1999 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1232

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1232

House Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date 1-25-99

Tape Number	Side A	Side B	Meter #
2	x		49.1 - 54.0
2		x	0 - 33.2
Committee Clerk Signature			

Minutes:

HB 1232 Relating to Confidentiality of Workers' Compensation Employer's Reports.

Chairman Berg opened the hearing on the bill.

Rep. Rose, introduced and testified in support to the bill.

(see attached written testimony)

Berg asked what the purpose of the bill was.

Rose said it is to reduce costs because employers don't always report actual costs on payroll reporting as well as other areas of noncompliance.

Mr. Gary Nelson, Ironworkers 793, testified in support of the bill.

(see attached written testimony)

Rep. Johnson asked what 5040 classification was.

Nelson said it is structural steel classification.

Kempenich asked about how specifically this bill can help from what was done in the past.

Nelson said it will determine a classification for anyone that wants to check on an employer.

Keiser asked about how the miss classification would affect the internal accounting system.

Nelson said that the 5040 is $25.96 per hundred and the new construction which is $12.70 for classification 5010. This can be a large difference when there are many employees involved.

Glassheim asked where does it go from here.

Nelson said a new business that comes to town to build and someone can call the bureau and find out how many people were employed in certain classifications. If a difference is noted, the bureau can be notified and the bureau can check it out. Along with the classification research, the dates of work by employees would have to be checked out also.

Mr. David Kemnitz, NDAFL-CIO, testified in support of the bill. He agrees with Gary Nelsons introduction and remarks.

Mr. Steve Latham, ND Trial Lawyers, testified in support of the bill. He said it helps eliminate the bad seed employers. It will help some contractors to be more competitive, however, by allowing them to see what other contractors are bidding for labor costs.

Mr. Drew Wrigley, Counsel for Workers Compensation, testified in opposition to the bill. (see attached written testimony)

Berg asked him to explain the fraud process.

Wrigley said they get calls and do interviews and follow up on reported possible fraud activities. Most of the fraud is miss classification reporting. Over $6 million has been saved through the fraud audit process.

Stefonowicz asked about costs spent investigating fraud activities verus how much the fraud actually was.

Wrigley said he will get the information to him later. The cost savings do, however, help keep the costs down.

Mr. Curt Peterson, ND Assoc. of Contractors, testified in opposition to the bill. He said the information obtained from the bureau is unfair and will hurt contractors.

Glassheim asked about premium costs and why information will hurt. He went on to say the information may be an advantage because it will help contractors find out if they have made mistakes in classifying employees.

Mr. Pat Trynor, Director of WC Bureau, testified in opposition to the bill. He said the toll free number can be used now. The total investigation costs were about 1.5 million at 10-98. Fraud can be employee as well as employer fraud. About 50 cases were open for investigations recently and if investigators go out to a site they charge that employer for the costs. 40 criminal cases were reported to the states attorney for criminal process. Employee fraud is more difficult to identify.

Chairman Berg closed the hearing on the bill.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1232

House Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date 1-26-991

Tape Number	Side A	Side B	Meter #
1		x	44.3
Committee Clerk Signature	Lisa Horner		

Minutes:

HB 1232

Chairman Berg opened the meeting on the bill.

Committee members discussed the bill and were concerned about making information available to other people to include competitors. Employment fraud is a conern by the committee.

Moved by Representative Keiser for do not pass, Second by Representative Kempenich

By roll vote, 12 yes, 2 no, 1 absent, motion carried.

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: HB 1232 Amendment to: _____

Requested by Legislative Council Date of Request: 1-21-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   See attached.

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:						

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: _____
   b. For the 1999-2001 biennium: _____
   c. For the 2001-03 biennium: _____

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

If additional space is needed, attach a supplemental sheet.

Signed J. Patrick Traynor

Typed Name J. Patrick Traynor

Date Prepared: 01-22-99

Department Workers Compensation Bureau

Phone Number 328-3856

NORTH DAKOTA WORKERS COMPENSATION BUREAU
1999 LEGISLATION
SUMMARY OF ACTUARIAL INFORMATION

BILL DESCRIPTION: **Confidentiality of Employer Reports**

BILL NO: **HB 1232**

SUMMARY OF ACTUARIAL INFORMATION: The Workers Compensation Bureau, with the assistance of its Actuary, Glenn Evans of Pacific Actuarial Consultants, has reviewed the legislation proposed in this bill in conformance with Section 54-03-25 of the North Dakota Century Code.

The proposed legislation would allow the Bureau to disclose additional information pertaining to employer files including the number of employees in each classification and the expiration date of the premium paid by an employer.

FISCAL IMPACT: Not quantifiable. The proposed legislation may serve to increase the number of requests for employer specific information along with the costs associated with processing those requests.

DATE: 1-21-99

Date: 1-26-99
Roll Call Vote #: 1

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1232

House Industry, Business and Labor Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken do not pass

Motion Made By Keiser Seconded By Kempenich

Representatives	Yes	No	Representatives	Yes	No
Chair - Berg	✓		Rep. Thorpe		
Vice Chair - Kempenich	✓				
Rep. Brekke	✓				
Rep. Eckstrom	✓				
Rep. Froseth	✓				
Rep. Glassheim	✓	✓			
Rep. Johnson	✓				
Rep. Keiser	✓				
Rep. Klein	✓				
Rep. Koppang	✓				
Rep. Lemieux	✓				
Rep. Martinson	✓				
Rep. Severson	✓				
Rep. Stefonowicz		✓			

Total (Yes) 12 No 2

Absent 1

Floor Assignment Kempenich

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1232: Industry, Business and Labor Committee (Rep. Berg, Chairman) recommends **DO NOT PASS** (12 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). HB 1232 was placed on the Eleventh order on the calendar.

1999 TESTIMONY

HB 1232

HOUSE INDUSTRY, BUSINESS, AND LABOR COMMITTEE
HB 1232
REPRESENTATIVE WANDA ROSE DISTRICT 32
JANUARY 25, 1999

Chairman Berg and members of the House IBL committee.

For the record I am Wanda Rose, Representative from District 32.

I come before your committee in support of HB 1232.

Escalating workers' compensation insurance premiums set off a series of unsubstantiated charges about widespread claimant fraud as a major cost driver in the workers' compensation system. States that passed anti-fraud legislation began to pursue fraud cases and to collect information on fraud. These efforts revealed employer fraud is a far larger drain on the system. The best evidence from the states that have pursued fraud and generated detailed records indicates that for every $1 lost in claimant fraud, at least $4 to $5 are lost through premium fraud.
Premium fraud includes a number of schemes used by employers to reduce the workers' compensation insurance premiums by underreporting payroll, misclassifying employees' occupations and misrepresenting their claims experienence.

HB 1232 allows upon a request to disclose the number of employees in each classification, and the expiration date of the premium paid by and employer. This would hold employers accountable for proper classification of their employees.

I urge your support of HB 1232

Workers Compensation Bureau

500 East Front Avenue
Bismarck, North Dakota 58504-5685

Pat Traynor
Executive Director & CEO

October 2, 1998

Gary Nelson
Fax 663-4266

Dear Mr. Nelson:

Here is the information you requested regarding rate classification 5040. Please feel free to call me with any questions at 328-3813.

In the last twelve months ending August 30, 1998, 75 different employer accounts reported actual wages paid under the 5040 rate classification. For the information below, the reporting periods included were those with inception dates after July 1 of each year. The figures were calculated as of September 30, 1998.

Year starting	gross payroll	employees reported
6-30-93	$1.50 Million	344
6-30-94	1.54	339
6-30-95	2.43	431
6-30-96	2.37	754
6-30-97	5.58	1211

6-30-97 The accounts incepting during this fiscal year have not all reported. Any available figure would be speculative.

Part of the cause for the increased employee numbers starting July 96 may be the Bureau's increased review of the rate classification and the addition of the rate classification to all construction accounts reporting form.

Sincerely,

Bill Riedman
Assistant Director Policyhholder Services

Workers' Compensation Fraud : The Real Story

Prepared for the

Injured Workers Bar Association

Prepared by the

LABOR RESEARCH ASSOCIATION

June 1998

Workers' Compensation Fraud: The Real Story

Executive Summary

Escalating workers' compensation insurance premiums in the late 1980s and early 1990s set off a series of unsubstantiated charges about widespread claimant fraud as a major cost driver in the workers' compensation system. A number of states passed anti-fraud legislation and began to pursue fraud cases and to collect information about fraud on a serious basis. These efforts have uncovered no evidence to support the charges of widespread claimant fraud and, in fact, have revealed that employer fraud is a far larger drain on the system. The misplaced focus on claimant fraud has created an atmosphere of fear and intimidation for injured workers with legitimate claims. It has also distracted policymakers, law enforcement officials and the public from the real fraud problem in workers' compensation: employer fraud.

Unsubstantiated charges of rampant claimant fraud have created an atmosphere of fear and the "unwarranted and anecdotal vilification of the work force."

"While claims fraud is a significant problem . . . it pales in comparison with premium fraud."

A recent study by California state agencies calculated that nearly one out of every five employers either underreport payroll or have no workers' compensation insurance.

The use of managed care in workers' compensation has created more opportunities for provider fraud.

The real question is not why there is so much claimant fraud, but why there is so little. A system that leaves injured workers in poverty invites abuse.

Workers' Compensation Fraud: The Real Story

Dramatic increases in workers' compensation premiums throughout the late 1980s and early 1990s fueled unsubstantiated charges that costs were high in part because workers abused the system, fraudulently collecting benefits for faked injuries or remaining on benefits far longer than their recovery required. The American Insurance Association estimated fraud losses at 10% of the cost of claims paid, or about $3 billion. The National Insurance Crime Bureau doubled the AIA's estimate to $6 billion, even though it was involved in only 99 fraud prosecutions in 1994 and 134 in 1995 nationwide. The Coalition Against Insurance Fraud adopted the AIA's estimate. One insurance company president put the cost of workers' compensation fraud at $30 billion a year. These huge numbers grabbed the attention of the public and policyholders. The presumption in the press and in the state houses was that fraud was rampant and that most workers' compensation fraud was claimant fraud.

Since that time, more than half of the states have passed legislation on workers' compensation fraud, with most of the laws directed primarily at claimants. Thirty-three states currently have active workers' compensation insurance fraud units, many of them geared to fighting claimant fraud.[1] In every state, some claimant fraud has been discovered; publicity about these cases has created a deterrent for workers who might contemplate fraudulent claims. But it has also created an atmosphere that Frederick Hill, California analyst for Firemark Research of New Jersey, describes as the "unwarranted and anecdotal vilification of the work force."[2]

In its extensive investigation of workers' compensation fraud, the *Santa Rosa Press Democrat* concluded that, "The perception that workers are cashing in by faking or exaggerating injuries has created a climate of mistrust in which every person who is injured and files a claim can become the subject of suspicion by insurance adjusters, doctors and industry lawyers."[3] Perhaps most importantly, the fixation on claimant fraud has distracted policymakers, enforcement agencies, and the public from growing evidence of the real problem: millions of dollars in employer and provider fraud.

Fixation on Claimant Fraud

Few experts believe that claimant fraud is a major cost driver in workers' compensation. But some estimates, including those adopted by California Governor Pete Wilson, suggest that fraud accounted for 25% of all employers' workers' compensation costs and 10% of the claims.[4] In California, a wave of legislation in the late 1980s and early 1990s was fueled by allegations from employers that workers' compensation costs were too high and that fraud was rampant in the system. But between 1979 and 1991, insurance carriers in California reported only 532 cases of alleged fraud.[5]

According to the *Santa Rosa Press Democrat*, "Some insurance companies saw fraud as a way to explain why premiums were soaring, and politicians and the media jumped on the bandwagon."[6] The *Press Democrat* found that, "While some insurance companies claim one out of three workers lie about their injuries, or 33%, the actual number of fraud cases sent to prosecutors is less than 1 out of 100, or less than 1%."

In its estimates of fraud within its own state, Kentucky reversed California's estimate of fraud accounting for 10% of claims and 25% of costs, saying that "as much as 25% of all workers' compensation claims involve some element of fraud, accounting for 10% of paid premium."[7] Kentucky then calculated its own fraud losses as $60 million a year. It noted, however, that "while the extent of the fraud cannot be quantified, there is no doubt that workers' compensation fraud is in the public eye. Reports of fraud ... are proliferated by the media."[8]

High workers' compensation costs led to more anti-fraud efforts. The Arkansas legislature created the Workers' Compensation Fraud Investigation Unit in 1993, in response to then-escalating workers' compensation costs.[9] In its first year of operation, the new Fraud Unit opened 116 investigations, leading to 10 claimant fraud prosecutions and five employer fraud prosecutions, and quickly discovered that the employer cases accounted for a large portion of the dollar value involved.

New York's massive 1996 workers' compensation legislation, including its fraud provisions, resulted a directly from employer claims that workers' compensation costs were out of control. New York State Controller H. Carl McCall announced flatly in October of 1997, "Fraud is a factor in New York's compensation costs." A statement from his office made the link between rising costs and the presumption of widespread fraud, stating that, "In response to the high cost of workers' compensation, reforms aimed at fraud detection and prosecution were enacted in 1996."[10] But according to the New York Sate Insurance Department's annual report on insurance fraud, workers' compensation fraud represented only 3% of all the fraud reports in the state in 1996, the year that the legislation was passed.

Of the more than $6 million in insurance fraud documented in the New York report, workers' compensation claimant cases accounted for less than 2%. The report cited cases of pharmacists, physicians, and medical clinics making a total of almost $3 million in fraudulent claims. Three cases of premium embezzlement totaled over half a million dollars. The report cited only five cases of claimant fraud totaling $107,300. [11] Like other states that are pursuing workers' compensation fraud, New York is quickly discovering that the real drain on the system stems from employer and provider fraud.

Common Forms of Employer Fraud

The best evidence from the states that have pursued fraud and generated detailed records indicates that for every $1 lost in claimant fraud, at least $4 to $5 (and in some states as much as $10) are lost through premium fraud. Premium fraud includes a number of schemes used by employers to reduced the workers' compensation insurance premiums by underreporting payroll, misclassifying employees' occupations and misrepresenting their claims experience. According to the National Council on Compensation, the most common frauds include:

- **Underreporting payroll.** Employers reduce their premiums by not reporting parts of the work force, paying workers off the books or creating a companion corporation to hide a portion of the employees.

- Declaring independent contractors. Employers avoid premium payments for employees by classifying them as independent contractors even though they are legally employees.

- Misclassifying workers. Employers intentionally misrepresent the work employees do to put them in less hazardous occupational categories and reduce their premiums.

- Misrepresenting claims experience. Employers hide previous claims by classifying employees as independent contractors or leased employees or creating a new company on paper.

- Employers deliberately underestimate employment projections at the beginning of the premium year and essentially receive an interest-free loan from the insurance company for the amount that would have been required to insure new employees.[12]

In addition to premium fraud, employers often fail to purchase workers' compensation insurance, despite state laws mandating that they do so. There are also reports of employers instructing injured workers to seek treatment under group health insurance rather than workers' compensation, employers discouraging workers from filing workers' compensation claims and firing workers who file claims.

Recognizing the Real Fraud

While some states and the media continue to focus on claimant fraud, states that have pursued workers' compensation fraud in a serious way are now concluding that the emphasis on claimant fraud is misplaced, and employer fraud is by far the greater problem. According to Jerry D. Stewart, the bureau chief of workers' compensation/law enforcement operations at the Division of Insurance Fraud in Florida, "Historically, there has been a common presumption that those committing the most costly type of workers' compensation fraud have been claimants whose actions, such a double-dipping or claims for false injuries, drove up the cost of workers' compensation

insurance. While claims fraud is a significant problem in Florida ... it pales in comparison with the occult type of fraud known as 'premium fraud,' where loss estimates range around $400 million ... " Stewart notes that, "Premium fraud scams are costly to companies in Florida, causing workers compensation insurance rates to escalate and legitimate companies to lose business because they are less able to compete with companies shirking the system."[13]

In Florida, the construction industry, the state Workers' Compensation Oversight Board, and the House of Representatives Committee on Financial Services all lobbied for increased enforcement of premium fraud and stiffer penalties for employers. Since 1996, Florida has turned its attention to premium fraud, with dramatic results. Florida now has a special strike force mobilized solely to fight premium fraud. The state prosecutor has also impaneled a statewide grand jury to hear complex insurance fraud schemes such as premium fraud. During the last months of 1997, 11 persons were charged with racketeering and schemes to defraud, which involved $7.5 million in workers' compensation premium fraud losses.[14]

In one case, a Palm Beach leasing firm misclassified employees and underreported their payroll, thus avoiding payment of more than $800,000 in workers' compensation insurance premiums. Another case involved underreporting of payroll at a large fruit harvesting company, with fraud charges totaling $3.5 million. Yet another employer in central Florida was charged with defrauding insurers of $2 million while operating one of the state's largest temporary employment agencies. The employer disguised the high-risk nature of the work done by many of the employees, concealed its claims history, prevented insurance companies from conducting audits and lied on applications for workers' compensation insurance.[15] In January of 1998, two Florida insurance executives and their attorney were charged with multiple criminal counts in connection with the $100 million collapse of two insurance companies caused by kickbacks to reduce workers' compensation premiums.[16]

Under a state law that took effect in 1994, Wisconsin's Division of Workers' Compensation now collects information and issues annual reports

on fraud. In 1994, the division referred to the district attorney five cases of claimant fraud, involving $44,674, out of 73,678 work-related injuries reported for the year.[17] In its 1997 study, the division concluded that, "There is no evidence that criminally prosecutable fraud is more than one percent of all reported claims in Wisconsin – a far cry from the 20-30% estimates thrown about elsewhere."[18] In 1996, there were 152 allegations of workers' compensation claimant fraud made to the division in Wisconsin. Eleven of those were referred to the district attorney, and seven were pursued, with fraud losses valued at total of $175,389. The division found that fraud is involved in six-tenths of one percent of all reportable claims in Wisconsin.[19]

A Texas study of workers' compensation fraud conducted by the state's Research and Oversight Council on Workers' Compensation found that, "In 1996, health care provider fraud was the most expensive type of fraud detected in the Texas workers' compensation system in terms of total dollars lost ($1,200,952), accounting for over eight times the dollar amount of injured worker benefit fraud ($134,351)."[20] In 1996, only 18 injured worker benefit fraud cases were referred to district attorneys, with an average fraud of $7,464 per case, compared with 46 health care providers, with an average fraud of $26,108 per case.

The Texas report found, however, that insurance carriers spent more money investigating injured worker benefit fraud than any other type of workers' compensation fraud. In 1996, Texas insurance carriers spent an average of $1,257 per claimant fraud investigation, compared with $991 per employer premium fraud investigation and $823 per health care provider fraud investigation. In 1996, the nineteen insurers studied spent over $5.5 million investigating workers' compensation fraud in Texas, yet recovered a total of $1,520,179. Of the 4,077 cases of claimant fraud that the carriers investigated, only 18 were referred for criminal prosecution. The report concluded: "It is clear that more resources should be spent fighting the most expensive and overlooked types of workers compensation fraud: employer premium and health care provider fraud."[21]

A 1995 law that requires the reporting and investigation of premium fraud has helped to shift the focus in California. "In terms of dollar costs, there's no question that employer fraud today costs more dollars to carriers and to the industry than employee fraud," according to Richard Schultz, a spokesman for the State Compensation Insurance Fund, California's largest compensation insurer.[22] A recent study by the California Department of Industrial Relations and the Employment Development Department (EDD) calculated that 19% of employers – nearly one out of every five – either underreport payroll to EDD or have no workers' compensation insurance. The California Department of Insurance concludes that, "Losses on premium fraud can and usually do exceed the amount of loss in claimant fraud, and, in some instances, medical mill fraud. For example, in several cases where criminal charges have already been filed, losses due to premium fraud for each case are estimated to be in excess of $5 million."[23]

New York's new anti-fraud efforts have dramatically increased arrests for workers' compensation fraud. In 1997, the New York Insurance Department investigated 408 cases of alleged workers' compensation fraud and made 37 arrests, with $900,000 saved by insurance companies and more than $1.2 million in court-ordered restitution.[24] Although New York continues to focus on claimant fraud, its investigations have uncovered premium fraud cases of far greater significance than any of the claimant cases. In one recent case, the comptroller of a trucking company pleaded guilty to mail fraud after he falsified the company's payroll records to defraud the State Insurance Fund of more than $1.2 million in workers' compensation insurance premiums.[25]

Massachusetts's largest workers' compensation fraud case for 1997 involved an employer who fraudulently reduced the premiums for his rubbish collection workers by classifying them as clerical workers, hiding payroll and using shell corporations to evade surcharges based on the business's unfavorable prior accident history. The employer concealed more than $1 million in payroll from insurance auditors.[26]

Employers also abuse the system when they fail to provide workers' compensation insurance for their employees or take out a policy but then fail to

pay the premiums. California is beginning to investigate employers who fail to provide workers' compensation insurance. In March of 1998, California launched a three-part pilot project to match computer databases from various state agencies to identify employers who are illegally uninsured for workers' compensation. According to John C. Duncan, Director of the California Department of Industrial Relations, the project is designed to "level the playing field for law-abiding insured employers and reduce the taxpayer burden created by those who are not."[27]

California's Commission on Health and Safety and Workers' Compensation 1997 report concludes that, "Especially in industries with high premium rates, the illegally uninsured employer is able to underbid the insured employer. Insured employers are again disadvantaged when taxes are raised to cover costs shifted to government services to assist the injured workers of employers who are illegally uninsured."[28]

Several other states, including Wisconsin and Colorado, are also using proactive programs to identify uninsured employers using computerized lists of employers and workers' compensation policies.[29] In New York, a 1997 audit by the state comptroller's office revealed that employers owe more than $500 million in overdue unpaid workers' compensation insurance premiums to the State Insurance Fund.[30] Failure to secure workers' compensation insurance is only a misdemeanor offense in New York. In West Virginia, the state has been forced to initiate a series of lawsuits to force payment of more than $100 million in unpaid workers' compensation premiums.

Medical Provider Fraud

Workers' compensation fraud also occurs among medical providers. These forms of fraud evolve as the nature of medical care changes over time. Outright fraud occurs when providers bill for treatments that never occurred or were blatantly unnecessary. Some of the newer forms of medical provider fraud include kickbacks from specialists and other treatment providers to referring physicians, and provider upcoding, where provider charges exceed the scheduled amount. Providers also shift from the less expensive, all-inclu-

sive patient report to supplemental reports, which add evaluations and incur separate charges.[31]

Medical provider schemes include:

- **creative billing** - billing for services not performed
- **self-referrals** - medical providers who inappropriately refer a patient to a clinic or laboratory in which the provider has an interest
- **upcoding** - billing for a more expensive treatment than the one performed
- **unbundling** - performing a single service but billing it as a series of separate procedures
- **product switching** - a pharmacy or other provider bills for one type of product but dispenses a cheaper version, such as a generic drug

Newer forms of fraud and abuse occurring under managed care arrangements include:

- **underutilization** - doctors receiving a fixed fee per patient may not provide a sufficient level of treatment
- **overutilization** - unnecessary treatments or tests given to justify higher patient fees in a new contract year
- **kickbacks** - incentives for patient referrals
- **internal fraud** - providers collude with the medical plan or insurance company to defraud the employer through a number of schemes

According to the National Council on Compensation, "The increased use of managed care for workers' compensation, as well as for other insurance lines, is bringing new twists to old schemes." [32] Managed care creates more opportunities for fraud because the of financial relationships and incentives between players.

Although the campaign against California medical mills wiped out a substantial part of medical provider abuse in that state, new cases continue to emerge. In October of 1997, for example, a pharmacist plead guilty to 21 counts of fraudulent workers' compensation insurance billing. The pharmacist increased his revenues by up to 500% per prescription on more than $600,000 of drugs sold over a four year period.[33]

Insult Added to Injury

Because of the assumption of widespread claimant fraud, injured workers who file a workers' compensation claim may be subjected to insulting questions and treated as malingerers and cheats. Under the auspices of "fraud prevention," they may face endless questioning and unnecessary medical examinations. They may be subjected to constant video surveillance by private investors hired to follow their every move. Their employer may refuse to provide light duty work, or take retaliatory actions against them when they return to work. If they look for another job, their application may be screened for prior workers' compensation claims.

Although some of these tactics are used in legitimate attempts to investigate questionable claims, they have also become part of a broad employer attempt to intimidate workers from filing workers' compensation claims. Under the pretext of controlling what has been falsely presented as rampant claimant fraud, injured workers are discouraged from exercising their legitimate rights to workers' compensation benefits. As a recent Michigan study demonstrated, the real problem in workers' compensation is not that too many workers claim benefits, but that too few do so. The study, sponsored by the National Institute for Safety and Health, found that only one in four workers with occupational diseases file for workers' compensation. Unsubstantiated charges of rampant claimant fraud undermine public confidence in the system and discourage legitimately injured workers from seeking the benefits they need and deserve.

In California, a detailed investigation by state auditors found that "workers' compensation insurers violated workers' rights in about half the claims it

audited." The violations included "unacceptably high amounts" of unpaid benefits, late payments, inaccurate benefit notices and failure to notify injured workers of their rights. In describing the experience of many workers' compensation claimants, The *Santa Rosa Press Democrat* found that many injured workers slam into a wall of suspicion and distrust that will paralyze them with shame and frustration and delay their recovery."[34] One of the injured workers interviewed by the newspaper commented: "You get the feeling that even though you have a legitimate complaint and a six-inch scar, you're somehow a malingerer."

The grossly overstated estimates of claimant fraud have not only subjected injured workers with legitimate claims to fear and intimidation, but have also obscured a more serious look at the workers' compensation system and the benefits its provides. The real question is not why there is so much claimant fraud, but why there is so little. In most states, workers' compensation benefits provide little more than poverty-level existence. Workers often wait weeks and months for payments.

Many employers refuse to provide light duty or alternative jobs for workers who might be able to go back to work in a modified capacity while they continue to recover, so workers are forced to continue on inadequate benefit payments even though they may be able to work in some capacity. Some injured workers lose their jobs or are only offered positions at much lower pay. It is little wonder that so many claimant fraud cases involve workers illegally continuing to accept benefits when they are in fact working at another establishment. Too many times, inadequate benefits put people in desperate straits, and they take desperate measures as a result. A system that leaves people in poverty invites abuse.

The presumption of widespread malingering and dishonesty undercuts any meaningful discussion of the adequacy of benefits and provides a convenient response for those opposed to the benefit increases that are so critically needed in many states. Until the misplaced focus on claimant fraud is overcome, district attorneys will continue to fry the small fish while the big fish go free, and the voting public will remain distracted by anecdotes.

Footnotes

1 National Council on Compensation, 1998 Issues Report, p. 94.

2 Santa Rosa Press Democrat, 12/7/98, p. A5.

3 *Ibid.*

4 Gary Schwartz, "Waste, Fraud and Abuse in Workers' Compensation: The Recent California Experience," Maryland Law Review, Vol. 52, p. 987.

5 Damon Darlin, "The System Was Spinning Out of Control," Forbes, Vol. 155, No. 6, 3/13/95, pp. 128-32.

6 *Santa Rosa Press Democrat*, 12/7/97, p. A8.

7 Kentucky Labor Cabinet, Department of Worker Claims, "Workers Compensation Anti-Fraud Effort In Kentucky," 9/17/97.

8 *Ibid.*

9 Bud Roberts, "Avoiding Workers' Compensation Fraud and Fraud Charges," The Law Journal, 1996.

10 "McCall Surveys Workers' Compensation Anti-Fraud Programs," New York Office of the State Comptroller, press release, October 10, 1997.

11 New York State Insurance Department, Insurance Frauds Bureau 1996 Report, January, 1997.

12 National Council on Compensation Insurance, 1997 Issues Report, p. 27.

13 National Council on Compensation, 1998 Issues Report, pp. 98-99.

14 National Council on Compensation, 1998 Issues Report, p. 100.

15 Florida Department of Insurance, "Six More Nabbed in Statewide Fraud Probe," *PRNewswire*, press release, 12/10/97.

16 Bureau of National Affairs, Workers' Compensation Report, Vol. 9, No. 3, 2/2/98, p. 66.

17 Governor's statement, June 26, 1995.

18 Wisconsin Division of Workers' Compensation, "Report on Alleged Workers' Compensation Fraud," October 1, 1997.

19 Wisconsin Division of Workers' Compensation, "Workers' Compensation Fraud Is Low,"

press release, 11/28/97.

20 Research and Oversight Council on Workers' Compensation, "Fraud in the Texas Workers' Compensation System," Texas Monitor, Vol. 2, No. 4, Winter 1997, p. 2.

21 *Santa Rosa Press Democrat*, 12/7/97, p. A8.

22 *Ibid.*

23 California Department of Insurance, Fighting Workers' Compensation Fraud: A Training Series for the Industry, 1997, Chapter 8, p. 1.

24 New York State Insurance Department, "Insurance Fraud Arrests Up 140% During Pataki Administration," press release, 2/2/98.

25 New York State Insurance Department, "Insurance Department Fraud Investigations Net 12 Arrests," press release, 1/8/98.

26 "Andover Man Charged in Insurance Fraud Scheme," Business Wire, 12/8/97.

27 "DIR Launches 'Operation Insure,'" California Department of Industrial Relations, press release, 3/10/98.

28 State of California Department of Industrial Relations, The California Commission on Health and Safety and Workers' Compensation 1996-97 Annual Report, September 1997. p. 73

29 *Ibid.*

30 New York Office of the State Comptroller, "McCall Audit Finds State Insurance Fund Needs to Strengthen Premium Collection Practices," press release, 8/27/97.

31 National Council on Compensation Insurance, Inc., 1998 Issues Report, p. 91.

32 National Council on Compensation Insurance, Inc., 1997 Issues Report, p. 25.

33 California State Insurance Fund, "State Fund Aids in Investigation That Leads to Prison Term for Sherman Oaks Pharmacist," press release, 10/31/98.

34 *Santa Rosa Press Democrat*, 12/7/97, p. 8

Fifty-sixth
Legislative Assembly
of North Dakota

RE: House Bill No. 1232

Reducing Employer File Confidentiality

Testimony
Before the House Industry, Business, and Labor Committee

Urging a "Do Not Pass" Recommendation

January 25, 1999

Drew H. Wrigley, General Counsel for Public Policy
North Dakota Workers Compensation Bureau

Mr. Chairman, Members of the Committee:

My name is Drew Wrigley, and I am General Counsel for Public Policy for the Workers Compensation Bureau. I am here today to oppose passage of House Bill No. 1232, a legislative proposal which is virtually identical to 1997 Senate Bill No. 2284. That bill was given a "Do Not Pass" recommendation by the Senate Industry, Business, and Labor Committee, and went on to defeat in the Senate during the 1997 Legislative Session.

Before specifying my reasons for opposing this legislation I first want to commend Gary Nelson, Business Agent for Iron Workers Local # 793, Terry Curl, Business Agent for the Boilermakers, and Dave Kemnitz, President of the AFL-CIO in North Dakota. Over the past several months, they have joined with the Bureau's legislative team in trying to craft legislative proposals that will improve the workers compensation system. We have not always agreed on specific remedies to perceived problems in the system, but I believe we found that our goals were very often identical.

The Bureau shares the goal of detecting fraud wherever it exists in the workers compensation system. However, we have carefully considered HB 1232 and have concluded it would violate the privacy rights of 21,200 employers and impose a heavy administrative toll on Bureau employees, while serving no measurably helpful purpose in our continuing effort to detect workers compensation fraud.

Current Privacy Protection vs. Reduced Privacy Under this Provision

N.D.C.C., section 65-04-15 currently protects the confidentiality of employer records by mandating that the Bureau "not disclose any information that would reveal the amount of payroll upon which that employer's premium is being paid or the amount of premium the employer is paying." The Bureau is free, however, to disclose an employer's rate classification.

HB 1232 would transform the content of employers' confidential files into open public documents. Specifically, this anti-confidentiality proposal would require that the Bureau "disclose to a requester the rate classification of any employer, the number of employees in each classification, and the expiration date of the premium paid by an employer[.]"

Interestingly, HB 1232 would retain the current prohibition on divulging the amount of premium an employer is paying. However, anyone with a pencil could calculate the total premium being paid by an employer. All they would need to do is multiply the number of employees in each classification by the premium rate for that classification. Then they could total the premium paid for each classification and they would have the total premium paid by an employer. This would create quite a stir: any Bureau employee who followed the mandate to divulge an employer's rate classification and the number of employees in that classification would necessarily violate the same statute's prohibition against divulging the amount of premium paid by an employer. (See lines 15 through 20, Engrossed HB 1232).

High Potential for Abuse of this Provision

HB 1232 would require the Bureau to divulge confidential employer information to anyone requesting the information. Specifically, the bill requires that "[u]pon request, the bureau shall disclose to a requester the rate classification of an employer, the number of employees in each classification, and the expiration date of the premium paid by the employer[.]" The term "requester" is left unqualified, so it would extend to virtually anyone. Unfortunately for employers, "anyone" would include competitors hoping to gather information relevant for upcoming bids or contract negotiations, disgruntled employees trying to discover what other employees are paid, non-union employees trying to harass union employers or visa versa. Indeed, the potential for abuse is limited only by the accumulated inventiveness of those who will seek to harass business owners.

Unfortunately for the Bureau, the term "requester" would also include sales and marketing firms seeking vital information on potential targets for literature and solicitations. The Bureau could incur enormous administrative expenses by complying with such requests, in addition to the cost of requests listed above.

This Provision is Unnecessary

In addition to being flawed, HB 1232 is also unnecessary. Under the current law, concerned parties can learn what classifications an employer is claiming. If, in the opinion of the concerned party, this information does not appear to be supported by what work is being done by an employer, then the concerned party can report their suspicions to the Bureau. The Bureau will then investigate the alleged discrepancies between information being supplied by the employer and actual work being done. If alleged discrepancies are verified, then the Bureau determines whether the evidence indicates an inadvertent oversight or a criminal fraud violation. All without violating the privacy interests and confidentiality rights of every employer in the state.

The Bureau is dedicated to fraud detection and prosecution, and is supporting separate fraud legislation this session. Last week, this Committee held a hearing on HB 1331, sponsored by two members of this Committee, Representative Keiser, and Chairman Berg, as well as the Speaker of the House, Representative Wald. As you may recall, David Thiele, Senior Litigation Counsel for the Bureau testified in support of that bill, including its provisions calling for stiffer employer fraud penalties and a continuing appropriation for costs associated with identifying, preventing and investigating employer or provider fraud.

General Considerations Supporting a "Do Not Pass" for HB 1232

Some reasons for opposing this legislation are not readily titled except to say they support the conclusion that this bill is unfair or unwise. North Dakota law currently recognizes the privacy of employee and employer files. While well-intentioned people could envision some good that might come from divulging information in confidential files, it is measurably more likely that damage will be done by breaching confidentiality provisions. HB 1232 intends to divest employers of their privacy, while employee privacy is left in place. The Bureau urges this Committee to leave both protections in the law.

If this law is passed, then North Dakota's business climate will suffer relative to states without monopolistic workers compensation coverage. We are neighbored to the west, south and east by jurisdictions offering competitive workers compensation markets where private insurance companies can ensure customer confidentiality. It is difficult to quantify every decision to locate a business in a particular jurisdiction, but it is not difficult to imagine that a jurisdiction that respects employee and employer confidentiality would appear more inviting than one that does not.

Closing Comment

I want to reiterate my thanks to Gary Nelson for the spirit of cooperation he and others have helped expand between the Bureau and employee groups in the months leading up to this Legislative Session. While we share Mr. Nelson's view that fraud must be

detected and prosecuted, our analysis of this legislation leads us to conclude that HB 1232 would cause significantly great damage for little or no appreciable gain in return. Accordingly, the Bureau urges this Committee to affix a "Do Not Pass" recommendation to this bill.

Mr. Chairman, I thank you and the Committee for your consideration of my remarks. I will be happy to answer any questions at this time.