

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

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

Thursday, October 12, 2006 - Friday, October 13, 2006

This policy symposium convened in the Ballroom of the National Press Club, 529 14th Street, NW, Washington, DC.

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Chairman and Co-Chairs' Welcome

Larry Thompson, Chairman of the Board, NASI

LARRY THOMPSON: Good morning, everyone. My name is Larry Thompson and I'm the Chairman of the Board of the National Academy of Social Insurance, and in that capacity, I want to welcome you to this symposium. I appreciate your interest and your attendance.

Many of you know a lot about the academy but some of you may not know too much, so let me just say a few words, that the National Academy is a membership organization consisting of 700 or so people who are elected to membership from all aspects of the social insurance. Members are academics, administrators, and practitioners of various kinds, whose interests involve social insurance, the pension program, Medicare, disability, workers compensation, as well as some allied programs such as private pensions, the welfare system, family income distribution and so forth.

The role of the national academy is to foster growth in knowledge and dissemination of information to encourage dialogue among people of different views. We are favor of rational policy. We don't take positions on policy. And we like to think that we can cast a big enough tent that all people who have an interest in social insurance can be a part of this organization and participate in our activities. In that vein, we sponsor internship programs and we have a dissertation award to encourage graduate students to do their work in social insurance. We have encouraged research projects and organized symposia such as this one.

This conference, as you know, will look at various aspects of workers' compensation, although, let's face it; the action forcing event is the reforms in California. And so they will play a major role in the discussion. It wouldn't be possible for us to be here if it weren't for our sponsors, and we have got a number of them with colorful logos on the cover of the flyer. I want to take this opportunity to thank the California Healthcare Foundation, Liberty Mutual, Zenith Insurance Company, the Washington State Fund, the United Food and Commercial Workers' Union, Safeway, the Survey Research Center at the University of California, Berkeley, and the RAND Corporation, all of whom who have contributed to make this possible.

But the people who really contributed to make it possible are the co-chairs. And I know from talking to the staff that they have put in an awful lot of work and energy into making this happen. So I want to thank them, and I want to introduce Christine Baker, who is the Executive Officer of the California Commission on Health and Safety, and Workers' Compensation, where she has served since they set it up in 1994. Prior to that, she served in several management capacities in the California Department of Industrial Relations, and she is a member of the National Academy, and has been since 2002.

And her co-chair is Edward Welch, the Director of Workers' Compensation Center at Michigan State, from the University of Michigan. (Laughter.) From 1985 to

1990, he was the Director of the Bureau of Workers' Disability Compensation in the state of Michigan, and he has been a member of the National Academy since 1989. Christine? Thank you.

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

CHRISTINE BAKER: Thank you, Larry.

Good morning. And it is an honor to be here and co-chair this very important conference. I am looking forward to this discussion and sharing information, discussing ideas, and gaining insights. First of all, I would like to thank also the sponsors, as well as Virginia Reno and the staff, who really worked tirelessly to bring this together.

Health and income security for injured workers is a goal that we all share, and it is not easily achieved. That is especially true when facing a crisis in workers' compensation, as we did in California in the last few years. Even though occupational injuries and illnesses were declining, the costs of the workers' compensation were raging out of control. Today we will discuss how California has been working hard to meet its constitutional mandate: to provide a workers' compensation system that shall accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character.

We will see that it is not only the workers' compensation medical costs that are skyrocketing, but the group health as well. We will hear about innovative programs that we hope will combine the efficiencies of both. This conference addresses a wide range of topics critical to ensuring the well-being of injured workers: workers' compensation benefit adequacy, access to quality of medical care, safety nets for workers, and preparing for catastrophes in the workplace, and the possible integration of workers' compensation, medical care and group health.

California is the focus, as we just recently came through one of the biggest reforms. And I hope you can bear with us with the agenda that is really kind of focused on California. But I would like to give you some insight in the process by which some of these reforms came to be made. A lot of it was based on empirical research. There are a few items that were included in there that were not based on research, and those items probably need some tweaking because of the lack of the empirical basis to substantiate those kinds of recommendations.

The California Commission on Health and Safety and Workers' Comp, of which I have the honor of being executive officer, is a commission made up of labor and management, and these two groups get together and make recommendations for research. And it is a win-win when that happens. And I just want to emphasize the importance of bringing the two key stakeholders together in making decisions on reforms.

The Commission focused on the permanent disability, and you'll hear from RAND on the permanent disability studies today. You will also hear about some of our interest in quality and access to care, utilization review and other kind of important aspects of monitoring a system. But I will defer now to my co-chair, and also welcome you wholeheartedly for discussions on these issues. Thank you very much.

(Applause.)

Edward Welch, Director, Workers' Compensation Center, Michigan State University

EDWARD M. WELCH: Thank you, Christine. Although my paycheck is green and white, my heart is blue and gold. (Laughter.) I am a graduate of the University of Michigan three times, and I was born and raised in Detroit, and it is a great fall, all right. (Laughter.)

It has been a lot of fun working with Christine in preparing this. And I really have to say that I'm almost embarrassed to be the co-chair because as you will see from the panels, Christine has already worked much harder than I have in preparing this. And we especially want to recognize the staff, particularly Virginia Reno, who has really been the force behind all of this in shaping this and designing this program, and putting it together. And Virginia is really the one we need to honor and credit for that, as well as the staff that works with her in putting this together.

(Applause.)

With that, we have a very great group of people out there. I hope today and tomorrow will get you stirred up a little bit, get you thinking a little differently, perhaps get you a little bit excited about some of these issues, and with that, I look forward to the program. Thank you.

(Applause.)

Panel I: What's Happening in Workers' Compensation?

Introductions

Ann Clayton, Senior Consultant, Clayton and Associates

ANN CLAYTON: Good morning. My name is Ann Clayton, and I'm your moderator for the first session of today. We are going to be talking about what is happening in workers' compensation from a number of different perspectives. And to give you just a little bit of background before I introduce the speakers today, let me share some of the information that was in your seminar information.

First of all, what has been happening? Cost as a share of payroll dropped 20 percent since 1990. Benefits to workers dropped 33 percent. A great share of the benefit dollar is being paid for medical care, and this is a national perspective. Significant legislative actions in multiple states, including in California, Florida, Missouri, Nevada, Oklahoma, Tennessee, and Texas over the last three to five years, have made workers' compensation once again a rapidly changing area of law. This is especially true in those states where there is a huge percentage of the workers' compensation premium.

So with the challenges and the changes that have come about over the last three to five years, one of the questions that has been asked the panel members this morning, and the presenters are, "Are we heading in the right direction?" The presenters this morning represent business, labor, government, and one of the largest writers of workers' compensation insurance in the United States.

We will begin first with a presentation by Bob Steggert, who is representing the employer community, as he often does. He started with Liberty Mutual in 1974. He spent his career involved in managing casualty claims and various occupational health programs. In 1980, he joined Marriott, and is currently the Vice President of Casualty Claims for Marriott International, where he is responsible for their global property casualty and EPLI claims activity, as well as occupational health nursing programs. He is also currently Chair of the National Academy of Social Insurance Work Comp Steering Committee.

After Bob makes his presentation, giving you a perspective from employers, Ed Welch, whom you have already been introduced to, will give an employees perspective.

After that, we will have individual comments from Art Wilcox, who is from the New York AFL-CIO, and has been very active in the workers' compensation issue in New York for multiple years. And as you may or may not know, there have been some fairly heated debates going on in New York about the workers' compensation issue in the last two years, I believe. And it looks like those will continue. So Art will give you a perspective from labor on the presentations of Bob and Ed.

After Art, we will have Bob Malooly, who is with the Washington Department of Labor. He, I like to say, is the CEO of the Washington state fund, but he has quite a long

government background in the state of Illinois before he went to Washington state. So he will give you a perspective, probably from government's perspective, but now he holds the title of the head of a workers' compensation state fund.

And lastly, we are pleased to have with us Paul Rodliff, who is with Liberty Mutual Insurance Company, and has spent a significant amount of time in workers' compensation, 28 years in the insurance industry. He is currently the Senior Vice President for Liberty Mutual Insurance group, responsible for commercial operations that include claims, managed care, loss prevention, underwriting, and application development support.

So you will be able to hear not only a perspective of what is currently happening in the workers' compensations' systems nationwide, which is not easy, since they all tend to be state systems, and they are all evolving over time somewhat differently in different states, but we are asking Bob and Ed to give you a national perspective, and then we'll have comments from Art, Bob, and Paul. Bob?

What Challenges do Employers Face in Delivering Cash Benefits and Medical Care?

Bob Steggert, Vice President, Casualty Claims, Marriott International, Inc

BOB STEGGERT: Thank you, Ann. I appreciate that. And welcome, everybody, to Washington, D.C. I am looking forward today and this opportunity, and I'm privileged to be on the first panel and the first speaker on the first panel. I don't know if that is a blessing or a curse. The good part is, Ed got to see my slides and I got to see Ed's slides. The difference is I gave him my slides first, and I have got two, and he has got 30, so he is coming second. (Laughter.)

With that said, I will do my best within 15 minutes. And Ann is going to keep me on schedule to talk about workers' comp from a national perspective and give you some views from an employer's perspective in particular.

State-based systems. Obviously we have 50 different laws around the United States dealing with workers' compensation and the pressures of competition are real between the states and globally for jobs and for effective systems that will draw businesses to those jurisdictions. Now, I don't happen to be in an industry where we choose which states to go to because of their workers' compensation laws, but there are many businesses that do.

The competitions are real and unstoppable, and states that fairly and properly address workers' compensation system from the balance of an employer and employees are going to succeed in the long run. The scrutiny that the states are under is deserved and will be constant. The states that win, if you will, will generally be those where business and labor change the way they work together on workers' compensation and other public policy issues, i.e., they will be less competitive for win-lose outcomes, and more cooperative for win-win solutions.

And while rhetoric perhaps has its place in debates, pragmatism is far more promising than parallel monologues delivered to constituencies, who frankly, on both sides incidentally, don't often really understand the complexity of issues and promising solutions that we are dealing with in modern workers' compensation systems.

One of my big premises in terms of changing workers' compensation systems is we need to look at stripping away unnecessary costs from the system. And I easily define that as those costs that do not improve the outcome of injured workers.

Now, you might find that interesting from an employer perspective, but our workers are our most important asset, and we want them to get proper, timely, and appropriate medical care for conditions that are deemed compensable under workers' compensation statutes. Costs that are unnecessary range the spectrum of wasteful medical care, causation battles, dueling doctor litigation, and the costs of medical cost containment services caused by over-regulation. Ideally, and I say this in an ideal world, these costs can be redirected to deserving and under-compensated workers, and as

Christine touched upon, that is far easier said than done in California and every other state.

On a big picture basis, while system cost is important, perhaps more important to employers is the question, “is the system balanced in working to achieve sound public policy objectives?” I would define those as injury prevention, timely loss reporting, delivery of proper and necessary medical care, and return to work in an appropriate timeframe. This may perhaps be Pollyannaish, but I believe these are the primary premises under which we should be operating. Stated another way, are there obvious practices, perhaps abusive practices and unnecessary costs, not improving outcomes? And is the system attorney-, medical-provider- or vendor- driven, and gamed primarily for their economic benefit at the expense of injured workers and employers?

Moving to medical cost and care under workers’ compensation – and I gave this slide to Ann that just said “Bob S.” I thought we might change it to be consistent with the first heading, but when you have a collaborative effort like this, that’s just it. So I am still the same person who was speaking on the first slide in case you fell asleep. (Laughter.)

Medical care explosion solutions. Again, I don’t have time to cover all of these areas, so I am just going to hit some highlights. As most everyone in this audience likely knows, the choice of physician in workers’ comp has long been contentious. It ranges from total free choice, like Art is dealing with in New York, where, quite frankly, I think their system is antiquated. Under certain rather ordinary circumstances, New York considers employer-directed medical care to be a criminal misdemeanor.

The other extreme is various forms of panels or authorized networks. Thankfully, the trend is moving away from gaming the system in total free choice states towards quality provider panels, whether under collective bargaining agreement carve-outs or state-regulated networks. This trend started well over a decade ago with creative win-win solutions with collective bargaining agreement carve-outs, and it has been adopted by a number of states.

Jim Ellenberger and I had the privilege of serving as co-chairs of a labor management discussion group many years ago that actually was started at the impetus of Gary Countryman, when he was the chairman and CEO of Liberty Mutual. And one of the white papers that we produced dealt with medical care. And we agreed, with certain caveats, that managed care under workers’ compensation not only had a place in workers’ compensation, but also should be encouraged under the law.

Another area of cost containment concern to employers is that modern workers’ comp systems need to address is the proliferation of prescription drugs and the general inadequacy of drug-fee schedules now in place. Another positive trend deals with utilization review. Generally, I think this is positive because it’s designed to curb abuse, promote best practices, and responsibly control costs. And utilization review can be

retrospective, prospective or current, and, again, I won't go into detail but it's something that I think every state should be looking at.

One of the most important positive trends that I heartedly endorse is the importance of nationally recognized and peer-developed evidence-based treatment guidelines in workers' compensation. This is increasingly supported by legislatures and prestigious organizations such as ACOEM, and if you are not familiar with that acronym, it's the American College of Occupational Environmental Medicine, and the Century Foundation also endorses it.

To quote ACOEM's incumbent president, Doctor Guidotti. Quote, "Guidelines are critical to the modern practice of medicine, and ACOEM is encouraging the adoption of guidelines by every state. The philosophy behind the Guidelines is that, properly constituted, good guidelines achieve better and more predictable results from the majority of patients. Properly implemented, they require the physician to justify and thus think through and document why something different should be done but allows physicians to do so if there is good medical reason," end quote.

Let me bring this to life in the workers' comp context through sharing some statistics from Marriott's qualified, and I might add quality, Medical Provider Network that we have established in the state of California. We happen to self-administer our claims in California. And Doug Kim and I may disagree with the results of the California reform, but nevertheless, provider networks were one of the major foundations for that reform.

We have over 20,000 employees in the state of California. And there is a legislative regulation or right for employees to "opt out" of that provider network if they have a family physician that maintains their medical records. We did not have a single employee of our 20,000-plus employees opt out of our network because we had a carefully selected high-quality medical network. We reviewed it with all of our employees, including our union employees, and not a single employee opted out.

The first six months of this year, we reviewed 852 files for utilization review under treatment guideline criteria. Eighty-four recommended surgeries were approved. Twelve recommended surgeries were denied, supported by peer-reviewed physicians and quality assurance measures we have in place under the direction of our managed care director and our California medical director.

Now, ask yourself one simple question. If these 12 inappropriate surgeries were allowed, how many of these 12 workers would have had better outcomes? And what are the corresponding costs of such inappropriate medical treatment, lost time, and incremental permanent partial disability? One state, one employer, six months, do the math anyway you want.

Turning to the Century Foundation. It advocates the quote, "use of evidence-based standards to reduce medical errors and encourage best medical practices," end

quote. Now, let's look at some realities in our healthcare delivery system that unequivocally carry over to workers' comp, and further magnify the need for evidence-based treatment guidelines. In 2004, Massachusetts has an organization called the Institute for Healthcare Improvement that had a "100,000 Lives Campaign." It basically challenged hospitals to adopt six basic measures of care and best practices.

In June '06, the first results from this study were released. It involved 3,000 participating hospitals, which represents three out of four acute beds in the hospital community in the United States. The estimates of savings from this program in two-and-a-half years are that 120,000 lives were saved over 18 months. That is literally unprecedented in U.S. medical history.

A second study, Johns Hopkins University right here in our backyard. The focus of their guidelines was on reducing hospital-acquired infections responsible for the death of approximately 90,000 Americans each year. This study involved only 68 participating hospitals with estimated six-month savings of 1,500 lives and \$165 million. If anybody wants the source of that, I'll be happy to give it to you later. I have got it footnoted here, and you can check it out for yourself.

Extrapolating from these two studies, is it reasonable to suggest that 2 percent of those 121,500 lives were injured workers? Remember, this is three out of four acute bed hospitals in the United States. If 2 percent of those workers were workers' compensation patients, we just saved 2,430 lives. If 2 percent is too generous for you, go 1 percent – 1,215 lives. Again, do the math anyway you want and estimate what workers' compensation systems without appropriate and modern medical case management protocols cost in lives, poor worker outcomes, wasteful medical expenditures, unnecessary lost time, and incremental permanent partial disability.

Now, let me turn to unnecessary litigation. Unfortunately, it still is driven too frequently in our state systems by imbalances and abuses, by a number of players. You know who they are. In response, largely over the last 15 years, states have heightened or clarified eligibility standards for workers' compensation benefits for injuries and conditions deemed truly to arise out of the employment under the law.

California is a classic example that got rid of mental stress claims because it was abused to the tune of billions of dollars a year, and that and other such horribly subjective conditions such as the impossible-to-determine general condition of aging, for instance. States have been forced to legislatively attempt to curb abuses in litigation by increasing legal burdens of proof, burdens of proof that, frankly, become indefensible and highly litigated because the old standard was often a scintilla of evidence of aggravation of any pre-existing condition. Scintilla basically means a gram necessary to find a case compensable. They have moved to what we view as a more balanced and realistic material or predominant cause standard.

Frankly, from an employer perspective, I think that is fair and balanced "arising out of" standard, and it should be adopted in most situations. But it falls short of a, quote,

“employers pay everything under workers’ comp,” end quote, mentality regardless of the degree of medical causation or off-the-job primary injury or condition origin, where, frankly, employers believe the remedy is under general health or disability plans, not contentious workers’ compensation entitlement battles.

Let me give you two simple examples experienced in our company, and it happens to every employer in the world. You have an admitted prior ACL tear in a knee – sports related or weekend warrior, you name it. You then have a contusion on that same knee in the course of work. Under the old scintilla of evidence standard, you just bought that knee. The new modern law says, employer, you pay for that contusion or bruise. For those who aren’t medically oriented, you pay for the bruise, and the treatment for that bruise, and the disability related to that bruise, but you don’t pay for the knee surgery. It wasn’t a material predominant cause of that knee injury. It was an admitted prior ACL tear, documented on medical records, and a bruise.

A second example: there is a two-day housekeeper pushing a cart with comorbidities of being female, obesity and pregnancy, and she claims bilateral carpal tunnel syndrome. This was compensable in the state of Oklahoma many years ago. Those types of situations have forced legislators to look at the liberal construction and frankly judicial activism around the country. Long frustrated by eroding case law, some states have taken the extraordinary measure to specifically affirm in their statute a strict construction mandate. They do not want elected judges or judges who are advocates deviating from the judicial intent of finding cases that arise out of employment if they do not rise to the statutory predominant or majority cause standard.

Permanent partial disability – I can’t do justice to that. Bottom line, we need to develop common agreement on system objectives. We need objective systems to measure permanency while keeping the system affordable. We don’t need subjective systems that waste unnecessary medical dollars for nonconforming treatment and forensic exams, which all leads to excessive litigation, divisive dueling doctor testimony, none of which improves worker outcomes, and it simultaneously alienates workers and employers.

In closing, I have got a metaphor relating to the current movie, “The Devil Wears Prada.” Incidentally, if you haven’t seen the movie, it sounds like a chick flick, but it’s a good movie. (Laughter.) I enjoyed it thoroughly. Neither legitimately injured workers, honorable employers, or capitalistic insurance companies like Liberty Mutual are the real demons in workers compensation. And as an eternal optimist, here is to hoping the 21st century brings less divisive rhetoric, more enlightened vision, leadership and pragmatic solutions to our morally well intentioned, yet still flawed workers’ compensation systems.

(Applause.)

MS. CLAYTON: Thank you very much, Bob. And now... Ed Welch.

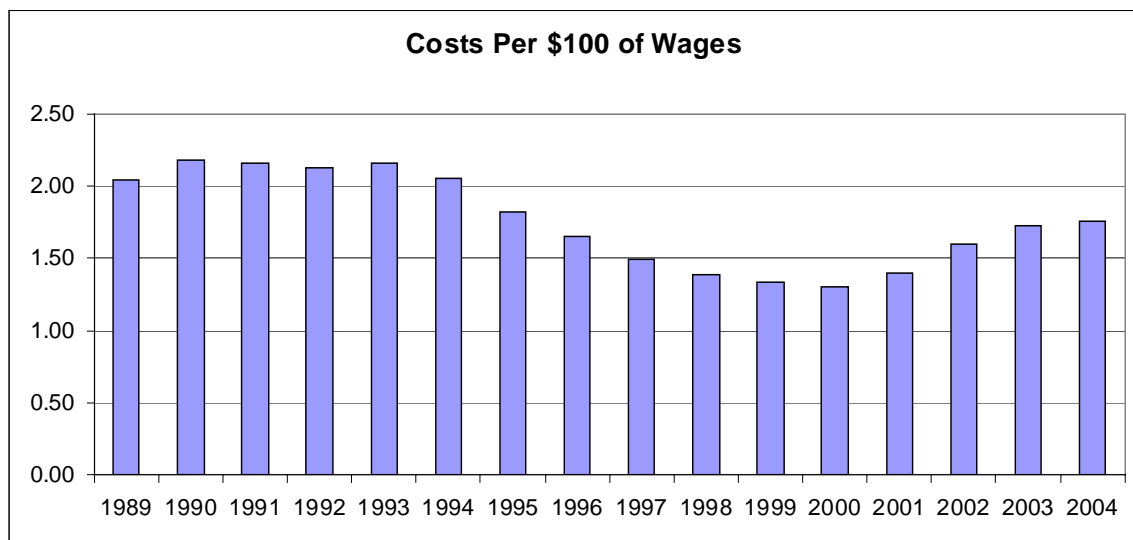
Do Injured Workers Need A Bill of Rights?

Edward Welch, Director, Workers' Compensation Center, Michigan State University

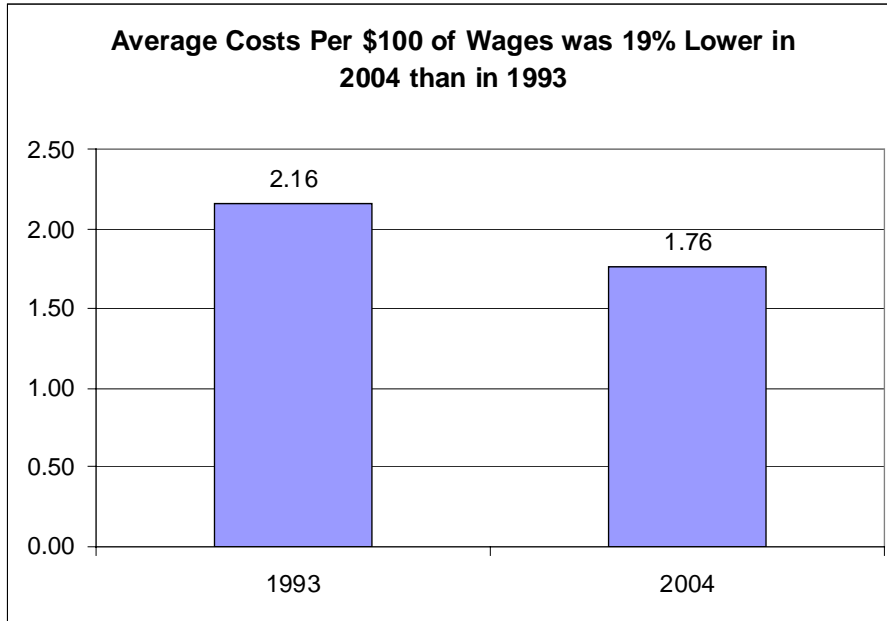
MR. WELCH: Thank you, Ann. I guess I have to go quickly through my 30 slides. (Laughter.)

MR. STEGGERT: You have got 15 minutes.

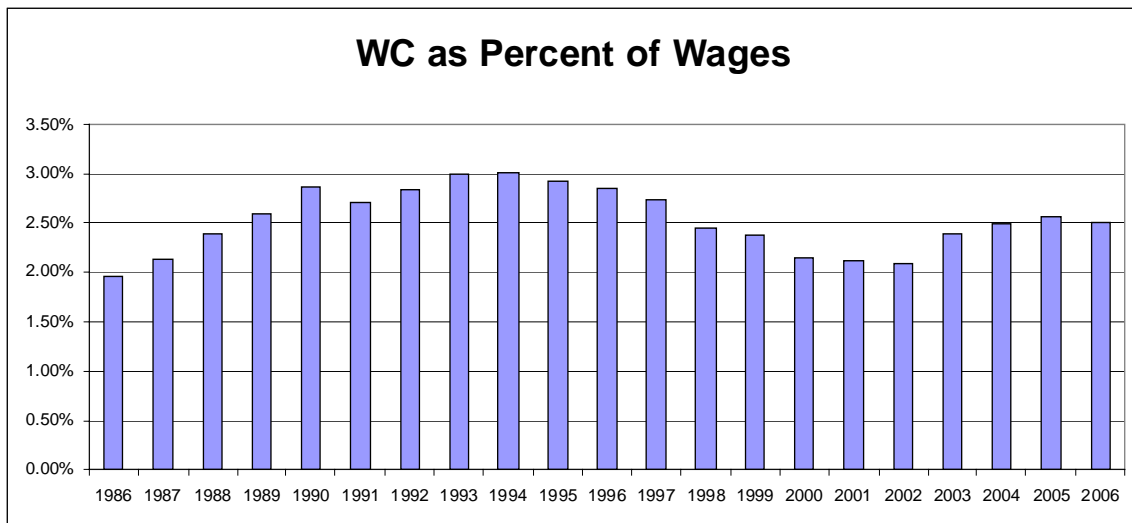
MR. WELCH: The workers' view of the workers' compensation system can be stated very simply. In the last 15 years, employers have done incredibly well, and workers have fared terribly. I'm going to show you several views of costs of workers' compensation.



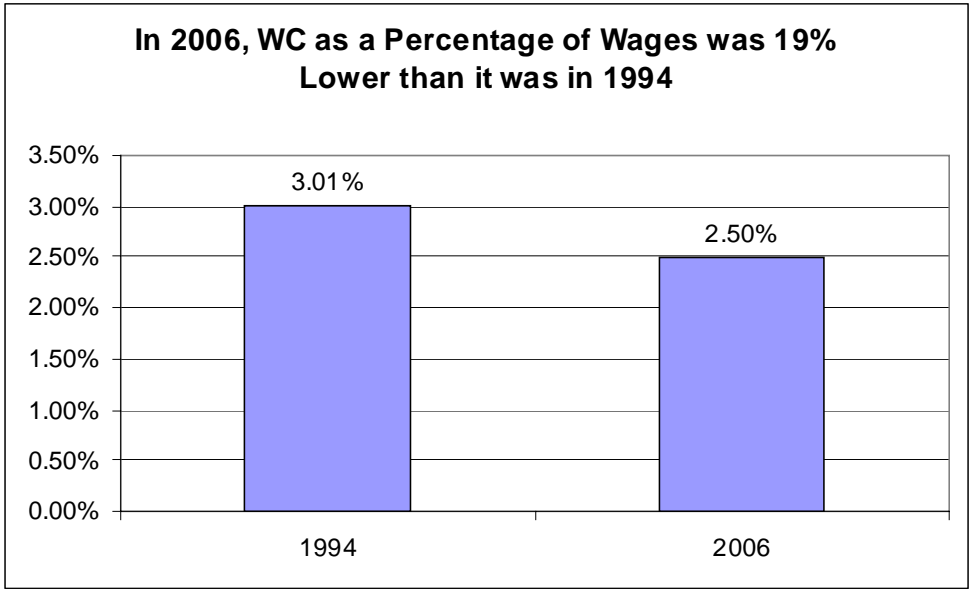
This is a measure of employer costs for workers' compensation published by the academy. (The publication is for sale if you are interested in buying it.) The costs are up slightly in the last few years but down dramatically since the early 1990s.



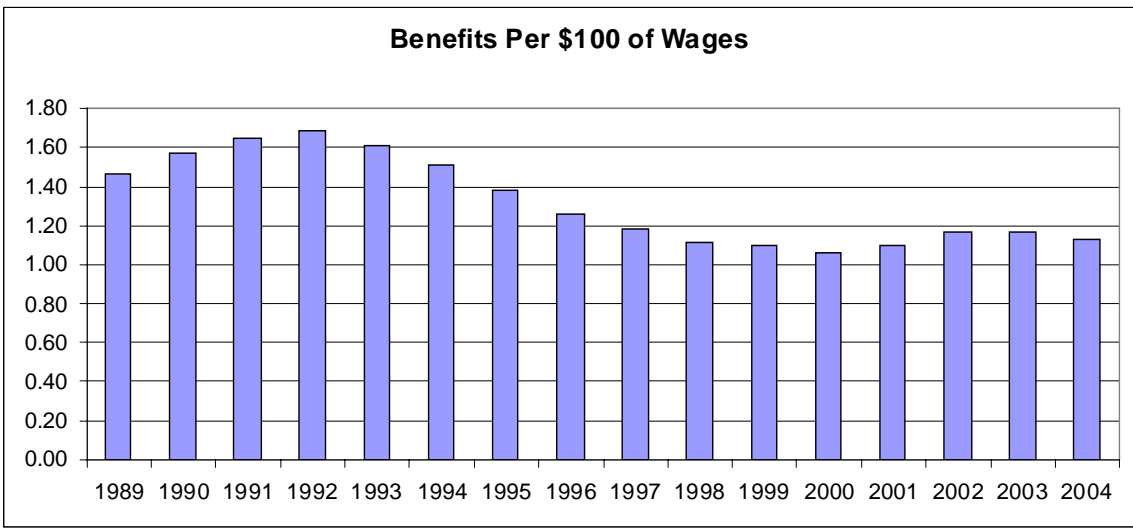
Costs, in the most recent year, 2004, were 19 percent lower than they were in 1993.



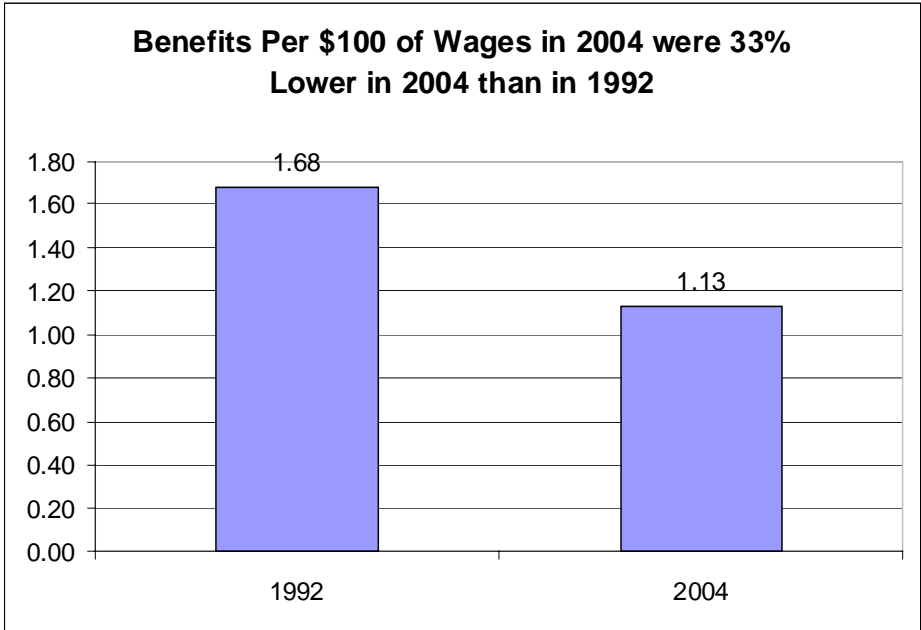
This is another measure of employer costs. It's a survey of the Bureau of Labor Statistics. It is a survey that asks employers what their costs are. Again, we see this same pattern, a high in the early '90s, a dramatic drop to about 2000 and then a slight increase. This series goes through 2006, and it shows that the increase has been reversed, and costs went down in the last year measured.



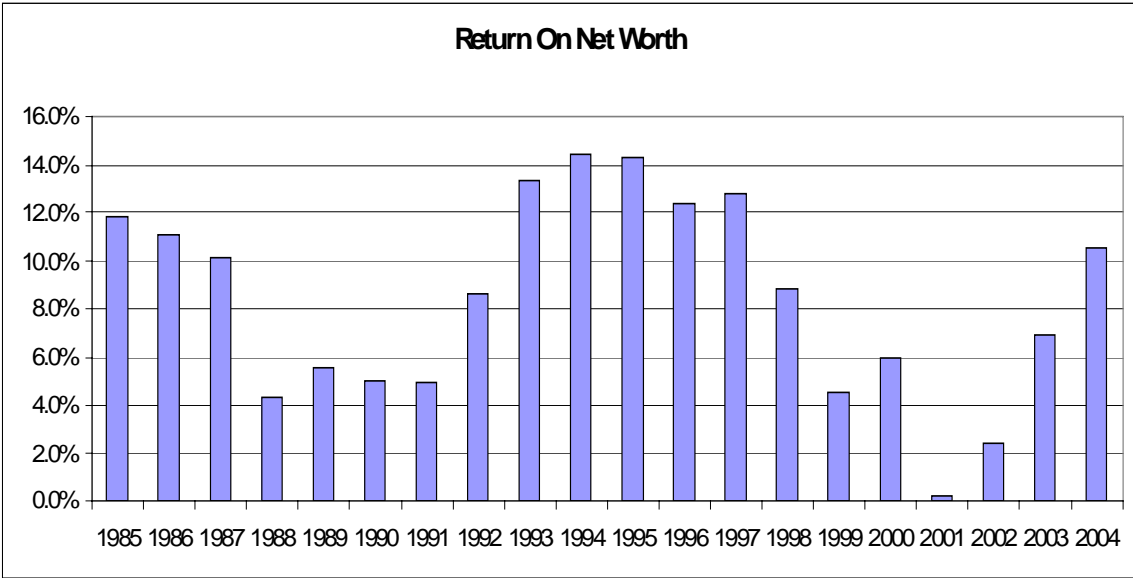
By this measure of employer costs, they are down 19 percent from their high, a little over 10 years ago.



This is another National Academy figure. This is benefits to workers. The pattern is pretty much the same, a high in the early '90s, a drop, a slight increase in the first part of this decade, and a beginning to drop again through 2004. This is benefits paid to workers and healthcare providers.



They are down 33 percent from their highs in the early '90s. What other cost of doing business is 20- to 30-percent lower today than it was 10 years ago?



This is a measure of insurance profits. These are more erratic than the benefits. Part of this, of course, is benefits paid to workers, but it is also a market cycle that has a big influence on this. They are significantly lower than their highs in the mid-'90s, and dramatically higher today than they were a few years ago. Where are they going now? I'll leave that to others who are more informed. In terms of insurance profits, a lot of it has to do with benefits, but there is also a great market influence that affects that.

Employers sometimes respond to these comments by saying, well, costs are down, but they are still too high. And that is a point of view that is probably valid. But the simple answer is employers can control their own workers' compensation cost. We have demonstrated that through research.

And I have to pause a minute and put in a little bit of a commercial here because this is what I do at Michigan State University; we teach employers how to deal individually with their own cost. The traditional approach has been if a worker didn't get benefits, they hired a lawyer and sued. If costs were too high, employers went to legislators and asked them to change the law.

But most employers – and this parallels what Bob was saying – understand that there are things employers can do to control their own costs, through providing good healthcare, through safety, disability management, and good claims management. And we offer a weeklong certificate program for workers' compensation managers dealing with this. Ann Clayton is one of our instructors in that program. So that an employer can legitimately say, well, costs may be down, but my costs are still higher than they should be; I still want to reduce them. And my response to that is there are ways you can reduce costs without taking benefits away from workers.

In workers' compensation in the last 10 to 15 years, employers have done very well and workers have taken the terrible beating. Benefits by every measure are down. I have showed you some trends and I'm going to share with you some anecdotes in a minute. If you listen carefully during a presentation tomorrow, John Burton is going to talk about some research he is about to complete that documents in a more empirical way a tremendous shift in the way workers' compensation benefits and costs are measured and paid in this country.

I think workers need a bill of rights. Undoubtedly, the situation was much more favorable to workers 15 or 20 years ago. And the insurers and the employers said that has got to change, and they convinced everyone that it should change, and I think it's quite clear that it has changed. Those of us who care about workers have to do something to bring that shift back. And I have put this together in terms of a bill of rights, a way of looking at this that I think those of us who are concerned about individuals need to sell to the public and to state legislators.

Workers Should Apply for their Rightful Benefits with Dignity

- "I'm not like all of those other people."**
- Injured workers have a right to their benefits**

The first is that I think workers should be able to apply for their benefits with dignity. Every attorney that I know of has a story that he or she will share that they hear over and over when a worker comes in to apply and says, "I got hurt on the job, my company isn't paying me, will you help me, and the first thing I want to tell you is I'm not like everybody else that applies for workers' compensation. I'm not like all of those other people you hear about on television. I really did get hurt."

Workers gave up their right to sue in return for workers' comp, and we have gotten to a place where they have to apologize to their own attorneys when they want to apply for benefits. This is a right that workers have, and they should be able to go after it

and get it with dignity without being embarrassed by their neighbors or their friends or even their attorneys.

What is the Proper Value to Place on Workplace Injuries and Deaths?

- For 9/11, the average death award was \$2.1 million**
- For 9/11, the average injury claim was \$384,000**
- These figures are about 10 times the average award given to workers who are injured on the job**

What is the proper value of a workplace injury or death? We had this terrible event on 9/11, and as a country, we appointed a commission and sat down and very carefully evaluated what compensation the victims of that awful tragedy should receive. And the average death from 9/11 received \$2.1 million, and the average injury, \$384,000. Now, it's hard to come up with averages across all of the states for workers' compensation, but that is probably 10 times what we pay for the average workplace injury or death. Why were those injuries or deaths worth 10 times the injury or death for an average worker? You can come up with reasons and explanations, but I don't think they were worth more.

Benefit Adequacy

- Most seriously injured workers suffer a large lifelong wage loss that is not replaced by workers' compensation benefits**
- Workers' compensation should replace 80% of the after-tax wage loss for work-related injuries*

There is an impression that workers' fake workers' compensation claims. And you know, it isn't easy to fake; you have to kind of walk that way all of the time and go through all of that. And there is an impression that people do that so they can live very well off of their workers' compensation benefits. Anyone who says that has no idea what it is like to live off of workers' compensation benefits. We should set a goal that worker's compensation will replace 80 percent of the after-tax lifelong wage loss. That is not an unreasonable goal. We should adopt that across the country. I don't think most people would disagree with that as a basic goal.

Defusing Myths

- The widespread belief that workers live well off of workers' compensation is not based on fact**
- States should conduct the research necessary to determine what happens to workers who suffer an on-the-job injury*
- There is a NASI commission report that discusses how to do this**

And as I say, we need to dispute this myth that people do this. We have developed methods and some of the people are represented here today. Christine's organization was a leader in developing this through RAND. The academy has published a study in a book that was edited by Alan Hunt. We know how to do this research. We know how to evaluate it. It has been done in only a handful of states. We need to do it in more states to find out just to what extent workers' compensation is replacing the wages that are lost by workers. And we need to do that.

Cost of Living Allowances

- The purchasing power of workers' compensation benefits erodes as time goes by**
- Workers' compensation benefits should be indexed for increases in the wages*

Every other social welfare system in this country has some provision to protect beneficiaries from inflation. With the exception of Washington, almost no state has anything that protects workers against inflation.

Pre-existing Conditions

- The laws in many states make it harder for a worker to get benefits if he or she works in spite of the presence of some pre-existing weakness**
- No worker should be penalized because he or she works in spite of a pre-existing condition*

Preexisting conditions has been a champion of employers lately. They argue that if you come to the workplace with a preexisting condition and suffer an injury your benefits should be less. In effect, we are punishing people for working in spite of their disabilities, and I don't think we should do that. I think what we want to do in workers' comp is compensate people for their loss of wage-earning capacity. The best measure of a person's wage-earning capacity should be the wages that an employer is willing to pay or was paying at the time of the injury. If the injury, the event that takes place at work, reduces that, then they should get 80-percent-of-the-after-tax value of the loss. It should not be further discounted because they in fact worked in spite of some other disability that they had. But many states have put those provisions in the laws in the last few years, and more would like to add them.

Older Workers

- The laws in some states make it harder for older workers to qualify for benefits and/or reduce the amount of benefits paid to older workers**
- Workers' compensation laws should not discriminate against older workers*

Employers tell me they worry about older workers: "I have this aging workforce. What am I going to do?" In fact, we know pretty well that older workers get injured less

often, but they tend to stay away from work longer, and there are some studies that try to balance those things out. But the message employers are taking to legislators and complaining about is that, “I have an older workforce now; I shouldn’t have to pay them all that will come of workers’ comp.”

Employers never wanted to give any money back to the system when they had a younger workforce when they got the benefit of that. And why is that older men and women are more likely to be injured? Is it perhaps to some extent because they have given their lives, their health and the fluidity of their joints to their employers over years? Yes, perhaps injured workers do stay off of work longer, but I think it ought to be part of the system that they are compensated. We shouldn’t penalize workers because of their age.

Fraud

- Employer fraud adds substantially to the cost of workers’ compensation**
- There should be aggressive procedures for identifying and prosecuting fraud by employers, insurers, and agents. These should include civil and criminal penalties.*

Fraud is a problem. I support the efforts to do away with fraud by claimants. Anyone from an insurance company will tell you that claimant fraud may be more frequent, but it isn’t where the dollars are. The dollars are in employer fraud, in employers who do not accurately report their payroll. And those of you who are insured employers must understand that insurance is a system for spreading the loss, and those of you who accurately report your payroll are paying for the losses experienced by your competitors who cheat in reporting their payroll. We need to have a system that enforces payroll fraud. We need 800 numbers for payroll fraud. We need as much enforcement of payroll fraud as we have gotten over worker fraud in the last few years.

Starving Out Workers

- Many states allow employers to withhold benefits from workers while disputes are resolved**
- Workers’ compensation systems should not allow employers and insurers to starve out workers while they await an adjudication of their rights*

There is an approach – and some of these apply to some states and not to others. But in quite a number of states, employers can literally starve out their claimants. They can deny benefits and not pay anything to workers while workers wait a year or more for a hearing. At that point, workers take settlements and take much less in settlements.

Ann is signaling the time is running out. I’ll go a little faster through some of these.

Pay What You Owe

- **Many states allow employers to withhold from workers benefits that are not disputed**
- *Employers should be required to pay immediately amounts that are clearly owing*

Pay what you owe. In many states, if an employer concedes that it should pay 5 percent disability and the worker wants 10 percent, it can withhold the 5 percent that it concedes in order to make it more difficult.

Penalty for Denying Claims

- **In many states, there is no incentive for employers to pay promptly, and no disincentive for employers to withhold benefits**
- *There should be a penalty for employers who unfairly deny the payment of benefits, and/or an incentive for employers who pay promptly*

There should be a penalty for denying claims. Very few states have any penalty for employers that deny claims.

Prompt Hearings

- **In many states, there is a long delay before hearings can be held**
- *Within 30 days of filing a claim, there should be at least a preliminary hearing, which will determine whether benefits will be paid pending the outcome of the litigation*

We should have prompt hearings so that employers do not wait.

Attorney Fees

- **Most states limit the amount of money a worker can spend on his or her attorney, but put no limit on the amount an employer can spend**
- *All parties to workers' compensation proceedings should have the same access to effective legal representation*

If I were to propose a law saying that if a realtor sues a bank we are going to cap how much a realtor can spend on his or her attorney but the bank can spend as much on its attorney as it wants to, everybody would say that is a denial of due process. In workers' comp, we limit what workers can spend on their attorneys, but do not put any limit on what employers can spend.

Withholding Healthcare

- In many states, employers can withhold healthcare from workers**

- Employers should not be allowed to withhold needed healthcare while a workers' compensation dispute is being litigated*

And in some states, employers can withhold healthcare while they are litigating a claim. That is a terrible and unfair tool to have.

We need to restore balance to the workers' compensation system. Thank you.

(Applause.)

MS. CLAYTON: Thank you very much, Ed. And now the panel members in response: First is Art Wilcox who is not only a past firefighter, but he is also a certified work-comp professional. Art?

Commentary

Art Wilcox, Public Employee Division Director, New York State AFL-CIO

ART WILCOX: Well, I guess what I have to do first of all is try to speed along because I see how the presenters had to go quick, and certainly the responders will have to go even quicker. And this is a tough job because as I look at the panel, it's labor, and that is me, and the rest are all folks who are not labor, with the exception of Ed, who I agree with probably all of what he said this morning. But at the same time, I thought he was a friend until he whispered to me from Michigan in my ear just when we sat down, "we sure took care of those Yankees, didn't we?" (Laughter.) So I think I have no friends on the panel. (Laughter.)

And as Ann said, you know, I'm just a former firefighter; I'm just a union guy. So I am going to try to get through this complex discussion that Bob talked about and seemed to imply that union folks didn't understand, and try to get to the same goal he has, which is getting rid of costs that really don't affect the outcome. But in order to do that, I think I have got to back up. I think we have got to talk about why workers' comp happened, and where the sides are at and what they wanted.

Now, labor didn't want workers' comp. This wasn't our idea. I mean, if we were to read what Gompers said about what labor want, he doesn't mention comp. I think Gompers says, what does labor want? We want more school houses and less jails, more books and less arsenals, more learning and less vice, more leisure and less greed, more justice and less revenge, in fact, more of the opportunity to cultivate our better natures. But he doesn't talk about workers' comp because that wasn't what Gompers wanted. And our state AFL-CIO president in New York, George Meany – both of them were afraid that labor couldn't keep the pressure on legislatively to keep the benefits going to where they had to be. You know, they were right. You know, like what Ed said this morning, they were right.

And what did business want? Business was upset because folks were bringing lawsuits, and in the middle of production cycle, it impacted on their costs unpredictably. Employers wanted a method that got rid of unpredictable costs and replace it instead with an insurance policy that they knew at the beginning of the year how much it was going to cost.

Then we got this other group, because when it was designed, it was an insurance product. And what the insurance industry wanted was an extremely socialized program where everybody was covered, where you could spread the risks, and they wanted a product that had a long tail with small payments over a long period of time so that they could invest and make money during that time period.

Well, let's fast-forward a bit from where labor was in the 19-teens. I mean, all of the sudden we started accepting things like unemployment insurance, Social Security, and they were okay. But one of the factors that was missing in that piece was the vendor. I mean, when we furnish unemployment insurance, we don't hire Liberty Mutual, or

AIG, which is our soon-to-be governor's favorite in New York. They don't bring a vendor in to dispense unemployment checks to workers who are out of work. But for some reason it has been okay in a workers' comp system.

And what has happened with employers in this situation? Employers no longer want predictability; they want to pay less. It is no longer about not being able to be sued in a spike and cost of production; it's about paying less. And as things go on, you know, where has the insurance industry gone? Well, the insurance industry in recent days – and with all due respects to the profit figures, just like banking, they change what they do.

I mean, when we were much younger, when you went to a bank, they loved to have that savings account because they took your savings account, and they gave it to folks in loans and made investment income. But now, banks now are happy to get your checking account. They are happy to get things that have service fees to it.

And so has the insurance industry changed. They have changed now to where they have got all kinds of ancillary companies to make additional profits out of the workers' comp arena to have nothing to do with investment income. I mean, they own IME services; they own durable good network companies and PPO panels that they sell to other folks; they do medical cost reviews for self-insured employers. So the whole system of where the money comes from in insurance has changed. And if you really start to think about it, it's really probably why the pressure on changing what workers' comp is all about is happening.

You know, if we really take a hard look at what is going on with premium, there are a couple of real drivers of this piece that nobody seems to mention. The first thing is – and Ed talked about payroll fraud and people not reporting what they actually pay, but there has been a tremendous growth in an underground economy, some of which is legal, and some of which it isn't legal. And certainly we all know about low-paid workers for whom their employer doesn't bother to pay Social Security or taxes, and certainly not unemployment. But there has also been a tremendous growth of folks who are deemed to be independent contractors, people with high-paying jobs, who no longer pay into the system.

So all of the sudden, that piece of premium is gone. And the other thing that has happened in workers' comp is there has been a tremendous growth in self-insurance. And labor has always been supportive of self-insurance because we always thought that self-insured folks had a real interest in keeping injuries down, and that is what we like. But the other piece that is happening is that good employers to have less injuries that for the most part pay their employees higher also don't pay premium any longer to the process.

So what is happening is there is more and more bad apples in the pot when it comes to premium, and premium is going up. So things have to happen in the legislative arena to push premium down. But it's about loss of premium. It's about the de-

socialization of the workers' comp system, of all of these folks that no longer are covered or pay premium.

So, and I mean, we hear about people that come in with a preexisting condition, and the answer is, well, cut them off. Well, I think the answer is that an independent contractor who comes down with some degree of carpal tunnel as an individual contractor should have been paying some kind of premium all along. And then when they switch to go to work for some other employer later – and I'm getting the two-minute warning – then when they go to work for an employer later, there is some way to go back at the policy that was there previously.

Now, as Ed said, it's not just about the adequacy of benefits; it's also about the accessibility of benefits. And one of the things we see as a real problem in the labor movement, is the consumer really isn't truly identified in the workers' comp system. And what I mean by that is I think we need to take a real look about whether we are going to have a system where carriers that make profit and unneeded cost with no outcome to workers continue to be in this process as they currently are.

I think we need to make a decision whether, one, we decide to let government agencies, through a collection of surcharge for workers' comp, pay benefits and run medical care, or do we start to give employees the option of who their carrier is? I mean, think about it, right now, the only criterion for which insurance company you select is the cost is for the employer.

It has nothing to do with the way you're happy or not happy, but how you were served as an injured worker. So I think either we, one, move to a system where there is a surcharge, like Social Security or unemployment insurance, where a government agency runs and administrates it, or we move to a system where the employees have a choice of carriers, and over a period of time, with information about the performance of the carrier, can decide to stay with that carrier or move to somebody else.

I have been given the signal that time is over. I need to, as a point of personal privilege, just to clarify that in New York, it is not a criminal act to direct medical care by an employer, but it is a criminal act not to tell the employee their rights under the law before you direct the care. And that is a far different than what our employer rep said.

(Applause.)

MS. CLAYTON: Thank you very much, Art. Interesting perspective because the next panel member is in fact the head of a mandatory state fund for the state of Washington. Bob?

Commentary

Bob Malooly, Assistant Director, Washington State Department of Labor and Industries

BOB MALOOLY: Well, thanks, Ann. I don't know if you noticed, but I was sort of stuck sitting between the labor guy from New York and the capitalist insurance company. (Laughter.) It's sort of the position that I find myself in pretty often because that is where we sit in Washington. We are sort of between business and labor. And when I was Chairman of the Industrial Commission in Illinois, I was sort of in that same position. You are between both sides.

And one of the problems that I see in workers' comp is there are lots and lots of good reasons for business and labor to fight. But unfortunately, those fights get so intense that both sides frequently lose the recognition that they have a very, very powerful common interest in making these systems work well.

I have the pleasure of conducting rate hearings around the state every year, and you may know that Washington had a 40-percent rate increase a couple of years ago, just after I came on board. (Laughter.) And it wasn't because of uncontrolled costs; it was because we lowered rates substantially in order to return excess capital to the ratepayers, both the workers who pay into the Washington system and the employers. We returned \$2 billion.

But that was a good excuse for both sides to fight, and I was at a hearing in Mount Vernon, which is north of Seattle, and after the hearing, we usually allow time for discussion. And one woman said, "Whose side are you on?" Since I was the new guy, she wanted to know. And I said, "Well, I'm on neither side; I'm really sort of in the middle." And she said, "No, you have to choose – (laughter) – are you on the side of the employer or are on the side of the injured worker?"

And I really took offense at it because when you think about what is best for workers in these systems, and you think about controlling costs and all of the other kinds of things the employers think about, they are exactly the same thing. You want workers to get good care. They get good care by good physicians. The costs are lower. The residual disability is less. So providing the best benefits and the best care for injured workers really is in the interest of employers. And you back up a step, providing safe work environments that avoid the entire cost is really in the best interests of both sides.

And so I find my job is trying to get both sides to stop fighting and recognize they really have a powerful and common interest. If you want to fight, then you can wind up with these systems not working very well, not serving the interests of workers or employers, and the consequences from an economic perspective – as Bob said, some employers look to workers' comp to make decisions about where they are going to put jobs. You want to keep the high-paid jobs here. So these systems should work together toward that goal because that is key to successful economic outcomes.

And one thing about workers' comp, in mentioning Ed's comments: good news is bad news and bad news is even worse. Success in safety. If you can imagine for a moment if you were driving a car from, maybe the 1960s, and you got in a fairly serious accident, back when they had the chrome knobs sticking out of the radio and all kinds of hazards and everything designed into the car: no airbags, no safety belts, none of that stuff, no crash zones.

Well, how many workers are killed on the job driving? And when you think about improved safety, not only the deaths that are avoided because of the design of cars, but think of the orthopedic surgeons that are getting less work as a consequence of safer automobiles. Well, that is good news for the general driving population. It is good news for workers, and it drives down costs.

So if you look at declining costs in this system and say that is bad news, if it is driven by increased safety, better healthcare, and better return to work, that is good news; it's not bad news. And so we really need to understand the complex interactions here when we are making assessments about what this system is doing. Washington has a 38-percent decline in claims. Why? How much is due to better safety? We think that there is some discouraging of filing claims, and that is a problem. We want people who are injured to file claims, but I think most of it is driven by improved safety in the system.

And we talk about healthcare for a minute. One thing you don't want to do is make your health policy decisions using a trial-lawyer mode. You know, I dealt with a lot of trial lawyers when I was running the workers' comp court in Illinois, and for individual rights, trial lawyers are great. Under workers' comp, you know, this person was helped; focusing on that individual worker, the trial lawyer, doing what they are supposed to do, says, "Pay my guy."

But if you looked at that technology from a broader perspective and said some people are helped. Maybe it's a placebo effect for some folks. For some people, they were lucky. The technology really helped them. But on the other end of the spectrum, you have workers who might be dying from it. Long-acting opioids, we have had 60 workers killed in the course of about three years from overdoses in Washington state. We have set healthcare policy using evidence-based medicine. What is the whole story? Not just what one trial lawyer's client story is, but what is the whole story? And if we use evidence-based medicine, we will pay for things that help, and stop paying for things that harm.

You know, we have all kinds of controversy about spinal fusions and all of that sort of stuff. Well, really what is helping injured workers on balance? When you can't tell in advance who is going to be helped and who is going to be hurt, what should we do? And those are very, very difficult positions that are very easily criticized. And I think evidence-based medicine is one very powerful tool.

And the other tool I think is strategic medical payments. I think Bob mentioned hospital-acquired infections. I think the accountants are the key to that. And accountants

don't have many opportunities to save people's lives, but I think you could design a system where the accountants would save people's lives. And when you think about hospital-acquired infections, a lot of them are simply because people don't wash their hands.

And if we had a strategic payment system that said if somebody goes into the hospital, for surgical procedure, and they come out without an infection, we will pay them more for that whole episode of care, not a lot more, just a little more. If somebody goes in and winds up with a hospital-acquired infection, pay them less, and I'll bet you you'll have the accountants running around the hospital making sure everybody washes their hands. That is what we are trying to do with workers' comp in Washington. We want the best orthopedic surgeons to be willing to treat injured workers because those are the guys that are busy, and those are the guys that will say, "look, I'm the best in this business, and I don't think surgery is going to help you."

Now, how much more valuable is that opinion than a surgeon that is having trouble filling up his surgery calendar? You know, when you want good outcomes from injured workers, it means that you have to be able to get the best docs willing to treat, and we are really trying to do a lot to cut down the hassles, the time and delay in the system that are driving out the best providers. We want to pay those guys more so the injured workers get the benefit of it.

And Ann is telling me I have got to leave here – (laughter) – so my closing message is focus on the common interest because that is the key to success in this program. Thank you.

(Applause.)

MS. CLAYTON: Thank you, Bob. And now, last, we have Paul Rodliff.

Commentary

Paul Rodliff, Senior Vice President, Liberty Mutual Insurance Company

PAUL RODLIFF: I may be given signal as soon as I step up here, given how much time we have taken. Thank you. There were a couple of kind comments about Liberty Mutual, and I would remind all of you that we do sell workers' compensation insurance if you're in the buyers market, and that we are also the seventh-largest writer of personalized insurance, so all of you, I'm sure, buy auto and home. So take those kind comments as a reflection of what our organization is all about.

The good news I guess is that I'll go quickly. If you look at the first four bullets, I guess you would say that all of the constituencies agree on certain things. A good comp system should have fair benefits. The incentives embedded in the system should reward good behaviors for all of the players. Access to quality care is critical and there should be an efficient process for handling claims and resolving disputes.

The two parts that are probably unique to an insurer's perspective on this slide is that we do like stability and predictability in our business. And if you think about it, we write a policy and we try to kind of guess what the costs ultimately will be. Most people in a business know their costs and price their product accordingly. We are in a business where in some regards we don't know our costs.

I happened to be in California selling insurance from the years 1998 to 2001, and those were very bad years, which led to California insurers going insolvent. And at the time, we were putting out rate increases of 40, 50, and 60 percent. It is not good to go to an employer and ask them to pay that kind of rate increase. And now you see rate decreases of significant amounts in California. So there is predictability about our business that is good for all of the players, I believe, and we like that.

And finally, you might be surprised that we like competitive marketplaces, but we do. And when you see residual markets getting up to 25 or 30 percent of the market share – I won't make any comments about state funds; I'll keep that out of it –there is an issue about having plenty of competition in the marketplace, and we are all in favor of it; we don't mind competing.

I'm going to give you some observations on some data, and we'll have the benefit again of knowing where everybody was going. But I think if I was sitting in the room after a few slides that I do, maybe there will be some interesting confusion, if nothing else.

Let me just say that the Bureau of Labor Statistics has been reporting workplace injury rates since the 1970s, well over 30 years ago. Workplace injury rates are at the lowest point in that 30-year period. That has an influence on the cost in the system. And I'll show you some data. But the next point about what we are paying on a per-claim basis to individuals for both wage replacement indemnity and medical benefits is outpacing some of the baseline indicators of both wage and medical inflation.

So as I said, if you look back over 1992 to 2005, workplace loss time accidents are down 40 percent. This is a good thing. I don't know how something like this becomes a bad thing in our business. Employers should be congratulated; employees should be congratulated. There are a lot of reasons for this but the reality is there has been over a 40-percent decline. It's pervasive.

If somebody wants to tell you the reason for this, it's across every state, it's across all industries, and it's across claim types. There are a host of reasons why, but for instance, we are safer in our cars, we are safer in our homes, we are safer in our businesses. So before you go to any conclusions that the reason why you have seen this decade-long trend in reduction of frequency, take into account the pervasiveness of it.

It can't be because there are bad employers out there, here and there. You would have to have every employer across every state and every industry to say, you know what, let's stick it to somebody. To me it doesn't make any sense. If you look at core wage inflation and you look what the benefit costs per claim, again, everybody agrees there are less aggregate costs in the system today. I would suggest it's a good thing.

If you look at it on a per-claim basis, over the last 10 years, wage inflation is up about 33 percent, so three-and-a-half percent a year or so. At the same time, we can't pay on anything else other than the claims we have, so I don't know what else you measure it on. But benefit replacement costs per claim are up 80 percent over that period of time. Medical costs are part of the benefit. I don't know if the providers are bad. You know, when we all know what is happening on the group side and why things like Medicare are threatened from a solvency point of view. Medical CPI in the last 10 years is up 42 percent. Medical benefits paid on behalf of the injured worker are up 125 percent over that 10-year period.

So, not surprisingly, we have some concerns. And, again, most of these have been mentioned: high growth and medical costs. Workers' comp is unlimited medical. It's lifetime medical. Let's put it this way, there are no insurance products sold today that have no limits or caps and are lifetime in their nature. Workers' comp is. We sell a product today. We charge it today's prices. If medical inflation is 10 percent a year and we have to provide treatment to that injured worker 40 years from now, you can do the math. Yeah, long-tail line of insurance is a good thing except when medical inflation rocks along at the kind of increases we have seen.

Prescription drugs. I would make one particular point here. In the state of California, provider-dispensed prescriptions drugs are 36 percent of the costs. In the rest of the country, it's 3 percent. You can go on websites in California by these folks that are pushing how doctors can make money by prescribing drugs out of their offices. The websites boldly state that you can make a hundred thousand dollars a year by giving that person that prescription in your office rather than sending them to the Walgreen's down the street. And they are very bold. They say, "hey, if it's worker's comp, we can charge two or three times what the same drug would be down the street." So just a little area we might have to address.

Finally, one concern probably not raised by other people is catastrophic events. Again, there is not another insurance product in the marketplace that you write with no exclusions and no limits. So needless to say the industry does look at issues of catastrophic events and that is why you hear a lot of talks about TRIA and federal back stubs.

My last slide: suggestions of regulations that I think are win-win. You have heard so many divergent points of view. At some point, we all believe in the fundamentals of this system, but why are we so divergent in how we go about crafting the right system so that everybody is well served? Here are some things that, in my experience, work in various states.

One, why you don't pay some benefits right away? Because in many states, you make that first benefit payment, you own that case, and so you better be real sure. And in many states, you have to make that decision within 14 days. You go look at some files where somebody has a heart attack at work and try to figure out within 14 days whether that heart attack is compensable or not. That is a tough job.

States that allow pay-without-prejudice periods essentially say for 90 days or 180 days you can in fact pay somebody, which is probably the right thing to do in many instances, but you're not on the hook indefinitely. If during that 90-day period you have the opportunity to obtain the evidence that says this is not a work-related injury, you then can stop the benefits. You are not on the hook then to apply and wait a year-and-a-half to do that. So pay-without-prejudice periods I think reduce litigation, do get benefits to injured workers more timely, but it protects the employer/insurer from buying a case prematurely.

The rest of it, we have talked about PPD ratings. And, again, I would just echo that there is a lot of science about this and shame on us if we don't use the science of the day. With the AMA and the ACOEM guidelines, there is enough science on this to figure out what really should be appropriate disability ratings.

Other than that, I think you have heard this stuff from other speakers. So I would say that the treatment within networks that the HCN and healthcare networks in Texas and the NPN medical provider networks in California from our perspective are great solutions to providing adequate quality medical care and at the same time taking a shot at controlling costs. Thank you.

(Applause.)

Discussion

MS. CLAYTON: We have purposefully left plenty of time for questions and discussion. One of the purposes of the day is to stimulate discussion and maybe even some new ideas or problem solving. I think that you have gotten plenty of issues raised by the speakers and the panel members about current workers' compensation, what is happening, and their perspectives on that. We now open the floor to questions. I would encourage you to come to a microphone because we are recording the sessions and that way we'll hear your question; everyone will hear your question. So open it up to questions, comments.

Q: It's more comments than questions because I am a physician. I don't know how many other doctors there are in the room. I practiced occupational medicine for 25 years trying to get benefits for people with occupational disease rather than injury. I also worked for a large hospital here in D.C. doing employee health and workers' comp. So I have the medical perspective.

And so I was writing down all of these things that everybody said that showed you knew nothing about the practice of medicine. There are two things I want to say, which is that evidence-based care sounds like a great idea, but it's amazing how much medicine we practice without any evidence on which to base it. And so, if you say we're going to just provide medical care based on what we know is good care, you're going to stop providing a lot of care, workers' comp and everything else.

Now, it's absolutely true that a lot of hospitals and providers don't treat to the evidence, and we do have evidence for treatment of stroke, treatment of coronary disease, treatment of risk factors like hypertension and high cholesterol, and you may be familiar with the Cochran review system, which is doing a wonderful job of going through specific diseases and really developing the evidence base. But it takes a couple of years for each condition.

So I think in the area of workers' comp, there is a good deal of evidence of work-related injuries and still much debate about treatment of back injuries, most of which says we don't really know how we can help these people. That is not at that helpful if you want to be a provider or you want to get the people back to work. But a lot of the other orthopedic injuries, there isn't a lot of evidence. So I caution people and say, "well, the problem is we're not using evidence-based care."

But I do think the approach of using the most experienced physicians gets you expert-based care, which is probably the next-best thing to evidence-based care. So that is just the doctor perspective. It's like the difference between pay-for-performance and pay-for-expertise. And if you're rewriting workers' comp systems, paying people more if they don't get a hospital-acquired infection makes sense. Medical societies are trying to deal with it, as are the insurance companies and Medicare.

MS. CLAYTON: Thank you for your comments. Any of the panel members want to address –

MR. STEGGERT: I have got one. Evidence-based medicine is absolutely not the panacea, and as ACOEM particularly acknowledges, there might be good reasons to deviate for patient outcome or reasons. In my view, all this evidence-based medicine does is ask the physician to document the whys and wherefores, and give the payer a responsible position to make a determination.

As respects such things – and every condition obviously is not addressed in terms of acute stages down the road, and there are certainly difficult aspects to address. But, for instance, in the area of intervertebral discs that are still experimental in certain circumstances, we have got experience for recommendation for back surgeries for artificial disks. In some circumstances we approve it; in some circumstances we don't approve it. If a peer-reviewed physician backs it up and says in this circumstance it's appropriate; we pay for it. If it's not, then we take a tough decision and don't pay for it.

So it's clearly not a panacea, but it's better than doing doctors and systems where you don't have any checks and balances on quality and the purchasing of medical services.

MR. WELCH: I think also you have to understand the level that we are dealing with. I had a colleague who hurt her back, went to her family doctor and he told she needed bed rest for three days. Okay, there are still physicians out there that these people are paying to give bad advice like that, and they are just very frustrated trying to raise that level of care.

MS. CLAYTON: Yes? And please introduce yourselves.

Q: I am Bob Aurbach.

Several of the panel members have noted my interest over the years in reforming the federal bankruptcy's treatment of workers' compensation, but I don't think I have ever had a chance to talk to either Art or Ed about it. And, Ed, I noticed with regards to your bill of rights, you had expressed concern about the starve out of injured workers that sometimes occurs. I'm just wondering whether you and Art had considered the de facto starve out that occurs every time a self-insured employer goes into bankruptcy protection and leaves the worker to the general administrations of the bankruptcy system.

MR. WELCH: Oh, sure – (laughter) – that is an issue; that is a problem. I guess I would say, Bob, that Bruno gets enough extra security that we don't do that, but if Delphi goes under, everything falls apart in Michigan. Insolvency of self-insured employers and the ability to get repayment through the bankruptcy system is a continuing problem that I agree we have to deal with.

MR. WILCOX: And I agree that most workers' comp boards have power that they don't utilize today. Some have it administratively. Some might need new legislation to do it. But I feel that once a case is decided, and there are periodic payments into the future, that those reserves should be put some place where they are then safe from bankruptcies, whether it be a fund within state government, but some place where that workers' payment wouldn't be impacted by a bankruptcy.

Q: There is a live proposal for reform of the federal bankruptcy code with some surgical language that does address that.

MS. CLAYTON: Thank you, Bob. That is okay, Doug, and then we will come to Peter.

Q: Doug Kim with the Applicants' Attorneys Association in California. I have two questions, one for my good friend, Bob Steggert; the second for the gentleman from liberty.

You both indicated that you think that the causation standard for compensability should be increased to predominant causation or some such. That goes against the exclusive remedy bargain. If you want to have a higher causation standard, would you support civil damages for negligence against employers?

And my second question for Rodliff is you indicated this staggering long-term trend in decline and claims frequency. You attributed part of that to better safety in the workplace. I hope that is true. I just wondered if you were familiar with a Los Angeles Times series about three years or four years ago that indicated the decline in claims frequency was in large part due to a national campaign by the industry to depict all claimants as frauds. And secondly, I was recall there was a study done by the state of Minnesota presented at an IAIBC conference a few years ago, which indicated that in that state, there was a precipitous decline in claims frequency following an extended media campaign on the issue of workers' compensation fraud. Thank you.

MS. CLAYTON: I think the first question went to Bob.

MR. STEGGERT: Okay, Doug, to address your question on predominant cause, as you know, in a lot of states they don't address that necessarily across the spectrum of all injuries; they do it in subcategories in many cases. In California, as you know, they had the mental-mental abuse stress claims that they threw out entirely. Other jurisdictions have elected to address it by the more subjective injury claims that relate to aging workers or other circumstances. Obviously, if you have an acute fracture arising out of work, that is compensable in all jurisdictions. That doesn't require a predominant cause finding it; it is compensable on a de facto basis.

As to supporting civil damages, when a state has made a carefully balanced public policy decision for entitlement under workers' comp and civil damages, no, I do not support a tort remedy there. Exclusive remedy is the remedy, and unfortunately, if it is

not payable under the workers' comp system because of a public policy decision of what is appropriately payable and what is defined under the law as a rising-out employment, there should not be tort liability to employers or insurers.

MS. CLAYTON: And Paul?

MR. RODLIFF: The predominant cause issue. I think you just have to recognize again that people are living longer, there is an aging workforce, there is this question about co-morbid conditions and how much of it do you owe, and you are operating in the environment where medical is lifetime medical.

We took a look at the top-one percent of our claims that on average were about \$600,000 in medical care. Well over a third of those claims were soft-tissue injury claims, but every single one of them had significant co-morbid conditions around hypertension, diabetes, and psychosocial issues. There becomes a point where what is the obligation to – for the life of that individual to treat it in its entirety and you get away from a low back strain. At a point, low back strains resolve, yet there is plenty of cases where 10 and 20 years later, with no surgery, no radical interventions, but lots of pain management, these cases become incredibly costly.

So it's a difficult issue. I don't mean to imply it's a simple one to say how do you get to this point where you say benefits associated with the industrial injury are resolved and ongoing disability is related to a general aging process, in co-morbid conditions. These are difficult issues, but you have got to give some relief to the employer community and not just have it that they continue to pay; the person who is disabled continue to pay. I just think that that is a system that will eventually go bankrupt.

The second issue is, no, I'm not familiar with the L.A. Times series. I was out of California by then. So I'm not familiar with it at all.

MS. CLAYTON: We have two other panel members that would like to comment on the questions. Art and then Ed.

MR. WILCOX: I'll take the second question first, and that is the issue of the decline of injuries. I'm a member of the New York state rating board. And what we have been told is that although there has been a decline in injuries, there has been an increase in severity. And if folks in the room from various states think about it, it's not just about an increase in severity. In recent years there has been legislation in a lot of states that no longer require you to report band-aid injuries. So the minor injuries are falling off the chart; the more major injuries are staying there, so of course there is an appearance that the injuries are more severe.

And the other thing on the predominance of evidence on the injury, I mean, either we are going to have a system that really is an insurance product or we are not going to have it. I mean, if I was to buy life insurance for someone and somebody died and it took me a year of hearings to get the benefit, I would think sooner or later I would say we are

not going to buy from that company any longer. And if I was to buy auto-insurance, and they would say, no, go to the junkyard and get your parts because we don't want you to get them from the new rack, I would think sooner or later I would say no to that carrier.

And if I was to buy disability insurance, and it wouldn't pay me, and I have to fight all of the way through the process to get paid, I think I would say I don't care how much that damn duck quacks on TV, I'm not going to buy the product. So either we are going to have an insurance line that really delivers or we have got to change the system.

MR. WELCH: If I can just comment. Paul suggested that part of the decrease in injury frequency is due to a real decrease in fewer workplace injuries, and he's undoubtedly correct about that. Doug suggests that part of the decrease in reported injuries is a decrease in who reports injuries and how we define a work-related injury, and Doug is undoubtedly correct as well. The question is how much is attributable to which and I think John has taken a very important step in trying to describe that. There are other ways we could examine that.

There is, for example, a national survey that asks a sample of Americans if they had healthcare expenditures that were related to a workplace injury. We could compare those responses to workers' comp claims, and there are probably five or six of us in this room, who, if you would give a grant to any of us, we would help you find some answers to that.

MS. CLAYTON: Okay, Peter, I think you were next, and we'll come to you, Bill.

Q: My name is Peter Rousmaniere. I would like to pick up on a really interesting observation by Mr. Wilcox, and then direct a question to Mr. Rodliff, and that is, Mr. Wilcox, your comment, which, if I got it correctly, is that we are going through in effect the de-socialization of risk. Now, we all know that it has, from the very beginning there were a lot of risks that were outside of the system; for example, agriculture. But we are now faced in 2006 with an increase in risks, which are not being covered.

One is the co-morbidity, which gets awfully complicated. And I would agree the quacking-duck scenario is exactly right. It may look like an insurance policy, but it doesn't seem to be; there is something wrong with it. There are no villains here. But I think the more pressing issue has to do with disease. And the most pressing issue has to do with disease is the greatest occupational tragedy we have had, well, since asbestos, and that is the World Trade Center cleanup workers. There were no heroes there, except for a few, and from – I have done some research on that, and by the way, the AFL-CIO is one of the few heroes in this tragedy.

Mr. Rodliff, if I were to accept all of the statements that you have made about the system working and the system that needs improving, how would you approach what appears to be an extremely large gap in the system in covering disease, particularly in the context that looking forward, if anything, we are going to see a much greater increase in disease issues than in acute injuries?

MR. RODLIFF: Occupational disease is a tough issue. And how to close a gap? I'm not sure; we would have to have a discussion about those diseases and so forth. One of the things that we do in our organization at least is we know we have industrial hygiene, and we get out to our employers' work places, and we do air samples, and quality samples around the workplace environment. So where the gaps are in the occupational disease coverage – most states – again, my recollection is provide three years for somebody to bring that – an occupational disease claim. So you would have to be a little more specific as to the gaps that exist in the workers' comp arena where somebody doesn't have a chance to bring that occupational disease claim.

Q: I'm not an expert on New York, but what seems to have happened was there is a massive collapse of the system, and that you cannot solve it by fine-tuning a few sentences in law, or fine-tuning court procedure. The system was never designed to handle this scale of disease. So we are getting with co-morbidities one obese body after another. Here we have 40,000 workers, and if you socialize the cost of these injuries, you probably double the cost of workers' comp in the state.

MR. RODLIFF: Yeah, I think if you look at the issues around the World Trade Center, you might find it's tort litigation that is underlying that, not workers' comp litigation.

MR. WILCOX: As an expert from New York, I don't think that is completely true. I mean, tort is an issue. Let's say this. First of all, you talked about heroes of the World Trade Center, and cleanup and rescue and recovery, and you gave some credit to the state AFL-CIO, and the AFL- – the gentleman in the back of the room, Bob Snashall, was the Chairman of the Workers' Comp Board when that happened, and I truly believe he is one of the heroes of the World Trade Center, for what he did with the injuries that happened within a very short period of the collapse. The fatalities and the injuries that happened in the first 48 hours have been fairly well taken care of by a board that became very involved in the case.

But what has happened is there are a lot of occupational disease cases that happened and are coming up now, and that the system just has not worked well with. And the case load that has been developed in New York on incidental exposures to toxics made it so that even deputy mayors who were high up in the chain couldn't get taken care of under the workers' comp system. And we have done some real little fixes, but as you said, there is going to have to be a lot of other fixes done in this system to make it reactive and comply with the World Trade Center folks.

So it's a work in progress. I think it's been a good job on the injuries and deaths that happened immediately, but a lot of things need to be done on the diseases because the system just doesn't match up well to take care of disease in New York.

MS. CLAYTON: Thank you. I don't want to mislead the audience either in leading them to think that all of the discussions and issues in New York are all related to 9/11. They are not necessarily. So, Bill.

Q: My name is Bill Zachry. I wear several hats. I would like to clarify a few things if I may. First of all, as the Chairman of the Fraud Commission for the state of California, 26 percent of the arrests made in the last fiscal year were injured workers. The rest were employers and medical providers. And frankly, one thing that was missed in the presentation is that one of the major cost drivers in the system is the fraud coming out of the medical providers. I believe Paul talked a little bit about the repackaging problem for which there are regulations that will stop that, and those regulations are in progress now. But I think you're missing a great cost-driver when you don't talk about medical provider fraud, which is pretty rampant.

The other comment that was made earlier was the self-insureds who may go into bankruptcy. Well, as a self-insured, I'm also on the board of directors for something called the Self-Insured Security Fund in California. And we were put in place when Cal-Can went under about 20 or 25 years ago. And to my knowledge, we have never missed a payment in the entire time that the self-insured security fund has been in place in terms of making sure that injured workers get their payments. We also provide a significant amount of money in security coverage so that when we go under, there is money in place to pay those benefits. I don't know of any state that I do business in where we don't have to have that money in place.

And so I am a little surprised that that is such a huge issue. Maybe there are states that I'm not aware of, but I don't think that is a big problem, frankly, and we can talk about that later.

But the other thing I thought was very interesting. I think that Ed, you, started your commentary by saying that the injured workers have really lost out in the system. And if you look at the increase in the benefits that have been paid on the individual cases, yeah, you are going to have an aggregate drop because there has been a drop in frequency, but I don't think that the injured workers necessarily are getting a short end of the deal. I think they are getting a good end of the deal if we are seeing a significant reduction in frequency, and that is where the focus has to be. And, yes, we need an adequacy of benefits on the other side, but I think that your presentation wasn't necessarily taking into account the overall reduction in the frequency of claims.

MR. WELCH: Well, you know, as I said, I think part of the reduction is a real reduction in real injuries, and that is a good thing for everybody. But part of what is driving the reduction in frequency is that we have changed the definition of what injuries are compensable in many states and that fewer claims are reported today. But I don't in general disagree there is a balance, and there is a question about that. We do have the tools to know the extent to which we are replacing wage loss. You have done that in California, but most states haven't looked at that.

MS. CLAYTON: We really need much more time, but we have none. It's 10:15. I would like to tell you that we are going to take a 15-minute break, and come back. I want to thank all of the panel members, and please help me do that.

(Applause.)

And lastly, in closing, hopefully you all have mentioned in your notes, as well as I have, that there are a number of things that all of these panel members support as far as being a fair and effective workers' compensation system. If we could just all get together to create one. Thank you all very much.

(Applause.)

(End of panel.)

Panel II: Issues and Innovations in Wage-Replacement Benefits

Introductions

Virginia P. Reno, Vice President for Income Security, NASI

VIRGINIA RENO: If everyone will take his or her seat, we can get started with our second session. Welcome to our second session at this symposium, *Health and Income Security for Injured Workers*. I'm Virginia Reno. I'm Vice President for Income Security at the National Academy of Social Insurance.

For this session, we have two presenters and then two panelists who will be reacting to what they've heard. Our first speaker is Allan Hunt. He is the Assistant Executive Director of the W.E. Upjohn Institute for Employment Research in Kalamazoo, Michigan. He has done extensive research on disability and worker's compensation. He chaired our Academy's study panel on adequacy of worker's compensation wage replacement benefits. And that report now is available from the Upjohn Institute Live Example. And his presentation will address exactly that question. That is, how adequately do benefits replace lost wages for injured workers?

Our second presenter was to be Bob Reville who is the director of the Institute for Civil Justice at RAND. He unfortunately is suffering a job-related illness and is not able to be with us today. And furthermore, that illness is not compensable under worker's comp, because the job is being a dad; his kid brought home germs from daycare that has laid him absolutely low. But we are fortunate that in his place, we have Frank Neuhauser who worked with Bob Reville on the research they have done assessing the worker's compensation changes in disability benefits in California.

Frank is on the faculty of the University of California at Berkeley at the Survey Research Center. His research covers a range of issues on worker's compensation, occupational safety, services for the aging, and benefit forecasts for the state of California. He will present the new research on the California methods for compensating partial disabilities in that state following the reforms.

And here, I would just like to make a personal comment. I came to worker's compensation white-eyed and innocent, but with a background in Social Security disability. Social Security is very different from worker's comp. It pays only for long-term disabilities that generally preclude gainful work. Worker's comp does two very important other things. First, it pays for temporary disability when workers are unable to go to work at all for a few weeks because of a condition that is expected to be cured and they will go back to their regular jobs.

Also, unlike Social Security, worker's comp pays what it calls permanent partial disability. It's the largest cost segment of the worker's compensation cash benefit program. In this case, workers reach their maximum medical improvement, but they have some residual loss in terms of impairment or earning capacity, and this is one of the most contentious and expensive parts of worker's comp, because that partial disability

can be anywhere from 1 or 2 percent to 99.5 percent, so the range is huge. And trying to figure out where in that range a particular worker fits is exceedingly difficult. I know for many of you in worker's comp this is obvious and old hat. For people who don't know comp, this is new.

Commenting on our two presenters are two panelists. First, Angie Wei. She is the legislative director for the California Labor Federation with the AFL-CIO. Her state federation represents about 1,200 unions and over 2 million workers in collective bargaining agreements. She also served on the California Commission on Health, Safety, and Worker's Compensation. William Zachry is the vice president for corporate worker's compensation for Safeway, Inc. He oversees the nationwide self-insured and self-administered worker's comp for Safeway. He is also chair, as he mentioned in the first session, of the California Fraud Assessment Commission.

More complete bios for all of our speakers are in your folders, and just to do a little commercial for what is in there, the bios are the blue sheets and they tell a little bit more about each speaker. The green is an evaluation form and we hope that you are filling this out as the symposium goes along, because we really do rely on the information in these to plan future events. One of the key questions on the back is what other issues might it be useful to have this kind of seminar focus on.

And before I give up my chance to do commercials, two other items in the packet are the orange is the latest of the annual reports that our academy does on worker's compensation, benefits, costs, and coverage. This is just a piece of it. The real thing is yellow and it's available on our website. And a new innovation this year, we have a state-level brief on the state of California, and it provides the data we produce and compares the state to the national trends. And one of the interesting things you find here is that California in the most recent year is between 20 and 25 percent of total benefit spending on worker's comp, so it's big and it's important.

Without further ado, I would like to turn it over to Alan, and then each speaker will go in turn.

How Adequately do Benefits Replace Lost Wages for Injured Workers? Allan Hunt, Assistant Executive Director, Upjohn Institute for Employment Research

ALLAN HUNT: Thank you, Virginia.

I have a couple of preparatory comments that I want to make. First, after 30 years in this business, I'm going to ask more questions than I'm going to answer. That's comment number one. Comment number two is that I did chair the NASI panel on benefit adequacy, and that was the start of an odyssey that led me to this place today, and I hope to recount some of that journey for you. Comment number three is that if you're not one of the worker's comp aficionados, I'm sorry, but you're going to have to try to follow along with the written version, because I'm going to go very fast and cover more material than I should. Part of that is because I want you to get the flow of this, and I will try to wave my hands when I'm making a big jump so that you are forewarned.

Fourth, I want to mention that, like my friend Ed Welch, my interest in benefit adequacy continues to be piqued by the fact that we recently both were shocked to discover in the latest Workers Compensation Research Institute study that Michigan has the lowest benefits among the 13 or 14 states. And actually I was pleased to talk to Ed about this, because I thought I was the only one who was surprised. I've lived in Michigan for 28 years – Ed longer than that – and we were both surprised to hear this. But it tells me something about how worker's comp reform goes and how basically it's easy to be lulled to sleep. And I am on the side of those who suspects that workers have not gotten a good shake out of worker's comp in the last 15 years, so I want you to understand that up front.

I want to make just a couple comments about the origins of the benefit adequacy issue, and I know that's a misnomer because there probably is no such thing as an origin. Then, I want to pay my respects to some of the wage loss studies that have been done that we depended upon when we did the NASI Study Panel. And then, I want to tell you what we've been doing in the two years since that publication, and how much confusion that has caused, at least for me.

And again, I'm not going to give you any instruction about worker's comp programs, but just so that you have a few facts in front of you. Most states pay two-thirds wage replacement, at least for temporary disabilities, after a waiting period and with a maximum and minimum; so those things are all in the mix. Benefits are, of course, tax-free. They may or may not be limited in time. There are lots of variations on these themes, and there's almost nothing you can say precisely that will apply to every state, so it's always a challenge, unlike the Social Security program as Virginia suggested.

But permanent partial disability benefits, which are the ones that seem to be getting most of the concern in the empirical work, are even more difficult. And I want to illustrate that with some numbers – pardon that, but there's going to be a lot of numbers here and some pictures to make the numbers easier. This was from a Workers

Compensation Research Institute study that wasn't aimed at this, but I just took it for the sample of six states, giving the average weekly wage, the average weekly PPD benefits – those are the permanent partial disability benefits – on a weekly payment basis. This gives what you could call a very primitive measure of benefit adequacy, the PPD weekly benefit as a percent of the former average weekly wage. And you see those numbers range from 26 to 58 percent.

But what I want to call your attention to is the bottom line also, which gives the average incurred PPD benefit, not necessarily weekly but the total estimated cost, and you'll notice that it's almost perfectly inverse to the weekly replacement rate. So again, we're not maybe getting it on a weekly basis, but we're making it up in the lump sum or some other form, and that's what makes PPD really difficult to understand.

The worker's compensation benefit adequacy panel from NASI was conceived as a way to provide some qualitative findings around the empirical research that had been done in the mid- to late-90s. I happened to chair that group of about a dozen of our colleagues who represented the whole spectrum of opinion, although we did not have a doctor on that panel as I recall. And the report was created by volunteers who offered to write particular chapters, and then the whole study panel evaluated those through several years of discussion and meetings, which I don't want to get into. But it was agony!

The final review occurred through the normal NASI board review, which means an external peer review, and then it was published by my organization, the Upjohn Institute, in 2004. We built upon the original wage loss study by Berkowitz and Burton, which was really path breaking and followed the national commission in the early '70s. The Bob Reville, et al. work at RAND, which I think you'll actually hear a little bit more about this morning, burst on the modern scene like a thundercloud in terms of defining benefit adequacy in a way that we all could understand and relate to, particularly using the matched worker design. This involves looking at the subsequent earnings of injured workers compared to earnings of workers in those same firms at roughly the same earnings level at the point of injury. I'll use that a little bit in my presentation, but not as much as I would have guessed two years ago.

And then Les Boden really re-started this line of work with a path-breaking study in Wisconsin, and was the first one to look at temporary disabilities as well as permanent disabilities, where I think more attention should be paid. Jeff Biddle also did a wage-loss study with Ed Welch in the state of Washington as part of a legislative audit. And then, thankfully for the panel that I chaired, those three authors pulled this all together with funding from the New Mexico Worker's Compensation agency, and RAND did a study that pulled the three states that had been done previously, plus New Mexico and Oregon together in one common presentation with identical assumptions and methods.

Here's the first, and almost last, thing I want you to see from this report, and you'll see why later. This figure, adapted from the New Mexico study, shows the relative earnings of PPD claimants – and we're going to confine our attention to that group for now – as a proportion of comparison worker earnings for 11 quarters before their injury

and roughly 15 to 20 quarters following injury – so two to three years before injury and four to five years following injury. And it shows basically, as you would expect, that the earnings before the point of injury are pretty much the same, although there is a blip for Wisconsin for some reason that never has been investigated as far as I know. And then, at the point of injury, there is a big drop in earnings, because there is absence from work as the result of the injury. These are PPDs, so they are fairly serious injuries – and then some recovery in earnings, but not much. So while wages drop something like 25 to 35 percent in that first quarter following the injury, they recover only to about 75 to 85 percent of the pre-injury earnings, as represented by the amount that the matched workers continued to earn. That was very troublesome to a lot of people who consumed this research and tried to design some sort of policy response to it.

The next slide shows, the consequences from the worker's comp side. Taking a ten-year window after the injury, looking at the earnings of those matched workers for the ten years, comparing the earnings of the injured workers, and computing that ten-year projected loss. Now, they did not have ten years of post-injury observations, so they basically used four or five years and then projected those losses out to ten years. The proportional wage losses were from 16 to 25 percent depending on the state. And then, taking the total worker's compensation benefits paid for that period of observation and projecting out to a ten-year level, they derived pre-tax replacement rates ranging from 29 percent to 46 percent for the five states. Our NASI Study Panel measured this against a two-thirds replacement rate and said, you know, there might be a problem here. We didn't say we were certain there was a problem because of several issues.

Some were analytical issues. How do you treat missing data, those with zero earnings? Are they missing or are they out of the labor force? If they're out of the labor force, why is that? Is it because of the injury, or for some other reason? The two-thirds standard itself was under some question. The ten-year term was an issue. TTDs versus PPDs was a major issue. And there are lots of others that I am not going to go into.

What I'm going to do now is to switch to Oregon, and try to present to you what I've been doing with a small team at the Upjohn Institute for the last two years since the publication of that book. We chose Oregon primarily because none of those other authors had published anything about Oregon, and it was in that RAND study. So I knew data existed, and in particular that they had matched worker's comp claims out to earnings data, which is not an easy thing to do. So I said, well, I'll just grab the Oregon data and do some sensitivity analysis and publish it. Two years later, we're still doing analysis and we haven't published anything yet, although I have made a couple of other presentations.

What this slide shows is the earnings of uninjured workers – a 10 percent sample from the state of Oregon. It's hard to see but it's that blue-green line that doesn't have the data points plotted on it. And then I array those that suffered three to seven days lost time (this is payment of three to seven days lost time); eight to 30 days; 31 to 60 days; more than 60 days; and PPDs. And it's pretty clear, I think, that they line up hierarchically. The 60 days and greater group apparently suffers greater earnings losses

than the PPDs. But like the RAND study, what this shows is that the earnings never do recover to what the uninjured group earns. In other words, there has been some slippage at the time of injury, and then there is a parallel growth here for all the groups, but the earnings gap is never closed. So somehow, that time that is lost from work is never recovered, so that those workers are always suffering wage loss.

To make that clearer, this slide shows you the difference in earnings for these various groups by injury duration. It's not huge, but we're talking about \$350 to \$400 per quarter five years after the injury, for people who were off work for 30 days due to a compensable injury. That just doesn't seem rational to me. It seems too large. And just a quick look at the medians, because there is one suspicion that it is just a few people who are suffering huge losses and they are pulling the whole distribution up. But the medians look very similar; so it's not just a few outliers.

I don't want you to spend much time looking at these real replacement rates, but I will just make two quick notes about it. Oregon spent a lot of time in the late '80s trying to adjust the worker's compensation benefit formula to make sure that workers with more serious injuries got more benefits, and that others didn't. And that is reflected here in terms of the replacement rates. These PPD replacement rates of 153 percent, remember these are the same workers that got 42 percent in the RAND study. And that is the same result except that this is a five-year group and the match was not done exactly the same way.

But here's the point that I want to make in three different ways. The first column here shows the percent of those injured workers who had no earnings losses, when you take that five-year window. Now, this is giving the worker's compensation system the benefit of the doubt, saying let's just take what they were earning before they were injured. Let's look at what kind of earnings they had in the subsequent five years. Forty-four to 60 percent of them had no earnings losses when we take that generous perspective. Let's look at the other side – what percent of all those injured workers had earnings losses that were replaced by the worker's compensation system at least at the 65 percent level? That's the right-hand column, which I guess shows that Oregon was successful in pushing benefits up to the more serious injuries, but it doesn't show very good results in my opinion.

A quick look at another issue from WCRI. This graph shows for a small sample of seven states the percent of workers who never returned to work for more than 30 days in the three years following their compensable injury. The red row here shows that number ranges from 10 percent to 20 percent – I'm not mentioning Texas because there were some special problems there - but 10 to 20 percent of injured workers did not go back to work in the three years following an injury.

In Oregon, we looked at labor force participation rates before the injury –and because of the sampling method, everybody had to be in the labor force at the point of the sample, so there is always this dip before and after. But after the injury, the dip is significantly greater, and again it seems to array by the seriousness of the injury. Here

are the gross differences; those with more than 60 days off work in their original injury spell are suffering about a 10 percent long-term labor force participation rate reduction.

My last comment, because my time is up, is that I don't feel very comfortable in saying much of anything about benefit adequacy at this point. I am concerned that workers' compensation benefits may not be adequate for either temporary or permanent injuries. I am even more concerned that many injured workers seem to be leaving the labor force. Getting people back to work has come to be a bigger issue in my mind. And what we don't know, of course, is exactly why, and we really need more investigation into this. Are these voluntary retirements – to some degree – or are these people who are forced from the job because of their work-related injury.

Thank you and I'll be happy to take your questions when we get to that point.

(Applause.)

New Empirical Methods to Tie Partial Disability Benefits to Lost Wages

Frank Neuhauser, Researcher, Survey Research Center, University of California, Berkeley

FRANK NEUHAUSER: Good morning. Thanks for the opportunity to be here. I know most of you thought you were going to get the young, cool, handsome Bob Reville – spiky hair, \$1,200 suit, cool glasses, and you got stuck with me. But Bob assured me that this was NASI and it was substance over style. (Laughter.) So you could have Bob or me – Angelina Jolie/Katherine Hepburn – young, vibrant, lovely – sophisticated, intelligent, dead. (Laughter.) Now, the advantage, of course, is dead people give very short presentations.

Also, one qualification: Bob agrees with everything on the slides, but not everything that I would say, so you know, if I make a political faux pas, that's not Bob speaking; that's just me speaking. So he wanted me to be sure to be careful, and I'm not always careful. So nothing I say can be taken as Bob's words.

RAND did this work. I helped RAND with some of the work. The Commission on Health and Safety was instrumental in funding this work, and it began quite a while ago, even before the crisis that we had in the worker's compensation system in California. And the driver for that, as people have made clear already, permanent disability is a very important part of the worker's compensation system, and it's meant to protect the most seriously injured workers. These people have the long-term disabilities that we see, the substantial wage losses, and often-substantial non-economic losses such as pain and suffering. And that's what the system is meant to help compensate.

At the same time, these are the cost drivers, especially in California. Permanent disability cases represent about 90 percent of all the indemnity costs and 80 percent of the medical costs. In California, permanent disability was about 30 percent of the total benefits paid before the reforms, which is substantially higher than most states. I think it's also the most controversial area of worker's compensation and benefit payments. And that controversy was really coming to a head in California, partly because our benefits were high and the outcomes were poor.

The commission funded work to look at how we evaluate and compensate permanent disability. Most permanent disability systems convert the permanent disability by rating the disability between 0 and 100 percent. That measures the extent to which the person is impaired or disabled. And then, these ratings are used to determine one, whether somebody is eligible for permanent disability; and two, to try to target benefits at those that are the most disabled. And here, let's distinguish between disability and impairment. The ratings systems, at least in the RAND's perception, and I think many of the people here, are meant to compensate disability. So how does somebody's impairment interact with the workplace as opposed to how much of the range of motion have they lost? What is the consequence of that loss of range of motion on their ability to earn a living?

And finally, a good rating system might be seen as one that reduces disputes. So if we can simplify the rating system and reduce disputes, I think most people would consider that a good thing.

Well, let's look at worker's compensation in California prior to the reforms, and this is the work that the commission and RAND did in the late '90s and early part of this century. This is a look at the percent of time lost cases that received permanent disability across the five states that Allan Hunt referred to – California, New Mexico, Washington, Wisconsin, and Oregon. California had by far the highest percentage of cases being compensated by permanent disability. Somewhat over 40 percent of our time lost cases receive some form of permanent disability payment. Oregon is the only state in this group that is close, and the other states come in at half or a third.

At the same time, California had by far the highest fraction of lost time cases that involved an attorney or, we might say, a dispute; this is considerably more than any other state, even Oregon. In California around 30 percent of all of its lost time cases – this is temporary disability as well as permanent disability – involved an attorney in some form. And just going back a slide, let's think about whether the degree to which California compensated a broader range of injuries might have led to this issue of more attorney involvement. Attorneys might be necessary in order to resolve very difficult cases that are at the margin of compensability in terms of agreement between employees and employers. And that might be one of the reasons that California had such a large attorney involvement.

At the same time, California's replacement rate, the proportion of lost wages replaced by worker's compensation benefits was only in the middle among states. You saw in Allan's presentation and some work that John has done have shown that during this time, California had the highest permanent disability benefit payments, but was among lower or middle in replacement rates. And what drives this? This means that our losses related to permanent disabling injuries were substantially higher than other states in the study. So it's not just the benefits you pay; it's the way the system drives losses. And some of that has to do with return to work. California had fairly poor return-to-work rates, and again, that might be because of litigation over worker's compensation issues or the broadness with which we define permanent disability.

In 2004, California had the highest worker's compensation costs in the country, 50 percent above the next closest state. RAND had results showing that benefits were inadequate and return to work in California was particularly poor, and there was increasing stakeholder pressure on reforming this system. And this was where the commission stepped in to fund discussions of exactly how to improve that system.

So I am going to talk about a couple of things related to that study, and the first one is RAND's evaluation of permanent disability ratings in California. There are really two big differences between the 37 states that used AMA guides and California, and actually between California and most states, in general. California had two sets of criteria. The first one was a set of objective criteria such as loss of range of motion,

which you could also add a subjective category that involved pain. And then, these were modified by age and occupation.

And the AMA guides rely largely on objective criteria. And if I had to draw a distinction between these two systems, the biggest one was in this area of work capacity guidelines, so we talk about what the impact of this disability is on your ability to work, and we define that in more general terms rather than medical terms. And one of the biggest areas is California had a substantial number of cases that involved permanent disability for prophylactic work restrictions. This means it is not because you can't do a particular function or that it hurts to do the function, but that if you do this function, you're likely to develop some kind of injury or impairment. So you don't have it now, but doing this could injure you. That would be compensated in California. It's not typically compensated in other systems.

So the RAND study for the Commission involved matching about 300,000 cases. We have permanent disability ratings going back for almost a decade and a half, involving something in excess of a million and a half ratings. And we match these to wage loss. And we think that wage loss should match your level of permanent disability, which is your level of compensation. So we would like to see that permanent disability payments are matched well to the level of disability, and also that there is limited level of dispute over the level of disability.

Here is a look at our results. This is looking at four different types of impairments: shoulder, knee, loss of grasping power, and back. And we divide each of these sets of impairments into groups of about 5 percent ratings, like from 1 to 5 percent disability rating up to 36 percent and above. Fortunately, those groups from 36 percent are fairly small. And you can see that on a first category, higher ratings have greater wage loss, so each of those columns represents the percent of wage loss five years after the injury, experienced by these workers against controls. So we do see that workers that are given higher ratings have greater wage loss.

But where this system fails substantially was that workers with different kinds of injuries – say a back relative to a knee – received very different levels of compensation relative to their degree of disability. So if you look at back injuries that got a rating of 21 to 25 and related compensation had about twice the wage loss than workers with a knee injury that got the same level of compensation. Moreover, it's not on this chart, but psychiatric injuries, which California is fairly generous among states in compensating with a lot of restrictions, looked dreadful in this picture. Not only do they have large wage losses, but they also have consistently large wage losses that are unrelated to the level of compensation or rating.

A second thing that the study looked at was the degree of disagreement between two parties in this system. So this is when there were two ratings proposed by the applicant and defense. The average rating for the applicant was about 36 percent for the same case, and the average rating for the defense was about 27 percent. And that difference is actually larger than these numbers suggest because there are a fair number

of times that the applicant rating would actually come in higher than the defense rating. There was that much ability in this system to differ on the nature of the ratings. So a substantial fraction of cases have higher disability ratings handed in by the applicant's doctor, so some of these cases can have staggeringly large differences in the perceived disability by the two parties.

But let's just look at one very important aspect of the reforms that were championed by both parties that you see on the podium and on the head table here, Angie and Bill. And that is that return to work is key to reducing worker's losses when they suffer permanent disability. This is looking at the average level of permanent disability for people given ratings in these ranges and the average level of disability for workers that return to that at-injury employer for just one year, for just two years, for just three years. And you can see that if you return to your at-injury employer, even if it's just for one year after work, your losses are substantially less – about 20 to 50 percent less. If you are at your at-injury employer two years after injury, your losses are yet less. And if you're at your at-injury employer three years after injury, your losses are much less. And California has very miserable return to work rates, and miserable return to the at-injury employer rates, which accounts for a substantial fraction of why our benefits might be high, but our replacement rates are low.

And again, you might think that a system that requires a great deal of litigation in order to resolve issues of permanent disability might result in problems that we see in California. It's unlikely that a worker that sues their employer over the level of permanent disability or its existence is going to maintain an employment relationship with that employer; at least it's much less likely. I mean, anybody here who sued a friend or relative or business partner knows that relationship is pretty much over. (Laughter.)

So RAND recommended to the Commission that we adopt a consistent underlying basis for the ratings, one that would pay different types of impairment and disability the same level of indemnity if they suffered the same consequences. So knees and shoulders should receive the same level of benefits if they have the same consequences. And it has recommended that a change in the rating system be combined with a two-tiered benefit system giving incentives for employers to bring workers back, and incentives for workers to go back to the employers. So an employer paid less in permanent disability if the worker was back at work. We've heard this a million times. The worker never lost a day of work; I've paid him disability benefits. Why is that? In this case, there is a substantial premium – when the law was enacted, they pay 15 percent less if the worker comes back to work and they pay 15 percent more if the worker doesn't come back to work. So there is a differential of 30 percent, which turns out to be approximately the differential between workers that return to their at-injury employer and those that don't in terms of their subsequent wage loss. That wasn't by accident, by the way.

So there are two approaches to defining permanent disability payments that are typically used. The first one is what California was doing, which would have been a prospective payment system. We decide that if you have a particular type of injury,

we're going to pay you x dollars. That's often criticized as being unfair to workers, because there's a lot of differentiation in the way in which a worker's injury may interact with their particular job. And often, we have litigation trying to resolve that issue in California, and that's a criticism of this one-size fits all approach. Another approach is the wage loss approach that retrospectively or concurrently pays people disability benefits if they're suffering losses. The criticism for that is that it tends to encourage people to not return to work. Their benefits go down if they're back at work. There is sort of a negative incentive there.

But RAND's recommendation was that they could improve both of these systems by using wage loss data, especially from large samples like this, to craft a system that more accurately paid disability benefits based on the kind of disability the person had and the nature of his or her work. And that was the basis for these very large disability data sets and the work by the Commission.

Now, one question is, what happens when you actually take these data and you go to the legislature and a law is enacted? This is the law that was enacted in California. And one thing that is unique here is that it actually adopted the RAND findings as a standard for designing a system. It said when you design a system, you're going to base it on RAND's data plus other data that would be appropriate. And it was meant to pay for diminished future earnings capacity, and it adopted return to work.

Unfortunately, and I think that Angie and Bill Zachry will deal with this in their discussion of this, I think that there was a good deal of misunderstanding and imprecision in this legislation and the legislature didn't provide complete guidance as to how to implement this. So one question is, did they mean to peg permanent disability payments in the old system to where they were prior to the introduction of legislation, but maybe change the way they were distributed among workers? Did they want maybe to peg them to proportional wage loss and make them equal to proportional wage loss?

I kind of disagree with Ed Welch on this point. He has this orotund voice that is absolutely convincing when he is talking, and I always nod my head. But in fact, I think there is a great deal of disagreement about what is adequacy in terms of permanent disability payments. Is it 80 percent? Is it 80 percent of five years loss; 80 percent of ten years of loss? Should it be greater than their loss? I mean, these workers not only suffer economic consequences; they suffer physical consequences. I think there's still a great deal of disagreement about what adequacy should be. And as an empiricist, I can't answer this question until the political folks answer the question of what they think is adequate and how they want to map these systems. And I think that's the basis for a lot of lively discussion, and I hope we hear something from Angie and Bill on it.

Also, there was no crosswalk between the AMA guides to accurately peg these wage losses, and the timelines for the implementation were quite short. The legislature set very difficult timelines for the regulatory agency to meet.

So now let's look at what those reforms did in terms of the adequacy of benefits. Remember that we were in the middle level of adequacy prior to the reforms. Well, first, they did reduce employer's costs by 60 percent. The average premium was \$5.39 in January 2004; it's now \$2.03, at least for the pure premium rate for administration costs. This is a substantial reduction in employer costs. The rating bureau estimates that there was a 38 percent reduction in the payment of permanent disability benefits. I disagree with this estimate. I think you'll see why. I think the reduction in permanent disability benefits is closer to 65 percent.

The average rating given to an injured worker with a permanent disability, when they received a rating, was a little over 40 percent less. Under the pre-2005 schedule before reform, workers that were unrepresented by a lawyer got close to a 20 percent average permanent disability rating. Now, they get approximately 11.5 percent, about a 40 percent reduction in the average. And we see that for represented workers as well. That's the difference between a summary and a consult. In terms of dollars, we pay progressively more dollars for higher percent disabilities, so the dollar impact of this is larger. We've seen almost a 55 percent reduction in dollars paid to the average worker receiving a disability benefit that is not represented by attorney, and 50 percent reduction for those represented by an attorney. Very substantial reductions, this is now over almost 18 months of research the commission has done in connection with the rating bureau and the division of worker's compensation.

I want to say one more thing that was touched on this morning related to this. California did something very unique when they adopted this new schedule. They adopted apportionment of permanent disability to causation, meaning that when we establish permanent disability for a case, the doctor is also supposed to apportion that disability to non-occupational causation if that's appropriate. This is a very unusual, and is, I think unique, to California. And it's meant that about 11 percent of workers are getting their disability benefits reduced even more than you saw because of apportionment. And the outcome of that is a reduction of about 5 percent in their overall benefits. This is particularly contentious. I think the parties that negotiated this will have something to say. I think it had something to do with not setting causation as the threshold level for getting in the worker's compensation system, but still giving employers some release from this issue of non-occupational causation.

So I know my time is up. California is leading the way in this process. There are many issues that remain to be resolved. One of the most important issues is the extent to which these reforms, by simplifying the system – I think that's clear – has reduced litigation, disputes between employers, and maybe return to work. If it improves return to work, that means we've reduced the losses workers face and consequently, the cuts in benefits might not have been so dramatic in terms of replacement rates. Thanks very much.

(Applause.)

Commentary

Angie Wei, Legislative Director, California Labor Federation, AFL-CIO

ANGIE WEI: Good morning. I've always wanted to say this. I want to thank the academy for having me this morning. (Laughter.) I also want to acknowledge, off the top, Christine Baker, the executive officer for the Commission on Health and Safety and Worker's Comp. Christine, in my opinion, is one of the hardest working and most effective public servants in California, and I want to thank you for having me here. I have to acknowledge, of course, Tom Rankin, a past president for the state labor federation in California, who was the font of knowledge in representing workers and injured workers in our state.

One of the things that Tom Rankin taught me as I started trying to pick up the expertise he had in worker's comp is that we have to be data-driven; too often anecdotes drive our public policy. And anecdotes are very powerful, but what really should drive our decisions and the positions that the state labor federation takes on legislation and policies are the data, and that's why I feel especially grateful to be here at the academy and sit on the commission, because the data that you provide and the research that you do really help illuminate the policy discussions in which we're engaged.

I want to start by saying in California, we at the State Labor Federation really believe in worker's comp; maybe not in a lot of other issues. But in worker's comp, the employees and the employers do share the same goals for worker's comp outcomes. We think that these two parties are the two principals in a worker's comp system. Everybody else is a vendor. It doesn't mean that they're bad people. But let's face it; they have a financial interest in the system. So we want to do as much as we can to work with the employer community because we do think that we have shared goals.

Bill and I worked hard this year to regulate and impose a fair fee schedule on doctors dispensing prescription drugs, and after a good two years of hard work – why we had to work so hard on such a clear issue is still kind of beyond me – we are going to get to a point where we will have a fair fee schedule for doctor-dispensed prescription drugs. Bill, I want to acknowledge also, was also critical on behalf of some employers to help us maintain our own right for some of us in California to see our own doctors under the pre-designation system. And while that right was supposed to sunset in April of '07, we did get Governor Schwarzenegger to assign a bill to extend that right to December of '09. And there are parts of the employer community who I think are reasonable who helped us make that happen. And I want to acknowledge and thank him for that. Bill and I will likely disagree from here on out on permanent disability. (Laughter.)

Two other final opening comments from me: we live in a term limited situation in California and probably in a lot of your different legislatures, and on term limits, there is a lot of churn, both at the legislator level as well as the staff level. We've lost tremendous expertise in social insurance programs and in worker's compensation. And these new legislators come to town, they hear a lot about worker's comp and they all want to bang a home run with big changes in comp, based on anecdotes. And that's why

we need the data to make rational and reasonable decisions, because we've lost so much expertise in our state house, I believe, in social insurance programs.

For the state labor federation, we like to consider ourselves as leaders in helping contain costs in worker's compensation. I talked about vendors in the system. We have all kinds of vendors who try and introduce bills to increase the reimbursement rates and the fee schedules. You know, they provide durable medical equipment, specialty doctors, pharmacists. You name them; we've got them – probably like you do in every other state. And we try to be very consistent on the positions that we take on legislation that is introduced by some of these stakeholders. It has to be data-driven. If you want change in the system, if you want to justify a fee increase or change in your reimbursement rates, show us the data for why it's needed and then we'll make an informed decision.

I think that there are certain employer trade associations that have big tents, and represent a variety of interests, not just pure employer "I-pay-the-premium" interests. They represent the insurers. They represent the durable medical equipment providers. They represent the doctors. And so, in my opinion, some of these trade associations, like the chamber of commerce, don't take the right positions on these issues that drive up costs. We want to stand in the way of cost drivers in the system because we want the system to be fair and for employers to pay fair premiums, but we also know that as costs go up, in the end it comes off our backs. As costs go up, the first place people often look is at injured workers' benefits and how to slash those benefits to retain costs. So we want to play an important role to make sure that people are getting paid fairly – people, the vendors – so that in the end, it tries to save the benefits of the injured workers and we have to look beyond some of these employer trade associations. We're lucky to have Bill who represents an employer, a single employer, as opposed to some of the larger, big umbrella, big tent, trade associations who may not have the best employer interests at heart.

With that being said, I want to start talking a little bit about permanent disability. And I'll talk about the policy and about the politics. To put the permanent disability new system that we have adopted in context – Frank started on this – we see in total about 65 percent cuts in total dollars in permanent disability, 5 percent from apportionment that Frank described earlier; we've cut the number of weeks on the low end of the rating system and that equates about 9 percent of the dollars in the system. We haven't talked anything about the zeros, those claims that don't get rated under the AMA and fall out of the system altogether. And that's going to total about 15 percent of the total dollars in the system. And then we have the actual permanent disability ratings schedule, which as Frank closed his presentation, it's about 50 percent cuts in total dollars.

Aggregate those four changes in permanent disability – I'm not a mathematician – it adds up to something in the 70s for me, but Frank tells me it's 65 percent cuts in dollars because of cumulative impacts across the board or something. But if you take all those factors into place, the total is 65 percent cuts in dollars in permanent disability.

The labor movement in California was neutral on the Schwarzenegger reforms adopted in 2004. We would have never been neutral on a bill that would have taken 65 percent of the dollars out of the system. Governor Schwarzenegger and his negotiators told us that they did not mean to cut benefits to the severely injured workers, to the permanently disabled workers. And Schwarzenegger made those promises, and that's why we and Tom Rankin insisted that we write into the labor code statute, the reference of the RAND study; if we base things on real, empirical data and wage loss data, we would have a fair system. We recognize some benefits would go up and some benefits would go down based on the type of injury. But we never anticipated a 65 percent cut in the dollars in the system. And when the administration was putting together the new rating system, they told us, oh, this will not end up in 50 percent cuts that you guys are estimating. And I was taught to never say, I told you so; but on this one, we told them so. We told them it would be 50 percent cuts, and actually we were right.

As we look at permanent disability, a couple of things that I was reminded listening to Frank and Mr. Hunt. For us, return to work is the best outcome for injured workers. That's the way that we can get maximum wage replacement. We don't support keeping injured workers off the job. If they can and are ready and able to go back to work, we think that is the best outcome for them.

Secondly, as Frank outlined in his presentation, and I'm remiss that I didn't bring a copy of it with me, the labor code was amended to take into account the RAND study. We went to the AMA guys and we had adjustments – age, occupation, and this notion of the future earnings capacity, the FEC factor. And that future earnings capacity was supposed to be based on the empirical data of the RAND study and to do the crosswalk to wage loss. The regulation that was adopted by this Schwarzenegger administration never did that crosswalk, never tied it to the empirical wage loss data, and that's why we see the 50 percent cuts in the rating schedule.

Let me say this: at the end of the legislative session, the president of our state senate, Don Perata, moved a piece of legislation that would have increased the number of weeks of benefits for permanently disabled injured workers. It was a bill that we supported even though it might not have been, in our opinion, the best approach to restore fairness in the permanent disability schedule. We saw it as increasing the number of weeks for extremely low benefits. The better solution we would have liked was to actually adjust the future earnings capacity. But we supported it. Partially why I think our legislative leadership took that approach is because Stanley Zax of Zenith Insurance Company supported this piece of legislation. He thought that if we restored and increased the number of weeks for injured workers that the system could absorb that amount, and maybe decreases in the employer premiums may have slowed down by less than 5 percent. So we actually had an insurer support this legislation with respect to the AMA guide with these adjustors for age, occupation, and the future earnings capacity, because we agreed with the notion that we wanted a more consistent and more predictable permanent disabilities system.

But with slashes in benefits this deep, I think we're moving away from that stated goal. We're not going to get consistency and predictability because I think some of the permanent disability raters themselves think that these cuts are too deep, and may be trying to find ways to adjust them as much as they can. The lawyers who represent the injured workers think that these cuts are too deep and are going to find every methodological way to try and get the ratings increased. Some of the judges in the comp system are going to think that these cuts are too deep and find ways to adjust upwards as well. So while we try to get to the goal of consistency and predictability, having such deep cuts in the system I think actually works against that goal.

I see the time clock ticking so let me just close in terms of the politics of the situation. You know, Governor Schwarzenegger kind of pushed the legislature and all the different stakeholders to a position of having to face this reform by kind of holding up the threat of a ballot initiative over our heads. And he used that way to get to this deal. And, I would argue that this was his only legislative success in the first two years of his administration. Everything else failed; we killed everything else or it never got off the ground. And so, to be able to tweak the permanent disability system meant that they would have to admit that they made a mistake, and that's a pretty uphill battle to push to get the administration to admit that they made a mistake when he's up for reelection. And for us, it became his first promise broken. He promised not to cut benefits for severely injured workers and clearly that has been broken. So Governor Schwarzenegger is out on the campaign trail now touting his worker's comp reforms in every commercial and every piece of mail that they have. We, of course, are touting the 50 percent cuts in permanent disability benefits as another reason why we should not send this guy back. And in the end, injured workers are suffering.

Now, I understand that the administration's division of worker's comp is undertaking some studies to try and tie wage loss to return to work rates to look at whether or not in their opinion the permanent disability system needs to be tweaked. And for us, the CHSWC commission in California has come up with a methodology that takes baby steps to bring some justice back into the system and some fairness back into it. The policy question in our minds is should we let injured workers suffer these deep cuts for as long as it takes to do these studies or should we make minor adjustments on a regular basis so that we can bring a little bit more relief to them? And we think that it's important to make the investment now and make these changes rather than wait for however long it's going to take to get these empirical studies done. I understand the RAND study based on ten years of data. We don't have time to wait. We can't wait ten years to try and restore some of these benefits. So we'll come back next year, regardless of who is in the governor's office and try and do both regulatory and legislative work to restore these benefits. Again, I thank the academy.

(Applause.)

Commentary

Bill Zachry, Vice President, Corporate Workers' Compensation, Safeway, Inc

BILL ZACHRY: I would also like to thank everybody for the invitation to be here. I certainly appreciate the opportunity. Frankly, I find this group rather intimidating because I really consider myself sort of a claims geek. With all the academics and other esteemed folks here, speaking before you is something that I was quite nervous about.

I want to complain to Angie Wei a little bit. I was going to use the immediate provision of benefits as part of the incentive to get labor to work with Safeway to implement an alternative dispute resolution. Labor took it away from me when it was implemented as part of SB-899; I am a little miffed that I don't have that as an incentive to get our alternative dispute resolution up and running.

It was the right thing to do, and I think it's very important that we do the right thing for the injured workers.

Out of curiosity, how many here have been injured on the job? One, two, three – a few of you. I started my career as an injured worker. I was a playground director and I went to break up a fight between two girls. Eight guys attacked me. The knife went through my back, through the lung, through the diaphragm, and through the spleen. I was in the hospital for a week.

I know what it's like to be an injured worker. It's ironic to me that I end up as a workers' compensation claims professional. I know and handle a lot of claims. It is personally extremely very important for me that we do the right thing for the injured workers.

I agree with Angie in terms of anecdotes driving public policy. Research should drive it. I am learning more and more about research as the Chairman of the California Fraud Assessment Commission, because we're trying to research how much fraud is in the worker's compensation system. You can't really do that kind of research on a straightforward basis, because if you go into a room – we'll try it here – all right, how many of you are committing worker's comp fraud; raise your hand. (No one raised his or her hand)

The research is pretty difficult. Professor Malcolm Sparrow out of the Harvard Kennedy School of Government has a process in place to identify fraud, and we're trying to use his process to research the over and under payments on the medical arena in workers' comp in California. Frankly, it's amazing how difficult it is to get consistent and accurate data even though there are some groups who have been working very, very diligently on data collecting. So I am getting educated on that piece of the puzzle.

The word that has been bantered about a little bit here that I want to talk about (or focus primarily on) in terms of worker's compensation is the word **incentive**. I think that is the key concept for worker's compensation that is undervalued.

You need a balance between the adequacy of the benefits with the incentives in the right place to get the right outcomes. I'll give you a specific example of that: We had a presentation here that talked a little bit about the 15 percent permanent disability up and down as an incentive for the employer to provide permanent modified work. The incentive should work both ways. If the employer offers a permanent modified position, then they get to pay 15 percent lower PD. If they don't offer that position, it's 15 percent higher. There are, incentives both for the employer and the employee with this process.

I would submit to you that even though the charts up there showed that it's a 30 percent net, the way the 15 percent process works is not good enough. I think it should be much, much higher up and down, because you need to get the incentives to the employers. Insurance companies provide a barrier between the process and the incentives. Incentives have to go all the way down to the employer level.

I have another comment on incentives. The incentive for the applicants' attorneys – hi, Doug – (laughter) – is to make sure that their client is as disabled as possible in order to increase the amount of benefits that are paid. And that's absolutely wrong. We have to figure out how to do a process that doesn't have incentives not to return to work, and right now, the way it works nationwide is the incentive is for the applicants' attorneys to make sure that their clients are disabled. We've got to fix the incentive process so that people are encouraged to go back to work and employers are encouraged to take them back. And we're missing the boat on that.

The other piece of the puzzle is that there is an inherent assumption that small employers can't or won't do the return to work process. And I'm going to go back to my first comment, which was anecdote versus research. I don't have any research on that, but I haven't seen anybody's research supporting the assumption that smaller employers cannot physically accommodate injured workers back at work. My anecdotal discussions with small employers indicate they have a closer relationship with the employees, and they bring them back. We're potentially missing the boat on that one. We need to bring people back to work and then everything else becomes moot in terms of benefit adequacy, unless you really are severely disabled.

I want to talk a little bit temporary disability. It's very interesting. In California, the public safety officers have a law that allows them one year of salary continuation. Incentives are in the wrong place again to get some of those folks back to work.

I have found, in my experience of administration of cities and counties and public safety officers, is that the younger folks who get injured, generally speaking, come back to work fairly well. The real problem is when the employees get later on in their careers and they're just tired.

I'm not going to get into the question of why is it good to get exercise but bad to go to work because you break your body down. I still haven't figured that part out yet, but that's a secondary issue.

At Safeway we have what our medical director calls "a bolus of claims," which are, frankly, the most difficult claims we have. These are the claims by employees who are within three to five years of retirement and just are tired of working. They are looking for a bridge so that they can get into their retirement.

With regards to the issue of PD replacing lost wages. Does anybody remember the Batman show? All right, riddle me this, Batman. How much are women paid compared to men in today's marketplace? Seventy-seven percent; it was in the Wall Street Journal. The question is, are women paid less because they're pulled out of the marketplace for child bearing, or are they paid less because they're just not paid for the same work that men do? I think there's a lot of social issues on that in terms of all of the statistics we saw in terms of the overall uncompensated wage loss from industrial accidents. There are many, many reasons behind the numbers. Some of the people pull themselves voluntarily out of the marketplace because they don't want to be in the marketplace. Some people are at retirement age, and I think that information was not considered.

I think these are the issues that we need further research on. We have to find out what are the causes for the alleged dip in earnings post injury.

More importantly though is we have to focus in on where are the incentives and how do we fix the incentives so that the entire system is focused on getting the people back to work.

The large increase in workers compensation costs over the past few years caused employers to focus on safety. It scares the tar out of me that with a significant drop in costs might result in less of an attention to safety. That's something we need to keep an eye on, as well.

In terms of the AMA guides in California, we've had a significant problem with implementation because it was such a radical change. We have most of the doctors who have no idea on how to rate. I've seen some reports that say 80 to 90 percent of the reports coming in are inaccurate. We still have a long ways to go to create consistency. I can tell you on the front lines, when we're rating out reports, it's a very, very hard thing to do when the doctors don't know how to write up the reports and the claims adjusters don't know how to rate them. It's a learning process that will take at least another year, probably two or three more years for us to really get consistently good at rating the PD system.

The governor and his team are doing research. I don't think they're going to wait too long in terms of making necessary adjustments for the more severely – not injured, but disabled workers in terms of the reimbursement rates in that level.

As far as adequacy is concerned, the way to create adequacy within this entire system is to get people back to work, and we all need to focus on that. I think that's one of the areas that we need incentives in terms of the indemnity rates, in terms of the way we pay things. As far as I'm concerned, the PD system in California should be about 65 percent up or down depending on if the employer brings him back to work, and we need some way to bypass the insurance company, and get the incentive straight to the employer's bottom line, so that they'll see the benefit one way or the other in terms of making return to work a process that works.

We've got to put incentives in the right place to get people back to work and we don't have it yet. It's a good start; it was a great start. But I think that the 15 percent just doesn't cut it as far as really providing employers the fiscal incentive to make that happen. Thank you.

(Applause.)

Discussion

MS. RENO: Wow, what a fabulous panel. We do have some time for questions or comments. And please step up to the mike and introduce yourself.

Q: Kalman Rupp, Social Security Administration. First, I would like to congratulate both of the authors. I'm not sure whether it's Frank or just Bob, but both of them were very good papers. And one of the reasons is that both papers used longitudinal data and earnings records and, in your case, a comparison group methodology. The only kind of general comment that I would have is that there are other outcomes you can look at, for example, mortality, which is a very objective indicator, or have outcomes that would be useful as far as future program participation in DI and SSI and other programs.

I have a more fundamental kind of question with respect to the RAND study. As much as I liked what you did, throughout your presentation, I was thinking about a way of looking at classification errors as two different types, one is incorrectly screening in someone who should not get the benefit; another is incorrectly screening out. And one, it seems like maybe you have looked at these two perspectives in the more detailed story, but insofar as policy implications are concerned, ideally, you would like to reduce both sources of error. But often time, when you change a system, then what you actually do is reduce one type of error at the expense of increasing the other. It's interesting that Social Security has gone through some changes where they have moved from a more medical, more quote "objective" model, to a more judgmental system, and that has been looked at by several studies as a major source of growth in the program.

But in California, let's say you have a mental impairments issue. It's very difficult to find objective criteria to correctly screen in someone with a severe mental impairment. So I was wondering whether in your follow-up studies of the new system, whether you look at this tradeoff or not?

MR. NEUHAUSER: There have been some efforts to look at this already, and you're absolutely right. And I think Allan is going to address this, and I'm going to use some of his data. We compensated substantially more cases that had temporary disability than virtually any other state. And the question is, was that wrong or were all the other states wrong? I mean, the difference was, it cost us more and there were probably a lot of disputes connected with it. But if you look at Allan's data, and some of the work that's been done by Bob Reville rather than me and some of his other co-authors, people that have long-term temporary disability, but did not have eligibility for permanent disability, turned out to have just as serious or sometimes more serious wage loss than people that were compensated for permanent disability. So they certainly had permanency of wage loss, but the criteria we used didn't define them as permanently disabled. And you saw that in Allan's data, people that had greater than 60 days temporary disability had wage losses on the long term that were equivalent to the average permanent disability case.

There's two ways to go here. It's an error where we're not giving benefits to people that have permanent disability. But it may be that it's just too expensive to deliver

permanent disability benefits to cases that are on the borderline. And that's, again, a political and social question for the people to our right.

MS. RENO: Okay, we had another comment or question here?

Q: Bryon McDonald from the World Institute on Disability. If you could comment as a panel, we all agree in this room that the nature of the systems of both worker's comp and social security is that if you show increased signs and symptoms, you get a bigger benefit. We actually induce people to leave the workforce. The other major piece of your panel is that data should drive the policy not the anecdote. The facts are we don't have return to work data that supports the incentives that you guys want to return to work. I would argue we're never going to get that data in the current environment because the systems are built to pay – and should pay – increased benefits to people with increased impairment. If we're not going to have that return to work data and we realize that the longer the separation from the workplace, the longer likely they're going to stay there, how do we move forward to reduce that detachment from the workplace without probably having that data in hand for the kinds of levels of reform that we need?

MR. NEUHAUSER: Big question. I'll start just on one side. We are trying to put together studies that identify the impact of increasing the speed with which people return to work or the likelihood that they return to work at all. Those studies are difficult, but we've made substantial changes in California along the lines, and maybe we can use those changes to get at this issue. And maybe if we highlight the importance that it's very important, then more states will use incentives.

MS. RENO: Allan?

MR. HUNT: I'd just like to add that we are like the guy who lost his car keys in the parking lot, and he's looking under the light because that's where he can see as opposed to where his car was or where he dropped the keys. We are victims of the availability of data, and this also goes back to Kalman Rupp's comment. So we have measurements of earning, because it's of necessity in an unemployment insurance system, and that conditions the research that we do because we've got to have something empirical to do empirical work on. But it's a terrible tragedy, and someone ought to be designing the ideal study, or at least a more ideal study to get at some of these things. We have very few studies of return to work really. The National Academy might be once place. And we need to understand this process much better than we do.

MS. RENO: Thank you. Bob?

Q: Bob Steggert, two part question. The first one is for Angie and Bill, and the second part is for Bob. Angie and Bill, with respect to the 65 percent PPD decrease in California, how much of that PPD was related to what is classically called the four-by in California? It doesn't happen anyplace else in the country. And for those that are uninformed, a four-by is essentially permanent partial disability stacking. The case starts as an orthopedic case. They get a forensic exam; it turns into a neurological case. They

get another forensic exam; it turns into an internal organ case. And then, they add the psych element on top of it. You've got four element of PPD stacked up for the PPD award. First part of the question.

Second part of the question for Frank, is that going to be studied from the standpoint of data in terms what we would consider to be abuse and excessive litigation and wasteful medical expenditures? Thank you.

MR. ZACHRY: Bob, I don't want to speak for Stanley Zax, but I was talking to him about projected savings out of the comp system, and he said even in his annual reports, he did not project very much permanent disability savings over the long run because he thought that the applicants' attorneys would figure ways to game it, and one of the ways is the multiple parts of the body under the new permanent disability system. You know, I've not seen a lot of that yet in the front lines in my particular operations, both northern and southern California, because I think it's a little harder to get the medical evaluations and the doctors who really understand that piece of the puzzle. And particularly when you have medical control through the medical provider networks, it really limits some of the mischief that used to be in the system.

MS. WEI: I don't want to be in a position, because Doug Kim is here for the applicant attorneys, to defend the applicant attorneys, but I feel that something has to be said. We're seeing more and more problems and we'll have a panel this afternoon on medical treatment and lack of access to medical treatment in California. And it's a shame that applicant attorneys have to put in a lot of time now to try and gain access to medical treatment for the injured workers and they don't get compensated for that. And so what we're seeing – as a business decision from them, I believe – is that more and more applicant attorneys are having to come out of the marketplace because they can't afford to do the work, because they're not getting reimbursed or paid for something that's a bigger part of the system, which is access to medical care.

MR. NEUHAUSER: And that final question was about disabilities that involve multiple body parts and Bob's description, stacking. The database that we used had a substantial number of claims that had disabilities to more than one part of the body or psychiatric and a physical disability, and we didn't look at those yet. We have done some preliminary work. It's a little more difficult to look at every possible combination because the data sample just gets smaller. It is large enough to do some of that.

As to a first approximation, people with more than one disability suffer more wage loss than two people with the separate disabilities. They seem to be more than additive. But there's a lot of work that needs to be done to look at exactly how that works.

MS. RENO: We have one final question. I hope it's short, because we are running a little bit over time. Is this one that can wait for another panel?

Q: This is a rhetorical question. (Laughter.)

MS. RENO: Great, the shortest of them all.

Q: I'm Jennifer Christian. I'm going to be speaking at lunch, but I'm not going to be speaking about this. I'm the project director right now for an expert panel for social security on how to make better use of functional and vocational expertise in the disability determination process. And one of our expert panelists' advice to social security, which I'm now realizing ought to be advice to this particular group, is have you considered what effect the system itself has on the perception of the applicants, about who they are, and what their future looks like? And that when you were showing the slides about the length of TTD correlating very much with long-term economic loss, if someone has decided that they are disabled, that's going to have a profound impact on the way they perform at work and their job-seeking behavior. And for us to think that these questions are merely benefit entitlement or financial questions is taking a tremendously too superficial look at the impact that we're having on people and their expectations.

MS. RENO: Thank you. And a nice lead-in to our luncheon.

Last word then, Doug?

Q: I'm Doug Kim with the Applicants' Attorneys. We represent the injured workers in California. I think Mr. Malooly from the Washington State Fund made the fairest comment about what our people do. And that is that we deal with individual people with individual problems. We are not looking at macro-data to make our decisions. And because we are looking at individual people, our job is to get them the benefits to which they are entitled. We can't change the rating they get. All we can do is make sure that they are appropriately rated, and they get the benefits to which they are entitled. I don't think it's fair to call that gaming the system.

I also want to point out that in California, because we have such an incredibly contentious system, and as Mr. Zachry points out, there is so much litigation; there are so many disputes that very frequently the process of prosecuting a claim for an injured workers leads to additional compensable consequences. And we believe that it's fair that the workers are appropriately compensated for additional disability caused by the problems in going through the system.

I have a lot more to say about California. I'll do that on my panel. Thank you very much.

MS. RENO: Thank you. Thank you for your brevity. We now have a break for lunch. And let me just tell you the ground rules are we have about 25 minutes for networking while the Press Club staff comes in and set up these tables for lunch. So you can leave your materials here, but leave them on the chair; don't leave them on the table. And be back at 12:30 sharp. And join me in thanking our panel, of course.

(Applause.)

(End of panel.)

Luncheon Address

Introductions

Bob Aurbach, CEO, Uncommon Approach

ROBERT AURBACH: Good afternoon. My name is Robert Aurbach. I'm the president of a company called Uncommon Approach, a company that I started after being the chief legal counsel for the New Mexico system for quite a few years. Nowadays I spend my time doing research on legal aspects of workers' compensation and helping jurisdictions, businesses and workers in the evaluation and redesign of workers' compensation systems.

I've been asked today to introduce our luncheon speaker. It's kind of a rare privilege for me, because it gave me an opportunity to meet in person somebody whose work I have admired for some time, but had never met.

The thing about Jennifer is that it's a really rare opportunity to talk to somebody who is at the same time both extremely credible but down to earth, and authoritative, but commonsensical, and who manages to present her message in a way that makes people want to listen to what she has to say. Jennifer has devoted most of her professional life to the reduction and prevention of workplace injury. Those of us who spend a lot of time worrying about return-to-work and its implications for workers' comp system design, such as the ripple effects on litigation resolution, benefit adequacy, stakeholder buy-in and reduction and system costs, know that the design and implementation of return-to-work programs is no easy task, but an extraordinarily important one, as you've heard this morning.

Dr. Christian's work provides both systematic and very specific assistance in this regard. Dr. Christian has over 20 years experience in occupational medicine, and she's the president of Webility, a company devoted to the dissemination and implementation of progressive return-to-work strategies. The website includes a link to the important ACOEM report that bears the same title as this speech, "Preventing Needless Work Disability to Helping People Stay Employed." There's a good reason for that. She chaired the ACOEM committee that developed that report, a process which if you take a look at the names that are on there, was probably somewhat more challenging than herding a large number of cats. By the way, if you haven't had a chance to pick up a copy of the report, there are extra copies over at the end of the table.

Her website also includes a monthly column formatted as a question and answer session with some of her clients. The columns contain wonderful commonsense insights presented in a delightfully conversational tone. Let me just give you an example of one. When she was asked by one of her clients, what kind of health care provider ought to be used for a particular kind of injury, she said very gently, "You're asking the wrong question. What you really ought to be asking is: what do you want to see happen with regard to this worker. And then, when you have the answer that question, you have a chance of picking somebody who could actually address those issues."

So it is my pleasure to introduce Dr. Christian, and I'd like to introduce you to her in the words that she uses to end each and every one of her monthly columns. So here is Smiling, Dr. J.

Preventing Needless Work Disability by Helping People Stay Employed

Jennifer Christian, M.D., President and Chief Medical Officer, Webility Corporation

JENNIFER CHRISTIAN: Well, hi. It's fun to be here. Some of you I've never met before. Some of you are my phone friends or my e-mail friends. I've only seen your name and never seen your face. And some of you are actually people that I didn't know came to these meetings, so this is kind of good to be here.

We only have a few minutes, and I'm basically loquacious and like to do two- to eight-hour things, so I'm going to roll you through these slides really fast. One of the hallmarks of a Jennifer Christian presentation is that I try and put all the words that are important on the slides so after the presentation, you will remember what I said. But there may appear to be too many words on the page, so pay attention to me, and you can have the slides later, how about that?

What I'm going to be doing today is introducing ACOEM's newest guideline. This is not the ACOEM Practice Guidelines that you may be familiar with. This one has another title: Preventing Needless Work Disability by Helping People Stay Employed. And I'm going to introduce Webility's 60 Summits Project, which is to convene stakeholder workshops and use the new ACOEM guideline as a framework to catalyze positive change in workers' compensation and disability benefit systems. That's Webility's purpose, to catalyze positive change, and we see this guideline as a great vehicle for doing so.

Now, actually Bob already told you most everything about me that's important here. I guess you might also want to know that I have been in private practice of occupational medicine; I've been a corporate medical director in heavy industry. I've been a chief medical officer of a workers' comp managed care company for which I actually helped build provider networks in about seven states. Worked for an HMO, worked in local governments. So I've sat in every chair, actually, except academia. And by the way, my career plan is I would like to end my career in an academic chair.

I'm an advocate of disability prevention, which is a new term. And the idea is not that we're preventing the injury. Other people are doing that. What we're doing is we are mitigating the impact, the disruptive and destructive impact of injury and illness on people's lives. As Bob said, I am active in ACOEM. I chair the Work Fitness and Disability section, which is the largest section in ACOEM. And I not only chaired the group that wrote this guideline, but I chaired an earlier group that wrote a previous guideline called, The Treating Physician's Role in Facilitating Return to Work.

Now, needless work disability is destructive and harmful. It's harmful for employees. It disrupts their daily life. It threatens their career and their self-esteem and leads to iatrogenic invalidism. I use the word iatrogenic here in a very broad sense. Technically, iatrogenic means, "caused by the physician or caused by the health care system." So for example, iatrogenic illness would be a hospital-acquired infection. But

there's another way of defining iatrogenic. It is how you and I and all of us respond to an injured or ill person. The way we respond or don't respond potentially creates their view of themselves as an invalid.

Needless work disability is also disruptive and costly for employers because it fundamentally reduces their productivity, and creates unnecessary hassle and expense. And at the employer level, at the level of the person who's really running the business, it's not the benefit cost that's the problem; it is the disruption in the production line.

And lastly, at the economy level, obviously, needless work disability is wasteful because it's diverting dollars from productive use, inviting petty fraud and corruption, and reducing economic efficiency.

The purpose of ACOEM's new guideline is to describe for the first time in detail the stay-at-work and return-to-work process, and to point out opportunities for improvement and provide some examples of current best practices. And, the way we managed to get all those 21 cats to work together is that all of us wanted to begin an ongoing dialogue among all the stakeholders. We saw that in our role as physicians we were trained to tell what was medical from what was not. And we're the most reliable tellers to you about that, so you know what's non-medical and you can work on it.

The authors are all ACOEM members and represent several specialties in occupational medicine, orthopedic surgery, internal medicine, family practice, physical medicine and rehab, psychiatry and emergency medicine. And we came from 15 U.S. states and Canada, and we're working in private practice, government, academia, heavy industry, and workers' comp and disability insurers. We looked for a doctor working for a union. We couldn't find one. But our goal was to represent the rainbow of all the places where physicians see these systems working. We used a collaborative and consensus-seeking method, and we widely circulated our paper before it was published for feedback from the stakeholders, and we also peer-reviewed it inside the college.

The structure of the Guideline starts with some introductory material, and then orients you to the stay-at-work and return-to-work process, how it works and the variability of medical conditions and their impact on work, and the relationship of the stay-at-work and return-to-work process with other processes. And then, in the last half of the paper, there are 16 findings and recommendations, each one of which is laid out with observations, discussions and examples.

So, what is the stay-at-work and return-to-work process? It is a sequence of questions, actions and decisions made separately by several parties that together determine whether a worker stays at work despite a medical condition, or whether, when and how that worker returns to work during or after recovery. And, this process often stalls or becomes sidetracked because the focus tends to be on corroborating, justifying or evaluating the disability rather than preventing it. The long and the short of this is that the stay-at-work and return-to-work process is a team sport, but we have not been playing it that way.

There are five parallel processes. There's the stay-at-work and return-to-work process, which is working in parallel with the medical care process of diagnosis and treatment; in parallel with the personal adjustment process, by which the worker is deciding how to respond to the situation and figure out what the implications are of this injury and illness for their future life, in particular, their vocational life. There's the benefits administration process and sometimes there's an ADA reasonable accommodation process. The sick and sad part is that the stay-at-work and return-to-work process, which is the one which is going to actually determine the outcome – along with the medical care process and the personal adjustment process – is being overwhelmed by the benefit administration process. The benefit administration process is frequently viewed as the real one, and yet the other ones are the one that are going to determine the outcome.

So I want to run you through at high speed the four general and 16 specific recommendations made in the report. The general ones are:

Number one, adopt a disability prevention model.

Number two, address behavioral and circumstantial realities that are creating or prolonging disability.

Three, acknowledge the powerful contribution that motivation makes to outcomes, and make changes to improve incentive alignment.

Four, invest in system and infrastructure improvements, and you're a good audience to be talking about that with this.

“Adopt a disability prevention model” means that we need to increase awareness of how rarely work disability is actually medically required. And we need to instill a sense of urgency, because prolonged time away from work is harmful. Some years ago, when I was the chief medical officer of a managed care workers' comp company, my boss asked me, how often after work-related injury does somebody really need to be away from work for strictly medical reasons? And when I told him my answer, he thought I was nuts. So I did a survey in order to prove my point. My favorite four words used to be: “I told you so”

So the key question in the survey that we did (we surveyed 99 occupational medicine docs who did work in 40 states) was: “Based on your clinical experience, what fraction of workers with work-related injuries and illnesses who seek medical care – which means it's bad enough they went to see the doctor – really need to be off work for more than a couple of days for strictly medical reasons?” And more than 90 percent of the doctors said it was less than 10 percent of the cases, and more than 50 percent of them said it was less than five percent of the cases. And the more experience that the doctor had with running transitional work programs or with helping people under ADA to stay at work, the lower the number got. I had told my boss two percent, because I had run an alternate work program for a shipyard. Now, the actual number nationwide has dropped

down to about 23 percent nationwide. I don't know what it is in your state or in your company, but if the real number is 25 percent – this makes the math easier – if the real number is 25 percent, and the most that is needed is 10 percent, that means we've got 60 percent of cases with non-medically required days away from work.

Today, my company, Webility, has a web-based course for doctors on disability prevention, and we're continuing that survey, continuing to get those same results. But we've added now a second question about non-occupational conditions. And the closest we could come to a similarly-constructed question was to ask: "What fraction of your patients with a condition that's not work related, but who have asked you to sign a form excusing them from work, really needed to be away from work for more than a couple of days for strictly medical reasons?" And the results are turning out to be pretty similar-looking on the left-hand side of this chart. Eighty percent of the doctors say it's less than 10 percent of the time of the people who asked them to sign a note. And 54 percent say it's less than five percent of the cases. But oddly enough, up to 100 percent of these people are actually away from work because they are asking the doctor for a note.

So, when is work disability really required? Remember: by work disability, I mean, absence from work. When is absence from work attributed to a medical condition really required? The new ACOEM occupational medicine practice guidelines, chapter five – if you have not paid attention to it, it's a landmark chapter – is called Disability Prevention and Management. The definitions that you're going to see here are very similar to what's in there. In fact, Webility donated our language to the ACOEM practice guideline. These definitions have also been in front of hundreds of doctors, and they don't push back. So those of you who are not medical doctors, you can feel comfortable with these definitions. You need to be away from work if you have to be at a place of care – if you have to be in a hospital, you have to be in a day treatment program, if the p.t. office closes at 5:00 – because your healing should take priority over being at work. You also need to be away from work if you have to be confined to at-home or in-bed. And usually the reason for that is as follows: Immediately following injury, the body has a biochemical cascade where basically you're prostrate; you need to be still in order to heal. Or, you may need to be at home because there's a risk of infection, contagion or quarantine. Either you're dangerous to me, or I'm dangerous to you. You need to be in the house. Or, you may need to be in a protected environment. Somebody who's delusional or psychotic has to be protected from the real world, or the real world needs to be protected from him or her.

And lastly, if there's some reason why working or commuting is medically contra-indicated. And by that I mean, there's something about all kinds of work, or any kind of commuting that would worsen the medical condition or delay the recovery. But many circumstances that look like they are medical contra-indications turn out to be environmental. So here's an example. I used to work on the north slope of Alaska for British Petroleum, and a guy wanted to come to work for BP. He had hemophilia. I said, whoa, I don't think it's a good idea for you to work on the north slope of Alaska, because if something bad happens and you need blood, we're an hour and a half away by jet from the nearest blood, and we're frequently weathered in. You can't come to work here. But,

the guy could work just about anywhere else, right? He could work anywhere where there was blood near by. So, many times when something looks like it's a medical contra-indication, you have to look at the circumstances and say, if we shifted the circumstances, could this person work? If so, then they do not need to be away from work for medical reasons only.

Work disability prevention is not about eliminating medically required disability; it is about eliminating unnecessary disability or preventable disability, which shows up as the result of discretionary decisions. And most often, those discretionary decisions are being made by somebody who may say it's for medical reasons, but they are actually making a business decision. It's usually a cost-benefit decision. Is it worth making use of whatever productive capacity this person has while they're recovering? And usually that shows up as, oh, we can't find anything for him to do. Or, there's no way to get him to work. Or, the bother of dealing with it seems to be more than the benefit. Et cetera. Many times, when you hear someone describe why somebody's not back at work, it needs to be unmasked and revealed for the business decision it really is. Because sometimes, the leaders in the business have made a decision – they want to reduce their workers' comp costs, or they want to increase workforce availability, but at the first-line of supervision, they're getting undercut by supervisors who are making decisions for their own convenience or out of ignorance. Sometimes it's an appropriate decision to keep somebody away from work. For example, if they only need a week of recovery time, and it would cost you 20 grand to get them the wheelchair that would climb the stairs that would let them work for that week, then that might be stupid. But if somebody's going to be away from work for a year, it might make good business sense to invest in getting that person back to work right away.

And there are a lot of medically unnecessary disability days caused by system friction, by ignorance, by resistance, and by administrative and bureaucratic delays. Again, these are masquerading as medical reasons for time away from work, but are in fact not. And the awkward part is those delays are decreasing the likelihood of people ever going back to work. You guys already know that length of time away predicts bad outcomes, and yet you persist in systems that have unreasonable delays.

So the second group of recommendation is intended to address behavioral and circumstantial realities. People's normal human reactions need to be acknowledged and dealt with. When somebody has been injured or become ill, even if it appears to be minor to you, their life might have been turned upside down. Today, when so many people have two-career families and childcare and work here and there, even a modest thing can turn a family upside down. Somebody who is uncertain whether they're ever going to be able to work again, or uncertain what the meaning of this injury is for their future has a big deal going on. And when I first came in to workers' compensation 25 years ago, I was so struck that people with injuries and illnesses have the question arise whether or not they can work again have a major life situation they are facing, and who is going to help them with it?

The doctor's just going to do the diagnosis and treatment. The claims adjuster is just going to decide whether to pay it. The employer is just going to frequently tell stories about him behind their back and decide to fight the claim. Who is helping the person sort out the situation? Who is helping them identify the optimal resolution of this for today, for tomorrow, and for the rest of their life?

Also, one of the peculiar things about workers' compensation is how inauthentic and superficial it is. There are social and workplace realities that we know from all the evidence have a profound impact on outcomes, and yet the system says, don't tell me about any of that stuff. I only want to talk about the stuff that's in the law. And lastly, people with injuries and illnesses – about 20 percent – this number may not be exactly right, but about 20 percent of us already have psychiatric conditions at the moment we're injured or ill. And the co-existence of a psychiatric condition with an illness or an injury prolongs recovery. Many of us, when we develop a chronic illness, will then also develop a psychiatric condition with it. Fifty percent of people with chronic illnesses have diagnosable psychiatric conditions. The fact that you guys don't want to deal with it doesn't mean it doesn't exist. The fact that you guys don't want to deal with it, doesn't mean that it isn't screwing up outcomes, right? So this is an issue, which absolutely has to be addressed if you want to achieve optimal outcomes in this system.

And there are modifiable factors that predict long-term disability. Dr. Gordon Waddell in the UK did a big study of all the things that predict long-term disability. Some of them we can't do anything about, like age, like educational attainment, like what kind of work you do. But here is the list of things, which are modifiable. And what is fascinating is that with the exception of number one, interval away from work, which we can do something about by helping people recover on the job, getting them right back on the horse. All the rest of them have to do with how the person sees their situation. Remember what I said about expectations? Who is helping set the expectations for people? Who is helping them envision the best possible outcome, and who is on their side trying to achieve that best possible outcome. Pain intensity and pain behavior, by the way, are intensely driven by expectations and the person's perception of their situation. And time is of the essence.

This is my slide from a population from General Electric; on the left is the likelihood of ever going back to work and on the right-hand side is time away from work. And for that population, by three months, the likelihood of ever returning to any job had dropped by 50 percent. So the reality is, every day the odds are dropping, and unless you're managing your system by elapsed time, you don't know where you are. Instead, everybody is managing by from when they got the case or the claim, as opposed to from the day the person left work. So when you talk about iatrogenic disability, if you have any part of your system, which is operating slowly, you are creating disability.

Three, acknowledge motivation and align incentives. You have to pay doctors for disability prevention work if you want to increase their commitment to it. Right now, any doctor who provides assistance with return-to-work is a sucker in most systems because they're not paid for those minutes. They're in a revenue maximization program

like everybody else. In today's world, doctors are basically high-priced assembly line workers. The only CPT codes that they get paid for are ones where the patient is in the room. They don't get paid for time speaking to employers. They actually don't even get paid for time spent talking to employees about return to work. If you want them to do the work, you've got to signal that it's valuable and important, and you've got to pay them to do it.

You also want to help doctors by supporting appropriate patient advocacy, by getting treating doctors out of a loyalty bind. I do a lot of workshops with employers and payers, and basically employers and payers love to blame doctors rather than do anything about it. One way to help doctors get out of that loyalty bind is make it easier for them to give you an answer that you will find useful. And there actually is a self-assessment you can use on our website that helps you figure out whether you are teeing the doctor up to help you, or are you just looking at the world from a you-centric point of view – and simply feeling comfortable blaming the doctor for your problem.

And lastly, obviously we need to increase the availability of on-the-job and recovery and transitional work opportunities, because this is the thing that helps people stay well: getting them right back on the horse. I want to comment, though, that I don't use the phrase "get everybody back to work", because that may not be the solution for some people. Everyone will agree that what people want is to get their life back to as normal as possible. And for most people, that will include a return to work. We can all get behind looking for optimal resolutions of situations, which usually will include return to work. But just be careful; because most workers might feel jammed if all they hear is "get you back to work."

And also, we need to reduce distortion of the medical treatment process by hidden financial agendas. Employers, payers, and workers love to basically trick doctors into saying things they want them to say, and the doctors feel uncomfortable and manipulated. That's part of why they don't want to participate in this system. We really want this system to be transparent to all players. Also, because we allow so much minor abuse and cynicism in workers' compensation, we make the system unattractive to people. We need to be more rigorous, more fair and more kind all at the same time, in order to reduce the cynicism which permeates the system and makes it so unattractive to people.

This November at the National Workers' Comp and Disability conference in Las Vegas, Richard Pimentel and I are going to be doing a session called "Are you being hostile or firm? Are you being kind or a sucker?" And that essentially is the balance point we need to find in this system. We want and need to be kind and firm, and neither hostile nor a sucker.

And lastly, we need to devise better strategies to deal with bad-faith behavior. And that's not just doctors. And that's not just employers who hide their premium. And that's not just employees who falsify injuries. There is another problem, which is the employer who will not work with you to bring somebody back to work. That is a huge problem for many workers. In fact, the employee has the most power to determine the

eventual outcome of a disability situation. Because he or she decides how much discretionary effort to make to get better and get life back to normal. And many of these systems really do not acknowledge that the employee has responsibility in these situations. I've never been able to understand why the worker doesn't have responsibility to mitigate the impact of his or her own situation. And the employer plays the second most powerful role in determining the outcome by deciding whether to manage the employee's situation actively, passively, supportively, hostilely, and whether to provide for on-the-job recovery. When I was at the shipyard, the senior VP of Operations one day said to me, "Jennifer, you know, in the medical department, the only ones you see are ones where there's a problem between the employee and the employer. Because whenever the first-line supervisor and the worker are in alignment, those cases never even become visible because they work it out."

So by definition, we see problematic cases where we have a problem between the employee and the employer at the first-line level. And why are we not paying attention to that?

Lastly, the fourth big group of recommendations is intended to invest in system and infrastructure improvements. First of all, I don't know if you know this, but doctors have never been educated on what their role is in preventing disability or in managing disability. And they have never been trained in how to assess functional limitations or put on medical restrictions or do work capacity. You guys want them to know how to do it. You guys insist and write a role for them in the law, but they do not know how to do it. I do a lot of lecturing to doctors, and when I say, I know you're making it up, there's this great sigh of relief. They're making it up, right? So stop writing mandates for doctors without providing and insisting that they have the wherewithal to do the thing you're asking them to do.

It's a peculiar feature of this whole system that you not requiring that doctors actually know how to do the stuff you think it's so important they know how to do. And you need to disseminate information about the strong scientific evidence that staying active and at work fosters recovery -- and not just to doctors, but also to employers and payers the.

We also need to improve in standardized methods of information exchange between employers, payers and medical offices. It's so bizarre. In this country, 100 to 200 million return-to-work slips are flowing back and forth between doctors' offices, employers and payers every year -- and it is a non-standardized paper process. Every big employer has to deal with thousands of different forms from different doctors' offices. And every doctor's office has got to deal with hundreds of forms from so many different employers and insurance companies. This is a place where we really have a lot of system friction. We also need to improve and standardize the methods and tools that provide data for stay-at-work and return-to-work decision making. The AMA Guides to the Evaluation of Permanent Impairment is one example. The ACOEM Occupational Medicine Practice Guidelines are another great example. Evidence-based disability duration guidelines are another one. My favorite is Presley Reed's Medical Disability

Advisor because the data is the most solid. What is really missing right now is an encyclopedia where a doctor goes to look up what should be the medical restrictions or considerations for specific conditions. Actually, right now, in order for a doctor to figure out what you should or shouldn't do because of your diabetes or your lung disease or your insomnia or whatever, they just have to pull it out of their head. And we need to increase the study of and knowledge about stay-at-work and return-to-work.

It is bizarre that we've spent so much money in this country studying the way health services are delivered to children, to Medicaid recipients, and to Medicare populations, and how little investment we have made on how well the workers' compensation system is delivering care, and how well the stay-at-work and return-to-work process is working.

So that's a fast overview of the ACOEM Disability Prevention Guideline. I was thrilled when I got a totally unsolicited call from the risk manager of Wal-Mart telling me he thought this was the best written description of the stay-at-work and return-to-work process he'd ever seen, and that it is a blueprint for improvement. So I really do recommend you to it. I think you'll enjoy it.

Webility, as a company, has invented a project to take this new Disability Prevention Guideline to 50 states and 10 Canadian provinces, and use it to move the system forward in those states – to waste less money and needlessly disable fewer people. The idea is to assemble the stakeholders, have them learn about the guideline, learn about the stay-at-work and return-to-work process, and then to break into small groups. Each one then considers one of the recommendations and asks, how can we implement that recommendation here? What is the concrete next step that would make that possible?

We've already held summits in Oregon and New Mexico. The one in Minnesota is being planned. And part of why I'm talking to you is, hey, you want to do a summit in your state? So in your packet are several papers: (a) a vision for what a summit might look like, (b) some questions to ask yourself on what would help a summit in your state achieve maximum impact, (c) a draft editorial written by the guideline authors on what we hoped and the reason why we wrote our paper, and (d) the new ACOEM guideline itself.

That's it. Any questions? Reactions?

(Applause.)

Discussion

Q: I'm from the House Ways and Means Committee. Should I use the mike?

DR. CHRISTIAN: Yes.

Q: Your chart from GE looks pretty depressing when I think about Social Security Disability Insurance and return to work under that, because clearly it's showing that if somebody's been out of the workforce for a year, chances are they're really never going to go back to work. Can you talk about that for a minute?

DR. CHRISTIAN: Actually, this year we've had a contract with Social Security to think about how they can make better use of functional and vocational expertise in SSDI and SSI. . So for the first time I've really been doing – this is my new term – deep thinking about Social Security. You know, it's really two processes. One is the disability prevention end and the other is the rehabilitation end. And I don't know if anybody's really looked hard at what the batting average is when you put a good full-faith rehab effort to work on somebody who wants to go back to work. Because the system has been so uncurious about its fruits, we don't know. What I do know is that where I learned this stuff was at Bath Iron Works Naval Shipyard, and we put in place two groups. We put in place a group that managed hard the first six weeks to get cases on the right track. We had fabulous results. Here's the metaphor I used – I walked in there and they have 425 people out of work, and they wanted me to work on the ones that had been out of work a long time. And I said, listen, you just invited me into your kitchen. You've got the faucet going full blast, you've got the sink overflowing, you've got water all over the floor, and you want me to work on the floor? No, to heck with that. I'm going to go turn off the faucet. Right?

So disability prevention is where we need to start. Stop creating these fiascoes, right? But in order to appease the shipyard's management, I also set up what I called the Rehab Roundtable. We took people who had been out of work one or two years – and we knew that the odds, because I'd actually seen the slide myself, I knew the odds were one to two percent. We got 40 percent of them back to work. And of those 40 percent we got back to work, we got them back in the shipyard and more than 75 percent of them were performing above average by the time we got them back. Now, what we did is we decided to take a complete look at those people from every dimension. We had their claim behavior, their previous personnel record, their discipline record, and their labor relations record. We had the department they'd been working tell us whether this guy was ever any damn good at the start. We looked at the whole person. And my role was to interview the person and figure out if there was a hook in their heart somewhere that we could haul on that we could pull them back. And that turns out to be a big piece of it. What is there in you that I can call out that makes you want to try again when you've gotten into a hardened or a hopeless position.

So we made three decisions. We had a group that included the top management of the shipyard – medical, labor relations, personnel, everybody that had done the

evaluations. And the three decisions were, (1) we'll put the full faith of the shipyard behind your recovery. (2) We will give you conditional support, because we're not sure you can make it – or, we want to give you enough rope to hang yourself. (3) Or we will go for a claims-oriented defense period. But what happened is we took claims that had been dragging, and we said, what this person needs and what this situation needs is a resolution. They need to figure out what life is about for them, going forward. I think there is better luck at the back end, but it took a lot of work (and resources) to accomplish what we did.

Thanks very much. Let's talk later.

(Applause.)

MR. AURBACH: Wonderful panel. We're going to have a 15-minute break. Please come back and be in your seats at 1:45 for our next panel.

(Break.)

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

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 banded 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 PEPOWSKI: This is a great dovetail, Teryl, to your comments. I'm Bernyce Peplowski. I've 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. PEPOWSKI: 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. PEPOWSKI: 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. PEPOWSKI: 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.)

Panel IV: Preparing for Catastrophes in the Workplace

Introductions

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

CHRISTINE BAKER: Good afternoon. I think we'd like to get started to keep on our schedule. Welcome to session four: Preparing for Catastrophes in the Workplace. We would be remiss without this as an agenda item, and of real concern to the United States. Again, I'm Christine Baker, and I'm on the California commission as the executive officer. And I've got the honor to serve as moderator of this session.

First, I'd like to introduce the panel members, and then share with you some of the efforts that California has done to prepare for catastrophes in the workplace. For this session, we are privileged to have four distinguished experts who will give us various perspectives on this important topic.

They are, in alphabetical order – and I think in order of presentation as well – John Howard who is currently the director of the National Institute of Occupational Safety and Health, as well as coordinating all of the Department of Health and Human Services secretaries on the World Trade Center programs. John has also served as the Chief of the Division of Occupational Safety and Health in California, Department of Industrial Relations from '91 through 2002. And I had the pleasure of working with John during that time.

James MacDonald is Director of Insurance and Reinsurance at Navigant Consulting, in Philadelphia, Pennsylvania. With over 30 years of experience, Jim is concerned with insurance challenges, including medical malpractice and the insurance of terrorism, and the future of the terrorist risk insurance – TRIA.

We're honored to have Irv Rosenthal, Senior Fellow at the Wharton School, University of Pennsylvania. Irv was also employed by Rohm and Hass for 38 years, and served a five-year term on the United States Chemical Safety and Hazards Investigation Board.

Robert Snashall is Counselor at Law and Founder of Snashall Associates. Mr. Snashall was the Chairman of the New York State Worker's Compensation Board at the time of the World Trade Center terrorist attacks.

Thank you for all being here and we look forward to hearing from you. There will be an opportunity for the audience to ask questions after the presentations have been made.

As we have learned from September 11th, the risk of catastrophe while people are at work and the risks to the workers who respond require the urgent attention of employers, workers, and policymakers. Recognizing as we do that employers and

workers should be prepared if a catastrophe strikes at the workplace, the Commission has held a series of forums. And I'm not going to go into depth in those, except for the fact that we did identify several main themes. And disaster preparedness is an occupational safety and health issue. Occupational safety and health is about labor and management, labor and employer's cooperation as well as public and private partnerships, and preparedness includes first responder safety. And the definition of first responder has been broadened to include the employees themselves as well as the employers. So, without further ado, I will let Dr. Howard present.

21st Century Emergency Preparedness and Response: The Scope of Emergency Responder Safety and Health

John Howard, M.D., Director, National Institute for Occupational Safety and Health

JOHN HOWARD: Thank you, Christine. And thanks for inviting me here to participate in this session this afternoon. Whether we're speaking about natural disasters like an earthquake, a hurricane, or the appearance of a pandemic strain of influenza, or whether we're talking about manmade disasters like a chemical release in a populated area, a truck bomb detonating next to a government building, or massive structural collapse due to a terrorist incident, the one thing that all of these events have in common is the participation of an emergency responder.

And even beyond those that choose to work in an emergency responder profession, there are many others who can be assigned incidentally or who just decide to volunteer to respond to a large-scale emergency event. Protecting those who do respond to emergencies from injuries and illnesses arising from their response activity is a prime concern of my institute. And I think it's also a concern of government at every level, as it should be for all of us, whether you're an employer, a laborer, or in the insurance industry.

And specifically, I think that our concern should be for responders in all three phases of their life – before they are deployed, while they are being deployed, and after they are deployed, whether it's immediate or long term. We partnered with RAND in 2001, after the World Trade Center disaster at which 450 emergency responders lost their life, to examine the lessons from that terrorist attack on New York City. We produced three monographs, which I would invite you to go to the RAND site or to NIOSH site to look up.

But in those, we had recommendations for pre-deployment and deployment. Of our pre-deployment recommendations, I think the most important was to develop guidelines for the appropriate personal protective ensembles for long duration disaster responses involving rubble, human remains, and a various range of respiratory threats. Two, define the appropriate ensembles of personal protective equipment needed to respond to biologic, chemical, or radiological events. Three, design respirators that are CBRN protective and can be worn for hours at a time. And four, create interoperability with respirator filters so that any filter can fit any respirator.

The deployment recommendations were chiefly related to proper site management, which is critical to ensuring the safety of responders, including whether personal protective equipment is available, appropriately prescribed, used and maintained. Second, coherent command authority is necessary to maintain perimeter control at all times and to have – which we did not have at the World Trade Center – a zonal census record for each responder and volunteer to know where they are or were on the site, how long they were there, and for both immediate management and for future post-deployment issues.

And three, to optimize safety management during a large-scale disaster when you have multiple agencies coming from around the country, it's vital to integrate safety and health management of multiple organizations into the single incident commands structure, which was not done very well in New York. Integrated safety management allows for the assessment of potential harmful exposures in real-time, whether you're at the site and what levels they are at the site and what kinds of controls need to be put in place immediately before entry, and for future reference.

And lastly, to ensure that all communications at the site are interoperable. And so, the institute, working with a lot of partners, including equipment manufacturers, labor, and industry, have been working on those national preparedness recommendations.

What I wanted to do, in my short time with you today, is to give you some idea from my current perspective, working with the World Trade Center health issues. I can tell you that there probably is no more important message for me to say today that no amount of time that is spent on preparedness, careful pre-deployment, and during deployment emergency response is wasted. Such preparedness is really critical to the post-occurrence, the post-deployment consequences. And what I wanted to do was to give you some idea of what I consider to be a 21st century view of that term "emergency responders," and contrast it with our traditional view and with the view that we are currently using.

The traditional view is that a first responder is someone who is involved in the immediate stabilization activities of a disaster, such as putting out a fire or reducing an explosion or collapse risk; engaged in the search and rescue of live victims of the disaster for evacuation to first receivers; and engaged in the search for deceased victims. These workers in the World Trade Center experience were employees of the New York City Fire or Police Departments or other departments in New York City, New York State National Guard troops who did perimeter control, the Port Authority of New York and New Jersey, and the federal government. Many of the federal workers that came to the site were not traditional federal employees but rather were federalized for short periods of time to carry out search and rescue activities, or to do disaster medical assistance.

Well, there are some non-traditional categories that I think were used at the World Trade Center that we now have accepted as a part of what is an emergency responder. And these are first receivers. First receivers were not thought in that way. But these are people, in the case of New York City, who are health workers and volunteers who provide a diagnosis and treatment to injured or ill victims at the site, at a temporary location, or at a permanent healthcare facility, or they were employees of the New York City Medical Examiner's Office that had to do post-mortem examination on human remains. Many of these employees, and even today, do not think of themselves in the category of emergency responders. And that, I think, is an interesting issue in terms of attitudinal adjustment to a new era.

The second category is recovery workers. In the World Trade Center, these were primarily construction laborers and other volunteers who engaged in stabilization of the

site, deconstruction, removal of debris on barges to Staten Island. In their activities, they encountered deceased victims, human remains, and participated in their retrieval. And the question remains whether or not the current cadre of construction workers in New York City that are engaged in current deconstruction activities around the World Trade Center site should be included in that category of emergency response workers.

The third non-traditional category is cleanup workers. These are workers or volunteer contractors, chiefly immigrant laborers, who engaged in the cleanup and removal of dust in the Lower Manhattan area from commercial buildings and from residences, hired through EPA money through general contractors.

In the next category are restoration workers employed in critical infrastructural industries like utilities and communications, who engaged in the restoration of essential services to Lower Manhattan after the World Trade Center disaster. And clearly, as we know, restoration of financial markets was considered to be a national goal, and many of these restoration workers were from the financial services industry themselves. And they certainly did not consider themselves to fall into the category of hazardous employment before 9/11 or in the category of emergency response workers.

And clearly, beyond this sort of expanded 21st century definition of World Trade Center, we have others that are affected – commercial and school building occupants, teachers and students, nearby residents of Lower Manhattan, Chinatown, and western Brooklyn. These multiple categories of exposed persons affected by the World Trade Center are the center of much concern by the Congress who has funded medical monitoring and treatment programs for responders and also a captive insurance fund for World Trade Center claims against the city of New York, by the state of New York who recently passed extensions to the filing time in the World Trade Center Rescue, Recovery and Cleanup Workers and volunteers' compensation cases, and three, by the city of New York, which recently funded medical monitoring and treatment for residents at Bellevue Hospital, a city of New York hospital.

Medical monitoring funded by the Department of Health and Human Services to date demonstrates that a number of conditions are occurring in the Responder, Recovery, Cleanup and Restoration worker volunteer population at frequencies in excess of the referent populations, such as upper and lower respiratory disease conditions, post-traumatic stress disorders, gastrointestinal reflux disorders, and musculo-skeletal disorders. And even for affected residents and commercial building occupants, there are reports in the scientific literature from early after the disaster of health effects, which mirror those in the responder community, albeit at a less prevalent level. In a re-survey of a sample of New York City residents and workers is currently taking place in the World Trade Center health registry, and we hope to be able to update those early surveys by looking at the persistence of that symptomatology now almost five years later.

So in conclusion, I just want to emphasize that preparedness for disaster needs to include all three phases of emergency response: pre-employment, during employment – and clearly, the area that I'm involved with now that I don't think any of us foresaw was

the post-deployment health issues. And so I'll end with that and be happy to take questions during the question period.

(Applause.)

Management's Role in Preventing and Mitigating Catastrophes in the Workplace

Irv Rosenthal, Senior Fellow, The Wharton School, University of Pennsylvania

IRV ROSENTHAL: I want to contrast what I've heard here and place in perspective catastrophic risks as compared to the bulk of the risks and hazards we deal with in worker's compensation. Our symposium is focused on extending trends in healthcare and income benefits for injured workers. Our session is focused on preparing for catastrophic risks in the workplace. More specifically, I would like to talk mainly about the challenges facing employers in preparing for catastrophes, because I think this is where the real opportunity is.

As I said, my remarks are focused on the role employers in preparing for high consequence, low probability risks, which I'll refer to as HCLPs. I want to stimulate discussion on the proposition that firms can and should do more in instituting preventative measures in regard to terrorist attacks or any other catastrophic risks, rather than relying on so heavily on insurance aimed at compensating firms and victims after the fact. Many firms already take this approach in regard to LPHC processes, and natural disasters. All of the discussions that we've had on terms of trying to eliminate terrorist attacks, and the thrust of the legislation under OSHA dealing with process safety management and with EPA dealing with risk management, which can affect the public.

Terrorism is only one of a multitude of catastrophic risks. And one of the things that applies to catastrophic risks and dealing with terrorist risks as well as more conventional risks is to use the techniques of risk assessment that have been developed in industry to deal with the more conventional hazards. An enterprise can use these existing tools and approaches to reduce the likelihood and consequences of normal workplace catastrophes with some modification can use these against terrorism. The enterprise should examine existing risk management approaches before deciding to either only buy insurance and let the insurer worry or do nothing and hope for good luck or post-hoc government bailout.

My experience in some 38 years in the industry was that if I were to tell our insurer that I've reduced the risk of a catastrophic accident from 1 in 1,000 years to 1 in 10,000 years, he would say that's lovely. And if I'd ask him what's the risk reduction I would get in our premium for doing this, he would laugh.

I put on this strategic risk management framework purely because it embraces the essential elements of a technical thing. T.J. Anderson of Denmark, a financial analyst, put it out. And it's interesting to see that a good part of the measures he deals with are risk transfers and financing in excessive risks. And as with most business-oriented authors, Anderson's paper is highly focused on the use of risk assessment and risk management processes and the financial side of the event, though it also touches on the need to do something about assessing physical risks. And their focus is on how to properly structure your financial instruments and insurance to protect the firm.

However, my feeling is that the firms should recognize that many of the potential emotional and financial catastrophic losses to the totality of the operation's stakeholders, such as the community, the government, and the employees, are most effectively addressed by reducing the operations' physical risks, rather than ensuring coverage of the enterprise and stakeholders' financial losses. And a sound risk assessment is critical for guiding efforts aimed at reducing physical and operational risks. Many risk assessment models exist, and hopefully – I'm going to point to the generic OECD model on the next slide – can be helpful in thinking about it in this fashion.

I'm just going to briefly mention the main headings of this. For many of you, it's routine. Basically, you have to identify what are the sources of potential to cause undesired outcomes for the subjects of concern? Now, in some instances, like we use the World Trade Center, being blown up in a bomb is something that you don't think about normally in terms of structures.

However, there are a number of instances in which you can eliminate the hazard and make the operation intrinsically safer. You then have to go through what types of events can result in the explosion concern. Terrorism, of course, is an intentional act, whereas most accident scenarios arise from unintentional sequence of events. You have to ask yourself what damage can result from such an event, and it's amazing in how many instances firms have not assessed the consequences of such occurrences. And under such conditions, John, it's almost impossible to organize responders, because they never tell you about the possible hazard. And then, you make assumptions about how the risk is ranked.

Risks can arise from any sequence of events that actualize the hazard. For instance, you can have the introduction of corrosive materials or the release of a toxic or a flammable substance and subsequent explosions or mass poisonings. The risk assessment process can tell us what scenarios might lead to the actualization of the hazards; you sit down and get a group of people together and run through the various scenarios that can happen. What measures might we take to prevent this occurring and the process modifications that can be put into prevent such a scenario?

There are many instances in which steps can be taken. I think the classic case that is taking place right now has been the replacement of chlorine by hypochlorides in water treatment. This is the result of a conscious decision that chlorine, which can be released accidentally or by a terrorist attack, can have widespread community implications. There are a number of different approaches. Some people reduce their inventories. Some people replace with hypochloride. Some people are going to completely different treatments. They're eliminating chlorine altogether by using UV light and electronic measures. But it's a necessary assessment to physical risk reduction.

The enterprise has to go through a dual analysis. It has to analyze what can be done cost-effectively to reduce the hazards or the likelihood that a scenario that is enacted with the purpose of releasing the hazard, what can occur and what measures can they take to reduce this?

It then can and should compare the cost-effectiveness of improving risk management versus managing just the financial consequences via insurance. In some cases, it may be cheaper – aside from everything else – to go this physical way. But what the enterprise often doesn't take into account, and what's very evident right now with the case of British Petroleum who had a major accident in Texas City, is that some of their own and their stakeholders' losses may not be adequately compensated solely by monetary results. Regardless of the insurance, the loss of social credibility and social license, the problems that BP will face in trying to get government to give it new leases on oil or anything else are much higher than the direct physical losses that they face as a result of this accident.

And that comes from the fact that after the accident is done, even if the firm has obeyed the letter of the law and done everything that it's had to do, the stakeholders don't focus on that. They ask themselves this question: if the firm were to act prudently, did they take reasonable measures to prevent and mitigate all of the stakeholders' catastrophic losses? And if they didn't do that, the firm tends to lose its social license and that alone can be catastrophic.

And just a brief note that when we talk about terrorism risks, these risks are not solely under the control of the firm. They're interdependent risks. They go from the fact that people may share a pipeline, an industrial park, or an electrical grid. And one person's failure to take adequate measures can affect all the other stakeholders on that grid. The result of this type of thing is that to the extent that the enterprise does not address these catastrophic risks and these catastrophic risks are interdependent, the only way they can be addressed is by government policy or law.

It's interesting to see that there's an organization, the International Nuclear Process Organization, which was formed after Three Mile Island. It has every nuclear facility in it. It's not a regulatory issue. Every nuclear facility joined it, because at the end of Three Mile Island, the nuclear industry was at the edge of being closed down as it has been in some countries. And they realized at that point how dependent they were on having a social license to operate. And so they went on to form this association, which every member's chairman goes in. They ordered themselves very rigorously. They do cultural surveys. And they get very, very excellent adherence from their members because their very existence is threatened. And this is occurring with some other industries, as well.

I'm just showing this next overhead because it shows the complexity of dealing with the catastrophic risk. Our discussions today on workers' compensation indicate that this is not a simple matter either. It runs from every locality, city, state, unions, are involved in it. But when you're dealing with terrorism risks, you are really dealing with issues that extend from foreign policy to government reinsurance under TRIA and you are dealing with very complex issues, which to some degree are even more complex than the issues faced with workers' compensation. Thank you.

(Applause.)

Preparing for Catastrophes in the Workplace

James Macdonald, Director, Insurance and Reinsurance, Navigant Consulting

JAMES MACDONALD: Hi there. I'm Jim MacDonald.

Bob Reville of RAND asked me if I would speak about workplace safety and worker's comp and terrorism and TRIA. And I'm pleased to be here thanks to the NASI. I want to plug a little book that just came out this month. Let's see Bob Reville and Lloyd Dixon have a chapter in here. It's called Seeds of Disaster: Roots of Response. The co-editors are from Harvard, Wharton, and George Mason – Erwann Michel-Kerjan and Phil Auerswald, Lewis Branscomb, and Todd LaPorte. But it deals with the subject we're talking about today. It's not just about terrorism, but also about disaster preparedness and what the private sector can do.

Just to explain my current role at Navigant: as the former chief underwriting officer for a major insurance company, I'm frequently asked to speak giving the underwriting case. I now work for Navigant Consulting, which is an independent consulting firm, so I will try to be as objective as possible, with the understanding that I have spent 35 years of my career in the underwriting ranks.

I think the major theme I want to express to you today is that - at least when we're talking about Fortune 1000 companies - there has been more work done in the terrorism preparedness area for the next big one than the Treasury report last year or other surveys would indicate. Obviously, if you survey everything from small retail stores to medium-sized accounts, you're probably going to conclude that the private sector is not doing much to prepare for terrorism. But having spent a lot of time working with risk managers of Fortune 500 and Fortune 1000 accounts, I think one of the things we need to do is take a look for a second at what risk management is all about. I mean, all too often, we think of insurance as the sole solution. We think well, we're going to create some insurance for this problem and file it away. But I think if there is one healthy thing about disasters, looking at these things positively, one thing it's done is it has focused most of us on the holistic set of risk management options, the total set of options that Irv was just mentioning.

[Reference to slide showing pre-loss and post loss risk management goals:]
Insurance is actually only one of the options that a risk manager for a corporation needs to consider. Before a loss, the goals of a risk manager are economic efficiency, tolerable uncertainty - not eliminating all possibility of loss, but determine how much loss can we live with - and what do we need to do to get to that level of tolerable uncertainty, and of course the legal requirements and ethical conduct.

Post-loss, business continuity planning is a key goal. It is important to comply with Sarbanes-Oxley, section 404. Most companies, not because of TRIA, but because of Sarbanes-Oxley, have effectively implemented business continuity planning. If you are publicly traded, you better have a business continuity plan. This is very unappreciated by

the people that wrote the Treasury report last year assessing TRIA. They asked the wrong questions.

But the big question today is “What is ‘tolerable uncertainty’ in the world after 9/11?” So let’s just look at the options. Basically there are three risk-management options. And, as individuals, we all live with some of these options all of the time. For example, we all practice risk avoidance. Whenever possible, you are going to avoid the problem. For example, you’re not going to go to a bad part of town.

[Reference to slide showing traditional risk management options to address hazard risks:] Really there are three options: avoidance, control or risk transfer. You can think of risk transfer as risk financing – that could mean self-insuring, it could be buying insurance, or it could be contractual liability agreements where you get the other guy to hold you harmless.

So there are really three options: avoid it, control it, or figure out how you are going to finance it after it occurs. So let’s move on.

[Reference to slide showing various possible types of terrorism attacks and the estimated probabilities of each being the source of a new attack:] What is the threat? Well, with terrorism, it’s not a data-driven world. I mean, we have got a few data points out there and they span a long period of time. In their latest assessment, RMS estimates that if a major attack occurs, there is a 5-percent probability that it will involve a Chemical, Biological, Radiological or Nuclear – or CBRN device or agent, as noted in the slide. I don’t know how many of you read the presidential working group report, which also talks a lot about CBRN, chemical, biological, radiological, nuclear, also called NBCR, which is the insurance acronym. The 5-percent probability is what RMS is pegging. They are still basically saying we have got a 95% chance the next major attack will not be CBNR – so we have got to worry more about truck bombs, car bombs, suicide bombers, conventional weapons These are the attack scenarios that most insurance underwriters contemplate when they underwrite accounts.

[Referring to a slide showing New York City to be the most likely city to be attacked by terrorists:] Where is a terrorism attack most likely to occur? I was raised in Manhattan; that is why I speak pretty fast sometimes. But as a guy that grew up in 43rd street and 2nd Avenue, when we see things like this, we get a little disturbed. But it is interesting, this is the risk relativity of major urban centers, and intuitively, a lot of us would have said, well, New York is first; Washington is second. Washington is not even third. Washington is down the list. Why is that?

Well, when you don’t have data, what you do is you use your best estimates, and that is usually game theory in the terrorism world, where you look at what is the utility of the adversary, what are they trying to achieve: mass casualties, economic destruction, and an iconic site – I’m a fun guy to invite to meetings, by the way – (laughter) – let me tell you. They want to knock out something that everybody in the Islamic world is going to recognize. Oh, and they want a 90-percent or better chance of success. So they are

probably not going to do a chemical attack in Chicago, right. I mean, it's a "windy city". (Laughter.) So that is basically the framework for analysis. You have got to assume these guys are sane too, and they are strategic. It's like playing chess; you never assume they are not as smart as you.

[Referring to a slide showing quake zones across the USA and both active and dormant nuclear power plants:] You know, the truth is when you look at extreme event risk in the workplace— I just found this map — we have got quake and nuclear exposure all across this country. Terrorism isn't really just a major urban problem— they could achieve their goals in Florida or in California, in New York, or even in Kennebunkport, for that matter, up in Maine, certainly from an iconic standpoint, and possibly economic as well.

[Referring to a slide showing 9/11 Workers Comp deaths and injuries:] It's interesting that one of the prior speakers talked about workers' comp losses on 9/11, because I wanted to check out the latest scene with workers' comp, lessons learned, from 9/11. And, you know, a lot of us think about the fatalities, because it was an unusual attack in that the thinking was afterwards was that either people got away okay or died. But it's interesting that there were about — this is from the GAO report — about 8,000 injuries, or 4 serious injuries or illnesses for every one fatality.

We also see that post-loss responders at the WTC site are showing serious injuries. Have any of you seen this Mt. Sinai report that was just came out analyzing 40,000 WTC rescue workers who were exposed to caustic dust? The report also states that 70 percent of World Trade Center's first responders are now showing new or worse respiratory symptoms. When underwriters had to establish estimated loss reserves right away, we thought, well, what are we going to do? We figured pulmonary would have to be a long-term problem. And we also anticipated the post-traumatic stress claims that we are now seeing.

Now, there are statutes of limitations and reporting comp claims, but they were actually extended in New York, if I'm not mistaken. This is frequently what happens after a major catastrophe; it also happened in New Orleans. This kind of gets insurers upset! After losses, sometimes the regulators come in and say, well, we're going to give you another year or two to report the claims. And that has got insurers kind of miffed.

[Reference to a slide showing insured loss estimates based on various attack modes including nuclear and biological:] What are the possible insured losses from a new attack on the scale of 9/11 or worse? If you look at the potential size of the losses — these are RMS estimates and this is "thinking the unthinkable" here — a nuclear bomb, 5 kiloton, which is actually small — if it exploded in Manhattan, would produce an estimated \$200 billion insured Workers Compensation loss. And if you added the property, which I didn't put in this slide since we are focusing on Workers Comp, we go to a \$450 billion insured loss. That is more than all of the net worth in the U.S. insurance business, right now. So we are talking big bucks.

[Reference to slide showing RMS estimates of a hypothetical terrorism truck bomb attack in Chicago:] But even if you're talking about synchronized truck bombings, this is a scenario in Chicago, RMS scenario, synchronized three-ton truck bombs, where they estimate you could have 70,000 injured people, 5,000 fatalities, and an insured loss in the billions. The key point is that a weapon of mass destruction does not have to involve a Chemical, Biological, Radiological or Nuclear agent.

One important point to note, when people talk to you about how rich the insurance business is and the more than \$400 billion capital they have available, read the GAO report about a year ago. It makes a clear point: all of that capital is not available to pay for one loss. There are only going to be so many insurers exposed in the next event. Half of that capital is dedicated to personal lines, by the way. It isn't even included in the federal terrorism insurance program.

So you do have a significant risk of insurer insolvency without TRIA.

There is a hundred billion dollars of reinsurance made available under TRIA. Nothing, not even the PWG report, suggests the private sector can replace that capacity if the federal program expires next year.

[Reference to a slide showing several specific areas of risk management improvements since 9/11] Okay, if we look at progress since 9/11, there really has been quite a bit of pre-loss improvement in a number of areas. But there is no consistency to it. I won't go over each of these items, but both pre-loss and post loss – we have seen improvements.

[Slide showing Jersey City and lower Manhattan skyline labeled Asset Separation] For instance, here is Jersey City. This is a Google chart. Jersey City's skyline has taken off since 9/11. This is an example of asset separation – one way that risk managers address catastrophe risk. Right after 9/11, one of the major investment banks in Manhattan said half of their employees would be moved to New Jersey.

[Reference to a slide showing an employee's "disaster emergency kit"] Here is a photo of an actual a disaster kit. It's an emergency disaster kit issued to employees in a large office building in a major city. It contains a lot of things. *But what are the minimum items that it should it contain?* There are no guidelines for that. The items in this kit were selected from a long checklist on the DHS website of possible items to consider.

[Reference to slide labeled "Beyond the Basics":] I know one company that issued gasmasks to all its employees. How about aerial egress chutes? How about potassium iodide pills to protect your thyroid in the event of a dirty bomb radiological attack? All of these things are worth thinking about but no minimum standards are currently defined.

[Reference to slide showing building code changes due to terrorism risk] In the building construction area, there has been a lot of progress made. I can't go over this whole slide, but there has been progress made. It's not like everyone in the private sector has been sitting around. ASTM International, NFPA 1600 – a lot of people have been working at improving codes.

[Reference to slide showing “report card” grades from the 9/11 Commission:] However, despite all of this, the 9/11 Commission gives bad grades and says national preparedness is only beginning to find its way into the private sector, driving the overall consensus. It is very clear the hardening of public sector has shifted terrorism risk to the private sector. It's very clear most people don't think they are at risk, and we have this information-sharing problem that is driving the fact that 40 percent of the property buyers still don't buy terrorism insurance.

The emerging question, as discussed in a recent Howard Kunreuther paper on this subject called Rules Not Discretion, is: Do we really need a more entrepreneurial world or do we need a world with clear rules for what to do? For instance, new federal rules might automatically define certain situations as “incidents of national significance”. Maybe a category five hurricane like Katrina on Sunday afternoon in the Gulf headed toward New Orleans should be automatically defined as an “incident of national significance”. Why not make it clear? Don't wait two days to think about it.

Also: Workers Compensation requires a continued federal terrorism backstop even if TRIA expires at the end of 2007. There is no way you can exclude terrorism coverage from Workers' Compensation.

[Reference to a slide showing a quote from Douglas Holtz Eakin, former CBO director,] You know, I did a lot of debates last year on TRIA. I did one at AEI with this very bright guy named Douglas Holtz-Eakin, who was the head of the CBO. Even though the CBO wrote a very critical report about TRIA, and this was just one day after the July 7th bombings, Douglas said, look, if we're going to let TRIA go away we still need some solution for Workers Compensation and the risk of a CBRN attack.

And by the way, everyone I know wants TRIA to go away. Nobody wants another extension. What we need is a new permanent solution addressing CBNR and Workers' Comp. There seems to be a consensus on that point. Thanks very much.

(Applause.)

Workers' Compensation Challenges

Robert Snashall, Counselor-at-Law and Founder, Snashall Associates

ROBERT SNASHALL: Good afternoon. I want to thank the academy for scheduling this conference. I also want to thank Christine and Ed for co-chairing this conference. It has been a great conference. And as the last speaker of the last panel, Christine is already showing me the two-minute warning (laughter). I'm not going to get locked into the PowerPoint presentation; I'll simply try to add to what the previous speakers have already shared with you, and also to keep you awake for the balance of the show.

My focus will be as a former regulator. I was the chairman of the New York state workers' compensation system from 1995 through 2003, and therefore the chairman at the time of 9/11. And so my focus will be as a former regulator, and my focus will be on terrorism and the impact on an agency dealing with the influx of cases.

Now, interestingly, we all know about 9/11 as being the most significant act of terrorism here in this country. We also remember the Murrah building bombing in Oklahoma. We probably remember the first World Trade Center bombing as well. But actually, the first act of terrorism that took place in this country that impacted workers' compensation was in September 1920. A band of anarchists pulled a wagon full of explosives up in front of the House of Morgan on Wall Street in New York City, detonated the explosives, killing about 35 people, some of whom obviously were at work, and some of their families filed for benefits under the newly enacted workers' compensation system.

So terrorism has always been with us and has always impacted workers' compensation system. So there is no doubt in my mind that in the future it likely will impact our systems with the next act, and one thing that we do see is that these acts are becoming increasing more violent and increasingly more destructive.

So I'm going to just focus on probably four main points today. I'm going to assume that you are going to take all of the recommendations that John and Irv and Jim gave to you, and you are going to implement those. You are going to look at your systems. And I am going to just simply ask you to expand a little bit and take into some other considerations.

I will ask you to consider four different factors.

First of all, I will ask you to consider some legal issues.

In my opinion, our workers' comp laws are not set up to absorb these types of losses and these types of cases. These laws were not set up and have serious deficiencies in the ability to respond – and I'll give you some examples – such as the purely jurisdictional issues and the coverage for the volunteer issues.

When I went to Ground Zero several times to visit with the responders and to get an idea of what was happening down there, I was talking with volunteers from Alabama, Florida, California, and around the country. And I'm saying to myself, I'm at Ground Zero within 10 days of 9/11, and there are people from around the country that have come in to respond to the event and to offer help. Where do they file claims when they have adverse effects? Do they file claims in New York? Do they file claims in their home jurisdiction? This is a real jurisdictional issue.

Aside from the jurisdictional issue, let me give you a couple of additional examples. A standard or normal workers compensation statute provides benefits for deaths at work. Where there is a death at work, generally you have a body. You can document that the death took place at a certain time, at a certain location. With 9/11, there were no bodies, so the question then becomes how you deal with a widow saying: My husband left the house this morning. He works on this floor of the World Trade Center. He works in this location. He has not come home. As a regulator, how do you respond to those situations? And, as a regulator you must respond to those claims.

Likewise, the law provides funeral expenses for the widows. In most states, the law provides that you are entitled to \$5,000 or \$6,000 for funeral expenses. What happens when three weeks after the event, the responders find a finger and they match it up with Jack Jones, or a toe and they match it up with Jack Jones? And there is a ceremony and the insurance company pays the \$5,000 funeral expense for the funeral. And then three weeks later another body part is found. The family wants to exhume the casket, and join the two body parts in the same casket. Does the carrier have to pay again? We faced those sorts of questions. We faced them more than we wanted to face them.

The exposure issue is another legal issue, which needs to be addressed. I think Jim or John pointed out that a year after 9/11, there were about 6700 claims, a third of which were death claims for 9/11. Now look at the Mount Sinai numbers. Look at the number of people being tested. What happens with the long-term effects?

In short, after looking at the current statutes you must conclude that these statutes themselves are not adequate to deal with these acts of terrorism and should not be absorbed into our traditional workers' compensation systems.

The second area I would like you to consider is the operational area.

We were fortunate in one respect at the workers' compensation board of New York. We had just implemented a new computerized system. We had just designed a business continuity plan that had gotten two thumbs up from our Office of State Controller. And so when we had to deal with the influx of cases, we were able to rely on state-of-the-art technology.

Not all of our outside partners, however, had that same benefit. There was a self-insured employer in the state of New York who stored all of their workers' compensation

files for all of their cases for the last 25 years. Where did they store them? They kept the files in the World Trade Center. They lost their complete inventory of files. They had no redundancy. They had no backup. They had no technology. As a result of the destruction of their files, they had to come to us and we had to recreate the files that they lost as well.

In addition, although we did have a new computer system allowing us to track and handle the influx of cases, we nonetheless had to change a number of aspects of our operations.

For example, prior to 9/11 the normal procedure in a death case would have a widow come to the workers' compensation board. She would have to testify at the workers' compensation board that she was married on such and such a date. She would have to offer proof of the marriage and recite the fact that there were two or three children from the marriage and that there were no divorces and remarriages.

After 9/11 we decided that we were not going to force two thousand or more widows to come to the workers' compensation board, to testify in person and to verify those claims. So we put into place an affidavit program so that they could complete the affidavit with their attorney, file it with us, and then we would process the claims.

Also be aware of the fact that even though you have your plan and even though you're making your operational changes, there are outside forces out there that may not want to see the program move forward as smoothly as you want it to move forward. For example, there was a defense firm in New York City that did defense work for workers' compensation. Within two weeks after 9/11 the firm had produced a glossy brochure and distributed this bulletin to its clients base. The piece advised the clients on how to controvert these cases, how to fight these cases, how to oppose these cases. In response to this situation, I composed a letter, which I sent to every insurance company and every self insured employer in the state of New York, asking them to treat these cases with compassion and to pay the benefits and to act in a professional manner.

So beyond the legal considerations and operational considerations, you also must face the political environment.

You have internal politics and you have external politics. You have the short-term politics or the long-term politics associated with it. Right after 9/11, one of our biggest challenges, quite frankly, was gaining information from the city and federal officials.

We had two people working day and night trying to get and share information. One of the biggest impediments to getting that information were privacy statutes, where the feds would say we can't share this information on this matter with you, or the city said we can't share this information with you at this time.

I suppose that you could say that in the case of an event the size of 9/11 there is a huge collision of governmental agencies as the several agencies strive to react. The local people want to control the event, the feds want to control the event, and the state wants to control the event.

So you have to be aware of this political dynamic.

These acts of terrorism don't occur on a perfect day for you. They might happen on a day or during a week when your chief person who is in charge of your program may be on vacation in the Canadian Rockies. You cannot wait for that individual to return. You must act at once.

In our case, on 9/11 we did not have a plan in place to handle such an event. We did not anticipate such an event.

And, although the numbers of deaths from 9/11 were overwhelming, I hold the opinion there were considerations or factors, which might in fact have mitigated the losses of 9/11. When the attacks occurred, it was the first day of school and it was primary day in the city of New York meaning that a lot of people were coming to work late that day.

I believe this because when we did our projections and ran our numbers based upon how many people were working at World Center on an average day, we thought the losses could have been significantly higher. And if they were significantly higher, where would our efficiencies have stopped, and where would we have just crashed into a complete failure in terms of meeting the needs of the community.

I was fortunate also to have a great partnership with the AFL-CIO in the state of New York, who wanted us to succeed in meeting the needs of everyone that was impacted by the terrorism. I met with the NYS AFL-CIO, and Denis Hughes, who is the president of the NYS AFL-CIO, told me a story about how when he was a young electrician, he was engaged in the buildings of the towers, how he sat on the top of the towers looking out on the New York skyline, looking out on New Jersey, looking out on the harbor.

And he told me the story of how on 9/11, a young electrician from local three was on the job for the first time. It was this young man's first job, his first day on the job and he was at World Trade Center. His life was lost on that day.

And so this really meant so much to the AFL-CIO, and they were such great partners in helping us succeed and leading the charge for federal money.

The last point I want to make is that aside from the legal issues, the operational issues, and the political issues, don't underestimate – and I think Irv pointed out or made mention of this – the emotional attachment that occurs when this happens.

Again, I was amazed at the emotional strength, short term, that everyone could demonstrate when this sort of act occurs.

Everyone responded. How can I help? How can I do this? Whether it was the responders and the volunteers; whether it was the agency personnel; whether it was other partners in the community, you can underestimate the short-term emotional strength that flows from a disaster such as 9/11.

At the same time, don't overestimate the long-term fragile nature of the event. I note those numbers that Jim pointed out from Mount Sinai regarding the respiratory conditions are there. In addition, I think you are going to see a number of long-term stress cases, in the future.

In conclusion, let me just say, as you build your programs, as you assess your risk – and it's going to be different for everybody. And I see Bob Steggert sitting here from Marriott. And Marriott had a facility right at World Trade Center. It changed their company, I'm sure, forever. It changed Cantor-Fitzgerald. It changed AON. It changed the Port Authority. It changed everybody.

You're not an island. And as Irv pointed out, you're a community. You must realize that when a tragedy strikes a community it strikes everyone to one degree or another. You need to recognize that if my business trading partner is impacted then I am impacted.

As Christine I think mentioned, it's a partnership; you have to look at these programs from a partnership. You have to have your risk-management program constantly reviewed, and if you deal in multiple states, you have to do multiple reviews, which leaves me to conclude – I really truly believe that these risks for terrorism have to be extracted from our state systems and put into a federal system.

I think Shelby left already so someone can give him the word that his system is going to absorb all of these according to me. (Laughter.) But I mean, the feds really should absorb these cases. These acts of terrorism, if they do become more numerous, if they do become more destructive, they threaten our system because then we start to take and adjust these systems that we have for industrial accidents to cover acts of terrorism.

So those are the points that I wish to leave you with. And, again, thank you for staying awake, and I think we'll make the reception. I hope I didn't bump into that. And thank you for a great conference. It was a fantastic conference.

(Applause.)

Discussion

MS. BAKER: Thank you all for giving us so much to think about. You all will have the opportunity to ask questions of our panel members. Please come to the microphone and identify yourself and ask your question if we have any questions at this point.

Q: I'm just going to make an observation on the New York workers' compensation situation. When the World Trade was built, it was built by the Port Authority of New York, New Jersey, and so on, as a public entity. They didn't have enough clients to fill up that building, and so for many years, the New York workers' compensation board was in the World Trade Center. And it was only after they began to fill up with paying renters that they moved them out to Brooklyn. But can you imagine what the situation would have been if that is where you still were, because I have no idea whether you had redundant records or not, but you certainly didn't have enough redundant staff to even begin to deal with the problem.

MR. SNASHALL: Yeah, you're right, John. For years, when the towers were built, the private market didn't fill the towers, so government filled the towers. And I was reminded before 9/11 that the prior chairman's office had this wonderful corner office that overlooked the Statue of Liberty and just this panoramic view. And we moved out of the Trade Center in 1986 or something like that. But, you may have read in the paper recently that there has been a commitment from city and state government to lease a great deal of footage in the Freedom Tower. And I would not be surprised to see more state agencies and city agencies moving into the Freedom Tower when that work is completed.

Q: Hi. Eric Nordman with the National Association of Insurance Commissioners, question for James. I would like to hear your opinion on whether you think the insurance industry would be willing to lend its sort of claims handling, claims paying ability with the notion that you would have some sort of federal backstop for workers' comp and the nuclear, biological, chemical scenarios.

MR. MACDONALD: Right, I mean, the insurance industry has a huge role to play in any solution with thousands and thousands of loss inspection and claims adjusters out there. I like the write-your-own-NFIP plan, frankly. The national flood plan allows insurers to do write-your-own programs so that the private sector performs the claims and risk management functions, and the federal backstop re-insures the insurer to optimize the use of the private sector's capabilities.

Q: Okay, so do you think then – I assume that the insurance industry really doesn't have much appetite for the nuclear, biological, or chemical, but on workers' compensation, would there be a risk sharing in your ideal scenario?

MR. MACDONALD: Well, we do have a metric to go back to if TRIA had gone away. It did say that we're not going to dispute whether a loss is terrorist or not terrorist

if the property in shared value is 25 million or less, and then for a liability if there were 50 serious injuries.

So in other words, some line has got to be drawn in the sand. The PWG report incorrectly infers from that terrorism must be insurable. But the truth is that we don't know who did those anthrax letters yet, and the next time something happens, we may never know whether it was a criminal act or a terrorist act. So the thinking generally is there has got to be some kind of line in the sand, and below that, we'll consider it vandalism if you will, right, and the insurance industry has already been willing to do that.

Q: And do you think that line needs to be raised or do you think \$25 million threshold for an aggravated event is adequate?

MR. MACDONALD: Probably it does need to be raised. You know, if you exclude 9/11, the average of the 10 largest terrorist attacks ever is about \$500 million. So it's unlikely you're going to have a terrorist attack that is anywhere close to the \$50-million or \$100-million-minimum coverage triggers under the extension act. And so there is probably a higher benchmark that they could live with, and probably by reinsurance board too.

Q: And then we keep hearing that the reinsurance isn't really interested that much in terrorism. They put maybe 6 to 8 billion as far as capacity. Are you seeing any change in that?

MR. MACDONALD: Not much, virtually no capacity for NBCR and about 6 to 8 billion in traditional reinsurance capacity. I'll tell you, if TRIA had gone away, there were rumors about some hedge funds being interested, but not more than 5 to 6 billion in additional capacity at a very high price, likely from hedge funds.

Q: And what is your perspective on maybe getting a voluntary mechanism sort of like what they do for the nuclear liability, nuclear property damage. Do you think something like that is feasible for terrorism?

MR. MACDONALD: You mean like the American Nuclear Insurers' program?

Q: Yes.

MR. MACDONALD: Is that what you're referring to? I think that is a very good model to consider, the pool that was created with the American nuclear insurers. I know a lot of people don't like that, but it was a successful response to the crisis we had. You know, in the '50s, the fear factor was a lot higher.

Q: Well, I think the fear factor in the '50s for the nuclear events is the same sort of thing you're getting with the terrorism events now.

MR. MACDONALD: Yeah, I think some kind of pool make sense, speaking personally. There are some insurance companies really opposed to pools, but I think some kind of pool with the federal backstop and lots of room for private-sector involvement makes a lot of sense. That is probably where we are headed.

Q: And mandatory coverage or mandatory offer of coverage.

MR. MACDONALD: (Chuckles.) You know, the RAND people wrote a report where they suggested mandatory might be necessary, but in critical-infrastructure companies, it may be a smart idea. If you are one of the 13 critical infrastructure companies – that does not, by the way, include hotels and leisure, which have about a 70-percent take-up rate on property, right.

Yeah, I think there – for critical infrastructure companies, some consideration about mandatory purchase. But I personally like the idea – and this has come up on coastal flood, wind insurance, integrating with minimum mitigation efforts – just like the NFIP works. If you want NFIP insurance, you have to do certain mitigation things, right, and why not just agree as to some minimum preparedness issues to qualify for the plan.

Q: Thanks.

Q: Jim Ellenberger. I'm president of the AFL-CIO Retirees Association, formerly with the safety and health department at the AFL-CIO. Bob, I want to add my thanks and thanks to the National AFL-CIO, along with that of Art for the work and the leadership that you did following the terrorist attack in September of '01. And as a former administrator myself, I know it's not just the leaders who make that happen; it's the men and women who staff the agencies. So I know you're no longer at the board, but we should all recognize that there are a whole lot of dedicated people that work in this system who make the things happen that need to happen.

John, I really think you hit the nail on the head talking about the importance of making sure we take the right actions both before and during and after catastrophes. Somebody has got to be in charge, and as we see the continuing unfolding of the catastrophes – the results of the catastrophe from the World Trade Center attack, and perhaps even the Pentagon attack in terms of exposures to concrete dust – I would just like you to elaborate a little bit on who should be in charge of making sure that we take whatever measures we can to make sure that we hopefully eliminate but at least contain the exposures and the harm that results?

MR. HOWARD: Well, I think it depends on the phase. Obviously in a pre-deployment phase for the emergency responders in the traditional sense, it falls to local governments to ensure that their responders are properly outfitted and have the right kind of equipment. During the response, it is the responsibility of the instant command structure. And we have tried to educate all local responder communities, because in these large-scale disasters where multiple agencies come, in the 9/11 and other situations, those

agencies are very reluctant to let go of their own equipment inventories and safety management structure.

And unless it's integrated at the top of an incident command structure, it really doesn't work very well. I think that is really key. Safety management has to be integrated into the incident command structure such that the safety manager has the decision-making authority over the influx and afflux of responders out of a site. The issue of the exposures that occur in any large-scale event is critical for management at the time and order at that real-time point, that point of influencing the exposure, having the ability to do something about it then. If you don't take advantage of that at that time, then you have to deal with the consequences after. So the real decisionpoint has to be safety management at the incident command structure during deployment.

It is very difficult, as everyone knows, in these situations, to prevent professions whose professional and emotional dedication to their job is to rush into extremely hazardous situations. That is what people do. But we don't send firefighters into burning buildings without proper equipment. And I think that when you have trapped individuals, and in this case of the 9/11 situation, we had trapped brothers and sisters of firefighters, it became a very different situation. They were in charge of the site, remained in charge of the site for many months, and it's a very difficult tragedy now to see that those people are the ones that are primarily affected by the consequences of what happened there.

And I think that the balance between taking the initiative in an emergency and having some command structure say, no, you can't go in there right now; we need to do the following things before you go in, I think that is really the key in any disaster, and it's probably the most difficult situation now dealing five years later in the World Trade Center situation.

The thing that I have been impressed with the most is what I heard today from experts in insurance and that I have experienced myself, is the absolute failure of the traditional workers' comp situation to deal with a situation of this magnitude and complexity. There has to be, and there have been these adjustments. We have just seen one with the New York state legislature and the extension of the filing time for cases. And that is a small extension; it's a 12-month extension. And it may not yet be enough for us to capture claims. People may not file because they feel well now, but there may be health events that have not yet occurred.

That amount of energy and inefficiency in a system that spends all of this time money and resources, and the terrific human tragedy that is still going on post-event, again, emphasizes the issue during the deployment. Unless you fix it then, you really don't have any truly efficient way of handling the events that happen afterwards.

So I think that from my perspective, the workers' comp system, given its jurisdictional complexity in any state, and doubly so in New York, the absence of the necessary authorities on behalf of the state workers' compensation board to make mandatory certain actions by a self-insured carrier, such as the city of New York, further

complicates the situation. It is an extremely complex situation now when you're dealing with the natural propensity of systems to doubt individuals' illness situations.

You know, the system works I think quite well for instantaneous or short-term injury situations where the event occurs and the injury occurs very close thereafter. For illnesses that come on years later, we all know that the system doesn't work very well. And this is the most difficult situation we're encountering now. And it's really corrosive in terms of the systemic attitude of workers' comp systems, and the people that we are trying to take care of.

Q: Tom Rankin, California Labor Federation.

For anyone on the panel, in California, the insurers through the workers' comp insurance rating bureau have proposed several times to include a factor for earthquake, the risk of earthquake into the workers' comp premium calculation, as well as for terrorism. And the insurance commissioner has rejected those attempts. And I just wondered what you folks thought of that.

MR. MACDONALD: Are you saying that California has refused loadings for terrorism and quake in the filings of admitted insurers?

Q: Pure premium.

MR. MACDONALD: In the pure premium.

Q: Pure premium.

MR. MACDONALD: They have denied that? Now, I didn't know that. I don't want to change the subject, but there is a crisis right now in wind insurance, for instance, in the Gulf and in Florida, and the insurance industry would like the admitted market to be deregulated. Now, Illinois has apparently deregulated most of its commercial sector. Most states have deregulated large accounts for pricing. The insurance industry ideally would like deregulation so they don't have to deal with those issues that don't seem very logical at times as to why these loadings aren't allowed.

But some form of deregulation of commercial pricing is needed for small accounts and personal lines. Large accounts are frequently bigger than insurance companies. If you're dealing with a Fortune 100 account, it probably has more net worth than most of the two thousand insurance companies in this country.

So I think looking at deregulation in a controlled manner makes a lot of sense. Flex-band rating has been proposed by the AIA as the partial solution to the wind insurance crisis, for instance. And that might be another solution over there. But I'm not sure what their logic is.

Q: I hate to speak for Commissioner Garamendi – (laughter) – but I think the concept of loading the advisory pure premium rates for either earthquake or terrorism or that sort of category was partly in the idea that the pure premium should take care of more operational losses, what you would expect to see on a year-to-year basis, as opposed to something you would expect to see once every 20 or 30 years. And I think that was part of the thinking. The other part of it – and just taking commissioner at his word, is that there is no guarantee that the companies would take that load factor and put it somewhere that then could be tapped should those events occur, and he wasn't willing to do one, which is a lot of load, without something said on the other.

MR. MACDONALD: Well, yeah, and it kind of reminds you of the de-tech filing that the NCCI did, which is for domestic terrorism. So NCCI did a filing for a loading specifically for domestic terrorism and earthquake, right. And that not subject to premium tax, as I recall, it's not subject to the normal loadings. And this is the kind of fresh thinking we ought to encourage. But typically, if an insurance company is going to be allowed to set aside reserves for catastrophes, which is what they want, and which maybe needs to be considered – well, don't you want some way to monitor all of that. And in Europe, they do allow that, by the way, in most European countries, but it is important to monitor it on your balance sheet as to what part of the reserves are set – are there for catastrophes.

Q: I'm not going to say anything that is particularly insurancy, but to go back to this kind of an implication in the room about the respiratory problems and how we should have done something differently. And I just wanted to tell a very brief story about how catastrophes actually happen, which is that I was the city health officer for Anchorage, Alaska, when a volcano exploded. And we had a couple hours' notice, and the question was: what are we going to tell the public, and how are we going to protect everybody from the plume that is coming our way?

And the answer is that when a volcano explodes, you actually don't know what is in the plume, unless somebody goes to look at it. Some of them are toxic and kill people, like in Pompeii; some are just dirt. So in a couple of hours, we had either a potentially life-threatening thing going to happen in Anchorage or a big dud. Now, the answer is that it luckily turned out to be mostly a big dud, but I don't think anybody did anything wrong. I didn't have knowledge ahead of time about what was in the air.

The definition of catastrophe is that it overwhelms human systems. I'm not arguing that by the time we started realizing people at the World Trade Center were having trouble from a respiratory point of view, there probably should have been faster mobilization, but it's like part of what is going to happen with a catastrophe is that you will be overwhelmed, and there is nothing wrong that.

I did a lot of disaster prevention work also in Anchorage, and one of the things that came about was in defining your success as how well you manage the preventable part, and so I guess it's partly just trying to figure out in each situation how well did we manage the preventable part.

MS. BAKER: Thank you.

Q: Just one last kind of comment and question, and that is, shortly after the events of 9/11, we at the Academy put together a little brief that said, this is what workers' comp provides to family, and this is what Social Security provides. Then there is this additional victims compensation fund, which is kind of a one-time special response. And it raised a question, to which we don't yet have an answer: should there be some sort of social insurance coordinated response that deals with victims of terrorism, as opposed to this kind of overlapping and dispersed programmatic response? Do you have observations on that?

MR. SNASHALL: Again, my sense is that according to the profiles that were done in the risk modeling, we know that these acts of terrorism will hit urban areas. And because they will hit urban areas, you going to have a very diverse population that will raise I think too many challenges for any individual workers' compensation system.

When we met with the AFL-CIO to try to compute the \$150 million for the federal action, you know, we had to put together what we thought would happen over the next 20 years from these exposures. We anticipated that there would be significant post-traumatic stress disorders and significant respiratory problems.

Mount Sinai, I think, is primarily focusing on the respiratory problems. You know, Jim raised a great point. The area that I think will be impacted by the post-traumatic stress disorders are the employees from the agency that dealt with taking in those cases, taking in those claims. So, short answer is that there has to be some sort of coordinated approach to make sure that everything is working together. And I see Art is coming up, and he can probably update you better on the status of the – of some of the federal monies as well.

Q: Art Wilcox, New York State AFL-CIO. Bob, what I want to do basically is to clarify the victims' compensation fund piece. The victims' fund only covered people that were injured, I think, up to 48 hours after the collapse, anybody that got hurt after that wasn't covered at all. And the other thing that folks should know is if you accepted the victims' fund money, there were offsets for workers' comp, there were offsets for disability pensions or fatality benefits for pensions, there were offsets for life insurance that people have. So the victims' fund did do a coordination of benefits by doing the offsets.

So I think for the cases here forward, we have got to figure out some fix because it's just – it's such a catastrophic situation that it is just too big for one state or a group of carriers or self-insured employer to figure out the fix on it. And I think we have got to come up with some other advice to do that.

And just one other personal point I have got to say about what wasn't expected. I mean, we hear and read a lot in New York that there were a lot of folks and agencies that knew this stuff was bad to breathe, but decided not to put the word out at the federal, state

and city levels. So it wasn't whether it was bad dust or good dust; they knew it was bad dust and decided not to tell people to wear masks. That is one other thing I have to throw in there.

MR. SNASHALL: You know, just one little point too, you know, when you have all of these multiple programs trying to meet the needs, I think it goes to Tom Rankin's point earlier about all of these transactional costs, these frictional costs that come into play. If you have to use legal expenses to get this recovery, administrative expenses, all of the sudden you are depleting the net recovery that goes to one of the victims.

MR. ROSENTHAL: I want to make an observation. It is interesting to note that shortly after Bhopal, several companies in the United States that were using a process similar to the one at Bhopal came under tremendous pressure to change what they were doing and they found inherently safer ways of doing so. As far as I know, the firms that made the change to inherently safer processes all seemed to still be competitive.

The interesting question is why didn't the switch to an inherently safer process take place before the Bhopal accident? And what, if anything, should be done with regard to analogous situations that exist today?

For example, there are a group of firms that use sulfuric acid as a catalyst in certain refinery processes and another group who use hydrofluoric acid as the catalyst to accomplish the same thing. The release of hydrofluoric acid, according to the data filed by the companies with EPA, could kill many thousands of people, whereas a release of sulfuric acid would probably cause much relatively smaller deaths and injuries.

Now, the likelihood of an HF release taking place is extremely small, but it is a cost that is imposed on our society since we will ultimately have to take care of citizens and employees injured by such avoidable Low Probability-High Consequence risks. I think there is something to be said for imposing the social costs of operating with high risks on the firm that profits from such an activity. One of the ways of accomplishing this is via requirement that firms have insurance coverage that applies to all individuals placed at risk by an enterprise and the cost of this insurance would hopefully reflect the magnitude of such imposed risks.

MS. BAKER: I think we have one last comment from Bob Stegert, who was instrumental in September 11th in addressing his company's needs.

Q: Yeah, thank you, Christine.

I do want to compliment Bob and his team. They did an unbelievable job under extraordinary circumstances dealing with the tragedy. We lost a hotel. We lost two employees, and we had about 150 workers who filed workers' compensation claims. The one fatality was very, very unusual because we had an employee whom we thought was single from Yemen. As it turned out, the father came forward and said his son was married. We said, well, let's talk to a widow. And they said, you can't talk to a woman

in Yemen. And since they don't have legal records in terms of marriages, so we looked at pictures. We sent the pictures, we stipulated liability, and we said, okay, we'll pay benefits voluntarily, and this is just one of I'm sure a zillion examples. But you did a good job.

The one claim that we did contest was properly adjudicated after an initial erroneous filing, and frankly it was a worker who wasn't at work and filed a claim because his co-workers died and he was stressed out. That is was the only claim we denied.

A comment about the respiratory situation and post-traumatic stress disorder, we recognized both of those elements on day one, and had nurse case managers on all of our cases, identified mental health professionals in the New York, New Jersey, and Connecticut area, and immediately referred all of our injured workers to mental health workers. As a consequence, we have paid over \$15 million and the clock is still running, and we have certain employees who still are not back to work as a result of that.

But the respiratory piece of it is perplexing to me as a practitioner and as somebody who went out and made certain that these people would get immediate medical care. When this surfaced a couple of months ago, with all due respect to anybody who was legitimately exposed and has got a latent problem that came up, it was kind of perplexing because the law said, if you bring a claim within two years, and you seek medical care, and you have got causal relationship, you are protected and you get the benefits in medical care.

And to my way of thinking, it was kind of unusual not to have symptoms in two years, and then I saw the "60 Minutes" piece and there was one applicant's attorney who had 9,000 claimants, and I just had difficulty believing that there could be 9,000 people who had respiratory problems that didn't make a claim within two years and didn't get medical care that said this is related or possibly related.

I don't know, Bob, do you want to comment on that from your perspective from the board, and why do you think there were so many latent cases that nobody got care within two years within the statute of limitations?

MR. HOWARD: You know, that collection of Mr. Wharbi's cases is a mixed medical bag. It includes over 300 cases of cancer, not respiratory disease, and a lot of post-traumatic stress, mental health, and behavioral health issues, alcohol, abuse, and drug abuse and things like that the plaintiff is connecting to the event. So his cohort is not all respiratory disease problems.

MR. SNASHALL: I think there is no one answer for all of those cases, Bob, but certainly, I think some of those cases are simply filed as a protective measure because when an individual reads that perhaps there were some toxins in that dust, and you know, they are going to file a protective claim. And this extension that was filed was really a registration period where you end up registering that you were at that period.

I don't know what the ultimate numbers are going to be, and which cases will be established, and which cases will give rise to disabilities, and which cases will give rise to deaths, but I think that anybody who was working there for a period of time will probably file a protective claim and then see where the evidence takes it. I mean, that is my sense.

MR. MACDONALD: I'm not sure whether or not any presumptions will attach to that. Obviously in New York, if an attending physician files a medical report that says condition A is due to exposure Z, then that presumption attaches by reason of the medical report, then the employer has to then refute that. And, you know, if you think about it, the injury fund in the state of New York and others around the country were set up for nemo coniosis condition, silicosis, asbestosis, beriliosis, because the notion was you spread it across the entire industry and you don't have any individual employer absorb the entire risk. So then the question is, is to what extent should these claims be spread across the industry as opposed to absorbed by any risk as well?

MR. ROSENTHAL: I would like to make a comment in regard occupational diseases with long latency periods. A firm that I worked for became aware of a significant increase in lung cancer among its employees. It turned out that the excess cancers were associated with exposures to a specific process about 15 years earlier. The only way to establish that these lung cancers were occupationally related to a particular chemical process was via epidemiological studies.

Similar studies might be undertaken in regard to the delayed incidence of disease that may be manifesting itself among persons exposed to the debris and fallout of the Trade Center tragedy

Q: Bob Steggert, again. I would agree with that. But most state statutes on the OD side of it say that the statute of limitation does not begin to run until the person knows or should know that their condition is related to work even though if it's a latent condition that is coming up 10 or 15 years later. That is why I was perplexed by the New York situation. (Laughter.)

Q: I'm John Burton from Rutgers.

The New York situation was triggered this year by an interesting case. The former deputy mayor filed a workers' compensation claim that the city of New York was fighting. And it wasn't until the mayor intervened to call off the lawyers that he ended up I think successfully getting his claim.

Now, what was the problem of New York? Well, the statute of limitations does not run for occupational diseases until – I have forgotten – two years after the date of disablement. However, what is an occupational disease? In New York, it has a very strict definition. It is a disease peculiar to or characteristic of your occupation. There is nothing about being a deputy mayor that makes you particularly prone to having a respiratory disease.

And so he did not meet the definition of an occupational disease; as a result, he had to file his claim as if it were an accident. The statute of limitation for an accident is two years from the date of exposure or the incident. So he was out of the system because of a combination of a restrictive statute of limitations for injuries in combination with a very restrictive definition of occupational disease. And is not unique to New York to have restrictive definitions of occupation disease; it just happened to manifest itself in a very dramatic way with our deputy mayor.

MR. ROSENTHAL: I have to counter. You are absolutely wrong because one of the occupational diseases of Deputy Mayors is meeting in smoke-filled rooms. (Laughter.)

MR.. SNASHALL: Well, we needed you to come in and testify in that case because the board was going along with the city in this case. (Laughter.) So can you give me your card? I'll make sure we get the people in New York City that can have you as an expert with us.

MS. BAKER: I think we can go on and on about this very interesting topic. And it just shows that we need to have more time on these kinds of issues. Thank you again to our distinguished panel.

(Applause.)

And next on the agenda is the reception in the Holeman Lounge. The lounge is down the hallway on the right. Our thanks to the Survey Research Center at the University of California, Berkeley, for providing the food for the reception. A cash bar is available to meet your beverage needs. Our session is adjourned; see you at the reception. Thank you.

(End of panel.)

Panel V: How Does the Safety Net Fit Together?

Introductions

Jackie Nowell, Director of Occupational Health and Safety, United Food and Commercial Workers International Union

MS. JACKIE NOWELL: Good morning, everyone. Come on. When I start a union meeting and I say, “Good morning, everyone,” they say “good morning” back.

AUDIENCE: Good morning.

MS. NOWELL: Thank you so much. My name is Jackie Nowell and I’m the Safety Director for the Food and Commercial Workers Union. For folks who don’t know, we represent the folks who work in grocery stores. So my California friends certainly remember our strike of three years ago. We are going into negotiations this coming year. We have no plans to go on strike that I know of. We also represent meatpacking and poultry workers. And whenever I come to conferences like this, I always know that I’m in a room with the good guys, but I always feel like it’s my job to let you know that there are bad guys out there. The meat and poultry and food processing industry would fall into that latter category, and I certainly don’t want to paint too broad a brush, but I do want to tell people in the room about some of the conditions those workers face and I’m just going to take a minute here; since I have a podium I never can miss an opportunity here.

Workers get fired for being injured on the job when they may not have good documentation, when they are worried about losing their jobs, when they’re in a precarious situation. So not only is it one of the most dangerous industries in the country, but also if you get hurt, you do get fired or you get a big hassle to get workers’ compensation. So again, for folks who may not come across these situations, it’s good to understand that those situations exist out there and that’s why we need all of you advocating for workers’ comp reform and for good access.

The other issue is that we talked about lost time injuries yesterday and I just want to comment on that. For the last ten years, what we’ve seen, just looking at OSHA logs, is that the lost time injuries have gone away, but that doesn’t mean the severity of injuries has gone away or that people are being injured in practically as high numbers that I can see, 30 to 40 per 100, but there are all restricted duty or they’ve had a change of job. So I just looked at a set of logs where 93 percent of those injuries were restricted duty and a mere 3 percent were lost time, and I saw that shift. It was a shift from lost time to restricted duty about ten years ago.

So I am anxious to hear from our panelists here who not only will be talking about what’s going on in comp for workers who actually get it, and we know all the problems with that, but also just keep in mind that they’re not all getting it – but also what other systems are out there to try to fill in the gaps.

So we're going to begin with Les Boden, who is Professor of Public Health at Boston University and chairs the environmental health doctoral program.

We're going to hear from John Burton, who is Professor Emeritus in the School of Management and Labor Relations at Rutgers University. Frank Neuhauser, who we heard from yesterday, is on the research faculty at the University of California at Berkeley's Survey Research Center. Finally, Ed Welch, who we also heard from yesterday, is Director of Workers' Comp Center at Michigan State University. So we'll begin with Les.

How Often Do Workplace Injuries Go Uncompensated?

Les Boden, Professor, Boston University School of Public Health

LES BODEN: Thank you, Jackie. Actually, she did the first minute of my talk so now I've got 12 minutes instead of ten. (Laughter.) Allan Hunt talked yesterday about some of the work that's been done recently looking at workers' comp adequacy, where we're trying to understand how adequate are workers' comp benefits by looking at people who have received compensation and looking at the proportion of their losses that are covered by workers' comp benefits. That works very well for people who get workers' comp after they're injured, but of course the replacement rate is easy to calculate for those people who don't get workers' comp: it's zero.

And so it's important to know how frequently people are injured at work and don't receive workers' comp. It's also not easy to figure out how to do this, although in the last several years there have been a number of studies in this area mostly looking at either a specific state or a specific subset of injuries like carpal tunnel syndrome, where they seem to show, for example, that probably at best 10 percent of workers with carpal tunnel syndrome end up getting workers' comp.

So being somebody who likes challenges, I tried to figure out if there is a way to get a bigger picture idea of what proportion of injured workers get workers' compensation. And there are a number of other reasons in addition to the fact that workers are left without the safety net that it's important to study this. To the extent that workers' comp acts as a safety incentive for employers, then workers' not receiving those benefits reduces that safety incentive. And in addition, if we think about workplace safety and health as potentially a national priority, if you're only reporting half the injuries, then you only understand half the problem. So for those reasons and others, it's important to do this.

Well, there are a lot of factors that affect workers' comp filing and receipt of benefits. One of them is just knowing that you've got this entitlement: do you know that a particular injury could be compensated in the workers' comp system? Second is that a lot of people feel like getting workers' comp is kind of like how we used to feel about getting welfare, that it's something you really shouldn't do, that it's a sign that you're a bad worker, and so people understanding that social stigma don't apply.

A third thing, which is the thing that economists mostly focus on, is expected benefits. If benefits are low, you're less likely to file than if they're more generous. A fourth thing, which Jackie referred to before, is what I just call workers' comp hassle. We've interviewed a number of people who have gone through the workers' comp system, and even in states that have the reputation for having a good system, people find it often to be a difficult and demeaning experience.

Employer's attitudes and policies are another issue. So if an employer makes it easy for people to get workers' comp, people are more likely to file. For an employer that either in a positive or negative ways – either by discriminating against people who

apply or by providing group safety bonuses for groups of workers who don't report an injury – you've got the other side of the story. Concerns about job security: also a lot of low-wage workers, particularly if they're illegal immigrants, are going to be worried that filing will not only have them lose their job, but maybe get them sent back to where they came from and, in fact, there is a recent low-wage worker report that CHSWC produced that talks about some of these issues.

So how did I go about trying to figure out the level of underreporting? Basically, I used something called capture-recapture analysis, which looks at information from different sources and links individual injury reports. So you're actually trying to look at the same report and ask the question: How many injuries are reported to both sources? How many are only reported to one? How many are only reported to the other? And given certain assumptions, you cannot only add together all the injuries that are reported to one or the other, but you can also try to estimate the injuries that are reported to neither.

Mostly when you use this method, you assume independence of reporting. What does independence of reporting mean? Let me just go to the sources for a second. One of them is the Bureau of Labor Statistics' Annual Survey of Injury and Illnesses. This comes from the OSHA 300 form that employers are required to fill out. The other is a complete count of all the workers' comp injuries in half a dozen states, and what we're doing then is we're matching the injuries that are reported to both of these on the understanding that each one of them alone probably doesn't get complete reporting.

So question: If you knew that an injured worker had received workers' comp, would you think it was more likely than another injury to be in the OSHA log? So how many people think that you wouldn't really expect it to be more likely to be in the OSHA log if it had been a workers' comp injury? And how many people think that if you knew it was a workers' comp injury, it would be more likely to be in the OSHA log? Okay. So most of you think like I do that these two things are positively correlated. The statistics show us that when they're positively correlated, that if you use those data that you're going to get a lower-bound estimate of underreporting. Okay.

So I'm looking for a very conservative estimate of underreporting first by assuming that these are not positively correlated. So quickly, these are the states we're looking at: Minnesota, New Mexico, Oregon, Washington, West Virginia, and Wisconsin. We've just recently gotten California data and hopefully by this time next year, I can tell you what the story is in California, and here's what we found. First of all, Bob Malooly should be very happy. Washington on these very conservative assumptions compensates the highest proportion of work place injuries. On these very conservative assumptions, only 6 percent of lost time injuries in Wisconsin go uncompensated. In a second, I'll relax the conservative assumptions and show you some other information.

And our top two, Washington and West Virginia, both are above 90 percent, but our bottom three are below 75 percent, that is, more than one in four injuries with lost time greater than the waiting period didn't receive workers' comp. Now, supposed we

relaxed this independence assumption, which 90 percent or more of you thought was not a realistic assumption, and supposed we assume instead that (and here I'll use an epidemiology term and try to explain it roughly) that the odds ratio for getting workers' comp benefits is five if you've got an injury that's reported to BLS. Basically, what that means is sort of like a horse race. You want to bet on the horse that's reported to the BLS or the horse that didn't report, and basically fair odds would be five to one that the horse that reported to BLS would receive workers' comp benefits.

And what do we see? Well, with an odds ratio of five to one, our estimate of completeness of workers' comp payments drops substantially. Washington goes from 94 percent to 85 percent, that is, 6 percent of workers to 15 percent have lost time injuries, but aren't compensated. But Minnesota and New Mexico actually go below 50 percent. Let me stress that this system probably only works for acute occupational injuries. I don't have a lot of confidence that it works for occupational illnesses, chronic illnesses because basically, virtually none of them get into the system. If you look at the numbers, there are some states where I couldn't even estimate what the reporting rate might be because there were so few reported.

What are the implications for workers' comp? Well, if you think about benefit adequacy and you've got a replacement rate of zero for conservatively 6 to 37 percent of injuries or less conservatively 15 to 55 percent of injuries in the states that we're looking at, you've got a bigger adequacy problem than might already have been indicated by the studies that were based on workers' comp beneficiaries. Safety incentives, to the extent that they exist are going to be reduced as well because employers aren't paying these benefits, and as the CHSWC report and others have said undercompensation may be particularly concentrated among workers who are already low-paid and otherwise marginal, thus exaggerating the problem for those workers.

So I've said my conclusion and my time is up. In four out of the six states under the most conservative assumptions, less than 80 percent of the injured workers received workers' comp benefits; under the less conservative assumptions, it's less than 60 percent in those four out of six states. Important questions are still left: can we identify why it is that particular workers aren't receiving benefits? And what is the impact on those workers? What happens to them? Do they end up on Social Security Disability Insurance? How do they manage? How do the families manage to cope when there is no income replacement from workers' comp?

Here's a list of people I want to thank, but it'll take me five minutes to read the list. So you can take a look at it. (Laughter.) Thank you. (Applause.)

MS. NOWELL: Thank you.

How Do Changes in Workers' Compensation Affect Social Security Disability Claims?

John Burton, Professor Emeritus, School of Management and Labor Relations, Rutgers University

JOHN BURTON: This is an examination of how changes in workers' compensation affect social security disability claims. It's a paper that I'm working on with Steve Guo, a PhD student at Rutgers. Monroe Berkowitz is also involved in this project, although he's not had the opportunity to review and critique the results. I also want to mention that Terry Thomason was involved in the beginning stages of this research and was crucial in formulating some of the variables.

These are preliminary results that were only available as of last week. You're the first humanoids to have seen these results other than Steve and me, and so I want to warn you that these results may change as we do further work. However, we thought it would be interesting to show you these preliminary results. As to the presentation I'm going to make, the best analogy I can think of is when I was a kid I sometimes used to play speed chess, where you had to make a move every 30 seconds or you lost. I feel that's kind of what I'm into now in terms of these slides. So if they're going fast for you, they're going fast for me as well.

Figure 1 shows you what happened in workers' compensation in terms of cash benefits per 100,000 workers over the period from 1985 to 1999. Those are the only years for which we currently have data available for some of the variables. You will see that there was an increase from about \$17 million per \$100 of payroll in 1985 to a peak of about \$25 million in 1989. Then there is a steady decline through to 1997 when there was a little less than \$13 million per 100,000 workers, and there was a slight increase by 1999. Steve and I are working on a paper that tries to explain those changes in workers' compensation cash benefits over that period.

Today, however, we're looking at a different question, although it's related, as you'll see it in a moment. This is a look at what's happened to applications for the Disability Insurance program under Social Security, as shown in Figure 2. The DI program, as you probably know, requires that you have an extended work history in order to be eligible for the benefits. It also requires that you have a total disability. So it's obviously not directly comparable to workers' compensation, but one of the questions is whether there's any relationship between these two programs and specifically whether the developments in the workers' compensation program during the '90s might have had an impact on the general increase in DI applications during that period?

There's been some speculation that workers' comp changes affect the DI program. Emily Spieler and I have written a couple of studies saying we thought that there might be some spillover from workers' comp to DI. The NASI annual report on workers' comp has also raised this possibility. Those were qualitative speculation because they only were based on changes in national averages without any real way to quantitatively test the relationships. Today is a first look at what I will call an empirical

examination of this issue. What we have done is to collect data for not only the 15 years, but for 45 or 46 states in each year. So we're looking at a series of variables, with state level data; there are 529 observations that we're using in this empirical examination.

And now I'm going to show you what we did in our study. If you want to think about the data in Figure 2 as being the dependent variable, I'll show you what the independent variables are. I'm going to make you econometricians by the Socratic method – (laughter) – in six minutes or less.

One of the things that we postulate may affect applications to the DI benefit is the level of benefits that you could expect to get from the workers' compensation program. The data in figure 3 shows you our estimate of the generosity of cash benefits prescribed by state workers compensation statutes. The estimate is based upon an actuarial procedure related to procedures used by the National Council on Compensation Insurance (NCCI) when they evaluate statutory changes in workers' comp programs. It's what I'll call an objective assessment. It's an assessment Terry, Steve and I made using the data from each state's law for each year on benefit levels, durations and so on. We estimated the benefits that a representative sample of injured workers would receive. And you can see that the benefits declined over parts of this period, although benefits increased in the last several years through 1999.

Now, here is where the economics comes into this. If you have the data in Figure 3 as an independent variable, what sign would you expect on this variable in predicting changes in the DI application rate (Figure 2)? As benefits get higher in workers' comp, would you expect the DI applications to go down or up? Down. Okay, good. That's what we expected, too. It is nice to have at least one person out there who is into the spirit of this thing. The notion is if your workers' comp benefits are more generous, you're less likely to apply for DI benefits.

Figure 4 gets a little more complicated. This is what we call workers' compensation compensability rules. Every year, the NCCI publishes state-by-state estimates of the effect of statutory changes in workers' compensation laws. They take into account not only the objective changes, that is, duration of benefits and so on, but they also assess the expected changes in benefit payments due to changes in compensability rules. If you change the eligibility rules to make it more difficult to get benefits or easier to get benefits that will be included in the NCCI's overall estimate of these statutory changes. So we can take the overall estimate of the statutory changes from the NCCI and subtract from that our estimates of the objective changes due to objective factors like duration and the difference is what we've termed changes in compensability rules.

So for example, if a state were to pass a law making carpal tunnel syndrome compensable that presumably would make the variable we're measuring here a positive number. If the state pass a law that – along the lines that Emily Spieler and I identified – changes the burden of proof and makes it more difficult for workers to obtain benefits, or requires objective evidence for medical causation, or excludes certain conditions, or

makes medical conditions only compensable if the work injury was a major contributory cause, then you would expect a negative number for this variable. And what you can see in Figure 4 is that over the periods of 1985 to 1999, there was a rather significant and continuing decline in compensability rules for state workers' compensation statutes.

Now, what sign would you expect on this variable if you're trying to predict applications for DI benefits? If workers' comp were easier to get, you'll expect the applications of DI to go down. So this is, as I said, a little more complicated, not quite as intuitive; you would expect a positive change in this variable to have a negative impact on DI applications.

Figure 5 is a variable that measures the relationship between what's reported to BLS and what shows up on the workers' comp system. The higher the value of this variable, the less likely it is that cases reported to BLS show up in the workers' comp system, and you can see over this period of time benefit stringency increased. We expect the sign on this to be positive, that is, if a workers' comp system was tougher to get into, we would expect more cases to show up in applications to the DI system.

The next variable is the disability prevalence rate (Figure 6). This is from surveys of population by state that shows the percentage of disabled persons among ages 21 to 64. And you'll see that the number in general was increasing over this period. We expect a co-efficient on this variable -- the disability prevalence rate -- to be positive; the more disabled persons in the state, the more we would expect people to apply for DI benefits

The next variable shown in Figure 7 has to do with all persons who apply for disability insurance. This is the question: Of all those people who apply for DI benefits, what percentage is accepted? And you'll see it fluctuated quite a bit over time. Here we would expect the sign to be positive. The higher the acceptance rate, the more there should be people applying for DI benefits.

And then finally, in terms of explanatory variables: the unemployment rate, as shown in Figure 8. We expect that the higher the unemployment rate is in a state, the more people will to apply for DI benefits. So we expect a positive co-efficient.

Now, we go to Table 1, which provides a test of the hypotheses. This is what we do as economists. We offer a set of hypotheses and then we test them with data. We have 529 observations and we run regressions. (For those of you who are interested in this "stuff," the regressions control for fixed effects.) The results are in Table 1, which you're going to have trouble reading on the screen, and it's even worse if you try to read the handout: we should have provided magnifying glasses.

Essentially, what we found was this. The unemployment rate has a positive co-efficient that is statistically significant -- that is, the higher the unemployment rate, the more people apply for DI benefits. This is what you would expect. The DI acceptance rate had no statistically significant relationship with the application rate. That's quite surprising to me, but that's what we found. Also, the disability prevalence rate in the

state – how many people in the age from 18 to 64 were disabled – had no impact on the number of people who applied for DI benefits? Again, not what I would have expected.

The benefit allowance stringency, that is, what percentage of cases that are in the OSHA system end up on workers' comp? Also, not significant. The results that I find most interesting are that the changing compensability rules in the workers' compensation program had a negative impact on DI applications, which is what we would have expected and the results are highly significant. In addition, the expected benefit levels in workers' compensation also had a significant impact on DI applications. The states that had higher workers' comp benefits had fewer applications for the DI program.

These results are tentative, as I said before, but for what they're worth, we now have some evidence that indicates changes in the workers' comp program have an impact on the DI program. Over the period from 1985 through 1999, which are the years we've looked at, workers' compensation changes were a factor in increasing the number of applications for Social Security Disability Insurance benefits. Whatever the merits of the changes in workers' comp system in the 1990s – and obviously over the last day and a half, we have heard various view points as to whether these changes in the workers' comp system are good or bad – the point of the current study is that we now have some evidence that changes in workers' compensation have a spill-over effect on the DI program. I would like to talk about the political implications of that finding, but I believe my time is not only up, but exceeded.

Thank you.

MS. NOWELL: (Laughter.) Thank you. (Applause.)

How Do Workers' Compensation and Short-Term Disability Programs Overlap?

Frank Neuhauser, Survey Research Center, University of California, Berkeley

FRANK NEUHAUSER: Good morning. It's nice to be here again. And let me start up by wrapping up a couple of things that we've covered the last couple of days that have been a theme and lead well into my talk, actually led even better into John's talk and the session that comes after this, and that's first that we saw a lot of concern by employers about this issue of causation. People discussed the fact that some people interpret the causation, whether an injury is occupational as in terms of the evidence implying that an injury was caused by work.

In California, we use the level of contributing cause, which many people define as 5 percent or more, and many injuries particularly things like psychiatric injuries are hard to assign injuries are given a causation level of preponderance of evidence. So they want 50 percent of the cause in these cases to arise out of work and then the employer is responsible, and one of the big problems with this is none of those standards are easy to define either legally or in practice and that's because increasingly occupational injuries and cumulative trauma cases are what dominates workers' compensation.

Now, on the other side, workers are concerned about what John was talking about, a increasingly limited eligibility for workers' compensation benefits and a strict interpretations of what's an eligible injury. As Les was pointing out, there's really a lot of concern with underreporting of injuries especially on the part of workers because this means that employers are going to underinvest in safety and consequently; it's not that injuries are underreported, it's that the underreporting results in poor safety and poor investments in safety. And all of these things result in something that we don't want, which is lots of conflict and litigation, and with lots of litigation comes lots of extra disability.

The luncheon speaker yesterday, Dr. Christian, was talking about iatrogenic disability, the kinds of things that are caused by the process rather than by the actual work injury. This is a case where this process of trying to define the proper reporting and the proper payer for disability could be leading to problems. Part of the problem that I want to address today is maybe this is just that we've been trying to push this round peg of workers' compensation into a square hole.

Let's think back. A hundred years ago when workers' comp was being introduced and rapidly developed, there wasn't any other social insurance program for NASI to consider. There weren't any DI programs, the Social Security disability program that John was talking about; it didn't exist. There weren't any health benefits from work; workers didn't get those, right? There wasn't a non-occupational health benefit system. There wasn't a Medicare system. There wasn't any social security system. There wasn't any welfare. These were decades away. This was the only system

by which workers could recover. That's not true anymore. There's lots of overlapping systems and there's lots of other support that comes out of work.

In California, over 80 percent of employers offer workers health benefits. So it's a changed world and we're dealing with it like we did before. So this project to look at state disability insurance system in California and the overlapping of benefits has been funded by the Commission on Health and Safety as part of an effort to get at this issue of multiple social insurance programs and how do we make them coordinate in an efficient manner. And so Christine Baker is the first person I want to thank. She's the head of the Commission and the person that has the foresight to generate funding for programs like this, and Tom Rankin, who was actually the head of the Commission when this project started, and then Anita Mathers – she'll raise her hand, many of you've met – is the graduate student that did most of the hard work on this.

Okay, so just a little background, then I'm going to briefly discuss the data and then we'll look at the results and the implications. Like all other states, California has a workers' compensation system. It's paid for by the employers. The costs range from 4 percent of payroll to 60 percent of payroll. It includes medical, temporary disability and long-term disability in the form of partial and permanent total disability. Every state has a program like this.

There are only five states and one territory that have a near universal non-occupational disability insurance system: New York, Hawaii, New Jersey, Rhode Island and California. These systems are paid for by employees; so very different from the workers' comp system. The rate in California is 1.1 percent of payroll and they cover disability payments so wage loss only. In California, it's seven to 365 days. So up to a year, and there's no medical and no long-term disability payments. So two very different systems, but they cover exactly the same thing, at least in part: short-term disability from up to a year.

So our concerns: first off, we want employers to internalize the cost of injuries. So we would like injuries to be reported in a correct system if we care about this process of internalizing the cost. We want employees to have the proper signal about the cost of SDI. Recently, we expanded the state disability insurance program in California to cover family leave. So we're the first state in the nation that not only has guaranteed family leave, but also has paid family leave for up to 12 weeks. And there's frequent litigation over the correct payer between these two systems and that's a major concern. So reporting is not a concern in terms of injury reporting in California. They're all reported. Disability cases get reported in California. The question is do they get reported in the employee-paid system or the employer-paid system.

Now, just to finish up on this. This is a unique effort that the Commission has undertaken because this is really the first time that anybody has investigated these short-term disability systems and the very large dataset that goes along with this in California. There's approximately a million cases in the state disability insurance system each year, a

good portion of them are for pregnancy, which are not included here, but these are quite unique datasets.

We've obtained a 20 percent sample of all cases reported to the state disability insurance system, the employee-funded non-occupational system, and we corrected for the fact that some employers can opt out of this system by self-insuring. So some employers self-insure. I don't know if Safeway is one of them for non-occupational disability. That was supplied by the Employment Development Department and the Commission was very helpful in getting these data for us because the Commission has a mandate to get data for oversight of the workers' compensation system and this has been a very powerful tool.

And then we used Bureau of Labor Statistics data to analyze occupational injuries and compare the frequency of occupational injuries at the two-digit industry level with non-occupational injuries at the two-digit industry level. And if these systems accurately sort cases into occupational or non-occupational and we've accurately controlled for the characteristics in any industry they control for that caused an industry to have higher non-occupational disability, then we should see a scattering of dots when we compare the different industries that would look like this. So non-occupational disability rates don't change, but occupational disability rates certainly change and they wouldn't change, they certainly shouldn't change in a consistent manner.

Now, if some cases from the occupational disability system were being reported as non-occupational, then the scattering of dots would look more like this. As occupational on the Y-axis increases, we would see increased reporting of non-occupational illnesses on the X-axis. This would mean that we were poorly reporting and poorly sorting these cases. And this is what we see: There's clearly a relationship between non-occupational disability and occupational disability even after we've controlled for the characteristics of the people in the industry. This is for injuries and illnesses. It's much worse when we include illnesses. The misreporting is even worse.

So this is a look at these two systems. The top line is the non-occupational disability system. Our state disability system is dominated by illnesses. The occupational disability system is dominated by injuries; there are very few illnesses, and a lot of injuries, and this is really the key statistic in this. That second row shows you the percent of cases that are misreported. In this case for injuries, about 6 percent of occupational injuries resulting in disability in California are misreported as non-occupational and paid in the non-occupational disability system.

That second statistic is the one that really should surprise some people. If it's an illness, three out of four times, an illness is misreported as non-occupational when it's actually occupational. The impact of this, because there are more occupational injuries than there are illnesses, at least reported, is that it's pretty consistent. About 20 percent of our injuries and 20 percent of the illnesses that are reported in our state disability insurance system, the one that's paid by workers, are actually occupational.

And the implications for this: First off, we have substantial misreporting or underreporting by employers. It's not necessarily the employer's fault, but there is misreporting. The workers are getting the temporary disability benefits. They may be getting the health benefits under group health, but there's misreporting of about 20 to 25 percent of injuries. It is very costly to litigate this system and we could save substantially on administrative costs if we could come up with a way to integrate these and not have to resolve the issue of causation. That integration is not that expensive.

If you figure out what this would cost employers, if they accurately paid for the injuries and illnesses that were occupational, it would increase their cost by about 0.13 percent of payroll, just a little more than one-tenth of one percent of payroll. High-risk industries would pay substantially more, but we would internalize cost correctly; we would avoid litigation and the disability related to it; and for a fairly small price, we would integrate two of these systems in a way that might help both employees and employers.

Thanks. (Applause.)

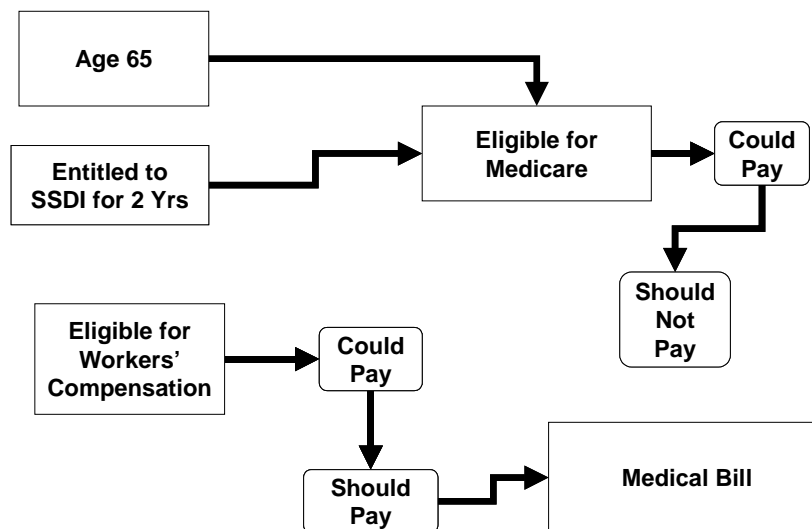
How Are Medicare Secondary Payer Rules Working?

Edward Welch, Director, Workers' Compensation Center, Michigan State University

EDWARD WELCH: We're going to have a session later this morning in which we say, "What would we do differently if we do this again?" And I think the first answer is: Give each of the speakers a little more time. (Laughter.)

It's difficult to talk about the relationship between workers' comp and Medicare in ten minutes because it's a complicated topic, but I think also because I expect in the room there are people sitting there who didn't know there was any problem between Medicare and workers' comp, and other people in this room who spend about two hours everyday pulling their hair out over this issue, and the challenge is to say something in ten minutes that will be a little relevant to all of you and I'm going to try and do that.

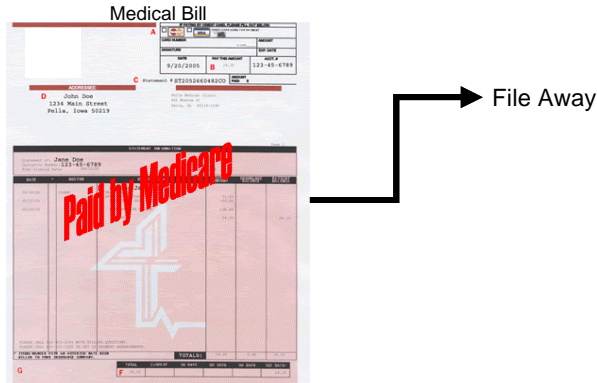
Medicare provides healthcare benefits to everyone who is 65 or older. I've been giving talks like this for a long time and I used to introduce them by saying Medicare is a healthcare system for the elderly, but about a year ago, I qualified and I no longer use the "e" word. (Laughter.) If you have been on SSDI for two years – Social Security Disability Insurance – you are also eligible for Medicare. There is obviously a considerable overlap between men and women who are entitled to workers' compensation and men and women who are eligible for Medicare.



What happens if a medical bill comes in? It is possible that either workers' comp or Medicare could pay this. Since the early 1980s, a federal law called Medicare as a Secondary Payer Act has provided quite clearly that under those circumstances workers' compensation should pay and Medicare should not pay.

Now, before we go any further, we must confess our sins of the past, and I hate to do this because we are so close to CMS, but the truth is that until about 2000, those of you who managed claims, if a bill crossed your desk that could have been paid under

workers' comp and you noticed that it had been paid by Medicare, you simply filed it away. Now, let's be honest; that's what we all did.



Similarly, those of you who managed claims and those of us who were attorneys representing injured workers until five or six years ago when we were settling a workers' comp claim and the worker said, "How am I going to get my medical paid for?" We said, "Just put it on Medicare." Now, we confess that we did that; it was wrong. I don't think anybody has done that in the last six years. We simply cannot do that anymore.

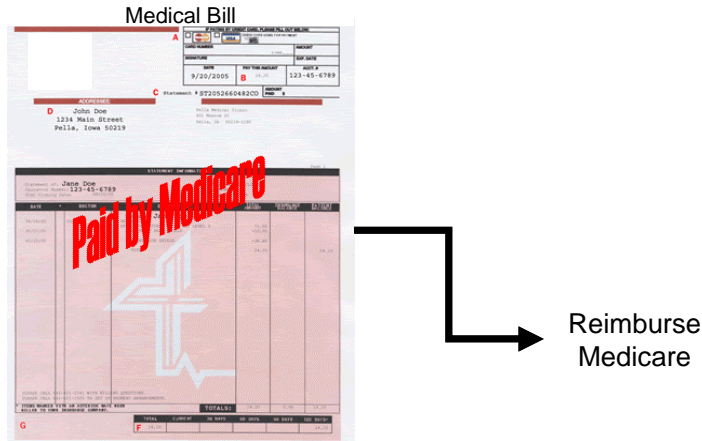
How will I pay
my medical
bills?



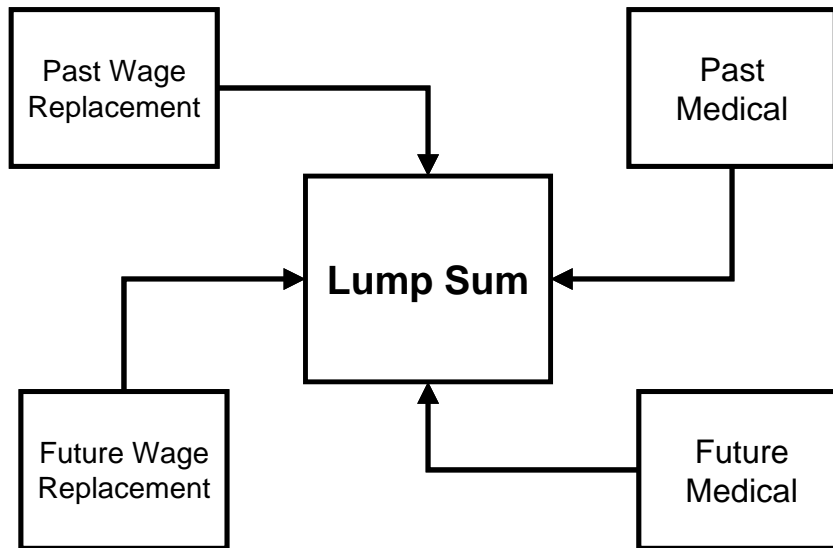
Just put them
on Medicare.



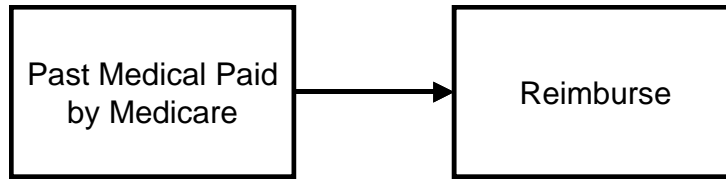
There is an organization that is called Centers for Medicare and Medicaid Services. Is anyone here from CMS? I want to know – they go by CMS – I want to know what happened to the second "M." I've been suspicious of them from the beginning. (Laughter.) They manage Medicare and a memo in July of 2001 is the turning point; since about 2001, they have very aggressively enforced the Medicare as Secondary Payer Act. Some things under this are very clear, there is not much question about them. If you are a claims manager and you see a bill that comes across your desk that was paid by Medicare that should have been paid under workers' comp, there is no question today: you reimburse Medicare. You are just taking a huge risk and I'll explain in a minute why if you don't reimburse that.



That's easy; the difficult thing is settlements. In the typical state, a settlement incorporates four things: past wage replacement, past medical, future wage replacement, and future medical.

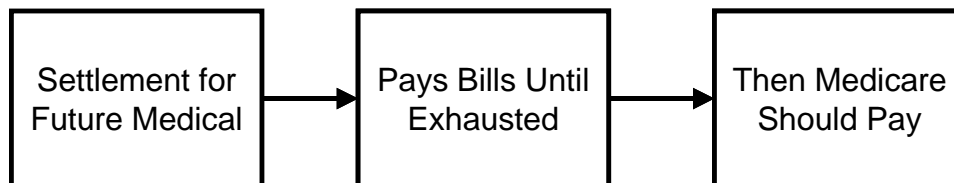


First, let's talk about past. If you're settling a workers' compensation case and there are medical bills from the past that have been paid by Medicare and could have been paid under workers' compensation, you need to reimburse Medicare. That's the first thing. Medicare calls them "conditional payments" because the statutes says that if there's someone else like workers' comp that could pay, Medicare can make the payment on the condition that they get reimbursed. Now, in fact, that isn't what's happened. They are more like inadvertent payments. Medicare didn't decide we're going to pay this because we'll get reimbursed. It just got put through the Medicare system, but there's no question that you should reimburse those.

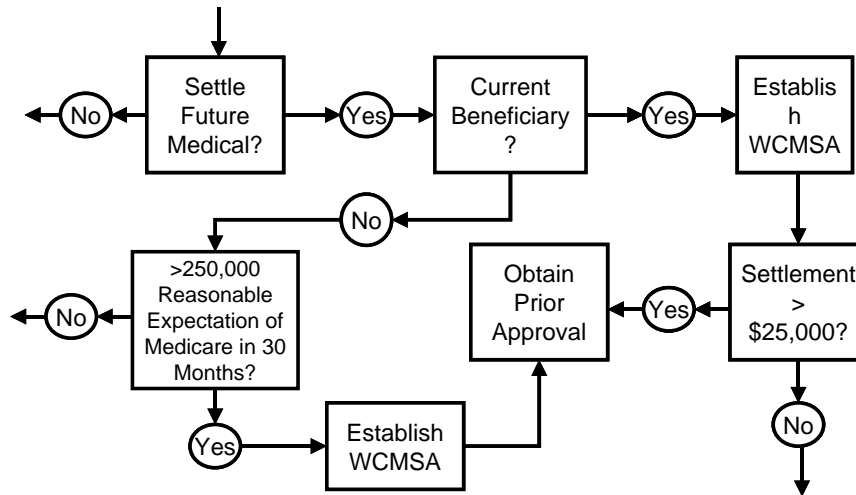


And there was a case that was decided a couple of years ago, Manning vs. Utilities Mutual, No 98 Civ 4790 (RCC), 2004 us Dist LEXIS 1674, it involved about \$200,000 in medical bills that could have been paid under workers' comp. It was not paid under workers' comp; Medicare paid, and the worker sued the insurance carrier and got double damages. That's why if you see that bill, you reimburse Medicare because if Medicare or the claimant's attorney comes after you for that, you'll pay double. That's past medical; that's easy. We know what we have to do. We might like it or not like it, but we know what we have to do.

The problem is that portion that is for future medical. The theory is very simple. The part of the settlement that is for future medical should be set aside and used to pay future medical bills. When they are exhausted, then Medicare should begin paying. It's the implementation that has been a terrible problem. CMS takes the position that the money should be set aside in what they call a Workers' Compensation Medicare Set-Aside Agreement, WCMSA – the acronyms get longer and longer all the time. Even that is not a bad idea, depending on the size of the settlement.



The problem is that Medicare wants to pre-approve settlements in certain workers' compensation cases. Which cases? Is there a settlement of future medical? If you're not settling future medical, you don't worry about this. If you are settling future medical, you ask is the worker a current Medicare beneficiary? If the answer is yes, then CMS says you should establish a Workers' Compensation Medicare Set-Aside Agreement. Next, you ask is the settlement over \$25,000? If it is not, then you have to set up the WCMSA, but you do not have to obtain pre-approval. If it's a current beneficiary and the amount is over \$25,000, then Medicare wants to pre-approve the settlement of the workers' compensation case.



If the individual is not a current Medicare beneficiary, then you ask is the settlement over \$250,000 and is there a reasonable expectation of Medicare within the next 30 months? If it is over \$250,000 and the guy's going to apply for SSDI, in my view, any comp settlement where you get \$250,000, the guy ought to apply for SSDI, if he hasn't. Then if it's not, then you're okay. If it is, then you must establish a WCMSA and obtain prior approval.

Now, those of you who do this every day are thinking, Ed, you forgot this and forgot that, and I'm going to hasten to say this is an oversimplification. Those of you who are new to this are saying, "That's an oversimplification?" But it is. There's much more to it than that.

Practical problems

- Delay
- Lack of understanding of workers' compensation laws
- Failure to recognize differences among state workers' compensation systems
- Unrealistic accounting expectations
- Cost vs. benefits
- No appeal

Of the practical problems, the biggest is the delay: the amount of time between when you're ready to settle the workers' comp case and when you get it. Other things include the lack of understanding, the contractors who've been hired by CMS to do this, their lack of understanding of workers' comp laws, failure to recognize the difference among states, unrealistic accounting explanation.

They expect workers to put this money aside and the whole thing is if it's a \$250,000 settlement, it works. You know, I see these people with catastrophic losses, where you're setting aside a million dollars for future medical. You can spend all the

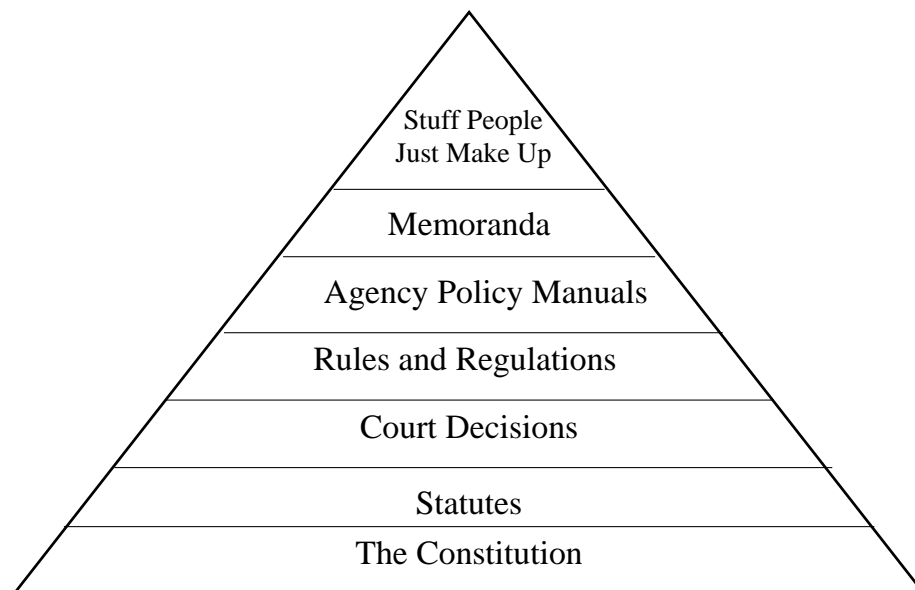
money on this. You can hire a trustee to administer this, but for current beneficiaries, CMS is expecting us to do this for \$30,000 comp settlements, and then they are expecting the worker to keep track of all his or her medical bills and account for all this.

The cost versus the benefit is problem. There is no appeal. In Michigan, we currently have 900 cases in which the workers and the employers have agreed to settle and they are on hold waiting for CMS. Some people say the system works; others report terrible problems. I talked about this new bill I'm going to mention and all of the wonderful things in the bill and an attorney said to me, "Ed, I don't care about all that if they just return my phone calls."

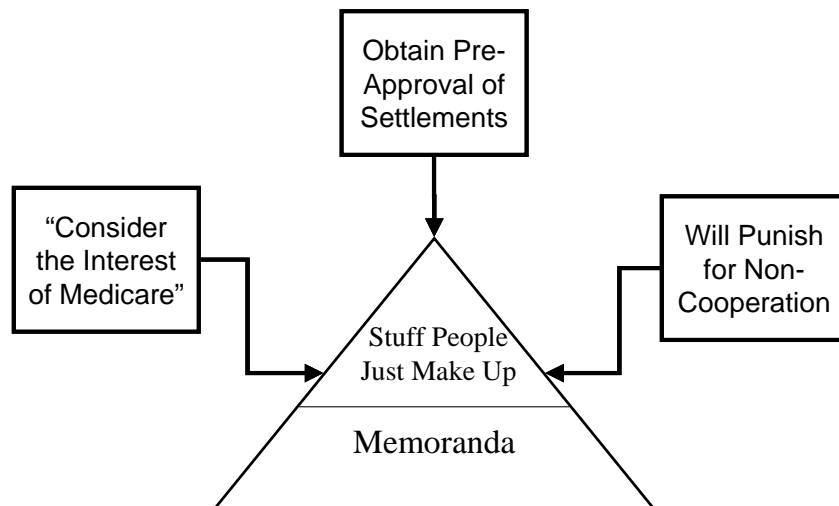
The role of vendors: some people say they can be very helpful, some people say they don't need them, some people say they are what stirred up the pot, that there is a group of vendors that are making money off of this and they are encouraging all of these problems.

There are serious legal problems with the positions that CMS takes. I'll look at a couple of these.

When I went to law school, I was taught that we live under the rule of law and there's a basic foundation for laws in this country, and the Constitution is the bottom level and then there are laws that are passed by the Congress or the state legislatures, and then there are court decisions that interpret all these and it's a hierarchy. Everything has to be within the Constitution. The court decision has to be based on the statutes, and then federal or state agencies can publish rules or regulations, but there's a formal procedure for them to do that and they have to be, again, based on the statutes, and then there are agency policy manuals that are published in a formal way, and then there's memoranda and stuff people just make up. (Applause, laughter.) All right?



Now, the problem is that most of the foundation for CMS's position comes from this category. All right? (Laughter.) They say you must consider the interest of Medicare. That is not in the statute. It is not in their formally adopted regulations. It is in stuff they make up. The same with obtaining pre-approval for a settlement, it is not anywhere. It's just stuff they made up, and finally, the idea that they can punish a worker who doesn't obtain pre-approval; it's not in the statute, not in their very elaborate formally published regulations, has not a word about this. This isn't just memoranda that they have put out.



CMS says it recommends pre-approval. It agrees to review certain cases. (Times up, but I'm just going to take a couple minutes more.) (Laughter.) But here's the catch, it will punish you if you don't get pre-approval. What it says: if you do not get pre-approval, it will treat the whole settlement as if it were for future medical. There is no statutory authority for doing that. They'd tried to do that in Medicaid and they lost at the United States Supreme Court. In the last year, they said, you know, under Medicaid, if you don't do this and that, we're going to treat it as if the whole settlement were for future medical. The United States Supreme Court said there's no basis in law for you to do that.

It's a different statute. It's a different language, but the same principle, I think, will apply eventually. The trouble is if you're a claims manager, you can't take the risk of litigating this all the way to the Supreme Court. So you go along with what they do.

There is proposed legislation that would resolve most of these problems. The lead organization in supporting the bill is UWC—Strategic Services on Unemployment and Workers' Compensation (UWC) (<http://www.uwcstrategy.org>). Their president is Eric Oxfeld. They can be reached at info@UWCstrategy.org. Those of you who are having trouble dealing with these issues need to contact UWC. You need to contact your members of Congress.

It is a reasonable legislation. We are not trying to cheat Medicare. We know this has got to change. We want to find a workable approach. I think we need somebody to

litigate this, but the solution, I think, is this bill, which we need to get through Congress. It is a bill before Congress that has support of the trial lawyers, the insurance industry, the largest employers in the country and some representatives of organized labor. If we can't get that through the Congress, I don't know what we can. The trouble is Medicare is 25 percent of the federal budget and that's the issue we're up against.

Thank you very much. (Applause.)

Discussion

MS. NOWELL: All right. So this was not like herding cats, it was like herding lions. (Laughter.) Wonderful talks and very fruitful thoughts at the end of each one, but we do have about four minutes. I'm going to break us at 9:35 because you have to be out at your break and back at 9:45.

So, Virginia?

VIRGINIA RENO: This is a very mundane comment, but I would suggest, given the provocative sessions we've have, if we skip the break and have just a little more time to discuss and then go immediately into the next session.

MS. NOWELL: Consensus of the group? Excellent. Well, then we have 13 minutes for questions. (Laughter.)

Q: Hi, I'm Dave Rafferty from the Congressional Budget Office. I had a question for John. I was really surprised to see that there was no statistical – statistically significant correlation between disability prevalence rates and the rate of DI applications?

MR. BURTON: Yes, I was also surprised.

Q: I'm looking at the two – two of your slides, numbers two and six, and they look nearly identical to me.

MR. BURTON: They what?

Q: They look nearly identical.

MR. BURTON: They certainly do.

Q: They are the same slides. (Laughter.)

MR. BURTON: There must be an error in Figure 2 or Figure 6. I don't know which it is. I have not seen that before, but you're correct. I think the data used for the statistical analysis shown in Table 1 are correct because if in fact there had been identical data used for the two variables, the correlation between the two variables would have been one and the statistical analysis would not have been possible.

Q: That's – yeah, that was what – (inaudible).

MR. BURTON: All right. I'll have to correct that and I'll make sure we get the correct data on the NASI website. Good eye. [Figure 6 was corrected before the slides were posted on the NASI website.]

Q: Thanks.

MR. BURTON: As I've said, when I began, these are preliminary results – (laughter) – and when you're on the frontiers of science...

Q: I was thinking about the nature of the relationship between workers compensation and I think that if you look at it longitudinally, if more people apply for workers' compensation, these people, if approved, may be more likely to end up on DI than others.

I know that Les Boden is going to propose a project that uses longitudinal data where you can track, but I think that would be a useful thing to consider. The other thing is you mentioned you were puzzled by this relationship between the DI acceptances and the disability application rate. I think there is an explanation which may have to do with the reverse kind of causal interpretation: that as application go on more and more marginally qualifying people apply and the system cleans them out. And there is quite a bit of literature on DI, which is consistent with this point.

There have been some studies done that look at the DI acceptance rate and applications using some lagging mechanism so the idea is that this is a relationship that should be there, Don Parsons has done I believe the first study on this 1980 and there have been a lot of other studies done that basically did not totally agree with the point estimates he had, but most of the studies I have seen show that there is a relationship of the kind you would expect.

MR. BURTON: Well, I wouldn't be surprised as we revise this, if we find that relationship because as I said before, this is very quick and dirty. Again I think the thing that's interesting to me is whatever the problems are in terms of the DI system in explaining the application rate, it's kind of amazing the workers' comp comes though. And it will be interesting to see where that holds up after we do those corrections. Thank you for your comments we'll follow up on that.

Q: Just a general observation about the concern in the decline in filing rates. As I said yesterday, good news in workers' comp sometimes is bad news. And I agree that there's lots of pressure not to file claims. When you look at the construction industry, if you're a major contractor and you've got a mod above one, you can't bid. So there's tremendous pressure to suppress claims in that industry just to stay alive, but I really think workers' comp should be a declining business.

I think workers' comp should be a declining business because if we're successful on the safety side and we design workplaces with ergonomics in mind, you should have fewer claims. And one of the problems that we're facing in Washington is we looked at average time loss duration; it's a big push to reduce time loss duration. But what we're really trying to do is get people to work faster, avoid disability payments at all because the worker's kept them on salary or has a light duty job. If you can maintain that connection with the employer at time of injury, the outcome for the worker is much better. Breaking that, you wind up with an injured worker who's also unemployed and the prospects of going back to work are very limited. But if we're really successful on

the front end of the claims avoiding time loss at all or getting people back to work in a much, much shorter time – we’re looking at cutting the cycle time in every single thing we do – if we’re very, very successful what will happen is average time loss duration will grow and it will be made up of a smaller number of catastrophic losses which everybody agrees we’re going to pay for, no ifs, ands, or buts.

The percentage of the perceived to be bad claims – people taking advantage of the system and manage to stay in will increase. The system as a whole is getting better because fewer workers are injured, they’re getting better care, and they’re getting back to work sooner. But the perception could very easily be, boy, look at all these bad long duration claims, we’ve got to do something dramatic to fix the system. And so when you’re looking at the filing rates keep that in mind because we could be doing really good things but it could very easily be interpreted as bad things.

And, John, in your study did you look at the effects of welfare reform on the DI filing rates? Because I think that it drove a lot of people from state welfare systems into Social Security.

MR. BURTON: We haven’t looked at that yet. That’s a good lead. Just a comment on your thing about workers’ comp. I do think, part of what you’re saying I certainly agree with: the notion that the best solution would be to get the injury rate down, and that’s obviously a win-win situation. What we found, and this is in the results here, we try to explain why the things I showed in figure one – the decline in workers’ comp benefits per hundred thousand workers – we found that the injury rate itself was a major explanatory factor in why workers’ compensation benefits are going down. No question about that. We also found that a good deal of the drop in benefits was due to these tightening compensability rules.

And another way of putting that which shows up on this thing, if you look at the ratio of lost time cases under OSHA that show up in a workers’ comp system, that percentage is going down. It went down during this period, so there’s clearly something other than just injury rates and I understand your point about more serious injuries maybe showing up but if the control for this lost time injuries you see a smaller percentage of those lost time injuries getting into the workers’ comp system.

Q: Thanks.

Q: Hi, Jay Himmelstein. Great panel. I’m just wondering whether any of you have looked at the issue of Medicaid in terms of overlapping compensation system and interactions with CMS, because my understanding is that in every state, Medicaid is the payer of very, very last resort, even after Medicare. And I think every state has to have a third party liability recovery program by law where they’re making sure that Medicaid is not paying bills that are paid by others. And I know in Massachusetts, when they looked at that, within last year alone, they had 20,000 pending workers’ compensation cases on their Medicaid rolls waiting for resolution. And it might inform some of the research that you’re all doing.

MR. WELCH: I think the experience here is that the difference is that CMS is nationally approaching Medicare and Medicaid is being approached on a state-by-state basis very differently, probably not as aggressively. They don't want to pre-approve things. In Michigan it's basically a reporting and I think they're in for their filing liens and I would say that, in Michigan at least, Medicaid is doing it effectively in a way that is not interrupting the workers' comp system, the way the Medicare approach is.

Q: But they're still attaching liens on the settlements.

MR. WELCH: But they're doing it in a way that the workers comp practitioners can live with.

Q: Right.

MR. NEUHAUSER: There is a pretty aggressive program in California to sort these payments accurately when there's a workers' compensation claim and they should be paying. We're undertaking a program now to look at a related issue which is when you have a workers' compensation case that results in disability, are you more likely to end up on Medicaid – in our case MediCal – for all of your medical treatment just because you're now outside the workforce and you qualify for benefits independent of that particular injury? So that's a future study that we're probably going to start at the end of this year, and looking at that in relation to SSDI, SSI, welfare and that whole panoply of social safety net rather than social insurance.

MR. BODEN: In a way all of us are doing these studies where we're looking at the big picture and trying to figure out what's going on and what we really want to be able to do and I think it's going to be some years before we figure out who to do this is to take people who are injured at work and to see what happened to them. And so the question is okay, so you don't have a lost time injury because your employer is not putting you on workers' comp, you're getting back to work quickly. What happens to that person? Are there some people who just do much better because the employer has brought them back to the workplace? Are there other people who can't do the work even though they're brought back and either they're brought back on some job that really doesn't mean anything and eventually they disappear from the workplace without having gotten workers' comp – end up some other social support program? So there are just a whole bunch of questions that we're just at the first stage really of trying to understand. But this first stage is going to inform I think what we then find later on.

MS. NOWELL: I'm going to cut this off, as much as I hate to. This was a great panel. Thank you so much. We have like a minute or two to set up the next one. I want to remind everybody that there are evaluations in your packet. Please fill them out, the Academy is anxious to hear your comments. And thank you again. (Applause.)
(End of panel.)

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

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 from 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. Confirmation 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 than \$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 his earnings, his SSDI is still in place 12 months later, but this is 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 works 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 non-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)