MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By Senator Tom Towe, on April 2, 1993, at 3:03 PM.

ROLL CALL

Members Present:

Sen. Tom Towe, Chair (D)
Sen. Gary Forrester, Vice Chair (D)
Sen. Gary Aklestad (R)
Sen. Sue Bartlett (D)
Sen. Jim Burnett (R)
Sen. John Harp (R)
Sen. John Hertel (R)
Sen. Bob Hockett (D)
Sen. Tom Keating (R)
Sen. J.D. Lynch (D)
Sen. Bill Wilson (D)

Members Excused: None.

Members Absent: Sen. Harry Fritz (D)

Staff Present: Susan Fox, Legislative Council
Kelsey Chapman, Committee Secretary

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

Committee Business Summary:

Hearing: HB 622, HB 361
Executive Action: None.

HEARING ON HB 622

Opening Statement by Sponsor:

Representative David Ewer, House District 45, told the Committee HB 622 was a conglomeration of workers' compensation issues. He said it was a bill brought together by a coalition of businesses and workers. He said HB 622 established a new category of injured worker disability, being "temporary partial", which would allow a worker to receive benefits from workers' compensation and in addition work with the employer in a lesser job, and receive wages to some extent, as well as benefits. He said this provision would provide incentive to workers to go back to work.

Representative Ewer said on page 15, an injured worker that fails to keep medical appointments would forfeit claims benefits. He said this was a good disincentive for a worker to fail to keep medical appointments. He said HB 622 also allowed for lump sum payments of medical benefits. A new section 10 on page 29 provided for there to be deductibles for insurance companies. He explained this would not hurt the workers, but rather allow the employer to purchase a policy and have a large deductible. If there was a claim, the employer could pay back the deductible over a period of time. The employer would have to be credit-worthy to get this insurance. Section 11 attempted to augment SB 164, Senator Harp's fraud bill, and provide that people who knowingly file claims that are fraudulent are themselves guilty of fraud. Representative Ewer said section 8 dealt with medical providers and what kinds of actions by these providers were subject to penalties. He said section 21 provided the State Fund must adopt a business plan that includes specific goals. He said HB 13 tried to give the State Fund the flexibility it needed, but at the same time, HB 622 made some analogous requirements for the Fund to be held responsible for actions, and to act like a corporation. Section 23 would provide for group discounts, but would not obligate the Fund to accept a group. He said there was a section that dealt with employers who employed workers covered by collective bargaining. This section would enable the employers to use the pension assets of the employees to enable the employer to self insure if the employee wanted to trust the employer.

Proponents' Testimony:

Jim Puttman, Coalition for Workers' Compensation System Improvement, offered an amendment to page 27, line 12. He recommended "weekly compensation benefits" be stricken, and "an insurers' liability" be inserted. On page 27, line 18, he recommended that "state's average weekly wage at the time of injury" be stricken, and "a workers' temporary total disability rate" be inserted. He explained as HB 622 presently read, the injured worker that returns to work could earn more than the temporary total disability rate. He said the worker should not retrieve more than the benefits that would have been earned if the worker was totally disabled. He stated the amendment would limit the insurers' liability to the temporary total disability, but still allow for the partially disabled worker who returned to work in a lesser capacity to earn more than the total disability benefits would be. He recommended page 25, section 8, stricken in the House, be reinstated. He said the apportionment issue should not be open for dispute between the worker and the employer or the insurer, but rather be independently assessed. Section 8 would provide for a panel to assess the apportionment, but would also allow that should an insurer or a worker agree with predetermine apportionment, the panel would not have to be used. He said the panel currently existed under the occupational disease act, and would not require any change in the evaluation process that was currently in effect. It would provide for an

independent assessment of apportionment. Mr. Puttman said apportionment was a new concept for Montana, and would require change. He stated apportionment was based on apportioning liability to those responsible for the injury, rather than having an employer take the brunt for a preexisting work-related injury. He explained there were additional federal laws to take into consideration when dealing with workers' compensation. The Americans with Disabilities Act (ADA) requires that employers hire people with known disabilities, but gives those employers no opportunity to apportion liability for conditions unrelated to that employment. Under the apportionment in HB 622 a medical panel would assess who's liability belongs to whom. The employer and insurer would then be assigned that liability attributable to the aggravation. All benefits up to the time the employer reaches maximum healing would be paid in full. Once that individual has reached maximum healing, there would be a limitation on the part of the employer, providing the preexisting condition was aggravated, and providing there was less than 100% on the part of the employer. If here is an insurer on record for a previously unsettled workers' compensation claim, the employer would have the right to go back to the insurer and request further benefits. Mr. Puttman said the medical panel would make the decision as to the liability, and thus limit debate between insurance companies that would not want to accept liability. He stated apportionment worked in other insurance industries in Montana and other states with workers' compensation insurance. He said apportionment was fair for all parties involved.

Jim Senrud, Chairman of the Coalition for Workers' Compensation System Improvement, told the Committee the fairness and cost issues were the arguments for apportionment. He said there were insurance companies and employers who knew how to use employees until they are hurt badly, and then get rid of them. If those employees were employed with other employers, those employers would pay for the whole injury of those employees caused by the previous employers.

Harley Thompson, Montana Building Association, spoke from written testimony (Exhibit #1).

George Wood, Montana Self Insurers' Association (MSIA), handed out reference sheets to the Committee (Exhibit #2 and 2a). He said MSIA strongly supported temporary partial, but did not think the Coalition's amendment went far enough. He said in the Workers' Compensation Act the sections that deal with benefits provide an injured worker will receive 66⅔ percent of the loss of wage as a benefits. He stated that the Coalition's amendment said that any benefits that the employee receives after returning to work is not subject to the 66⅔ percent benefits. He said he was confused as to the exact benefits an injured worker would receive under the apportionment section. He asked how apportionment would work if the preexisting condition was congenital, developmental, caused by illness, or caused by something non industrial. He asked if the insurer would have to

interplead to every previous employer to find in which workplace the preexisting condition originated. Mr. Wood said that section 8 had a method for dealing with apportioning, but did not specify a mechanism for getting information. He said HB 622 should pass, if the proposed amendments to the temporary partial disability were adopted, and the apportionment section was stricken.

Gary Willis, Montana Power Company, said that the 66⅔ percent temporary partial benefits should be amended into HB 622, and that MPC supported the Bill.

Reily Johnson, National Federation of Independent Businesses (NFIB), told the Committee to amend the temporary partial section. He said NFIB supported the coalition in the apportionment issue. He stated NFIB was concerned with the ADA, and was wondering how to address these laws. He asked the Committee to look at apportionment and try to address this issue.

Jan Van Riper, an attorney in Helena, said she did not support lump summing of medical benefits. She said many injured workers, when it came time to settle claims, needed money, but it was in the workers best interest to keep the medical benefits open, rather than lump summing. She said apportionment was a very confusing section, and may cause litigation. She said the section assumed that there was a prior workers' compensation insurer in the picture, but that was not always true. She said she understood the fairness issue, but not all injuries were equal; and the ADA problem was dealt with in Montana through the subsequent injury fund.

Oliver Goe, Montana Municipal Insurance Authority (MMIA), Montana Association of Counties (MACO), and Montana School Groups Insurance Authority (MSGIA), said these associations were in general agreement with HB 622. He said there were concerns about four provisions that either conflicted with HB 361 or caused problems in general claims management. He said lump summing benefits was not a good idea for the reasons Ms. Van Riper noted, as well as for the reason that the insurer could be hurt if there was a reopening of the claim after a lump sum settlement. He said temporary partial disability was a good mechanism for getting injured workers back to work. He said the difference should be 66⅔ percent. He said it could be amended in page 27, line 13. He also expressed concern with page 47, line 11, the augmentation of temporary total disability benefits with sick leave. He said this section is a disincentive to go back to work and also treats employees that have a collective bargaining agreement differently than those that do not. He said if the person is getting workers' compensation benefits plus the remainder of a salary, there would be no incentive to go back to work. He said the apportionment portion of HB 622 could open up the workers' compensation system to litigation.

Nancy Butler, General Council, State Fund, said the State Fund had concerns about the lump summing of medical benefits on page

18. She said HB 622 allowed for lump summing of medical benefits upon request, and this could cause problems with many components of the system. Ms. Butler said the apportionment section dealing with an employee reaching maximum healing would catch an employee between insurers. She handed out a deposition from a case the State Fund litigated (Exhibit #3). She said other portions of the apportionment sections were confusing, and could greatly increase litigation. She pointed out that putting the panel back in could slow the system there. She said there was unclear language about pre or post-maximum healing, and stated that the apportionment would create more problems than it would solve.

Representative Chase Hibbard, House District 46, Chairman of the House Select Committee on Workers' Compensation, told the Committee the area of apportionment had been taken out of HB 622 in the select committee, only to be reinstated in House Labor and Employment Relations. He said there were many problems with the apportionment section, as well as a conflict between the apportionment language and the preexisting condition language in HB 361. He suggested deleting the apportionment in HB 622 and working on it in the interim, because there were valid parts of the ideas.

Representative Jerry Driscoll, House District 92, told the Committee the attorneys testifying were worried about lump summing of medical benefits because it was not in the best interest of the worker, but it was the same attorneys who put a 60 month cap on medical benefits. He said these attorneys were also complaining about the temporary partial benefits. He stated currently unless the employer would pay 100 percent of the injured worker's pre-injury benefits, the worker did not have to go back. HB 622 allows for the employer to find a job that the injured worker could do, the worker could go back to work and receive medical and wage loss benefits while working. He said in the apportionment section, dividing liability between insurers of repetitive motion injuries and occupational disease. Carpal Tunnel takes several years to develop, yet without apportionment, when the condition shows up, the present employer must pay the full cost.
Representative Driscoll said one employer used sick leave to keep health insurance for families of employees. He said what happened, was that if sick leave was used up, the injured worker could still draw up to ⅔ of the pre-injury wage not to exceed $349.00 per week. He said the sick leave section attempted to allow employees with sick leave or vacation time to use it while drawing temporary partial or total so they can keep the health insurance for their families and supplement their income.

Jacqueline Lenmark, American Insurance Association, told the Committee AIA thought if HB 622, HB 347, and HB 361 were all passed, a successful workers' compensation reform package would be enacted. She said AIA supported the fraud provisions in HB 622, and explained that when Senator Harp chaired a subcommittee of the Governor's Workers' Compensation Task Force, that

committee unanimously recommended the provisions contained in sections 11 through 19 of HB 622. She asked the Committee to restore the language amended out in the House in section 18, page 46. She explained the language required that lawyers who practiced workers' compensation law advertise workers' compensation law as an area of practice, and in that advertisement state that fraud in the workers' compensation system is illegal. She said the provision was passed unanimously by the Governor's task force, and was stricken because of a misunderstanding. AIA supported the large deductibles in section 10 as a mechanism to allow employers to quasi self-insure. She said the worker would be protected as well under this provision as under regular workers' compensation coverage. She explained that the provision in section 10 was optional to the employer and the insurer, and would encourage the reentry of private insurers into the Montana market. Ms. Lenmark voiced AIA's support of the group discount section of HB 622. She handed out drafted amendments (Exhibit #4), and other informational articles and papers (Exhibits #5, #6, #7).

Bob Emerson, Montana School Boards' Association, told the Committee the concerns the Association had were with regard to section 22, the augmentation of temporary total disability benefits. He said this would be a disincentive to workers to return to work and that it presented the possibility of double dipping in the system.

Russell Hill, Montana Trial Lawyers Association (MTLA), said MTLA had concern with apportionment as a terrible, complex, and exploited provision in HB 622. He said from the workers point of view, the best thing to happen would be apportionment would cause massive and lengthy litigation. He stated that what was more likely to happen is the worker could not afford an attorney, and insurance companies would play "keep-away" with the benefits that employee is entitled to. He pointed out that on page 27, lines 5 and 6, the term "objective medical findings" was used, but there was no definition.

Mike Micone, Montana Motor Carriers Association (MMCA), told the Committee he agreed with the AIA amendments (Exhibit #4). He said MMCA supported sections 22 and 23, dealing with the group policies. He said these sections would allow small employers to join together in a group and apply to an insurer for group discounts. He said this was a benefit to each of the individual employers, and also to the insurer. The group would have to submit a plan to be approved, and would have to function as the provisions provided. He said HB 163, the safety bill, would require each employer to have a safety program, and report to the insurance commissioner how that safety training and other safety issues in the workplace would work. He said this was a benefit to the insurer. The deductible with the group plan would be a benefit to the State Fund because it would encourage private companies to start writing workers' compensation insurance in Montana. He offered a technical amendment (Exhibit #8).

Bill Crevello, Rehabilitation Association of Montana, said the association supported Representative Cocchiarella's amendments that would provide appropriation and responsible notification to workers of their benefits.

Russ Miller, F.H. Stoltz Land and Lumber, said F.H. Stoltz was self insured. He said the temporary partial issue in HB 622 was good, and noted that apportionment was also a worthy issue. He said ADA was making employers hire injured workers.

Daryl Holzer, Montana State AFL-CIO, said the best part of HB 622 was the new category of temporary partial disability benefits. He told the Committee encouraging people to get back to work was very important, as most every person on workers' compensation wanted nothing more than to get back to work.

Opponents' Testimony:

Norm Grosfield, an attorney in Helena, said he was an opponent because he was concerned about the apportionment section. He told the Committee the major problem with allocating liability was with cases that have been settled out. He asked if this section meant if a preexisting case had been settled out, then the worker would not be entitled to anything, or only a small portion. He said in 1991 he was involved with creating legislation for a bonafide rehabilitation program, which was passed. In HB 622, there is a provision to restrict settling out rehabilitation benefits. He said his concern was that this would require the insurance company to restrict its options. If it did not want to settle out rehabilitation benefits, then it would not have to, but the decision should be made through discussion between the employee and the insurer. He handed out an amendment to this section (Exhibit #9).

Informational Testimony:

None.

Questions From Committee Members and Responses:

Senator Bartlett asked Jim Puttman if the intent of the temporary partial section was to allow a worker who was able to return to work part-time, but was not yet able to work full-time, would not be eligible for that provision. Mr. Puttman answered this was not the intent. He said anyone who can not go back to work at the same wages or higher wages at the time of injury would be eligible for temporary partial disability.

Senator Harp asked Daryl Holzer if the language on pages 8 through 12 would allow the use of the Taft-Hartley Fund. Mr. Holzer answered this language would, and it was a very important protection for the workers.

Senator Aklestad asked Representative Ewer about the temporary partial disability section of HB 622. Representative Ewer said the main intent of the temporary partial disability benefits was that these benefits would be an incentive to get injured workers back into the workforce as quickly as possible.

Senator Towe asked Representative Ewer to explain the purpose of the sick leave provisions in HB 622. Representative Ewer stated the purpose was to allow an injured worker to receive sick leave benefits while receiving temporary partial or temporary total benefits, and to augment income in this manner.

Closing by Sponsor:

Representative Ewer closed, saying HB 622 would provide injured workers with incentives to return to work, would encourage private insurers to start writing workers' compensation insurance in Montana. He said he would resist putting rehabilitation back in HB 622.

HEARING ON HB 361

Opening Statement by Sponsor:

Representative Chase Hibbard, House District 47, told the Committee HB 361 provided on pages 4 and 5 that there be objective medical findings that an injury was legitimate before benefits could be awarded. He said HB 361 also provided that the work related injury be the major contributing cause of that injury to have benefits awarded. He explained if a worker had a preexisting bad knee, and then had a back problem, if the knee is found to be the major contributing cause of the bad back, then the back injury would not be compensable. He said that if there was a 0.10 or greater percentage of alcohol in the blood, the alcohol would be considered the major contributing cause under HB 361. There needed to be a preponderance of existing medical evidence to deny claims to an injured worker. He said HB 361 would level the playing field for the insurers and medical providers in the workers' compensation system.

Proponents' Testimony:

Bob Chambers, a surgeon in Great Falls, handed out informational papers (Exhibit 10 through 10d), and explained them. He said as a doctor he had people who came to him with pain that was not provable by any objective medical basis. He told the Committee benefit for pain may lead to pain, and pointed out the first cartoon as an example (Exhibit #10).

Tim Wiell, a medical doctor, told the Committee that HB 361 would defeat the psychopathology of pain. He encouraged passage of HB 361.

Nancy Butler, State Fund, rose in support of HB 361, saying it

would help level the playing field for medical providers and insurers in the workers' compensation system.

Jacqueline Lenmark, American Insurance Association (AIA), told the Committee AIA supported HB 361 as a bill that would help end frivolous claims based on pain that had no objective medical proof.

Oliver Goe, Montana Municipal Insurance Authority (MMIA), Montana School Groups Insurance Association (MSGIA), and Montana Association of Counties (MACO), rose in support of HB 361.

Harley Thompson, Montana Homebuilders' Association and the Coalition for Workers' Compensation System Improvement, rose in support of HB 361.

Reily Johnson, National Federation of Independent Businesses (NFIB), rose in support of HB 361.

Opponents' Testimony:

Representative Jerry Driscoll, House District 92, asked if it was such a bad idea to bother a doctor because a person was in pain. He if it was a bad idea, pain should be taken out of all insurance as a compensable injury. He said HB 361 presumed workers wanted to get on the workers' compensation benefits system. He questioned what a person would benefit from getting on the system. He said ⅔ of whole wages were paid, not to exceed $349; health insurance was lost; pension was lost; and impairment can only be claimed if a doctor says there is some permanent injury. He added that these points are not benefits to a worker. He said workers did not want to get on the system, as their take-home pay would drop drastically, there would be no health insurance because they were no longer working. He said if all workers had to do to get on the system if they wanted was say they were in pain, then why not take pain off all health insurance.

Russell Hill, Montana Trial Lawyers Association (MTLA), spoke from written testimony (Exhibit #11).

Daryl Holzer, Montana State AFL-CIO, rose in opposition to HB 361 for the same reasons stated by Representative Driscoll and Mr. Hill. He said he had never been more personally offended then by the categorization of workers as cartoon characters.

Norm Grosfield, a workers' compensation attorney, said in litigation the treating physician was often asked for an opinion. He said he thought physicians made fair judgements in their opinions. He said there were physicians that would testify that disabling pain is not always based upon objective medical findings. He stated there were ways of telling the honesty of a pain complaint, even without objective medical findings, and pain should not be defined in statute. He said if the insurance

companies wanted a second medical opinion, all they would have to do was request it.

Jan Van Riper, an attorney in Helena, told the Committee she opposed HB 361 for the reasons Mr. Grosfield mentioned. She submitted into the record a letter written by Dr. Cooney, a neurologist in Missoula, information from the American Medical Journal, and other informational papers (Exhibit #12). She said benefits had already been cut in both 1987 and 1991, and "the jury was not in" on the results of those benefit cuts. She suggested the financial impact on the State Fund from cases of malingering patients was minimal because of the cuts and caps. She said in the benefits the State Fund showed as going to the claimants and the doctors, there was a great amount of administrative costs that went into rehabilitation work. She urged, that without the data on the cost savings and other effects of the benefits cuts of 1987 and 1991, HB 361 not be passed.

Informational Testimony:

None.

Questions From Committee Members and Responses:

Senator Towe asked Dr. Chambers if he would acknowledge that there was genuine pain that could not be measured by objective medical findings. Dr. Chambers said that in the area of workers' compensation, where injuries and traumatic events were in concern, unverifiable pain was very rare. He said the history of how the patient got hurt was very important, and the doctor's job in workers' compensation cases was to substantiate and discover the cause of the patient's pain. He said there were very subtle injuries, but when the medical evidence was weighed with the award factor of benefits, the picture would be clear. He said physicians were patients' advocates, and that provided a buffer from insurers denying claims on the basis of no objective medical findings.

Senator Towe said he had a case in which a lady was sitting in a dentist chair, and a light fell on her shins, causing much pain. He said eventually the pain got so bad that she had to quit her job. The insurance company had her go to many doctors, but none could find any objective medical basis for her pain. Never-the-less, it was obvious she could not work anymore because of pain.

Dr. Chambers said pain was a basic mechanism that told a person to stop what was causing the pain. He said HB 361 was dealing with traumatic and injury related pain, because that is what the workers' compensation system was designed to take care of. He said medical science was not perfect, but understood pain fairly well. He said pain was explainable. He stated chronic pain complaints in workers' compensation claims, where there were benefits for the complaint were wrecking the State Fund. He said

the pain did not occur as much in other situations with out the benefits.

Senator Towe asked if Mr. Chambers recognized the fact that if HB 361 was passed there would be some people that would be affected negatively, because the pain was really there, but there were no objective medical findings. Mr. Chambers said the situation Senator Towe was describing was very rare in the workers' compensation system.

Senator Lynch said on page 28, HB 361 provided that a jail term exceeding 30 days for a misdemeanor would mean termination of benefits. He said usually if a person goes to jail on a misdemeanor it is because the other alternative is to pay a fine. He said this provision would hit a person who was too poor to pay a misdemeanor fine, and yet injured, twice: once for making the person miss work, and once for not allowing for benefits on an injury.

Representative Driscoll said all that would be lost in this case would be the temporary total. If there was a certain degree of impairment once the worker left jail, the impairment benefits would still be awarded.

Senator Towe told Senator Lynch to look at the top of page 28 to clarify the provision. He said while the person was incarcerated, the benefits would be lost. After release, the benefits would start again.

Representative Driscoll clarified that for the first 30 days the temporary total benefits would be paid, and they would be cut off if the sentence extended beyond that.

Senator Bartlett said Nancy Butler had given the Committee a copy of a deposition during the hearing on HB 622 (Exhibit #3). The doctor has said that another doctor with the same medical training as he, might reach a different conclusion on how much of an injury was due to a previous injury or injuries. Senator Bartlett asked Nancy Butler why the same situation could not happen in the objective medical findings and major contributing cause portions of HB 361. Ms. Butler said it would probably not occur because it was not such a specific issue.

Senator Towe clarified that primary cause required 50 percent, while major contributing cause needed only to be the largest percentage of several causes.

Senator Lynch asked Representative Hibbard to clarify that if he had a bad knee from a ski accident from years before, then broke his knee while working, that the job, and not the skiing, would have been the major contributing cause of the break. Representative Hibbard said this was correct.

Senator Harp said that a Minnesota study showed that 68 percent of soft tissue injuries were unverifiable. He asked Pete Strizich, Montana Insurance Fund, what his experience in that area was. Mr. Strizich answered that he did not have any data, but he did not think there were very many claims that would be affected by HB 361.

Senator Towe asked Representative Hibbard if the end result of HB 361 was that if two skiers each got hurt, and both had industrial accidents after the ski injury, but one of the industrial accidents was claimed to be the major contributing cause and the other was not, then the one worker would get compensation and work after healed, but the other would receive no benefits, and not be able to return to work. Representative Hibbard said the definition of major contributing cause meant the lead factor contributing to the result. He said if one of the skiers had a bad injury and then an industrial accident, then to the extent that the industrial accident was the cause of the final injury, the skier would be compensated.

Nancy Butler said that she would have a problem believing a doctor would not find a worker's industrial injury that caused inability to ever work again to be the major contributing cause.

Senator Towe asked if "the employer's permission, encouragement, or actual knowledge of consumption of alcoholic beverages or drugs may not be determined in considering the compensability of an injury" meant the previous paragraph would or would not apply if the employer knew about it. Nancy Butler answered that the language that had been deleted on line 16, "if the employer had knowledge, or failed to attempt to stop the employee's use of alcohol, the subsection does not apply" tried to clarify that whether the employer knew, or did not know that the employee was using alcohol or drugs while working, the section would still preclude the worker from getting benefits.

Senator Towe asked if there was a birthday party under the auspices of the employer, and everyone had some wine, and someone gets injured on the job, the worker is still precluded from benefits. Nancy Butler said if the alcohol was the major contributing cause of the accident, then the benefits would be denied.

Senator Towe said under HB 361, if an employee who had a blood alcohol percentage of 0.1 a the time of an injury would be precluded from benefits for that injury forever. Nancy Butler said this is how HB 361 read, but the chances that a blood-alcohol test would be done in such a case were few.

Senator Forrester said if Senator Harp supplied a keg on the job, and an employee was injured, Senator Harp would be liable for negligence suit. There would be a remedy, whether or not it was a workers' compensation remedy.

Senator Towe said in Senator Forrester's example, there would not be a way for the worker to sue Senator Harp, because there was workers' compensation coverage.

Senator Harp said his liability would be in question, and OSHA provides that the employer that violates a safety plan looses common law defense and could get sued for negligence.

Senator Towe asked if the safety plan was violated the common law defense was lost. Senator Harp answered it was under OSHA.

Senator Towe said the fine OSIA might impose would not help the worker. Senator Harp answered it would only help because the employer would not let the situation happen in the first place. Senator Towe acknowledged this was a disincentive.

Closing by Sponsor:

Representative Hibbard said the intent of HB 361 was not to deny coverage, but rather to catch abuses to the system. He said he thought it was a fair bill based on successful plans implemented in Oregon.

ADJOURNMENT

Adjournment: 5:58 p.m.

THOMAS E. TOWE, Chair

KELSEY CHAPMAN, Secretary

TET/ksc

ROLL CALL

SENATE SELECT COMMITTEE ON Workers' Compensation **DATE** 4/02/93

NAME	PRESENT	ABSENT	EXCUSED
Senator Towe	X		
Senator Forrester	X		
Senator Bartlett	X		
Senator Wilson	X		
Senator Burnett	X		
Senator Lynch	X		
Senator Aklestad	X		
Senator Fritz		X	
Senator Hockett	X		
Senator Hertel	X		
Senator Harp	X		
Senator Keating	X		

Attach to each day's minutes

Homebuilders Assoc. of Billings
252-7533

W. Montana Home Builders Assoc.
5-8181

Great Falls Homebuilders Assoc.
2-HOME

Flathead Home Builders Assoc.
752-2522

Missoula Chapter of NAHB
273-0314

Helena Chapter of NAHB
449-7275

Montana
BUILDING INDUSTRY
ASSOCIATION

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

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 1
DATE 4/02/93
BILL # HB 622

HB 622

Recommend:
DO PASS

Mr. Chairman: Members of the Committee:

I am Harlee Thompson a delegate from the Montana Building Industry Association to the Coalition for Worker Compensation System Improvement. (CWCSI)

The Coalition for Worker Compensation System Improvement supports Hb 622 in its entirety. However the way subsection 2 in section 8 on page 27 is currently drafted the possibility exists that the insurer could be required to pay a greater benefit than is required under current temporary total disability rates. To eliminate this possibility we would like to amend as follows :

1. Page 27 line 12
   Strike: " Weekly compensation benefits "
   Insert: "The insurer's liability "

2. Page 27 line 18
   Strike: " The state's average weekly wage at the time of injury. "
   Insert: " The worker's Temporary Total Disability rate."

IMPACT ANALYSIS OF SECTION 8, PAGE 27, OF HB 622

Weekly Earnings	$200	$300	$400	$500
Estimated Deductions	15%	20%	25%	25%
Take Home Pay	$170	$240	$300	$375
Compensation Rate (TTD-66 2/3)	$133.33	$200	$266.67	$333.33

ESTIMATE RETURN TO WORK 1/4 TIME BEFORE MMI

Earnings	$50	$75	$100	$125
Estimated Deductions	15%	15%	15%	15%
Take Home Pay	$42.50	$63.75	$85.00	$106.25
Compensation Rate (Temp-Partial/-622) Difference Between Pre & Post Injury Earnings	$150	$225	$300	$349.50
Income Take Home Compensation to Employee	$192.50	$288.75	$385	$455.75
Take Home Pre Injury	$170	$240	$300	$375
Take Home Post Injury Per (622)	$192.50	$288.75	$385	$455.75
Increase Income	$22.50	$48.75	$85	$80.75
Employers Increased Comp Cost (622) Weekly over TTD	$16.67	$25.00	$33.33	$16.17

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 2
DATE 4/02/93
BILL # HB622

IF HB 622 TEMPORARY PARTIAL PROVISION IS CHANGED TO 2/3

Weekly Earnings	$200	$300	$400	$500
Take Home Pay	$170	$240	$300	$375

RETURN TO WORK 1/4 TIME

Earnings	$50	$75	$100	$125
Take Home Pay	$42.50	$63.75	$85	$106.25
Wage Loss	$150	$225	$300	$375
Compensation Rate 2/3 of Difference	$100	$150	$200	$250
Take Home Compensation & Pay	$142.50	$213.75	$285	$356.25
Loss of Take Home Pay	$27.50	$26.25	$15.00	$18.75
Employer's Compensation Savings	$50	$75	$100	$99.50

House Bill 622 by George Wood
Montana Self Insurers Assoc.

Page 27 line 13
after the word be
insert: "66⅔ percent of"

Pages 52 and 53

Strike sections 24 and 25 in their entirety

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Q. Doctor, is there any recognized -- and by recognized, I mean within your profession -- objective basis for assigning percentages of causation in these cases?

A. I don't believe that there is.

Q. Is it possible, therefore, for different physicians to come up with different percentages in answer to the kinds of questions Mr. Bach was propounding?

A. I have no doubt that other physicians with the same training and experience that I have in these matters may come up with a different set of numbers.

Q. Is it fair to characterize the percentages you assigned as an educated guess?

A. It is fair to characterize them in that fashion, counselor.

Q. And so that I understand, although it is clear that the cervical pathology which was evidenced in '86 and '87 did not exist in 1979, your testimony is that 30 percent of that pathology can be attributed to the 1979 accident?

A. I think it would be impossible to discount the possible effects of the '79 injury, and my best educated guess is that it's contributed to 30 percent of his most recent neck problems.

Q. As to his lumbar problems, the 1979 accident appears to be neutral; am I correct?

A. That is correct.

Amendments to House Bill No. 622
Third Reading Copy

Prepared by Jacqueline Lenmark
American Insurance Association
April 2, 1993

1. Page 2, line 19
Following: "the"
Strike: "department"
Insert: "commissioner of insurance"

2. Page 46,
Following: line 10
Insert: (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).
Renumber subsequent subsection.

3. Page 49,
Following: line 19
Insert: (3) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE.

4. Page 49, lines 17, 22, 25,
Page 50, lines 5, 9,
Page 51, line 5,
Strike: "department"
Insert: "commissioner"

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 4
DATE 4/02/93
BILL # HB 622

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 5
DATE 4/02/93
BILL # HB 622

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

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 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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SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 6
DATE 4/02/93
BILL # HB 622

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

By Arthur Gilbert, CPCU
Aetna Senior Account Executive, National Commercial Accounts
from R.O.M. 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.

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 20 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." □

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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.

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

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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 mechanisms 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.

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.

Amendment to House Bill No. 622
Third Reading Copy

Prepared by Mike Micone
Montana Motor Carriers Association
April 2, 1993

1. Page 50, line 15
Following: "state"
Strike: "."
Insert: ","

2. Page 50, line 15
Following: ","
Insert: "Except that the state fund has the right to refuse coverage of a group and it's plan of operation but cannot refuse coverage to an individual employer."

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 8
DATE 4/02/93
BILL # HB 622

Norm Grosfield

Amendments to House Bill No. 622

1. Page 20, lines 17 and 18.
   Strike: "AND ARE NOT SUBJECT TO THE LUMP SUM PAYMENT PROVISIONS OF 39-71-741"

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION

EXHIBIT # 9

DATE 4/02/93

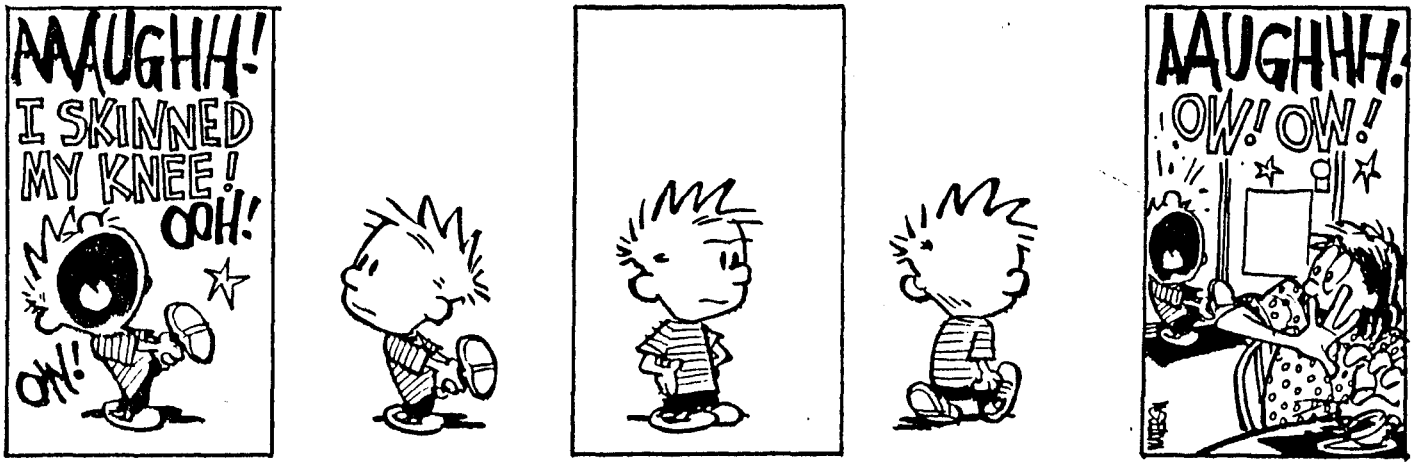
BILL # HB 622

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION

EXHIBIT # 10

DATE 4/02/93

BILL # HB 361

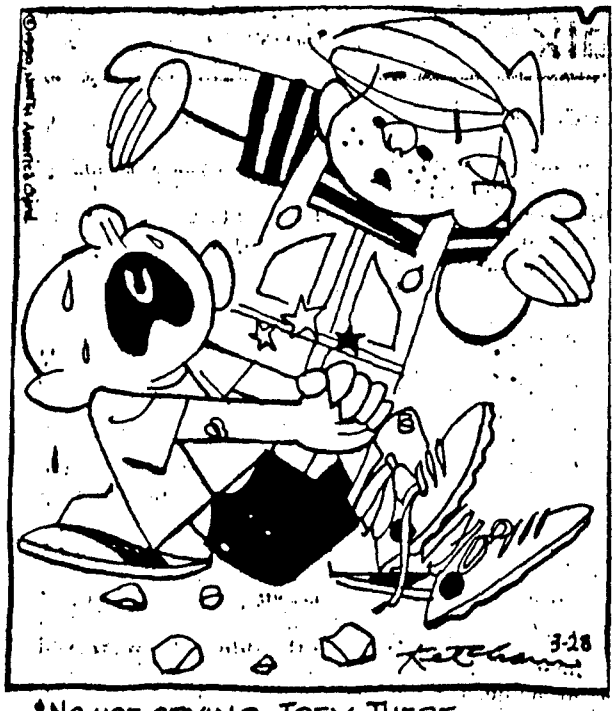


SENATE SELECT COMMITTEE
WORKERS' COMPENSATION

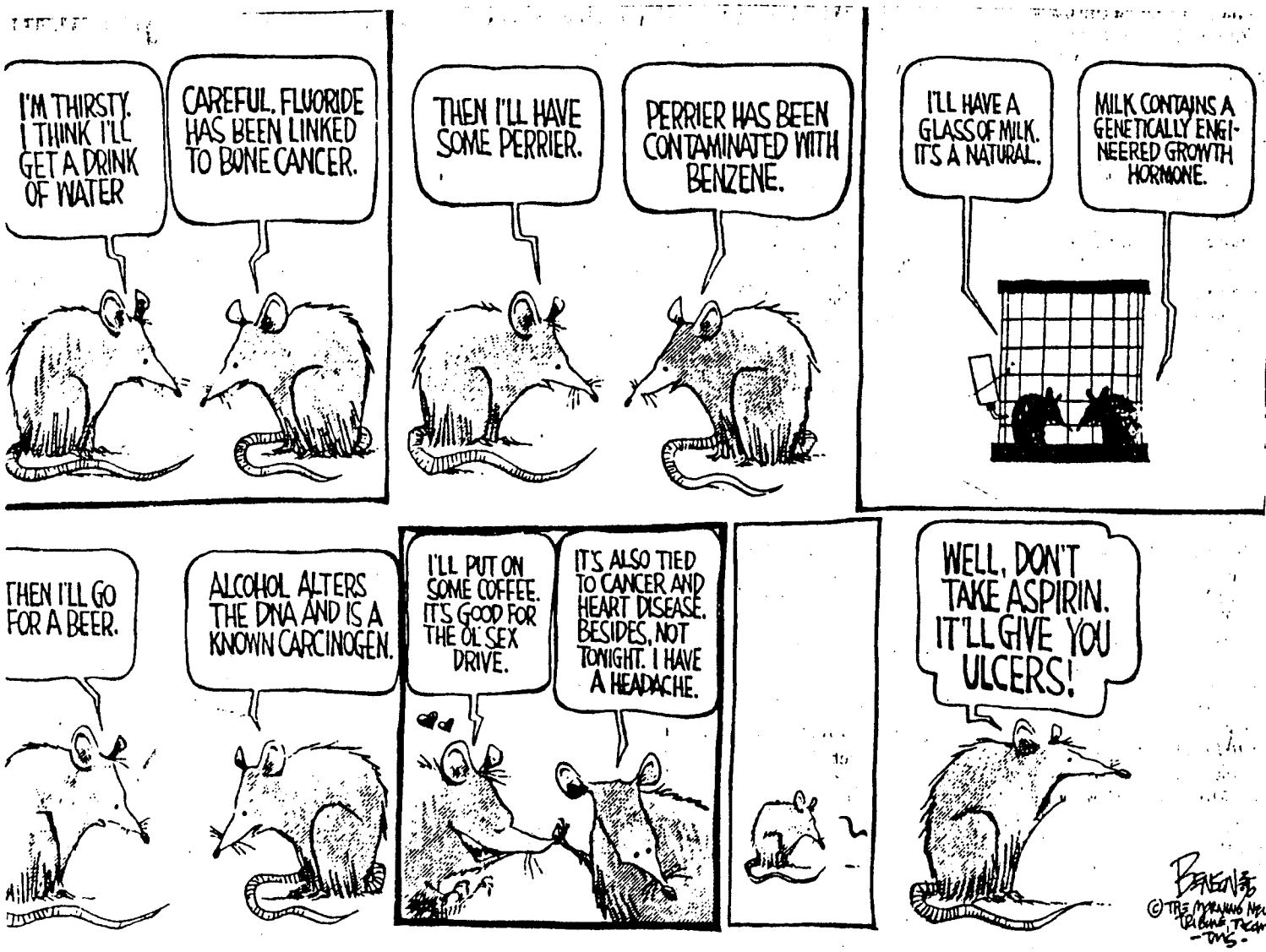
EXHIBIT # 10a

DATE 4/02/93

BILL # HB 361



"NO USE CRYING, JOEY. THERE AREN'T ANY GROWN-UPS AROUND."



SENATE SELECT COMMITTEE
WORKERS' COMPENSATION

EXHIBIT # 10 B

DATE 4/02/93

BILL # HB 361

Guest Editorial

SHOULD WE GO SOFT?

Vert Mooney, MD

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 10C
DATE 4/02/93
BILL # HB 361

The implication of the title is the limited attention currently given to evaluation and treatment of soft tissue injuries. For many who deal with the musculoskeletal organ system, care of soft tissue injuries makes up the largest percentage of patients. Yet the historic focus of research and training is on the skeletal system—naturally because it can be evaluated objectively by radiographs. The title of the oldest orthopedic journal says it all: *The Journal of Bone and Joint Surgery*. We have apparently ignored the emerging science in regard to soft tissue injuries.

Have I overblown the problem? Not at all. The Department of Labor and Industry of the state of Minnesota recently funded a comprehensive review of medical benefits in the workers' compensation system of that state (report to the Legislature on Health Care Costs and Cost Containment in Minnesota Workers' Compensation, published by the Minnesota Department of Labor and Industry, March, 1990). This report documented that back injuries accounted for 41.2% of all charges. Sprains and strains of extremities accounted for an additional 17% of the charges. Soft tissue injuries, such as contusions, caused another 8.8% of charges. Thus, 67% of all the workers' compensation charges were based on the treatment of "unverifiable" injuries.

Were the charges justified? Draw your own conclusions. In this report, verifiable injuries, such as fractures (only 6.2% of all the charges), were compared to unverifiable injuries, such as back injuries, in terms of charges to workers' compensation insurance vs charges of similar patients to private insurance (Blue Cross). The charges for fractures compensated by workers' compensation insurance were only 1.1 times more than those of private insurance, whereas treatment for back injuries was 2.4 times more for workers' compensation insured individuals compared to those patients with private insurance (not injured on the job). Charges for sprains and strains were 2.2 times more for workers' compensation vs private insurance.

There is nothing to suggest that workers' compensation reimbursed injuries were more severe than those paid for by private insurance. In the case of lower extremity fractures, 49% of Blue Cross patients required surgery vs only 20% of workers' compensation patients. In the case of back disorders, 4% of Blue Cross patients required surgery vs only 3.4% of workers' compensation patients. Back surgical care is usually based on verifiable abnormalities. Thus, there is no evidence that injuries sustained on the job were more severe.

The significance of these data is that, where verifiable diagnosis is available, standards of care are clearly definable and treatment costs for private vs workers' compensation are about the same. The discrepancy in soft tissue injury care charges is therefore questionable.

In general, the same physicians are treating patients in the workers' compensation system as in the private care system. Lacking any clear cut diagnostic and prognostic guidelines for soft tissue injuries, the physicians apparently continue treatment longer or until the patients say they are better. In the case of private insurance, there is no reason not to get better as quickly as possible. But, for the worker with partial compensation for time off, there may not be as much enthusiasm to declare improvement and well-

Dr Mooney is Medical Director, UCSD Spine and Joint Conditioning Center, University of California, San Diego.

ness. As long as the health care system legally must provide care until the patient declares himself or herself well, there is little motivation for restraint in the amount of care.

What about the amount of care? This addresses the realities of physical treatment. Is the purpose of physical treatment to make the individual feel better or function better? Over the past several decades, numerous systems of pain modulation using various counter stimulants, such as hot packs, massage, diathermy, ultrasound, and have focused on making the patient feel better while spontaneous recovery occurs. This is probably justified in the early phases of soft tissue injury treatment, and it is certainly safer than pharmacologic pain control. But once spontaneous recovery has occurred—if it is going to happen—additional pain control offers no benefits. Only focus on function can provide a rational therapeutic program when spontaneous recovery has not occurred.

Sports medicine focuses on function. Feeling better is a side issue. For the psychologically healthy individual, functioning better is indeed an analgesic. The rewards of improving performance reinforce to the psyche that the system is working. Pain is regarded as tolerable and does not represent destruction.

The purpose of this discussion is a plea to those who specialize in musculoskeletal care to take a leadership role in the care of these individuals. The only rational treatment program for injured soft tissues is a gradual, progressive exercise program channeling the repair by means of relatively slight progressive overloads. There is no magic. The repair rate must be measured in terms of performance, ie, strength, range, and endurance. Whether this performance is the number of hops on one leg for a knee injury, or the amount of weight lifted occasionally or repetitively for a back injury, it must be measured. The more specifically the weak link can be measured, the more economic and efficient the treatment program. Special equipment may be necessary to isolate and measure this weak link, and the value of objective measurement should offset the cost of equipment. We must not allow the treatment programs for soft tissue injuries to deviate from these principles.

Passive care unassociated with progressive exercise programs is unscientific and should not be covered by health care insurance. We must recognize that for the chronic patient (with injuries lasting more than 6 or 7 weeks), only treatment of dysfunction is justified, not treatment of pain alone.

We cannot allow undefined and undefinable care to continue indefinitely. We must be willing to identify it when we provide medical reports to the insurance company. Disability awards should be provided only to those individuals who have failed a rational rehabilitation program. Failure to improve after 6 months of treatment with hot packs is no justification for a disability award.

Passive care and a passive attitude in the treatment of benign soft tissue injury can no longer be tolerated. By appropriate testing we have learned that progressive exercise is therapeutic to the connective tissue and the muscles to which it attaches. We need to encourage action for those who are passive on soft tissue injury care.■

An Original Paper

Treatment Outcome in Low Back Pain Patients: Do Compensation Benefits Make a Difference?

Robert N. Jamison, PhD; Denise A. Matt, BS* and Winston C.V. Parris, MD**

ABSTRACT

Some evidence suggests that chronic pain patients who receive worker's compensation benefits have a tendency to exaggerate their symptoms and not benefit from treatment. This study compared 110 male chronic low back pain patients receiving either no compensation, time-limited compensation, or unlimited compensation on pretreatment and follow-up variables. The patients who received unlimited compensation tended to have a higher percentage of physician-rated symptom dramatization, to have more pain behavior, and to use more medication than the no-compensation and time-limited compensation patients. At follow-up, fewer patients with unlimited compensation had returned to work as compared with the other groups. These results suggest that time-limited compensation may not affect treatment outcome or interfere with return to work, while unlimited compensation may adversely influence overall treatment outcome and the probability that patients will return to work.

A common belief among medical specialists who work with chronic pain patients is that financial compensation perpetuates pain behavior.[1] Pain behavior is defined as external indicators of pain, such as symptom exaggeration, avoidance of work or other activities, and intake of pain medications.[2] For example, if a man complains that his back hurts and, as a result, his wife brings him breakfast in bed and his son offers to mow the lawn, the pain complaints are likely to recur. In the same way, chronic pain patients receiving financial compensation may feel obligated to continue exhibiting pain behavior in order to maintain their monthly income.[3]

Distinguishing between experienced pain and exhibited pain behavior unrelated to the actual pain level can be difficult. Preconceived ideas of symptom dramatization often lead medical staff, employers, and third party payers to prematurely suspect

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Accepted for publication July 1, 1988.

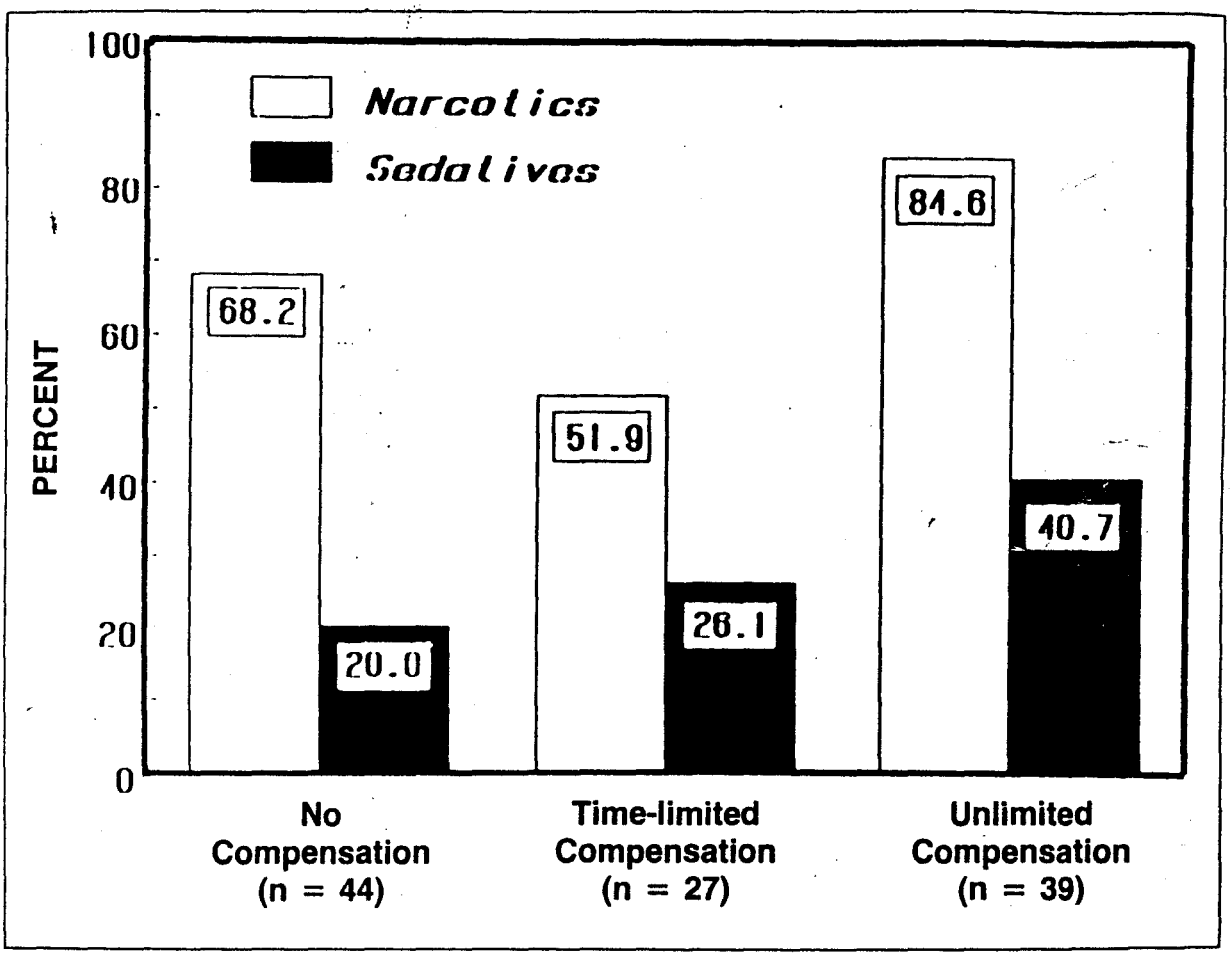

Figure 1. *Percentage of patients relying on narcotics and sedatives in no compensation, time-limited compensation, and unlimited compensation low back pain groups. Differences were significant at the $p < 0.05$ level.*

malingering in patients receiving compensation. In fact, some physicians and pain clinic specialists refuse to treat this subgroup of patients because they expect the chances for optimal recovery to be poor.

Not all compensation associated with chronic pain is alike. Benefits may be divided into two broad categories: time-limited and unlimited.[4] Time-limited benefits are generally received during the time that a patient is obtaining medical treatment following an accident such as a work injury. Once it is established that maximum medical improvement has been reached, a settlement is obtained and no further benefits are given. Unlimited compensation, on the other hand, consists of financial disability benefits which are awarded for an indefinite period of time. Once patients are awarded unlimited compensation, they are entitled to regular monthly payments until they feel able to return to work. Worker's compensation benefits in most states are time-limited, while disability benefits derived from federal or state funds are generally unlimited. In some states, however, worker's compensation benefits are also unlimited.

The purpose of this study is to examine differences between low back pain patients who are receiving no compensation, time-limited compensation, and unlimited disability benefits on pretreatment and follow-up variables.

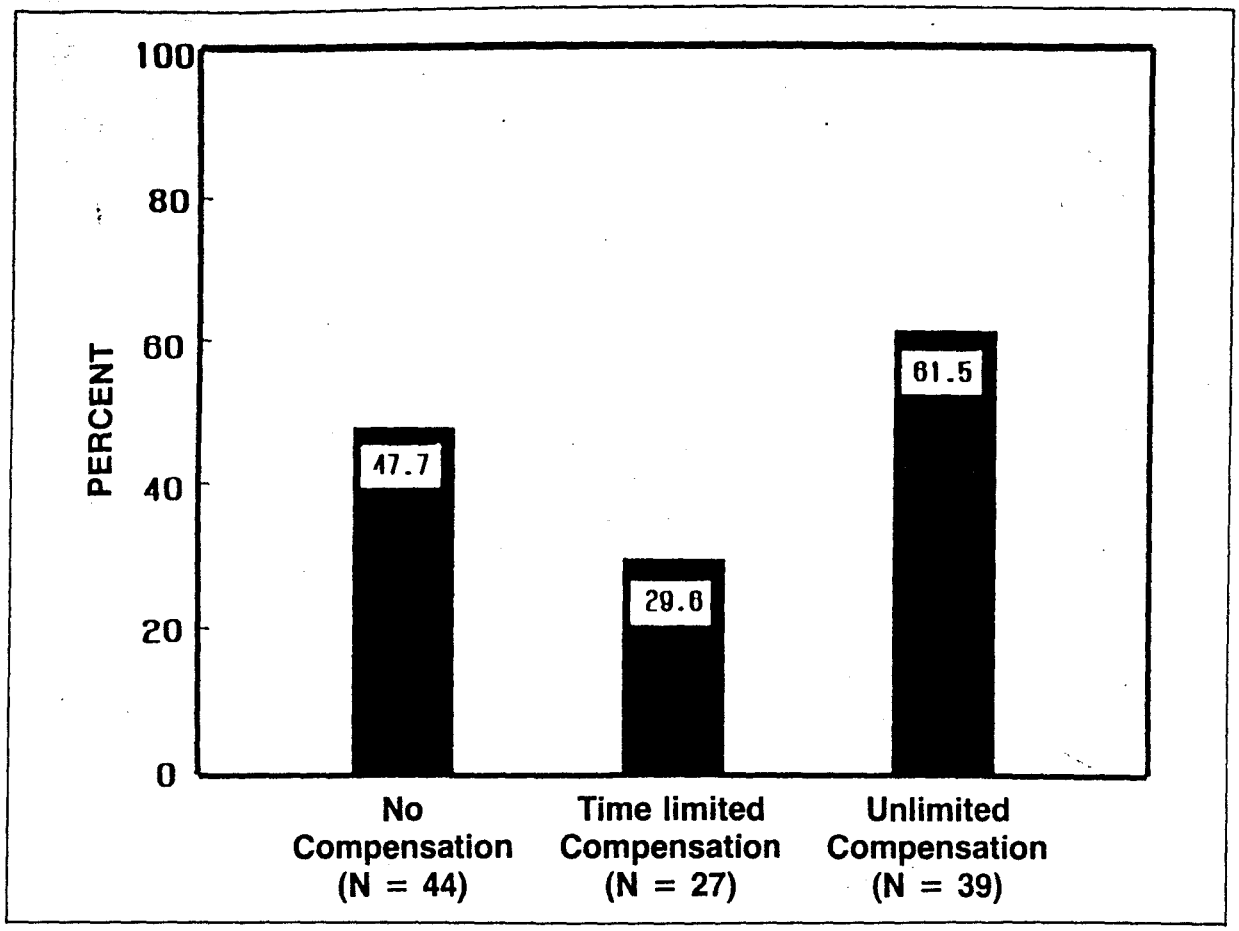

Figure 2. *Percentage of physician-rated symptom dramatization in no compensation, time-limited compensation, and unlimited compensation low back pain patients. Differences were significant at the $p < 0.05$ level.*

PROCEDURE

The patient sample consisted of 110 males referred to the Vanderbilt Pain Control Center for treatment of chronic low back pain. Of these patients, 44 were receiving no pain-related financial benefits, 27 were receiving time-limited worker's compensation benefits, and 39 were receiving unlimited disability benefits.

Patients completed a pretreatment questionnaire assessing self-reported mood, pain characteristics, and perceived impact of pain on daily activities. A physician performed a thorough pretreatment physical and neurologic exam. Following the physical evaluation and pain assessment interview, the physician gave each patient either a high or low pain behavior rating according to the Emory University Pain Classification Scale.[5] Patients with a high pain behavior rating generally use excessive dramatization in describing their pain. They tend to be inactive, rely on medication, and show evidence of significant emotional distress.

The patients underwent multimodal outpatient treatment for approximately three months. All but five patients received a series of four nerve blocks. Other modalities included relaxation training, patient education, group therapy, EMG feedback, transcutaneous electrical nerve stimulation (TENS), physical therapy and individual counseling. Approximately 12 months (mean = 11.3) after completion of their

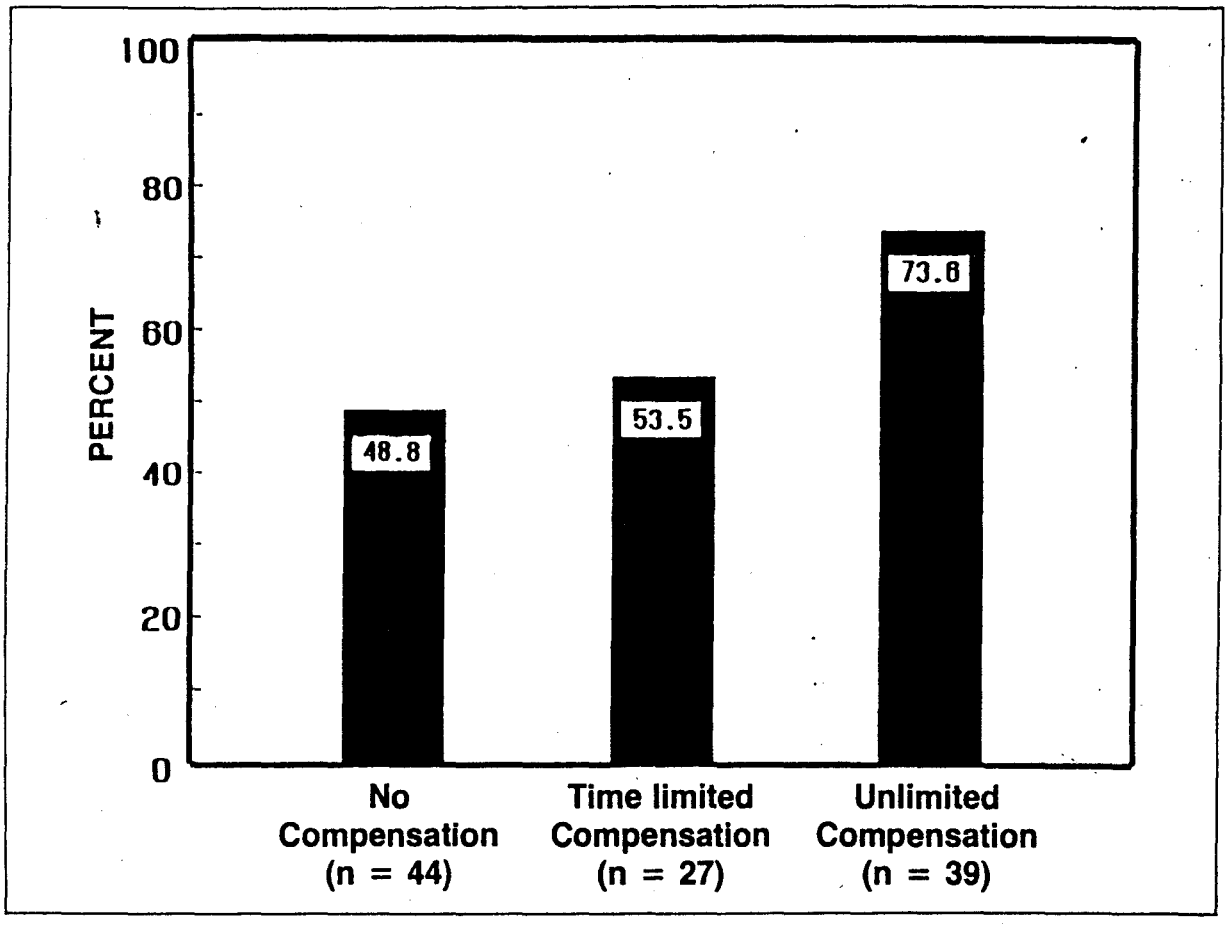

Figure 3. *Percentage of physician-rated high pain behavior in no compensation, time-limited compensation, and unlimited compensation low back pain patients. Differences were significant at the $p < 0.001$ level.*

treatment, patients were mailed a follow-up questionnaire to assess their present functioning and employment status. Attempts were made to telephone those patients who did not respond to the mailed questionnaire. Of the 110 original patients, 51 were followed.

RESULTS

The three groups did not differ in age, marital status, race, pain duration, pain intensity, or pending litigation. Not surprisingly, a higher percentage of the no-compensation group reported they were presently working than the other groups, while significantly more of the time-limited compensation patients reported having an initial work-related injury than the other patients. The groups were not significantly different in physical findings, which included range of motion, postural defects, ambulation, presence of trigger points, limb defects, reflexes, changes in cutaneous sensation, vibration changes, trophic changes, or motor functioning. Also, no differences were reported among groups in radiologic findings.

As shown in Figure 1, the patients who received unlimited compensation used medications more often than the no-compensation or time-limited compensation patients. The unlimited compensation patients also showed a higher percentage of physician-rated symptom dramatization

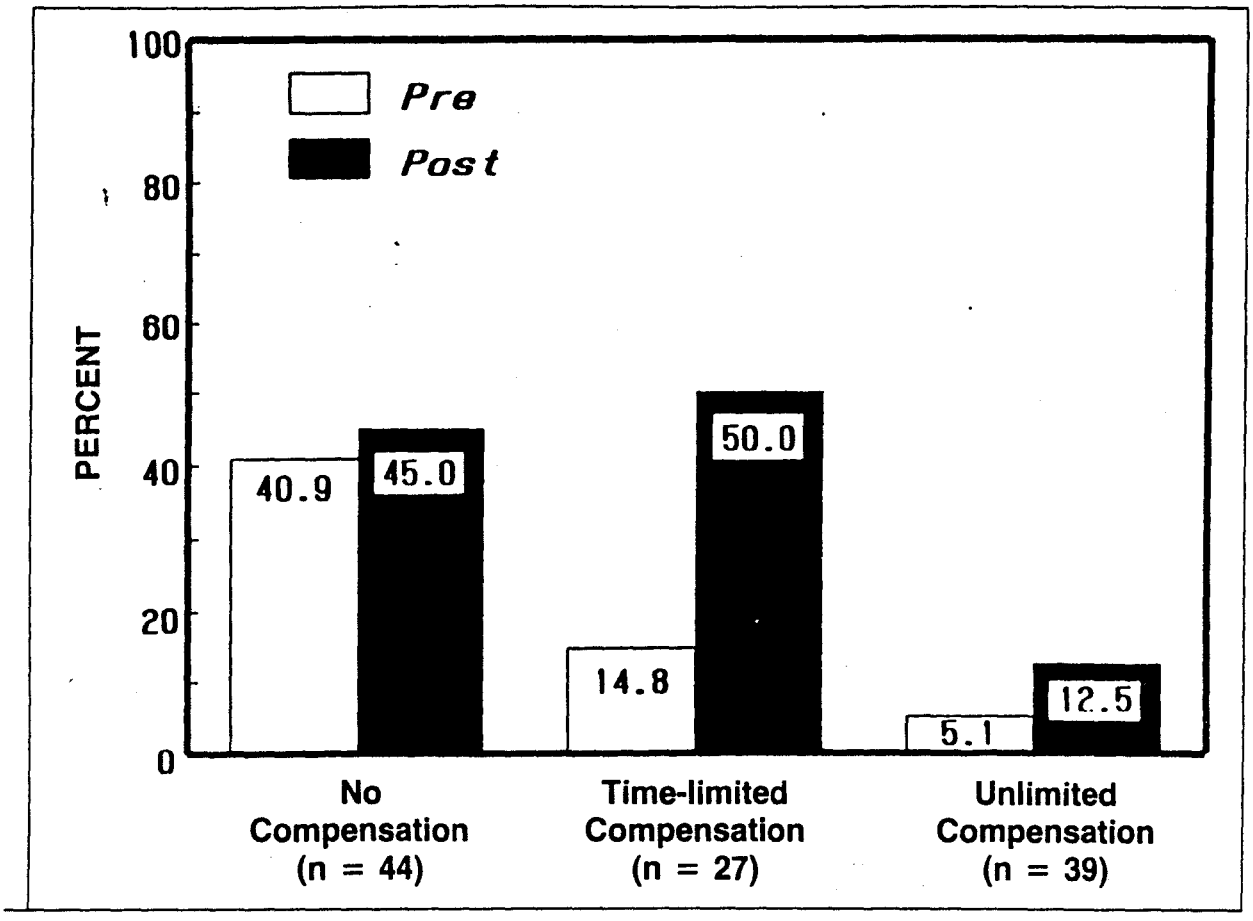

Figure 4. *Percentage of no compensation, time-limited compensation, and unlimited compensation back pain patients who were working pretreatment and at follow-up. Differences were significant at the $p < 0.001$ level.*

(Figure 2) and pain behavior (Figure 3) compared with the other two groups. The time-limited compensation patients used narcotics less often and showed lower rated symptom dramatization than the other patients.

On follow-up, the no-compensation and time-limited compensation groups reported less pain, less medication usage, and an increased activity level compared with the unlimited compensation group. As seen in Figure 4, the time-limited compensation and no-compensation patients who were initially not working were more likely to have returned to work at the time of follow-up than those who were receiving unlimited compensation.

CONCLUSIONS

The results show that certain types of financial compensation for pain may influence pain behavior. Unlimited compensation seems to increase the likelihood of medication usage and symptom dramatization in chronic pain patients. Moreover, receiving unlimited disability benefits may reduce the probability that patients will eventually return to work. On the other hand, few differences in pain behavior seem to exist between patients who receive time-limited worker's compensation and those who receive no compensation as reported in previous research.[6] According to physicians' ratings, patients receiving time-lim-

ited benefits did not show greater symptom dramatization or exaggeration. Time-limited compensation does not seem to affect the probability of the patient returning to work.

IMPLICATIONS FOR CLINICAL APPLICATION

Overall, these findings support the notion that chronic pain patients receiving time-limited worker's compensation do not represent a "problem" subgroup of chronic pain patients. In fact, time-limited compensation may encourage patients with chronic low back pain to return to work following treatment. Patients who receive unlimited disability benefits, however, may be at risk for poor treatment outcome. These patients may require additional interventions to improve their response to treatment.[7,8]

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April 2, 1993

Sen. Tom Towe, Chair
Senate Select Committee on Workers Compensation
Room 413/415, State Capitol
Helena, MT 59620

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 11
DATE 4/02/93
BILL # HB 361

RE: HB 361

Mr. Chair, Members of the Committee:

Thank you for this opportunity to express MTLA's opposition to HB 361, which generally revises workers compensation benefits. MTLA opposes the bill because:

1. The definition in Section 1 of "objective medical findings" (beginning at page 4, line 25) conflicts with the recommendation of the subcommittee of the Governor's Task Force on Workers Compensation, which debated this issue and reported that the last sentence regarding complaints of pain should be deleted "to protect a worker who suffers genuine pain." The workers compensation court, which is in the best position to evaluate the credibility of witnesses, currently determines whether pain is genuine and whether it causes physical restrictions. This bill, however, presumes to remove the issue from claimants, doctors, and the workers compensation court and submit it instead to some unspecified marvel of modern medicine tantamount to a Pain-O-Meter.

2. HB 361 effectively requires "objective medical findings"--and thus additional medical expenses--in <u>all</u> cases, not just those cases based solely on complaints of pain. It guarantees increased health-care costs. For example:

* Even in cases which involve complaints of pain alone without supporting medical evidence, <u>some</u> of those claims are presumably legitimate and <u>some</u> of those illegitimate claims are presumably detected and rejected already. Yet HB 361 requires "objective medical findings" in all such cases.

* To be safe, some claimants will immediately obtain "objective medical findings" which, in hindsight, prove unnecessary or excessive.

* Injured workers in rural areas without sophisticated clinical equipment will incur additional travel expenses to obtain "objective medical findings."

* Finally, in light of other provisions of HB 361 requiring claimants to prove that workplace injuries are the major contributing cause or primary cause of resulting conditions, insurers which seek to introduce evidence of pre-existing conditions, non-work-related injuries, and similar contributing causes will also, like claimants, be forced to obtain "objective medical findings" to substantiate those other contributing causes.

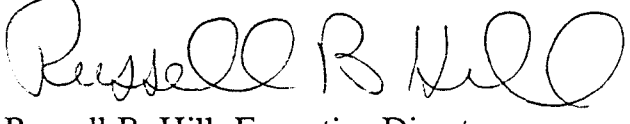
3. By limiting the definition of "injury" in Section 2 to physical harm established by "objective medical findings," the bill expands the circumstances under which an injured worker can sue an employer for civil damages. Workers who cannot satisfy the requirement of "objective medical findings" are not injured within the scope of workers compensation law and thus can sue their employers. More ominously, some workers will, for precisely that reason, prefer not to obtain "objective medical findings." And ironically, that will cause enormous problems for employers and insurers who must either obtain and pay for "objective medical findings" themselves or else face the prospect of civil liability. Note, too, that HB 361 requires claimants to prove temporary total and permanent total disability by a preponderance of "objective medical findings" (page 15, lines 13-14; page 17, lines 24-25).

4. The amendment in Section 2 to 39-71-119(5), MCA (page 9, lines 4-7) directly contradicts the Montana Supreme Court's holding in the 1990 Gaumer case (795 P.2d 77). In that case the State Fund initially denied liability for the claim, not on the basis of cumulative physical harm, but instead because it claimed it could not identify the exact chemical agent responsible for the injury. The hearings examiner, workers compensation court, and Montana Supreme Court each declared the State Fund's denial of liability unreasonable and imposed a 20 percent penalty on all benefits because the State Fund made no effort to investigate the cause of the injury, even after a physician's report linking the injury to exposure to workplace chemicals.

5. Section 4 of the bill regarding pre-existing conditions (page 12, lines 11-21) requires doctors to do the impossible: determine whether an aggravation of a pre-existing condition is responsible for more than 50 percent of the resulting condition. Worse, the amendment requires doctors to do so repeatedly in order to determine whether the aggravating injury remains (page 12, line 14) the major contributing cause. Finally, introducing the element of "major contributing cause" (page 14, lines 7-10) will necessarily increase litigation expenses by forcing the parties to dispute the relative significance of health conditions completely unrelated to the workplace accident.

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

With best regards,



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Also, refer to AMA Guides to the Evaluation of Permanent Impairment, 3rd ed, p. 250... re: "malingering"

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 12 (Jan VanRiper)
DATE 4/02/93
BILL # HB 361

complaint that he is experiencing low back pains which are of disabling severity is valid. Unhappily, there appears to be a notion that patients complaints of pain in the absence of corroborating physical, laboratory, or radiographic abnormalities is fained, imaginary, or of exaggerated severity. There are numerous painful medical conditions which occur in the absence of such objective findings (migraine headaches, tic douloureux, post herpetic neuralgia, and tennis elbow immediately come to mind). I hope this information is useful to you.

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Post '91 Settlements Nave

labor market. He has for the past 4 years lived in Lake Co. and been employed there for the past 3 years. This Court has held that pre-87 labor market is the area of residence, not of injury. Morrison's expert Randy Kenyon's testimony is accepted; he recently evaluated Morrison based on Lake Co. Testimony of Buttrey's expert Bruce Carmichael is not accepted; he used Great Falls where the injury occurred 8 years ago and where Morrison was living at the time of the assessment and has not brought his labor market information current for 5 years, and his projection that Morrison could earn up to $25,000/yr as an auto salesman is not supported since his 5-month attempt at auto sales ended in termination for failure to produce.

He was earning $9.29/hr at time of injury, which is $12.10 present value. He is earning $6.07 as a full-time habilitation tech. Kenyon testified to a 15-20% loss of labor market. The Court finds that post-injury capacity is $6.07. The wage differential in combination with other factors support loss of earning capacity which is above the statutory maximum.

He is not entitled to the remainder of his benefits ($33,976) in a lump sum. He lists $67,925 debts including $16,931 fees. He has 2 cars which he has not paid for, a motorcycle, a camper, a boat, and a computer. Before his injury he owned a Porsche, 3 snowmobiles, 2 boats, a motor home, a Cadillac, and a Jacuzzi. He has sold most of his assets to sustain himself. He and his wife earn $1,418/mo; with one child they have expenses of $2,168. With the award of $33,800 retroactive benefits his current debts will be paid and he will be able to live within the family income. He has not shown why it would be in his best interest to remove all of his permanent partial benefits when he has shown a preference for expensive recreational vehicles rather than family stability. Only after payment of his debts with the retroactive benefits can his financial condition be clarified.

Morrison v. Buttrey Foods, 1/13.

David Lauridsen, Columbia Falls, for Morrison; Sara Sexe, Great Falls, for Buttrey.

Work Comp Settlements

(Total settlement amounts. Year of injury in parenthesis.)

Plans I & II.
(ERD has declined to identify claimants.)
1. Back (87), $32,334, D. Lauridsen
2. Back (91), $72,763, M. Beck
3. Back (85), $71,500, L. Hartford
4. Leg/back (79, total), $44,905, J. Hennessey
5. Back (90), $17,000, C. Ferguson
6. Shoulder (90), $52,600, D. Lind
7. Nerve breakdown (92, disputed), $11,000, J. Edmiston
8. Knee (92, disputed), $6,621
9. Foot (91), $7,500

Plan III.
PEDERSON, r. hand (90), $46,636, L. Haxby
WARNEKE, knee/hands (82, 82, 91, 91, 92), $49,500, B. Everett
BEMENT, back (90), $44,651, T. Lynaugh
BOURNE, back (86, total), $60,251, E. Thueson
KIDD, back (82, 91), $21,684, C. Ferguson
BEIBER, leg/hip (87), $70,564, G. Drake
CARNES, r. hand/arm/elbow (90), $18,684, R. Pyfer
ROBERTSON, back (86), $25,000, R. Skaggs
VANDERSLOOT, neck/l. shoulder (91), $17,000, T. Spear
HARDGROUND, r. hand (92), $13,255, V. Halverson
SPOON, wrist (91), $32,568, D. Lauridsen
MELTON, r. shoulder/wrist (89, total), $35,000, R. Buley
ANDREWS, back (91), $21,000, R. Melcher
THOM, low back (86), $13,718, P. Sheehy
BIG MAN, back (92, disputed), $22,500, R. Plath
LARSEN, arm/hand (87), $10,000, J. Bothe
SAYLER, toe (86), $26,370, B. Everett
THAO, arm/shoulder (89, total), $21,615, T. Lynaugh
HILE, back (90), $40,000, B. Bulger
WOODS, back (82, 82, 87, 87, 89, total), $72,666, B. Olson
FRAZIER, low back (87, 87, 88, 88, 89, 90, 90, 91), $40,000, M. Datsopoulos
KIEDROWSKI, low back (83, 84, 91, total), $60,000, J. Edmiston
BEAN, low back (84, 87, 89, 90, total), $31,243, D. Lauridsen
JOHNSON, back/neck (86, 87, 87, 88, 89), $31,500, J. Bothe
HUNGEFORD, back (91), $13,862, D. McLean
DURBIN, knee/l. wrist (78, total), $10,000, P. McKittrick
HOVLAND, back (84), $29,733, A. Clark
JENKINS, back/neck (91), $52,154, T. Lewis
HAUFF, back (89, 89, total), $40,500, T. Lynaugh
DEES, back (82, 91), $40,502, B. Asselstine
TURNER, low back (90), $48,396, T. Bulman
VINCENT, back (86), $73,250, M. Beck
MATTOON, l. hand (89), $15,600, G. Wolfe
JONES, back (92), $24,696, R. Buley
LANE, back (90, total), $50,000, T. Lynaugh
DREYER, back (91, 92), $28,812, M. Beck
McCROREY, neck (91), $53,664, S. Pohl
MORALES, neck (91), $5,000, J. Vidal
ECONOMU, back (88, 90, 91), $47,245, R. Skaggs
LARSEN, back (89), $4,000, T. Oaas
GUMESON, back (93, disputed), $3,000
GEORGE, back (93, total), $4,886
BARTON, knee (92), $4,704
BECHLER, back (92), $11,172
HANCE, hands (92), $2,000
PEAK, fingers (92), $5,216
DEVINE, neck/back/shoulder (82, 90), $21,153
LAWRENCE, multiple (81), $43,800
BLAIR, back (92), $8,904
ASBURY, knee (83, 87, 88, 88, 89, 90, 91), $8,600
HERAUF, low back (91), $14,594
NICHOLLS, low back (89), $12,000
HALL, back (91), $48,170
MAIER, neck/shoulders/back (92), $10,000
ETHERIDGE, back (92), $4,000
SHERRARD, eye (93, disputed), $81
EVANS, neck (92, disputed), $1,100
SEITZ, knees (92, disputed), $1,000
DIBBLE, r. hand (92), $1,246
STOILOV, back (92), $10,413
WIMSETT, cervical/thoracic spine/shoulders (91, 92), $22,000
UPHAM, knee (91, total), $12,758
HANSON, arm (93, disputed), $200
BUCKLEY, ankle (92), $625

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Federal Trial Courts

INSURANCE: No liability stacking... Shanstrom.

Shawn Skorupa was driver of a Jeep that plunged over an embankment in 2/91, killing 4 students and injuring 2 others. Skorupas had 2 Allstate liability policies; one listed the Jeep and a Mustang, the other listed a Subaru and other vehicles. Defendants contend that they are entitled to stack the policies.

Tuells allege ambiguity in the Subaru policy by referring to the "Combining Limits of Two or More Autos Prohibited" provision: (1) "If you have two or more autos insured in your name and one of these autos is involved in an accident, only the coverage limits shown on the declaration page for that auto will apply." (2) "When you have two or more autos insured in your name and none of them is involved in the accident, you may choose any single auto shown on the declarations page and the coverage limits applicable to that auto will apply." (3) "The limits available for any other auto covered by the policy will not be added to the coverage for the involved or chosen auto."

Tuells argue that the second sentence may be read to refer to all autos insured by Allstate in the insured's name and/or to just those insured under the Subaru policy. However, the provision suggests 2 possible situations in which coverage may be available and clearly prohibits stacking. The first sentence prohibits stacking when the insured has 2 or more autos insured by Allstate in his name and one is involved in an accident. In that situation the insured is entitled only to the limits shown on the declarations page for the auto involved in the accident; that is the situation of the accident at issue. The second sentence prohibits stacking when the insured has 2 or more autos insured in his name and none is involved in the accident (a situation usually involving a non-owned vehicle). Liability coverage remains available but is limited to that of any single auto chosen by the insured and shown on a declarations page of a policy; this was not the situation in the underlying accident; the Jeep was involved in the accident and therefore the coverage limits attached to that vehicle applied.

Defendants object to this reading on grounds that separate premiums were charged for each vehicle for bodily injury and property damage liability. Tuells make much of case law allowing stacking of *uninsured* and *underinsured* motorist coverage, but there are no Montana cases allowing stacking of liability coverage. Further, their interpretation gives no effect to the "Limits of Liability" section which states that liability limits will not be increased if the insured has other auto policies that apply.

The Montana Supreme Court has not addressed whether an injured party may recover under 2 policies when the vehicle involved in the accident does not qualify as an "insured auto" under one of the policies. However, other courts have consistently held that policy limits are unavailable and therefore that stacking need not be addressed. Summary judgment for Allstate.

Allstate Ins. v. Skorupa et al, 13 MFR 355, 1/15.

Susan Roy (Garlington, Lohn & Robinson), Missoula, for Allstate; W.A. Forsythe (Moulton, Bellingham, Longo & Mather), Billings, for Skorupas; Kenneth Peterson (Peterson & Schofield), Billings, for Kuchinskis; John Mohr, Laurel, for Taylor; Clifford Edwards, Billings, for Boyer.

Workers' Compensation Court

"Available" suitable positions preclude permanent total finding under old law... Campbell, Hearing Examiner.

Arlene Meagor, 50, suffered disk herniation in 6/86 while working as a surgical nurse at St. James Hospital. James Murphy treated her without surgery and released her in 3/87 to restricted part-time work. She worked part-time in the Chemical Dependency & Psyche Unit until it closed in 11/91. She has not actively sought suitable part-time employment since, and is unable to return to full-time work as a registered nurse, her normal labor market. The employer's expert Patricia Schendel identified 7 part-time positions with duties consistent with Murphy's restrictions, with one opening available at a nursing home.

She is not permanently totally disabled as a result of her 6/86 injury. Although she satisfied the first 3 elements of §116(13), the employer provided credible evidence that she can return to suitable available employment. At the time of her injury the test was whether positions were *available* in the normal labor market. The fact that some positions may not be open at this time does not mean they are not in her normal labor market.

Meagor v. Hartford Accident & Indemnity Ins./Sisters of Charity of Leavenworth, 1/14.

Bernard Everett, Anaconda, for Meagor; David Slovak, Great Falls, for Hartford.

Work Comp Settlements

(Total settlement amounts. Year of injury in parenthesis.)

Plans I & II

(ERD is not disclosing names of claimants.)

1. Back (90), $45,000, M. Beck
2. R. wrist (93, disputed), $5,000, J. Nye
3. Back (84), $80,000, J. Hunt
4. Hernia (93, disputed), $7,000
5. Back (91), $36,238, J. Harrington
6. Back (87, total), $67,500, J. Bothe
7. Back (91), 45,000, M. Datsopoulos
8. Spinal cord (91, disputed), $30,000, J. Seidlitz
9. Back, (90), $12,981, I. Eakin
10. Electrical shock (91), $63,187, M. Beck
11. Low back (91), $9,000
12. R. hand (92), $3,000
13. Wrist (91), $15,000

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Plan III.

WOODS, back (82, 82, 87, 87, 89, total), $72,666, B. Olson
GARDINER, back (92), $16,621, J. McKeon
TIFFANY, r. arm (92, disputed), $2,000, T. Bulman
SCHERM, back (92, disputed), $6,000, E. Duckworth
TROUPE, back (92, total), $17,266, T. Lewis
GAGNON, low back (89), $47,791, J. Bothe

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Simons v. State Fund/Reserve St. Pet, 1/26.
Morgan Modine, Missoula, for Simons; Asst. AG Kristi Blazer.

Permanent partial benefits for forklift operator with subsequent injuries... Campbell, Hearing Examiner.

Craig Steichen, 42, hurt his left shoulder while operating a forklift in 6/82. Orthopedist Thomas Power, who saw him at the request of the insurer, diagnosed muscle strain/fibrositis. Repeated chiropractic treatments failed to eliminate shoulder pain which disturbed his sleep. He consulted with Susan Effertz in 1/84 but did not seek other medical attention for his shoulder until he saw orthopedist Mark Rotar in 10/89. Rotar and orthopedist John Avery diagnosed mild chronic rotator cuff tendinitis. Orthopedist John Diggs, who examined him in 7/91 at the request of the insurer, determined that his shoulder had worsened since Rotar's exam. He assessed 12% permanent impairment to the left upper extremity, which is a 7% whole person impairment. He suffered other disabling job injuries including back in 1984, right shoulder in 7/85, and right knee in 10/85. His vocational expert Clifford Larsen testified that his left shoulder alone would have prevented him from returning to his warehouse job. The insurer's expert William Goodrich reluctantly agreed because of inability to lift above 7'.

He is permanently partially disabled from the 6/82 injury and entitled to 280 weeks at $120.50 pursuant to §703. Even had he not suffered additional injuries, his left shoulder would have prevented him from working at his old job. This injury has restricted him to light work and as a result he has lost a substantial part of his labor market. The wage he was earning at time of injury would be $12 today. His earnings as part-time janitor and self-employed office cleaner have averaged $5 for the past 4 years. The evidence does not support a whole man injury; the 12% impairment to upper left arm and shoulder is a scheduled injury with maximum 280 weeks. Considering the other factors he is limited by the maximum rate for the maximum weeks.

The insurer argues that the subsequent injuries caused him to become disabled and should be considered before calculating loss of earning capacity attributable to the left shoulder. But its vocational witness was directed to consider the left shoulder in combination with the other injuries. *Tiedeman* (Mont. 1985) held that "each new compensable injury, though successive, begins a new benefit consideration beginning at zero."

Steichen is not entitled to a penalty; there was a legitimate dispute and the insurer did not unreasonably refuse to provide benefits. He is entitled to fees pursuant to §611 (1981).

Steichen v. Travelers Ins./Super Valu Stores, 1/28.
James Regnier, Missoula, for Steichen; Michael Prezeau, Missoula, for Travelers.

Benefits pending trial over OD/injury dispute denied.

Edward Bott contends that he was injured as defined in the Comp Act; the insurer contends that he suffers OD. The insurer has paid some 49 days of benefits pursuant to §39-71-610. Bott seeks an order that OD benefits be continued pending trial, as he is without income.

Bott provides no persuasive authority for his position. Further, OD benefits were paid on a non-acceptance basis. Thus, contrary to Bott's assertion, it does not appear that this is a situation whereby benefits are admittedly due under one act or the other. Payment on a non-acceptance basis raises some doubt as to liability. Payment pending trial denied.

Bott v. Lumbermen's Mutual Casualty/Kemper Group/ Interstate Brands, 1/27.
Thomas Lynaugh, Billings, for Bott; Michael Heringer, Billings, for Lumbermen's.

Work Comp Settlements

(Total settlement amounts. Year of injury in parenthesis.)

(ERD is not disloging names of claimants.)
1. Back (92), $17,222, J. Ellingson
2. Back (89), $5,000, W. Hennessey

Plan III
LANDE, wrists (89), $15,000, E. Duckworth
GODIN, hip/foot (83, 84, 85, 87, 88, 88, 89), $52,015, D. Lauridsen
KELLEY, r. hip (92), $2,000, D. Hawkins
SEPEDA, back (91), $4,000, R. Plath
FRY, wrists/elbows (90), $8,000, D. Lauridsen
RALLS, multiple (85, 90), $24,660, D. Lauridsen
GODFREY, low back (92), $3,000, D. Lauridsen
DAYTON, r. shoulder (91, total), $21,155, D. Lauridsen
PETERSON, neck/low back (90, 92, 92), $38,220, T. Lynaugh
KENNEDY, knees (92), $4,098
NELSON, low back (89), $12,000
LaFORGE, ankle/knee (92), $11,164
REMMICK, cognitive (92), $10,000
HANEY, l. hand/shoulder (88, 92, 93), $3,700
OLDENBURGER, arm/shoulder/face (90), $1,500
MILLER, neck/low back (89, 90, 91, 91, 92), $10,888
MORRISON, CTS (86, 87, 87, 89, 91, 92, total), $10,000
WISTI, leg (90, 90), $52,936
WILLINGHAM, hand (87), $5,000
HOWARD, finger (92), $3,752
WEIDINGER, r. shoulder (92), $2,100
CONKLIN, back (89), $3,800
AHLIN, knee (92), $1,373
HOUSEL, low back (89, 92, 92), $4,519
SUTHERLAND, back (92, total), $14,990
CHAPMAN, knee (92), $832
FERGUSON, ankle/hand/cheek (88), $8,210
McMILLAN, r. shoulder/back (84, 91, 91), $50,022
TESKE, back (82, 83, 84, 86), $6,500
ANDERSON, leg (88, 89, 89, total), $27,881
BAUER, ribs/back (92), $16,464
McCAFFREY, back (92), $28,244
KIMMET, back (92, total), $17,640
KRUGER, bilateral clavicle/ribs (90), $49,658
CHARLAND, eyes (93, disputed), $1,000
SMITH, leg (92), $3,798
KRANK, back (92), $37,044

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STEPHEN R. DAVENPORT, M.
JAMES F. SCHWARTEN, M.D.
PERRY M. BERG, M.D., Retire

April 2, 1993

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 13
DATE 4/02/93
BILL # HB 361

Mr. Pete Strizich
SCMIF
P. O. Box 4759
Helena, MT 59604-4759

TELEFAXED: (406) 444-5963

Dear Mr. Strizich:

This letter is pursuant to your request to my office for clarification of the appropriateness of utilizing "objective medical findings".

As you are aware, there are objective findings and subjective complaints that are dealt with in the treatment of particular medical problems, injuries, etc.

We have to expand the consideration of objectivity to include not only the physical findings that are evident on the clinical examination of a patient, but also included as objective have to be the findings that we can demonstrate on certain tests.

There is one basic premise, and that is that significant problems have significant objective findings either on physical examination of the patient by the physician or demonstrated on objective testing on studies such as myelography, MRI, EMG, etc.

The basic premise is that we all want to be fair to the patient, and we all realize that objective findings do not always exist solely on clinical exam. When we include objective findings on other studies, then we can feel quite safe, in the treatment of injury in one form or another, that we've done our absolute best to be objective and fair and still properly evaluate the patient's complaints.

Hopefully this will meet your needs. Please let me know as soon as possible if there's something else that needs clarification.

Yours truly,

James T. Lovitt, M.D.

JTL/jrd

DATE FRIDAY, APRIL 2, 1993

SENATE SELECT COMMITTEE ON WORKERS' COMPENSATION

BILLS BEING HEARD TODAY: HB 361 - Hibbard; HB 622 - Ewer

PLEASE PRINT

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Tim Weill MD	self	361	✓	
Jim Putman	CWCSI	361	✓	
"	"	622	✓	
Ross Miller	F.H. Stoltze Land & Lumber	622	✓	
Robert Hamberg	self	361	—	
Darrell Holzer	mt. St. AFL-CIO	361		✓
Darrell Holzer	mt. St. AFL-CIO	622	✓	
Nancy Butler	State Fund	361 622	✓ ✓	
Jim Tutwiler	MT Chamber / MT Retail Assn	361	✓	
George Wood	~~Mt. Self Insurers Assoc.~~	~~361~~ ~~622~~	~~✓~~ with amendments	
Mike Micone	MTCA	361 622	X	
~~Ann~~ Jacqueline Lenmark	Am. Ins. Assoc.	361 622	X	
Jan VanRijn	self	361 622		✓
Nancy Butler	State Fund	361	✓	
Hailee Thompson	NIBIA	361 622	✓	
Carl Willis	Montana Power Co.	622	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE FRIDAY, APRIL 2, 1993

SENATE SELECT COMMITTEE ON WORKERS' COMPENSATION

BILLS BEING HEARD TODAY: HB 361 - Hibbard; HB 622 - Ewer

PLEASE PRINT

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Don Allen	CWCSI	361 622	✓	
Jamie Doggett	MT Cattlewomen	361	✓	
Vern Cole	MMIA-MSGIA-MACO	361	✓	
Ross Rutten	Wash Corp	361 622	✓	
Norm Grosfield	Self	361 622		✓

VISITOR REGISTER

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