

Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING

October 22, 2009

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

In Attendance

Acting Chair Kristen Schwenkmeyer

Commissioners Catherine Aguilar, Faith Culbreath, Robert Steinberg, Darrel "Shorty" Thacker,
and Angie Wei

Absent

Chair Sean McNally

Executive Officer Christine Baker

Call to Order

Commissioner Kristen Schwenkmeyer, Acting Chair, called the meeting to order at 10:00 a.m. She stated that she was Acting Chair because Sean McNally was on an aircraft carrier with his son; the carrier had been redirected and he could not attend the meeting.

Acting Chair Schwenkmeyer stated that public comment for each agenda item, as applicable to the item, would be limited to three minutes.

Minutes from the August 27, 2009 CHSWC Meeting

Acting Chair Kristen Schwenkmeyer requested a vote on the Minutes of the August 27, 2009 meeting.

CHSWC Vote

Commissioner Thacker moved to approve the Minutes of the August 27, 2009 meeting, and Commissioner Aguilar seconded. The motion passed unanimously.

Introduction of New Commission Member

Acting Chair Schwenkmeyer stated that Faith Culbreath is a new member of the Commission representing labor. Commissioner Culbreath has been President of Security Officers United in Los Angeles (SOULA), Local 2006, of the Service Employees International Union (SEIU) since 2007. In April 2009, Faith was asked by the Trustees of SEIU United Healthcare Workers West (UHW), a 150,000-member statewide local union, to head up its External Affairs Department, which includes building and promoting the Local's Political Power and Community Strength program.

Acting Chair Schwenkmeyer welcomed Commissioner Culbreath.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Workers' Compensation Medical Study of Impact of Recent Reforms: Selected Key Issues

Barbara Wynn, RAND

Background

Ms. Wynn stated that she would focus on actions and policies that could reduce workers' compensation medical expenses without compromising quality of care. She stated that this work draws on previous RAND reports, as part of the Medical Cost Study. The topics to be discussed include in-patient hospital services, ambulatory surgery facilities services, physician services, and the adoption of electronic billing. The information is fairly technical, but it is important to understand the bases for the recommendations and findings.

In-patient Hospital Services

Ms. Wynn stated that the recommendations and findings stem from the changes made to the Official Medical Fee Schedule (OMFS) in 2004. She stated that the aggregate limit on allowances or maximum allowable amounts is 1.2 times the Medicare rate for comparable services under Medicare. The Administrative Director of the Division of Workers' Compensation has authority to adopt a lower multiplier or to adjust relative weights for specific diagnosis-related groups (DRGs). The provisions provide for regular updates for inflation and the inflation factors specified in the Labor Code. She stated that prior to these changes, there was a pass-through for implanted hardware used in both back and spinal surgery. The changes in the Labor Code limited the pass-through to complex spinal surgery until the Administrative Director specifies otherwise in the fee schedule.

Ms. Wynn stated that the 2004 OMFS changes eliminated the exemption for care provided in specialty hospitals (psychiatric, rehabilitation hospitals in particular, and long-term care hospitals) effective January 1, 2005, but the change has not yet been implemented, which means that payments to those facilities continue to be based on hospital charges or negotiated amounts between the payor and the facility.

Ms. Wynn stated that there are three policies that raise concern. The first is the pass-through for spinal hardware, which is not a new topic for the Commission. The pass-through amounts for spinal hardware duplicate the amounts already included in the standard rate for spinal surgery. The second issue is related to the change that Medicare made in 2008 to adopt severity-adjusted DRGs. The changes improved payment accuracy, but they also lead to an increase or inflationary effect on the average relative weight that is used to determine payment. The third issue is the continued exemption for specialty hospitals.

Pass-Through

Ms. Wynn then presented a technical slide with an illustration of the formula and factors used to determine the payment rates. She stated that it begins with a standard rate, based on the Medicare payment rate, which is then adjusted for facility characteristics, such as the location of the hospital or whether it involved in teaching activities. On average for the spinal fusion DRGs, it increases the payment 51%. She stated that a 1.2 multiplier is attached, as provided by the

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Administrative Director. It is then multiplied by a relative weight, classified into a DRG; each DRG is given a relative weight (relative costliness of providing the care in that DRG relative to overall care). She stated that these factors make up the calculation for the standard allowance. In addition, when there is spinal surgery, there is a pass-through for the cost of the implanted hardware. Based on analysis of Medicare data, the average is about \$14,000 in this DRG. She stated that they do not know the actual amount for workers' compensation patients, since that data are not available; however, she stated that they hope to have better information on that using the Workers' Compensation Information System (WCIS) in the near future. In this example, the total allowance amounts to \$50,071. An analysis of the total estimated allowance and estimated the cost of providing care on average in the DRG was done. That estimated cost applied an overall cost-to-charge ratio for each facility that provides care for each case and adjusted for charge compression and inflation. The result was an estimated cost of \$35,811 for this particular DRG. The allowance-to-cost ratio ($\$50,000/\$35,800$) demonstrates that facilities are receiving 40% more than the cost of providing care.

Ms. Wynn stated that the pass-through is problematic. The allowance is paying twice for hardware costs. Research shows that approximately 51% of the standard Medicare rate is already dedicated to device costs. The allowance-to-cost ratios exceed costs, and based on Medicare usage, the pass-through provides at least \$60 million more. Because the cost is based on invoice prices net of rebates and discounts, it imposes a significant unnecessary administrative burden on the hospitals and payors to process. The excessive payments create incentives for unnecessary device usage. Ms. Wynn stated that she likens the situation to having a travel expense account versus a per diem allowance. She stated that the Medicare Payment Advisory Commission (MedPAC) and other researchers find that device manufacturer payments to physicians for developing new technology and training in the use of the new technology or devices lead to unnecessary usage. There is pending legislation in Washington, D.C., that would require public reporting of payments to physicians by device manufacturers. She stated that many of these payments are justified in terms of product development and training, although some incentives for overuse are created.

Ms. Wynn stated that they looked at all of the spinal surgery DRGs to calculate allowance-to-cost ratios. An allowance-to-cost ratio of 1.0 means the allowance is equal to the cost. If the ratio is 1.17, it means the allowance is 17% higher than cost. If the ratio is .90, it means that the allowance is only 90% of cost, less than the estimated cost. She stated that the costs are estimated by applying an overall cost-to-charge ratio to total charges, with the caveat that there is a problem in that hospitals tend to have lower markups on high-cost items such as devices than lower-cost items; this is called "charge compression." She stated that this does lead to an understatement of costs by approximately 13% to 15%, and they do adjust for this as mentioned earlier. Allowances do not include the hardware pass-through, in this particular case.

Ms. Wynn stated that there is variation in the allowance-to-cost ratios; the highest is for the combined anterior/posterior spinal infusion, and the DRG for spinal procedures for nervous conditions, which is a relatively small group, has a relatively low allowance-to-cost ratio. She stated that for all workers' compensation inpatient stays, a ratio of 1.2, or 20% above costs was estimated, which is pretty much in line with the ratio for private payors for hospitals.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Ms. Wynn then stated that charge compression is offset to some extent by other factors. A study by the Research Triangle Institute (RTI) for the Medicare program concluded that payment adjustments may offset the effects of charge compression. (The 2009 payment simulation found payment adjustments increased rate by 51%.) The 1.2 multiplier used by workers' compensation creates another cushion. She then stated that the shorter length of stays for workers' compensation patients in most MS-DRGs adds an additional cushion. This frees up some of the revenue that could be used for devices instead of room and board costs.

Ms. Wynn stated that there are some other considerations when weighing the options. First, technology has diffused since pass-through was initially adopted, when only a few hospitals were providing spinal surgery. Since that time, 186 hospitals performed spinal surgery on workers' compensation patients in 2007. Now, 51% of the Medicare rate is paid for devices, suggesting diffusion. An earlier RAND study found considerable variation across hospitals in reported hardware usage, making it difficult to craft policy. She stated that workers' compensation device usage may actually exceed Medicare because the pass-through does not provide for incentives for efficiency. The estimated allowance-to-cost ratios with pass-through may be understated. However, Ms. Wynn stated that one does not need to know exact amount of hardware costs in order to address the issue of duplicate payments. It is anticipated that there will be better coding of device usage and complications and co-morbidities, which will actually increase the allowances for workers' compensation patients under Medicare severity (MS)-DRGs.

Ms. Wynn then discussed 2003 workers' compensation spinal surgery discharges and average actual usage to estimated hardware usage, which revealed a range of little to twice the average usage by hospitals. She stated that there are three basic options for eliminating duplicate payments:

Option 1: Eliminate the pass-through. This would create a standard allowance and would create an incentive for efficient device usage. It assumes average usage for all patients. She stated that one could adjust the multiplier by specific DRG; where there is a lower allowance-to-cost ratio, a higher multiplier could be used. This would recognize different usage rates for workers' compensation patients based on the charges made for their stays.

Option 2: Reduce pass-through by amount implicit in the OMFS rate. This would not provide any incentive for efficient device usage. She stated that it would continue an administrative burden. This recognizes above-average variation in usage.

Option 3: Reduce the OMFS multiplier to exclude the amount implicit in the OMFS rate and continue the pass-through. This recognizes to the maximum extent the variation in usage. She stated, however, that the cost-reimbursed pass-through would still have no incentives for efficiency and continues administrative burden. One possible way around this lack of incentives is to establish fee schedule-fixed allowances based on type of hardware. This could create incentives for efficiency and reduce administrative burden (needs further study), but may still be an administrative burden on the Division of Workers' Compensation to maintain the fee schedule.

Medicare Severity-Adjusted DRGs Introduced in 2008 (Severity Adjustments and Coding)

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Ms. Wynn stated that these DRGs improve payment accuracy by paying more for severely ill patients and less for other patients. This creates an incentive to improve coding of complications and co-morbidities. In some MS-DRGs, devices now count as a complication and co-morbidity. Before 2008, there were two categories; and since 2008, there are three categories of coding for cervical spinal fusion: without complications and co-morbidities; with complications and co-morbidities; and with major complications and co-morbidities. As a result, there is now an incentive to code for a major complication and co-morbidity.

Ms. Wynn stated that Medicare actuary estimates coding improvements will inflate payments 4.8%; this is an artificial inflation unrelated to any changes to the actual types of patients being treated. The results derive from more complete coding of the complications and co-morbidities. The effect is to increase the average relative weight by 4.8% without any real change in the patient severity. She stated that it inflates the OMFS, through annual recalibration of relative weights, independent of the way workers' compensation patients are coded by the hospital.

Ms. Wynn stated that through the annual recalibration process, the relative weights are set to recognize changes in new technology and practice patterns and the average case mix. Because of the coding improvement, the average relative weight is inflated, which means that for all workers' compensation patients, relative weights are inflated by the same amount. The amount of inflation in 2008 is overstated by 2.5% because of coding improvement. She stated that the average relative weight for 2010 will be normalized to the average relative weight in 2008. Workers' compensation allowances will be 2.5% higher independent of any improved coding for workers' compensation patients. An additional 2.3% increase is estimated for 2009 affecting 2011 relative weights. She stated that this is not a one-time inflationary effect, but that this permanently builds coding improvement effect into workers' allowances unless adjustments are made. The estimated 2010 impact is \$23 million, but that will continue.

Ms. Wynn stated that there are options for workers' compensation to consider to adjust for the coding improvement effect. The Labor Code specifies the update factor that will be used to adjust workers' compensation allowances for inflation, but administratively, there is authority to adjust the multiplier (1.2 is upper limit) or the relative weights. Adjusting either the multiplier or the relative weight has the same effect. Options include:

- “Catch up” to Medicare’s adjustments by making a -1.5 percent adjustment now and follow Medicare’s adjustments in future.
- Remove the full coding improvement effect by making a -2.5 percent adjustment in 2010 and another -2.3 percent (estimated) in 2011.

Rehabilitation and Psychiatric Hospital Stays Accounted for Most OMFS-Exempt Services in 2007 (Exemptions for Specialty Hospitals)

Ms. Wynn stated that among the specialty facilities, rehabilitation is the most important, where there were \$52.2 million in charges. The Medicare-based fee schedule is based on a per discharge rate that takes into account functional status and without the data on the workers'

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

compensation patient function status, there is no way of knowing whether the Medicare method would be appropriate or not for workers' compensation to adopt.

Ms. Wynn stated that exempt facilities pose OMFS issues. Continuing to pay on hospital charges exposes payors to unnecessarily high expenditures. For example, for a 2007 workers' compensation stay in a rehabilitation facility, the average charge was \$56,564, and the estimated average cost was \$20,962, so the average cost-to-charge ratio is .37, almost three times the mark-up.

Ms. Wynn stated that the psychiatric per diem payment rate is less problematic because it adjusts for length of stay; there is less volume, so the per diem rate could probably be adopted for workers' compensation patients. She stated that there are too few and highly variable stays in long-term care hospitals for a per discharge rate, and she stated that it would not be worth bothering with it. An alternative might be to allow percentage of charges based on the hospital's overall cost-to-charge ratio, based on the facility's charging practices. Medicare makes that information available each year; therefore, it would be fairly easy to adopt. It might require Labor Code change, since this would be a departure from the required Medicare payment methodologies.

Ambulatory Surgery Facility Services

Ms. Wynn stated that the OMFS for Ambulatory Surgery Facility Services was first implemented in 2004 for ambulatory surgery provided in hospitals to outpatients and to services provided in freestanding ambulatory surgery clinics (ASCs). It applies only to facility fees for the surgical procedures; separate payments are made to the physician under the physician fee schedule. The maximum allowance in the Labor Code is 1.2 times the Medicare rate for hospital outpatient surgery. At the time that that provision was adopted, Medicare rates for ASC services were outdated, based on old cost data, and the list of covered procedures were not as comprehensive and were outdated as well; however, the rates have since been updated in 2008.

Ms. Wynn stated that the OMFS also defines ASCs as facilities that are either: licensed by the California Department of Health; or Medicare-certified as an ASC; or accredited by an organization recognized by the Medical Board of Licensure. Most of the ambulatory surgeries performed on workers' compensation patients are performed in a free-standing ASC instead of a hospital, which is different from the pattern under group health where nerve injections and arthroscopy were the most common procedures.

Ms. Wynn stated that the OMFS departure from Medicare rules raises two issues that warrant consideration. She stated that surgical procedures cost less in ASCs than in hospitals, yet the OMFS allowance is the same. Starting in 2008, Medicare has been paying ASCs 67% of the hospital rate for most procedures. The physician fee schedule amount applies for office-based procedures. ASCs that do not meet Medicare standards (definition) may receive a facility fee payment, which may result in facility fee payments to physician offices for office-based surgery which is not the original intent of the Labor Code to recognize the higher cost in an ASC.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Ms. Wynn stated that in a previous RAND study unrelated to workers' compensation, California financial data and claims data were used to compute the average relative weight for each ASC vs. a hospital outpatient department. The findings were that the relative weight is about 71% of hospital costs (if one includes professional contract expenses), or 66% of hospital costs (if not including professional contract expenses, because they are usually paid under the physician fee schedule). This result is in line with the differential that Medicare has adopted for those services.

Ms. Wynn discussed considerations in weighing fee level options. She stated that Medicare's fee schedule now provides regular ASC updates that reflect the resources required to provide services. Payment levels for services requiring a surgical facility approximate the estimated cost differential between an ASC and a hospital. Payments for office-based procedures are tied to resources required to provide services in a physician office. She stated that adopting 1.2 times Medicare ASC fee schedule would reduce OMFS allowances about \$70 million. This is based on Office of Statewide Health Planning and Development (OSHPD) data. It could be higher if there is significant volume in non-licensed ASCs, and it could be lower if services because of reduced payment amounts were to shift to hospitals. She stated that an adverse impact on access is unlikely because the allowances provide a reasonable return (20%), because surgeons prefer to provide services in ASCs because it is more convenient, there are faster patient turnover times, and many surgeons also have an ASC ownership interest.

Ms. Wynn stated that the second issue is accreditation. Facilities must meet one of three criteria to qualify as an ASC and be paid as such:

1. Licensed by the Department of Health. Licensure of physician-owned facilities was optional before September 2007, but this was often done because private payors required it before paying a facility fee. A court decision, however, eliminated licensure of ASCs with any physician ownership. Therefore, licensure is no longer an option for physician-owned ASCs.
2. Medicare-certified.
3. Accredited by an organization recognized by the California Board of Medical Licensure including: The Joint Commission (TJC), Accreditation Association for Ambulatory Healthcare (AAHC); American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAASF); American Osteopathic Association; and Institute for Medical Quality (IMQ). The first four are deemed by Medicare to have standards comparable to Medicare standards.

Ms. Wynn stated that there are considerations in deciding which entities should receive ASC facility fees. There is no clear distinction between ASCs and physician offices; some ASCs look like physician offices, and some physician offices may be highly equipped to look like an ASC. Medicare certification requires that ASC facilities be used "exclusively" for surgery but then allows space to be used differently when an ASC is closed, after hours.

Ms. Wynn stated that the OMFS current definition (revised in 2004) includes accredited facilities in the ASC definition, and that it potentially results in facility fee allowances to physician

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

practices/offices. The resource-based physician fee schedule pays more for procedures performed in offices than facilities. She stated that the accredited facilities may not meet Medicare ASC standards. For example, AAAHC and AAAASF have different standards for ASCs seeking accreditation only and for those “deemed” to meet Medicare standards. AAAASF standards vary based on level of anesthesia; it has separate standards for type of anesthesia used by clinic but accredits both facilities and physician offices. The IMQ accreditation is the most inclusive and could include facilities that do not perform surgery. She stated that it has the capability of using an outside surveyor, upon request, to determine if a facility meets Medicare life and safety standards.

Ms. Wynn stated that there were a few potential options for refining the ASC definition.

Option 1: Require Medicare certification. That would ensure that facilities meet Medicare health and safety standards. It would impose an administrative burden on facilities that have low Medicare volume, e.g., clinics specializing in plastic surgery.

Option 2: Require facilities to meet the standards deemed comparable to Medicare. That is commonly required by other payors. It would ensure that facilities meet Medicare health and safety standards as well as California code. She stated that this would eliminate facility fees for services performed in physician offices.

Option 3: Defer the changes. This option is not mutually exclusive. The volume of surgery conducted in non-Medicare certified settings and types of clinics has not yet been determined, but is not believed to be a large volume prior to 2007, although since then, it may be higher volume. This option would be an opportunity to assess the standards of accreditation organizations that are not “deemed” to meet Medicare requirements. It would also allow time to coordinate with changes in physician fee schedule. Under the resource-based relative value scale (RBRVS) proposed for physician services, the payment will actually be higher to a physician performing a surgical procedure in the office as opposed to in a facility site, which is not the case now.

Physician and Other Practitioner Services

Ms. Wynn stated that the upcoming physician fee schedule changes present opportunities. Payment equity will improve with a move from a fee schedule based on historical charges to one based on relative costs of providing services. Evaluation and management services are currently undervalued; a few years ago, the OMFS did set Medicare as a floor for those services. A single conversion factor would increase payments, but in doing that, it is important that the documentation requirements for level of service provided be adopted at the same time. Benchmarking data indicate that California patients tend to have more evaluation and management services than in other states and that they also are reported at a higher complexity level. Therefore, documentation requirements should help safeguard appropriate payments. She stated that there is also an opportunity to provide financial incentives for improved processes of care. For example, explicit fees are for work-related activities such as coordination with employers on return-to-work, or to reward desired activities such as timely first reports of injury. She stated that Washington State adopted this and that it has been highly successful.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Electronic Billing

Ms. Wynn stated that electronic billing would increase administrative efficiencies and that it has the potential to:

- Reduce paperwork burden through standardized billing forms and protocols.
- Reduce claims processing timeframes and costs.
- Increase efficiency of medical cost containment activities, which have been increasing rapidly.

Ms. Wynn stated that the final rules need to be published. The proposed rules were issued in July 2007. Payors will have 18 months to comply with the final rules. Electronic billing will be optional for providers, but there is an incentive for prompter payment. She stated that further consideration could be given for additional financial incentives to bill electronically because it would be helpful in reducing administrative costs.

Summary of OMFS Policy Issues

Ms. Wynn stated in summary that: for inpatient hospital services, the pass-through for spinal surgery remains problematic; coding improvements artificially inflate payments; and payors are at risk for unnecessarily high payments to exempt facilities. In regard to facility fees for ambulatory surgery, it is not necessary to allow ASCs and hospitals the same fees; the ASC definition is problematic and needs to be reconsidered. In addition, the new physician fee schedule presents opportunities to provide incentives for improved care. Finally, electronic billing would improve program efficiency.

Questions from Commissioners

Commissioner Wei asked whether the standard allowance in the OMFS for \$35,000 represented the cost for medical equipment only, or the entire procedure. Ms. Wynn responded that it was the estimated cost for the entire procedure. The amount of \$14,214 is based on Medicare usage rates. Commissioner Wei asked for further clarification. Ms. Wynn responded that the hospital, not the device provider, is receiving all of the \$35,857 and the \$14,214; the hospital gets \$50,000 and is paying the medical equipment suppliers what they are receiving as the pass-through amount which they are presenting as the invoice costs (\$14,214). Commissioner Wei asked if they are passing through the medical equipment cost out of the \$35,857, and Ms. Wynn responded that the hospitals are keeping that cost.

Commissioner Steinberg asked Ms. Wynn to comment on the responses received from Medtronic and the California Ambulatory Surgery Association (CASA). He stated that Medtronic makes the point that the reason for the statutory provision for the pass-through was in response to hospitals refusing to do complex surgery in the absence of a pass-through. Ms. Wynn responded the technology has diffused so that many more hospitals are involved in providing the surgery, and the rates under Medicare reflect the provision of those services to Medicare patients. She also stated that when technology diffuses, it starts with a younger population and then moves

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

to an older population, so that in the early period, Medicare rates were not accurately reflective of the level of technology that is now pervasive through all age groups. Commissioner Steinberg stated that her point was that technology improves to the point that the burden of the cost of the devices has fully been absorbed. Ms. Wynn responded that the Medicare rates are based on the charges hospitals make for the services, and that when the charges for services were examined, the Research Triangle Institute (RTI) estimated that 51% of the cost was for devices. The surgery is device-intensive, but that is reflected in the rate. Medicare rates now reflect more technology than at the time that the initial pass-through was adopted; in addition, many more hospitals are now providing the service than before.

Commissioner Steinberg asked about the payments to ASCs and cost savings, given that ASCs are designed for providing certain types of surgery. Ms. Wynn responded that the question becomes to what extent the centers should garner the cost savings or the workers' compensation program should benefit from those cost savings. Providing a Medicare-based rate with a multiplier of 1.2 is almost splitting the difference. Commissioner Steinberg asked if it was the difference between what they are now getting and what they propose. Ms. Wynn stated that she has not done the calculation, but the concept is that their resource costs are about 2/3 the amount that it costs a hospital to provide the services. Therefore, Medicare has adopted a fee schedule that pays at 2/3 the hospital rate. Under workers' compensation, there is an added multiplier beyond the estimated resources, equaling a 20% rate of return, which is comparable to what private payor rates are.

Commissioner Wei asked if those ASCs for which the fee schedule does not apply now are primarily non-Medicare certified. Ms. Wynn responded that the concern is that the definition in the OMFS rules allows a more liberal interpretation of when facilities fees are payable. They may be payable under that interpretation to facilities or physician offices that do not meet the Medicare standards and are not Medicare-certified. The question is who should receive the fees and whether a more restricted definition should be adopted. Commissioner Wei asked whether the point of having the facility fee is to cover the overhead costs at a stand-alone facility, not the kind of sunk costs in a doctor's office. Ms. Wynn stated that that was correct, since a doctor's office would be providing a much lower level of anesthesia, for example, and some procedures may not be done in an operating room environment, which is more costly. Ms. Wynn stated that she did not know how much is being done and paid for in those settings as the data are not readily available; RAND estimates are based on 2007 OSHPD data which included all licensed facilities, when most physician-owned ASCs were licensed at that time. She stated that she believes it is understood what was happening in 2007 but that there may have been some services provided in physician offices as well.

Commissioner Wei asked whether following the court decision, which disallowed/did not require physician-owned ASCs to license, the trend would be that more facility fees are reimbursed. Ms. Wynn responded that prior to the court decision, the largest volume of the ambulatory surgery performed was in licensed facilities or Medicare-certified facilities. With the court decision, licensure is no longer an issue. The accrediting organizations for facilities have standards comparable to the Medicare standards, but even they have different levels of certification. Some facilities may be accredited but may only actually be a physician office, yet they receive a facility fee for a simple procedure such as a dermatological procedure.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Commissioner Wei asked how after the imposition of a fee schedule on ASCs in 2004 access to care may have changed. Ms. Wynn responded that she could not speak to that because accurate baseline data are not available. The first data are for 2005, so they cannot compare what it looked like before. There were many other changes going on at the same time, in terms of utilization guidelines, second opinion on spinal surgery, and other provisions. The best indicator is two-fold: first, the access report done for the Division of Workers' Compensation that did not identify any access issues; and second, workers' compensation patients are receiving a disproportionate share of ASC services. Commissioner Wei asked whether since 2005, the trend line was going up in terms of care received from ASCs. Ms. Wynn responded that even that would be difficult to conclude, since injuries were going down during that period, and there was an overall lower usage of services but there were also fewer injuries. She stated that they hope to be able to answer those questions using WCIS data, where services on a per claim basis could be examined.

Public Comments and Questions

Bryce Docherty, legislative advocate for the California Ambulatory Surgery Association (CASA), stated that he wanted to speak to the written comments CASA had made to the "Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California's Workers' Compensation Program" report, one of the subjects of Ms. Wynn's briefing to the Commission. CASA's letter to the Commission was dated September 28.th CASA appreciates the opportunity to make public comments and see the additional data that Ms. Wynn presented. Mr. Docherty stated that CASA is an organization that represents over 200 free-standing ASCs in California. Many of them are structured as single, specialty-only, multi-specialty, physician-owned, partial physician ownership, or joint ventures with hospitals and/or physicians.

Mr. Docherty stated that he wished to speak to two points regarding the report. CASA has concerns with the data methodology that was used to derive the findings in the report. The data were basically MIRCAL data that are required by ASCs to report to OSHPD on an annual basis, but only for those centers that are state-licensed. There are hundreds of ASCs that would meet the definition under the workers' compensation system and state law but that are not required to be state-licensed. They can be accredited or Medicare-certified, as Ms. Wynn has pointed out.

Mr. Docherty stated that therefore CASA's concern is that they are not looking at the whole picture of procedures and encounters being done at ASCs as it pertains to workers' compensation. He stated that the data set from OSHPD only requires those state-licensed entities to report such patient encounter data. He stated that further complicating matters is the Capen decision from September 2007 that Ms. Wynn mentioned. What happened was that an interpretation by the Department of Public Health, based on the Capen decision, was that if you were an ASC that had any portion of physician ownership, which is 99.9% of ASCs in California, the State would no longer be allowed to license the ASC, based on that decision. The impact was that as of September 2007, even though CASA was encouraging ASCs on a voluntary basis to report their surgery encounter data to OSHPD, they were no longer required to report that due to the State "washing their hands" of the state licensure requirements. He stated that CASA wants to make sure that if policy decisions are being made where injured workers are concerned, that a complete data set is being used.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Mr. Docherty stated that another issue is the fact that irrespective of how people believe the fees were derived for hospital outpatient departments and ASCs back in 2003-2004, he believes there was some policy discussion, and he believes the intent of the law at the time was to treat outpatient surgery the same, irrespective of where that procedure is being performed. He stated that if one is doing a shoulder, or knee, or pain procedure that is an outpatient procedure, whether that is being done in the hospital outpatient department or the free-standing ASC, the rate should be the same because it is essentially the same procedure on the same patient by the same doctor. He stated that CASA is concerned that if a two-path, two-tiered system is created with regard to fees and/or conversion factors or multipliers, and if they are looking at higher fees at a hospital outpatient department than fees at a free-standing ASC, then it may create a perverse incentive where many ASCs will no longer participate in the workers' compensation system, and a lot of those case will be transferred to the hospital outpatient department and/or to the in-patient setting. He stated that those procedures can be conducted there as well. The reality is that 120% of the Medicare ASC rate, particularly for a workers' compensation patient, is very problematic. As of the 2003-2004 reforms, there were a lot of procedures that were no longer done in ASCs. He stated that if things go in the direction of different fees, access will continue to be a problem for a lot of workers' compensation patients. There are a lot of benefits to ASCs as opposed to hospital out-patient departments (HOPDs), but even if one can do more procedures in any given day in an ASC, if those procedures are done at a loss, you are simply losing more money more quickly. He stated that CASA is looking to keep those fees the same for HOPDs as it applies to ASCs.

Mr. Docherty stated, thirdly, that CASA wonders whether the Division of Workers' Compensation has the authority to adjust the fees for ASCs, irrespective of the HOPD fee. He stated that statute is clear in subdivision (c) of the fee schedule code section that says that the maximum fee allowable for outpatient surgeries done in an HOPD or an ASC shall not exceed 120% of the HOPD rate. He stated that there are different interpretations of the additional provisions in that section which allow the Administrative Director to ratchet those fees downward. CASA believes the intent of the Legislature at the time is that both ASCS and HOPDs would be paid at 120% of the Medicare HOPD rate, largely based on procedures being the same, but also based on the administrative efficiency of doing that. The reason for this conclusion is that every update of that fee schedule over time has been done at 120% of that rate. Those fees have been downloaded and uploaded on a quarterly basis ever since then.

Mr. Docherty stated that he believes that Ms. Wynn makes some excellent points and that she has raised some areas where there may be some blind spots regarding recommendations related to patient encounters in the workers' compensation system for patients getting care in ASCs. He thanked the Commission for being able to speak and stated that CASA looked forward to working with the Commission on this issue.

Commissioner Steinberg asked if CASA wanted to maintain parity between the ASC and HOPD charges. Mr. Docherty responded that this was correct. Commissioner Steinberg asked if CASA's point is that if you do the same procedure at a better rate, the ownership of the ASC, having assumed the risk and burdens of overhead, should be able to make whatever additional profit they can. Mr. Docherty responded that this is a case of the same procedures being done by

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

the same physicians; the only difference is the building. He stated that what happens in ASCs is based on efficiency, lower infection rates, and high patient satisfaction. A physician may schedule three or four different cases in an ASC on any given day. If, for example, one or two cases are workers' compensation cases, some are private pay and some have other payors. What may happen, as happened in Texas, is that the ASC and the physicians will de-select the workers' compensation cases. The physicians will continue to do the private payor and Medicare cases in the ASC, but they will de-select the workers' compensation cases, and those cases will be forced to go into the HOPD or the in-patient department, which based on the data from Ms. Wynn, is going to be at a much higher rate based on morbidity. Commissioner Steinberg asked whether Mr. Docherty's point was that the physician would de-select based on the disparity of rates they are getting between workers' compensation and other payors, and Mr. Docherty responded that this was correct.

Commissioner Wei asked Mr. Docherty what CASA's position would be on the issue of a physician receiving the facility fee when it is not a facility, as well as the issue of going back to required licensure for an ASC that has any portion of physician ownership. Mr. Docherty responded that, in related news, even prior to the Capen decision, CASA has sponsored three legislative proposals that were vetoed by the governor that would have established the licensure criteria for ASCs. There are no criteria currently. There was a requirement that a facility could be licensed, but there were no criteria. CASA supported a legislative proposal that was sponsored by the Administration last year that required mandatory licensure of ASCs in the State, much like hospitals. CASA is on record for supporting that and is in support of more regulation of the ASC industry as opposed to less. What is further complicated in that issue is the relationship with the physicians. Because outpatient surgery can be done in an office by either being accredited or being Medicare-certified or not being licensed. this throws a "monkey wrench" into the analysis. A physician may receive an OMFS professional fee in workers' compensation but also may have one operating room in an office or adjacent to it which is actually their accredited ASC. They might then be billing a facility fee as well under what may currently be done. Mr. Docherty stated that it might help everybody to look at the whole picture including types of brick and mortar facilities and what fees are being charged where before having a discussion about what amount the fee should be.

CHSWC Vote

Commissioner Wei moved that the Commission post and adopt recommendations from the working paper prepared by RAND: "Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California's Workers' Compensation Program," and Commissioner Aguilar seconded. The motion passed unanimously.

Another action item related to the working paper "Hospital Emergency Department Services Furnished Under California's Workers' Compensation Program" report also by RAND was raised for a vote.

CHSWC Vote

Commissioner Aguilar moved that the Commission post and adopt recommendations from the

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

working paper prepared by RAND: “Hospital Emergency Department Services Furnished Under California’s Workers’ Compensation Program,” and Commissioner Wei seconded. The motion passed unanimously.

Briefing on Comparing Administrative Overhead Between Medical Treatment Under Workers’ Compensation and Health Insurance – Could Integration Pay for Covering the Working Uninsured?

Frank Neuhauser, University of California, Berkeley

Frank Neuhauser stated that the presentation would discuss work performed for the California HealthCare Foundation which focuses on the administrative costs of delivering medical care in the workers’ compensation system and comparing those to administrative costs of delivering medical care in other private health insurance, what we typically think of as group health insurance that also represents single person insurance. A key question of the analysis is: if occupational medical treatment were integrated into group health, whether it would be possible to pay for a significant fraction of the cost of extending health care to cover the currently uninsured.

Mr. Neuhauser stated that the co-authors of the paper brought specific expertise to the project, and he thanked Mark Priven for his actuarial expertise and Rena David for group health experience. In addition, he stated that Christine Baker was involved in the project because the Commission has funded several projects that involved the Commission and the University of California (UC) Berkeley to look at integrated care on a pilot basis and work with the Service Employees International Union (SEIU) and Diversified Management Services (DMS) and that work has been continued here. Ms. Baker provided input from a policy point of view and was able to gain access to the people in the political arena. Mr. Neuhauser acknowledged and thanked the California HealthCare Foundation for providing key funding for the projects done by the Commission and UC Berkeley. He stated that he also received generous assistance from: the Workers’ Compensation Insurance Rating Bureau (WCIRB), particularly Dave Bellusci; the National Council on Compensation Insurance (NCCI), particularly Barry Llewellyn; the National Academy of Social Insurance (NASI), which develops national estimates for workers’ compensation insurance that are published every year; the California Department of Insurance (CDI), which provides guidance on how to interpret particular classes and definitions in the rate filings; and the National Association of Insurance Commissioners (NAIC), that provides that type of information on a national level. He also acknowledged Ginny Snyder and UC Berkeley student Joshua Pines. Mr. Neuhauser then stated that assistance by the associations acknowledged does not imply agreement with findings of the authors.

Mr. Neuhauser stated that he would present an overview of some of the differences between workers’ compensation and group health and highlight some areas that lead workers’ compensation to be more expensive. He stated that he would review the data and methods and then look at the results of the comparison of administrative costs and the potential savings from integration. Some of the differences between the two systems include:

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

- Workers' compensation is mandatory but group health care for employers is a discretionary benefit. Everyone is covered in workers' compensation from the first day. Not all employers offer group health insurance, even when offered, some workers are not eligible and some workers do not take up the benefit. About 20% of workers at employers who offer health insurance do not receive the benefit.
- Workers' compensation is paid entirely by the employer and the premiums are frequently shared between employer and employee on the group health side. There are no co-pays and deductibles in workers' compensation, whereas co-pays and deductibles are the norm for employment-based health insurance these days. Another important difference is that workers' compensation is event-based: the liability for an injury or illness is tied to the policy during which the event occurred. In contrast, group health is a service-based system. For instance, if you have diabetes or a shoulder injury and if you enter the program with the shoulder injury, the health care provider typically is not interested in when the injury occurred. The provider treats it during the policy period; however, the insurer does not pay after the patient exits the plan. In workers' compensation, an injury is attached to a policy and the liability can last for years; therefore, it is a very expensive way to handle an injury.
- Workers' compensation is insurance by property casualty carriers while health insurance is delivered by health insurers; these are typically entirely separate companies and businesses.
- Workers' compensation is regulated almost exclusively at the state level, whereas federal regulation plays a significant role in employment-based health benefits. Within states, workers' compensation benefits are identical, but health insurance benefits may vary depending on health care policy. In workers' compensation, statutory and regulatory requirements drive a portion of the extra overhead costs, and these costs are not the fault of insurers, employers, or workers.

Mr. Neuhauser stated that the prerequisites for the integration of occupational and non-occupational medicine include:

- Near universal coverage for the working age population is needed; this has to do with whether workers will pass in and out of coverage, and it is part of what is trying to be resolved at the national level.
- Regarding event-based versus service-based difference, there would be decoupling of the liability for medical treatment from the employer at injury. Indemnity might stay with the employer or the insurer for that employer.
- Integration of treatment and the payment process do not mean seeing the same provider for occupational and non-occupational treatment. It also does not mean that workers' compensation insurer pays for the occupational treatment and a group health insurer pays for the non-occupational treatment. It means paying for all the treatment by the health

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

insurer and making it a truly integrated 24-hour care process with a single payor. This is different from the 24-hour coverage programs that have been suggested at the national level, which generally integrate the provider for healthcare, which has advantages, but keep the payment process at separate levels. The goal is to create a truly integrated process that is different from all the programs that have been provided at the national level. The question arises about how an integrated system would handle American College of Occupational and Environmental Medicine (ACOEM) guidelines and utilization review. They would not exist in integrated care, and utilization review and related activities would be handled by health insurers.

Mr. Neuhauser stated that data gathered for this project were pretty extensive and included: data from WCIRB from January 1st pure premium rate filings from 1999 to 2009, focusing on years 1999 to 2007; WCIRB data on losses and expenses for the same years, generally from quarterly summaries of insurer experience; and CDI premium rate decisions which are frequently different from what WCIRB proposes. Additionally, all rate filings by insurers writing coverage in California for the period 1999 to 2009 were included.

Mr. Neuhauser used two methods to estimate the administrative costs observed for medical treatment in workers' compensation. The first method focuses on predicted expenses and this is what insurers file in their rate filings for the coming policy years; the second one is actual expenses. Three to five years out, data are available on actual expenses for those particular years based on insurers' rate filings but looking retrospectively at what their actual costs were for expense categories. The differences between the two are that the predicted expenses are what insurers are reporting they are expecting to make and are not subject to random variation in insurers' medical costs or unanticipated increases or decreases that are seen in the past ten years. Also, the period covers the best and worst of times in the past ten years, and the predicted expenses ignore that. The actual expenses are more important because that is what insurers actually pay but are subject to random variations seen, particularly in medical costs over the last decade. Both of these estimates were done, and in some categories, they are substantially different.

Mr. Neuhauser clarified that the WCIRB has loss and loss adjustment expense calculations as developed by WCIRB and member insurers, which represent a consensus of expected losses or WCIRB's calculation of actual losses looking back and loss adjustment expense, so they are calculated for the industry as a whole. For the insurers, individual insurers' data on expenses, predicted investment return, and estimated profits are obtained.

Mr. Neuhauser discussed how insurers develop proposed rate filings. Insurers start with the pure premium rate which consists of losses and loss adjustment expenses estimated by WCIRB and submitted to CDI and which can be modified by CDI. Therefore, what the Bureau submits is not necessarily recommended by CDI, and this modification was noted in the latest rate filing by WCIRB which was 24.8% increase and the CDI said no rate increase was needed. The pure premium issued by CDI is often at odds with what the insurers estimated as their losses and expenses. Insurers can apply a rate deviation to the pure premium rate, and the rate can have several purposes because the insurers are in better or worse niche markets and feel that their premium rates can be above the premium rate or may be that insurers are increasing their rates to compensate for CDI rates which are typically lower than the WCIRB proposed rate. A fourth

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

component is the underwriting expense that is supplied after the pure premium rate and rate deviation are calculated, and the components are: commission; other acquisition costs (advertising); general expenses (buildings and related items); taxes, license and fees which are then are overlaid; profits and contingencies; investment return; and off-balance sheet provisions.

Mr. Neuhauser stated that the next step was to extract what insurers file as expenses and then make three changes. The modifications to losses and expenses were:

- Administrative expenses. Some administrative expenses are included as “benefits.” California is particularly aggressive about having insurers report some administrative expenses as medical benefits. The two largest categories are medical cost containment expense and medical-legal expense. Even though these are treated as administrative expenses on the group health side, they have been treated in workers’ compensation as medical benefits for purposes of reporting medical losses. Because of work by the Commission, Mark Previn and Mr. Neuhauser, CDI will be adopting a regulatory change requiring that medical cost containment expense be reported as an expense and not included in losses, but during this period, medical-legal costs and medical cost containment were reported as expenses, and they were fairly large. Mr. Neuhauser explained that the analysis took medical legal costs and medical cost containment out of losses and put them in expenses to make them comparable to group health.
- Calculation of “other off-balance provisions.” These are when insurers file rates with the Commissioner; when premiums are calculated, they offer credits and debits which can increase or decrease the employers’ premium. The other off-balance sheet provisions are meant to adjust for those credits and debits and give an accurate financial picture to the Insurance Commissioner. Mr. Neuhauser dropped the off-balance sheet provisions expenses from the calculations, assuming that they were cancelled by credits and debits on the other side. This reduces what insurers are reporting as expenses but leaves losses unaffected.
- Investment income. Investment income is not included in the WCIRB report of losses and expenses. There are several categories of loss ratios reported, but the Bureau does not include investment returns in these calculations. This is true of all Bureaus; however, investment income can be sizeable. In rate filings, insurers treat investment income as an offset to expenses, so they reduce expenses in their rate filing by investment income. Mr. Neuhauser in his project treated investment income not as an off-set against expenses but as an offset against losses.

The Bureau calculates losses and reports the undiscounted sum of all future losses for a particular policy year or a particular accident or calendar year. An example of undiscounted losses is if the insurer is going to pay a medical bill for \$1,000 in 2015, it will be calculated as \$1,000 in the current year; there is no discounting for the fact that that payment will not be paid for 10 or 20 or 30 years. Mr. Neuhauser discussed an example of what the Bureau published in 2003 on how California typically pays out medical costs. In the first year after injury, the insurer pays out about 10% of the total medical costs on an undiscounted basis for the life of the claim; in the second year, it will

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

be 20%; and in the third year, it will be 11%. 7.5% of benefits are paid out between 20 to 30 years after the injury. Another 7% of benefits are paid more than 30 years after the accident occurs. It is not appropriate to treat these as undiscounted costs in the current year without an offset; one can discount these or can calculate the investment return on the monies held to pay these liabilities which include medical liability, indemnity liability and loss adjustment expenses.

Mr. Neuhauser stated that the calculation involved the amount that insurers need to set aside in the current year to pay for future liabilities on cases that occur in the current year. The project then calculated the difference on what insurers must set aside and the Bureau's calculation of ultimate losses. The insurers file average investment return of about 7% of premium and about 10% of loss and loss adjustment expenses; this is what they file as part of their rate filing. What insurers actually earn on the money while it is held until payment is 17% or 18% of premium and 24% of losses. In the current year, insurers can set aside about 75% of what they would pay on their losses, and it will be sufficient to cover their losses out through the end of the claim. For example, on an average \$10,000 claim, they can set aside an average of \$7,500 and it will adequately cover the cost of the claim out for 30 years.

Mr. Neuhauser stated that at the end of this exercise, actual or predicted expenses workers' compensation that insurers report and what the health insurers report in the same categories can be compared. The total of 12.4% for health insurance was calculated by the federal government National Health Expenditure Accounts done by the Center for Medicare and Medicaid Services (CMS), and the categories were developed by Price Waterhouse for the large health insurance plans several years ago as a presentation to the U.S. Congress. Mr. Neuhauser stated that these categories were the best estimate to categorize these sub-categories. For loss adjustment expenses, for workers' compensation, both the actual and predicted expenses are about 13% and for group health which has claims handling cost, these expenses are about 3%. General expenses, which include everything else, are about 5% (spent) or 9% (predicted) for workers' compensation versus 1% for health insurers. Commissions and other acquisition costs, which represent advertising and other efforts to improve business, are 11% to 14% for workers' compensation insurers and about 4% for group health insurers. Group health insurance policies are typically larger, leading to lower commission rates; for example, auto commission rates are twice workers' compensation rates, because those are yet even smaller policies. Taxes, licenses and fees are about the same. Profits are much higher on workers' compensation. Profits are even higher if we calculate what insurers earn on money they set aside to cover liabilities. Therefore, there are big differences in profits, commissions and claims handling expenses between workers' compensation and group health.

Commissioner Wei asked if these are all carriers who sell workers' compensation or whether the data include only workers' compensation carriers. Mr. Neuhauser responded that these are for all carriers who sell workers' compensation, but it is only for the workers' compensation line. For example, property casualty carriers sell many other lines of insurance. In fact, these numbers are only for California. Health insurers report about 12.5% of premium as administrative costs, and about 88% are paid out as direct benefits to providers (for medical treatment). On the workers' compensation side, depending on whether one uses actual and predicted expenses, it is about

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

52% to 57% for administrative costs, so it is a number of times higher than on the health care side. It is more expensive to deliver health care under the workers' compensation side versus the group health insurance side.

Mr. Neuhauser then posed the question of what can be saved if occupational and non-occupational medical treatment were integrated under the group health side and the integrated system would pay the lower administrative costs that are typical of the group health side. There are two estimates on what can be saved. One estimate is from the data supplied by California, and the second is the estimate based on the data from NCCI. NCCI has national data and NCCI has a faster payout for medical treatment than California does. Investment return is lower in NCCI estimates. Both estimates use NASI calculations of total employer costs for workers' compensation for each year. Mr. Neuhauser stated that the analysis split NASI's estimate of total employer cost, which is premium loss plus administrative expenses for self-insured employers, split it by the estimate of medical and indemnity benefits, and then assigned a fraction premium to medical costs equal to the fraction of the benefits that are predicted to be medical benefits for that year. Next, the analysis is calculated for each year for what would have been paid for a group health plan as opposed to a workers' compensation plan. Mr. Neuhauser stated that we look at the national estimate for 2011 to 2020 to be consistent with the earliest time that near universal health care might be implemented in the U.S. Mr. Neuhauser projects the NASI estimates forward for 2011 and then projects them on to 2020. For 2011, employers would pay upfront a little over \$60 billion to cover the cost of occupational medical treatment, and this would increase to \$100 billion in 2020 (based on the NASI estimates).

Mr. Neuhauser reviewed what employers would pay out if on January 1, 2011, there were a switch to having medical treatment for occupational injuries paid out under group health care insurance instead of workers' compensation insurance. In the first year, it would be very low. First, employers have already paid for liabilities for all injuries that occur up through 2010 in the form of their insurance or set asides for self-insurance; starting in 2011, employer liabilities will only pay for 2011 injuries. For 2012, they will pay for injuries that occurred in 2011 and 2012. Upfront, there is a very large payoff; it is one-time accounting change, but it does work for the advantage of savings up front. Over time, a greater fraction of the injuries is covered, and consequently, the costs rise rapidly initially and then level out. Eventually, what employers would pay in workers' compensation increases more rapidly in absolute dollars than what they would pay under integration, and the gap widens again in absolute if not in relative terms. The calculations were based on California and NCCI estimates for national data. The NCCI national estimates are national data for payouts, and the numbers are based on less aggressive NCCI numbers. The first year, there are savings of about \$52 billion; this narrows to \$43 billion after three or four years and then begins to widen as a larger fraction of employer costs increases more rapidly than what is paid out in benefits. Mr. Neuhauser stated that investment income was not used in the calculation. He then stated that one could think about what employers would do with \$52 billion in the first year and what they would earn on the savings in the second year.

Mr. Neuhauser stated that the ten-year cumulative savings for the U.S. would be \$490 billion to \$560 billion for the NASI/California-based estimate. For California, it will be \$120 billion, and it represents about 21% to 22% of workers' compensation market. The health care bill that U.S. Senator Baucus presented is calculated at \$800 billion to \$900 billion over a ten-year period. The

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

cost estimated to cover the incremental change in expenses to cover the currently uninsured over the same period is about \$700 billion to \$1.8 trillion dollars. This is about 25% to 75% savings under integration of 24-hour care, so it is about 25% or 75% of the incremental cost of covering the uninsured, and it is about 70% to 80% of what it is estimated to be the cost of the Baucus bill.

Mr. Neuhauser stated that integration does not happen in the absence of universal health care. People would not be willing to put workers at risk of being uncovered by insurance, which would be the characteristic observed in today's system where 20% of Californians, most of them in working households, are uncovered for insurance. The liability for conditions for the employer needs to be decoupled so that conditions are not tied to where the conditions first originated. Finally, both the treatment and the payment have to be integrated to get the efficiencies on the health care side.

Questions from Commissioners

Commissioner Steinberg asked Mr. Neuhauser about where the cost savings are and what the cause is of the positive difference between the present workers' compensation system and the costs of integration. He stated that he assumes that there will be savings because the cause of injury would not be a concern. Mr. Neuhauser responded that that is a part of the savings, but not a major part. The major part is that we are not paying up front for a single condition and paying for all other conditions separately. If an individual has two different occupational injuries, they could have a different doctor for each injury and a third doctor for all other medical care. For the small amount that is being paid for workers' compensation cases, there are separate doctors and separate payors. With a back injury, someone has to adjudicate if that is a new injury or re-occurrence of an old injury and who is liable to pay for it, and that in itself is expensive. In addition, there is a very complicated regulatory overlay on workers' compensation, which is meant to resolve how to pay for an occupational injury and meant to set a fair rate for workers, employers and medical providers. That is done on a contracting basis, negotiated upfront, in group health. In workers' compensation, employers have to pay money up front on something that will be covered in 20 years. He stated that some of the savings of integrated care would come from a one-time switch from an upfront payment to a pay-as-you-go process. If we are going the other way, there would be a loss of money. This way, it is a beneficial accounting process.

Commissioner Steinberg stated that the report indicates that the change to the cost to injured workers happens because they would have to assume the burden of co-pays and deductibles, and the report advances that are a substantial cost savings to the system. He stated that that is constitutionally impermissible under the present system. He also stated that he assumes that that is being advanced as a potential cost savings in the system. Mr. Neuhauser responded that that was not calculated. Commissioner Steinberg stated that that is prohibited under the current system, that there is a constitutional guarantee. Mr. Neuhauser stated that many things at the state level would have to be changed. He stated that the savings are not being calculated from co-pays and deductibles. Under integration, the worker would pay co-pays and deductibles, while the employer paid all the costs; however, there could be provisions that would result in no co-pays and deductibles and the average premium would be slightly larger. One of the reasons for the higher costs of services in workers' compensation is that it costs substantially more to deliver

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

benefits in the workers' compensation system because there is more treatment and there are higher costs of treatment, 50% to 100% higher. If there were a change regarding co-pays and deductibles, that would be a change to total costs but in a way that has not been included in this calculation. Administrative costs are being paid for in workers' compensation but would not have to be paid in group health. Going to group health may mean that treatment would be delivered more efficiently and then the savings would be about three times higher in terms of what the administrative savings are.

Commissioner Steinberg stated that he is troubled by the report issued by this Commission which even suggests some constitutional change of the long-standing guarantee for injured workers at the present time, and he questions the appropriateness of the Commission making that kind of recommendation which is a political judgment. He stated that cost savings under a health care-only system for a specific injury appears to be less than the same injury in the workers' compensation system. Commissioner Steinberg also stated that we are dealing with two different cohorts. In the workers' compensation environment, generally one is dealing with injured workers and there is an imperative to get back to work and treat the injury more aggressively as compared to a non-workers' compensation setting. He stated that he questions the cost savings and the propriety of the report advancing such cost savings, which may result in the imposition of co-pays and deductibles on injured workers. Mr. Neuhauser responded that the savings estimated in this report do not assume charging workers' co-pays for an occupational condition that is occupational.

Commissioner Steinberg stated that he and the Commission are only concerned with the injured worker, and the Commission has been established for the purpose of making the system work for employers and injured workers. Mr. Neuhauser responded that he agreed. Commissioner Wei stated that she comes from a different perspective and she wholeheartedly agrees with raising the concern that workers should have the burden of a share in the costs for injuries at work. She stated that there is a fundamental trade-off in the California workers' compensation system: that the employers do not get sued, but there is a robust workers' compensation system that takes care of workers who get injured on the job.

Commissioner Wei further stated that this report is not recommending that injured workers will have to pay co-pays or out-of-pocket costs, and that this is not what the Commission would be recommending. She stated that the report identifies the administrative inefficiencies on the workers' compensation side and is trying to quantify the savings and take the HMO efficiencies and impose them on the workers' compensation insurance. She stated that requiring workers to pay for their medical treatment under workers' compensation is not part of the administrative savings; it is not in the analysis of this report and not part of the potential savings. This report highlights what the problems are and what the savings could be from integration of the two systems. She stated that this Commission would never take up a recommendation to require co-pays or out-of-pocket costs for injured workers who get injured on the job.

Commissioner Aguilar stated that removing cost containment from the calculation of medical is going forward, but she has verified by checking with self-insured plans that that will not be the case under self-insurance, so that there will be a variance, and data in the future will be skewed. Mr. Neuhauser responded that the Division of Workers' Compensation could standardize it.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Commissioner Aguilar responded that it has to be one way or the other and it is definitely showing the inflation of medical costs. Utilization review, nurse case managers, and bill review fees are paid under medical and inflate the costs, but that does not mean that medical costs are not going up because they are. She stated that it is important to keep that in mind going forward when the Commission uses statistics and data.

Mr. Neuhauser responded that medical cost containment typically is utilization review and bill review, which are used to control the cost on cases, particularly where there is no upfront contracting; they are important components to workers' compensation system and are reported as medical benefits rather than loss adjustments expenses. Commissioner Aguilar stated that if they could go under expenses versus medical, it would be easier to track.

Public Comments and Questions

Mark Gerlach, a consultant for the California Applicants' Attorneys Association, requested that Mr. Neuhauser refer to the chart with percentages. Mr. Gerlach stated that the starting point is that the health insurance figures were from CMS data. Mr. Neuhauser responded that the total at the bottom is national estimates done by CMS for all health insurance that is privately paid. Mr. Gerlach responded that to make it more accurate, taxes, licenses and fees should be primarily premium tax, and for to be consistent, premium tax should be the same for both. Mr. Neuhauser stated that the data are from both California insurers and national data and could be somewhat lower. Mr. Gerlach stated that the data primarily represent national data to a large extent also, but that there will not be a point savings on taxes, licenses and fees. Mr. Neuhauser stated that this is also similar for State Fund data which is not national, i.e., largely for California.

Mr. Gerlach asked whether the numbers are only loss adjustment expense on just medical costs or loss adjustment costs for all workers' compensation claims. Mr. Neuhauser responded that the loss adjustment expense is just for medical claims. Mr. Gerlach stated that he did not know that was possible.

Mr. Gerlach asked if the ten-year cumulative savings is based on the NASI data. Mr. Neuhauser responded that for the top line of the calculation and for the NCCI estimate, he used the NASI estimate on national totals for medical benefits paid. Mr. Gerlach stated that savings then are based upon the savings calculated based upon California expenses versus national health insurer expenses. Mr. Neuhauser responded that this is correct on the lower line but not on the hatched line, which is based on the NCCI estimates of paid medical development; this is complicated and is noted in the Appendix of the paper. Mr. Neuhauser stated that NCCI estimates two things: what self-insured employers pay through administrative costs and direct medical payments; and what insured employers pay in the form of premiums. This would be about \$27 billion in the first year, but everything that is paid on all medical conditions under workers' compensation in 2011, which includes cases from 2010 and 2009 and possibly even from 1950, is only a fraction of what is actually paid out on cases that occurred in 2011. NCCI paid medical development is used, but it is much more front-loaded and a fraction is calculated which is 30% of what calendar year payments in 2011 would be for 2011 accidents, and the same calculation for California would be substantially less.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Mr. Gerlach asked if the percentage of 10% was paid out the first year in California, and Mr. Neuhauser responded that for NCCI, the calculation is 24% of costs on a claim that are paid in the first year, and there is an intermediate calculation that has to be translated into fractional payments in that year, and that is higher than the numbers paid out in the first year. That is in the Appendix and is higher than either one of those numbers. Mr. Gerlach stated that he did not see the administrative savings and needed more explanation.

Mr. Gerlach asked if the ten-year cumulative savings is based upon the savings if workers' compensation were paid using the same deductibles as co-insurance and health insurance. Mr. Neuhauser responded that the calculation does not include that inclusion of co-pays and deductibles would have led to lower overall costs and could lead to a greater difference between workers' compensation and health insurance. Mr. Neuhauser further stated that the main idea is to analyze what would be paid for the same treatment if delivered under health care and workers' compensation and not divide the payments between employers and workers. If an occupational causation could be noted, it would shift who was paying but it would not shift any savings.

Mr. Gerlach stated that based on the chart, the assumption has to be made that either health insurance is being paid without co-insurance or co-pays, or that workers' compensation is being paid with co-pays. Mr. Neuhauser stated that this is what is paid to the doctor, but it is not who is making the payment. Mr. Gerlach stated that that is only looking at one half of the equation. He clarified that this will result in either reducing benefits to injured workers or increasing cost on group health, which is the only way that it can work. Mr. Neuhauser responded that the savings are on the administrative side; more than half the costs, between 50% and 60% in workers' compensation are administrative costs, and on the health care side, the costs are 11% to 13%, and those are just efficiency savings. He stated that admittedly, that is coming out of someone's pocket, but it is not the employer or worker or doctor.

Mr. Gerlach stated that 24-hour care is for the working uninsured and it has to combine the systems; then if you are looking at administrative savings, one has to look at other costs, either increasing the administrative cost to injured workers or to the health insurer. Mr. Gerlach reiterated that he is not taking the position that workers' compensation insurers' expenses are not higher than group health expenses. He stated that he does not know why 15% commission should be paid on a workers' compensation policy and only 4% for health insurance; this was probably due to historical precedent and that that workers' compensation ended up being in a property and casualty field. If these administrative costs are to be saved, it would have to be done by integrating the systems, and if the proposal is that the systems not be integrated, then the title of the report should be changed with 24-hour care taken out of it.

Acting Chair Schwenkmeyer stated that these discussions should be held after posting the report for public feedback.

Mr. Neuhauser stated that they are integrating the systems but not taking all the administrative costs out of the workers' compensation side and keeping them but getting them back to participants. Commissioner Wei stated that integrating the systems does not necessarily mean changing out-of-pocket shares between employers and employees. She stated that one can imagine an integrated system in which injured workers who have an occupational claim are not

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

charged co-pays, and a co-pay system is still maintained for the group health side. Mr. Gerlach stated that Mr. Neuhauser was not talking about that system. Mr. Neuhauser responded that he is talking about matching exactly, but it is not a requirement, and an integrated system could have co-pays and deductibles as Commissioner Wei stated. Mr. Gerlach stated that he agreed. Commissioner Wei stated that this will not necessarily change the administrative savings and that does not come from imposition of out-of-pocket cost exposure for workers.

Mr. Neuhauser responded that flagging a particular condition will create some kind of administrative cost. Commissioner Wei stated that once you integrate, then you will have cost savings or new administrative costs, depending on how you would handle them. The report only addresses claiming efficiencies in a bloated workers' compensation system and how to get savings from that system. She stated that the report indicates where the problems currently are in the system. Mr. Gerlach said that he could not argue with that.

Commissioner Wei then stated that she would defer to Acting Chair Kristen Schwenkmeyer's recommendation that further comments can be taken in written public comment.

Mr. Gerlach asked how the ten-year cumulative savings for California of about 21% was calculated. Mr. Neuhauser responded that the savings would be about 22% and that California savings would be higher because the California-specific costs are much more expensive.

CHSWC Vote

Commissioner Aguilar moved that the Commission post the working paper "Comparing the Costs of Delivering Medical Benefits Under Group Health and Workers' Compensation – Could Integration Pay for Covering the Working Uninsured?" for feedback and comment and create and Advisory Group to discuss the findings, and Commissioner Wei seconded. The motion passed with Commissioner Steinberg opposed.

Executive Officer Report

Christine Baker, CHSWC

2009 Annual Report

Ms. Baker stated that she was pleased to submit the draft of the 2009 Annual Report for consideration. The report covers information gathered since the last year's annual report. This year's annual report was particularly difficult because of the changing data systems within the Department of Industrial Relations (DIR). The report will need some final copy editing and a few updated numbers but it is ready for approval pending those updates. Ms. Baker stated that it takes time to get the document ready for publication and posting on the website once the final fatality statistics are available.

CHSWC Vote

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Commissioner Wei moved to approve for final release CHSWC's 2009 Annual Report pending final edits and update of some data points, and Commissioner Aguilar seconded. The motion passed unanimously.

Acting Chair Schwenkmeyer thanked Ms. Baker and Commission staff for work on the Annual Report and stated that the Annual Report is a considerable amount of work. Ms. Baker responded that the staff is dedicated and the work is a priority.

Report on Self Insurance Groups

Ms. Baker stated that Commission staff is respectfully requesting deferral of the self insurance group report until the December meeting, due to workload issues. It should not be a problem finalizing the draft report and getting it on the Commission's website for public comment before then.

Director's Request: Public Release of Draft Proposal and Analyses

Ms. Baker discussed work that was being done at the request of the Commission's Chair Sean McNally. This was in response to questions from the Chair in the course of discussions held between some employer and labor representatives. Commission staff work consisted of technical support for those discussions, based on staff expertise and ability to provide interpretation of the research that has been done by the Commission and by RAND. Ms. Baker stated that this was not a Commission project, per se. Unfortunately, one of the early drafts was later given to the press, and people inferred that this was a Commission-led project. The public perception was further confused by the fact that the date appearing on the document was automatically updated to the date the file was opened, so it did not reflect the refinements in staff analyses or anyone's position in those discussions. Finally, the document did not reflect the balance of the discussions because it was only a laundry list of potential savings that could be put toward a potential improvement to permanent disability (PD) benefits. PD benefit increases were not included in that draft. Overall, it left the public with numerous misinterpretations, and it did not even reflect Commission staff's best analysis of the impacts of the various scenarios.

Ms. Baker stated that this work was technical analysis, not Commission recommendations. The Director of the Department of Industrial Relations has asked that the latest version be made public since there have been so many different developments and misunderstandings. The latest version does not present recommendations, only a list of potential cost savings and potential benefits. He felt this analysis should be made public. Commission staff would like to prepare this information for public dissemination, not as a recommendation from the Commission, but as a list of scenarios with analyses of their impacts. This has been done in the past with fee schedules and presumption of correctness of the treating physician and other projects. If the Commission wishes the staff to assemble this work for public release, the latest version would be ready for review at the next meeting in December.

Comments by Commissioners

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Commissioner Aguilar stated she would like to give credit to the group of stakeholders from labor and management that took their time to try to help resolve some of the problems with worker's compensation. The analysis was a great effort and it was unfortunate that it was displayed to the public with inaccurate information. She stated that she would like to support getting out current information, with the specification that it is information and not a Commission recommendation. This would ensure that everyone would have access to the correct information.

Commissioner Steinberg asked whether the latest draft that the director of the Department of Industrial Relations requested be published is now in existence. Ms. Baker responded that the latest work produced by Commission staff is in now existence. Judge Lachlan Taylor stated that the participants in the discussion kept trying out and discarding ideas, and Commission staff provided analysis for the different iterations. The director of the Department has asked for the draft that was in place when the process was interrupted.

Commissioner Steinberg asked for further clarification of director's request that the latest version be published and he asked whether it was something that he had seen or would see. Judge Taylor stated that making the latest draft public would be an opportunity to incorporate minor edits (typos). He also stated that he did not believe that anyone here had seen it, but he also stated that he was not aware that the information had gotten out when it was put on the Republican Caucus website.

Commissioner Steinberg stated that to his knowledge, this was not a Commission project and that he learned about it after the fact when it was released in Work Comp press, so that there was some embarrassment about not knowing that the analysis existed and the discussions were going on. To the extent that it has not been a Commission project and continues to be kind of a private discourse among some members of the Commission, he believes that it is not the Commission's business to pursue this matter further. He stated that this is his opinion. Judge Taylor responded that a lot of work went into the analysis and that it could be of benefit to some constituents throughout the system if it is not buried. He stated that Commission staff undertakes a number of projects like this, some at the request of the Legislature and others, which are tailored for different constituents of the system.

Commissioner Steinberg stated that what was published was more of a political document than an even-handed discussion of the issues. He also stated that this work had some problems and that he was not sure how it would be helpful in correcting the situation.

Commissioner Wei stated that her understanding is that director of DIR is interested in putting out the staff product of the discussions to the public as an avenue to get public feedback. She stated that there was some critique about private negotiations going on, but she stated that private investigations are typically part of negotiations. She then stated that she believes that the director would now like to build a stakeholder process around the task assigned to the Commission staff. If the Commission is not comfortable with that, then other stakeholders might have to ask the primary parties involved for the information, and that would not be a public process. Making the information public would help create a stakeholder discussion about how to fix the PD system for injured workers.

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Commissioner Wei asked what the next steps would be as the process moves into the public eye. Ms. Baker responded that they would prepare a draft for public presentation of what the discussion was when it was interrupted, not changing the information, except for correcting some typos, and then make it public because there was technical support for cost benefits and benefit distributions. Commissioner Wei asked if the Commissioners would hear the public comments. The draft would be presented to the Commission at the December meeting and then posted for public comment. Ms. Baker stated that public comment would be available at the January meeting. Commissioner Aguilar stated that she supported this process, with Commissioners seeing the document in December before it is out for public comment. The document would not be a product of the Commission.

Commissioner Steinberg asked what input, if any, would be expected. Judge Taylor responded that the document would likely have its critics and supporters for different elements, and that that is an ongoing conversation that need not result in a Commission decision, but that would be part of the public discourse. Commissioner Steinberg asked if additional involvement by other stakeholders, insurers and lawyers, for example, were expected for this latest draft. Judge Taylor stated that he was sure that members of the public might use part of the document as they like. Commissioner Steinberg asked if the staff of the Commission would not be adding additional input. Judge Taylor responded that that is correct. Ms. Baker responded that that is where the process is right now, but it is not known if the Legislature might ask for further analysis.

Commissioner Steinberg stated that he would suggest that DIR Director John Duncan get the governor and the Legislature to express some interest in changes to the structure of the PD system, or the discussion would not go anywhere. He stated that the problem is that the paper presents itself as a trade-off between what all the changes could be worth in terms of what the savings are and what can be done to establish a fair PD structure. The trade-off has already been made as far as injured workers are concerned. Talking about more trade-offs is a non-starter, and this is another objection of his to the direction of the document.

Acting Chair Kristen Schwenkmeyer asked if the new timeline discussed meets the needs of the request of the director of DIR, and Ms. Baker responded that it does.

CHSWC Vote

Commissioner Aguilar moved to have Commission staff prepare a report of the staff's most recent drafts and evaluations of proposals that were prepared in connection with discussions among labor and employer representatives for the Commission's consideration for public release at its next meeting, and Commissioner Thacker seconded. The motion passed with Commissioner Steinberg opposed.

International Forum on Disability Management 2010

California and the Commission are leading the national and international community in efforts to ensure successful disability management. California and the Commission will host the fifth International Forum on Disability Management (IFDM) in 2010. The forum is scheduled to take place in Los Angeles on September 20-22, and will be co-hosted by DIR and the Commission in

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

partnership with the International Association of Industrial Accident Boards and Commissions (IAIABC).

Key topics for the conference include:

- A Global Perspective on Disability Management.
- The New Paradigm: Changing Social Attitudes Toward Disability Management.
- The Government's Role in Disability Management.
- Emerging Economies and Disability Management.
- Legal Aspects of Disability Management.
- Research and Metrics to Guide Public Policy Decisions on Disability Management.
- Innovative Programs in Workplace Health and Safety.
- Medical Issues in Disability Management.
- Disability Management for Special Populations.
- Success Stories, Case Studies and Solutions for Stakeholders.

This is an exciting forum with key stakeholders from around the country and the world sharing successful disability management outcomes. It is hoped that results of the forum will provide for a better understanding and wider acceptance of the importance of disability management.

Other Studies

At the next Commission meeting, a briefing from RAND on the insurance study and on the return-to-work study will be presented. A change in date to the meeting is suggested for December 17th due to logistics and will be determined in the near future.

Other Business

None.

Adjournment

Acting Chair stated that the next CHSWC meeting is tentatively scheduled for December 17, 2009, in Oakland, at 10:00 a.m.

Approved:

Kristen Schwenkmeyer, Acting Chair

Date

Respectfully submitted:

MINUTES OF CHSWC MEETING
October 22, 2009 Oakland, California

Christine Baker, Executive Officer

Date