NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
APRIL 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Hyatt Regency in Louisville, Kentucky on Friday, April 17, 2026 at 9:45 a.m.

Ohio Representative Brian Lampton, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Adrielle Camuel (KY)
Rep. Mike Clines (KY)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Del. Mike Rogers (MD)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Jeff Barta (ND)
Sen. Jerry Klein (ND)
Rep. Tim Barhorst (OH)
Sen. George Lang (OH)
Rep. Tom Oliverson (TX)
Rep. Barbara Dittrich (WI)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Stephen Meskers (CT)
Rep. Brett Barker (IA)
Sen. Beverly Gossage (KS)
Rep. Shaun Mena (LA)
Sen. Alonzo Washington (MD)
Sen. Mark Huizenga (MI)
Rep. Sarah Lightner (MI)
Sen. Keri Heintzman (MN)
Sen. Kristin Roers (ND)
Sen. Bill Gannon (NH)
Sen. Tim McGough (NH)
Rep. Julie Miles (NH)
Asw. Pamela Hunter (NY)
Rep. Kellie Deeter (OH)
Rep. Emily Gise (OK)
Rep. Ellyn Hefner (OK)
Rep. Chris Kannady (OK)
Sen. Mark Mann (OK)
Rep. Mark Tedford (OK)
Rep. Greg Scott (PA)
Rep. Perry Warren (PA)
Rep. Yusuf Hakeem (TN)
Rep. Calvin Callahan (WI)
Sen. Mary Felzkowski (WI)
Sen. Jamie Wall (WI)
Sen. Cale Case (WY)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Lana Theis (MI) and seconded by Rep. Matt Lehman (IN), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Barbara Dittrich (WI) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 13, 2025 meeting.

EVALUATING THE OHIO WORKERS' COMPENSATION SYSTEM

Rep. Brian Lampton (OH) stated we're going to start with a presentation on Ohio's workers' compensation system. As you know, Ohio is very unique in that we are one of four states that have basically monopolistic workers' comp coverage throughout the State. Since I'm from Ohio thought it would be a great idea to for the committee learn about the Ohio system.

Stephanie McCloud, CEO and Administrator of Ohio Bureau of Workers Compensation (BWC) thanked the Committee for the opportunity to speak and stated that BWC represents 6 million Ohioans, and we are responsible for the prevention and treatment of workplace injuries for them while they are in the workplace. As Rep. Lampton stated, we are only one of four states that by law is the exclusive provider for workers' compensation with the others being Washington, Wyoming and North Dakota. Our job is ensuring that workers injured on the job receive the medical treatment necessary, fair compensation during recovery, and support to return to work safely. We are dedicated to our mission of delivering consistently excellent experiences for each BWC customer each day. Our operations are funded by premiums that Ohio's 245,000 private and public employers pay for insurance coverage.

We have roughly 1,600 employees. We are serving about 200,000 workers comp claims. We have about $24 billion in assets to service those claims and we'll talk in a minute about our premiums, we have the fifth lowest premiums in the country, which we're very proud of. Under the leadership of Ohio Governor Mike DeWine, BWC has fostered a safety first mindset across Ohio and has been able to reduce rates by 50% and achieve the lowest rates in at least 65 years. When Governor DeWine was elected, he told his cabinet directors to listen to the needs of our customers and scrutinize our service offerings to improve them. And that's exactly what we have done at BWC. In fact, at Governor DeWine's request, the BWC Board has authorized $9.2 billion in dividends to Ohio's employers since 2019. Governor DeWine said in his State of the State that Ohio cannot reach its full potential unless every Ohioan is able to reach their full potential. At BWC, we believe every working Ohioan deserves the chance to go home to their families healthy and safe at the end of the day. Since the beginning of Governor DeWine's Administration in 2019, we've seen a reduction in workplace injuries from 2.6 injuries per 100 workers to just two. That's a pretty significant drop and that's a huge safety win for both employers and our workforce. These efforts reflect our state's and this Administration's ongoing commitment to maintaining fair and sustainable rates for employers, while ensuring continued support for workplace safety and claims management.

Last month, I had the privilege to speak before the U.S. House of Representatives Workforce Protection Subcommittee and highlight Ohio's success in workers' compensation. My testimony, similar to today, was focused on our growth as a state and how our workers' compensation has worked for both employers and the workforce. Back in the 1990s, I worked for Governor Voinovich and for a period, I also worked for BWC as a staff attorney. BWC was referred to as the silent killer of jobs. Escalating costs, delays, inefficiencies in the workers' comp system were killing our economy. At the time, fewer than 1% of claims were processed within the first two weeks which is an essential window for supporting injured workers' recovery. Ohio's leaders responded with sweeping reforms that laid the groundwork for today's nationally recognized system and since then, BWC has achieved the fifth lowest premiums in the country. In 2008, we had the third highest. We've strengthened partnerships with managed care organizations that help injured workers receive timely, high-

quality care and return workers safely to work. At BWC, everything we do starts with the customer. Their needs and expectations drive every decision we make. We see every interaction as an opportunity to deliver value. It's not just the big picture items, it's being there for our customers every day. As an example, our customer contact center has answered over 188,000 calls in 2025 with an average speed of 44 seconds. Also, the customer satisfaction rate in 2025 exceeded 97%.

One example of us working hand in hand with our employers is our Substance Use Prevention and Recovery Program. It provides incentives to support Ohio employers and continues goals of addressing substance use disorders affecting our workforce and communities throughout the state. As you know, Ohio was hit very hard, as were our neighboring states Kentucky and West Virginia, by the opioid crisis. This program merged three popular programs we have, but they were overlapping, so we merged them: the Drug-Free Safety Program, Drug-Free Safety Program Grants, and our Substance Use Recovery and Workplace Safety Program. The goal of this merger was to end employer confusion and let them better utilize this program and its offerings. Employers in this new program can receive reimbursement for testing, training, and rebates for completing program requirements. As you know, with the workforce challenges that our employers have seen over the years, for every Ohioan living up to their God-given potential, we need every able body in the workforce. Substance use disorders have been a huge damper on getting people and keeping people in the workforce. This is our attempt to help employers where we can and to help them ease some of the concerns that they have about hiring someone in recovery and help them move forward for a successful relationship.

As we move forward and continue to modernize our efforts, we are updating the way we interact with our staff and customers. We want to simplify our processes and create easier and excellent experiences for our customers. In 2025, we launched major improvements to our services, including the survivor portal specifically just for survivors and representatives when there's a decedent. If they don't have enough worry and sadness going on in their life, dealing with a bureaucracy is not something we want to see them have to do. So, we created a survivor portal just for them. Real-time, true-up, real-time cancellation of coverage. We're also utilizing artificial intelligence to augment our staff, so they can be freed up to do what they do best, making decisions and providing the best service in the state. We're currently having a staffing shortage at our agency. It's hard to recruit young workers into government and insurance. I saw a study that said millennials have about a 4% interest in joining the insurance industry. You layer on top of that a really sexy name like Bureau of Workers' Compensation, and the challenges are exactly what you would expect them to be. So, we are using AI to supplement where we can.

When we outsourced our managed care, it was a fantastic thing. You heard the statistics that I gave you. It turned workers' comp around in Ohio but what it also did was we did a buyout of the pensions. That was a wonderful thing because it meant we didn't have to do layoffs, but it also meant a lot of people retired that we necessarily didn't need or want to retire. That was their right. I would have taken advantage of it if I hadn't literally been one year into the pension system when we did it. But it also created a lot of hiring. That was great. If you're doing the math in your head, you are recognizing that was about 30 years ago, which means we are experiencing a very large number of retirements. Last year in 2025, voluntary turnover alone at an agency of over 1,600 people, I lost over 13% of my staff primarily to retirements. That is way out of the ordinary for us. That's okay, they're entitled to it, they've worked their time, they've earned their pension but that has put us in a position of hiring. Last year we hired over 200 people. We are hiring like crazy. You also know if you've had a 32-year employee retire, that that Full Time Equivalent (FTE) that retires is more like a 1.2, 1.3 FTE. and that person that you hire is about a 0.7, 0.8 FTE for quite some time.

So, we're using AI wherever we can to bridge that gap. We're using robotics to help our staff not be overwhelmed by the increased workload. The worst thing that can happen to me is that the folks who are picking up the slack from the retirements while we're hiring and bringing new people in, is that they don't see an end in sight and they begin to look for other work, which will only exacerbate my problem. So, we're working hard using AI trying to get rid of the tedious and repetitive tasks with the use of bots that can complete hundreds of claims documents overnight. AI is not a perfect system. We're not using it to replace people. We always have a human in the loop but we are using it when it comes to those repetitive tasks, but not for reviewing the work. We create more opportunities and better solutions for everyone when we do it this way. We want to focus on AI augmenting our staff, so they can be freed up to do what they do best, make those decisions and better service our customers. So, I hope everything I've shared with you today has been helpful and demonstrates our commitment to being a partner with the state's economic development and a force for workforce safety and health.

Rep. Lehman stated that I'm an insurance agent in Indiana, literally six miles from the Ohio line. We seem to at times have a conflict with what state pays what claim. If we have Indiana workers working in Ohio, you have something like 90 days you can work and questions like whether that's consecutive or non-consecutive days. But if it's an Ohio employer and they work in Indiana, you cover them regardless of the amount of time they're in Indiana. Is that correct? Ms. McCloud stated we have what's called other states coverage and we take out actually a private policy to cover other Ohio employees in other states. Rep. Lehman stated we have other state coverage as well, but it excludes the monopolistic states, which one of them is Ohio so I'm just curious down the road. I think there's some confusion sometimes among employers who being close to a border have a lot of people who are contractors who work in Ohio and they're always thinking they have coverage and they do but they might have to have Ohio coverage under certain circumstances like the employee might live in Ohio and things like that. So, have you had those kind of ongoing discussions with making sure we don't have barriers? Ms. McCloud stated we have not, to my knowledge at least, if we're having those problems, those haven't been raised to my level. But I'm going to make some notes here and dig into that.

Senator George Lang (OH) stated that depending on what ranking, Ohio is between the 5th and 15th most business friendly states in America and 10 years ago, we were amongst the 10 worst. And one of the big reasons that always comes up is our low workers comp cost. So, thank you very much for what you do. My question revolves around the recent legalization of recreational marijuana. Have you seen any increase in claims from people coming to work impaired and/or do your actuaries anticipate any increase in those claims? Ms. McCloud stated interestingly enough we have seen a slight uptick in claims. We haven't necessarily been able to assign those to the legalization of recreational marijuana in Ohio. We're digging into those. For quite a few years, we worked hard, employers worked hard, and we also had some shifts in our industry that caused our claims to slowly decline. We've always wondered where the bottom is. It's not zero. We think we may have hit that bottom, which is roughly about 70,000 new claims filed a year. We're seeing a slight uptick. What we don't know is if that's going to start riding a wave. It's too early to tell. I'm having staff look into that, but we have not seen that necessarily tied to recreational marijuana.

Sen. Bill Gannon (NH) stated I run the Judiciary Committee in our Senate. I tend to be more of a punisher on fentanyl things and I look to punishing the suppliers and the dealers. I was very intrigued with your three part Drug Free Safety Program. Could you just go into that a little more for me because I tend to use a strong hammer for drug sales and I'm not always as nice and soft handed as I should be with people with problems. Ms. McCloud stated it's not a matter of not using the hammer. That's just not our job. Our job is, of course, preventing and dealing with workplace injuries. Certainly, our fine state legislators and our Governor, and our Attorney General are working hard to deal with the fentanyl dealers in our

state. But as we have people who are in recovery looking for jobs, and we have a shortage in the workforce, certainly there has to be an opportunity to marry those two up. Where we have a shortage of workforce and employers may be reticent, rightfully so, to hire someone in recovery because maybe they've never done it before and they're nervous and they don't know what exposure that they have. We are offering resources to them, such as random drug testing that we will reimburse for and pre-employment drug testing. We will offer managers training and counseling in how to manage someone in recovery, what to look for if you're afraid of a relapse. And then we also offer some grant programs for that.

PRESENTATION ON INNOVATIONS IN TREATMENTS FOR MENTAL INJURIES

Rep. Lampton stated the next item on the agenda is a presentation on innovations in treatments for mental injuries. This topic is going to be very interesting, focusing on the emerging trend of using non-traditional types of medicine to treat injuries. It has obvious implications for the health care sector, but also for work comp, since treating mental injuries in the work comp marketplace has become an issue that states have wrestled with in the past several years. So this will be an interesting presentation to improve our knowledge on these things so we can properly address things as we move forward.

Gretchen Schaub, Director of Government Affairs at Definium Therapeutics thanked the Committee for the opportunity to speak and stated that we are currently facing a mental health crisis, and I'm here today to talk about why early dialogue is necessary to ensure system readiness and timely patient access to innovations in mental health treatment once they've gained Food & Drug Administration (FDA) approval and Drug Enforcement Administration (DEA) rescheduling. Mental illness costs the US over $282 billion each year, and suicide remains a leading cause of death particularly among our veterans and hometown heroes: police, first responders, firefighters, nurses, teachers. One life is lost to suicide every 11 minutes. After decades without new options, significant medical innovations for psychiatric conditions and substance use are finally emerging. Per workers' compensation policy research by the National Conference of State Legislatures (NCSL), untreated mental health issues cost employers significantly in the form of worker absences and lost productivity on the job. An already outdated 2007 study estimated that diagnosed depression alone among the workforce costs employers as much as $50 billion annually. It's 2026, we can assume it's much higher and that first responders suffer from post-traumatic stress disorder (PTSD) at a rate 50% higher than the national average. A 2021 survey of nurses revealed that nearly a third of all nurses planned to leave their current job by the end of 2022, again, outdated, citing stress and burnout as the top reason for leaving.

At the height of the pandemic, healthcare workers and first responders accounted for nearly 75% of all workers' compensation claims. In response, states have targeted much of their efforts to expand workers' compensation coverage for these workers. It is evident that untreated as well as inadequately treated mental health conditions are large drivers of cost burden to states and employers. As a reminder, one in five Americans suffer from a mental health condition. Fortunately, hope appears to be on the horizon when it comes to promising innovations in mental health. There are several drug sponsors developing new treatments working with schedule one substances for serious mental diagnoses by pursuing the existing regulatory pathway via large late-stage clinical trials, ultimately seeking FDA approval. As of 2026, the FDA has given eight clinical development programs in this space breakthrough therapy designation. This is important context as it shows the Agency's understanding of the grave unmet need in the treatment of serious mental illness like debilitating depression, anxiety, trauma, substance use disorder. This also indicates the Agency's understanding of the promise of clinical trial data illustrating potentially effective new treatment options.

Medical progress depends on innovation. Outdated state laws and regulations should not stand in the way of progress. While science advances, policy must advance as well. For

patients who have tried existing remedies, new technologies and newly approved medicines are often the next and only step forward. Denying or delaying access to new tools does not preserve safety. It prolongs suffering. As an industry, we're using the opportunity to modernize policy at the federal and state levels to ensure access. As in most facets of life, timing is paramount. But in mental health, timing can be the difference between life and death. Weeks, months or years of unnecessary regulatory lag could bring about preventable tragedy. If a therapy has passed rigorous federal review for safety and efficacy, physicians should be able to use it as soon as it is legally available. In this context, it's why policy modernization is necessary. It provides a small policy change with great impact, particularly at the state level. Because timing matters. Before a medication in this class reaches a patient, it must demonstrate safety and efficacy through extensive clinical research and satisfy federal risk mitigation strategies. For controlled substances in development, following FDA approval, the DEA must determine the appropriate rescheduling for that medication based on medical use and abuse potential. These are two independent robust federal safeguards weighing the risk benefit ratio for a new treatment. Inconsistent scheduling frameworks at the individual state level create unintended barriers. Without the alignment of federal and state determinations, a medication could remain inaccessible for months or years while each state completes a separate legislative or administrative process. This creates legal uncertainty for licensed practitioners and continues suffering for patients.

By having conversations early and often, we can improve existing systems, setting the foundation for patient access. This includes system readiness by ensuring that once federal regulators determine a medication is safe and effective, states are ready to deliver new treatments without unnecessary delay. This is maintained oversight. This is not blanket deference or broad legalization of a drug class. These medications remain prescription only, dispensed and administered under licensed medical supervision and subject to state monitoring, licensing, and enforcement mechanisms. It provides regulatory clarity by aligning federal and state rescheduling timeframes. It allows certainty for practitioners, manufacturers, pharmacies, and insurers reducing compliance risks and confusion caused by inconsistent frameworks. And it's a very focused scope. The policy modernization that we're discussing only applies after FDA approval and DEA rescheduling at the federal level. In other words, no state is asked to make a decision or act until after federal action has been determined. Importantly, this modernization approach does not legalize any drug class or create a framework for recreational use of the drugs within this schedule. Instead, it's a narrow practical modernization of the Controlled Substances Act state by state, providing regulatory clarity. It's about responsible technical updates so that our legal framework keeps pace with medical progress with the hope that a strong foundation will allow for meaningful discussions around access, coverage and reimbursement with state authorities when that time comes. We all deserve access to better tools if we're going to make a meaningful improvement in addressing the mental health crisis. And we all deserve better.

Rep. Mike McFall (MI) stated I appreciate you bringing this up. This is a very important conversation that we need to be having. In Michigan, I have introduced a bill that will decriminalize psilocybin use for people that are diagnosed with PTSD. As we know for our veterans, it's not just life changing. It's life saving for many because they're not getting high off from it. They're just microdosing it, but I don't want them to be in a world of hurt if they get pulled over and they happen to have some in their pocket for medications that they're using. So, I appreciate you bringing this forward and I appreciate this topic too. This is a very important topic. Is there something specific? Because I know there are others because I've had a veteran actually ask about something that was recommended by the Department of Veterans Affairs (VA). He reached out to me because he had seen that I had a bill on this and he had just gone to the VA that day and the doctor actually recommended he look into it. I know at the federal level there's a lot of discussions around rescheduling and doing all those things but are you talking about anything specific because I know there are other psychedelics and such as well. Could you expand on that?

Ms. Shaub stated yes. So, I use the analogy often to think about a large swimming pool, and we all have our individual lanes. I represent a company that is developing a drug and seeking FDA approval for a prescription product and there is a subset of companies that are developing drugs so that they can be options that are on formulary and integrated into the existing medical system. Then the other swim lanes are legalization or decriminalization. There are a variety of studies that are happening at local academic medical centers through the VA, etc. So, within the swim lane of FDA approved products. And those eight companies that I referenced, they're all in late-stage trials. So, it's a variety. You have MDMA for PTSD. There are multiple companies looking at synthetic pharmaceutical grade psilocybin for different mental health conditions. Really the focus here is about trigger legislation. Essentially, making sure that timelines are aligned once FDA approval occurs. Then DEA subsequently has to then move that approved drug down in scheduling so that it's prescribable. And then all 50 states have their own framework for handling alignment with DEA scheduling of those drugs so that they're available for practitioners. I say all of that because the umbrella is quite large in terms of the different companies focusing on different drug products and different diagnoses but the model is the same. And the industry at large is a complete innovation in the mental health space. So, it's kind of laying the foundation for access that's necessary on the industry side.

Rep. Yusuf Hakeem (TN) stated regarding PTSD, I believe there was a number you gave of $150 million of care that has been needed. Is it reasonable for leadership or advisors in those companies or within the military to have some idea of signs of problems for individuals? If you're looking at $150 million, we need to be finding a way to identify this early on. And I'm just wondering, is there any insight you have to give in regard to that? Ms. Shaub stated I think it's kind of a two level process in terms of the hope provided through the development right now and kind of the impetus for the research that's happening with this drug class. Because these are acute interventions. So, patients are coming to a clinic and it is a full day experience, but under medical supervision, much like being under anesthesia. I say that because it's also allowing psychiatry and mental health at large as a profession to get to the root cause of a lot of these conditions that for a long time, our best tools available have been to suppress symptoms. When you think about PTSD or anxiety, there are physical, mental, and emotional symptoms that are quite difficult to manage and a lot of overlap and comorbid states for patients. I think for leaders to have the ability to have an additional tool in the toolbox for those really severe cases that it's a single treatment, one day is important. People are coming off of their medications, and it will be different certainly outside of clinical research in the real world. But that's also why I think these conversations are really necessary early so that we can all learn together and make sure that these are adopted and integrated into the medical system appropriately.

Rep. Julie Miles (NH) asked what are the top three drugs you have in your pipeline to come out first? Ms. Shaub stated right now we have two early-stage companies. One is DT120, and it is a derivative of LSD. And then we have an R-MDMA drug.

Rep. Miles stated my follow up is insurance companies are currently dropping many drugs off formularies that are already FDA cleared, have been on the formularies for years, and they're dropping them because of cost. How do you respond to the approach to getting these drugs on formulary once they're cleared through the FDA? And how do you see that path? Ms. Shaub stated like any other drug, unfortunately we will be going through the process as every other company does for a new drug. I think the important context is that again, these are acute intervention, so it's going to look different. As an industry, we don't know yet because there hasn't been FDA approval. So, working with the Centers for Medicare & Medicaid Services (CMS) on pricing and understanding at the federal level what this means for Medicare and then commercial plans and Medicaid programs, we will certainly get there, and the conversation will continue to evolve. I want to put a fine point on the fact that it's a single administration. One time. Our phase three trials, speaking for Definium, we are

following patients out over a year post that dose to really understand durability and retreatment, so that will also go into kind of where this sits on a formulary and all the additional kind of step therapy and prior authorization context, but again, we're looking as an industry at most of the clinical trials, I think by design, you end up getting the most acute patients. So, these are patients that have been very expensive to the system in terms of hospitalizations and on and off medications. So, all that to say, I would say think about it more like a specialty drug or infusion.

Rep. Stephen Meskers (CT) stated one of the issues we've faced with some persistent diseases, and I'll use multiple sclerosis (MS) as a case, is the adoption and use of formularies. I've had a number of constituents and a number of advocates talk to me about the change in medication and the dramatic effects in terms of reduction in efficacy or the reestablishment of a baseline of efficacy at a lower level. I don't know what we're considering here but when we talk about mental health issues, when we get to a proven track record, we're going to have to be very careful about the change in formularies. If people are using substances to prevent ideations of suicide, etc., we're going to have to watch formularies to make sure they're not changing medications, which could have material impact. I'm not sure how we handle that, but it's something I think you might want to address in the concerns going forward particularly with mental health, I don't know where the studies can give us the efficacy in the change in formularies and I'd be very concerned.

Ms. Shaub stated it's certainly something that I think keeps the industry up at night. Thinking about the next steps post approval and where this falls on formulary. We don't know yet. But your point is certainly taken. I think one of the opportunities with this new class of treatments is that it's a one-time thing, so think about it like getting an ACL repair versus being dependent on that drug to function every day. It's a really interesting trajectory to be able to follow the science right now. And the late-stage trials are following durability just as much as safety and efficacy. Because to your point, we don't know how long on average this will last. We followed patients out to three months and the results were pretty incredible in terms of remission rates. At three months after a single dose, almost 50% of patients were still in complete remission with generalized anxiety disorder. Other studies are showing the same thing so I think discussions are going to be incredibly important in letting the data and the best information available when that time comes guide what insurance coverage looks like.

PRESENTATION ON TRENDS AND DEVELOPMENTS IN THE KENTUCKY WORK COMP MARKETPLACE

Rep. Lampton stated our final agenda item is a presentation on trends and developments in the Kentucky work comp marketplace. Scott Wilhoit, Commissioner of the Kentucky Department of Workers' Claims thanked the Committee for the opportunity to speak and stated that our system came about first in 1914. It went to the state supreme court at that time, saying it was unconstitutional. It was revamped, revised and came back in 1916, and we're now celebrating our 110th year of Kentucky workers comp. As a Kentuckian, we sometimes brag not only about our bourbon, not only about our basketball, but we also brag about our workers comp system because we have a very good system. We like to say that Kentucky tries to set the gold standard when it comes to workers comp. What I mean by that is maintaining that particular balance. It's all about balance. That means we have to take care of injured workers but you also have to make sure that costs are not so prohibitive that we cannot sustain that and we can't maintain and grow economically. I say my job as Commissioner, I'm sure you all know this as legislators, if I've got everybody unhappy with me, then I've done a good job because that is just what this is maintaining that balance.

I'll just say we are a private market. We are not a monopolized state. We are a private market like most of the states. And in that regard, I'm proud to say that Kentucky's rates continue to decline in the cost of workers' comp. I talked to my friends in the insurance

industry, and they had told me that workers comp lines are probably some of the most profitable, meaning that it is an industry where the insurers are not running from the business but coming to the business. And that's a result you making sure we have legislation that maintains that balance. That balance also means staying hyper focused on getting that injured worker back to work and making sure that injured worker can receive the best medical care. One of the problems we're having is access to medical care. Back when I started in workers comp, it was kind of like my father who was an anesthesiologist, and he grew up in the very traditional way medicine was practiced. The old Marcus Welby days are gone. Most likely your constituents are not often seeing an MD or a DO. They're seeing a nurse practitioner or physician's assistant. And that's great, but we in the work comp field have to make sure to allow that access to those folks to get that medical care.

In Kentucky, we have a definition for "physician" and we have expanded that definition over the years to include psychologists, chiropractors and so forth. One of the things we realized in trying to keep our costs down is that in Kentucky, if you have a hearing loss, you must go to get an examination and get determined what that level of hearing loss actually is. Up until last year the hearing loss had to be signed off by an MD or a DO. We took a look at that and realized, okay, that's great but it's the audiologists who are actually performing the examination. And the physician comes in, takes a look at it and signs off. Usually, they agree with it. So, we expanded the definition to include doctors of audiology to reflect what is really happening out in the marketplace. In Kentucky, especially the rural areas of eastern Kentucky and in western Kentucky, we are lacking medical care in terms of doctors. So, we've got to expand and work on that. We need to look at that in order to expand out that definition to reflect what's actually happening out in the field. I became Commissioner four years ago and I made a promise that I'm not going to be at my desk all the time in Frankfort, Kentucky. Four years later, I'm at my desk all the time in Frankfort but I try to get out and try to listen to others on what's going on out there. It's very easy to live in a vacuum and not see what's actually happening. That's what's great about these forums here today, to hear from others and know what's happening and what's going on.

I also will pick up a little bit where Ms. Shaub spoke a few moments ago. I think PTSD is a major issue. Kentucky, like many other states, back in the mid 1990s did a reform. And I understand that. I was a defense attorney. But with work comp, we try to get the goal making sure that injured worker gets back to work and the proper benefits are payable. I look at it that way. It is adversarial, but we all have that same goal. But back to the mid 1990s, we were part of that same trend where we eliminated pure mental claims. And by that, I mean there used to be, and I'm going to use an exaggeration here, you could file a claim if I don't like my boss or I'm stressed out by my boss and there were crazy examples. I defended a couple of those kind of cases. But for the most part, there was reaction to that to eliminate mental claims. I understand it but we also have to reflect again. Just as I talked about how the medical field has changed and progressed over the years, so has the medical science. We now realize that PTSD, as Rep. McFall stated, is a real thing. Back in the mid 1990s, we didn't have nearly the diagnostic tools we have today. Where today, they can look at a brain scan, and they can see anatomic physical changes to the brain, we know that happens. So, we need to look at PTSD.

Kentucky right now still is a mental state. In order to be covered for PTSD or any other mental trauma, you must first show a physical injury. Then you have a psychological overlay. Here's the problem, and here's an example that I'm concerned about that I hope that you as legislators might want to think about as well. I use tragically an example that happened in Kentucky a couple years ago. It just is truly tragic and it was workplace violence. We had a terrible situation where a fired disgruntled employee came into a local bank and opened fire. Several people were killed. It was mayhem. And here's the problem with PTSD coverage as it exists now. And this is hypothetical. Two employees walk out of that and both witness the carnage. One slips on the debris and it hurts her back and has PTSD because she saw what

she did. The other employee manages to walk out. He gets no coverage. Now, it's hard to say why that is fair and equitable. And remember, workers' comp is designed to get those employees back to work. What do you do about the employee who didn't have a physical injury, who still has the trauma? What do you do about that employee? The studies have shown that if you get that employee therapeutic care, get the necessary medication, you're not talking about a lifelong treatment of family therapy - it is hyper focused on keeping that employee through that trauma and getting them back to work. That needs to be maintained as the goal. But we also have to watch the cost because it'd be great if we covered everything from a scratch on your hand but we have to be realistic about the cost. One of the things we're proposing is that we have strict criteria pursuant to the American Medical Association (AMA) guidelines, pursuant to the DSM-5 on what is PTSD. And there are those strict guidelines for those. I think one of the things we need to think about is where does that all fit in? How do we maintain that balance? Because again, we have to keep costs in mind. We have to get employees back to work.

One of the other areas that I'm concerned about is GLP-1s. They work. They are really expensive. When an individual sustains a knee injury or sustains a back injury, through the years I've seen the doctor before they'll do surgery or do anything to the patient say you have to lose weight. The problem is again that cost. I heard an insurance representative ask me if GLP-1's are going to become the statins of the future? Meaning that once you go on it, are you on it forever? And as far as workers' comp is concerned, does that mean the states, the workers' comp, the employers have to pay that forever? I don't know the answer to that. That's something we have to figure out. We know they work, but I think the science is showing that once you stop taking it, guess what happens? And that could again affect the knee, the back, and so forth. And Kentucky's like many other states, we did have lifetime medicals. It now goes for 780 weeks plus renewable. So, we have someone with a back injury or knee injury that happened 10 years ago, and they're taking their GLP and so forth it is preventing them having to get another knee replaced here soon. That's a good question, and I don't know the answer. All of you are going to be faced with that with your legislatures on what do we do because we have to control those costs. We have to make it reasonable. We can't have a system that is so cost prohibitive that we drive business away.

Medical fee schedules are also important. Every two years, we update that medical fee schedule to make sure it's current. But we have to be careful too again in how much we increase that medical fee schedule? But we also want to make sure we have doctors and medical care specialists who are willing to take workers comp patients. In Kentucky, I say proudly with this administration, with Governor Beshear's Administration, we've added 68,000 jobs to the market. Kentucky is a smaller state. Ohio is a much bigger state. We are growing. We have to face those needs that we have as a rural state. Kentucky is one of those states as well that we still we have a lot of folks who still suffer from pneumoconiosis, black lung. Black lung is expensive. A lung transplant if someone suffers from pneumoconiosis is $1 million and sadly, it only has about a 50% success rate. I'm kind of talking about challenges here today as trends. Now I want to shift a little bit. I love workers comp because show me another social private government program that accomplishes as much as workers comp. We promote business, we take care of workers, and we do it in a way that has balance. As I often say, comp is pretty cool. We talk about the kids who don't want to go into workers' comp. It's really cool because we see the impact of what comp does. We get the worker back to work. For that worker too, who at the time is suffering from an injury and is healing, workers comp makes a difference making sure the lights stay on, the food stays on the table, and the kids are clothed as they recuperate, and they go forward and return to the workplace. That's what it's all about. Helping that injured worker when they can't get back to work, making sure they are taken care of.

Some of the things I think we are looking at in Kentucky as we're looking at those trends, is how we address those medical matters. We're also looking at artificial intelligence and what

it's role is. I don't know but we have to look at it and as Ms. McCloud said a few moments ago, AI can be helpful, but we can never replace the human connection. Your constituents want to talk to a human. We always have to make sure that the judge is assigned to cases and not a robot. Those are the kind of things we need to look at. It's a tool that we can all use. It's there, it's going to be there. We have to move forward to it and adopt that in the best practice we can. We also in Kentucky have the Official Disability Guidelines (ODG). That's part of that process by which we try to make sure that the medical costs are proven, our medical procedures are proven effective procedures. We try to do that. We try to keep the best care, the appropriate care for those workers.

One of the things we're trying to work on is modernizing that access. One of the complaints I hear about workers comp because we still have some old-fashioned ways is that in Kentucky, when you have an injury, your insurance carrier provides you with a card. That you take that card that has your name on it, has your claim number on it and so forth. And you take it to your primary care provider, and they are supposed to do that whole process and then they send the records to the insurance carrier. They review it and go back and forth. Oftentimes what happens? Delay, delay, delay. Because waiting for medicals can go back and forth. The insurance carrier is not sure exactly where that claimant is getting treatment. The doctors aren't getting paid. So, one of the things we're trying to do is come up with a system called Compass. I raised my phone mainly for the idea of a QR code. We're going to develop a QR code that that claimant can take and have it be assigned a QR code and take it to that doctor. The doctor will scan the QR code and it will have all the information on it. It will link up with the insurance carrier. The insurance carrier will have the information right away, have records right away, have medical bill and everything right away and communicate back and forth. Also too, at times comes litigation with a claim and we want to eliminate all that unknown there to make sure the provider gets paid fast and make sure the claimant gets the treatment as they should. Technology will help. But again, we don't want to lose that human connection with it all. There are so many really interesting things that comp does. Whether it's a monopolistic system or whether it's a free marketplace, private sector, we all share that same goal, helping those workers, keeping our costs contained and making sure we have a thriving economy.

Rep. Barbara Dittrich (WI) stated that I am Chair of the Assembly Committee on Insurance, but I've also done a lot of policy work on mental health and substance abuse. My question is really in regards to how you decide what you're going to cover with workers comp and mental health because I have real concerns about using things that are derived from psilocybin and LSD when you're trying to treat PTSD. I'm wondering if you consider any therapeutics like Eye movement desensitization and reprocessing (EMDR), Cognitive behavioral therapy (CBT) or Dialectical behaviour therapy (DBT) coverage for workers comp? Mr. Wilhoit stated I'll go back to the ODG we do. The legislature passed a few years ago kind of a universal guideline. Let me explain the ODG a bit more. Because we've had some pushback regarding the ODG, and ODG is a private company that produces it, and other states use it as well. What an ODG does, it makes it that we have one system of what the appropriate guidelines are for treatment guidelines, but I believe under ODG, it's not the final say so. It's a tool by which we can look at to see which way a medical procedure would be approved or not approved. When I hear people say, well, wait a minute, why the access to the ODG? Well, it's really no different than each insurance carrier had their own ODG or own system for saying, "Well, we'll approve this one. We won't approve that one." This tries to put everybody on the same level playing field, we all share the same rules.

With regard to the question on experimental drugs, it's a good question and I'm very much of the believer that we have to have proven science in order to determine that. As Commissioner, I don't adjudicate claims. I am an administrator. We have 17 administrative law judges who decide cases that come up on whether a medical care is reasonably necessary and is causally connected to the injury. But one of the factors they look at is that

ODG and also what the doctors are saying. We also have a process in Kentucky where we have a university evaluator where we can get a person, not a doctor hired by the plaintiff or a doctor hired by the defense. We can go to one of the medical universities to try to get an impartial opinion on that and I think we need to utilize that more but to come back to your question about experimental drugs and so forth. I don't know. I'm not sure workers comp is a place to experiment because we have that obligation to keep costs down and to do that treatment for the claimants to get them back to work. So, I'm not exactly sure that we're there yet for that.

Rep. Mark Tedford (OK) stated I wonder if you could talk about additional types of work related claims to which GLP-1s would be used and and then also what guard rails need to be in place to make sure that the claimant is not incentivized just to use it as a personal weight loss treatment? Mr. Wilhoit stated that's a major concern because again, the problem then becomes as you just said, say someone needed a knee replacement and oftentimes the doctor will say, "You got to get a knee replacement, but you got to lose 50 pounds before you get that knee replacement." Let's assume that was a work-related injury. There's not a question of causation. The patient goes on a GLP-1. They lose the weight. And it's a fair question. I don't know the answer to that because does that mean the insurance carrier has to pay for that forever? I don't know. Are we talking about a specific period until they lose a sufficient amount of weight? I think what's going to have to be is a combination. They're going to have to also learn that it's not just the pill you take, but you have to do some other steps because otherwise until those costs of those medicines come down that's going to be a cost driver. That is really a concern. Now, it's a great medicine, but it's a huge cost driver.

Rep. Tedford asked if you know of any states that are doing a good job with this that now that have any guardrails for this? Mr. Wilhoit stated I don't really know. We're looking at other states. I'm a member of an organization called the Southern Association of Workers Compensation Administrators as well as the International Association of Industrial Accidents. There are several big organizations and I can tell you the two topics that come up every conference is PTSD and GLP-1. I think we're all trying to figure out what we're supposed to do. We've had representatives in about these marvelous medications that are coming out. But it's a tough one. There's got to be some balance but where do you strike that?

Rep. Tim Barhorst (OH) stated I wanted to ask each commissioner a couple of questions because I think it'll be valuable for the group to see how we compare a monopolistic system to the Kentucky system. Obviously, the big issue is the risk pools and how you manage them. That's why we can't change a lot because once you've picked your lane, you pretty much have to stay in it as what I've been told and I agree with. Then can you also talk about the rural health challenges with providers and how you contract with them? I know Ohio has a reference based system that's based on Medicare Plus. I think those two things might be a little different or I'm just curious how that's managed in two different types of systems.

Mr. Wilhoit stated in Kentucky we don't have strict contracts with doctors. We have the medical fee schedule. Any doctor, any medical care provider that's defined as providing a service has to abide by the medical fee schedule on that. That's how we do that process and it's similar to what other states do as well with a medical fee schedule on it. As a medical care provider treats that claimant, they are consenting to abiding by the workers' compensation medical fee schedule. You're consenting through that process to be paid per that process. There's no balance billing allowed in Kentucky, as in other states, I don't think other states allow it. That's the other thing about Kentucky comp that is similar to all the other states. Zero cost for the employee, no out-of-pocket expense for the employee to get that medical care. But it is a challenge, and that's why we make sure that we sufficiently compensate the medical care provider, the hospital, the outpatient clinic so they are willing to accept comp claimants. I've got a good friend of mine from some of the other states in which they have difficulty attracting and maintaining providers into the system. We're doing

okay. We are getting folks in by being competitive but not outrageous. I'm not sure if that exactly addresses all of it, but I think it all comes down to making sure that we adequately compensate those providers. And the good thing about comp is that the provider will get paid. They don't have to wait 9 months, 10 months, whatever it is to get the payment. They will get payment.

Ms. McCloud stated we struggle as well in our rural areas with getting providers in. We were spinning a lot of wheels with signing up providers around the state, certainly where we had provider deserts whether they were psychologists, dentists, things like that. And then we'd sign up these providers who said, "Yeah, I'll do that," and then they may not see a BWC patient for years. And then they eventually fall off the rolls. We decided that was kind of a waste of time and switched our efforts to moving toward kind of a concierge service. So, if we have an injured worker in southeast Ohio, they need a dentist. There's not a dentist certified around them. We say, "what dentist do you use?" And, then we go out and enroll that dentist if they're willing to be enrolled. That we have found is a much better use of our time than signing up people who may never see BWC injured workers.

Rep. Oliverson stated to Cmsr. Wilhoit that you got my attention when you were talking about the definition of physician. Did I understand you correctly to say that you have redefined that term to include audiologists, chiropractors, and psychologists? Mr. Wilhoit stated that is correct because we refer to physician throughout our act as the medical care provider. We don't use the term medical care provider per se as we use physician. So, we define physicians not only being an MD or DO, but also under all that as well a Psychologist, a Doctor of Psychology, a Doctor of Audiology, and Doctor of Chiropractic Medicine. All those we do include under that definition of what we mean by physician in terms of compensation and coverage on Kentucky workers' comp. Rep. Oliverson stated I'm curious because I think your definition is now very inaccurate. I mean, the term "provider" is a very inclusive term. The term "physician" is a highly specific term to someone that either has an MD or a DO. Why not just change the statute to say provider, instead of creating a definition that's inaccurate. I don't know that anybody up here would agree with you that a psychologist is a physician. Mr. Wilhoit stated I agree with you. I think that is something that has been passed down over the years. I think it is something we need to look at, especially as we talk about medical care providers. I think it's a really good point. As we all further broaden it out to reflect who's providing that care, such as nurse practitioners. Such as Doctors of Physical Therapy. I agree with you on that. I think it is time we do need to look at that. It's something that has been in our books since going back to the 1950s. Rep. Oliverson stated so you're trapped by the statutory language basically. Mr. Wilhoit responded exactly.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Mike Clines (KY) and seconded by Rep. Peggy Mayfield (IN), the Committee adjourned at 11:00 a.m.