

Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING

December 14, 2012

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

In Attendance

2012 Chair Angie Wei

Commissioners Martin Brady, Doug Bloch, Christine Bouma, Faith Culbreath, Sean McNally

Acting Executive Officer D. Lachlan Taylor

Absent

Commissioners Kristen Schwenkmeyer and Robert Steinberg

Introduction of New Commissioners

Chair Wei stated that there are three new Commission members, two appointed to represent labor and one to represent employers. She stated that the Commission is pleased to welcome Christine Bouma from the California Profession Firefighters Union, Doug Bloch from the Teamsters Union, and Martin Brady from the Schools Insurance Authority Association.

Approval of Minutes from the January 19, 2012 CHSWC Meeting

CHSWC Vote

Commissioner McNally moved to approve the Minutes of the January 19, 2012 meeting, and Commissioner Brady seconded. The motion passed unanimously

Election of 2013 Chair

Chair Wei explained that each year the chair rotates from labor to management and from management to labor.

CHSWC Vote

Commissioner McNally nominated Martin Brady for 2013 Chair, and Commissioner Bouma seconded. The motion passed unanimously.

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Commissioner Brady accepted the nomination. Chair Wei stated that with Commissioners Brady's concurrence, she would continue chairing the meeting today.

Comments by the Director Department of Industrial Relations (DIR)

Christine Baker, DIR

Ms. Baker thanked the Commission for inviting her to speak and stated that she would provide a briefing on the activities of the Department. DIR staff has been working tirelessly with the Division of Worker's Compensation (DWC) to implement Senate Bill (SB) 863 since the day after it was passed by the Legislature. Implementation has been led by DWC Acting Administrative Director Destie Overpeck, DIR Chief Counsel Kathy Zalewski, DWC Acting Chief Counsel George Parisotto, and DWC Medical Director Dr. Rupali Das, and Commission staff who have been brought in to assist. SB 863 is a comprehensive bill that will help avert a crisis in workers' compensation. It is a balanced tradeoff between bringing down costs and bringing up benefits. The Department stands ready to make adjustments if problem areas are identified during the implementation.

The information technology (IT) component has handled several challenges: payment systems had to be put in place for the court systems; feasibility studies had to be done in record time; and change management procedures had to be implemented throughout DIR with training of judges, training of staff, and putting out bulletins.

SB 863 Implementation Overview

The Department has done the following:

- Negotiated a contract for Independent Medical Review (IMR) with the same organization that does Independent Medical Review (IMR) for the Department of Managed Healthcare, as authorized by SB 863. Set up processes for the secure exchange of medical information and for managing the workflow. The contractor is Maximus. This contract has been approved by Department of General Services.
- Negotiated a contract for Independent Bill Review (IBR), also with Maximus.
- Moved forward with emergency regulations to implement SB 863, effective 1/1/13:
 - IMR regulations and forms.
 - IBR regulations and forms.
 - Spinal hardware payments in the inpatient hospital fee schedule.
 - Ambulatory Surgery Center fees.
 - Supplemental Job Displacement Benefit.
 - Interpreter certification.
 - QME regulation, limiting to 10 locations and eliminating chiropractic specialties.
 - Lien filing fees integration into EAMS.
 - Pre-designation and chiropractor as primary treating physician regulations.

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It is unprecedented that all these efforts have moved forward. DWC staff has been incredibly dedicated and have been working long hours and weekends to get this done in time to meet the statutory timelines. Almost every one of these was a major project by itself. These are emergency regulations, and it will be possible to amend them until July 1, 2013.

SB 863 Return-to-Work Program; Special Earnings Loss Supplement Payments

People have been asking about the Return-to-Work Program that was added in the final hours before the bill was passed. The Department is working closely with RAND to estimate average wage losses.

Legislation

Labor Code Section 139.48 establishes a return-to-work program for making supplemental payments to injured workers whose permanent disability (PD) benefits are disproportionately low in comparison to their earnings loss. Eligibility and the amount of payments are to be determined by regulations adopted by the Director.

Naming

The program will have to target the payments to people who do not return to work, and the program is geared to making cash payments to them, not for recreating vocational rehabilitation, and not for duplicating the supplemental job displacement benefit (SJDB). So instead of calling it a return-to-work payment, we will probably want to call it the Special Earnings Loss Supplement.

Effective date

The intent of the Legislature was to provide a replacement for *Ogilvie* ratings or whatever might come after *Ogilvie* for rebutting the future earning capacity (FEC) factors in the 2005 Rating Schedule. FEC adjustments are eliminated for new injuries beginning 1/1/13. The question was what to do for the worker who has unexpectedly severe earnings losses compared to the rating, once rebuttal to the FEC is taken away, so the supplemental payments will be for workers injured on or after 1/1/13.

Eligibility

An injured worker will be eligible for a payment if:

- The worker received an SJDB, and
- The worker's actual percentage of earnings loss after the permanent disability (PD) award is unexpectedly severe compared to the earnings for workers with similar PD ratings.

An SJDB on a 2013 or later injury will show that the worker did not have an opportunity to return to work with the at-injury employer. We are hoping that employers will encourage return to work at the at-injury employer; that creates the best outcome.

The PD benefits are designed to compensate for earnings losses that are expectable for the PD rating, so only workers with losses outside that expectable range will be eligible.

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Payment

The payment will be a lump sum in each case that is based on:

- The difference between the workers' percentage of earnings loss and the average percentage of earnings loss for workers with similar PD ratings.
- The worker's earnings in the year prior to the injury.

In order to know what a worker's actual earnings losses are, data will be needed on what the worker earns in at least two years after the PD award.

Regulations timeline

Ms. Baker stated that the Labor Code requires the regulations to be based on studies conducted by the Director in consultation with the Commission. Bidding on that contract has been completed, and the contract will be awarded next week. The study report is due in July, and the final regulations will follow the normal rulemaking timeline. The Department plans to release a preliminary outline of the program for public feedback early in 2013. There will be plenty of time to complete the regulations before anyone with a 2013 injury is ready to apply for a supplemental payment based on the years of post-award earnings history.

Ms. Baker stated that until the regulations are adopted, there has to be something that shows us the PD rating. If a case is settled by compromise and release without a distinct award of PD benefits, it will need to show the PD rating that the settlement is based on. Documentation of the worker's actual earnings loss will be needed. The process will rely on documents that should be available even for people who do not save everything. To be on the safe side, though, it would be a good idea to save earnings records going back a couple of years before the injury and continuing after the award. Within a few months, there should be much clearer guidance from RAND and other research on how a worker will apply for the benefit.

Ms. Baker stated that she also wished to acknowledge Frank Neuhauser of the University of California, Berkeley, and many staff at RAND who provided data to the Department.

Ms. Baker stated that the Department is focusing on the underground economy and enforcement and that she will provide a briefing on that at a later time.

Questions from Commissioners

Commissioner McNally stated that he wished to commend Ms. Baker for the dedicated work she has been doing. Commissioner Bloch also stated that he wished to thank Ms. Baker for the Department's work on behalf of workers who do suffer from permanent disability. There are a lot of workers in the solid waste and recycling industry who do very dangerous work, and it is gratifying to know that the State of California is looking out for their interest and the interest of employers. Chair Wei also commended Ms. Baker for moving forward on critical issues.

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Opioid Pain Medications: Mitigating the Risks

Teryl Nuckols, University of California, Los Angeles

Dr. Teryl Nuckols thanked the Commission for the opportunity to present today on opioid pain medications and the steps that can be taken to mitigate the risks. She acknowledged her co-investigators: Ioana Popescu; Laura Anderson; Allison L. Diamant; and Roger Chou. Dr. Nuckols stated that there are substantial risks associated with opioids for the treatment of pain which have become clear in recent years. These risks are overdoses and substance abuse disorders and other problems. It cannot be overstated that there is an epidemic of opioid-related overdoses in California and nationwide. National data from 1999 to 2006 indicate that there was a 250 percent increase in opioid-related fatalities, and these include accidental overdoses due to opioids. Until recently, statistics have shown that between the ages of 1 and 45, car accidents were the leading cause of death; now accidental overdoses due to prescription medications, including opioids, have surpassed car accidents as the leading cause of death. Emergency department visits and hospitalizations are increasing for opioid abuse as well and are 12 times as common as fatal overdoses. Dr. Nuckols stated that she would explain the evaluation of opioid-treatment guidelines and systematic reviews, as well as describe how this information can be used to mitigate the risks associated with opioid medications.

Dr. Nuckols stated that three major factors have contributed to the rise in opioid-related fatalities. The first is that opioids are inherently risky. Opioids suppress the drive to breathe because they act on the brain stem and interact with other drugs, such as benzodiazepines and alcohol, which also suppress the drive to breathe. Opioids are addictive, and there are certain people who are more susceptible to addiction than others. A second major factor is that in recent years, the public has decided that prescription drugs are safer in terms of abuse than street drugs for recreational purposes. Prescription drug abuse has risen, while street drug abuse has dropped. When surveys are conducted of people who admit to misusing prescription opioids for recreational purposes, 31% admit that they obtain them from physicians and the rest of the time from the medicine cabinets of friends, parents, grandparents, and others. The third factor lies with the medical profession. Over the past 20 to 30 years, the standards of care for pain management changed, and the profession has become more lax in the way it prescribes opioids. Some of this is appropriate. In the distant past, providers did not use opioids very much for the management of pain. People with severe advanced cancer and long bone fractures would not receive any pain medication. In response to that, there was a push to increase the use of pain medicine for the management of severe pain. Now it is part of hospital accreditation standards; the California Continuing Medical Education (CME) demands that the standards be used and requires that 12 CME credits are given, except for a few types of practicing physicians; in addition, there are a lot of guidelines on opioids for the treatment of pain. Part of the problem is that physicians are often taught that there is no objective measure of pain or maximum dose of opioids, so medications can be titrated up to the patient's self-reported degree of pain control. The result is that there has been a dramatic increase in the number of patients receiving opioids and in the dose received. What there has not been until recently is an acknowledgment that there should be some sort of balance about what the threshold is for treating pain.

Dr. Nuckols stated that prescribing practices are contributing to the overdoses. In one study, 40% of the time, patients experiencing prescription drug overdoses had been seeing multiple doctors

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and had been involved with diverting opioid medication, 60% of the overdoses did not involve diversion, 40% of the patients were seeing one doctor and receiving relatively high doses, and 20% were seeing one doctor and receiving low doses and still experiencing overdoses. Some of this may be due to taking opioids together with another prescription medication or taking opioids with alcohol and not realizing that that could be a problem. A second drug is involved in at least half of fatal overdoses, most frequently benzodiazepines that are used for anxiety or sleeping medications; an unbelievable number of people are taking those medications. In another study, over 75% of patients who experience serious overdoses have been prescribed sedative-hypnotics in the recent past so they may have the pill bottles lying around the house.

Dr. Nuckols stated that the overdose risk is also related to the type of opioid, as well the dose prescribed. There are recent data from 2011 which note that people taking even relatively low-dose opioids have an increased risk of serious and fatal overdoses relative to people taking the lowest doses of pain medication. At doses equivalent to 50 to 99 mg of morphine per day, the risk of serious overdose is increased by 300% and the risk of fatal overdose is increased by 200%. At doses equivalent to more than 100 mg of morphine per day, the risk of serious overdose is increased by 1200% and the risk of fatal overdose by 300%. Dr. Nuckols described, as a frame of reference, studies that have looked at people on chronic opioids for non-malignant pain outside the workers' compensation system. In some of those studies, people are taking as low 20 milligrams of morphine equivalents while in other studies, they are taking well over 100 milligrams, and that is average, so some people are taking higher doses. Thus, people are experiencing overdoses when they take doses of opioids that are within ranges that are considered average in some segments of the population on opioids. Dr. Nuckols stated that another frame of reference is the use of Vicodin, a medication that probably many people have taken since it is given after having a tooth removed or after having the appendix out. The maximum number of doses of Vicodin someone might consume in a 24-hour period is associated with almost 300% risk of a serious overdose; this is almost a two-fold increase of fatal overdose just for the maximum use of Vicodin. This indicates that even within the standard amount of medications that people are taking, there is definitely risk of a serious overdose or a fatal overdose. This is relatively new information about the risks of overdose despite the fact that these medications have been used for a long time.

Dr. Nuckols stated that when comparing practices in workers' compensation to non-workers' compensation, frequency of opioid use is almost twice as much, even though not all workers' compensation patients have chronic pain. Comparing workers' compensation patients to non-workers' compensation patients, 32% of patients used opioids. In non-workers' compensation settings, 18% of patients across nine studies versus seven studies with chronic non-cancer pain used opioids. The average daily doses used are about the same: in workers' compensation, it is 48 milligrams (mg) morphine equivalents per day; and in non-workers' compensation, it is 42 mg morphine equivalents per day; however, there is quite a range across studies. One study from Ohio showed that some people are receiving relatively high doses. In the studies from 2011, the threshold of overdoses goes up 100 to 200 mg a day, and this is a real inflection point at which risk increases. In the Ohio workers' compensation population, 9.2% had doses greater than 120 mg morphine equivalents/day; and 0.2% had doses greater than 1,000 morphine equivalents per day, an amazingly high dose. When there is such a high dose, the question becomes whether the medication is working any more since people can get opioid-hypersensitivity syndrome. People

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become hypersensitive to pain and opioids no longer work, so people have to be completely withdrawn off of opioids.

In California, there was a study by the California Workers' Compensation Institute (CWCI) that looked at prescriptions for opioids. The study found that there was use of what the guidelines consider to be inappropriate medications for higher-risk medications such as fentanyl patches and methadone. Of all the prescriptions from 1993-2009, 27% were for medications with a high risk of overdose (fentanyl patches and methadone). There have been FDA black box warnings about fentanyl patches, but they are frequently used; the problem is that the absorption can be unpredictable. If people are close to heat or if they exercise, they can absorb a good deal more opioid than expected and then overdose. There also have been tragic stories about when the patch gets folded up and a child becomes exposed to the fentanyl. Dr. Nuckols then stated that 48% of the prescriptions were for medications with a high addictive potential, and oxycodone is one of them. Oxycodone is a highly commonly used medication, and it would be difficult to manage pain without it. Everybody agrees that the immediate-release fentanyl should not be used except for cancer patients as it has high addiction potential and overdose risk. Dr. Nuckols stated that another statistic of interest is that 1% of the physicians who prescribed opioids within the California workers' compensation system generated 33% of all opioid prescriptions.

Workers' compensation has more opioid use, and studies suggest that this may result in worse outcomes and higher costs. In the Washington State study, people with back problems were prescribed greater than 9.3 mg morphine equivalents a day in the first 15 days of their claim, and they had longer disability and higher medical care costs. Two other studies from California reached similar conclusions. The study tried to account for the severity of illness using disease codes obtained from the billing data. However, the challenge is to determine whether the more severely injured are more likely to use opioids and are likely to have more severe medical costs, or whether the opioids are leading to longer disability and higher medical care costs. Nevertheless, it is clear that overdoses are leading to emergency department visits and higher hospitalization costs, and when people are placed on long-term chronic opioid use, a certain percentage of them will go on to develop substance abuse disorders which will result in worse outcomes and higher costs.

Dr. Nuckols stated that the standards of care of opioid use have been evolving over the past several years, and guidelines are paying more attention to issues of abuse and risk. State of California guidelines are placing increasing emphasis on these issues whether it is in the workers' compensation system or on the state level, and policymakers in a variety of settings at the national level and in other states are actively working to address these issues. People are dying from overdoses and everyone is paying attention. This provides an opportunity for the California workers' compensation system to implement the latest standards of care for using opioids to treat pain, to develop systems for identifying high-risk prescribing practices, and to identify patients who are doctor-shopping and using opioids inappropriately.

Dr. Nuckols stated that two research objectives of this study were: to search for recent guidelines and systematic reviews; and to develop a method for identifying high-risk prescribing practices using administrative (billing) data, so if there were pharmacy claims data, the data could be used to figure out which doctors need a little bit of guidance or which prescribing practices need to be

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flagged and some improvements made. A third objective of the study was to determine if an opioid-treatment guideline would be adopted for the State of California, which guidelines would be better than others. Therefore, the first step was a systematic review of guidelines and of systematic reviews. Standard sources and websites were used, such as: National Guidelines Clearinghouse, MEDLINE; websites of relevant specialty societies' guidelines; websites of California, Colorado and Washington state workers' compensation systems; and different websites that are search engines for systematic reviews. There were general inclusion criteria. These inclusion criteria were looking for general pain management guidelines, not for specific conditions such as for back pain, shoulder pain, and ankle pain. The guidelines should have been published recently because the standards of care are evolving and guidelines can become out-of-date as recently as within three years. Additionally, the guidelines had to be published in English. Duplicate or old guidelines or guidelines applicable to children were excluded, and guidelines had to meet criteria for a guideline or systematic review.

Dr. Nuckols stated that one of the research objectives was to develop a system for identifying high-risk prescribing practices using administrative (e.g., billing) data. The study looked at the elements that could be identified if there were a system for identifying high-risk practices; if claims data for pharmaceutical prescriptions were available, what data elements would be present in those systems; those elements would include: the type of opioid medication: fentanyl, methadone, meperidine (i.e., the specific drug); and the formulation and the route of administration, an example being the fentanyl patch, the immediate-release fentanyl, the long-acting versus short-acting morphine, and the maximum daily dose (morphine equivalents per day). The last element was the drug-drug interaction of taking opioids along with a medication that increases the risk of overdose or other adverse events, such as if a person is on morphine and also gets a prescription for benzodiazepines. The study went through the guidelines and looked at the information relative to those key elements of the prescriptions and what the guidelines recommended for immediate-release fentanyl and other drugs. The study also looked at other ways of reducing the risks of prescribing to determine the benefit of opioids versus other types of pain medication such as non-steroidal acetaminophen, the value of written treatment agreements between providers and patients, the value of urinary drug testing, the value of screening for substance abuse to risk-stratify the patients, and other factors that the guidelines highlight that may affect patient outcomes. Finally, the guidelines were evaluated based on the standards and the systematic reviews using standardized instruments, one being AGREE and the other being AMSTAR which looks at specifically the quality of literature used in guideline development. AMSTAR was used to evaluate the quality of systematic review.

Dr. Nuckols stated that 17 guidelines were identified that met the inclusion criteria. There were 12 general opioid-treatment guidelines able to be fully evaluated using AGREE II, AMSTAR criteria. Information on their development methods was available. For the Washington State guideline, there was no information on how it was developed. For the systematic reviews, nine systematic reviews were identified and then evaluated using AMSTAR.

Dr. Nuckols summarized the information gleaned from all the systematic reviews and guidelines. Four systematic reviews have found that opioids are significantly more effective than placebo in treating chronic pain. Although one of the limitations is that none of these studies have followed patients for a long period of time, there were findings in general that patients had declines in pain

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of 30-50%, a significant decline. Additionally, using opioids for chronic pain is associated with significant improvements in measures of functional status, such as the SF-36 which is a general measure of health. Functional status is closely linked to the ability to work, which is very important in workers' compensation. Dr. Nuckols stated in conclusion that opioids are effective at improving pain and functional status and are even more effective at improving pain and functional status than non-steroidal anti-inflammatory agents (NSAIDs). On balance, opioids are effective therapy if directed at the appropriate people and if opioid risk is managed.

Dr. Nuckols stated that in terms of flagging high-risk prescriptions, the types of drugs and formulations that should be focused on are immediate-release fentanyl, which is highly addictive and has a high risk of overdose, and meperidine, which is also called Demerol, which should not be prescribed because it is highly toxic. A small percentage of people are still getting meperidine which has toxic metabolites that accumulate in the body and cause seizures. Dr. Nuckols stated that she is not sure why it is still being used. She then stated that methadone is a drug that should be started carefully, if used if at all, as it has a long half-life. There is even pain control with methadone and is very inexpensive, which is why people have been using it more and more for chronic pain. It has additional properties so that it acts like tricyclic anti-depressants which are used for neuropathic pain; for these reasons, increasingly, pain management doctors have been using it. However, methadone is not appropriate for everyone because the pain-suppressant effects of methadone do not last as long in the body as the effects that suppress breathing, and so it gets into an adverse situation where half the drug is still in the body after 72 hours. It might take a week or longer to get the full amount of methadone out of the body if people have been on it long-term, so it is a highly risky drug. If one looks at the statistics nationwide, the number of fatal overdoses related to methadone has been rising dramatically. This is a medication that needs to be handled carefully and has a role in the hands of very selective providers, specifically pain management experts.

In terms of maximum daily dose, the guidelines agree that a dose of 200 milligram morphine equivalents per day warrants scrutiny. Some of the more recent studies that were not incorporated into the guidelines suggest that a lower dose, such as 100 milligrams a day, warrants additional scrutiny. If prescriptions that warrant additional scrutiny are going to be flagged, that could be the threshold. It does not mean that people could not get greater than that dose, but that the specific situation should be watched closely.

Dr. Nuckols stated that benzodiazepines are extremely common for drug-drug interactions and this is therefore a concern. This is also true for other sleeping medications. There are a large number of other drugs that affect the metabolism of opioids in the liver. There are many people who do not know about the adverse effects so it would be helpful to have an automated system to flag it for providers because one does not want accidental overdoses just because somebody got started on other drugs, such as antibiotics, or they are HIV patients who are on HIV medications.

Dr. Nuckols stated that the other ways of reducing risk associated with opioid-prescribing is written treatment agreements or contracts with patients who are on chronic opioids; data are limited but favorable for this approach. Standardized risk assessment questionnaires are also a good way to reduce risk. There are several good standardized risk assessment questionnaires that screen patients for risk factors for substance abuse and personal history of substance abuse and

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family history of substance or abuse or misuse. These questionnaires can help to stratify the risk that an individual might go on to develop substance abuse problem before being put on long-time opioid for chronic pain. There are fairly limited data, but there is general consensus among the guidelines that this is a good idea. Dr. Nuckols stated that another way to reduce opioid abuse is urinary drug testing. The guidelines are generally in agreement that there is a role for urinary drug testing. There are a couple of challenges with this testing, which the guidelines go into in more detail, specifically false negatives and false positives. There are a variety of different types of urinary tests for opioid drugs, but some of them miss extremely commonly used opioids, leading to false negatives. The other issue is false positives. According to basic epidemiology, any test has a rate of false positives, and if there is a large population of patients across the entire workers' compensation system, a lot of people may be on long-term opioids for chronic pain and most will statistically be at a low risk for developing a substance abuse disorder. There is a huge population of people who will have positive urine drug test for no reason except for chance. The question is whether those people will be treated as drugs addicts or treated in some other way. Some of the guidelines state that some of these people should be taken off of opioids and never started on them again. That is probably not the most effective way to treat somebody who is a low-risk person and is suffering with pain. A nuanced way of approaching those patients may be to consider combining the initial risk assessment with the results of the urinary drug test and using both sources of information. Dr. Nuckols stated that it is not likely that there will be a perfectly specific test.

Dr. Nuckols then stated that the final results of the AGREE evaluations put the Canadian Guideline and the American Pain Society-American Academy of Pain Medicine guideline at the top in terms of overall quality. She stated the other key guidelines. The American Geriatric Society Guidelines is relevant to the increasing population of people over the age of 65 who are staying in the workforce, though it would not be the main guideline that is to be adopted. The Fine Opioid Rotation Guideline focuses on transitioning patients from one opioid to another, which is not that easy to do.

Dr. Nuckols stated that the American Pain Society Guideline and the Canadian Guideline apply to a general population of patients and address a range of clinical issues in addition to having the highest score. They have the highest rigor of development scores, with the American Pain Society guideline being slightly better than the Canadian guideline at that. Both guidelines describe barriers to implementing recommendations, which is very important and many guidelines do poorly on this point, as many guideline developers do not think about the real world implications of the ideas that they are coming up with and never field test the ideas. The Canadians did a better job of real world testing of the guidelines, not that the American Pain Society did a poor job but the Canadians did a better job of it. Dr. Nuckols stated that there are tools for pilot-testing guidelines, but they are underused. Both the American Pain Society Guideline and the Canadian Guidelines use systematic reviews, which is not true of all of the guidelines, and they definitely used the most rigorous methods possible to review the literature.

Dr. Nuckols stated in conclusion that opioid-related substance abuse and overdoses are clearly growing problems, and a large part of the problem is physician-prescribing practices. This can lead to poor outcomes and growing costs in workers' compensation settings. There are new standards of care guidelines emerging to address these issues. Using administrative databases

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with pharmaceutical prescriptions and flagging high-risk prescriptions would be one way to tackle the problem, which could be done by flagging specific types of drugs, doses, formulations, and drug-drug interactions that are problematic. That would be very feasible and could be done close to real time, that is, within a couple of days from the prescription. Dr. Nuckols stated that there are a couple of high-quality guidelines identified by the study that could be considered for adoption and further implementation in California.

Questions from Commissioners

Commissioner McNally stated that the drugs are dangerous and asked if it was feasible to restrict which physicians could prescribe opioids in an effort to providers who are more sophisticated and have an understanding of the impact of opioids. Dr. Nuckols responded that that could be possible. You could look at prescriptions and determine that if a physician is prescribing opioids that should not be prescribed, that physician would be dropped. This way you would be re-directing the provider to an appropriate opioid and not penalizing the patient

Commissioner Bloch asked why opioids are believed to be prescribed at a higher frequency in workers' compensation than with other chronic non-cancer pain patients. Dr. Nuckols stated that this is an interesting and complicated situation; possible reasons might be that patients may have more acute pain because they are early in their pain condition, or other reasons. Dr. Nuckols stated that she does not practice occupational medicine and therefore is not sure of the reason. There can be a lot of variation in prescribing practices which may be due to geographic patterns such as where the physician is trained.

Commissioner Brady stated that the report was well done and that in his work with schools, he is well aware that these medications become available to students. He asked how much time is spent in training of physicians about opioids. Dr. Nuckols stated that the statistics about how young people get opioids indicate that they come from parents and grandparents. Based on a being a faculty member at a major medical school, she stated that training on pain management in medical school is non-existent. That was why California instituted the 12 mandatory units of Continuing Medical Education (CME).

Commissioner Culbreath stated that urinary drug test was mentioned as a way to mitigate the abuse and asked whether there are data that show that workers were penalized if they tested positive for drug in ways other than just being removed from the drug. Dr. Nuckols responded that data on this are pretty limited. Most guidelines did mention that there is a role for urinary testing. Some guidelines discuss the complications of drug testing, while other guidelines take a hard line on urine testing. She stated that the workers' compensation record should be confidential and she does not know if workers' compensation records leak to the employer. Commissioner Brady stated that that does happen.

Commissioner Bloch stated that he was thinking about anecdotal stories that come out of his union about substance abuse problems and the question about a small concentration of physicians prescribing opioids. He asked how California tracks physician-prescribing, and Dr. Nuckols responded that there is a database that allows physicians to see if their patients are getting drugs from multiple sources. Providers have to register for a database and they can look

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up their individual patients. There may not be many physicians that do this because, anecdotally, it is a burdensome and not efficient system. On the provider side, the Medical Board tracks provider-prescribing patterns, but this has not proven to be very vigorous, as suggested in an *LA Times* article. Commissioner Brady stated that the article was insightful and it tracked fatalities due to opioids and indicated how physicians are surprised at what patients receiving opioids experience. This suggests that more analysis of this situation would be appropriate. Commissioner Brady asked if there was any information about opioids affecting tissue structure, and Dr. Nuckols responded that it is an interesting question but she does not know of information on that.

Commissioner Wei stated that one question in the review of the literature is whether there is anything that indicated that prescribing an opioid is part of a treatment plan or whether it is a stand-alone physician practice. Dr. Nuckols responded that patients receiving an opioid should also be prescribed a non-steroidal drug or acetaminophen. The two medications go together. However, some patients should not be prescribed a non-steroidal drug. There are a lot of medications that are non-opioids that are adjuncts for treating pain and there is a large range of other modalities, such as exercise, meditation, yoga, acupuncture, chiropractic manipulation, and others.

Commissioner Wei asked whether physicians are treating pain by prescribing only or do they also address what is causing the pain. Dr. Nuckols stated that some conditions are more amenable to fixing than other conditions; for example, chronic back pain most of the time, cannot be fixed. Treating the underlying cause works with a reversible condition; in a lot of situations of chronic pain, there is no cure.

Commissioner Wei asked if Dr. Nuckols found anything in the literature about tracking systems in other states or other countries by prescription, by patient, by prescriber. Dr. Nuckols responded that she has talked with people who are interested in setting up systems like that; there are a variety of things that go on where you can risk-stratify. If a medical system has an electronic data system which is also a communication system, like Kaiser does, it is easier to communicate when a change in prescribing practice is needed. It depends on the sophistication of the data systems and communication systems.

Public Comment

Steve Zeltzer, California Coalition for Workers' Memorial Day, stated that in the past, there have been testimonies to the Commission from workers who were not provided medication and who committed suicide. He stated that perhaps there should be a study of workers who are not provided medication and have committed suicide. He stated that acupuncture was excluded by SB 899 under ACOEM rules and he stated that acupuncture should be included as it is a treatment. Chair Wei stated that there are acupuncture guidelines. Mr. Zeltzer acknowledged that it was included and stated that acupuncturists had to fight for that. Mr. Zeltzer stated that there has been an increase in the use of drugs because injured workers are waiting for long periods to get approvals through a bureaucratic process and as a result, they get drugs instead of therapy and eventually, many of those workers wind up on social security disability and other programs. He stated that the study does not address the efficiency of the system and the ability to get proper

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treatment. The correlation between drugs and the inability to get treatment and increased drug use should be investigated.

Carolyn Ginno, California Medical Association (CMA), stated that CMA is in support of addressing this issue. Physicians and specialists who do occupational medicine will review the study and provide comments. She stated that more pain treatment is seen in workers' compensation, and injured workers need more pain treatment. A concentration of pain prescriptions from a small number of physicians is normal because pain management is a new specialty. She stated that it is important to look carefully at any restrictions on medications for pain management so that access to care is not denied and physicians can effectively manage pain. She also stated that it is good to hear conversations about the tracking system; CMA has run a database but it has been de-funded, and CMA and other stakeholders are trying to work with the Administration to re-enable the database. Ms. Ginno re-stated that it is important to look very carefully on prescribing limitations and to monitor and track where the prescriptions are going, given that there are more severe cases and more specialty cases in workers' compensation. Having the data is a critical first step.

Michael Nolan, California Workers' Compensation Institute (CWCI) stated that in California, there is a cure system for monitoring prescriptions drugs; nationally, it is known as a prescription drug-monitoring system. He stated that the International Association of International Boards and Commissions (IAIABC) has done a study on this, and last week, under Brandeis University, there was a major conference on drug limitations, which may be of assistance in this issue. Two major issues are funding and access to data; regarding access to the data, is it only physicians or both physicians and those people who are adjusting the claim. He stated that it is important to keep confidentiality from employers. There is an additional question about drug formularies and whether they should be brought into the workers' compensation system. He stated that the belief that there are sicker patients in workers' compensation has been challenged by studies; an important question is whether an injured worker is getting different types of treatment or whether injured workers are getting different types of treatments.

Floyd Miñana, practicing chiropractor and representing the California Chiropractors Association, stated that from the point of view of the chiropractic professionals, Senate Bill (SB) 228 ignored the fact that chiropractors are providing effective treatment for injured workers. By using a few over-utilizing chiropractors, the Commission used that as proof that the limitation was necessary; when this limitation was imposed, more injured workers turned to using drugs. As a result, drug costs sky-rocketed, and more cases of gastro-intestinal problems (such as, GERD, stomach ulcers, kidney and liver failures) developed from the over-use of medications. Mr. Miñana stated that the Commission got what it wanted – an arbitrary limitation on chiropractors which ignores the needs of individual patients and forces them to use drugs. He stated that he urges the Commission to get over its bias against chiropractic care, as that bias has not improved the lot of injured workers.

Dr. Rupa Das, DWC medical director, stated that she would like to know why the Washington State guidelines were not evaluated in the study. Dr. Nuckols responded that those guidelines were included in the report and information was extracted from those guidelines related to the recommendations. She stated that the guidelines were not formally evaluated using the AGREE

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or AMSTAR instruments because Washington State does not provide any information on the development method for the guidelines.

CHSWC Vote

Commissioner Culbreath moved to approve to post for feedback and comment for 30 days the DRAFT report “Identifying Risky Opioid Prescribing Practices” and then pending feedback, approve for final release and posting, and Commissioner Brady seconded. The motion passed unanimously.

Public Comment

Steve Zeltzer, California Coalition for Workers’ Memorial Day, stated that in the past, there have been testimonies to the Commission from workers who were not provided medication and who committed suicide. He stated that perhaps there should be a study of workers who are not provided medication and have committed suicide. He stated that acupuncture was excluded by SB 899 under ACOEM rules and he stated that acupuncture should be included as it is a treatment. Chair Wei stated that there are acupuncture guidelines. Mr. Zeltzer acknowledged that it was included and stated that acupuncturists had to fight for that. Mr. Zeltzer stated that there has been an increase in the use of drugs because injured workers are waiting for long periods to get approvals through a bureaucratic process and as a result, they get drugs instead of therapy and eventually, many of those workers wind up on social security disability and other programs. He stated that the study does not address the efficiency of the system and the ability to get proper treatment. The correlation between drugs and the inability to get treatment and increased drug use should be investigated.

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Dr. Rupa Das, Medical Director of the Division of Workers' Compensation, stated that she would like to know why the Washington State guidelines were not evaluated in the study. Dr. Nuckols responded that those guidelines were included in the report and information was extracted from those guidelines related to the recommendations. She stated that there was limited inclusion because Washington State does not provide any information publication on the development method for the guidelines.

CHSWC Vote

Commissioner Culbreath moved to approve to post for feedback and comment for 30 days the DRAFT report "Identifying Risky Opioid Prescribing Practices" and then pending feedback, approve for final release and posting, and Commissioner Brady seconded. The motion passed unanimously.

Update on Quality-of-Care Indicators Project

Teryl Nuckols, University of California, Los Angeles

Dr. Nuckols stated that she was providing an update on work that the Commission was instrumental in getting off the ground. Work on the quality of medical care for carpal tunnel syndrome and effects on clinical outcomes and cost is ongoing and is being done with a colleague, Dr. Steven Asch.

Dr. Nuckols stated that the motivation for the study was the quality of care for carpal tunnel syndrome in workers' compensation settings. One study that found that better medical care for

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patients with musculoskeletal disorders reduced time on temporary disability (TD) by 37%, reduced the percentage of TD patients who became permanently disabled by 50%, and reduced medical and disability costs by 37%, thereby generating a substantial return on investment. The study was done several years ago and was not in a workers' compensation setting. The present study is the result of a public-private partnership, with the Commission being instrumental in developing the project. Funding came from the Commission and Zenith Insurance Company to develop quality measures. Partners-in-kind were Kaiser Permanente Northern California and the State Compensation Insurance Fund (State Fund). Quality measures were developed using a multidisciplinary approach, with a national panel of experts rating the measures. A tool that supports the use of the measures was also developed and is available for free on the RAND website. It can be used to rate the quality of care for carpal tunnel patients. Both Kaiser and State Fund pilot-tested the measures.

Dr. Nuckols stated a distinction between treatment guidelines and quality of care measures. Guidelines are meant to be flexible and advisory and acknowledge gray areas. Quality measures, on the other hand, are tools for accountability; they are more black and white (e.g., what to do and what not to do), with explicit algorithms describing mandatory requirements. Seventy-seven (77) measures that addressed diverse aspects of care were developed: 31 measures address diagnosis and non-operative management; 6 measures address electro diagnostic tests and how to do them well; 18 measures can be used to determine when surgery should or should not be performed; and 22 measures are used to address care before, during and after surgery.

Dr. Nuckols stated that there publications are available on the RAND website, including a list of the measures and an algorithm that could be used for utilization review purposes. One example of a measure assesses delays in diagnosing carpal tunnel syndrome (CTS), causing increased disability. In a Washington State study of CTS claims, half of the claims for CTS were initially filed for other conditions like tendonitis. In 20% of the claims, CTS was not diagnosed until three months or longer after the claim was first filed, and the longer the delay in the CTS diagnosis, the longer the disability. One measure attempts to recognize CTS symptoms early on and therefore implies that treatment will be earlier and outcomes will be better. In prior studies, however, when these types of measures were used, it was found that the measures were followed only 50% of the time.

Dr. Nuckols stated that the main objective of the current study is to determine whether better outcomes in treatment and costs result when quality measures are used. The project is funded by the U.S. Agency for Healthcare Research and Quality. The study site/partner is Kaiser Permanente Regional Occupational Health (Northern California). The study uses a timeline of clinical, legal and research events to determine if the injury is work-related. CTS is a chronic condition; symptoms could start a few years before the patient becomes part of the study. The patient is at some point evaluated by a Kaiser physician to determine if the CTS is work-associated. Once a workers' compensation claim is filed, the patient becomes a subject in the study. There is a lot of controversy about whether CTS is work-related. There are some quality measures that ask whether the provider evaluates the patient for standard factors creating CTS. Some patients in the study will be off work, some will be at work; some will get surgery; some will not. The medical records are reviewed, along with costs and disability rating over an 18-month period. Quality of care will be examined during the first 12 months by reviewing the

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medical records. Medical and disability costs over an 18-month period will be examined. De-identified data from the Workers' Compensation Insurance Rating Bureau (WCIRB) and the Employment Development Department (EDD) will be used in addition to patient surveys to get a broader picture of costs including medical, disability, legal defense, absenteeism and presenteeism, lost income and any home care expenditures. Clinical outcomes will be examined through surveys at baseline and follow-up.

Dr. Nuckols stated that clinical outcomes will be evaluated by a condition-specific instrument that will be used which looks at physical limitations due to CTS. A standard instrument for assessing physical and mental health, the SF-12, will be used. Diagnoses will be corroborated using a hand diagram, medical records and return-to-work measures. Return to work will also be evaluated. Dr. Nuckols stated that all information is confidential.

Dr. Nuckols stated that to evaluate the quality of care, the highest and lowest quartiles for quality will be examined and effects will be compared. The highest quality would involve physical outcomes and return to work. To date, about 2/3 of the study subjects have been recruited, with over 500 people, which is close to the target. Two-thirds of the study subjects are 2/3 female, the average age is 47, 62% are working full-time, 12% are working part-time, 25% are not working; it is a relatively affluent population, but subjects are in poor physical and mental health in comparison to the general population.

Dr. Nuckols stated that the study instrument will soon be finalized and public comment is welcome until February 2013. The survey will then be finalized. She provided her email contact information.

Chair Wei thanked Dr. Nuckols for the details on the study and encouraged those in the workers' compensation community to send in their comments.

Dr. Nuckols stated that providers can use the tools available on the RAND website.

Questions from Commissioners

Commissioner Bloch asked about the reported income of the women and what types of occupations the women are working in. Dr. Nuckols responded that the study subjects by will be coded by occupation, but that that data has not yet been analyzed. Some of people are on disability and not currently working, so their income might reflect disability income. CTS is more common in females than males, which explains why there are more women than men in the study.

Public Comment

Steve Zeltzer, speaking for California Coalition for Workers' Memorial Day, stated that they would not approve the study; there has to be an examination of the correlation between refusal of

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treatment and forcing workers to go on drugs. That issue has not been investigated by the Commission.

Chair Wei stated that posting the draft report and the memo is to allow for public comments for 30 days. The Commissioners welcome all public comment submitted, which will then be written into the public record.

CHSWC Vote

Commissioner Culbreath moved to post for feedback and comment the DRAFT Memo “Evaluation of Opioid Prescribing Guidelines Using AGREE II,” then pending feedback, approve for final release and posting, and Commissioner McNally seconded. The motion passed unanimously.

Experience Modification Study

Frank Neuhauser, University of California, Berkeley

Mr. Neuhauser stated that the Commission requested a study that examined the impact of experience rating on safety in the workplace. The study has been done by RAND, University of California, Berkeley, and the University of Pittsburgh. Three issues are being studied within the area of small employers: whether extending experience rating to small employers reduces occupational injuries at these employers; whether any observed claim reporting reduction is claim suppression or a real safety impact; and whether in the absence of regulatory intervention, insurers would apply experience rating to small employers more efficiently.

Mr. Neuhauser stated that there is only a single approach in the U.S. for experience rating. Experience rating is designed and managed by insurers through the National Council on Compensation Insurance (NCCI) in 38 states and several independent state rating bureaus including WCIRB in California.

From its inception, the public policy motivation for experience rating was safety incentives in the workplace. In practice, the application of experience rating by insurers is strictly as an underwriting tool. Mr. Neuhauser stated that in 2008, he participated with the Commission and labor in a comprehensive review of experience rating in California conducted by WCIRB. WCIRB was explicit about its review of experience rating’s ability to predict employer’s experience in the future and to underwrite it appropriately. WCIRB did not look at safety aspects, which are important, but suggested that the Commission review safety aspects.

Mr. Neuhauser stated that experience rating is used in California and all U.S. jurisdictions. Experience rating is calculated for the year a policy is written based on a three-year period of a firm’s experience, which lags by a full year plus the current year. Basically, the experience applied is in years two to four preceding the policy year. California and all other US jurisdictions exclude small employers from experience rating. Eighty percent (80%) of

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employers in California are not experience-rated; only the largest 20% are rated. The question is whether the threshold should be lowered to allow more employers to be rated.

Mr. Neuhauser stated that a lot of employers are right at the threshold. The study looked at employers right around the threshold who got experience-rated for the first time in a policy year and compared them to employers right around the threshold who were not quite large enough to become experience-rated and therefore did not become experience-rated in the policy year. These are virtually identical employers, some of whom became experience-rated the first time and some that do not. When an employer becomes experience-rated for the first time as a small employer, the impact on premiums can be quite large; an experience modifier can be between .90 and 1.20, or about a 36% swing in premium.

Mr. Neuhauser showed the example of the third year after becoming experience-rated. In that year, there was an 8.4% decrease in claims reported. This was a substantial change and would be an argument for opening up experience rating to small employers. There could be an alternative explanation, that the change of about 8% is the result of claims suppression.

To evaluate whether the reduction in claims was a safety effect or due to claims suppression, Mr. Neuhauser analyzed the average cost per claim. Claims suppression would drive up the average cost per claim because claim suppression is most likely to lead to under-reporting of smaller claims. He reported there was no change in the average cost per claim, leading to the conclusion that the claim reduction was a true safety effect.

A key question is whether insurers would apply experience rating in the absence of legislation. Insurers have a lot of tools available to them such as debits/credits, having different companies within their organization insure the employer, etc. Consequently, even in the absence of experience rating, insurers can apply various tools that would adjust premiums in a way very similar to experience rating. However, to the extent that insurers do not consider the experience of small employers is credible for predicting future experience, they are less likely to impose underwriting debits and credits. Claims are infrequent for smaller employers, including those just around the current threshold for experience rating. An employer near the threshold has a claim once every 3 years and a disability claim once every 11 years. Therefore, having a claim one year is not a good predictor for what will happen the next year, but having a claim has a very large impact on premium. One moderate-size claim, even one that is less than an employer's expected losses for a calendar year, can lead to up to a three-fold increase in premiums if the employer is small and experience-rated.

Mr. Neuhauser examined employers just below the threshold for experience rating and found that insurers did not adjust the premiums for these employers when they had a claim. He stated that he concludes that absent statutory and regulatory requirements to impose experience rating, insurers do not, *de facto*, experience-rate employers below the current threshold and would likely not experience-rate many employers just above the threshold. That is, absent current regulatory requirements, insurers would experience-rate even fewer employers than they do today (20%).

Mr. Neuhauser stated that reducing the threshold for experience rating below the current threshold, which excludes 80% of employers, would reduce claims and costs. Legislative or

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statutory ruling would be necessary to have insurers lower the threshold. However, it is important to explore alternatives that would reduce the sensitivity of small employers experience rating to losses. The current formula will lead to quite large and probably inappropriate swings in smaller employers' premiums.

Questions from Commissioners

Commissioner Bouma stated that she is still left wondering if claims suppression is still actually taking place, and she asked if there are other measurements that have been used to determine claims suppression. Mr. Neuhauser responded that of course claims suppression exists to some degree; there are examples of people asked not to report. The question is whether the introduction of experience rating causes small employers or employees to act differently in terms of suppressing claims. He stated that there is no evidence that it has such an effect.

Commissioner Bloch asked whether Mr. Neuhauser found any evidence from employers of measures they are taking to improve safety in the workplace; if suppression is not happening, one would expect a reduction in claims to be due to improved safety. Mr. Neuhauser responded that there is only so much small employers can do to improve safety due to limited resources; however, this would be an interesting question for future research.

Commissioner Wei asked if it could be assumed that experience rating does not exist for large employers. Mr. Neuhauser responded that debits and credits can be applied to any policy holder, and they are frequently applied to policy holder just above the threshold. Insurers are required to apply experience rating in the development of premium rates. All employers that are experience-rated are required to have experience rating applied and it will appear on their bill, known as the "premium deck." Additional debits and credits and switching among insurers may attenuate the impact of the experience modifier for larger employers.

Commissioner McNally asked what percentage of the workplace is covered under experience rating. Mr. Neuhauser responded that 80% of employers are not experience-rated; self-insureds are considered fully experience-rated because they assume responsibility for all of the claim costs; however, there is no mechanical method in place in such situations. The larger employers and self-insured employers account for 65% to 80% of the workforce. He stated that WCIRB would have more precise percentages.

Commissioner Wei asked if there are any projects planned that will examine experience rating more fully, and Mr. Neuhauser responded that there would be an examination of whether or not raising experience rating sensitivity to large employers would have an impact on encouraging them to be safer. He stated that the study would look at some formulations for experience rating for small employers that might help rates jump around less following small claims.

Commissioner Wei asked if experience rating in California is similar to what other states do. Mr. Neuhauser responded that every state does experience rating the same way, with the exception that California experience rating is a little less sensitive than other states. There is a cutoff called primary and excess losses; primary losses count more heavily against experience,

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and California's threshold is quite low for that; other thresholds are higher. A higher threshold would make small employer rates jump around even more. WCIRB made the decision to keep the current split for primary and excess losses, at least for this year.

Public Comments

Steve Zeltzer, California Coalition for Workers' Memorial Day, asked why the study did not address the issue of whistle blowers in health and safety, especially those people who have been retaliated against, or the issue that in California, there are only 180 Cal/OSHA inspectors. He stated that they just had the situation with Chevron, which blew up and contaminated workers and people in the community. He asked where inspection at Chevron following the explosion was and why there was no Cal/OSHA inspection of Chevron before the explosion, considering it is a highly dangerous facility. He stated that there needs to be a study of retaliation against whistle blowers and how many workers are fired for making health and safety complaints and how many get their jobs back. He stated that there has been a decline in workers' compensation claims and an increase in disability claims because workers cannot get workers' compensation under the present structure, even under the structure being proposed. Serious health and safety issues on the job are being covered up and studies should address that.

CHSWC Vote

Commissioners Bloch moved to approve that the Commission post for feedback and comment for 30 days, and then pending RAND'S quality assurance, approve for final release and posting the DRAFT Working Paper "The Impact of Experience Rating on Small Employers: Would Lowering the Threshold for Experience Rating Improve Safety?," and Commissioner Culbreath seconded. The motion passed unanimously.

Acting Executive Officer Report

D. Lachlan Taylor, CHSWC

Lachlan Taylor stated that as the DIR Director commented, DIR staff has been busy and productive, and he appreciates the Commission staff's work in the weeks following the reform bill. There are four studies being contracted as part of the reform bill: to examine the return to work program; to examine average wage loss in connection with permanent disability ratings; to examine the copy service fee schedule; and to examine the public sector self-insurance program.

Mr. Taylor stated that another study being proposed now is to examine the impact of the statute of limitations on death cases for firefighters and peace officers. Governor Brown vetoed Assembly Bill (AB) 2451 because there was not enough information on the subject, and he has directed the Department to develop that.

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CHSWC Vote

Commissioner Bouma moved to approve that the study on firefighters be done, and Commissioner McNally seconded. The motion passed unanimously.

Commissioner Bouma thanked the Commission for undertaking the study. The families of firefighters experience the arbitrary nature of the statute of limitations on qualifying for death benefits and run the risk of experiencing a loss of benefits. The labor and employer sides would benefit from the study indicating the impact of what a policy change would be, as well as how significant the fiscal impact of a new policy and what the reserving requirements should be.

Commissioner Bloch stated that he represents police officers in the state of California. He stated that one group that comes to mind is police officers in the city of San Bruno who had to respond along with firefighters when there was the explosion of a pipeline there. The study would be helpful to them.

Posting Studies for Feedback and Provide Reports of Feedback in Advance of Commission Meetings

Judge Taylor stated that there is a proposal to post studies for feedback in advance of Commission meetings. Chair Wei stated that there would be some analysis and reporting of public comment before Commissioners gave final approval.

CHSWC Vote

Commissioner Bouma moved to approve that the studies be posted for feedback in advance of Commission meetings and that Commissioners receive a report of public comment before the meetings, and Commissioner Brady seconded. The motion passed unanimously.

Requirement for Insurer Review of Employer's Injury and Illness Prevention Program (IIPP) and the Impact of Adoption of AMA-based Permanent Disability Rating Schedule in California

Judge Taylor stated that there has not been any public comment on the Memo "Requirement for Insurer Review of Employer's IIPP." Public comment on the "The Impact of Adoption of AMA-based Permanent Disability Rating Schedule in California" has been received and is available during the meeting. He suggested that the public comment be posted along with the report.

CHSWC Vote

Commissioner McNally moved to approve for final release and posting the Memo "Requirement for Insurer Review of Employer's IIPP," and the report "Impact of Adoption of AMA-based Permanent Disability Rating Schedule in California," as well as the public comments on this report to explain the narrow focus of the study, and Commissioner Bouma seconded. The motion passed unanimously.

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Commissioner Bloch asked what steps are taken when employers are found to be in violation of the IIPP requirement. Judge Taylor stated that the employer is cited by Cal/OSHA if there is no IIPP. The memo reviewed the history of the insurer's role in assisting policyholders.

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

Judge Taylor stated that WOSHTEP has continued to present injury and illness prevention training programs and resources through: 3-day Specialist courses; Awareness Sessions; Small Business trainings; and a Young Worker Leadership Academy. New materials have been developed including: a Construction Case Study Training Guide with the State Building and Construction Trades Council of California, AFL-CIO (SBCTC), which includes trade-specific health and safety case studies, which make a significant impact; health and safety training materials on indoor heat illness, which are posted on the CHSWC website; and Injury and Illness Prevention Program (IIPP) training materials for general industry and for small businesses.

School Action for Safety and Health (SASH) Program

Judge Taylor stated that SASH training classes continue to be offered statewide.

Commission's 2012 Annual Report

Judge Taylor stated that Commissioners have a draft of the 2012 Annual Report. Some new data are expected shortly and final edits will need to be done before posting the report.

CHSWC Vote

Commissioner Culbreath moved to approve for final release and posting, pending final edits and updates, the 2012 CHSWC Annual Report, and Commissioner Brady seconded. The motion passed unanimously.

CHSWC Vote

Commissioner Culbreath moved to approve for final release and posting the 2012 WOSHTEP Advisory Board Annual Report, and Commissioner Bouma seconded. The motion passed unanimously.

Public Comment

Steve Zeltzer, California Coalition for Workers' Memorial Day, asked why there are no studies being done on health and safety issues in California such as the number of inspectors in California, the oil industry and explosions in California, and the effect of fracking on the health and safety of workers. It seems that the studies done look at the impact on the insurance industry and not the impact on the working people of California. The workers are being injured and seriously harmed. The Commission should address those issues and represent the workers of California, not the insurance industry.

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Commissioner McNally stated that he appreciates Mr. Zeltzer's comments but he has never seen anyone show any preference for the insurance industry. Commission studies evolve from recommendations from people like Mr. Zeltzer, and the Commission would take into account what Mr. Zeltzer and others say, and it will use its resources as best it can.

Chair Wei stated that the Commission welcomes all ideas for research proposals from anyone in the stakeholder community and the public sector. The purpose of public comment and open lines of communication are to welcome ideas for research and any suggestions for a research agenda.

Commissioner Bloch stated that he appreciates the WOSHTEP training developed for the dairy industry. This is a difficult time for the dairy industry in California, which produces more milk than any state in the country, with rising grain prices due to drought and the downward pricing pressures from employers who produce cheese. There are widespread bankruptcies in the dairy industry and there is concern how all of these factors may affect those working in the dairy industry. He stated that he would like to learn more about the WOSHTEP dairy industry training and how this might be extended to workers in dairy processing which is particularly dangerous work. Chair Wei asked Judge Taylor connect Commissioner Bloch with WOSHTEP training staff.

Former Commissioner Shorty Thacker

Chair Wei stated that she would like to request a moment of silence in memory of former Commissioner Shorty Thacker, a labor member, who passed at the end of July 2012. Ms. Baker stated that he was the longest standing member of the Commission. Chair Wei stated that Shorty Thacker never missed a meeting because of his commitment to worker health and safety and to his members.

A moment of silence was held.

Public Comment

Steve Zeltzer, California Coalition for Workers' Memorial Day, stated that he was here to protest Senate Bill (SB) 863. Injured worker organizations were against this measure; it excludes additions for psychological damage, insomnia and sexual dysfunction. Workers are bullied on the job and get depressed and should be compensated. In addition, this bill prevents injured workers from knowing who rejects their appeals. This legislation was passed without consultation with injured worker advocates. This legislation will benefit insurance companies; it will cause cost-shifting to the public. Even firefighters in Los Angeles were against the bill. Hearings were held, but the language and the changes were not presented. Injured workers are angry; they think it is an outrage and that the Commission and Director Baker who supported the bill should be held accountable.

Thank You to Chair Wei

Commissioner Bloch stated that he would like to thank outgoing Chair Wei for her service.

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Other Business

None.

Adjournment

CHSWC Vote

Commissioner Culbreath moved to adjourn, and Commissioner Bouma seconded. The motion passed unanimously.

The meeting was adjourned at 11:28 a.m.

Approved:

Martin Brady, Chair

Date

Respectfully submitted:

D. Lachlan Taylor, Acting Executive Officer

Date