

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 17, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Sheraton New Orleans Hotel on Thursday, November 17, 2022 at 2:00 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)	Sen. Paul Utke (MN)
Asm. Ken Cooley (CA)	Sen. Paul Wieland (MO)
Rep. Brian Lohse (IA)	Sen. Jerry Klein (ND)
Rep. Joe Fischer (KY)	Rep. Kevin Hardee (SC)
Rep. Rachel Roberts (KY)	Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)	Sen. Scott DeLano (MS)
Rep. Tammy Nuccio (CT)	Sen. Joseph Thomas (MS)
Rep. Kerry Wood (CT)	Sen. Paul Lowe (NC)
Rep. Matthew Gambill (GA)	Sen. Shawn Vedaa (ND)
Rep. Carolyn Hugley (GA)	Sen. Bill Gannon (NH)
Rep. Rod Furniss (ID)	Rep. Brian Lampton (OH)
Rep. Rita Mayfield (IL)	Rep. Forrest Bennett (OK)
Rep. Cherlynn Stevenson (KY)	Sen. Roger Picard (RI)
Rep. John Illg (LA)	Rep. Carl Anderson (SC)
Sen. Robert Mills (LA)	Sen. Mike Azinger (WV)
Sen. Kirk Talbot (LA)	Sen. Eric Nelson (WV)
Rep. Kevin Coleman (MI)	
Sen. Kevin Blackwell (MS)	

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Manager, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, and seconded by Sen. Paul Utke (MN), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Joe Fischer (KY) and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 15, 2022 meeting in Jersey City, NJ.

PRESENTATION ON FENTANYL AND ITS IMPACT ON THE WORKERS' COMPENSATION MARKETPLACE

Phil Walls, RPh, Chief Clinical Officer at myMatrixx thanked the Committee for the opportunity to speak and stated that by way of introduction I have been a pharmacist for the past 45 years. While I was in school I started giving talks to church groups and other groups on drugs of abuse so that means I've been speaking on subjects like this for almost 50 years now which makes me feel really old. Back in the 1970s, one of the primary drugs that I was speaking on of course was heroin. That was when our veterans were returning from Vietnam and unfortunately a number of them had become addicted to heroin. Today what I want you to think about as I go through this presentation is that the primary cause of death today with a heroin overdose is fentanyl, not heroin. So keep that in mind as we go forward. I'll help explain how that's the case and we're going to talk about Fentanyl and the fact that this is a prescription medication unlike heroin which is an illegal substance and it's a schedule 1 controlled substance. Fentanyl is a legal prescription drug. It's schedule 2 and yet it has made this journey from being a legal prescription drug to an illegal street drug. So how did that happen? I'll give a little bit of background on that. I'm going to start off with some definitions in talking about opioids and opiates and drugs like fentanyl. I'll talk about an individual named George Marquardt which is a name you may or may not be familiar with. I'll also talk about a term that if you don't know today you will become familiar with - illicitly manufactured fentanyl (IMFs). We'll talk about potency of these drugs and overdoses and then discuss special considerations for first responders and this is when we'll really get into workers compensation.

Opioids is a broad term that basically applies to all of these painkillers that we're going to be talking about today. Specifically though opioids are the ones that came from the opium poppy. So these are a natural product. We hear all the time today that cannabis is a natural product. Well that's true of many drugs, morphine and codeine in particular. Both of these are derived directly from the poppy plant. In pharmaceutical science we take drugs that occur naturally and we alter them and usually that's to do one of two things - make them safer or make them more potent. And in the case of opioids when we convert an opioid into something that's now man-made, a semi-synthetic opioid, that is referred to as an opiate. This includes drugs like hydrocodone, which we see so often in workers compensation. Hydrocodone, oxycodone, even heroin. Heroin was created shortly after morphine was isolated from the poppy through a process known as a chelation. You're probably all familiar with vinegar and what vinegar smells like. Well that's acetic acid. So a chelation is basically creating these drugs with acidic acid. It changes them. In the case of morphine it created diacetyl morphine or diamorph which was the brand name and became heroin. Heroin was a drug created by a company known as Bayer. Bayer is of course still around today. At the time they did this they were not Bayer Pharmaceuticals. They were the Bayer Carpet Dyeing Company. To make carpet dyes more vibrant they would use this chelation process. Well, one year there was a shortage of raw materials to produce carpet, so they had to look for something else to do and they tried this process of morphine and produced heroin. Shortly after they produced aspirin. So it's the same Bayer pharmaceutical company we know today.

And then we have synthetic opioids which is unique in that with these opioids, we do not have to start with the opium poppy. So that means that they're a lot easier to produce. The most common ones that we know of are methadone and fentanyl. So where did fentanyl come from?

It's an extremely potent drug. Morphine is quite strong and all the other derivatives are quite strong. So why did we need this drug known as fentanyl? Well a doctor, a Belgian physician, first synthesized fentanyl in 1960 and what he found in producing this drug was that it had all of the good benefits of the opioids and then it had two unique factors. One is that it's extremely rapid acting and has a short duration of action. So for anesthesia these are very good qualities. You know you want to give the patient something that is going to put them under for a short period of time and then wear off quickly so you don't have that delayed recovery period. So from that perspective fentanyl was a very good drug. It also has fewer side effects than the other opioids, a lot less nausea and vomiting for most patients. So, his intention was to create a drug that was going to be an improvement over the existing opioid and he did that. Then the drug found further use when they created duragesic patches. So they took a drug that was extremely rapid acting and short-acting and turned it into a long-acting version. Why did they do that? Well, they wanted to go for those characteristics that produce less nausea and vomiting. So the fewer side effects. By putting it on a patch that is slowly released they were able to create an opiate that had these characteristics and yet would stay in a person's system for a long period of time.

Now a couple comments about the duragesic patch. It's effective for 72 hours. At the end of 72 hours there is still a significant amount of fentanyl left in that patch, enough to kill a child or pet. So with disposal of these patches, people have to be very careful and they have to be instructed. One, the sticky sides should be folded together and then it should be placed in something where it's not going to be retrievable. Throwing it out in the garbage is not a good idea. The U.S. Food and Drug Administration (FDA) years ago told communities to quit flushing drugs down the toilet because we were starting to see significant quantities of drugs in public water supplies and that's not a good thing. Then they sort of had to backpedal and they came back and they said, "okay there's some drugs that are so dangerous that actually we want you to flush them down the toilet." The opioids, all of them including fentanyl, made that list. They are so dangerous they have to be gotten rid of and they have to be gotten rid of in a way that no one can find them. So then pharmaceutical companies as they always do continue to find new uses for an old drug and that's when in the early 2000s they came out with something known as the actiq lollipop. It was a fentanyl lollipop. Now why on Earth would we put something as potent as fentanyl in a lollipop? Well it was designed again for a good purpose. Most drugs are designed for good purposes. It's just that then their use is changed and used in ways that it shouldn't be. With fentanyl the idea here was end of life cancer patients. They know they have a short time to live. They do not want to be in hospice. They do not want to be in the hospital. They want to be at home and yet most caregivers are not trained in how to take care of these patients especially when it comes to injecting something like morphine.

So the idea with fentanyl is that the fastest way to get a drug into the human body other than an injection is absorption through the oral mucosa. So by the patient sucking on a lollipop the fentanyl would go to work very quickly and so it made sense to do it this way but only for that use. Unfortunately we saw the actiq lollipop in workers compensation. It was never intended for low back pain. It was an off-label use of a drug that was not a good off-label use. So being purely synthetic, what that means is that this drug can be made by one person in a lab or in their parents basement. If any of you ever watched the series Breaking Bad, it's about production of methamphetamine. Apply that same thought to fentanyl. It is just that easy. A young man named George Marquardt was a high school dropout and self-described genius that did this. He went into his parents basement and started producing fentanyl. Now, the implications of this may not seem that striking but heroin is hard to produce. There's a huge market for it. So in the black market there's a lot of money that is made on the sale in the transport of heroin but you have to have the opium poppy in order to produce heroin. Fentanyl being entirely synthetic does

not have that restriction. It is very easy to reproduce. So if we stop thinking for a moment about the dangers of this drug and we stop thinking about the illegality of this black market and think as business people which one would you want to start with? The heroin and the opium poppy or a few chemicals that can be obtained fairly easily? Well George's idea was well if I can produce this I can take over the opioid market and that's exactly what he did. He ended up serving time and there were a number of deaths that were tied directly to him.

I think the number of deaths today tied to fentanyl is almost uncountable. It's tragic. But because it's so easy to produce and I started off saying that the majority of heroin overdoses are caused by fentanyl because fentanyl is replacing heroin on the streets. It is so much easier to produce. Now, a lot of it is coming in from China and a lot of it is coming in from overseas but a lot of it is also produced in this country. Now in just a little while I'm going to show you a map on how this is affecting first responders. You're going to see a predominance on the East Coast. This is because within the U.S. the type of heroin that is always been on the east coast is very different from the type of heroin that is in the western part of the U.S. The Western half U.S. deals with what is referred to as black tar heroin and it's exactly that. It is a black tarry substance. The heroin on the east coast is pure; it's a white powder. It's a lot easier to substitute fentanyl, which is also a white powder, for heroin on the East Coast than it is the West Coast. So that's why there's been this shift. Unfortunately though it is spreading throughout the U.S. so it's no longer restricted to the east coast. And now regarding IMFs, there are 42 IMF analogues on the market. So what's an analog? It's just a slight variation in that original structure to make it a little bit different. The one that you might read about right now from The Centers for Disease Control and Prevention (CDC) is known as para-fluorofentanyl. It's not better, it's not stronger, it's just different. It has already been identified by the Drug Enforcement Administration (DEA) and made a schedule I controlled substance. The problem with IMF's and many chemicals like this is these black market chemists are able to come up with things before the DEA can actually declare them illegal because they don't know they exist yet so that's a challenge in and of itself.

Fentanyl itself is 50 times more potent than heroin and 100 times more potent than morphine. There's actually another legal form of fentanyl on the market known as a carfentanil and it's a schedule 2 controlled substance known as an elephant tranquilizer because that's its primary use in veterinary medicine. It is 100 times more potent than fentanyl. Now if I'm doing the math correctly that means 10,000 times more potent than morphine. When carfentanil hit the streets overdose deaths rose dramatically because of this potency. It almost cannot be cut enough to get it down to a safe level to use in place of heroin so that's a challenge. With overdose deaths related to opioids, with most of my talks when I talk to a workers compensation market I'm talking about prescription opioids and it's been frustrating over the last few years because we've actually seen a significant decline in the use of prescription opioids. But we're seeing an increase in opioid overdose deaths. That's because of the increase of the use of illicit opioids. I don't know this for a fact so I'm going to go out on a limb here - we went through a period of time in not just workers' compensation but in this country where many people were receiving opioids inappropriately. We know that many of those patients became addicted to those prescription opioids. Then we launched some very good campaigns to educate prescribers, pharmacists, nurses, and everyone involved in the care of patients that we should use fewer opioids. And we've done that but we did it without thinking about the people that were already addicted to prescription opioids. So sadly in my opinion a lot of people that were addicted to prescription opioids turned to street opioids when their supply was cut off and the result we're seeing is a significant number of people are dying from opioid overdoses. 2013 is where we started to see the switch from heroin to the synthetic opioids, primarily fentanyl. It's still a problem today.

Let's now talk just for a moment about signs and symptoms of an overdose. The person's going to be unresponsive. Their lips and their nails are going to appear blue because they can't breathe. With a situation like this, first thing to do is call 911. If you have access to naloxone, administer it. Do not worry about whether or not you know for sure that this person has an opioid overdose because naloxone brand name Narcan all it does is block the effect of opioids. In many ways it's tragic that it's a prescription-only drug in most states because prescription drugs are made prescription only because of safety concerns. Well naloxone if it's administered to someone who is not in an opioid overdose basically it's not going to do anything so there's no concern over the safety for these individuals. Actually, there's more concern over safety if the person is indeed in an opioid overdose. Why? Because when you give them naloxone it immediately blocks all their opioid receptors and basically takes them out of an opioid overdose and puts them right into opioid withdrawal. They come out of it almost immediately for most opioids, not fentanyl. And when they come out of this overdose many times they're combative. These patients have been known to actually hurt the person that saved your life because they come out and they're agitated and fighting. They have gone straight into withdrawal which is not a good situation. So that's why I'm saying first thing anyone should do is call 911 even if you have naloxone and you can save their life you still need that support as soon as you administer that naloxone.

Now with first responders, when are they going to possibly encounter fentanyl? Well pretty much anytime. It could be a traffic stop or an overdose call - pretty much anything that a first responder is called to do. How can they be exposed to it – it could be skin contact, inhalation, ingestion, contact with mucous membrane such as the eyes, nose etc. Or it could be an accidental needle-stick. There has been a significant debate about skin contact and whether or not fentanyl can actually be absorbed through the skin. Forget the debate, it doesn't matter. First responders are being exposed to fentanyl and if they're exposed to enough of it, it can kill them. Whether it's absorbed through the skin, that debate can go on for years and quite frankly I don't care. More than likely what's happening is maybe they were exposed to their skin but if there's enough of it that they're exposed in that way they probably also inhaled some of it and it is so potent that's all it takes. There was a very famous case a few years back about an officer who brushed off a white powder on a colleague's jacket and he went into an overdose situation because of that. That's where most of this debate started. I think by brushing it that was all it took - a few of those particles from the powder went into the air and he inhaled it more than likely. When this occurs they're going to need access to naloxone. Most states have taken really good steps towards making naloxone more readily available. Before I retire if I had one wish it would be let's make naloxone over the counter. It's a safe drug. Remember what I said, if you give it to someone that's not in an opioid overdose it's not going to really do anything. Is there a chance of an allergic reaction? Yes, there's a chance of an allergic reaction to any drug on the market whether it's over the counter or prescription so I don't think that's a reason not to make it over the counter. We need more available access. An argument I hear about that is, "well if people have access to the naloxone it might cause risky behavior when it comes to opioids." We already have risky behavior when it comes to opioids. Making naloxone more available I don't think in my opinion is going to necessarily lead to more risky behavior than what we're already seeing. Now, this is a map that's a few years old and in 2015 it shows the incidence of fentanyl encounters and as I said you can see a predominance more towards the eastern part of the country but over time that is changing unfortunately.

In addition to access to naloxone our first responders also need access to personal protective equipment (PPE) such as masks and gloves and things of this nature. So any municipality should be providing this to anyone that's involved. There are kits on the market that a first responder can use to test a substance to see if it's fentanyl or not. Don't spend your money on

these kits. Train our first responders that if there is a substance of an unknown origin assume that it's fentanyl. Just taking the time to test it is going to expose these first responders to the possibility of fentanyl so don't go through that process and assume it's fentanyl until we can find out later once it's sent off to a lab. Start with PPE. If someone is exposed to it make sure they have access to naloxone. With naloxone the overdose is heroin and morphine - the prescription opioids that we're familiar with. A shot of naloxone or even a nasal spray is going to bring that person out of an overdose. Fentanyl and the IMF analogues are so potent that it's probably going to take repeat injections of naloxone in order to bring them out of an overdose so having one kit available or one vial may not be enough. They need to have access to quite a few because fentanyl is just that potent and powerful. After the incident that our first responder has gone to, anything that's potentially exposed needs to be handled very carefully and needs to be marked as fentanyl contaminated or possibly fentanyl contaminated until we know otherwise. It's vital that nobody else gets exposed through that. I've got some more resources here but if you just Google fentanyl you're going to find a lot of information on it. A few sites do better jobs than others. The CDC in particular has a lot of very good information on fentanyl and naloxone and opioids in general so I would encourage you to start with that.

The Hon. Tom Considine, NCOIL CEO, thanked Mr. Walls for his presentation and stated that it was great. With the testing I totally understand the rationale on the first responders, but I watched something that was advocating the testing oddly enough for use at parties so that if kids are thinking they're going to use ecstasy they should use the testing on ecstasy to make sure it's not laced with fentanyl. Do you have any views on that? Mr. Walls stated that is a very good point and my thoughts today were to focus on workers compensation which sort of led me to the first responders but you're absolutely right. Fentanyl is so cheap and easy to produce that it is showing up in all sorts of different things such as recreational drugs and even in things that you would not even think would be related to a drug so in those instances absolutely you're right to test just to know.

Rep. Rita Mayfield (IL) stated that my state has had a large increase in opioid overdoses - is there legislation that we could work on that can reduce access to fentanyl or carfentanil or to any of the other ingredients that are going into these items that they're trying to cut as heroin? Mr. Walls stated that is a good question. Fentanyl is unique in that we're not seeing prescription drug diversion the way that we saw with Oxycontin and some of the others because we're not taking prescription drugs and putting those on the street. We have a chemist and to use that comparison again to Breaking Bad it is just like that TV series where an individual once they can get the chemicals can produce fentanyl through a fairly easy process. I'm not sure if there should be restriction to the purchase of chemicals. I'm a pharmacist and certainly not an attorney and I don't know what type of restrictions exist today. I'm sure there would be barriers because many of these chemicals are used for many different processes so by trying to ratchet down on them to keep them from being turned into fentanyl we're probably going to upset some other industries that are using them for a perfectly legal reason so I don't know about that. The biggest thing is that the DEA has a tough job and they also have an excellent website. Their job is almost insurmountable so anything that we can do in my opinion to fund them and give them more access to resources the better.

Rep. Ferguson stated that I just want to make sure I understand clearly - you're saying rather than turn your opioid prescriptions into the sheriff's department or take them to the Walmart disposal Rx system, you're saying to put them down the toilet instead? Mr. Walls stated that I'm glad you brought that up. The DEA has created something known as the DEA take-back day. You mentioned Walmart's program and a number of different pharmacies participate in that. Until the DEA did that it was actually illegal for a pharmacist to take back a controlled substance.

We legally cannot do that because there's no paper trail there. When the DEA created the take-back day that is the best and safest disposal method. I'm so glad you brought that up. Short of that if it's not possible, the FDA says okay if there's no alternative then flush it down the toilet.

Sen. William Gannon (NH) stated that my state of New Hampshire is one of the most afflicted with opioid problems and it has been for the last five or six years. Is the production predominantly coming from out of the country or is that anecdotal that I hear? Mr. Walls stated that the last time I looked, China was the primary source. Now that has changed. There was a period of time where China did not even treat fentanyl as a controlled substance the way that we do in the U.S. That may have changed but I would be surprised if they're not still a predominant supplier.

DISCUSSION ON LOUISIANA WORKERS' COMPENSATION SYSTEM

Kristin Wall, President & CEO of the Louisiana Workers' Compensation Corporation (LWCC), thanked the Committee for the opportunity to speak and stated that I'm really honored to be here again as I spoke to this Committee in 2017 when NCOIL was last in New Orleans. I don't do a lot of speaking to groups but I really enjoyed it and I also really appreciate and understand what all of you do. You are setting the policies for your state. We are following all of the policies that you set. Workers compensation is done differently in every single state so the chances we get to learn from one another are importance because great things are being done in every state and there's some things that we should be learning from one another. If you think back to workers comp, it came about in the early 1920s with the Industrial Revolution and people started creating these workers comp funds and that was kind of the first generation that came about and they really were trying to support the competitive economy because back then if workers got hurt they sort of moved on to the next one and that's not right. State funds came in and they said we we've got to do something and we must make workplaces safer. I was listening to Phil talk and I was thinking about how that's changed just over the 30 years that I've been doing this - now safe workplaces involve things like what are first responders being exposed to.

We underwrite a lot of municipalities and fire district's with first responders of all kind so with safety now and what we're supposed to do now, we do that in addition to falls from heights, slips and falls and things of that nature. So it really has evolved. We strive to provide fair access to insurance as the worst case is when you can't get insurance and there's nobody to take care of an injured worker. Taking care of injured workers is why we're all here. We operate on a self sufficient basis and we have a relentless focus on the injured worker and I have seen that in all the state funds. I'm a big part of the national organization that we have and that's what we all have in common is that we understand that's the most important thing that we do. And again, that's evolved as we have people now who are addicted to opioids. Simply cutting them off might not be the right thing to do. We have to make sure we do those types of things very carefully or else we might actually be causing greater harm. Some common features of state funds are that they are self-supporting and pay dividends. Some people are paying dividends across the country. Some are organized like mutual insurance companies. Some are more state agency driven subject to regulatory requirements and then operate in both residual and competitive markets. I will tell you that there was a big crisis in the 1980s and 1990s and it hit a lot of states. I can give you some particular insights into Louisiana, and Maine was also really in crisis. There was this instability crisis where the states that had state funds tended to weather it better because they had this mechanism of they were providing this insurance and were very focused on safety and injured workers. But a lot of states had what we call assigned risk pools and I'm sure a lot of you have been around long enough to know about that. We had them in Louisiana and it really wasn't working very well. That's when all the other insurance companies across the

country sort of put in money to find out how it's going to run and how insurance is going to be delivered. It kind of comes down to no one is really accountable and that's what happened. Rates were increasing all across the country. Coverage was becoming unaffordable. And then there was this new self-insured market that started popping up in the 1990s and the economy really did suffer.

John Leonard, former president of the Maine Employers' Mutual Insurance Company (MEMIC) said, "if you've seen one state fund you've seen one state fund" meaning that we're all different. But we do have a variety of characteristics. We're created by our legislators. Many of us operate as the insurer of last resort. Insurance companies in general terms don't want to provide insurance to a business that pays them say less than \$1,000 or \$2,000 or \$3,000. It's a commercial product and you have to deliver it as a commercial product but it comes at a steep price. So in general there's not always an available market for the smaller ones and then also there's not always an available market for those who have very high hazards. Some of the state funds are writing the line of other states. Some have subsidiaries. A few are monopolistic. I know some of you are from monopolistic areas as well. In 1991 in Louisiana 1991, the state of play was that rates had increased by over 260%. That's a lot. Employers were leaving the state because workers compensation was becoming one of their largest budget items. So you can create an economy where if you don't design it right, it's not attractive to stay. Ninety percent of our employers were in the assigned risk pool back then and most insurers began leaving to avoid all of these heavy assessments. So we really were left in a crisis. We didn't have carriers in to operate. So the LWCC was created. Most people thought it was the dumbest thing ever to create this company with absolutely no money and most people thought it was going to fail but it was there to provide workers comp to Louisiana's employers who began issuing the policies in 1992. I was there, I remember it. And we were set up happily by our legislature. They did a really great job. As a private company, a domestic company, and a non-profit mutual insurance company they put all of the right fundamental pieces in place. We're not a state agency. Our trade-off if you will is we write all business good, bad, and small - we write everything. But we get to price it. We get to have the freedom of rate. Rates have to be actuarially sound and there's an awful lot that goes into that.

So with LWCC and kind of looking back over the eras that we had I mentioned that people didn't think we would survive but we did. And then as we sort of began to come out of those survival years we said we really need to learn how to do this well if we want to keep doing this so we were really in striving mode and focusing on getting better and better and really understanding the intent behind the legislation. Then we came and we moved into our thriving years. Things were good and things were getting better and more recently we realized that we really need to have pride - pride in our state, pride in the associations that we have with one another, and pride in our systems. And so we've been very much involved in that as well. If you look at LWCC we say we're a specialist, meaning that this is all we do. We only write workers comp. We're a private mutual as I mentioned. We've now been recognized for 17 years a Ward 50 company. There are about 3,000 property and casualty companies across the country and we make it into the top 50 every year. We have an AM Best rating of A which we're very proud of and we operate this competitive and residual market of state and federal risk. So there was market collapse but there's no longer a market collapse. We really like competitors in our state. We want a healthy state environment and I'll show you in a minute kind of how that all worked out because the carriers had all left and instead of having those rates going up by 260%, the rates have come down by 60% so we charged 60% less for the business than when we started.

I work with an incredible group of teammates and we are very purpose driven about everything we do. We are, we say, a model workers comp provider and the champion of Louisiana. What

do I mean by that? We are dedicated solely to Louisiana - Louisiana employers, Louisiana workers and most of the people who treat our employees are Louisiana physicians. So it really does create an ability to get to know the environment that you're in. I mentioned the rate decrease and we've also been able to give back some of the premium our 20,000 policyholders have given us. In fact in current standing we've given back over \$1 billion dollars. So that money when you have excess profit if you will, you can look at that and you can release that back to the people who gave it to you in the first place so we're very proud of that as that goes back to those Louisiana businesses and gets reinvested back into Louisiana's economy. We have paid over \$2.6 billion to injured workers. I noticed that I say injured workers. We don't say claimants. That's not okay in our business because you want to treat them like you want to treat your other family members. And we also invest in Louisiana so we've got invested \$518 million in mortgage securities and that helps support the Louisiana housing market and we've overseen the treatment of return to work for over 34,000 employees and serviced 186,000 work-related injuries.

So here do we have a good market? I would say we absolutely have a good market. This is a three-year snapshot on the slide and as you can see it's a really great healthy competitive market. We work hard at being competitive as well so there's nobody that takes an easy at bat or a bunt or anything like that. I know some of you are from different states and I don't know if you can read these states down at the bottom of the slide but it goes from Pennsylvania over to Washington to the far right and then the dark green is Louisiana and LWCC. But what you have here is sort of a rating of funds. I mentioned AM Best and they rate your funds. An A is the highest rating that you can get for a single state, single line carrier. Some of the funds in this group aren't trying to be rated and they're very different. If you look over to the far right, Ohio, North Dakota, and Washington are monopolistic state funds. That's not a competitive environment. That state fund takes care of everyone and they have 100% of the market accordingly. So you can see the ratings but you can also see the percent of the market that each of your state funds has. So you'll see Maine over here at close to 70% so they write a big portion of the market. LWCC is 30% of the market and we try to balance that out as we don't want to get too big but we need to be big enough to have critical mass and to do a good job and to do all the things that we need to do. I'll note again that we're a purpose driven business. Insurance is primarily a purpose driven industry and workers comp is I believe the biggest purpose because we're taking care of people and our mission is to elevate Louisiana and celebrate it. So we've got a movement called Louisiana Loyal which if you're in Louisiana hopefully you'll be seeing and hearing more about that. I'm not going to play the video here but there's a lot of activities that are going on to support that. And finally, here's our destination statement - we showed you where we've been and where we are but where are we going? And if you were to take a look at that statement you can see that we're very proud to partner with all of our agents and we're about giving compassionate care to workers and we want to make sure we are giving unique benefits to our policyholders in the form of dividends and safety. But ultimately we want Louisiana to be a great place to live and work and we're doing our part and we're going to work hard at that and we are going to keep growing incrementally, but carefully. The statement ends by noting "as a result of our efforts, Louisiana citizens' lives will be improved, the state economy will be elevated, our state payroll share will return to 10%, and our state market share will return to 32% by 2027, while maintaining profitability."

Angela McGhee, SVP of Underwriting & Chief Actuary at LWCC thanked the Committee for the opportunity to speak and stated I've been in the industry for about 25 years so I have a little bit of experience pricing. I'm going to take you back just a little bit too just covering some basics of workers compensation and what it covers. It's designed to provide benefits to workers who were injured on the job. Sometimes those injuries are clearly tied to the work that a person is doing.

For example if somebody falls off a ladder while they're working on a roof that was obviously in the course and scope of their job and would naturally be considered a worker's compensation claim and that would be covered under the traumatic injury portion of workers compensation. But workers comp also has an occupational disease component and the one that you might be most familiar with is asbestos. Before we realized that asbestos was as harmful as it is this was a disease that some workers contracted while they were working with it. That would be covered under the occupational disease portion of workers compensation. But there's some requirements for it to qualify - it has to be due to causes and conditions that are characteristic and peculiar to the workers trade and it also has to result from those conditions present in the employment and not from other conditions to which the employee might be exposed. So you might think about for example the flu - if someone is working in a doctor's office and a patient comes in and they have the flu they might get the flu from that person but we're all exposed to it and it's everywhere we go so it's not really peculiar to that person's trade because they're exposed to it elsewhere, not just in their occupational work.

So how are presumptions different from workers compensation? There are about 30 states, maybe a little more that have presumptions for workers compensation for certain occupations. So what the presumption does is take the burden of proof out of the employee's hands and it puts it on the employer or the insurance company's hand to deny the claim. So for an injury to qualify for occupational disease the employee has to prove that disease was caused by the exposure. The presumption takes that completely out of the picture and that disease is assumed to be caused by the work that the employee was doing. For occupational disease disability is generally required meaning that they can't work. So for a presumption disability might be required or like in Louisiana disability is not required. Occupational disease is generally applicable to all employees who are covered under the workers compensation act. Presumptions are generally only applicable to employees who are in a certain occupation. And occupational disease has this characteristic of and peculiar to the trade that we talked about. A presumption has none of that. It doesn't have to have any kind of direct cause tied to their occupation. So what's the problem with that? Well workers comp is based on causation - the whole point of workers comp is to tie it back to what they were doing in the workplace. So the presumption actually contradicts the whole basis of workers comp because it's assuming that it was tied to their work. So generally what happens with the presumption is it takes benefits or injuries that would have been treated under their general health care and it shifts over to workers compensation.

So, what's wrong with that? Well, Ms. Wall mentioned workers comp rates have to be actuarially sound. So what that means is that you can't have any kind of subsidization across different types of occupations. So every occupation has a certain rate in each of your states including Louisiana and those rates have to be actuarially sound which means it has to be tied back to the expected cost for that particular occupation. So, we can't subsidize across industries so as businesses increase benefits or employees are eligible for higher benefits they end up with higher rates because it costs more. So the types of presumptions vary a little bit as well as the groups that are eligible for presumptions but they're generally applicable to first responders. That's the most common area where we see presumption, in particular for firefighters. They may cover a variety of diseases but cancer and heart and lung disease are probably the most common but we also see things like post traumatic stress disorder (PTSD) and even COVID-19. In Louisiana just like work comp has evolved, the presumptions for firefighters have evolved significantly since work comp started. Back in 1914 when work comp was created, cancer was covered under occupational disease. So that would have been for anybody including firefighters. Ultimately in 1968 Louisiana opted to create a heart and lung presumption so any heart attack or lung issue that a firefighter had would be presumed to have been caused in the workplace and

therefore treated under workers compensation rather than general health care. Cancer was later added but the cancer had to be disabling so the worker had to be unable to work to qualify for the presumption and it was limited to only a handful of different types of cancers that had been shown through research to be significantly tied to firefighter exposures and it was applicable during the time the employee was working in the fire service and up to five years post leaving the service. About nine years later more cancers were added to the presumption. In 2006 a new presumption came in where hearing loss was covered.

In 2017 we had a significant change - the disabling requirement was removed and essentially every type of cancer was incorporated into the presumption including things like prostate cancer that are generally more common in retired men of that age where the presumption applies post leaving the service. But the disabling piece was actually the more significant part because now things like skin cancer including things that you might just go into the dermatologist and have it removed, that's all work comp now. In 2019, PTSD benefits were added. In 2020, indemnity benefits for hearing loss claims were added and then in 2022 we actually just went through some significant legislation where although LWCC was able to help educate some of the stakeholders as this bill was being written and passed, the cancer presumption was increased from five years after the firefighter leaves the service up to ten years. So as long as they have ten years of work with the service they're covered during the time they're working and ten years after they leave. One of the significant changes besides the offset of the additional costs that are obviously going to be incurred as a result of more cancer claims being pulled into the work comp system is there was a reduction in the medical costs. Louisiana has a very old medical fee schedule. Many of you are from states where your work comp fee schedule is likely tied to Medicare. A lot of states may say okay all my work comp cost will be a 150% or 200% of the Medicare schedule.

In Louisiana our med fee schedule is actually 90% of whatever the provider charges for outpatient. So for all outpatient claims I know you've all seen your explanation of benefits (EOB) from your insurance company and you see the very high number and then you see the reduction for the insurance negotiated costs. Whatever that number is, we pay 90% of that in Louisiana so the medical costs in Louisiana are very significant and they average about double what general health care pays. So it's huge when you add benefits like this to work comp. There has to be an offset and that's what was done here and so they opted to charge for any medical cost we would now pay 150% of Medicare. So that offset some of those additional claims costs that are coming into the system. So these cancer presumptions, just like state funds, if you've seen one you've seen one. These cancer presumptions are very different across states. I'm going to walk through some of the different characteristics. On the left in the light green is the less generous provision in the presumption and on the right is the more generous meaning they get more generous benefits. So, this starts from just having a presumption. There's actually about 10 states where there is a presumption for cancer in firefighters but it's actually removed from work comp and covered under some kind of different provision so they have a special policy or provision that provides benefits for those.

In Louisiana we started as being an occupational disease and we are now obviously presumed to be covered under work comp or caused by the workplace. In some states there's also a service eligibility requirement so the firefighter may have to work a certain amount of time before they would be covered under the presumption. Some states actually have no minimum and they're covered day one by the presumption. In Louisiana we're on the ten year side so they have to work ten years to be eligible for the presumption. There's a presumption application period. There are a handful of states that only provide that presumption while the firefighter is employed meaning once they leave the service the presumption no longer applies and there's actually one state that provides this presumption for life. In Louisiana we started at up to five

years post leaving the service and we're now ten years post leaving the service. It also varies depending on the type of cancer. Some states have the low end of four different cancers that are covered all the way up to all types of cancers. Louisiana has obviously been moved all the way up to the all types of cancers now. There is an ability to rebut - in Louisiana, if the firefighter has cancer there is really no way for the employer or the insurance company to rebut or argue against that to deny the claim. Some states have the ability to do this through tobacco use. If the firefighter used tobacco or there's some kind of family history the employer may be able to rebut that claim. And then there is the disability requirement that we talked about - Louisiana started as being unable to work and we now have no disability requirement. There are also a handful of states where there's really only coverage if the firefighter passes away from the cancer.

Sen. Hackett stated that in Ohio we don't cover mental health unless there's an accident - is that how you do it here in Louisiana? Ms. McGhee stated that it depends on the state and in Louisiana it's like PTSD. In Louisiana for firefighters we have a PTSD presumption which would mean if they're on the scene of an accident and they suffer from some kind of mental issue afterwards then that would be covered automatically for first responders. Sen. Hackett asked if Louisiana separates PTSD from any other mental health condition that they think was brought on by that? In Ohio you have to have an injury first. Ms. McGhee stated that here it's presumed. So, for firefighters it's presumed to have been caused by that accident. If it was another occupation then I think you would have to tie it back to that particular incident in order for them to have some kind of coverage for that. Sen. Hackett then stated that we just passed in Ohio the cancer exemption but we did put in for people who are smokers a ten year exclusion that they had to have quit smoking for the last ten years before we pay on lung cancer - how does Louisiana handle that? Ms. McGhee stated that there's none of that here. Even if they're smoking they are eligible. It doesn't matter what the firefighter has done during their employment or pre-employment - it's covered here.

DISCUSSION ON WORKERS' COMPENSATION LEGISLATIVE AND REGULATORY TRENDS

Tim Tucker, Washington Affairs Executive, External and Government Affairs at the National Council on Compensation Insurance (NCCI) thanked the Committee for the opportunity to speak and stated that I'm going to go through some of these issues that you've all been working on in the states in somewhat of a rapid-fire fashion in the interest of time. The good news is that all the things I'm going to go through are available at ncci.com through the numerous resources we have. This year has been somewhat typical in the volume of legislation and regulations you all have been working on in your respective states. We've seen about 800 bills be considered countrywide and 450 in NCCI states. About 100 of those were actually enacted and of course a 120 of those dealt with COVID-19 and workers compensation. Briefly I'll touch upon COVID-19 and work comp, mental injuries, marijuana legalization, single payer health insurance initiatives and their impact on workers compensation, and worker classification. With the onset of the pandemic back in 2020 we saw states take various approaches to the presumptions similar to that which we've seen for firefighters and other first responders previously for COVID-19. In this past year several states have extended the deadline for those presumptions and extended them into the future. Others have expanded the presumptions. Initially in some states they were solely for first responders. They've been expanded in some cases to other occupations as well. There's been some activity around that. And of course new presumptions have been considered. Some states who did not act at the onset of the pandemic have looked back and some have actually retroactively enacted legislation to cover injuries caused by exposure to the COVID-19 virus.

We talked a little bit about infectious diseases. Some states have taken a very broad approach and actually have gone and amended the occupational disease provisions of their workers compensation acts to include various infectious diseases as compensable under their state workers compensation statutes. Something new this year and not surprising is that states are taking a look at the impact of the COVID-19 vaccines and potential compensable scenarios for workers. Several bills were introduced that established presumptions for adverse impacts to the vaccination. There've been a number of bills that specify the injuries from the vaccine are compensable under work comp laws. And two states actually enacted legislation that creates a private right of action against the employer if they mandate vaccinations for their workforce. Regarding mental injuries, we've seen an uptick in this area as far as legislative and regulatory proposals. Out of 60 bills, 45 relate to PTSD. A handful of states have actually enacted those proposals. Regarding state activity related to marijuana legalization, as you all know the impacts of marijuana legalization reaches a lot of different areas including the workplace. Some states this year such as Rhode Island enacted legislation that approved the use of recreational marijuana for recreational purposes. Two states last week by ballot initiative, Maryland and Missouri, made marijuana legal for recreational purposes. And then of course the issue that some state courts have been grappling with is the reimbursement for medical marijuana in workers compensation.

I think that's a trend we'll see more of as courts are working through that now both at the state and federal levels. There is certainly more to come here as the state's comparatively on the marijuana reform issue are far ahead of the federal government. For years there's been different proposals to legalize or otherwise address the treatment of marijuana under federal law. The real tension in Congress now is the scope of those reforms. It is one of those odd bipartisan bicameral issues that enjoys support. The devil happens to be in the details of whether to go with a comprehensive approach such as a Cannabis Administration and Opportunity Act that was put forward earlier this year which has a host of provisions from expungement of criminal records to the creation of a regulatory framework, to a taxation mechanism. Just this week the House Oversight Committee had a hearing on marijuana reform at the federal level. There does appear to be some bipartisan support for doing something, perhaps even in the upcoming lame-duck. The principles that were laid out in a joint memo released over the weekend by both the House Republicans and Democrats put a framework together that addresses those issues I just mentioned - expungement, taxation and a regulatory framework. There is a chance there could be a narrow reform such as a Safe And Fair Enforcement banking act that creates the safe harbor for banks and insurers and others who are working with legitimate cannabis-related enterprises. I mentioned the hearing this week so we'll see if there's enough time and momentum to get something across the finish line before the 118th Congress comes in in January.

I'll be very brief on single-payer. Obviously states have looked at this in varying degrees for decades now. The one stumbling point that always seems to come up is how to treat workers compensation medical costs and whatnot. States generally have kicked the can down the road and created a board or a commission within the proposed framework to deal with workers compensation so it really does present a challenge when you're looking at these universal single-payer systems. I will also note that for a number of years Medicare-For-All has been introduced in Congress which would create a single-payer universal plan and the provision within the Act does require workers compensation carriers to reimburse the Medicare For All program for services rendered to injured workers. So, that is something that needs to be considered when policymakers are looking at moving towards a single-payer healthcare system. And then of course worker classification continues to be a significant issue and states have taken various approaches. I know several states have carved out transportation network companies or other

gig type employments and treated them different than other independent contractors. And some states have created a framework that would provide certain benefits and services to those gig workers. At the federal level the Biden Administration has proposed regulations that would really create a more stringent framework for the classification of workers making it more difficult to classify workers as independent contractors. That is open for comment now. It really looks a lot like Assembly Bill 5 in California from a number of years ago which created a framework for employee classification. So we'll see what happens. I expect that there will be legal challenges to the Biden Administration's independent contractor rule.

One thing I wanted to follow-up from our July meeting where we presented to you – my colleague indicated at that time we were just beginning our annual rate filing season. We are about three-quarters of the way through that. You can look to see how your state compares to others. I will tell you with the exception of Hawaii, in all NCCI jurisdictions we have filed rate decreases so far this year. So we have about 32 of 38 states filed and those with the exception of Hawaii indicate decreases. I also want to put a few things on your radar for the upcoming year. NCCI will continue to examine the impact of COVID-19 both in terms of the impact of long-COVID as well as the existing trend of claims. Earlier this week NCCI and some of its partners released a report on the claims activity around COVID-19. A couple of numbers that stand out - there's been \$1.1 billion in COVID claims paid to date. That represents a 117,000 claims with an average claim of just below \$10,000. So you can see that there's been quite a bit of activity around COVID-19 claims that has impacted the industry. Another thing to keep an eye on is obviously trends in claim frequency and severity. While we've seen some severity tick up a little bit it largely has been offset by the continued decade or more long trend down in frequency. And then lastly and not surprisingly something that we've always kept our finger on is the impact of medical costs and workers compensation both in terms of course inflation but also utilization. So those are some things that I think we'll be looking at and determining how they impact workers compensation going forward.

ADJOURNMENT

Hearing no further business, upon a motion made by Del. Steve Westfall (WV) and seconded by Sen. Kelin, the Committee adjourned at 3:15 p.m.