MINDER Managing Disability

Dialogue

Could 500,000 California Employers Refuse to Purchase Compulsory Workers' Compensation Insurance Coverage Citing P&Cs' Bad Faith?

By law, purchasing a workers' compensation insurance policy is compulsory for the majority of employers and is provided exclusively by Property & Casualty ("P&C") insurers.


Sunset Blvd, Los Angeles CA

In most jurisdictions, the workers' compensation insurance product operates in a free market encouraging P&Cs to compete for market share on premiums and services. Even though competitiveness exists in most jurisdictions, **the consensus of business owners, CFOs and HR Directors nationwide is that premiums are unaffordable**, with P&Cs under threat of losing their exclusivity for providing an insurance product.

In light of this, California was selected for a study to objectively identify causes for the high cost. The study separated components of both medical and indemnity benefits into those **truly benefiting employees** and the **P&Cs' true cost to administer and deliver these benefits.** **It concludes with identifying possible causes for the costs and solutions available.**

Medical and Indemnity Benefits that truly benefited the employee accounted for 53 cents of each $1 dollar of employer's premium.

The latest data from the WCIRB[1] for the 2014 cost of the P&C insurance product was used for the study including data from the California Department of Insurance ("CDI"), California Workers' Compensation Institute ("CWCI"), Workers' Compensation Research Institute ("WCRI") and the National Council on Compensation Insurance ("NCCI").

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[1] Workers' Compensation Insurance Rating Bureau (WCIRB) - WCIRB 2015 Report on the state of the California Workers' Compensation Insurance System and WCIRB Report on 2014 California Workers' Compensation Losses and Expenses. Some figures from the WCIRB reports include estimates. Further to this, some of the figures derived from the Study are also estimates and therefore it is at the reader's discretion whether to agree or disagree with the study's formulations.

FINDINGS

Separating premium cost driver components truly benefiting employees from those involving administration of claims and the delivery of benefits, resulted in the following changes to the WCIRB component costs:

- **incurred medical benefits** of $6.6 billion were revised down to $4.8 billion reflecting a **truer cost of employees' medical benefits.**

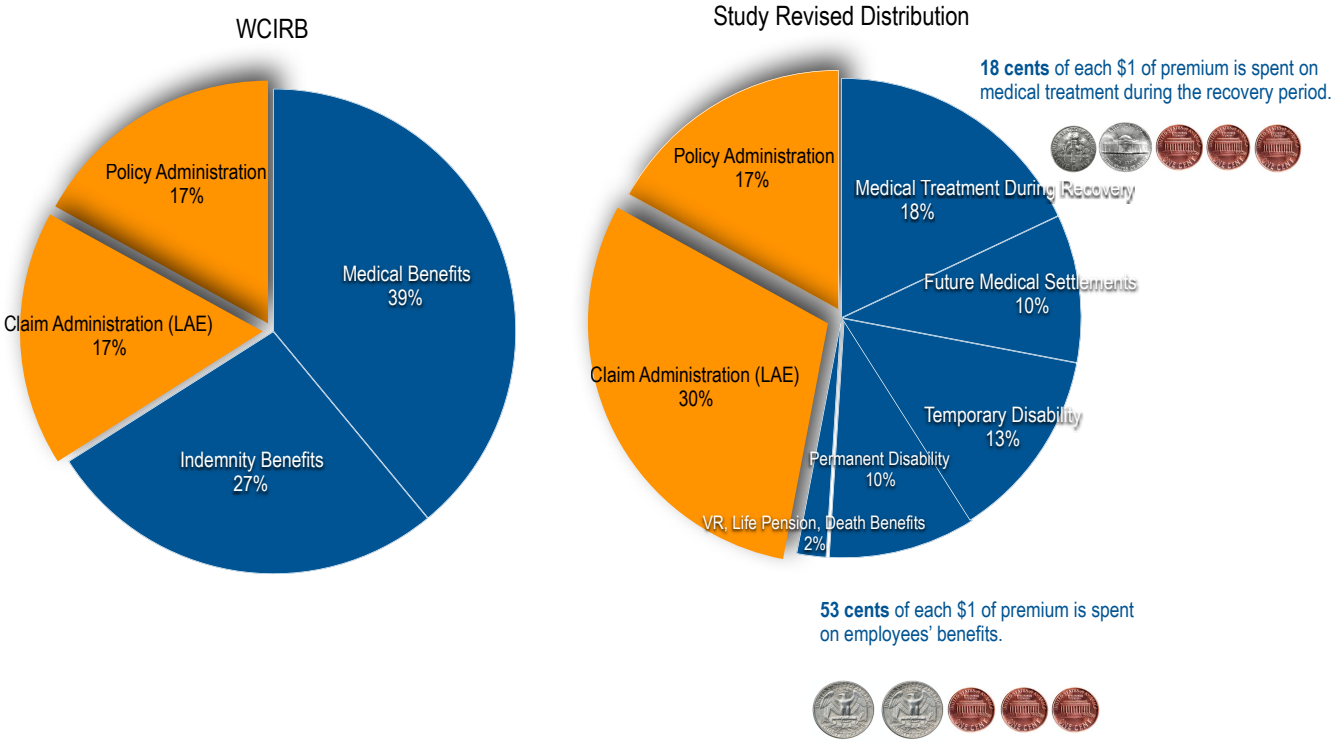
- **incurred indemnity benefits** of $4.5 billion were revised down to $4.1 billion reflecting a **truer cost of employees' indemnity benefits.**

- **loss adjustment expenses ("LAE")** were revised upwards from $2.9 billion to $5.1 billion.

- After applying these revisions, medical and indemnity benefits that **truly benefited the employee accounted for 53%** of the overall insurance product cost of $16.9 billion with the remaining 47% for administrative costs and premium taxes. In other words, **for each $1 of the employers' premium, employees received 53 cents in benefits.**

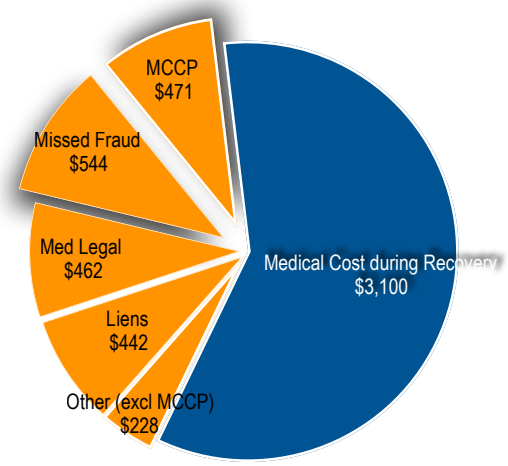
- Of the overall cost of $16.9 billion for the insurance product, the **true medical services cost** during employees' recovery period accounted for **$3.1 billion or 18% of the total.** In other words, **for each $1 of employers' premium, 18 cents was spent on employees' medical services during their recovery period.**

Distribution of 2014 P&Cs' California Workers Compensation Insurance Product Costs Totaling $16.9B



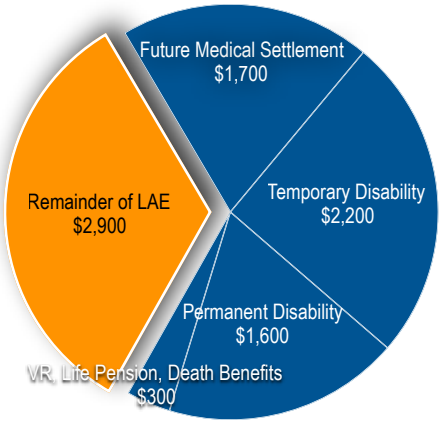
- Further to the $3.1 billion paid for truer medical services which benefited the employee, it is estimated P&Cs paid additional LAE costs of **$2.2 billion to administer the medical services. This included $1 billion to circumvent medical billings abuse by fraudsters** within their own Medical Provider Networks ("MPN"[2]).

LAE Costs during Employee Recovery Period ($'s in Millions)



- The balance of $2.9 billion of the total LAE cost of $5.1 billion was spent on delivering the remaining employees' benefits totaling $5.8 billion[3]. **In other words, for each $1 the employee received for benefits other than medical treatment during the recovery period, it cost P&Cs 50 cents to deliver the benefit.**

LAE Costs for Remainder of Benefits ($'s in Millions)



This suggests that P&Cs overall costs for providing a workers' compensation insurance product is disproportionately high when compared to the true cost of benefits provided to employees, with LAE clearly a major premium cost driver.

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[2] This study acknowledges that employees can predesignate their Primary Treating Physician ("PTP") & employers can utilize a Health Care Organization ("HCO"). However, both are rarely used in the P&Cs' insurance product.

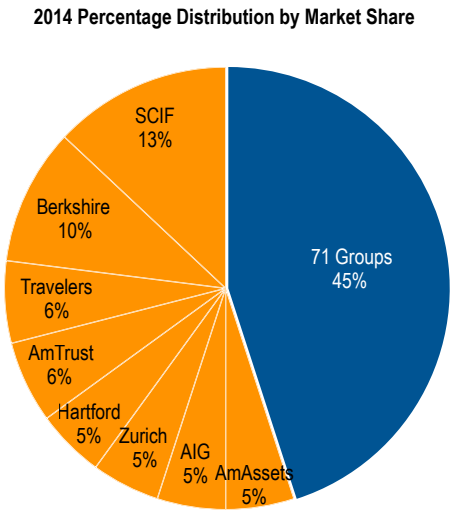
[3] Employees' benefits totaled $9.4 billion. Medical services of $3.6 billion during recovery including a provision of $500 million for missed medical fraud leaves a balance of $5.8 billion for payment of future medical services settlements and all indemnity benefits.

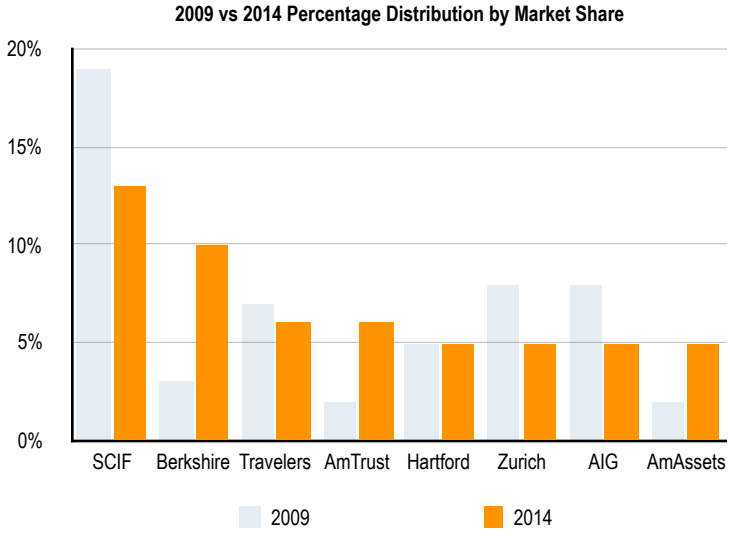
APPROACH

In 2014, more than 500,000 employers in California purchased a workers' compensation insurance policy from either the State Compensation Insurance Fund ("SCIF") or one of 78 P&C Groups totaling $11.4 billion[4]. Although the number of P&C groups offering insurance appears quite large, the market is fairly concentrated, with SCIF and 7 Groups accounting for 56% of the market share, leaving the balance of 44% distributed over 71 Groups. This phenomenon could in itself influence premium cost drivers, but does not form part of the study.

California handles in the vicinity of 800,000 claims annually with claims processing potentially continuing on for many years after policies have expired. Any significant changes in a group's market share can increase the cost of services in administrating claims. Again, this factor does not form part of the premium cost driver study but could be considered in future studies. Market share for the top 8 in 2014 compared to 2009 were:

	2009		2014	
SCIF	18.6%		13.4%	
Berkshire Hathaway	3.4%	5 insurers	9.9%	9 insurers
Travelers Group	7.4%	14 insurers	6.2%	11 insurers
AmTrust NGH	1.5%	4 insurers	6.1%	7 insurers
Hartford	5.1%	6 insurers	5.4%	9 insurers
Zurich	8.1%	15 insurers	5.2%	7 insurers
AIG[5]	7.8%	8 insurers	5.0%	7 insurers
American Assets Group[6]	2.0%	2 insurers	4.7%	2 insurers
TOTAL	53.9%	54 insurers	55.9%	52 insurers





[4] Based on reports provided by the California Department of Insurance ("CDI").

[5] American International Group (AIG).

[6] Previously know as the ICW Group consisting of Insurance Company of the West and Explorer Insurance Company.

Total cost for the California workers' compensation insurance product in 2014 reported by the WCIRB was $16.9 billion with medical and indemnity estimated at $11.1 billion or 66% of P&Cs overall costs, LAE estimated at $2.9 billion and policy administration also estimated at $2.9 billion totaling 34% of overall costs.

On examination of the $6.6 billion for medical benefits, the following components totaling 20% which did not directly benefit the employee were excluded from medical benefits costs in the study; medical legal evaluations 7%, medical liens 6.4%, other costs of 6.6% which included some Medical Cost Containment Program costs ("MCCP"), capitative medical payments and nurse case management. Another component of medical benefits costs which cannot be overlooked and needs exclusion is undetected or unreported medical fraud (i.e. "missed fraud").

The prevalence of medical fraud in both frequency and cost is impossible to accurately estimate. However, based on some recent cases reported in California Workers' Compensation and other states and the Federal Bureau of Investigation's ("FBI") estimate for medical fraud of between $77 billion and $259 billion, the study estimates missed medical fraud at a conservative 15%. With the medical services and equipment component totaling $3.6 billion of total medical benefits costs, applying this 15% computes to an estimated figure of $544 million.

Applying these adjustments to the **medical benefits costs** shown below, **reduces the cost from $6.6 billion to $4.8 billion:**

	($'s in Billions)
Incurred Medical Benefits	$6.6
less	
Medical-Legal Evaluation (7.0%)	
Medical Liens (6.4%)	
Other (6.6%)	($1.3)
less	
Estimate for missed Medical Fraud	($0.5)
Truer Medical Benefits to Employee	**$4.8**

Costs associated with medical-legal evaluations, medical liens, medical other and missed medical fraud are all administrative costs which are better represented under LAE.

On examination of the $4.5 billion for indemnity benefits, a total of $404 million was paid to attorneys representing the employee. As this amount is part of the cost of delivery of benefits, it is more representative under LAE than indemnity. Applying this adjustment, **reduces the cost of indemnity payments from $4.5 billion to $4.1 billion.**

LAE accounted for $2.9 billion of total costs according to the WCIRB and after applying the adjustments, **increased to $5.1 billion** as shown below:

	($'s in Billions)
Loss Adjustment Expenses (LAE)	$2.9
plus	
Medical-Legal Evaluation (7%)	
Medical Liens (6.4%)	
Other (6.6%)	$1.3
plus	
Estimate for missed Medical Fraud	$0.5
plus	
Fees paid to Applicant Attorneys	$0.4
Truer Loss Adjustment Expenses	**$5.1**

OBSERVATIONS

Benefits Delivery

In its broadest definition, LAE revised to $5.1 billion covers **all costs associated with handling claims and delivering benefits**. One major consideration affecting costs associated with LAE is the intensity of processing required to deliver benefits. To identify this, cost components from both medical and indemnity benefits were grouped by processing intensity. Of the $5.3 billion paid for medical benefits, $1.7 billion was paid directly to the employee for settlement of future medical treatment with the balance of $3.6 billion used for medical services provided during the recovery period. Some P&Cs choose to make a one time settlement payment to the employee in order to reduce their administrative burden and eliminate the possibility of a blowout in medical costs some time in the future. These settlement payments require low intensity processing, whereas payments for medical services may require a high level.

Overall, payment of indemnity benefits does not require intensive processing activity. Of the different types, the highest processing intensity is for payment of temporary disability which accounts for $2.2 billion of the $4.5 billion total indemnity payments. The remaining indemnity payments relate to permanent disability, vocational rehabilitation, life pension and death benefits which all require low intensity processing. Permanent disability accounting for $2 billion of which $404 million was paid in fees to the employees' attorneys, has been excluded from the processing intensity analysis.

The breakdown by degree of processing intensity follows:

	($'s in Billions)
High	
- Provider Medical Payments (including missed fraud)	$3.6
Medium	
- Temporary Disability	$2.2
Low	
- Future Medical Settlement Payments	$1.7
- Permanent Disability Payments direct to employee	$1.6
- Vocational Rehab, Life Pension and Death Payments	$0.3
Total Processing Activity	**$9.4**

The question here is, **"How much of the $5.1 billion in LAE costs should be spent on delivery of the above benefits totaling $8.9 billion (excluding missed fraud of $500 million) of which only $3.6 billion (including missed fraud of $500 million) is associated with high intensity processing?"**

Claims Handling

In addition to the cost of delivering benefits, LAE includes the cost of handling claims. In general, claims dealings with P&Cs' insurance products are regarded by many insureds as a more adversarial than rewarding customer experience especially at a time when they are most distressed and vulnerable. The employees' experience with the P&Cs' workers' compensation product is far more adversarial for two main reasons - the employee (i.e. beneficiary) is neither the insured nor the customer of the P&C. Workers' compensation is often referred to as a "***battlefield of communication***" between the many parties involved including claims adjuster/examiner, employee, medical providers, nurse, nurse case manager, utilization review

("UR") medical director, independent medical review physicians, medical billing services professionals, medical bill review professionals, independent bill review specialists, defense attorneys, applicant attorneys, judges, employer and other stakeholders. This animosity and adversarial relationship provides ideal conditions for both professional and opportunistic fraud and for costs to escalate.

Professional fraud in workers' compensation is generally associated with medical services, which in 2014 totaled $3.6 billion. Perpetrators of medical fraud are in all segments of medicine and include physicians, hospitals, surgical centers, diagnostic centers, durable medical equipment suppliers, pharmacies through to medical transport companies all using medical billings and kickbacks[7] as their modus operandi. However, workers' compensation is not the only insurance vulnerable to medical fraud. Any P&C insurance product that provides injury and illness compensation such as motor vehicle bodily injury liability, or accident and disability insurance provided through L&A[8] insurance products as well as schemes that provide an alternative to the P&Cs' workers' compensation insurance product can equally be subject to medical fraud.

Opportunistic fraud is usually perpetrated by an individual and generally for a lower dollar amount than professional fraud. Fifty-one opportunistic fraud convictions relating to claims were reported by the CDI for the period January 2014 through December 2014 for a total of approximately $871,000[9].

With uncertainty of the true cost of fraud and LAE costing $5.1 billion, the following questions need to be asked, **"How much of the claims handling costs should P&Cs spend on detecting fraud?"** and **"How many P&Cs are accepting fraud as one of the costs of doing business, citing the law of diminishing returns (i.e. the gain is not worth the pain) and passing this cost onto employers by increasing their premiums?"**

In 2014, a total of $471 million was spent on MCCPs which were associated with fraud detection in billings for medical services totaling $3.6 billion (i.e. 13% or 13 cents for MCCP costs for each $1 paid for medical services). The most common breaches included:

- billing for services not provided,
- up-billing for services and equipment, where a provider submits a billing code that yields a higher payment for the service and or equipment provided,
- submitting invoices for services already paid for,
- unbundling tests or procedures that should be billed together and,
- providing excessive or unnecessary services.

The WCIRB's reported MCCP costs of $471 million of which $208 million was included in the 'other medical benefits' costs component and $263 million as a separate LAE cost component which included Independent Medical Review ("IMR") and Independent Bill Review ("IBR") costs, should most likely be regarded as only the minimum amount paid for medical fraud detection. Additional MCCP costs are at times included in either general LAE (i.e. unallocated "ULAE") or bundled in with nurse case management costs. For 2016, the rule which included both IMR and IBR in MCCP costs has changed to now being a general claims expense (i.e. allocated expense). If this same rule had applied in 2014, it would have reduced the MCCP costs by approximately 10% to 15%, however, the overall P&Cs' administrative claims costs would still have remained the same.

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[7] Medical practitioners receiving payment for referrals.

[8] Life and Annuity.

[9] A number of the CDI cases did not report a dollar amount.

Despite all the data provided by the WCIRB, CWCI, WCRI and others on the P&Cs' workers' compensation insurance product, a close up view of what really goes on is not apparent. Sources however such as the FBI, media and medical boards do at times provide details which can give a greater insight into the internal workings of the product. Following are examples of California medical fraud within the P&Cs' own MPNs and the level of detail provided by various sources:

- Between 2008 and 2013, the FBI and the media reported that Pacific Hospital in Long Beach, California is alleged to have submitted fraudulent bills in excess of $500 million involving up-billing for services and supplies to cover the costs of kickbacks to medical providers who performed spinal fusion surgeries. To date, three have been charged with receiving kickbacks for referring more than 200 patients to the Hospital; Philip Sobol, an orthopaedic surgeon received $5.2 million in kickbacks, Alan Ivar, a chiropractor received $1.24 million and Mitchell Cohen, an orthopaedic surgeon received $1.64 million. All three have previously been listed in a number of the MPNs used by P&Cs. It has also been reported that SCIF is seeking to recover some of the $160 million it paid to entities of Pacific Hospital under civil statutes.

- The FBI reported that their case called "Operation Backlash" uncovered a widespread fraud scheme in San Diego involving attorneys and numerous medical providers including radiologists, chiropractors and others who referred patients for health services in exchange for kickback payments. To date, a total of 18 organizations have been identified as victims of the Scheme, some of which include SCIF, Berkshire Hathaway, AmTrust NGH, Hartford, Zurich and Third Party Administrators Gallagher Bassett and Sedgwick CMS.

- According to a CWCI report, drug testing within a study sample increased by 4,537% between 2004 through 2011 with 186,000 tests paid for during 2011 costing $27.4 million. This extraordinary increase, would suggest fraud involving excessive and unnecessary services. In some instances P&Cs also paid bills where up-billing for drug testing had occurred, for example, CPT code 82486 costing $1,200 was billed instead of HCPCS code G0431 which cost only $120. Details relating to the providers who performed these tests or the P&Cs who incurred these costs was not provided by the CWCI.

As a general practice in MCCPs, any medical bill which is found to have breaches is either adjusted accordingly to pay the correct amount or payment is withheld. The three previous examples illustrate clearly that an estimate for missed medical fraud on payments made following the vetting of medical bills needs to be properly accounted for under LAE. Adding the cost of $471 million for MCCPs to the estimated cost of $544 million for missed fraud, increases the LAE cost for circumvention of medical fraud abuse to $1 billion. This means, in 2014, P&Cs paid $3.1 billion for truer medical services to their MPN providers and paid an additional $1 billion of LAE costs to administer the MPN provider payments. This LAE cost is very significant and disproportionately high when compared to the cost of $3.1 billion for truer medical services payments to their own chosen providers.

Is a minimum of 32% expenditure warranted for the detection of medical fraud associated with payments to providers within the P&Cs' own Medical Provider Network (i.e. an additional 32 cents for each $1 paid for medical services)?

Since 2005, P&Cs that either established their own MPNs or contracted with workers' compensation medical provider networks, have had control in selecting providers for employees to choose from for medical care for the life of their claim. Since MPNs were introduced almost a decade ago, it would be reasonable to expect P&Cs to have established a network of providers that were trustworthy. Instead, according to these figures and the WCIRB reporting that since 2007, MCCP expenses have almost doubled, suggests that this burgeoning problem may be due to a significant number of providers in the MPNs being fraudsters. A common definition of a fraudster is "***any person who commits an illegal act characterized by deceit, concealment or violation of trust.***"

SOLUTIONS

California has a long-standing reputation for having the highest nationwide premium rates for workers' compensation insurance. Providing solutions to reduce these rates has been hotly debated now for a good three decades.

The first major legislation introduced in 1995 was aimed at reducing high premiums by abolishing the premium minimum-rate law and replacing it with an open-rating system. Its intention was to encourage competitiveness by allowing P&Cs to become innovative in the pricing of their insurance product. Instead, P&Cs interpreted "open-rating" as a "price war" with premiums decreasing from $9 billion in 1993 to $5.7 billion in 1995. The effect of the "price war" resulted in a number of P&Cs becoming insolvent between the late 1990s and early 2000s. With a reduction in the number of P&Cs offering workers' compensation insurance[10] and the remaining P&Cs attempting to recover their losses, premiums increased to $16.3 billion in 2004.

The second major legislation introduced in 2005 was aimed at reducing the cost of claims with the expected flow-on affect of lowering premiums. Following on from earlier legislation introduced between 2002 and 2004 which specifically introduced a variety of what have been called "managed care" techniques, the 2005 introduced legislation allowed P&Cs to select their own medical service providers which employees could choose from for the life of their claim. Prior to this legislation, P&Cs typically controlled the employee's medical treatment for up to a maximum of 30 days, which is still the case when a P&C chooses not to establish an MPN.

Based on the Oregon Workers' Compensation Premium Rate Ranking study, California has continued to repeatedly rank amongst the highest, ranking first in 2014. **What has gone wrong? Have P&Cs failed to take full advantage of the legislated managed care techniques in their workers' compensation claims operations?**

Some suggest more legislation relating to managed care techniques especially in addressing fraud needs to be enacted and that until this occurs, the cost of the P&Cs' insurance product will continue to remain high. History suggests attempts to introduce anti-fraud legislation and regulations result in a cat-and-mouse game - implement regulations to address one area, fraudsters shift their focus elsewhere - establish guidelines and thresholds and fraudsters will quickly invent ways to avoid detection.

Others have suggested that claims handling in workers' compensation insurance is too highly regulated resulting in significantly higher claims handling costs compared to other P&C insurance products. Being a social insurance, Workers' Compensation is subject to greater requirements in statutes, administrative agency regulations and court decisions because the employee is neither the insured nor the customer of the P&C and consequently, their benefit entitlements must be guaranteed. How a P&C complies to the statutes and regulations however, is totally at their own discretion and primarily governed by the P&C's Culture, Resources, Operations and Procedures ("CROP")[11]. Within CROP, Operations represents the processes by which claims are handled, whilst Culture, Resources and Procedures represent the framework that supports those processes.

The initiative therefore, to reduce the overall cost of the workers' compensation insurance product needs to come from the P&Cs. Insurance is often described as both a product and a service - at time of selling a policy it is a product and when a claim occurs, it becomes a service. The main focal point therefore in reducing the cost of the workers' compensation insurance product should be **through the effectiveness and true efficiency of the processes** in the claims service.

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[10] In 2000, SCIF's market share was 28%, peaking at 53% in 2003. Since then, SCIF market share has reduced to 13% in 2015.

[11] Airmic, Guide to Best Practice, Insurance Claims Handling.

Claims Services

When a P&C accepts payment from an employer for a workers' compensation insurance policy (i.e. the product), they are making a promise to the employer. They promise to pay the costs of the employer's financial burden[12] in providing the employee's entitlement to receive prompt, effective medical treatment and loss of income benefits until they are able to return to work or become self-reliant (i.e. the service). In addition, being a social insurance, P&Cs have a responsibility to fulfill this promise and to ensure they do not place financial burden on the community at large through forcing the employee and their family to end up in public programs such as Federal funded Social Security Disability Insurance ("SSDI"), Supplemental Security Income ("SSI"), Medicare and Medicaid. **There is an implied duty on the part of the P&C to generally act in good faith with respect to the handling of claims.**

The two most important external factors that are continuing to challenge P&Cs' claims services in delivering on their promise are:

(1) With the U.S. economy continuing to further expand from manufacturing to service-based, work related medical conditions remain dominated by both cumulative injuries and occupational illnesses which typically relate to an incident that is either subtle or has multiple causes in contrast to traumatic injuries such as fractures or contusions where causation is easily defined.

(2) The ever-changing demographics of the work-force is becoming increasingly segmented. With the general population living longer and requiring to work, there are currently three generations in the workforce; Baby Boomers, Generation X, Generation Y (the Millennials) and in a few years, Generation Z will enter the workforce adding a fourth. Also, the rapid expansion of corporate globalization has witnessed an increase in the movement of people in the workforce which requires P&Cs to develop a critical understanding of the myriad of personal characteristics including race, ethnicity, language, religion, culture/subculture and citizenship[13]. This is in addition to diversities of gender, sexual orientation, socio-economic and urban/rural and regional factors.

To address these challenges, claims services need to advance from **simplification** to **complexification**. The one-size-fits all approach with claims handling best practice adherence measured by some key performance indicators ("KPIs") needs to give way to greater sophistication in claims handling which is flexible and bespoke, yet consistent, timely and fair mannered, as well as being transparent, secure and compliant.

Culture

Two of the cost components identified by the WCIRB in California directly influenced by the P&C's culture and philosophy are settlement payments and the use of legal services.

There are many reasons why a P&C may enter the long tail workers' compensation insurance market. For P&C Groups owned by financial services groups or multinational conglomerates such as Berkshire Hathaway, a common reason is to increase their amounts of cash or "float" to be used for investment purposes. According to their 2015 annual report, Berkshire Hathaway's float from insurance operations was $88 billion, increasing by $4 billion from 2014. Some P&Cs on the other hand, may choose to enter the market to profit primarily from their underwriting acumen including their claims services expertise with minimal reliance on profits from investments.

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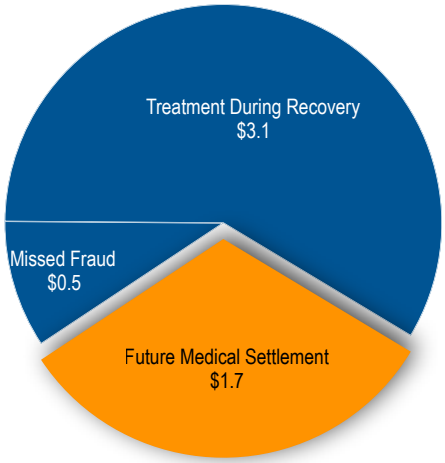
[12] Protecting the employer from financial loss.

[13] To live in the U.S. today, an individual does not have to give up who they are. They do not have to choose between their religion or what may be common in America, or between their culture or what may be common in America.

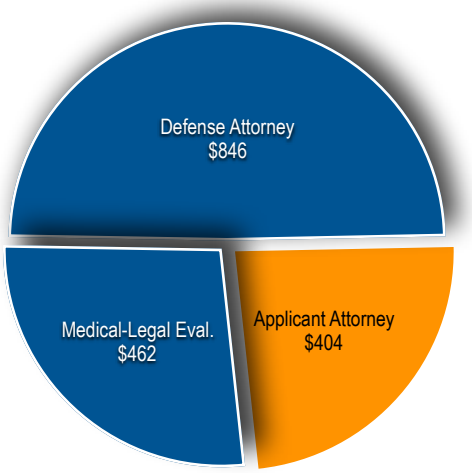
With California's highly concentrated market, the mix of the top seven insurers (i.e. excluding SCIF) primarily seeking investment income for profit as opposed to those seeking profit solely from underwriting, can have a profound effect on the total cost of the insurance product in any given year. For instance, in 2014, settlement payments for future medical treatment increased overall total costs for the insurance product by $1.7 billion (i.e 10% of total costs). In contrast, if payment for this medical treatment was to continue over many years as intended, there would be less impact on the overall cost in a specific year. If the high cost of settlement payments applied to a specific year is considered to be a concern to employers, its use as a practice in the P&Cs' claims service can be controlled through legislation.

2014 Medical Benefits $5.3 Billion ($'s in Billions)



Some P&Cs lack expertise in determining work-relatedness and compensability for medical conditions which are caused by either subtle work related incidents or those due to multiple causes. In such cases, the decision whether or not to pay for a claim is made by the workers' compensation judicial system, which results in both the employee and the P&C having to incur legal costs. P&Cs' legal costs in 2014 also added $1.7 billion to the total cost of the P&Cs' insurance product (i.e. 10% of the total costs), with medical-legal evaluations accounting for $462 million, defense attorney costs $846 million and reimbursement of applicant attorney costs $404 million. The only option to address the P&Cs' lack of expertise and control legal costs at the same time is through legislation explicitly identifying the medical conditions and their causes that are entitled to workers' compensation benefits. This cost will otherwise increase possibly exponentially as research studies are identifying other medical conditions and their causes which may to some degree be identified as work related. For instance, there are ongoing studies to see if there is an association between rotating night shift work and the risk of coronary heart disease among women. Another is whether causes such as "power harassment" of verbal abuse or intimidation could be regarded as a work-related disease because the employer failed to provide a safe working environment - this is a valid work-related cause and medical condition in Japan. A similar case has recently been reported in France, where former executives of France Telecom may face prison sentences for "workplace harassment" and "destabilizing" employees, which resulted in thirty-five France Telecom employees taking their lives between 2008 and 2009. Another event involving work environment conditions recently reported[14] in the poultry industry in Texas, Arkansas, North Carolina and in other states may be a cause for both psychological and health problems in the future for these employees, which may lead to the filing of workers' compensation claims. Although these examples may appear as outliers today, they will be tomorrow's norm in claims.

2014 Legal Costs $1.7 Billion ($'s in Millions)



Both the use of settlement payments for future medical services and legal services added $3.4 billion to the overall insurance product cost total of $16.9 billion (i.e. 20% or 20 cents for each $1 of employers' premium) in 2014.

[14] Oxfam America, Report, No Relief, Denial of Bathroom Breaks in the Poultry Industry.

While workers' compensation statutes and administrative agency regulations could effectively curtail the extent to which P&Cs use both these practices in their claims services, their ability to influence the parameters a P&C uses to choose resources and the P&Cs' activities associated with their procedures and operations is less likely to be as effective.

Resources

The single most important factor supporting the P&Cs' claims operations is resources. Clinician selection consists of two vital steps, (1) ascertain the most appropriate specialists to provide optimum opportunity for the employee to stay or return to work as soon as possible, with consideration for their personal safety and that of their colleagues throughout their recovery period, and (2) match the clinician to the employee to ensure there is a bond of trust promoting a more participatory clinician-patient relationship. The level of their interpersonal relationship[15] can cause a significant variation in process and outcomes.

"How have these steps been addressed through the P&Cs' MPNs?"

As SCIF holds the largest market share, their MPN list was used for a detailed analysis of the types of specialties available for the employee to choose from[16]. With the interpersonal relationship between the clinician and the patient (i.e. employee) identified as a key factor in achieving the most optimum outcome for the employee, only specialties where an individual's name was listed have been included in the following analysis (in descending order by number of individuals):

Orthopaedic Surgery			848
plus	Orthopaedic Surgery/Hand Surgery	114	
	Orthopaedic Surgery/Orthopaedic Surgery of the Spine	52	
	Orthopaedic Surgery/Foot & Ankle Surgery	7	
	Orthopaedic Surgery/Sports Medicine	7	
	Orthopaedic Surgery/Adult Reconstruction Orthopaedic Surgery	3	
	Orthopaedic Surgery/Orthopaedic Trauma	1	
Dentists			703
plus	Orthodontics & Dentofacial Orthopaedics	51	
Anesthesiology			573
plus	Anesthesiology/Pain Medicine	80	
Emergency Medicine			540
plus	Emergency Medicine/Medical Toxicology	5	
Family Medicine			499
plus	Family Medicine/Sports Medicine	9	

[15] How responsive the clinician is to the patient's needs; how well the clinician communicates with the patient.

[16] The SCIF pdf listing, Complete Provider Directory Listing for State Fund MPN by Harbor Health, dated March 22nd, 2016. The Analysis was performed manually and therefore may be subject to errors.

Internal Medicine			474
plus	Internal Medicine/Gastroenterology	23	
	Internal Medicine/Infectious Disease	19	
	Internal Medicine/Rheumatology	11	
	Internal Medicine/Pulmonary Disease	8	
	Internal Medicine/Nephrology	6	
	Internal Medicine/Magnetic Resonance Imaging (MRI)	3	
	Internal Medicine/Sports Medicine	2	
	Internal Medicine/Allergy & Immunology	1	
	Internal Medicine/Cardiovascular Disease	1	
	Internal Medicine/Endocrinology Diabetes & Metabolism	1	
Preventative Medicine/Occupational Medicine			236
plus	Preventative Medicine/Occupational Environment	10	
	Preventative Medicine/Public Health & General Preventive Med.	13	
	Preventative Medicine	8	
Surgery			200
plus	Surgery/Vascular Surgery	18	
	Surgery/Surgery of the Hand	17	
Physical Medicine & Rehabilitation			166
plus	Physical Medicine/Pain Medicine	30	
	Physical Medicine/Sports Medicine	1	
Chiropractor			159
General Practice			125
Podiatrist			116
Psychiatry & Neurology/Neurology			115
plus	Psychiatry & Neurology/Diagnostic Neuroimaging	26	
	Psychiatry & Neurology/Psychiatry	8	
	Psychiatry & Neurology/Pain Medicine	2	
Psychologist			115
Neurological Surgery			87
Ophthalmology			77
Oral & Maxillofacial Surgery			40

Plastic Surgery			39
plus	Plastic Surgery/Surgery of the Hand	8	
Acupuncturist			33
Otolaryngology (ENT)			30
plus	Otolaryngology/Facial Plastic Surgery	1	
Dermatology			25
Pain Medicine/Interventional Pain Medicine			24
plus	Pain Medicine	2	
Urology			24
Radiology/Nuclear Radiology			16
plus	Radiology/Diagnostic Radiology	5	
Thoracic Surgery (Cardiothoracic Vascular Surgery)			14
Colon & Rectal Surgery			8
Physical Therapist (Except for the six PTs listed by name, only address details were provided with no names and no direct phone numbers to the PTs. These have been excluded from the list)			6
Nuclear Medicine			5

Sprain and strain medical conditions generally involving the lower back continue to trend with the highest frequency of 136,289 cases as well as the highest cost of $1.6 billion (i.e. 42% of total costs or $11,800 per claim) reported by the WCIRB[17]. These are followed by fractures, contusions, lacerations and punctures with a total of 100,089 and a cost of $784 million (i.e. 20% of total costs or $7,800 per claim). Frequency of these medical conditions remains consistent compared to the United States Department of Labor report for 2003[18], which had sprains and strains accounting for 43% of all medical conditions resulting in days away from work followed by fractures, contusions and lacerations accounting for 23%.

This raises the following questions, **"Are the allocation of medical specialties identified in SCIF's MPN adequate to address the high number of cases for strains and sprains?"** and **"Is the proverb 'If all you have is a hammer, everything looks like a nail' applicable when comparing the allocation of SCIF's MPN specialties/sub-specialties to the treatments and outcomes currently experienced by the P&Cs' workers' compensation insurance product overall?"**

Medical literature suggests that the most common specialists involved in treating sprains and strains are Physiatrists, Physical Therapists, Sports Medicine Internists, Chiropractors and Orthopaedic Surgeons. Sprains and strains are generally graded

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[17] WCIRB, Report on 2014 California Workers' Compensation Losses and Expenses, Released June 30, 2015.

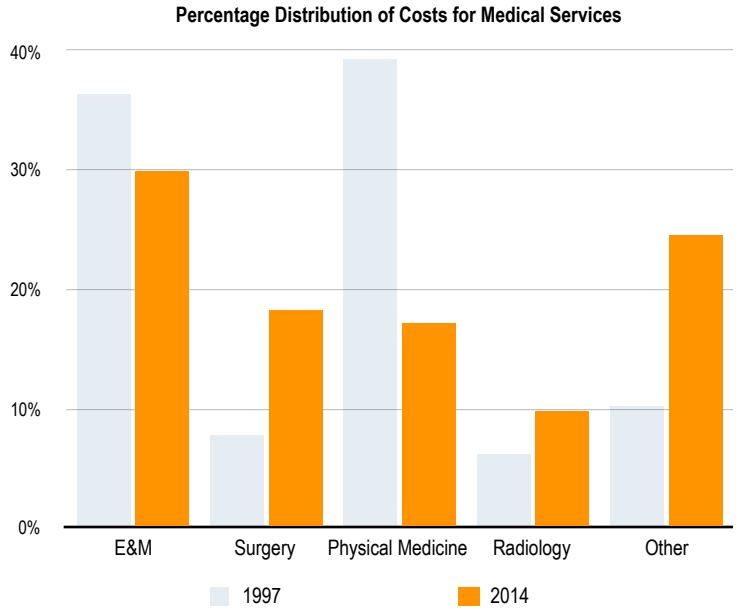
[18] United States Department of Labor, Lost-worktime Injuries and Illnesses: Characteristics and Resulting Days Away from Work, 2003.

from first to third degree with focus on controlling pain and muscle spasm during the recovery period as well as restoring function to ensure durable return to work. When conservative treatment fails to alleviate symptoms, surgery is considered as a last resort mainly due to the possibility of infection, malfunction of implant hardware and extensive post-surgery rehabilitation. Any one of these causes can greatly lengthen the period off work, adding to P&Cs' costs which may increase the employers' overall costs through increased premiums as well as any additional costs caused by an employee's unexpected extended absence from employment.

According to the analysis performed on SCIF's MPN list, there were 1,032 Orthopaedic Surgeons, 197 Physical Medicine and Rehabilitation doctors (i.e. Physiatrists), 159 chiropractors, two Sports Medicine Internists and six Physical Therapists. Apart from the six named physical therapists, only physical address details were provided, so these locations were excluded from the analysis. In addition, the specialty of osteopathic medicine was included under the general grouping of Physical Medicine and Rehabilitation and could not be readily identified.

The table below compares the distribution of costs for medical services in 1997[19] and 2014[20], suggesting the distribution of specialties in a P&Cs' MPN may significantly influence the distribution of costs:

	1997	2014	Change
Evaluation and Management	36.4%	30.0%	-6.4%
Surgery	7.8%	18.3%	+10.5%
Physical Medicine	39.4%	17.2%	-22.2%
Radiology	6.2%	9.9%	+3.7%
Other Medical Services[21]	10.3%	24.6%	+14.3%



[19] CWCI, Top 100 medical procedures billed under California Official Medical Fee Schedule (OMFS), October 16, 1997, No 97-19.

[20] WCIRB, 2015 Report on the state of the California Workers' Compensation Insurance System.

[21] In 1997, other medical services included medicine 5.4%, special services 4.3%, anesthesia 0.4% and pathology 0.2%. No breakdown was provided by the WCIRB for 2014.

Harbor Health Systems manages SCIF's MPN and hosts their "Provider Finder" inquiry screen (https://search.harborsys.com/statefund#ProviderSearch). The inquiry screen provides the person's name, address, phone number, specialty/sub-specialty, whether a referral from the Primary Treating Physician ("PTP") is required, whether they are in the Blue Cross of California health plan and when available, languages spoken, gender and the name of medical group if applicable. The top five P&Cs have similar MPN arrangements as follows:

- **Berkshire Hathaway.** Network provided through the Coventry Workers Compensation Network and hosted by Talispoint on behalf of Coventry (https://www.talispoint.com/firsthealth/?AE=997636628&CAID=CVTMPN&).

- **Travelers Group.** Network administered by Coventry/First Health PPO Network and hosted by Talispoint (http://www.talispoint.com/travelers/ext/?lob=wc).

- **AMTrust NGH.** Network administered by Blue Cross WellPoint and hosted by Talispoint (https://www.talispoint.com/amtrust/campn/).

- **Hartford.** Network provided by Anthem Blue Cross MPN and hosted through Talispoint (https://www-sf.talispoint.com/talispoint/login.pl or https://www.thehartford.com/ca-workers-compensation).

- **Zurich.** MPN Network administered by American Claims Management (http://mpn.acmclaims.com/zurich/Default.aspx).

"Have P&Cs' MPNs in general, as well as the P&Cs' outsourcing approach to establish an MPN lived up to the touted expectations of excellent medical care with faster recovery for the employee and at a lower cost?"

Before this question can be answered, consider the following in addition to the three earlier examples of fraud:

- **Increased use of medication especially drugs of addiction to control pain.** Excessive use of Schedule II medications (i.e. opiates and opioids) as well as compound medications have been identified as contributing to poor outcomes and higher costs caused by a very small percentage of prescribers as reported by the CWCI[22]. In contrast to the CWCI findings, a study utilizing data provided by the Centers for Medicare and Medicaid Services[23] listed the top 25 specialties that prescribed Schedule II medications and also identified that prescribing was not limited to a small percentage of clinicians. The overall top four specialties by volume of Schedule II prescriptions were Family Practice, Internal Medicine, Nurse Practitioners and Physician Assistants. Frequency of prescribing Schedule II medications however showed concentration in the speciality services of pain, anesthesia, and physical medicine and rehabilitation.

Based on SCIF's MPN, there were 1,182 individuals listed under Family Medicine, Internal Medicine and General Practice in the category of high volume prescribers of Schedule II medications. Within the category of high concentration prescribers of Schedule II including prescribers of compound medications, 138 individuals were listed with a specialty or sub-specialty of pain management. Within SCIF's MPN therefore, the expectation for prescribing opiates and opioids[24] for sprains and strains is extremely high and compound medications moderate to low, compared to a P&C's MPN which promotes using specialties such as Physical Therapy along with exercise programs to alleviate pain during the healing and recovery period. There are six Physical Therapists listed by name in SCIF's MPN.

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22 California Workers' Compensation Institute ("CWCI"), Prescribing patterns of schedule II opioids in California Workers' Compensation, 2011.

23 JAMA Internal Medicine, December 2015,Distribution of Opioids by Different Types of Medicare Prescribers.

24 Opiate medications include morphine and codeine, whereas opioid, a synthetic medication includes oxycodone and fentanyl.

- **Physician dispensing of medications.** According to the CWCI[25], dispensing of medications by physicians has caused the cost of pharmaceuticals to be much higher and increased the time off work (i.e. poor return to work outcome). Studies undertaken by both the WCRI[26] and the NCCI[27] however, have identified that Schedule II medications were dispensed more often through a pharmacy/pharmacy benefit manager ("PBM") than through physicians. For example, Meloxicam[28] with an average price of 14 cents per tablet accounted for the highest cost share of the top 10 physician dispensed medications, but when both pharmacy/PBM and physician dispensing were combined, OxyContin[29] with an average price ranging from $2 through $14 per tablet depending on strength, accounted for the highest cost share. OxyContin was not in the top 10 physician dispensed medications, suggesting pharmacy/PBMs were responsible for the majority of dispensed OxyContin, handsomely profiting from dispensing the high price medication, which hit the market in 1996. It has been reported[30] that across the U.S. physician population, a total of 5.4 million prescriptions were written for OxyContin during 2014. Following changes however, where for instance hydrocodone combined with a second analgesic, like acetaminophen went from a Schedule III to a Schedule II medication and with States placing greater emphasis on their prescription drug monitoring programs, prescriptions written for opiates and opioids have begun to decline across the U.S. physician population.

A further study by the WCRI[31], identified that P&Cs had been paying more than the California legislated maximum amount for medications. The study listed the average price paid for both the 5mg and 10mg Cyclobenzaprine[32] tablet as ranging between 35 cents and 70 cents, whereas the maximum price regardless of whether dispensed through a pharmacy/PBM or physician should not have exceeded 15 cents for the 5mg and 10 cents for the 10mg.

Actuaries first apply models to their claims costs to calculate estimated future claims costs, which along with other factors are then used in their calculation of premium rates. The table below shows the impact on the estimated future claims cost of the 10mg Cyclobenzaprine tablet based on the tablet's current statutory maximum price of 10 cents, compared to paying 35 cents or 70 cents for the same 10mg tablet. The actuarial model used here was also used by the California Commission on Health and Safety and Workers' Compensation ("CHSWC") in one of their studies[33].

Claims Cost Price Paid per Tablet	Estimated Future Cost as used to set future premium rates	
10 cents	29 cents	
35 cents	99 cents	An increase of 70 cents ($0.99 - $0.29)
70 cents	$1.98	An increase of $1.69 ($1.98 - $0.29)

Paying more than the legislated maximum amount for a medication can significantly increase the estimated future claims costs which in turn inflates the P&Cs' future premium rates.

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25 California Workers' Compensation Institute (CWCI), Differences in Outcomes for Injured Workers Receiving Physician-Dispensed Repackaged Drugs in the California Workers' Compensation System, February 2013.

26 Workers' Compensation Research Institute (WCRI), The Prevalence and Costs of Physician Dispensed Drugs, September 2013.

27 National Council on Compensation Insurance (NCCI), Workers' Compensation Prescription Drug Study: 2013, September 2013.

28 Meloxicam is a Non-Steroidal Anti-Inflammatory (NSAID) analgesic.

29 OxyContin is a 12 hour opioid analgesic.

30 IMS Health and Symphony Health Solutions.

31 WCRI, Are Physician Dispensing Reforms Sustainable?, January 2015.

32 A central acting muscle relaxant.

33 California Commission on Health and Safety and Workers' Compensation ("CHSWC"), Impact of Physician-Dispensing of Repackaged Drugs on California Workers' Compensation Employer Cost and Workers' Access to Quality Care, 2006.

- **Screening Providers and their services prior to appointment to an MPN.** In addition to the FBI investigating Pacific Hospital in Long Beach, California, there is also the mirror image case involving Tri-City Regional Medical Center ("Tri-City") in Hawaiian Gardens, California. Some have suggested the opportunity to commit fraud by both these hospitals was due to the so-called "spinal hardware pass-through", where hospitals bill separately for spinal implant hardware used in orthopaedic surgeries. In reality, hospitals billing separately for hardware used in surgery should be a deterrent to commit fraud simply because instead of bundling all costs for a surgery into one amount, billing separately provides an opportunity for the P&Cs to vet and price the hardware appropriately.

These two fraud cases question the processes undertaken by the P&Cs in appointing surgeons to their MPNs, of which SCIF has 1,464 listed, including the hospitals the surgeons are affiliated with. For example, Mitchell Cohen was affiliated with the following hospitals:

- Chapman Medical Center, Orange, CA
- Fountain Valley Regional Hospital & Medical Center, Fountain Valley, CA
- College Medical Center, Long Beach, CA
- Tri-City Medical Center, Oceanside, CA
- Garden Regional Hospital & Medical Center formally Tri-City Regional Medical Center, Hawaiian Gardens, CA
- Pacific Hospital, Long Beach, CA

This raises the following question, **"Why did P&Cs continue to allow Mitchell Cohen to perform surgeries at both Pacific Hospital and Tri-City Hospital when they should have detected during their review and payment of hospital billings that their costs for both surgery and implant hardware were much higher than other hospitals?"**

It is alleged hardware prices were increased 1200% above the price paid by the distributor who supplied both hospitals. Over a three year period, Tri-City billings to P&Cs increased from less than $3 million to $65 million.

"Who approved the surgeries to be performed at these hospitals and who approved payment for the hardware?"

Fraud can emanate equally from internal as well as external resources. Tri-City's billings increased by more than 2000% over a three year period at a time when they were also charging an inflated price for both hardware and surgeries, suggesting fraud may have been committed in collusion with internal resources and/or outsourced vendors within P&Cs' operations.

Tri-City however, went beyond using billings and kickbacks to commit fraud, risking harm to employees by performing surgeries that were not necessary in furtherance of their fraud schemes. Consuelo Solorio, a 52-year-old tomato cannery employee died from breathing difficulties the day after surgery at Tri-City after being given a bone-growth product known to the FDA to be life-threatening. Based on the information published to date, it is alleged that neither her chiropractor nor her local spine surgeon recommended surgery, yet she travelled three hours from her home in San Joaquin Valley to have spinal surgery at Tri-City.

"Who and what motivated her to do this?" and **"Why did the P&C's staff including the Claims Examiner/Adjuster, the Nurse and Nurse Case Manager and finally the UR medical director approve the surgery?"**

- **Monitoring of vendors.** After investigating a complaint, Kimberly Kirchmeyer, Executive Director of the Medical Board of California, filed accusations against Janak K. Mehtani ("Mehtani"), a psychiatrist, California license number A32632, case number 02-2012-224474 on January 13, 2015. Some 18 months later, a hearing has still not been held. The accusations filed against Mehtani include:
  - Gross Negligence
  - Repeated Negligent Acts
  - Prescribing Dangerous Drugs without Appropriate Examination or Medical Indication
  - Failure to Maintain Adequate and Accurate Medical Records
  - General Unprofessional Conduct

These accusations relate to three workers' compensation claims, two of which are identified as SCIF claims. Services provided by Mehtani spanned three years from 2010 through 2013 with a total of 128 patient visits over the three claims, with visits ranging from 31 to 57 per claim. The three claims relate to a 47 year old female, a 48 year old male and a 59 year old male.

This poses the following questions,

"Why was Mehtani allowed to treat these individuals for a three year period, when there was no improvement or progress in their recovery?"

"Why did it take so long for a complaint to be filed against Mehtani considering the severity of the accusations?"

"Why hasn't there been a hearing considering the severity of the accusations?"

"Who are the three people being treated by now and have their medical conditions improved?"

"Are the three self-reliant or have they been forced into public programs?"

"If the medications were pharmacy/PBM dispensed, why weren't red flags raised by either the pharmacy or the PBM relating to the medications prescribed?"

"Who approved payment for the medical services and the medications dispensed?"

"Should those handling the claims on behalf of the employer (i.e. the P&C and the P&C's outsourced vendors) be equally accused of Gross Negligence, Repeated Negligent Acts, Failure to Maintain Adequate and Accurate Medical Records and General Unprofessional Conduct?"

A search for Mehtani in the MPN lists of the top six by market share, identified Mehtani as being listed on four MPNs, with the exception of SCIF and Berkshire Hathaway. The fact that Mehtani has been accused of gross negligence and repeated negligent acts would suggest that P&Cs should at least highlight in their MPN list that he has accusations filed. This however, is not the case, potentially leaving employees who choose Mehtani vulnerable to the same outcome as reported for the above three workers' compensation claims.

- **IMR and IBR.** Both IMR and IBR were established as a trade-off in negotiations to increase permanent disability benefits without impacting on the overall cost of the P&Cs' workers' compensation insurance product. These processes were intended to streamline the dispute resolution process by appointing an arbitrator from Maximus Federal Services, Inc., with the ultimate decision being made by the Workers' Compensation Appeals Board. Prior to the introduction of IMR and IBR, disputes between MPN physicians and P&Cs were adjudicated before a workers' compensation judge with the ultimate decision also being made by the Workers' Compensation Appeals Board, which at times became both a lengthy and costly process.

The IMR & IBR processes have been promoted as the clinical oversight to resolving disputes regarding treatments and costs between the employee's physician and the P&C. In actual fact, disputes are between the P&C's appointed MPN physician and the P&C's appointed utilization review medical director[34], with the employee who is forced to select physicians from their MPN list, caught in the middle.

All eight examples illustrated failed to deliver excellent medical care and all increased medical costs possibly resulting in higher premiums for the employer. They suggest deficiencies exist within the MPNs beginning with the processes associated with appointing clinicians to an MPN as well as their ongoing monitoring.

Operations and Procedures

Statutes enacted in California since 2000 have been described as embracing "managed care" techniques implying there has been a dramatic departure from earlier activities used in claims procedures, especially associated with the approval of medical services.

The CWCI's study published December 2, 2015[35] made the following comment, "*Following California workers' compensation reforms enacted in 2002-2004 and 2012, the process of approving payment for medical care for injured workers has undergone significant change, most notably through the adoption of an evidence-based medicine treatment utilization schedule and the addition of the independent medical review (IMR) to resolve medical necessity disputes. The approval process includes a series of checks and balances to reconcile a request for authorization (RFA) from an injured worker's physician for a specific course of medical treatment with the Medical Treatment Utilization Schedule (MTUS)* ***that defines the medical standard of care for workers' compensation in California****. Components of medical review and dispute resolution may include review of medical reports and bills by claims adjusters, bill reviewers, nurses and utilization review (UR) physicians, and when requested, by independent medical review physicians.*"

On close examination, these legislations are in fact evolutions of earlier legislations. Some may have extended parameters, provided further clarification or formalized processes that were previously left to the discretion of the P&C, all intended to reduce the high level of conflict between parties, particularly between treating clinicians and P&Cs, without impacting on existing P&Cs' claims operations.

Much of this conflict has come about as a result of the disparity in perceptions of necessary medical care in terms of timeliness and cost, heavily influenced by physicians wanting to maximize income and P&Cs' wanting to minimize costs for medical services rendered. The key objectives from most of the legislations passed since 2000 have been to deal with this conflict. Some of the legislations' objectives were to:

- Extend P&Cs' medical treatment control from 30 days to life of the claim when they established an MPN.
- Introduce "Evidence-Based Medicine".
- Introduce a pharmacy fee schedule based on the Medi-Cal pharmacy fee as opposed to using the Average Wholesale Price ("AWP").
- Modify the official medical fee schedule ("OMFS") for a number of services including physicians. Also introduce guidelines for specific medical services, such as Evaluation and Management adopted from the Centers for Medicare

[34] Since 2004, P&Cs have been required to establish a utilization review process headed by a medical director, who is either an employee of the P&C or a designated medical director.

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

and Medicaid Services ("CMS") which are consistent with practices followed by all physicians including Psychiatrists in treating non-occupational medical conditions.

- Introduce a Medical Treatment Utilization Schedule ("MTUS") for utilization review comprising of prospective, concurrent and retrospective reviews by a UR medical director.

- Introduce the Request for Authorization ("RFA") process for clinicians to obtain authorization for medical services as an extension of the MTUS. Also, to reduce the frequency of RFAs, P&Cs are able to implement a "prior authorization program" for medical services which they will automatically approve for payment.

- Introduce the IMR process to resolve disputes between the P&C's UR medical director and the P&C's MPN clinician relating to medical services requested through an RFA.

Workers' compensation statutes in California have attempted to reduce the frequency of disputes by embracing evidence-based medicine ("EBM") to help both the P&C and their MPN clinician interpret what is meant by "necessary medical care". Over the last 15 years, this term has gained momentum in all specialties of the medical profession around the world, being broadly described as a set of principles and methods based on good evidence of effectiveness and benefits.

The earlier definition of EBM in California[36] stated, "*Evidence-Based Medicine (EBM) means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE.*", which some referred to as a "cookbook approach" in providing medical services. The current definition 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 latest definition specifies the inclusion of the clinician's experience as well as the needs of the employee, which is commonly referred to today as shared-decision making.

In order to treat low back complaints with EBM, California has adopted the ACOEM Guidelines[37] for their MTUS. ACOEM membership comprises of over 4,500[38] doctors of medicine and doctors of osteopathic medicine as well as MDs and DOs[39] who are full-time residents. Non-physicians with a degree in an occupational and environmental health discipline and medical students earning an MD or DO degree can also apply for membership. ACOEM claim that their guidelines are the gold standard in treatment for occupational injuries and illnesses focusing on returning employees to work within 90 days of an injury or illness.

To believe that medical services required for the treatment of lower back sprains or strains caused by either a work-related or non work-related incident should somehow be different, as California believes through their introduction of the ACOEM guidelines, is regarded by some as a fallacy and only a matter of time before it is challenged through the legal system. Imagine the backlash if a medical service was excluded from workers' compensation guidelines, which if available, could have resulted in a better medical outcome for the employee and their employability opportunities as well as lowering the overall cost of the claim.

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

[37] American College of Occupational and Environmental Medicine (ACOEM), Practice Guidelines as published by the Reed Group. Prior to current regulations, the guidelines referred to 2nd Edition (2004), Chapter 12.

[38] According to the Agency for Healthcare Research and Quality, there are over 624,000 physicians in the U.S. who spend the majority of their time in direct patient care.

[39] MD - Doctor of Medicine, DO - Doctor of Osteopathic Medicine.

IMR Case Number CM16-0056548 may demonstrate the limitations of using the MTUS and/or the IMR process, including the possibility of an IMR decision not complying with the definition of evidence-based medicine as per regulation 9792.20.

- In IMR Case Number CM16-0056548, the UR medical director denied 12 aquatic therapy sessions and the services of a nutritionist. Both decisions were upheld by the IMR physician, whose specialty was Family Medicine. The decision to deny aquatic therapy was based on the MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy, which states, *"Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity."* It goes on to state, *"Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. (Tomas-Carus, 2007)."* The IMR went on to state that aquatic therapy was denied because the requested 12 aquatic sessions exceeded the MTUS limit of 8 to 10 sessions and the person was only obese, was still weight-bearing and able to ambulate. The IMR physician stated, *"Aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land-based physical therapy when reduced weight bearing is desirable. There is no documentation that the patient has physical findings requiring an alternative to land-based therapy, besides obesity."* Although the IMR physician stated that the patient would benefit from nutritional counseling, the approval for a separate visit with a nutritionist was denied, suggesting the patient's primary care physician advise on nutrition.

In this particular case, the IMR physician, who had a specialty in Family Medicine appeared to have simply confirmed the MTUS guidelines used by the UR medical director in denying the requested medical services. If the IMR process is only to confirm whether the UR medical director has quoted the correct MTUS guideline for their denial, this questions whether the IMR physician's decision should be final and warrants the cost of $390 for a simple lookup service, which in 2014 added between $47 million and $70 million[40] approximately to the cost of the P&Cs' workers' compensation insurance product. There is also no indication that the IMR physician made attempts to use the "best available research evidence" or that consideration was given to the clinician's expertise or the patient's values. As the employee's medical condition had not improved after 11 months and was now suffering from depression, suggests urgent consideration for alternative medical services was needed.

A review of recent articles relating to aquatic therapy, suggests that overweight and obese females may experience some improvement in their chronic low back pain following aquatic therapy.

- **"Effect on health-related quality of life of a multimodal physiotherapy program in patients with chronic musculoskeletal disorders."** This study, published in 2013 suggested that aquatic therapy can be recommended to patients with chronic lower back pain, chronic neck pain and osteoarthritis.

- **"Effects of Different Frequencies (2-3 Days/Week) of Aquatic Therapy Programs in Adults with Chronic Low Back Pain."** This study published in 2013 stated the following, "…. *therapeutic aquatic exercise appears to be a safe and effective treatment modality for patients with low back pain. Water immersion decreases axial loading of the spine and, through the effects of buoyancy, allows the performance of movements that are normally difficult or impossible on land. By utilizing the unique properties of water (buoyancy, resistance, flow and turbulence), a graded exercise program from assisted to resisted movement can be created to suit the patients' needs and function. Aquatic exercise may improve pain and disability, and maintain quality of life in patients with chronic low back pain, especially in individuals with low level of physical fitness*. The study went on to state, *"Research has consistently demonstrated that impairment in strength, flexibility, endurance and obesity are present in many patients with chronic low back pain."*

- **"Disability Predictors in Chronic Low Back Pain After Aquatic Exercise."** This study published in 2014, concluded with the following statement, "*Changes in pain intensity and abdominal muscular endurance were significant predictors of change in*

[40] CWCI - 137,761 IMR requests filed in 2014. Costs range from $345 to $515.

disability in patients with chronic low back pain after therapy. Aquatic exercise decreases levels of disability and back pain, increases quality of life, and improves BMI and fitness in sedentary adults with chronic low back pain. Therapists working with patients with chronic low back pain should take into account these relationships to improve the management of chronic low back pain related disability."

- **"Hydrotherapy: An innovation treatment for obese Malaysians."** This study published in 2015, states the following, "*This study reveals that hydrotherapy has improved patient's mobility, flexibility and exercise capability. Results reveal the reduction in the weight of subjects, with both quantitative and qualitative data results show that Hydrotherapy improved the quality of life in terms of body pain reduction and general health improvements. Therefore, it can be concluded that hydrotherapy can be seen as extensions of exercise and one of the methods in reducing body fat and weight."*

- **"Improving Chronic Pain and Limited Mobility with Water-Based Therapy".** This article stated, *"For some, pain management involves taking over-the-counter and prescription medicines, but many believe in a holistic approach that does not rely on pharmaceuticals to mask the pain. Those seeking a better way to keep their pain at tolerable levels using a minimum amount of drugs are finding relief through the benefits of warm-water physical therapy."* The article went on to state, "*It is critical for individuals affected by pain symptoms to understand that when they are exercising a joint that has arthritis or a chronic muscle pain condition, the more muscle strength that person has, the lower the sensation of pain. The muscle is the shock absorber for movement, and when muscles are strong, they take pressure off the joint. On land a person fights against gravity, but in the water a person has the opportunity to build muscle with the effects of gravity and pain minimized."*

- **"Jumping into the deep-end: results from a pilot impact evaluation of a community-based aquatic exercise program."** This study published in 2015 concluded with the following statement, "*This pilot study provides an overview of the potential effectiveness of the community-based, peer-led Waves aquatic exercise program, and valuable information to inform the design of a larger evaluation. Overall, findings suggest that Waves classes may improve pain, joint stiffness, physical function, and health related quality of life ("HRQoL") in adults with musculoskeletal conditions. Based on these findings, a large-scale trial is warranted to definitively test the Waves program."*

- **"Aquatic therapy improves pain, disability, quality of life, body composition and fitness in sedentary adults with chronic low back pain. A controlled clinical trial."** This study published in 2014 concluded with the following statement, "*A two-month intensive aquatic therapy program of high-frequency (five times/week) decreases levels of back pain and disability, increases quality of life, and improves body composition and health-related fitness in sedentary adults with chronic low back pain."*

- **"Comparing Energy Expenditure During Land and Shallow Water Walking in Overweight and Obese Females."** In addition to studies suggesting aquatic therapy may be beneficial to address pain associated with chronic low back pain, this study published in 2014 suggests it may also assist with weight loss. The study made the following comments, "*The prevalence of overweight and obesity in the United States has reached epidemic levels. Reduction in body weight is of great importance for overweight and obese individuals through the increase in physical activity.".* It went on to state, "*Water-based exercise is rapidly growing in popularity as a potential alternative to land based exercise for numerous populations including overweight and obese individuals."*

- **"Sex differences between Veterans participating in interdisciplinary chronic pain rehabilitation."** This study published in 2016, related to improving the management of pain among female Veterans receiving care through the Veterans Health Administration and published the following statements, "*The Chronic Pain Rehabilitation Program ("CPRP") uses a biopsychosocial approach and targets the physical and emotional effects of pain with a focus on active treatment modalities including graduated physical therapy, aquatic therapy, daily paced walking, relaxation techniques, occupational therapy, recreational therapy, individual psychotherapy, educational groups, and family interventions as appropriate."* It went on to state, *"In addition, effective medication management is an important goal and includes cessation of all opioids and centrally acting muscle relaxants. The use*

of other non-opioid analgesics are reviewed at admission and adjusted throughout treatment." The study concluded, *"The current findings add to a growing body of research suggesting that sex differences may exist in the determinants of pain treatment outcomes. Additional examination of the differences that may exist between sexes and their implications for effective pain management should continue to be explored."*

Some of the treatments outlined in the Veterans Health Administration study could equally have applied to case number CM16-0056548, which if provided in a timely manner, most likely would have resulted in a better outcome for both employee and employer, as opposed to its current poor state. These studies also question how up to date the MTUS guidelines are, and is their level of detail adequate. For example, should the MTUS be providing guidelines based on employee's demographics such as gender, age, weight, height, BMI and comorbidities? In the case of treating chronic low back pain in an obese 23 year old female with depression, this would have been worthwhile. Based on the MTUS and decisions of the UR medical director and IMR physician, a female needs to be extremely obese to be eligible for aquatic therapy, so, a female who is 5 feet 4 inches tall, weighing 235lbs and has a BMI of 40.3 kg/m2 which is considered to be extremely obese, is eligible for aquatic therapy. However, a female who is 5 feet 4 inches tall, weighing 230lbs (i.e. 5lbs less) with a BMI of 39.4 kg/m2 and considered obese only, could in fact be unreasonably denied aquatic therapy by both the UR medical director and the IMR physician, as was illustrated in case CM16-0056548.

The MTUS are not specific about which aquatic therapies are approved, for example, passive (i.e. spa) or active hydrotherapy (i.e. pool) such as deep water running, Ai Chi aquatic exercises, underwater treadmills and resistance jets, etc. There is also no mention of approval or restrictions based on employee demographics, such as male or female, being overweight, obese or extremely obese, and age band, say 20 to 30 for instance. For the many treatment services currently used by clinicians for both work-related and non work-related medical conditions, there is and will continue to be a lack of published evidence from studies, especially as research funding by the National Institute of Health ("NIH") focuses more on life threatening medical conditions such as heart disease, cancer, diabetes, and AIDS. Hence, why the Department of Veteran Affairs conducts their own studies and publishes their own results. **In the case of medical treatments provided by workers' compensation, each and every claim is in fact a one-person trial**. The treating clinician, the P&Cs' UR medical director and the IMR physician must become more acutely aware of each employee's unique circumstances, vet the effectiveness of different treatment options and not simply rely on EBM guidelines such as the MTUS.

As EBM guidelines used in the MTUS are commonly based on randomized controlled trials ("RCTs") and systematic reviews, published evidence can at times be biased, influenced by research funding or specific interest groups. In the approval of medications using EBM guidelines, it is important to remember that a medication may only help a small percentage of the population, as in the case of statins only benefiting as few as 1 in 50. Further to this, some medications may be harmful to certain ethnic groups because of the bias towards caucasian western participants in RCTs. Based on the latest U.S. Census data, California has the highest Asian population with Hawaii having a majority Asian population. The total of Hispanics in the U.S. has grown to 57 million and are nearly a majority in New Mexico, making up 48 percent of the state's population. This further emphasizes the need for P&Cs' to be mindful of the limitations of only using EBM guidelines and the MTUS so as not to compromise the employees' necessary medical services recommended by the clinician.

A recent example of where the results from RCTs were distorted was exposed with the OxyContin medication. OxyContin a frequently prescribed medication until recently and which gained market dominance on the presumption that it controlled pain for a full 12 hours has been found to be false. Purdue Pharma, the manufacturer of OxyContin was aware since their RCTs that the medication wore off well before 12 hours. Through their patient's experiences, clinicians also became aware of the medication's shortcomings with some prescribing 8-hour dosing or increasing the strength[41] which was Purdue's recommended approach. In this situation, P&Cs relying on OxyContin RCTs alone without consideration for the employee's

[41] LA Times, "You want a description of hell?" OxyContin's 12-hour problem, Harriet Ryan, May 5th, 2016.

experience may result in increased costs[42] for the P&C, increased premiums for the employer as well as probably causing harm to some employees with progression from dependence on OxyContin to reduce pain to becoming heroin addicts. For example, with RCTs stating OxyContin provided pain relief for 12 hours, clinicians who either prescribed additional pain control medications or changed dosage frequency based on their patient's (i.e. employee) experiences, could be accused of overprescribing and with both the P&Cs' UR medical director and IMR physician most likely denying the prescription, also possibly causing the employee to self medicate to control pain, often with heroin. Furthermore, if the employee died from heroin because they were denied prescription medications, is there exposure for legal action by the employee's estate against the P&Cs UR medical director and/or the IMR physician for not taking into consideration the employee's experience with the medication? According to the UN's 2016 World Drug Report, the number of heroin users in the U.S. reached around one million in 2014 - almost three times the number in 2003. Heroin-related deaths have also increased fivefold since 2000.

The CWCI study suggests that the combination of the MTUS, RFA and IMR processes, has subjected P&Cs to tight timeframes along with significant administrative requirements and associated expenses, which have contributed to an increase of 347% in medical cost containment expenses between 2002 and 2014.

To corroborate the CWCI statements relating to RFA/IMR processes, a number of IMR cases were investigated with Case Numbers CM15-0093014 and CM16-0074130 selected to illustrate how P&Cs' operational practices may be the major contributor towards the issues identified by the CWCI.

- On May 8th, 2015 in IMR **Case Number CM15-0093014**, the UR medical director denied a request for a medication commonly referred to as "New Formula Terocin" (NDC 50488-1129-1) which probably provided similar pain relief to the Ultra Strength Bengay cream costing $17 for a twin pack of 8oz. The case related to a 75 year old male who sustained an industrial injury in 1998 resulting in ongoing treatment of daily exercise and medications. The lotion which was denied contained active ingredients of Methyl Salicylate 25%, Menthol 10% and Capsaicin 0.025%, which appear to have similar pain treating qualities to both the OTC Ultra Strength Bengay cream - active ingredients Methyl Salicylate 30%, Menthol 10% and Camphor 4% and the OTC IcyHot products. The application for a retrospective medical review was received 6 days later on May 14th and was assigned to Maximus Federal Services on May 19th, 11 days after the P&C's UR medical director's denial. On June 19th, after an elapsed period of 43 days from the initial denial date, Maximus also denied the lotion quoting a number of MTUS guidelines, including that capsaicin, a topical analgesic of which the lotion contained 0.025%, was not recommended by MTUS. The lotion denied, appears to sell between $350 and $450 for a 4fl oz (120 ml) bottle and according to the manufacturer, Alexso Inc. in Thousand Oaks, California (http://alexso.com) may be adequate for a one month supply. They do state however, that two 4fl oz bottles may be required. Based on the active ingredients and without any published evidence from clinical trials on the lotion's effectiveness in providing temporary pain relief, it appears that New Formula Terocin may provide similar temporary pain relief to that of the Ultra Strength Bengay cream. The price of a single bottle of the New Formula Terocin lotion is equivalent to purchasing over 10lbs (4.5kg) of Bengay Ultra Strength cream.

The IMR cost of $345 paid by the P&C plus all additional costs incurred through their denial process will undoubtedly be factored into future employers' premium rates. As this was a denial from a retrospective review, the employee has already probably received and used the lotion and is probably now left with owing the dispenser for the lotion, who most likely was a clinician selected by the employee from the P&C's MPN list. The total cost for all parties combined was a minimum of $695 (i.e. P&C's IMR cost of $345 plus the Employee's cost of $350 for the lotion), when it should probably only have cost $17, the price for two small tubes of Ultra Strength Bengay cream.

This poses two questions, **"Who was responsible for incurring the cost of $695 - the legislators who enacted the RFA/IMR statutes, the P&C's MPN clinician who prescribed the lotion or the P&C who appointed the clinician to their MPN?"** and **"What processes could have been put in place to have avoided the situation described?"**

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[42] OxyContin is available in strengths from 10mg costing $2 per tablet to $14 for a 80mg tablet.

If the terms and conditions between the P&C and clinician had been agreed upon at time of appointment to the MPN, such as when topical medications could be prescribed along with their price if dispensed by the physician, then the need for the RFA and IMR would not have been required. It is also worth noting that the lotion was not listed in the Medi-Cal pharmaceutical formulary, meaning the price needed to have been established by other methods and agreed upon with the dispenser prior to their appointment to the P&C's MPN and most definitely before it was supplied to the employee. Also during screening of clinicians, P&Cs need to ensure they are made aware of any arrangements clinicians may have with pharmacies, such as home delivery services including mail order specializing in providing medications for workers' compensation and motor vehicle bodily injury claims such as Drugs 4 Less Pharmacy (https://www.d4lpharmacy.com/home.html). Knowledge of these arrangements can further reduce the need for both IMRs and IBRs. Lastly, if P&Cs communicated more frequently with employees under long term care then perhaps in this example, alternative exercises and medications could have been discussed, avoiding the costly RFA and IMR processes. Adequate screening in the selection of clinicians to the P&Cs' MPN, the prior establishment of terms and conditions and the monitoring of medical services in order to reduce the frequency of RFAs and IMRs is clearly not happening. To some degree, P&Cs have already admitted to these shortcomings with the inclusion of their MPN disclaimer statements stating, "***… does not warrant the accuracy of the directory information, or the quality of the medical care.***" or similar, which do little to promote employee confidence in the P&Cs choice of clinicians. These factors are most likely the primary causes for the 137,761 IMRs in 2014 reported in the CWCI study[43], adding between $47 million and $70 million approximately to MCCP costs.

- In IMR **Case Number CM16-0074130**, the P&C's UR Medical Director incorrectly denied the P&C's MPN clinician's medical service request for an MRI lumbar spine without contrast on March 30th, 2016. The application for an expedited IMR was received on April 18th. The case was assigned to Maximus on April 20th with their decision approving the MRI received on April 22nd, a total of 23 days after the initial UR medical director's denial. The employee was a 65 year old female who filed a claim for chronic lower back pain associated with a December 4th, 2015 work related incident.

The CWCI's study stated, *"Final IMR determination that resulted in modified or denied treatment requests underwent multiple levels of review that often included review by claims adjusters and nurses in addition to the UR and IMR physicians. The end result is a consensus that the physician's treatment request did not align with the MTUS standard of care and consequently, the requested service could delay a worker's recovery or lead to further impairment or disability. The high level of system-wide agreement at these different stages of medical review realizes the legislative intent of reforms to provide the injured worker with the most effective medical care through a process that is more objective, transparent and consistent."*

This poses the question, **"Are adequate checks and balances in place within the P&C operations and procedures to ensure denial decisions are at a minimum in compliance with appropriate guidelines?"**

In this example, assuming that the P&C's procedures required at least one reviewer (i.e. examiner/adjuster or nurse) prior to a final decision being made by the UR medical director, the answer to the above question is "No". The decision made by Maximus was based on one specific page in the ACOEM guidelines. The P&C paid $515 for this expedited IMR plus all additional costs incurred though their denial process. Further to this, the employee had already been absent from work for well over 90 days at the time of the IMR decision and with the MRI denial, which added at least 23 days to her absence, probably decreased any opportunity for her returning to employment with the same or different employer. By incorrectly denying the MRI and in addition to the cost of $515 for the IMR, at least 23 days of temporary disability indemnity benefits were also paid. These costs most likely would eventually end up being paid for by employers through increased premiums.

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

Pharmaceutical guidelines as introduced by Texas can be equally ineffective as illustrated in the example below:

- Effective February 1, 2016 Fentanyl transdermal patches (aka Duragesic) and MS Contin, both described as potent and highly addictive analgesics used to control moderate to severe pain required pre-authorization in Texas with no grandfathering period. In response to the change, Healthcare Solutions, an Optum Company released a pharmacy alert with the following statement, *"In order to support our clients, the following steps will be taken by Healthcare Solutions: Healthcare Solutions will identify current claimants (sixty days prior to the rule effective date) to assess potential disruption and provide the claimant list to our customers. If requested from our customers, Healthcare Solutions will send notice to the prescribers of the change in status of the two medications, sixty days in advance of the rules effective date. The letter is a reminder to the prescribers to either move their patients to other medications or initiate the preauthorization process."*

This poses the question, **"Is it to be assumed that neither the P&C nor Healthcare Solutions performed initial or ongoing reviews as to the necessity for these medications simply because they had a status of "Y" in the ODG[44] Workers' Compensation Drug Formulary, meaning no pre-authorization necessary?" The formulary is maintained by the Work Loss Data Institute and used as the Texas Workers' Compensation Formulary.**

From an employee's safety perspective, it is important to note that fentanyl, an opioid 50 times stronger than heroin and 100 times stronger than morphine is highly addictive. Side effects range from severe fatal breathing problems to severe withdrawal symptoms when abruptly stopped, suggesting it is a medication of last resort only to be prescribed during some form of pharmaceutical progressive plan or step therapy when other medications cannot control the employee's chronic pain or they are unable to take alternative medications. A conscious decision would therefore be made by the clinician before prescribing this medication. P&Cs would equally be aware and conscious of the decision to prescribe fentanyl and by previously paying for the medication, suggests its use was already approved by the P&C.

From a monetary perspective, fentanyl transdermal patches are very expensive considering each patch only provides 72 hours of pain relief. Prices range[45] from $11 per patch for 25mcg/hr (NDC 00245-0420-05, Usher-Smith Laboratories, Inc.) to $51 per patch for 100mcg/hr (NDC 00093-6903-45, Teva Pharmaceuticals USA, Inc). Less common available strengths of 37.5mcg/hr, 62.5mcg/hr and 87.5mcg/hr from Mylan Pharmaceuticals, Inc are more expensive with prices of $54, $79 and $107 per patch respectively. With the medication's high price and significant pricing variations between manufacturers, suggests P&Cs should be vigilant in monitoring both the use and price of the medication on an ongoing basis and most importantly at time of paying for the medication.

Like fentanyl, MS Contin is not intended to be taken on an "as needed" basis and it would be expected that P&Cs or their outsourced vendor, in this case Healthcare Solutions would have established the medication's necessity prior to approval of the initial payment for the medication. This would also have included a background check on an employee's history of medication overdose or substance-use disorder and whether they may be taking other medications such as benzodiazepine[46]. Based on the assessment of the employee's risk factors, a conscious decision would then have to be made whether the employee should be prescribed MS Contin and if so, whether other medications should also be approved such as naloxone, as a precaution to reduce the chance of a fatal overdose. This highlights that it is far from desirable to only rely on guidelines such as the ODG pharmacy formulary or updates to the formulary to trigger a P&Cs' pre-authorization or review activity in delivering the most effective care at the lowest cost. Further to this, relying only on the ODG may overlook the latest available pharmaceutical research which could improve the employee's opportunity to resume normal daily activities

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44 Official Disability Guidelines.

45 Based on California Medi-Cal Pharmacy Formulary Pricing as used for Workers' Compensation.

46 Tranquilizers, such as Valium and Xanax.

including return to work, which in turn reduces the need for indemnity benefits. A recently published study,[47] suggests that rotating from morphine ER (e.g. MS Contin) to hydrocodone bitartrate (e.g. Hysingla ER or Zohydro ER) may improve controlling moderate-to-severe chronic pain, without increasing safety risks. As with all medications, not everyone will experience a reduction in pain and with Hysingla ER and Zohydro ER being significantly more expensive compared to MS Contin, it would be monetarily irresponsible for the P&C to continue paying for the more expensive medication if there was no sign of improvement. By way of price comparison[48], an MS Contin tablet[49] provides 12 hour pain relief and comes in strengths of 15mg at 38 cents, 30mg at 67 cents, 60mg at $1.35, 100mg at $2.07 and 200mg at $4.42. A Hysingla ER tablet[50] provides 24 hour pain relief and comes in strengths of 20mg at $7.17, 30mg at $10.46, 40mg at $14.09, 60mg at $19.51, 80mg at $26.31, 100mg at $33.47 and 120mg at $37.09. A Zohydro ER capsule[51] provides 12 hour pain relief and comes in strengths of 10mg at $6.11, 15mg at $6.53, 20mg at $6.75, 30mg at $6.95, 40mg at $7.16 and 50mg at $7.48.

The pharmacy alert release by Healthcare Solutions suggests that some of their P&C and TPA clients may be solely relying on the "Y" or "N" value recorded against a medication in the ODG Workers' Compensation Pharmacy Formulary when deciding whether to review a medication's necessity as illustrated with fentanyl transdermal patches and MS Contin. P&Cs should be focusing on the medication's efficacy, safety, cost and the opportunity they provide for the employee to return to the workforce regardless of the value of "Y" or "N" in a pharmaceutical formulary.

While P&Cs, legislators and others rely on statistics to gauge the effectiveness of enacted statutes, one is reminded of the phrase "lies, damned lies and statistics". With SCIF and seven P&C groups highly concentrating the Californian market and market share varying from year to year as illustrated earlier, results from statistics can be extremely biased and skewed. When an opportunity arises to investigate specific cases as was undertaken here, greater insight into how P&Cs' procedures have been implemented becomes apparent. These two California examples suggest that for at least two of the statutes enacted over a decade ago, they were not implemented as intended and probably contributed to the high increase in LAE costs reported by the CWCI. The Texas example, suggests that both the P&Cs/TPAs and/or their outsourced vendor may have little knowledge of an employee's medical conditions and/or have no interest in monitoring medical services and their costs including prescribed medications, all directly affecting not only the opportunity for the employee to return to the workforce, but also the employers' premiums.

Upcoming challenges for P&Cs in determining medical necessity will come with the growing acceptance of **"precision medicine"** by clinicians in the U.S. (i.e. biopsychosocial/shared decision making approach). With precision medicine, approval of medical services by P&Cs will not be as black and white as referencing guidelines (i.e. cookbooks), or looking up the value of "Y" or "N" in a pharmacy formulary. A biopsychosocial approach combines an understanding of an employee's medical history[52] including past and current medical conditions (e.g. comorbid conditions such as diabetes, vascular disease, cancer, depression and other psychosocial conditions (e.g. ethnic groups)), past and current medications, including length of time they were taken, together with the specialties/sub-specialties of the clinicians who may be concurrently treating them. Additional factors a P&C will need to understand are the employee's treatment preferences and if they have been

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47 Efficacy and Safety of Once-Daily Extended-Release (ER) Hydrocodone in Individuals Previously Receiving ER Morphine for Chronic Pain, Kathleen Broglio, Columbia University Medical Center, New York, New York, March 2016

48 Based on California Medi-Cal Pharmacy Formulary Pricings used for Workers' Compensation.

49 Purdue Pharma, NDC 59011-0260-10, -0261-25, -0262-10, -0263-10, -0264-10

50 Purdue Pharma, NDC 59011-0271-60, -0272-60, -0273-60, -0274-60, -0275-60, -0276-60, 0277-60

51 Zogenix, Inc. NDC 43376-0210-10, -0215-10, -0220-10, -0230-10, -0240-10, -0250-10

52 Mayo Clinical Proceedings, April 2016, Healthy Lifestyle Characteristics and Their Joint Association With Cardiovascular Disease Biomarkers in U.S. Adults. This study examined people's diets, exercise, body fat and smoking habits and identified that more than 97 percent of Americans were not living a healthy lifestyle.

emotionally affected by concerns regarding prospects of future employment opportunities and their livelihood. P&Cs will also need to be conscious of timelines employers may establish to provide reasonable accommodation for employees to return to their employ without it causing undue hardship for the employer.

Adding to the complexities outlined above, P&Cs will be challenged with clinicians' changing their views on the use of opiates and opioids and other analgesics for controlling chronic pain and reverting to earlier treatments which relied on non-pharmaceutical therapies such as physical therapy (capped at 24 visits in California), mindfulness based stress reduction (MBSR) such as meditation and yoga and cognitive behavioral therapy (CBT). Using these therapies will at times not only require a multidisciplinary approach but an interdisciplinary approach integrating a number of specialties and sub-specialties along with Primary Care in providing medical services, with the P&C needing to play an integral role. This interdisciplinary approach may also challenge the IMR physician in determining which medical services should be approved, possibly requiring multiple IMR physicians to make a determination, which could also increase IMR costs and extend the time needed to make a decision. The CWCI stated in their study, ***"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."*** suggesting some P&Cs may already be struggling with the current situation, making **the future in delivering on their promise to the employer look bleak,** unless they address the deficiencies in their claims operations.

Understanding there is an infinite number of permutations and combinations clinicians can use for medical services in treating employees' during their recovery period as illustrated earlier, California statutes have provided an opportunity to significantly reduce the frequency of RFAs by allowing P&Cs to prior authorize medical services. Some consistency in the trend of medical conditions handled by workers' compensation over the last decade, has provided an opportunity for P&Cs to establish which specialties/subspecialties, and which individual clinicians along with their medical services have delivered the most optimum outcomes. This accumulated medical data has allowed P&Cs to establish their own evidence-based practice database which they can use to prior authorize medical services and heed **the principle that every claim is a one-person clinical trial**. For example, pilates or yoga may be prior authorized for some individuals to control pain, whereas for others with weight issues, it may be aquatic therapy. The more effort a P&C devotes to identifying the best combination of medical services with specialties/subspecialties applicable to an employee's specific medical condition and demographics for prior authorizations, the less likely the need for RFA/IMR processes. Without P&Cs' establishing prior authorizations, clinicians wanting a guarantee that they will receive payment for services rendered, are left with no other option but to submit an RFA at least each time they submit their Evaluation and Management reports.

The RFA/IMR processes were intended for minimal use only considering the expected improvement in relationships between the MPN clinician and P&C as well as being able to prior authorize medical services. The experience to date however, has been the opposite with excessive numbers of RFAs and IMRs being reported, causing delays in providing medical services as well as increased costs to P&Cs which all result in increased premium rates for employers.

This poses the question, **"With the high cost associated with RFA/IMR processes, why haven't P&Cs attempted to reduce their frequency including establishing prior authorizations for medical services?"**

The answer may have been provided by the CWCI with their following statement, "*The study population included payors that use in-house utilization review resources and those that contract with external utilization review organizations (UROs). In addition, some of the data contributors administer their own claims while others use third-party administrators.*" and "*While the study advances prior attempts to measure the outcomes of medical review and medical necessity dispute resolution, the authors were limited by available data and data sources. The final databases used in the analysis were compiled from distinct information systems across each segment of medical review, RFAs and IMR. There was an abundant volume of data for each segment, but due to confidentiality requirements as well as different data capture standards across data sources (individual payor, independent UR vendors and IMR), it was not possible to link each medical service record across the continuum of medical bill review to utilization review to independent medical review.*"

The issue of information disparity has existed since P&Cs began handing over the management and control of medical bill review to other organizations (i.e. outsourcing) in the late 1980s and early1990s. Its negative impact however, on a P&C's decision making regarding the necessity for medical services recommended by their MPN clinician, has only been recognized since Utilization Review was introduced and further exacerbated since the introduction of RFA/IMR processes. Losing control of encounter data, limits the P&Cs ability to establish prior authorizations except for the most rudimentary medical services, forcing clinicians to use RFAs. **The CWCI report suggests that RFAs have contributed to highly excessive LAE costs.** These costs are only likely to increase because of inefficiencies in the P&Cs current operations and procedures caused primarily by losing control of their encounter data. With outsourced vendors storing encounter data such as ICD-10s[53], NDCs[54], HCPCS[55] and CPT[56] codes along with associated details directly applying to decision making in their own silos[57] and P&Cs storing only minimal encounter data required to make payments, the all too common challenges of integrating data, including addressing data quality[58] issues will face P&Cs if wanting to create their own evidence-based practice or practice-based evidence databases. Although some say this is achievable, it will undoubtedly take a lot of effort and in the end may still lack credibility due to the difficulty of corroborating and vetting data back to the original providers' invoices. One thing is certain, the effort will be expensive and add more cost to the P&Cs already unaffordable workers' compensation insurance product.

Although there are no accurate figures, there are estimates that **8% to 10% of the California workforce experiences an occupational injury or illness each year**. Fortunately around two-thirds require only minor medical treatment with one or two days absence or no absence from employment. In California, employers and treating medical providers have 5 days in which to report a claim to a P&C, by which time many employees would have returned to work. Most P&Cs handle claims requiring indemnity benefits payments differently from those classified as "First Aid" or "Medical Only". Although First Aid and Medical Only categories may suggest there is no absence following a work related incident, this is not necessarily the case. Most jurisdictions impose a waiting period and/or conditions before an employee is entitled to receive indemnity benefits. For example, in California, the employee must be absent from employment for three days or hospitalized overnight before they receive indemnity benefits and until that time, the claim is classified as First Aid or Medical Only. As illustrated, claim classification for First Aid or Medical Only is defined through statutes and generally used in establishing a claim's statutory reporting requirements and to assist in preparing the employer's claims rating which P&Cs use in quoting premium rates. Although this classification of claims has been in existence for over four decades predating the use of technology, which probably explains why different procedures and separate resources have been in place to handle these claims, the reason to continue this traditional practice today, is less clear. Some say it's because the insurance industry in general is steeped in tradition and too set in its ways when it comes to administering claims services.

Claims services in workers' compensation are often described as both administrative intensive and data intensive due to the high volume of events that take place during the life of a claim. Over the decades P&Cs have been conscious of administrative costs and operational efficiencies, establishing different handling procedures based on a claim's classification as described above. Although some P&Cs have outsourced medical bill review to other organizations since the late 1980s, they have still maintained overall medical control of a claim, including the selection of clinicians to treat the employee within their medical

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

[54] National Drug Code.

[55] HealthCare Common Procedure Coding System.

[56] Current Procedural Terminology codes.

[57] A vendor's own separate database that is not part of the P&C's claims data.

[58] How to Find Best Work Comp Doctors, Karen Wolfe, insurancethoughtleadership.com

control period. Today however, this has changed markedly, with P&Cs outsourcing more and more of their medical control, which has seen the outsourcing market grow from around a $4 billion market in 1990 to $18 billion today[59].

Current outsourcing practices P&Cs use include the selection and monitoring of clinicians for their MPNs, medical bill review, pharmacy monitoring and bill review which was first attempted in the early to mid 1990s, medical utilization review, nurse case management and any activity they choose not to perform within their claims operations. In many cases, each of these activities is outsourced to different organizations, resulting in processing discontinuities and information disparity, which may provide some explanation for the fraud and poor claim outcomes relating to the eight earlier examples.

The P&Cs' adage **"the only good claim is a closed claim"** refers to the promptness with which a claim is resolved, preferably at the least cost. With the P&Cs' Workers' Compensation insurance product, claims are closed by either the employee returning to work with no further payment of benefits or a settlement is reached, whereby the employee becomes self-reliant for their ongoing medical treatment and livelihood. Closure of claims by settlement of future medical expenses accounted for $1.7 billion (or 10%) of the total cost for the P&C insurance product in 2014, with medical treatment during the recovery period accounting for $3.1 billion (or 18%). This indicates that settlement of medical benefits as a means to promptly close a claim is becoming a preferred and advantageous option for some P&Cs, but **not necessarily preferable or advantageous** for the employee, employer or the community at large.

P&Cs generally have established procedures for their claims operations based on either an **administration-oriented** or **outcome-oriented** methodology, with some attempting to create a hybrid of the two. Although the two are diametrically opposed, outcome and cost can be very similar for certain medical conditions such as contusions or fractures and also for claims which involve either no or minimal absence.

Administration-oriented is modeled on the examiner/adjusters' traditional role of monitoring claims, with the level of success measured solely on some key performance indicators ("KPIs"). Some of these indicators include the time taken to complete a 3-point contact[60], length of time to determine compensability, the time taken to establish an estimated cost of a claim as well as accuracy of the estimate (i.e. the reserve amount), the length of time a claim remains open and the frequency of claim penalty payments caused by noncompliance to perform a statutory activity or not completing it within the regulatory period. Overall, it is **best described as claims administration which is reactive to a statutory or regulatory event taking place**, such as receiving a request for an RFA or IMR.

Outcome-oriented focuses at all times on delivering the most optimum results at claim's closure. This requires the establishment of a pathway (i.e. "roadmap") with ongoing monitoring of progression milestones and timelines ending preferably with the employee returning to the workforce with the same or different employer or if that is not achievable, provide resolutions to the satisfaction of all interested parties. It is **best described as claims management which is focused on proactive and dynamic processes to achieve the most optimum results with the least cost** for a claim. Within this approach, an RFA or IMR is treated purely as a formality and documents how a dispute between the MPN clinician's recommended medical services and P&C's UR medical director is resolved and should not require any additional actions.

Regardless of whether P&Cs implement an administration-oriented or outcome-oriented methodology, they all should ideally strive to close a claim by returning an employee to the workforce rather than offering a one-time settlement payment. There are however many challenges in achieving this quintessential goal, with the most significant centered around

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[59] Peter Rousmaniere, Surge in Work Comp Services is Ending, July 2014, (insurancethoughtleadership.com).

[60] A 3-point contact refers to making voice contact with the employer, employee and the treating clinician.

the size of the employer's workforce. California has approximately 637,000 employers with 20 or less employees, totaling 2.5 million people[61]. A rule of thumb to determine the window of opportunity for the employee's return to the same employer, is to establish the longest vacation period the employer is prepared to offer an employee, regardless of whether paid or unpaid. Returning to the same employer after being away for more than the maximum vacation period diminishes with each passing day, with little or no opportunity once absent for more than double the vacation period.

In the event an employee is off work and requires medical services which are under dispute, the employee in all probability will not return to their pre-injury employer or could be sacked soon after returning. Further to this, prospective employers as a whole tend to treat employees with skepticism if they've previously filed workers' compensation claims and were off work for a lengthy period, some even regarding the employee as a malingerer. With this stigmatization, there is little opportunity of returning to the workforce at all, with the employee and their family being forced to end up in public programs, indirectly placing a financial burden on the community at large. Furthermore, employees who find themselves in this situation often shift into survival mode and use the workers' compensation system as a means of providing financial support for as long as possible, even progressing at times to committing opportunistic fraud. All this can be avoided if P&Cs establish pro-active processes within their claims procedures to reduce disputes and conflicts between all parties, especially with their MPN clinicians. This would instill confidence in the employee that the most appropriate medical care will be delivered and address any reasons for reluctance to continue on at work or for an early return with their current or different employer.

Sir John Collie, M.D., J.P. stated in 1913[62], "*It is a mistake to think that all malingering is the outcome of deliberate wickedness. Because a man does not return to work as soon as one thinks he ought, it is harsh to assume that he is a shammer, and should be branded as a wilful malingerer. Such a view is not only unjust but demonstrates a poor knowledge of human nature. Great allowance has to be made for the personal equation. Moral responsibility, even amongst the highly educated, is a variable quality, indeed, it varies almost as much with different individuals as do the features.We cannot always fully appreciate the mental processes taking place in each individual mind, and, as long as unregenerate human nature is being dealt with, so long are we bound to weigh all the circumstances of each case, if we wish to be fair. The mental attitude of workmen with regard to recovery after sickness is a very complicated one, and it is only by studying and fully understanding it that such cases can be successfully dealt with.*"

While robotic assembly line processes described in the CWCI's study may work effectively in Health insurance products, combined with administration-oriented and outsourcing models, it is in fact ineffective and too costly in delivering the P&Cs' promise as illustrated earlier. The robotic processes used to administer a health insurance plan are not concerned with the quality of the medical services provided. They only focus on adhering to the medical services limits set either by quantity or dollar amount and contributing the agreed health insurer's percentage towards the insured's medical services expenses. It also cannot be overlooked that even though a person may have health insurance coverage, they do not have to use it, especially if the policy has a high deductible. An insured with a high deductible health insurance policy may selectively choose when to use their health insurance coverage as was recently reported in the LA Times[63]. The article describes how Torrance Memorial Medical Center charged Blue Shield of California $408 for which the insured had to make a co-payment of $269.42. After making enquiries, the insured established that tests billed at $80 to Blue Shield of California, each carried a cash price of around $15, suggesting it was cheaper to pay cash for the tests bypassing the healthcare insurer and avoiding the high co-payment amount. The U.S. has without doubt some of the best clinicians and medical treatments available in the world for those who can afford to pay. For the majority however, the U.S. has the most expensive healthcare insurance product in the world and is regularly ranked amongst the last in the world for efficiency and outcome. Even with this

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61 United States Census Bureau, 2013 County Business Patterns.

62 Malingering and Feigned Sickness, Sir John Collie, M.D., J.P., 1913

63 LA Times, David Lazarus, Even if you have health insurance, you may want to pay cash.

knowledge, some P&Cs continue to introduce healthcare insurance robotic assembly line processes into their workers' compensation insurance product.

Workers' compensation is often described as three insurance products rolled into one - health insurance, disability/accident insurance and life insurance, with the combination delivering all the necessary benefits to the employee until they either return to the workforce or become self-reliant (i.e. the P&Cs' promise). The sooner P&Cs begin to focus their efforts on "how" to return the employee to the workforce or to self-reliance, instead of the current practice of entirely focusing on limiting employees' medical services, which as illustrated, takes an exorbitant amount of time and money delivering less than desirable outcomes for the employee and employer, the sooner the overall cost of the workers' compensation insurance product will begin to decrease.

The "how" is only achieved by using the outcome-oriented methodology with the P&C establishing an employee's recovery plan ("plan") along with identifying the resources necessary to deliver on the plan. Regardless of whether the resources are internal or external, they are only engaged in the claim's life cycle on an as-needed basis (i.e. on timelines) and all resources' efforts are billed to each claim on a time allocation or service basis. This allows the cost of administrating a claim to be included in each individual's claim's costs as opposed to being consolidated into a P&C's unallocated loss adjustment expense ("ULAE"). A component of LAE, ULAE is generally used to record all costs associated with claims' resources under an administration-oriented methodology, but due to its lack of accountability has resulted in costly inefficiencies in the administration of claims.

Outcome-oriented is described as being both proactive and dynamic in dealing with individual differences (i.e. employees' differences). Its focus is always on early intervention in a claim, assigning the first resource, based on specialty necessity rather than administrative necessity. For example, when a claim is first reported, regardless of whether it is classified as a First Aid or Medical Only, an investigator may be automatically assigned to perform interviews and inspect the site if there is concern the claim may develop into Lost Time or there may be an element of opportunistic fraud. Also, if an employee suffers severe or multiple medical conditions where the impact may be devastating to the employee and their family, a social worker may be automatically assigned first, to assist in addressing any negative impacts, and help reduce opportunistic fraud which the family may use to survive. This is in stark contrast to the administrative-oriented methodology which always begins with the appointment of an examiner/adjuster to a claim who then decides when resources are required, potentially delaying appointments which can make a real difference to the outcome of a claim.

In addition to the outcome-oriented methodology incorporating details from early intervention resources such as investigators and social workers, its primary source of information is obtained from the employee's first visit with the clinician. The clinicians' diagnostic and therapeutical procedures are generally known as **Evaluation and Management services ("E&M").** E&Ms follow strict guidelines established by CMS called the "1995 Documentation Guidelines for Evaluation and Management Services" and the "1997 Documentation Guidelines for Evaluation and Management Services". These guidelines are adhered to by all clinicians including psychiatrists regardless of whether treating a work-related or non work-related medical condition. Both guidelines involve a comprehensive medical history and examination of the body system and the clinician's proposed medical services for the recovery period. Initially focusing efforts on ensuring the clinician's E&M report has adhered to all requirements, provides P&Cs with the opportunity to develop and manage their plan with the most appropriate resource, which may not necessarily be an examiner/adjuster as is commonly practiced under an administration-oriented approach.

If there are signifiant variations between the clinician's proposed treatment services and the MTUS or between proposed treatment services and the P&C's evidence-based practice database or if complications arise in delivering the necessary medical services, then the most appropriate resource needs to ascertain through discussion whether the proposed treatments

have been successful in the past and/or whether they were requested by the employee. It is prudent for P&Cs to be open-minded in discussing treatment options with both the clinician and the employee.

In the event the P&C is unconvinced that the clinician's proposed treatments are the best choice for the employee, then and only then should the clinician submit an RFA to begin the IMR process. If this approach was followed in the three IMR cases illustrated, the need for the RFA/IMR would have been removed and in the case of Healthcare Solutions, the services relating to fentanyl and MS Contin would not have been necessary. All four cases unnecessarily added to administration costs of the workers' compensation insurance product.

With the most appropriate resource assigned to read the E&M report, verification of the invoiced CPT code and preparation of the plan are all completed as one continuous process. Combining these three tasks eliminates the need for a separate bill review, which in turn reduces MCCP costs and the estimate for missed medical fraud, which totaled $1 billion in 2014. E&Ms were the single largest cost component accounting for 30% of the $1.9 billion cost for physician services during the recovery period in 2014. Combining the three tasks into one continuous process reduces MCCP costs by $74 million and the estimate for missed medical fraud by $85 million, producing an overall saving to circumvent fraud of $159 million (i.e. approximately a 16% saving). This is all accomplished by using the outcome-oriented methodology instead of administration-oriented. An administration-oriented and outsourcing model would likely separate activities into robotic functions increasing MCCP costs and possibility of fraud through processing discontinuity and information disparity.

California requires clinicians to submit a progress report ("PR-2") when an employee's medical condition has changed or every 45 days which provides the necessary details to adjust timelines and milestones in the plan, especially relevant for an employee's employability. In addition, the clinician's performance can be somewhat measured by progress made in the employee's medical conditions and the costs involved.

As emphasized earlier, individuals, particularly clinicians associated with a claim, govern the effectiveness and efficiency of the processes and activities of that claim. A clinician's performance can be influenced by their age, gender, training, economic incentives, beliefs, attitudes, preferences and job satisfaction. Considering the current outsourcing practices used for MPN networks are probably a major contributing cause for the high costs experienced with MCCP, IMR/IBR processes and missed medical fraud, P&Cs may need to reconsider their practices and establish and maintain their own MPNs, which can be achieved as follows:

- With sprains and strains associated with the lower back accounting for approximately 40% of medical conditions in California, P&Cs should begin by screening members of the ACOEM for their MPNs who are familiar with the treatment services included in the MTUS.

- Regardless of whether the clinician is a member of the ACOEM, background checks are critical in the selection process which should include education, training, years of practice, board certifications and any disciplinary actions. In the case of surgeons, vetting of the hospitals they are affiliated with is also critical as having knowledge of the hospitals where they can practice and admit patients provides an opportunity for pairing, increasing the chances of the most desirable outcome from a surgery. In other words, performing these checks provides the answer to the single most important question when choosing a clinician for an MPN, *"If I required treatment for a medical condition, would I want this clinician to treat me?"*

- Any disputes arising from medical services the clinician is to provide under workers' compensation, should not occur when terms and conditions for services (including negotiated discount rates from the official maximum rates) are agreed to prior to a clinician being appointed to the P&C's MPN. This arrangement also reduces the cost of IBRs and the likelihood of clinicians filing liens. In 2014, P&Cs paid a total of $422 million to settle lien disputes related to charges for medical services.

- To assist the employee in selecting a clinician from the P&C's MPN, details such as those obtained through the vetting process should be provided in addition to those mentioned in SCIF's Provider Finder. This provides the employee with a better opportunity to choose a clinician that encourages a participatory clinician-patient relationship.

All the above mentioned pro-active initiatives will reduce delays in providing medical care, reduce fraud and reduce the need for both IMRs and IBRs all resulting in improved medical care for the employee and reduced premiums for the employer.

While the steps above are directed towards selecting clinicians for a P&Cs' MPN, similar steps for the screening and monitoring of outsourced vendors such as Third Party Administrators ("TPA"), Pharmacy Benefit Managers, Nurse Case Managers as well as internal resources should equally be applied.

Two words often used to describe the P&C workers' compensation insurance product are "animosity" and "adversarial", directly caused by the lack of trust between parties. While the lack of trust between P&Cs and their providers including MPN clinicians can be addressed as outlined, the lack of trust between employee and P&C is far more difficult to address. Some say, it's well nigh impossible which is why the P&Cs' insurance product is subject to greater requirements in statutes and administrative agency regulations. This lack of trust is often caused by the P&Cs' culture with some treating an employee claiming benefits for a work-related medical condition who may appear adversarial, as a shammer or malingerer as described by John Collie some 103 years ago. However, there are always two sides to every story and some of the actions of claims administrators, either within a P&C or TPA may be the cause for some of the employees' adversarial behavior.

Traditionally, "word-of-mouth" has often been described as having the biggest influence on a person's decisions and actions. Today's word-of-mouth is the internet's social networks. The following are extracts obtained from the internet relating to the TPA, Sedgwick CMS ("Sedgwick").

- In the 2012 California Workers' Compensation Appeals Board, Case No: ADJ1372133 (VNO 0488219), the Administrative Law Judge (WCJ) stated that Sedgwick CMS egregious behavior increased the suffering of a horrifically ill individual. The Appeals Board identified 11 separate incidents of unreasonably delaying medical care, ending in the employee's family forced to seek medical treatment through Medi-Cal (California's version of Medicaid, the federal health insurance program for the poor) and self-procuring additional treatment. The community at large through MediCal incurred costs in excess of $380,000 over a two year period before the employee died at Community Memorial Hospital. Theresa McDivitt, the examiner at Sedgwick CMS testified that she did not authorize this hospitalization because *"they didn't know what was wrong with him."* The WCJ imposed the harshest penalties possible under section 5814 because of the **defendant's extensive history of delay in the provision of medical treatment.** Following the decision, Jill Singer of the California Applicant's Attorneys Association (CAAA) made the following statement, *"This is just ridiculous. For every one story we know, there are thousands out there that may not quite rise to this level, but are close".*

- On January 5, 2016, in addition to the above case, Sedgwick CMS agreed to pay a fine of $1.1 million to settle allegations of Labor Code violations associated with an audit of 274 claim files handled by their office in Long Beach, California. **The violations included modifying, delaying or denying requests for medical services by someone other than the UR medical director (i.e. a licensed physician).**

While Sedgwick received a fine of $1.1 million for the violations, what has not been reported is the impact on the recovery of those employees and the flow-on effect for the employer. At a minimum, their actions may have invoked the IMR process, which would have added LAE costs of approximately between $95,000 and $141,000 for these 274 claims.

The following statements appear on the website www.complaintsboard.com relating to Sedgwick's workers' compensation claims handling practices.

- www.complaintsboard.com March 14th, 2016. Sedgwick. **WC lost wages.** *"Sedgwick claim adjuster did not make me aware how how [sic] little my weekly lost wages payout would be … $932/wk vs my usual $2,000+/wk net take home. Sedgwick had mu [sic] income info weeks prior to surgery. I had no idea how onerous WC was for a higher earner in PA. My Sedgwick claim adjuster sucks. She puts nothing in writing and will for the most part only communicate over the phone. My advice, hire a lawyer as soon as you have an on the job injury and come out guns-a-blazin."*

- www.complaintsboard.com March 18th, 2016. Sedgwick, Lake Mary, Florida. **Mistreatment.** "*attorneys help and sue Sedgwick making Sedgwick pay bigger settlements to claimants that were only looking for medical assistants [sic] and get well this adjusters and supervisor don't care because they still keep their job regardless. The more your adjuster and supervisor miss [sic] treat patience [sic] the more money your company will pay in settlement cases they are the ones driving the claimants to seek legal help when they were looking for medical help."*

- www.complaintsboard.com January 28, 2016. Sedgwick, Honolulu, Hawaii. Date of Injury 7/14/2015. *"Ive [sic] been out of work since October 21, 2015, after getting the paperwork all in, I finally got to speak to Suzette at Honolulu Office in early Nov, she actually called me! I was so excited as she apologized for my long wait. She explained to me that she was having a check sent to me Via FedX, because it was my first check, afterwards a weekly check would come in. This was on a Wednesday so, no later than Saturday. That she would be emailing any details or info. I was elated! She told me she would call me back with the exact amount in 5 minutes. She had taken my email, my phone number, details of the injury, everything … Since that phone call I've must've called and left numerous messages to no end. In a Dec i [sic] called and the person answering the phone said that Suzette was on Vacation, so I asked to speak to a Supervisor, Andrew, but he was also on vacation, she said that my file shows that since Suzette was on Vacation the adjuster was working on my case. She gave me their phone numbers and I could only leave messages —- NOBODY EVER EMAILED ME, CALLED ME … Then out of the blue I believe it was the Jan 4th FedX came to my door with a check?! I appreciated it, really I did…but imagine the holidays for me and my kids? Im [sic] a single dad…now I thought it would start coming in weekly as promised. But sad to say, im [sic] again leaving countless messages, oh yeah the gurl [sic] at front desk connects me to Suzettes phone or Mr Andrews phone…I never got/got [sic] a call, an email, nothing, and so leaving me in the dark. I am sending you this complaint in hope that I don't have to take more serious further steps. Please email, call or text me back. Mahalo from Hawaii alex mateo. address 1053 wiliki drive Hon. HI. 96818, Company work for Dollar Thrifty Hertz Rent a car, contact info ph# 808-397-7663, email* alika401@yahoo.com*"*

- www.complaintsboard.com January 29th, 2016. Sedgwick, **impossible to reach claims adjuster or any person who can help me and no one will call me back.** *"All of my prescriptions for some reason now require previous authorization from Sedgwick. I never needed this before I have been paying cash for less expensive medications of mine but cannot afford the nerve blocker recently prescribed to me. No one can get hold of my claims adjuster or anyone to approve these medications. I have left several messeges [sic] and not once spoken to anyone other than the customer service reps. This is ridiculous I work for Starbucks coffee coorperation [sic] and if they know how Sedgwick treats there [sic] injured partners I highly doubt they would continue to do business with them."*

- www.complaintsboard.com December 16th, 2015. Sedgwick, **Workers comp.** *"Another un [sic] pleased claimant I was physically hurt at work rushed to hospital from work as I was unconscious. So it's def [sic] a workers comp case. I've had nothing but problems with sedwick [sic] and my advisor. I've done every step every paper that needed to be filled out and sent in that was done. I've been out over a month and been fighting since. I call sedwick [sic] everyday since I've been out and I have talked to my advisor 3 times total only when she needs something from me. But when I call it's always voicemail. So I contacted my advisor boss 2 times of her to say well we have not gotten any papers from any doctors showing proof why I'm out. Well that right there is a lie all three doctors that I have seen personally send the papers out the same day so that right there I no [sic] they sent them. That's what's stopping me from getting my check according to them. Also every time I finally get a hold of someone they tell me we will leave an email with your advisor and she will call back. Its not like I purposely got hurt. I'm 22 years old been working since I was 16. No excuse for me to purposely get hurt I got 2 kids that I gotta feed but with this bull it's not happening. I need some type of assurance like what I should do maybe get an attorney or??*

This poses the following questions,

"Is there adequate monitoring of responsibility, answerability and accountability for the actions of P&Cs, Third Party Administrators ("TPAs") and outsourcing parties?"

"While P&Cs have been protected under the Workers' Compensation Exclusive Remedy whereby they cannot be sued, could there be reassessment as to who should be included in the exclusive remedy?"

"With the introduction of the MPN and increased use of outsourcing by P&Cs, could employers insist on LAE costs being excluded from the calculation of the WCIRB advisory rates, with P&Cs' including these costs as an additional overhead in providing the workers' compensation insurance product?"

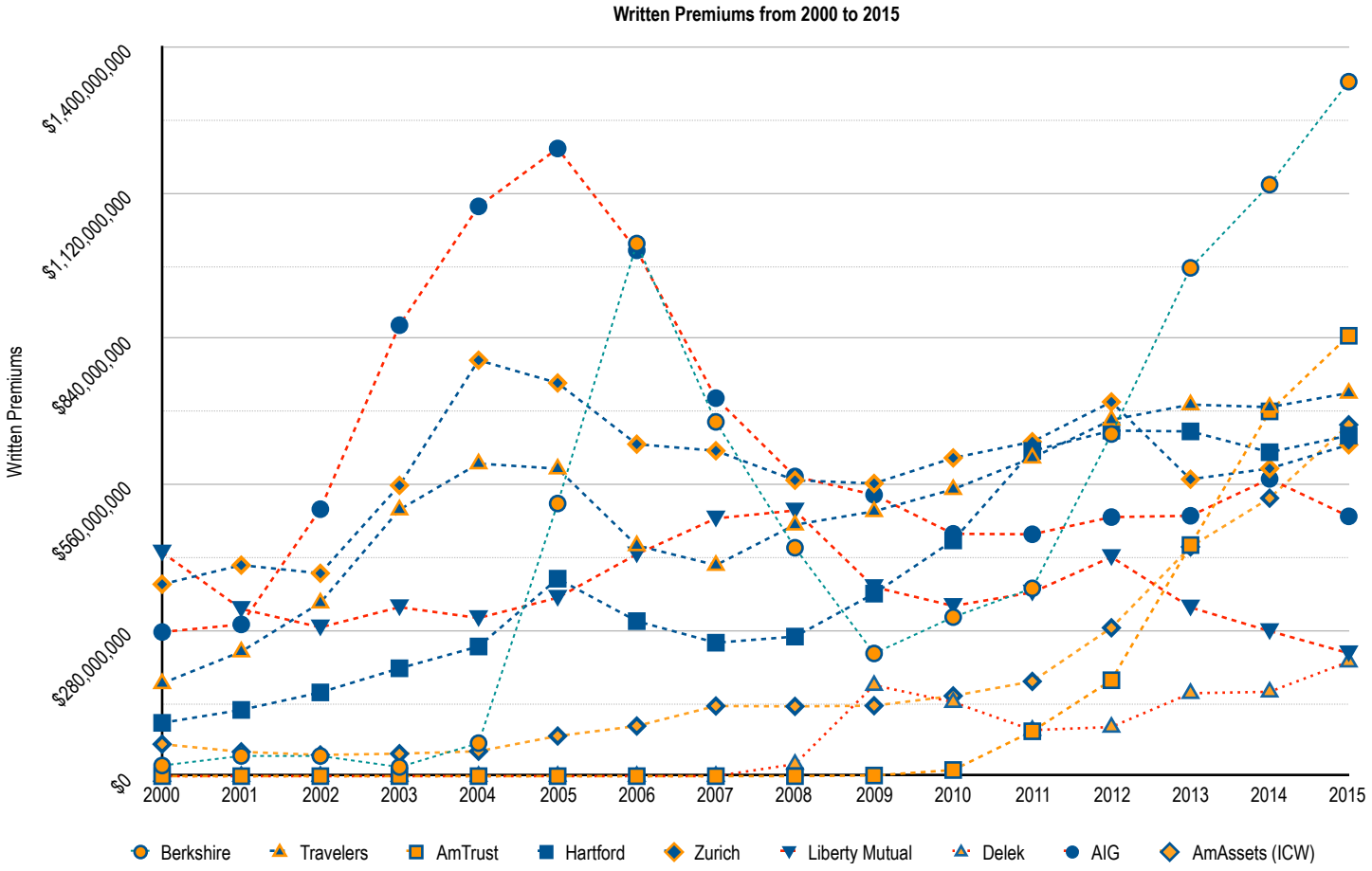
Under the California Minimum Rate Law, premium rates determined by the WCIRB were fully loaded for all expenses including general expenses, commissions, other acquisition expenses and premium taxes. Since the introduction of open rating in 1995 however, the WCIRB has determined advisory rates (i.e. pure premium rates) based on their estimate of future employees' benefits costs as well as costs associated with handling claims and delivering benefits. With the introduction of MPNs and the variability in how P&Cs handle claims and deliver benefits including outsourcing claim functions, it has become impracticable for the WCIRB to estimate these costs. Employers could insist the WCIRB's advisory rate be solely based on their estimates for future employee benefits costs, which for 2014 totaled $8.96 billion of the total $16.9 billion (i.e. 53% of the total P&C Workers' Compensation Insurance product). Assuming costs associated with claims handling and delivery of benefits were no longer included in the employees' benefits and with P&Cs' continuing to outsource the most important activities associated with medical benefits, suggests a revision into who, apart from the employer, should have protection under the Workers' Compensation Exclusive Remedy.

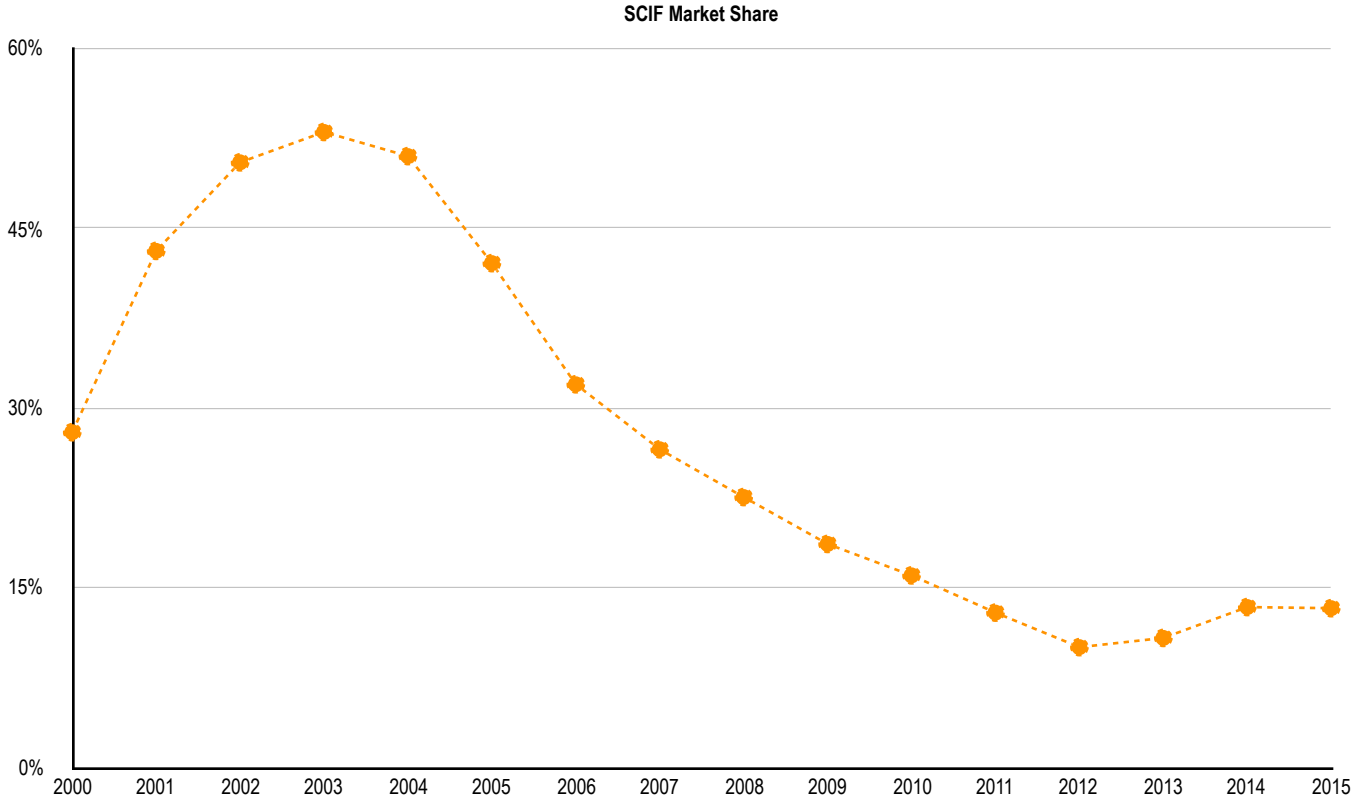
Infrastructure

The P&Cs' claims operations infrastructure consists of resources, procedures (i.e. processes) and operational tools. While resourcing is indisputably the most important, the technology solution i.e. **the claims management software ("software")** - part of operational tools, plays a critical role in bringing together and delivering the services promised by the P&C in the most effective and efficient manner and at the lowest cost.

Some P&Cs have decided to extend outsourcing in delivering their services, significantly reducing infrastructure and referring to the practice as "forming partnerships". This is not unique to the P&Cs' workers' compensation product, applying equally to all their insurance products. With workers' compensation however, being both administrative and data intensive, outsourcing can provide a certain attraction for P&Cs wishing to enter the market with minimal start-up costs and exiting

with little or no impact on infrastructure. It also allows P&Cs to increase or decrease their market share without impacting on infrastructure.





This practice can also be attractive to multinational conglomerates such as Berkshire Hathaway and possibly holding and management companies such as the Delek Group who may use premiums collected for other business ventures until required to pay claims[64]. Also, some of these organizations are more likely to enter and leave the market at short notice compared to companies such as Liberty Mutual, Travelers, Hartford and Zurich whose market share may fluctuate from year to year, but are more likely to remain in the market. The Delek Group for example, underwrote $23 million of California workers' compensation insurance when they first entered the market in 2008, increasing to $174 million in 2009, then to $220 million in 2015. They sold Republic Underwriters Insurance Company and Southern Insurance Company[65] to AmTrust Financial Services in September 2015 for $233 million and are no longer offering their California workers' compensation insurance product.

While outsourcing for some P&Cs may be an extremely attractive option, it appears to **have been the major cause for the very significant and disproportionally high LAE costs in 2014,** as well as possibly delivering less than desirable outcomes for some employees. In addition, it has most likely been **responsible for inflated premiums** for the P&Cs' workers' compensation insurance product, which by law, the majority of employers must purchase.

A recent article[66] stated 75% to 85% of employees had less than one week absence following a work-related incident, 80% to 90% had up to four weeks and 85% to 95% had up to six weeks absence. This suggests up to 85% of claims can be handled mostly through fully automated processes, leaving the balance of between 15% to 25% requiring some level of human effort in management of the claim. In order to address the majority of claims, P&Cs' should **focus on their software, as an alternative to the costly outsourcing approach.**

Both in general terms and in specifically dealing with a claim for workers' compensation benefits, all insurance is based on forms - forms needed to report a claim, to request pre-authorization of medical services (i.e. RFAs), to request an IMR and so on. Forms also mean that the data is structured, which enables the software to easily determine validity and accuracy.

By adapting some of the e-commerce principles associated with collecting and managing data, P&Cs are able to complete what are currently very costly processes, at no cost (i.e. free). Furthermore, errors are eliminated making data more reliable and accurate also removing inefficiencies and waste. In California for example, P&Cs can receive a minimum of three claim notification forms[67] for each claim - a form from the employer advising a work-related incident has occurred and that an employee is filing a claim for benefits (5020[68]), a form from each treating clinician advising an employee is being treated for a medical condition caused by a work-related incident (5021[69]) and a form from the employee advising a medical condition has eventuated caused by a work-related incident for which workers' compensation benefits have been requested (DWC1[70]).

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64 Extract from the Berkshire Hathaway 2015 Annual Report, " *Insurance float – money we temporarily hold in our insurance operations that does not belong to us – funds $66 billion of our investments. This float is "free" as long as insurance underwriting breaks even, meaning that the premiums we receive equal the losses and expenses we incur."*

Extract from the Berkshire Hathaway 2014 Annual Report, "*The nature of our insurance contracts is such that we can never be subject to immediate demands for sums that are large compared to our cash resources. This strength is a key pillar in Berkshire's economic fortress. If our premiums exceed the total of our expenses and eventual losses, we register an underwriting profit that adds to the investment income our float produces. When such a profit is earned, we enjoy the use of free money – and, better yet, get paid for holding it."*

65 Southern Insurance Co was acquired by Republic Insurance Holdings, LLC on September 16, 2015 and was included in the sale of Republic Insurance Holdings to AmTrust Financial Services.

66 Sedgwick Institute, Dr. Richard A. Victor, Are Workers' Comp Systems Broken?, July 2016, insurancethoughtleadership.com Return to Work percentages quoted from WCRI Compscope Benchmarks, 15th edition: The Databook (April 2015) Table 2.12. Data for claims with 2013 injuries valued in 2014.

67 First Report of Injury "FROI".

68 DLSR5020, Employer's Report of Occupational Injury or Illness.

69 5021, Doctor's First Report of Occupational Injury or Illness.

70 DWC1, Workers' Compensation Claim Form & Notice of Potential Eligibility.

Traditionally, these forms are either mailed, faxed or in more recent times completed in a PDF format[71] then emailed to the P&C. Once received they are scanned and/or filed in either a paper or electronic claim file, then manually established by an examiner/adjuster, nurse or their assistants using the P&Cs' software. This process is inefficient and costly for many reasons including missing information and illegible writing on the form.

Since the 1990s, some P&Cs have chosen to establish call-centers where employers can provide details over the phone with P&Cs posting, faxing or emailing them a copy of the completed form. The call center approach takes far too much time to enter information, especially if the employer isn't able to provide all necessary details during the conversation. While traditional practices of phoning in a claim, manually completing a form and mailing, faxing or emailing may still be needed to support some employers' FROI reporting requirements, reliance on these should be minimal. The employer, clinicians and employee should instead have direct[72] access to enter FROI details using the P&C's software. This immediately validates all data as it is entered, automatically establishing a claim without any manual assistance by the P&C. In addition, to determine whether an incident is work related (i.e. AOE/COE[73]), the software should provide the employer and employee with a series of questions and based on their answers, either accepts the claim or delays a decision until it is investigated. The software should also automatically select data based on the most appropriate notification source[74], ensuring the most up to date information including contact details are available for the software to send automatically selected correspondence to the employee, clinician and employer. Formal notifications sent in letter form, such as advising of the acceptance of the claim along with benefits' entitlements including any appropriate statutory paragraphs, should be prepared by the software in a style and language matching their demographics. By making their software available for direct entry of FROIs, the **P&Cs receive validated and accurate FROIs, establish a claim, determine AOE/COE and send appropriate correspondence to the employee, employer and medical provider without any human effort or involvement on their part (i.e. free).** Being able to submit mandatory forms at any hour of the day or night, with the ability to update, view or download completed forms in PDF format, provides a much improved service for employers, employees and medical providers.

Placing greater reliance on the E&M report as illustrated earlier, further reduces costs by combining reading of the E&M report with CPT code verification for their services, preparation of the employees' recovery plan and authorization of medical services. Where an employee returns to employment within a week, which may occur in up to 85% of claims, a recovery plan would not be necessary and for those returning within four weeks, a plan may also not be required. The report however, would still need to be read, authorizations established and the clinicians' invoice for E&M approved for payment. Billing for E&M is generally limited to selecting one CPT code from a primary list of ten[75], with one criteria used to select the most appropriate code based on the complexity of the medical conditions and time spent with the employee. For example, E&M CPT code 99202 refers to a new patient's 20 minute visit to a clinicians' office for a low to moderately severe medical condition and code 99214 refers to an established patient's 25 minute visit to a clinicians' office for a moderately severe medical condition.

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71 Portable Document Format (PDF). A universal file format supported by most application software and operating systems.

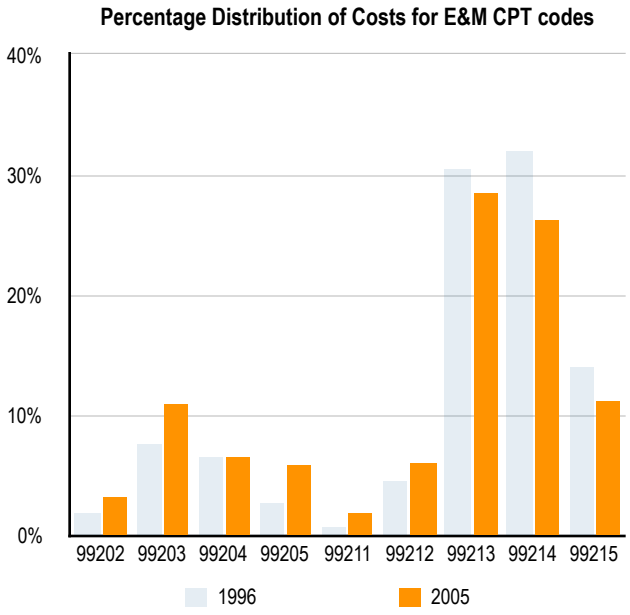
72 Direct entry refers to either entering the details into a screen that is linked to the P&C claims management database or data uploaded from the employers' or physicians' software to the P&Cs' database after validation.

73 "Arising Out of Employment" or it is in the "Course Of Employment".

74 As each form may contain the same data such as employee's name, address, phone details and personal identity details (e.g. social security number), the software based on a data hierarchy determines which source should contain the most accurate and current data.

75 E&M CPT code 99201, New patient, 10 minutes visit to a clinicians' office for a low to moderately severe medical condition amounted to $331,000 in 2005. No amount was available for 1996 and as a result, was excluded from the chart. Data for 1996 was obtained from the CWCI report dated October 16, 1997, No 97-19. Data for 2005 was obtained from the CWCI report titled "California Workers' Compensation Medical Payment Study: Medicare Reimbursement Models for Evaluation and Management Services.", January 24, 2007.

The chart shows the vast majority of E&M services were limited to the codes 99213 and 99214 in both 1996 and 2005[76]. To verify whether the clinician has invoiced their E&M services using the correct CPT code requires that the E&M report be read only by the most appropriate resource and using the P&Cs software, a précis of the report is prepared for others to use, along with the establishment of authorizations for benefits including any remaining medical services. While questions answered by the employer and employee at time of FROI provide an opportunity to determine whether the reported work-related incident meets the AOE/COE criteria, it is only by reading the E&M report that each medical condition can be assessed to determine whether each meets the AOE/COE criteria and benefits' entitlements. Assigning the most appropriate resource to read the report can potentially reduce the frequency and cost of Medical-Legal Evaluations which totaled $462 million (or 3% of the total insurance product cost) in 2014.



Instead of submitting paper invoices, clinicians have been strongly encouraged to submit billings for medical services electronically, which can be cumbersome, prone to errors and costly for the clinician and P&C, **especially if they both need to outsource the service**. A company providing full electronic service to clinicians is DaisyBill (www.daisybill.com). According to a study of medical billing practices[77], a claim on average receives one medical bill per month, which can contain 4 billing items (i.e. encounter data). With the majority of these bills relating to E&Ms, P&Cs should consider offering clinicians direct entry for medical services using their own software as an alternative to outsourcing to organizations such as Daisybill. The P&Cs' software should both instantly and automatically approve payment of medical services after the E&M report has been read and deemed to meet the CMS guidelines and deposit funds directly into the provider's specified accounts. Providing this service immediately eliminates the opportunity for clinicians to bill for a service already paid for or overcharge for services, two methods often used by providers to commit fraud. Again, apart from providing their software, the P&C has encounter data entered free, which is accurate and entered in a timely manner. To take further advantage of this function, providing employees access to an inquiry screen displaying their provided medical services (i.e. encounter data) including all supplies as well as pharmaceuticals prescribed and quantities dispensed, automatically provides transparency and a means to detect fraud associated with billing for services not provided. Again, apart from providing the software, fraud detection efforts here are free. The greater transparency of selective encounter data made available to the employee, providers and employer, the less opportunity there is to commit opportunistic or professional fraud.

The California Department of Industrial Relations provides an electronic file containing current Medi-Cal prices for pharmaceuticals which can be loaded into the P&Cs' software. With the P&C's software capturing all medical encounter data including pharmaceuticals' NDCs, overpayment for pharmaceuticals as illustrated with the cyclobenzaprine tablet is eliminated. This also removes the need for the service provided by Healthcare Solutions relating to fentanyl and MS Contin mentioned earlier. For physicians or pharmacies dispensing medications, a similar screen entry feature described previously could automatically perform the approval process, calculate the correct amount for medications as well as deposit funds directly into the physicians or pharmacies specified accounts. For processing pharmaceuticals through a PBM arrangement,

[76] Later data on E&M was not available from either the CWCI or the WCIRB, however, in all probability these two codes would continue to account for the vast majority of E&M services invoiced by clinicians.

[77] California Department of Insurance, Workers' Compensation, Medical Payment Accuracy Study, June 17, 2008, Navigant Consulting.

P&Cs' software could process pharmaceutical details supplied in a file format paying either the MediCal price (i.e. preferably the lowest price recorded in the MediCal formulary for a specific generic medication) or a lower agreed price with the PBM. Pharmaceuticals, medical supplies and equipment combined accounted for 13.7% of medical costs in 2014. Providing the automated services described above, would have potentially reduced MCCP costs and estimated missed fraud by $140 million. Combining savings from MCCP costs and missed fraud with savings from an outcome-oriented methodology for handling E&Ms as outlined earlier, has the potential to reduce MCCP and estimated missed fraud costs by 29% or $299 million. This is all achieved at no cost to the P&C (i.e. free of charge) by providing employers, providers and employees with direct input using the P&Cs' software.

Capturing encounter data is essential to reducing the opportunity for professional fraud - cases such as Pacific Hospital involving $500 million in fraud and Tri-City Regional Medical Center would not have occurred if the encounter data had been captured by the P&Cs' software. Overpayment for cyclobenzaprine and cases similar to Janak M. Mehtani where there were 128 patient visits for three patients before a complaint was lodged with the California Medical Board would also not have occurred.

P&Cs' software that captures all medical encounter data and provides standard accounting debit, credit and journal functions for each and every billing item listed in an invoice, allows the online transaction processing database ("OLTP") to be used as both evidence-based practice and practice-based evidence databases. Transaction data pertaining to employees' medical conditions and demographics and the clinicians' demographics combines the best available research, clinical expertise and patient values, which again is collected free when the P&C allows their software to be used by employers, employees and providers. Using this data combination provides the ability to automatically monitor a claim against others with similar characteristics ensuring at a minimum, it is adhering to the best practices of earlier claims. The OLTP can also serve many claims management processes including authorization of medical services, determining the length of time the employee is likely to be absent from employment, the level of indemnity benefits that may need to be provided as well as identifying the combination of providers and specialties consistently providing the best overall outcomes for similar claims. It is worth restating that each claim is a one-person clinical trial and by looking for commonalities across claims, P&Cs can draw inferences from effectiveness of medical services in certain employee demographics, which forms an important part of evidence-based medicine. This approach also overcomes the limitations of only using evidence based on RCTs as described for OxyContin and only relying on the MTUS as described in IMR case CM16-0056548 relating to aquatic therapy and a nutritionist. Using this data also allows a P&C to establish prior authorizations which in turn may significantly reduce the frequency providers are submitting RFAs including reducing the frequency for IMRs, which added between $47 million and $70 million to LAE costs in 2014. Another important deliverable from this approach is the ability to measure both the clinician's progress as well as the P&C's management of a claim. This is accomplished by clearly defining what needs to be achieved in the employee's recovery plan by establishing timelines, durations and resources and monitoring that goal concretely. Using this plan, the quality of a clinician can be measured to some degree by the progress made in an employee's medical condition and the P&C measured by the management of medical care co-ordination, with the overall claim's performance measured by its outcome and costs.

While certain software vendors suggest the need for specific statistical tools and separate silos to create an evidence-based practice or a practice-based evidence database, it is really unnecessary. Most database software products provide all the necessary tools and features required, such as Oracle's In-Memory feature which may assist in transaction data being readily used for analytics. In addition, in capturing all encounter data, claims and general accounting audits associated with payments are simplified and provide full compliance with the Sarbanes/Oxley Act of 2002, ultimately reducing P&Cs' overhead costs in providing their workers' compensation insurance product.

While the above initiatives will undoubtedly simplify and speed up administrative processes and management of a claim with much reduced costs compared to current practices, the 10% to 20% of claims exceeding four weeks of absence, will require

a more concentrated effort involving a "team" approach in reducing the probability of not returning to employment. Assuming up to 800,000 claims are reported in California each year, the overall percentage requiring a team approach which in perspective may appear small, is actually between 80,000 and 160,000 employees. If a P&C has poor infrastructure, these employees may never return to employment forcing them and their families to end up in public programs.

Moving to a team approach in managing a claim can also result in a less adversarial relationship, through the team developing empathy for the employee. This is less likely to occur with a single adjuster/examiner and/or nurse managing a claim as illustrated with claims handled by Sedgwick CMS, which appeared very adversarial. Equally the appointment of ineffective or inappropriate resources to a team will result in similar experiences to those reported for Sedgwick CMS services. The challenges then are to find and mobilize the right resources along with timely communication between the P&C resources, employee, employer and other interested parties. Meeting these challenges is crucial as with each delay there is less opportunity for the employee to return to the workforce as well as their claim's costs increasing unnecessarily.

The term "leakage" has been used by P&Cs in recent years to describe a situation where costs should not have been incurred. Examples include correspondence sent to the wrong address causing delays in providing an employee's benefits resulting in monetary penalties for the P&C, careless review and denial of RFAs, previously illustrated, where a request for an MRI resulted in unnecessarily adding a minimum of $515 to LAE costs with 23 days of additional temporary disability benefits being paid and bill review overpayments for services, most likely caused by using unsuitable resources for the bill review function. Although P&Cs prefer to call these leakages, they are in fact inefficiencies which add to the price charged for the P&C's workers' compensation insurance product.

The ideal framework to manage all P&Cs' internal and external resources including timely communication, is based on a hybrid model which combines features from the disciplines of both Customer Relationship Management ("CRM") and Supplier Relationship Management ("SRM"). Through this framework, every individual is screened and their demographics captured including personal identifications, for example, social security number, driver's license as well as education/qualifications, age, race, occupation/profession, ethnic and cultural preferences. Entities such as service provider organizations and individuals they are associated with, are equally captured with all their service offerings including prices for services, payment terms and preferred method of payment, including identification details such as National Provider Identifier ("NPI") and Employer Identification Number ("EIN"). In the case of Mitchell Cohen for example, the framework is able to identify his affiliation with Pacific Hospital, Tri-City Regional Medical Center and the four others.

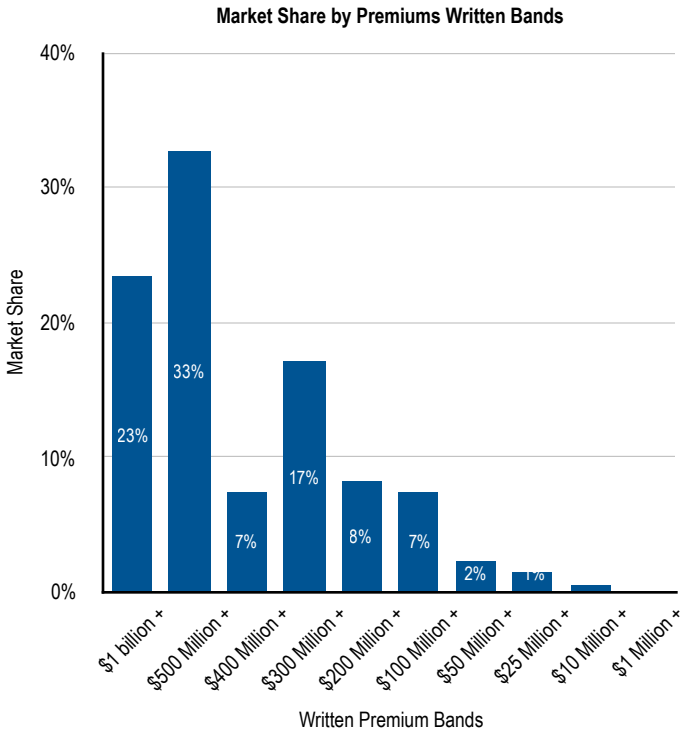
While P&Cs can easily identify the likelihood of a fraudster by counting the number of times they have used "oops" as an excuse for such actions as overcharging for a service, resubmitting services previously paid or requesting payment for services not provided before discontinuing with their services, the opportunity to identify a likely fraudster associated with receiving kickbacks is much harder. A kickback payment may be received for instance, when a clinician recommends medical equipment or refers an employee to a specialist or facility such as a hospital. Without the use of the hybrid CRM/SRM framework and its link feature, it is very difficult for a P&C to distinguish between a medical practitioner's financial interests and the best interests of the employee. The link feature can readily identify the possible presence of fraud rings such as those uncovered by the FBI's "Operation Backlash" and the kickbacks paid by Pacific Hospital and Tri-City Regional Medical Center. Again, all this is delivered "free" from within the P&C software relying only on their OLTP database. This multidimensional model transforms the way P&Cs may be currently attempting to identify fraud and fraud rings using separate process-intensive applications with their own data silos, to using just a few keystrokes on a screen to access their OLTP database.

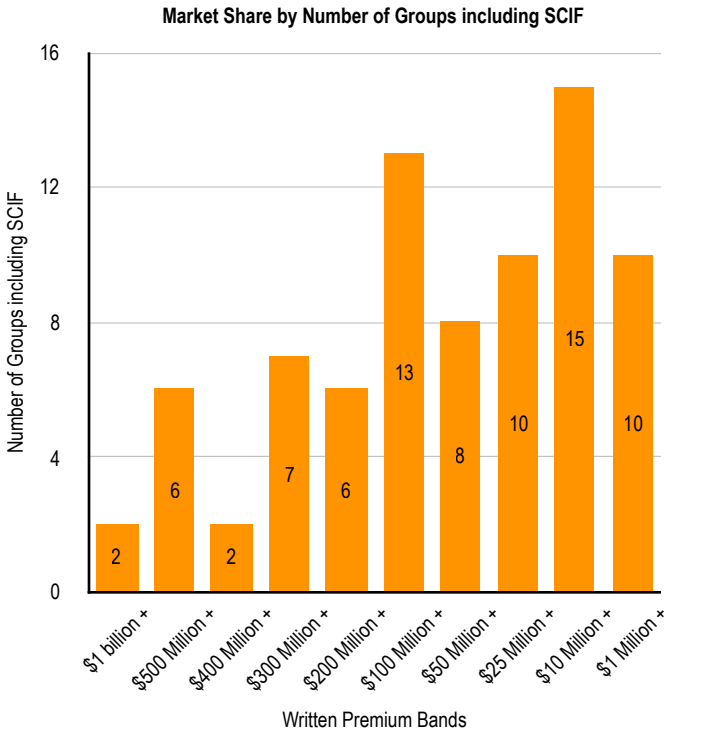
Plummeting prices for electronics and signifiant reductions in telecommunication prices for wireless internet in recent years, has witnessed the emergence of a highly digitally empowered community. This trend has allowed P&Cs to rethink their entire infrastructure, especially with the utilization of technology to improve efficiencies and decrease their claims' costs.

Some ways claims' costs can be decreased have already been illustrated. In addition, providing access to a P&C's software from almost anywhere, the ability to send and receive correspondence in PDF format and the ability to make a video call, enables a "bespoke" team to be established to handle a specific employee's claim's needs. This team can be made up of internal resources from multiple offices spread across different states or even countries. Using the hybrid model for managing resources, equally allows the inclusion of individuals with a specialty outside the P&C on an "as needed" basis. This mobile workforce is achieved without compromising the team's ability to collaborate in addressing the needs of the employee and reduces internal resources and premises costs, all possible due to the use of the P&Cs' software and advancements in technology.

With claims management comprising multifarious, interdependent processes and activities, the signifiant advantages for P&Cs using their own holistic stand-alone software for end-to-end claims management compared to outsourcing include (1) specialty resources are used on an "as required" basis instead of being actively involved in every claim and (2) the P&C manages the external resources as opposed to handing management and control of an activity over to other organizations. For example, based on an employee's medical complexities, a P&C may appoint a consulting clinician based on their qualifications and experience to act as a facilitator in jointly deciding with the treating clinician the most appropriate medical services, reducing the need for an IMR. A pharmacist may be assigned on an "as required" basis to review an employee's medication schedule or the active or inactive (i.e. excipient) ingredients proposed in a compound medication. A specialty inquiry agency, investigator or private detective may be assigned to provide investigatory services when opportunistic or professional fraud is suspected. More than likely these professionals are not employees of the P&C with their expertise only called upon when required as facilitators. With the OLTP database acting as an electronic claim file, the treating clinician, primary claim representative for the P&C and facilitator all have access to the same level of information to discuss and resolve any disputes, again reducing the need for an IMR or other legal interventions. Within all insurance products, a P&C's claim's handling is gauged by whether their actions have adhered to the insurance principle of utmost good faith and regarded as the moment of truth. The approach outlined above ensures a P&C adheres to this principle.

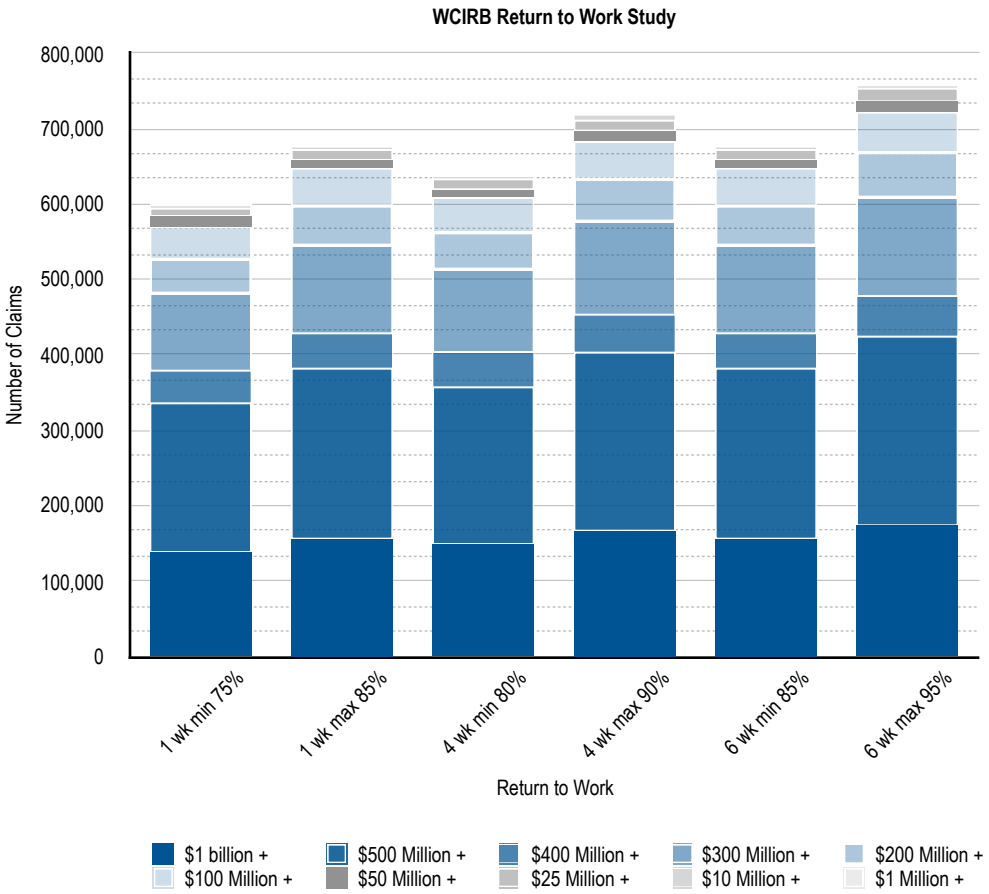
In addition to SCIF, there were 78 P&C groups offering a workers' compensation insurance product in 2014. As shown in the chart, seven groups plus SCIF had 56% of the market while another 28 groups held 39% of the market, giving a total of 95% controlled by 35 P&C groups plus SCIF. The balance of 5% was underwritten by 43 P&C groups.





Fluctuations in premium market share shown previously in the graph entitled **"Written Premiums from 2000 to 2015"** **(page 39)**, illustrate the volatility in distribution of market share from year to year. The graph highlighted Liberty Mutual's continuing trend to reduce written premiums since 2012. The Berkshire Hathaway spike in market share in 2006 was followed by a decline through 2009 then a further spike which continued through 2015. AmTrust NGH, which commenced in 1998 continues to increase its market share and with the purchase of two companies from the Delek Group, will likely see it underwriting $1 billion of the P&C California workers' compensation insurance product in 2016. There has also been a spike since 2009 in the American Assets Group market share where it reached similar share to traditional P&Cs such as Hartford, Zurich and AIG in 2014. In general terms, when one thinks of competition in the market place, visions of innovation involving new technologies and strategies, along with lower prices for a product all benefiting the customer come to mind. Is this the case with the P&C workers' compensation insurance product?

The stacked bar graph shows a representation of the number of employees who returned to work based on percentages mentioned previously of 1, 4 and 6 week periods following a workplace incident. The graph is based on the WCIRB's estimate of up to 800,000 claims a year reported in California. Without specific claims counts available by insurer groups or written premium bands, the hypothesis for distributing claim counts was based on market share[78]. Assuming there are up to 800,000 new claims each year, the graph shows around 600,000 to 680,000 employees returning to employment within a week across all bands. The impact on these claims if a P&C decides to reduce their market share or exit the market is insignificant. For the remainder of the claims however, their decision can effect both the employee and the employer. For example, a P&C may choose to use settlements to close claims prematurely, which as illustrated accounted for 10% of P&Cs' product costs in 2014 (i.e. $1.7 billion), and may impact on the price of a policy in the subsequent year, albeit those specific P&Cs may no longer be offering a product.



With legislations enacted in the early 2000s such as allowing P&Cs to select clinicians for their MPNs, which ideally should have resulted in collaborative relationships between treating clinicians and P&Cs, through to the most recent where an arbitrator from Maximus Federal Services is able to resolve disputes, it seems the more things change the more they stay the same. The P&Cs' Workers' Compensation insurance product continues to provide a poor choice of clinicians, delays in providing medical treatment and continued fraud, all resulting in poor return to work outcomes and still remains far too expensive for what it promises to deliver.

[78] With SCIF and Berkshire Hathaway in the $1 billion band accounting for 23% market share, 184,000 of the 800,000 claims were assigned to this band.

While some have cried "wolf" regarding the high cost of medical conditions such as carpal tunnel syndrome, similar conditions caused by repetitive strain have existed for over a 100 years for example Twisters' Cramp caused by twisting yarn and Telegraphists' Cramp due to the use of telegraphic equipment. This cry has also been made in reference to the excessive use of opiates and opioids, physician dispensing, compound medications, lack of a pharmacy formulary and the P&Cs' workers' compensation insurance product being subject to high levels of regulatory controls, all contributing to poor outcomes and high policy prices. In no uncertain terms with marijuana products becoming available on the legal market and the recently reported abuse of seizure medications such as gabapentin being taken with an opioid, or opioids with muscle relaxants or anxiety medications, the "wolf" cry will undoubtedly continue.

What has been **overlooked in this assessment however, is the inefficiency in the P&Cs' claims management practices**, especially in their handling of claims data and how it is used in the management of claims. The California Department of Insurance study in June 2008 conducted by Navigant Consulting titled, "Workers' Compensation, Medical Payment Accuracy Study" glaringly exposed the shortfalls of how P&Cs collect, manage and use their claims data. It stated that from 761 medical bills selected, only 97 (or 13%) could be verified for accuracy, mainly due to the lack of supporting documentation and data. This questions the processes P&Cs used when they first paid the bills. A study conducted by the WCRI in September 2013 titled "The Prevalence and Costs of Physician-Dispensed Drugs" also criticized the quality of data provided by P&Cs where NDC codes for medications and quantities dispensed were missing, which begs the question, how did the P&C determine the amount to be paid for these medications as well as monitor the types of medications the employee was prescribed? And more recently, the CWCI study conducted in December 2015, titled "Medical Review and Medical Dispute Resolution in California Workers' Compensation System", made the following comment, *"There was an abundant volume of data for each segment, but due to confidentiality requirements as well as different data capture standards across data sources (individual payor, independent UR vendors and IMR), it was not possible to link each medical service record across the continuum of medical bill review to utilization review to independent medical review."*

This suggests there has been very little or no improvement in how some P&Cs collected and utilized data in managing claims through their software over an eight year period, with the CWCI stating that attempts to correlate or unify data from the different outsourced vendors own silos was not possible.

When considering the hype and fads in commercial technology beginning with the "dot com" boom and collapse in the late 1990s and the confusion in understanding the difference between the internet and browser requirements to access specific data formats over the internet, through to the more recent terms such as "big data" and "cloud computing", these factors may explain why some P&Cs are unsure whether to outsource or use their own software. **The only sure way however to reduce the cost of their workers' compensation insurance product, especially costs associated with LAE is through their software.** P&Cs wishing to choose a software approach need to roll through the fads and focus on technology solutions that address the challenges caused by the multifarious and interdependent nature of claims management, but most of all, focus on restoring the employee to self-reliance at the lowest cost, which will result in lower premiums for the employer.

The principles of insurance are based on utmost good faith, which requires all parties involved in an insurance contract (i.e. the policy) to exercise these principles in all their dealings. With workers' compensation being a "no fault" system, there are no expressed obligations of "utmost good faith" or even "good faith" in workers' compensation statutes or regulations. However, although good faith may not be mentioned, this requirement is a product of common law whereby all parties to a contract owe a duty of good faith and fair dealings. Under common law, if a party fails to act in good faith or fair dealings, the other party may sue based on some statute or general societal expectation. **Have P&Cs observed utmost good faith or good faith and fair dealings by delivering services promised in the most effective and efficient manner at the lowest premiums for their California workers' compensation insurance product?** Generally, in an insurance contract, **if a party fails to observe the principle of utmost good faith, the contract can be voided by the other party.**

COMPETITORS TO THE P&Cs' PRODUCT

Some insurance historians have stated that the first P&C Workers' Compensation Insurance product was offered in England in 1906 with the enactment of the Workmans' Compensation Act, which followed the passing of the Employers' Liability Act of 1880. The Act of 1906 extended workers' compensation coverage to employees of private households, such as indoor domestic servants, chauffeurs and gardeners. As property insurance at that time was offered by Fire insurers (known as P&Cs today), they were forced to provide coverage for these employees. Prior to this, employers secured protection against exposure to workers' compensation benefits through a Friendly Society.

Apart from the state of Texas, all employers must provide statutory benefits to employees who experience work-related injuries or illnesses. This equally applies to most countries around the world regardless of their level of social benefits such as universal health coverage. To protect employers against severe financial exposure due to the paying of benefits and ensure employees receive benefits, an employer by law, must purchase a workers' compensation insurance policy from a P&C. Some employers are exempt from this requirement and are allowed to self-insure when they are able to demonstrate they have sufficient funds to cover the costs of the benefits.

To control premiums charged by a P&C, some employers with very few claims choose to use a captive or specialty insurer that generally provides coverage for a specific profession or industry. The Pharmacists Mutual Group (www.phmic.com) and Dentists Insurance Company (www.cda.org) for example are included in P&Cs with 5% of the California market. Other employers may choose to share the risk with a P&C through either a deductible program or a Retrospective (Retro) Rating Plan.

With Oklahoma recently enacting the Opt-Out statute and the proposed opt-out legislations for South Carolina and Tennessee all claiming to provide similar benefits, exclusivity of the traditional P&C insurance product is being threatened. However, as shown, the core issue is not about cost of benefits, but about the P&Cs' administration costs to provide their policy to employers (i.e. product and service) which accounted for 47 cents of each $1 of premium paid by the employer in 2014, totaling $7.9 billion. There has been no discussion or evidence put forward as to how opt-out reduces administrative costs in comparison to the P&Cs' product.

Regardless of the method used to distribute administrative costs associated with claims, the cost is far too excessive as shown below[79]:

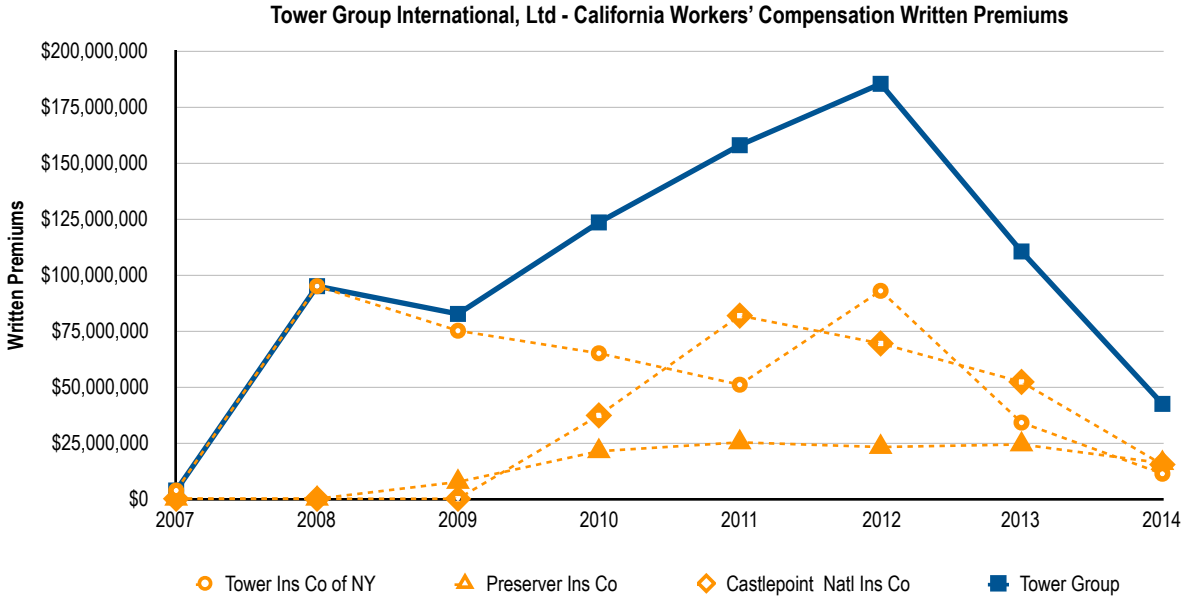
- Evenly allocating the $5.1 billion over 800,000 claims computes to $6,375 per claim for management and delivery of benefits. Taking into consideration that up to 680,000 claims are likely to be closed within a week, the cost of $6,375 far exceeds the costs of an employee's benefits for this period. Less than $1,000 would have been paid for temporary disability based on the maximum 2014 TD rate and the TD waiting period. Less than $2,000 would have been paid in the majority of these claims for medical services including E&Ms and medications.

- Allocating the $5.1 billion to each claim based on the duration the employee is absent from work, computes to a claims management and handling cost of $31,000 for each of the 120,000 claims with over one week absence and a cost of $2,000 each for the remaining 680,000 claims. This calculation assumed a claim count of 680,000 with up to 1 week absence from work with an allocation of 20 hours to manage the claim and deliver benefits by an examiner/adjuster or nurse with an hourly rate of $100, including their overhead costs. This computes to $1.36 billion, leaving a balance of $3.74 billion to manage and deliver benefits to the remaining 120,000 claims, which computes to $31,000 per claim.

[79] The average LAE costs per claim as shown are INDICATIVE ONLY and should be used only as a guide to P&C expenses in administering a claim. This figure can vary from one P&C to another.

The P&Cs' product has two offerings, (1) to transfer or share the employer's risk and (2) to administer the statutory employee's benefits. As stated at the start of this section, prior to P&Cs offering a product, employers obtained protection through a Friendly Society. Today, employers frustrated with the cost of purchasing a P&C policy have prompted some states to offer an alternative i.e. an opt-out product. There are however, **many options besides opt-out** for transferring or sharing a risk and managing and delivering employee benefits. Options which do not reduce benefits to employees but instead target the 47 cents spent by P&Cs on administration.

Ramifications from poorly managed claims in a P&C claims operation caused by deficiencies in their infrastructure can be far reaching. The recent announcement by CDI to put ten insurers from the Tower Group into conservation after its reserve deficiency exceeded $400 million and continued to deteriorate primarily relating to accident years 2008 through 2011, suggests their claims operation's infrastructure was a major contributing cause. Whether an outsourcing strategy was a contributing factor is unknown at this time. In California, three insurers offered the Tower Group's P&C workers' compensation insurance product as shown in the graph below, with insurers sharing infrastructure costs[80]. The impact on future employers' premiums caused by this conservation is unsure, but most likely will cause the WCIRB's advisory pure premium rates to increase, possibly substantially if the remaining open claims have been poorly managed.



As stated earlier, a method commonly used by P&Cs to close claims prematurely is to offer an employee a lump sum settlement payment. If the settlement amount is inadequate for the employee to remain self-reliant for the period they remain unemployed, then the employee and their family will be forced into public programs, which burdens the community at large. With the increased practice of closing claims through settlements, Workers' Compensation as a social insurance goes well beyond a "no fault" agreement between the employer and the employee. The community at large equally has a vested interest in ensuring employees return to employment or are self-reliant and do not become a burden to society. According to U.S. census data, 46.7 million people or 15% of the population live below the poverty line. Also, a recent Harris Poll found that 43% of Americans without jobs have given up looking for employment and that 59% who have been out of the workforce for 2 years or more, have stopped looking for work altogether.

[80] State of New York, Insurance Department, Report on the Examination of the Tower Insurance Company of New York as of December 31, 2009.

If 500,000 employers refuse to purchase a P&C workers' compensation insurance policy citing bad faith in failing to deliver a cost-effective product, lawmakers will be forced to look for **alternatives to provide coverage for workers' compensation social insurance**. The future of P&Cs' exclusively providing an insurance product can no longer be taken for granted especially if their product continues to spend only 53 cents of each $1 of premium in paying employees' benefits. To retain exclusivity, P&Cs will need to be much more conscious of their infrastructure in order to significantly reduce processing costs, especially those relating to claims, **without impacting on employees' employability, benefits or the delivery of those benefits**.

As highlighted throughout, the integration of operational excellence in claims handling achieved through the P&Cs infrastructure with emphasis on its software will create the greatest savings in administration costs. Not only will this integration identify and eliminate waste caused by inefficiencies, it will also align and better utilize the P&C's software to keep the employer and the employee front and center where they belong.

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