NATIONAL ACADEMY OF SOCIAL INSURANCE

Health and Income Security for Injured Workers: Key Policy Issues

Panel III: How are California Reforms Affecting Cost, Access and Quality of Medical Care in Workers' Compensation?

Thursday, October 12, 2006

This session convened at 1:45 PM in the Ballroom of the National Press Club, 529 14th Street, NW, Washington, DC.

Introductions

Jay S. Himmelstein, M.D., MPH, Director, Center for Health Policy and Research, University of Massachusetts Medical School

JAY S. HIMMELSTEIN: We have a really full panel, and I want to call everybody back to order.

My name is Jay Himmelstein. I'm the assistant chancellor at UMass Medical School and director of the Center for Health Policy. This panel is going to be looking more deeply at the California reforms and how they affect cost, access and quality. You've heard this morning a lot about California reforms, but still it feels a little bit to me like what's happening in the medical care arena is very much of a black box. And I'm hoping, among other things, to sort of understand what these reforms were, how they're actually affecting medical care and hopefully get from the presenters what the early findings are about that, and from our reactors how those reforms look from their perspective from their stakeholder group.

I'm not going to use my time other than to introduce people, because we have a really full panel, and try to keep people on time. I think that's my primary job. So really quickly, we have full bios on everybody in your handout. And Barbara actually suggested maybe you would all introduce each other as you move along, but I'll just read the names of the panel members, and then when you start speaking just remind people who you are if it's not otherwise obvious.

Our first speaker talking about the California problem reforms will be Barbara Wynn, who is a senior health policy researcher at RAND. Following that will be Michael Nolan who's going to talk about the impacts on costs and access to health care in early findings. Michael is the president of the California Workers' Compensation Institute. Next we'll hear from Teryl Nuckols Scott, a health services researcher and a physician, who's also from RAND, who is talking about their early attempts to assess how we can get a deeper understanding about the quality of care. We're going to have them talk for 12 to 15 minutes. I'd like to sort of keep it alive because it's after lunch and I don't want people falling asleep. I'll leave you time for a couple clarifying questions, instead of waiting all your questions, for each of those speakers. So if there's any points of fact that you want to clarify or have them go a little deeper in before we transition to the next person, hopefully that will keep us all awake. And then we have panelists, including: Dr. Bernyce Peplowski, the medical director for Zenith; Doug Kim, who you've met, a legislative advocate; and Tom Rankin, who's the past president of the California Labor Federation and a visiting scholar at the Institute of Industrial Relations at the University of California Berkeley.

So I think with no further ado and to keep us on time, we'll get started. Okay, Barbara Wynn. Thank you.

Overview: The California Problems and Reforms

Barbara Wynn, Senior Health Policy Researcher, RAND Corporation

BARBARA WYNN: Thanks, Jay. I really do appreciate the opportunity to be here this afternoon and to share with you some of the observations that I've had in working to evaluate the medical care furnished to California's injured workers over the last four years or so. We're currently embarking on a new study to evaluate the impact of the actual reform provisions and have no data other than some early impressions from other researchers and from various key informant groups.

My job this afternoon is to try to set the context for the presentations that are going to follow from the other panelists. First, I'll provide a brief review of the pre-reform medical treatment system. Second, I'll summarize the major reform provisions that affected medical care. And then, I will share some of those early impressions from our research and also from other research that's been done about the impacts of the reform, and what the lessons might be learned in considering other reforms.

There's a lot of information to absorb on this chart. Across the x-axis are the expenditures by various categories. I call your attention to the columns on the far left showing the rate of increase in medical payments over the period from 2001 to 2005. Most of the reforms were implemented in 2004. The medical networks started about January 1, 2005. What I want to really call your attention to, as the take-away, is that payments for medical care were increasing more than twice as rapidly as indemnity payments during this period, and represented 51 percent of paid losses in 2003. The teaser that Michael Nolan will fill in is the declines in payments that have occurred since then. The largest component of expenditures was for physician and other professional services. Physical medicine, including chiropractic care, accounted for 35 percent of spending in this category; evaluation and management services about 20 percent; surgery, 16 percent.

But the two fastest growing components were hospital payments for outpatient services and pharmaceuticals. Pricing policies were an important factor in both of these. Hospital outpatient surgery fees – the facility component – were not subject to maximum allowable fee schedule amounts and were paid basically on billed charges. And those of you who follow hospital charging practices know that they are commonly four to five times the cost of actually providing the services. Fees for pharmaceuticals were substantially higher than the amounts paid by Group Health and Medicaid.

When employers looked at other states, the costs for medical care were much higher than elsewhere, using several different measures. For example, the premium analysis that the state of Oregon does annually has shown that California premiums were the highest in the nation. This particular chart is from the National Academy and it compares the rate of increase in workers' comp costs per $100 of payroll over the period 1999 to 2003, and shows that the medical treatment cost as well as indemnity costs rose much faster than the national average -- twice as fast with regard to medical costs. The fee schedule for professional services, though, had been essentially frozen since 1999,

and some fees had not been increased for a number of years even preceding then; so that the reason for the higher costs has been utilization, rather than price as one of the cost drivers. Benchmarking data from the Workers' Compensation Research Institute indicates the prices were in fact below average, but that the number of visits per claim was considerably above a median of a 12-state comparison group. For example, the chiropractic visits were more than twice the median – 34.1 visits per claim, compared to 16.6 for the 12-state median.

Yet despite the higher expenditures, a number of measures indicate the California workers had poorer outcomes. For example, one RAND study has shown that 13.7 percent of the partial-permanent disability workers claimants after three years were still out of work in California, compared to 9.7 percent in Oregon and 11.2 percent in Washington. Survey data also indicated that injured workers in California were no more satisfied and, in fact, frequently less satisfied with their care than other states.

In terms of the policy context, California law provides that an injured worker is entitled to all the care needed to cure or relieve an industrial injury or illness. The policies regarding provider choice and medical necessity determinations made it extremely difficult for employers and payers to control unreasonable expenditures during this period. The employer controlled care for the first 30 days, after which time an injured worker could choose a primary treating physician. And the law provided that the care ordered by that primary treating physician was presumptively correct. In particular, medical necessity determinations made by a utilization review physician were not admissible as evidence in the appeals process. And finally, as noted previously, the fee schedule was outdated and not comprehensive, particularly with respect to outpatient fees and pharmaceuticals.

There were a series of three legislative provisions starting in 2003 and ending in the spring of 2004. In summary, here's what they did. They really show a desire to improve the tools to assure that workers received appropriate care. The first thing was the treating physician assumption was repealed, and the ACOEM guidelines were deemed to be presumptively correct until the Administrative Director of the Division of Workers' Comp in California issued a medical treatment guideline. So there is a very strong sense of evidence-based medicine. The utilization review guidelines that had previously existed were repealed and new standards were set that tied any utilization review decisions to the ACOEM guidelines.

In terms of control of medical care, employers may establish medical networks and control the care throughout the duration of the claim. In addition, there were 24-visit limits per industrial injury set on chiropractic care, physical therapy and occupational therapy. This was in addition to the ACOEM guidelines pertaining to those services. A second surgical opinion program was established for spinal surgery. And knowing that one of the issues had been workers getting prompt treatment; there was a provision that established that employers were responsible for up to $10,000 in care before a determination was actually made in terms of compensability. The fee schedule was expanded. It was linked to Medicare-based fee schedules with the exception of physician

services, and it was expanded to include hospital outpatient facility services. The pharmaceutical fee schedule was lowered to the amount that Medi-Cal would pay for those services. So there was a tremendous amount of change in a very short period of time.

What we've been doing is conducting interviews with key informants as of now. And also, of course, looking at other research that has been done, for instance, by the California Workers' Comp Institute. Basically, you saw in that first chart there have been substantial reductions in utilization and medical costs, but the impact on access, clinical quality, work-related outcomes and indemnity payments is simply not known at this point. Part of that stems from the lack of a single comprehensive database that can be used to look across the care being delivered to injured workers.

The interviewees are raising two common issues that are more systemic. One is about the challenges created by the complexity of the system. As of now, there are four different delivery systems depending on whether there's a medical network or not, and whether the employee has pre-designated a primary treating physician or not. This makes the dispute resolution process extremely complicated. Secondly, in part because of the amount of change and the lack of time, I think, that the Division of Workers' Compensation had to issue regulatory guidance, the level of distrust and contention within the system is still very problematic. Some of it is also driven by the incentives of the various stakeholders. And that's an area that we think really warrants analysis.

When we think about what's needed in California workers' comp to drive value-based medical care, and by that I mean appropriate access to high quality care, one is an ongoing monitoring system. California simply doesn't know the impacts at this point. Setting up an ongoing monitoring system is extremely important. Dr. Teryl Nuckols Scott will talk to you about the need for clinical criteria and measures to really give you the tools for evidence-based medicine. A new physician-fee schedule is still needed. The current one is still based on charge-based methodologies, and there need to be financial incentives to improve quality built in to that fee schedule.

So what are the lessons learned? These are very general ones. You'll hear more specific ones later. But one is the importance of having an ongoing monitoring and evaluation system to produce information at critical junctures. Those include: during the technical assistance process as the policy changes are being considered; an early warning system during implementation; and monitoring and evaluation to inform and refine policies.

The second one is that off-the-shelf policies still need to be adapted and it's resource-intensive to do so. The ACOEM guidelines, for instance, that you'll hear are not comprehensive. There are areas where additional work is needed. The Medicare fee schedules don't address some of the services that are provided in occupational medicine. Successful implementation really does require time and resources. It's important that all the stakeholders be involved in some of the decision-making. Educational materials are really needed for anything as complex as this.

And then finally, regulatory authority for oversight is important. The legislation itself needs to provide enough flexibility for issues to be addressed administratively and not to solely require legislative solutions.

So, I appreciate being able to provide that overview and look forward to hearing from the others.

(Applause.)

Initial Impacts on Costs and Access to Health Care

Michael Nolan, President, California Workers' Compensation Institute

DR. HIMMELSTEIN: Before we go and while Michael's getting set up, are there any questions or clarification of any issues that Dr. Wynn brought up? No one does. Great. Michael Nolan.

MICHAEL NOLAN: Good afternoon. It's great to be here. I appreciate the work of the people who put the conference together and gave me the opportunity to speak to the National Academy, its distinguished members and guests. And if you would permit me to share a senior reflective moment, when I think back 30 years I was in Annapolis, Maryland. I commuted to Georgetown Law School. I graduated from that law school. The undistinguished building we were in was probably sold. And now I'm here at the National Press Club, an organization that was well known back when I was going to law school, representing the state that was 3,000 miles from here, talking about a subject I'd never studied in law school, with this wonderful group of experts. And I assume that many of you have come to work comp in very much the same way. It's not something you necessarily go to college and law school for.

I'm here to talk on behalf of the California Workers' Compensation Institute. We're a unique organization in many ways. We're dedicated to research and education about the California workers' compensation system. Our members underwrite the majority of the insurance policies, which are issued in that state. We have both carriers and self-insured employers as members. Our work puts us in touch with government agencies and their researchers, so I have the opportunity to work with Ms. Christine Baker and the wonderful, charming people that she employs like Mr. Neuhauser and the people from RAND. In addition, I have the privilege of working with many of the stakeholders in the system who care deeply about the workers' compensation system and are well-represented on this panel – people like Doug and Tom, who are up here with us today.

I'm here to talk about two topics. One is to talk about the early results from the reforms in terms of numbers, an empirical number approach. And the second is to talk a little bit about the issue of quality of medical care in terms of access to medical care, again a little bit more from an empirical side. So let me begin.

Let me start out by saying – not surprisingly I'm sure – there are many organizations that publish information tracking the reforms. The California rating bureau does them; the Bickmore folks do them in what's called the Bickmore Study. We have a representative from Bickmore here with us today. I wish to acknowledge our shameless commerce division and plug our own organization's reports; it's CWCI. And of course back to the California rating bureau. I want to talk a little more about them in another aspect--another report.

If I talk about the California Workers' Compensation Insurance Rating Bureau – the rate bureau puts out a number of typical slides and information. They do it

periodically. And one of the things they do is try to track the average cost of an indemnity claim in California. You can see from the slide that during the period of the '90s average costs were rising greatly each year, and then started to dip – and remember these are accident year numbers – when the reforms took place. And reforms started to take hold toward the end of 2003, on an accident year basis. So we start to see the dip. And a part of that was the impact of medical costs. You can see medical was rising significantly, double-digit inflation year to year. The reforms came in. And they started to do something which is amazing in California, which is not only did we halt the increase in medical costs, but we saw actually saw a decrease. And even though it flipped up again in '05, it still hasn't hit the levels that there were in 2002. So that, from California's standard, just talking about numbers, is something of great interest to us.

Now if we look at the system more from a macro standpoint, there was a study done by the Bickmore organization. It came out early in January 2006. It was a first shot at what the effects of the reforms were. And just a note that they said in comparison with 2003 policies, they thought that the 2006 policy year would save about $8.1 billion, and even went on to say that if you compare it to what the system costs would have been if the reforms were not enacted, it was a $15 billion savings. Quite dramatic. And where did those savings come from, according to Bickmore? Most of it came from permanent disability savings, about 40 percent, and evidence-based medicine savings, about 27 percent. And of course as good actuaries, they have a great caveat that their quantified savings are uncertain because who knows what the future will bring that will go back and impact the accident years.

We looked upon some of the system changes in a more micro way using CWCI studies. For example, what's the impact on outpatient surgery facilities fees that Barbara talked about—a problem for us in California because such fees were unregulated? And you can see reduction of 38.9 percent. By the way, these are the results we put out last year in a six-part series, and we're in the process of refreshing them. But you can see in every category, and I didn't list all six, that there were savings, but in some cases, like pharmacy fees, not as much as we anticipated. But certainly on a micro level, we started to see savings come through the system.

The reason I wanted to flip back again to the California rate bureau is that they are required by law to put out an annual analysis of the reforms, and they recently put out a 200-plus-page study. I spared you the many possible slides on that. I just copied one segment of the report dealing with medical costs. What they tried to do on a percentage basis – not converting that to dollars – is say in different categories of medical costs, like physician fees and inpatient fees, where the savings came from in the system. Now, this is tough to read when you're reading it up here off the screen, but you have this information with you as part of the meeting package. And in addition, if you look at the bottom of each one of the studies' slides, I gave you the website to the Bickmore Study and to the rate bureau's and where you can go and find these types of documents and read them yourselves.

So if we look in general, there's no question there have been significant financial savings generated by the California reforms. There has also been a decrease in medical utilization. There has been a greater use of MPNs (medical provider networks) that were put together post-reform. And even though I don't have slides on all these things, these are factors that are generally accepted as being the principles in the post-reform system financial savings. But then these factors raise many debates. And part of it is on the issue of quality of medical care, among others. We heard about the PD issues this morning. Here we're talking about medical. Some of the issues dealing with the medical go to what's the cost impact of medical and how does that affect our premium reductions, if you're an employer. Other issues include: what do we do in addressing the issues raised by the physicians about dissatisfaction with the system, or, as we heard from our friend, the applicants' attorney, questions of denial of care.

So the question comes about have all these reforms compromised access to care? And we know there are many ways of looking at access. In fact, we can step back and look at access in the group health area in the man-in-the-street way. How do they look at it? They look at it in terms of do I have insurance or not? And we know, for example, in the group health area – and I'm sure Tom and Doug could tell more than I can about how many employers in California have dropped their group health--whether you have insurance or not is not so much a question in the work comp system, but when you think of access, that's one way of measuring it.

Of course, provider choice, choice of specialties, proximity to your doctor, wait time and all these things are a way to look at the access to medical care issue. We at CWCI wanted to find out what research in this area is out there. And actually there has been some work. The California Medical Association did what they term an unscientific poll, or a survey, which brought up issues that doctors are expressing feelings about dissatisfaction in a number of areas. To try to track that in a more scientific way, the California Division of Workers' Compensation is doing an access study, mainly in the way that the California Medical Association did, which is "ask people." So they're doing a survey-type of approach. And we hope to have at the results of at least that survey announced in the not-too-distant future. They're surveying providers, claims people, and patients.

And it's clear that another area to look at – the idea of access to medical care—is: are there issues beyond work comp that may be impacting that question in the work comp arena? So all of these areas are ways to look at access. And we were trying to think, in our little work comp research institute, what are ways we could add to the literature connected to this access issue. And our way was to do geography-proximity, noting that proximity doesn't equal access, but trying to do a study in a way that proximity and access were tied together--sort of a "goodness of fit" type of relationship-analysis. So we looked at claims both pre- and post-reform. We looked at claims, and tried to marry up claimants who were actively seeking and receiving medical treatment as one list, and comparing it with doctors who were actively treating – meaning they were billing – as another list.

And we did it by doing a geo-access type of study, and we calculated using the benchmarks set by our Division of Workers Compensation. They set their access standard for medical provider networks, and those are listed on the slide that you have on a primary care and specialist care basis. I'll skip the first item and come back to that in a moment. The DWC standard is access to three providers in a 15-mile area for primary care, and three in a 30-mile area for occupational health specialists. And the specialists we're talking about include orthopedists, neurosurgeons, neurologists and the rest. And we looked at a million claims; we looked at 65,000 unique provider ID codes. (There's always an issue when you're dealing with provider ID codes as tax IDs, but we did the best we could with that situation.) And we looked at the average distance between injured workers and physicians.

Now, we also tried to keep in mind: did access issues come up in the past? And indeed they did. Back in the '93 reform, there was an issue with what was called the medical legal writers. There were predictions that access to medical care from these forensic physicians, meaning doctors willing to treat who had provided medical legal reports, would significantly decline because now the medical-legal written report costs became part of the fee schedule. We asked ourselves whether that reform had an impact on access. So pre-reform there was about a 2.1 distance between three medical legal report writing physicians – people who would actually write these reports – and applicants. And actually it improved a bit post-legislation as you can see from the slide. Now whether 2.1 to 1.5 are a significant difference, I'll leave to you. But the idea is that a concern expressed at that time that doctors were going to leave the system and we wouldn't have medical legal physicians didn't pan out.

Now that was a very specific reform, and there were certainly other areas of medical that may have impacted access. But it was just a keynote to us to going into looking at post-reform – which is the '03 and the '04 reforms – looking at both pre-reform and what was happening in '96 and '98, and post-reform looking at 2004 and 2005. And we looked at it in two ways. One is distance. And again, whether you think 3.2 to 3 or even 2.7 are a major difference, I'll leave to you. But secondly from the idea of access in terms of has the system kept the 15-mile parameter set by the Division of Work Comp. In '96, it was about 97 percent that met the standard. In 2005, it was about 96 percent. So you can argue that the access trend is actually flat both pre- and post-reforms. I would add that this is looking at projections we made using 2005 numbers. We haven't developed the numbers for 2006, and we certainly intend to do a refresh as we get those numbers fed to us in the earlier part of 2007.

In primary care, there's a high correlation with access that we measure here. With respect to specialty care – which are again physicians like orthopedists and the rest – there the standard is three providers within 30 miles. And again, teaming up people who have been receiving medical care with those doctors who are actually treating and billing for that and getting paid for that. What we've found is 98 percent access fit in 1996 pre-reform, and a 98 percent fit in 2005 post-reform in the state. And the driving distances being, again, 2.7 versus 3.1, I'll let you all decide whether that's a significant difference or not. So in this sort of an empirical approach, which we suggest is one way of looking

at the access issue – not the only way by any means – but one way, we hoped to lend at least some data to the access issue being addressed here in California.

There are a couple of other things to note while we're on the access issue. There are market force factors operating to include our large number of MPNs, medical provider networks, which have been approved by our Division of Workers' Compensation. They range in size from smaller to larger networks. They have to go through an approval process; they must meet the access standard, which we talked about. We've seen that in some cases, there is physicians who want to get into the networks, and who are even willing to litigate the issue. So if we look at those sorts of market issues, we can say there certainly are physicians out there who are willing to treat even if they are dissatisfied, but we can't measure dissatisfaction in the way that you can other types of issues. But there seems to be at least a good fit, to date, in our type of analysis. Now in conclusion, again noting that you can look at the access issue from anecdotes and surveys, you can look at it from a data approach like ours as one approach. We also know that future national and statewide issues may affect access, which may have nothing to do with the work comp system design directly.

And we also know that if access issues appear that there are ways the DWC can work on the problem. I'm talking about raising reimbursement levels and even as a fix, having a mandatory availability requirement: if you're a doctor and you're in the network, you've got to treat. Those are different types of responses, but usually they're not good fixes.

So if I sum all this up, I'd say doing this type of measurement – again not the only measurement – we haven't seen an access to medical care issue. We intend to update the study in '07 to see whether using this methodology sheds some additional light on this question. Thank you very much.

(Applause.)

DR. HIMMELSTEIN: While we're setting up the next speaker, are there any questions or points of clarification?

Q: There was a mention on the blog that the drug reimbursement prices were set so low that they triggered the re-packaging surge. And in fact, if the drug pricing had been not as aggressively low, you would not have inherited that re-packaging surge. Could you comment on that?

MR. NOLAN: Well, I think actually that way I approach some of it is that the physician reimbursement was considered by them to be low, and what they attempted to do is get additional income through other sources, like drug repackaging, as opposed to the issue being that the drugs themselves were priced too low. I would think that both labor and the employers banned together to support taking away or controlling physician dispensing that was out of step with the drug reimbursement system. So at least from

those two stakeholders, and I don't represent them, they thought that the drug pricing system was appropriate.

DR. HIMMELSTEIN: One other point of clarification, Andrew, did you have a question?

Q: I'd put a finer point on that say that I think the data and the political lobbying shows that those doctors who were at the outpatient surgery centers were actually because that they got capped at the fees of the outpatient surgery centers moved to the re-packaging to make up their losses. I have two quick questions.

One is, Mike, on your fourth and fifth slides – estimated ultimate medical indemnity claims and total loss per indemnity claims – these two slides exclude medical only claims. If you throw medical only in, do the trends change at all?

MR. NOLAN: You know, that's a question I don't know how to answer at the present time. I don't have the data in my head that can answer that. Just to go back over the question, when the rate bureau puts out their studies on the average cost of medical for a claim, they look at the indemnity claims, not the medical-only claims. Medical-only claims, although there's lots of them, they make up dollar-wise a small percentage of the dollar spent on medical (possibly, 20 percent), so I don't think in general they have a significant impact on the marketplace right now.

Q: Thank you. And my second clarification is on the access to medical providers data, you say the claims are '93 to '05 from the DOI valued at December of '05. Could you explain what the value – are these actual '05 data or did you say something about projected '05 data?

MR. NOLAN: What we try to do is for the study is link up people – we had two points of time, pre-reform and post-reform. So for the post-reform what we did is link up those applicants who were being treated in '05 with doctors who were delivering services in '05.

Q: So it's real data from '05?

MR. NOLAN: Yes.

Q: Okay. Thanks.

DR. HIMMELSTEIN: We're going to have a more general question and answers after everyone speaks. Or is this a point of clarification?

Q: I just wanted a clarification on some of the charts. You had charts that showed travel to doctors. Was there any difference between rural doctors and urban doctors? Did you breakdown differently between the two?

MR. NOLAN: I'm glad you asked that question.

Q: I know what we did in New York for PPOs and MCOs we had to do great differences, because if you didn't, it screwed up all the numbers.

MR. NOLAN: Sure. And I'm glad you asked that question. In the actual study itself, if you get it, you will see the breakdown. We do it by the counties. And certainly what you would see is what you would expect, where people in the outlying counties may have one doctor. And the people in the cities have lots of choices, but when you average them together, you're well within the access standards of the Division of Workers' Compensation. We list counties that have difficulties; you could look at that to answer your question.

DR. HIMMELSTEIN: Good. Thank you very much. We're going come back Barbara introduced the concept of what are we doing to monitor the system. You mentioned that you're doing one type of access study. I suspect that we could have a nice discussion about other ways we might measure access in addition to that. So, Teryl.

Assessing Effects on Quality of Care

Teryl Nuckols Scott, M.D., Health Services Researcher, RAND Corporation

TERYL NUCKOLS SCOTT: Thank you very much. My name is Teryl Nuckols. I'm an internal medicine physician practicing at UCLA, and I do health services research at RAND. And I'm going to be discussing the potential effects of the California reforms on quality of care and particularly the value of higher quality of care. We've been hearing a bit about win-win possibilities today, and I think this is one of them.

As you just heard, in 2003, California implemented utilization management as one of several reforms. Utilization management has been around for over 30 years, and is widely accepted as an effective technique for controlling the overuse of medical care. It is best used selectively because nurses and physicians review the claims, so it can be a somewhat costly process. And the California experience shows that there are several challenges to applying utilization management in workers' compensation settings at this time. We did an evaluation in 2004 of existing medical treatment guidelines that could be applied to work-related injuries, and we found that none of the guidelines are very high quality. The best of the guidelines was the ACOEM, American College of Occupational and Environmental Medicine, guidelines. But, California stakeholders have reported quite a bit of difficulty having the guideline apply being used for utilization management purposes, because it was developed for use by clinicians.

In addition, if claims review is not done in the most judicious fashion, sometimes it can delay the receipt of beneficial care and that can slow return to work. Also, in contrast to managed care settings where utilization management has been used for a long time, resolving disputes in workers' comp settings often results in litigation which can also increase costs. Nevertheless it does seem that this is one of the factors that have led to the better control the medical care costs in worker's comp settings in California. And there is one last major disadvantage to utilization management by itself: it does nothing to insure that workers receive highly beneficial care that would get them back to work faster.

This is an overview of the points I'm going to discuss in this talk. I'm going to present some national research on quality of care in general; talk about how these issues apply in workers' compensation settings; discuss a framework of strategies for improving quality of care; talk about some next steps that are going on in California; and then lastly conclude with implications for other states.

There was a landmark RAND study published just a few years ago that found that US adults on average received the right care only a little more than half the time. Care for back and joint injuries, which are obviously common in occupational settings, were not much better than average, with patients with low back problems receiving recommended care 68 percent of the time, and those with shoulder and knee problems only 57 percent of the time.

There are two principle types of quality of care problems: overuse and underuse. And perhaps surprisingly, they often occur simultaneously. Even an individual patient can receive both overuse and underuse of services. Because they are kind of tricky to explain, I'm going to spend a couple minutes on these diagrams that I hope will be helpful.

Consider a hypothetical patient with acute low back pain. This green circle represents the highly beneficial care that that patient should receive. For example, they should have a history and a physical exam that reveals symptoms and signs of severe or disabling conditions. This red circle represents care for which the risk to that patient outweigh the potential benefits. Obviously such care should not be provided. An example for an acute low back pain patient would be being prescribed bed rest because the evidence suggests that this actually makes people worse. This blue circle represents the care that is actually provided to this patient.

So now I'll discuss the categories created by the overlap. The hatched green area represents the highly beneficial care that the patient did not receive. And this is what we call underuse, and on average across the health system as a whole it affects about 46 percent of patients. The purple hatched area is when that patient received care that was more likely to hurt them than benefit them, and that's what we call overuse. That actually affects about 11 percent of patients. As you can see, underuse across the health system as a whole, is about four-fold more common than overuse.

Let's take a look at the implications of quality problems in a workers' compensation context. The pervasiveness of quality of care problems in the US suggests that these problems probably exist in workers' compensation settings, too. But, quality care does not appear to have been examined directly in workers' compensation settings to date, so we really have no information about the magnitude of this problem. And in California, this means that we have not information about or current means to assess the effects of the recent reforms on quality of care.

Underuse and overuse are both costly to workers and employers. Overuse of potentially harmful tests and therapies is unlikely to make workers better, and may actually make them worse. And in addition, the costs of that care are unnecessary. With underuse, workers' health is also unlikely to improve, and this can increase both temporary and permanent disability, and it can create a need for more care in the long run. Consequently, cost to payers can increase.

There are a couple of studies that support these assertions. In one of them, researchers randomized over 13,000 workers with musculoskeletal injuries to either routine care or to a quality improvement program that emphasized treatment protocols and active return-to-work planning. This program succeeded in reducing temporary disability time by 37 percent. The number of patients on temporary disability going on to permanent disability dropped by 50 percent. And the total cost dropped by 37 percent. Now the one drawback of this study is that it was done in Spain, so we don't know whether similar effects would happen in the United States or not. But there was a recent

study in Washington State that uses a similar type of quality improvement program and reduced disability costs by 30 percent. Together these two studies support the idea that better quality of care can positively affect both worker outcomes and costs.

Next, here is a framework of improvement strategies. There are three basic ways to evaluate quality of care according to a widely accepted model by Avedis Donabedian. The first of these is to look at the resources available to providing care. This includes hospitals, MRI scanners, the number and qualification of providers and elements like that. Somebody earlier was talking about the experience of providers. That would fall in this category.

The second mechanism is looking at the actual care provided. This is what the doctors and other providers do when interacting with patients; examining them; ordering tests; performing procedures. Things like that.

The last category includes outcomes of care, which have also been discussed today. These include temporary and permanent disability rates as well as elements like satisfaction with care, functional status, pain and other things along those lines.

In the interest of time, I'm going to focus on monitoring the actual care provided, because it is widely accepted in the quality of care measurement field as being the most informative strategy. Monitoring resources and outcomes are indirect approaches. And this direct approach of looking at the care that was actually provided has these several advantages. First of all, it identifies both the quality problems and the changes that need to happen in order to improve quality. It supports comparisons between different types of providers, even when the patient populations differ. And there's also a minimal time lag between when the care occurs and when the quality monitoring can take place. In addition, when you go about developing the measures in a rigorous evidence-based fashion, providers will often support them as reasonable achievement goals. The one drawback is that it is a rather complicated and costly process. Although in recent years there have been some scientific advances that have addressed these problems to a good degree.

This slide lists three key strategies that focus on evaluating the actual care provided. We talked about utilization management already as one of them. I think it is a promising and helpful strategy, but by itself will not address a large proportion of the quality problems that exist. Another one is report cards. Report cards attempt to describe the quality of care provided by individual doctors, hospitals, health plans, insurers and the like. These enable consumers to make informed decisions about the care that they're purchasing. For example, payers, employers, insurers can use this as away of selecting who they want to work with. Report cards are often published by neutral organizations, which gives them some credibility. And the last of these is pay-for-performance, and this is a relatively new strategy that somebody mentioned earlier, that combines report cards with financial incentives for better quality of care. The premise of the strategy is that current reimbursement systems reward quantity, which drives the overuse of highly reimbursed services. And proponents argue that providers need financial incentives and

accountability for quality as well. There are a number of major on-going studies that are evaluating the effectiveness of pay-for-performance programs.

I'm going to focus on report cards. They have several advantages. They enable you to address both underuse and overuse. From the payer perspective, they allow payers to be proactive rather than reactive in addressing quality problems. They allow them to contract on the basis of quality, or perhaps if they wanted to use utilization management selectively for lower quality providers, then that would be an option. At the state policymaker level, they would enable policymakers to track changes over time and determine the effects of new policies, which would be very helpful in California.

I'm going to show you a hypothetical report card for a state workers' compensation system. Being completely hypothetical, it shows a desirable trend over time starting with a little over half of care provided as recommended and improving. If there are specific quality problems that are identified – we just heard a lecture on return-to-work planning – report cards could highlight and track those types of problems. So again, a desirable trend in a completely hypothetical state, an improvement in return-to-work planning over time and a decline in inappropriate back surgeries.

Now I'll move on to discussing the next steps that are being taken in California to address some quality of care issues. At RAND and UCLA, we've been working on developing a demonstration project that would show how quality measurement could be applied in the California workers' compensation system. We're going to focus on the actual care, rather than the outcomes of care or resources for reasons I discussed. Our goals are to show how report cards could inform workers' compensation payer decisions and hopefully lay the groundwork for an ongoing quality monitoring system. To do so, we plan to develop measures for carpal tunnel syndrome as a test condition because it is common and it causes severe disability. We are starting to develop these measures at this time, and I would say thank you very much to the California Commission for Health and Safety and Workers' Compensation, and also to Zenith Insurance, who are currently supporting the development of these measures. Just as a side note, we've talked a lot about guidelines today. It's very important to note that quality measures are related to guidelines, but they're actually very different, and anybody who has questions about that I'm happy to talk to them more. But they serve very different purposes and are designed very differently. So the next step in the project will be developing tools so that the measures can be applied to administrative data and medical records consistently, and we'd also like to pilot-test the measures to make sure that they will reflect actual quality.

We are looking for additional funding partners, and this would enable us to develop a complete set of quality measures that will be nationally applicable and certainly used in other states. In the future, we hope to measure quality of care in several medical networks, develop a sample report card comparing networks, and translate the findings into an ongoing quality monitoring system.

So what are some implications for other states? Quality of care should arguably be more valued in workers' compensation settings than almost anywhere else. Low

quality of care impedes recovery and can increase costs. Quality of care for injured workers should be evaluated. And as I hope I've explained, monitoring the actual care provided is the most informative and direct approach, and it also addresses overuse and underuse, the two major quality problems. Report cards and pay-for-performance are promising strategies for monitoring and improving care. And we are currently working on developing nationally applicable quality measures for carpal tunnel syndrome, and if anybody is interested in learning more about those measures, I'm very happy to speak with them later. Thank you.

(Applause.)

DR. HIMMELSTEIN: Since all our speakers stayed on time, we have a chance for a couple quick clarifying questions for Teryl before we go on to our discussants. Are there any general questions? Yes?

While he's coming to set up, I'm thinking for our panelists who we're going to ask to talk maybe five to seven minutes, or until you get tired of talking, or until people start throwing things. Some of the questions that come to my mind and the panelists should be thinking about are: after all that is said and done, after all the theoretical models, what do we really know about the quality of care in California? And how will we find out we need to find out, and how do we get them into the system?

Go ahead and introduce yourself.

Q: I'm Darrell DeMoss from MedRisk. I have a question about your statement that utilization management was potentially useful but an incomplete solution to the problem. Is that because you believe that it would only really address the overutilization as opposed to underutilization?

DR. SCOTT: That's really its main purpose, yes.

Q: And do you think that – just a follow up question – do you think that it's possible realistically to use utilization management to also address the underutilization?

DR. SCOTT: That's an interesting idea that I haven't heard before. I think that it would be somewhat unwieldy. You would have to have claims reviewers going through every single chart and trying to identify opportunities for care that didn't happen. And in addition, sometimes they would identify that care after it was really needed. So, I'm not sure that it would do a whole lot for outcomes.

Q: One of the indicators that you put on your slide was return-to-work programs, but that's not really medical care as much as employer-based, or the interaction between the two. Have you gotten far enough to figure out how you want measure that in the context of quality of care?

DR. SCOTT: It's one of the domains that we're talking about. I would say I personally don't treat injured workers, and I would defer to the other experts here who do. My understanding is that doctors do have an influence over when people go back to work because they're writing the off-work slips. And also as Jennifer Christian pointed out, we don't receive any training in how to get people back to work. And so I think some basic quality measures addressing those types of issues – you know, are people even discussing return to work, are providers even discussing return to work with their patients. Not to replace the workplace-based programs, but just to include that as a component of care that people probably are not thinking about right now.

DR. HIMMELSTEIN: Thank you. Why don't we go on to the panel discussants?

Commentary

Bernyce Peplowski, M.D., Medical Director, Zenith Insurance Company

BERNYCE PEPLOWSKI: This is a great dovetail, Teryl, to your comments. I'm Berynce Peplowski. I'm been practicing occupational medicine for 25 years. I've been with the Zenith since May of this year. At the Zenith, we're represented in 46 states, but more than 50 percent of our business is in California, about 30 percent in Florida. And when you wonder how are we from a practical perspective, how are we responding to the reforms? Our focus is on partnering with quality physicians, empowering quality physicians, and holding them accountable. We are not focusing on processes. We are focusing instead on outcomes, which makes it a perfect dovetail to the work that we're doing right now in conjunction with Teryl and RAND.

As we've discussed earlier, we know what traditionally has driven cost in workers' compensation; it's the perm disability and the future medical. If you look at where your money goes, those are the two places where it goes. If you step back from that and say, well how do you get there? What drives the PD and what drives the future med is most likely the temp disability that a physician's prescribing, along with the claim duration and whether or not that claim became litigated. So, we believe if we're looking at outcomes in terms of what matters with physician performance, those three things matter. Certainly, we've had reform that addresses that we've got reform that addresses PD with the AMA guides. We have reform that addresses the quantity of care and the quality of care via the ACOEM guides. But in addition to that when you take it a step further, we want to look at the outcomes, and to focus and use that as our measuring stick for quality; again we are not using processes.

We are in the midst of trying to slim down our network. Many companies in California prior to reform leased networks. And using Zenith as an example, when we leased a network, it was very large. It included 27,000 providers in the state of California. Some of those providers in that leased network aren't even alive right now. Many of them do not accept workers' compensation, so as you can imagine –

DR. HIMMELSTEIN: The one's who are alive.

DR. PEPLOWSKI: The one's who are alive, yes. (Laughs.) And as you can imagine, with that type of network, with an employer who is our client, did we make them feel as if we gave them a really workable and usable network? Probably not. What we're in the midst of doing right now is literally hand choosing our network. And we're using several quality measures. We're looking at quality credentialing type measures, such as where did you go to school, where did you train, is your board certification current, what kind of continuing education does that physician do? And we've ranked physicians – we started out with San Diego as our pilot site – we've ranked all the physicians in San Diego by those means. We then took that a step further. We utilized a company who went out to those physicians offices to see are the offices clean? What do they look like? What's the access in the office? What does it look like in the waiting room? Is there a chair to sit down on? How long does the patient wait? We have also

utilized the company to interview those physicians to ask, do you accept workers' compensation or not? Because certainly if someone is starting out with a negative attitude about an injured worker, that's not going to fly. That's not going to work. That was our first set.

Our second set, we took the data we have internally on those 27,000 providers, again the ones that exist, the ones that accepted comp and the ones that are alive and practicing. And we looked at the data, and by ICD9 grouping – and we used the ACOEM groupings for ICD9s, for the diagnoses – we looked to see by physician time off, claim duration, litigation yes or no. And what's absolutely fascinating right now, we're taking our different sets of data. The pure quality as to where'd you go to school, do you keep up your continuing education – we're merging that with the outcomes data of per the ICD9 groupings, time off, claim duration, litigation yes or no – we're merging those two along with other data such as pharmacy utilization. Do we have a physician that uses a lot of narcotics, etc? And likewise, what were some of the utilization review outcomes? But we're putting all those data sets together and in San Diego, California, we anticipate having around 200-300 quote unquote "preferred providers." We hope to go forward in November with that group of providers, and we, in essence, will be partnering and empowering those physicians. We are saying, we don't care about your process. We're going to measure it, we're going to track it, but we're not going to say that you get three physical therapy visits or you get two. We're not going to say yes or no to acupuncture. We're going to say, dear doctor, we've looked at your outcomes and who you are and where you went to school, and we're going to empower you.

Now certainly, at the same time we're going to track that. We will likewise be utilizing report cards, and the report cards will track the physician by ICD9 grouping, by diagnostic grouping. We will track outcomes such as time off, the TTD, the claim duration, the litigation yes or no. And the physicians in that preferred group will receive a report card every month. It will be comparing that physician group to their peer set, as well as to ACOEM. And along with that we're scheduling many other things, such as continuing education that will be at least once a quarter, where we will sit down with those physicians with the underlying message we're partners, we want to empower you, certainly we will hold you accountable for those outcomes but we want to work with you. A part of that work has also included working with our internal staff, our claims and case managers. Because as Jennifer and many of our speakers have mentioned earlier, sometimes with worker's comp there's the feeling that there's something wrong with the patient and there's something wrong with the doc. And we have to quash that adversarial relationship that has existed between our own internal staff and physicians and patients.

So we're very excited as to how the outcomes we get we can bring back and merge with all the other work that's ongoing to see what difference can we make if we focus on quality, we measure outcomes, we loosen UR – we care about how you got there. And what will be very interesting is to see: who did have the better outcomes? And did someone use more physical therapy or less? What kind of outcomes did we see? And likewise in terms of reimbursement there will be no fee reductions. If anything, if

there are some subsets of physicians who need above fee schedule, we will pay that as well.

DR. HIMMELSTEIN: Thank you. That was an excellent description, because one of the questions that people were bringing up this morning was, you know, this issue. It's not just where there is an evidence base, at least you can have a quality base, or what did you say? Expert base – it sounds like you're going to expert base. At the same time, it's interesting to note that you started out with 27,000 people in your network. I've heard from claimants in California that are going to these networks where people don't even necessarily accept workers' compensation. And I'm sure not everybody is being as progressive as it sounds you are in trying to really get those experts. So, yes, experts can be helpful, but just saying someone's in a network doesn't mean that they are in fact expert, that they're even trained in the subject, or they even accept the claim. So networks don't guarantee access is what I hear and I want to reinforce.

Tom, would you like to sort of add in?

Commentary

Tom Rankin, Past President, California Labor Federation and Visiting Scholar, Institute for Industrial Relations, University of California, Berkeley

TOM RANKIN: Hi, I'm Tom Rankin of the California Labor Federation. I want to just spend a few minutes responding to a few things that were said. I guess we're supposed to really talk about how the reforms are affecting cost and access. I think it's clear how they're affecting cost. The costs have gone way, way down. We're dealing here with medical issues. We already talked about permanent disability, but medical costs have gone down significantly. However, they still, I think, comprise almost 50 percent of the premium – 50 percent indemnity, 50 percent medical. So there's still a big, big part of the cost in California. What wasn't mentioned was that the – the employers have seen premium reductions of about 58 percent since the reforms have taken place.

And actually most of the reforms took place before Governor Schwarzenegger. His were the reforms that really affected permanent disability and some of them affected medical treatment. The network was the main one there. That's great for employers. And could be okay for workers, depending on where the savings come from. The real problem is that the insurance industry is not passing on the savings that they've actually achieved to the employers. They're taking it out of the hides of injured workers in terms of denying medical treatment in many, many instances.

The insurers have a record low loss ratio. Their loss ratio is now 31 percent. It's unbelievable. It's just unbelievable. They are making money hand over fist and the employers are not seeing the results of that. So, as Angie mentioned this morning, that bill could have been signed and the insurance rating bureau – if it had done its job right, it was actually going to – if the bill had been signed it was going to recommend I think a 1.8 percent increase in premiums. But if they did things right and took into account the huge decline in permanent disability benefits, employers still would have seen a decrease in their premiums had that bill been signed.

So the workers are really bearing the brunt of a lot of these reforms. And the problem, I think, is not so much what happened with the law. It's what happened in the implementation of the law, and the regulations that were adopted. We had a hostile administration. The regulations for permanent disability, the way the schedule was re-done, could have been fine. They did it the worst possible way for insured workers. The same was true with a lot of the things they did in the medical area. It was clear to everyone that the ACOEM guidelines don't cover anything. The workers' comp commission held hearings on it, made recommendations to the administration that those guidelines be supplemented by other guidelines. Did the administration do that? No. So that is causing a lot of problems in terms of denial of medical treatment. I don't think, Michael, the problem is access in terms of how many miles you are away from your doctor. The problem is not being able to get your medical treatment paid for. That's the problem that's resulting from the misuse of the ACOEM guidelines and from the misuse of utilization management. Workers are being denied medical treatment.

Now, we don't have a lot of data on this yet, because it's too early. But we do have a lot of anecdotes and Angie sort of made it hard for me to talk about this, but you can talk to doctors involved in the system, you can talk to lawyers involved in the system, you can talk to injured workers, and I think they'll all tell you that workers are being denied access to medical treatment because of the way these reforms have been implemented. In terms of the medical networks, it shows part of the problem with the way workers' comp works. It's just a whole new bureaucracy is developing. Employers have had to apply to participate in a medical network. So there are hundreds of them. It's ridiculous. And they have medical networks where the doctors don't even know they're in the medical network and the worker is going to that doctor and the doctor is saying, I don't take workers' comp, get out of here. This is a major problem. It's not the way it was supposed to work. But I don't want to go on and on about that.

What I want to finish with is what I think you're going to be talking about some tomorrow. The longer I work in the workers' comp system and watch it operate, the real problem is – and someone who introduced this whole thing this morning talked about how NASI tries to come up with rational solutions to problems. I don't think you're ever going to come up with a rational solution to the medical treatment problems in workers' comp inside the system. We have to get universal health care and get medical treatment out of workers' comp. That's what causes all these problems. Everyone's trying to protect their own economic interest, and that's what causes distortions. You've heard about distortions from the doctor because of the financial interests in the system. It's because it's a separate system. If you make it one system, the worker doesn't care if they broke their leg falling off their bicycle or if they broke their leg falling down the stairs at lunch. What difference does it make? They have the same interest in getting the leg fixed, and getting back to work.

We create so many problems by having this separate system, that causes so much friction and so many fights, and I think people really have to start seriously looking at getting the medical treatment out of the workers' comp system and into the regular health care system. We in California have the ability to do that to some extent because we have carve-outs. And we have the ability to now, under changes in the law where there's a collective bargaining agreement, to actually negotiate 24-hour care. That's really not the solution. The solution needs to be global. And I think maybe this country's coming more and more to the realization, partly because of what's happening in the auto industry in Michigan, that we need universal health care. It's crazy. We can't even compete with the rest of the world the way our health care system works. And I think we really need to stop thinking within the workers' comp framework and think more broadly in terms of these medical issues, because I don't think they're ever going to be solved inside the workers' comp system. We can do this and we can do that, and there will always be a new set of problems coming up because of the financial interests involved. Thank you.

(Applause.)

DR. HIMMELSTEIN: One question before Doug speaks. We'll keep it conversational down here. You mentioned that you do have some examples where

you've blurred that through the carve-outs in California. Do you know much about the perceptions of quality and the outcomes of those systems that are happening there?

MR. RANKIN: What we have so far is limited in terms of what's being done here. And in carve-outs, it involves an agreed upon panel of doctors and so forth. What we've allowed in the new amendments to the law is that they could actually try to figure out how to integrate their regular health care plan, which most employers with collective bargaining agreements have, with their workers' comp. The problem is going to be to try to find an insurer who will do that. And that's a problem also in integrating the benefits. We tried once in California to get employer-based coverage, we passed a law that was overturned by referendum sponsored basically by the insurance industry and the employers, but I think we'll get back to that point eventually. And maybe we'll even do it nationally. The problem we're going to have is that the workers' comp insurers will probably resist the hell out of it because half of their premium base is medical.

So, if you just leave them with indemnity payments, then they could of course expand – and Zenith might be a possibility – could expand into the health care arena. And it looks like they're trying to do a good job of dealing with quality care issues. But there are so many financial interests involved and jockeying around in this arena, that I just don't see the problem getting solved.

We tried to solve the prescription drug problem. We solve it here with a fee schedule for prescription drugs that pops out over here in doctor's offices because they're trying to prescribe drugs and make money off repackaging. These things are going to happen all the time. And if you took the medical out of the system, at least you would remove a lot of frictional costs.

You know you have to have two sets of medical records. Kaiser can talk about this. They have a regular patient. He gets hurt on the job. They have to ask, well, is this work-related or not? Then they have his old medical records for him being a regular patient. They have a new set of medical records for that patient as a workers' comp patient. The frictional costs are just amazing.

DR. HIMMELSTEIN: And just one other quick point of clarification, because it sounded like when you were talking about the reforms, you didn't sound like the reforms were fundamentally flawed, but the way they were implemented. It's not the nature or the existence of the network that's the problem so much as how it's implemented?

MR. RANKIN: Yeah. I actually wrote an article before it was implemented and after it was passed that that was going to be the big question. And labor lost every time a regulation was adopted. I mean, it's a lesson. We didn't write the law, but the law could have been implemented in a fair way to injured workers in most instances. It just wasn't.

DR. HIMMELSTEIN: All right. Thank you very much. Doug?

Commentary

Doug Kim, Legislative Advocate, Green & Azevedo

DOUG KIM: Thanks very much. I'm Doug Kim. I'm with the law firm of Green and Azevedo. We have been the legislative advocates for the California applicants' attorneys since 1972. We've been their only advocates. We also specialize in workers' compensation and personal injury law, so that I see injured workers everyday. For me, workers' compensation is not an abstract study. It is not a review of data. It is not looking at trends or graphs. It's not looking for statistical symmetries or compatible co-efficiencies. It's about real people. I've been coming to various national forums on workers' compensation for at least the last 16 or 17 years. And I am very, very, very rarely ever asked to make a presentation. I don't know why. (Laughter.) I am mindful of the fact that I am the last speaker, and I am seated on your extreme left on the dais here. (Laughter.)

So, I want to first acknowledge and thank the Academy for having me, and Ed Welch for inviting me. I would just say that if all of the players in workers' compensation were as good-willed and as committed to dealing with the issues as all of the panelists have been here, whether we agree or not on what the appropriate approaches are, I think we'd do a lot better in trying to resolve the problems.

I particularly want to thank Angie Wei and Tom Rankin, whom I've worked with for many years, advocating on behalf of injured workers. I am mindful, as Mr. Wilcox from New York pointed out this morning that organized labor has a number of other issues besides compensation. For the applicants' attorneys, that is our only issue. We represent injured workers. My organization of 1,200 lawyers has as their only practice the representation of injured workers. A few of them represent workers in the federal venue, but primarily in the state of California.

And I do want to thank Stanley Zax. Stanley has always been one of the more responsible insurance carriers in California. As you all know, he's one of the last remaining carriers domiciled in California. He stepped up to the plate this year, recognized that what happened in California was grossly unfair, if not absolutely tragic for injured workers, and he offered at least a partial step into restoring permanent partial disability benefits which the governor unfortunately vetoed. We hope he'll reconsider that next year, should he be re-elected, and he will not have the restraints of a campaign to color his decision. If by some chance, his opponent is elected, we would feel much better about our chances of getting the situation corrected.

I think you've heard enough this morning to understand that what happened in California has been a disaster for injured workers. And I think if we were candid and honest with each other, we would not refer to it as reform. What has happened clearly and simply is that benefits have been eliminated for injured workers, both indemnity benefits and medical benefits. And access to both of those kinds of benefits has been extremely restricted as the result of the legislation of 2003 and 2004. The applicants'

attorneys were the most vocal opponents in both years to all of that legislative activity. And unfortunately, we were unable to prevail.

Before I talk about the medical treatment issues, I wanted to respond to a couple of other points that were made by other panelists. I'm sorry Bob Reville was not here to talk about his research dealing with the adequacy of benefits. As Allan Hunt pointed out, there's something doesn't smell right when such a low level of earned income is not replaced as a result of the benefits.

The RAND study found, if you caught it in the slide, that permanent partial disability benefits in California replaced 37 percent of lost earnings over a 5-year period. Thirty-seven percent. Could you live on a 67 percent wage cut? In California those benefits are paid at $230 a week. Two hundred and thirty dollars a week. Can you live on $230 a week? In addition, as the study pointed out, the cuts in those benefits amount to 65 percent. So 65 percent of 37 percent, and what's left? What has happened in California has been an absolute disaster. The panacea of the new rating schedule, as Mr. Snashall from New York pointed out to me, if that were a panacea, if we had truly objective evidence-based ratings, there shouldn't be that 34 percent discrepancy between the ratings for unrepresented and represented workers. That's clearly why workers in California come to my people and look for representation.

Let me just say a couple of things about the medical treatment. I want to tell you not about studies, not about trends, but about real people and what has happened to them. You've heard that the ACOEM guidelines are presumptively correct. There's nothing we can do about them. Whether we go to a utilization review or an independent medical review, all doctors are held to the same standard: the ACOEM guidelines. The statute requires that the guidelines be evidence-based. I don't think the ACOEM guidelines are evidence-based. Other health systems provide multiple sets of treatment guidelines. It makes no sense to me that in California we should have a single set of presumptively correct guidelines, which by their own admission do not apply to anything but the acute stage. I saw an article just before I came out here by a physician writing for the National Association of Occupational Health Professionals, who was talking about a new set of ACOEM guidelines that focuses on functional improvement and return to physical activity, which is something short of addressing work disability.

I had a whole bunch of things I wanted to say. I'm not going to get to it, obviously. I will say, with respect to the medical provider networks, one of the major problems that our people are having is that we don't know who the doctors are in the network. For example, say that somebody says his or her network is the Aetna medical provider network. There are 40-something Aetna networks in the state of California. We don't know which of the networks is the one that applies to our injured worker. And we don't know if our doctor is in the right medical network for Aetna, and we're having a devil of a time trying to find out how to find out who is in the network and how they can be treated.

Another problem is injured workers who have been treated for a long time are now being forced away from their treaters into medical networks. And I want to give you one example. This is a letter that an injured worker received from his employer: Your doctor is not a member of our medical provider network. It is our intention to transfer your medical care to a physician within our network. If you wish to control your own medical care, you have the option of settling your claim in full. A review of your case reflects that we had previously offered to settle your case for $9,000. That offer was either rejected or we received no response. We are renewing our offer to resolve your claim for a full and final settlement in the amount of $6,000. This offer is good for 25 days. If we do not receive a response, we will assume you have no interest in settlement, and we will proceed to transfer your care to a physician within our medical network.

This is what is happening everyday in the state of California. Now let me just conclude by giving you a couple of real-life instances of what is happening. We have collected hundreds, if not thousands, of examples from attorneys around the state of California about problems that their clients are experiencing in trying to get medical treatment. Alan Wechsler was found to be 100 percent permanently disabled in 1995, and part of his award was for lifetime medical treatment. His issue was persistent reflex sympathy – sympathetic dystrophy – and his physician recommended epidural steroid injections to various nerves. Under utilization review, because this issue was open, the new law was applied retroactively, and so any request for additional treatment that was awarded in the past is under the new law. The utilization review entity denied the steroid injections. They even questioned whether or not the injury, which was 10 years old, was industrial or not. So those steroids were denied. Then the physician asked to have a spinal cord stimulator. The same utilization review company denied the spinal cord stimulator on the basis that the injured worker did not first try the epidural steroids that it had refused. The physician in 2004 requested a consultation for chronic depression and for suicidal tendencies for the injured worker. Only a single visit was okayed. To this date, he has not been treated for his condition.

Secondly, just before I came out here I read a newspaper article from the small town of Chico, California. It's about 190 miles northeast of San Francisco. It's in the Sierra foothills. This is not a liberal community. And this is not a liberal newspaper. It referred to a Larry Brown, married with two children. He had a back injury in 2000 that required two surgeries, and three removed discs from his neck. And when he had sought additional medical treatment, an appeal court ordered the treatment in as late as 2004. The insurance company wants to comply and provide that treatment, but it can't. And the reason is, in that particular county there is no willing provider who can provide the necessary treatment. Right now, Larry Brown is living on pain medications that are being paid for by Medicare.

In that same town, lives Pam DeRange, a 51-years-old married mother. She had to wait three months to get authorization for an MRI. She had to wait two for years for authorization for back surgery. She finally had the surgery done last month, but she had to do it in San Francisco because there was no physician available in Chico until March of next year.

Larry Dyer was a 45-year-old electrician– let me just do this one more time – 21 years as an electrician and part of his job required him to pull wire through hundreds of yards of conduit everyday. In July 2004 he reported to his supervisor that his wrists and hands were numb and they weren't getting any better. The employer told him, there's nothing wrong with you, just go back to work. In the meantime, it took the employer two weeks to file a report of injury. The employer denied the claim, sent him to their own physician who diagnosed carpal tunnel surgery. The physician – this was the employer's physician – recommended physical therapy, but because as you heard there's a cap of 24 visits per injury, after 24, the carrier denied any further visits even though the physical therapy was prescribed in hopes of obviating the need for surgery. Later, he required surgery on his left elbow, but any post-surgery therapy was denied. His hands are still numb. It's one and a half years later. He hasn't had satisfactory treatment. The employer removed his physician from their medical provider network. And second medical provider network doctor recommended that therapy – that still has been denied. A state-appointed medical evaluator has approved the therapy. That still has been denied. Now he needs surgery on both hands, and he's still waiting for authorization.

And let me just give you one last example. Robert Sedam was a helicopter mechanic who was found 100 percent permanently disabled. He's married and has two young children. He had surgeries for closed rib and back fracture injuries as the result of an accident in a helicopter. And he suffered from seizures as a result. His physician was able to wean him off opioids, but he was extremely concerned about the likelihood that Robert would be susceptible to blood clots. Authorization was refused for medication dealing with the blood clots even though the carrier previously had authorized coumadin. After three weeks or so, the carrier suddenly denied any further medical treatment, February 22 of this year. A hearing was set for June 20, where Robert could appeal the denial of treatment. But, he was unable to attend the hearing. The reason he could not attend is that he died earlier that month. He died from a blood clot. And because of the statute of limitations, his widow and children were unable to file a claim for death benefits. This is what my people deal with every day. Thank you.

(Applause.)

Discussion

DR. HIMMELSTEIN: I think it's really helpful to have real-life cases to talk about. And maybe, if I can, we've got sort of a few minutes late. One thing that's confusing to me, for those of you in California, I heard earlier that ACOEM guidelines were guidelines and that there was a way that the insurance companies and the utilization management were supposed to be responsive to doctors. So can you clarify that, how it's actually operating, Bernyce?

DR. PEPLOWSKI: I think it's sad for all of us. There's so many of us in the room who are one of the committee members for different sections of the guidelines. The intent from the beginning is the underlying message of the ACOEM guides is that if you're requesting a treatment, as long as you can demonstrate that patient is getting more functional recovery, there is nothing in those ACOEM guidelines that says you can't do that particular treatment. But sometimes, when someone loses the intent and the flavor of what sits behind ACOEM, and uses it instead as a cookbook, which it was never intended to be, that's why you hear the adverse outcomes. Again, this saddens all of us who know that the intent was not –

DR. HIMMELSTEIN: So is the interpretation in fact up to each insurance company and the medical director of the insurance company decides?

DR. PEPLOWSKI: To a degree, yes. And that's probably part of the challenge. If there were ACOEM committee members sitting in each one of the insurers, it would be a very different world.

DR. HIMMELSTEIN: Right, because it's one thing to state this as guidelines, and then physicians can go around them. But it sounds like insurers are not being supervised and that leads to some really horrible outcomes. One thing – I think we have to sum up; we don't have time for discussion. We have to take a break now. But there is this theme that's emerging between the theories of the law, the regulations as they're written and how it's actually being implemented at all levels. And I think as California revisits this, there is obviously some potential good here; but there's a lot of potential harm. And the other thing that comes up is where is the data? I mean, these stories are very compelling, Doug, and I think Tom also talked about not having data, but at some point, we have to get serious about how we present data in addition to the very strong and moving anecdotes.

MR. RANKIN: Well, I'm all for studies and data, but often times, and especially right now in this instance, they become the excuse for not doing something Not necessarily in terms of the medical stuff, but in terms of permanent disability, the division of worker's comp in California is doing this study that was mentioned earlier on return to work to show that wage loss really isn't so bad overall because more people are returning to work. Whether or not they'll find that out, I don't know. But that is absolutely no reason that those workers who are not returning to work who are compensated under this totally inadequate fee schedule shouldn't be getting a benefit increase. As I said before,

we can study worker's comp to death and we're never going to come up with a solution inside this system. It's just inherently flawed.

DR. HIMMELSTEIN: Okay. I'm going to have to end there. I want to say thanks to the panelists. That was excellent.

(Applause.)

(End of panel.)