NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 25, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Francis Marion Hotel in Charleston, South Carolina on Friday, April 25, 2025 at 9:45 a.m.

South Carolina Representative Carl Anderson, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Mike Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. David LeBeouf (MA)
Del. Mike Rogers (MD)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Brian Lampton (OH)
Rep. Tom Oliverson, M.D. (TX)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Brett Barker (IA)
Sen. Steve McClure (IL)
Sen. Julie Morrison (IL)
Rep. Bill Sutton (KS)
Rep. Adrielle Camuel (KY)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Sen. Rick Girdler (KY)
Sen. Franklin Foil (LA)
Rep. Robert Foley (ME)
Rep. John Fitzgerald (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Rep. Jennifer Balkcom (NC)
Sen. Bill Gannon (NH)
Asm. David Weprin (NY)
Rep. Forrest Bennett (OK)
Rep. Perry Warren (PA)
Rep. Alex Finkleman (RI)
Sen. Matt LaMountain (RI)
Rep. Joe Solomon (RI)
Rep. Calvin Callahan (WI)
Rep. Barbara Dittrich (WI)
Sen. Cale Case (WY)

Also in attendance were:

Will Melofchik, NCOIL CEO
Anne Kennedy, NCOIL General Counsel
Pat Gilbert, Director of Policy, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Mike McFall (MI) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Del. Hall and seconded by Sen. Lana Theis (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 22, 2024 meeting.

DISCUSSION ON THE USE OF ARTIFICIAL INTELLIGENCE IN THE WORK COMP MARKETPLACE

John Alchemy, M.D., Founder & CEO of RateFast, thanked the Committee for the opportunity to speak and stated that I'm here to give you a report on the use of artificial intelligence (AI) in workers' compensation. Just a few credentials about myself. I've been doing workers' comp in California for 30 years now and I have the privilege of both running a software company that utilizes AI and an actual practice where I serve as the primary treating physician. I do about 10,000 visits a year. We hold eight method patents in the area with more pending in intellectual properties out of Silicon Valley. I know that there's a lot of questions about AI and I'm doing a high level talk about it. The slides are interesting, I may or may not get through them all within the time, but what I do want to say is a couple of things. Our company manages just a sliver of California's work comp injuries. Each year we have about 600,000 claims about 30% of which will be litigated and with the application of AI, the early results we're seeing is that our company, which is extremely small, utilizing it through the actual interface in the medical practice, which works with insurance companies and the judicial system, has already saved about $3.9 million in just to date for this year. And we've saved about 333 years of litigation throughout the first quarter. These are big numbers and if we scale that to California, which is the fourth largest economy last time I checked, we're looking at a savings annually of $3.2 billion, and I calculated it this morning, 270,000 years of litigation. So, there's a lot of exciting leverage up ahead for AI. We're still in the early days and I wanted everyone to kind of think back to the year 2000, because that's where we are with AI right now, at least in workers' compensation. That's back when everyone was looking to the Internet as the new next thing and weren't really sure if it could be monetized or not. And that's exactly where we are with AI. We're trying to understand what do we do with it, how does it serve us, and how do we understand it. And if I bring one message today, I really want to bring my thoughts and ideas as to what the regulations should look like and how we should think about this going forward, because the regulation is very superficial right now. Not a lot of people understand what it's doing, and I have some thoughts that I'd like to share with you. The first experience I've had, and we've been working with AI and the company in earnest now for about 18 months, is that it's very much like trying to work with a five-year-old. You ask it some very simple questions, it can do it. Sometimes it won't. You make it more complex, it's less cooperative. And that's the age, I think, of AI right now as far as its benefit to us. As time goes on, I think that that's going to get more helpful.

The next thing I want us to think about is two types of AI. One is the generative that we're all familiar with, chat GPT. You type in something, it gives you a response. The other one that I'm much more interested in is the extractive AI and that's where AI can use its large language model and pull out the information for clarity, consistency, large data files, etc. Now, the other thing I also want us to think about when we're thinking about regulation, at least from my standpoint, is that if two cars run a stop sign, one's driven autonomously, and the other's driven with a person, do they both run it for the same reasons, and this is going to be the big problem I think with regulating AI because when the human ran the stop sign it was covered in snow and they didn't see it. But when the self-driving car ran the stop sign it ran it because it didn't see any other cars coming. So, I think we can use that as a model to think about the biggest challenge in regulation is going to be understanding the mental steps and how they match the human expert and being able to verify that as we start to integrate this into AI. I think the other big question we need to think about is intellectual property and work products of doctors. The AI

regulation I think belongs more squarely in the intellectual property arena than anywhere else. And I think if we wanted to look at the canary in the coal mine we only need to look at the legislation and litigation around self-driving cars right now. So, that's what I wanted to hold out.

I'm going to run through my slides quickly and I'll take any questions. Basically, in work comp, our big challenge is getting fair benefits in a timely solution, scaling it, getting it consistent. Doctors typically tend to give variable results. They have various understanding of the rule sets, and that all translates into high friction and a lot of litigation. This is just another slide talking about the big administrative delays. In California, I've read anywhere from five to seven years is the average for a litigated case to close. So, a lot of money, a lot of delay. AI solutions, the data-driven approach is really great. We use the American Medical Association (AMA) guides fifth edition. Getting that integrated into a format that is consistently followed is very challenging. But I'm going to show you a slide how I think AI oversight really needs to be run and how we run it in our company. So, the benefit is, of course, improved data quality. I'm just going to throw this out there. California really doesn't have any insight into its impairment rating. They have boxes and boxes of scanned faxes, but they have no way of looking at the data. And once we start doing more of an automated rating system, we're going to have great insight into the efficiencies and the waste of the system. So, I think that there's a lot of great data opportunities above, and we're basically at the tip of the iceberg on that one. Stakeholder advantage. I've always thought this is interesting about Work Comp. The system is really developed for two stakeholders - the employers and the patients. And the great irony of the whole thing is that the stakeholders are the least educated of the system. It's the insurance companies, it's the doctors, it's the litigators, it's the administrative judges. So, being able to use AI to give insight and to also simplify the reports is extremely valuable for a patient to understand what a 9% means and why it's not 50%. All of these things can be clarified through AI and also reflected in the reports.

This is probably the most important slide that I'll show you, and this is how I see AI being developed in a responsible way that's consistent. Remember, when a doctor writes a report, if it has to go into AI, the real question is, is the doctor's work product being materially changed? And that's an intellectual property and a copyright question. And for AI to be properly applied, it cannot change the work product of the doctor, in my opinion. It has to come out with their work intact, and AI is really just used to simplify and clarify the facts for all the stakeholders.
So, in this process, you can see that when a client submits data, it first goes in front of the human eyes, and then it goes into the AI system, and when it comes out, the human expert on the other side also reviews it, compares the two, and then it goes back into the AI, which is that center box if it's correct, to train the model. And then, of course, it goes back to the client.
Now, the second loop is when the client looks at that finished product is it what they want to sign their name to? Has it been changed materially? And if it has not then that definitely goes out and it gets litigated and processed and closed. But if it isn't it goes back through the system. So, this is a really important human oversight expert where the AI is the assistant. Now someday I will say that the roles may switch where AI has a human assistant instead of a human having an AI assistant. But this is the way that we develop our data cycle in AI training because we are in a very litigious interface between the medicine and the law.

This is just a case study, it was actually a real case and I'm what's called a qualified medical evaluator (QME) in California. We had a case come in a case of mine where I served as the medical legal expert and the problem was that the primary treater could not rate the case. So, in California when the doctor cannot read the case, it goes into the QME system. So, this case came to me, but because of the system I had to work in, turning around reports, getting things done so the case could be finalized, it really added 35 months and almost $150,000 to the claim file. And had we been using an AI-supported model, this could have been resolved at the

primary treating physician. And when you think about 30% of 600,000 cases going through a process like this, that's a big number. And that's a very expensive proposition. Just some of the things I hope I've impressed upon you, AI is very good at administrative rule sets. It's great at pulling out the identity of cases and the data that can be distilled down for a very easy examination. The other thing that we have with AI that we've never had before is a repair list. AI can actually look at a report and it can create a list of what's missing and what's present, extremely helpful. There's also applications where AI is probably going to be guiding more and more depositions with attorneys, claim strategies, and all of these things. And then, of course, reducing bias and improving transparency, which I think everyone wants, of course, speeding up the claim resolution and getting everyone settled and happy. And then I'll leave you with a positive note that I think is happening. Over the last six months, I'm getting more referrals to the practice and to the company because insurance companies are getting reports back from their doctors in California that give them a zero impairment rating when they have clear limitations in disability. And these insurance companies that are becoming much more smart to the process are submitting this to us saying, please analyze this report. We cannot submit it for zero to the judge and what is the true claim value? And that's becoming more and more of a trend now. So, we're having AI review and support cases and insurance is already seeing the benefits of it.

Sen. Lana Theis (MI) stated that I found it interesting that you were talking about saving litigation years and I'm wondering how you came up with that estimation. Dr. Alchemy stated that at least by California standards, the average case, when a doctor can't rate a case on their own at the primary treating level, which is legislated, actually, a doctor is required to do that if they're treating a patient. But if they can't, the average of putting that case through the qualified medical legal system that is the alternate in the state is 18 months. It's 18 months to move it through the process, about two and a half visits spread out by about six to eight months. So it's a lot of time investment when that has to happen. And I will say it's a huge inconvenience to the patient. A lot of these people don't have income coming in and putting them through another 18 months of sitting around is really a hardship.

Sen. Jesse Bjorkman (AK) stated that where I serve in Alaska we've seen the use and introduction of AI in the prior authorization space for health care and essentially, it's been an AI battle between payers and providers of who has the best AI to navigate that space and who gets paid and what care gets provided, resulting in lots of delays and things take more time. That's certainly not what I just heard from you in describing your product in the work comp space. What protects workers who are injured who need to get evaluated and hopefully back to work as soon as possible from delays caused by AI? The use of AI in health care has caused significantly longer delays and higher costs and people getting less care. Can you outline for me how we can put sideboards on this so that states don't have to build up their own AI systems to battle AI systems that are put up by payers? Dr. Alchemy stated that utilization review is a big problem in California as well and the problem is right now it's going to be AI appealing to AI. Eventually it’s the way that it's going to go. The way I would like to see it is a centralized AI system where either the doctor or the insurance company could submit their files and it would be the AI that's of neutral territory, if you will, or state regulated that would determine what needs to be done on the case to either get it approved or what's missing in the case, and function in a much more neutral situation. And I was a utilization review doctor for a couple of years with the insurance company, so I've played both sides of that. But that's I think where it really needs to go. Otherwise, it's going to be who has the most money in development to get the better AI.

PRESENTATION ON IMPACT OF VERTICAL INTEGRATION ON PRICES, MEDICAL UTILIZATION, AND OUTCOMES

Sebastian Negrusa, Ph.D., VP of Research at the Workers' Compensation Research Institute (WCRI), thanked the Committee for the opportunity to speak and stated that today I'm going to talk about some work that we conducted at WCRI on the impact of vertical integration in the medical sector on various outcomes of interest for the workers' compensation industry. So, I'm going to talk briefly about three main things. What exactly do we understand by vertical integration in the medical sector? How pervasive, how widespread vertical integration was in the last few years? How is that reflected in workers' compensation? And of course, I will spend perhaps most of my time talking about our estimates of how vertical integration has been impacting the workers' compensation industry. And those outcomes are already in the title, medical utilization, medical payments, and the duration of temporary disability. WCRI is an independent, not-for-profit research organization. We only provide the facts. We are researchers who provide state legislators and public officials with information that is helpful in workers' compensation issues. Our studies are peer-reviewed. We have no positions. We make no recommendations. We only, as I said, provide you all with the facts.

So, what is vertical integration? Vertical integration is a form of market consolidation, and as with all market consolidation situations, that can lead to a reduction in the competition in the market. In this case, the market being the healthcare market. And the ultimate consumer, which in our case would be the injured worker, might be negatively affected by this type of consolidation in the healthcare market. Now what we understand and what we have been using as an operating definition for vertical integration throughout our work was situations where a health system or a hospital takes over or purchases ambulatory service centers or independent physician practices. So this is a situation that I believe most of us encounter these days when we go to the doctor, we have a medical bill and if there's a health system logo on that bill that means we have been treated by a vertically integrated provider. And again, this is a phenomenon that's external to the workers comp system it's not necessarily happening just in the workers comp system. So, let's see how pervasive this phenomenon was over the timeframe of the study 2012-2018 just before the pandemic. To simplify things in terms of empirical estimation, we see that there is a substantial increase in the proportion of physicians providing care to injured workers within vertically integrated organizations. And the bars at the top show you the change from 2012 to 2018 for all physicians providing care to injured workers. And then at the bottom, you see similar trends for primary care and orthopedic surgery, two specialties that are of higher relevance for the workers' comp industry. So, this has been a phenomenon that has been fairly widespread and anecdotal evidence indicates that it has continued through the pandemic period. Let's move to a preview of our main results - what we find is that vertical integration leads to changes in the amount of medical care injured workers receive, that is, it increases the amount of care, and that happens through more services when a physician or a provider sees the injured worker through more visits, that is, the injured worker is seen multiple times by providers. There are more imaging services being provided.

Okay, then what are the implications in terms of per-claim medical payments? The implication is that per-claim medical payments go up as a result of vertical integration, and then we also find that this doesn't translate into faster recovery as measured by duration of temporary disability. We do not see a decrease in temporary disability when an injured worker is treated by a vertically integrated provider. So these are the three main things that I wanted to talk about. Let's get into some of the details about these main findings. Now, we are researchers, so please bear with us. We have a bunch of numbers here. Those should be fairly easy to follow. As you see on the left-hand side of this chart, we have four measures of medical utilization, services per visit, claims, number of visits per claim. And on the right-hand side, we see our estimates coming from our empirical objective work, indicating the impact of vertical integration on these measures of medical utilization. So, we see an increase in the number of services per visit, and

this is all at six months maturity, so six months since the injury. We see also an increase in the number of visits per claim, something that becomes much more clear at 12 months and later in the injury. And what's also noticeable here is that there is a substantial increase in the number of evaluation and management (E&M) visits. So, at that time, six months since the injury, we go from about eight E&M visits to nine E&M visits as a result of vertical integration. So, a substantial change that only grows larger as a claim matures. So more care is being provided. How exactly is this more care being provided? Interesting to see that it is provided through more medical providers, and that happens through more advanced practitioners like nurse practitioners and physician assistants being present in the treatment of the injured worker, but also specialists. So, specialists may be available down the hall in a vertically integrated organization, therefore there are more specialty services provided. That's one hypothesis we came up with. But definitely what we see is a substantial increase in the number of medical providers caring for the injured worker as a result of work integration. One other aspect of medical utilization, imaging services. A lot of the injuries in the workers' comp space are musculoskeletal injuries and some of them may require MRI or CT scan services. But treatment guidelines are very conservative and oftentimes they do not recommend such procedures unless really well justified. What we do see in our work is that there is a substantial increase in the number of MRIs and CT scans, so major radiology services that are provided to injured workers as a result of or after or in the aftermath of vertical integration.

Okay, so let's come back now to the details of what vertical integration in the medical sector does to medical payments in workers' compensation. So, medical payments per claim at six months' maturities are about $4,000 for claims with lost time, more than seven days of lost time. Now when a worker is treated by vertically integrated providers, that medical payment per claim goes up by about $280 so that is around 7%. This is at six months since the injury. Then when we look at the difference between vertically integrated treated versus non-vertically integrated treated injured workers, the difference in medical payments per claim goes up even more to 11% and that translates into something like $560 per claim additional medical payments. So, more care, more expensive care, in terms of per-claim terms, does that lead to a quicker recovery? Well, we do not find evidence pointing towards quicker recovery as a result of more care and more expensive care being provided to injured workers. If anything, we see that the duration of temporary disability, which is only a proxy for the actual return to work, we do not have information on the actual return to work of the injured worker, but we do have information on their duration of temporary disability. We do find that the increase in the duration of temporary disability at six months since the injury goes up by about 7%, which translates into something like 0.7 weeks, so a little less than a week. But when we go to 12 months since the injury, that difference goes up to almost two weeks. So, of course, one potential explanation here is more care is provided so that automatically takes more time. So instead of, if the injured worker receives, as I said, nine E&M visits now relative to eight, well that automatically takes more time. But what we see is definitely no evidence that a vertical integration leads to a shorter duration of temporary disability and a quicker return to work. So that's what I had on these slides and this is what I wanted to bring to your attention and these are the main conclusions coming from this study. And of course, we have a report with a lot of details and we have a lot of other studies on this topic and similar topics on our website so please feel free to reach out to us and please let me know if you have any questions or comments.

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated that I really appreciate this presentation and I know in Texas, this is something that we've been very concerned about, vertical integration. The workers' comp perspective is interesting to me since the medical treatment guidelines are fairly standardized in most states, and so it's not like the doctors are really thinking outside the box. They're sort of following the protocol, right? And so, I would say

that's very structured, and probably thus the amount of damage that's being done in terms of it increasing cost is probably relatively contained to what it could be if the sky was the limit, right? Because you have all of these various things. But what I'm really curious about is has WCRI looked at how many of these vertical integration type practice settings where there's an actual statement of principles or governance documents or clinical governance structure that would essentially prohibit conflicts of interest between the physician and the employer, as the physician is trying to take care of the patient? Have you studied that at all? Because that's the thing I really worry about. Dr. Negrusa stated that's a great question and this was a statistical study in which we didn't go down to that level of detail but that's definitely venue for excellent future research.

Sen. Theis stated I have a couple of questions. First, is there any evidence of improved outcomes as a result of increased costs? Dr. Negrusa stated that our data do not allow us to get into quality of care measures. We do not have information on mortality or outcomes that health services research would look at. We only have information on medical payments provided to injured workers, indemnity benefits, and a number of services. Sen. Theis stated that my second question is, are there any states where they discourage the vertical integration where you'd be able to do a side-by-side comparison? Dr. Negrusa stated that we did not take that dimension into the analysis. Something similar what we did along these lines was to look at states with and without fee schedules.

Rep. Barbara Dittrich stated that hearing this data, I think of what are possible solutions? And I know you're focused on the research but I guess that goes to what are you seeing states do with this sort of information? Dr. Negrusa stated that I'm going to resort back to our initial statement that we are an independent research organization and we do not make recommendations and we do not take positions.

INTRODUCTION AND DISCUSSION OF NCOIL EXPERIENCE RATING MODIFICATION MODEL ACT

Rep. Anderson stated that next on our agenda is the introduction and discussion of the NCOIL Experience Rating Modification Model Act. You can view the model in your binders on page 13, as well as on the website and the app. Before we go any further, I'll recognize Rep. Michael Sarge Pollock (KY) who is co-sponsoring the model.

Rep. Pollock stated that I'm pinch hitting for Rep. Matt Lehman (IN), sponsor of the Model, as he unfortunately couldn't join us due to some last minute session issues. But I'm happy to co-sponsor this model which deals with a pretty straightforward but important issue. In work comp, businesses can have experience rating modifications which involves calculating a summary of losses against what is set as expected losses in that class. If you perform better than expected, you obviously will get a credit modification. Your premium will be lower. If you perform worse than expected, you will get a debit modification and your premium will be higher. This model deals with the situation Rep. Lehman described to me where it was a trucking risk and the company's driver was in an accident and he wasn't at fault. He had medical expenses, lost wages that were paid by work comp. But during the process with subrogation by the work comp carrier against the at-fault auto carrier, that loss hit the company's experience modification. And they were paying an additional 30% in premium through no fault of their own. Due to the extent of the injuries, it was several years until the claim was successfully subrogated. And while the carrier was made whole, the trucking company was out the additional premium during that time. So, this particular model deals with two issues against that backdrop. First, many times in an effort to limit a pool of potential bidders on a project a company may prohibit an entity from

submitting a bid if they have an experience rating over a certain amount. Section 3 of the model prohibits the experience rating from being the sole basis for not bidding on a contract. Second, if the carrier is successful in their subrogation, then the governing rating bureau shall go back to the date of the loss and recalculate the client's experience rating to make the entity whole. I don't want to take up any more time, so I'll just reiterate that I'm glad to co-sponsor this model, and I look forward to this committee discussion throughout this year.

Tim Tucker, Executive Director of Legislative and Gov't Affairs at the National Council on Compensation Insurance (NCCI), thanked the Committee for the opportunity to speak and stated that I'm not here to speak to the model that's under consideration by the committee, but rather I've been asked to discuss NCCI's experience rating plan, which would be impacted should this legislation be enacted in a state. NCCI is the Workers' Compensation Statistical Agent and Rating Organization in 38 states. In addition to our role as a stat agent rating organization, we provide tools, insights, information to state and federal public policy makers. Those issues can directly or indirectly impact the state-based workers' compensation system. Like my counterpart to my left, NCCI is not an advocacy or lobbying organization. We do not take public policy positions on legislation, regulations, or model acts. So, we're really here to present some information, and answer any questions you may have. So, NCCI's experience rating plan, or ERP, is an integral component in determining the cost of workers' compensation, and it's a method for tailoring the cost of that coverage to the characteristics of an individual employer. The ERP gives employers an incentive to manage its own expenses through meaningful and measurable cost-saving programs. Experience rating recognizes the differences among employers with respect to such things as safety and loss prevention. It does this by comparing the experience of individual employers with the average employer in the same classification. So, roofers are compared to roofers, office personnel are compared to office personnel. The differences are reflected in the employer's experience modification factor, which is unique to that employer. The modification factor can result in an increase, a decrease, or no change in the premium. In Workers' Compensation experience rating the actual payroll and losses of the individual employer are analyzed over a period of time, usually the current plus the past three years. However, that can vary from state to state. Policymakers in states have taken slightly different approaches. But these look-back periods, if you will, do formulate the experience modification factor.

So, what does the ERP do? Employers are grouped according to their business operations or their classification code. Estimated losses for the group are added together to determine an average, and then the experience rating is designed to reflect individual differences by the employer. Some have asked why even have an experience rating system. Experience rating presents a refinement in the premium determination process. It benefits employers by adjusting the premium cost, which is the best indicator of an individual employer's own potential for incurring future losses. Implicit to any form of experience rating is a prospect of both debits and credits. Experience rating also provides an incentive for employers to focus on loss prevention and claims management programs. There are three types of experience rating modification factors, unity, which is one. There's credit mods and debit mods. For example, taking $100,000 of premium, an employer with a unity mod would pay a premium of that $100,000. An employer with a credit factor or a mod of .75 would pay $75,000 in premium. And an employer with a debit modification factor of 1.25 would pay $125,000 on that premium. So, really we're looking for precision on the individual employer to provide the best indication of potential future losses. So, that's an overview of our rating plan. We have a lot of information on the formulas and the details on our website at www.ncci.com. But I'm happy to answer any questions.

Rep. Pollock thanked Mr. Tucker for the information and stated that I'd like your opinion and your thoughts on that scenario I described in my opening remarks as to whether you think that's fair or not. Mr. Tucker stated that what I will say is there is a mechanism within the experience rating plan that does account for recoveries whether it be through subrogation second funds or things like that. I think the question if I understand the intent of the model is to consider whether or not that duration of the look back is adequate or should be extended and that's a matter of public policy which of course we wouldn't opine upon.

Rep. Brenda Carter (MI) asked if these provisions create legal or administrative challenges for NCCI and would it increase potential cost to the insurers? Mr. Tucker stated that I'm not really sure but what we do look to do with our experience rating program is be as precise and reflective of actual loss as Rep. Carter stated what I'm looking for potentially is you use actuarial models to determine rates, is that true? Mr. Tucker replied yes. Rep. Carter stated and in doing so, is there a risk of exposure of the information that you receive and could that potentially lead to legal actions? That's what I'm getting at. Mr. Tucker stated that we're a little unique in the workers' compensation line as NCCI generally does not have personally identifiable information, so we wouldn't have those type of things that we usually think about as exposing to privacy issues and those type of things.

Rep. Alex Finkelman (RI) stated that if I'm not mistaken, a couple of the primary factors of an experience mod are the actual losses versus the intended or expected losses. Is there a possible way, because they bring up a great point that people are being penalized and losing out on jobs potentially because of the experience mod, that there could be a third factor of expected or intended subrogation? Mr. Tucker replied yes, states have looked at the uses of experience mods, say for contracting, which is part of the model as I understand it, but there are other factors that can indicate whether or not it's a pure threshold for employer safety. There's other things such as subrogation or other recoveries that could impact that. So, we do have some information on the use of experience modification factors in contracting, which I'll be happy to share with the committee, which kind of looks at the other things. So, taking this on its face, there is more that you need to look at beyond just the outright modification. Rep. Finkleman stated but more so as far as the experience factor is calculated, is there a way to include the potential for subrogation factor if an insurance company could specify when they're reporting to the NCCI that this is expected to be subrogated and recovered? Mr. Tucker stated I'm not aware of that approach being applied to experience rating, but I think that's a matter of public policy.

Rep. John Fitzgerald (MI) stated just to underscore the point made by Rep. Finkelman, there are claims practices, I know in many cases where if there's an opportunity for subrogation, deductibles are waived. There's an expeditious claims process that happens. And so, when you include that exact scenario, you have the opportunity to, I think, get a better result for the consumer and for situations like the one described by Rep. Pollock.

PRESENTATION ON TRENDS AND DEVELOPMENTS IN THE SOUTH CAROLINA WORK COMP MARKETPLACE

Scott Beck, Chairman of the South Carolina Work Comp Commission, thanked the Committee for the opportunity to speak and stated that before I get started on some trends, I think it's important to have a little bit of an overview of what our commission looks like. It's substantially different than a lot of states. I've been actively involved in an organization called the Southern Association of Workers' Compensation Administrators (SAWCA) and in the National Association of Workers' Comp Judiciary and I have an opportunity to see what other states' organizational

structures look like, and we're somewhat unique. We're a small agency. We have 51 full time employees (FTEs). Of those 51 FTEs, we have seven commissioners, similar to what you would refer to as an administrative law judge in other states. Those commissioners are appointed by the Governor with advice and consent of the Senate on a staggered system. We have two come up, two come up, and then the final three. So, each of those is assigned an administrative assistant that sort of serves as a clerk of court for that respective office. So, out of 51 employees, 14 of those are those Commissioners and their assistants. So, you really only have mid-30s or so really carrying the load of the work at the commission. We've got a $11.8 million budget, and I think it's important to sort of get some perspective on that. We've looked at Virginia, North Carolina, Georgia, who process roughly the same number of contested cases that we deal with. Virginia's got six times the employees, twice the budget. Georgia and North Carolina, about double to triple the budget, and about double the employees. So, I'd like to think that we're getting a pretty good return on investment for the amount of work that this small agency does. Interestingly, we're not funded by any insurance premium tax. Those are passed directly through to the General Assembly, as are all the self-insurance premium taxes as well. We're funded partially by a general fund allocation of about $6 million and the rest through earned funds, either filing fees, fines, other fees that the Commission collects. Interestingly, though, the workers' comp insurance trends are up. We had last year about almost 129,000 employers purchasing insurance in South Carolina, which was an increase of about 5.5% over the prior year, and then our employers qualifying as self-insured entities was up almost 12% last year. So, the market's looking pretty good. Interestingly, we struggle sometimes with folks that subject themselves to our act and then believe that merely by canceling their insurance policy, they are no longer subject to it. South Carolina, I'm not sure whether it's unique or not, but we have a requirement that those employers have to take an affirmative action to come back out from underneath that umbrella.

So some interesting trends. We have a rather robust compliance program. I think it's important for the system to work fairly and efficiently and that there be a level playing field and those people that are subject to the act should have insurance. Unfortunately, that's not always the case. The role of our insurance and medical services division is sort of twofold. It's an education, public awareness role where we're going out and talking with employer groups with insurance agents, educating them on requirements under our Act. And probably the bigger role is the enforcement section. Looking for employers that are required to have insurance that don't. Those investigations are started in a variety of ways. We partner with our Department of Employment Workforce and data mine from their records. We get claims filed by employees to find out that the employer is not covered. And then oftentimes we get complaints from competitor groups, because obviously somebody is paying a workers comp premium, their cost of doing business is going to be more than somebody who's not. Our goal is to have covered employees. That's the whole purpose of the act from its very inception. From a statistical standpoint, since 2019, these numbers actually surprised me. Now, considering we're a fairly small state, since 2019, we brought into compliance 2,455 employers who were required to have insurance but did not. And as a result of bringing those into compliance, 21,248 employees obtained coverage that they did not otherwise have.

Other trends we're seeing at the commission in South Carolina, claims this year were up, we had 61,320 claims filed in South Carolina this year, which was about a 6.5% increase over the prior year. This is a big industry. Last year, between indemnity and medical, we were over $1 billion dollars paid out in benefits. Of that, about $677 million went to indemnity, $336 million went to medical. Now, we've done some major adjustments over the years on our medical fee schedule. In 2011, which is a few years after I came on to commission, we went, from a hospital fee schedule standpoint, from a discount-to-charge system to a Medicare plus 40 and it saved

us about $100 million a year just converting to that system. The other issue that we try to keep a lid on is the annual update to our fee schedule. We have a Medicare-based system. It's an Resource-Based Relative Value Scale (RBRVS) system with a conversion factor. That's important. We were prohibited from utilizing multiple conversion factors in our system for now. So, when we look at that system every year, we're also bound to a 10% swing in the practice groups from one practice group to another. So, if we see something go above 10% up or down, we have a contractor that does our fee schedule work for us. We normalize to 9.5% because the current legislation in South Carolina gives any practice group the right to sue us before the Administrative Law Court if those swings go up or down greater than that 10% swing. The balancing act is controlling cost but also making sure that we have access to care for the injured workers that we serve. And that's sometimes difficult. We struggle in a couple of practice areas in South Carolina. Neurologists are difficult to find practitioners that want to play in the comp sandbox, and psychiatrists.

There is some current legislation pending in both the House and the Senate here that would give the Commission some additional freedom to factor in adjustments for those types of practice areas. One would eliminate the single conversion factor requirement. The second would eliminate that 10% swing that causes us to try to normalize to avoid litigation costs. I've been on a commission 17 years and I can only recall two years where our loss costs was in the plus category. We've typically been in the minus category most of those years. Some perspective, out of the 61,000 claims we docket over 10,000 of those for single Commissioner hearings. So, administrative law judge (ALJ) type hearings. Where South Carolina's a little bit unique is we're also the first level of appeal where most states have an ALJ and then they have three commissioners that hear the appeals - the seven of us do both. So, if I have a single Commissioner hearing and that gets appealed it goes to three of my colleagues for that first appellate level hearing before it leads to the Court of Appeals in the Supreme Court. Many would think, well, they're just going to get rubber-stamped because they're your colleagues. I assure you there's probably more robust debate in those appellate hearings than maybe at the appellate courts. Interestingly, out of those 10,000 that were docketed, only about 630 were actually tried among the seven. And out of those, last year we only had 64 full commission appeals, which was down 11% from the prior year. And only 13 left the Commission to go to the Court of Appeals. When I came on to Commission in 2008, that number was in excess of 200. So, we've seen quite a reduction in the amount of cases that are leaving the Commission going up through appeal.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Oliverson, the Committee adjourned at 11:15 a.m.