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

**MINUTES OF MEETING**
**June 24, 2010**
**Elihu M. Harris State Building**
**Oakland, California**

In Attendance
Chair Angie Wei

Commissioners Catherine Aguilar, Faith Culbreath, Sean McNally, and Robert Steinberg

Absent
Commissioners Schwenkmeyer and Thacker

Executive Officer Christine Baker

Call to Order

**Approval of Minutes from the March 4, 2010 CHSWC Meeting**

*CHSWC Vote*
Commissioner Aguilar moved to approve the Minutes of the March 4, 2010 meeting, and Commissioner Steinberg seconded. The motion passed unanimously.

**Lien Study Interim Briefing**
Lachlan Taylor, CHSWC

Judge Lachlan Taylor stated that the study of liens has been a project by Commission staff with help from the University of California (UC) Berkeley and a lot of help from the Division of Workers' Compensation (DWC). He stated that it began in response to the perceived problem of a huge number of liens and the legal problems that were hidden in this body of liens. When the study began, the problem seemed to be close to 700,000 liens per year being filed by 2007; it looked as if there were a steadily increasing amount of liens being filed since 2001, with a dip, and then a spike, and then a surprise. He stated that the questions are why there are so many liens and what is going on that is affecting the number of liens being filed.

Judge Taylor stated that the big drop in 2003 and 2004 was due to the enactment of a $100 filing fee beginning in 1/1/2004. He stated that the filing fee was repealed on 7/1/2006, and the number of liens immediately went up. Until the last couple of years of data were obtained, one might have thought that 2007 was a bounce after the liens were suppressed for a number of years and that it might level out around 600,000 per year. However, in 2008, the number of liens goes down; that is when the Electronic Adjudication Management System (EAMS) went live, on

August 25, 2008. After that, all filings had to be made through EAMS. He stated that by 2009, filings were down more than half the volume at the peak.

Judge Taylor stated that they wanted to understand the characteristics of the lien phenomenon and what was driving liens in California. He stated that they were rare in most other jurisdictions, and that there were a number of proposals to try to reduce the number of liens and the types of issues that were going to lien. He stated that they might be able to characterize the types of liens in order to evaluate the effects of any of the proposals.

Judge Taylor stated that in order to conduct the study, they looked at several sources: boxes of liens that had been processed into EAMS (scanned in at Oakland, from Anaheim, Long Beach, Los Angeles, Santa Ana and Van Nuys offices) and sampled; EAMS e-filing record; and a survey of claims administrators to determine why a lien is being filed using a sample of the work flow for several weeks during January-April of 2010. Judge Taylor stated that they obtained 1,900 liens of which about 1,800 were complete enough to analyze. Finally, they used work flow data from DWC.

Judge Taylor stated that he would speak mostly to the survey data, which helped identify the types of liens. Most (two-thirds) of the liens will be medical, with the following areas covered:

- Types of Medical Providers
- Issues in Dispute
- MPN Relationship
- Timing of Lien Filing
- Assigned or Factored Claims
- Prolonged Disputed Treatment

Judge Taylor presented results on charts: he stated that two-thirds of liens filed are for medical treatment and represent 90% of the dollars in dispute. Medical-legal was probably the second biggest volume of liens, and copy services are also in that range. He stated that most of the analysis for today would be on medical treatment.

Judge Taylor stated that physicians, MDs and DOs, account for the largest share of liens at 22% and by far the largest share of dollars; hospitals have fewer liens but larger dollars per lien. Of all the medical liens, billing issues are present in about one-third of them. These are typically Official Medical Fee Schedule issues or PPO discount issues. He stated that this does not mean it is the only issue, but if you are looking for interventions to reduce the amount of liens, an expeditious way is to resolve fee schedule disputes. He stated that another question asked was whether the treatment was authorized, and if it was not authorized, why not. He stated that there were five response choices available. In close to 30% of the medical treatment liens, treatment was authorized. Claims were denied in only 7% of the liens. The body part was an issue in only 1%; he stated that this was somewhat surprising, as a lot of participants in the system expect the body parts issue to be much larger. In addition, the provider was not the authorized provider in the opinion of the claims administrator in more than a one-third of medical liens. Utilization denials accounted for about 1 out of 20 medical liens. In about one-fourth of the cases, the respondent was not certain of the reason or another reason was not identified. A member of the public asked whether the percentages were dollars amounts or volume; Judge Taylor stated it

was volume, by head count. He stated that in 12% of the medical liens, the provider was within the medical provider network (MPN); in two-thirds of the responses, the claims administrator contends that the MPN was applicable, and the provider was not in the MPN; and in about one-fourth of the medical liens, an MPN does not exist or the service was not one that was subject to an MPN.

Judge Taylor stated that it becomes interesting when the intersection of issues is examined. He presented a three-axis chart describing the MPN status, the authorization issue, and the percentage of each combination. He stated that by far the largest group was unauthorized providers in circumstances where the claims administrator contends that the MPN was applicable and the provider was not in the MPN; that was by far the predominant reason that the treatment was not authorized.

Judge Taylor stated that another issue was when liens were being filed. He stated that there was some concern that some "assignees" or "factors" were responsible for a significant share; he stated that they have seen situations where these "factors" will buy out old, stale accounts receivables where fee schedule payments have been made and where physicians may have written off the balance, and someone will come and try to get some more money out of the claims administrator. He stated that there was some thought of singling out those "factors" to control lien volume. They asked claim administrators when the lien was filed, the date of service, and who filed it, the owner or an assignee. He stated that whether they look at year one or beyond, the differences were indistinguishable. He stated that this tells them one of two things: one cannot tell the difference between the assignee or the owner, or they behave the same way. Either way, it does not bode well for efforts to manage lien volume by singling out assignees.

Chair Wei asked Judge Taylor to define owner and assignee. He stated that if a medical provider does not think his bill was paid properly, he may pursue the lien himself, or he may have an agent file it for him, or he may just sell his accounts receivable to somebody else, having nothing more to do with it, and the other party will go after collections. He stated that the last category is the assignee or factor. Neither the owner nor the agent for the owner will be in that category. He stated that there is nothing wrong with having agents do the work for you; maybe there is nothing wrong with having factors; maybe they play a valid role in the financing of medical care delivery systems. He stated that they do not seem to be uniquely responsible for stale liens, which are liens filed more than five years from the date of injury, or, if they are responsible, they cannot recognize them as such.

Judge Taylor stated that when looking at all the liens filed within one year of date of service, close to 20% are filed on the day of service. He asked why that would be. He stated that firstly, it is in violation of the rules to say that one does not file a lien, only that the time for payment has passed. A member of the audience asked whether they looked at the type of cases that were filed on Day 0, i.e., whether they were out of network, or denied body part, etc., or whether they are anticipating trouble. Judge Taylor stated that they have not looked at that yet, but it is the obvious next question to ask: who is filing and how does it tie in with the other issues. He stated that there is a regulation prohibiting filing premature liens; he stated that there is a question whether how it is written really catches the liens that should not be filed yet; he also stated that there is also evidence that this regulation is not being enforced.

Chair Wei restated the process about questions and comments from the audience, asking for people to identify themselves and to leave comments for the public comment period at the end of the presentation.

Judge Taylor stated that it was striking that in the first-year liens, close to a one-fifth were filed on the day of service, and over a one-third were filed after the first day of service and within the first quarter. He stated that according to the time allowed to make a timely payment, most of those first quarter liens are also probably premature. He stated that another area to look at is the time of liens which shows that one in ten medical liens is for treatment that spans at least a year from first date of service to last day of service, by a provider whom the claims administrator says is not authorized to treat. He stated that these liens are averaging more than $14,000 each. This may suggest that there is a large problem either with claims administrators who fail to recognize providers who are entitled to treat, or with providers who are treating in disregard of MPNs or other restrictions about who is entitled to be in this case. He stated that there is a lot of money at stake in these cases.

Judge Taylor stated that just a couple of days ago, he obtained from DWC a month-by-month breakdown of lien filings. From January 1, 2002, through December 2009, as expected, the volume of liens dropped off sharply the month when the filing fee took effect, and it rebounded immediately when the filing fee was repealed. There is also a spike in liens rushed to get in December 2003 just before the filing fee, more than triple the rate prevailing the several months up to that time. In September 2008, the filings drop off; August 25, 2008, EAMS goes live and claims can only be filed through EAMS, and the liens suddenly drop to 10,000 in September. He stated that liens appear to be a leveling off at 20,000 and heading for about 25,000 liens per month for 2010.

Linda Atcherley, California Applicants' Attorneys Association, asked whether the data reflect initial filing liens or amended liens. Judge Taylor responded that he believes DWC counts amended as well as initial liens. Since EAMS has gone live, eFilers cannot show the difference; eFilings are included in this measured population. He stated that he will check again with DWC to confirm that the numbers reflect all filings. He stated that the yearly filings number is slightly different from what was published earlier; Walter Sensing at DWC worked through the numbers and pulled out what are called "informational liens" that were in the old tallies. Informational liens were not liens at all; they were simply a tool to get someone's name into the record in order to get notices about what is happening in a case, without becoming a party or filing a lien. He stated that the shape of the curve did not change, but the numbers may have changed a little bit from what was published in the past.

Judge Taylor stated that with this new information about the volume of liens, it was thought that maybe 400,000 per year might be expected, based on the average from 2002-2009; however, at the rate liens are going now, around 300,000 liens are expected per year. There were 1,871 usable records in their survey; if one extrapolated 1,871 liens to 300,000, there are $2.7 billion in medical claims in dispute this year. Judge Taylor asked Frank Neuhauser for confirmation about total medical costs, and Mr. Neuhauser stated that there was about $6 billion in total medical spending. Judge Taylor stated that the Workers' Compensation Rating Bureau data will be re-

evaluated, but it looks like almost half of the total medical costs are in dispute. He stated that this is a very large part of benefit delivery. It does not mean that these are all valid services that should be paid, nor does it mean that these are all thieves and scoundrels who want to take money that they are not entitled to. The problem with adjudication is to sort out these two categories. There is not just an enormous head count, as at the beginning of the study; it is possible now have a concept of how much money is at stake.

To recap, Judge Taylor stated that today's presentation is an interim briefing with some of the key findings of what they have done so far in the analysis; they just obtained the additional lien status census data from DWC. He stated that they want to talk to stakeholders, and he hopes the presentation will prompt questions or that the public will send comments so that they can refine the questions they are examining with the available data. The analysis and a final draft report will be presented at the next Commission meeting for public comment and subsequent revision and adoption by the Commission.

*Questions from Commissioners*

Commissioner Aguilar asked whether they surveyed any lien filers, in addition to claims administrators. Judge Taylor stated that they did not because there is not a good way to get a cross-section of data from lien filers. The claims administrators represent insured, self-insured, public entity, self-administered, and third-party administrator (TPA)-administered. This is a decent cross-section compared to lien filers. He stated that he would invite lien filers to submit information, but he does not believe that they can state that it is representative. Commissioner Aguilar stated that she is curious as to their reasons for filing, especially on Day 0. She stated that what she has heard is that they just submit lien claims automatically now because they always have a problem getting timely payment. She asked if timely payment was an issue. Judge Taylor responded that if they are using liens as bills, rather than as a separate legal tool as it is supposed to be, that would be a violation of a regulation – if the regulation was drafted to hit the target it is aiming for.

Commissioner Steinberg asked how much the filing fee was and whether it was by a rule or statute, and why it was revoked. Judge Taylor stated that the filing fee was enacted by Senate Bill (SB) 228 in 2003; it took effect January 1, 2004. He stated that due to administrative reasons, it turned out not to be valid until June 30, 2004, and all of the past six months had to be refunded. He stated that it was repealed effective July 12, 2006; he stated that he understands the reason was that the collection of the filing fee was difficult for DWC, and it was costing more to manage the collection than the amount being collected. Commissioner Steinberg asked whether the filings were being resolved and what the rate of resolution was. Judge Taylor stated that there were some production statistics from DWC which have not yet been incorporated in the analysis, but which will be addressed in the final report.

Commissioner McNally asked about the filing fee, and Judge Taylor responded that it was $100. The filing fee was payable by the claims administrator if the lien claimant recovered any part of the lien. The lien claimant would not be out $100 unless they failed to collect anything. One might think this was a deterrent both to frivolous filings and to frivolous denials, because the claims administrator would be stuck with another $100 if they denied or reduced a bill

improperly. In practice, it was not clear whether everyone received the $100 back when things were negotiated. Most lien settlements are resolved by discounts and negotiations, and not by formal adjudication on the merits.

Chair Wei asked whether the filing fee had to be paid to file the lien; i.e., was the check submitted with the lien? Judge Taylor responded that yes, either it was paid with the lien or, if it was a bulk filer, they would be billed monthly. He stated that it did have to be advanced by the lien claimant; you could not wait until the day of the hearing to pay it. Chair Wei asked if Judge Taylor could speak a little more about the bulk filers. He responded that there are services that will handle lien filing for you. The study de-identified most filers intentionally. He stated that in the eFilings, it is not a representative sample, but those are clearly going to be services that are set up to do it. Chair Wei asked whether they knew how many bulk filers there, were as for example, 1 or 50. Judge Taylor stated that he would guess a dozen or so. He stated that one single eFiler that filed all the liens under the category of "other" solely accounted for the difference in the distribution; that is, one filer does not specify the type of lien, rather checks "other" and there is apparently no consequence for doing so, so why should an e-filer go through the effort of figuring out what type of lien it is. For litigation purposes, it may not matter; but it does wreak havoc on research purposes. He stated that he reassigned that eFiler to "medical" and suddenly, the distribution issues involved in the eFilings looked a lot more like the distribution in the sample.

Commissioner Wei asked if claims administrators sent every lien for the sample or if there was a selection process. Judge Taylor stated that they sent claims administrators a survey in electronic format with 15 questions that they would answer on each lien that they processed into their files for the duration of the survey; the duration was typically four weeks, but it varied among the survey participants. He stated that for every lien, those surveys entered the first day of service, last day of service, date the lien was filed with the Appeals Board, type of lien, and type of lien filer. He stated the type of lien is usually what the claimant enters on Form 6, and he added that the form was found to be inaccurate because it has been changed over time, but people are still used to it and are checking the same boxes, even after the boxes on the forms have changed over time. He stated that one would be amazed by how many people claim that they are still seeking benefits as reimbursement for benefits paid by the asbestos fund; not one of them was the asbestos fund. He stated that there were additional questions that claims administrators answered, which were on: MPN status; authorization, whether authorized and if not, why not; if there was a fee schedule issue; and owner vs. assignee.

Chair Wei asked about the unauthorized provider issue and about what kind of treatment was provided. Judge Taylor stated that he would need to go back to look at which type of filers were involved, such as copy services or treating physicians, as well as how much money was involved. He stated that this issue would be addressed in the full report. Chair Wei stated that it would be helpful to know what kind of treatment goes on for a year and is then filed for treatment at the end of year. Judge Taylor stated that without going through a statistical analysis, he can describe the few he did look at; medications and physicians' visits stood out; however, he has not tried to characterized the whole set.

*Public Comments and Questions*

Johnella Shackelford, an injured worker, asked about a slide in the presentation on the "effect of filing fees" and whether "informational liens" were excluded. Judge Taylor responded that they were excluded; the only liens counted are those in which someone is claiming entitlement to payment.

Nancy Roberts, an attorney with Bowman Associates, stated that she represents lien claimants and that the firm was probably one of the bulk filers when the $100 fee was in effect. She stated that she deals with claims adjusters on a daily basis, and when she calls to resolve a lien, frequently the adjuster does not know what bill review did; they do not know the reason for the dispute. It may be a hospital that was paid for the surgery, but not the implants. She asked whether the researchers could take the data available and refer back to the lien claimant and see how they would answer those questions. Judge Taylor responded that he would like to figure out how to get the lien claimant perspective on a cross section; he stated that he believes that the best they can hope for is anecdotes. He stated that he hopes to speak about the problems she experiences, but that he does not know how they can say that any experience is representative. Ms. Roberts asked whether they could go back to the same lien claimants. Judge Taylor stated that the survey was designed to be anonymous, and the file was deleted which would have enabled referring back to the respondents. Ms. Roberts stated that it would be interesting to see what the two parties would say about the issue in dispute. Judge Taylor said it would be interesting to hear her perspective, even if that would not be representative of the whole population.

Commissioner Aguilar stated that every bill review company has a telephone number that you can call and get an exact answer; the adjuster may not know, but the bill review company does. Ms. Roberts stated that they do call, but they get a big runaround. They are usually out of state, and one is lucky to get somebody; they do not always provide the number, but if you get it, they cannot address the lien; it is very compartmentalized. If you do get somebody, they say they do not have all the information, so you send all the information again and you get no response. Judge Taylor stated that this could turn into a discussion about the pending proposals for changing billing situations, which is way beyond the scope of the three-minute time limit on the comment on this survey.

Lewis Lawrence of CHSI, a self-insured group program administrator, asked whether the research revealed any distinctions between the Northern and Southern California. Judge Taylor stated that they know where the volume of liens is found; those five offices that were sampled account for more than half of all the liens that are filed in the State. He stated that they do not anticipate that any public policy intervention will be geographically distinctive. Whatever the Legislature or Administrative Director does will apply to the whole State. Local boards may set up their own procedures for managing them, but broad policy will be statewide, so, they did not try to isolate state regions. Mr. Lawrence asked whether it is a particular problem with certain boards and not others. Judge Taylor responded that anecdotally, lien volume concentrated in certain boards. The volume may represent any number of things that are happening in the vicinity. Mr. Lawrence also asked about the possibility of fraud being involved in many of these filings and whether any information was being captured that could related to fraud. Judge Taylor

responded that the type of study they are doing does not enable them to measure any element of fraud. He stated that even 300,000 liens per year is a very thick forest for thieves and scoundrels to hide out in, as well as for the innocent to get mowed down by the same techniques they try to use to identify the thieves and scoundrels.

Commissioner McNally asked whether Judge Taylor did not want to say that there are more liens filed in one end of the State than the other. Judge Taylor stated that there are far more liens filed in the L.A. basin and those five offices named. Commissioner Aguilar asked if they only looked at Southern California. Judge Taylor stated that they sampled liens that were waiting to be scanned into EAMS in the Oakland office. He stated that they pulled liens from boxes that came from those offices which send their overflow to headquarters to do the scanning. Judge Taylor stated that the survey with claims administrators was statewide, with no distinctions made; the participants represented both ends of the State. He stated that he assumes that the participants have the same concentration in the L.A. area that claims have and that the population has. He stated that there was no effort made to isolate any area in the survey.

Melissa Cortez-Roth, Governmental Advocates, asked about the final study and the medical liens. She asked if certain services filed for more often would be reported vs. other services; i.e., if it is a problem with pharmacy or certain procedures. Judge Taylor responded that pharmacy can be distinguished from other services, but not by specific drug, for example, oxycontin vs. some other drug.

Chair Wei asked how public commenters feel about the reinstitution of the $100 filing fee, or what their thoughts or experience are with the filing fee.

Steve Cattolica, California Society of Industrial Medicine and Surgery and the California Society of Physical Medicine and Rehabilitation, stated that the count of all liens included the initial and amended liens up to the EAMS period. He stated that the spikes in the chart included the amended liens and therefore in some cases, the same lien is counted several times. Judge Taylor responded that he would have to check with DWC but he believes that that is true. He stated that they did not ask claims administrators in the survey whether the liens were initial or amended liens; they asked for everything that came across their desk. Mr. Cattolica asked about the results slide which estimates $2.7 billion in medical lien claims filed annually and how they accounted for the possibility that the liens were amended liens as well as initial liens. Judge Taylor stated that they did not account for the possibility of a lien showing up twice. Mr. Cattolica stated that the dollar figure could be double or triple, literally counting dollars multiple times in the $2.7 billion figure. Judge Taylor stated that that was possible; if it was that common to file amended liens, it could distort the estimated figure. Mr. Cattolica stated that any frequency would distort the results.

Chair Wei asked Mr. Cattolica the reasons a lien would be amended. Mr. Cattolica stated that, for example, if physicians provided services on Day 1 and find that the claim is denied, they are going to continue to treat the patient on a lien basis; three or four or five months later, they amend the lien to include the services in between. Chair Wei stated that this is the problem with the unauthorized provider. Mr. Cattolica stated that it may not be an unauthorized provider; it may be a denied claim that the provider is providing services for; it may even be an MPN

provider – for example, it could be a pysch overlay on a physical injury and they deny the psych overlay. Chair Wei asked how often he thinks liens do get amended. Mr. Cattolica stated that it was conceivable that it happens every day. They have a right to do so; it is an administrative situation; it is not improper. Judge Taylor stated that he believes he can find a way to determine the number of liens that are amended. He stated that the positive aspect of this process is knowing which questions to ask. Mr. Cattolica stated that the $2.7 billion number needs to be culled out and refined very carefully because it connotes a whole lot of other things that people will run off and make bad decisions based on.

Commissioner Culbreath asked if when it is an amended lien, whether the dollar amount reflects the previous lien and the new amount or just the new amount. Judge Taylor stated that ordinarily a lien would reflect the entire claim. The amended lien supercedes the first filing and would be cumulative in subsequent, amended filings. Judge Taylor stated that as Mr. Cattolica pointed out, it is important to make sure the cumulative number is reported rather than the aggregation of each individual or amended lien which reflects a cumulative effect itself. Mr. Cattolica stated that the $300,000 estimate for liens per year is also involved in that question.

Ms. Roberts stated that a lot of her clients are institutional clients like the health plan industry, for example, Blue Shield or the Veteran's Administration. Often, they provide the treatment when a claim is denied; for example, there are instances where a firefighter or police officer lands in the hospital with a heart attack. While that worker is on the gurney, the spouse is giving the insurance information and does not know that there is a presumption for heart attacks and that it might be work-related. All they know is that they were injured at home and had a heart attack, so they end up going to Blue Shield. There is no MPN involved; they land in the emergency room and continue to get treatment with a doctor, the same doctor that treated at the hospital, and a lien gets amended.

Ms. Roberts stated that regarding the $100 filing fee, she never remembers ever getting paid back; it was always negotiated away. She stated that if they did pursue getting paid back, there would be a lot more litigation because they would have to try every issue; no one was volunteering the $100. She stated that the fee was also a deterrent for informal resolution; she stated that they had defendants who would refuse to negotiate because they wanted to force them to pay the $100 or lose their rights to pursue it. She stated that they were also having problems because of the way the statute was written; they were insisting that the defendant get proof that they paid them the money, but they were a bulk filer so they did not have receipts for having paid. She stated that there were all kinds of collateral problems that were not directly related to addressing the lien issue that was in dispute. She stated that that did not even speak to the administrative problems of collecting this money. She stated that if it were to be reinstituted, there would have to have some things ironed out. She stated that she obviously would not be in favor of a filing fee, but there were a lot of collateral problems.

Commissioner Steinberg asked Judge Taylor why they should be concerned with this issue at all; he asked if this was a time bomb that would impact rates. He asked whether they should continue to give benign neglect to resolve these issues. Judge Taylor responded that there may be over $2 billion at stake, subject to recalibration. There are instances of payors wrongfully denying treatment and getting away with it, and then settling for 10 cents on the dollar. There are also

instances of fraudsters billing for services that were not needed, or were not provided, and then settling and making a profit for 10 cents on the dollar. The liens are a sign that the system is not working to deliver the correct benefits on time. The liens are symptom of the problem and they choke the system of judicial resolutions; in addition, the fear of not getting paid keeps good providers from being willing to treat injured workers. He stated that they should worry about this issue.

Ms. Shackelford stated that as an injured worker, she has started to see more liens being placed because there is more utilization review now. Since treatment is going through utilization review, claims are not being automatically denied. She stated that when a provider received certification for a treatment, sometimes they are providing that treatment but the claims administrator is not paying. She stated that they provider then has to file a lien to protect its ability to get the money. She stated that she did not know if that accounts for the first-day filings, but they are seeing an increase down the road. The provider is still treating because they have certification, but they are not being paid. Judge Taylor stated that there is a statue that has been passed that states that once treatment has been authorized by the claims administrator and the care has been provided, they cannot change their minds. Ms. Shackelford stated that the claims administrator is not authorizing the care; rather utilization review is certifying that the care is medically necessary, and the provider is providing that care.

Mr. Lawrence asked if Judge Taylor could comment on the other jurisdictions that do not have the problem with liens, which states those are and any speculation as to why they do not experience the same problems as California. Judge Taylor stated that Texas is one of the states, but he does not have a list handy, and he is not familiar enough with the policies and procedures to give a useful response. Mr. Lawrence stated that this issue is another California issue.

Ms. Atcherley stated that the current EAMS requirement is that all liens be filed as initial liens, even when they are amended liens. She stated that that is a rule that is actually being enforced, and they will not process a lien as an amended lien; she stated that that was a problem. She then stated that in response to Chair Wei, sometimes utilization review denies a treatment or modality and the patient can still get it through their own provider; this is not for not spinal surgeries, but for procedures like MRIs and sometimes prescriptions or physical therapy. That was another reason why a provider would not initially know that it was a workers' compensation claim and be filing a lien. If someone has Blue Shield or the Operating Engineers Trust Fund or the Laborers Trust Fund, they can sometimes get treatment after utilization review denials and the qualified medical evaluator (QME) process as perceived.

Marc Glaser, Liberty Mutual, stated that this area is probably one of the most critical areas that they have been working on trying to resolve. It is very frustrating for a claims organization to have liens continue to go on for years and to have re-openings where customers expect the insurer to close files and to know the cost of a claim. Liens will trickle in due to no effective statute of limitations. He stated that they need an effective statute of limitations to deal with this. As regards the country, their statistics show approximately 87% of the liens is in California compared to the rest of the country. It is not an issue anywhere else. Judge Taylor asked how much of their business is in California, and Mr. Glaser responded that their share of business in California is around 22%. He stated that they do a lot of things to encourage proper and timely

billing so that they can pay providers in a timely manner as they should. There are a lot of things in the system that have been implemented that they have to manage for their customers; at the same time, providers have to do their share to make sure they are doing appropriate treatment, requesting treatment appropriately, and following the treatment guidelines. He stated that when they try to implement that themselves but providers are not following that and billing for that, then they are not going to pay for those services. He stated that they do have the systems in place, such as 800 numbers and technicians to deal with this process; however, what they find a lot of the time is that providers will submit balance bills and they will submit bills again, bills that have been paid, and physicians do not have good systems in terms of tracking payments. He stated that physicians will not review their Explanation of Benefits, in terms of what they paid and why they paid it. He stated that they need to do a better job of cleaning up the Official Medical Fee Schedule and putting everything in place so that when a bill comes in, they know what should be paid and what should not be paid. He stated that it was a very difficult system, and they have tried to figure out how to improve it so that they can be efficient in their payment and yet resist any fraud or inappropriate bills.

*CHSWC Vote*

Commissioner McNally moved to post for feedback and comment and for final posting in 30 days the Lien Study Interim Briefing, and Commissioner Aguilar seconded. The motion passed unanimously.

**Benefit Notice Study and Recommendation**

Christine Baker, CHSWC
Juliann Sum, UC Berkeley

Juliann Sum stated that she has been working on benefit notices intermittently for more than ten years since she has been assisting the Commission with projects to help injured workers and others in the system to communicate clearly about the rights and obligations of the different stakeholders in the system. Benefit notices have not improved over the years, and it was important at this time to take another look at this problem in a more creative way. With more layers in the system, benefit notices have had more layers added to them. With the Internet becoming more of a way of communicating, the study looked at using the Internet as a way of having the information that all workers should have access to be clear and linked with specific concrete events in the claim. Meetings were help with a group of advisors who have a great deal of expertise and passion in this area to try to get their input. The advisors, who were from different sectors in the workers' compensation system, were basically in agreement as to the problems; they were also in pretty close agreement about potential solutions, as long as the solutions do not lose sight of giving all of the important information to injured workers and do not lose sight of making the system as easy as possible and as practical as possible for claims administrators.

Ms. Sum stated that the Commissioners have a packet with the background vision and principles of the study, which were discussed with the advisors, and a summary of problems with the

benefit notices based on the meetings. There is also a summary of the possible solutions which includes: identifying what workers need to know at each stage; providing background explanatory information about the overall process, not just piecemeal to workers; and having this information continually available and universally available in California. There is also information as to how and where to access this information; she stated that this allows for simplification of the language of each individual notice so that it will not contain repetitive information about legal rights and details about consequences of not doing certain things.

Ms. Sum stated that to test the waters, they worked with the Division of Workers' Compensation (DWC) to identify Information and Assistance (I&A) offices where workers might have potential problems accessing the Internet to a greater degree than other workers in California. An informal survey was conducted over four working days in April in Salinas, San Bernardino, San Diego, Oakland, and Stockton asking workers how they accessed the Internet. The survey revealed that of 162 workers participating in the survey, 16% did not indicate that they accessed the Internet. This gives a rough idea of what the access issues might be. The draft paper identifies costs for making sure that these workers have paper copies available to them of background information, so that not everyone would have to access the Internet to get the information and there would be an alternative backup of paper copies. Comparing the cost of doing that with estimated savings in reduced friction in the system results in a ballpark estimate of roughly more than $40 million per year in net savings, assuming the Department of Industrial Relations (DIR) takes on the cost, probably through the user-funded system, of providing paper copies. In addition, there will be savings within the claims industry on reduced legal defense expenses. This is a very conservative cost estimate as the study did not look at other reduced friction costs. Legislative language to implement these ideas has been proposed and is included in the Commissioners' packet.

Chair Wei stated that she wanted to acknowledge and thank DIR Director John Duncan for joining in the public meeting today. Chair Wei asked for questions from the Commissioners and seeing none, asked Christine Baker for any additions. Ms. Baker stated that the results from the offices selected were surprising, as they thought those offices would be where workers would have the least amount of access to the Internet; the efforts were to try to ensure that they reached out to those workers who would have the most difficulty accessing the Internet; however, the results, in her opinion, showed fairly high access to Internet services.
Chair Wei stated that this was an action item to post for feedback and comment. Commissioner Aguilar stated that she asked for one consideration of Director Duncan that at least one Internet kiosk be provided in each Workers' Compensation Appeal Board, so that an injured worker could go to a Board and have access to the Internet. Chair Wei moved that that be included in the recommendations, or as official feedback from the Commissioners. Commissioner Aguilar stated that that was a fairly inexpensive way to ensure that they at least have one option, but the written option as a backup would still be needed.

*Public Comments or Questions*

Ms. Shackelford stated that the question that the study asked was whether people have access to the Internet. She stated that she knows for Salinas, because she lives in Gilroy and she deals with the Salinas and San Jose offices, that a lot of the workers have access to the Internet, but they do not know how to use the Internet; they use Facebook or whatever those chat rooms are, and they

go to the library and they use it there; sometimes they cannot even get onto their Facebook account without help. She stated that having access to the Internet and knowing how to use this particular website are two different things. She stated that it is good to have access to the information online as opposed to getting paperwork that people do not understand and then have to bring to other people or groups to explain what it means.

Ms. Atcherley stated that she had the pleasure of speaking to Juliann Sum and Christine Baker about the benefit notices. Her office has just gotten rid of two tons of paper on old files, and she is aware of the benefit notices issues. When benefit notices are properly done, they provide important information as to when benefits start and stop, both for the purposes of filling out paperwork such as stipulations and compromise and release (C&R) cases. However, when they are improperly sent out or done, they are incomprehensible. She stated that she gets some that are five pages long with no boxes checked; she has no idea if the benefits will be provided or not, etc. She stated that she agrees that something needs to be done. She took home some Commission booklets from 2006 on the workers' compensation system and placed them in her waiting room. They all were taken, except for the ones that said "do not remove." The comments she received, some from employers, some from injured workers, were positive. Especially at the beginning of a claim, this information was more useful than the medical provider network (MPN) notices that they receive.

Ms. Atcherley stated that she did not look at the proposed legislation, but there is supposed to be an Internet kiosk at each Appeals Board office with the institution of the Electronic Adjudication Management System (EAMS), as that is in the EAMS plan, but there are none. She stated that she agrees that it is not enough just to have an access point, but one has to at least know how to get to the correct website. It would be good to have Internet kiosks at the I&A offices so that I&A Officers can show people what they need to do and quickly do what they need to do. The Commission has done a great job of providing booklets and information on workers' compensation, but unfortunately, people are not getting the information. People in her office waiting room do not have the booklets, and if she tries to provide them herself, there is a storage problem as a result. Information is great, but if it is difficult to access or understand, then there is still work to be done to deliver it. She stated that the MPN notices can be absolutely incomprehensible, so if they are going to go to MPNs, injured workers need to know how to access the MPN and get to the doctor within 30 miles; some MPNs are very good, but if she has to spend half an hour trying to find a doctor and then finally needs to seek the assistance of her secretary to help her as well, that is not good. She stated that many injured workers do not know how to use the Internet and do searches.

*CHSWC Vote*

Commissioner McNally moved to post for feedback and comment and for final posting in 30 days the Benefit Notice Study and Recommendations, and Commissioner Culbreath seconded. The motion passed unanimously.

**QME Study**

Lachlan Taylor, CHSWC
Frank Neuhauser, University of California, Berkeley

Frank Neuhauser thanked Commission staff, especially Nurgul Toktogonova and Nabeela Khan, for assistance with the data used for the study. He also acknowledged Jeff Seeman from the Division of Workers' Compensation (DWC) Medical Unit for his assistance in overcoming the challenges the first time that an administrative database like the Qualified Medical Evaluator (QME) data is extracted to use for public policy research purposes.

Mr. Neuhauser stated that the QME study was initiated because there are a number of concerns about how the QME process has been working. Many people have raised the concern that there are too few QMEs to perform evaluations, especially post-reform when there was an increase in demand for QMEs. Simultaneously, there are people complaining that QMEs are leaving the system because there are too few reports assigned to QMEs to make it worthwhile for QMEs to remain in the system. Although these two assertions sound contradictory, they could be complementary, and resolving both of these problems is necessary. Mr. Neuhauser stated that there is also concern that the number of QME reports requested is increasing dramatically, and that alone is driving some of the delays for assigning QMEs and scheduling appointments and getting QMEs to submit the reports. There is also concern about the demand for Agreed Medical Evaluators (AMEs), as observers claim AMEs are in particularly short supply since the reforms. AMEs are an alternative to the QME process, and because they are increasingly hard to schedule and require long delays, that puts pressure on QMEs. Finally, there is concern that the Disability Evaluation Unit (DEU) backlog has been increasing and driving long delays in the process. Mr. Neuhauser stated that he had previously examined DEU time frames for issuing ratings, and Judge Lachlan Taylor has previously presented those findings. While there are concerns, DEU backlogs have not gotten worse over the period examined.

Mr. Neuhauser stated that the reforms did not change the process for unrepresented cases. If the primary treating physician issues the report, one can evaluate based on that report, and if there is a disagreement, the parties are obligated to use a QME; a panel of three QMEs is assigned, and the worker selects from that panel of three. [Editor's note: The speakers did not mention that the reforms eliminated the employer's ability to obtain an initial evaluation on compensability from any physicians of the employer's choice, so the QME process became the sole alternative to the treating physician for these issues, too.] On the represented side, prior to reforms, the treating physician wrote the report and the case could be resolved based on the report. However, if there was a disagreement, there were several options open for the parties: they could use AMEs or they could each choose any QME they wanted without being limited to a choice of three randomly assigned QMEs. After the reforms, the process became more specific; if the parties do not want to resolve the case from the primary treating physician's report, they are first obligated to try to agree on an AME, and if they do not reach an agreement, they are required to use the QME process to select an evaluator. They each strike a QME from the panel of three, and the remaining panel member does the evaluation. This has had the effect of pushing more cases of represented workers into the QME process, and that is driving some of the increase in the demand for QMEs.

Mr. Neuhauser introduced a chart showing the number of QME panels issued, the number of QME physicians participating, and the number of disabling injuries. The number of QME panels and the number of QME physicians EW shown from January 2005 through July 2010. The increased demand for QMEs begins soon after January 1, 2005; not only is this shortly after the reforms, but it is also at the time the AMA *Guides* were introduced for claims with medical evaluations after 1/1/2005 and the AMA-based schedule became the required rating schedule.

Mr. Neuhauser stated that the trends for demand in QMEs are also going to be driven by the underlying injuries. All things being equal, there should be a decline in the number of QMEs for medical-legal evaluations as the number of injuries decline. The QME reports are usually needed some time well after the injury occurs. For this reason, the injury data in the chart are lagged by two years. The injury data from 2003 to 2008 are paired with the QME data from 2005 to 2010. For this period of about five years, there has been a substantial decline of 35 to 40 percent in the number of disabling injuries reported. This is comparable with the decline in the number of physicians registered as QMEs. The fraction of QMEs relative to the number that was registered in 2005 declined, so there are 40 percent fewer QMEs in the system now than in 2005. This does not represent such a big problem immediately because the number of injuries has been declining at about the same rate.

Mr. Neuhauser stated that using January 2005 as the starting point, the number of QME panels in 2010 has increased somewhat, but it has increased significantly more relative to the number of injuries over this period. In addition, during the period between late 2007 and late 2008, there is a big spike in the number of QME requests from 40 to 50 percent, and this was even larger compared to the decline in the number of injuries. This spike happened at the same time that there was a large decline in the number of physicians performing QME evaluations.

Mr. Neuhauser explained that the chart shows the number of unique physicians that are registered as QMEs; that does not have anything to do with the number of locations, just the number of doctors that are registered as QMEs. Mr. Neuhauser introduced a chart showing the fraction of DEU ratings done on reports coming from primary treating physicians, AMEs, QMEs in represented cases (QMRs), and QMEs in unrepresented cases (QMUs). The first observation is that the reports submitted by primary treating physicians as a fraction of all reports submitted to the DEU on represented and unrepresented cases have fallen from 50 percent of the reports to 20 percent of the reports. Mr. Neuhauser stated that most likely, the driving force for that decrease is the AMA *Guides* that made permanent disability evaluations more complicated and more difficult for primary treating physicians to do and could have led to more disputes and consequently, people asking for QMEs. There is a big jump in the fraction of QME reports in represented cases. Judge Taylor stated that the reports in represented cases are not required to be submitted to the DEU. If a QME report is completed on an unrepresented case, then it is automatically submitted to the DEU. Therefore, in all likelihood, the represented QMEs are somewhat under-counted in these data.

Mr. Neuhauser stated that the final observation is that AME cases have increased substantially and are becoming the dominant source of reports being evaluated at DEU. There are probably even more AME reports than seen here, because AMEs and QMEs on represented cases do not have to go to DEU to be resolved and could be rated outside DEU.

Mr. Neuhauser introduced a chart showing the numbers of cases being submitted by different types of doctors to DEU to be rated. The chart shows the same relative shares as the previous chart, but there is an overall downward trend in the numbers of reports from all sources, even during the period where there was a spike in QME requests in late 2007 through late 2008. Therefore, it appears that the spike in QME requests was driven by medical issues and not by permanent disability issues. That spike was probably driven by medical treatment utilization disputes using QMEs. After the Sandhagen decision, employers and insurers could not request QMEs for treatment disputes. Judge Taylor stated that of the spike fell off after July 2007 when the Supreme Court decided Sandhagen and made it clear that claims administrators did not have the option to request a QME when they did not like what the treating physician recommended.

Mr. Neuhauser stated that a problem with workers' compensation research is that there are substantial lags in the data. Many of the problems in the QME process that resulted in the spike have pretty much dissipated. There can still be many problems due to a mismatch between the types of QME specialists and locations, the concentration of reports among the QMEs, an undersupply of physicians, and problems with the willingness of doctors to participate.

Mr. Neuhauser stated that another factor involves the distribution of specialties that were registered by QMEs and the distribution of demand by specialty. Mr. Neuhauser presented a table showing the percent of all registrations represented by each specialty in the first five months of 2010. The table also showed the fraction of all panel assignments that involved each specialty. The predominant specialty requested was orthopedics including sub-specialties. Over 45 percent of panels assigned requested an orthopedic specialist, but only 25 percent of the QMEs are orthopedists. The opposite is true for chiropractic specialties, where over 20 percent of QMEs registered in chiropractic specialties but only 5 percent of panels were assigned to chiropractors. A chiropractor may be getting relatively few QME assignments for no other reason than there is an oversupply of chiropractic QMEs. The same thing occurs in psychiatric specialties; there are more psychiatrists and psychologists listed than the percentage of requests for these specialties. There is also an under-representation of pain specialists. Finally, there are large numbers of acupuncture specialists listed as QMEs, but there are few acupuncture requests for QMEs. Judge Taylor stated that an acupuncture specialist cannot evaluate permanent disability, only treatment issues, so that is one reason for fewer acupuncturist panels.

Mr. Neuhauser stated that between 2005 and 2010, the fraction of requests for orthopedic specialists has remained relatively high compared to the number of orthopedists participating, but the relative under supply of orthopedists has remained constant. Meanwhile, the number of requests for chiropractors has declined by almost two-thirds during this five-year period, much more rapidly than the decline in registered chiropractic QMEs. The oversupply of chiropractors has been increasingly large. On the other hand, psychiatrists and psychologists had 6 percent of the requests in 2005 and 12.5 percent of requests in 2010. The rapid increase in requests for psychologists and psychiatrists will put pressure in that specialty for scheduling QMEs. The most acute developing problem may be pain specialists, which experience both a big increase in requests between 2005 and 2010 and are under-represented in QME registrations. Both factors together can cause especially severe problems in scheduling QME panels in the specialty.

Mr. Neuhauser stated that problems in the mismatch between the concentrations of QMEs by specialty and the concentrations in the kinds of requests being made can simultaneously lead to delays in scheduling some specialties and lead to other specialties getting too few panels. This may be the answer to the seemingly contradictory observations made by stakeholders that we mentioned earlier. There could also be issues about whether the QMEs dominating the process are giving fair evaluations or evaluations that favor one side over the other. This concentration is driven by the way panel QMEs are assigned, which is based on the specialty requested and geographic location. The geographic area is drawn wider and wider if there are not sufficient QMEs in the minimum diameter. If QMEs sign up for multiple specialties, and even more importantly, more locations, they are more likely to get assigned a panel because they will appear in the pool multiple times.

Mr. Neuhauser stated that in 2005, over 45 percent of QME offices were registered by physicians with just have one location. That has dropped to 20 percent in 2010. In 2005, only about 4 percent of locations were assigned to doctors that registered at more than 10 locations. In contrast, by 2010, almost 40 percent of all QME locations are concentrated among doctors who list more than 10 locations. There are some physicians with over 40 locations where they can see patients. Judge Taylor stated that this was analogous to raffle tickets, and one location means that one physician has one raffle ticket, while 11 locations mean that physician has 11 raffle tickets. Therefore, the likelihood of a physician being drawn increases when the physician has 11 raffle tickets, and the likelihood of any physician holding just a single "raffle ticket" getting assigned to a panel is substantially less because there are more tickets in the bin. Mr. Neuhauser stated that there are a number of doctors with more than 40 or 50 locations listed.

Mark Gerlach, California Applicants' Attorneys Association, commented that if there are more than 1,000 different locations of QMEs in the State, then approximately 40 percent of those locations are where they have 11 or more locations. Mr. Neuhauser stated that at least 40 percent are concentrated among physicians who list at least 11 locations. Mr. Gerlach asked what happens when multiple doctors list the same location. Judge Taylor stated that what is being measured is a multiplicity of locations per doctor, which may coincide with one location having multiple doctors. Mr. Gerlach stated that if there is a QME list, then one could name the doctor, and the QME list could show all the locations of the doctor.

Mr. Neuhauser stated that the system is developing a class of QMEs who only perform evaluations versus a class of practicing specialists who do QME evaluations part-time. Mr. Neuhauser analyzed the number of assignments that go to a number of doctors within a six-month period. That does not mean that they did a QME evaluation, just that they were one of the three QMEs assigned on the panel. In the last six months of 2009, 30 percent of panel assignments went to QMEs who received in excess of 300 panel assignments in that period. These doctors are doing a very high volume of evaluations. This implies that there is a class of doctors who are specialized as QMEs. This may or may not be the type of system desired by stakeholders or intended by the legislature.

Commissioner Culbreath asked for clarification if this means that the number reflects the assignments but not that QMEs have actually completed that many evaluations, and Mr.

Neuhauser responded that that was correct; the number of evaluations assigned is likely about one-third of the number of panels assigned.

Commissioner Wei asked if this is 300 over six months, or actually 100 examinations over six months. Mr. Neuhauser responded there could be doctors averaging 1,200 panel assignments and 400 hundred evaluations in six-month periods.

Mr. Cattolica asked if there are geographic distributions of where the assignments and the offices actually are. Mr. Neuhauser responded that comparing the number of assignments and the number of QME locations led to a nice match, with 20 percent in Central California, 50 percent in Southern California, and 30 percent in Northern California. This is a complicated issue to think about; that is, a physician with 40 offices does not get 40 times the number of assignments as a physician with one office in a high-volume area.

Jerrold Garrard, GSG Associates, asked if there has been a study of timeliness, and whether if physicians are not timely, the question is if there is a benefit to having specialists. Chair Wei asked that only clarifying questions be asked at this time, and that this comment would be deferred for the public comment section.

Ms. Atcherley asked for clarification about whether the 300 requests were over a six-month period. Mr. Neuhauser responded that the cutoff for the 300 was just physicians that were assigned at least 300 times over that period; some of those were assigned as many as 1400 times.

Mr. Gerlach asked if the numbers are for all QME panels and are not broken down by represented and unrepresented. Mr. Neuhauser responded that this is for all panels; however, about half the panels assigned are represented and half are unrepresented.

Mr. Neuhauser stated that time frames were an important factor. The QME data are being matched to DEU data. Mr. Neuhauser stated that one could think of these as two different groups: primary treating reports at the DEU and QMEs for unrepresented workers, which are generally unrepresented cases. The time frames are probably shorter for the unrepresented cases because they are usually less severe cases. It is about 546 days from the date of injury to the time of a report written by the primary treating physician; if you have a QME, it is about another 104 days to get the report written. A good estimate of the time from getting a QME to getting the report from the QME to the DEU is another two to three months. The AME should proceed more quickly than the QME, and yet the time frames are significantly longer for an AME, about four months longer, probably because heavy demand and possible under supply of respected AMEs are leading to delays in scheduling. Represented cases get through DEU much more quickly than unrepresented cases. In most instances, this is because walk-ins get evaluated almost immediately. There will be an attempt to evaluate whether a mail-in gets evaluated more quickly for represented cases. Looking at the time frame from the date DEU records the doctor's report, either when the doctor scheduled it or wrote the report, it is between 150 and 180 days until the rating gets done. Mr. Neuhauser stated that this delay is too long and is something to concentrate on in the short-term. Judge Taylor asked what period of time the delay was, and Mr. Neuhauser responded that the period was 2007 through 2010.

Mr. Neuhauser stated that the Commission would like to get feedback from the audience on preliminary impressions about the process and the study:

- Some problems in the QME process were probably the result of the spike in demand, and that spike was probably driven by medical issues. That has been reduced as the process for understanding medical disputes has improved, so that should not drive future actions.

- The current problems are probably driven by a mismatch between supply and demand for particular specialties. Another factor is a high concentration of assignments with a small number of QMEs.

- Mr. Neuhauser stated that the time frames from report to rating are probably too long, but the DEU backlog is getting shorter despite employee furloughs.

- The increase in psychiatric and pain specialties warrants further research to see why there is such a dramatic increase. The fraction of panel request for psychiatric specialties is much higher than the fraction of rating is in the disability evaluation unit; that includes a psychiatric impairment. The fraction of cases with a psyche component may be trending towards a level not seen since the early 1990s.

- Finally, some specialties are so rarely requested that the medical unit should think about aggregating some of these specialties; if there are very few specialists, then workers may have to travel very long distances because the panels would have to reach out very far geographically to include a sufficient number of specialists.

*Public Comments and Questions*

Mr. Cattolica asked if the timeframe from report to rating could be the date of evaluation or could be some other dates in the sequence of events, and he asked how that be more specifically known. Frank Neuhauser stated that investigation would have to be done about what DEU records. He stated that this might be an issue of consistency with the doctors. Mr. Cattolica stated that doctors submit reports to the attorneys who are the ones requesting the DEU rating; the doctor is reporting the date and that is what is being reported by DEU. The delays can come because it goes to the parties and then the parties can argue before they submit to DEU. Mr. Catollica stated that this is a significant consideration and should be analyzed. Mr. Cattolica stated that the physicians who are adhering to the time frames within the regulations have no control over what happens after they deliver a report.

Mr. Catollica stated that there was a percentage change in the presentation and later on a number in absolute terms for the number of ratings per quarter; he asked what the spike in 2008 indicated about the total number of panel requests. He stated that what is missing is the relationship between the total number of QME and AME panels and reports produced and how many actually end up at DEU; the total number of ratings per quarter may be many more times than the actual number of reports. Mr. Neuhauser stated that the reports do not end up in DEU if the issues

involve medical treatment or if the permanent disability rating can be resolved by the parties without being submitted to DEU. Mr. Cattolica stated that the conclusions based on using only DEU data are the best Mr. Neuhauser may have, but that is only addressing a small fraction of what is going on. Mr. Neuhauser stated that the issue is whether the spike is driven by permanent disability requests or by requests for medical treatment issues, and it appears that the driving factor is requests for medical treatment issues. Judge Taylor stated that DEU data represent 100 percent of reports on unrepresented QME permanent disability cases. Mr. Cattolica asked if that was broken out separately, and Mr. Neuhauser responded that this can be done.

Mr. Cattolica stated that Mr. Neuhauser had made the observation that the frequency of psychiatric requests was approaching the level of the early 1990s and he asked Mr. Neuhauser to clarify that statement. Mr. Neuhauser responded that in the early 1990s, about 25 percent of permanent disability cases had a psychiatric evaluation done as part of the process. In the mid-1990s and late-1990s, it was 3 or 4 percent; in 2005, it was 6 percent, and in 2010, it was 12 percent, and that is a trend that needed to be watched. These could be medical issues; they do not have to be permanent disability issues. The fraction of cases requiring a psychiatric evaluation is about four times as high as it was in the mid- to late-1990s. Mr. Cattolica asked if the increase in psychiatric evaluation has to do with a larger denial of psychiatric claims. Mr. Neuhauser stated that he would not expect to see this in the 2000 to 2010 period, except in cases of apportionment; the rules in those two periods had not changed. Mr. Neuhauser stated the AMA *Guides* reduced permanent disability ratings substantially, but the *Guides* are incomplete in two areas: the evaluation of psychiatric conditions; and the consideration given to chronic pain. Those two areas offer opportunities to expand upon what the AMA *Guides* offer, in particular, the psychiatric component. Mr. Neuhauser stated that psychiatric ratings components are slightly higher under the current regime than they were under the previous schedule. A completely different way has developed for doing psychiatric evaluations which is not part of the AMA *Guides* and is more generous than the schedule used prior to 2005.

Ms. Shackelford asked if the study looked at who is actually requesting the QME panel, the injured worker or the employer, and how many times that same case was submitted to DEU for rating. Even though it has been stated that the issue has gone away with Sandhagen and J.C. Penny and the Labor Code, it is still an area that with an accepted claim, the employer is still pushing unrepresented workers to QME and sending that to rating even when the person has not received treatment but the claim has been accepted. Mr. Neuhauser stated that DEU gets ratings for permanent disability, but it does not resolve medical issues. Ms. Shackelford said that claims administrators may be asking for a QME on a contested case so they can terminate medical treatment. Ms. Shackelford stated that hers was an uncontested claim, an accepted claim, but rather than going to UR, some cases are going to QME. The J.C. Penny case stated that you cannot use a permanent and stationary date with a past date that was not found to be correct and then send it to QME at the current time. She asked if anyone has looked at this issue. Judge Taylor responded that it might not be possible to look at that issue with the data available in the study.

Ms. Shackelford stated that more QME doctors are listing multiple locations, but they are not necessarily seeing the patient at those locations; the patient gets a notice that the appointment has been changed to another location that is further than a 35-mile radius. Judge Taylor stated that

there have been other reports of the same problem. Mr. Neuhauser stated that the data do not indicate where the where the examination was done.

Brenda Ramirez, California Workers' Compensation Institute, stated that another source of delay to focus on is the date between the evaluator's examination and the date the report is submitted by the evaluator. Mr. Neuhauser stated that it might be the case that it differs between high-volume doctors and low-volume doctors; it might be that high-volume doctors are adept at doing the process.

Mr. Garrard asked about whether any evaluation is being done of how timely the high-volume QMEs are. If the high-volume doctors are not timely, that would definitely be a serious issue. Mr. Neuhauser stated that high-volume doctors are creating a special class of QME specialists.

Ms. Atcherley asked whether the study was looking only at panel QMEs, and Mr. Neuhauser responded that that was correct. Ms. Atcherley stated that before dates of injury of 1/1/2005, each side was able to select its own QME, and in a represented case, there would not be a request for panel QME. Currently, in a represented case, if each side cannot agree on an AME, they have to ask for a panel QME; therefore, there may not be a direct correlation to the increase in panels. That includes Labor Code 4060, particularly when unrepresented, they could still select their own QME, but after 1/1/2005, you are compelled to get a QME panel. Judge Taylor stated that he believed that Ms. Atcherley was correct on this matter.

Ms. Atcherley stated that the concentration of offices with 300 and up to 1,400 cases is a concern. Applicants' attorneys complain that the same doctors are showing up every time. This can be a way of gaming the system which we are trying to get away from by having a panel QME. A lot of reports are not effective, fair or unbiased. When there is this concentration of doctors, it puts an incentive on selecting a specialty where this is not so much gaming. Lining up fair reports and timely reports with depositions reveals that the doctors do not provide 30 minutes for a thorough evaluation. This is a critical problem. QME regulations used to require that the doctor actually treat patients, and this could be compromised by having too high a volume of evaluations.

Ms. Atcherly stated that there is an issue with dates. A date that will appear on the doctor's report is the date when the patient first saw the doctor but not necessarily when the report was sent or received. It is critical to determine when the patient was first seen and when the report was actually issued. In addition, there is the date the report was sent to DEU. On the represented side, one factor to consider is that a lot of requests for DEU ratings may be the result of a request for DOR. This leads to getting both a conference and a rating at the same time.

Ms. Atcherley asked whether in regard to the spike in 2007 and 2008, it was taken into consideration that only injuries beginning 1/1/2005 were required to have a panel QME. An injury in 2004, for example, would not be required to go to a panel QME. This might lead to a concentration of the post 1/1/2005 cases with a two-year temporary disability cap which would become permanent and stationary, and therefore, there would be the spike in demand and in medical treatment issues. Judge Taylor stated that there may be a reason for the increase, because more represented cases had to have QMEs, but that would not be the case of permanent disability

issues, where comparable spike is not seen. Ms. Atcherley stated that some of those cases may not actually require a permanent disability rating.

Kathy Biala, Milestone MMA, asked if there are initiatives are to recruit more orthopedists and physical medicine and rehabilitation (PMR) specialists and how that would be accomplished. Mr. Neuhauser stated that that is an issue that should be considered, as well as figuring out how to increase the supply of AMEs. Ms. Biala asked who would take initiative regarding suggestions in that area, and Mr. Neuhauser responded that it would be the Commission. Judge Taylor stated that she could also communicate with the Administrative Director of DWC.

*CHSWC Vote*

Commissioner Culbreath moved to approve for final posting the Study of the QME Delay, and Commissioner McNally seconded. The motion passed unanimously.

**Break**

A 30-minute break followed the vote. When the meeting resumed, Commissioner Culbreath assumed the role of chairing the meeting at the request of Chair Wei.

**Return to Work Study Draft Final Report**
Seth Seabury, RAND

Seth Seabury stated that he would provide an overview of the final results of the study on "Workers' Compensation Reform and Return to Work: The California Experience." Most of the study results were presented in previous briefings to the Commission. Mr. Seabury started by providing some background. He stated that improving return to work became a heightened priority after the 2004 workers' compensation reforms which overhauled the way permanent disabilities are evaluated and compensated, with a large cut in permanent disability awards and numerous provisions to reduce waste and improve return to work. Evaluating the reforms and their impact on return to work motivated the return-to-work study. The study focused on three questions: what the role of workers' compensation policy has been in driving return to work for permanently disabled workers; what the trends in post-injury employment of disabled workers in recent years have been; and what the impact of reforms on the trend in income replacement has been. With respect to income replacement, the key questions are: if someone loses dollars because they have become disabled, how much of that loss is replaced by benefits? and how has income replacement changed since the reforms?

Mr. Seabury then stated that an important underlying question is why public policy regarding return to work is needed at all. One of the key challenges with return to work is to find the match between tasks that the injured worker can do and the requirements of the job. There can be significant obstacles to finding the right match, including: uncertainty over work limitations and job requirements, including legal requirements, lack of coordination, and potential friction; cost

of accommodations; and conflicting agendas resulting from various legal processes and on the part of workers and employers. These are all areas that public policy intervention can help overcome. Workers' compensation policy can address these obstacles in multiple ways including: medical management (including improving medical care by achieving higher quality or care and better coordination or communication with providers); changing worker or employer incentives through tiered benefit structures (as in California) or direct worker wage subsidies (as in Oregon) or subsidies to premiums; and direct promotion of accommodations through subsidized worksite modifications or subsidized alternative work.

Mr. Seabury stated that there was a dynamic reform environment in California from 2000 on. In 2001, Assembly Bill (AB) 2222 included reforms to the Fair Employment and Housing Act (FEHA); in 2002, AB 749 included a permanent disability benefit increase; in 2003, Senate Bill (SB) 228 included medical utilization review, and AB 227 included replacement of vocational rehabilitation with a voucher system; and in 2004, SB 899 overhauled the permanent disability benefit delivery system and introduced medical provider networks. The multiple changes that occurred to workers' compensation and other policies make it is critical to take great care interpreting trends in return to work and relating them to the provisions in SB 899. He noted that it is possible that part or all of the changes could come from FEHA, medical reforms, or other external factors. In addition, in the early 2000s, workers' compensation in California was in crisis with costs at their highest, and it is possible that employers were taking steps on their own to improve return to work and contain costs.

Mr. Seabury stated that the study included a survey of employers that explored their perceptions on the relationship between workers' compensation costs and return-to-work decisions. The survey revealed that 82% responded that workers' compensation costs were an important factor in terms of return-to-work decisions. He said that specific policies affecting return to work were not as generally perceived as important. About 40% of employers thought that the reforms to the workers' compensation system and to FEHA were an important factor in return-to-work decisions.

Mr. Seabury stated that the study used methods from previous RAND studies for the Commission, which included: using administrative data on workers' compensation claimants; linking data on claims to quarterly data on earnings from unemployment insurance (UI) records; and matching injured workers to observably similar uninjured "control" workers, with the match based on pre-injury earnings at the same firm. Mr. Seabury stated that employment data include earnings in a quarter. The relative employment ratio is of the likelihood that injured workers are employed in a quarter after injury divided by the likelihood that their control workers are employed. The control workers allow the analysis to eliminate non-injury-related effects on employment. Mr. Seabury stated that the data used for the analysis included: (1) claims from the Workers' Compensation Insurance Rating Bureau (WCIRB), covering injury dates of Q1 2000 through Q2 2006 and the date of the first report of injury; this was linked to earnings data through Q2 2008; and claims from the Disability Evaluation Unit (DEU) covering injury years 2000-2007 and linked to earnings data through Q4 2008.

Mr. Seabury first compared the relative employment in the quarter before and after injury. Injuries have a significant impact on employment. The relative employment of injured workers

drops to about 80% in the first quarter; then it dips to 65% to 70% five or six quarters after injury, followed by a slight recovery in employment over time. Five years after the date of injury, injured workers are still 20% less likely to be working.

Mr. Seabury then described the study findings on the trends in return-to-work outcomes over time. For this analysis, Mr. Seabury used relative employment two years after the date of injury, the latest period after-injury available for the entire study sample, as the measure of return to work. The study revealed that overall, in the early 2000s, the return-to-work rate was declining; from mid-2002 to late-2002, however, the trend shows that return to work has improved and there are some significant gains. This is based on WCIRB data of workers at insured firms with some temporary disability claims. The trends for one year and for two years after injury are similar. The trends with DEU data are also similar. Mr. Seabury also noted that the trends in return-to-work gains are statistically significant and that the trends were evident prior to SB 899 return-to-work reforms.

Mr. Seabury summarized the evidence on return-to-work trends by stating that: return to work was declining but began to improve for injuries in 2002-2003, with much of the improvement appearing to pre-date the return-to-work reforms in SB 899; and that because these trends started in mid-2002 to late-2002, they may be due to FEHA, medical care reforms, and/or employer initiatives to contain workers' compensation costs. With regard to the medical reforms, a key unanswered question is whether the care that is being restricted by utilization review is necessary or unnecessary care. If it is necessary care that is being restricted, then the medical reforms should worsen rather than improve return to work. There is a need to know more about the impact of medical care reforms on return to work.

Mr. Seabury stated that it is also important to look at how trends in earnings losses and how return to work and the changes in benefits affected the level of income replacement. Mr. Seabury stated that study methods for income replacement were based on comparing earnings of disabled workers to uninjured controls, and then comparing differences in earnings to incurred indemnity benefits. In the past, assessing the adequacy of replacement rates was generally considered most reliable when using five or more years of post-injury data. For this study, however, data on five years of post-injury earnings were not available for all workers. However, it was possible to make a projection based on observed return to work and to simulate the changes that would have occurred had return to work not improved. He stated that because two years of return-to-work outcomes were observed for all workers, they were used to predict longer-term earnings losses. Thus, the study is predicting the five-year earnings losses based on two years of return to work, as well as predicting how those losses change over time.

Mr. Seabury clarified that the earnings loss estimates are the projected cumulative earnings of injured workers for the five years after injury minus the cumulative earnings of the injured worker; that is, earnings losses are the potential earnings a worker would have made minus the wages they actually made. The average estimated earnings losses are $45,000 over a five-year period after injury. Cumulative earnings loss estimates based on actual return to work experienced are compared with the estimates of earnings losses that injured workers would have experienced if there had not been improvements in return to work. Return to work was improving since 2002, and the estimated earnings losses for those with poor return-to-work

outcomes fell considerably, from $50,000 in first quarter 2002, as compared to estimated earnings losses for those with good return-to-work outcomes which were $40,000 in first quarter 2005. Thus, there was a big difference between the losses observed as opposed to the losses that would have been observed without gains in return to work.

Mr. Seabury stated that disability benefits declined sharply over the same period, particularly for workers with permanent disabilities. For someone injured in first-quarter 2002 and even through 2004, the average benefits were comparable with those injured in 2000-2001. Starting with 2004 injuries, however, there is a sharp decline in disability benefits. For temporary disabilities, there were some initial gains in benefits, particularly because of AB 749 and improved return to work, followed by a decline. However, the decline was nowhere near as severe as the decline for workers with permanent disabilities.

The study also estimated the replacement rates, or the fraction of lost income replaced by disability benefits, by quarter of injury. The replacement rate was approximately 40-45% for all injured workers in the sample for injuries from 2002-2004; from 2004 onwards, there was a steep drop in average replacement rate from 42% to 35%. Return to work did improve over this time period and that did lead to lower losses. If there had not been return-to-work improvements, the replacement rates would have fallen further that what was observed, from 42% to below 30%.

With the adoption of the new disability rating schedule, there are fewer people receiving permanent disability benefits. Thus, the initial findings were conducted on all injuries (including permanent and temporary disabilities) to control for possible trends in the underlying severity of workers with permanent disabilities. The study did consider, however, the trend in income replacement just for workers with permanent disabilities. For permanently disabled workers who were injured in 2000 through 2004 or 2005, the replacement rate was stable at around 50%. From third-quarter 2004 to first-quarter 2005, there is a sharp drop in replacement rates after adoption of the schedule, a 10 percentage point drop to 40%. The study estimates that if there had not been improvements in return to work, then there would have been a bigger drop to 35%, instead of to 40%.

Mr. Seabury stated that if we look at the severity of disability, in past studies, replacement rates for more severe injuries tend to be higher than replacement rates for less severe injuries. The replacement rate in 2002 for the most severe injuries was 68%; for the middle severity category it was 38%; and for the least severe category, it was 15%. The drop in replacement rates for the most severe category was about 68% in 2000 to 47% in 2006, about a 20% decline. With lower return-to-work rates, the decline would have been 41%. Therefore, a piece, but not all or even most, of the decline in replacement rates has been offset by improved return to work.

Mr. Seabury stated that some have commented that disability rates have been increasing, which would potentially offset some of the decline in disability benefits. The study looked at data to see whether there is a trend in disability ratings in the recent periods. Using DEU data, the average disability rating by month from June 1, 2005, six months after the introduction of the new schedule, through December 31, 2009, was evaluated. The average rating observed in DEU ratings data was increasing substantially over the latter part of this period. Starting in 2007, there was an increase from an average rating of 15 to an average rating of 20. While permanent

disability ratings fell significantly overall, resulting in a large decline in permanent disability benefits, the recent trend in ratings suggests that benefits have been increasing in at least the past two years.

*Summary of Key Findings*
Mr. Seabury summarized the key findings of the study as follows: return to work of disabled workers in California has improved significantly, with the biggest gains coming from the most severely disabled; the exact cause of the return-to-work gains is uncertain, with much of the gains predating the 2004 reforms; and benefits fell substantially after the new Permanent Disability Rating Schedule (PDRS) was adopted, leading to about a ten-point decline in replacement rates on average. There were even bigger declines in the replacement rates for the most severely disabled, despite the fact that they had the largest improvements in return to work.

*Policy Implications*
Mr. Seabury stated that policy implications include: return-to-work gains improved outcomes for disabled workers, with a decline in earnings losses; return-to-work gains were not enough to maintain an adequacy level of benefits, offsetting about one-third of the decline, and benefit increases are needed to maintain previous adequacy levels, as improved return to work alone will not maintain previous adequacy levels. There were questions about whether California benefit levels were adequate prior to the reforms. He stated that there is mixed evidence for the impact of different return-to-work programs: the old vocational rehabilitation systems appears to have been largely ineffective (either the program had no effect, or the voucher system that replaced it is equally effective); the worksite subsidy program had not much effect; and the tiered benefit might have had an effect, but any effect it might have had was muted by some implementation problems. One of the biggest problems seems to have been a timing issue of when an offer of permanent and stationary has to be made and when permanent disability benefits actually start being paid. He stated that the advancement of a permanent disability is sometimes a barrier to effectiveness of the two-tier benefit and its ability to improve return to work. Ways to make the tiered benefit more effective in terms of return-to-work incentives would involve addressing advancement of permanent disability (e.g., either by advancing permanent disability at the baseline level, or not advancing it at all when a qualified offer of return to work has been made).

Mr. Seabury stated that a number of aspects of the system need ongoing monitoring. The gains seen in return to work have important implications for the adequacy of benefits, and the system and should be monitored to see if the gains can be sustained. There are also ongoing questions about how permanent disability ratings are applied. Still another area for monitoring is the overlap between FEHA and workers' compensation and whether the gap will continue to grow or whether return-to-work decisions in the two systems can be better integrated.

*Questions from Commissioners*

Commissioner Aguilar stated that she agrees that ADA/FEHA has affected people when you start to do the interactive process and determine if there can be accommodation. In some cases, there has been a reversal in the permanent disability determination. The increase in permanent disability ratings may mean that people are doing a better job of either gaming the system or doing the actual work.

Commissioner McNally stated that he thinks it is important to come up with a better policy that integrates the return-to-work program under the umbrella of FEHA and the interactive process. Historically, industrial and non-industrial injuries have been handled separately. There are a lot of employers who are still trying to handle things that way and do not realize the exposure they have under the interactive process for not conducting that process adequately. The motive and goals during the reforms were good in the tiered benefit, but there was a lot of confusion about time frames and steps the employer can take. The interactive process emphasizes a good faith effort and honest discussion about what the employee can do. Whatever is done to encourage return to work has to be done from the perspective of the interactive process. He stated that he appreciates that one of the policy recommendations of the study is to emphasize the interactive process. This is particularly important with an aging workforce and the goal of having a stable workforce. He stated that it is important that employers approach the issue of return to work in a creative way. Mr. Seabury stated that the ADA has recently strengthened requirements, and the overlap of occupational vs. non-occupational injuries could be a growing issue nationwide. The Commission has made a lot of progress learning what the benefits are of integration of medical care and could potentially make similar gains exploring the benefits of integrating indemnity benefits. Commissioner McNally stated that he agreed.

*Public Comments and Questions*

Linda Atcherley asked a methodology question about whether the replacement rate for the most severely injured workers is calculated by the highest amount of medical spent for that particular case. Mr. Seabury responded that that was in relation to other workers injured in the same quarter; absolute measures were not used. Ms. Atcherley asked whether temporary disability and temporary disability payments were calculated in, and Mr. Seabury responded that that was correct. Ms. Atcherley then asked whether it is important to discuss the two-year temporary disability cap in terms of how that works with wage replacement. Mr. Seabury responded that it is important in terms of the net impact in the changes in benefits on overall replacement rates; the temporary disability two-year cap would have an impact on the total benefits paid; the study looked at replacement rates for total benefit payments. Ms. Atcherley asked about the declining trend in permanent disability rating, and Mr. Seabury responded that actually, the trend is going up. Permanent disability benefits fell, but there were other changes, such as the cap on temporary disability, and the study looked at the net impact on permanent disability benefits. Ms. Atcherley asked about whether there was a need to adjust permanent disability ratings, and Mr. Seabury responded that if there is a goal of restoring benefit adequacy to previous levels, one way to accomplish that is by changing permanent disability, but there are other aspects of benefits that might be addressed, including temporary disability. Ms. Atcherley stated the study seemed to focus on all benefits, temporary and permanent.

Johnella Shackelford stated that she has not been present for prior presentations, but that she recently read a study entitled "Workers' Compensation to Welfare." She stated that Mr. Seabury commented that benefits fell by more than the income loss was, so income did not fall as much as benefits did. Mr. Seabury responded that benefits fell by more than income rose. Ms. Shackelford stated that she thought that meant that people did not suffer as much because their income did not fall that much. She stated that Mr. Seabury claimed there was a 95% confidence level. She said that she would like to read about the sample size and what the standard deviation

were. Ms. Baker stated that the study is looking at cohorts, so there is comparison with people at the same firm with the same wages. Because there was improved return to work over this period, wage loss did not decline as much. Ms. Shackelford stated that that is the contention that she would like to look at because the "Workers' Compensation to Welfare" study stated that those who were severely injured did not return to work. Mr. Seabury stated that all the analyses will be documented in the final report, and that the study looked at the severe disability category and those within the sample who returned to work. Ms. Shackleford stated that she did not know what the sample size or standard deviation was. Ms. Baker stated that the CHSWC/RAND study focused on those within the workers' compensation system versus the welfare system.

Mark Gerlach stated that the numbers presented in the study are averages, and what it shows is that some workers went back to work and those had less wage loss. However, the benefits went down, so those injured workers who did not return to work are getting reduced benefits. He stated that there was a 50% drop in benefits because of the schedule, and the decrease in benefits is affecting disproportionately those workers who did not return to work. This is why options for return to work are very important. However, for those who cannot return to work, then there have to be efforts to ensure that benefits are adequate. This study points out that people who do not return to work are in bad shape due to reduced benefits.

Commissioner Aguilar asked if additional information will be available in the report to be posted or the final report. Ms. Baker stated that the final report needs to be cleared by RAND's final review, and Mr. Seabury stated that the final report will be complete and fully documented.

*CHSWC Vote*

Commissioner Aguilar moved to approve for final release and posting pending RAND's quality assurance the draft final report "Workers' Compensation Reform and Return to Work: The California Experience," and Commissioner McNally seconded. The motion passed unanimously.

**Executive Officer Report**
Christine Baker, CHSWC

Ms. Baker stated that Commission staff has been working on a number of studies and on the annual report. Staff has been working cooperatively with the Division of Workers' Compensation (DWC), as well as with key stakeholders, to obtain data on many of these studies.

*International Forum on Disability Management (IFDM) 2010*
Ms. Baker stated that Commission staff has also been involved in planning the International Forum on Disability Management (IFDM) 2010: *Collaborating for Success* to be held in September at the Los Angeles Wilshire Grand. This event is a partnership between the International Association of Accident Boards and Commissions (IAIABC), the Commission, and the Department of Industrial Relations (DIR). Currently, 29 countries are represented, and over 120 researchers will participate from around the world about the issue of return to work for the

disabled. The concept of collaboration for success has caught the attention throughout the world in the area of disability management. A draft program and the forum website, www.ifdm2010.com, are included in the briefing packet. Disability management is a very important topic, and the forum will provide a global perspective on labor and management efforts to improve return to work.

*Study on Older Workers and Post-Injury Outcomes*
Ms. Baker stated that the Commission, with the assistance of UC Berkeley, is preparing a study on older workers and their post-injury outcomes. It has been a recommendation of our annual report for several years to examine disability duration by age. The study will help determine if older workers experience longer average time off work when disabled in California, or if older workers simply experience the kinds of injuries that are associated with longer disability durations. This will be ultimately important for both safety and prevention. Commissioner Culbreath asked what the age of the older worker population is, and Ms. Baker responded that age will be distributed.

*Lien Study and QME Study*
Ms. Baker stated that Commission staff continues to work hard on the lien study and the QME study. Ms. Baker stated that working with administrative data is not always easy, but there has been incredible support from stakeholders in the system, as well as the cooperation from DWC and DIR.

*Safety Project*
Ms. Baker stated that a safety project is also in process with RAND. All of the projects require MOUs and confidentiality agreements and legal reviews. The safety project studies include: an evaluation of the Injury and Illness Prevention Program (IIPP) in California to see if the standard should be adopted on a national level; a study of X-Mods; and a study of pricing of apprenticeships safety and premium. There will be an interim briefing on all the studies in August. The study of the pricing of insurance for apprentices and the impact of apprenticeships on injuries is about ready to start. The necessary data from the Apprenticeship Bureau have just now been received. For the other studies, the necessary data were received only in the last two months.

*Evaluation of the California Injury and Illness Prevention Program*
Ms. Baker stated that the evaluation of the California IIPP standard has carried out linking of Cal/OSHA inspection records to the Workers' Compensation Information System (WCIS) injury reports and to Employment Development Department (EDD) establishment employment data. The EDD matching just finished in June. The next step is to link all three data sets together.

*Underground Economy Study*
Ms. Baker stated that the underground economy study is finally underway and data are expected soon from EDD. The delay has been due to obtaining the necessary data.

*Study of Workers' Compensation Benefit Delivery System*

Ms. Baker stated that the Request for Proposal (RFP) is underway for the Commission's next study of the workers' compensation benefit delivery system. This will include continued evaluation of medical and return-to-work measures. The RFP evaluation takes place in August.

*Social Security Disability Insurance and Workers' Compensation Disability Benefits*
Ms. Baker stated that proposals for two more studies are included in the briefing packets. The first is piloting an electronic linkage between Social Security Disability Insurance and workers' compensation disability benefits. Matching these records will provide immense insights and has the potential to reduce costs for employers and improve benefits for workers. This is a pilot study and is not expected to cost very much.

*CHSWC Vote*

Commissioner Aguilar moved to carry out a study on piloting electronic linkage between Social Security Disability Insurance and workers' compensation disability benefits, and Commissioner McNally seconded. The motion passed unanimously.

*Policy Implications for Workers' Compensation Because of the New Healthcare Laws*
Ms. Baker stated that the next proposal is to explore and identify areas with policy implications for workers' compensation because of the new healthcare laws. Many people are wondering if there are implications, and the study would attempt to identify what those might be for California. This is an exploratory proposal; further information will be presented in August before proceeding on a grand scale. Commissioner Aguilar asked whether the study will be done in conjunction with others, and Ms. Baker responded that no one is doing this type of study for California.

*CHSWC Vote*

Commissioner Aguilar move to approve that the Commission conduct an exploratory study on the coordination between healthcare reform and workers' compensation, and Commissioner McNally seconded. The motion passed unanimously.

*Self Insurance Groups*
Ms. Baker stated that it has come to the Commission's attention that the New York task force has recently completed its evaluation of self insurance groups in New York, which were at greater risk than in California; however, their conclusion is that they do not believe the benefits of such a program outweigh the risk. The Commission would like to continue investigation of self insurance groups in California. Judge Lach Taylor was primarily responsible for the investigation done before.

*CHSWC Vote*

Commissioner Aguilar moved to approve that the Commission conduct further study of self insureds, and Commissioner McNally seconded. The motion passed unanimously.

Ms. Baker stated that all of the staff is working extremely hard. A special recognition is due to Nurgul for her work on QMEs, Lach on liens, and Nabeela for the annual report. In addition, Frank, Juliann, and Seth, our external research team, are also dedicated and doing great work. Commission staff is down with Irina out to have her baby boy, and Denise will soon be out for her baby boy in September.

*RAND Report: Musculoskeletal Injuries to Firefighters in California Study*
Ms. Baker stated that the study on musculoskeletal injuries to firefighters in California has been posted and no comments have been received; therefore, the study report is ready to move to final release and posting.

*CHSWC Vote*
Commissioner Aguilar moved to approve for final release and posting the report prepared by RAND titled "The Frequency, Severity, and Economic Consequences of Musculoskeletal Injuries to Firefighters in California," and Commissioner McNally seconded. The motion passed unanimously.

**Other Business**

None.

**Adjournment**

The meeting was adjourned at 2:20 p.m.

Approved:

_____ _____

Angie Wei, Chair Date

Respectfully submitted:

_____ _____

Christine Baker, Executive Officer Date