

The California Commission on Health and Safety and Workers' Compensation



A Report on Health Care Organizations (HCOs) in Workers' Compensation

**Prepared at the Request of
Assembly Member Rick Keene**

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April 6, 2006

Commission on Health and Safety and Workers' Compensation
A Report on Health Care Organizations (HCOs) in Workers' Compensation

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INTRODUCTION AND SUMMARY

This report was requested by Assembly Member Rick Keene to address the effectiveness and viability of Health Care Organizations (HCOs) and compare this model for medical care delivery with Medical Provider Networks (MPNs) and with the employee-choice model for provision of medical treatment in workers' compensation.

The October 25, 2005 letter to the Commission on Health and Safety and Workers' Compensation (CHSWC) from Assembly Member Keene is included as *Attachment A*.

In this report, CHSWC finds:

- Health Care Organizations (HCOs) have the potential to reduce costs for employers.
- HCOs have the potential to improve the quality of medical care and reduce time lost from work for employees.
- The data reported by some HCOs suggest that HCOs can fulfill the potential to reduce costs and reduce time lost from work.
- Sufficient data have not been systematically collected by the State to definitively evaluate the costs and benefits of HCOs.
- The market viability of HCOs is jeopardized by the introduction of Medical Provider Networks (MPNs) that allow employers longer control over medical costs through Preferred Provider Organization (PPO) containment without the regulatory fees that are currently imposed on HCOs.

CHSWC recommends legislative changes to make HCOs more competitive and compatible with MPNs so that both options remain open to employers until research and experience can demonstrate the preferred system for providing medical treatment.

FIVE MODELS FOR DELIVERY OF MEDICAL TREATMENT

Four general options are available for employers to fulfill their statutory obligation to furnish medical treatment for industrial injuries. (Unless otherwise indicated by the context, "employer" is used here to include a self-insured employer or the insurer for an insured employer.) The options differ primarily in who has the control over selection of treating physicians.

- Employee choice is the traditional model and it remains the default option unless another option is elected. In the employee-choice model, the employer controls the selection of medical providers only for the first 30 days after an injury is reported. After 30 days, the employee may select any physician within a reasonable geographic area. These provisions of Labor Code Section 4600 have remained basically unchanged for more than 20 years.

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- Health Care Organizations (HCOs) are an option given to employers by the 1993 enactment of Labor Code Sections 4600.3 through 4600.5. An HCO selected by an employer controls the medical treatment for the first 90 or 180 days after the injury is reported, depending on whether or not the employer (not the workers' compensation insurer) provides medical coverage. At the end of the period of HCO control, the employee has free choice as in the default option. Where collective bargaining is in place, the employer may contract with an HCO only if authorized by agreement with the union..
- Medical Provider Networks (MPNs) are an option available to employers following Senate Bill (SB) 899 enacted in 2004. An MPN established by an employer controls medical treatment for the life of the claim. The degree of control differs from an HCO because after the first visit, the employee covered by an MPN has the right to select any physician in the MPN.
- Predesignation is an option available to some employees which, if exercised, preempts any of the other three options. If an employee has designated a personal physician prior to an injury, the employee has the right to receive all treatment as directed by that physician.¹ For more than 20 years prior to enactment of SB 899, predesignation was open to all employees who had a personal physician, but predesignation did not receive much attention because employees had free choice after 30 days anyway. Predesignation is the subject of much more interest now that an employer's MPN can limit the employee's choice of physician. SB 899 restricted eligibility for predesignation to those employees whose employers provide nonoccupational health coverage.
- ADR Carve-Outs are an option where carveout agreements between employers and unions may negotiate any aspect of the delivery of medical benefits to employees that are eligible for group health benefits in construction industries (Labor Code Section 3201.5) or other industries (Labor Code Section 3201.7). These agreements include alternative dispute resolution systems that carve these cases out of the WCAB trial process, so they are sometimes known as ADR Carve-Outs.

COMPARING COSTS AND BENEFITS—LEGISLATIVE INTENT

HCOs were intended to produce cost savings for employers and improved outcomes for employees by bringing managed care into workers' compensation. Managed care is a system that controls the use of medical services, limiting utilization but protecting the patients' access to the treatment that is appropriate for that patient. The trade-off for restrictions on free choice by the patient is the requirement of compliance with administrative and regulatory oversight. As designed by the Legislature, HCOs incorporate patient protections modeled after managed care in the health insurance field. MPNs were subsequently introduced with fewer patient-protection

¹ "Personal physician" means "the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code" [this means an M.D. or D.O.] who "has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history." Labor Code Section 4600.

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features. Now that employers have the option of MPNs with lifetime control of medical treatment and fewer patient protections, it appears that employees have nothing to lose and they may gain potentially better care if an employer chooses to use an HCO.

The key features of HCOs assuring quality medical care are:

- A program for internal review of the quality of health care.
- Provisions to assure availability of care and referral to other providers at any time as consistent with good professional practice.
- A process to assure that health care decisions are rendered by qualified providers unhindered by fiscal and administrative management.
- An expeditious internal grievance and dispute-resolution process for disputes over appropriate treatment.
- Integration of the disability management and return-to-work coordination as part of the HCO service.

These features are no longer entirely unique to HCOs. Utilization review, for example, has been adopted system-wide beginning January 1, 2004 (Labor Code 4610), and physician compensation in MPNs shall not be structured in order to achieve the goal of reducing, delaying or denying medical treatment (Labor Code 4616(c)). The requirement of integrated disability management and return-to-work coordination, however, remains unique to HCOs.

The costs of HCOs to employers arise from the required structure of HCOs and from regulatory fees. HCOs are more tightly controlled by statutes and regulations than MPNs or employee-choice providers. The structural requirements of HCOs are based on the requirements of the Knox-Keene Health Care Service Plan Act (Health & Safety Code Section 1340 *et seq.*), which governs managed care for nonoccupational health care service plans. Compliance with those requirements inherently imposes business costs on HCOs. Additional costs are imposed on HCOs by the requirement of exhaustive data reporting which, as will be discussed later, has been a waste of resources. Additional costs are imposed on HCOs by the requirement of annual notification to every covered employee. Finally, additional costs are directly imposed on HCOs by the fees charged by the Division of Workers' Compensation (DWC) to fund its regulatory operations over HCOs and repay a loan from the General Fund for DWC's startup costs for the program.² Those fees are the \$20,000 application fee, the \$10,000 three-year renewal fee, the \$1.50 per covered employee annual fee, and billable-hour staffing charges for DWC to process material modifications.

Savings for employers are expected from the control of excess utilization of medical services, from a reduction in indemnity costs resulting from improved health outcomes for patients under managed care and, optionally, from the use of discounted fee agreements with medical providers. Discounted fee agreements are permissible wherever employers have contracts with medical providers, including both HCOs and MPNs. The practice is understandably unpopular with

² According to the DWC, the loan balance is down to approximately \$250,000 as of early 2006 and may be fully paid within a year.

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physicians, and even some employers and insurers contend that obtaining high-quality services is more cost-effective than obtaining discounts. Medical cost savings can be obtained through management of medical care to assure that each patient gets all the appropriate care without excess utilization. Bottom-line savings may also result if improved quality medical care and active case management is delivered in an integrated manner that produces shorter durations of temporary disability and reduced levels of permanent disability. Linking medical and disability management in HCOs makes for different measures of outcomes including return to work. The quality review process designed into HCOs is intended to achieve that improved quality of care.

The design expectation of HCOs is that employees would enjoy the advantage of reductions in disability through prompt provision of appropriate medical care. Potential disadvantages to employees would arise if HCOs only marginally comply with the statutory and regulatory requirements while delaying or failing to provide all appropriate medical treatment. The reality is probably that the various HCOs perform differently in meeting employees' needs.

While the structure of HCOs shows their potential for cost-efficient care with favorable outcomes for patients, empirical data would be needed to determine if HCOs have fulfilled their potential.

COMPARING COSTS AND BENEFITS—EMPIRICAL DATA

There are promising indications but no comprehensive collection of data to evaluate the costs and benefits of HCOs and MPNs. Some HCOs report that they have been able to reduce total claim costs by about 50% through reductions in disability through improved return to work as well as control of medical costs. A detailed data-collection program established for HCOs has been unsuccessful, and no comparable program has existed for any of the other models of health care delivery. A comprehensive data-collection program applicable to all cases, regardless of the medical-care delivery model, is still in its infancy within DWC. That program, called the Workers' Compensation Information System (WCIS), has begun collecting data on First Reports of Injury and Second Reports of Injury, and is expected to begin collecting medical billing transaction data from payors by October 2006³ (8 Cal. Code of Regs. §§9701 et seq.). Eventually, the WCIS will permit analysis of individual providers, provider organizations or networks, and medical-care delivery models. Until that time, the limited data currently available provide an intriguing indication of the potential savings and improved outcomes under managed care.

A detailed data-collection program for HCOs was set up within the DWC. If the program were operating as intended, it could provide reliable information on diagnoses, costs of medical care, durations of lost time from work, permanent disabilities, and other measures of the effectiveness of HCOs. The data-collection program has failed for a number of reasons. The reports required of HCOs are custom reports, not standard reports used elsewhere in the medical and insurance industries. While HCOs are responsible for submitting the reports, they do not have direct access to important data elements such as paid indemnity and paid medical costs. Compliance

³ Under certain conditions, claims administrators may request reporting variances from 6 to 12 months.

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with these awkward requirements has been inconsistent among the HCOs operating in the state, and errors in one report may invalidate the correlations among other reports. To compound the difficulty, for years, the DWC did not have the staff resources to train every HCO in the reporting requirements and to enforce full compliance. Possibly, the data collection envisioned by the statutes was never feasible. The result is that the data-collection program is unable to definitively evaluate the benefits of HCOs.

The only available measures of the effects of HCOs are from the reports released by some of the HCOs themselves. The information presented below was voluntarily provided to CHSWC by two of the HCOs still in operation, CompPartners and MEDEX. CHSWC cannot verify the accuracy or validity of the data, nor can CHSWC assume that all HCOs could claim similar results. On the contrary, it is expected that the voluntarily disclosed results reflect the best outcomes. The following information should therefore be taken only as an indication of the potential performance of HCOs.

CompPartners

CompPartners has furnished a comparison of results for one of its contracted insurers. The comparison is presented in the table and chart below.

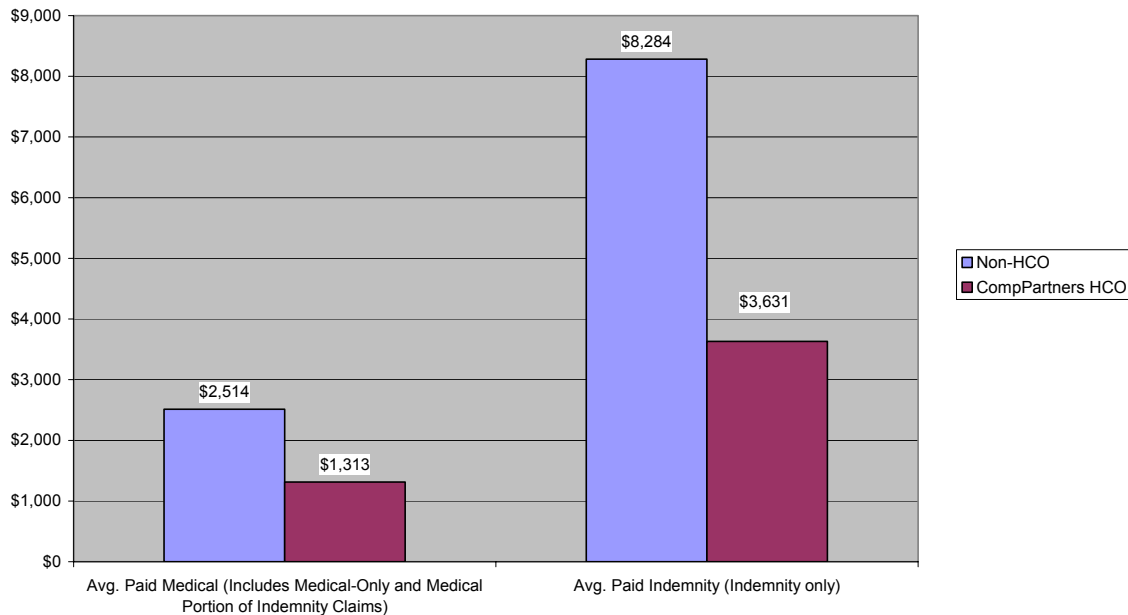
Table 1 – CompPartners Comparison of Results

CompPartners	Non-HCO	CompPartners HCO	% savings
Avg. Paid Medical (All types)	\$2,514	\$1,313	48%
Avg. Paid Indemnity (Indemnity only)	\$8,284	\$3,631	56%
% Litigated	6.3%	3.3%	

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Chart 1 – CompPartners HCO v. Non-HCO Results

CompPartners HCO vs. Non-HCO Results for All Claims for One Carrier
Claims over a 2 1/2 year period and closed as of 1/31/03
(Data Collected by CompPartners from 3 separate sources)



According to CompPartners, the table reflects data from one insurer that allowed its policyholders to choose whether to participate in the HCO. About 60% chose to participate, and about 40% did not. The policyholders were mostly small and medium-sized businesses with an average of about 25 employees. The industries represented were restaurant/fast food, auto repair, auto dealerships, light manufacturing, child and adult daycare, self-storage companies, property management, hotels, parking, small retail, supermarkets, janitorial services, and bakeries. The data set reflects all 21,655 claims for that insurer arising over a period of about two and a half years up to January 1, 2003, and closed as of that date. These include 4,713 indemnity claims (temporary or permanent disability benefits were paid) and the remainder are medical-only claims. The average medical cost for all claims (including medical-only as well as indemnity claims) and the average indemnity cost for indemnity claims are shown in the table and chart above. The litigation rates are presumably for the indemnity claims only.

MEDEX

Another HCO, MEDEX, disclosed its analysis of before-and-after data from records shared by its clients, as shown in the following table and charts.

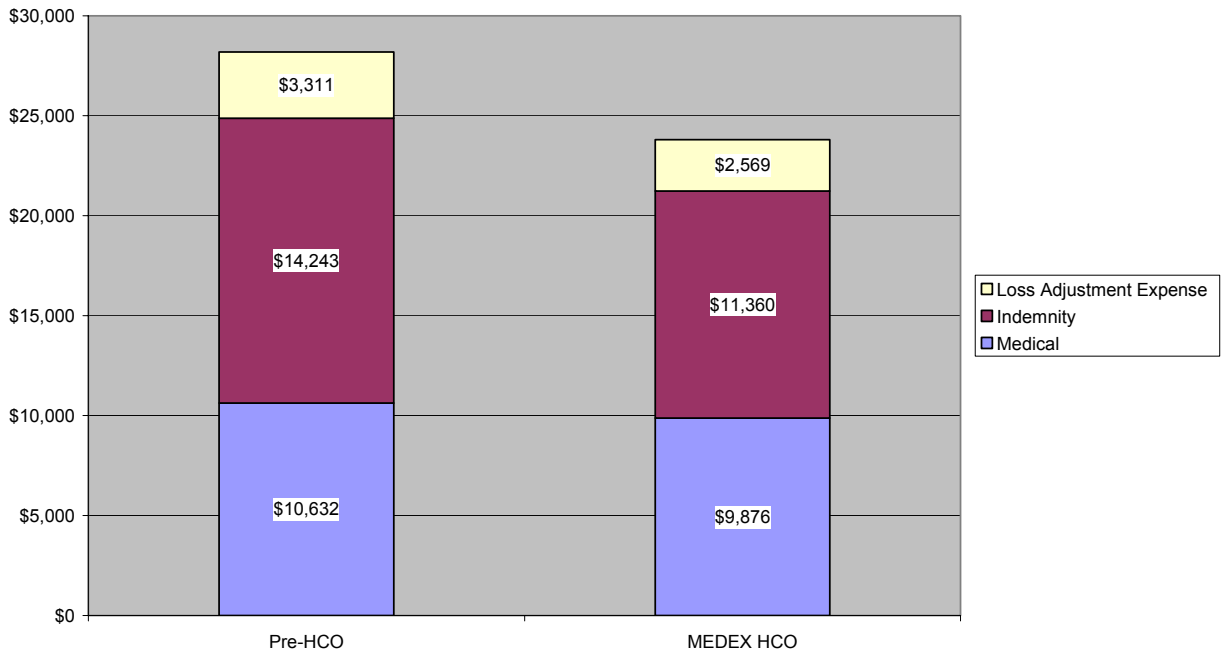
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Table 2 – Medex Comparison of Results

Medex - Year 1	Pre-HCO	MEDEX HCO	% savings
Medical-Only	\$866	\$590	31.87%
Medical Part of Indemnity	\$10,632	\$9,876	7.11%
Indemnity	\$14,243	\$11,360	20.25%
Loss Adjustment Expense	\$3,311	\$2,569	22.42%
Total (excluding Med-Only)	\$28,187	\$23,805	15.55%
% Litigated	19%	7%	

Chart 2: MEDEX HCO v. Non-HCO Results

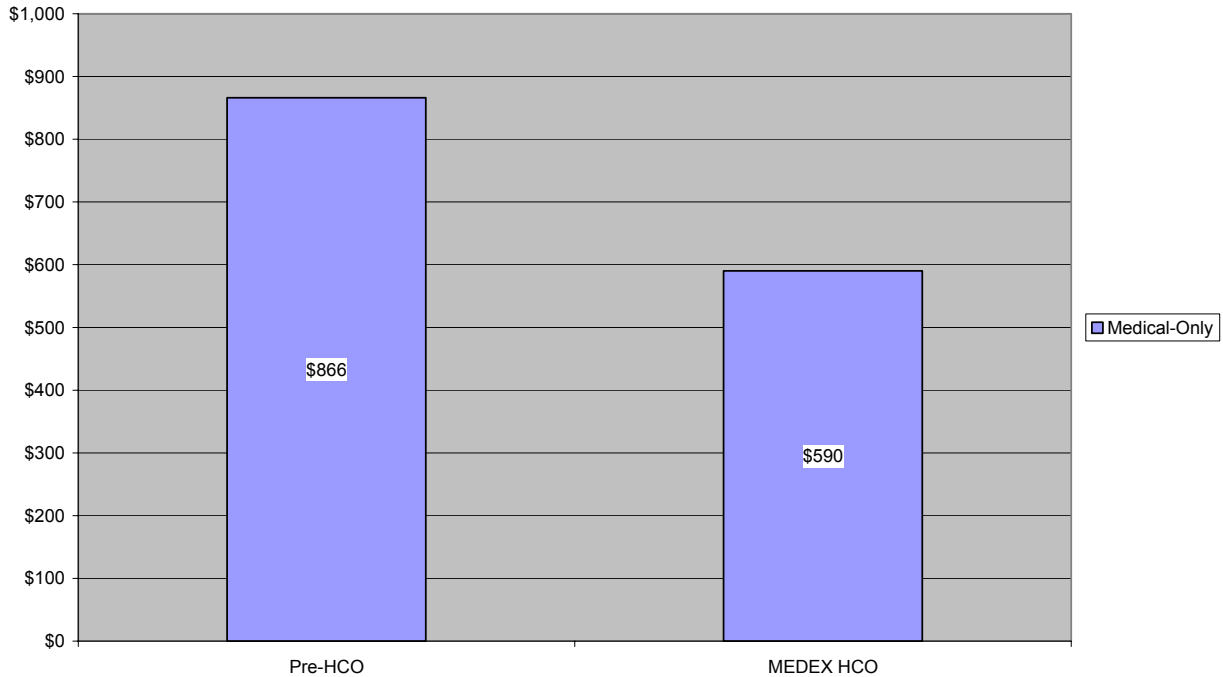
**Medex Comparison with 15 Employers Pre- and Post-HCO over a 1-year period (Y1)
Average Claims Cost Break-Down for Indemnity Claims
(does not include Medical-Only claims)
(Data Source: Medex)**



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Chart 3: MEDEX HCO v. Non-HCO Results

Medex Comparison with 15 Employers Pre- and Post-HCO over a 1-year period (Y1)
Average Cost for Medical-Only Claims
(Data source: Medex)



MEDEX states that it had approximately 80 employers in its HCO, and 15 of the larger ones agreed to the anonymous release of their confidential data. These employers included approximately 65,000 enrollees (covered employees). The data set includes each employer's claims arising in the one year before that employer entered the HCO and two years after that employer entered the HCO. The employers began participating in the HCO at various dates in 2001 and 2002. The pre-HCO year for each employer was the 12 months prior to that employer's joining the HCO. Claims arising in the pre-HCO year and closed by 12/31/03 were valued as of 12/31/03. Claims arising during the first year of each employer's HCO participation and closed by 12/31/04 were valued as of 12/31/04. This means that the valuation might be anywhere from 1 to 2 years after the end of the year in which the injury occurred, but the maturity was the same for both the pre-HCO set and the Year 1 set for each employer. MEDEX also reported the values of Year 2 claims as of 12/31/04. Year 2 data are not directly comparable to the pre-HCO data due to the one-year difference in maturity between injury date and valuation date, so the Year 2 data are not included in the table above.

Both CompPartners and MEDEX used closed claims and did not include any claims more than three years old. The small fraction of cases that remain open for years and account for a disproportionate share of the costs are not captured in these comparisons. On the other hand, medical experts suggest that appropriate management early in the history of a case can reduce the chance of the case becoming one of those long-term, high-cost cases. It is plausible that the

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benefits of managed care in HCOs would extend beyond the two-to-three-year evaluations provided by these data.

Notably, employees also appear to benefit from HCOs. The savings to employers do not appear to have been obtained at the expense of the employees. Short-term savings could be obtained by simply withholding medical care, but that tactic would not improve medical outcomes or reduce disability or reduce litigation. The savings in indemnity apparently result from shorter durations of time off work and/or reduced permanent disabilities. Those outcomes are clearly in the best interests of injured workers.

The reduction in litigation rates also implies that the workers receiving care from HCOs were largely satisfied with the care they received and with the outcomes of their disability claims. This is not the only possible explanation, however. It is also possible that in some cases, workers were unable to obtain legal representation because their prospective attorneys would not take cases while the employers had control over medical care. While other factors cannot be ruled out, it appears that HCOs actually achieved some of their intended goals of cost-efficient medical management and integrated disability management.

Comparisons of HCO results with MPN results are not possible without additional research. Comparisons with MPNs are not possible because MPNs are too new to have developed a meaningful track record. Even comparisons with the employee-choice model and with predesignation are uncertain because of the many changes in California law governing the provision of medical care.⁴ Treatment guidelines and utilization review may now be applied to all medical treatment in workers' compensation, and caps on chiropractic and physical therapy visits have been adopted for injuries occurring on and after January 1, 2004. (Labor Code Section 4604.5.) Medical costs were dropping for the system as a whole in 2004.⁵ Savings attributed to MPNs which began in 2005 cannot be readily distinguished from those system-wide savings. Likewise, the savings reported by HCOs when compared to the employee-choice model might be diminished now that these system-wide controls are applicable to employee-choice care, too.

Further research is necessary before CHSWC will be able to identify the benefits of HCOs as compared to MPNs or the benefits of either model as compared to the employee-choice model. The reports available at this time support the conclusion that HCOs are a potentially valuable option for employers.

⁴ One recent report of mention is Victor, R., P. Barth and D. Neumark. November 2005. The Impact of Provider Choice on Workers' Compensation Costs and Outcomes. A Joint Publication between Workers' Compensation Research Institute (Cambridge, MA) and the Public Policy Institute of California (San Francisco).

⁵ WCIRB, 2004 California Workers' Compensation Losses and Expenses. June 7, 2005, Paid Medical Costs Table, page 6, <http://wcirbonline.org/index2.asp?section=5&subsection=0>; and CHSWC, 2005 Annual Report, December 2005, System-wide Estimated Costs – Medical Benefits Paid Chart and Average Claim Costs Chart, pages 40 and 44, <http://www.dir.ca.gov/CHSWC/Reports/AnnualReport2005.pdf>.

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MARKET VIABILITY OF HCOs

HCOs have never been more than a niche market, never exceeding a 3% market share in the annual December 31st census of enrollees. HCOs were about to break out of that niche in late 2003, with the State Compensation Insurance Fund (SCIF) initiating an HCO pilot. In early 2004, the number of HCO enrollees rose as high as 750,000 just before passage of SB 899 and the introduction of MPNs. In the short time that MPNs have been available, the HCO market share has declined to just over 1%.⁶ HCOs are likely to disappear altogether unless they are relieved of some of their competitive disadvantages compared to MPNs.

Under existing law, an employer cannot use both an HCO and an MPN. One of the attractions of HCOs was the ability for employers to retain medical control for 90 or 180 days instead of the default 30 days. This advantage of HCOs now pales in comparison to the lifetime control of medical treatment that is possible with an MPN. The reason the employer cannot use the two options sequentially is that the employee's return to the default path (return to employee-choice) was written into the HCO statutes. MPNs have now been created as another alternative to the default path, but there is no coordination between the two statutory options.

Other competitive disadvantages for HCOs are requirements that now appear inconsistent when compared with MPNs, specifically the high cost of administrative fees, data-reporting requirements, and annual employee notifications.

- Administrative fees for HCOs include a \$20,000 application fee, a \$10,000 three-year renewal fee, an annual charge of \$1.50 per enrollee (covered worker), and billable-hour staffing charges for DWC to process material modifications. No fees are imposed on MPNs.
- Data reports for HCOs are intended to provide all the information that would be useful for measuring the performance of the system. The data elements are not all within the knowledge of the organization, however, so compliance requires obtaining information from other sources such as the employer or insurer. Some of the data are buried in medical records and not routinely reported in a machine-readable fashion to administrators. None of these regular data reports were required of MPNs. The special data-reporting requirement on HCOs will soon be lifted, however, as Rule 9778(c) (8 Cal. Code of Regs. §9778) relieves the HCOs of data reporting when the WCIS begins collecting similar data from all claims administrators regardless of medical-delivery options.
- Annual notices are required for all workers covered by HCOs. The process is called enrollment, but the employees covered by an HCO are enrolled by default unless they opt out of the HCO by predesignating a personal physician. The annual notice to every covered employee is a costly process that is distinct from the notices required in connection with individual claims. MPNs may only be required to give one notice to

⁶ Percentages are calculated based on a peak enrollment of 475,000 and the latest reported enrollment of 200,000 out of a workforce of 15 million employees, as reported by DWC.

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every covered employee, apart from the notices in connection with individual claims or material modifications in the MPN. (8 Cal. Code of Regs. §9767.12.) It appears inconsistent and disproportionately burdensome to require costly annual notices of a right to opt out of 180-day employer control in an HCO while requiring only a one-time notice of a right to opt out of lifetime employer control in an MPN.

Another inconsistency and competitive disadvantage is how an employee's right of predesignation under an HCO has become different from the right under an MPN. The general right of predesignation under Labor Code Section 4600 as it existed in 1993 was mirrored in Section 4600.3 for HCOs. Eligibility to predesignate was subsequently restricted by the 2004 amendments of Section 4600. The provisions of the HCO statutes were not amended to conform, so employees who would not otherwise be eligible to predesignate a personal physician may become eligible if their employers adopt an HCO. An HCO may lose medical control more frequently than an MPN due to this lack of conformity in the statute.

As stated earlier, certain structural and administrative costs are inherent in the operation an HCO. Those additional costs are not examined in this paper because any effort to streamline the basic structure and procedures of an HCO would erode the very features that distinguish an HCO from an MPN or some other alternative. The competitive disadvantages discussed in this section reflect additional costs that do not alter the design or intent of HCOs to provide appropriate managed care.

PENDING LEGISLATION

Assembly Bill (AB) 871 (Keene) would make HCOs a more viable choice for employers weighing their options because:

- An employer choosing an HCO for treatment in the first 90 or 180 days would no longer forfeit the opportunity to also establish an MPN for treatment for the remainder of the life of the claim.
- HCOs would no longer be singled out for additional fees to fund the State's supervision of their program, compared to MPNs which pay no fees for the State's supervision of their program.
- HCOs would be relieved of the burden of annual notification to employees of their right to predesignate a personal physician, compared to MPNs which are not required to give annual notices.

AB 871 would offer advantages to employees whose employers choose an HCO:

- To the extent that HCOs achieve improved return-to-work rates as a result of integrated medical and disability management, covered workers will experience reduced wage losses.

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FINDINGS AND RECOMMENDATIONS

CHSWC finds that HCOs have demonstrated the potential to produce benefits for employers and employees, even though the actual results are poorly quantified and likely to be variable. MPNs are too new to have demonstrated their potential, but their results are also likely to be variable in light of the wide variation that is allowed in the design and implementation of MPNs. HCOs in general appear to be at least as favorable to injured workers as MPNs because of the greater degree of patient protections and disability management designed into HCOs. Therefore, CHSWC recommends that HCOs should be better coordinated with MPNs so that both options are available to self-insured employers and to the insurers for insured employers. Control of care should be coordinated so that HCOs and MPNs are not mutually exclusive. To ensure that HCOs can remain a competitive option available to employers, costs that are imposed on HCOs and that are neither imposed on MPNs nor essential to the defining characteristics of HCOs should be removed. In this way, MPNs and HCOs can co-exist in the marketplace, employers or insurers will have the choice of either or both models for medical-care delivery, and actual performance results and free-market forces can guide employers' choices.

To accomplish those purposes, CHSWC recommends:

1. When a self-insured employer or the insurer for an insured employer contracts with an HCO to provide medical services for injured workers, and the HCO's control over medical care ends after 90 or 180 days under existing law, control over subsequent medical care should pass to an MPN if the employer or insurer has established an MPN and otherwise to the employee's free choice of physician.
2. Fees and surcharges charged to HCOs payable to the DWC should be eliminated as soon as repayment to the General Fund is completed.
3. Predesignation rules should apply equally to MPNs and HCOs. Labor Code Section 4600 should apply also to HCOs, instead of having a separate predesignation rule in Labor Code Section 4600.3.

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Attachment A: Letter from Assembly Member Rick Keene Requesting HCO Report

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Assembly
California Legislature



RICK KEENE
ASSEMBLY MEMBER, THIRD DISTRICT

COMMITTEES:
VICE-CHAIR:
BUDGET
MEMBER:
NATURAL RESOURCES
UTILITIES AND COMMERCE
JOINT LEGISLATIVE BUDGET COMMITTEE

October 25, 2005

Mr. John Wilson, Chair
Commission on Health and Safety and Workers' Compensation (CHSWC)
State of California, Department of Industrial Relations
1515 Clay Street, Suite 901
Oakland, CA 94612

Re: Request for CHSWC Study of Health Care Organizations

Dear Mr. Wilson:

As you are aware, I have introduced legislation to allow Health Care Organizations (HCOs) to remain competitive with medical provider networks while preserving their built in quality assurances.

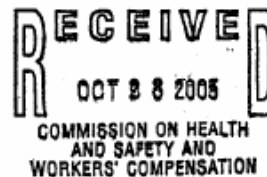
In order to confirm the benefits of HCOs and evaluate whether legislation is necessary to preserve those benefits, we would appreciate information from the Commission on Health and Safety and Workers' Compensation regarding the following questions:

- What is the current viability of HCOs?
- What are the differences in requirements for HCOs, MPNs and the fee for service system in workers' compensation?
- What changes, if any, should be made?
- Is there empirical data that would demonstrate HCOs' effectiveness?

Thank you for your consideration.

Sincerely,

Rick Keene
Assemblymember, 3rd District



Cc: Christine Baker, Executive Officer, CHSWC

Representing Butte, Lassen, Nevada, Placer, Plumas, Sierra and Yuba counties

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Attachment B: Comparison Chart of HCO, MPN and Employee Choice

	Program Component Description	Health Care Organization HCO	Medical Provider Network MPN	Employee Choice
1	Organizational Oversight	Statutory and Regulatory oversight by DWC, including mandatory audits LC4600.6	After application is approved, no oversight other than reviewing material changes to the plan.	None
2	Provider Network	Certified by DWC as to: **Coverage Area/Access **Provider contracting **Provider credentialing	Approved by DWC as to: **Similar **Same **None	No requirements
3	Choice of Plan	Mutually exclusive with MPNs, requires annual notice of affirmative predesignation option; may opt out by predesignating any time pre-injury	Mutually exclusive with HCOs, requires one-time notice of affirmative predesignation option; may opt out any time pre-injury if eligible to pre-designate	Requires one-time affirmative predesignation option to every new employee Reg. 9880
4	Choice of Physician and Changes	May request change of physician no less than once; right to a second opinion. LC 4600.3(e)	After first visit, employee has right to choose physician from network. LC 4616.3(c)	May request one change of physician in first 30-days; free choice after. LC 4601(a)
5	Days of Medical Control	Minimum of 90 days, maximum of 180 days in the HCO provider network, depending on whether employer provides non-occupational health care coverage to injured worker LC4600.3(c)(1-2)	Treatment within the MPN for life of claim, subject to treating outside the network pursuant to dispute resolution process (below) LC4616	30 days LC4600 (c)
6	Enrollment and Notification	Annual notice, including mandatory employee enrollment on DWC Form 1194, with required opportunity for return of form by employee, such form to be kept in employee personnel file. LC 4600.3(a)(1) and Reg. 9777 and Reg.9779.3	Notification at the time the employees are placed in the MPN, at the time of injury, and when there is a change to the network. Also, notice of IMR required at the time employee requests 3rd opinion. Reg. 9767.12	Notification at time of hire on DWC Form 7

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7	Physician Peer Review	Requirements of a Medical Director, Occ-Med specialist, Quality Assurance, Utilization Review and other committees LC 4600.5(c) and Reg 9774	None required	None required
8	Grievance Procedure	Mandated grievance process and procedures for injured workers and providers required and approved by DWC; annually informed. LC4600.6 (j)(1-4) and LC4600.5(l)(4)	See Dispute Resolution below	None
9	Utilization Review (UR)	Routinely incorporated with the nurse case management program: independent determination, not subject to payor's approval; "integrated." LC4610, and "universal" Reg.9792.6	"Universal" UR requirements; may be outsourced. Reg. 9792.6	Universal UR requirements Reg. 9792.6
10	Return to Work (RTW) Provisions	Mandatory RTW program for injured workers. LC 4600.5 (c)(2), Reg. 9776.1	None required	None required
11	Safety Programs	Mandatory integration with reported injuries LC4600.5(e)	None required	None required
12	Choice of Physician	HCO provides all treatment from primary care and specialist physicians within the certified network. Employee has statutory right to at least one change of physician per year. LC 4600.3	Employee has unlimited choice within the MPN Network after the first medical visit. LC4616	Unlimited choice within reasonable geographic area after 30 days LC4600 (c)

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13	Credentials of Physician	Mandatory credentialing as occupational LC4600.6(i) and LC 4600.5(c)(5)	Network has physicians primarily engaged in treatment of occupational injuries, with a goal of at least 25% non-occupational physicians. LC4616(a)	Licensed physician; occupational specialty not required.
14	Dispute Resolution	See Grievance Procedure above	Through mechanism that allows disputes regarding diagnosis or treatment to be adjudicated by a 2nd and 3rd opinion within the network, then to an Independent Medical Review (IMR) as directed by the DWC LC4616.3 Reg. 9767.7	None
15	Data Reporting	Monthly enrollment report to DWC. Annual employee and claim data to DWC Reg. 9778	None required	None required
16	Mandatory Oversight and Audit	Survey of procedures, from UR, peer review, quality of care, and overall performance of HCO--once every three years. LC 4600.6	None required beyond approval of applications and amendments	None required
17	Fees	\$1.50 per enrollee per year payable to the DWC. Reg. 9779.5	None	None
18	Certification cost	Application: \$20,000 Recertification every three years: \$ 10,000. Reg. 9771(f) & 9779(d)	None	None

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19	Number Approved or Certified	Number of HCOs: 5 Number of HCOs deemed MPNs: 5, as of January 2006 Number of Enrollees: 200,000 as of December 2005 (source DWC)	1,000 approved applications as of March 2006, number of covered employees unknown (source DWC)	N/A
20	Cost Control and Physician Compensation	Health care decisions to be rendered by qualified providers, unhindered by fiscal and administrative management. LC4600(h)(7) Fees may be set by contract.	Compensation cannot be structured to achieve goal of reducing, delaying or denying medical treatment LC4616 (c) Fees may be set by contract.	Official Medical Fee Schedule, unless provider and payor have contract.