

## **Commission on Health and Safety and Workers' Compensation**

### **MINUTES OF MEETING August 19, 2004 San Francisco State Building San Francisco, California**

#### In Attendance

Tom Rankin, Chairperson  
Commissioners Alfonso Salazar, Kristen Schwenkmeyer, Robert B. Steinberg,  
Darrel "Shorty" Thacker, and John C. Wilson  
Christine Baker, Executive Officer

#### Not in Attendance

Commissioners Allen L. Davenport and Leonard McLeod

#### **Call to Order / Minutes from the June 10, 2004 Meeting**

Chairperson Rankin called the meeting to order at 9:05 am.

#### *CHSWC Vote*

Commissioner Wilson moved to approve the minutes of the June 10, 2004 CHSWC meeting.  
Commissioner Thacker seconded and the motion passed unanimously.

#### **Update on the Division of Workers' Compensation**

Andrea Hoch, DWC Administrative Director

#### *DWC Priorities*

Ms. Hoch gave an update on the Division of Workers' Compensation's (DWC's) priorities. She indicated that these include the Workers' Compensation Medical Fee Schedule, Permanent Disability and Independent Medical Review regulations. The Workers' Compensation Medical Fee Schedule regulations were recently adopted. The Permanent Disability regulations will be adopted on January 1, 2005. For the Independent Medical Review regulations, DWC will be convening an advisory group.

#### *DWC is Hiring*

Ms. Hoch advised that DWC is currently hiring and that there is a new Administrative Law Judge list. There will be an Office Technician exam and they are currently compiling questions for a Workers' Compensation Consultant examination. DWC is also looking for key managers including a Medical Director and Assistant Administrative Director. She made a request that if anyone were interested in any of these current positions to please contact DWC.

#### *California Performance Review Commission*

Commissioner Salazar stated to Ms. Hoch that he was sure she was aware that the California Performance Review (CPR) Commission recommended that CHSWC be eliminated. He stated

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that CHSWC was unique, as it is comprised of both labor and business representatives. He then asked Ms. Hoch for specific advice on what CHSWC should do or how it should go about having input in the process and if the Department was going to ask CHSWC to provide information. Commissioner Salazar asked Ms. Hoch how she could help CHSWC or how could CHSWC help her provide such information. Ms. Hoch replied that she was not involved with the process that led up to the CPR report. Ms. Hoch recommended that after the meeting, she and Christine Baker could talk to figure out how to respond to the report.

Chairperson Rankin clarified that under the CPR proposal CHSWC is to be abolished with its functions somehow taken over by the new agency. He opined that he was not sure how that could be done and that he is strongly opposed to the abolishment of CHSWC.

Ms. Hoch clarified that the California Performance Review report contain only recommendations and that public comment on the recommendations is open to everyone. The recommendations will then be presented to the administration and at that point the administration will determine what the next step will be.

*Permanent Disability Study*

Commissioner Steinberg noted that at the last meeting there was some concern expressed about accomplishing the permanent disability study by January 1, 2005. Commissioner Steinberg stated that he understood Ms. Hoch had been helpful in getting RAND funded so they could go ahead and get the work done needed to put in place the permanent disability schedule. Ms. Hoch stated that the Division has money to contract with RAND to take the next steps to develop the regulations for the permanent disability rating system.

Commissioner Steinberg asked if Ms. Hoch could give CHSWC an idea of what the PD schedule timetable is and if there will be public hearings held. Ms. Hoch replied that with all the regulations, including the medical network provider and permanent disability regulations, DWC would be going through the same process with the difference being that the process will be expedited because of the deadlines. DWC will have an advisory group and an opportunity for input from the advisory members of the group required after developing the regulations. The regulations will be posted on the DWC public forum website. The time frame to respond is going to be much shorter because of the deadlines in the statute. Once the regulations are adopted, they will then go through the formal regulatory process. Ms. Hoch stated that people are very interested in this process. She has already received a lot of public comment from the advisory groups who have met.

Chairperson Rankin thanked Ms. Hoch for updating CHSWC on DWC activities.

**Other Business: The California Performance Review (CPR) Commission Report**

Tom Rankin, CHSWC Chair

While the next presenter was setting up, Chairperson Rankin brought up other business, the California Performance Review (CPR) Commission and their proposal to abolish CHSWC and CHSWC's response to that proposal. Chairperson Rankin recommended that CHSWC participate in the public hearings to defend CHSWC and lobby for its continued existence. Chairperson Rankin feels that CHSWC has done very good work and was confused that a

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commission that has been instrumental in saving billions of dollars for California employers would be scheduled for abolition. He put the issue forward for discussion.

Commissioner Wilson concurred with Chairperson Rankin's comments and stated that he has been involved with workers' compensation for many years. He noted that CHSWC is the first thing that has come along to provide some basis for the legislation that has been passed. In past years colossal mistakes have been made in legislation simply because research was not done prior. Commissioner Wilson believes it would be foolish to eliminate CHSWC and would be happy to contact the employer community he works with for their support.

Commissioner Salazar completely agrees as well. Working in State government and knowing the commissions that exist out there, he believes there are many commissions that do a lot of good work and CHSWC is definitely one of them. CHSWC has been doing some incredible work over the years and he noted that the research that CHSWC has provided to the Legislature to help formulate legislation over the last couple years has been unparalleled. The reforms are the result of many, many years of research and dialogue. To see recommendations that CHSWC be abolished in the next couple of months, whether through a vote of the Legislature or a referendum to the voters of the State of California is a big concern to him.

Commissioner Salazar would like to help organize the business community, drum up support and shed light on the value that CHSWC provides to the State and the billions of dollars that CHSWC is saving on the business side as well as the State side. He stated that currently there is a process for comments and there are hearings going on. CHSWC needs to figure out how best to organize and approach these hearings and how to approach the administration as well as the legislature at the State level. Commissioner Salazar is not quite sure the specific actions that should be taken but he would like to come up with information and recommendations. Commissioner Salazar would embrace actively moving forward with respect to CHSWC's position.

*CHSWC Vote*

Chairperson Rankin suggested a motion to explore what needs to be done to ensure the continued existence of CHSWC, including testifying at the hearings that were mentioned and at possible Legislative and/or Labor Agency hearings. CHSWC needs to get support from constituents, both from labor and management and from the rest of the workers' compensation community. Chairperson Rankin stated that this is a political situation and that Executive Officer Christine Baker should not be put in the position of testifying by herself at the hearings.

Commissioner Salazar moved to adopt the motion, Commissioner Thacker seconded and the motion passed unanimously.

**Update on the Study of Medical Treatment Guidelines/Permanent Disability  
Recommendations for Developing a Research Agenda**

Robert T. Reville, RAND  
Seth Seabury, RAND

Dr. Reville thanked CHSWC for the opportunity to present an update on the various research projects that RAND is involved in for CHSWC and for the DWC.

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*Medical Treatment Utilization Schedule*

Dr. Reville talked about RAND's plans for the evaluation of potential medical treatment utilization schedules. The research team includes Barbara Wynn and Dr. Teryl Scott.

The objectives of the study are based on the requirements of Labor Code §77.5(a), modified by Senate Bill 228, which mandates CHSWC to conduct a survey and evaluation of evidence-based, peer-reviewed and nationally recognized standards of care. In addition, SB 228 calls for looking at those schedules, which, at a minimum include the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation. With those conditions in mind, RAND has designed the study to screen and evaluate existing clinical guidelines -- not create new clinical guidelines. RAND plans some public meetings to discuss the findings.

RAND will be looking at guidelines that are comprehensive rather than trying to put together a patchwork of different guidelines that deal with various elements of the workers' compensation medical system. RAND is also only looking at those guidelines that are developed by a multi-disciplinary panel rather than by one individual medical practice. This is regarded as a best practice for the development of utilization guidelines and produces a more balanced interpretation of the literature than any single specialty group. RAND will also look at those that are reviewed or updated at least every three years so that it can provide an ongoing basis for having utilization schedules in California workers' compensation and those that are available to Californians at a modest cost.

RAND envisions that four to six guidelines will emerge as finalists, which will undergo a technical and clinical evaluation. They will first be assessed for technical quality associated with the ways in which they were developed. RAND will convene a multi-disciplinary panel of national experts who will then evaluate the clinical content of the utilization schedule. Dr. Reville noted that they will be using existing schedules and evaluating them because an independent literature review and guideline development is a very large task and beyond the project scope.

RAND has developed a timeline to provide recommendations in time for the AD to adopt the guidelines by December 1, 2004. RAND is currently involved in identifying and screening guidelines and in determining who will be on the technical panel to evaluate the guidelines. RAND is expecting to hold the clinical expert panel meeting on October 1, 2004 and will be submitting a draft report on October 15, 2004 to DIR for comment. A stakeholders panel meeting will be held at the end of October 2004. The final report will be submitted to DIR on November 15, 2004. After that, DWC will also be holding public hearings before actually adopting the guidelines.

Ms. Baker noted that CHSWC must review and approve the medical treatment utilization report and submit it to the DWC Administrative Director. CHSWC is scheduling a public meeting on November 3, 2004, to vote on the medical treatment study report.

*Questions and Answers*

Commissioner Steinberg asked Dr. Reville if CHSWC is just consulting on this or if it has a decision-making role. Dr. Reville stated that he did not know the answer to this.

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Chairperson Rankin asked that given the passage of SB 899 that set up medical networks, how do the utilization guidelines fit in with this medical network system. Judge Lachlan Taylor responded that networks will be required to deliver their medical treatment in accordance with the adopted guidelines and if the network providers fail to do so that would be grounds for an employee to receive disputed treatment outside the network.

Commissioner Salazar asked if there was going to be one guideline or a couple of sets of guidelines layered. Dr. Reville replied that the idea is to have a comprehensive guideline rather than trying to piece together multiple guidelines into a patchwork.

*Update on Other RAND Work*

- The Permanent Disability report is for review only in the meeting as a working paper. It has been circulated to CHSWC for review as part of RAND's peer review. It has now completed peer review and the two reviewers had no objections to the content of the report. RAND is in the process of responding to their relatively minor comments at which point it will go through final edits and be available.
- The 24-Hour Care report that is also available as a working paper. RAND sent many copies to CHSWC last week. It has not yet completed peer review.
- The Five State Study is slated for publication in a book to be published by Upjohn and will be made available to CHSWC. There is an additional document under preparation by RAND specifically for CHSWC.
- The Public Self-Insured study addressing issues related to Labor Code Section 4850 will be entering peer review at which point CHSWC will receive copies very shortly, within the month.
- The Disability Rating Implementation Study is in process. Dr. Reville then turned the microphone over to Seth Seabury to discuss this study.

*Permanent Disability Rating Study*

Dr. Reville introduced Seth Seabury, an economist at RAND, to discuss the Permanent Disability Rating Implementation Study.

Mr. Seabury noted that SB 899 enacted very sweeping changes to California's permanent disability system including a complete overhaul of the system for rating permanent partial disabilities. A large part of this is the adoption of the American Medical Association *Guides to the Evaluation of Permanent Impairment 5<sup>th</sup> Edition* (AMA Guides), to be used for "descriptions and measurements of physical impairments and the corresponding percentages of impairments." However, one thing that SB 899 also does is, which is unique, is to require the schedule to reflect "the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees."

In the study RAND will be looking at the section in SB 899 that talks about adjusting disability ratings to reflect earnings loss.

Mr. Seabury explained that the earnings loss adjustment is intended to improve the equity of

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permanent disability compensation. The interim report outlines the proportional earnings losses for different types of impairments suffered by workers in California. RAND is looking at the proportion of income lost by an injured worker three years after injury and the disability rating broken into groups. For injuries with a very similar rating, there are wide variations in the actual earnings loss suffered. For example, for a shoulder for every rating there are higher earnings losses than a knee. The idea of the disability rating is to incorporate all the medical information about a condition, so essentially, for a same rating; two types of injuries should have the same earnings losses. RAND's results showed the schedule did a poor job of equalizing these earnings losses. The adjustments are intended to increase the equity of permanent disability compensation by minimizing these differences with the different types of injuries.

The idea of the adjustment factor is that the relativities between the types of impairments are established by empirical data on the earnings losses so that the earnings losses provide the means for determining that relativities are in the rating schedule. Whereas now, in the AMA, the relativities were decided by physicians but were not based on any empirical evidence about the impact of impairment on ability to work.

Mr. Seabury went on to discuss how the adjustments are going to be implemented. A likely scenario is that the physician rates an injury according to AMA guides. Then the wage loss adjustment is applied to that physician rating based on the injury description the physician provides. Then there is an age and occupation adjustment and finally, the benefit delivery. The actual mechanics of this likely scenario might be that the Disability Evaluation Unit applies the wage loss adjustment based on the medical evaluation that is submitted to them.

Mr. Seabury noted that there are some challenges to implementing this new schedule. The AMA Guides are far more complex and this requires a lot of new training for physicians. This is something that people are aware of and efforts by CHSWC and others are being made to train physicians.

For RAND's purposes, one of the real challenges is that injury descriptions are very different in the two systems. Earnings loss data is only matched to ratings provided using the descriptions on the old California system. Implementing the earnings loss adjustment requires RAND to create a crosswalk between the injury descriptions in the AMA Guides and the injury descriptions in California system, which needs to be done in order to meet the deadline of January 1, 2005.

Mr. Seabury stated that the main work of the project RAND has undertaken with the DWC is to provide this crosswalk to allow RAND to compute the adjustments for the AMA Guides to be implemented. The first step to this crosswalk is to look at major body parts which can be aggregated and have very similar descriptions in both systems. For example, a shoulder or knee impairment can be grouped together under the same system and this will cover a wide majority of the cases. The ratings for these categories can be adjusted using average earnings losses that exist for the California system. This can be completed in time to allow, with certainty, the deadline to be met.

The second step is the creation of an empirical crosswalk by using dual rated reports, having the same injury rated by a physician using both systems. This allows RAND to look at what the California rating and what the AMA Guide ratings are for the same injury to pull out what the

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earnings losses would be for an injury rated under the AMA Guides. .

*Issues for the Future*

Mr. Seabury stated that RAND wanted to raise issues that are not part of current projects but are important to think about for the future.

The first issue mentioned was the long-term implementation and update of the permanent disability schedule. He noted that the ideal solution for the compliance with SB 899 is to adjust the schedule using data on earnings losses for workers evaluated initially under the AMA Guides to have a direct match between an AMA Guide evaluation and the actual post-injury earnings losses for the injured workers. This is not useful for the initial implementation because three to five years of post-injury earnings are needed in order to provide that match. However, SB 899 does call for periodic revision of the schedule to reflect changes in average earnings losses. RAND thinks it is useful to start thinking about a data collection plan and reporting requirements to be in place on January 1, 2005 or soon as possible thereafter and to think about some of the different aspects of this. For example, getting participation from self-insured employers that do not have the same reporting requirements but as other RAND work has shown, is a very important group of employers for thinking about average earnings losses.

Mr. Seabury also brought up a key unanswered question that has not really been addressed in the current studies: What should be the effect of the adjustment on the average ratings? He noted that the scale of the AMA Guide ratings is almost certainly lower than current system. The scale of the disability ratings is important because this is what essentially determines the amount of disability benefits. There are questions about how to implement the schedule based on the AMA Guides. Do you keep average rating equal to the pre-899 levels? Do you keep them equal to the AMA Guide levels? Do you try to equalize them to proportional earnings losses? These important questions need to be answered because this will impact the adequacy of the PPD benefits.

*Questions and Comments*

Commissioner Wilson noted that the conclusion section of the report indicated that the adjustment for age is unfair and the assumption is that the earnings losses are higher in the older population than in the younger population. Commissioner Wilson asked if RAND recommended that age be taken out of the system and if complexity would be reduced if that factor were removed. He also noted that it would require legislation to make such a change.

Mr. Seabury replied that their results do cast doubt on the effectiveness of the age adjustment as it is currently implemented. RAND has found that the differences in earnings losses by age group are not as severe as suspected. They are relatively small but the largest earnings losses appear to be suffered by the youngest workers, followed by older workers<sup>1</sup>. Middle age workers sustain the lowest earnings losses. It does appear that California's current adjustment is problematic since there are some equity issues.

Commissioner Wilson asked if other states use age adjustments. Mr. Seabury replied that they use it in different ways. Some states do the same things that California does, while other states

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<sup>1</sup> Dr. Reville said that RAND defines younger worker as 20-29, middle aged workers are 30-39 and 40-49.

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do the opposite. It is an open question.

Chairperson Rankin asked if the statute says which way the age adjustment has to go. Ms. Baker responded that it does not.

Commissioner Wilson asked what would be wrong with taking the age adjustment out if it does not seem to work. Dr. Reville added that there are different ways to think about what is the purpose of the age adjustment. Some people have said that the purpose of the age adjustment is to reflect the fact that older workers with a given impairment have a greater difficulty getting back to work.

RAND's results suggest that, perhaps, because older workers have a greater attachment to the labor force and for various kinds of reasons, it appears as though the youngest workers have the greatest adjustment to their disability. As a result, younger workers suffer larger earnings losses over a fixed period of time. The notion of the Colorado system, for instance, is supposed to address the additional issue of the fact that a younger worker who experiences a disabling injury is going to have to live with that injury for a far greater time period than the older worker. The purpose of paying younger workers a greater amount is to address that issue. Both issues point to the same direction toward compensating younger workers more than older workers rather than the way California does it. It would be a good idea to make that change.

Commissioner Steinberg stated that on page 37, footnote 33, regarding the AMA Guides, the report mentions that no empirical data exists. The report indicates that RAND is planning or proposing doing research on this. Commissioner Steinberg asked them to expand on this. Mr. Seabury responded that this is the new research they are talking about now. Looking at it in terms of the short run implementation, this idea of matching the AMA Guide ratings to the ratings in California is one way of accomplishing that. The long-term implementation idea is the notion of actually collecting new earnings loss data on AMA Guide rated claims.

*Public Comments*

Trudy Maurer, Chief Executive Officer with Spine Network of California introduced herself and stated that there are 22 spine surgeons across the state involved in this network. The main reason that she came to the CHSWC meeting is because although she thinks that the new regulations have value and need to be done, one of the major things that has not been addressed is the actual injured worker. She noted that from the beginning that CHSWC was going to institute a program to teach the doctors how to use the new regulations. She believes that before the regulations come into force, January 1, 2005, there is not much time for educating the physicians.

Meanwhile, the major problem that they are seeing now is the lack of authorization. She suspects that there are two factors; the Director addressed one when she began her speech. The AD said that there are not enough people working for the organization. Here there is a huge new group of laws and regulations and there is no one to implement them. Ms. Maurer came to the CHSWC meeting with an injured worker and is asking CHSWC to look at these new regulations to say how they will impact injured workers. Currently, to get an authorization for surgery or treatment is about six to eight months, a very serious situation. She has been doing this for fifteen years and she has never seen such a lack of addressing the issues that have to do with the

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injured workers. It is laudable that CHSWC and that the Board has put together new regulations which most of the physicians are not familiar with and will further delay the treatment. It is not that she thinks that the Board is not actually going to give treatment to the injured workers; it is the delay in treatment that she would like to address. She is listening to what is being planned and she sees two, three, four levels more that the injured worker will have to go through without a real program to educate the physicians. She would like to know how CHSWC will address this and what kind of timetable or even if there is a timetable that CHSWC has thought about.

Ms. Baker thanked Ms. Maurer for her comments. Ms. Baker added that this particular project is on the permanent disability schedule and the AMA Guides, not the medical treatment schedule. Ms. Baker agrees entirely that there is an entire educational effort that is needed on the AMA Guides. That is why CHSWC has put together a comprehensive educational program and there are independent parties that are doing it as well. CHSWC is partnering with the Division of Workers' Compensation, the AMA and the California Medical Association. These trainings will be intensive, they will take place in November, both North and South, for all doctors and for the entire workers' compensation community. Ms. Baker stated that the trainings will take place at the Convention Center in Anaheim and in the South San Francisco Convention Center. Ms. Baker noted that the program is going to be intense, two days, targeting on the most critical areas. Apart from the AMA guides, the conference will address the permanent disability schedule, which will be out as well in January.

*Proposed CHSWC Research Agenda*

Dr. Reville then turned to speak on the possible future direction of CHSWC research. He commented that these are suggestions by RAND that have been discussed with the Executive Officer and are not intended to be exhaustive. They are suggestions to be thinking about now and are open to further discussion. Dr. Reville stated that CHSWC had the foresight to begin comprehensive study of permanent disability eight years ago that helped the State in a dramatic way to improve permanent disability via SB 899. The decisions made now by CHSWC can have dramatic impact on the ability of the State to face some of the issues that they may be facing down the road.

- RAND is already involved in a project for CHSWC looking at the full employer cost of workplace injuries and illnesses. As part of that, CHSWC has seen the proposal where RAND is going to be working with the National Institute of Occupational Safety and Health (NIOSH) to look at the issue of the relationship between health promotion and injury and illness reduction. Much of the focus of workers' compensation and Cal OSHA has been specifically on injury and illness reduction. There are another set of programs intended to achieve other purposes associated with reducing the costs of employers and also with improving the health of the workforce. These are things such as programs intended to reduce obesity, to provide assistance with workplace stress, and in general, to promote the health of the worker. There is some preliminary new evidence that combining programs intended to address injury and illness reduction at the same time with programs to promote the health of the workforce of a particular employer, tend to be more effective than either approach in isolation. NIOSH has identified this as a priority area moving forward. RAND is, as part of the project looking at the full employer cost of workplace injuries, are going to be preparing a paper for CHSWC to

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help think about this issue and where to go with it.

- RAND is also suggesting that CHSWC continue an ongoing evaluation and monitoring function, which is more critical now, in light of the sweeping changes that have occurred with SB 899. A few specific areas where RAND thinks that evaluation and monitoring would be advisable and warranted, include monitoring the transition to providing medical care through networks, and insuring high quality care is provided to injured workers on a cost effective basis through networks.
- Dr. Reville suggested that CHSWC monitor and evaluate the apportionment provision of SB 899 that is addressing a new issue in California workers' compensation. This may have a significant impact upon the average payments to injured workers and therefore the cost of the system but also potentially, adversely affecting the adequacy of benefits. It is something that should be monitored and CHSWC could make suggestions for doing this on a more scientific and evidence-based way.
- In RAND's opinion, a high priority area would be continued monitoring of the changes that are occurring with respect to permanent disability, both issues related to equity and costs and also the ongoing effect on the adequacy of benefits.
- Dr. Reville will shortly be providing CHSWC with their 24-hour care pilot study. The next step with this might be to consider pilots for 24-hour care.
- Senator Alarcón has mentioned the priority of thinking about the challenges faced by small businesses as they deal with the workers' compensation system. The flip side of this is a tragic tendency for workplace fatalities to often be occurring within small businesses. A focus on the issues for small business and protecting injured workers at small businesses and helping small businesses cope with the complexity of the workers' compensation system would be an excellent initiative for CHSWC to consider.
- RAND is involved in work with CHSWC to design a conference in late January or early February to look at another clear, emerging issue that is facing California workers' compensation and workers in California -- the issue of terrorism. While there has not been a catastrophic terrorist attack in California, there have been plans that were disrupted. There is also a great belief among terrorism experts that the likelihood is that the place in which the next catastrophic terrorist attack will occur will be while people are at work as it happened with the World Trade Center disaster. Therefore, thinking about the issues of worker safety in the context of a potential terrorist attack seems to be a critical issue. This issue has many different facets that it is hoped will be covered in the conference that may also be a useful area for future research. One is that is well known in the tragedy of September 11<sup>th</sup>, the terrible outcomes for firefighters in New York and for police officers raise the particular issue of thinking about how to protect our firefighters and police officers from building collapse, from exposure to smoke, dust and other elements leading all the way up to potentially chemical or biological attacks. The area does not just extend to firefighters and police officers but also health care workers who make be on the front lines of a biological attack that could potentially happen in California. In addition to these worker safety issues, there is looming on the horizon the potential for, in the case of a large attack, a significant payout from the workers' compensation system. There are very realistic scenarios under which without

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Federal involvement in the workers' compensation system an attack in California could destabilize the California workers' compensation market. Many in the insurance community have identified this as the greatest issue facing California workers' compensation. All of these issues clearly create a very important area for CHSWC to consider for future research.

RAND is continuing to work with the CHSWC Executive Officer and staff to help refine these issues and add to them or subtract from them as appropriate.

Chairperson Rankin asked if there were any questions on that part of the report. Chairperson Rankin noted that given the comments today, the timeliness of medical care would be part of the study of the networks. Chairperson Rankin asked CHSWC if they would like to take a formal motion on adopting the proposed CHSWC research agenda outlined by Dr. Reville.

*CHSWC Vote*

Commissioner Schwenkmeyer moved to approve the proposed CHSWC Research Agenda as described. Commissioner Wilson seconded and the motion passed unanimously.

**Electronic Payment Systems and Access to Funds Report**

Christine Baker, CHSWC Executive Officer  
Lachlan Taylor, CHSWC Staff Judge

Ms. Baker stated the entire team of CHSWC staff, including Irina Nemirovsky and Brooke Nagle, working with other agencies identified what kinds of savings can be achieved by recommending an electronic deposit system in the State of California. CHSWC has developed an issue paper on improving administrative efficiency by reducing the transaction cost of processing paper checks for the payment of unemployment and disability benefits in the State of California to include workers' compensation.

CHSWC believes that over \$2.8 billion of administrative savings can be achieved over a five-year period by utilizing electronic deposit and electronic transfer cards for the unbanked population. These efficiencies can be used for unemployment insurance, state disability insurance, non-industrial disability, uninsured employers and other administrative systems including the State's own workers' compensation benefits.

There will be an immediate cost savings. CHSWC has done several estimates, because within the State of California, different control offices use different estimates for this kind of conversion. It costs approximately 4.5 cents to do an electronic deposit versus anywhere from \$1.00 to \$10.00 even up to \$40.00 to do a manual transaction on a check.

CHSWC has drafted legislative language that would require the payer to offer the payee the choice of receiving indemnity benefits by direct deposit and authorize the option of payment by means of an electronic access card for those who do not have checking accounts.

Ms Baker called upon Judge Taylor to speak about the language that was developed for CHSWC.

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Judge Taylor explained that the rollout of the electronic deposit system would best go first in EDD benefits. In this situation there is a single payer that is exempt from Federal banking regulation controlling electronic access cards because it is a government entity. EDD could make its electronic benefits payments mandatory. The recipient would have to receive benefits by direct deposit if the recipient wants to receive it as a bank account, or a stored value card, similar to an ATM card, if the recipient does not have his or her own bank account. That could be done forthwith. There is no need for delay there.

For the payments by workers' compensation carriers where there are multiple payers around the state using different systems, direct deposit into checking accounts of the payees could be done immediately as well, but the use of electronic access cards would a bit more complex and would be optional with both the payee and the payer for workers' compensation benefits, at least until there is an established market with electronic access cards.

Judge Taylor has spoken to providers and electronic access cards can be made available so the recipient who may not have a bank account will not have to go to a check cashing shop and pay an exorbitant fee to get the benefits. The recipient can get the funds without fees in cash and does not have the perils of receiving checks in the mail.

Judge Taylor believes that electronic deposit has great promise, will be save money as Ms. Baker has described and will be of convenience to the payees as well.

*Questions and Comments*

Chairperson Rankin asked if there were any questions about this project.

Commissioner Schwenkmeyer asked how the card works for the non-banking individuals. How do they redeem it? How do they use it? Judge Taylor invited one of the providers to explain the procedure.

Cynthia Fuller was a banker with Japouri Solutions, Inc. which is addressing payment solutions for unbanked and underbanked workers in the California Central Valley right now. Using payroll as an example, stored value cards work for the underbanked in a way quite similar to workers' compensation and other disability distributions. The individual, through a commercial client of a bank, like an employer or insurance company, receives the card as part of their normal sign-up process. For example, an employee would receive it as part of employee orientation. The product can be made available.

Education is generally required on how to use the electronic access card for most of the unbanked, underbanked population, particularly here in California and farmworkers in the Central Valley. There are language issues, distrust of the banking system and all kinds of issues surrounding this.

There is generally an education component that is provided by the distributor of the bank card product. Once the card is in their hands there are also training issues including how to use an ATM and a point of sale terminal. This is very similar to what happened with the rollout of electronic benefits transfer cards on a state-by-state basis through the late 1980's and early 1990's.

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There are a lot of things that have to be done in order to get people familiar with the electronic systems, including where the cards can be used, which ATMs and how to handle the fees associated with it.

Commissioner Schwenkmeyer asked if there were certain banks where the cards can be used.

Ms. Fuller replied that was correct. In the case of payroll, just like when employers distribute checks there is legislation that requires that the paycheck be available at no cost. Similarly when any institution, insurance company or benefits provider, provides a replacement for a check of things like workers' compensation and other types of benefits, they need to take into account the fact that automated teller machines, if using an ATM other than our own bank, there is the potential for the fee. Regarding the cards themselves, the issuer of them needs to make sure that there are points of use that are convenient for the end user, that do not require them to travel great distances. That is a real issue for farm workers in the Central Valley. There are actually agreements made with the ATM networks to provide surcharge free transaction activity.

Ms. Fuller also said that there is also a huge merchant education issue generally involved in these programs as well. Merchants, like drug stores, often do cash back at the point of sale that can be done as free transactions. Merchants sometimes need education in that regard as well as the cardholder themselves. Typically when dealing with an unbanked or underbanked population, there are literacy issues, English as a second language issue and all kinds of other things that come into play.

Commissioner Wilson asked for a ballpark estimate of the fees involved.

Ms. Fuller stated that typically the fees are much higher for a use of a check product, cashing a check at a check casher, than use of a bank card, a stored value product. Typically for those who use checks today, a typical farm worker in the Central Valley can spend as much as \$1,300 a year on a range of financial services fees, money transfers as well as check cashing and bill payment when they are using a check product. Ms. Fuller opined that no one at this meeting spends anywhere near that for the financial transactions.

Stored value cards are not as cheap as an individual having a bank account. There are additional fees. The average stored value payroll card product generally costs about \$10.00 per month or thereabouts, depends on the issuer. If it is a big bank with lots of ATMs available it will be lower cost than if it is a smaller institution that issued the card which may not have quite the network of automated teller machines and other points of free access for the individual.

Judge Taylor advised that the statutory language proposed in the Commissioners' information packets do include the fact that there must be geographic availability where stored value cards could be cashed out without transaction fees to the user.

*CHSWC Vote*

Commissioner Wilson moved to approve the draft report on Electronic Payment Systems and Access to Funds and that CHSWC send copies to the appropriate legislative committees, to the Labor Agency and to the Employment Development Department. Commissioner Salazar seconded and the motion passed unanimously.

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**Update on the CHSWC Report on CIGA: Development of a Model**

Frank Neuhauser, Project Director, UC DATA, UC Berkeley  
Christine Baker, CHSWC Executive Officer  
Lachlan Taylor, CHSWC Staff Judge

Chairperson Rankin stated that he understood that yesterday (August 20, 2004) the California Insurance Guarantee Association (CIGA) completed its bond sale to the tune of approximately \$775 million so at least they should have the money to pay the benefits now for a while.

Ms. Baker explained that CHSWC requested that a study be conducted of the California Insurance Guarantee Association. CHSWC has done a draft report that was out for circulation at the last meeting. Judge Taylor has done further research together with Frank Neuhauser on trying to estimate what the percentage distribution should be.

Judge Taylor noted that employers carry deductible policies paying an assessment into CIGA, based on their net direct written premium, which is a premium reduced by the credit or discounts for deductibles. CIGA is receiving a 2% assessment on net written premium but they are not receiving an assessment on the deductible portion of these large employers' policies. Chairperson Rankin stated that this is about \$7 billion.

Judge Taylor added that the deductible portion of the policy does not carry the same risk to CIGA that the fully insured portion carries, but it does carry some risk. CIGA may not collect that deductible from the employer for a number of reasons. For example, the employer may become insolvent at the same time as the carrier so that CIGA is left holding the bag for the deductible part as well.

Other questions looked at include whether the current legislation is clear that CIGA has the right to those deductibles as opposed to going to the defunct carrier's general creditors. Another question is whether CIGA is actively pursuing collection of the deductibles. There has not been any information received that CIGA is having problems in collecting the deductibles. That is something that might be looked into further. There is the risk of the simultaneous insolvencies.

Judge Taylor stated that they have developed a statutory proposal that would allow CIGA to collect an assessment on the amount of the discount or credit that the employer gets for its deductible. Pursuant to CHSWC's suggestions at the last meeting, they have tried to come up with a rate that would allow for a reduction in the assessment that small employers are paying, the employers who do not get the advantage of carrying deductible policies. Based on the numbers Ms. Neuhauser has to show, it appears that if the deductible portion of the policies were assessed at 0.75% of the premium credit, then the current 2% assessment that is being paid on net written premium could be reduced to 1.5%. CIGA would still achieve positive cash on hand at about the same schedule as it would now. That is one possible place to strike the balance between reducing the cost for employers generally and increasing the assessment on the deductible policies.

Mr. Neuhauser showed his model for how CIGA will achieve this cash balance. At the previous CHSWC meeting, it was requested that CHSWC staff put together this discussion and in connection with that Ms. Baker and Judge Taylor asked Mr. Neuhauser to make some estimates to what it would mean to adjust the assessment for the Guarantee Fund. In that process, Mr.

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Neuhauser discussed with the Guarantee Fund how they develop their estimates of cash flow and the liabilities that are faced by CIGA and consequently, their borrowing. This model allows one to look at the expectations for CIGA in terms of borrowing, positive cash flow and how different assessment levels would affect that.

Mr. Neuhauser talked about the CIGA estimates made at UC Berkeley and then some about the deductibles and conclusions. CIGA is a first dollar coverage on all claims held by the insolvent insurer. CIGA actually pays the claims regardless of whether they are part of a deductible policy and then attempts to recover from the insurer or self-insured employer. That recovery can be from the assets of the insolvent insurers. It can also be from insurers other than the insolvent insurer who have some responsibility for the claims. CIGA will shift that responsibility to an insurer that has part of the responsibility, for example, a cumulative injury claim. They now become the source of payment and then employers' deductible policies.

Mr. Neuhauser explained that CIGA estimates that their liabilities will be \$3.5 billion from the insolvent insurers. CIGA will recover about 40% of that from the estates of the insolvent insurers or about \$1.4 billion. This will leave CIGA short over the time to pay off the claims by about \$2.1 billion. That shortfall is covered in two ways. The obvious was is by assessment on employers. That has always been the purpose of CIGA and the source of funding. That was not sufficient for the level of liabilities faced by CIGA. Borrowing is the other proposed solution for CIGA. The assessment that is 2% of premium goes through 2007 and then reverts to the 1% of premium. There was some question on the part of CHSWC at the last meeting about whether or not that sunset time was appropriate and whether CIGA should be preparing for extending that sunset period. Mr. Neuhauser stated that he will show that will not be necessary. The deductible portion is not assessed currently. It is about 1/3<sup>rd</sup> of the premium that is written by insurers is in the deductible portion. CIGA finished borrowing yesterday about \$750 million at an interest rate of about 4.3% to 4.5%. CIGA considers it may have to borrow an additional \$750 million on or before 2007 in order to meet the obligations shortfall.

This model they developed is somewhat different than that used by CIGA to estimate its cash flow. CIGA does not estimate the savings that it will receive on their liabilities from the reforms of SB228, AB227 and SB899. Those reforms had substantial impact on past liabilities. CIGA also does not include potential recoveries from the insolvent insurers' estates as part of their cash flow. CIGA is unsure of the amount and the timing of the cash flow from the recoveries and consequently, does not include them in their balance sheet. This seemed to result in somewhat too conservative an estimate and consequently, they made some estimates of the recovery and the timing.

The model developed by Neuhauser allows one to vary the estimates, which make quite a large difference in the level of borrowing. The assessment level was adjusted to examine different impacts of assessment levels on the net premium, that which all employers pay and on the deductible portion, which large employers avoid.

Mr. Neuhauser reiterated that CIGA does not include estimates of the reforms. CIGA's system size growth estimates are slightly different than Mr. Neuhauser's. The impact of recoveries is not included. The borrowing costs for the future are not included into their current cash flow estimates.

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Mr. Neuhauser stated that under a reasonable assumption, the assessment at the current rate, using net premium only, would leave CIGA solvent in 2007 with maximum borrowing requirements of \$360 million, or about half of what they contracted to borrow as of yesterday. If the assessment was at the current rate, but was applied to both premium and deductible portions of policies, CIGA would be solvent in 2006. Borrowing requirements would be about \$120 million. There are other combinations of these assessments included in the back of the handout on the model information received before that talks about the different possible combination of assessments both on the deductible portion and on the net written premium portion, how that would affect cash flow, solvency and the amount of borrowing that is required.

Mr. Neuhauser brought up a couple of unresolved issues. The most important one is that it is not clear from the cash flow estimates that CIGA is making adjustments to their estimated requirements for borrowing or their time to solvency based on recoveries for the deductible portion of the policies. Mr. Neuhauser and Judge Taylor have not been able to gather sufficient information from CIGA about whether they have been successful at recovering from the employers. About 30% of policy dollars are written as large deductibles. SCIF writes almost no large deductible policies so the portion written by insurers who have gone insolvent or who could potentially go insolvent, is going to be considerably greater than the 30%. SCIF's past liabilities may be substantially in deductible portions of policies. Although deductibles are a newer component of the market, they have gotten important recently. Older claims do not have as large a deductible portion. It does leave open the possibility that CIGA could be recovering more money or could be more successful. They just do not know the level of that success.

Mr. Neuhauser concluded by saying that CIGA's cash flow is much less severe than what was anticipated and came to the Commissioners' attention at the previous CHSWC meeting. Assessment of a deductible portion would reduce the overall assessment for all employers who are paying on full premium and/or reduce the borrowing required by CIGA and consequently the cost of meeting these obligations. They still remain open to the issue of whether or not they will be successful in recovering from employers for the deductible portion of the policies.

*Questions and Comments*

Chairperson Rankin asked if there were any questions on this issue.

Commissioner Wilson asked if the Department of Insurance has a watch list for other carriers that might be coming into this state of bankruptcy and if Mr. Neuhauser given any consideration to this. Mr. Neuhauser replied that he hesitated to answer this but he does think there are different levels of oversight for insurers based on markers for solvency.

Chairperson Rankin invited Willie Washington from the California Manufacturers and Technology Association to speak.

Mr. Washington said he just had a chance to look at Mr. Neuhauser's model and went through the preliminary draft done by CHSWC. This raised some concerns and he has further concerns especially in view of Judge Taylor's brief report relative to the CIGA funds. He is encouraged by Mr. Neuhauser's presentation because he is looking at the situation in a somewhat different way. Mr. Washington stated that they want to change the dynamics of a system that was put into place knowingly and willingly some time ago by the Legislature.

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The initial report indicated the rise in the number of people who participated. It correlates precisely with the way that the reforms acted and the fact as insurance went higher, more and more people looked for ways to avoid the premiums. They went either self-insured entirely or they did retrospective self-insurer. That is another way of describing high deductibles. That was made entirely totally legal by the legislature. There was no hidden agenda there. It was not utilized until it became something that would work in the economy.

When the high deductibles are taken they are not a part of CIGA's computation to begin with. There is no question that they are not there. Mr. Washington understands that the Chair has an interest in trying to lower the 2%.

Mr. Washington represents both small and large employers. To the best of his knowledge, the Manufacturers were the only ones who opposed that increase when it went from 1% to 2%. Mr. Washington has an interest in all employers but his interest at the meeting is that there is a report that he believes is seriously flawed. He has not heard anyone mention exactly how high deductibles work. High deductibles require the employer, who engages in this with an insurer, pays the insurer to do the adjusting. They pay the insurer a retention. They have to have the same amount of reserves. Now you have an employer who did not pay a 2%, but they have to have liquid money, they had to pay claims on an ongoing basis that they put up front. The insurer does not pay a dime on a claim until it reaches deductible up to \$500,000.00 in California. The insurer has reduced their risk. There is no reason why they would be charging more for that because the risk has been reduced. The employer is carrying all of that risk up to \$500,000.00. That is the trade-off.

Mr. Washington's concern about the report is that no one has mentioned the retention that the insurer has to have or require of the employer. Neither CIGA nor the report indicates whether or not the insurer who goes insolvent transfers that retention along with those reserves over to CIGA. It is not addressed. There is nothing to indicate that they were collecting it or not. Does the insurer spin that down or dispose of it? Do they have any obligation? Does the Insurance Commissioner collect that? When it is part of the deductible system that is a requirement that they have that there. This report does not make any mention of this whatsoever.

The larger amounts that Mr. Neuhauser referred to that might be collected could be the some that the insurer has no obligation to turn that over. If that is the case, that should be fixed rather than trying to go back and revise a system that seemed to be working.

The other provision here is that if the workers' compensation system reforms work, then that will work the same way. Those same people who got into this system because of the high cost will leave this system when the cost goes down. It will make that adjustment on its own. That is why it was put there, the option to have insurer policies, self-insured policies and high deductibles. They work when the system puts the pressure on them to look for they ways. It is just another mechanism.

Mr. Washington's organization is not supportive and they have serious questions and serious doubts about the accuracy and validity of what would happen if the things Judge Taylor mentioned were done. Mr. Washington would be interested in finding out more about Mr. Neuhauser's analysis of this. They are opposed to just artificially, on the assumption, go and revise a system that appears to be working. All the money talked about at the meeting is still

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employer money, the loan that was done and the 2% tax. The Guarantee Fund is basically an employers' guarantee fund because it is employers who are putting the money up. The conversation is all about employers' money. He has an opposition to CHSWC redistributing this when there is no sound factual basis on which to do this.

Judge Taylor responded by saying that the question he alluded to earlier is when there is a simultaneous insolvency of the employer and the insurer. For fully self-insured employers, there is a Self-Insurance Guarantee Fund. For fully insured liabilities, there is the California Insurance Guarantee Association. The deductible portion of the policy does not have either of those securities in place except for the fact that CIGA winds up holding the bag if it cannot collect from the employer. That is the rationale for imposing some sort of obligation on the employers carrying the deductibles to secure the payment other than by their own balance sheets.

Mr. Washington replied that he has a serious objection to this hypothesis. CIGA has no authority to go directly to that employer to collect anything. CIGA has no authority to come to the employer. His relationship is with the insurer and CIGA has a relationship with the insurer, not with Mr. Washington. Chairperson Rankin stated that was the problem. Mr. Washington replied that the insurer requires the retention, and they are holding the retention.

Chairperson Rankin stated that the problem is that no one foresaw that our regulatory system in California would be a total failure and that 27 companies would go bankrupt and that small employers would be left holding the bag for the CIGA assessments. Large employers are avoiding paying an assessment on \$7 billion.

Judge Taylor said that perhaps he and Mr. Washington should work together to figure out a way to secure the payment of the portion of the policy that is subject to deductible.

Ed Walters from Clarendon Insurance Company stated that with large deductible policies there is always a letter of credit. On large deductibles, the insured is paying dollar one in most states. He cannot speak for California. Large deductibles are between the carrier and the employer. That employer has to put up a letter of credit or has some money sitting somewhere that the insured can go get at any time. What happens with these large deductibles lots of times is that the insured does not pay the carrier immediately. Sometimes it is 90 or 120 or 180 days before the carrier sees the money that they have laid out. He does not know all the ins and outs of California law, but he can guarantee that there is not a carrier in the world that does not have a letter of credit on the deductible and they are going to call down on it if that money is not received in a timely manner. Mr. Walters does not understand why carriers are paying a tax on dollar one on that policy.

Chairperson Rankin replied that carriers are not paying the tax, employers are and that is a whole question they can get into. When the California Legislature decided to set up this system, instead of taxing insurers they decided that they would fund bankruptcies of insurers by an assessment on employers. Not every state does it that way and that is a basic question that maybe should be looked into. Maybe the solution is that when other insurers go bankrupt the rest of the insurers should bear the burden instead of the employers. If you want to go there, maybe we should look at that one.

Richard Hurd from CIGA explained what CIGA has encountered with large deductible policies. The trucking firm Chairperson Rankin spoke of had a large deductible policy. CIGA has and is

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paying first dollar on those claims. Whatever collateral was posted by that firm and the other large deductible policies CIGA is dealing with, that collateral becomes an asset of the State and is marshaled by the State Liquidator. The State Liquidator controls those assets all during the time while CIGA is paying the claims. In this particular insolvency, CIGA has received one distribution of about \$30 million and has paid out about \$300 million.

Mr. Hurd also commented on the problem of the recovery situation. While historically CIGA has recovered about 40%, the solvencies that CIGA saw pre-2000, before their "perfect storm" of 27 insolvencies, were much different in terms of how they operated versus the last 27 carriers. In case of Mission which went broke in 1985, CIGA had received almost \$0.65 on the dollar that CIGA had paid within three years.

With most of the insolvencies in the past four years, CIGA has not seen any distributions. The distributions CIGA has seen have been relatively small, 10% to 15%, if CIGA is lucky. In all of the substantial new insolvencies in the last four, CIGA is in litigation with most of the liquidators over how, when and how much. This impacts not just CIGA but also the 49 other guarantee funds across the country. While CIGA did not include recoveries in their projections, that is because CIGA does not know when they are coming. CIGA also did not include any new insolvencies that they may or may not be aware of. Sometimes it is a phone call when CIGA finds out about them.

Steve Jimenez commented that one of his concerns as a practitioner is CIGA's ability to close their files by settling their medical awards by way of compromise and release. The big cost drivers in the past have been the medical awards. With ACOEM and the expected treatment guidelines, those new reforms are going to change that picture, but Mr. Jimenez wonders if there has been any research done to determine whether or not the cash flow problems have affected CIGA's ability to execute compromise and releases that close out the medical awards. What are projected closings or compromises and releases averages in comparison to carriers?

Mr. Neuhauser replied that in the modeling he has done, he has modeled the potential impact of the reforms on the medical costs and how that might change CIGA's estimated liabilities. The work CHSWC did that helped the Legislature reduce medical costs substantially has had a very positive impact on CIGA's future cash flow. This is because a lot of the reform measures, particularly the ACOEM Guidelines and, changes in the presumption and all, substantially reduced the liability on past medical cases, which is what the gentleman was referring to. Mr. Neuhauser does not know CIGA's position on compromise and release agreements. He would assume that they close out cases much the same as insurers and he does not know about CIGA's average payment relative to active insurers.

Mr. Hurd responded that CIGA's average claim payments approximate the insurance industry insolvent carriers. They are a little bit lower because of other issues. As far as the C & R issue, he is not a claims person and cannot answer that.

Chairperson Rankin asked Mr. Neuhauser how much recovery he what percentage did he project using his model. Mr. Neuhauser believes he estimated about a 20% reduction in past liabilities meaning that they increased the recoveries percent by a similar amount.

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Chairperson Rankin asked that if Mr. Hurd is saying that they are only recovering in four years 10% to 15% whereas in the past they received 65%, did Mr. Neuhauser factor that in that CIGA is not really recovering very much from newly insolvent insurance companies.

Mr. Neuhauser explained that this might have changed since he talked to CIGA and Richard Hurd a little over a month ago, but 40% on average was CIGA's estimate of what they were going to recover and they do not have an estimate on the time. In this model, he assumed that the recoveries would start in 2006 and run for five years. As Mr. Hurd, is saying it is possible that the recoveries will take longer to start with the level of litigation.

Chairperson Rankin asked if the Department of Insurance is responsible for those recoveries. Judge Taylor responded that the Conservation and Liquidation Office (CLO) at Department of Insurance collects the assets of the insolvent carrier and that includes the contractual obligation of an employer with a deductible. CIGA has to go through the CLO to get anything. CIGA is a priority claimant on the assets of the liquidation estate.

Michael Nolan from the California Workers' Compensation Institute (CWCI) commented that they might want to factor in on this issue if the end game is simply to make the CIGA cash flow neutral to them. In other words, it comes from different sources, more from larger employer and less than smaller employers and keep it neutral, what effect does that have on the borrowing assumptions on a go forward basis? He suggested that CHSWC may want to roll that in, not only how much but how it will be looked at by the financial markets. They have a certain view of the CIGA collection process when they bought the bonds. How will this affect them when they look at the bonds on a go forward basis for the next options?

Mr. Neuhauser stated that the model estimates for any level of assessment on the premium and the deductible portion, the amount of borrowing and when CIGA becomes solvent or solvent plus a reserve. Mr. Nolan replied that this is the number side. He is looking at the standpoint that you are a buyer of the bond. Does it have any effect if it is a financial question and not an economic one? He wonders what a financial person who buys bonds would say.

Mr. Neuhauser responded that the model allows you to say whether it would be neutral or not neutral and consequently, the level of future borrowing. The results also suggest that there probably will not be a need for any future borrowing. This borrowing was more than sufficient to cover CIGA's needs and then some.

Chairperson Rankin asked what CHSWC wants to do with this report. It has been suggested that CHSWC might want to hold it open until the next meeting and maybe fill it out a little more and possibly have a working group on the issue of what kind of solution we might want to come up with. Chairperson Rankin suggested that they do not need to take any action right now.

**Update on the Project: Cross-State Comparison of Occupational Injury Rates and time to Return-to-Work**

Frank Neuhauser, Project Director, UC DATA, UC Berkeley

Mr. Neuhauser noted that the handout he developed covers this topic and offered to send it to anyone who gives him a business card.

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This is a study for CHSWC by UC Berkeley adjusting injury and illness rates and time to return-to-work across all the states. The study used the Bureau of Labor Statistics (BLS) micro-data in Washington DC to get a fuller picture of injury and incident rates after adjusting for industrial mix and employer size, the two most important factors in determining injury rates. UC DATA has been working on this in Washington DC for CHSWC. The project research in DC is finished and they are waiting for the BLS to release California specific data by industry level. There is an extra level of review for sub-state level data.

Mr. Neuhauser stated that the objective is, after they adjust for the important characteristics like the industrial mix and the size of the employers within those industries, to determine how California or other states stack up on the issue of injury rates, illness rates, cases with days away from work, cases with restricted workdays and the duration of restricted workdays and days away from work. The first page of the handout shows graphically an example what it means to adjust states. The lower graph is unadjusted data, the upper graph adjusted data. You see a substantial change. States can change relative to each other by as much as 50% through the adjustment factor -- they go up as much as 25% and down as much as 25% in their injury rates.

Mr. Neuhauser pointed out on the first page of the handout that California injury rates tend to be fairly close to the national average. After adjusting for industry mix California's injury and illness rates tend to be substantially worse than the national average. This means we are doing worse in terms of safety than our unadjusted data would suggest.

Mr. Neuhauser pointed out a comparison of injury rates and illness rates on the second page. Again, on the basis of injuries, California is, even on an adjusted basis, not so far out of line with the nation. But on illnesses, California is in the top tier of states, as far as the incidence of illnesses. They are somewhat more than 50% above the national average after adjusted for all the characteristics previously mentioned. This suggests we are doing poorly in the area of injuries but are doing much more poorly in the area of illnesses.

Commissioner Wilson asked if the definition of "illness" has anything to do with that. Mr. Neuhauser replied that it is possible and that is one of the things that they are looking at. The Census Bureau collects the BLS data for OSHA. Their definitions are consistent state-to-state so it is a national standard, basically the OSHA 200 logs. It is also possible that states like California include things like psychiatric injuries as workplace injuries. This is a broader definition than, say, a state like Virginia. Even though the definition should be the same, such differences affect what is actually reported. That will certainly be an area that they will look at once these data are all released.

Commissioner Wilson responded that in certain states heart disease is not considered industrial where it is in California. Mr. Neuhauser explained that BLS and OSHA are consistent in their definitions but it is possible that just exactly that affects the employers' reporting.

Mr. Neuhauser turned to the duration of lost time on cases on the final page where there is some data about California. There are two definitions of lost time that BLS uses: one is days away from work and the other is restricted workdays when the employee is at work. California is about 30% above the national average for the total duration of lost work time even controlling for industrial mix and the size of employers. It does considerably worse on days away from work and it ranks somewhat better on restricted workdays.

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California is number one in the country with the worst record of total lost workdays. California has the second worst record for duration for illnesses and overall for both injury and illnesses. California ranks in first place or dead last depending on how you want to cut it. California has the longest durations of the states.

When these data are fully released by BLS, Mr. Neuhauser said they would be looking at the kinds of laws that exist in different states that have better results than California does and at states that have similarly poor results.

CHSWC has already studied issues and made recommendations to bring workers back more quickly through reduced permanent disability benefits and through some of the incentives to modify workplaces that were adopted through SB899. When the impact of this is visited in several years, the lost time results may be much better. Mr. Neuhauser expects by the end of this month, BLS will release all the data.

A unidentified woman in the audience stated that she hoped, when Mr. Neuhauser does his study, that he takes into consideration previous studies that were done for CHSWC about the effect of such things as the PPD presumption and the duration of disability and not assume that days away from work necessarily equate always, 100%, with unsafe work places or employers not taking employees back to work. There are plenty of studies on how duration on TD, for example, has been affected by other decisions made on medical treatment and control and things like that.

Mr. Neuhauser replied that these data run from 1995 to 2001 at this point and unfortunately indicate poor outcomes throughout that whole period. Certainly this is a combination of many things that we have done in California, some good, some bad.

**Proposed Study – Evaluation of the Second Opinion Process**

Christine Baker, Executive Office

Brenda Welling, UCLA Graduate Student

Ms. Baker said that Ms. Welling and co-partner are both very dedicated UCLA students getting a graduate degree. They asked Ms. Baker if there was a project they could work on to meet the requirements for one of their courses.

CHSWC has a mandate to look at the second opinion process as described by Section 48 of SB 228.

The two graduate students have drafted a proposal to conduct this study, working with Ms. Baker and Mr. Neuhauser to identify the data and the issues. There is no charge for this study. CHSWC staff and UC staff would be working with the graduate students on this project over the next three months. By October, the project would be submitted to their professor who would also be reviewing their work. This would be a closely monitored evaluation project.

The proposed study would review the requests that are coming in on the second opinion, the access issues, the access to care, the delays in care, the operational impact, the rate of cases needing the set time frames, the rate of cases being denied, the reasons for the denial and the outcomes of the decisions if adjudicated. This would be a preliminary study and there would be a need to review the data over time.

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Since the spinal surgery second opinion process was put into place prior to the medical reforms of SB 899, the question we may want to ask is the second opinion process necessary now that there are treatment utilization protocols and medical networks.

Chairperson Rankin asked if there were any questions or comments about this. He asked if Ms. Baker and Mr. Neuhauser would be involved in the supervision as well as their professors. Ms. Baker answered in the affirmative.

*CHSWC Vote*

Commissioner Thacker moved to approve the proposed study to evaluate the second opinion process. Commissioner Schwenkmeyer seconded and the motion passed unanimously.

**Other Business /Proposals/Public Questions and Comments**

*Patti Ryan* is an administrator for Clement Jones, M.D, a spinal surgeon in San Francisco, She commented regarding the study that will be done about the second opinion. She wanted to bring up a couple of problems with the second opinion process, which does not work for them. She understands that there is a 45-day period but it has taken them months, sometimes six, seven, eight months. They call the insurance companies. They do not return their phone calls. There is no repercussion for them. There is no punishment. There is no nothing. They do not respond. By the time they finally talk to somebody after two months, they are new to the case and say that they do not know anything and ask that all the information be sent again. They start all over again from day one. This goes on and on. When they complain, they yell at them and get very angry saying that they are doing the best that they can. Meanwhile, their patients are getting sicker and sicker. Maybe their foot is dropping, they are losing sensation and there is nothing they can do. It is a problem.

Ms. Ryan does not know if there is anything in the Senate bill that can impose a fine on these insurance companies for not complying with the bill. Ms. Ryan has called the offices here and has spoken to people in the administration. She has been told there is nothing and to keep track of the all the times that they do not call you back and someday we'll do a study on it.

The other thing she wanted to bring to CHSWC's attention is sometimes they request surgeries on people who have had previous surgery and they get a denial because they say that there has been no conservative treatment. Conservative treatment is not usually done on somebody that has already had surgery and having a revision done. ACOEM Guidelines do not even address that. They are not for that kind of thing. They just get a denial. They are caught in this treadmill and just keep going and going and going and nothing gets authorized. She is hoping that somebody, somewhere down the line is going to do something. Maybe punish the insurance companies in some way or somehow making them comply with this bill, making them stick with the deadlines.

*Alison Heller-Ono*, an ergonomics consultant with Worksite International wanted to talk about the link between 5110 and SB 899 or linking ergonomics to workers' compensation reform. As they are putting the treatment guidelines together she would like CHSWC to consider what she has to say.

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As a refresher, the scope of 5110 is a reactive ergonomics regulation that requires an employer to comply with the ergonomics standard if they have more than one repetitive motion injury (RMI), that is work related predominance, there is a relationship of the RMI to the workplace and that is objectively diagnosed by a physician within a twelve month period of time of the previous one. The program criteria for 5110 require worksite evaluation of the identical work activity that may have contributed to the RMI and to assess those exposures. It also includes controlling those exposures through correction to the extent feasible and that would be through engineering and administrative controls. The third aspect of 5110 is training. When an employer fulfills those three obligations they are in compliance.

To tie it in with SB 899, workers' compensation reform, it fits very nicely in with the clause for medical networks, the use of ACOEM Guidelines or the prospective guidelines that are being planned for development and the return-to-work strategies that are played out in SB 899. The ACOEM Guidelines have significant reference to primary prevention of ergonomic risk factors, which include forced repetition and awkward postures, as well as personal and psychosocial factors. It references the use of engineering controls and administrative controls as does 5110. There is substantial ergonomic research over the last 10 to 15 years through NIOSH and OSHA that have come out in the development of the Federal regulations, although we do not have it anymore.

Ms. Heller-Ono added that the ergonomic analysis, when done correctly, can provide a plan of care for all those involved when returning the injured worker back to work. The ergonomic worksite analysis will provide strategies to eliminate or minimize the exposures in the workplace that likely contributed to the claim. In addition, oftentimes when these evaluations are done they impact healthy workers or workers that are exposed to the same risk factors. The last thing the employer and the physician should allow the employee to do is to return back to work to the same environment where the injury occurred and where symptoms can be aggravated.

The analysis, when performed correctly, includes those solutions, engineering and administrative controls as well as recommendations for purchases of products, training for the employee in safe work practices to avoid exacerbation or further aggravation of injury. Also, this involves the supervisor in implementing administrative controls. The evaluation should be done in a timely manner, within 30 days or so. Completion and implementation of the strategies should be done within four to eight workweeks.

How can we tie this in, using it with the return-to-work incentives? SB 899 has included some additional incentives for those employers who actively seek to return injured workers back to work. A number of those incentives have been created to encourage accommodation of temporary or permanently disabled workers. Employers who have 50 or less employees who provide worksite modifications can receive reimbursement up to \$2,500 either for temporary or permanent disability. Temporary disability is slightly less. Larger employers can have a discount. The relationship is very significant.

The ergonomic analysis creates the plan of care to provide the modified work environment and can set the stage for the employer to implement strategies that will successfully return an injured worker to work. Ms. Heller-Ono has been involved in this area for the last twelve years. She has seen success after success of employers following through with her recommendations and successfully integrating injured workers back to work as well as keeping injured workers who

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are on medical only working productively and successfully. They do this relatively inexpensively. The reimbursement laid out is very appropriate. This can really help to further have success in return-to-work. Ms. Heller-Ono would like to recommend that ergonomic worksite analysis be included in the guidelines that are being planned to develop and present later this fall. In particular, she recommends this for the prevention and management of MSD's and maybe vision-related injuries as well.

*Michael Nolan*, President of the California Workers' Compensation Institute (CWCI), wanted to make one comment to the woman who was commenting on the second spinal surgery opinion process, just to note or suggest one of the difficulties from the standpoint of carriers. The way the process works, in part, is that a carrier needs to make a timely request of the second surgery process to go into effect. To make it work, they have to get a doctor, they have to be on a panel, and the process and the regulations has to come out of the Division of Workers' Compensation (DWC). The DWC has only recently passed emergency regulations that talk about the process and only recently have set up the panel. Some of this issues, hopefully, on a go forward basis will be resolved. They other thing he understands is if they do not follow the timeline, then carriers cannot avail themselves of that process and not use it. They have to come up with another reason to deny it. There are a lot of issues connected here. It is hard to tell from a quick statement by the speaker, expressing a very difficult issue for her, but there are a lot more technical issues involved.

*Art Azevedo*, President of the California Applicants' Attorneys Association (CAAA), noted that previous comments demonstrated the monumental task that CHSWC will have on November 3<sup>rd</sup>. CHSWC is going to submit medical treatment guidelines to the Administrative Director. Those guidelines are really regulations, because they are presumed to be correct. Mr. Azevedo has always been suspicious of medical objectivity and to put together guidelines that become a medical cookbook is extremely difficult to do.

Mr. Azevedo, who has practiced workers' compensation for 32 years, said he has probably filed more penalties for medical treatment in the past two months than he has in the past two years. He has filed more expedited hearings for medical treatment because of the across-the-board denial by many carriers of medical treatment using, at times, the ACOEM Guidelines and at times, just denials without explaining anything. Mr. Azevedo believes when CHSWC looks at the guidelines on November 3<sup>rd</sup>, they have to understand that these guidelines fit within a very rigid timeframe. It is intended that way. Although, in the previous year, 4610 says that within 24 hours of a particular recommendation, the doctor must be notified of any delay or modification of his treatment recommendation. A decision has to be rendered within 14 days. He is getting situations where the doctor has been recommending, whether within or without the guidelines, treatment for six months, and yet, they are being denied, again using guidelines.

On November 3<sup>rd</sup>, CHSWC will accept guidelines that will take the place, probably, of the ACOEM Guidelines. The idea that was encompassed in the guidelines, of trying to prevent excessive, unnecessary treatment, was probably a very, very good idea. The problem is the misapplication of these guidelines is causing absolute catastrophe and will continue to cause absolute catastrophe over the next year in the denial of medical treatment. Workers are angry. They are seeking assistance. They are knocking his door down. He cannot take all the cases.

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He cannot process them through expedited hearings or through the QME process. From his standpoint, there is a tremendous increase in litigation. Someone should really consider the costs. Utilization review firms, the cost of QMEs or AMEs to arbitrate these disputes over everything from analgesics to gym membership is taking place step-by-step on a very costly basis. The result of denials is more that just litigation or costs that eventually will be paid by the employer. It is the harm to the worker, the delays and the frustration. In many instances employers that he has talked to want their workers to get immediate care, usually by an orthopedic specialist if it is a back injury. They want them back to work. They understand that the sooner you get to the problem, the better it is.

Mr. Azevedo is not sure that the ACOEM Guidelines get to the bottom of the problem as quickly as possible. Certainly they provide some sort of structure. Evidenced based medicine, which is required in these guidelines, is an extremely narrow group of studies. Certainly ACOEM does not do this. Identifying those studies to help doctors out is going to be a problem.

The other factor Ms. Baker addressed very well in terms of the AMA Guidelines. The education problem exists almost on a cataclysmic level with respect to guidelines, whether they be the ACOEM or the new guidelines of November 3<sup>rd</sup>. Adjusters do not understand them. Mr. Azevedo spoke to a risk manager yesterday who was a very good risk manager for a self-insured entity, who wanted his comments on how to administer these. Mr. Azevedo told him to focus on excessive or unnecessary costs, not to do, as some carriers are doing, including the major carrier in the State of California, look at every individual recommendation within guidelines. That is insane.

The costs are going to be astronomical. The delays are going to be astronomical because 4610(e) and (g) are not being complied with. What are being built into this system are delays. The anger of his clients is rising. He tries to deal with that by either getting them a QME or getting them to an expedited hearing. What about the unrepresented? In his area, there is not even an Information and Assistance Officer to talk to them. It is becoming a serious problem.

The other thing that is happening that in future years CHSWC may wish to look at is dramatic cost shifts. What is happening is that his clients are seeking medical care. The doctors are shifting it to private policies. Mr. Azevedo represents carpenter, machinists and teamsters. They have union contracts. Much of this treatment is now being provided in that forum or by Medi-Cal or by the county emergency room or hospital. He believes that shift is going to increase. He does not know how to do this.

He wishes he had suggestions except to caution whoever is drafting these guidelines to be cautious, be direct and understand that it is impossible to cover even a majority of situations in a medical guideline cookbook. Injured workers are not a recipe for lasagna. There is a lot of critical judgment that needs to be done usually by the treating doctor. Mr. Azevedo does appreciate that there are people, including the risk manager he spoke to yesterday, that are using it really to control costs. He believes that is a legitimate basis of guidelines. If something does not work, it probably should not be done again. He has had situations where the doctor writes that it is a flare-up and he had been treating the patient for ten years. If an injection worked two years ago to keep the patient working, those are being denied because ACOEM does not deal with injections well. He believes that kind of attitude should be avoided, particularly among

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carriers because it does not benefit employers. Mr. Azevedo is trying to educate his lawyers on ACOEM and is soon going to start on the AMA. Doctors are very much confused. Some doctors he has talked to will not call the 800 number to discuss the treatment with the UR doctor. This was clearly contemplated by law. They are resisting. Change is always resisted. Again, we have to put this in a context of what is and this transition is coming very, very badly with some very bad impacts for both workers and employers who end up paying the costs.

Mr. Azevedo's final comment is about the situation with networks. To what extent networks will be implemented, he does not know. He does worry about, but is not sure that the power exists for CHSWC to recommend as part of studies, if you have had a doctor for ten years and are receiving some medication, physical therapy now and then for flare-ups, to apply a guideline that is enacted now, retroactively, or a network where this person would lose the continuity of care. The injured workers gets funneled into a network with a doctor that he has never met, that has not treated him for ten years. This is going to have a catastrophic impact on the confidence of treatment that is going to be held by injured workers.

Mr. Azevedo is interested in taking a look at the guidelines that CHSWC is going to consider. He just hopes that they do provide an affirmative aspect to help workers. The ergonomics, incidentally, he discovered very early. He made at least five demands for ergonomic consideration to help his client, the worker, with the consent of the employer, to maintain his job in an ergonomic station. He has not had a response. He has not gone to expedited hearing or attempted to enforce it but he has two of those cases pending. Again, we are trying to come up with something that is effective, that is cost effective and he is not sure we are going to get there soon. He thinks there is going to be a serious transition period and he worries about the harm to both employers and particularly, injured workers.

Chairperson Rankin stated that he understood that sometimes even though you get a list of QME's from the DWC, it is impossible for the injured worker to get an appointment in a timely fashion to meet the deadline regarding when the employer has to make the decision as to whether or not to accept or reject the claim. He asked Mr. Azevedo if he had that experience.

Mr. Azevedo replied in the affirmative and stated that the two day/fourteen day rule is violated 80% of the time, the QME is violated probably at least that amount or more. That is resulting in delay and harm to both the employer and the worker.

*An unidentified woman* came up and introduced *Gary Roberts*, because she wanted CHSWC to see the face of someone who has gone through all these delays and what has happened to him. He is one of thousands in the state. Often she and groups like this do not really realize the cost to the injured worker of all our rules and she is also creating rules all the time to help the whole process work. Unfortunately, people like Gary Roberts are the ones who are paying for it. He has been in treatment probably for little over a year. He has had two physicians who have testified and have written documents and have made referrals for treatment. After he had one treatment that seemed to help him he was refused the other eleven for the rest of the year. The denials are the problem here. The delay of treatment is the problem. She does not know if the regulations will help that or if they only compound the problem. The reason she attended the meeting was because she wants CHSWC to realize when making these regulations and rules, that effectively they are destroying many lives. They are destroying marriages, they are destroying

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income and that they cannot just be rules that work for cost savings. Cost savings are very important but if you are destroying the injured in California in the process, you have to sometimes adjust the regulations to get them timely treatment.

The real problem she is seeing here is timely treatment. She concurs with Mr. Azevedo. There are some injured workers who resort to attorneys because they cannot get their treatment. There are many workers who are non-English speaking who do not have attorneys available to them to help their cause. Often they go without treatment for months and months and years. As a result, can never go back to work. After all, she believes that the reason for workers' compensation is to address that issue. Return to work, return to health and make a system that really works for the injured worker, not so much for the regulatory commission, not for the physicians, not for the facilities but for the worker.

Chairperson Rankin clarified that CHSWC does not have the power and does not make rules. CHSWC is a study and advisory group. It is the legislature and the Administrative Director of the DWC who is responsible in the end for adopting laws and rules.

*Darlene Tiller* works for a managed care company (Total Managed Care, Inc.) that does utilization review and case management. She would like to respectfully disagree with some of the people that have been before CHSWC. The Administrative Director, with the new legislation, has mandated that every single person or entity that provides utilization review must file with the Administrative Director their treatment plan and how they are going to do utilization review. They must also file with the Administrative Director who their peer review physician is or who their medical doctor is that is providing this peer review. They follow the guidelines that the Administrative Director and the legislation have put down for utilization review. That it must be looked at within five days, that is must be approved within fourteen days if all the information is available. Oftentimes, they will have from a physician recommending epidurals. For what? What is the diagnosis? Where are these epidurals going to be given? How many? Oftentimes the information is not there. She believes that what everyone needs to look at now are that all of these, AMA, ACOEM, evidenced-based medicine, they are all guidelines. They are not set in concrete. They are guidelines that if Ms. Tiller has a back injury or another person has a back injury, they may be treated differently. The other person may be in better physical condition than she is. She may need a different plan of treatment than he does. ACOEM Guideline is a guideline. When they look at a utilization review request from a physician, they look at the entire patient. You look at their age, their occupation, the mechanism of injury, the ergonomics of the position that the employee has. She would hope that this CHSWC would really reinforce with their recommendation, that what they are presenting are guidelines only. Just like in the private healthcare side. If she cannot get a particular MRI it is because her policy does not allow it. The ways she believes it if you cannot get on the private healthcare side, you should not be getting it on the comp side. She believes that is something everyone needs to take into consideration.

*Tom Gilmore* introduced himself as President of the California Association of Rehabilitation and Reemployment Professionals. He believes that many things have gone right with some of the changes that have been made. His concern is that there is a portion of it that may be a large tragedy for the injured worker and therefore for the State of California and its employers.

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Specifically, once a person is injured now and found that he cannot return to his or her job, they are given a voucher for \$10,000. Previously, they were able to use part of the monies they had for vocational rehabilitation for subsistence living. Now, after they are permanent and stationary, they will be going out into the workforce or going back to school but they will have no money for childcare, no money for subsistence, paying the bills. Picture yourself if you are a single parent you have to go back to school because you cannot do your old job. How are you going to survive?

The reason he thinks it is appropriate for this CHSWC to take a look at this is because when he brought it up at the regulatory meetings they said it really was not part of their purview to track the effectiveness of the vocational rehabilitation change in the law. What they were doing was trying to develop regulations. Mr. Gilmore thought that if there was a traffic safety problem and he reported it to traffic safety people, they would send someone out to look at the intersection. He is telling CHSWC right now that even if though there is a benefit of \$4,000.00 to \$10,000.00 for somebody to get retraining, how are they going to use it. This is something that should be looked at. The people want to get back to work. The longer they wait the harder it is for them. One possible thing that could be helpful is returning the people to school sooner when they are still TTD. If you did that, then they would not be sitting at home getting agitated, getting angry, wondering why they cannot do anything and instead would put themselves to a use. Mr. Azevedo is correct. Many of the injured workers are getting very frustrated and you are going to see a tidal wave of repercussions including FIHA and ADA suits that will cost the State of California and the employers. Mr. Gilmore urges CHSWC to take a look at what is actually happening as a result of the institution of the voucher system and make a report as soon as possible if indeed these things come to pass.

*Bill Zachary* introduced himself as a representative and Chair of the California Fraud Assessment Commission. Earlier this week they allocated approximately \$19.7 million for distribution to district attorneys throughout California to prosecute workers' compensation fraud. However, there were some issues that were raised before them that they do not have a capacity to handle that is why he is before CHSWC. SB 899, AB 227 and SB 228 created massive changes in the workers' compensation system and probably also created opportunities for fraud within the California workers' compensation which are new and different and which they have not been faced with in the past.

One issue that came before them that they do not have an ability to handle is to determine just how extensive the problem is with repackaging of pharmacies. They understand that physicians, clinics, outpatient surgery centers and other individual and groups are repackaging pharmacies in order to get around the California fee schedule for pharmacy. The Fraud Assessment Commission would like CHSWC, if possible, do some research into this area to see if that is happening and if it is, what can be done to stop it and make some legislative recommendations to the State of California if possible.

California has gone to a punitive system of auditing insurance companies for compliance with benefit provision. Mr. Zachary believes that we took away one of the best opportunities and best tools we had to make sure there was prompt and accurate benefit provision in the state and that is the "promise of payment report." It used to be in California that third party claims

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administrators, the insurance companies and self-insureds all competed to make sure that they looked good on the report which he believes was done on a quarterly basis. The last one he recalls came out in September of 1987. They would like to encourage bringing back this report because they believe that will certainly help indicate where there might be problems with the promptness of provision of benefits. It will also encourage the participants in the industry to do a better job of providing fair and accurate benefits to the injured worker.

Chairperson Rankin stated that they had talked about this issue in the past and the Administrative Director could reinstitute that. They have had a request from one of the legislators that CHSWC do they report. He has missed that report for many years and it makes no sense not to have it.

Mr. Gilmore replied that there was at times, opportunities for mischief in the data that was reported but all in all, he believes it positively drove the industry versus trying to be punitive and negative in auditing once the benefits have been provided. He believes it was the right thing to do for the State of California.

*Andrea Hoch* replied that she is here because she wants to hear the comments by the public of the concerns and what is actually happening out in the workers' compensation community. They do have a big job ahead of them, no question about that. They will take it step by step. She does not have all the answers. Nobody in the room has all the answers or the guaranties of what the best solution is to each of these issues that we have in the system. It took a long time to get to where we are here. It is going to take some time to make improvements in the system. The point is you make the improvements. You go through the public process like this meeting to hear what is going on. You go through the public process with the regulations to hear what is going on and to get the input so that the regulations that are adopted by her, with the input of everyone else, are the best that we can come up with to improve the system and make it work for the benefit of the injured worker. That is really the whole point of the system in the first place. With regard to the "promptness of payment report," she is not aware of that report, probably because the last report was in 1997. It is something that she will look into.

*Cynthia Fuller*, from Japouri Solutions, wanted to compliment the people who worked on the white paper regarding the electronic deposit. They really covered a lot of complexity of the cost and options that are out there for moving people away from checks. There is one area that she would encourage further look. There are a lot of collaborative efforts underway between financial institutions, local and federal government entities and nonprofit organizations. Lots of folks are now working together, teaming together to address the issues of the unbanked and underbanked. The State of California can help employers, help the individuals who are underbanked, help the financial system, if in fact, the State similarly joins those collaborative efforts and works together with those folks, contributing the resources it has at its disposal. Even the power of office of EDD and others who can really help employers move forward to electronic payment options.

Chairperson Rankin thanked everyone for their comments and in terms of the ideas for more research, CHSWC will be looking at those. He believes there are some good ideas. We are clearly in a very difficult transition period. In order to do the research, CHSWC has to continue to exist so all of those who want CHSWC to do more make sure that you tell the powers that be

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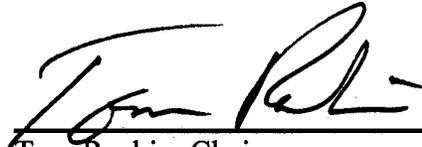
that CHSWC is worthwhile.

**Adjournment**

There were no further matters for discussion. The meeting was adjourned at 11:45 pm. The next meeting will be set for November.

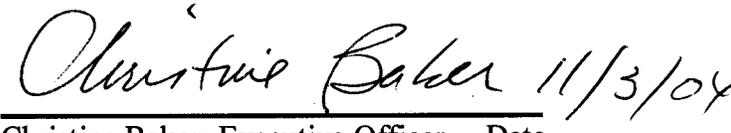
Approved:

Respectfully submitted,

  
Tom Rankin, Chair

11-3-04

Date

  
Christine Baker, Executive Officer

Date