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To: The Honorable Members of the House Labor and Industry Committee

From: Samuel R. Marshall

Re: House Bill 1141 – revising provider payment rules in workers compensation

Thank you for this hearing. We don't agree with the bill: We believe it will raise the cost of medical care in workers compensation without improving the quality of that care or access to it.

We do agree that the provisions in the Workers Compensation Act tied to medical care need to be revised, and we appreciate this committee's ongoing interest in that. We were disappointed when you tabled House Bill 1800 in June; that also deals with medical care in workers comp – it establishes treatment guidelines to improve the consistency and quality of care, and it helps address an opioid problem that is uniquely acute in Pennsylvania's workers comp system.

Still, tabling is not rejecting. So we hope this hearing reflects a desire to improve this part of the Workers Compensation Act. While workers comp rates are flat, suggested reforms shouldn't be dismissed as "solutions in search of problems."

The reality is that we – and by that, I mean injured workers, providers, employers, lawyers, insurers, regulators and judges – muddle through medical payment and review rules that are cumbersome without promoting quality care at the best cost to get injured workers better and back to work.

We don't believe the measures in House Bill 1141 address that muddle. The core of the bill makes workers comp networks harder to establish, and makes it harder for those networks to pay providers less than the fee schedule established

in the Workers Compensation Act. This isn't a new complaint from some in the provider community; it goes back over 20 years. I'll offer some perspective and history.

- Insurers and employers have long used networks to provide the physician panels allowed in the Workers Compensation Act. These networks generally have payment schedules lower than the statutory fee schedule. And these networks may be established for more than just workers compensation: A provider in a given network may be taking on, and gaining access to, patients from health insurance plans as well as workers compensation plans.

- There is nothing hidden or secretive about these networks and their payment schedules. Providers aren't unwittingly being forced to treat injured workers at unreasonably low rates: These networks and their fee schedules have been commonplace for over two decades; we estimate they cover just over half of workers comp medical treatments. And we're not hearing complaints from injured workers about the quality or accessibility of care these networks provide.

- It seems that providers' real gripe is not with networks, but that the networks' pay schedules are less than the fee schedule in the Workers Compensation Act. While a provider may be willing to accept that network pay schedule for other patients and other lines of insurance, the provider doesn't want to accept it in workers compensation.

We all wish we could "pick and chose" what we do and what we get paid. Life doesn't work that way, not even for providers. When you join a network, you don't automatically get to join just for certain types of patients – you can try, and that's what negotiations are about. It seems providers don't like the results (or more accurately, the pay schedules) of their negotiations with the networks they have joined, and they want some statutory help.

I know that feeling. But I don't think it merits legislative intervention. We've had networks, and we've had network rates lower than the statutory fee schedule, for over two decades in workers compensation. Nothing suggests that has hurt the quality or availability of care to injured workers.

Taking a step back, what you are seeing is a need to take another look at the fee schedule in the Workers Compensation Act. We don't like it; the providers obviously do.

The question for both sides is why?

Again, some history:

- In the early 1990s, the cost of workers comp was spiraling. Governor Casey led a bipartisan reform that culminated in Act 44 of 1993 and a medical fee schedule pegged to 113% of Medicare. This was taken from the 1990 reform of our auto law, which implemented a fee schedule at 110% of Medicare.

- The workers comp law came with a last-minute twist: It "froze" the Medicare fee schedule as of year-end 1994, with future increases set by the statewide average weekly wage. By decree of the Department, that is done annually on a compound basis. At the time, the fear was that Medicare would become inadequate in compensating providers.

- Twenty-two years later, the problem is that 1994 Medicare has become obsolete everywhere but here. Fee schedules are common-place in health insurance, and Medicare is the keystone in setting their payment levels. But nowhere else in the country is 1994 Medicare used; only in Pennsylvania workers comp has time stood inexplicably still in 1994.

- Over time, two things have emerged with this fee schedule: First, dealing with it is increasingly illogical, as we have procedures and facilities that weren't even around in 1994. Second, and most relevant for today, it is incredibly generous to many providers: For many of them, especially orthopods, it pays 200% or more of current Medicare.

- That's much higher than anywhere else: Medicare, obviously, but also auto (which remains at 110% of Medicare without provider complaint) and regular health insurance, which is generally around Medicare rates – and much higher than the state pays under Medicaid. And figuring it out is an administrative nightmare, as being an expert in 1994 Medicare is hardly a growth industry.

If you want to make the workers compensation fee schedule a floor, not a ceiling – that's the practical and intended impact of this bill – you should first examine whether that fee schedule makes sense. The one in the Workers Compensation Act doesn't: It is based on an outdated version of Medicare, and it results in payment levels that have no rational relation to what is generally paid to and accepted by providers for the type of medical treatment they provide to injured workers.

In that spirit, we'll offer a compromise: Make the statutory fee schedule a floor, but bring it in line with what providers are being paid everywhere else. **End the increasingly indefensible and inexplicable 1994 freeze and amend the Act to go with 113% of current Medicare.**

That will bring logic, fairness and administrative simplicity to medical payments in workers compensation. It may also obviate the need for some other objectives in this bill which merit mention:

- Quick annual updates of the statewide average weekly wage: That problem goes away if we use current rather than 1994 Medicare as the payment base. We've gone through this with the providers in years past – the real problem is that some years, the Bureau wasn't timely in letting insurers know the statewide average weekly wage increase.

- Electronic billings: We all want increased automation; some of the problem is that not all providers submit bills this way. We don't have this problem in other lines of insurance, though, so it may be something more tied to workers comp being tethered to an obsolete fee schedule.

We'll close by emphasizing that whatever our objections to this bill, we hope you delve deeper into the medical side of the Workers Compensation Act. This bill is focused on ensuring adequate payment to providers, and that's a legitimate goal: While we think the networks they've joined do that, we urge you to revisit the underlying fee schedule and get it consistent with current Medicare rates.

We also urge you to focus on the quality of care given to injured workers as well as how much is paid for that care. That's what HB 1800 is about, with treatment guidelines to ensure that providers meet the highest standards of their professions, and with high standards for the entities and judges engaged in the utilization review of medical treatment.

That's a three-pronged objective -- fair payment levels, high standards for treatment, and high standards for utilization review. It is a worthy objective, and we hope you take it up.