is determined that the radiologic technologist or limited permit technician:

(1) is guilty of fraud or deceit in activities as a radiologic technologist or limited permit technician or has been guilty of any fraud or deceit in procuring the license or permit;

(2) has been convicted in a court of competent jurisdiction of a crime involving moral turpitude;

(3) is an habitual drunkard or is addicted to the use of narcotics or other drugs having a similar effect or is not mentally competent;

(4) is guilty of unethical or unprofessional conduct, as defined by rules promulgated by the board, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72, or has been guilty of incompetence or negligence in ~~his~~ activities as a radiologic technologist or limited permit technician;

(5) has continued to perform as a radiologic technologist or limited permit technician without obtaining a license or

permit or renewal as required by this chapter."

NEW SECTION. Section 19. Prohibited actions -- penalty. (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (3):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person licensed to practice law in Montana or a medical care provider who advertises services or facilities with the intention that a worker use those services or facilities with regard to an injury or illness that is compensable under chapter 72 or this chapter and who fails to announce in the advertisement that filing a fraudulent claim is theft, as provided in 39-71-316, is subject to the penalty in subsection (3).

(3) A person who violates this section may be assessed a penalty of not less than $200 or more that $500 for each offense. The department shall assess and collect the penalty.

NEW SECTION. Section 20. No liability for reporting violation. A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of chapter 72 or this chapter.

Section 21. Section 39-71-736, MCA, is amended to read:

"39-71-736. Compensation -- from what date paid. (1) (a) No compensation may be paid for the first 48 hours or 6 days' loss of wages, whichever is less, that the claimant is totally disabled and unable to work due to an injury. A claimant is eligible for compensation starting with the 7th day.

(b) However, separate benefits of medical and hospital services must be furnished from the date of injury.

(2) For the purpose of this section, except as provided in subsection (3), an injured worker is not considered to be entitled to compensation benefits if the worker is receiving sick leave benefits, except that each day for which the worker elects to receive sick leave counts 1 day toward the 6-day waiting period.

(3) Augmentation of temporary total disability benefits with sick leave by an employer pursuant to a collective

bargaining agreement may not disqualify a worker from receiving temporary total disability benefits.

(4) Receipt of vacation leave by an injured worker may not affect the worker's eligibility for temporary total disability benefits."

Section 22. Section 39-71-2315, MCA, is amended to read:

"39-71-2315. Management of state fund -- powers and duties of the board -- business plan required. (1) The management and control of the state fund is vested solely in the board.

(2) The board is vested with full power, authority, and jurisdiction over the state fund. The board may perform all acts necessary or convenient in the exercise of any power, authority, or jurisdiction over the state fund, either in the administration of the state fund or in connection with the insurance business to be carried on under the provisions of this part, as fully and completely as the governing body of a private mutual insurance carrier, in order to fulfill the objectives and intent of this part. Bonds may not be issued by the board, the state fund, or the executive director.

(3) The board shall adopt a business plan no later than June 30 for the next fiscal year. At a minimum, the plan must include:

(a) specific goals for the fiscal year for financial performance. The standard for measurement of financial performances must include an evaluation of premium to surplus.

(b) specific goals for the fiscal year for operating performance. Goals must include but not be limited to specific performance standards for staff in the area of senior management, underwriting, and claims administration. Goals must, in general, maximize efficiency, economy, and equity as allowed by law.

(4) The business plan must be available upon request to the general public for a fee not to exceed the actual cost of publication. However, performance goals relating to a specific employment position are confidential and not available to the public.

(5) No sooner than July 1 or later than October 31, the board shall convene a public meeting to review the performance of the state fund, using the business plan for comparison of all the established goals and targets. The board shall publish, by November 30 of each year, a report of the state fund's actual performance as compared to the business plan.""

Renumber: subsequent section

27. Page 27, lines 18 through 23.
Following: "(1)" on line 18
Strike: the remainder of subsection (1) in its entirety through "14]" on line 23
Insert: "[Sections 8 and 9]"

28. Page 28, line 1.
Strike: "[sections 13 and 14]."
Insert: "[sections 8 and 9].

(2) [Section 11] is intended to be codified as an integral part of Title 39, chapter 71, part 4, and the provisions of Title 39, chapter 71, part 4, apply to [section 11].

(3) [Sections 19 and 20] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 19 and 20]."

29. Page 28, line 2.
Following: line 1
Insert: "NEW SECTION. Section 24. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 25. Effective date. [This act] is effective July 1, 1993."

EXHIBIT 1
DATE 3-12-93
HB 672

Amendments to House Bill No. 672
First Reading Copy

For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 13, 1993

1. Page 9, line 10.
Following: line 9
Insert: "NEW SECTION. **Section 4. Coordination instruction.** If House Bill No. 504 is passed and approved, then [this act] is void."
Renumber: subsequent section

EXHIBIT 2
DATE 3-12-93
HB 622

Amendments to House Bill No. 622
First Reading Copy

Requested by (Coalition)
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 11, 1993

1. Title, lines 12 through 14.
Following: "INFIRMITY;" on line 12
Strike: the remainder of line 12 through line 14 in their entirety

2. Title, lines 17 through 19.
Following: "BENEFITS;" on line 17
Strike: the remainder of line 17 through "HIRING;" on line 19

3. Title, line 23.
Following: "AND"
Strike: "REPEALING" through "MCA"
Insert: "PROVIDING AN EFFECTIVE DATE"

4. Page 7, lines 1 through 4.
Following: "39-71-119" on line 1
Strike: the remainder of line 1 through "healing" on line 4
Insert: "in which a worker, prior to maximum healing:
(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;
(b) returns to work in a modified or alternative employment; and
(c) suffers a partial wage loss"

5. Page 9, line 24 through page 10, line 7.
Strike: subsection (4) in its entirety
Renumber: subsequent subsections

6. Page 10, line 23.
Strike: "(6)"
Insert: "(5)"

7. Page 11, line 16.
Strike: "applying"
Insert: "who apply"
Following: "compensation"
Insert: "or who are entitled to benefits"

8. Page 11, lines 20 and 21.
Strike: lines 20 and 21 in their entirety

9. Page 13, lines 24 and 25.
Following: "insurer" on line 24
Strike: the remainder of line 24 through "days" on line 25

EXHIBIT 2
DATE 3/12/93
HB 662

10. Page 14, lines 2 and 3.
Following: "payments" on line 2
Strike: the remainder of line 2 through "days" on line 3

11. Page 17, lines 17 through 23.
Strike: subsection (8) in its entirety

12. Page 19, line 2.
Following: "paid"
Insert: "biweekly"

13. Page 19, line 4.
Following: "plan"
Insert: "and are not subject to the lump-sum payment provisions of 39-71-741"

14. Page 19, line 20.
Strike: "the job" return to job
Insert: "work"

15. Page 20, line 6.
Following: "of"
Strike: the remainder of line 6
Insert: "the services and benefits available"

16. Page 20, lines 7 and 8.
Following: "to" on line 7
Strike: the remainder of line 7 through "section"
Insert: "the vocational rehabilitation provisions of the Workers' Compensation Act"

17. Page 20, line 10.
Strike: "with"
Insert: "to"

18. Page 20, line 12.
Following: "settlement"
Insert: "or be paid in a lump sum"

19. Page 21, line 2.
Strike: "an attending"
Insert: "a treating"
Following: "physician"
Strike: the remainder of line 2

20. Page 22, line 13 through page 23, line 15.
Strike: sections 11 and 12 in their entirety
Renumber: subsequent sections

21. Page 25, lines 14 and 15.
Following: "worker"
Strike: "is medically"
Insert: "has a physical restriction as determined by objective medical findings, and is"
Strike: "the same," on line 14

EXHIBIT 2
DATE 3/12/93
HB 622

Insert: "a"
Following: "modified" on line 15
Strike: ","

22. Page 25, line 21.
Strike: "hourly"
Insert: "average weekly"

23. Page 25, line 24.
Following: "disabled"
Insert: "not to exceed one-half of the state's average weekly wage at the time of injury"

24. Page 26, lines 1 through 8.
Following: "weeks" on line 1
Strike: the remainder of line 1 through line 8
Insert: ".
(4) A worker requalifies for temporary total disability benefits if the modified position is no longer available to the worker and the worker continues to be temporarily totally disabled as defined in 39-71-116."

25. Page 26, lines 14 through 19.
Strike: section 15 in its entirety
Renumber: subsequent sections

26. Page 27, lines 16 and 17.
Strike: section 17 in its entirety
Renumber: subsequent section

27. Page 27, lines 18 through 23.
Following: "instruction." on line 18
Strike: subsection (1) in its entirety through "14]" on line 23
Insert: "[Sections 11 and 12]"

28. Page 28, line 1.
Strike: "13 and 14"
Insert: "11 and 12"

29. Page 28, line 2.
Following: line 1
Insert: "NEW SECTION. **Section 15. {standard} Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 16. {standard} Effective date.** [This act] is effective July 1, 1993."

EXHIBIT 3
DATE 3/12/93
HB 622

Amendments to House Bill No. 622
First Reading Copy

Requested by Coalition
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 9, 1993

1. Title, lines 15 and 16.
Strike: line 15 through "DISPUTES;" on line 16

2. Page 10, lines 13 through page 11, line 3.
Following: "(6)" on line 13
Strike: the remainder of subsections (6) and (7) in their entirety
Insert: "If an injury, as defined in 39-71-119, occurs that involves an aggravation of a preexisting condition, the permanent total, permanent partial, and medical benefits payable under this chapter after the worker reaches maximum healing must be apportioned between the liability attributable to the preexisting condition and the liability attributable to the aggravation injury. The insurer for the injury is responsible only for the portion attributable to the aggravation injury.

(7) If a workers' compensation insurer had a compensable claim for the preexisting condition, the insurer remains liable for the portion attributable to that insurer for permanent total, permanent partial, and medical benefits."

3. Page 21, line 25 through page 22, line 3.
Following: "be" on page 21, line 25
Strike: the remainder of page 21, line 25 through page 22, line 5
Insert: "apportioned between the liability attributable to the preexisting condition and the liability attributable to the occupational disease after the injured worker reaches maximum healing.

(2) If a workers' compensation insurer had a compensable claim for the preexisting condition, the insurer remains liable for the portion attributable to that insurer for benefits paid."
Renumber: subsequent subsection

4. Page 22, line 6.
Strike: "reduced a proportionate amount"
Insert: "apportioned"

5. Page 23, line 16 through page 25, line 11.
Strike: section 13 in its entirety
Renumber: subsequent sections

6. Page 27, lines 19 and 22.
Strike: "15"
Insert: "14"

EXHIBIT 3
DATE 3/12/93
HB 622

7. Page 27, line 23.
Strike: "[Sections 13 and 14] are"
Insert: "[Section 13] is"

8. Page 28, line 1.
Strike: "[sections 13 and 14]"
Insert: "[section 13"

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Amendments to House Bill No. 622
First Reading Copy

Requested by Rep. Ewer
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 11, 1993

1. Title, line 20.
Following: "SELF-INSURE;"
Insert: "ALLOWING GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE;"

2. Page 1, line 24.
Insert: "STATEMENT OF INTENT
(This amendment requires that a statement of intent be attached to the bill because it requires the department rules to implement [Section 18(4)]."

3. Page 27, line 16.
Following: line 15
Insert: "

NEW SECTION. **Section 17. Definitions.** As used in [section 18], the following definitions apply:

(1) "Business entity" means a business enterprise owned by a single person, corporation, organization, business trust, trust, partnership, joint venture, association, or other business entity.

(2) "Group" means two or more business entities that join together with the approval of the department to purchase individual workers' compensation insurance policies covering each business entity that is part of a group.

NEW SECTION. **Section 18. Group purchase of workers' compensation insurance.** (1) On receiving approval of the department, two or more business entities may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

(2) To be eligible to join a group, the department shall determine that a business entity is engaged in a business pursuit that is the same as or similar to the business pursuits of the other entities participating in the group.

(3) The department shall establish a certification program for groups organized under this section and shall issue to eligible business entities certificates of approval that authorize formation and maintenance of a group.

(4) The department by rule shall adopt forms, criteria, and procedures for the issuance of certificates of approval to groups under this section.

(5) A group certified under this section may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state. Under an individual

policy, the group is entitled to a premium or volume discount that would be applicable to a policy of the combined premium amount of the individual policies.

(6) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group.

(7) Rating manual rules and rates must be used in computing the rates for policies under this section, and the rating organization shall determine any experience rating factor that is applied to those group policies.

(8) A group shall adopt a plan of operation that must include the composition and selection of a governing board, the methods for administering the group, and guidelines for the workers' compensation insurance coverage obtained by the group, including the payment of premiums, the distribution of discounts, and the method for providing risk management. A group shall file a copy of its plan of operation with the department."

Renumber: subsequent sections

4. Page 28, line 2.
Following: line 1
Insert: "(3) [Sections 17 and 18] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 17 and 18]."

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HB 622

Amendments to House Bill No. 622
First Reading Copy
(Large Deductibles)

EXHIBIT 5
DATE 3-12-93
HB 622

Requested by (Lenmark)
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 10, 1993

1. Title, line 20.
Following: "SELF-INSURE;"
Insert: "ALLOWING CERTAIN OPTIONAL DEDUCTIBLES TO POLICYHOLDERS;"

2. Page 27.
Following: line 15
Insert: "NEW SECTION. **Section 17. Workers' compensation and employers' liability insurance -- optional deductibles.** (1) An insurer issuing a workers' compensation or an employer's liability insurance policy may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).

(2) A rating organization may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).

(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:

(a) Claimants' rights are properly protected and claimants' benefits are paid without regard to the deductible.

(b) Premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.

(c) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.

(d) Recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.

(e) The policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(f) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.

(g) Failure by the policyholder to reimburse deductible amounts to the insurer is treated under the policy as nonpayment of premium.

(h) Losses subject to the deductible must be reported and recorded as losses for purposes of ratemaking and application of the experience rating plan on the same basis as losses under policies providing first dollar coverage.

(4) The state compensation mutual insurance fund, plan No. 3, may adopt the plan filed by the rating organization or adopt an optional deductible plan that meets the requirements of this

section.

(5) For purposes of 39-71-201, liability for assessments must be ascertained based on premiums collected, in the case of policies written under plan No. 2, or on the assessment levied, in the case of policies written under plan No. 3, for which the policyholder would have been obligated without the deductible. For all other taxes and assessments based on premium, the amount of premium or assessment must be determined after application of the deductible."

Renumber: subsequent sections

3. Page 28.
Following: line 1
Insert: "(3) [Section 17] is intended to be codified as an integral part of Title 39, chapter 71, part 4, and the provisions of Title 39, chapter 71, part 4, apply to [section 17]."

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WORKERS COMPENSATION DEDUCTIBLE CONSIDERATIONS

EMPLOYER INCENTIVES

The cost differentials between insured and self insured programs are increasing, and they provide definite incentives for employers to self insure or find some other means to self fund a large amount of their Workers Compensation benefits. These cost differentials are principally driven by the following:

1) The statutory surplus required to guarantee benefits is becoming increasingly more expensive. A large Employer's internal rate of return is invariably such as to show at least a 5% advantage for self funding.

2) The Federal Tax Reform Act of 1986 requires that Property and Casualty loss reserves be discounted. The impact of this on Workers Compensation Insurers is a 4% increase in costs. There is no impact on a Self Insurer.

3) Insurer taxes and assessments have all increased significantly. Insurers now pay from 1% to 10% of premium in taxes, assessments and fees. Self Insurers pay 1% to 5% less of imputed premium - an invariably lesser base as well as a lesser rate.

4) Residual market costs for Workers Compensation Insurers have exploded to 16% of voluntary premium countrywide. Self Insurers do not participate and so, pay nothing.

With as much as a 25% cost disadvantage, conventional insurance plans - either guaranteed cost or loss sensitive - are no match for self insurance. However, large deductible plans can narrow the cost differential sufficiently to provide a reasonable alternative. This is accomplished by reducing the premium upon which these costs are based.

In addition, all the guarantees and services of conventional insurance programs are provided as a further incentive. And finally, by remaining in the insurance system, the necessary framework is maintained for the employer to exercise various other insurance options in the future.

UNDERWRITER INCENTIVES

Survival in any business is predicated on response to customer preference. Employer demand for traditional insurance guarantees and services packaged with the cost savings of self funding is the underwriter's principal incentive.

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Surplus is a scarce resource. If it can be used to underwrite more business and provide comparable security, an increase in productivity results. The same is true for loss reserves particularly now that they must be discounted. The result can be a more attractive return from a line of business which has grown increasingly less attractive.

CLAIM HANDLING

The hallmark of Workers Compensation Insurance is the insurer's direct and impartial relationship with and responsibility to the injured worker. Regardless of how the employer funds the benefits, this responsibility and relationship must be maintained for a deductible plan to be a bona fide alternative to conventional insurance. So the insurer must not only adjust all claims from first dollar, but be the sole guarantor of all claims as well.

REIMBURSEMENT PROVISION

Since the insurer is solely responsible for claim payments the standard Workers Compensation Policy must be used as the coverage vehicle. An endorsement provision for reimbursement of deductible losses by the employer must be established in such a manner as to provide no greater threat to benefit guarantees than non payment of premium would under conventional insurance.

SECURITY

The employer's reimbursement agreement serves the same purpose as respects losses within the deductible that surplus and loss reserves would serve otherwise. It must fully support the insurer's financial capacity to pay claims. Therefore, a cash deposit is required to fund current claim payments and an irrevocable letter of credit on a bank acceptable to the insurer is required to fund ultimate future claim payments.

APPLICATION

In order to respond to risk management principles, required reimbursements must be reasonably predictable, protect the employer against catastrophe and afford the opportunity to manage the risk. Including allocated loss adjustment expense in the definition of deductible loss provides for risk management involvement. Applying the deductible limit to all injuries arising from a single accident and each person for disease, protects against catastrophe, and is consistent with the standard employers liability approach.

EXPERIENCE RATING

EXHIBIT_____

DATE_____

Standard premium is the point of reference by which the cost of all Workers Compensation benefit funding arrangements can be compared. It represents the established price for a fully insured program on a guaranteed cost basis; and, given reasonable rate adequacy, provides a basis for underwriting a risk. Thus the integrity of experience rating should be maintained so as to provide the basis for future insurance options.

PRICING

The premium credit for a deductible should identify that portion of an individual employer's premium which is designed to fund losses within the deductible limit. Therefore it should be applied to the employer's otherwise applicable standard premium.

The remainder of the standard premium should be unaffected by the deductible credit since the guarantees and services funded by the remainder are unchanged. So premium discount should also be based on the otherwise applicable standard premium.

Deductible plans are designed to encourage more effective employer implementation of cost control measures. To the extent that these are implemented there should be a means for recognizing their anticipated result. Parameters should be established as well as the means for regulatory oversight.

DATA REPORTING

Current data calls provide sufficient information to establish proper deductible credit formulas. So long as unit statistical data is reported gross, ignoring deductible impact, existing rate making and individual risk experience rating mechanisims will be preserved. Allowing net losses and credited premiums to impact rate making and experience rating will undermine each, and undermine the basis for underwriting flexibility which employers would want preserved.

ELIGIBILITY

We must be careful not to encourage the purchase of deductible coverage by employers who are neither sufficiently risk management oriented nor financially responsible. Those who would gamble that no losses would occur rather than prudently fund and manage them, will cause great grief to themselves and the insurance industry.

To the extent that political expectations will permit, eligibility requirements should discourage all but the relatively few employers who can effectively use the plan as part of an overall program to manage workers compensation benefit costs.

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Excess Loss Premiums and Insurance charges based on industry claim data by state, provide the basis for a deductible credit formula sufficient to discourage those who should be discouraged. We should resist pressure to reduce these risk charges in an attempt to make the plan attractive to more employers.

DISCRIMINATION

Deductible Plans are designed to provide larger employers with the means for funding and administering their Workers Compensation benefits within the insurance system. We are convinced that involvement of these large employers in the system is critical to its continued viability. They not only provide needed funding but leadership and inovation as well.

The incentive for them to remain is partly based on reduced costs for programs funded by assessments against premium. Otherwise the incentive is for them to leave or stay out and provide no funding for the residual market deficit, no contribution to insurance industry surplus, no insurance guaranty fund support, and no taxes and premium based assessments. Those relatively few employers who can self fund will do it. The only question is whether they will do it within the insurance system and provide some support for it or self insure and provide none.

This could be perceived as discriminatory against smaller employers and their insurers who would have to share a larger proportion of the burden. However a broader question is whether its to the industry's advantage to have some participation from the larger employers or none. If it's none then the proportion for the smaller accounts is total and the actual cost is greater. If it's some then their actual cost is less and their proportion is less than total.

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Backgrounder on Workers' Compensation Large Deductible Plans

October 25, 1992

What are large deductibles?

A new insurance product for workers' compensation coverage is now available from many insurers - large deductible plans. Workers' compensation coverage is mandatory for most employers. Traditionally, workers' compensation insurance was available only with first dollar coverage. Employers willing to take the entire risk could self-insure -- if they qualified. However, there was no insurance product for employers who wanted to take some of the risk. Large deductible plans fill this gap.

Why large deductibles should be available

There a number of reasons to allow authority for large deductibles.

✓ *Responsive to demand* - employers want the flexibility to choose taking part of the risk without having to take the entire risk, while continuing to receive professional claims, loss control, and other services from the insurer. Unlike self-insurance, a large deductible protects the employer against catastrophic loss.

✓ *Security for injured workers* - large deductible plans provide for direct payment of benefits by the insurer, including the deductible amount, subject to reimbursement from the employer. These plans provide workers and state officials the confidence of knowing that benefits will be paid as required. The insurer, not the injured worker or the state, takes the risk of collecting amounts owed by the employer.

✓ *Safety and return to work incentives* - by taking part of the risk, the employer has additional financial incentive to prevent injuries. At the same time, the deductible gives employers strong financial incentive to better control claims costs through effective return to work programs.

✓ *Promote insurance availability* - large deductible plans enable insurers to compete against self-insurance. Insurance is subject to taxes and assessments that generally do not apply to self-insurance. Most states levy a premium tax on all insurance policies. In addition, in many states

insurers are assessed to pay for any deficits in the workers' compensation assigned risk pool. The assessment, called a "residual market load" or RML, is levied on each insurer in proportion to its voluntary workers' compensation business - in effect, a subsidy from the voluntary market to the assigned risk pool. Premium taxes and the RML can create a significant competitive disadvantage for insurance, ~~because~~ because self-insurers are exempt. An insurance policy written with a large deductible has a smaller premium and thereby a reduced tax burden and RML - which may make it financially attractive to write compared to first dollar coverage for the same employer.

How do large deductibles compare to retrospective rating?

Most states already permit another form of loss-sensitive workers' compensation insurance coverage - retrospective rating. The question arises how large deductibles differ from "retro" plans. Retrospective rating plans provide a range - a minimum and maximum premium - with the over-all cost to the employer determined within that range based on the employer's claims experience. A large deductible plan is like a retro in the sense that the cost is sensitive to the employer's experience. However, it is more flexible, allowing an employer to attain greater savings by bearing more of the risk than would be allowed under a retro plan, while providing fully insured protection for losses over the deductible amount. Unlike a retro, the price is determined by the cost of the insured amount, plus actual claims costs (including an agreed allowance for the cost of claims adjustment and administrative fees for handling the account). Some large deductibles have no cap, but are based on the employer's losses. However, unlike self-insurance, these deductible plans require the insurer to pay the benefits and then seek reimbursement from the employer.

How are large deductibles regulated?

Insurers are permitted to use large deductible plans in most jurisdictions. Insurers wishing to use these plans file them with insurance regulators. In a few states, however, the insurance rating law or workers' compensation act has been interpreted to prohibit or severely restrict their use. For example, some states that expressly permit small deductibles at various dollar amounts - typically $500, $1000, $2500 - interpret the law to preclude large deductibles.

How do large deductibles affect state assessments and premium tax collections?

Normally state assessments and premium taxes are levied on insurance premiums on a *net* basis - after application of any price adjustments, including the workers' compensation experience

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modifier, discounts, rate deviations, and other price adjustments. This practice applies equally to adjustments recognizing the price effect of the deductible.

In states where assessments are levied equally on insurers and self-insurers, there is no competitive advantage for self-insurance. For example, Idaho imposes a special assessment on insurers and self-insurers, with the proceeds dedicated to finance the Industrial Commission, which administers the state workers' compensation act. When assessments apply equally to insurers and self-insurers, AIA recommends that states use losses rather than premiums as the base, to help distribute costs fairly and accurately.

How do large deductibles affect the ratemaking process?

Insurers report losses on an aggregate basis, including amounts paid under deductibles. Reporting on a gross basis is needed to protect the integrity of the experience rating system and to maintain complete and accurate data to establish rates. Without this complete information, it would be difficult to know how to price the coverage with and without the deductible amount.

What are the arguments against large deductibles?

- Some insurers have objected to use of large deductibles by their competitors on grounds they reduce or redistribute the assessment base for the assigned risk pool as well as the premium tax base. However, they do not make a convincing case that large deductibles should be treated on a different basis from other competitive pricing adjustments and the uniform experience rating plan, which affect the base as well. Moreover, some employers would undoubtedly drop out of the assessment base entirely by self-insuring, if the pricing flexibility of large deductibles were not available. With respect to these employers, large deductibles actually preserve or expand the base.

- Some insurers also argue that large deductibles may give an advantage to their competitors who can afford to pay the deductible amount and collect back from the policyholder later. However, this is not a strong argument, because any insurer may extend credit to its policyholder over payment of premiums. An insurer wishing to use a large deductible plan may negotiate with its policyholder the schedule for collection of amounts paid under the deductible and any security requirements. In practice, insurers using large deductible plans establish dedicated policyholder-funded accounts and/or negotiate funding arrangements to use policyholder supplied resources to pay claims and expenses, thus there really is no significant extension of credit.

► Large deductibles will be used disproportionately by employers with good experience, constricting the first dollar coverage pool to smaller businesses and those with bad experience. Insurance may become prohibitively expensive for those remaining employers using first dollar coverage. However, this argument assumes that employers using deductibles would have remained in the insurance market. Moreover, to the extent employers with deductibles have better loss results, it is because they devote more attention to safety and make greater use of return to work programs to control their losses. Consequently, they *should* pay rates reflecting their true insurance exposure.

► Insurance regulators in a few states have raised solvency questions. If the deductible amount is very large and competitive pressures in the insurance market place are intense, they express concern that some insurers may take unacceptable risks. AIA recommends that insurance regulators address this concern in the filing process by refusal to approve plans for those few insurers whose financial condition gives rise to such concerns or by requiring that such insurers obtain adequate financial security for the deductible amount.

► Some insurance regulators have expressed concern that large deductibles will materially reduce the premium tax receipts used to finance insurance regulation, even though the burden of insurance regulation is no smaller. For example, regulators must make sure insurers are handling the deductible amounts properly and reporting them correctly for ratemaking. However, if the employer were to abandon insurance and self-insure, there would be an even greater reduction in tax receipts. Where the adequacy of adequate funding for insurance regulation is a concern, AIA supports reaching an accommodation if necessary to gain approval of otherwise acceptable deductible legislation.

► In a few states, workers' compensation agencies have raised objections that large deductibles are not permitted because they do not satisfy workers' compensation self-insurance laws. However, large deductibles are not self-insurance because they are used for employers who want to take *part* of the risk and because the insurer is responsible for payment of claims, including the deductible amount.

Security for deductible

A few regulators have proposed regulation of the security for the deductible amount furnished by the employer. Because this question is normally addressed in the negotiations between insurer and policyholder, AIA opposes regulation of the form or amount of security. States require security for self-insured

employers, whose solvency is not regulated. Workers employed by insured employers with large deductible plans do not have the same risk as those employed by self-insurers, because benefits are guaranteed by the insurance carrier, whose solvency is regulated by state insurance departments. Unlike self-insurers, insurers have strong financial incentive to require adequate security from policyholders - an insurer will not make the deductible plan available unless it is confident of being reimbursed. Therefore, it is unnecessary to regulate the solvency of the individual employer using a deductible plan. Consequently, AIA opposes prescriptive criteria for the form or amount of the security.

Size of deductible amount and size of employer

In a few cases, regulators have recommended that large deductible plans be available only to employers whose premium is over a threshold. AIA does not advocate there be any minimum threshold but believes that if one is adopted it should not unduly restrict the flexibility to use these plans and that it should operate with a lower threshold for multistate employers.

AIA is opposed to arbitrary quotas restricting the number or premium volume of large deductible plans. Insurers should be permitted to offer these plans to all qualified policyholders interested in them.

AIA recommends that large deductibles be permitted in amounts negotiated between the employer and insurer. For employers interested in large deductibles, there is an arm's-length business relationship between the employer and the insurer which justifies greater flexibility.

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Are Large Deductible Plans a Way Out of the Workers' Compensation Crisis?

By Arthur Gilbert, CPCU
Aetna Senior Account Executive, National Commercial Accounts
from RQM, Risk Management Section Quarterly

Over the past one and one-half to two years, several major writers of workers' compensation insurance have introduced large deductible workers' compensation plans and have actively solicited approval of such plans from insurance regulatory bodies of nearly every state. Where approval of these plans has been received, compensation large deductibles have been aggressively marketed to brokers and risk managers as a way of dealing with several of the shortcomings of the current workers' compensation market. The questions each risk manager must ask are: Will a large deductible plan be right for my company? Is it merely a gimmick, or is it something really worth my attention?

A New Application of an Old Concept

In order to answer these questions, we must first look at those characteristics of large deductibles which make them a workable option. After all, deductibles have been around for almost as long as insurance policies, and the idea of a large deductible as a loss-responsive rating plan is not new. Large deductible plans have been used successfully for decades as an alternative to retrospective rating for liability lines. Such plans often present unique advantages, both to the client and to the insurance carrier, which can make them highly attractive.

To define what we are discussing, in the casualty lines of insurance, any deductible of $25,000 or more is usually considered a "large" deductible. From a practical standpoint in today's market, however, a deductible of $100,000 per occurrence or more is common. Under a large deductible plan, the insurance carrier initially charges the client an up-front "handling fee" (deductible policy premium). This premium includes the carrier's expenses for overhead, profit, taxes, bureau fees, and the like. There is also a premium for coverages the carrier is providing in excess of the deductible amount to the policy limit of liability.

Beyond this initial handling fee, the client agrees to reimburse the carrier for losses up to the amount of the deductible selected. The carrier retains the responsibility for handling and payment of all claims from first dollar, with the client reimbursing the carrier for the amount of any loss within the limits of the deductible. In addition to the loss amount itself, the carrier may require the reimbursement of claim-handling expenses. Allocated expenses — those identified with the handling of a specific claim — are generally included within the loss reimbursement, while general claim-handling expenses are handled through a loading in addition to each reimbursement. Losses and claim-handling costs are usually reimbursed on an "as paid" basis. That is, the carrier makes a payment to a claimant and, within a specified time period, requests a reimbursement from the insured. Loss reserves are not subject to reimbursement.

Dual Advantages

The advantages to the insured lie in the cash flow provided. Most other loss-responsive rating plans, including retrospective rating, require reimbursement for paid losses and loss reserves. (Even if the client has a plan wherein only paid losses are reimbursed under a retrospective rating plan, the term of this deferment is usually only a few years.) Under a deductible rating plan, the client reimburses the insurer only for losses which are actually paid, and this reimbursement method remains as long as there are losses outstanding. For the average account, this will likely result in a more favorable cash flow pattern.

Conversely, the carrier enjoys advantages stemming from the fact that only the deductible policy premium (not loss reimbursements) is booked. This is important to carriers from the standpoint of policyholders, surplus requirements, and to carriers and insureds from the standpoint of premium taxes.

The Number One Issue

Workers' compensation has become the number one insurance issue for many businesses today. Ever-increasing loss costs, along with an overburdened assigned risk pool encumbered by individual state political and economic issues, have all contributed to the problem.

In the search for possible solutions, many risk managers are looking at self-insurance of workers' compensation in a way they would not have considered previously. However, self-insurance is not for all risks. Many states have strict financial requirements for self-insurance and the costs (often hidden) of loss control and claim handling must be provided and managed. There is also the potential of catastrophic workers' compensation loss for which insurance is essential. Often excess workers' compensation insurance is only available in a finite limit as opposed to a statutory limit provided by primary policies.

A Viable Alternative

Large deductible plans are a viable alternative to self-insurance, offering relief from many of the issues discussed, yet not creating a new set of dilemmas of their own. Under a large deductible workers' compensation plan, the insurance carrier retains all obligations under the law with regard to claim handling and payment, so the claim-handling mechanism remains fully in place. Unlike a retrospective rating plan, losses reimbursed under the large deductible plan are not considered premium and, thus, are not subject to premium tax. Eligibility for large deductible plans varies by state and by carrier, although, in general, an account producing $500,000 in annual premium may qualify. Finally, the plan utilizes a standard workers' compensation policy coverage form, so there is no difference in the statutory coverage provided under the deductible plan from that provided under other types of commercial rating plans. Thus, the need to consider excess insurance to cover statutory obligations in the event of a catastrophic situation is eliminated.

Limitations

Carriers that offer a large deductible plan stress its appeal, especially in comparison to other rating plans, as an alternative to self-insurance. Yet the large deductible is not without its limitations. First of all, the plan is not approved in all states. For an account with multi-state exposures and planning to insure all exposures commercially, some states may be written under a deductible plan, while others must remain on some other type of plan. The costs of administering such a split program may be higher than those of a single program. However this situation would be no different if there were a decision to partially self-insure. Second, there may be security requirements for a deductible plan, since most carriers will request security to cover losses. The amount and type of security will vary by carrier and type of plan filed. Finally, since deductibles are reimbursed on paid losses, a long and, perhaps, irregular payout pattern may be the rule, giving rise to the need for an in-house "funding" mechanism.

A Mixed Reception

To date the various state regulatory bodies have given large deductible programs a mixed reception. A study conducted by the Missouri Insurance Department in August 1990, and reported by the National Association of Insurance Commissioners (NAIC), noted that many state regulatory authorities saw large deductible plans as useful alternatives to self-insurance, but expressed specific concerns. Among those concerns were compliance with statutory requirements that the insurance carrier not be allowed to abdicate its responsibilities regarding payment of workers' compensation claims, and impact on statistical reporting.

The underlying premise of the large deductible plan is that a carrier retain the full responsibility for handling and payment of claims. In this respect, the large deductible is more of a reimbursement agreement than what is traditionally thought of as a "true" deductible. Likewise, under the large deductible format, the carrier is required to report fully all losses, including those within the deductible layer, and losses within the deductible layer are included in the calculation of an account's experience rating. These provisions differ sharply from those of small deductible plans, which are currently available in several states.

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Large Deductible Plans

(continued from page 33)

These latter plans represent true deductibles, since they generally apply to medical benefits only and are payable by the employer directly, and losses within these deductibles are not included in statistical reporting for experience rating.

While some states have rejected the use of deductible rating plans as being contrary to state laws, a number of states have either already enacted or are now considering modifications to state statutes to permit large deductible rating plans. The fact is that many states are recognizing the need for reform and are looking favorably on any plan which appears likely to generate improvement in the overall situation.

A Long-Term Solution

The large deductible plans that are being offered represent hope for risk managers trying to deal with some of the worst features surrounding the current workers' compensation crisis. However, it cannot be expected that any one rating plan can offer a total solution. The fact that carriers and state regulators have been receptive to the concept of deductibles in workers' compensation indicates an intense desire to change the overall picture for the better. The ultimate solution lies in reform of the workers' compensation system through cost control, rate adequacy, and depopulation of the residual markets. A concerted effort in support of reform on the part of all in the industry is the only permanent solution. □

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Author's note

Since this article was originally written the interest in workers' compensation deductible plans has continued to increase. Aetna has filed two large deductible programs. One, in Farmington Casualty Company, is intended for National Commercial Accounts generating $500,000 or more in manual premium, and has been approved in about 30 states. The other, in Aetna Casualty and Surety, is for Standard Commercial Accounts generating $100,000 or more in manual premium. It is approved in about 22 states at the time of this writing.

The reference to a study commissioned by the Insurance Department of the State of Missouri is in no way intended to imply any particular predisposition either for or against the principle of deductible compensation insurance on the part of that regulatory body. Earlier this year, Missouri enacted legislation permitting carriers to offer deductibles to insureds.

The article states that small deductible plans differ from large deductible plans in that losses within small deductibles are not reported statistically or for experience rating. This point requires further clarification. The National Council on Compensation Insurance notes that of the nearly 30 states which have enacted small-deductible plans, about half require that losses be reported net of employer reimbursement, while the other half require reporting on a gross basis. NCCI staff members are currently studying the potential impact two different methods of loss reporting may have on the experience rating system, with the objective of minimizing any possible rating distortions. □

Agency Earns Special Thanks

The General Insurance Agency of Culpeper, Virginia, recently received the kind of thank-you note that puts insurers and agents in touch with just how important their work is.

The letter, from St. Stephen's Episcopal Church Rector Rev. H. Vance Mann III, a client of General Insurance, was an expression of gratitude for the support and assistance the agency had given the church when it was heavily damaged during a storm.

The letter, which General Insurance re-ran in its client publication, says:

"We have received hundreds of compliments from persons in the community about how handsome our reconstructed church looks after the extensive storm damage in July 1990. It's hard to believe it is the same church, and that the mess created by the storm could have been resurrected. Much of the credit for this is due to you and your agency and Bob Shiflet of Aetna.....

"...Your compassionate concern for our situation helped bolster our hope and determination to keep going. You constantly kept in touch with us to make sure we were getting the support and skilled help we needed. Consequently, repairs were made more quickly than I and others ever expected." □

CSRs Learn PRISMS

More often than not, customer service representatives are the public's first contact with a company. CSRs are also the major source of support for agents working to meet the needs of their clients.

With that in mind, Aetna's New York City office sponsored a seminar to expand and enhance the skills of the CSRs in it's territory.

Called PRISMS for CSRs, the one-day course was held in the Aetna training room in the World Trade Center. More than 70 CSRs attended the seminar, which was offered for the first time last spring, according to Kendra J. Carson, homeowners sales representative in Aetna's New York City office.

The seminar covered communications, organizational skills, processing functions, errors and omissions and professional image.

"The program helped me realize that although I'm organized, I'm not as thorough as I could be," said Marygene Anderson, personal lines manager of Richards and Fenniman Agency. Nancy Anatra, a former Aetna employee who is now a CSR, said "The seminar really helped to change my perspective. I thought company first, agency, then client. Now I realize the client is always number one." □

Amendments to House Bill No. 622
First Reading Copy
FRAUD

EXHIBIT 7
DATE 3-12-93
HB 622

Requested by (Lenmark)
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 10, 1993

1. Title, line 20.
Following: "SELF-INSURE;"
Insert: "REQUIRING SUSPENSION, REVOCATION, OR DENIAL OF A PROFESSIONAL OR OCCUPATIONAL LICENSE FOR VIOLATION OF THE WORKERS' COMPENSATION LAW; REVISING THE DEFINITION OF UNPROFESSIONAL CONDUCT; PROHIBITING CERTAIN ACTIONS; PRECLUDING LIABILITY FOR REPORTING VIOLATIONS OF THE WORKERS' COMPENSATION LAW;"

2. Title, line 20.
Following: "SECTIONS"
Insert: "37-1-131, 37-3-322, 37-6-310, 37-10-311, 37-12-321, 37-14-321,"

3. Title, line 21.
Following: "39-71-307"
Insert: "39-71-316"

4. Page 27, line 16.
Following: line 15
Insert: "**Section 17.** Section 39-71-316, MCA, is amended to read:
"**39-71-316. Filing true claim -- obtaining benefits through deception or other fraudulent means.** (1) A person filing a claim under this chapter or chapter 72 of this title, by signing the claim, affirms the information filed is true and correct to the best of that person's knowledge.
(2) A person who obtains or assists in obtaining benefits to which the person is not entitled under this chapter or chapter 72 of this title may be guilty of theft under 45-6-301. A county attorney may initiate criminal proceedings against the person.
(3) A person licensed under the provisions of Title 37 is subject to suspension, revocation, or denial of a license if the person knowingly claims or assists in the claiming of benefits in violation of the provisions of chapter 72 or this chapter."

Section 18. Section 37-1-131, MCA, is amended to read:
"**37-1-131. Duties of boards.** Each board within the department shall:
(1) set and enforce standards and rules governing the licensing, certification, registration, and conduct of the members of the particular profession or occupation within its jurisdiction;
(2) sit in judgment in hearings for the suspension, revocation, or denial of a license of an actual or potential member of the particular profession or occupation within its jurisdiction. The hearings shall be conducted by legal counsel

when required under 37-1-121(1).

(3) suspend, revoke, or deny a license of a person who the board determines, after a hearing as provided in subsection (2), is guilty of knowingly defrauding, abusing, or aiding in the defrauding or abusing of the workers' compensation system in violation of the provisions of Title 39, chapter 71 or 72;

~~(3)~~(4) pay to the department its pro rata share of the assessed costs of the department under 37-1-101(6);

~~(4)~~(5) consult with the department before the board initiates a program expansion, under existing legislation, to determine if the board has adequate money and appropriation authority to fully pay all costs associated with the proposed program expansion. The board may not expand a program if the board does not have adequate money and appropriation authority available."

Section 19. Section 37-3-322, MCA, is amended to read:

"**37-3-322. Unprofessional conduct.** As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or in securing a license or in taking the examination provided for in this chapter;

(2) performing abortion contrary to law;

(3) obtaining a fee or other compensation, either directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition of a person can be cured;

(4) employing abusive billing practices;

(5) directly or indirectly giving or receiving a fee, commission, rebate, or other compensation for professional services not actually rendered. This prohibition does not preclude the legal functioning of lawful professional partnerships, corporations, or associations.

(6) willful disobedience of the rules of the board;

(7) conviction of an offense involving moral turpitude or conviction of a felony involving moral turpitude, and the judgment of the conviction, unless pending on appeal, is conclusive evidence of unprofessional conduct;

(8) commission of an act of sexual abuse, misconduct, or exploitation related to the licensee's practice of medicine;

(9) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors, otherwise than in the course of legitimate or reputable professional practice;

(10) conviction or violation of a federal or state law regulating the possession, distribution, or use of a narcotic or hallucinatory drug, as defined by the federal food and drug administration, and the judgment of conviction, unless pending on appeal, is conclusive evidence of unprofessional conduct;

(11) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other drug or substance to the extent that the use impairs the user physically or mentally;

(12) conduct unbecoming a person licensed to practice medicine or detrimental to the best interests of the public as defined by rule of the board;

(13) conduct likely to deceive, defraud, or harm the public;

(14) making a false or misleading statement regarding the licensee's skill or the effectiveness or value of the medicine, treatment, or remedy prescribed by the licensee or at the licensee's direction in the treatment of a disease or other condition of the body or mind;

(15) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(16) use of a false, fraudulent, or deceptive statement in any document connected with the practice of medicine;

(17) practicing medicine under a false or assumed name;

(18) testifying in court on a contingency basis;

(19) conspiring to misrepresent or willfully misrepresenting medical conditions improperly to increase or decrease a settlement, award, verdict, or judgment;

(20) aiding or abetting in the practice of medicine by a person not licensed to practice medicine or a person whose license to practice medicine is suspended;

(21) allowing another person or organization to use the licensee's license to practice medicine;

(22) malpractice or negligent practice;

(23) except as provided in this subsection, practicing medicine as the partner, agent, or employee of or in joint venture with a person who does not hold a license to practice medicine within this state; however, this does not prohibit:

(a) the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4;

(b) a single consultation with or a single treatment by a person or persons licensed to practice medicine and surgery in another state or territory of the United States or foreign country; or

(c) practicing medicine as the partner, agent, or employee of or in joint venture with a hospital, medical assistance facility, or other licensed health care provider. However:

(i) the partnership, agency, employment, or joint venture must be evidenced by a written agreement containing language to the effect that the relationship created by the agreement may not affect the exercise of the physician's independent judgment in the practice of medicine;

(ii) the physician's independent judgment in the practice of medicine must in fact be unaffected by the relationship; and

(iii) the physician may not be required to refer any patient to a particular provider or supplier or take any other action the physician determines not to be in the patient's best interest.

(24) willfully or negligently violating the confidentiality between physician and patient, except as required by law;

(25) failing to report to the board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

(26) failing to transfer pertinent and necessary medical records to another physician when requested to do so by the

subject patient or by the patient's legally designated representative;

(27) failing to furnish to the board or its investigators or representatives information legally requested by the board;

(28) failing to cooperate with a lawful investigation conducted by the board;

(29) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate parts 1 through 3 of this chapter or the rules authorized by them;

(30) having been subject to disciplinary action of another state or jurisdiction against a license or other authorization to practice medicine, based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section. A certified copy of the record of the action taken by the other state or jurisdiction is evidence of unprofessional conduct.

(31) any other act, whether specifically enumerated or not, which, in fact, constitutes unprofessional conduct."

Section 20. Section 37-6-310, MCA, is amended to read:

"**37-6-310. Unprofessional conduct.** As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or in securing a license or in taking the examination provided for in this chapter;

(2) obtaining a fee or other compensation, either directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition of a person can be cured;

(3) willful disobedience of the rules of the board;

(4) final conviction of an offense involving moral turpitude;

(5) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors, otherwise than in the course of legitimate or reputable professional practice;

(6) final conviction of a violation of a federal or state law regulating the possession, distribution, or use of a narcotic or hallucinatory drug, as defined by the federal food and drug administration;

(7) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other drug or substance to the extent that the use impairs the user physically or mentally;

(8) conduct unbecoming a person licensed to practice podiatry or detrimental to the best interest of the public;

(9) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, <u>including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72</u>;

(10) testifying in court on a contingency basis;

(11) conspiring to misrepresent or willfully misrepresenting medical conditions to increase or decrease a settlement, award, verdict, or judgment;

(12) aiding or abetting in the practice of medicine a person

not licensed to practice medicine or a person whose license to practice medicine is suspended;

(13) gross malpractice or negligent practice;

(14) practicing podiatry as the partner, agent, or employee of or in joint venture with a person who does not hold a license to practice podiatry within this state; however, this does not prohibit the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4, nor does this apply to a single consultation with or a single treatment by a person or persons licensed to practice podiatry in another state or territory of the United States or foreign country;

(15) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate parts 1 through 3 of this chapter or the rules authorized by parts 1 through 3; or

(16) any other act, whether specifically enumerated or not, which in fact constitutes unprofessional conduct."

Section 21. Section 37-10-311, MCA, is amended to read:

"**37-10-311. Revocation -- unprofessional conduct.** (1) The board may revoke a certificate of registration for:

(a) physical or mental incompetence;

(b) gross malpractice or repeated malpractice;

(c) a violation of any of the provisions of this chapter or rules or orders of the board; or

(d) unprofessional conduct.

(2) Unprofessional conduct includes:

(a) obtaining a fee by fraud or misrepresentation;

(b) employing, directly or indirectly, a suspended or unlicensed optometrist to perform work covered by this chapter;

(c) directly or indirectly accepting employment to practice optometry from a person not having a valid certificate of registration as an optometrist or accepting employment to practice optometry for or from a company or corporation;

(d) permitting another to use ~~his~~ the optometrists's certificate of registration;

(e) soliciting or sending a solicitor from house to house;

(f) treatment or advice in which untruthful or improbable statements are made;

(g) professing to cure nonocular disease;

(h) advertising in which ambiguous or misleading statements are made; ~~or~~

(i) the use in advertising of the expression "eye specialist" or "specialist on eyes" in connection with the name of an optometrist. This chapter does not prohibit legitimate or truthful advertising by a registered optometrist; or

(j) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or a claim for benefits under Title 39, chapter 71 or 72.

(3) Before a certificate is revoked, the holder shall be given a notice and an opportunity for a hearing.

(4) Any optometrist convicted a second time for violation

of the provisions of this chapter or whose certificate of registration or examination has been revoked a second time shall not be permitted to practice optometry in this state."

Section 22. Section 37-12-321, MCA, is amended to read:

"**37-12-321. Unprofessional conduct.** As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or securing a license or in taking the examination provided for in this chapter;

(2) obtaining any form of compensation, directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition can be cured;

(3) practicing chiropractic under a false or assumed name or impersonating another practitioner of like or different name;

(4) knowingly disobeying a rule of the board;

(5) conviction of a criminal offense involving moral turpitude. A certified copy of the judgment of conviction is conclusive evidence of the conviction. This subsection is subject to chapter 1, part 2, of this title.

(6) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other substance to the extent that such use impairs the user's physical or mental professional capability;

(7) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors;

(8) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(9) testifying in court on a contingency basis;

(10) conspiring to misrepresent or knowingly misrepresenting physical conditions in order to increase or decrease a settlement or award;

(11) aiding or abetting in the practice of chiropractic a person not licensed to practice chiropractic or a person whose license is suspended;

(12) practicing chiropractic as the partner, agent, or employee of or in joint venture with a person not licensed to practice chiropractic in this state. However, this does not prohibit incorporation as a professional service corporation under Title 35, chapter 4, or prevent a single consultation with or a single treatment by a person licensed to practice chiropractic in another state or territory of the United States or a foreign country.

(13) violating, attempting or conspiring to violate, or aiding or abetting in the violation of this chapter or the rules adopted under it; or

(14) conduct unbecoming a person licensed to practice chiropractic or detrimental to the best interests of the public."

Section 23. Section 37-14-321, MCA, is amended to read:

"**37-14-321. Revocation or suspension of license or permit.**

A license or permit may be suspended for a fixed period or may be revoked, or such technologist or technician may be censured, reprimanded, or otherwise disciplined as determined by the board if, after a hearing before the board, it is determined that the radiologic technologist or limited permit technician:

(1) is guilty of fraud or deceit in activities as a radiologic technologist or limited permit technician or has been guilty of any fraud or deceit in procuring the license or permit;

(2) has been convicted in a court of competent jurisdiction of a crime involving moral turpitude;

(3) is an habitual drunkard or is addicted to the use of narcotics or other drugs having a similar effect or is not mentally competent;

(4) is guilty of unethical or unprofessional conduct, as defined by rules promulgated by the board, or has been guilty of incompetence or negligence in his activities as a radiologic technologist or limited permit technician;

(5) has continued to perform as a radiologic technologist or limited permit technician without obtaining a license or permit or renewal as required by this chapter."

NEW SECTION. **Section 24. Prohibited actions -- penalty.** (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (3):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person licensed to practice law in Montana or a medical care provider who advertises services or facilities with the intention that a worker use those services or facilities with regard to an injury or illness that is compensable under chapter 72 or this chapter and who fails to announce in the advertisement that filing a fraudulent claim is theft, as provided in 39-71-316 subject to the penalty in subsection (3).

(3) A person who violates this section may be assessed a penalty of not less than $200 or more that $500 for each offense. The department shall asses and collect the penalty.

NEW SECTION. **Section 25. No liability for reporting violation.** A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith and without malice information that the person believes proves a violation of the provisions of chapter 72 or this chapter."

Renumber: subsequent sections

5. Page 28, line 2.
Following: line 1

EXHIBIT 7
DATE 3/12/93
HB622

Insert: "(3) [Sections 24 and 25] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 24 and 25]."

EXHIBIT 7
DATE 3/12/93
HB 622

EXHIBIT 8
DATE 3-12-93
HB 622

Amendments to House Bill No. 622
First Reading Copy

Requested by Rep. Ewer
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 11, 1993

1. Title, line 20.
Following: ";"
Insert: "INCREASING TO SEVEN THE MEMBERSHIP OF THE BOARD OF DIRECTORS OF THE STATE FUND AND INCREASING THE COMPENSATION OF MEMBERS; PROVIDING FOR A BOARD NOMINATING COMMITTEE TO SUBMIT NAMES TO THE GOVERNOR TO FILL VACANCIES ON THE BOARD;"

2. Title, line 20.
Following: "SECTIONS"
Insert: "2-15-1019,"

3. Page 17, line 18.
Strike: "terminated"
Insert: "closed"

4. Page 26, line 20.
Following: line 19
Insert: " **Section 16.** Section 2-15-1019, MCA, is amended to read:

"2-15-1019. Board of directors of the state compensation mutual insurance fund -- nominating committee --compensation. (1) There is a board of directors of the state compensation mutual insurance fund.

(2) The board is allocated to the department for administrative purposes only as prescribed in 2-15-121. However, the board may employ its own staff.

(3) The board may provide for its own office space and the office space of the state fund.

(4)(a) The board consists of ~~five~~ seven members appointed by the governor~~. The executive director of the state fund is an ex officio nonvoting member.~~

~~(5) At least three of the five members shall represent state fund policyholders and may be employees of state fund policyholders. At least three members of the board shall represent private, for-profit enterprises. A member of the board may not:~~

~~(a) represent or be an employee of an insurance company that is licensed to transact workers' compensation insurance under compensation plan No. 2; or~~

~~(b) be an employee of a self-insured employer under compensation plan No. 1.~~ as follows:

(b) A board nominating committee of five members consisting of the speaker and the minority floor leader of the Montana house of representatives, the president and the minority leader of the Montana senate, and the insurance commissioner shall submit to

the governor a list of nominees including at least twice as many names as there are vacancies on the board.

(c) Within 30 days of receiving the list of nominees, the governor shall appoint members, from the list of nominees submitted as provided in subsection (4)(b), to fill the vacancies on the board.

~~(6)~~(5) A member is appointed for a term of 4 years. The terms of board members must be staggered. A member of the board may serve no more than two 4-year terms. A member shall hold office until a successor is appointed and qualified.

~~(7) The members must be appointed and compensated in the same manner as members of a quasi-judicial board as provided in 2-15-124, except that the requirement that at least one member be an attorney does not apply.~~

(6) Compensation of each board member is $12,000 a year, and each member is entitled to be reimbursed for travel expenses, as provided for in 2-18-501 through 2-18-503, incurred while performing board duties.

(7) The board must adopt a business plan no later that June 30 for the next fiscal year. At a minimum, the plan must include:

(a) Specific goals for the fiscal year for financial performance. The standard for measurement of financial performances will include an evaluation of premium to surplus.

(b) Specific goals for the fiscal year for operating performance. Goals are to include, but not be limited to, specific performance standards for staff in the area of senior management, underwriting and claims administration. Goals shall, in general, maximize efficiency, economy, and equity as allowed by law.

(8) The business plan must be available by request to the general public for a fee not to exceed the actual cost of publication. However, performance goals relating to a specific employment position are confidential and not available to the public.

(9) No sooner than July 1, nor later than October 31, the board shall convene a public meeting to review the performance of the state fund, using the business plan for comparison of all the established goals and targets. The board will publish, by no later that November 30 of each year, a report to the state fund's actual performance as compared to the business plan."

Renumber: subsequent sections

Amendments to House Bill 622
First Reading Copy

EXHIBIT 9
DATE 3-12-93
HB 622

Requested by Rep. Ewer
For the Committee on Workers' Compensation

March 12, 1993

1. Page 14
Following: line 8
Insert: "**Section 7.** Section 39-71-736 is amended to read:

39-71-736. Compensation -- from what date paid. (1) (a) No compensation may be paid for the first 48 hours or 6 days' loss of wages, whichever is less, that the claimant is totally disabled and unable to work due to an injury. A claimant is eligible for compensation starting with the 7th day.

(b) However, separate benefits of medical and hospital services must be furnished from the date of injury.

(2) For the purpose of this section, except as provided in (3), an injured worker is not considered to be entitled to compensation benefits if the worker is receiving sick leave benefits, except that each day for which the worker elects to receive sick leave counts 1 day toward the 6-day waiting period.

(3) Augmentation of temporary total disability benefits with sick leave by an employer pursuant to a collective bargaining agreement shall not disqualify a worker from receiving temporary total disability benefits.

(4) Receipt of vacation leave by an injured worker shall not affect the worker's eligibility for temporary total disability benefits."

Renumber: subsequent sections

EXHIBIT 10
DATE 3-12-93
HB 453

Amendments to House Bill No. 453
First Reading Copy

For the Committee on Workers' Compensation

Prepared by Susan Fox
March 13, 1993

1. Title, lines 7 through 9.
Strike: "CREATING" on line 7 through "FRAUD;" on line 9

2. Title, lines 11 and 12.
Strike: "REDUCE" on line 11 through "FUND" on line 12
Insert: "SUPPORT THE INVESTIGATION AND PROSECUTION OF WORKERS' COMPENSATION FRAUD"

3. Page 2, line 10.
Following: "shall"
Insert: ": (i)"

4. Page 2, lines 11 and 12.
Following: "(3)(a)" on line 11
Strike: ":" on line 11 through "(i)" on line 12

5. Page 2, line 13.
Following: "section;"
Insert: "and"

6. Page 2, lines 14 through 20.
Strike: "to" on line 14 through "39-71-2312" on line 20
Insert: "forward any surplus money to the department of justice. The forwarded money must be used exclusively for the staffing and operation of the workers' compensation fraud investigation and prosecution office established in [section 1 of Senate Bill No. 164]."

7. Page 5.
Following: line 17
Insert: "NEW SECTION. **Section 3. Coordination instruction.** If Senate Bill No. 164 is not passed and approved or does not establish a workers' compensation fraud investigation and prosecution office, then subsection (3)(b)(ii) of [section 1 of this act], amending 39-71-316, must read:
" (ii) forward any surplus money to the state fund, as defined in 39-71-2312, to reduce the unfunded liability of claims arising before July 1, 1990"."

EXHIBIT 11
DATE 3-12-93
HB 504

Amendments to House Bill No. 504
First Reading Copy

Requested by Representative Benedict
For the Committee on Workers' Compensation

Prepared by Bart Campbell
March 12, 1993

1. Title, line 7.
Following: "TAX"
Strike: "TO 1 PERCENT"
Following: "IMPOSING"
Strike: "A 1 PERCENT"
Insert: "AN"

2. Title, line 9.
Following: ";"
Insert: "PROVIDING APPROPRIATIONS;"

3. Title, line 10.
Following: "SECTIONS"
Insert: "15-30-207, 39-71-406,"

4. Page 5, line 7.
Strike: "1%"
Insert: "0.28%, plus the additional amount of payroll tax provided in [section 5],"

5. Page 5, line 11.
Strike: "1%"
Insert: "0.28%, plus the additional amount of payroll tax provided in [section 5],"

6. Page 5, lines 17 and 18.
Following: "a sole proprietor"
Strike: the remainder of lines 17 and 18 in their entirety
Insert: "or a working partner of a partnership who elects coverage under 39-71-401 shall pay only the employer's portion of the payroll tax on the sole proprietor's or working partner's own employment. A corporate officer who is also an employee of the corporation and is engaged in a covered employment, as provided in 39-71-401, shall pay only the employer's portion of the payroll tax on the corporate officer's own employment. All other employees of a corporation, sole proprietorship, or partnership shall pay the wage tax as required in this section."

7. Page 6, following line 16.
Insert: "(e) An employee does not have any right of action against an employer for any money deducted and withheld from the employee's wages and paid to the state in compliance or intended compliance with this section.

(f) The employer is liable to the state for any amount of wage taxes, plus interest and penalty, when the employer fails to withhold from an employee's wages or fails to remit to the state

the wage tax required by this section."

8. Page 7, lines 3 through 5.
Strike: "withhold" on line 3 through "department" on line 5
Insert: "remit withholding for employees' wage taxes at the same time"

9. Page 7, line 19.
Strike: "willfully"

10. Page 8, following line 21.
Insert: "

NEW SECTION. **Section 5. Payment of unfunded liability for injuries resulting from accidents occurring before July 1, 1990.** (1) Beginning July 1, 1993, the state fund shall pay for the cost of administering and paying claims for injuries resulting from accidents that occurred before July 1, 1990, not covered by any other funding source, by borrowing from the board of investments, from time to time, the amount that the state fund determines and the budget director certifies, as provided in 39-71-2354, will be needed to pay for administering and paying the claims for the ensuing year.

(2)(a) In January of each year, prior to the start of the following fiscal year, the state fund shall forward to the budget director information pertaining to the amount that the state fund will borrow for the ensuing fiscal year to pay for the cost of administering and paying claims for the injuries provided for in subsection (1), except that for fiscal year 1994, the information on the amount to be borrowed by the state fund must be forwarded to the budget director no later than 45 days prior to the start of the fiscal year. In addition, the state fund shall forward to the budget director the schedule of projected liability payments and cash needs on which the amount to be borrowed is based. The schedule must include but is not limited to total projected liability payments, loans and bond debt payments, revenue from the employer payroll tax and employee wage tax provided for in 39-71-2503, projected fiscal yearend cash, and the projected fiscal yearend cash for the year 2003.

(b)(i) There is imposed on each employer a workers' compensation payroll tax and on each employee a workers' compensation wage tax as provided in 39-71-2503. For fiscal year 1994, the employer payroll tax is an amount equal to 0.5% of the employer's payroll in the preceding calendar quarter for all employments covered by 39-71-401. For fiscal year 1994, the employee wage tax is an amount equal to 0.5% of the employee's wages in the preceding calendar quarter for all employments covered by 39-71-401.

(ii) The rate of the employer payroll tax determined by this section includes the 0.28% employer payroll tax provided for in 39-71-2503.

(iii) The employer payroll tax that is in excess of the 0.28% tax provided for in 39-71-2503 and the employee wage tax terminate at the end of fiscal year 2003.

(iv) The employer payroll tax and the employee wage tax described in this section must be collected and deposited as

provided in 39-71-2503 and 39-71-2504.

(3) If in any January the projected amount to be borrowed by the state fund exceeds $50 million for the following fiscal year, the tax rate on the employer and employee must be increased by 0.05% for the following fiscal year over the current tax rate. If in any January the projected fiscal yearend cash balance for the current fiscal year exceeds $25 million, the tax rate on the employer and employee must be reduced by 0.05% from the current tax rate for the following fiscal year.

(4) The total tax on employers may not exceed 0.75%, and the total wage tax on employees may not exceed 0.75%.

(5) The budget director shall certify the cash flow projections of the state fund required by this section and shall notify the department of revenue no later than April 1 of the rate of tax to be collected pursuant to this section."

Renumber: subsequent sections

11. Page 9, following line 22.
Insert: "**Section 7.** Section 15-30-207, MCA, is amended to read:

"**15-30-207. Annual statement by employer.** (1) Every employer shall, on or before February 28 in each year, file with the department a wage and tax statement for each employee in such form and summarizing such information as the department requires, including the total wages paid to the employee during the preceding calendar year or any part thereof and showing the total amount of the federal income tax deducted and withheld from such wages and the total amount of the tax deducted and withheld therefrom under the provisions of 15-30-201 through 15-30-209 and 39-71-2503.

(2) The annual statement filed by an employer with respect to the wage payments reported constitutes full compliance with the requirements of 15-30-301 relating to the duties of information agents, and no additional information return is required with respect to such wage payments.

(3) In addition to any other penalty provided by law, the failure of an employer to furnish a statement as required by subsection (1) subjects the employer to a penalty of $5 for each failure, provided that the minimum penalty for failure to file the statements required on or before February 28 of each year shall be $50. This penalty may be abated by the department upon a showing of good cause by the employer. The penalty may be collected in the same manner as are other tax debts.""

Section 8. Section 39-71-406, MCA, is amended to read:

"**39-71-406. Deduction from wages of any part of premium a misdemeanor.** It is unlawful for the employer to deduct or obtain any part of any premium required to be paid by this chapter from the wages or earnings of his workers, and the making or attempt to make any such deduction is a misdemeanor. The employee wage tax under 39-71-2503 is not a premium for the purpose of this section."

Renumber: subsequent sections

12. Page 10, following line 3.
Insert: "

NEW SECTION. **Section 10. Appropriations.** (1) There is appropriated $65,000 from the workers' compensation payroll tax account to the state auditor for fiscal year 1993.

(2) There is appropriated $47,190 from the workers' compensation payroll tax account to the department of revenue for fiscal year 1993.

NEW SECTION. **Section 11. {standard} Codification instruction.** [Section 5] is intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [section 5]."

Renumber: subsequent sections

13. Page 10, line 5.
Following: "tax"
Insert: "and the increase in the employer payroll tax"
Strike: "section 4"
Insert: "sections 4 and 5"

14. Page 10, lines 5 and 6.
Strike: "commences" on line 5 through "1993" on line 6
Insert: "commence on July 1, 1993"