NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 16, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Thursday, November 16, 2023 at 2:00 p.m.

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

Other members of the Committee present were:

Rep. Brian Lohse (IA)
Rep. Matt Lehman (IN)
Rep. Rachel Roberts (KY)
Rep. Mike McFall (MI)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)

Other legislators present were:

Rep. Chad Aull (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Jane Pringle (ME)
Rep. Helena Scott (MI)
Rep. Stephanie Young (MI)
Sen. Pam Helming (NY)
Asm. David Weprin (NY)
Rep. Tim Barhorst (OH)
Sen. Bill DeMora (OH)
Sen. George Lang (OH)
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. Matt Lehman (IN), NCOIL Immediate Past President, 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 Sen. Jerry Klein (ND) and seconded by Rep. Nelly Nicol (MT), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 21, 2023 meeting.

NAVIGATING WORKERS' COMPENSATION AND MEDICAL MARIJUANA

Doug Jones, MAAA, FCAS, of the American Academy of Actuaries (AAA), thanked the Committee for the opportunity to speak and stated that for those who aren't familiar with the AAA, the Academy is the group in the U.S. that sets professionalism standards for U.S. actuaries. But

our mission is to assist the public and policymakers trying to offer objective expertise and advice on risk, financial security issues. So, earlier this year, the Workers Compensation Committee prepared an issue brief related to medical marijuana. The reason we did that was the landscape continues to evolve as it relates to medical marijuana. The Drug Enforcement Administration (DEA) still treats marijuana as a schedule one drug. So it's illegal at the federal level, but it is increasingly decriminalized across the nation. I think there's something like 38 states across the U.S. that have decriminalized it to some degree but because of the schedule one drug, research is pretty limited so we wanted to just collect some thoughts. We interviewed a variety of participants in the workers comp system. We talked to third party administrators (TPA's), talked to lawyers, claims professionals and being actuaries, we talked to more actuaries. What we focused on really is just talking about some of the things that make the landscape so complex. Medical marijuana when it intersects with workers comp it's not cut and dry. So with research being thin, there are very few things that are clear cut. What I'll try to talk about briefly are some of the prominent cases, some of the case law that we've seen. But also, some of the issues and considerations as it relates to reimbursement for the use of medical marijuana, but also issues as they relate to employment.

So, in terms of what we saw, there's kind of three big themes through some of the high profile cases across the U.S. First is who has jurisdiction over marijuana usage? And is it a crime? And the question is the contrast between federal and state. At the federal level marijuana is cut and dry. It's schedule one, it's illegal. But many states have been moving to decriminalize. So what happens when marijuana is a contributing factor to a workers comp claim? Second is the question of proximate cause. So, was the use of marijuana, recreational or medical, the cause of a workplace injury? And then third is the question of is it the right treatment? So pardon me I'm not a lawyer, I'm not going to get into the details of these cases but I just wanted to highlight a couple of cases here. So, with respect to who has jurisdiction and is it a crime - different states have different conclusions. The New Hampshire case listed here is kind of symptomatic or it's a good example of what happens across many states. Initially, the New Hampshire courts found that an employer that reimbursed for medical marijuana would be violating the Controlled Substance Act and thus aiding and abetting a crime. That was later overturned. So states are struggling to decide which side of the fence they're on. New Jersey is a different example on the spectrum, they have concluded quite clearly that insurers or employers are compelled to reimburse if it's been identified as a potentially useful treatment for pain. They should reimburse. Minnesota raised this as well and again there's a question of who has jurisdiction and do state laws preempt the federal law?

In Minnesota there were a couple of cases that concluded that you can't force an employer to facilitate the potentially illegal or unlawful possession of marijuana. Those cases were pushed to the U.S. Supreme Court, but the Court declined to take them up. So, there's still a lot in flux. For the question on proximate cause, really the question is should or could a workers comp claim be denied if marijuana, even if it was medical marijuana, was determined to be the proximate cause? So, in Florida, there's a lot of debate over sort of how you determine that. It's testing for the presence of tetrahydrocannabinol (THC), the psychoactive chemical in marijuana. It's not conclusive as to whether the existence or the presence of that means that there was an issue. Kentucky has created a situation that's kind of interesting, they've shifted the burden to the employee who has to demonstrate one of two things. Either that the marijuana did not cause impairment or that the impairment did not cause the injury. So, different issues, different states. So, last in terms of court cases, what's the right treatment? And part of the question here is, was medical marijuana a necessary treatment for the injuries that were sustained. The issue in Maine is that physicians turn to medical marijuana as a last resort. It seemed to be the one source of pain relief that existed but the initial decision was that the employer needed to pay.

But they appealed. And it was eventually overturned due to the conflict with the Controlled Substance Act. So again, more fray and unclear treatments.

For employment issues, the impact of medical marijuana on employment. I think there's a variety of issues but think back, following the pandemic, the labor market has been challenging for employers, it's been tough to fulfill jobs. You combine that issue with society's generally increasing acceptance of the use of marijuana, in some case recreational and in more cases, medical. It's led to an adjustment to how many employers treat their drug screens pre employment or drug testing of employees. I think that THC has been in many cases dropped from the list of things to be screened for because it's intended to keep the pool of potential applicants as deep as possible. The flip side though is that there are certain industries where marijuana in any form is an absolute no go. So I think about employers that have federal contracts or the safety sensitive industries. Think about oil, gas, transportation, aviation, trucking, railroads. Those are never going to go and take a step that's contradictory to federal law. So in those cases it's more clear cut. In terms of reimbursement issues, it's interesting. While three quarters of the U.S., state-wise, has accepted to some degree that marijuana is okay, it's been decriminalized. In terms of requirements on employers there's only six states that require reimbursement for the use of medical marijuana and there's another six that are part of the group that have legalized it, but they prohibit reimbursement of medical marijuana. So, there's conflicts, and then there's all the other states where things are just not well defined. But what you find is it does depend on where you are in the industry. TPAs will tend to take a conservative approach in the sense that they will not look to take any steps that might put them afoul of federal regulations. Employers, it's conflicting issues internally. I mentioned earlier, any employer with a federal contract, safety sensitive industries, they're not going to support it. But there is the recognition that medical marijuana could have potential both in terms of helping their employees but also think about cost savings. One of the stats that we cited in our brief was a few years ago Opioids, which are very well known for their pros and bigger cons, they were costing employers something on the order of $18 billion a year. So medical marijuana could be an alternative that could result in some real savings.

Regarding opioids, there's a question about marijuana versus opioids. Opioids have been studied frequently. They're in the news all the time regarding the cost both financial but also to families, to communities, is huge. But it's not crystal clear yet whether medical marijuana is necessarily a better option and it comes back to the original observation that there's not been much research done. Being a schedule one drug, research is pretty thin. So I think there's a thought, maybe an expectation, but it's not been proven that medical marijuana would be helpful. There have been observations that marijuana is less addictive. It may have fewer severe side effects, but there haven't been a real depth of studies done. And then the cost I mentioned I think that Opioids are certainly expensive but it's not clear how that would be, different with medical marijuana but I think there's a soft optimism that it could be.

Sen. Hackett stated that in Ohio we just passed recreational marijuana. We've had medical marijuana and we passed recreational. One of the problems we saw is that marijuana stays in the system for a longer time. So when a prosecutor deals with a driving under the influence (DUI), they really have to have really bad driving at the time or they just won't even mess with it even though the person from the blood test or the urine test will test positive. He'll just say he smoked it a week ago and it stayed in the system for so long. So do you have any problems on medical marijuana versus people trying to go to work for companies and they only use it for medicinal reasons but it just stays in their system for a while? Mr. Jones stated that I think you're nailing one of the real key issues in terms of the compensability for a workers comp claim - what is the cause? So Joe might take marijuana a week ago and it's still in the system. You can still

track it with hair, blood, what have you. So that experience from a week ago may be visible in the system but you almost certainly was not the cause of any sort of problem. So, I think that's one of the trickier issues related to the potential for medical marijuana and marijuana in a general sense of trying to understand how long is that potential impairment? And some of the case law debated some of that exactly so I don't have an answer for you but just an appreciation that you're definitely seeing one of the trickiest parts of this as an issue for workers comp.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated I'm from Indiana and we are now an island because Michigan is both medical and recreational, Illinois is both, now Ohio is both, and Kentucky's medical. I'm a border community. I live six miles from the Ohio line. We have a large employer who employs a lot of people from Ohio. The issue isn't so much now of marijuana in their system and they get injured at work, it's if they're working in Indiana now they can be denied their work comp benefits and they can be arrested because in Indiana it is still illegal and is a term for denial of your work comp. So, are you seeing in the places where you have those border states where if I live in one state where I'm taking it absolutely prescribed legal, and I get with recreational is completely different, but I'm taking a prescribed legal product in Ohio and I'm working in Indiana. How's that going to play out in the work comp system? Mr. Jones stated that I think that is one of the issues that employers are going crazy over because it it's impossible to know how things will land. And say you did something in one state and wind up in the other state, what do you do? Employers are at a complete loss for how do they treat things and what the ramifications are on their workforce. So again I don't have a clear response for you but it is definitely something that's been observed and it's kind of a real conundrum. Rep. Lehman stated that many of the large employers simply say now we're just not going to test for marijuana. We'll test for alcohol. But we're not going to test for marijuana. So if it's now recreational use in Ohio and I get injured at work in Indiana, you're not testing for marijuana. How's that different than testing for alcohol which is a legal product? We're creating almost a two-tier system of what is now in Ohio a legal product but we're not going to test for it in Indiana because we don't want to run the risk of losing a good employee. Mr. Jones stated even if you did, it'd be hard to know how long - maybe took a vacation in Ohio for a few days and went back and now facing all these dilemmas when that experience in Ohio practically speaking may have no impact on what I'm doing days later.

Michael Choo, M.D., Chief Medical Officer and Senior Vice President at Paradigm stated with regard to how long marijuana remains in your system, that is a very problematic issue because it can last as long as 30 days or more. And so typically people will say, "Oh I smoked something last week and it should be negative today." And for most of the time if you only smoke once, within seven days it should be out of your system. But for those who have been smoking for a long time, the THC gets absorbed into your fat cells and it gets released over time and sometimes it can last 30 days. And depending upon how much you used, it can last for a few months. And I do drug screen reviews as a medical review officer (MRO) and I see a lot of employers who test their employees with drug screening and their THC comes back positive and the typical routine that we normally follow is we call the employee to understand the situation as to when they may have been exposed but we tend to follow the policies set by the employer as to how we're going to report out if it's a negative or it's a positive because remember the employer doesn't see the drug screen results, they only see the results that come after the MRO review which is the next question that I'd like to answer. In terms of testing, and I know there is the border issue with employers that have employees from Ohio and Indiana, but if the employer is located in Ohio and they're in and they accept medical marijuana as one of the approved drugs for getting a negative drug screen test whether it's pre employment or even I guess post-accident, the MRO who will be reviewing these test results will report out as a negative test if the

company has a policy that says that they accept marijuana as an acceptable substance versus maybe those in Indiana they'll be reported as a positive test.

Rep. Rachel Roberts (KY) stated I'm from Kentucky and we're just now facing all of this since we've just passed our first medical cannabis bill. I guess my question is, could you speak a little bit more to if testing positive is a reason for a denial only because of the federal status of cannabis? Or would a worker also potentially be denied if they test positive for legal and properly used opioids or anti-anxiety meds for instance if they were injured in the course of their job responsibilities but were having to go through other medication protocols? Mr. Jones asked if the question is the difference between marijuana and other meds? Rep. Roberts stated I guess the question is, is it a level playing field? If I get injured on the job and it's perhaps because I'm having to take a medication for a treatment that is legal and responsibly used, is it a level playing field if that is a normal prescribed medication or if it's cannabis and if it is not a level playing field, is it only because the status of cannabis at the federal level? Mr. Jones stated that I think the treatment of cannabis at the federal level is a big part of it. I think there's always going to be the issue of the medication, was that the cause of impairment and was the impairment the cause of the injury? But it definitely gets muddier for marijuana. It's just an extra level of headache. So in terms of your question was it a level playing field? I think no. I think cannabis is always going to be one extra level of complication but I think if you were taking opioids or drinking at lunch, if those things cause you to be impaired, and then you caused a workplace injury, I think that there would be room for denial of those claims.

Dr. Choo stated to give a little more insight as to what Mr. Jones was talking about, I think it depends on the employer. So, number one, if you're an employer providing services that are federal or government related, if a cannabis test comes back positive, you will fail the drug test. If you're a not a federal employee or agency that deals with federal services or department of transportation and you would do something different and your policy accepts cannabis as a visible substance, just like benzodiazepines and other medications that they're taking, and we can prove that person has a medical reason for the positivity which means that they have a medical marijuana card that has been approved for use because of the conditions they have, or they have a prescription from a physician that gives them the medical reason to have benzodiazepines and other substances like Adderall, then it will be reported as a negative test. So the employer will not see that as a positive test. In fact, they'll see it's a negative test. So it does level out the playing field but it depends on the employer.

Rep. Mike McFall (MI) stated that we're focusing on medical marijuana and medical marijuana cards, but we have seen a huge decrease in people applying for medical marijuana cards in Michigan after recreational was passed. We peaked at almost 300,000 at one point. And now we're down to 123,000 or something like that. So, if we're just talking about medical, I think there's a lot of people that are utilizing it because it's become so cheap in Michigan without actually having to go through all those steps to get the medical card. So many people are utilizing it for medicinal purposes without a card. And so, for example as Dr. Choo said about whether or not you talked to them and they have a card, but what if they don't have a card? I guess that’s my question? Are we always just relying on them having a card when it comes to these? Dr. Choo said getting back to my comment about the MRO service, if the state has a medical marijuana program but did not allow recreational in that state it's easier for us to go ahead and say that if you have a medical marijuana card then you have a justified medical reason. Therefore, it's a negative test. And if you have a state that has a recreational program in place where obviously people can use marijuana without the medical marijuana card then it will fall back to the employer's policy.

PRESENTATION ON WORK COMP TRENDS AND THE FUTURE OF MEDICINE

Dr. Choo thanked the Committee for the opportunity to speak and stated that it's a pleasure for me to be here this afternoon and to share with you my thoughts and opinions on medical trends in workers compensation. But before I actually start to speak I do want to preface my perspectives. That is based upon two things. One is that I've been a Paradigm Chief Medical Officer for the company for 11 years. And for those who may not be aware, Paradigm is a national accountable care management company that has been specializing in catastrophic injuries. So we specialize in caring for brain injuries, spinal cord injuries, multiple trauma, severe burns and amputations. And we are unique in that we guarantee a clinical outcome for a fixed price or a set price at the beginning of the case which means at the time they get injured and we guarantee an outcome that is a bit of long term either return back to work or returning back to community integration. And because of the outcomes that we guarantee are so long term we reside in the workers compensation space and liability. So I want to make sure you knew that. The other thing is that I still practice. I've been practicing for 33 years so I can give you some sense of what has been happening in the healthcare market as well. So with that, my goal is really to walk through the highlights as well as innovation related opportunities and dilemmas that I think will be faced by the workers competition industry in the years to come. And again these are my perspectives and my perspective alone but hopefully you will agree and hopefully prompt some interesting discussions.

So with the highlights, I'm going to start with the long-COVID. Long-COVID, long haulers, I think those are terms that I think you all heard it before and it's really the terms that were created by the public lay people and the media to describe a condition where after getting ill or contracting the COVID-19 infection a number of people continue to have ongoing and persistent symptoms lasting more than four weeks. In fact lasting months and some actually lasting more than a couple of years. And this particular condition that will be used to call long-COVID had really three or four big common symptoms. One is obviously people experienced severe fatigue as well as exercise or physical activity induced malaise where you feel terrible after you do stuff and you feel exhausted. And then also experience cognitive brain fog where people really felt like they couldn't really think straight. They had memory issues. They couldn't concentrate. And there were other symptoms like palpitations, chest pains and dizziness but to be candid, there were over 200 symptoms documented across the medical industry within this condition and it was a conundrum for the medical community in that we have all these symptoms that really could apply to every organ system in the body. And it was lasting a long time. So obviously this condition was evaluated and the National Institutes of Health (NIH) finally did agree that it is a true condition. And in 2021 they gave this long COVID long haulers a new term called post acute sequelae of SARS-CoV-2 infection (PASC). So since it was dubbed as being a real condition, there were a lot of questions about what is the prevalence of this long COVID in the industry? So, I helped the National Council on Compensation Insurance (NCCI) and they have the largest data set for all workers compensation related claims. And we actually analyzed the data and we went back to 2020 and we looked at all of the lost time claims with COVID from point of start to 2023. And what we discovered was that in 2020 the overall aggregate prevalence of long-COVID was 26%. So, 26% of the cases that had lost time claims had long-COVID symptoms beyond four weeks. When you looked at the hospitalized population it was much higher like around 47%. And for those who are not hospitalized it was around 20% but in aggregate it was about 26%.

We looked at the cases in 2021. In 2021 it showed a decline in the prevalence where it went down to like 22%. And in 2022, the decline continued and it was only around 11.4%. So, the good news is that long-COVID prevalence has been declining over the past three years since the

pandemic started. And I attribute this decline to three factors. One is obviously the vaccinations. Vaccination started in January of 2021. Actually, I got mine in December of 2020, but I think vaccinations have really curtailed the rate of infection. So certainly, if you decrease the frequency of infection, then you decrease the prevalence of long-COVID. The second driver is that it's clear we now have therapeutics that really work for COVID infection. We have Paxlovid. We have Remdesivir. I know there were many other options that were considered but those two drugs currently we use every day and it's been very effective in limiting the impact of COVID-19 infection in patients who actually get them. We also know how to treat the so-called cytokine storm much better. The hyper inflammation reaction from the COVID-19 infection we now know how to immune modulate the inflammatory response so the patients are much better treated. And then lastly, I think that we all have been hearing about this in the news - the Sars-CoV-2 is a coronavirus and they mutate. They mutate naturally. And as they mutate they become less virulent. And so, over the course of two and a half years as it starts with Wuhan virus, now I think through Omicron and I think the most prevalent variant that exists today is the EG 2.5 variant. And it is much less prevalent as compared to his predecessors. And so I think that's the good news. The bad news is that it has become a part of the general group of viruses that we will be be facing every year. It has joined the ranks of the influenza virus as well as the RSV virus, and chicken pox virus. They're out there and we're going to see these infections ongoing for the years to come.

So that's the long COVID. The next topic is the claims frequency. So, as you all know, NCCI publishes their report annually with regards to the workers compensation claims and the good news is that the workers compensation claim frequency has been declining over the past 15 to 20 years and it has remained so which is pretty amazing. In fact, year over year claim frequency from 2021 to 2022 declined an additional 4%. So, it's all good news. The thing that they noticed this year though, is that even though the frequency has been declining, we noticed that the claim related severity has been on the incline which means that the indemnity severity, what's been paid out for the indemnity side has been increasing. In fact, the year over year change was 6% from 2021 to 2022. The medical severity has also been climbing. It's been increasing at a rate of 5% from 2021 to 2022. The wage I think drives much of the indemnity severity so that's kind of explainable but we wanted to look better at the more detailed information on the medical severity. And so we did some more analysis and what we discovered was that there's a subset of claims within the workers comp claim population which we termed the fast emerging large loss claims. And the definition of that particular group is that within the first two years of experiencing the injury the payout for medical costs alone was over $1 million. And so that's the category we talked about. And what was interesting is that if you look at just that subset of the claims, the large loss claims from 2012 to 2021, that's been growing at a year over year rate of 2% to 3%. And if you take another cut through that particular subgroup, there is a subgroup that deals with traumatic brain injuries, spinal cord injuries and burns. Those three categories, that particular group, actually were when you look at their medical severity it was growing, the frequency has been growing at 7% year over year from 2012 to 2021. So even though the overall frequency has been falling, there has been a subset of the large loss claims that's been growing at a pretty steady state and when we did some further analysis as to where it's coming from, I think it's pretty intuitive these claims were most prevalent in the construction section of the industry as well as transportation. And one of my concerns is that as you all know, Congress has passed the infrastructure bill that's going to be passing down through the States and the biggest I think benefactor of the infrastructure bill I think will be the construction sector as well as transportation. And my question from a workers compensation industry perspective is would that accelerate the frequency of such injuries just because there's a lot more money going into those two segments?

So that's my highlights for workers comp. Moving to the innovation related opportunities, I could spend five hours talking about it but I'm going to be very brief. I've been practicing for 33 years and I would say we are currently living through probably the golden years of medical innovation. It started in the 1980s when I was in medical school and I've been the benefactor of watching this incredible growth in medical science, knowledge and innovations. And most recently what's amazing to me is that the advances that may been introduced with regards to technological advances over the past five to six years have further accelerated the pace of medical innovation. And the innovation is such that I think we have made significant impact to the survival of people who are experiencing catastrophic injuries as well as other really severe complex diseases that years ago they didn't survive but today they do. And unfortunately, because they do survive many of the survivors that I see in workers compensation who experience those catastrophic injuries are left with severe disability and impairments. And what I'm happy to say is that we are also seeing great innovations coming to surface now that are helping those people who have been severely injured with severe disabilities to actually regain some of the functional capacities that will help to reduce their disability and mobility going forward. So, just a couple of things I'm going to mention. I don't want to give you a whole lecture on the life saving medical innovations but I do think that there are some that I do want to mention that you heard about. I think COVID has really enlightened the whole public about procedures like extracorporeal membrane oxygenation (ECMO) which allows us to oxygenate the blood outside the body and then recirculate back into the body to keep people alive when the lung is basically useless. We have technologies or interventions like left ventricular assistive devices (LVAD) that are mechanically able to pump blood externally back into your system so that we keep the organs alive and this system used to be pretty much an intensive care unit (ICU) based product or intervention but the LVAD has progressed, technology has progressed to the point where now we can give people these LVADs miniaturized so they can wear this device outside out and about and they can actually engage their life as they normally would.

And so it used to be a bridging program to get people to transplants. But now it's destination therapy. People can live with LVADs for a long time. The concept of dying from hemorrhage from trauma is no longer the case. We have incredible interventional radiology procedures that can go in and embolize ruptured vessels, arteries and veins to stop the bleed. We have an interventional procedure that's done in the emergency room like resuscitative endovascular balloon occlusion of the aorta (REBOA). They can actually stop the bleeding internally like abdominal traumas and pelvic traumas so they don't die from hemorrhages anymore. So if you survey the American College of Surgeons Trauma Services they'll say that the number one cause of death today from trauma is not hemorrhage but rather brain injury. So we've made some incredible progress. With regards to what I call survivorship innovations, I do want to mention three because I've been integrally involved with them. And these are the innovations that actually I think improve the mobility and the disability associated with catastrophic injuries. The first one is osseointegration. And some of you may have heard about these interventions but they're pretty new and out there in the public. Osseointegration is a process where they implant the titanium metal rod into the bones of the amputated limb and through this process we actually anchor the prosthetic right onto the amputated limb and it gives the patient or injured worker with a lost limb the ability to directly control their limb in the prosthetic. It improves biomechanics, improves function, range of motion. It really improves the quality of life. And this has been available since 2021 when the U.S. Food & Drug Administration (FDA) approved the process and the implant. We also have a surgical reconstructive technique called vascularized composite allotransplantation (VCA) and this is an incredible technique where this is the next level of transplants. You heard about organ transplants where we've been transplanting hearts and lungs and kidneys but now because of the advances made in the immunosuppression, we can actually transplant body parts.

So this is why when we talk about hand transplants, arm transplants, facial transplants, ocular transplants, these sound like science fiction but they're being done today and in fact, we have a patient in Paradigm who is in his 40s and has significant severe injury from an electrical injury that burned off his face and his eyes and he's lost his limb. We tried everything to reconstruct his facial structures, but it was impossible so the only option for us to do was to seek a facial transplant and ocular transplant because he had no option. And we had this done successfully this past summer at New York University (NYU). And then you may have heard about this because there's been a big new splash in CBS last week and the patient is doing incredibly well with regaining the function of the face. He can smile. He can kiss his wife. It's been pretty impressive to watch. And then one last innovation I want to share. I think it's very exciting. It's not here yet, but it's coming. And maybe you have heard about this. It's called the brain computer interface and this technology is pretty impressive in that 20 years ago when I was practicing and doing research people will be putting little metal implants micro circuitry in the brain and trying to see how they can help people who could not move with spinal cord injuries but still have brain function to be able to use the computer interfaces to move other external mechanical devices like robots to their function. Well, technology has improved significantly that right now we have a stint which I'm sure you heard of a putting a stint in the heart to keep people from having heart attacks. Well they perfected the stint. They can actually collect their brain signals, the electrical impulses in the brain. And how we do this, we actually put the sensor in the blood vessels of the brain next to the areas of the brain that controls motor functions and cognition and thought. And this signal is then captured by the computer outside the body and then with someone just thinking about doing something the signals then can be translated by the computer and moves the robotic hands and the exoskeletons to do the things for the patient. And so I do foresee this becoming a reality in the years to come where patients who have been paralyzed or have a degenerative disease and can't move will be able to actually engage life again with exoskeletons and robotic care and even those computer based systems can actually voice their wishes. So, it's pretty incredible stuff.

And then lastly because of the technological advancements that are out there, we are seeing a lot of movement toward remote healthcare where we can now monitor patients outside of the hospital. Conditions that we used to admit patients in the hospital for we are now thinking we can send these people home so they can be cared for at home through monitoring. So, pretty incredible stuff, but I'm really excited to be in the field still practicing using these devices that have the options for it. But there is a downside. The downside is these options are very expensive. Some of these options can account for $1 million the first year and that in my mind leads me to the third segment, dilemmas. And I'm posing this to all of you as a way to think about the workers compensation industry as it goes forward because I think these are things that we need to think about because it is coming and the question is how to deal with them? First, is the medical comorbidities. I would say that I think everyone here knows that our U.S. population is getting sicker. More and more people have chronic medical conditions that include diabetes, cardiovascular diseases and we in fact have probably the fastest growth in the immune related diseases as compared to the rest of the world and unfortunately, what I've learned and seen over the past 11 years as being the Chief Medical Officer of Paradigm and dealing with workers compensation cases and catastrophic injuries is that many people who get injured at workers comp have comorbidities. Premorbid conditions. And many times these premorbid conditions get aggravated and exacerbated and now becomes rolled into the workers compensation responsibility. And my question to all of you would be in the years to come when we know that the fastest growing worker population is the elder population and the Bureau of Labor Statistics (BLS) actually predicted that from 2019 to 2029, the fastest growth in the workforce will be in those aged above 65, which I have a hard time believing, but that's what they say. So, if you're saying 55% growth in that particular age category, I'm going to assume they're going to have a

lot more medical problems that we'll be bringing to the table. So they will get injured and the question is what does that impart to workers comp?

The next concern that I have is with healthcare access. I think everyone here has been hearing about the growing burnout rate with physicians and healthcare professionals in our country. In fact, Medscape did a survey of the doctors last year and discovered that 42% of the physicians claim that they have burned out. Right now they're practicing, but they've burned down. Modern Health Magazine did a study where they figured out that in 2022, 145,000 healthcare professionals left the industry. Half of them were physicians, 71,000 doctors stopped practicing. And ultimately my question is as we have demand that's increasing, but supply shrinking, how are we going to take care of these patients? And from a workers compensation perspective it's going to be taking much longer to get our injured workers to be seen by the practitioners and if there are delays in the care then I think it's going to impact both the medical costs as well as the indemnity severity as well. And then lastly, the concern I have with healthcare delivery system. I'm not saying anything new when I say that our healthcare system is broken. It's a very complex and very fragmented system that we live in. But there are two factors that I see that are growing and that's going to be a challenge for the workers compensation industry. First is the issue of consolidations. Consolidations are growing in the healthcare market. Consolidation that involves hospital systems combining and merging. Consolidation involves practitioners, physician groups that are combining and consolidating. And other healthcare professionals are consolidating. And when you look at the data and the research out there on the impact of these consolidations, and Robert Wood Johnson did a study on this, they showed that the quality did not improve with consolidations but what they did see was a heightened rate of pricing. The prices go up an average of 10% to 40% after consolidation. And so my concern is what is that going to do to the workers compensation industry when we are the only payer left in the healthcare market that pays the first dollar forward? So, that's my second concern is the fact that the healthcare industry has become efficient and they become proficient in cost shifting. Every payer besides workers compensation has become great at cost shifting. Even Medicare, Medicaid, group health has been doing this for a long time but they've been cost shifting to other people or other entities to pay for cost of care. And the biggest way they do it is through co-pays and deductibles, for some. But others, I think it's time to figure out that, "Hey, if I can get my medical cost paid for by workers comp because when I get injured they may be able to absorb some of my medical care needs that has to do with my comorbidities" - this is a great way to cost shift to workers comp and I think workers compensation is a great system. I think it's the best system. It really cares about the injured worker and does what they can to make sure that the injured worker gets the best care, best level of function and gets back to reality, and back to work. But I wonder how long can we do this when the rest of the healthcare system is set up to exploit workers compensation.

Sen. Hackett stated before I turn it over to the committee, I have a couple of questions. First question - when you talked about and summarized COVID it was that we had good news and bad news. And the second question - commercial real estate is not a great investment in Ohio now because of so many more people are working at home. But you talked about the cost shifting so when we have claims at home are they really workers comp claims? And that's a real dilemma that our state-run workers comp system is facing now if people get hurt at home. So the first question is, in your professional opinion do the pros outweigh the cons? I realized claims have gone down, but severity claims have gone up. We've had a little of a new COVID come in but it's more like the flu, etc. It's not as dangerous as it once has. So in your professional opinion do you think long range, we're going to continue the downward spiral of cost of workers comp or is it going to level up and start going up again? Dr. Choo stated that my personal perspective is that I think the cost related to COVID is going to go down and the reason

I say that is because I think the pandemic was a period of confusion for many. And I think we now have more knowledge and more safety nets and safeguards to make sure that we appropriately manage the COVID related kind of situation. I think that the COVID issue will be on a decline. Now having said that, I know that most of us know that the companies are still in the hybrid situation where a lot of people are working from home and it's my personal perspective that I think more infections occur at home versus at work just because the closest to contact. So I don't know the answer, but I do think that the longer we stay hybrid, it could potentially increase the frequency of COVID infections but I think the severity of COVID has definitely been dampened so I don't think that would amount to a high cost. As far as the other severity that you mentioned, I do think the severity of medical cost will continue to grow and the reason for that is because I do not see the healthcare delivery system as it's set up today to curb the appetite for the increasing costs of medical care.

Sen. Hackett stated one of the dilemmas you talked about was the healthcare dilemma delivery system. I come from a smaller rural town and I was on the hospital board. We're affiliated now with two big city hospitals in Columbus. Actually, if you remember, we went to a time and we still have a little of it where everybody had to have an MRI, everybody had to have this, and we didn't really have good efficiency. One of things we're seeing is the rural hospitals aren't being closed. They're just not being hospitals, instead of being called Madison County Hospital, it's Madison Health. And so, I think we're looking at doing better in efficiency where they send them to Columbus for all the cancer and all the heart and the MRI's etc. So in some ways, don't you think we're getting a little better efficiency because of the forcing of healthcare systems to smaller and to bigger healthcare systems? Dr. Choo stated that I do agree that there is a growing movement toward efficiency in the way you described it where previously I think there were county hospitals and hospitals all around the country to serve the needs of the population and I think that the driver for that was if you have an acute care hospital in the city or in the township and it's easily accessible, that would lead to better care. I do believe that the level of expertise and the specialization has evolved to a point where the specialized care has become much more important. And so some of these outlying hospitals may not have the capacity to be able to be proficient in taking care of such conditions and so it does make sense to have them be efficiently transferred to a center where they do a lot more of those cases. I would say that even though that is true, I still think that there is a way to work out a delivery system in a way that can benefit both - that it can be delivered much more timely and accessible to the local community while at the same time being able to be transferring the appropriate patients to the bigger centers where they can do more of these kind of specialized procedures. But I think the challenge with that is that the big centers would love to be able to go ahead and just pull patients from all over the area to their location because it makes sense for them. But I do think there's a way to take care of some of those people still at the local level through the guidance and through the telemonitoring and telemedicine and other ways to share expertise so that some of the care can be delivered locally.

Rep. Jane Pringle (ME) stated I have more of a statement in response to your comments. There's a large body of literature about the burnout and that the burnout in large part is moral injury. People who go into medicine go in because they want to take care of patients and they want them to get better and they want them not to have barriers to getting the care they need. So, as we have developed the kind of for-profit healthcare system that we have, we put a lot of barriers to patients getting care. High co-pays. People can't afford it so they go without the medicine they need. We know if we prevent diabetes, you wouldn't have the comorbidities. I spent 43 years as a primary care doctor and I know that I saved a lot of money and a lot of lives but I can tell you I've had two terms nonconsecutive on health coverage and insurance and financial services in my state. And I can tell you it is just discouraging where it's hard to recruit

primary care doctors coming out of medical school into primary care. And our medical organizations and other states are pooling together and making public statements that we believe there is a solution and it would be national single payer health system that was evidence based and proven to have good health outcomes and the only thing we need is a national will to do that.

UPDATE ON FEDERAL WORKERS' COMPENSATION INSURANCE ISSUES

Doug Holmes, President of Strategic Services on Unemployment & Workers' Compensation (UWC), thanked the Committee for the opportunity to speak and stated that UWC is a national association that represents business in many states with respect to unemployment insurance and workers compensation legislation and policy. I think the discussion about cost shifting is really a big part of what I do professionally to analyze federal legislation and policy and try to avoid cost shifting to the employer financed state based systems of unemployment and workers compensation. That shifting comes in a number of pieces of legislation. So, I'm just going to take a few minutes to discuss federal impacts on workers compensation and here are ongoing issues that we're engaged in. First of all, many of you may remember that way back in 1972 there was a National Commission on workers compensation that had a series of recommendations. We're still talking about those recommendations, many states adopted some of those recommendations but many states did not oftentimes because of cost or because they did not want to make a new federal mandate matter of state law. But that's still on the agenda it seems every time we have a discussion. Oftentimes we see proposals to shift costs from Social Security disability insurance to workers compensation. There are 15 states that have reverse offset provisions. So there was already a workers compensation law in place going back to as long ago as 2011 in the state based on a state constitution or legislation. Yet we have these proposals that seek to eliminate the reverse offset. So, many states, 15 or so, enacted laws that said, when you make a determination as to what the workers compensation indemnity payment is going to be that there's an offset for Social Security. Social Security also has an offset going the opposite way. So, there are proposals from Social Security on a regular basis to eliminate the reverse offset as a way to save money for Social Security but of course that shifts costs to employers and to states. So, we oppose those.

Shift costs from Medicare and Medicaid to workers compensation conditional payment reimbursement. Many of you may be aware of this that if an individual goes in and receives services under Medicare or under a state Medicaid plan and those are charged because of convenience, because they're unsure about whether there's workers comp coverage but go ahead and provide the services and then seek reimbursement from workers compensation. Unfortunately, the services to be provided don't necessarily match and so you oftentimes have demands for conditional payment recovery made to payers that are inconsistent with what the workers compensation and the state law provides so that creates friction. So, we try to eliminate that as much as we can and we oppose that kind of cost shifting from usually it's the Centers for Medicare and Medicaid Services (CMS) to workers comp payers and in some cases the states if they're monopoly states like Ohio. Medicare for All, I'll talk a little bit about that. We have proposals again from Senator Sanders and Representative Jayapal and they create federal preemption against states providing items and services under a workers compensation medical plan. That creates quite a transition issue and a series of issues and we're opposed to those pieces of legislation as they have been introduced. There are proposals to expand federal workers comp programs and leverage for state workers comp expansion advocacy. So you will have proposals that seek to require states to make changes in state law and do it as a function of federal law. So, we're always on the lookout for that. The things that we look at are what is the real impact of the change? Is it a cost shift or not? What is the impact for payers? What is the

impact for employers? And what is the impact for the individual injured worker? And try to come up with solutions that make sense but preserve the state based workers compensation system.

We also opposed the COVID-19 presumption legislation that was introduced by Representative Frank Mrvan from Indiana who sought to create a new presumption if anyone had an infection due to COVID that they would be presumed to be covered for workers compensation. We oppose that not only at the state level, but also at the federal level with respect to longshore noting that COVID-19 is an infectious disease and you can be exposed and acquire the disease virtually anywhere so it's not an occupational disease. In fact, that was recognized by the Supreme Court in recent case law finding that it was not an occupational disease. So we opposed that legislation as well. We also oppose the quote "monitoring" issue - there are multiple proposals to have federal agencies monitor state workers compensation and to evaluate how the state workers compensation programs are shifting costs to federal programs. Of course, we thought that was sort of an absurdity since workers compensation at the state level was created going back to 1911. We didn't even have Medicare and Medicaid and Social Security disability until decades later. So these programs are built on top of an already mature system that was legislated at the state level and oftentimes under state constitutions. It's sort of crazy to talk about how that state system is shifting costs to the federal system. Of course, congressional staff have a hard time figuring this out because there are of a mind to protect the federal programs, not the state programs.

Regarding, Medicare for All proposals, I'll give you a flavor for what is included in those proposals. In H.R. 3421, each workers compensation carrier that is liable for payment for workers compensation services furnished in a state shall reimburse the Medicare for All program for the cost of such services. Of course, that has a problem because the services that are covered for workers compensation under the state law are not the same items and services that are covered for Medicare. So, it doesn't work. Beyond the fact that if there's a presumption or a federal preemption against having workers compensation insurance that creates significant transition issues and of course, tremendous problems for many of the claims that have long tails. Got a workers compensation claim that is for life, how do you end it in the middle because of the new federal preemption? Doesn't make sense. So, we coordinate efforts to oppose those kinds of proposals. Now, on the plus side, what we are doing is working on a proposal we call the COMP Act to clarify that if there is a settlement under an applicable workers compensation law that the workers compensation law determines the terms of the settlement. It seems like an obvious thing, yet you have CMS in its administration of Medicare second guessing the settlements that are arrived at under the applicable state law and creating lots of confusion and unnecessary administrative costs and unnecessary risk. And so, what our legislation does which we expect to have introduced fairly soon, is to clarify that state workers compensation law applies to state workers compensation and it is not preempted by new federal statutes. I'll stop there and note that a big part of our mission as an association is to protect the employer financed state based programs of unemployment and workers compensation. We actively do that on a regular basis in all policy and legislation at the federal level.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Roberts and seconded by Rep. Nicol, the Committee adjourned at 3:15 p.m.