NATIONAL ACADEMY OF SOCIAL INSURANCE

# *Health and Income Security for Injured Workers: Key Policy Issues*

## Panel VI: How Do We Coordinate Care for Ill, Injured or Disabled Workers?

## Friday, October 13, 2006

This session convened at 9:45AM in the Ballroom of the National Press Club, 529 14th Street, NW, Washington, DC.

## Introductions

Lee Goldberg, Policy Director, Long Term Care Division, Service Employees International Union

LEE GOLDBERG: My name is Lee Goldberg. I direct the long-term care policy work at the Service Employees International Union. As the moderator before me commented, SIEU and UFCW share a common concern over work place injuries. We have almost half a million members who work in nursing homes and provide home care services around the country. And like meatpacking these are dangerous jobs, compounded by the fact that individuals often don't have health insurance. Disability and workers' comp is particularly crucial for this segment of the workforce.

This session we'll look at the interaction of workers' comp with health insurance, both employer sponsored and private and the interaction of workers' comp with disability benefits. And we're going to examine some new initiatives going on in California that try and integrate medical benefits with employer-sponsored health insurance. And hopefully this will be useful for everybody working on programs designed to help the wellbeing of workers.

On our esteemed panel today, we have four individuals. The first is Darius Lakdawalla who is an economist at the RAND Corporation in Santa Monica. He's currently a Faculty Research Fellow at the National Bureau of Economic Research in Cambridge and is an Associate Professor of Microeconomic Theory at the Pardee RAND Graduate School of Public Policy.

Bryon MacDonald is the Program, Policy and Development Manager of the California World Incentives Initiative at the World Institute on Disability. And prior to that position, Mr. McDonald was a consultant and an advocate for the Center for Independent Living in Berkeley and Oakland.

We also have Christine Baker who is the Executive Officer of the California Commission on Health and Safety and Workers' Compensation.

Finally, we have Dr. Douglas Benner, who is the Coordinator of Occupational Health for Northern California Kaiser Permanente and has led its occupational health service since 1982. Dr. Benner envisioned, designed, and implemented Kaiser Permanente's development of an integrated, multidisciplinary occupational health program with 31 centers built in Northern California over the last 13 years.

So we'll have presentations hopefully for about ten minutes each and then we'll have plenty of time for Q and A afterwards. So, Darius?

## Are Workers More Likely to Claim Workers' Compensation if They Lack Health Coverage?

Darius Lakdawalla, Economist, RAND Corporation

DARIUS LAKDAWALLA: Thanks, I'll try to take it as a matter of principle to finish within ten minutes, which may be setting a precedent hopefully. So I'm going to talk about the relationship between health insurance and workers' compensation filing. It's a project that I've done with my colleagues at RAND, Bob Reville and Seth Seabury. Unfortunately, as you may have heard yesterday, Bob was supposed to be here but has taken ill, so hasn't been able to make it. But we have just finished off this project on what the filing behavior of workers looks like and how it's affected by health insurance.

It was motivated by this table which is a little puzzling particularly to economists who have taken as an article of faith the fact that workers with health concerns typically have much less incentive to file for worker's compensation claims. The data show in fact that workers with health insurance are more likely to file worker's compensation claims even though they seem to have less severe injuries as measured by the proportion that lost wages or the average number of work days lost.

This was a little bit surprising, it's been taken as an article of faith as I said for many years among economists that workers with health insurance have less incentive to file a worker's compensation claim and more incentive to seek redress through their own health insurance when they get injured, but this doesn't seem to be the case.

Now, to motivate some of our answer to this puzzle, I'm going to expand this table with two more columns. And these columns show whether an employer offers health insurance as distinct from whether a worker has health insurance. And as you can see, it kind of widens the gap a little bit when you look at the employer offer of health insurance; workers who work in firms that offer health insurance are even more likely compared to their other counterparts to file a worker's compensation claim.

It's a little bit harder to draw conclusions from this table, though, because the workers and firms that offer health insurance also have slightly less severe injuries. But nonetheless it gives some insight into what we're going to find in our analysis of this problem. So we're going to look at the determinants of filing behavior of young workers in a nationally representative data set. The data are from a commonly used survey called the National Longitudinal Survey of Youth, and the NLSY is a huge survey with all kinds of variables on lots of interesting topics, but one of the topics is workplace injury. So the data asked respondents: were you injured on the job; did you file a claim for that injury; did you receive benefits for the claim that you filed? So you can figure out which workers self-report an injury on the job, which workers self-report filing, and which workers self-report claims.

Okay so just to summarize the findings of our study, what we found is that possession of health insurance per se has very little effect on whether workers file claims, and that's in either direction. So having health insurance doesn't cause you to file any

less, and not having health insurance does not cause you to file any more. However, working for a firm that offers health insurance is a very strong factor in whether or not a worker files a claim. So when a worker works for a firm that offers health insurance, that worker is much more likely to file a claim in the event of an injury and suggests the importance of employer incentives, workplace environment factors, and other aspects of the employer's incentives and behavior. And it suggests that workers' incentives and behaviors are less important in the filing decision.

So the data on injuries are collected from this panel of about 13,000 individuals. Obviously, not all of these individuals are injured but this is the entire size of the data set. So from 1988 onwards, respondents in this data were asked whether they were injured at work since the last wave of data collection. The data had been collected approximately biannually for about 20-odd years now, saying if they were injured had they filed a claim? If they filed claim did they receive benefits? And, again, if they were injured what was the nature of the injury?

Just to quickly summarize, we have approximately 4,700 workers reporting injuries and illnesses, about a little more than a half of those workers report filing a claim and then a little under half still report receiving a benefit conditional on filing a claim.

So the essential findings that we obtain are on this slide. So what we find is that when an employer offers health insurance, a worker is about 15 percentage points more likely to file a claim in the event of an injury. Compared to the other effects that we think are fairly important in driving filing behavior, this is a rather large number. So for instance, a worker who is in a union is about five percentage points more likely to file a claim. And unionization we know is a fairly important determinant of whether workers end up filing.

It's similar in magnitude to whether or not a condition that you suffered was a disease, which is very hard to link to a workplace or very hard to prove work relatedness. So when you have an occupational disease, you're about 15 percentage points less likely to file a claim and it's kind of similar to severity measures. For every ten work days you lose, you're about one percentage point more likely to file. So this is a very big number in the context of a lot of other important factors.

What's particularly interesting is if you take out this employer offers health insurance variable and you put in a variable that says "do you have health insurance" you get back a very small number: one that is essentially insignificant. So whether or not the worker possesses health insurance does not seem to explain very much about the worker's filing decision.

So to drill down into this a little bit more, we said, well, if it's the case that the source of health insurance matters – that it's all about whether your employer is offering insurance to you – then we ought to be able to see differences and outcomes depending on where workers are getting their insurance. So that's exactly what we did. We looked at the effective insurance by source. On this table the white numbers are all statistically

insignificant, so for all practical purposes you can think of them as zero. The yellow numbers are significant and what you see is that the only drivers of worker filing in this data are whether or not your current employer is offering you health insurance and that increases your propensity to file. And whether or not you're on Medicaid or welfare, which decreases your propensity to file.

So nowhere do we really see evidence that insurance is serving as a substitute for workers' compensation filing for the vast majority of workers. We see quite the converse really, that workers in firms that are providing health insurance seem to be more likely to file claims in the event of an injury. Whether you have insurance from a previous employer, from your spouse's employer, from your spouse's previous employer, whether you bought insurance on the retail market – none of these sources of insurance matter, which suggests that having insurance in and of itself is of relatively little importance.

Okay, so what do we take away from this finding? On the one hand, it's interesting and surprising that we seem to have overturned an article of faith that was long held in the economics profession, but we have to kind of move beyond that and talk about why it's important for understanding a wider range of behaviors. I think that this points to a future research agenda that looks at the incentives and behaviors of employers and how these determine worker's compensation filing behaviors.

What we've shown essentially is that employee incentives don't really have a whole lot to do with explaining filing behavior. There aren't workers who are just simply more likely to file or less likely to file, and the worker's own incentives seem to be strongly driven by what the employer is doing.

There are lots of plausible reasons why employers can have different incentives to offer or encourage workers compensation filing, and similarly to offer health insurance to their workers. Certain firms may want to encourage or discourage risk-taking on the job. A very nice canonical example is fire fighters and police. So even among public sector workers, fire fighters and police tend to have some of the most generous worker's compensation and health insurance and disability benefit packages anywhere, and part of the reason is that a safe cop is probably not a very effective cop taking risks is a really big part of the job of being a policeman or being a fire fighter.

Certain employers want to encourage workers to take some risks and conversely other employers may want workers not to take risks. The relationship between risk and productivity has a huge impact on what kinds of incentives employers have for providing bundles of health insurance and easy workers' compensation filing. And conversely, some employers may not want to provide significant amounts of insurance either through health insurance coverage or by discouraging workers' compensation filing. And I suggest the importance of understanding employer incentives and characteristics if we want to understand why some workers file and why other workers do not file.

So that's essentially the gist of our research and gives you kind of a flavor of it in this short ten-minute timeframe and hopefully I've stayed in bounds. And thanks a lot for your time. (Applause.)

## Disability Benefits 101: Securing Health Coverage and Working with a Disability

Bryon Macdonald, Program, Policy and Development Manager, World Institute on Disability

BRYON MACDONALD: I'm Bryon MacDonald of the World Institute on Disability. I want to start off by thanking Virginia Reno and NASI for this opportunity. It is a wonderful opportunity for us, but I really want to be honest: the real reason I'm here is to follow up Ed Welch, and share with you all that stuff people make up is not limited to CMS. So we're going to talk about some other places where that happens.

Deputy Commissioner Martin Gerry has said many times over the last four years: "we're trying to get rid of the idea that there's something inconsistent between benefits and work." To be bipartisan, his predecessor Dr. Daniels was often quoted as saying: "independent living for people with disabilities without employment options is a dead idea." We are trying to operationalize the fact that many people who live independently use state and federal public and private benefits, and have no clue how to do that, and plan for a job, look for a job, or work. The Social Security Administration is the pioneer federal agency that has grants out to community-based organizations to do benefits, planning, and services in the community for their beneficiaries. That's the first federal money of its kind form the Ticket Act of 1999 that outlays federal dollars to community-based organizations to help folks to benefits planning.

Our project at California in Oakland at the World Institute on Disability is a state-focused information service for people who are on benefits, at risk of being on benefits, have a new diagnosis or emerging disability. We focus on they can get the help they need in terms of the information they need at the right time. The right information in the right hands at the right time is what this program is all about.

Our anchor service is this website which is person-centered and state-centered, not program-centered. So there's a range of 30 different programs on the left hand side from state disability to Social Security to the ticket program, to short-term disability private products, and so on. The website is highly popular, we get 20,000 visitors a month in California. It is state-focused because then people will know the rules are for them in California.

Having said that, the website does not connect the dots between these two programs. We are helping to connecting the dots between the multiple programs that people use by creating benefits calculators. I'm going to show you our first calculator, which we just launched July 1st of this year.

The benefits to our calculator, which we're going to demo in eight minutes, is the first of six, this is a three-year project that we've had in design and development in California since 2003 with private funding and the Department of Rehab, and now we have a Social Security contract to finish this project over the next year, and launch six calculators total to discrete different target populations.

The first calculator is the one we are going to look at today. This is the home page. It is dedicated to people who are on public benefits now, and are planning to work, working, or want to work more. And what would that look like? What does the healthcare look like? What does the income look like after the job starts? How do I look at that information before the job starts and not get in trouble? So that is the essence of what we're doing here as an overview. Because you've heard so much in the last day and a half, I kind of want to set the context.

There's another main overview I want to get to here, and that is we are designing for Aunt Martha; we're designing for the customer who has very little understanding of working center rules which confuse most of the Ph.D.s I know. We are designing for the regional center case manager in California who knows how to do case management services, but has no clue how to do benefits planning. So it has a breadth and depth filter in it, in that we don't go deep into programs, we go just to the level of depth that the customer needs to get a reasonable estimate of what life would be like after a job.

So the calculator needs to know basic information about the person now, what benefits there are now, what healthcare there are now, what job they want to take, and then we go to the results page. And I am really under the gun to get you to the results page as quickly as possible. So I'm going to be going through the calculator as fast as some other folks went thorough their power point, but we are now actually live on the internet and you will see the actual application.

So the person we're talking about, we'll name Frank, is born in 1960, he's not married, he has no dependents, and he lives in Berkeley, which is 94709. Social Security has determined that he is disabled, so we click yes, and we click, no, that he is not disabled because he's blind. If we click the blind button yes, different screens would pop up for that population. As the consumer goes through the process, or Aunt Martha or a case manager, there's a confirmation page: "is what you told us accurate?" and that repeats itself.

We want to know current income: Frank is receiving $400 a month in SSI, and $368 a month in SSDI; we have a high supplement in California for the SSI program so he has a recent work history. He's not on state disability insurance; that's a zero. He's not on long-term or short-term disability. He's not on workers' comp, and he has no other unearned income. The texts on the right are called tips. These are qualitative tip information about the reasons why we're asking the questions we're asking, and all the blue links in this calculator take you to actual content descriptions of the blue link on DB101, so it is designed to be a qualitative learning environment as well as a calculator.

Are you contributing to a pass? We say no, and this is not Benefits 101 here because I don't have the time. (Laughs.) Have you worked since you've been on benefits? The calculator needs to know if you've used any of your trial work periods with the SSDI programs, and the answer is no, Frank has not worked at this point. Confirmation page. Frank rents his home, he's paying $400 out of pocket, doesn't know about section 8, so that's a no. Conformation page.

Now we want to ask about healthcare. The computer already knows he's on MediCal because the computer already knows he's on SSI, the computer knows that he's on Medicare because of the time he's been on, he's eligible now for Medicare, and the defaults for the rest of these are no. They could change. Is there any other health coverage in the household that can help cover your health care costs? Qualitative question. Confirmation page.

And now we go to the future. The calculator knows about his income, his benefit profile, and the calculator doesn't know about part-time job, so we'll just give it a name. That name is now associated with all the data in this profile. He will receive money from work. He will not do a pass plan. He expects the job to start in December. He's just planning now; it's an open job he's seen in the paper a couple of times. Hourly wages is what he will be paid. He's seen that the job pays $15 an hour and is part-time at 25 hours a week. No tips at the library.

Well, you have to see the result section. He's got $30 a month in new impairment work expenses, which we'll give you all the red book and you can read up on that. He's going to have other work expenses that he didn't have not working so the calculator wants to know that. Confirmation page. Private health coverage, he doesn't think so. Calculator gives a prompt question about the private health coverage rules for folks who earn more that $20 a week. This is the confirmation page of what the calculator thinks it knows about Frank, summed up all in one page. And the reason I'm going so fast is that the results summary pages are robust, multi-leveled information about the outcomes of a job before Frank starts to work.

The top section of the result summary are boxes on incomes on the left, healthcare options on the right after the employment, and the middle of the results summary is our graph that says very clearly that you're going to have more money. If the calculator got dated and said you have less money because you lose the cash or you'd lose something in your benefits; the calculator is not an advocate; it is neutral. The middle line means Frank didn't take any job. The graph is that particular data for that particular job, and each one of those exclamation points is a breakout to that month in question as to what's happening to Frank because of the job he took.

For example, and these are the second layer of information that comes up with the calculator: this is a result summary for just the month of November, a year after he took the job. You'll note that his SSI has gone away, because of he earnings, his SSDI is still in place 12 months later, but this the last month of it, and you'll see his total income, total expenses, and his net income based on the data the calculator has.

We go to the next month, because of my time constraints, and this is the end of the trial work period. He has lost his SSDI check so you see SSDI is zero. Because of that loss in the SSDI check and the current earnings of this particular job, he's actually eligible now for a small SSI payment, which he will have to go to Social Security and rework that up, and that's also listed here. Health options are on the right hand side for this profile, for this person.

Going back to the results summary. Again, the monthly breakouts are rich, and throughout this calculator so that the person can get the detailed view of what's going to happen to his life after the job starts. The next phase of the results summary are more details about the actual income pre-job, post-job and his breakouts of that on this page, for the real policy wonks among us. Time up. A visual graph of the healthcare options after employment.

This is a full summary of all the tips you've seen on the right-hand side throughout the experience, these are all summarily listed for this particular scenario, so Frank can print the tips out and use them and review them after the experience. And those are the main features of the benefits-to-work calculator at the World Institute on Disability. This is the last page where he can go back to the website, and order other information qualitatively to supplement the work the calculator is doing. The calculator is not designed to be a replacement for service providers, but a tool for service providers, family members, and the consumer.

Thank you. (Applause.)

## New Experiments in 24-Hour Health Coverage for Service Workers

Christine Baker, Executive Officer, California Commission on Health and Safety and Workers' Compensation

CHRISTINE BAKER: Good morning. Thank you for the opportunity to share with you kind of very exciting project that Frank and I, Dr. Benner and a number of other people are working on as kind of an experiment in California. We are looking at 24-hour integrated health coverage for janitorial services, SEIU 1877, and employer maintenance companies in California. Again, I'm just going to go briefly over the bargain and the benefits in the workers' comp system.

In California, we paid $4.4 billion in indemnity and medical, paid $3.8 billion in 2005, and incurred would be double that rate. The growth in California workers' comp medical cost compared with medical care inflation since 1887 has grown 124 percent for workers' comp, and 32 percent for the medical CPI since 1997. It's coming down, but there is still room for improvements in medical cost and workers' comp. Recent reforms reduced workers' comp medical costs, you probably all know this, but caps on chiropractic and physical therapy, medical treatment guidelines, employer control through approved networks, and Medicare-based medical fee schedules. These were accomplished between two reforms: one was 227228 in 2003, and then in 2004 with 899.

Workers' compensation carve-out programs are now permitted in California to all industries, and this is a wonderful opportunity where labor and management can get together, and agree upon the worker's comp system and reduce litigation. Also in SB899 under Governor Schwarzenegger, one can integrate into a 24-hour care, which would protect workers, improve benefit delivery and reduce costs.

What are carve-outs? Worker's compensations carve-outs allow organized labor and management to establish improved benefit delivery systems and alternatives to the dispute resolution procedures in the state system. The state courts are a terribly clogged. They're six months behind in terms of addressing the litigation and the claims; this allows for an entire carve-out of the dispute resolution process. The carve-outs in California are labor-management negotiated agreements, and the statute only allows unions and union employers to negotiate carve-out agreements. It can cover all aspects of the workers' compensation medical and benefit delivery system, negotiated as an addendum to collective bargaining agreements and carve-out is a system essentially separate from the state system, the DWC and the WCAB.

Carve-outs were established initially for the construction industry, and then again in 749 they added the aerospace and timber, but that was later repealed. SB228 in 2003 expanded it to all industries, and 899 in 2004 allows employer and unions to negotiate any aspect of the benefit delivery if employers are eligible for group health and non-occupational disability benefits. Carve-out agreements may include the following: dispute resolution, alternative delivery of medical benefits such as 24-hour integrated care, agreed lists of medical evaluators, joint labor-management safety committees and return to work programs to facilitate safe transition back to full employment.

We believe there's cost savings through lower medical costs, fewer delays in disputes, reduction in overuse, standardization of provider fees, discounts from insurers, and prompt medical care for faster healing, and fuller recovery. There is the effective return to transitional work and sustained employment, fewer misunderstandings and delays, faster resolution of disputes and reduced litigation and satisfaction, morale, productivity and competitiveness of the business. These opportunities for improvement achieve further medical care costs savings and reductions in overuse.

The challenge in carve-outs is determining the cost of the combined program in the 24-hour care, estimating the potential savings and premium reductions, and passing actual savings onto management and labor. We're doing some preliminary calculations in the savings in combining both the group health and the workers' comp, but it can save conservatively 5 to 15 percent on the entire medical care up to 30 percent potentially depending on utilization.

How can carve-out save money while improving benefits delivery in all these areas including duration of disability? I'm going skip what an EDR program is and go on a little bit more to focus on the 24-hour aspect. They can have an agreed list of medical providers. They can negotiate service delivery design, the capitated medical plans, both for workers' comp and health care so it would be one capitated program. There's also the potential for co-pays and deductibles with contribution by workers, and a dispute resolution with medical provider networks, like group health.

Moreover, there can be improved quality and coordination of care, and the elimination of duplication between group health and workers' compensations; for example, the diagnostic test as well as the pharmaceuticals; same medical provider for occupational and no-occupational treatment, and having improved access to care because there is no dispute over coverage, and fewer disputes and delays over treatment. The care just gets taken care of. (Laughs.) A reduction in administrative costs for the two systems. The treatment issues resolved within the same health plan; disputes minimized some are to group health. The first step would be dispute resolution process within the health plan, and the last step would be an independent medical review by the California Department of Healthcare, so it never goes into the workers' comp litigation.

Medical legal evaluations: there would be agreed list of medically legal evaluators. It yields high quality evaluations respected by both sides, resolves disputes quickly and fairly, helps control the permanent disability and temporary disability costs, and results in appropriate apportionment and causation decisions without litigation. The temporary disability duration and return to work encourages cooperation between the employer, worker and medical providers to determine appropriate return to work, eliminate attorneys for most return to work decisions, and aligns and centers for all parties to reduce time away from work.

In summary, carve-outs can provide substantial savings and advantages to both unions and management, in terms of reduced disputes, faster benefit delivery, less litigation cost, better return to work, the lower insurance costs union labor, more

competitive, reduced medical treatment disputes, and potential for higher quality care at lower cost.

This project that we are embarking upon is funded by the California Healthcare Foundation; the California Commission is a partner in kind; the University of California Berkeley, Frank Neuhauser and his team, Kaiser Permanente; the State Compensation Insurance Fund is the partner in kind; SEIU local 1877, and the building maintenance contractors. In order to do this, we're having meetings with labor, meetings with management, and meetings with the healthcare provider to determine the feasibility and the cost benefit. And until the agreement is reached and the proposal for ongoing monitoring and evaluation, we will be applying for another grant to see if we can implement this, but this is still kind of a feasibility stage.

We have a number of informational packets on our website on how to create a worker's compensation carve-out in California, practical advice for unions and employers, a carve-out guidebook for unions and employers and workers' compensation, and an analysis of the experience of the first carve-outs in the California construction industry, which we will be updating with data fairly soon. Our reports on the commission are on our web sites, and I thank you for the opportunity to share with you this really wonderful project that we have undertaken this year.

Thank you. (Applause.)

## Commentary

Douglas Benner, M.D., Coordinator of Occupational Health, Northern California Kaiser Permanente

DOUGLAS BENNER: Good morning. I guess I'm near the end and I think everyone is looking forward to that. I'm Doug Benner with Kaiser Permanente and I'm really happy to follow Christine. I'm quite an admirer and I thank her and Mr. Welch for this fabulous conference. I think it has been very good.

They asked me to reflect a little bit on this panel and then also talk about the topic we're on. What did I hear? What did you hear? Well, I heard a lot of great things this week, a lot of great observational studies, a lot of interesting data, a lot of food for thought. We've seen the usual things we have in workers' comp, which is a lot of controversy, a lot of disagreements, various stakeholders having different views of what's wrong and what's right. I think we've also hopefully learned, and I have learned some things to think about what we can do to change the system, and I think this carve-out idea is very interesting.

One thing Christine mentioned is capitation; we actually did that. We had a pilot in California in the early '90s and we did four years of capitation of workers' comp medical care in the system. We sold that not only to the self-insureds, which would be pretty simple, but we also had Argonaut Insurance, we had the State Fund, and we had some other insurance companies who actually figured out how to fit this in the workers' comp system.

We had the workers' comp rating bureau in California also figure out how to adjust rates when you have a medical organization capitating medical care. We didn't take the tail, but we did it one year at a time sort of like you do group health. And we're going to do it again. We're dusting off our models, and we have new underwriters and actuaries going to figure this out, and so we want to go with this carve-out product with capitation. Because that is also where you can help save some of the frictional costs of the system. It takes a lot of money to make and collect a bill.

But I want to also reflect a little bit on this topic today. And it's really as how can we – and I mean we, all of us – really help co-ordinate the care of the ill and injured worker and the disabled workers? And I say we, that it's the policymakers, which are out here; it's the labor organizations; it's the employers; it's also the medical providers and it's the claims administrators.

I just want to hit four topics that are close to my heart that I think we all can do a better job on and I think there's room for improvement in the whole system. That is, we're talking about an injured worker and we're talking about medical care, and the disability management. I think we have to keep the focus on who the object of our admiration in our activities are, and that's the injured worker. We need not forget that they are a whole person. I think what's wrong in the system is we forget that, and we forget that this is a human being. We forget it's a person. It comes with a life. It comes

with a past history. And everything we do we try to segment them as we approach them. We have to not forget that we're very inclined both in medicine and in the comp system and in administration to make medicalization of things that aren't medical problems.

I know Dr. Jennifer Christian has great strong views on the same subject and I hope she agrees with what I'm going to say. We also have to not forget that what we're talking about in the big picture is that humans are capital. They are the most important capital we have in industry. Most of our organizations now are very much into service and everything we do requires human capital or knowledge, and have a lot of components, and we tend not to remember all of those components. Now, I want to talk a little bit about that. We have to make sure our incentives are in line. Show me the incentive, and I'll show you the behavior. And very often I think the policymakers and the medical providers do not have the incentives – and the legislators and regulators – in the right direction, and you heard some comments about that earlier.

I'd like to quote William Osler, who was a Canadian physician long ago, and he had two comments. The first of two fairly similar, "but it's much more important to know what sort of a patient has a disease than what sort of a disease the patient has". And another way of saying that which might for some be easier to think of is, "a good physician treats the disease and a great physician treats the patient who has the disease." I think I'd like to reflect on this and some of what we heard in the utilization review (UR) discussion, especially yesterday.

The UR system can really work and I think the UR system in California is set up to work. It's not being administered correctly and there were some comments made about guidelines that I think were misstatements, even about the ACOEM guidelines. Evidence-based guidelines start with reviewing the evidence, but I haven't seen any that then don't make some conclusions. And so when you look at ACOEM or any other good guidelines, it starts and evaluates the evidence, but then they end up with some low-value evidence or no evidence, but then they still have to make conclusions. How that is done is with a very laborious process which probably takes most of the time, and that's expert consensus.

So for them to say, well, guidelines are not useful is wrong. They actually are, because you have the evidence that's really very clear what is known to work and what is known not to work, plus you have a long-term effort – if it's a good guideline – of getting the experts to agree what we should be doing, consensus. And so that is something to refer to, instead of each individual provider or each individual claims examiner deciding oh, no, you shouldn't get that or yes, you should. This is now something to refer to that has a lot of good consensus. And I think we must not forget that.

The other thing about the UR process in California is that only a physician can deny or modify a treatment plan. So as you go through this whole UR process, it is not a claim examiner that says no; they can say yes, and a nurse can say yes, but it takes a physician to say no. And what has UR done very well? You have a peer-to-peer discussion about what's being requested.

One thing I was talking about with Teryl from RAND yesterday, as being a part of our process done well is that actually we actually do see recommendations from good UR physicians about what under treatment should be provided, as well as what over treatment should not be provided. So it should be a dialogue, and when you do that, you understand the total patient better because the treating physician probably understands the patient better as a whole person, hopefully if they're doing their job correctly and not just as a body part or how they would fit in with the "cook book".

Another thing that is unwarranted is medicalization. Nortin Hadler is a physician at the University of North Carolina, with whom I disagree much of the time, but who definitely correct when he asks, "how does a person with a problem become a patient with an illness?" Now, he'll take this on to such things such as fibromyalgia syndromes and other things which he's not sure exist, and I'm not going to debate those, but I think we've seen this with a lot of problems in the system.

In California, one of the classic examples we had was with respect to psychiatric claims, which we've done a lot to change. We really had huge amounts of psychiatric claims in California, and many of them were just HR problems or problems at work. They were not psychiatric illnesses. They were people not getting along with each other and people not getting along with their supervisors. There was no medical psychiatric diagnosis that you really could make. However, we were making them. And I think we tend to do this in a lot of the comp system and we have to be careful about it.

Osler sort of reflected on this a little bit when he said "a young physician starts with 20 drugs for each disease (just let's treat it all), whereas the old physician (who has hopefully learned something,) ends life with one drug for 20 diseases." Now, I don't think with the pharmaceutical advertising and direct marketing to consumers we have today, that holds up, because it is very hard for physicians to counter Madison Avenue and the huge interest of the drug pharmacies to convince people to take these very expensive drugs. But I think we have to be careful of them.

I think what's relevant to this is we have to make sure we understand what we're treating. And very often I see so many claims that are just so lost. And I think the physicians got lost in their way, the workers got lost in their way, and the claims administrators got lost in their way, because we don't know what we are treating anymore. What started out as an acute injury is now someone's chronic disease. And it's not the chronic disease caused by the injury, it's a chronic disease they already had or they would have had. And we have a great deal of difficulty separating this out. So those of you who are in claims, I guarantee you about half of your old claims are not related to the injury it started with. I mean, at that level probably half are not related. And yet we've lost the way to figure that out.

And so that's why I think things like an integrated system makes sense, because we're terrible at keeping these things in their silos. We've seen a lot about the bleed-through, crossovers and the cost shifting in the various systems. We're not good at that, and we're never going to be good at that. So why don't we just take care of the person?

Take care of their back, take care of their knee, and forget about who should have paid for it. And that's why I think integration is our long-term solution.

We're also not very good at knowing when to stop; we don't really know when we're done. And so we see this in the chronic pain world, we've seen this with fusions in California, where you just keep treating and treating and treating. And I think some of the best people in the chronic pain world will tell you that not everything can be fixed. And that in a good chronic pain program – what they figure out how to do is convince the patient: "You've had what you're going to get as far as curative therapy. Now we have to figure out how to help you survive in life and improve your functional activities, because we can't do any more things to you. Okay?" But we're very bad at that. As physicians, there are many physicians, who feel like "you've come to me, I want to help you". And if people keep going to doctor to doctor to doctor, people are going to try to keep doing more and more things to them. And sometimes it's not very helpful.

Again, we need to focus on the person's total functional restoration. And the ACOEM guidelines are very good about that. As people said yesterday, if you are doing something that's going to help, and you've shown evidence that this person will get better or they've already gotten partially better with what you're doing, ACOEM guidelines support doing it. However, it doesn't support doing more of what did not help. We see too much of this, and that's why we had to put caps on PT and caps on chiro (not acupuncture, but we probably should have) in California, because we keep doing things that haven't helped. There's really no reason to keep doing more of something that did not help. Yet we would see people repeatedly getting more PT, more chiro, and more surgery when none of it had done anything.

The comment on human capital is that human capital is being discussed more and more these days; from an economic perspective, we all are human capital and we bring our skills, our motivation and our health to the market place. And we exchange them for wages, opportunities, and rewards. What we tend to focus on is a bit of a health, but we don't do much about the motivation and the skills; and we focus on the wages, and we don't do much about the opportunities and the rewards. And I think this has a lot to do with why people do not return to work, it's why people do not get over their medical problems, and it's the reason why we have a lot of the problems we have in the workers' comp system. Because as we're treating people, and as we're handling their claims, and as their employers, and as their labor representatives and their attorneys, we have to keep making sure we're keeping the people motivated. Because as Dr. J. talked about yesterday, motivation is a huge problem in getting people back to work.

So in this whole process you got to keep that motivation intact. You also have to make sure the skills are intact. We must make sure we're continuing developing skills. I don't know about Jennifer – I'm not going to speak for her, but yesterday she had a comment about, well, it's not always the best thing to get the person back to work, even though most of the time it is. I think this is one of the cases. Some people are not in the right job. They don't have the skills set to do it, so you're not going to fix that by trying to return them to work.

We have a rehab program, which has pretty much failed, I think, in many states. We don't have the resources to really train people to give them the skills; in places like California we've sort of given up to a great extent to try to match skills as part of the workers' treatment process. But we have to make sure we're keeping people motivated; we focus on encouraging people to optimize their health. But I think the other aspects are so important, especially motivation and making sure we're matching people to skills.

On the incentives, I think a lot of people think about this as "providers do what they do, and they do what they know", and if you go to a surgeon you're more likely to get surgery, if you go to someone who injects for chronic pain, you're going to get more likely an injection. And we have to be careful, because their experience and training will tell you more likely about what the surgeon is going to do, because of where and when they got their training.

We have to make sure that we have gate-keepers or primary treating physicians in the system who are not being paid for doing these various procedures, so that they can help assess what is important for this individual and thus, get the incentives correctly assigned. I think providers do what gets paid. In the California system, we highly compensate procedures, up to 400 percent above Medicare. Yet treating physicians who are managing disability are paid below Medicare rates, and this is going on for 20 years in California. It has to be fixed because we're incenting people to get surgery and procedures they do not need, and not incenting physicians to manage disability.

Also when more care is sought, utilization happens. RAND has done a lot of work on this, and I think people are misinterpreting some of this work because as RAND showed, when someone is there to pay for the care, people will get the care more often. But they've also shown that if someone starts having co-pays in the system, people will not get as much care. But this can hurt, because for example one of the studies I think RAND did was when you go to co-pays from $5 to $10 on pharmaceuticals, a third of the people who need chronic care medication stop taking them, and that's not good.

So in summary, I just want us to be thinking about what we all can do. That's you, as a regulator, you as a policy maker, you as a labor representative, you as a physician, you as an employer, you as an injured worker, that we all have something to do to contribute to make sure that we are helping get these injured workers back to work, getting them fully functional, and restored, and productive so our whole society can recognize that workers are human capital and to be a capitalistic society we have to make sure we're maintaining our capital in the highest condition possible.

Thank you. (Applause.)

## Discussion

MR. GOLDBERG: Thank you very much to our panel. We have ten minutes left for questions, so if people with questions want to come to the microphones. They don't sound like they are on, but we can hear you.

Q: So thank you for teeing me up a little bit, Doug. Yes, everything you say I agree with. The only thing I'd like to comment on just because we're sitting here in a meeting where we're talking about workers' compensation as a whole, is I just want to sort of represent for you what it was like for me as doctor to enter the workers' comp system 20 years ago and just discover the amount of cynicism and distrust and inauthenticity in the system as a whole. And it's just such a shock to doctors who operate in group health where people want to get well and there is a general environment of trust.

So I think when we start talking about what we really want to do, we want to start engendering trust, which is engendering trust in workers that the employer actually has an interest in their achieving a good outcome. And engendering trust on the employer that the worker is actually aligned with them and trying to do that, and start having a vision of what ideally it would look like in some specificity.

What is to me one of the hallmarks of the problems with workers' comp is we're very clear about what we don't want, and we don't articulate very well a vision of what we do want and what that would precisely look like.

MR. GOLDBERG: Other questions? All right. Well, excellent. Everybody please join me in thanking our panel for this very good session. (Applause.)

MR. WELCH: Oh, right. Well, thanks to all of you. Thanks to all of the presenters who came, who fit their remarks in our framework. Thanks to Christine, who put together so many of the panels. (Applause.) Virginia and the entire Academy staff, for all they did to put it all together. (Applause.)

MS. BAKER: I also want to thank Nancy, the sponsors who supported this forum, and all the participants who joined here, and particularly to Angie Wei, my boss, who is the chair of the Commission and supports these efforts. Thank you very much. (Applause.)

MR. WELCH: Have a safe trip.

(END)