NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 21, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Friday, July 21, 2023 at 9:00 AM.

Senator Bob Hackett (OH), Chair of the Committee, presided.

Other members of the Committee present:

Rep. Brian Lohse (IA)
Rep. Jonathan Carroll (IL)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Rep. Nelly Nicol (MT)
Rep. Mark Tedford (OK)

Other legislators present were:

Asm. Tim Grayson (CA)
Rep. Dafna Michaelson Jenet (CO)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Cara Pavalock-D'Amato (CT)
Rep. Kerry Wood (CT)
Rep. Rod Furniss (ID)
Rep. Camille Lilly (IL)
Sen. Michael Fagg (KS)
Sen. Beverly Gossage (KS)
Sen. Julie Racque Adams (KY)
Sen. Pamela Beidle (MD)
Sen. Arthur Ellis (MD)
Del. Mike Rogers (MD)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Gary Dahms (MN)
Rep. Liz Reyer (MN)
Sen. Pam Helming (NY)
Rep. Tim Barhorst (OH)
Sen. George Lang (OH)
Rep. Bob Peterson (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Del. John Paul Hott (WV)
Del. Steve Westfall (WV)

Also in attendance were:
Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Brenda Carter (MI) and seconded by Rep. Brian Lohse (IA), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Jonathan Carroll (IL) and seconded by Rep. Rachel Roberts (KY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 10, 2023 meeting in San Diego, CA.

“STATE OF THE LINE” PRESENTATION – AN UPDATE ON THE STATUS OF AND TRENDS IN THE WORKERS’ COMPENSATION INSURANCE MARKETPLACE

Jeff Eddinger, Senior Division Executive at the National Council on Compensation Insurance (NCCI) thanked the Committee for the opportunity to speak and stated that I'm going to give a pretty quick overview of the workers’ compensation system. So this is the first time really that we can see data pre pandemic and post pandemic. So certainly, the pandemic had some impacts on the workers compensation line but when we start looking at the results you could see that it really did not have any bad impacts on what was already a stable and well performing system. The calendar year combined ratio which compares losses and expenses to premiums came in in 2022 at an 84 which is a three point improvement over 2021. This was the sixth year in a row where the calendar year combined ratio was below 90% and the ninth year in a row that the calendar year combined ratio was below 100% so obviously this line of insurance has seen very consistent, very good results and that has not changed due to the pandemic. The three point improvement was basically in the loss ratio so the other components of the combined ratio have remained fairly stable. So that's a 16% underwriting profit for the latest year and when you look at the investment gain on insurance transactions for 2022, it was down a couple of points from 11% the previous year to 9%, slightly below the long-term average of about 12%. But when you combine the underwriting profit with the gain on investments, you're looking at a 25% pre-tax operating gain, well above the long term average and even above last year. So when we look at the premium, we will see the impact of the pandemic. So you can see there from 2019 to 2022, the dip in workers comp net written premium and then the latest year is up 11% from the previous year to $47.5 billion, pretty much returning to the pre-pandemic levels. So, even though that's a large increase for one year, really when you look at it from 2019 to 2022 it's a fairly small increase, about 3%. So we're going to kind of dig into that a little bit as to what is behind that. So from 2021 to 2022 that large increase is really being driven by a 10% increase in payroll and that's pretty much evenly split between increases in the levels of employment and increases in the wages.

So then if we look over the pandemic period from 2019 to 2022 as I said, it's a much smaller increase, although during that time payrolls did increase more than 20% driven almost entirely by a 20% in wages. However, what's also happened during the last several years was NCCI has been filing pretty consistent loss cost decreases in the states that we handle. So this shows the latest round of filings with the largest decrease being almost a 17% decrease in D.C. and there was only one state that showed an increase. So, we've seen a pretty consistent drop in the bureau premium levels over the last decade. Just for the last year alone, it was almost a decrease of 8%. So over this pandemic period, while payrolls have been up more than 20% the loss costs have been down 20% pretty much offsetting that sp that's why it's only a slight decrease. And then looking at the other premium levels in the residual market, they've remained pretty consistent, but they've also dropped in the residual market both because we've been decreasing the rates in the residual market and also because the line is very competitive. Companies are willing to write business voluntarily, so the residual market is the smallest that it's been in recent years with a residual market share of about 6%. The pandemic period also saw some fluctuations in some of the loss drivers. So we were seeing pretty consistent improvements in claim frequency prior to the pandemic and then the year the pandemic hit, 2020, we saw a pretty large drop in frequency of 8% and then the following year, we saw an increase of 8% and now for 2022, after the pandemic, we're back to more the average historical improvement of 4%. So during that whole pandemic period, we're looking at a decrease of 5% in claim frequency. Claim severity or the average cost per claim for both indemnity and medical over the last few years has been pretty moderate. So, when we talk about why for workers compensation can we see year after year of loss cost decreases? Remember that the exposure

base is payroll, so payrolls go up, premiums are going to go up automatically and if the losses don't go up as much as the premium, we need to decrease the loss cost and so when we're in an environment where workplaces are getting safer, there's fewer accidents, there's fewer benefits being paid out.

Now, sometimes the amount of benefits could go up, but we have not seen that in recent years. So for wage replacement for indemnity, we did see a 6% increase in the latest year but over the pandemic period it's been about a 2% increase per year in the average indemnity claim. So when you consider that indemnity benefits pretty much you'd expect them to be in line with wages, but that has not been the case. So over this long time period when wages have grown 90% indemnity claim severity has only grown 57%. So it's lagged. It's been below the actual wage inflation. So again payrolls are going to go up when wages go up. If indemnity benefits don't go up as fast loss costs need to decrease. A similar story for the medical payments, even though it's up 5% in the latest year, over the pandemic period, it's been about an annual average increase of only 1%. Now you'd expect medical benefits to go up maybe with wages but also with kind of a medical consumer price index (CPI) but similar to indemnity payments we have not seen the medical payments keep pace with how we would measure “a medical CPI”. A bit closer, the changes for medical than indemnity but still below what you might see. So again with severities not even keeping pace with wages and with claim frequency dropping, this is why we're in an environment where we've seen decreases and in many cases double digit decreases in the loss cost levels for our states.

So now that we're through the pandemic, we can look back on just the impact of COVID claims in particular. So for NCCI states we did see over 100,000 COVID claims, resulting in more than $600 million paid out in losses. They're pretty much small claims about $5,000 on average and they really represented only 1% of total losses. This just shows how those amounts break out by year. So obviously 2020 was the largest and then 2021 started to taper off and there's been a really huge drop in the number of COVID claims from 2021 to 2022. So doesn't mean there's zero but they're at an extremely low level. So these are kind of the big highlights, that premium increase of 11% kind of gets that premium amount back to the pre pandemic levels. A combined ratio of 84% percent for the calendar year and even for the accident year the 97 is below 100. I didn't really touch on it, but there's the largest reserve redundancy we've seen probably in history. So there are carriers sitting on a lot of what we feel extra reserves at this point. Claim frequency has decreased back to normal levels of about 4% a year and indemnity and medical severity are up for the latest year, but still fairly moderate.

PRESENTATION ON TRENDS IN STATES AFTER ADOPTION OF DRUG FORMULARIES

Sen. Hackett stated that next on our agenda is a presentation on trends in states after the adoption of drug formularies. With us today is Ramona Tanabe, CEO of the Workers Compensation Research Institute (WCRI). As a reminder, NCOIL adopted a Workers Compensation Drug Formulary Model Act in 2019. That Model can be viewed in your binders on page 171 and on the website and app. Today's presentation will provide good information for this Committee to consider before we go through the model for readoption at the five year period next year.

Ms. Tanabe thanked the Committee for the opportunity to speak and stated that WCRI, if you're not familiar with us, we are an independent nonprofit research organization and our mission is to be a catalyst for significant improvement in workers compensation by providing credible, high quality independent research so that when there's a policy debate it's an informed policy debate with data. So that said, today I'm going to talk about some of the states that have adopted drug

formularies and what we see of the effects. I know there's a Model that was adopted by NCOIL in 2019. There hasn't been a state that adopted a drug formulary since then but before that, 17 states have adopted drug formularies for injured workers. Today, we're going to talk about California and New York specifically. A drug formulary is essentially an approved drug list, and drugs that are not on the list require pre-authorization before they can be dispensed or prescribed. So 17 states have adopted drug formularies and they all have different features to them. So you can't quite do a comparison of one to another because they all have different requirements for pre-authorization. Many had different phase in periods and some states wrote their own drug formularies. So the states that are in dark blue are the ones that have adopted drug formularies as of the beginning of this year and 10 of the 17 are based on either Official Disability Guidelines (ODG) or American College of Occupational and Environmental Medicine (ACOEM) guidelines. California that we're going to talk about today has something state specific that works in conjunction with the ACOEM guidelines and the purpose for California was to define reasonable and necessary pharmaceutical treatment for injured workers.
So when we think about drug formularies after the implementation, there are a number of questions that we ask. Did it reduce the utilization of prescriptions? What was the impact on drugs that were either on the formulary or not on the formulary after the implementation date? And what about the different types of drug groups, did it hit everything differently? And also physician dispensing, I know there's another Model I think it's referred to as something with repackaging that NCOIL adopted. There, what's the effect on physician dispensing and generic use within the formulary? And most importantly or sometimes least importantly, did it reduce payments for the spend on prescription drugs.

So this is a summary of the effect of pre and post formulary for California and New York and it's answering those questions and you can see in the left hand column for each of those for California and New York, the numbers are all negative. They're compared to the group of states that don't have a formulary in place and because there might be externalities that also affect what's happening within the payments for prescriptions and the reason those non formulary columns are not the same is because there are two different periods. They adopted them at different points in time and the pre period and the post period are different time frames. So you can see there are pretty significant effects and we'll go through each one of these in detail. So first California – California's was adopted on January 1st of 2018 and you can see California and the blue line there this is looking at the number of prescriptions per medical claim and the yellow line there shows the non formulary states. So there was a significant decrease in California. What this doesn't show is what percentage of claims actually received prescriptions. So when we look at that you can see on the left hand side the percentage of medical claims that received prescriptions. California looks more similar to non formulary states after the decrease in 2018. And then on the right hand side, the number of prescriptions per claim when you have one, how many did you get? So it also decreased the effect of requiring pre authorization for certain types of drugs. The proportion of prescriptions and prescription payments in California before the adoption of the formulary was about half of the prescriptions that were issued in California before it was adopted. So they call them non exempt and exempt drugs from the formulary or ones where you don't require pre authorization but non exempt and unlisted drugs require preauthorization. And so when we look at what happened to those different groups of exempt drugs, non exempt drugs and unlisted drugs, you can see that the non exempt drugs had a large decrease in that time period. So we're looking at the number of prescriptions per claim that had a prescription and the exempt drugs, the ones that didn't require pre authorization were pretty static over the time, a very slight increase over time. And unlisted drugs were not or were infrequently prescribed. So that one stayed pretty stable as well. This is just a different view to look at how did California compare to those non formulary states for

those other measures and for those non exempt drugs there was a small decrease in non formulary states but not to the extent of California so the effect of the formulary was significant.

The physician dispensing in California also had a large decrease compared to the non formulary states. The physician dispensing was also a piece of the formulary that they had requiring pre authorization so hand in hand, they worked together. We don't see any change in that in the pharmacy dispense prescriptions so those didn't increase or decrease. They were essentially the same. And this is compared to other states, what was happening in terms of physician dispensing and pharmacy dispensing. So, California had a much larger decrease than states that didn't have any regulations affecting drug formularies. The other thing we wanted to look at was what types of drugs were mostly affected and you can see the largest one there was the 50% decrease for the muscle relaxants, musculoskeletal therapy agents and those include things like Flexeril and the dermatologic agents are the gels and patches. Those didn't decrease as much, but they did decrease. The next largest one was opioids, but also at the same time you can see in the non formulary states there was an 11% decrease in opioids. There was a lot of attention paid to opioids during this time period so some of it were external to the drug formulas that were in effect at the time. So in summary, California's adoption of the drug formulary was large and immediate. You could see an effect in the quarter after its adoption. It restricted non exempt drugs and it required pre authorization and a prospective review before it's prescribed. The prescriptions that exempt from pre authorization didn't increase. We saw those stay pretty flat. And the combined effect of those was an overall decrease in the number of prescriptions and a shift towards the mix of drugs dispensed. So there was a cost savings also that happened because of the drug formulary.

Next we're going to look at New York. New York is a little bit more complex. It was adopted the year after California, but they had very different phase-in provisions and timing. New York was adopted in the fourth quarter of 2019, so the phase-in that was due to happen in 2020 there were some intentional delays because of COVID and things that were happening there for lack of a better term, they didn't want to disrupt some of the treatments that were happening for injured workers to shift from formulary to non formulary or non formulary to formulary. So we looked at a slightly longer time period for New York to see one year after the implementation what was happening. You can also see an effect compared to the non formulary states there. The other thing you notice in the non formulary states during the beginning of the pandemic the first two quarters of 2020, there was an increase in the average prescription payment. The largest effect of the New York formulary was a decrease in the prescription payments. So this is looking at the number of drugs that had a prescription and you can see compared to the non formulary states, New York also had a pretty large decrease between the end of 2019 and the beginning of 2021. This is looking at those measures - the questions that I posed at the beginning of the presentation and compared to the non formulary states and you can see that the largest effect in New York is that first bar there, the prescription payments for medical claims were decreased by 34%. And that wasn't happening in the non formulary states. So what kind of drugs require pre authorization in New York? They do have an approved drug list, so it's drugs that aren't listed on the formulary and a combination of those that aren't directly listed or compounds. So some of those are pre made or patent drugs that are specifically made for an individual. And brand name drugs that have generic equivalents also require pre authorization as do brand name drugs that have the same active ingredient but might be at a slightly different strength. So those also require pre authorization which is affecting brand name dispensing. The same as California, what percentage of the pre formulary effective date accounted for the non formulary drugs? And it was about half, half of the payments and half of the prescriptions were drugs that were not on the formulary. So it should have a large effect. What kind of drugs were being dispensed in that area? We saw dermatological's and the lidocaine products. There was

also the effect of these higher priced NSAIDs (nonsteroidal anti-inflammatory drugs), Fenoprofen calcium that came into effect in 2019. And you see that in California that it does show up later outside of the formulary opioids but opioids were also affected by some other provisions like PDMP's (prescription drug monitoring programs) that were being implemented by states over time as well as new drugs that are being introduced and show up in the workers compensation system for injured workers.

So when we look at the different types of drugs within New York for formulary drugs and non formulary drugs, this is looking at the number of drugs per claim where there is a prescription. We can see the decrease in the non formulary drugs by that green line in the middle. But you see a corresponding increase in the formulary drugs without limits, the top line there, the dark blue one. And so that's a substitution, the physicians are choosing to practice differently and prescribe different types of drugs. Not much of a change in formulary drugs that required limits as well. And what types of drugs were being dispensed or changed with the formulary impact? You can see a large decrease, for the opioids, a little bit for the muscle relaxants and anticonvulsants. There was an increase in dermatologics and some of those have to do with things are outside of the formulary that are new formulants. Interesting to note, the anticonvulsants, probably 98% of them are permitted and don't require pre-authorization under the formulary but New York's drug formulary works in conjunction with other controls that they have in place, including medical treatment guidelines. And the medical treatment guidelines specified that anticonvulsants are used as second step therapy for things like back and neck pain and so one would first have to exhaust first line therapy drugs before moving to anticonvulsants for pain so that's why there was a decrease in those. So in summary, the drug formulary in New York was also immediate and sizable and the drugs that required preauthorization were very much reduced. The prescriptions were increased by kind of a substitution effect, a shift in the mix of the types of drug dispensed and there was a substantial cost savings for prescriptions. And lessons from California and New York are that formularies decreased the prescription drugs that required preauthorization, there were small increases in drugs that didn't require preauthorization, and that the payments also decreased for both states. The trends that we see is that there are also new drugs that require preauthorization and what the lesson from this is is that it's not a static document and that there are continuous reviews required overtime just like any price control such as a medical fee schedule or any utilization review that type of thing. So in California, we saw these higher cost NSAIDs in the years following the effective date of the drug formulary and we also saw in New York some of the dermatologics, the lidocaine drugs increased after the implementation to be a much larger share than it was previously, requiring again review of this.

Rep. Liz Reyer (MN) stated that I really appreciate the data on workers comp and just have a couple of questions on whether you've looked at two things. One, the satisfaction of both patients and providers from past research I've been involved in. I know that formularies are often linked to frustration and declined satisfaction. And then more importantly, outcomes. If you've seen any impact, positive or negative, on the patient and a return to health type of metric. Ms. Tanabe stated that we have not done any studies on the patient satisfaction or injured worker satisfaction and pre and post formulary. However, as outcomes one of the things we would look at in workers compensation is return to work and was there a delay? Was there a difference? And we don't see any significant difference pre and post.

Rep. Tammy Nuccio (CT) stated that looking at your presentation, I have two questions. The first is from the utilization of the formulary. Is it basically just looking at how infrequent they are prescribing these certain types of medications because they have to go through a process now? So is it just a reduction in prescription of these certain classes of drugs? Ms. Tanabe stated that

the data that we look at includes all of the prescriptions that are written on a claim over a period of time. So we looked at the period before the formulary was implemented and then the period after to look at specifically the formulary list and the non formulary list, did it change in those types of drugs? So yes, we're looking at before and after for all of those different metrics. Rep. Nuccio stated that so in essence, you're basically just putting in a pre-authorization I believe then for certain types of drugs, whereas they weren't before if I'm hearing you correct. Ms. Tanabe stated that for some because we saw a decrease because sometimes there was rather than have a pre-authorization there was a shift to use a drug that was on the formulary which is what we saw in New York. Rep. Nuccio stated that and then the last question that I have is you looked at New York and California, which seemed to have pretty significantly higher rates than non-formulary states to begin with. But if I looked at your data as it was coming up, it looked like the institution of a formulary kind of brought them in line with non-formulary states so I don't know that necessarily if you have a state that's on that non formulary line with a pretty steady line now and not high utilization you'd see the same sort of results, would you agree? Ms. Tanabe stated that we also studied other states that have recently adopted formularies, Arkansas and Kentucky being two of them. And we did not see as significant effects, mostly because they weren't high to begin with and they weren't commonly prescribed drugs that ended up not on the formulary list. So it does have a differing effect in different states.

Rep. Stephen Meskers (CT) stated I have a two part question. Within the prescribing medication, did you look to see how many of the medications were off patent versus on patent? Because I'm just wondering in the cost structure, I know many of the drugs that are off patent still only have a singular producer so I'm wondering if you had any background on the patent versus non patent? Ms. Tanabe stated that where we see the effect of the patent falling is usually in the pricing, the payments because it converts to a generic even though it's no longer covered, but it could still be prescribed. And you could see that affect overtime. And when we know that something has either gone off patent or changed classes, we specifically look for those drugs to see what the effect is on the overall prescriptions. Rep. Meskers stated that within those studies, have any of the states looked at the opportunity to create a manufacturing formulary or to work in conjunction to actually produce some of those drugs? Because what I'm finding is that the fall off is not as significant, the cost of production, the cost of manufacturing is low and a lot of the drugs that have come off patent still have a huge margin of profit and I'm wondering whether there's a way to drive those prices lower by making a formulary that actually works on a manufacturing basis. Ms. Tanabe stated that I have not heard of that.

Rep. David LeBoeuf (MA) state that I have one question around some of the data. I know there are some states that either have or are looking to have medicinal cannabis covered by workers comp. How has either use of that alternative played into some of the data that you see, or what you're hearing from some of the states that have formularies? Ms. Tanabe stated that is a good question and I think there are six or seven states that currently reimburse for medical marijuana under workers compensation and the reimbursements would be not directly to a dispensary, they would be reimbursed to the injured worker and so the data are actually not existent in what we've seen in the data so far. We continue to watch that though.

PRESENTATION ON MINNESOTA WORKERS' COMPENSATION SYSTEM

Jennifer Wolf, President of the Minnesota Workers' Compensation Insurers Association (MWCIA) thanked the Committee for the opportunity to speak and stated that MWCIA serves as the rate making organization here in the state. I've been in this role for about 18 months and I will share that the last 18 months we've really been working with our carriers, our agents, and other members of the stakeholder community to really understand how we can continue to

serve and make workers compensation sustainable here in the state. So let me share a little bit about MWCIA and then I'll share some measures about Minnesota's work comp system. First of all, our mission at MWCIA is to advance Minnesota's public welfare and our economic security by supporting a sustainable workers compensation system. And I'll share with you that the concept of our public welfare is really a nod and recognition that workers compensation does have a societal impact. We're protecting the lives of citizens and ensuring employers bear the cost of coverage, not the states. That phrase, public welfare, is directly taken from our enabling statute, which is to promote the public welfare and to regulate insurance rates so that their premiums are not excessive, inadequate or unfairly discriminatory. So, our core reason for existence is to provide a rate making report. We publish that rate making report annually. We've been doing that since we were reorganized in the 1980s. But a rate making organization in the state has been around for 101 years so we're excited to continue that tradition, making sure that the rates here in Minnesota are adequate and also that we provide value and do research and provide insights into Minnesota's workers compensation system.

Just a little bit about what MWCIA does. We develop base rates, our rate making report has pure premium base rates that are released on an annual basis. They go into effect in January of every year. We're about to file here in the next couple of weeks our 2024 rate making report. We also support workplace safety. We promulgate experience rating modification factors which provide credits and debits to employers based on their individual loss experience. We maintain the workers compensation manuals for the state that includes our basic manual, our classification manual, forms and other manuals. And we ensure that the rules based on those manuals are applied consistently and equitably across the state. We receive workers compensation policy data which is used by the Department of Labor and industries to confirm that employers are complying with coverage requirements in the state of Minnesota. We do a lot of education and outreach to stakeholders about the Minnesota Workers Compensation system. We participate with the Department of Economic Development to educate new employers about workers compensation coverage requirements and making sure they understand the difference in coverage for independent contractors and employees. We do a lot of education with carriers to make sure that they're properly reporting data to the state so that we can have the highest quality of data to inform our rate making process. And then we use that data to not just create our annual rate making report, but to do other research which gives us insights into what's happening in Minnesota's workers compensation system. We've recently collaborated on several research reports with NCCI and the other independent rating bureaus to look at issues related to COVID. We've done two studies on COVID, what we saw first in COVID and then what we're seeing in long-COVID claims. We've looked at mega claims recently.

So that's a little bit about how MWCIA serves Minnesota's work comp community. Now I'll share a little bit about Minnesota's workers compensation landscape. Minnesota has a very healthy private insurance marketplace. We have over 220 carriers writing coverage in the state. Those carriers serve more than 28,000 employers across Minnesota and in 2022, we had $1 billion of direct earned premium and over the last decade we have seen premium growth of 17%. And in 2022 it mirrors country wide trends, premium now is above its pre-COVID levels and that was really a product of both employer growth and also payroll growth. The assigned risk market has remained remarkably stable for decades. We're at about 3.5% percent of the private insurance market. We have more than 2 million employees across the state who are covered by private insurance in Minnesota. And in 2022, more than $457 million was paid in direct losses. I want to share just a little bit about my perspective on why Minnesota has created a sustainable insurance market for workers compensation. In the last decade, Minnesota has seen a cumulative decrease in pure premium base rates of 26% and there are several trends

influencing that decline. First and foremost, we continue to see a loss of frequency, which is really positive news for our employers and workers in the state. We mirror trends across the country that there is a cumulative, although modest, year on year decline of the number of injuries and illnesses that are impacting workers.

Our annual year over year decline is about .4%, but over a decade that has that does add up. Cumulatively, we've seen a decline of low back strains and strains of 23% and low back injuries have declined by 28% in the last decade. Another contributing factor to the sustainability of Minnesota's market is there has been a real focus, both from a legislative and a regulatory perspective, to proactively manage medical claim costs in workers compensation. The state has implemented treatment guidelines. They have implemented fee schedules for a variety of different services. And we also have electronic medical billing in workers compensation and that has been very effective. In most areas medical costs are at the median or below average compared to other states and particularly compared to our regional neighbors. Another I think important factor in Minnesota's workers compensation insurance system is a real commitment to the Workers Compensation Advisory Council process. So the Department of Labor and Industries facilitates throughout the year a Workers Compensation Advisory Council. It's made up of representatives of labor and management and they come together and do an agreed upon bill process and that agreed upon bill is generally given to the legislature and enacted and that makes sure that the changes to Minnesota's workers compensation system represent a balanced perspective. I like to think of workers compensation as that fragile balance between making sure that the benefit levels are adequate for injured workers but are at a reasonable cost to employers. And so working together, they propose legislation that both parties can accept. In 2023, there was a significant bill passed in Minnesota that increased permanent partial disability (PPD) rates for injured workers and it also provided some adjustments to the dispute resolution process and we saw some reductions in our hospital fee payment system. But that commitment to making sure there is measured and modest change has really created a very even Minnesota workers compensation system. And I wanted to share one of the most unique aspects about the Minnesota workers compensation system is the WCRA (Workers Compensation Reinsurance Association) and Minnesota is the only state that has reinsurance for Minnesota's workers compensation claims that reach a sort of catastrophic level that is provided by a statutory entity. So our insurers are required to purchase reinsurance through the WCRA. It's the only one in the country that has a statutorily created reinsurance association.

And then I just thought I would highlight some current issues that are impacting Minnesota's workers compensation environment. These issues are not dissimilar to other issues that we see in other state workers compensation systems. The state is really trying to grapple with how to cover mental health conditions and in particular how to address post-traumatic stress disorder (PTSD). Minnesota has a presumption for PTSD for first responders and most recently, there was consideration of expanding the PTSD presumption to healthcare providers. The legislature enacted a study on PTSD in the healthcare industry but there has been a lot of consideration and a lot of discussion about how we address mental health, anxiety, depression, and PTSD within the workers compensation system. We are now from a rate making perspective looking at what will happen to workplace illnesses as we have seen COVID go from the pandemic to endemic in our communities so we'll be watching that very closely over the next several years to see how COVID will continue to impact our workplaces. We are looking at extreme climate events. So here we've been experiencing lovely weather in Minnesota but our southern neighbors, it's very, very hot. But in the winter, Minnesota has seen more extreme winter conditions and those winter conditions are translating to an increase in slips and falls throughout the winter and so we're looking at how will more extreme weather events impact our businesses and our workers. And then mega claims is something that we're looking at. There are many

trends that are being driven in the workers compensation system by a very small percentage of the claims. And so we're seeing an increasing number of claims that have $1 million or more in total cost and those very significant claims oftentimes are driving the larger claim trends that we're seeing.

Rep. Tim Barhorst (OH) stated that I'm from Ohio and we have a monopolistic system, so it's a little bit different than yours obviously. The question I have is when you contract with providers, is that a standard contract, do your insurance carriers facilitate that and have their own networks? And if you do your own contracting, what's the structure? Because in Ohio we're on a Medicare plus model. I think it's 114% of Medicare and I'm just curious where you guys are at. Ms. Wolf stated that our insurance carrier members will develop their own provider contract networks. Here in Minnesota however, employees actually have the choice of provider so the carriers can't direct care but from a regulatory perspective on pricing, there is a resource-based relative value scale (RBRVS) that has been implemented.

Sen. Michael Fagg (KS) then asked a question regarding Minnesota's experience with its PTSD presumption. Ms. Wolf stated that the PTSD presumption was enacted in 2018 and in terms of the rate making process, rate making looks at the previous experience so we would just be getting experience related to PTSD. I could not tell you specifically what has happened at that class code level but I'm happy to follow up with our actuaries to get more information. If I'll just grab your contact information.

Sen. Hackett stated that we're a state-run system in Ohio and when we talk about PTSD, a person has to have an accident in Ohio to be able to collect. Is that the same way in Minnesota? Ms. Wolf replied, no - PTSD does not have to be associated with a physical injury to qualify in the state of Minnesota. Sen. Hackett asked how can you cover one area of mental health and not protect all those other areas of mental health with first responders? Don't you worry about lawsuits from first responders who have other mental health areas that they think came from their job? Ms. Wolf stated that is absolutely a topic of rigorous debate within the Workers Compensation Advisory Council. At the moment there is a pretty concrete and firm definition of meeting that PTSD standard. We could get you the legislation on that. And there is of course concern about making sure that first responders and all employees have their mental health conditions addressed. But the PTSD, you have to meet specific requirements to be diagnosed with PTSD, and that's how the claims are processed.

Rep. Nelly Nicol (MT) asked if you can you back up a little bit and explain who exactly is doing your reinsurance and if there are different carriers for each tier? Ms. Wolf stated that there is only an association and it was created by statute and they provide the reinsurance based on different thresholds and I could get you some more information. I'm not an expert on WCRA but I'm happy to connect you to the Executive Director there.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Sen. Hackett stated that last on our agenda today is the consideration of readoption of model laws. As I said earlier, all model laws must be readopted every five years or they automatically sunset. Today we have four model laws that are to be considered for readoption. They are: the Model Act on Workers Compensation Coverage for Volunteer Firefighters; the Workers Compensation Pharmaceutical Reimbursement Rates Model Act; the Construction Industry Workers Compensation Coverage Model Act; and the Model Act Regarding Workers Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships.

Hearing no questions or comments on the Models, upon a Motion made by Rep. Jonathan Carroll (IL) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to re-adopt the Models.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Rachel Roberts (KY) and seconded by Rep. Carter, the Committee adjourned at 10:30 AM.