NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
LAS VEGAS, NEVADA
MARCH 4, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at Harrah's Las Vegas in Las Vegas, Nevada on Friday, March 4, 2022 at 11:15 a.m.

Ohio Senator Bob Hackett, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Asm. Tim Grayson (CA)
Rep. Kerry Wood (CT)
Rep. Roy Takumi (HI)
Rep. Brian Lohse (IA)
Rep. Deanna Frazier Gordon (KY)
Rep. Kelly Breen (MI)
Rep. Brenda Carter (MI)
Rep. Jim Lilly (MI)
Sen. Paul Lowe (NC)
Sen. Randy Burckhard (ND)
Rep. Emily O'Brien (ND)
Sen. Shawn Vedaa (ND)
Asw. Maggie Carlton (NV)
Asw. Michelle Gorelow (NV)
Asm. Steve Yeager (NV)
Rep. Brian Lampton (OH)
Rep. Lacy Hull (TX)
Rep. Dennis Paul (TX)
Sen. Mary Felzkowski (WI)
Sen. Janis Ringhand (WI)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Oliverson, and seconded by Sen. Paul Utke (MN), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 18, 2021 meeting in Scottsdale, AZ.

WORKERS' COMPENSATION IN THE POST-COVID ERA

Matthew Zender, SVP, WC Strategy at Amtrust North America, thanked the Committee for the opportunity to speak and stated that it's a pleasure to be here today. As a form of introduction I work for Amtrust Insurance Company. We are the fifth largest writer of workers' compensation in the US. We have about 320,000 policyholders in force and about $2 billion of premium. When I was talking with NCOIL staff about subjects for today, I offered a historical view of COVID and this is going to be from my perspective as an insurance executive. And the thought is that perhaps we have some lessons that we might be able to take from this. My son was just in Cabo and he was in the airport when all that was going down. And when he returned safely, thankfully, I asked him if he realized how historically significant that event was and he assured me that he did. And when I think about COVID from a work comp perspective it was an existential event. It was an event that had many of us questioning things at root levels and asking ourselves what this was going to mean.

And so as we go through this, I'm going to talk about COVID but from one perspective that's a little tired. We've been dealing with it for a couple years now. So, I'd ask you to maybe think about it through a lens of what this might mean for the next example that we're dealing with. And if you look at Warren Buffet's 2001 Annual Report, he obviously is a major insurer and he was talking about post 9/11 events and he said, "why, you might ask didn't I recognize the above facts such as –", this is now me paraphrasing, the probability of such mind-boggling disasters though likely very low at present is not zero before September 11th? The answer sadly is that I did but I didn't convert thought into action. I violated the Noah rule - predicting rain doesn't count, building ark's does. So, as we go through this presentation we're going to talk about: some of the economic impacts and how the state responses varied of course; the compliance efforts and those challenges that they pose to us – putting a state specific agenda through a national filter as obviously we write in all states except for Ohio, Wyoming, Washington and North Dakota - those are monopolistic states; the nature and number of COVID related claims and how the insurance industry responded; and the reopening efforts and the challenges that those posed both to business owners and to the insurance community.

So, I think we can all remember March of 2020. I think we can all kind of remember where we were when we first sort of realized that COVID was a thing and it was going to be something that needed to be dealt with differently. For me, I live here in Las Vegas and I remember closing our office as we all transitioned to working from home and the manager of the office looked at me and said, "I'll see you in a week or two." And I remember thinking, we'll see about that. And obviously, that office was closed for 18 months as many were. But when we were looking at the needs of our insureds we immediately transitioned to okay, we've got hundreds of thousands of policyholders. How can we support them and what can we do to leverage existing resources? So, one example was that we knew that we were going to have insureds that were going to have needs with payment terms. And some of this was directed by the states and some of it was directed by our agents and our insured's needs.

They were going to need payment deferrals. They were going to need to endorse the payroll down and I'll talk specifically about a couple examples of that. And so what we did is we transitioned our call center into giving them some authority. They did not have any authority prior to that and we gave them authority so we could take an existing resource and allow that to be used for thousands of policyholders needs. One of the things that we noticed with regard to agents is that they were less positioned to work from home than say we were on average. There were exceptions of course. So we needed to create a mechanism to help support them as they moved into their work from home process. Each state had various requirements and they were all different. So, we needed to set up a framework that was going to allow us to make sure that we were properly responding to those state requirements. So we created a spreadsheet that

would take the incoming requests and at first it was every couple hours we would send it out to the field so we can make sure that if a state such as Arizona or North Carolina was asking for something we could make sure that we were responding in fashion with what they were looking for. And then lastly, this is all still in March, we created some stress models. At Amtrust we insure 21% of all the restaurants in the State of New York. All of those restaurants were closed. The National Restaurant Association was estimating that a third of those restaurants could close forever. So, we had to create some stress models to help us determine what is that going to mean on our book of business as an insurer. How are we going to be able to make sure that we can continue to meet their needs going forward?

Into April it was starting to become a little bit more solid at this point. I think we were starting to settle in a little bit. This is now April of 2020. At this point, we started to look at insurers that insured policyholders and they were making some changes. I remember a dry cleaner contacting our firm saying that their payroll was down 97% because they did all the payroll and all the dry cleaning in Anaheim and Disneyland was closed so they needed some help. But other insureds were looking at what are they doing and how are they going to be changing? Hotels for example weren't taking on customers so they took on COVID patients in many cases and so we as an insurer had to ask ourselves how comfortable are we with that change in exposure? We also looked at the impact on the policyholder's revenue and whether or not it was going to impact their view towards safety. The dollars that they were spending say to put up plexiglass are now dollars that they might not be spending to make sure that their employees are working safely. And we had to find ways to encourage them to realize that they aren't mutually exclusive. There's a lot of shift mix that was going on as employees were now working from home and in some cases they were being fully furloughed meaning that they were being paid to stay at home. And so various states were coming up with different mechanisms to help us realize that payroll and in some cases that payroll could be just noted as zero and we had to set up the mechanics to be able to respond to that. And additionally, we had to make sure that we had the tools and the analytics to help both our insureds and our agents, and frankly us thrive during this period.

Now we move up to May, and I was recording notes as we were going through this historical period and I wrote down businesses are starting to look towards reopening. That feels a little optimistic now considering this was in May of 2020. But even then I wrote as the businesses start to look towards reopening, will they be able to find employees? I have a friend who's a contractor and he had received a paycheck protection program (PPP) loan and he tried to get his employees to come back to work even on furloughed basis where they'd get paid to stay at home and they were rejecting him as they wanted to stay on unemployment because many of them had figured out the dislocation between the federal and state unemployment programs. So, as they were struggling to find employees, I will tell you that's a theme that's continuing today and I'm sure it's continuing in Ohio too for you. The impact of PPP was absolutely a thing. In May, the compensability presumption started to roll in. We saw them in states such as California, Illinois, New Jersey, Kentucky and they varied and we had to make sure that we were looking at those individual state requirements and making sure that we were handling them in strict accordance with the intent of those state requests.

And we also then spent a lot of time as an industry asking ourselves what the heck does this even mean? And we started to see industry estimates with numbers that had b's in front of them in terms of the impact of COVID. There was one estimate that had the spend as much as $80 billion. The work comp industry as a whole is around $40 billion so to put some context on that they were estimating that the total spend of making COVID compensable could be twice as much as the annual premium collected. There was also around this time period, this is still in May, where we had some employers starting to get really concerned about employer liability in part B.

I think most of you in this room would understand that work comp is an exclusive remedy where about 100 years ago they gave up the right for tort action in exchange for a more estimable and reasonable pay structure. So, some people had a sense as to whether or not exclusive remedy was going to be under attack and businesses were asking themselves, there's all of these regulations and all these things I'm trying to understand, what is my standard of care? How can I make sure my employees are safe? And we as an insurance carrier and many others tried to put out a bunch of information to help sort of navigate all of this and make sure that as they opened safely they were not exposing themselves or their employees.

Now, into June, we had some moratoriums that were being lifted in terms of whether or not we were now able to cancel a policy. Up to this point we hadn't canceled a single policy ourselves and in fact, in many instances had returned quite a bit of premium. In California for example we returned $38 million in endorsement payroll back to our policyholders. That's just an Amtrust figure and I know many other carriers did the same thing. So now, we were looking at a situation where they've received maybe some PPP loans, they've evaluated whether or not their business model is going to be able to change and they were asking themselves whether they want to continue to stay in business. And so, we started closely tracking the ratio of cancellations and endorsements and making sure that those weren't getting well out of bounds. We also saw businesses that started to completely change their business model. I have a couple examples here. I had a lacrosse manufacturer that started making masks and they quadrupled their payroll because of a government contract. That's great for them, that's a success story. We had a whiskey manufacturer that changed into making sanitizer and that's a great example of somebody pivoting quickly. And my son was graduating college around this time and we wanted some barbeque food and I went to the barbeque place to pick it up and they had probably 100 orders of takeout listed there and I told my son that I don't see them going back to an in person dining situation anytime soon.

So, as they changed their model, we had to ask ourselves how comfortable are we with that? Are we comfortable with a restaurant that's doing mostly takeout? Does that change the way that those employees are going to be impacted? And from a behavioral perspective I can go on to this for a long time but I don't have time, but basically the macroeconomic dollars were flowing differently than we would have expected. There was a study that showed that 49% of the total reduction in spending came from households that were in the top income quartile, whereas only 7% came from the bottom quartile. Put another way the top quartile reduced their spending by 13% and the bottom only reduced it by 4% and so what that meant is business in some of the more affluent areas were actually at a greater risk of closing than a business in a more lower economic area and we had to ask ourselves what does that mean for us in terms of how we're feeling about those businesses and how we can support them.

In the third quarter we started to see some re-closings and the moratoriums came back and many states told us that we were now unable to cancel those policies or do anything with them. And we understood our obligation with that. We just had to make sure that we were keeping concert with what the requests were. And again, that wasn't always the easiest thing when you had, forty odd states sending in differing requirements. So, we had to make sure that we kept our procedures in place to respond properly and frankly, around this time we started to see some policyholders who understood the economics of their own situation and were perhaps deprioritizing their insurance spend. And so, we had to ask ourselves, they knew that they were under a moratorium, so they knew they weren't going to get canceled, so they weren't going to pay us and we had to ask ourselves how do we balance our compassion for their plight versus perhaps in some cases, and I'm not suggesting that this was a great percentage, there were some insureds who were just being opportunistic about their current situation. And so we had to

make sure that we were evaluating that. And the last bullet talks about drawing from the well, and we were trying to find ways to support our agents during this time because we found it was very difficult for them to find new opportunities. So we looked to find ways that we can help support our agents through this and helping them to grow.

The fourth quarter is clearly where we were seeing the spike in claims. We did see many businesses close around this time. Many of them said, "All right, I tried the first time around, I worked through the PPP, the second wave is too much." I heard from a restaurateur who said, "Look, my business model contemplates 100% capacity seven days a week." I first said that's just not a successful business model and you should be able to be profitable at say 80% occupancy but he said even though it doesn't make any sense, it's just not something I'm going to continue going forward. And then the other thing that we were looking at was we spent around this time energy into whether or not the stimulus was going to happen and whether that stimulus was going to move from the personal stimulus into small businesses. So, the fourth quarter ends and we're getting ourselves ready for 2021 and we're like excited that the year is over and then 2021 said, "hold my beer I think I still got some stuff for you."

So, then we're looking at what just happened here and premium movements were continuing. First off, I think all of you know that work comp is payroll exposure based - it's organized such that the payroll moves up and down, our premium does as well. At this point we're starting to get payroll audits coming in. All policies are subject to an audit that just reconciles the estimated exposure to the actual exposure and at this point we are starting to see some of those flow through and get some sense as to the depth of how low it was during March, April, and May and we had to find a way to help support them. At this point too, we saw COVID claims starting to come in but one of the things that we noticed was that as these claims were coming in we needed to standardize our approach. So, we created a COVID Unit so these people were only responsible for handling COVID claims because again, each state had different approaches and we wanted to make sure that we were acting in accordance. From a loss data standpoint, we started to see the claims trickle in and it may be a little hard for you in the back to see but just focus on the spikes. The first one you see on the left is June and July, these are California numbers but nationally they track fairly similarly. June and July you'll see the first spike that was when the compensability presumption started. That was when COVID was now a thing. It could be a work comp claim. And I think most of you may know this but for the 100 years of work comp airborne claims were not a thing. And so this is why it was such an existential thing for the work comp industry to sort of wrap their head around since we had never had airborne claims in the system. That's why some of these estimates were as large as they were.

The second spike you see is the fourth quarter of 2020. So, you'll see that big spike in December where we had 44,000 claims alone just in December of 2020 and then it dropped in January. But that's where the real spike was and if you look at the infection rates, it follows a very similar pattern. So, the number of claims that were coming in absolutely worked in correlation to the infection rates within the system overall. And then you can see it's been fairly low since then. In total, about $260 million in claims came out in California alone but the average cost is about $6,000 a claim - the claims were either very large or very small on average. So, now that we move into the second quarter of 2021, we get into some issues that persist to this day including where did all the employees go? And the shortage really is affecting a number of industries and at this point we started to see wage growth that was clear. Wage growth was up during this period. But it was confusing, because if you looked at it, it really reflects shift mix – 80% of the lost jobs were amongst the low wage earners. And so, the people who had greater paying jobs were generally unaffected. The people who had lower paying jobs were absolutely affected and that has an impact on our book of business as we look at shift mix and the

likelihood of that factor's actually generally positive in terms of the frequency metrics within the work comp space.

I'm going to also talk here about how do we keep energy levels up and frankly at this point it was becoming a bit of a challenge. In the third quarter of 2021 the picture's starting to come a little bit more into focus. Around this time the estimates started to come out in terms of 2020 and they had a combined ratio of 85% - the most commonly used metric to determine profitability. So, on average that means for every $100 of premium collected we had about fifteen points of profit on that. So, 2020 was clearly not the end of days as we had thought it to be at one point when we were first asking ourselves what this was all going to mean. We saw the premiums declined, and that makes sense because of the shift mix and everything else I was talking about before and the number of people who just simply weren't working. But the strong combined ratio reserve meant that the industry actually increased their reserve redundancy to $14 billion - that's an industry number. I have a typo on the last bullet point but that really was talking about inflation and what we were seeing happening with inflation and inflation absolutely affects the work comp industry and that is continuing to this day too.

So, the last slide here is sort of looking into the future and you I ask myself at this point whether the finish line is in sight or are we still standing on the starting line. And frankly, that was a very reasonable question for a lot of periods during COVID. I think we're feeling closer to the finish line now but we also talked about how we can facilitate ease through technology. So, during this period for example, we weren't able to have any contact with our policyholders. We couldn't meet with them, we couldn't do a premium audit in person, we couldn't do loss control in person, for obvious reasons. But there were some lessons that we learned through this. There were some things that we were able to do through technology that allowed us to actually have connections with our insureds and it worked out fairly well. I talked about the claims being fairly minor and then lastly, science tells us this will not be an isolated event. So, from our perspective, we now know that this door is open. We now know that work comp does contemplate airborne diseases in this particular example. So, the question that we have is, what's our role going forward? How's that going to continue? Does it become something that is baked in as an accepted cost of the industry? Or is it something that COVID gets treated as a true anomaly? These are questions that are still definitely to be determined.

Monica Verduzco-Gutierrez, M.D., Professor and Chair of the Department of Rehabilitation Medicine at the University of Texas Health Science Center at San Antonio thanked the Committee for the opportunity to speak and stated that I'm going to give you a different perspective of COVID mostly about what's happening to patients and what we expect to happen long term especially long after COVID. So, we're very happy things are going down, numbers are going away, the disease is becoming less severe. But there's still millions of people who are living with the long-lasting effects of COVID which can affect insurers and work comp payers and babies, friends, and families. So, I'll go over the terminology. "Long COVID" is what we talk about with the persistent symptoms and health effects after someone's had the acute COVID-19. Usually it is about 4 weeks or after that they consider it long COVID. "Long haulers," is the term that the survivors use, and usually put on themselves and then the National Institutes of Health (NIH) gave us the fancy "post-acute sequelae of SARS-CoV-2 infection" (PASC). The Centers for Disease Control and Prevention (CDC) calls it "post COVID conditions" and again, defined by experiencing symptoms 4 or more weeks after. And the World Health Organization (WHO) gave it a more case description that I think's helpful – it's persons that had a history of probable or confirmed SARS-CoV-2 because a lot of times at the beginning people were not having testing and didn't have access to testing and then that within 2 months they developed symptoms so it

may be that someone has COVID, gets better, and then some symptoms occur within the first couple of months and that's still considered attributable to their COVID-19 infection.

So, there are so many different reasons why people continue to have ongoing symptoms after COVID - even for people who are mild will have these ongoing symptoms long term. It has to do with the inflammation and cytokines that change - sometimes cytokines that you see in other states of inflammation including people who have cancer or strokes. Auto-antibodies are also important, so the body may be starting to turn on itself because of the spike protein and the parts of the virus that are in the body. There is a persistent viral presence meaning did it not all die off and they found places, like in the gastrointestinal (GI) tract, where there's still some COVID remnants left and this may be driving further disease. Mass cell activation is also important - something related to the immune system and patients still having an immune system gone awry. Dysbiosis means your GI tract goes off and that changes and then there are also micro clots.

So, who gets long COVID? There's starting to be more and more symptoms. It doesn't just have to be people who are very severe. It could have been people who were at home and had mild disease and I think they're starting to learn more and more with people who had maybe a higher viral load initially. Some people, if you've had a history of Epstein-Barr virus which is the virus that caused mononucleosis, they actually have a reactivation of their mono which may be driving the chronic fatigue symptoms. For some patients, it doesn't matter the age, but for some – having certain infections before, being overweight, having asthma and diabetes was also a risk factor for who gets long Covid as well. And also, having more symptoms at the beginning.
So, what does recovery look like for patients? What can we expect? And again, this is the worst picture, seeing someone that has very bad COVID lungs. And not everyone has to have the worst type of COVID lungs but it can look different for every patient just depending on the course that they have. And I think the outcomes are different. It just depends. Some people may have had silent COVID and they've done really well. Some may have silent COVID and still have long COVID symptoms. Some may have had pneumonia where they weren't hospitalized. Severe are the people who end up being hospitalized. And then there's some percentage of patients who die - I think it depended on where you were.

So, it's something that has to be considered for people who get it on the job and then there are some patients that recover just wonderfully - some that have long COVID. And I think if you look at the data it's anywhere from 10-15%. And then we don't know what's going to happen long term. This is a new disease. And just like they found out recently Epstein-Barr virus is the highest risk factor for someone to get multiple sclerosis. Or people who've had Polio, their post-Polio syndrome didn't occur until decades later. So, we still are not a 100% sure what's going to happen long term with COVID. We do know that it's definitely important to get patients rehabilitation. I'm a specialist in physical medicine and rehabilitation. I've been authored in different types of journals with colleagues from 11 other countries where we said, this is very important. If someone's going to be critically ill, that they be able to be hospitalized, taken care of as needed, and get the best rehabilitation possible both in the inpatient setting and the outpatient setting and sometimes in a post-acute brain injury facility because some of these patients also have something that looks very much like brain injury. That was my specialty before COVID came along - taking care of patients with traumatic brain injuries, strokes, and other catastrophic events and some of their behaviors and their cognitive issues were very much like treating a patient with brain injury.

We know that mobilization early on is important in the hospitals. So, they can even do it when patients who are on the ventilators or on extracorporeal membrane oxygenation (ECMO) and it helps patients have better outcomes and get out of the hospital sooner. So, we try to do that as

much as possible early on. A study looked at patients through the University of Colorado systems who had COVID and the ones who were least likely to get rehabilitation consultants were ones who were Hispanic and who spoke Spanish. There is more data just showing these are the patients that need to be covered for rehabilitation and they need to be covered whether that be their insurance or their work comp, or even a lot of them lost some of their jobs also. It's been very difficult. So, we're trying to ensure even at a larger level that patients maybe get their disability sooner than they did before. I fill out lots of disability forms for these patients who have lingering effects because it's important for them to get more rehabilitation. So, how frequent is this happening? I think if you looked at the U.S. they're saying something about 23% overall. If someone had been hospitalized, 50% will have ongoing symptoms. And different studies from different countries have probably similar numbers.

In this paper they looked at big data - there were one million plus patients who had a positive COVID test, some were hospitalized some were not. And they looked into the electronic medical record to see over the next 150 days how many of them were coming back into the system, what were the diagnoses that they had, and what were the complaints that they were had. Patients who had tested positive definitely were coming back and using more resources in the system. Mostly, if they were older than 20 years old, they were having shortness of breath, fatigue, and sleep issues. If they were less than 20 years old, there was a change in bowel habits, fatigue, shortness of breath and then some anxiety and depression as well. And in the end they said the percentage of this was only 11% but I think 11% is really high especially when you've considered that there's been almost 80 million people who've had COVID in the U.S. That could be 8 million people who are going to be impacted, who can't go to work, who can't get their life back on track. So, what are the symptoms that patients have? A study did a systematic review and they took all the studies looking at what were the symptoms after long COVID and it there's so many parts of the body that can be affected. There were 50 or more symptoms in this study with fatigue being the most common and that's always difficult to really put on paper to say how much that helps or hurts people because there's not often a test that's positive for someone who has debilitating fatigue.

I had one patient tell me that it was a hundred times worse than when she had cancer and we can kind of understand how cancer impacts people because people either have had it or their family members had it. This person said it was a hundred times worse than when she had cancer - the headaches, attention disorders as part of the brain fog, memory issues, hair loss, shortness of breath and everything else that you can imagine. So, what is happening in the brain? They've done a little bit more studies and they started in mice and gave them mild COVID and then they looked at it in people who are having long COVID symptoms and looked at the similar cytokines in their cerebral spinal fluid. They did spinal taps in these patients and found that they had abnormalities as well and including CCL11 that was elevated and that's one that's also elevated in chemo brains so it's very to a patient that may have chemo brain. A lot of patients can have cognitive sequelae as well. That's a big complication where patients say my brain is foggy and my memory's not good - I can't remember things, I don't know what word I want to say next. And we definitely knew that was a thing before with patients who had been hospitalized severely but then now we're seeing that they did positron emission tomography (PET) scans and the PET scan shows that there's less profusion to the brain and then also they found the type of signaling and what's happening to some of the proteins is similar to what happens in Alzheimer's. So, this is what we have to deal with and we'll see continuing studies long term to see what's going to happen to people and how we treat them as they need certain evaluations. They need to see neuropsychologists, they need to see brain injury specialists, they need to try medications, they need to get into brain injury programs because this very much affects the brain.

It's multiple systems of the body that are affected. Patients are having issues with blood flow to the brain, patients are having pain, they're having tinnitus which is weird buzzing in their ear that's sometimes very, very debilitating to patients. And there is more testing showing the blood is not pumping the way it should to your brain and your brain's the most metabolic part of your body and so it's really important that you get your blood to your brain. In this study basically it showed the same as others - fatigue and cognitive impairment. It was looking at 81studies – 32% of patients were still having fatigue at twelve weeks; 31% at six months. And it didn't matter if the patient was a mild case or a severe case. They were still having these cognitive symptoms and fatigue at six months or later. So, we can't even judge on they were hospitalized so we understand it - there's some people that were not hospitalized and they're still having long COVID. There are psychiatric problems, sleep problems, anxiety, depression, and some of that is driven by neuro inflammation as well. Like I said, these inflammatory markers that are in our spinal fluid can also drive depression and anxiety which I've also seen in workers as well and that's going to also impact their ability to return to work.

Health equity is a big issue. I know that's important to everyone that's here and to ensure that everyone gets the care that they need is important. There are many organizations who are working on this, including my national society, and the American Association of Physical Medicine and Rehabilitation. I'm taking care of patients and I've started two clinics in San Antonio one of which is in south Texas. We take care of some patients in our county safety net and some in our regular health practice. So, I get to see the haves and the have nots and I'm able to get patients back to work and try to get them back to work as much as possible but they need to be listened to because like I said, a lot of the tests can come back negative. A lot of the insurance doesn't cover some of these tests. If I want to give someone a PET scan that's not covered. That's usually something they'll only do sometimes for cancer to look for metastasis. If I want to do an invasive cardiopulmonary test, that's also not done all the time. I opened up the clinic because I wanted to ensure equitable care for these long COVID patients and give them concierge type care and look at their physical, cognitive and functional difficulties. And we treat everything from as severe as someone who's had a stroke and has had clots that have caused amputations in all their limbs, to patients who are fatigued, can't walk well, have brain fog or are depressed.

Our national society has also worked on consensus guidelines. So, of course we're working on trying to get these out so as many patients can be treated as possible for fatigue, for breathing difficulties, and for cognitive difficulties as well. With vaccinations, there's a new study that just came out and it's asks if vaccinations help patients. It definitely helps patients have less of a chance of getting long COVID but even if you're vaccinated there's still some risk of getting it but the chance is probably half. And then for some patients, if they get vaccinated, they may actually improve with a vaccination because it might actually help their immune system. So, it's something where usually I'm still getting patients to try to get vaccinated because it may help them. Probably the next most important thing I do is support patients for disability and work accommodations because I can really make patients be successful if they get back to work in a graduated return to work program. They may go and try to get back to work and it will be too overwhelming to them physically and mentally, and they go two steps back and they'll never get back to work. But if I can get someone working from home first on a partial basis that is going to definitely make someone more successful in getting back to work. And we have to have jobs that are going to be able to be flexible with this kind of work accommodation. And then I'll sometimes do things like help patients park closer and getting them some mobility equipment and just anything that will make it easier for them to get back. We know long COVID is a disability under the Americans with Disabilities Act of 1990 (ADA) and it's the number one thing right now that is getting to social security for disability - things related to long COVID.

The other thing is we refer patients as much as possible to research. Research is really important. So, please support research. I know that Senator Kaine recently introduced a bill related to long COVID. He has some long COVID symptoms himself and he wants to put more money towards research and getting treatments for patients who have long COVID. I work in a community based approach and take care of patients and want to get them seen, seen early and get them the type of appropriate rehab services that they need and with a goal of getting them back to work as much as possible.

Rep. Dennis Paul (TX) asked if these are people that had COVID but have negative tests so they're no longer showing that they have COVID. Dr. Verduzco-Gutierrez replied yes. Rep. Paul asked if anyone has looked at any of these symptoms described and looked at whether they are results of medication that was given to them for COVID. Dr. Verduzco-Gutierrez stated that it depends. For the ones in the hospital that were given medications, is it possible, maybe - but then the ones who weren't hospitalized didn't get any treatments. Rep. Paul stated that so there is no correlation as far as what you're seeing about treatment that they had and drugs they might have taken with long COVID. Dr. Verduzco-Gutierrez replied correct.

Rep. Kelly Breen (MI) stated that when we talk about the labor market, and in particular people like our first responders, police, fire, and emergency medical services (EMS), we do not have enough people entering these fields and most states have had COVID presumptions which expired and after that workers, and in particular first responders, they've been denied work comp benefits. So, my question to the first responders is this, did the number of reported claims include denied claims? And then my next question in general is as we try to encourage more people to enter the labor force, and especially these critical first responder roles, has consideration been given to creating a model policy with the presumption that contracting an airborne pathogen like COVID is work related? Because I think we can all agree the we definitely need people like our first responders and people that are up close and personal working with other people and they should be given some due consideration. It may mean that more claims will be paid out but it would also help with recruitment and retention as far as the labor market.

Mr. Zender stated that I can speak to parts of that and parts of it are well outside of my scope. In terms of the claims themselves, the strong majority of claims across all industry segments were accepted. Most of the ones that were denied were actually denied because they did not have a positive test. So, they submitted a claim and they went and they got their test and it was negative. The second reason that claims were denied, and this again goes across industry segments, was because they simply weren't able to document the exposure and that varies by state because some states as you know had a compensability presumption that made that be irrespective of that and some states it was such that you would actually have to prove where their exposure could have been. So, again, most of them were accepted. In terms of by industry segment, clearly the first responders were the ones that if you go back to the graph that I had those first ones were almost all in the first responder or the medical space. Beyond that of how the industry's going to respond to it, that kind of gets back to my point in terms of, what's next and insurance companies are not stakeholders. The injured workers are. And how this gets responded to we will just then work in accordance and act appropriately.

Sen. Hackett stated that he has the same question. We see so much on TV and everything but for the first responders especially the nurses in the hospital - how many are leaving the hospitals in droves? Because they're worked to such a level and the long term effects of that could be really disastrous. Mr. Zender stated that's a very real thing. Labor shortages are hitting everybody and it absolutely hit some of those areas first and as we all know that's where we can

tolerate it the least. Dr. Verduzco-Gutierrez stated that she treats a lot of nurses, a lot of first responders, and a lot of physicians and some of them are not able to go back to work.

CONSIDERATION OF RE-ADOPTION OF MODEL STATE STRUCTURED SETTLEMENT PROTECTION ACT

Sen. Hackett recognized Sen. Utke who stated that we in Minnesota are working on this and I had announced that back at our November meeting and the part we're working on is we took the current NCOIL language and we're patterning it off of what is already taken place in Georgia, Louisiana and Nevada and others that are currently working on it. I would like to bring back the language and offer it up for consideration at the July meeting to put it before the members and see what they would like to adopt. A couple of things that are in the new language affect the purchasers of these structured settlements and that includes a registration and the requirement for surety bonds. The whole idea is trying to get away from the fly by night operations and protect all ends of this but particularly the person or persons, what we would refer to as the payee, that would be receiving the money in making this agreement. So, that's part of it and then we've got a prohibitive practices and private right of action section, too. I would like to bring that back here in a few more months and present whether the group wants to adopt any or all of it.

Hearing no questions or comments, upon a Motion made by Sen. Jerry Klein (ND) and seconded by Rep. Oliverson, the Committee voted without objection by way of a voice vote to re-adopt the Model until the Committee's July meeting at which time amendments to the Model will be discussed.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Oliverson, the Committee adjourned at 12:30 p.m.