

Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING

March 5, 2009

**Elihu M. Harris State Building
Oakland, California**

In Attendance

Chair Sean McNally

Commissioners Catherine Aguilar, Allen Davenport, Kristen Schwenkmeyer, Robert Steinberg,
Darrel "Shorty" Thacker and Angie Wei

Executive Officer Christine Baker

Call to Order

Sean McNally, 2009 CHSWC Chair, called the meeting to order at 10:05 a.m.

Minutes from the December 12, 2008 CHSWC Meeting

Chair McNally requested a vote on the Minutes of the December 12, 2008 meeting.

CHSWC Vote

Commissioner Davenport moved to approve the Minutes of the December 12, 2008 meeting, and Commissioner Thacker seconded. The motion passed unanimously.

Revised Claims Adjuster and Bill Reviewer Training and Certification by Insurers Report
CHSWC Staff

Ms. Baker stated that at the November 6, 2008 meeting, the Commission instructed staff to review the regulation, compliance and enforcement of claims adjuster and bill reviewer training and certification. At the December 12, 2008 CHSWC meeting, the draft report which reviewed regulation, compliance and enforcement of claims adjuster and bill reviewer training and certification was presented and approved for distribution for public comment and feedback. At that meeting, the Commission also requested that Commission staff hold an Advisory Group meeting to look further into the oversight process for claims adjuster and bill reviewer certification.

Ms. Baker stated that the Advisory Group meeting was held on January 23, 2009, with various stakeholders of the workers' compensation community. This Commission staff report updates the December 2008 report and includes information from the Claims Adjuster and Bill Reviewer Training and Certification Advisory Group meeting.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Mrs. Baker stated that it was the feeling of Commission staff that based on the Advisory Group discussion, any enforcement of claims adjuster and bill reviewer training and certification should be the responsibility of the respective agencies. More coordination between the Department of Industrial Relations (DIR) and the Department of Insurance (CDI) regarding the lists and who is certified could be improved, as well as outreach and education by DIR and CDI in order to improve compliance.

Commissioner Davenport asked for clarification about whether the recommendation of the Advisory Group was that individual employers monitor the training and certification of its employers. Ms. Baker responded that the Advisory Group recommended that the respective agencies should do the monitoring.

CHSWC Vote

Commissioner Aguilar moved to approve for circulation and comment the Draft Revised Claims Adjuster and Bill Reviewer Training and Certification by Insurers Report and to post the final report within a month if no comments are made, and Commissioner Thacker seconded. The motion passed unanimously.

Draft Report on the California Return-to-Work Program Established in Labor Code Section 139.48

CHSWC Staff

Ms. Baker stated that in November 2008, at the request of the Acting Administrative Director (AD) of the Division of Workers' Compensation (DWC), the Commission on Health and Safety and Workers' Compensation (CHSWC) voted to conduct a study of the Return-to-Work Program established in former Labor Code Section 139.48. This report describes the operation of the program in the period August 18, 2006, to December 15, 2008. It discusses rates of participation by employers, awareness of the program among small employers, and possible future funding.

Ms. Baker stated that this report summarizes information provided by the DWC Retraining and Return to Work (RRTW) Program Unit describing employers' applications for workplace modification expense reimbursement and approvals and denials of those applications. In addition, Commission staff prepared a brief questionnaire asking small employers whether they were aware of the Return-to-Work Program, how they learned about it, and whether they would use it in the future. Small Business California, a nonprofit advocacy organization, sent the questionnaire to its members in December 2008.

Findings from the report include that:

- The California workplace modification program has been underutilized, probably because most small employers who qualify for the program were unaware of it.
- More than two-thirds of the employers that applied were denied.
- The average amount received per employer was less than \$800.00.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

- To date, the program has not been cost-effective. The costs to process applications and administer the program far exceeded the amounts paid out.

Commission staff recommends two alternatives for this program:

- California may wish to consider eliminating the program and consider a program that more directly assists injured workers who are unable to return to their previous jobs.
- If the program is maintained, outreach and communication about the program should be improved, taking into account the channels through which small employers most commonly receive information.

Ms. Baker stated that the Commission would like to thank the following people for their assistance in providing information for this report: DWC Acting AD Carrie Nevans; Otis Byrd, Program Manager, and Sandra Lee Cortes, Area Supervisor, both of the Retraining and Return to Work (RRTW) Unit of DWC.

Ms. Baker stated that additional thanks go to the many vocational rehabilitation and return-to-work professionals in the state agencies surveyed, as well as to Small Business California for sending out the questionnaire to its members and enabling the Commission to get a sense of the awareness of the RTW program in California. Other states were also contacted; many states are re-considering their programs despite a lot of outreach because not many small businesses were utilizing the program. In particular, CHSWC staff would also like to thank Juliann Sum, of the University of California (UC), Berkeley, who provided valuable technical assistance in preparing the report.

Questions from Commissioners

Commissioner Aguilar stated that she was concerned about whether the employers whose applications were rejected were notified and instructed how to re-apply. Ms. Baker responded that some employers did not qualify, but that there was a large team of people on this program and there should be enough communication with employers who apply. Commissioner Aguilar also asked if consideration had been given to increasing the number of employees for small businesses to qualify (currently 50 employees), and Ms. Baker responded that the number is set by legislation.

Commissioner Davenport asked why two-thirds of the applicants were rejected and why so many small businesses do not know about the program. He asked whether there was some standard that was established or whether some of the requests were inappropriate, and Ms. Baker responded that most of the rejected requests were because the small businesses did not understand the program. Commissioner Davenport asked if enough money was being spent on outreach, and Ms. Baker responded that enough money has been allocated to do outreach, but it was not clear if sufficient outreach had been done to advise small businesses. Some small employers indicated on the survey that they would not apply even if they could because of the bureaucracy. Commissioner Davenport asked if a recommendation was made for improvement, and Ms. Baker responded that there were two recommendations: to abolish the program; or improve

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

communication targeted to the small employer. Commissioner Davenport asked if there were a recommendation on how to improve the communication and targeting. Ms. Baker responded that that could be done through employer channels and through insurance carriers. Chair McNally asked if it made sense that insurers would be required to handle the communication.

Commissioner Wei stated that it was disturbing that there was \$500,000 available for reimbursements to employers and there was an average of \$800 in reimbursements per employer yet on the administrative side, the costs were over \$1.65 million. Commissioner Aguilar stated that this definitely was not cost-effective. Commissioner Wei stated that return to work is a policy priority, and it was not clear why the program was not being utilized to its maximum capacity. She stated that at this time, it is very difficult to obtain State funding, and that it was a shame that this program was not being used appropriately. She suggested that it might be helpful for Commission staff to come up with concrete recommendations for insurance brokers to offer this program as an option for small employers. She asked if information about the program is on the DWC website, and Ms. Baker stated that she believed it was. Commissioner Wei asked what further outreach could be done, and Ms. Baker responded that a promotion campaign and working through insurers for small employers could be done.

Chair McNally suggested that if it was too bureaucratic for small employers, Commission staff should make some recommendations on how to streamline it. Ms. Baker responded that the paperwork definitely could be streamlined. Commissioner Aguilar stressed that communication about the process would be key. She asked how many employers there are with 50 or less employees, and Ms. Baker responded that there is a significant number. Commissioner Aguilar stated that those employers do emphasize not having enough information about the workers' compensation process. Commissioner Davenport stated that this situation should be reported in the media as the situation needs exposure.

CHSWC Vote

Commissioner Davenport moved to release the Draft Report on the California Return-to-Work Program Established in Labor Code 139.48 as a draft report and direct staff to further develop recommendations for how to make this program more efficient and how to better communicate and streamline it so that it will be easier for the smaller employer to make use of the program, and Commissioner Aguilar seconded. The motion passed unanimously.

Public Comment

Joe Severino, a return-to-work consultant for the State Compensation Insurance Fund (SCIF), stated that the only way to make the program easy for the small employer is to work through insurance companies. Ms. Baker stated that Commission staff would be interested in talking with Mr. Severino after the meeting.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Briefing on Medical Study

Barbara Wynn, RAND

Inpatient Hospital Services

Ms. Wynn stated that she would share the recent findings about facility services provided to workers' compensation patients using Office of Statewide Health Planning and Development (OSHDP) data. The previous report looked at inpatient data from 2003 through 2005. The new analyses include inpatient hospital discharges through 2007 and ambulatory surgery data from 2005-2007. The analyses looked at service volume and maximum allowable fees under the Official Medical Fee Schedules (OMFS) for the facility component of these services. Actual payments for services are not collected by the State, so it is not possible to compare allowances to payment amounts. Services payable under the OMFS for physician services were not a focus of this study, although some services provided in facilities are paid under OMFS for physician services. Analyses of emergency department data are ongoing and will be discussed at a later time.

Ms. Wynn stated that the policy context for the study is important. There were a number of changes within the workers' compensation system including:

- Changes in medical treatment policies which potentially affect the volume and mix of services including adoption of medical treatment (ACOEM) guidelines and establishment of medical provider networks.
- Changes in the Official Medical Fee Schedule (OMFS) which affect maximum allowances for facility services and could create incentives to shift the site of service.

It is important to determine if the fees are appropriate and do not create any incentive to shift payments.

- Reduction of nearly 20 percent in the number of injuries involving days lost from work between 2003 and 2007.

Important changes in the OMFS for inpatient hospital services included:

- Tied regular updates to 1.2 times the Medicare rate, probably the most important change.
- Eliminated exemptions for special high-cost cases, e.g., burns, trauma, and tracheostomies, which had not been subject to the OMFS previously.
- Eliminated adjustment factors that altered the 1.2 multiplier for certain types of cases.
- Restricted pass-through for implanted hardware and devices for complex back and spinal surgery (Senate Bill 228).
- Eliminated an exemption for care provided in psychiatric and rehabilitation hospitals effective January 1, 2005. This provision has not yet been implemented, so those services are still payable through negotiation between the payor and the hospital.

Ms. Wynn stated that the questions considered in the study included:

- What changes occurred between 2003 to 2007 in terms of the volume and mix of

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

inpatient stays and the OMFS allowances?

- What was the impact of the OMFS changes?
- How do estimated OMFS allowances compare to estimated costs of stays? and
- What are the payment implications of continued exemptions for specialty hospitals?

Ms. Wynn stated that from 2003 to 2007, workers' compensation inpatient discharges decreased by 17 percent; however, there was a 20 percent increase in the estimated allowance per stay. In the first year, 2003 to 2004, the elimination of the OMFS exemptions offset any increases in the rate updates. In fact, the total allowances for inpatient hospital services in 2007 of \$487 million were the same as the total allowances estimated for 2003.

Ms. Wynn stated that the distribution of inpatient stays across different types of cases was fairly stable over the period, but there was some difference in the distribution of payments:

- The share of estimated allowances accounted for by two major types of cases increased: non-cervical spinal surgery, from 14 to 16 percent (before consideration of "hardware" pass-through); and hip and knee replacements, from 6.1 to 10.3 percent.
- The share of estimated allowances for previously exempt cases decreased: for example, tracheostomies decreased from 7.8 to 2.5 percent; and burns decreased from 4.2 to 1.6 percent.
- The share of estimated payments for OMFS-exempt services (estimated at 90 percent of charges) dropped from 32 percent to 14 percent. Eighty-six percent of inpatient services are now under the OMFS.

Ms. Wynn stated that the estimated ratio of the OMFS allowance to cost in 2007 varies by type of stay. For example: a ratio of 1.0 means that the allowance equals the cost; a ratio of 1.17, the overall ratio, means that the allowances, on average, are 17 percent above cost; and a ratio of .90 means that the allowance is only 90 percent of cost. While the ratio is greater than 1.0 for spinal fusions before consideration of "hardware" pass-through, it is lower than average; for non-cervical conditions, it is 1.06; for cervical conditions, it is 1.03. However, for anterior/posterior conditions it is substantially higher than average at 1.42.

Ms. Wynn stated that the ratio is less than 1.0 for some high-volume high-cost categories, including: other back and neck procedures other than spinal surgery, .92; lower extremity and humerus procedures except hip, foot and femur, .95; and major shoulder/elbow procedures, .99. In 2008, Medicare adopted severity-adjusted rates to improve payment accuracy and to pay more for patients with major complications and co-morbidities; for example, spinal procedures for nervous system conditions with device implants are treated the same as co-morbidities. These changes increase the workers' compensation allowance for some cases and reduce it for others; the overall change is estimated to increase workers' compensation allowances by 0.5% in 2008 and 2009. Spinal fusion goes up 9%, cervical fusion up 6.23%, and combined interior/posterior fusion will have a reduction in payment. The estimate is based on using 2007 cases and 2008 and 2009 payment rates. In addition, there will be coding improvements that are likely to increase allowances another 4 to 5% between 2008 and 2010, thereby increasing the expenses for workers' compensation cases.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Ms. Wynn stated that a study was done in 2005 for the Commission on spinal hardware implants. The current analysis shows that payments are still problematic: hardware costs are being paid for twice; and approximately 50 percent of the Medicare rate represents device costs in the spinal fusion diagnostic related groups (DRGs), and rates are likely to increase under the severity-adjusted DRGs. The 1.2 multiplier adds a “cushion” to the OMFS allowance and accounts for the fact that workers’ compensation patients have a higher use of devices. The payments appear excessive.

Ms. Wynn stated that another issue is inconsistencies in the procedures qualifying for the pass-through payment allowed for neurostimulators for nervous system conditions but not musculoskeletal conditions. Further, the pass-through creates financial incentive to shift from outpatient to inpatient surgery. Ms. Wynn stated that there is some evidence of growth in spinal procedure inpatient stays and a reduction in outpatient neurostimulator insertions. There may be some shifting going on there.

Commissioner Wei asked what the estimate would be if hardware were paid for as well and what the resulting allowance would be. Ms. Wynn responded that basically, the standard payment rate for the most common case, which is lumbar spinal fusion, is \$17,600 before adjustments. If you assume another 50% of that for hardware, the payment rate is another \$8,000. The standard rate gets adjusted for the hospital’s wage index and teaching, and there is a 60% add-on for those adjustments. That becomes \$33,000, and then there is a multiplier on top of that which brings the allowance to \$42,500.

Commissioner Wei asked if the device costs the same despite the adjustments, but that with the adjustments, the device gets reimbursed at a higher rate even though it is a fixed cost. Ms. Wynn responded that that was the case, and that there could be over-paying of device costs. Commissioner Wei asked if every Medicare payment has the device usage in it, and Ms. Wynn responded that it has the average usage by Medicare patients in it and might not be reflective of workers’ compensation patients.

Ms. Wynn then stated that she would discuss OMFS-exempt services, which are concentrated in rehabilitation facilities, with nearly \$50 million worth of charges for 975 discharges. Medicare’s payment method is on a per discharge rate, with rates adjusted for the patient’s functional status. In addition, psychiatric cases had almost \$9 million paid by Medicare on a per diem rate; long-term care hospitals, which are paid on a discharge rate, are expensive cases, and there is a lot of variation in the charges, with the total for 24 cases amounting to \$700 million. One other type of hospital that had small volume is critical access hospitals, which are small rural hospitals that stabilize and then transfer cases.

Ms. Wynn stated that the exemption poses several issues: charge-based payments expose payors and employers to unnecessarily high payments for exempt stays. The average charge for rehab stays was \$50,000, but charges are substantially higher than costs. The average cost is less than \$20,000. Payment information is not available. The appropriateness of Medicare rates for workers’ compensation patients needs evaluation. Medicare’s per discharge rate for rehabilitation care is based on functional status information not available in administrative data, so it is not possible to compare Medicare cases and costs to workers’ compensation cases and costs. The psychiatric per diem payment rate is less problematic because it adjusts for length of stay. While there are some other rate alternatives that may reduce the risk of unreasonable

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

payments, alternatives to Medicare rates may require statutory changes.

Ms. Wynn stated that some key OMFS issues for inpatient services include:

- A wide variation in the ratio of allowance to estimated cost across types of cases. The AD of the DWC has authority to adjust rates within the aggregate 120 percent of Medicare cap, and some adjustment factors may be needed to improve payment accuracy for workers' compensation patients. This could be determined in a couple of years when at least 2008 data and possibly even 2009 data are available.
- The pass-through for spinal hardware remains problematic. The AD has authority to eliminate or modify the way it is paid.
- Coding improvements in response to severity-adjusted rates may lead to some unnecessary increases in allowances beginning in 2008. Medicare is addressing this through reduced update factors, making smaller adjustments for inflation over the next few years to take into account the coding effect; however, under the OMFS, the update factor is fixed in the Labor Code. The AD has authority to reduce the 1.2 multiplier, so the same effect could be accomplished by changing the multiplier.
- The workers' compensation program is at risk for unreasonably high payments for exempt hospital stays, but there is no readily identifiable solution which is easy to implement.

OMFS for Ambulatory Surgery Facility Services

Prior to 2004, these services were not subject to fee schedule allowances. In 2004, the facility fees for ambulatory surgery provided in hospitals and freestanding ambulatory surgery clinics (ASCs) became subject to the OMFS. The OMFS applies only to facility fees for surgical services and emergency department visits. The allowance is tied to 1.2 times Medicare rate for hospital outpatient surgery. Medicare rates for ASC services were outdated in 2004 but were updated in 2008 and tied to the outpatient rate but at a percentage of that payment. The rate includes the costs for any implanted devices. In addition, the OMFS adopted Medicare's "inpatient only" procedures list but allows the payor to approve those services as ambulatory surgery on a case-by-case basis.

Ms. Wynn stated that data are available for the first time, and the study questions on ambulatory service include:

- What is the volume and mix of ambulatory surgical procedures?
- How do they vary between hospitals and ASCs?
- How do they compare for a non-workers' compensation comparison group of patients: non-Medicare, non-workers' compensation patients age 18 through 65? and
- Are there potential issues regarding inpatient-only procedures that are most appropriately performed on an inpatient basis and most commonly performed in physician offices?

Getting the payment rate right means that you do not overpay and create incentives to shift costs or services or underpay and shift services from ASCs to hospital outpatient or even inpatient

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

basis. In addition, the study looks at what other services are provided in conjunction with ambulatory surgery and whether the outpatient fee schedule should apply; as well as if there is a relationship between ASC reliance on workers' compensation patients and profitability.

Ms. Wynn stated that OSPHD financial data are available only for 2005 onward; therefore, the impact of changes with the implementation of the OMFS cannot be examined. The top surgical procedures performed in ASCs by type of payment are arthroscopy musculoskeletal procedures other than hand, nerve injections, nerve procedures, hernia/hydrocele, hand musculoskeletal, treatment of fracture/dislocation, and implantation of neurological devices. In terms of total volume, the procedures most performed in ASCs are nerve injections; only the hernia procedures are done more often in a hospital setting than an ASC. Many of these procedures are low-risk. In comparison to workers' compensation cases, a much higher percentage of the same procedures is done in the hospital as compared to an ASC for non-workers' compensation cases. This can mean that some services have migrated from the office to ASCs, or it can mean that for non-workers' compensation patients, the payors may have negotiated more comprehensive contracts with hospitals and do not contract with ASCs.

Ms. Wynn stated that other findings include that: 0.9 % of procedures are "office-based"; and 0.4% of procedures are "inpatient" only procedures, primarily spinal procedures, of which 80% are done in ASCs vs. 86% in hospitals for non-workers' compensation. The most common non-surgical services billed at the same time were: fluoroscopy, discography, and myelography, which are bundled into OMFS allowance beginning in 2008; X-ray is also a high-volume procedure, it remains as separate allowance and will be affected by changes in physician fee schedule.

Ms. Wynn stated that in summary, consideration should be given to adopting a new Medicare-based fee schedule for ASC services, as ASCs are less costly than hospitals. The Medicare system pays for facility-based services at 67 percent of the outpatient rate and for office-based services under the physician fee schedule. She stated that this would probably require a statutory change.

Ms. Wynn stated that further research is needed to examine the distribution of services across physician offices as well as facility settings and whether there have been shifts in the site of services from outpatient to inpatient for high-cost procedures (e.g., neurostimulators) and from physician offices to facility settings. Ms. Wynn stated that she hopes that data from the Workers' Compensation Information System (WCIS) will become available to look at some of these broader issues.

Questions from Commissioners

Commissioner Wei asked if it were possible to tell if the financial incentives are right. Ms. Wynn responded that they looked for shifts in site of service and did not see "caution flags." There were some shifts, for example in neurostimulators, but there were indications that only a small percentage of what Medicare classifies as office-based procedures are being done in ASCs. In terms of determining whether incentives were right, for the inpatient side, it is important to look at payment accuracy, to be sure that payment covers care and a reasonable profit or return on

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

investment. Too low an allowance can create access problems, or too excessive/high an allowance can create over-utilization. That is why the allowance to cost ratio is examined.

Commissioner Davenport asked for clarification as to how WCIS data would help better analyze these issues. Ms. Wynn responded that WCIS medical data includes transaction data: all the services provided; who provided them; and what the diagnoses are. She stated that there is a host of questions that the data could answer, and that they are ready to start looking at WCIS data. The outstanding issues are that not all insurers are providing data and there are no penalties for not providing data. So the question is how representative the data are.

Ms. Baker stated that it has been complicated to obtain data, but CHSWC staff has been working closely with DWC and RAND to work through issues with WCIS, data cleaning, MOUs, confidentiality requirements, and research requirements from different agencies, as well as ensuring that the data are coming in and are representative. RAND and DWC have done an incredible job, holding more than six weeks of discussion to get the data ready. The Inpatient Hospital report has been out for public comment. Some comments have been received. That report will be updated in a final report on the whole medical study, but it is now ready for approval and posting.

Public Comment

Tim Madden, representing Medtronic Spine, stated that he would like to focus on implant hardware issues. Before the hospital inpatient fee schedule was put in place in 1999 at 120% of Medicare for the complex spinal procedures, a number of these procedures were beginning to be delayed or cancelled because the actual cost of the procedure was greater than the reimbursement. Medtronic believes that determining the right level of reimbursement or payment accuracy is critical to ensuring adequate access and that the spinal surgery second-opinion process works to control over-utilization. Using an average charge to cost ratio is difficult, as the items are marked up at different rates: the lower-cost items are marked up at a higher rate; and the higher-cost items are marked up at a lower rate. Medicare is addressing that issue of charge compression right now. Medtronic believes that that should be evaluated over time. Medtronic also urges that the pass-through not be eliminated but that any changes to the pass-through should be analyzed before making that change to determine the effect on access.

Judge Taylor stated that the other public comment that was received in face-to-face meetings was from Access Mediquip, a third-party supplier of hardware for surgeries. Their concern was the same as Medtronic, that charge compression would distort the figures that RAND presented. They used in-house surveys to suggest that the cost of hardware may exceed the entire amount of reimbursement currently payable. He stated that he has not received these comments in writing and therefore has not been able to provide it to the Commissioners or Ms. Wynn for review and response.

Commissioner Wei asked why there is a pass-through and why the “right rate” is not built into the Medicare reimbursement rate. Ms. Wynn responded that the issue was whether Medicare patients receive the high-cost devices at the same rate as workers’ compensation patients. The average Medicare usage is built into the rate. If there is not an accurate determination of usage,

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

then there might have to be an adjustment of the rate. One of the points of an earlier paper was to reduce the rate to exclude the estimated cost and then pay an additional amount for what is actually used by workers' compensation patients on a case-by-case basis. In the earlier report, there was a lot of variation among workers' compensation patient rates across hospitals.

Commissioner Steinberg asked if there is an access issue, and Ms. Wynn responded that there is no access issue today and that over-access may be the problem.

Chair McNally stated that this is a complicated area to unbundle. He suggested that it was important to take a harder look at the problem and try to unbundle what the economics are and what the motivations are before further recommendations are made.

Judge Taylor suggested that all of these concerns are consistent with what Ms. Wynn proposes to look into. He stated that Access Mediquip also focused on the difficulty for hospitals to take advantage of the pass-through to obtain an additional reimbursement if it is needed. This issue is also part Ms. Wynn's overall recommendation for further analysis.

Chair Wei asked if the treatment guidelines address hardware and when it was either appropriate or not appropriate to use it. Ms. Wynn responded that she did not have the knowledge to answer that, and Judge Taylor responded that this is the part of medicine that is a judgment call and difficult to determine outside the community of physician specialists. Commissioner Wei stated that they are worried about access, but when there are no guidelines, pricing and cost could drive decision-making, and that is also a concern. Ms. Wynn stated that one of the advantages of including it within the rate instead of making a pass-through of the cost is that the bundled payment creates incentives for efficiency, that is, making sure that the least costly alternatives are used that are medically appropriate. When you start passing through the cost, then incentives are lost. That is why Medicare went from a cost-based reimbursement system to a prospective rate.

Judge Taylor stated that he has questioned how the reimbursement rate to the hospital could affect the physician's decision. Ms. Wynn stated that purchasing of supplies is through the hospital purchasing department, and frequently, there is group purchasing; typically, the affected medical staff members will decide jointly with the hospital purchasing department on the types and brands of equipment to buy. There appear to be some standardization and some attention to cost. If the more costly items are not more beneficial, they are likely to drop out. If physicians are purchasing directly, oversight and agreement are lost.

CHSWC Vote

Commissioner Wei moved to approve the RAND working papers on Inpatient Hospital Services and Ambulatory Surgery for circulation and comment, pending final review by RAND, and to post the final paper within a month if there are no comments, and Commissioner Aguilar seconded. The motion passed unanimously.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Draft Self-Insurance Group Interim Report

Lachlan Taylor, CHSWC Staff

Judge Taylor stated that he would give a status report on the examination of the self-insurance groups. Assembly Member Joe Coto requested that the Commission review the statutes, regulations and operations of Self-Insurance Groups (SIGs) to determine whether California needs to change the way it oversees these groups, and to see if California is learning the lessons that have been learned in other states. He stated that there was quite a bit of press about the failure of several SIGs in New York State over the past few years, particularly last year.

Judge Taylor stated that SIGs among private employers as opposed to public employers are a new phenomenon in California. From the early days of the workers' compensation system, employers have been allowed to self-insure individually. In that case, self-insurance is a misnomer. There is no insurance; it is an employer self-funding its liability because it is approved as having the capacity to absorb its own workers' compensation liabilities. He stated that there is self-insurance for public employers and in groups for public employers that are called Joint Powers Authorities (JPAs). California first allowed private employers to group self-insure by statute in 1993, with regulations adopted in 1994, but there was no uptake for almost a decade. The first SIG in California was approved in 2002. By the end of 2007, SIGs accounted for \$5.2 billion in covered payroll, which is almost 6% of covered payroll in private self-insurance; the other 94% are individual employers, for example, Safeway, Marriot, PG&E, Grimmway Farms and others that can absorb their own losses. Private group self-insurance is a relatively new phenomenon in California; it has been around for years elsewhere. It has just gone through or is going through its first stage of maturation. The regulations adopted in 1994 have been under debate for revision for about four years, and new regulations are effective as of Monday of this week. He stated that they are also seeing the first shake-out in participants in this program; in the past few months, it has been announced that a couple of programs are closing because they cannot meet the security requirements in the tightened credit market. Therefore, this is a good time to be looking at the program.

Judge Taylor stated that a SIG is a group of employers that when banded together can meet the minimum financial qualifications set by the Office of Self-Insurance Plans (OSIP). That minimum can be met through OSIP examining the financial reports of just a core number of members that cross the threshold; there is no need for the OSIP to review the financial condition of every member of a group. The group must pay a deposit to DIR, intended to secure the payment of its obligations, but its primary fund to pay for its obligations is contributions from its members. In the insurance world, these contributions would be called premiums; however, since this is not called insurance, a different nomenclature is used.

Judge Taylor stated that in many SIGs, the risk of future liabilities is being transferred from the employers to the groups; the risks are being paid from the contributions, and transfer of risk is characteristic of insurance whether it is regulated by the Department of Insurance (CDI) or DIR. When there is a transfer of risk in exchange for the payment of consideration upfront, it is fundamentally an insurance transaction. Not all SIGs do this, but some of them do look a lot like miniature insurance companies. Some SIGs look a lot like self-insured employers in that the members are funding their own risk. It is not that easy to distinguish them.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Judge Taylor stated that one of the characteristics of a SIG is that each member agrees to joint and several liability; in other words, if the money on hand in the SIG is insufficient to pay the losses, then there is recourse to the members. In contrast, when buying an insurance policy and when an insurance company fails, the policyholder does not get sued for the problem. A member of a SIG is at least theoretically responsible for the liabilities of the entire group. He stated that that could be impractical to enforce when there are hundreds of members, such as small employers, in the group. It is perhaps much easier to enforce when you have a group of three, and there are several SIGs with only three members. Judge Taylor stated that the largest SIG has over 740 members and over \$1 billion in covered payroll; it is over one-fifth of the entire size of the program. He stated that there were 28 SIGs as of February 2009.

Commissioner Wei asked who was in the 740-member group, and Judge Taylor responded that it is the restaurant group, with details on the OSIP website. He stated that there could be advantages to having lots of members, in that it is diversified, and that may be said of what insurance does. He stated that one other characteristic of SIGs in California is that all of the employers must be members of the same industry. This has the advantage of coherence, the ability to deliver specialized services, and the ability to deal with the special risks of that industry. He stated that it has the drawback of vulnerability: the insolvencies of insurance carriers seen in the last decade, the ones that went under, tended to be limited to California and limited to workers' compensation. The ones that were diversified by lines of insurance and by regions of operation were more able to absorb the hit that California carriers saw.

Commissioner McNally stated that as a case in point, one of the SIGs that recently went insolvent was the auto dealers. Judge Taylor stated that he was not sure that the auto dealers declared insolvency; his understanding is that one of the four or five auto dealer SIGs has decided to close because it could no longer obtain an unsecured letter of credit to post a security deposit with DIR. He stated that some of the SIGs have no problem with their credit because of the way that they are structured.

Judge Taylor stated that one of the strengths of the California system and the reason that it did better than many states is that it required that the group carry funds in-house sufficient to pay its future losses, and future losses are always an estimate; there could be a 50-50 chance that the estimate is too high or too low, but instead, California required that it be at the 80% confidence level. That means that in eight out of ten years, the estimate would be at least enough to pay the losses, and in only two out of ten years, it might be wrong. He stated that that is a very conservative way of estimating and added that insurance carriers do not have such a requirement. He stated that this is one of the strong points of the California SIG program. One of the weak points is that there were differences in how the requirement was interpreted. He stated that that has been clarified in the new regulations; the funding must be carried at the 80% confidence level for each and every program year. This gives a higher level of confidence. Another strength is that the surplus in one year can be swept over to fill a deficit in another year.

Judge Taylor stated that a SIG is a non-profit corporation managed by a Board of Directors/Trustees, which primarily represents the member companies. The day-to-day operations are managed by a program administrator. At its best, there is an active Board of Directors that is responsible to the group to carry out its fiduciary responsibilities. At its worst,

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

there is a Board of Directors that signs off on whatever the program administrator says. This has been observed in forensic audits of failed groups in New York, in which a program administrator sets up a group, gets someone to sign the papers as the organizing employer, and actually conducts the group for the program administrator's own profit. He stated that although that could happen in California, he did not state that it is happening; and it is certain that there are groups where that is not happening, and program administrators are being very responsible and looking after the members. He stated that there is quite a range of personalities in these 28 groups in California. In New York, it was possible for the program administrator to also be the claims adjuster; the claims adjuster then low-balled the estimates of reserves to make the group look healthy. California did not allow this and tried to slap the hand of administrators who interfered in claims administration. With the new regulations, California has maintained separation of interests, and there are additional prohibitions of conflict of interest, all of which are strengthening the California program.

Judge Taylor stated that some SIGs in California were operated by a publicly traded company, which on its SEC filings described that its profitability required the channeling of its reinsurance of SIGS into its own reinsurance company. Even that company acknowledged that in some states, its business model might be considered to be prohibited by conflict of interest. He stated that he did not want to be negative about all SIGs, but there are vulnerabilities that have to be watched for. The new regulations aim to be sure that the CPA, the actuary and the claims adjuster should not be the same as the group administrator, or if they are, that it be disclosed, and the Board of Trustees has the option to choose a different service provider.

Judge Taylor stated that there is still the problem that some of the SIGs are effectively insurance companies in which risk is being transferred, though some of the SIGs are effectively small groups of self-funded employers. These require somewhat different concerns in the process of regulating, and it would be in the best interest of the State if all of the SIGs had a common interest in elevating the level of quality and surety among them to prevent default. He stated that it might be that a separate security fund is appropriate for SIGs. SIGs have been put into the same security fund as individually self-insured employers. The nature of the risk, the concerns, and the risk of failure are quite different. Individually self-insured employers have their own risks. For example, it has been said that one large employer went bankrupt because venture capitalists acquired the corporation, bled off the assets, and left the shell to go bankrupt. Now the Self-Insured Security Fund has to pick up after that; that is different from the type of risk described for SIGs where it might be desirable to hide the losses, maximize the apparent profitability, and draw in more members. Because of the differences in risk, it makes sense to have a different security fund, a different group of employers that have an interest in common looking after their own and the standards that would be applied to them.

Judge Taylor stated that concurrent with announcing the new regulations effective Monday, OSIP has taken steps toward convening a meeting of self-insurance administrators and self-insured employers that are often left out. He stated that OSIP is moving in the right direction to get the collective insight of the people within this industry sector. He stated that perhaps one of the items on the agenda should be how to define who should be in a common security fund and whether they belong in the same fund as the large self-insured individual employers.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Questions from Commissioners

Commissioner Wei asked if they are covered by the California Insurance Guarantee Association (CIGA). Judge Taylor responded that CIGA covers insurance carriers and is under the jurisdiction of CDI. Group self-insurance is under the jurisdiction of DIR, and SIGs are today in the same security fund as the large stand-alone self-insured employers. Commissioner Wei asked if it was known how well the fund was doing. Judge Taylor responded that he did not know. Commissioner McNally stated that he knew that it was doing quite well. Judge Taylor stated that despite the bankruptcy of one of its members, the group as a whole has the capacity to absorb that situation.

Judge Taylor stated that one of the options that probably should be under consideration is the formation of a separate security fund for self-insured employers. Another option that might be under consideration is whether those SIGs that amount to insurance companies perhaps should be shifted over to mutual insurance companies under CDI. There is not a specific answer to these, but there is a recommendation to continue to explore this. Much of this could be done administratively; some of it would have to be done by legislation; for example, if there is to be a separate security fund, that would be a matter of legislation.

Commissioner Aguilar asked whether it would be a conflict to have that security fund exist as an arm of the existing one. In other words, it would be a separate fund but administered by the same group; this would be in order to save money. Judge Taylor responded that it was possible, but the correct allocation of risks might need legislation. Commissioner Aguilar asked if SIGs could come up with the action to state their own fund. Judge Taylor stated that there was some pushback on this suggestion. The CHSWC staff recommendation is to recognize that some groups are acting as insurers with a transfer of risk despite joint and severable liability, etc., whereas others are truly self-insured employers that just happen to be multiple instead of single. Commissioner McNally asked how the larger SIGS are different from mutual benefit insurance associations. Judge Taylor responded that when he asked about forming a mutual insurance company under the jurisdiction of CDI, he was informed of the requirement for raising capital to form an insurance company, and that a capital formation requirement is not present for SIGs. Commissioner Aguilar stated that SIGs have to have a security deposit but not the capital. Judge Taylor responded that this correct; that the individual members have to have a certain net worth, at least the core members.

Commissioner McNally stated that that is one of the issues, that just the core members can meet the minimum financial requirements for the SIG; that dilutes some of the meaningfulness of joint and several liabilities is that many of the smaller members might not be able to pay their share of a loss. Judge Taylor stated that some have advocated putting all of this under CDI, and in many states, it is the Department of Insurance, not workers' compensation, which regulates them. Judge Taylor stated that that change may not be necessary, since the groups may be regulated regardless of the agency. The questions are: what are the risks? and what are the tools to manage those risks? There has also been interest in the transparency of these groups. He stated that it may not be necessary to disclose individual financial information if there is an assertive and well-resourced regulator. He stated that sometimes, transparency and exposure to critics are one way to assure responsible behavior, but this is controversial. He stated that SIGs and their

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

members do not want to be exposed to too much public disclosure. Even some of the best self-insurance administrators do not want too much disclosure because then insurance companies could deduce what their rates are and could under price them. He stated that that argument does not hold up because group self-insurance is not supposed to be a competitive commodity; it is supposed to be a different model about how to meet one's obligation to secure the payment of workers' compensation.

Commissioner Aguilar stated that she wanted to make a comment about the members of the restaurant group and not have it come across as negative. She acknowledged that while there are some large chains under big brand names like Burger King or Jack-In-The-Box, six or seven of them may actually be owned by one person as one company. Judge Taylor stated that the restaurants and the members of the group can be looked up on the OSIP website. He stated that he was hesitant about naming individual groups because he does not want to generalize based on a particular group or seem to focus attention on any one particular group. Commissioner Aguilar stated that she just wanted to clarify that there are smaller groups owned by individuals.

Commissioner Steinberg asked what kind of assurances SIGs have for paying claims, and whether they have their own CIGA. Judge Taylor stated that the layers of protection for SIGs are: first, that the funds are collected and held and vested in the group available for paying claims; second, that there is the right to assess employers and some do so based on individual loss histories; there is the letter of credit deposit with DIR; ultimately, the backstop is the Self-Insurers' Security Fund, not CIGA – this fund backstops Mervyn's, for example. Judge Taylor stated that DIR has authority over self-insurance, be it group or individual self-employers. With joint and several liability, it is in the interest of those self-employers to assure that there is adequate protection. Commissioner Steinberg stated that so far, there have not been defaults. Judge Taylor stated that there have been defaults of self-insured employers; Mervyn's is the most recent. The Security Fund has never defaulted. There have been no defaults among SIGs during the seven years of their existence. Ms. Baker stated that there may be some confusion because the Self-Insurers' Security Fund assures both individuals and groups.

Commissioner Steinberg asked who oversees that backstop fund and makes sure the fund is adequate. Judge Taylor stated that the large self-insured employers have a commitment themselves to stay in business and not be threatened by the losses of fellow self-insured employers; in fact, that is the difference between them and SIGs, where members may come and go, group administrators who take a fee up front may come and go, and there is no one with "skin in the game" to the same extent as in stand-alones. He stated that, of course, there are some SIGs with "skin in the game," and not all SIGs can be characterized as being identical.

Commissioner Steinberg stated that SIGs do not call it insurance, but the AIG analogy is apt; they take on massive risk and called it a credit default swap or something else; maybe CDI should be overseeing this as it is really premium-based insurance. Judge Taylor stated that a number of states regulate all of their self-insurance by the states' Department of Insurance. With group self-insurance, some states regulate through the Department of Insurance, some through workers' compensation, and some do not allow it at all.

Commissioner Steinberg stated that an alarm bell has been set off and that the question is where

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

to go from here. Judge Taylor stated that to respond to Assembly Member Coto's request, it does not appear that it is the time to write legislation to fix anything; it may well be that a rearrangement of the Self-Insurers' Security Fund would be in order, and that would require legislation. However, the question would remain to define who belongs in each fund. Given the diversity of enterprises operating as SIGs, it is not clear if one rule will fit all. He stated that he looked forward to the convening of experts of these groups under OSIP to use their collective wisdom. He stated that when this rule making process began four years ago and the manager of OSIP called people together, one could tell which groups were interested in a secure program and which ones were out to make a quick profit. He stated that the manager knew whom to listen to, and he stated that he hoped the same process would occur again.

Commissioner Aguilar asked whether he needed the OSIP meeting in order to complete the report. Judge Taylor responded that that meeting was under the management of OSIP, which is due later in the month. He stated that Assembly Member Coto was hoping for something sooner. He stated that CHSWC staff could submit a report that is incomplete, leaving questions, but open to public comment and available to the Assembly Member. He stated that staff could also wait until the meeting, inserting questions into the discussions at OSIP, so that the Commission could make recommendations for improvements to the system.

Commissioner Wei asked what happened to the injured worker claims when Mervyn's went bankrupt and what happens to the outstanding claims in the auto insurance group. Judge Taylor responded that when Mervyn's went bankrupt, the claims were turned over the Self-Insurers' Security Fund; the Fund steps in and pays for the claims using what is there from the employer's deposit and then using its own funds. This Fund has gone from a deficit about 10 or 12 years ago to having sufficient funds to meet the demands of a defaulted member. He stated that the auto dealer group has not defaulted; their claims administrator had determined that they could not continue to do business if they could not continue to grow, and they could not grow under the current credit market. Were it an insurance company, they would be considered to be in "run-off," paying off their claims from available assets but not writing new business. Members have to find other ways to secure the payment of compensation under the Labor Code.

Commissioner Wei asked when the stakeholder meeting would be held. Judge Taylor responded that it was still being scheduled. Commissioner Wei stated that she would suggest holding off on the report until the stakeholder meeting and then putting the report out for public comment. Judge Taylor responded that he defers to the Commission or Assembly Member Coto as to whether or not to wait. Commissioner Davenport stated that it was a request from the Chair of the Insurance Committee and should be answered as expeditiously as possible. He stated that there may be a lot of questions that the Commission might want answered, but he stated that Mr. Coto's request should be answered promptly. Judge Taylor stated that perhaps the Commission would like to direct staff to release the report for public comment as soon as it is complete and to consult with the Assembly Member's office to determine if they want it wants the report completed by the 15th, or if it wants the Commission to wait until more information can be added to the report. Commissioner Aguilar stated that she wished to make a motion to do that, and Mr. Davenport seconded.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Public Comment

Joe Burgess from CHSI, the administrator of the large restaurant group mentioned in Judge Taylor's presentation, stated that one of their board members was also available. He stated that a SIG is the only provider of workers' compensation coverage in California that is required to meet an 80% confidence level is the SIG; stand-alone insurance companies and self-insurers do not have to meet that requirement. He stated that they are pre-funding reserves, and as Judge Taylor pointed out, the auto dealer SIG is not in trouble because they have adequate funds to pay their claims because of the 80% confidence level maintained as required by regulations.

Mr. Burgess stated that California has the strongest regulations in any state where SIGs are operational. He stated that there are SIGs instead of mutual companies because it is an option for that small and mid-sized employer that cannot self-insure on their own but wants to have more control and support. Referring to the earlier return-to-work presentation, he stated that the members of their SIG program have access to more services than they would ever get were they not in a SIG. There is more support on training and on return to work, and there is a triage service for every injured employee; there is a very dedicated crew that is there for them. Members have their own website to go to get resources and the information they need. The members are motivated in these programs to do everything they can to improve safe workplaces and to control costs. He stated that because SIGs have to meet an 80% confidence level and because they are so dedicated to loss prevention and management, SIGs should be an important part of the future of California workers' compensation.

Mr. Burgess stated that his group is not opposed to a separate fund; he stated that he thinks their fund is safer than stand-alone self-insureds' funds. He stated that if California were to examine new regulations, he suggests consideration for all stand-alone self-insureds and insurance companies to meet the 80% confidence level. He stated that the reason insurance companies are talking about SIGs so much is because they are the competitors of SIGs. SIGs take the members who perform the best; those are good risks for insurance companies. He stated that that is why insurance companies are the competition that wants to see SIGs not do as well. He stated that SIGs are going to be active on these issues because they believe in SIGs; especially in these hard times in California, employers need every bit of support and help they can get.

Mr. Burgess stated that in reference to Judge Taylor's remarks about New York that it is a completely different from California: their regulatory environment was poor; the regulations were poor; and regulators were "asleep at the switch." He stated that there should be no self-administration of claims allowed; California has never allowed it and there should be a separation of service providers and that should continue. He stated that they should also consider disallowing self-insureds to self-administer, because that is the area where you could have the greatest vulnerability when a Chief Financial Officer can come in and tell a risk manager that they need to bring reserves down immediately. SIGs have to be at 80%; they are audited by the State regularly. He stated that he believes that the mistake SIGs have made has been to not communicate sufficiently. He stated that the meeting by OSIP is being proposed for April 13th, 15th and 16th, that dialogue is good, and that hopefully, the meeting will be a beginning of dialogue.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Don Balzano, General Counsel at Medex Healthcare, stated that they administrate health care organization (HCOs) and medical provider network (MPN) programs. He stated that he does not represent any self-insured groups; however, he stated that they had HCO services in seven SIGs in the State. He stated that the SIGs they deal with are extremely involved and just by putting in an HCO, there is a lot of work to try to ensure a higher quality of care and better return to work, as the Chair McNally knows. He stated the Boards of Directors of the SIGs they work with are extremely involved, and they are constantly overseeing their auditors and claims administrators. He stated that one of the SIGs they have was the auto dealers and unfortunately, since they cannot obtain a surety bond, their SIG is going out of business. He stated that from their perspective of an HCO and MPN, the dedication of the groups probably surpasses most of the carriers that they deal with. He stated that those SIGs are at a level of the large self-insureds, and that SIGs do get the same sort of service that the large self-insured have by coming together. He stated that some groups have been in existence for over 20 years in a lot of other states and in California just since inception, and they are doing very well. He stated that some groups have members of 5,000 employees ranging down to 10 employees; for example, there is a trucking association where there are members that only employ 2 or 3 people. If it were not for SIGs, they would not be able to put these services together for themselves.

Clay Jackson, President of Affinity Group Administrators, a group administrator for two SIGs in California, stated that many of the concerns that were made by Assembly Member Coto have already been addressed in the new regulations. He stated that since the process started almost four years ago, those regulations have sometime languished and never moved. It was disappointing that it took four years, but he stated that they are happy that the new regulations are out. Involved in the meetings to discuss the regulations were Judge Taylor, Commissioner Wei, and many members of group administrators and third-party administrators (TPAs). He stated that the new regulations already address the concerns; after input from many groups, they were ultimately written by DIR. He stated that two independent separate managers from OSIP have been involved: Mark Johnson who drafted the initial regulations; and James Ware who independently from Mark Johnson worked with the Office of Administrative Law (OAL) for the past year to get them through. He stated that many of the concerns have been met; they include firewalls between the various service providers, between group administrators, TPAs, the actuaries, and the independent auditors to make sure the laws are complied with; there are independent eyes on all aspects of SIGs.

Mr. Jackson stated that as far as transparency, it has been his firm's contention that Security Fund is the appropriate entity to inspect and review what OSIP and DIR are doing. If a SIG were to ultimately fail, the Fund would step in and provide coverage to the SIG's member employees. He stated that his group has been very vocal in attempting to obtain openness of their books, providing independent audits and actuarial reports to the Fund.

Mr. Jackson stated that if there were a regulation revision -- the effort which he stated that he has been working on with Mr. Pettigrew and also Mr. Ware, to revise the regulations even from this current adoption -- to allow the Fund to have access to SIG books before a SIG is in trouble, that would address many of the concerns of Assemblyman Coto. He stated that there will be a discussion at next month's meetings which will probably be held on April 16th.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Mr. Jackson stated that SIGs are indeed funded at 80% plus expenses, plus administrative costs, so that unlike insurance companies that are required to be funded "at expected," SIGs are required to be funded at an actuarial 80% confidence level, and on top of that there are expenses. He stated that: SIGs are mandated to have specific excess insurance coverage that stand-alones are not mandated to have; SIGs have independent audits; SIGs are not public entities; they are not made up of public entities, as are JPAs; so it is important to note that, unlike JPAs, where transparency is good because there are so many laws that allow transparency in government, private entities are not required to have transparency; there is no request being made that stand-alone self-insurers provide their books to the public. He stated that maybe if there were a requirement, then there would not have been the Mervyn's debacle. However, Mervyn's has happened, and the Fund is now on the hook for \$20 million. If there were to be SIG transparency and an opening of SIGs's books to the public, then he would agree with Mr. Burgess that all self-insurers should provide their books to the public so that all of self-insurance is treated equally.

Mr. Jackson stated that lastly, he would like to thank Judge Taylor and Ms. Baker for their work on this and that he is grateful to the Commission for taking the time to hear public comments today. He stated that he would recommend that if there were a motion, that it would allow for a complete report to go to Assemblyman Coto and the Insurance Committee, and not just a status report, because they are meeting next month, even though that it is after the deadline. He stated that Assemblyman Coto allowed in his request a continuance of the final deadline if it were necessary; he would ask that they take that continuance and allow the staff to complete their work.

Mike Whitehurst stated that he is a Burger King franchisee who owns seven Burger King restaurants in Union City, Hayward, San Leandro and Oakland. He stated that in the years 2000-2004, he paid over half a million dollars in workers' compensation premiums and approved around \$50,000 in claims. He stated that in 2003 and all of 2004, he met with five Burger King franchisees and three McDonald's franchisees multiple times in the month. They also met with CHSI who is their current administrator. He stated that they chose CHSI because they have a SIG in Nevada with Burger King franchisees, and they are very pleased with their performance. On January 1, 2005, they opened the California Restaurant Mutual Benefit Corporation. He stated that they currently have \$1 billion in restaurant employee payroll covered. He stated that if 5 Burger King and 3 McDonald's franchisees can get together on anything, you can see that there is a great need. He stated that they have met monthly over the past 4 1/2 years; at the Board of Director's meetings, they discuss the proposed versus actual budget. They review every claim over \$30,000, and they review every new member that comes in. He stated that any fast food franchisee knows how to read a budget. He stated that they have emails constantly when there is a new member coming up. They approve each new member themselves. He stated that the founding Board of Directors has complete oversight over the administrator.

Mr. Whitehurst stated that they have a contract coming up at the end of this year, and they will either renew or go with somebody else. He stated that apparently there was some concern that some of these SIGs are running around at the bequest of their administrator; he stated he did not understand that. He stated that they are very happy with CHSI; their claims control is phenomenal. He stated that he would be happy to have CHSWC talk about the California Restaurant Mutual Benefit Corporation; he stated that they would be happy with any scrutiny.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Mr. Whitehurst stated that he was very happy with the oversight by OSIP; he stated that he thought it is very burdensome and heavy-handed. He stated that he had been concerned about joint and several liability until he opened their doors on January 1st. He stated that the flood of restaurateurs that came into their group was phenomenal, which simply shows the need. He stated that they did this to improve their own workers' compensation costs and to have control; he stated that he was tired of giving half a million dollars to a big insurance company.

Mr. Whitehurst stated that they have offered over \$14 million in dividends in the past three years. He stated that he could not imagine going back to ask the members for any other funds. They have a half a million dollar excess insurance, so they would have to cover the first \$500,000. He stated that they could handle probably 30 of those events, such as an earthquake or a terrible shooting.

Commissioner McNally stated that he has a few comments. He stated that in the interest of full disclosure, he sits on the board of the Self-Insurers' Security Fund and he is intimately aware of this issue. He stated that he wanted to thank the three representatives of the SIGs for their comments. He had heard many comments that were articulated before, but he particularly appreciated what Mr. Burgess had to say about return to work and the importance of the ability to facilitate that with the administrators and the group. He stated that return to work is an incredibly important issue, and there is a huge disconnect between the insurance industry and employers. The small and medium-sized employers do not get any assistance in that program; there are no insurance company incentives to help employers to get people back to work although it might reduce exposure for permanent disability and that it reduces premium. He stated that he fully agreed with Mr. Burgess that the insurance industry is making this an issue because SIGs are the better risk, and they would like to see those members buying insurance policies. He stated that he believes that the New York situation has besmirched SIGs nationwide, and that in this economy, it makes SIGs an easy target. He stated that his comments do not mean that they do not have to continue to look at the scrutinies and transparencies.

Chair McNally stated that there is a motion to release the report for public comment when complete and for CHSWC staff to contact Assembly Member Coto's office to see if it would like the report completed as is or deferred until there are further developments to meet the Assembly Member's timeline. Chair McNally added that CHSWC staff should ask the Assembly Member's office to allow the extra time, which is the Commission's preference.

CHSWC Vote

Commissioner Aguilar moved to approve the release of the Draft Self-Insurance Group Interim Report when complete for circulation and comment and to ask Assembly Member Coto's office if he would like to see the report completed as is or deferred until there are further developments to meet the Assembly Member's timelines, and Commissioner Davenport seconded. The motion passed unanimously.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Briefing on Premium Fraud

Frank Neuhauser, UC Berkeley

Mr. Neuhauser stated that a couple of years ago, the Commission funded a study on fraud in the workers' compensation system, done by the UC, Berkeley looking at under-reporting and misreporting of workers' compensation payments (payroll). Subsequently, the Fraud Assessment Commission (FAC) asked the UC Berkeley to extend that study from 2002 to 2005, which was the latest data available at the time.

Mr. Neuhauser stated that in 2002, workers' compensation "pure premium" rates ranged from \$0.36 to \$42.07 per \$100 payroll. Actual premiums are about 50% higher than that after insurer charges. Premiums averaged about 6% of payroll in 2003. The question is, to what extent do employers attempt to fraudulently avoid these premiums either through under-reporting or misreporting payroll. Mr. Neuhauser stated that a lot of under-reporting was found in the study for the Commission through 2002 when rates were beginning to peak in 2002-2003. He stated that the FAC wanted to see if reporting would improve following the reduction in premiums. Another question was whether in response to higher premiums, employers chose to use non-standard employment relationships to avoid premiums. Employers could misreport or underreport premium, or they could choose to classify workers as independent contractors, which could be a violation of California's strict standards regarding employment contractor laws.

Mr. Neuhauser stated that there was a change in payroll reported to insurers and a change in the premium rate. He stated that there is an immediate indication that payroll responds to premium rates; as premium rates increase, reported payroll growth declines, suggesting that employers hide payroll when premiums are high. Controlling for self-insurers and economic characteristics, the relationship remains strong and is most dramatic when premium rates were high.

Mr. Neuhauser stated that there are incentives for employers to cheat: they might not report all or part of payroll; and they might mis-report the type of employees as, for example, an office employee under 8810 (professional and clerical worker). During this period, 8810 rates for clerical were very low, at about 90 cents per \$1.00 of payroll compared to roofers at \$40 per \$100 of payroll. Mr. Neuhauser stated that if employers do cheat, either payroll reported is below what is expected due to under-reporting or over-reporting in some of the lowest-cost classes will occur, as people switch payroll from the high-cost classes to the low-cost classes or, more likely, both occur.

Mr. Neuhauser stated that they estimated the true payroll by using the Current Population Survey (CPS), which is the large survey that the Census Bureau conducts every month, covering about 60,000 households, which is where unemployment insurance numbers and health insurance coverage numbers come from. Mr. Neuhauser stated that they take what workers report as payroll and occupation and industry and then classify them in class codes in order to state what the appropriate amount of payroll is that would be reported; that is then compared with what is reported to insurers in the same classes. The study looked at the years 1997 to 2005, emphasizing the period between 2001 and 2005 when premium rates peaked and subsequently declined. As a caveat, he stated that not all payroll should be reported to insurers; some payroll is excluded, such as over-time and the high payroll (over \$80, 000) of executives who are officers of a firm. He stated that it is unclear what the appropriate exclusion for these classifications is, either 11%

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

or 8%. He stated he believes it is 8% and that the Workers' Compensation Insurance Rating Bureau (WCIRB) thinks it is 11%, if not more. In 2001-2002, under-reported payroll was between just under 4% before the premiums started to peak, then went up to about 12% in 2003 policy year when premiums were peaking, and then declined in 2005. He stated that the decline in premiums has led employers to improve their reporting, but it still remains substantially out of compliance with full reporting. He stated that by any count, a substantially large fraction of payroll is under-reported by insured employers.

Mr. Neuhauser stated that many people think that payroll reporting is fraud perpetrated against insurers. To a large extent, that is not quite true. In any individual instance, it is fraud perpetrated against the insurer; however, overall, it is fraud perpetrated against honest employers. He stated that under-reporting payroll means that premiums are higher, and insurers in the long run are covering their costs. He stated that those employers who are accurately reporting payroll are at the greatest disadvantage and, consequently, they are subsidizing the insurance costs for employers who are under-reporting or misreporting. He stated that there are few incentives across insurers to substantially improve reporting, except in individual cases where there might be some value. There are very few incentives for insurers as an industry to pressure improvement of under-reporting.

Mr. Neuhauser stated that reporting by riskiness of profession, or the riskiness of the class codes, is important. Class codes can be broken into five groups, from the least risky to the most risky, with the most risky class codes including many construction industries, roofing, etc., and the least risky class codes including real estate offices and software firms, etc. He stated that what is found at the low end is over 100% for reporting of premium for the lowest 20% of class codes by cost. This means that there is more payroll reported in those class codes than there is actual payroll, which can only be misreporting from higher-risk class codes to lower-risk class codes. He stated that as one moves to the highest class codes, less than 50% of payroll is reported, and that is an average, as some class codes have less than 50% reporting.

Mr. Neuhauser stated that medical costs that are reported for the highest- class codes are about three to four times what they are in the lowest class codes, about what would be expected in employer premium rates, if there were full reporting, though premium rates are many times higher than this.

Mr. Neuhauser stated that the FAC was also interested in whether employers were avoiding premium by classifying workers as independent contractors to avoid both paying premium and financing accidents when they occurred. He stated that the study did not find evidence of that. The fraction of self-employed workers and independent contractors over the period between 1997 and 2005 did not change very much. There might be a violation of California standards; however, although one might expect to see self-employment rise when there is an increase in premium, there was no spike.

Commissioner Wei asked how to determine who is self-employed, and Mr. Neuhauser stated that it is according to the respondent's self-reported employment status. Commissioner Wei asked if the graph shown indicates the trends of self-employment over time, and Mr. Neuhauser responded that it does and that there is not much of a trend; self-employment actually declined during the 1990s.

Mr. Neuhauser stated that between \$15 and \$68 billion of payroll are unreported; this is about

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

4% to 12% in total wages that should be reported for the purposes of premium setting. He stated that many more dollars may be misreported into the less risky class codes so that there is substantial under-reporting in the more risky class codes. Mr. Neuhauser stated that WCIRB has one of the strictest “test audit” programs in the country; however, it is still not that strict. It gives free rides to many large employers, although they are auditing those now. The results of the audit are not available to the public or to the public members of the governing committee. The test audits are not available for wider examination, so this process is generally not very transparent. He stated access to the audit results could be requested or at the very least, access to the audit results could be requested to confirm whether the compliance errors are always on the side that provides advantages for the employer. He stated that while errors are to be expected, if there is no fraud, it would be expected that the errors would be randomly distributed among the class codes. He stated that he would suspect that they are not randomly distributed, but there is no access to that information from the auditing process.

Mr. Neuhauser stated that employers would like to have, and he assumes that honest employers would also like to have, access to Employment Development Department (EDD) unemployment insurance records where employers report payroll, in order to match against what is reported for premium purposes. This would be a simple check, inexpensive and easy to do, but it is not allowed under current law.

Mr. Neuhauser stated that in high-risk professions where rates are very high (as much as 200-300% too high), employers might have to identify prospectively the employees that are covered under the insurance program, rather than retrospectively when they get injured. He stated that when you look at the data, many workers get injured on the first day on the job and that he would suspect that it is not due to the first day being dangerous, but rather it is the first time that employment is recorded. He stated that in group health, the provider knows in advance that a worker has coverage (that premium is paid), and that employers could verify coverage for high-cost occupation workers. It is a reasonable and cheap way to correct substantial under-reporting.

Public Comment

Carol Reed, Deputy District Attorney from Monterey County, stated that she prosecutes workers’ compensation fraud, including premium fraud. She stated that while the Commission looks at the issue on the civil side, she wanted to offer a perspective from the criminal side. She stated that there is an incentive for employers to cheat by not having workers’ compensation insurance. This is a misdemeanor per Labor Code Section 3700.5. There is a problem when an injured worker’s employer does not have coverage and the employer might directly take over treatment. If the injured workers need further care, he or she can go to the Workers’ Compensation Appeals Board (WCAB), which means that taxpayers are being obligated. At times, legislation has been considered to make it a felony, and she urged the Commission to think along those terms. She stated that she knows of a case in which a worker was a victim of a crime at work and then is victimized a second time by the employer when there is no workers’ compensation coverage. She stated that an employer in a case she is thinking of did not initially pay for the coverage, so when the employee needed further care, he or she could not get it.

Ms. Reed stated that there are certainly “wobblers” that could be charged as felonies under the

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

penal code; there is a concealment under section 550, but in order for there to be a concealment, there has to be an insurance company involved, someone you are concealing it from. She stated that she did not know how that is applicable for employers that are uninsured. She stated that for Insurance Code 1871.4 to apply, there has to be a false or fraudulent statement from the injured worker. She stated that she is going forward on case that is a misdemeanor, which has an onerous fine associated with it. She stated she has another injured worker who is a victim of another crime but there is no charge, and the only remedy is to go before the WCAB.

Ms. Reed stated that looking at premium fraud at the application stage could benefit by a connection with the EDD. She stated that she has done joint operations with EDD, where they can get EDD records. However, in the application stage, the employer only has to provide numbers not definite names. If there were exact names, they could be matched with EDD records. She stated that in the underground economy, she sees employers using independent contractors and classifying them; she stated that they ask questions that identify workers as employees and not as independent contractors, as they are receiving cash in a lot of cases. She stated that some of these employees are also often also collecting welfare, disability, and unemployment insurance. Many are in neighboring counties, with one home address in one county but working in another county for cash. She stated that this type of fraud is costing all taxpayers. She offered to help the Commission identify employers who do not carry workers' compensation insurance and to be able to match records with EDD. She stated that Fraud works against honest employers, but there is also a huge impact on taxpayers.

Commissioner Davenport stated that his union contributes to a labor-management trust fund, and they go after the lack of coverage cases. He stated that they too think it should be made a felony and thereby be taken seriously. He then asked Mr. Neuhauser what exactly he suggested in terms of additional cooperation from WCIRB. Mr. Neuhauser responded that the test audit program is as good as any other in the country, but that the country has not set a very high standard. He stated that the program goes out and tests whether insurers are auditing in an appropriate way, not whether the payroll is being reported correctly, so there are some gaps. He stated that when the test audit program finds errors, and it finds errors in 40% of the audits, there is no information released to WICRB public members (4 of them). Sometimes an action is taken against the insurer, but the public members are not aware of it, the public is not aware of it, and the insurers essentially get a free pass. He stated that he thought there was a lot of information that could be made available to the public members, so one could assess how actively WCIRB and insurers are working, because they are working for employers to protect honest employers and keep the rates reasonable. He stated that it should not be seen only as an effort to protect the insurers from violations; it is really meant to protect good insurers from bad insurers. Workers get hurt by not receiving benefits in many cases when they are hurt, not insurers who have a lot of flexibility about not writing policies or raising rates.

Ed Walters of QBE, the Americas Group, a multi-insurance group, stated that fraud is rampant throughout the U.S. He stated that it not only hurts the State of California and federal and state tax dollars but it also undermines the whole system. He stated it also makes it difficult to provide a safe work environment. Insurers are not receiving the appropriate amount of money because they are not receiving the appropriate amount of premium. He stated that there are problems in California with enforcers who are not really educated on claims fraud. For example, with an

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

8810, a clerical worker, he will see a claims report where the worker fell 40 feet. He stated that his reaction is to be open-minded and that he will talk to the individual in the hospital and find out that the worker was an iron worker, or that he was an executive supervisor, when he was actually a foreman. He stated that this is rampant in California. He stated that they usually catch these cases. He stated that enforcers do not really understand the insurance business and this hurts everyone. Losing money means there is less money available for programs that prevent injuries.

Steve Catollica, of California Society of Industrial Medicine and Surgery (CSIMS) and California Society of Physical Medicine and Rehabilitation (CSMPR), stated that he represents several physicians and provider groups across the State. He stated that he had a technical question about page 13 of the handout, the bottom slide addressing average medical costs by class codes, and that he did not understand why the vertical axis was labeled percentage growth. He stated that it implied that the 5th decile medical costs were growing at 200%. Mr. Neuhauser stated that that is not the case and that with 10% of class codes, the average payroll will be .6 of 1% of payroll, or 1.2% of payroll. Mr. Catollica asked that that be better labeled to avoid confusion. Mr. Neuhauser agreed to do so.

Ms. Baker stated that this was an FAC study and there is no vote or action on this item.

Briefing on First Aid Study

Christine Baker, CHSWC
Lachlan Taylor, CHSWC
Juliann Sum, UC Berkeley

Ms. Baker stated that at the November 6, 2008 meeting, the Commission requested that staff prepare an Issue Paper on first aid and reporting criteria and that an Advisory Group be convened to discuss issues and potential solutions to problems with reporting first aid cases. The Issue Paper and an up-to-date booklet on the current law for reporting occupational injuries and illnesses for workers' compensation and Cal/OSHA were prepared, and suggested legislative language was drafted. The Advisory Group met on January 9, 2009. Stakeholders discussed ways to assure appropriate medical care, reduce administrative costs, discourage fraud by defining the process more clearly, and even the playing field for employers. Key issues include the fact that first aid cases are in a gray zone which can lead to opportunities for error, and there is often inconsistent treatment of first aid cases across different systems, such as OSHA and workers' compensation, as well as across first aid cases within workers' compensation.

Ms. Baker stated that suggestions from Advisory Group participants included the following possibilities:

- Develop a single definition of first aid that reflects Cal/OSHA's definition but retain the last sentence of the current definition of first aid addressing toxic chemical exposures.
- Do not make any changes to existing thresholds.
- Develop an educational factsheet.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

- Ensure that there are resources available to make any changes part of public information.
- Conduct further discussions about equity issues that arise when employers double pay (i.e., pay for first aid directly and pay through increased insurance premiums).
- Investigate and review the State of Oregon's handling of first aid cases.

The recommendation is for approval for circulation and comment and final posting if comments are not received. The legislative language is introduced as a spot issue. There still needs to be some fine tuning and revision of the language. Although the language that was submitted as a bill currently has errors and needs revision, stakeholder input is also required.

Chair McNally asked how stakeholder input would be encouraged. Ms. Baker replied that the process would include posting the report, and CHSWC staff would continue to have dialogue with stakeholders directly to get feedback. Commissioner Wei asked which stakeholder had put in the legislative language, and Ms. Baker replied that it was Small Business California, which was part of the Advisory Group. Judge Taylor commented that the language was intended to reflect the agreement by the Advisory Group that there should be a single definition of first aid; the particular language may need to be revised to best express this and to cope with any unintended consequences there might be. Ms. Baker stated that Juliann Sum provided key technical support for developing the report, along with CHSWC staff.

Chair McNally asked if there was general consensus by the Advisory Group on whether there should be a single definition and what that would look like. Judge Taylor responded that the Advisory Group agreed that there should be a single definition and it should move close to the Cal/OSHA definition only retaining a couple of necessary deviations.

Public Comment

None.

CHSWC Vote

Commissioner Wei moved to approve for circulation and comment the Draft Summary of January 9, 2009 First Aid Cases Advisory Group Meeting report and to post the final report within a month if no comments are made, and Commissioner Thacker seconded. The motion passed unanimously.

Executive Officer Report

Christine Baker, CHSWC

Ms. Baker introduced the new CHSWC staff manager, Denise Vargas, whose key responsibilities include tracking contracts, costs and budget issues. Ms. Baker also commented that staff is continuing to be as productive as usual despite two days furlough a month.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Worker Occupational Safety and Health Training and Education Program (WOSHTEP)

Ms. Baker stated that the Commission held its Worker Occupational Health and Safety and Health Training and Education Program (WOSHTEP) labor-management Advisory Board meeting this week. She stated that in addition to UC Berkeley and UCLA, UC Davis is now part of the program. Advisory Board discussion covered areas that will be pursued in the next year as well as accomplishments to date. Now that this program is well stabilized with a successful curriculum and materials, a proposal with a multi-year core contract will be submitted at the next meeting. This would save on administrative contract costs and further stabilize the program. New activity will be covered under a separate year-to-year proposal for approximately \$100,000, which will also be submitted at the next meeting.

Liens

Ms. Baker stated that over the years, the Commission has examined the lien problems of the boards. Legislation was introduced several years ago to ameliorate the problem. One of the consistent administrative problems that DWC has faced is the backlog of lien claimants and the increasing number of filings. Many of the liens are for medical treatment and medical-legal reports. However, liens are also filed to obtain reimbursement for other expenses.

Ms. Baker stated that in the past, CHSWC convened several roundtables and that led to legislation. Since 2000, there were about 347,101 liens that were filed; in 2008, there is a projection of 985,123 liens. These liens clog the boards and make them into bill review payment boards, rather than boards addressing key issues. CHSWC would like to work with DWC and the Workers' Compensation Appeals Board (WCAB) and anyone else who wishes to participate to conduct a new investigation into what should be the next steps to address the backlog and the lien filing problem and make some additional recommendations.

CHSWC Vote

Commissioner Thacker moved to approve that an investigation be done, working with the DWC and WCAB and others who wish to participate, to look at the next steps for addressing the backlog and the lien filing problem and to make recommendations, and Commissioner Aguilar seconded. The motion passed unanimously

Green Jobs and Worker Safety Conference

Ms. Baker stated that the issue of jobs and the environment has achieved national prominence in the past year during the current confront critical economic and environmental crises. Proposals to create green jobs to address both crises simultaneously have been promoted at the national, state and local levels and are accompanied by prominent media coverage.

Ms. Baker stated that too often the proposals do not include a health and safety component for workers employed in green jobs. It is not known if green jobs are safer than other jobs. The Commission has been asked to jointly sponsor a conference with the University of California, Los Angeles (UCLA) on the environment, green jobs and worker safety. UCLA has been

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

working in the area of green jobs and working with the building trades. The Commission would fund the program up to about \$5,000, which would allow the Commission to help with the agenda, prepare speakers and participate in the conference.

Commissioner Wei asked if the role of the Commission would be to look at the health and safety aspects of green jobs, and Ms. Baker responded that it would be.

CHSWC Vote

Commissioner Wei moved to approve that the Commission fund the UCLA conference on green jobs and worker safety up to \$5,000 and to participate in the conference, and Commissioner Aguilar seconded. The motion passed unanimously.

Underground Economy Study Re-Design

Ms. Baker stated that the Commission has funded a project at the UC Berkeley to analyze the underground economy and the effectiveness of enforcement efforts by the State of California against employers that go uncovered for workers' compensation insurance, violate safety and health standards, and fail to comply with other wage and hour and reporting requirements. Ken Jacobs and Frank Neuhauser at UC Berkeley have been working closely with the several state agencies that will be involved, EDD, Department of Labor Standards Enforcement (DLSE) and Occupational Safety and Health Administration (OSHA). It is difficult to obtain the data needed to make a methodological assessment of the extent of the underground economy.

Ms. Baker stated that a re-design is proposed that would be more cost-effective. Frank Neuhauser stated that the re-designed study would be able to estimate the effect of (DLSE enforcement efforts. The challenge is that DLSE does not have resources to re-engineer the way they conduct enforcement to do some random inspections; instead, the study will evaluate different strategies that DLSE has used and then propose to DLSE more effective methods of conducting enforcement. This might help identify non-compliant employers and get other employers in the same area to be in compliance.

Commissioner Wei stated that a key to the problems is that the Labor Commissioner does targeted, planned inspections and not random inspections so that there is no threat to employers for being out of compliance. Mr. Neuhauser agreed that the inspections are all targeted and there is no real threat to employers to be out of compliance.

Commissioner Aguilar stated that the study would benefit DLSE, but asked whether FAC would be involved. Commissioner Davenport asked who is paying for the study and asked whether other units interested in the underground committee are participating and funding the study. Ms. Baker stated that the FAC felt it had to dedicate resources to other efforts.

Commissioner Wei stated that the tip of the underground economy is the lack of workers' compensation coverage; this area is easier to address than other key areas, such as wage and hour violations.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Partnership with the California HealthCare Foundation

Ms. Baker stated that during a recent integration of care project funded by the California HealthCare Foundation (CHCF), estimates of the administrative costs related to the delivery of workers' compensation medical treatment were developed. These costs were compared to administrative costs of delivering medical care under private health insurance coverage. The estimates for workers' compensation were derived using a "top down" approach; that is, premiums employers pay were compared with direct medical payments made to medical providers.

Ms. Baker stated that during the numerous presentations given under the CHCF grant, these very large administrative cost estimates for the workers' compensation program met with considerable skepticism, if for no other reason that they seemed incredible because they were so high. Most importantly, the numbers lack explanations for how this large fraction of employers' premiums is actually spent. Frank Neuhauser and team have put together a new grant, approved by CHCF, and this grant needs a supplement.

Ms. Baker stated that the Commission's role once the report is finalized would be to conduct advisory roundtables, discuss feedback, and prepare roundtable reports. Up to \$5,000 to \$10,000 in technical assistance may be needed in addition to in-kind work.

CHSWC Vote

Commissioner Davenport moved to approve that the Commission partner with the California HealthCare Foundation to fine tune and estimate administrative costs in the delivery of workers' compensation medical care and group health, with an estimated work-in-kind and up to \$10,000 in technical costs, and Commissioner Aguilar seconded. The motion passed unanimously.

En Banc Decisions

Ms. Baker stated that two recent en banc decisions have greatly affected the workers' compensation system, and CHSWC staff has begun to estimate their impact on the boards, the costs and the system. Judge Taylor stated that in 2004, Senate Bill (SB) 899 provided that permanent disability ratings should be based on the *AMA Guides* and on future earning capacity factors. The rating schedule adopted by the AD is only *prima facie* evidence. The old schedule was not conclusive, but most injured workers could predict the outcomes and settle. The old schedule was treated as if it were conclusive in most cases; only a few cases, the Le Boeuf cases, went seriously outside the schedule.

Judge Taylor stated that with the new and unfamiliar schedule, it was predicted that there would be a lot more uncertainty about case dispositions and less efficient settlements despite the effort of SB 899 to make the system more efficient. WCAB found that the *AMA Guides* and the future earning capacity factors are rebuttable, and individual cases may be evaluated by using impairments which are determined only in partial reliance or without reliance on the *AMA Guides*, and the future earning capacity factors can be calculated without reliance on large-scale studies, such as the RAND study on permanent disability.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Judge Taylor stated that the impacts will likely be that getting through a permanent disability trial will be far more complex and far more time-consuming and the WCAB will be backlogged. There will still be cases that can be settled, but those cases where the worker has not gone back to work will get litigated, so return to work will be more important for employers, because without it, there will be time-consuming and costly trials. Judge Taylor stated that Commission staff is working with WCIRB, Frank Neuhauser and others to estimate the effects of these cases on the workers' compensation system. There could be greater delay in decisions for injured workers, much more litigation and much less premium dollars winding up in benefits to injured workers.

Chair McNally asked if there is a possibility that premium dollars will go up, and Judge Taylor responded that that could be true. Chair McNally stated that the other problem would be that there is no realistic way to reserve for future permanent disabilities and insurance companies would take a much more conservative approach on that. He also stated that he would not be surprised to see workers' compensation premiums going up, and Judge Taylor responded that he would not be surprised to see a mid-year rate increase. He stated that this has been a frustrating situation, with quite a bit of dissatisfaction about the existing schedule and a lot of uncertainty about what would rebut decisions. These two unanimous decisions might reflect pent-up frustration with the 2004 legislation and its implementation.

Commissioner Wei asked if these decisions were unanimous, and Judge Taylor responded that they majority were. Commissioner Wei asked if all of the WCAB judges are Governor Schwarzenegger appointees, and Judge Taylor stated that five out of seven were appointed by the governor. A member of the public stated that only one decision was unanimous, and Judge Taylor responded that that was correct. Judge Taylor stated that when it is not possible to predict outcomes, it is difficult to develop a position for negotiation. He stated that it is not clear if this will hurt one side more than the other, but that he did not see this as being good for any of the stakeholders in the workers' compensation system.

Chair Wei stated that an unfairly compensated permanent disability rating schedule is not fair for anyone in the system; until there is a fair permanent disability system, this may be the only reaction possible. Judge Taylor responded that the Commission voted in February 2006 that the schedule be revised to be acceptable to all the key stakeholders and that when it was revised, it should be made conclusive for most cases. That did not happen, and the current decisions are the consequences of that situation.

Return-to-Work/FEHA/ADA Guidebook

Ms. Baker stated that return to work after an injury or illness is important for employers and workers and their families in the State of California. Efforts are needed to reduce litigation, reduce friction and provide information to employers, particularly small employers who have the most difficult time complying with requirements regarding return to work. Improved information for all system participants about the requirements of the Fair Employment and Housing Act (FEHA) and the Americans with Disabilities Act (ADA) will be critical to efforts to improve return to work in California.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

Ms. Baker stated that several stakeholders have requested information to help workers and employers meet their responsibilities under FEHA and ADA. John Duncan, Director, DIR, has requested that the Commission work with the Department of Fair Employment and Housing (DFEH) and partner with DWC on a new guidebook on return to work, FEHA and ADA.

Ms. Baker stated that at the November 6, 2008 meeting, the Commission voted to proceed with this project. An Advisory Group meeting was held on December 9, 2008, with stakeholders from the workers' compensation community and representatives from DFEH.

Ms. Baker stated that the purpose of the Guidebook is to improve return to work and improve information for workers and employers in order to reduce confusion and litigation. Advisory Group recommendations included that the Guidebook should address all parties, not just employers, and clarify roles and responsibilities, as well as provide resources, including resources already in place. The Advisory Group emphasized that an affirmative approach to return to work is needed with FEHA being the umbrella for it. CHSWC staff is working closely with DIR, DWC, Juliann Sum, of UC Berkeley, and key stakeholders to develop the Guidebook.

Public Comment

Robin Nagel, Kaiser Permanente, stated that she represents an ad hoc group of California stakeholders interested in stay-at-work/return-to-work issues, which includes employers, health care providers, return-to-work coordinators, insurers, labor and other interested parties. She stated that it is time for the State of California to be very outspoken on behalf of California employers and workers, addressing all stakeholders at once. It is also important to assert the value of work in the lives of California families and the necessity for safe and healthy workplaces. There are many enthusiastic stakeholders who support efforts to keep people working safely and productively. She thanked the Commission for its support of these efforts at a time of great need in California.

CHSWC Vote

Commissioner Aguilar moved to approve the Draft Summary of the December 9, 2008 Return-to-Work/FEHA/ADA Advisory Group Meeting Report for circulation and comment and to post the final report within a month if there are no comments, and Commissioner Davenport seconded. The motion passed unanimously.

Other Business

None.

Adjournment

Commissioner McNally stated that the next CHSWC meeting is scheduled for April 30, 2009, in Oakland, at 10:00 a.m.

MINUTES OF CHSWC MEETING
March 5, 2009 Oakland, California

CHSWC Vote

Commissioner Davenport moved to adjourn the meeting, and Commissioner Aguilar seconded. The motion passed unanimously.

The meeting was adjourned at 1:35 p.m.

Approved:

Sean McNally, Chair

Date

Respectfully submitted:

Christine Baker, Executive Officer

Date