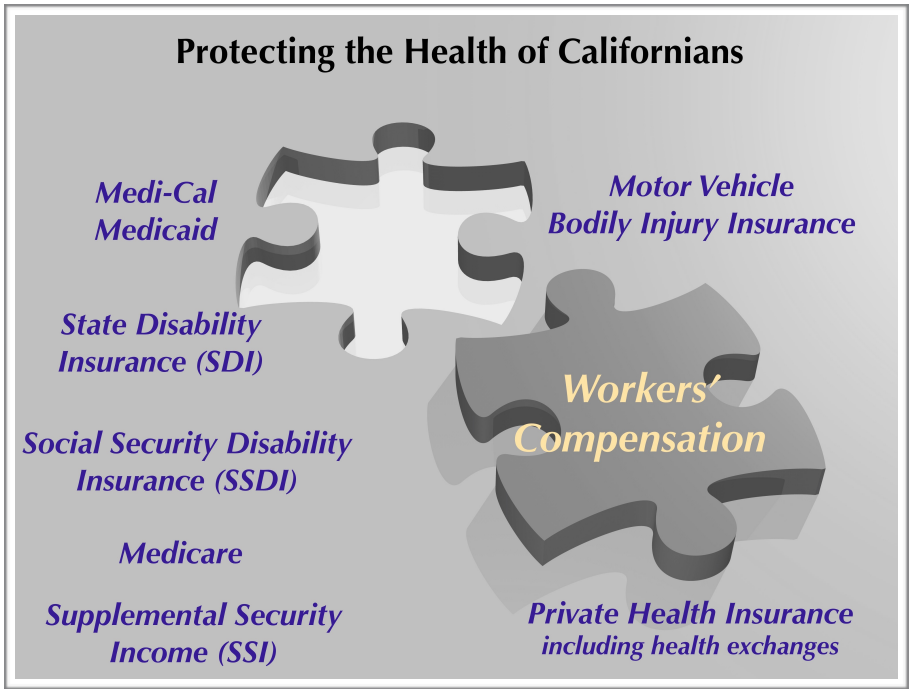
MINDER Managing Disability

Dialogue

What Impact Will President Trump's ACA Initiatives Have on State Social Insurance Programs Including Workers' Compensation?

The Affordable Care Act ("ACA") changed the delivery of health care for millions of Americans by providing both subsidized private insurance through the health exchanges and coverage to more low-income Americans through Medicaid, making its repeal and return to the old status quo a highly improbable outcome.



This, however, has come at a price - Medicare/Medicaid added $1.1 trillion to U.S. Debt followed by social security accounting for $900 billion. With increases of this magnitude unsustainable, politicians acknowledge the need for reforms to federal social insurance programs including health care.

Since the ACA, one in three Californians (i.e. 13.5 million) is now covered by Medi-Cal, the state version of Medicaid. Depending on federal reforms however, this $90-billion program which the federal government funds by approximately 65% may also require the State to reform their social insurance programs.

"The greatest wealth is health" Virgil (70 - 19BC)

This article proposes reforms to two California social insurance programs which include process and technology improvements and their role in a universal healthcare system.

WORKERS' COMPENSATION

Risk Sharing and Funding

The California workers' compensation social insurance program aims to protect employees and their families from falling into poverty caused by work-related personal injuries, including illnesses, by speedily providing necessary medical treatment as well as short and long term loss of income benefits.

While the intent is to provide these benefits in a friendly, courteous, respectful and sensitive manner where employees are active collaborators in both their medical treatment and return to employment, it is more often described as being humiliating, shameful, and ignominious with total disregard for an employee's needs. It appears the more lawmakers and regulators strive to implement solutions to improve the delivery of benefits, the more problems they come up against.

The benefits delivery service (i.e. claims service) is consistently criticized for its often provocative and confrontational approach generating excessive legal costs, its imprudent use of lump-sum settlements which do not always meet employees' long-term financial needs, and for its disproportionately high claims service cost compared to the cost of benefits received by employees.

In California, employers are required to fund the program and in 2014 employed 17 million of the 38.5 million population (i.e. 44% of the population). To protect themselves from financial hardship in funding the program, most employers must by law purchase a workers' compensation insurance policy from a Property & Casualty ("P&C") insurance company or the State Compensation Insurance Fund ("SCIF") to financially hedge against this risk. SCIF, a quasi-governmental agency competes with P&Cs and is also the insurer of last resort.

According to the Workers' Compensation Insurance Rating Bureau ("WCIRB") more than 500,000 employers in California purchased policies through 220 P&C insurance companies in 2014 which suggested a healthy competitive market with a large number of independent, direct competitors for employers to choose from. This however was not the case. These insurance companies were owned by insurer groups of which **7 groups plus SCIF held 56% of the market** and another 28 groups held 39%. Up to 13% of the market held by SCIF were unable to purchase insurance from a P&C group. Any further reference to "P&C"s in this article includes SCIF unless specifically stated otherwise.

Further to being concentrated to only a few groups, year to year market share can change dramatically which is not conducive to providing the optimal claims service required for this long-tail social insurance. In 2014, the cost of the P&C product in California was $16.9 billion of which 47 cents of each $1 of employers' premium (i.e. $8 billion) was spent on managing the product with the remaining 53 cents paid to employees in benefits. In 2015, benefits paid to employees reduced to 51 cents, and the cost to manage the product increased to 49 cents. Disregarding all its other shortcomings, the cost of providing the P&C product is inordinately high and continues to increase, which for this reason alone strongly indicates the need to explore alternative risk sharing arrangements, funding, and delivery of the social insurance.

Alternative Risk Sharing and Funding

Interestingly, similar criticisms of the P&C product were identified in the "Beveridge Report" prepared in 1942 by Sir William Beveridge, which lead to the abolishment of the Fire insurers'[1] workers' compensation insurance product in the United Kingdom. Many countries including Germany, New Zealand and the majority of states in Australia fund their workers' compensation programs with alternative schemes to the P&C product. While these schemes cannot be completely replicated in California, their principles can be applied.

[1] Now known as P&C, General or Non-Life insurers.

One alternative is to establish syndicates similar to risk sharing pools based on the North America Industry Classification System ("NAICS") where similar employers contribute as a way to self insure risks (i.e. insurance by industry). Some syndicates like agriculture, could be further grouped on geographic location, such as the Sacramento Valley Region.

Each syndicate would need to establish its own Executive Risk Committee consisting of employer and employee representatives who determine the employers' contribution rate to cover the syndicate's expected loss costs and oversee claims' handling. Supervision of syndicates would be provided by both the Department of Industrial Relations ("DIR") and Department of Insurance ("CDI"). Employers within a syndicate would be able to select the level of financial hedging they require, ranging from the syndicate paying all employer's claims' costs (i.e. guaranteed cost), to an employer meeting their own claims' costs (i.e. self insured).

Based on the 2014 P&C total product cost, **an immediate reduction of 17% (i.e. $2.9 billion)** can be achieved by removing costly P&Cs' policy administrative processes which for some insurance companies can exceed $100 million annually. Additional significant advantages include:

(1) making use of various levels of "probabilistic reasoning" achieved through a syndicate's intimate knowledge of their covered employees and their workplace environments to determine the degree of uncertainty they have to face,

(2) replacing the confusing method of using an employee's job classification to determine a premium rate with a single contribution rate for all employees covered by a syndicate,

(3) less demand on employers' capital as their syndicate contribution is paid along with each employee's weekly, bi-weekly or monthly earnings and held in a syndicate's fund from which benefits are paid,

(4) maintaining an individual's employment history along with earnings removing the need for employers to confirm employment and payroll details at time of a claim,

(5) an opportunity to effortlessly identify prior or concurrent employers who may need to contribute towards an employee's benefits for certain gradual onset (i.e. cumulative trauma) injuries,

(6) greater focus on a workplace safety culture, achieved through peer pressure applied to those employers in a syndicate who choose to ignore exposure to unsafe workplace practices, preferring to accept less costly injuries,

Construction Job Site Safety Comparison - U.S.A. versus Australia

(7) better opportunity for utilizing job retention services by providing access to other employers within a syndicate, especially for employees with limited education in low-skill jobs and,

(8) major claims service improvements in the delivery of benefits as well as very significant cost savings achieved through organizations keenly competing to provide employees with **assistance in managing their medical disability and absenteeism from employment**.

Claims Service

Personal injuries can be loosely categorized into five severity groups, **(1) first aid**, **(2) physician visit**, **(3) emergency room**, **(4) hospitalization**, and **(5) death**. For work-related injuries, approximately 75% of employees have on average less than one week absence from employment, followed by an additional 10% who return within six weeks, with the remaining number experiencing more severe injuries being absent from employment for longer periods[2].

In 2014, P&Cs in California spent $5.1 billion on administering 800,000 work-related claims to pay benefits to employees totaling $8.9 billion. This is a per capita cost of over $6,000 and accounted for 30 cents per $1 of premium, which is excessively high considering approximately 600,000 employees have on average less than one week absence from employment with a number of the remaining 200,000 claims being finalized with a lump-sum settlement.

In more recent times, to rid themselves of some of the approximately 200,000 employees (i.e. 25%) requiring extended medical treatment and/or prolonged periods of absenteeism, P&Cs have increasingly been offering a lump-sum settlement payment to employees, accounting for 35% of the $4.8 billion (i.e. $1.7 billion) total medical benefits cost. This approach of finalizing a claim at the most opportune time for the lowest possible cost is diametrically opposed to the social insurance claims service goals which primarily focus on the employee's speedy recovery from injury, their return to normal life and resumption of gainful and sustainable employment.

Furthermore, the U.S. Department of Labor recently questioned the effectiveness of states' workers' compensation programs, suggesting some may be failing to provide adequate benefits with employees and their families requiring assistance from federal social insurance programs. They estimate annual costs of $23 billion for SSDI[3] and Medicare benefits to employees injured at work. In addition, an employee may be eligible for SSI[4] and Medicaid benefits in certain situations. In a specific California workers' compensation case, Medi-Cal incurred costs in excess of $380,000 after the urgently required medical services for a horrifically ill individual were callously denied.

For any alternative claims service to be considered a viable replacement to that used in the current P&C product, it must at a minimum reduce the cost of the claims' operating model, and remove reliance on federal benefits for work-related injuries.

Alternative Claims Service

Process

When words like adversarial, provocative and confrontational are used to describe a situation, it generally implies a strong level of mistrust between parties. While there may be many reasons for this, the cause for the mistrust between the

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[2] WCRI Sedgwick Institute, Dr. Richard A. Victor, Are Workers' Comp Systems Broken?, July 2016, insurancethoughtleadership.com Return to Work percentages quoted from WCRI Compscope Benchmarks.

[3] Social Security Disability Insurance.

[4] Supplemental Security Income.

P&C and the employee at a time when they are distressed and vulnerable may be simply explained - the employee (i.e. injured worker) is neither the insured nor the customer of the P&C, consequently they are treated in the same draconian manner as a third-party filing a personal injury liability[5] claim against a P&C's at-fault insured. The workers' compensation claims service is known for playing games with employees' lives, frequently denying the employee choices which genuinely affect their lives and the lives of their children, resulting in an adversarial and animus claims service environment.

This mistrust has consequently contributed to at least $2.6 billion[6] of the P&Cs' claims service costs (15 cents per $1 of premium) consisting of expenses associated with the following: (1) injury compensability[7] disputes amounting to $462 million in medical-legal fees, (2) medical treatment disputes with providers and their service fees accounting for $263 million in independent medical and bill reviews, (3) $208 million for verification of correct billing for medical services, (4) $442 million for settlements of providers' liens, and (5) attorneys' costs adding $846 million for P&Cs' defense, and $404 million for employees' attorneys.

In contrast, the **alternative claims service helps the injured employee manage their medical disability and absenteeism from employment** and therefore is absolutely aligned with the social insurance goals. Its focus at all times is on dealing with the cognitive complexity of human interaction beginning with building trust. To achieve this, **a number of paradigm shifts from the current draconian claims service are required**.

The **first paradigm shift** begins with treating the employee as a customer and no longer a third party claimant. This is achieved by allowing the employee to choose a claims service organization registered with the DIR. The name for these organizations is purely semantics and here, they will be simply called "Claims Administrators".

The DIR would maintain a register of all claims administrators with no limit to the number eligible to register, ensuring employees have a vast number of direct competitors to choose from. To foster innovation in efficiency and effectiveness which is currently lacking in the P&Cs' claims service, the payment model would transition from the P&Cs' "open-ended operational and administrative cost" to a value-based remuneration. Standardized fees established by the syndicates as a whole in consultation with the DIR would be paid to claims administrators consisting of a per claim service fee with additional performance and incentive fees based on claims' outcome. This approach would immediately and significantly reduce the $5.1 billion spent by P&Cs on the claims service in 2014.

The **second paradigm shift** is in the delivery of the claims service. The current P&Cs' approach employs examiners/adjusters and/or nurse case management professionals to monitor an employee's acute care, expecting the primary treating physician to be totally responsible for returning the employee to employment. A common instruction to the physician may state, "***Please provide him with the appropriate evidence-based medicine for his injury so he can be in good shape to go back to work***". In contrast, the alternative approach requires the claims administrator and not the primary treating physician to be responsible for ensuring the employee achieves optimum outcome through coordination of services - in other words, transforming from an acute care mindset to comprehensive disability management where the claims administrator's role is that of a facilitator.

The concept of **evidence-based medicine using a biomedical model** was instigated by P&Cs as a means to control the cost of medical benefits. Many P&Cs struggle with their workers' compensation claims service for a variety of reasons with a major one being payment limits. When a P&C issues a liability insurance policy, it is effectively a contract clearly describing the terms in which a P&C is legally required to pay, including payment limits. Benefit limits for workers' compensation are established through statute, and while there are statutory limits for indemnity benefits, there are generally no limits on medical. The biomedical model comprising of treatment and pharmaceutical guidelines for each diagnosis code

[5] Also known as bodily injury liability.

[6] A separate costing for investigation services is not provided by the WCIRB and therefore is not included in this figure.

[7] AOE/COE (Arising out of employment/Course of employment).

is the P&Cs' substitute for medical limits. Examples of codes used to systematize medical conditions include ICD-10[8] and DSM-IV[9]. At the time of its introduction, the DIR's definition[10] for evidence-based medicine stated, *"Evidence-Based Medicine (EBM) means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE."*

Using diagnosis codes might group employees into treatments of like kinds, however there are no guarantees they share the same symptoms. The medical service options also need to consider factors such as, (1) an employee's habits, (2) their co-morbid conditions, and (3) their mindset. In other words, to determine the required medical services, a biopsychosocial model rather than a biomedical model needs to be applied. The DIR recognized this need and subsequently updated their definition which now states, *"Evidence-Based Medicine ("EBM") means a systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values"*. This definition goes by many names, with evidence-based practice ("EBP"), precision medicine, personalized care, and shared-decision making being some of the most common.

Some still insist however, that a biomedical model is sufficient to treat those 600,000 employees with less severe injuries, that it improves medical outcome and also lowers P&Cs' costs for medical benefits. While there is no disputing that medical costs will reduce when medical services are restricted, suggestions of an improved medical outcome appear to be anecdotal. Conversations on social networking websites suggest that medical services likely to be rejected by P&Cs because they do not adhere to a biomedical model or require exhaustive explanations by physicians, are either being paid for directly by employees or obtained through an employee's health insurance or other social insurance such as Medi-Cal as illustrated earlier. What is indisputable however, is that applying a biomedical model to those 200,000 employees with more severe injuries is a major contributing cause for excessively high claims service costs, poor outcomes, and inadequate benefits.

Consider the following personal injuries that could result from an employee falling from a multistory building's scaffold, or a recreational activity such as rock climbing or falling from a motorcycle - cracks to the neck vertebra, damage/dislocation to hip, damaged knee, broken bones in leg and full rotation of ankle. Medical services for these injuries could probably span a period of 5 years or more with numerous permutations and combinations. Utilizing the current P&Cs' reactive approach to monitoring a primary care physician's adherence to evidence-based medicine leads to numerous disputes over medical services, resulting in the hinderance of necessary and timely medical treatment and increased claims service costs. The California Workers' Compensation Institute ("CWCI") stated[11], "*Deciding the type, intensity and cost of medical care that is appropriate for injured workers is one of the most contentious, convoluted subjects in workers' compensation*". The CWCI went on to state that processes associated with evidence-based medicine increased P&Cs' claims service costs associated with medical cost containment efforts by 347% between 2002 and 2014.

The alternative claims service using a biopsychosocial model begins with setting an employee's expectations up-front with the claims administrator, in consultation with the employee, preparing a rehabilitation plan[12] (i.e. roadmap) which focuses on **how to address their medical disabilities and employment opportunities**. With the employee involved, the plan is attentive to their needs showing empathy, support, and reassurance, which at the emotional level evokes a sense of trust. This paradigm shift has the potential to effectively reduce the cost for mistrust experienced in the P&Cs' claims service by up to $2 billion, achieved through less need for medical-legals, fewer medical treatment disputes and less attorney involvement.

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[8] International Classification of Disease, 10th revision.

[9] The Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorder.

[10] California Workers' Compensation regulation 9792.20 Medical Treatment Utilization Schedule - Definitions.

[11] CWCI, Medical Review and Dispute Resolution in California WC, December 2nd, 2015.

[12] Also known as a recovery plan.

As well as evoking trust, the **"how" approach** being outcome oriented, delivers structure to the claims service which becomes the protocol to guide the employee's rehabilitation. This protocol combines all the resource types and all their services including medical regimes such as treatments and pharmaceuticals into an integrated team approach (i.e. interdisciplinary). With medical regimes consisting of a series of iterative processes and decision points, a proactive and dynamic environment is created which excludes ineffective treatment patterns and reduces the opportunity for cost leakages. The collaboration and synergy between team members and their interaction with the employee is managed and monitored by a lead facilitator, which further ensures delivery of an optimal result with the least cost.

The alternative claims service is far superior to the current approach in addressing the needs of the approximately 200,000 employees with complex medical conditions. It also has merit over the current approach in addressing the 600,000 employees with a transient medical condition. It is not uncommon for an employee who had an acute injury and who also has a co-morbid condition to experience a further work-related injury following return to work which could possibly result in a work-related disability. The alternative approach reduces this possibility by monitoring the employee after they have returned to employment and if necessary, stabilizing their health problems through medical services and tweaking their job duties at a much lower cost than if they developed a work-related disability.

Through the combination of the alternative claims service's collaborative environment and additional employment opportunities provided by telecommuting[13] and the gig economy[14] along with promising medical advances such as stem cell therapy, immunotherapy to treat cancers, optogenetics research in developing synthetic skin capable of sensing, 3D printed prosthetics, and the use of microbubbles and ultrasound to heal nonunion fractures in broken bones, administrators would at all times be able to focus on reducing employees' absenteeism from employment. The current P&Cs' practice of finalizing a claim through a lump-sum settlement would no longer be necessary or even considered an option, which in turn **would save the federal and state governments at least $23 billion annually** by not having to pay social benefits to employees injured at work.

Technology

Managing personal injury claims is a "people business", where human effort determines outcome with technology assisting in achieving optimal outcome. Identifying "people" as the most important resource suggests that the management and constant monitoring of individuals' actions and their interactions (i.e. encounters) through the core claims system is the cornerstone to achieving this goal. For P&Cs however, this has not been the case and yet another cause for their claims service sliding into entropy, requiring the need for alternatives to be explored.

Either through choice or necessity a number of pivotal processes and functions including the management of people have been excluded from the P&Cs' core claims system which in California in 2014 lead to a cost ratio of 71 cents for the delivery of medical benefits to each $1 paid for medical services provided through P&Cs. The delivery cost to provide medical benefits came to $2.2 billion[15] and for the same period, P&Cs paid medical providers $3.1 billion for medical services which may have helped to treat employees' medical conditions[16]. This delivery cost to provide medical benefits is excessively high considering the vast majority of services are provided by the P&Cs' own Medical Provider Network ("MPN").

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[13] employee working outside the office (e.g. from home).

[14] self employed or freelancers account for 34% of the workforce, expecting to be 43% by 2020.

[15] Includes a cost leakage estimate of $544 million for missed fraud.

[16] There are no published statistics on the frequency an employee may have been undertreated or mistreated by medical providers. However, **WorkersCompensation.com** published an article titled "Medical Misdiagnoses Cost Workers' Comp Systems Billions, Paper Says" which stated that as much as a fifth of medical diagnoses in workers' compensation claims involve errors.

In summary, the current P&Cs' MPN fails to meet all three of its crucial goals, (1) to identify providers who deliver quality and cost effective treatment, (2) to help employees choose the most capable medical providers, and (3) to exclude providers who use unethical treatment and medical billing practices. Common unethical treatment practices include receiving kickbacks for referrals, and excessive or unnecessary services, and unethical billing practices include charging for services not provided, and up-charging for services and equipment.

The failure of MPNs to function effectively since their introduction in 2005 has most likely been caused by their modus operandi. Many P&Cs have either leased an MPN from a third party provider or outsourced the build and maintenance to a third-party provider. This has resulted in P&Cs' having no prior knowledge of the quality of the services those individuals or facilities provide, yet employees are forced to choose physicians including their primary treating physician from the MPN. Further to this, the names of health care professionals such as physical therapists are suppressed from the MPN forcing the employee to accept whoever the P&C chooses, which becomes another factor contributing to the mistrust in the P&Cs' claims service.

The **third paradigm shift** is then to enable the core claims system to bring new dynamism to the people intensive claims service. According to the Kaiser Family Foundation (KFF.org) there are over 100,000 physicians in California of which around 50,000 provide primary care with the remainder being specialists. While some suggest that selecting physicians for an MPN and the recommendation of physicians to an employee can be a challenging task, this is not the case when using the core claims system. Physician directories available in electronic format (i.e. digital data) combined with mining employees' demographics and medical data, as well as claims' encounter data[17] all resident in the core claims system provide the ability to unlock trends and build predictive models to grow a dynamic "smarter and personalized" MPN in real time.

Achieving this goal begins with knowing as much as possible about each and every individual or facility regardless of their role in a claim which means the data collected by the core claims system needs to be granular. As well as collecting identity data beginning with names, social security numbers, various identities such as a driver's license, medical marijuana ID, National Provider ID (NPI), state medical license, and contact details such as physical/mailing address, voice/SMS/video, web and email, it also must collect data that provides an understanding of an individual's relationship with others that could influence an outcome. In the case of an employee with comorbidities, this includes details of individuals who are concurrently providing medical services including their specialty/sub-specialty. In the case of providers, this includes their relationship with facilities and individuals within those facilities.

Comprehensive demographic details also need to be collected. In addition to common details such as gender identity, age, race and preferred language, an individual may volunteer their habits like smoking, drinking/recreational drug use and high calorie diets. They may also provide further insight into their mindset influenced by their sexual orientation, ethnicity, religion and cultural barriers. These factors all influence the interpersonal style between individuals especially between the employee and their physicians. Their interaction can lead to significant variations in process and outcome, ranging from the frequency of clinical encounters, tests ordered and medication prescribed, through to the extent the employee participates in making decisions as well as the overall congeniality expressed during their clinical encounter.

While products offering Customer Relationship Management ("CRM") and Supply Relationship Management ("SRM") technology solutions may capture granular data on entities, using the core claims system transcends their functionality as it applies to the claims service by amalgamating all the data to address the complex interplay of choosing service providers, improving medical outcomes, reducing absenteeism, combating fraud and reducing benefit delivery costs.

[17] Encounter data means all transactional data such as contact actions, communication, service codes such as NDCs (National Drug Codes), HCPCS (Healthcare Common Procedure Coding System), CPT (Current Procedural Terminology) and ICD-10s (International Classification of Disease, 10th revision).

This paves the way then for a **fourth and final paradigm shift** relating to using digital data effectively and efficiently. All service-oriented organizations, from fast food outlets to a workers' compensation claims service are reliant on data and to varying degrees on technology to process the data and perform analytics. With the workers' compensation claims service providing three distinctly different employee's benefits, exhaustive data needs to be collected and leveraged from its multifarious and interdependent operational and administrative processes preferably by a core claims system with a highly normalized[18] data model instead of through disparate systems (i.e. discrete databases). Disappointingly, this has not been the approach used by P&Cs.

While the P&Cs' claims service does collect data on individuals and encounter digitally, it becomes meaningless when used in processes that function as silos with disparate systems. P&Cs' operational processes have grown unchecked comprising of a hodgepodge of disjointed processes plagued by problems including what P&Cs commonly describe as "cost leakages", a very subtle way of saying "***incurring costs that were unnecessary which are ultimately paid by employers through their premiums***". In addition to the sheer number of participants involved and disparities in data, some other common causes for these cost leakages are attributed to: (1) inadequate training and supervision of staff, (2) excessive data handling expenses, and (3) overpayment for services.

Even though California lawmakers have enacted legislation aimed at improving operational processes such as straight-through processing of medical invoices (i.e. e-Billings), their effect on the P&Cs' claims service appears to be the exact opposite. In 2014, the P&Cs' disjointed approach which is deeply, perhaps fatally flawed incurred a cost of $1 billion to monitor $3.1 billion of medical services[19] with all indications for this cost to continue to increase in the future.

Evidence to support this can be found in the physicians' evaluation and management services ("E&M") provided through medical benefits. Of the three workers' compensation benefits, medical is by far the most data intensive, repetitive and highly task oriented. In 2014, P&Cs in California paid $570 million for E&M services[20] with two of the highest priced service codes (i.e. CPT 99213 and 99214) accounting for the majority of the paid amount. Codes 99213 and 99214 are generally associated with treating multiple ongoing complicated medical conditions, yet as stated in preceding paragraphs, 75% of employees return to employment within a week, suggesting their presenting medical condition to their workers' compensation primary treating physician is of an acute uncomplicated nature. Also, a high percentage of the remaining employees' claims were finalized through a lump sum settlement payment removing the need for ongoing E&M services. The cause for this type of leakage is attributed to processes that function as silos which continues to remain the status quo.

Utilizing the core claims system and applying Business Intelligence techniques allows the claims service to cut across current P&Cs' disjointed processes. This is achieved by linking activities that can be done at the same time, eliminating the need for multiple checkpoints and approvals resulting in reduced elapsed times and costs (i.e. achieving optimum performance through an end-to-end approach). In the case of an E&M, it enables a cohesive and effective bill review, medical utilization review, pre-authorization of physicians' medical services, and the determination of incapacity periods along with the ultimate cost for an employee's rehabilitation. In other words, an E&M becomes a decision point in a medical regime's iterative processes within the employee's rehabilitation plan, and a focal point of the holistic approach, moving a step forward in reducing the $1 billion expense.

Exposing the many hidden values of the data allows the core claims system to be intertwined and become the overall driver for every decision in this holistic approach (i.e. it becomes the nucleus of the claims service). For example, an individual's qualifications and certifications are used in different ways depending on their association with the claims service. For a physician, it establishes their intellectual experience and proficiencies. For an employee the same data is utilized in job

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[18] Focused on reducing data redundancy and improving data integrity.

[19] Medical service costs were $3.6 billion to which an estimate of 15% for missed fraud was applied reducing medical services to $3.1 billion and increasing administrative costs by $544 million.

[20] E&M services accounted for 30% of the total $1.9 billion paid for physician services.

retention services. While a data element has value on its own, its value is extended when used as a whole. For a physician, including their encounter data recognizes their practical experience in treating specific medical conditions allowing for deviations based on the physician's judgement (i.e. experienced-based care). Combining data of individual physicians with the same speciality/sub-speciality extends the encounter data stored in the core claims system from an evidence-based practice database ("EBP") to a practice-based evidence database ("PBE") allowing for an even more pragmatic approach to treatment (i.e. analyzing encounter data to determine what works, for whom, when and at what cost). Extending the use of employees' data ensures communication is always in a complementary way (i.e. a personalized experience) considerate of their primary language, literacy skills and cultural etiquette where in some cultures a simple gesture like a handshake can be offensive.

The operational processes discussed have hinted that even a slight change in an individual's productivity can have a devastating effect on the people heavy processes. The claims service has often been described as an active "ecosystem" where the cliché "***what cannot be measured cannot be managed***" is very relevant. Performing administrative processes in the core claims system provides an intelligent insight into the claims service ensuring its successful running. While the operational and administrative processes are independent and unrelated activities, they are aligned and mutually supportive of the employees' rehabilitation plan. The administrative processes ensure tight sequencing of events by providing each individual with a clear understanding of their role - what they will do, when they will do it, how long it will take and at what cost. This allows the claims service to do more with less by constantly monitoring against itself (i.e. budget versus actual) as well as benchmarks (i.e. applying lean concepts and techniques) and so delivering increased productivity and reducing costs to the claims service.

Reduction in costs and savings.

In the face of such criticism of the P&Cs' claims service, those proponents of the P&Cs' product with an egocentric view will undoubtedly be skeptical of the **estimated $8 billion reduction in costs**. An accurate reduction can be determined through a detailed analysis of the P&Cs' data especially claims. While the reductions of $2.2 billion[21] and $2.9 billion relate specifically to managing the delivery of medical benefits and the overall claims service respectively, reductions in the cost for temporary and permanent disability indemnity benefits are also expected, but again only by accessing P&Cs' claims data can an amount be provided. A final reduction of $2.9 billion is achieved by implementing the alternative scheme for funding workers' compensation.

To determine the ultimate saving through implementation of both alternatives, the stated reduction would **need to be offset by the remuneration amount paid to claims administrators and the cost to manage the syndicates' funds**. At this time, it would be inappropriate to comment on the remuneration costs if for no other reason than it would be expected that a stampede of new entrants in addition to current third party administrators ("TPAs") seeking a share of the 800,000 employees would influence the standardized remuneration amount.

With profit driven by their innovative claims service and market share, the claims administrators' DNA is highly focused on responsibility, answerability and accountability where social media and sites like www.complaintboard.com used by some employees (i.e. injured workers) to share workers' compensation experiences promote a healthy competitive market quickly separating the wheat from the chaff. Furthermore, unlike the P&Cs' claims service which is protected from litigation by employees by the Workers' Compensation Exclusive Remedy provision (i.e. no fault), a claims administrator can be sued by an employee or syndicate for "bad faith" further ensuring their DNA provides an effective and efficient claims service. This is in stark contrast to the claims service provided by P&Cs where in addition to being protected from "bad faith" litigation, leakage costs caused through their claims service are passed on to employers through increased premiums.

[21] MCCP $471 million, Missed Fraud $544 million, Med Legals $462 million, Provider Liens $442 million and other medical costs $228 million.

In addition to the savings generated by the alternative claims service which allow employers to invest in initiatives they previously couldn't afford, there are savings in federal social insurance programs which may help to lower the current US debt of almost $20 trillion (or around 10% of the global debt[22]). Reductions are expected in the amount spent annually on Federal SSDI relating to California as well as in any work-related medical services currently provided under Medi-Cal, but above all, **the alternatives protect an individual's most important asset - their ability to work and earn a living**. With current US household debt rising to $12.73 trillion[23] of which $1 trillion is credit card debt, changes in employees' ability to earn a living could prompt a new wave of defaults, similar to the mortgage defaults a decade ago.

In addition to workers' compensation providing partial replacement of lost income, California also provides short-term income protection for non work-related personal injuries under their State Disability Insurance ("SDI") program.

State Disability Insurance ("SDI")

The Employment Development Department ("EDD") administers the social insurance program and its disability insurance ("DI") component which has similarities to a disability income policy offered by an insurance company. Another common name for this insurance is income protection. Funded by employees through payroll deductions it provides partial replacement of lost income for up to 52 weeks with Medi-Cal and SSDI at times providing medical treatment as well as loss of income beyond 52 weeks respectively.

To remove the need to use Medi-Cal and/or SSDI for these injuries, the DI component should be expanded to include medical benefits and long-term loss of income protection along with the alternative claims service. This would assist employees in gaining every opportunity for reducing absence from employment thus minimizing their need for state and federal services and subsidies.

Also, with EDD administering SDI, synergism is created by EDD collecting the employers' contribution for the alternative workers' compensation funding scheme through employees' payroll deductions. This approach ensures the vast majority of the $2.9 billion reduction achieved by eliminating the P&Cs' policy administration processes becomes a saving for employers. Furthermore, the employer is no longer required to endure payroll audit processes to meet their P&C policy obligations providing an additional saving.

By further expanding the DI benefits, consideration should also be given to extending coverage along with the claims service to all family members of the employee. With student loans accounting for 10.6% of household debt (or $1,349,380,000,000), protection would be provided for the heavy investment made in educating their children. Including the same alternative claims service provided for workers' compensation, should also ensure only a marginal increase in employees' contributions to meet the costs of the proposed DI coverage.

While not a social insurance, it would be remiss not to consider the other major cause for personal injuries - **motor vehicle accidents**. Latest statistics for California have shown a 13% increase in road deaths over a three year period through 2013 with the trend expected to continue.

States are divided on how motor vehicle personal injury coverage should be provided. Some states have introduced a "no-fault" insurance scheme referred to as Personal Injury Protection ("PIP") insurance while others like California are based on the concept of "fault" where the person at fault in a motor vehicle accident is required to pay for injuries caused to others.

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[22] Institute of International Finance ("IIF").

[23] Federal Reserve Bank of New York.

To ensure a driver in California has adequate protection for themselves as well as others, numerous insurance coverages are required beginning with group or individual private health coverage or Medi-Cal/Medicare, and uninsured/underinsured motorist coverage for their medical treatment. They also require some form of income protection coverage for situations where they are unable to work. To provide protection to others injured, the driver may require a combination of liability coverage for bodily injury, medical payment coverage and general liability umbrella coverage. The process of navigating this complex fragmented coverage at time of injury can cause interruptions and discontinuities to an individual's urgent medical care, hampering their recovery and ability to return to their former quality of life. In extreme cases, the complexity may cause individuals to rely on state and federal government support for the rest of their lives.

An alternative to purchasing coverages from insurance companies and reducing this current complexity is for the motor vehicle owner to pay a levy which covers the same types of benefits and claims service as workers' compensation for all those injured in their motor vehicle. The levy would be paid along with their motor vehicle registration payment to the Department of Motor Vehicles ("DMV") and would be based on the state's accident experience which could be influenced by the vehicle type or age of the owner for example. This is similar to how an insurance company charges premiums for motor vehicle liability coverage. Again, the claims administrator chosen by the injured party would ensure prompt return to their quality of life which should result in the levy costing far less than current insurance premiums and also removing the need for state and federal services and subsidies.

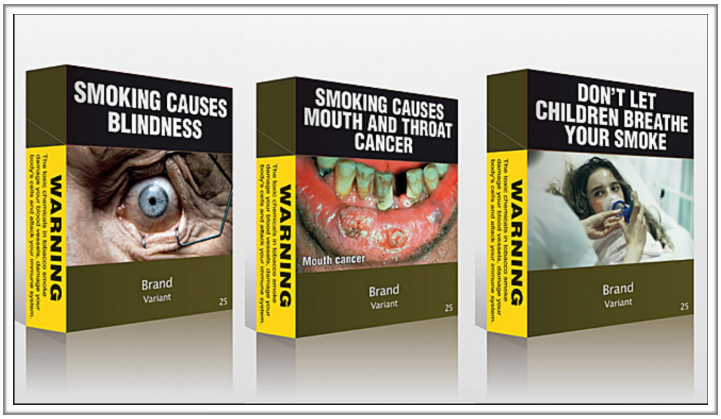
The influence an individual's health has on their personal injury medical service options, recovery time and therefore costs also needs to be mentioned. The overall health of an individual is very much determined by their genes, especially as they age. However, diseases and other problems can come from a combination of their genes, their choices in life and their environment.

Advertising is the most common method used to influence an individual's choices - from smoking to the foods and drinks they consume. Companies spend around $1.8 billion annually marketing sugary drinks, sweetened cereals, confectionary/candy, snack foods and fast foods to children and teens especially to those from families most likely to receive medical care through state and federal funded health care programs such as Medi-Cal. While advertisements shown here are no longer used, their impact on an individual's health can be long-term.

The prevalence of being overweight and obese in the U.S. has reached epidemic levels and has become more socially accepted with fewer overweight Americans attempting to lose weight which will undoubtedly result in an escalation in social insurance costs including the need for complex medical services. While addiction to cigarettes or e-cigarettes (i.e. electronic cigarettes), obesity and being overweight are a worldwide problem, countries like the United Kingdom and Australia address these issues at a federal level, whereas the U.S. addresses them at a state level resulting in inconsistencies in approach, leading to significant differences in population health between states, which in turn may impact on the state's medical costs[24].

The ad states, "*Not soon enough. Laboratory tests over the last few years have proven that babies who start drinking soda during that early formative period have a much higher chance of gaining acceptance and "fitting in" during those awkward pre-teen and teen years. So do yourself a favor. Do your child a favor. Start them on a strict regimen of sodas and other sugary carbonated beverages right now, for a lifetime of guaranteed happiness.*"

[24] In men, smoking explained nearly 40% of cancer deaths in Arkansas, Louisiana, Tennessee, West Virginia and Kentucky. In women, smoking explained more than nearly 26% of all cancer deaths in Kentucky, Arkansas, Tennessee, Alaska and Nevada. Counties in South Dakota and North Dakota had the lowest life expectancy, and counties along the lower half of the Mississippi, in eastern Kentucky, and southwestern West Virginia also have very low life expectancy compared to the rest of the U.S. Counties in central Colorado had the highest life expectancies.



Two initiatives used Australia-wide to address cigarette addiction is through awareness of the health risks and charging high prices predicted to reach a packet price of $45 by 2020 with tax making up 69% of the cost. Health risk awareness is achieved using graphic images on plain packaging as illustrated[25]. In the United Kingdom, the government intends to introduce a sugar tax on sugary drinks, investing the funds raised into health and sports projects for children. The U.S. state approach in comparison, can vary from banning the purchase of sugary drinks and confectionary with the use of food stamps (i.e. Supplemental Nutrition Assistance Program ["SNAP"]) to imposing a tax, and with cigarettes, the law can vary from imposing age restrictions (i.e. must be 21 or older to legally smoke) to placing a tax and/or a health warning on cigarette packets.

An alternative to the "nanny state" approach is for states to apply a levy on companies who sell goods known to be detrimental to the health of some members of the population as a contribution towards the cost of their medical services. In California, the contribution would be paid to Medi-Cal and used to both offset the cost of providing medical services under the Medi-Cal program as well as contributing to the cost for personal injuries covered by workers' compensation, SDI and motor vehicle where recovery costs were negatively affected by comorbidity (i.e. pre-existing conditions) caused by smoking or consumption habits.

Single-Payer Universal Healthcare System

The goal of a universal health system is to provide the population with a level of **financial risk protection for the necessary medical services** ("protection") required when there is a **disruption to an individual's health caused by a disease or traumatic event (i.e. personal injury).** While the U.S. does provide this protection, not everyone has it, even with the introduction of the ACA.

The ACA has been discussed ad nauseam since its first proposal through to its most recent discussion centering around its repeal and replacement. All states are evaluating the impact of its repeal with California undertaking studies for the introduction of a single-payer universal healthcare

[25] Philip Morris has been ordered to pay an estimated $50 million in compensation to Australia for its legal costs after unsuccessfully challenging the nation's tobacco plain packaging laws introduced in 2012. Australia became the first country to require cigarettes to be sold in unappealing packets with graphic health warnings. Following Australia's lead, other countries now also require standardized packaging. The list includes France (2017), United Kingdom (2017), New Zealand (2018), Norway (2018), Ireland (2018) and Hungary (2019).

system estimated to cost $400 billion[26], removing the need for health care insurance companies completely. Neither however, may be desirable.

Even though England has had a single-payer universal health program for over 70 years, some individuals still choose to purchase medical coverage through an insurance company, effectively paying twice for protection. Australia as well has a universal health system paid through a tax levy but not all medical services including pharmaceuticals are fully paid for and some Australians by law must also purchase hospital cover from an insurance company or pay an additional tax levy. As well as not covering all services or medications, physicians can charge their own prices for medical services regardless of the prices set by the Australian federal government. A patient pays the difference either through a "gap" insurance policy purchased from a health care insurance company or as an "out of pocket" expense. Therefore, while Australia has a single-payer universal health system, not all individuals have access to all medical services including pharmaceuticals because they simply cannot afford to pay.

Following on from the preceding paragraph, it may stand to reason that those in California who can afford to pay for protection against diseases through an insurance company or where it is provided through their employer should be allowed to continue to do so. With regards to Medi-Cal, attention needs to be directed towards efficiency and effectiveness to ensure its funds are used wisely to treat diseases for those individuals who are unable to secure protection.

In order to cut down on any abuse in the Medi-Cal program and ensure its affordability, the alternative claims service proposed for workers' compensation and the other traumatic event funding schemes should be introduced. It is a fallacy to believe that medical treatments or services required to treat a personal injury are different for work-related and non work-related injuries. It is also a fallacy to believe that co-morbid conditions such as obesity or diabetes treated at the same time as a personal injury should require medical services any different to those considered when treated under a private health plan or Medi-Cal/Medicare. Applying the 80/20 rule under Medi-Cal, an individual may only need to choose a claims administrator for a disease such as cancer or where one or more comorbidities exist. These diseases generally require a compassionate and personalized coordination of integrated services and are also more likely to experience unethical treatment which the claims administrator should be able to detect, circumventing medical fraud ensuring providers stay compliant with their medical services. This far exceeds the services offered by health insurance companies whose robotic assembly line processes are not truly aligned with an individual's welfare, and do not address their specific needs or the quality of the medical services provided.

To conclude, this article has illustrated how through a combination of contributions and levies by those deemed responsible for the cost of an individual's rehabilitation, a universal health program for traumatic events can be provided. Its single most important challenge however, hinges on its ability to remain affordable. It has been repeatedly highlighted that wastage is the major culprit affecting affordability which to date in California has been caused by a lack of coordination relating to either services or benefits or a combination of both as identified with workers' compensation, SDI and injuries caused by motor vehicle accidents.

The alternative claims service through its constant vigilance throughout its processes ensures wastage is stamped out allowing more of the population to be provided with protection against traumatic events along with expanded benefits compared to those currently offered and at a much lower cost than what is experienced in California today. Also, by facilitating medical services to Medi-Cal beneficiaries with serious diseases and health problems, the savings generated may provide an opportunity to continue the expanded 9.7%[27] Medi-Cal program in the event the ACA is repealed.

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[26] Funded by both the federal government and increases in state tax.

[27] Hattie Xu, Sacramento Bee, "A Third of all Californians depend on Medi-Cal. Here's who they are and where they live".

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Acronyms & Abbreviations

AOE/COE	Arising out of employment/Course of employment.
CDI	California Department of Insurance.
CPT	Current Procedural Terminology.
DI	Disability Insurance.
DIR	California Department of Industrial Relations.
DSM-IV	The Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorder.
EDD	California Employment Development Department.
E&M	Evaluation and Management Services.
HCPCS	Healthcare Common Procedure Coding System.
ICD-10	International Classification of Disease, 10th Revision.
MPN	Medical Provider Network.
Nanny State	Government regarded as overprotective or as interfering unduly with personal choice.
NDC	National Drug Code.
NPI	National Provider ID.
P&C	Property and Casualty Insurance Company.
SDI	California State Disability Insurance Program.
SSDI	Social Security Disability Insurance.
SSI	Supplemental Security Income.

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