National Council on Compensation Insurance, Inc.

ANALYSIS OF MONTANA'S LABOR MANAGEMENT ADVISORY COMMITTEE (LMAC) REFORM PROPOSAL
As Submitted to NCCI July 30, 2010

Summary of Montana LMAC 7/30/10 Reform Proposal

NCCI anticipates that the following provisions in LMAC's Reform Proposal (proposal), if enacted, may impact system costs in Montana.

Section(s)	Description	$ Impact	% Impact
1-13, 36, 39	Stay At Work / Return to Work	-$6M to -$1M	-1.3% to -0.3%
16, 21, 25	Termination of Temporary Total Benefits	-$5M to -$1M	-1.1% to -0.3%
22-24	Attorney Fees	+$1M to +$2M	+0.2% to +0.5%
27	Permanent Partial Awards	+$4M to +$19M	+0.9% to +4.2%
32	Introduction of Retroactive Period	+$1M to +$2M	+0.3% to +0.5%
	Overall Impact on MT WC Costs	**-$5M to +$21M**	**-1.0% to +4.6%**

NCCI has analyzed the following sections and determined that they do not have a cost impact in Montana, or that the impact is indeterminate:

Section(s)	Description
14	Claim Closure
17 & 19	Definition of Course and Scope
20	Timing of Insurer Decisions to Accept or Deny a Claim
26	Permanent Total Disability
28	Medical Services Maximums, Utilization and Treatment Guidelines
30	Require 5th Edition of American Medical Association Guide to Impairment Ratings
34 & 38	Settlements

NCCI anticipates that sections 15, 18, 29, 31, 33, 35, 37, and 40-42 are administrative in nature, or are considered to have a minimal cost impact. Any impact on system costs would be realized in future loss experience and reflected in subsequent Montana loss cost filings.

Medical fee schedules are adopted by rule. NCCI will estimate the cost impact of changes to the schedules when the rules become available.

There is no bill that accompanies this proposal, thus the analysis may be revised if statutory or bill language differs from the language in this proposal.

With a few exceptions, the proposal would be effective for injuries occurring on or after July 1, 2011. NCCI has not determined the cost impact for provisions effective July 1, 2013 (section 27), or the retroactive cost impact of any of the provisions (section 34).

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Actuarial Analysis of LMAC's Proposal

Sections 1-13, 36, 39 Stay At Work/Return to Work

The proposal would repeal the current vocational rehabilitation provisions in MCA §39-71-1006, §39-71-1014, and §39-71-1032.

The new sections 1-13 describe vocational rehabilitation benefits referred to as Stay at work/Return to work (SAWRTW) assistance. These services include evaluation, planning, and other services of a rehabilitation provider designed to facilitate a worker's return to work. SAWRTW assistance would be required when all of the following are true:

- A worker who has received permanent partial disability benefits claims to be permanently totally disabled (PTD)
- A worker has not returned to work
- A worker has not received a written offer of employment (for which the worker is qualified, which is within the workers physical abilities, and which pays wages equal to or greater than the time of injury position)

Enactment of the proposal would increase the maximum auxiliary rehabilitation benefit of $4000 annually, based on the percentage increase in the state average weekly wage (SAWW) for the previous year. The current maximum is fixed at $4,000.

SAWRTW assistance would be provided if the worker, employer, or medical provider directly ask the insurer or the department to provide SAWRTW services. Currently the worker must be a 'disabled worker' to receive rehabilitation services by requesting them.

If the worker has not returned to work and is not capable of returning to work, the rehabilitation provider shall document the services provided and barriers to returning to work. In certain situations, the worker may benefit from a retraining plan if the worker has reasonable vocational goals.

The employee would be eligible for retraining benefits if:

- The worker is no longer entitled to temporary total disability (TT) benefits
- The worker has not returned to work in regular employment
- A worker has not received a written offer of employment (for which the worker is qualified and is within the physical capabilities of the worker)
- None of the options of returning to work for the same or modified position to the same or other employer are appropriate
- The retraining plan is agreed to by the worker and insurer

Rehabilitation benefits would essentially be renamed retraining benefits. The nature and provisions of these benefits is essentially the same other than changing the eligibility for these

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benefits. The cost impact from changing the eligibility is considered in the cost impact for the SAWRTW sections.

Currently, many workers who are permanently totally disabled (PT), permanently partially disabled (PP), and temporarily totally disabled receive an evaluation of their ability to return to work, with or without restrictions, based on their age, education, work experience, and physical condition. Also, a 'disabled worker' (as currently defined) or a worker with whole person impairment rating of 15% or greater is eligible for rehabilitation benefits.

NCCI has analyzed the cost impact if the SAWRTW sections were enacted. NCCI received vocational rehabilitation (VR) data for fiscal years 2003-2009 from the Montana Department of Labor and Industry (DLI). Based on the more mature years 2003-2006, the average VR cost per VR claim is between $3,643 and $4,315. NCCI assumes that average cost for SAWRTW benefits would be comparable to the current average cost of vocational rehabilitation benefits. However, given the conditions for receiving SAWRTW benefits, NCCI estimates that the number of injured workers receiving SAWRTW benefits would be lower than the number of those currently receiving VR benefits, resulting in cost savings.

Since the proposal tightens the criteria for requiring vocational rehabilitation benefits, NCCI expects fewer claimants would receive evaluation and rehabilitation (retraining) benefits. Based on DLI data and input from stakeholders, NCCI assumes that between 67% and 100% of PTD claimants would receive SAWRTW benefits. Also based on input from stakeholders, NCCI assumes that approximately 25% to 40% of PP claimants would receive SAWRTW benefits. NCCI acknowledges that some TT claimants may request to receive SAWRTW benefits if the proposal were enacted, although this group is expected to be small since this group would be expected to return to their pre-injury employment, so NCCI assumes that no TT claims would receive SAWRTW. To the extent that a significant number of TT claimants request SAWRTW, unanticipated additional cost impact would materialize.

Applying the percentages of claimants expected to receive SAWRTW by type of injury to the total number of statewide claim counts from DLI data, NCCI estimates the cost savings on VR benefits would be as follows:

	Low	High
Impact on Vocational Rehabilitation Costs	-66%	-31%
Rehabilitation Costs % of Indemnity Benefits*	7.0%	4.0%
Indemnity % of Total Benefits	28.0%[1]	
Impact on Montana WC system costs	**-1.3%**	**-0.3%**

*7.0% Based on the MT DLI data reported to NCCI; 4.0% based on a sampling of claim data available to NCCI

[1] Based on private carrier + state fund Financial Call data for policy years 2005-2007; unlimited losses are developed to ultimate, trended to 7/1/2011, and onleveled to current benefit levels

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These provisions would allow the department to obtain SAWRTW assistance for the employee in certain circumstances after they have been requested. If the department is unable to determine the liable insurer promptly, the department would obtain SAWRTW assistance for the injured worker. In cases where the department obtains the services for the injured worker, they are to be paid out of a (new) SAWRTW fund. The SAWRTW fund would be financed by premium assessments on insurers determined on 'a pay as you go' basis, levied by the state, and based on insurers' proportionate share of paid benefits from the prior calendar year. Initially, according to section 39, a premium surcharge rate of 0.00082 will be levied on workers compensation premiums for policies written on or renewed in 2012. The degree to which SAWRTW services would be paid out by the fund, and thus the extent of the use of the fund would depend on how often employees request SAWRTW directly from the department, how difficult it is to determine the liable insurer, and the definition of 'promptly'.

The cost impact from the increase in the $4000 auxiliary benefit by the annual increase in the SAWW is included in the cost impact for SAWRTW, since these costs are included in the average VR cost currently. Eligibility for the auxiliary benefit is unchanged.

The overall cost impact for the provisions related to the SAWRTW services provided by the department is assumed to be included in the cost impact for the other SAWRTW provisions. Any frictional or administrative costs associated with potential switching of rehabilitation providers may erode the cost savings from the other provisions. Additionally, the provisions related to the department providing SAWRTW services are not likely to change overall costs, although it may distort the equitable allocation of those costs among insurers

The overall cost impact for the SAWRTW provisions in sections 1-13, 36, 39 are expected to result in overall Montana workers compensation system cost savings between 0.3% and 1.3%.

Section 14 – Claim Closure

LMAC's proposal would introduce a new section that would allow an insurer to close a claim after three years from the date of injury, last indemnity payment, or last medical benefit, whichever is later. The insurer would be required to notify the claimant and Department of Labor and Industry of the intended claim closure at the time the three-year period is expected to begin. Claims could be reopened if the claimant proves by a preponderance of evidence that there was a substantial or material change in condition as a result of the injury or disease.

Currently, medical benefits terminate after 60 months of inactivity and cannot be reopened after termination, except for the repair or replacement of prosthetics. Indemnity benefits remain open indefinitely, unless a settlement is reached, and any claim closure by the insurer would only be administrative in nature. Claims may only be reopened in the case of fraud, coercion or mistake of fact.

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The claim closure would appear to allow an insurer to close claims at a faster rate; however, the provision in the proposal which allows claims to be reopened due to a substantial or material change in condition may result in some claims receiving medical benefits indefinitely. The extent of claims reopening would likely depend on how "substantial and material change in condition" and the threshold for "a preponderance of the evidence" are interpreted.

The proposal would also shorten the length of time an insurer is required to keep a dormant medical claim open from five years to three years. This would allow an insurer to eliminate the reserves held for these claims two years earlier and reduce any administrative expenses associated with keeping a claim open. The insurer is required to provide notice to the employee and Department of Labor and Industry at the time the three year period is expected to begin. Such notice of expected inactivity may prompt a change in claimant behavior as some claimants may visit a physician every three years to keep the claim status open. Since claimant behavior is not predictable, NCCI is unable to quantify the impact this provision would have on system costs.

The provision in the proposal which allows claims to be reopened due to a substantial or material change in condition may possibly allow a medical claim to stay open indefinitely as opposed to the absolute termination that exists currently. For example, if an injured worker required a joint replacement upon initial injury with no follow-up for five years and 15 years later requires replacement of this joint, this additional surgery would be denied under current statutes due to closure as the result of five years of claim inactivity, but might be covered under this proposal if the claim is reopened.

It is uncertain whether the additional benefits and expenses associated with claims being reopened would exceed any costs savings realized from claims which are closed due to three years of inactivity.

NCCI anticipates that LMAC's proposal for section 14, if enacted, may impact system costs in Montana. The magnitude and direction of the overall cost impact is not quantifiable, however, since data regarding the length of claim inactivity is not readily available and any cost impacts would be dependent on claimant and insurer behavior. Any impact on system costs would be realized in future loss experience and reflected in subsequent Montana loss cost filings.

Section 16, 21, and 25– Termination of Temporary Total Benefits

The enactment of sections 16, 21, and 25 would shorten the duration of temporary total disability indemnity (TT) benefits since it would:

- Eliminate the requirement that TT benefits continue until the worker has been released to return to pre-injury employment
- No longer require a job or physical restrictions analysis by a rehabilitation provider to terminate TT

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- Terminate TT benefits 21 days after maximum medical healing (maximum medical improvement or MMI), but not before the date that the permanent partial impairment rating has been issued.

Section 16 would change the definition of permanent partial disability to require *all* of the following:

- Worker has reached maximum medical healing
- Worker has greater than 0% impairment rating
- Worker has not been offered a job for which they are qualified, that meets their physical abilities, and that pays wages greater than or equal to their pre-injury wage, from their time of injury employer
- Worker has not returned to work within 21 days of reaching maximum medical improvement

Currently TT indemnity benefits continue until the worker has reached MMI, received an impairment rating, and a job analysis has been completed by vocational rehabilitation provider, and TT benefits can continue for months after the worker has reached maximum medical improvement.

Currently, many workers who are permanently totally disabled (PT), permanently partially disabled (PP), and temporarily totally disabled receive an evaluation of their ability to return to work, with or without restrictions, based on their age, education, work experience, and physical condition.

Allowing the insurer to terminate TT benefits 21 days after MMI and after the impairment rating is received, would reduce TT indemnity costs. Insurers would continue to be able to terminate TT benefits if the worker returns to work.

Data used for this estimate was provided by the Department of Labor & Industry Employment Relations Division (DLI). It consists of all claims with TT benefits with injury dates occurring between 7/4/2004 to 7/4/2009 as of March 2010. Due to the lack of maturity, claims with injury dates on or after January 1, 2007 were excluded from this analysis. Key fields such as the workers weekly benefit rate and date of MMI were reported and reflected in the analysis.

Based on dates reported in the claim listing, NCCI calculated the amount of benefits paid beyond 21 days after MMI (for the lower end of the range), and benefits paid beyond 6 weeks after MMI (for the high end of the range). NCCI compared the amount of benefits removed from the system under these conditions to the total current reported TT indemnity benefits to determine the percent impact on TT indemnity benefits.

Due to the uncertainty of the actual point in time when TT benefits would be cutoff, NCCI assumed a range of possible cutoff dates which result in a range of cost impacts. The low end of the range of savings assumes that all TT benefits are terminated at MMI+21 days and that the same percentage of savings for those claims that do have an MMI date reported would apply to those that do not. This is based on the information from ERD that not all claim records where the injured worker has reached MMI have the MMI date reported.

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The high end of the range of savings assumes that for many cases the permanent partial rating is received approximately 6 weeks later than MMI, based on stakeholder input. For the high end of the range, TT benefits are estimated to terminate by applying a cap of 6 weeks after MMI date for the applicable claims, and for claims with no MMI dates populated in the data NCCI assumed no (additional) savings.

Given the expected reduced TT benefit durations as a result of this proposal, the following cost impacts are expected:

	Low	High
Impact on TT claims	-13.9%	-4.2%
TT % of Indemnity Benefits	10.9%[2]	
Indemnity % of Total Benefits	28.0%[1]	
Impact on Montana WC system costs	**-0.4%**	**-0.1%**

	Low	High
Impact on PP claims	-3.4%	-1.0%
PP % of Indemnity Benefits	69.7%[2]	
Indemnity % of Total Benefits	28.0%[1]	
Impact on Montana WC system costs	**-0.7%**	**-0.2%**

There could be savings on medical benefits if claimant TT benefits are terminated sooner and medical benefits that are currently provided would also be eliminated when the indemnity benefits are terminated. NCCI has not determined an impact on medical costs since there would be no data to support this type of analysis and the impact would be dependent on claimant behavior.

The overall workers compensation system savings from sections affecting termination of TT benefits would be between 0.3% and 1.1%.

The current definition of permanent partial disability is based on actual wage loss, so given that the proposed definition requires that the employee has not returned to work within 21 days would appear to allow more claimants to be given permanent partial disability status as described in section 16. The impact of this definition on costs is reflected in other sections in this analysis (sections 1-13, 27).

Sections 17 and 19 – Definition of Course and Scope

LMAC's proposal clarifies the definition of an employee's *'course of employment'* for workers compensation purposes, which would specifically exclude:

[2] Based on Statistical Plan data, 24 month policy period ending 12/31/2007 on the 7-1-2010 law level and developed to an ultimate basis by type of injury

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- Injuries that occur on a paid or unpaid break off the employer's worksite, and where the employee is not performing any specific tasks for the employer during the break;
- Injuries that occur while the employee is engaged in a social or recreational activity, even if the employer pays for some or all of the cost of the activity. This exclusion does not apply if the employee is paid during the time of the activity or is required or requested by the employer to attend the activity.

Currently, an insurer is liable for the payment of compensation to an employee who suffers an injury or dies while on break only if the employee is within the course and scope of employment when the cause of injury occurs. Factors that have been used to determine if an employee on break is within the course and scope of employment include:

- The employee is paid during the break,
- The employment contract entitles the employee to the break,
- Restrictions that limit where the employee can go during the break, and
- The employee's activity does not constitute a substantial personal deviation.

An insurer is also currently liable to pay compensation to an employee who suffers an injury or dies while participating in a recreational activity, but only if the employee at the time of the injury is performing prescribed job duties or is not relieved of those prescribed job duties.

The proposed language appears to clarify compensability in situations where it is unclear whether an employee was injured in the course of carrying out work responsibilities. For the vast majority of workers compensation cases, it is clear whether the employee was injured while working.

There may be modest cost savings associated with the proposed language regarding an injury that occurs while an employee is offsite on a paid or unpaid break and is not performing a specific task for the employer. Fewer claims would be compensable under the proposed language as the following factors are no longer considered when determining compensability:

- The employee is paid during the break,
- The employment contract entitles the employee to the break,
- Restrictions limit where the employee can go during the break

However, the impact on system costs is not measurable since records for workers compensation claims generally do not specify in a standardized format whether the claimant was on a break when injured.

Under the proposed language, injuries that occur while the employee is engaged in a social or recreational activity, even if the employer pays for some or all of the cost of the activity are not compensable, unless the employee is paid at the time of the injury or is required or requested by their employer to attend the activity. "Requested" is further defined as "the employer asked the employee to assume duties for the activity such that the employee's presence is not completely

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voluntary and optional and the injury occurred in the performance of those duties." This language appears consistent with current Montana case law and is therefore not expected to impact costs.

Based on the Montana Department of Labor and Industry Employment Relations Division's *2009 Workers Compensation Annual Report* (2009 WCAR), approximately 400 claims per fiscal year are denied due to course and scope of employment criteria. Based on the 2009 WCAR, there are approximately 32,000 claims per fiscal year

NCCI anticipates that LMAC's proposal for sections 17 and 19, if enacted, may result in some modest savings in overall system costs in Montana. The magnitude of the impact is not measurable, however, since the data required to complete such an analysis is not available. Any cost savings would be realized in future loss experience and reflected in subsequent Montana loss cost filings.

Section 20 – Timing of Insurer Decisions to Accept or Deny a Claim

The proposed language would reduce the number of days for an insurer to accept or deny a claim from thirty (30) to fourteen (14). Currently, an insurer who fails to comply with timely decisions and notice may be assessed a penalty, so this proposal may speed up insurer decisions. Since insurers would have to decide compensability more quickly, additional claim denials and related attorney involvement would result. **Since the cost impact would depend on behavior of claimants, insurers, attorneys, and potentially mediators and the Workers Compensation Court, any cost impact would be realized in future loss experience and reflected in subsequent Montana loss cost filings.**

Sections 22-24 - Attorney Fees

The proposed language of sections 22-24 would amend Sections §39-71-611, 612, and 614 of the Montana workers compensation (WC) statutes requiring insurers to pay costs and attorney fees for denial or termination of medical benefits that are later determined compensable by the WC Court, whether the denial is considered reasonable or unreasonable.

Attorney fees awarded for medical benefits would be:

a. Calculated using the hourly rate or contingency percentage in the attorney's contract of employment filed and approved under Section §39-71-613 if the insurer is not deemed to have acted unreasonably, and
b. Calculated using an hourly rate based on the attorney's customary and current hourly rate for legal work performed in Montana, subject to a maximum set by the department if the insurer is deemed to have acted unreasonably.

The proposed language also specifies that an insurer or claimant's attorney may not seek reimbursement or contribution from a health care provider or claimant for any costs or fees related

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to legal services provided. Accordingly, legitimate insurer subrogation rights would be eliminated in such instances.

Currently in Montana, the WC Court must determine that the insurer acted unreasonably in denying liability for indemnity and/or medical benefits in order to award attorney fees, which are payable by the employer/insurer.

The proposed language would (continue to) allow attorney fees for indemnity and/or benefits if the insurers actions (i.e., benefit denial) were unreasonable, while the proposed language would additionally allow attorney fees for medical benefits if the insurer's actions were reasonable, as long as the court determines the medical benefits themselves to be compensable.

Although the proposed language of sections 22-24 is expected to increase WC costs in Montana, the new claims to which the proposed language would apply are expected to be limited in scope. For a contested claim to be heard by the Montana WC Court, the parties to the dispute must first satisfy mediation requirements set forth by the Montana statutes under Section §39-71-2401. According to the 2009 WCAR, 81% of the petitions received over the past five years were resolved in the mediation process. The remaining cases were then subject to be heard by the Montana Workers Compensation Court (WCC).

The table below displays data from all claims heard by the WCC. The number of petitions and average claimant attorney fees in the table were obtained from the 2009 WCAR.

	FY 2005	FY 2006	FY 2007
(1) Number of Petitions by WCC	278	324	247
(2) Average claimant attorney fees	$5,408	$4,976	$5,041
Total attorney fees = (1) * (2)	$1,503,424	$1,612,224	$1,245,127

Under the scenario that *all* petitions by the WCC were related to denial or termination of medical benefits and were later adjudged compensable, and using an average of the three most recent fiscal years, the impact of Sections 22-24 under this scenario could be:

($1,503,424 + $1,612,224 + $1,245,127) / 3 = $1,453,592.

If instead we assume that 50% of the claims heard by the WCC were related to denial or termination of medical benefits that were later adjudged compensable (and not currently awarded attorney fees), the impact would be:

$1,453,592 * 50% = $726,796.

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NCCI compared the attorney fees dollar impacts from the scenarios above to the expected ultimate benefit costs for accident years 2005-2007[3]. **Sections 22-24 could be expected to directly increase overall Montana workers compensation benefits between 0.2% and 0.5%.**

In addition to the expected direct cost impacts, there are several indirect cost impacts. As the language allows for attorney fees (related to medical benefits) to be paid even with 'reasonable' denials by insurers, the proposed language may create an incentive to litigate more cases than are litigated currently, since attorney fees would be paid even if the insurer's denial actions for medical benefits are reasonable. Additionally, since fees would not be allowed to be deducted from medical providers' fees, attorney fees would be paid by the insurer instead of being paid out of the claimant's award, resulting in an advantage for claimants to pursue legal action. These provisions appear to create added incentive for an increase in attorney involvement.

It is also important to note that if the provisions of this proposal were enacted, an indirect effect such as increased settlement leverage on the part of claimants would result as insurers may be more likely to settle a dispute concerning denial of medical benefits or be less likely to deny these benefits in the first place.

Attorney fees incurred during mediation may also be contemplated in settlement amounts, putting upward pressure on costs. Therefore, in addition to the direct cost impact, these indirect effects may also result in additional costs for WC employers/insurers.

NCCI anticipates that sections 22-24, if enacted, would result in a direct increase in workers compensation costs in Montana between 0.2% and 0.5%. However, the extent of any direct increase in costs would depend on the prevalence of claims which are (reasonably) denied medical benefits and later determined to be compensable. The indirect cost impact of sections 22-24 may also increase WC costs in Montana, which would be reflected in the experience in future Montana loss cost filings.

Section 26 – Permanent Total Disability

Section 26 would allow for a worker with permanent partial disability and has not returned to work(according to the proposed definition in section 16) to request permanent total benefits, as long as the request is made within two years of receipt of the permanent partial impairment rating. In addition, the proposal would require that for those requesting permanent total disability benefits, the insurer would be required to provide SAWRTW benefits.

Currently, according to §39-71-116 an employee is considered permanently totally disabled if the worker does not have a reasonable prospect of physically performing regular work. The vocational rehabilitation counselor currently renders this determination.

[3] Based on NCCI Private Carrier and State Fund Financial Call Data and adjusted by 18.0% to reflect the self-insured market share (based on calendar year 2007 according the National Academy of Social Insurance as of August 2009)

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While the number of requests for PT may increase, it is unclear whether this would result in an increase in the number of permanent total claimants. The language changes in section 26 do not specify how or when the employee would be determined to have a permanent total disability. The definition of permanent total status according to §39-71-116 is not changing. In addition, any permanent partial claimant is presumably able to currently request permanent total status, so **NCCI would not expect any cost impact if this section were enacted**.

The cost impact due from requiring the insurer to provide SAWRTW benefits to all that request PT status was considered in the cost analysis within those relevant sections (1-13) above.

Section 27 – Permanent Partial Awards

The proposed revision to Section 39-71-703 of the Montana statutes would change the way that permanent partial impairment awards and permanent partial disability awards are calculated, and changes the conditions for receiving an impairment award and disability award.

Under this proposal, if the injured worker receives a permanent impairment rating and is no longer entitled to temporary total benefits, the worker is entitled to an impairment award under certain conditions. This impairment award is calculated by multiplying the percentage of whole body impairment by 375 weeks and is based on the impairment rating method provided by §39-71-711. If the worker suffers a permanent partial disability, the worker is entitled to both an impairment award and a disability award. The disability award would be based on the sum of the whole body impairment rating modified for age, education, and physical ability. This proposal also would increase the maximum weekly benefit rate from 50% to 75% of the SAWW for impairment and permanent partial awards for accidents occurring July 1, 2011 through June 30, 2013.

The proposed language also states that if an employee only received an impairment award and returned to work, and within six months after the return to work the position is no longer available for any reason, then the worker would receive a disability award. A disability award would not be provided if the position is no longer available due to voluntary resignation, termination for disciplinary reasons, or incarceration.

Currently under Section 39-71-703, the impairment award is determined using the latest edition of the American Medical Association (AMA) Guides (6th Edition) and the worker must not have any actual wage loss as a result of the injury to be eligible for an impairment award. If a worker has actual wage loss as determined by a rehabilitation counselor, currently the disability award is based on the whole body impairment rating, modified for age, education, physical ability, and wage loss.

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NCCI utilized permanent partial claim data received from the Montana DLI for all plan types[4]. Considering that older accident years are more mature, NCCI used closed claims data for accident years 2003-2007. The average weekly benefit rate was calculated based on the current cap of 50% and the proposed cap of 75% (both related to SAWW). The average impairment rating for impairment only awards and disability awards were calculated, and adjusted for plan type mix.

Given the changes in the conditions for receiving an impairment award and disability award, based on the MT DLI data NCCI calculated that one-third of permanent partial claims receive a disability award currently. For the low end of the range of impacts, NCCI assumed that the proportion of permanent partial claims receiving disability awards would continue. For the high end of the range, NCCI relied on stakeholder input that revealed an expected increase in the proportion of permanent partial claims receiving disability awards up to 55%. The average impairment only and disability awards were calculated under the current and proposed language, considering the changes in the formulas and caps, and incorporating the assumptions for the proportion of disability awards.

NCCI estimates that the average impairment and permanent partial disability awards would have the following cost impacts:

	Low	High
Impact on PP Awards	+7.7%	+37.3%
PP Award % of PP Benefits	57.5%[5]	
PP Benefits % of Indemnity Benefits	69.7%[2]	
Indemnity % of Total Benefits	28.0%[1]	
Impact on Montana WC System Costs	**+0.9%**	**+4.2%**

Normally with large increases in benefits, additional utilization of benefits might occur. Utilization impacts was considered in the high end of the range, although no explicit utilization of PP awards were considered for TT claimants since it is not anticipated that a TT claimant would be able to receive a PP impairment rating. Utilization impacts related medical costs are not contemplated in these cost estimates. Any potential for utilization of indemnity and medical benefits beyond what was considered in this pricing would have additional cost impact on the Montana WC system.

Note that the proposed language for permanent partial awards would also change the maximum weekly benefit from 75% to 100% of the State Average Weekly Wage, and would increase the maximum duration from 375 to 400 weeks on July 1, 2013. NCCI has not calculated the expected cost increase from this provision, however, any cost impact from this provision would be incorporated in the 7/1/2013 Montana loss cost filing.

[4] Type 1 = Self Insured, Type 2 = Private Carrier, Type 3 = State Fund

[5] Based on a sampling of permanent partial claims from NCCI's Detailed Claim Information for accident years 2003-2007

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National Council on Compensation Insurance, Inc.

ANALYSIS OF MONTANA'S LABOR MANAGEMENT ADVISORY COMMITTEE (LMAC) REFORM PROPOSAL
As Submitted to NCCI July 30, 2010

Section 28 – Medical Services Maximums, Utilization and Treatment Guidelines

Section 28 would alter two provisions:

- Department would not be able to set a rate for the medical fee schedule at a rate greater than 65% above Medicare
- Requires that the department establish evidenced based utilization and treatment guidelines (guidelines).

The department has separately developed a set of guidelines.

Currently the department is able to make changes to the medical fee schedule, and the maximum rate cannot be greater than 10% above the average fee of the top five insurers in the state. Medical fee schedules are adopted by rule. NCCI will estimate the cost impact of such rules when they become available.

Currently the current statutory language related to utilization and treatment guidelines says "…the department *may* establish by rule evidence-based utilization and treatment guidelines….The proposed language would change from "may" to "shall", thus requiring that the department establish such guidelines. The guidelines are subject to a rebuttable presumption of correctness. The implementation date of the guidelines would appear to be determined by rule, and would add additional uncertainty to the timing and implementation.

NCCI discussed the proposed utilization and treatment guidelines with stakeholders in Montana as well as in Colorado. Based on this input NCCI believes that the adoption of utilization guidelines in Montana based on Colorado's guidelines could reduce medical costs in Montana. However, much of the savings will depend heavily on several important factors:

- *The implementation of the guidelines.* There is expected to be a transition period in Montana, where the guidelines are initially voluntary. As the guidelines are increasingly used and become mandatory, it is anticipated that certain maximums and the consistent use of effective treatment protocols contained in the guidelines will reduce claim costs and durations. However, if the maximums become the typical treatment protocol, claim durations could potentially increase in some instances.

- *The interpretation of their presumption of correctness.* If the guidelines are not seen as fair by physicians, workers and attorneys, then frictional costs may increase as the guidelines are tested through litigation.

- *The extent of their use by insurers to make sound decisions regarding unnecessary treatments.* There will be exceptions requested, as some cases may require treatments that are a deviation from the guidelines. The resolution process adopted by Montana stakeholders will affect the ultimate impact of the guidelines.

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- *The extent of reliance on the guidelines by physicians treating work-related injuries.* There is extensive training planned in Montana to assist physicians to understand and work with the guidelines. Some physicians, however, may only see a few work-related injuries as part of their practice, and may have more difficulty with the transition. If there is not adherence to the guidelines, and regular correspondence is required to improve adherence, then the cost of claim handling may increase.

- *The content of the guidelines.* The degree of savings depends on the extent to which the guidelines (if strictly adhered to) would reduce utilization of medical services and/or improve return to work outcomes compared to current practice.

NCCI anticipates that the implementation of utilization and treatment guidelines in Montana could reduce costs. The large number of uncertainties in developing a range to estimate the potential impact of implementing utilization guidelines in Montana renders any such analysis unreliable. Any cost savings would be realized in future loss experience and reflected in subsequent Montana loss cost filings.

Section 30 – Require 5th Edition of American Medical Association Guide to Impairment Ratings

In 2009 NCCI evaluated the cost impact of a change from the 5th Edition to the 6th Edition in Montana. At the time, Montana statutes required the use of the "current edition" of the AMA Guides. NCCI was unable to determine the cost impact of a change from the 5th Edition to the 6th Edition of the AMA impairment guide.

Section 30 would restore the use of the 5th Edition of the American Medical Association Guide to Impairment Ratings (5th Edition) for permanent partial claims. Section 30 would also allow the DLI to adopt by administrative rule another system or method for evaluation and rating of permanent impairment, as often as it deems advisable. **Due to the uncertainty of how average impairment ratings may change overall from a change from the 6th Edition to the 5th Edition, and uncertainty about potential rules adopted, NCCI is unable to determine a cost impact from this section of the proposal.**

Section 32 – Introduction of Retroactive Period

The proposed revisions to Section 39-71-736 of the Montana statutes would introduce a 21-day retroactive period for indemnity benefits. Under this proposal, the injured worker would be paid indemnity benefits for the first 4 days of incapacity if the injured worker is unable to work in any capacity for 21 days or longer.

Currently under Section 39-71-736, compensation for disability is not payable for the first 4 days of incapacity no matter how long the injured worker is unable to work.

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Introducing the 21-day retroactive period would increase the amount of indemnity benefits for TT and PP claims. The cost of permanent total (PTD) claims would increase only minimally. Based on a distribution of temporary total durations of disability and increase in number of days benefits would be paid, **NCCI estimates the direct impact on TT indemnity costs (prior to the consideration of benefit utilization) to be an increase of 4.0%.**

PP indemnity costs are also affected because the majority of PP injuries begin as TT injuries. **NCCI estimates the direct impact on PP indemnity costs to be an increase of 0.9%**.

These direct cost estimates do not consider the potential indirect impact from possible increased utilization of the workers compensation system by some covered workers. Numerous research reports have confirmed the existence of economic incentives to file claims and prolong durations of disability in the face of increased benefits. As such, this proposal may provide incentives for longer durations on existing claims, and for the filing of new claims, given the eligibility to receive indemnity benefits starting on the first day away from work due to injury under the proposal. The additional indirect costs from these incentives may result in an impact higher than the direct impact noted above.

Most PP claims are not resolved in 21 days. Therefore, in our estimation of the direct impact on PP costs, we assumed that all PP claims would receive compensation for the first four days of incapacity under this proposal. Thus, our estimate of utilization impacts TT costs only.

Some TT claims that currently would have durations of less than 21 days may have a higher duration if this proposal is enacted, due to utilization.

For the high end of our range of impacts, NCCI assumes an average increase of four days in duration for each TT claim with current duration of less than 21 days. Based on the distribution of the duration of claims, NCCI calculates that this utilization effect could result in an additional 6.3% impact on TT claim costs. Thus, the increase in benefit costs for TT claims is estimated to be in the range of 4.0% to 10.3%, using the direct cost impact described above as the lower end of our range of impacts.

	Low	High
Impact on TT claims	+4.0%	+10.3%
TT % of Indemnity Benefits	10.9%[2]	
Indemnity % of Total Benefits	28.0%[1]	
Impact on Montana WC system costs	**+0.1%**	**+0.3%**

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	Low	High
Impact on PP claims	+0.9%	+0.9%
PP % of Indemnity Benefits	69.7%[2]	
Indemnity % of Total Benefits	28.0%[1]	
Impact on Montana WC system costs	**+0.2%**	**+0.2%**

The overall impact on Montana workers compensation system costs is estimated to be an increase between 0.3% and 0.5%, if this proposed revision to Section 39-71-736 of the Montana statutes is enacted in its current form.

Sections 34 & 38– Settlements

Section 34 would allow for the settlement of future medical benefits under the following conditions:

- The claimant has reached maximum medical improvement (MMI).
- The insurer and claimant mutually agree to a settlement.
- The claimant indicates by a signed acknowledgement an understanding of what medical benefits will terminate upon settlement.
- For any settlement of medical benefits that is subject to CMS set-aside approval, the DLI may not approve the settlement unless the settlement language provides for a CMS set-aside and is expressly contingent on CMS's approval of the set-aside.

Currently, medical benefits may only be settled if an insurer disputes their continued liability for medical benefits, or if there is a reasonable dispute over the medical treatment (where only the funding of the specific disputed treatment may be settled).

If introduced and enacted in its current form, section 34 would expand the conditions under which future medical benefits may be settled with claimants, as described above. The number of settlement agreements involving future medical benefits would increase if this proposal were enacted. If settlements are generally based on the medical condition of the claimant at the time of settlement, this proposal may reduce system costs as insurers obtaining such settlements would be protected from paying medical benefits due to the age-related or non-occupational progression of a work injury over time. However, employees considering settlement may seek the counsel of an attorney and historically the involvement of an attorney results in increased settlement amounts. The degree of savings would likely depend on the insurer's ability to adequately value future medical benefits and the insurer's ability to negotiate with claimants/attorneys, compared to current costs for claims affected by this proposed language. Since these circumstances are dependent on behavior of many parties, they are difficult to explicitly evaluate.

Under the proposal, the injured employee would still need to agree to settle their medical benefits. Injured employees may be reluctant to settle all medical benefits for a claim with the knowledge that all future medical benefits would terminate upon settlement. Employee motivation for settling

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medical costs is unclear other than to receive a lump-sum, so the extent of any increase in the number of settlements is uncertain.

If the number of settlements increases, it is likely that claims will close sooner than they do currently. Since costs are generally incurred while a claim file remains open, this proposal may decrease claims handling-related expenses.

Subject to the terms of the settlement, if the settlement funds are exhausted due to higher than anticipated future medical expenses, the workers compensation insurer would be protected from paying additional medical benefits. It is possible that if the funds were exhausted and the settlement did not require CMS approval of a set aside agreement, then the employee may seek other sources (such as CMS) to pay for unbudgeted/unanticipated medical costs associated with the injury. In those cases, Medicare may assert its position as a secondary payer and require the workers compensation insurer to pay for the additional medical care. Additional attorney involvement may result from disputes of this nature.

To the extent that the implementation of medical utilization and treatment guidelines are enacted in Montana, the settlement of medical benefits may be more objective, and may increase incentives for settlements of medical benefits.

NCCI anticipates that section 34, if enacted in its current form, may result in some savings in overall system costs in Montana. The magnitude of the impact is not measurable, however, since the data required to complete such an analysis is not available, and the cost impact depends on the behavior of claimants, insurers, CMS, and the DLI. Any savings would be realized in future loss experience and reflected in subsequent Montana loss cost filings.

Section 38 would allow settlements under the provisions of section 34 to be applied to claims for injuries or occupational diseases in which all benefits have not been settled. Given that the impact expected from section 34 is unknown, the retroactive impact is similarly unknown.

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