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HOUSE OF REPRESENTATIVES

LABOR AND INDUSTRY COMMITTEE
PUBLIC HEARING

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THURSDAY, MARCH 17, 2016
9:05 A.M.

PRESENTATION ON HB 1800 (MACKENZIE)
WORKERS' COMPENSATION
TREATMENT GUIDELINES

BEFORE:
HONORABLE MAUREE GINGRICH, MAJORITY CHAIRMAN
HONORABLE STEPHEN BLOOM
HONORABLE SHERYL DELOZIER
HONORABLE CRIS DUSH
HONORABLE MARK GILLEN
HONORABLE RICH IRVIN
HONORABLE RYAN MACKENZIE
HONORABLE DAVID MALONEY
HONORABLE STEVEN MENTZER
HONORABLE JESSE TOPPER
HONORABLE DAN TRUITT
HONORABLE JUDITH WARD
HONORABLE JOHN GALLOWAY, DEMOCRATIC CHAIRMAN
HONORABLE MARIA DONATUCCI
HONORABLE FRANK FARINA
HONORABLE MARC GERGELY
HONORABLE BRANDON NEUMAN
HONORABLE PAMELA SNYDER

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania

COMMITTEE STAFF PRESENT:

NOAH KARN
MAJORITY EXECUTIVE DIRECTOR

VICKI DiLEO
DEMOCRATIC EXECUTIVE DIRECTOR

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MAJORITY CHAIR GINGRICH: Good morning. Thank you all for being here.

We're going to get this hearing started, of course of the Labor and Industry Committee.

And I want to say welcome, and I want to say Top o' the Morning to all of you. I'm wearing my green in my eyes today. I ran out of the green wardrobe yesterday, so. But that won't cause us to celebrate any less, for sure.

But today we have before us a bill for discussion that we all want to hear more about. And our goal today is to be able to gather a lot of information from a very robust group of testifiers today.

So we have -- I think we have five panels before us, so we're going to do our very best to move it along. The structure that I'm going to use on our conversation today on House Bill 1800, which we'll hear a little bit more specifically about in just a moment, will be each panel and a limited time for questions, because I want the questions to be able to be asked while they're fresh in mind. And you can all help us manage that, because we eventually will be evicted out of the room, and I don't want that to be physical. So we'll be careful about

managing our time.

So before we get started and hear a little bit more about the bill, I would like for you to know who is here, and we'll introduce ourselves.

Of course, I am the Chairman of Labor and Industry currently, and I'm Representative Mauree Gingrich from Lebanon County. And we'll go off here to my right and around.

REPRESENTATIVE MACKENZIE: Good morning.

I'm State Representative Ryan Mackenzie from Lehigh and Berks Counties. It's the 134th Legislative District. Happy St. Patrick's Day to everyone else.

REPRESENTATIVE DONATUCCI: And Top o' the Morning to you.

I'm Maria Donatucci, the 185th District. That's Philadelphia and Delaware Counties.

REPRESENTATIVE DUSH: Good morning.

Cris McCracken Dush -- Top o' the Morning -- from Jefferson and Indiana Counties, the 66th District.

REPRESENTATIVE WARD: Hi.

Judy Ward, Representative in the 80th District in Blair County. I am the daughter of Patrick Farrell, so I am legitimate.

REPRESENTATIVE BLOOM: All right. We're really going to have to start stretching here. But Stephen Bloom

from the 199th District, Cumberland County. The middle name is "Larkin," named for my grandfather, John Larkin, whose parents were both from the County Mayo in Ireland.

REPRESENTATIVE MENTZER: Steve Mentzer, Lancaster County.

MAJORITY CHAIR GINGRICH: Nothing else?

REPRESENTATIVE GERGELY: Marc Gergely, Allegheny County.

REPRESENTATIVE NEUMAN: Brandon Neuman, Washington County.

REPRESENTATIVE SNYDER: Pam Snyder, 50th District, Greene, Fayette, and Washington Counties.

REPRESENTATIVE FARINA: Frank Farina, the 112th District, Lackawanna County.

REPRESENTATIVE TOPPER: Jesse Topper, the 78th District, Bedford, Fulton, and Franklin Counties.

REPRESENTATIVE MALONEY. David Maloney.

MAJORITY CHAIR GINGRICH: Your real name.

REPRESENTATIVE MALONEY: That's about as Irish as it gets. I know, you're either Irish or you want to be. They're even changing their names here today.

The 130th from Berks County. Thank you.

MAJORITY CHAIR GINGRICH: And my Minority Chair.

MINORITY CHAIRMAN GALLOWAY: I'm John Galloway, County Tyrone.

MAJORITY CHAIR GINGRICH: County Tyrone. Is that close to Mayo? Close enough; close enough.

I would also like to introduce my staff. To my right is Noah Karn, and I'm sure you would like to introduce Vicki.

MINORITY CHAIRMAN GALLOWAY: Vicki DiLeo, Executive Director for the Democratic House Labor Committee.

MAJORITY CHAIR GINGRICH: So much work comes out of that staff and our research staff and our support staff, and we thank them.

So we are pleased also to have on the Committee and with us today as the prime sponsor of House Bill 1800, Representative Ryan Mackenzie.

And at this point, Ryan, to lead us off, will you please give us the intent of the bill and some of the details of the bill before we have an opportunity to hear from stakeholders that are very interested in what this bill would do.

REPRESENTATIVE MACKENZIE: Absolutely.

Well, thank you, Madam Chair, for holding this hearing. And thank you to Chairman Galloway as well, new Chairman Galloway. Congratulations on the chairmanship.

And I do want to thank all of our testifiers for joining us here today. We have a great hearing before us

with representatives from labor and industry, from the health-care industry, the legal community, the business community. And we also have testimony provided by some other groups, including the AFL-CIO.

So I do want to thank everyone for their input today. It's a complex topic and one that's very important for all of our workers across Pennsylvania.

Anybody who is in a situation where they are injured, obviously we know how difficult that can be, and we want the goal of the workers' comp system here in Pennsylvania to be not only to return to work but also to return to function and get people back to the livelihood that they enjoyed prior to their injury.

So 1800 regards workers' compensation treatment guidelines, and this was a concept that first came to my attention when I was Policy Director at the Department of Labor and Industry.

And I had heard about this. Other States, many other States across the country, have already implemented treatment guidelines. They have found very positive results for their systems. And so it was something that we began to look into. That was, again, several years ago. I've done a lot of research on the topic and, again, found that it can be very beneficial for the system.

At the same time, we do want to maintain

Pennsylvania-specific guidelines. And so you'll see in the legislation that we've introduced here today, you talk about nationally recognized, medically evidenced treatment guidelines, so there is some predictability, some stability in the system, from those national guidelines. But at the same time, we still want to maintain control here in Pennsylvania, so we put that in place here and in our legislation that we have introduced.

At the same time, I do anticipate, again, through the course of this testimony today, we're going to have some great feedback. I look forward to listening to that and also making changes to the legislation as we move forward.

So again, this is a learning process for all of us, but I do think it is something that can be very beneficial for the workers' comp system and also individual workers here in Pennsylvania.

And just very briefly, you know, some of the positive things that I've heard for individual workers are that they can now receive treatment much quicker in places that have treatment guidelines, because previously they would go to an individual provider and they would have to go back and forth with the provider and the insurer to make sure that they were going to receive payment for that type of treatment.

If it's in the guidelines, a provider knows they're going to receive the payment for that treatment right away. They can start providing that treatment. The injured worker can receive that treatment immediately and get back into work quicker and back to work faster. And ultimately, that saves time and money for everybody, and that's a good thing to get somebody back to work and back to function. So that's a positive outcome.

Again, I think we're going to hear lots more discussion on this topic, and I really look forward to it. So again, Madam Chair, I do want to thank you and Chairman Galloway for holding this hearing today.

MAJORITY CHAIR GINGRICH: Thank you very much for your openness and willingness for this discussion and to look for and solicit input from all of us. That's the best way to create good policy and good legislation, is to invest our time in this type of effort.

Before we get started with the first panel, I want to give a few words over here to my Minority Chair, Chair Galloway.

MINORITY CHAIRMAN GALLOWAY: Thank you, Chairman Gingrich. I appreciate it.

And good morning, everybody. And again, happy St. Patrick's Day.

I've been fortunate in my life. I have never had

to go through the workers' compensation process. I've been lucky. So in reviewing the material for 1800 itself, there's a lot of information to process, a lot of information to go over. It's a very complex issue. And for me, it was walking through the existing process and then seeing what life would be under the proposed changes in 1800.

And even though it's a very, very complicated issue, the questions I have are very simple. The first question is, are the proposed changes better for the injured worker? Does moving to a one-size-fits-all approach, evidence-based medicine, benefit the injured worker? How does a system where doctors become irrelevant, where you just need someone who can read from a chart, how is that beneficial to an injured worker?

And the second question is, does it actually save money? The workers' compensation insurance rates have fallen significantly since 2012, saving employers some $570 million. The Department of Insurance announced recently that rates are going to fall again in April of this year, saving businesses some $20 million.

So those are the two questions, because if it isn't better for the worker and it doesn't save money, then what's the crisis? What's the reason for this legislation, and who does it actually benefit? Who is it really written

for?

I am disappointed that the AFL-CIO was not permitted to testify today, considering that this is the Labor and Industry Committee. I believe it is essential to have the labor community's perspective on issues that could affect, directly affect their members.

And on behalf of my Members, I would like to request a subsequent hearing and additional review of the legislation, and I hope going forward that this committee would welcome those comments.

And as I have said, I've been fortunate in my life. I have never had to go through this process, and I would be interested to know how many other people on this side of the desk, on this panel, have actually gone through the workers' compensation process. It would be interesting to hear their perspective if they did.

But I do look forward to hearing the testimony today. Again, I want to thank you, Madam Chair, and thank all of you for being here, and happy St. Patrick's Day again.

Thank you.

MAJORITY CHAIR GINGRICH: A feisty leprechaun here beside me I would say.

You asked your questions in advance, and I like an eager, new Minority Chair with me, without a doubt.

The questions you asked I'm sure will be answered today as we go through. So that's good, because you can just answer his questions and we don't have to have him go through all that again. I'm teasing you, John.

At any point---

MINORITY CHAIRMAN GALLOWAY: I'm just getting started.

MAJORITY CHAIR GINGRICH: Yeah.

I do want to say that we do have testimony from the AFL-CIO, and we have, as I mentioned earlier, a structured testimony here. We absolutely couldn't have the room any longer, and we really appreciate them putting this together for us.

And we're going to work our way. I think the prime sponsor of the bill said that clearly in the beginning, that this is an effort to work together on making this the right way to go. So that's our intent moving forward, positively gathering the information we need, and we appreciate the input from everybody so far.

PANEL I:

PA DEPARTMENT OF LABOR AND INDUSTRY

MAJORITY CHAIR GINGRICH: So let's get this show rolling here with our first panel. To come forward on the

agenda is the department. So we have Scott Weiant with us -- right? -- and Michael Vovakes.

If you would not mind coming forward. And just make sure you have a mic close enough so everybody can hear you. And our ears are open and our attention is yours.

DEPUTY SECRETARY VOVAKES: Good morning, Chairwoman Gingrich, Chairman Galloway, Committee Members, and committee staff.

I appreciate the opportunity to testify before you today in the House Labor and Industry Committee regarding workers' compensation treatment guidelines in Pennsylvania and specifically House Bill 1800.

My name is Michael Vovakes. I am the Deputy Secretary for Compensation and Insurance. I will forsake my Greek heritage in the spirit of the day and will be happy to be addressed as O'Vovakes for the next 18 hours or so.

MAJORITY CHAIR GINGRICH: That's too hard to say. I'm sorry.

DEPUTY SECRETARY VOVAKES: Yeah.

Workers' compensation represents a long-standing agreement between employers and employees, an understanding that in exchange for the inability to sue one's employer for injuries sustained on the job, an injured worker will

receive compensation for lost wages and necessary medical treatments so the employee, if possible, can return to work.

Inherent in this agreement is the understanding that an injured worker will receive the best possible care, receiving not only the required treatment but the reasonable, necessary, and related treatment prescribed by a physician.

The Department of Labor and Industry opposes medical treatment guidelines in House Bill 1800 for several reasons, the primary one being that such a change is nothing more than a solution in search of a problem.

Workers' compensation in Pennsylvania is currently achieving unprecedented results in terms of meeting the needs of both injured workers and their employers. Injured worker satisfaction of treatment is at a record high, while workers' compensation insurance rates have declined for 5 consecutive years.

The most recent annual medical access study performed by the Bureau of Workers' Compensation showed that approximately 90 percent of all injured workers believe that they received timely, appropriate, and satisfactory medical care for their work-related injuries.

These findings are supported by the recent study

conducted by the Workers' Compensation Research Institute, that we'll refer to as "WCRI," a national independent, not-for-profit research organization that provides high-quality, objective information of an academic quality about public policy issues involving workers' compensation.

The WCRI study documented that four in five injured workers in Pennsylvania reported overall satisfaction with the medical care that they received. This success in providing appropriate treatment has been coupled with annual decreases in the assessments on workers' compensation insurance carriers, which result in lower workers' compensation insurance premiums for Pennsylvania employers.

These assessments have been lowered for each of the past 7 consecutive years. Additional cost savings are expected to be realized as we evaluate the effects of the physician dispensing legislation enacted as Act 184 of 2014.

The Department of Labor and Industry has several other concerns specific to House Bill 1800.

House Bill 1800 effectively switches the burden from the insurance carrier to the physician, and ultimately the injured worker, requiring them to justify any treatment that exceeds the guidelines prior to providing the

treatment or risk not being compensated.

Currently, the treatment provided to an injured worker is based on the worker's injury, needs, and the obtainable outcome or outcomes. Accordingly, should an insurance carrier believe that the treatment is excessive or unnecessary, it may request a utilization review.

The present system is designed to provide a shield to the insurance industry, giving them the ability to challenge treatments, and ultimately, when appropriately determined, receive relief from charges. Flipping this assumption -- requiring treatment to coincide with specific guidelines -- inhibits care from the beginning, and only after an arduous process may additional treatment be given.

Under current law, an injured worker can be required to treat with a physician of the employer's choosing for the first 90 days after injury. Only if the disability continues and the need for care lasts longer than 90 days is an individual currently able to seek additional or different forms of care for the injury.

Individuals who sustain work-related injuries that are serious enough to require more than 90 days of treatment should be allowed the liberty to seek alternative methods to deal with their injury and not be confined to a few options that are prescribed by a board if their

original means of treatment is not giving them the results that are desired after the first 90 days of their treatment.

This legislation also creates a board that would be empowered to alter nationally recognized treatment guidelines. This six-member board would be empowered to modify treatment guidelines that will govern treatment for all injured workers, yet the legislation gives no policy guidance to the board in developing these standards.

This board is similar to other such appointed panels, which has resulted in repeated litigation regarding their authority and the exercise of their duties.

Additional concerns regarding this board include:

- The language would create a nonfunded mandate for the department. The department would be required to provide administrative support, professional support, and meeting space among other necessary logistics for this board, but is provided no appropriation to cover these costs.
- The bill provides that the Board Members will serve without remuneration. This will deter qualified individuals from serving, as it could take significant time away from their practices.

- The way the treatment guidelines would be created would cause a lack of stability, and the guidelines would be changed frequently with the changing of appointments to the board that issue these guidelines.
- With appointments to the board having 6-year terms, this means that every 6 years, treatment guidelines could change, thus creating issues with the stability of the guidelines and causing confusion among stakeholders and medical practitioners. This lack of continuity would negatively affect the treatment of workers' injuries.

The current process for certification of utilization review organizations, or that we refer to as "UROs," does not require training and treatment guidelines. Although training could be required and obtained, if the treatment guidelines are substantially altered from the national standard or changed frequently, training would become difficult at best.

Current UROs are not certified to implement treatment guidelines. The accreditation of UROs will result in increased fees charged to carriers by UROs since the UROs will be required to satisfy the criteria of a nationally recognized accrediting organization.

The current workers’ compensation system in place

in Pennsylvania is already designed to keep the cost of injury care in check. The provisions of Act 44 of 1993 and Act 57 of 1996 and the resulting cost-containment regulations have been important steps in controlling medical costs while ensuring that injured workers receive proper and timely treatment for their work-related injuries.

The fact that injured workers are overwhelmingly satisfied with the treatment that they receive while assessments on carriers and premiums charged to employers continue to be reduced is proof that Pennsylvania's workers' compensation system is already on the correct path and is balancing the needs of injured workers with cost-containment concerns.

To conclude, I would again like to thank this committee for the opportunity to testify today regarding workers' compensation treatment guidelines in Pennsylvania and House Bill 1800. The Department of Labor and Industry will remain devoted to provide workers who sustain an injury or work-related illness with the most treatment options available while controlling workers' compensation insurance costs to employers in Pennsylvania.

Before I conclude, I want to introduce Scott Weiant, who is the Director of the Bureau of Workers' Compensation.

Scott, I don't know if you have any comments that you want to add at this point.

MR. WEIANT: Sure.

Good morning. My name is Scott Weiant, and I am the Director of the Bureau of Workers' Compensation.

I have been with the Bureau of Workers' Compensation approximately 10 years, and I can tell you, I think I'm in a unique position where I have also spent about 22 years in private industry and manufacturing.

And to Chair Galloway's comments earlier, I was a young worker and I did experience a workers' compensation injury in the manufacturing environment, so I have been through the process as well.

At the Bureau of Workers' Compensation, we are continuously looking at ways to improve the workers' compensation system in Pennsylvania for both or for all of our stakeholders -- the insurers, the self-insured employers, and the claimants as well.

Taking a look at the treatment guidelines and the holistic picture involved with the whole workers' compensation process from not only the Workers' Compensation Bureau's side but from the side where I spent, you know, 22 years in private industry and how the workers' compensation system affects industry and the workers and everybody out there.

One of the things that I look at is the fact that, you know, 99 percent, if not even a higher rate of those employees that are injured on the job, they want to get back to work. They want to get back to work as soon as possible and provide for their families and all the good things that come with it. They want to receive the good medical treatment that they're looking for and is needed in the particular situations that they encumber.

So when I look at that and I look at our access ability study, and I see within that study that over the past 5 years in the study are statistics relating to satisfaction of treatment, they continue to get better within the system. If you look at our study back in 2010, the satisfaction was about 85.2 percent, and in the most recent year that we conducted this study, it was up around 90 percent. So you see those things continuously rising with the satisfaction of care from the injured worker's side.

But, you know, I go a step further, and I look at that satisfaction survey from a different perspective of the employer's side of the house as well, and what I see there is that, you know, when I worked in private industry, one of the key goals for us was, you know, getting that injured worker better and getting them back to work, you know, in as fast as a fashion as we could do that, as time

would permit within their treatments.

And if you look at the accessibility study back in 2010, the day's lost per injury were about 63 days of the individuals that we surveyed, and now in 2014, those days have gone from 63 days down to 47 days. So we have closed that window.

So that tells me two things. It tells me, this study, that the claimants are happy with their treatment, and also, the time away from work that they are experiencing because of an injury has drastically reduced from 2010 up until now.

And there are a number of reasons that I feel come into play with that. You know, number one, and probably first and foremost, you know, somebody that has come from the HR background in private industry with thousands of employees at a manufacturing plant, you know, you do the things that you do on a regular basis to try to be proactive and prevent the injuries in the workplace. You know, lo and behold, if we prevent these injuries, these issues we are talking about this morning are not as big of an issue as we think we're doing.

Well, in Pennsylvania, we've done some things where we have started reaching out to employers, and we’re proactive in providing the proactive measures and the training and things like that for the employees. Last year

alone, the Bureau of Workers' Compensation training arm has reached out and trained over 37,000 individuals in workplace safety classroom-type trainings through webinars and actually in-house trainings.

Now, why am I saying that in relation to the accessibility study and the number of days away from work? Because if you reach out and you do those trainings, statistics show you that the severity of the injuries are going to be much, much less when they do occur, and when you have much, much less severe injuries, those are going to reduce the time away from work. So I look at this from a holistic perspective. I really do.

Studies also show that the number of URs that have been conducted over the last few years have gone down as well. If you look at the health-care services division within the Bureau of Workers' Compensation, back in 2014, the number of URs were at 7,852. Last year, that number in 2015 had gone down to 5,644. So that's a substantial drop. That's an indicator as well.

And also, the costs associated with those utilization reviews. If you look at the costs associated, the charges that are applied from the utilization review organizations to the carriers, we track those costs as well, and in 2014, those costs were about $7.6 million, and in 2015, those costs have been reduced to about

$5.4 million as well.

So the number of utilization reviews being requested have decreased, and the costs associated with those utilization reviews that are pushed on to, say, the carriers or whoever request those reviews, they have gone down as well.

So just to summarize. You know, again, I like to say that, you know, we are always looking at ways to improve the workers' compensation process in Pennsylvania, whether it be for the claimant, the insurer, the employer, all of our stakeholders. And, you know, from a number of methods, from technology to outreach to proactive measures, and you can go on and on and on. But this is one of -- the way the bill is worded in this bill here, it's not something that I think would be proactive for all of the stakeholders within the system are beneficial.

So thank you.

MAJORITY CHAIR GINGRICH: Thank you both. Thank you for sharing the perspective and the data from the department.

MR. WEIANT: Certainly.

MAJORITY CHAIR GINGRICH: And I'm really happy to see it reinforced that our common goal is for, you know, the worker and the employee and to keep everybody working safely, and those safety statistics are very important to

all of us as well. So thank you.

We have a number of questions, so if you can, you know, hold your seats for a little bit.

I'm going to start with my fellow Minority Chair Galloway, and go ahead, and then we'll move on.

MINORITY CHAIRMAN GALLOWAY: Thank you, Madam Chair.

I know there are a lot of questions and we got a lot to get through. Just quickly on justification.

You made a statement about the transfer of burden from the injured -- or that the insurance carrier to the physician to the injured worker. Could you just take me through that, and the benefits, the pros and cons, that you see in this transfer. Thank you.

DEPUTY SECRETARY VOVAKES: Can I answer that first question?

MR. WEIANT: Sure. Go ahead.

DEPUTY SECRETARY VOVAKES: The current process -- and this is a rough description. Of course, there's some more detail.

But if an injury occurs and there's a notice of compensation payable issued, the current process is the claimant receives treatment from the employer's list of physicians for 90 days. The physician and the patient collaborate on what that treatment will be. The physician

sees the patient that's in front of them and determines what the best course of action is.

Claimants receiving treatment. The physician is billing the insurance carrier at this point, and the insurance carrier is getting those bills and determining whether those are reasonable charges in the insurance company's estimation or not. If they are, they are paid and everything stops in terms of that specific bill.

If the carrier determines that the bill is not reasonable, they can file for utilization review, and the utilization review organization reviews the records of the physician to determine whether the treatment is reasonable and necessary.

If the utilization review organization determines that indeed those treatments were reasonable and necessary, they send a payment order, and the insurance carrier can, again, either accept that and pay it or can appeal the utilization review decision to the Workers' Compensation Office of Adjudication, and then that's the whole adjudication flow.

If the utilization review folks or organization does not think that the treatment was reasonable or necessary, the URO sends an order that their treatment was indeed not necessary. The carrier at that point is off the hook. The claimant and the provider then have to deal with

the cost of the treatment that has been issued. And again, if the claimant doesn't agree with that, they can petition for utilization -- or for an appeal through the Workers' Comp Office of Adjudication.

The new, or the proposal in 1800, as I read it, is that, you know, if there's an injury, there is a notice of compensation payable. The claimant goes for treatment, and the treatment is based on the employer's -- on the guidelines that would be selected by the department.

If the claimant is recovered, that's great and the process ends. But if the claimant is not recovered, the worker has to file for utilization reviews, as I read it.

The utilization review looks at whether the treatment is consistent with the guidelines. I don't read anything that says that they can suggest other things. It's just a yes or no; is it consistent with the guidelines?

If it is, the insurer pays for the treatment with, of course, appeals to the Workers' Comp Office of Adjudication. If it's not, the claimant is liable for the costs of treatment.

So part two of your question is -- well, let me highlight part one.

Part one is that you asked about the shifting of

responsibilities. At the beginning -- or the current policy is that the insurance carrier is getting the bills, and the insurance carrier is contemplating whether the treatment and the fees are appropriate. And what I read in the new proposal, there's not, at least initially, no deviation in what treatment a claimant is going to get. My sprained ankle is going to be the same as Scott's, is going to be the same as Ryan's, and so forth. And, you know, it doesn't take into effect my weight, my age, my health, and so on and other variables that are important in medical decisions.

And I, the claimant, and perhaps my doctor are determining whether I'm fully recovered or not, and if I don't think I am, the worker, as I read 1800, is filing for the utilization review.

So that's where I see, you know, there's a shift in the insurance company/employer is doing it today. 1800 is contemplating that the utilization review would be filed by the injured worker or their physician.

And as I read it again, the decision that this board is going to be making is simply whether the treatment is consistent with the guidelines or not, not any sort of deviation from the treatment. Now, that's my read, so, you know, we can discuss that.

You know, the other issue is, who pays for the

UROs? Obviously the language is kept about insurers, insurance companies and employers paying for it that currently exists. But there is some ambiguity, I think, or something that should be made more clear with respect to, are there limits as to when an injured worker can ask for a utilization review? Since they're not paying for it, can somebody dispute it? So I think that needs to be clarified.

And, you know, the cost of these things is a thousand to $1,500, which if that falls, if that burden falls to the worker, the workers of Pennsylvania, the injured workers of Pennsylvania, you know, the decision might be, well, why not put that towards for the treatment rather than payment for utilization review?

So there are some process issues, but, you know, that's what I think -- that’s where I think the onus changes hands and what I think some of the issues are with the bill that we have in a more restrictive way.

Do you have anything to add?

MR. WEIANT: Yeah. I would just like to add one thing to that.

You know, when I look at this perspective, I take myself back into, you know, my early twenties when I was working in manufacturing and also when I was in private industry for those years after.

Within the bill where it stipulates that the injured worker may challenge the employer's determination at that time, you know, the majority of our folks out there in sales and manufacturing and administration or whatever they're doing in their daily activities, they really do not know anything about the workers' compensation system. It's very rare that you have employees out there that are experts in workers' compensation.

Now, there are some people that are very knowledgeable, but the majority of them do not know anything about workers' compensation. So when you take the burden from the employer, the insurer, submitting for the UR request and you put that upon the employee now, there's probably no other choice within that process for that employee to reach out then and become represented on the case by an attorney.

And that doesn't always happen, so the additional effects of that particular language is you're probably going to create more litigation within the workers' compensation system, and that has residual effects throughout the whole process as well.

MAJORITY CHAIR GINGRICH: Okay. Thank you, gentlemen. That was very comprehensive.

The question, I believe, was to walk us through the current process, and you went a little further to

challenge the language of the new. So we're going to have limited time for really answering just the questions.

MR. WEIANT: Sure.

MAJORITY CHAIR GINGRICH: I'm going to go to Representative Mackenzie at this point, and hopefully we can get in another question or two before the next panel.

REPRESENTATIVE MACKENZIE: Yeah; absolutely. Thank you, Madam Chair.

And again, I do appreciate the department being here. We share the goals of making sure that individual workers receive compensation for lost wages and the best possible care, and I think both of those can still be achieved with treatment guidelines.

Very quickly, I do appreciate, Mr. Vovakes, your opinion on the current system and I think your explanation to determine just how complicated the existing system is and what an individual worker who challenges determinations has to go through.

I think that's a very complicated process. And I think with treatment guidelines, I think you can actually simplify that, because what we've seen in other instances is when an individual worker goes that treatment, and we can discuss this later outside of a hearing, but I think the process that I see in the legislation is different than what you described for what would happen with treatment

guidelines where an individual goes to a medical provider.

As I see it, they can -- they're going to have a discussion with that medical provider about what their injury is and what type of treatment is available. There is wide latitude within these guidelines. It's not a one-size-fits-all based on -- I mean, they do take into account your weight, your age, all of these different things. You know, any medical professional will do that. And again, within the latitude of the guidelines, they can then make a determination.

So I do challenge that, but I will get to my very specific questions here.

Mr. Weiant, you mentioned that an individual worker may not challenge or may not be the best to challenge a determination. Would you feel better if the legislation and the language said a medical professional, that a medical professional would be the one to challenge that?

MR. WEIANT: I don't know that I would feel better in that respect either, Representative.

I think the way the system has justified through some of the statistical data and the numbers that we have in place relative to the costs and the satisfaction of the claimant outcome and the reduction, as well in the workers'

compensation costs per the State over the last number of years as being reduced, has really provided a very big picture that has been tested over a number of years, that the workers' compensation system in this respect of it is working pretty well. I really do, where the insurers, the self-insured employers, and the employers have to submit the UR request versus the providers or the employees.

Now, if I would have seen statistical data that I would have evaluated, I would have indicated this has only been for 1 year or 2 years. But the statistical data that I look at indicates that, you know, the workers' compensation costs have been stable, if not going down, over the last 5 to 7 years, and the satisfaction of injured workers has been there where it needs to be for a number of years, 5 years, and really to me an indicator.

And from an employer's side of the perspective is that, you know, if I can see that number going down where my employee is back to work on the job and I don't have to pay somebody overtime to cover for that employee, and if I can see that number going down consistently over 5 years, I think that we're in a position where we're seeing good things within the process as it is now.

Now, I'm not trying to indicate that, you know, we are opposed in any way to working with, again, all of our stakeholders to try to improve the workers'

compensation system, because I'm a believer that we can always improve the system with the help of all our stakeholders.

But to answer your question, a long-winded answer, I don't believe that would be the proper way to go.

REPRESENTATIVE MACKENZIE: All right.

You talked about the costs and your answer coming down over the years, but you mentioned in your testimony that the big cost drivers that have been changing, our safety is improving because of training, which is a great thing; URs, the number and the costs are coming down. So those are main cost drivers which are bringing down the costs.

Can you speak to the individual claims? In individual claims, is the medical costs coming down as well?

MR. WEIANT: Well, I can get those statistics for you, Representative, on the individual medical costs.

I can tell you this: that the numbers that I'm looking at that are going to be released for 2015, we're seeing a reduction, again, in the lost-time injuries and illnesses in Pennsylvania, the workers' compensation claims, and the numbers I'm looking at in fatalities relative to employees. You know, going to work in the

morning and not going home to their loved ones has been reduced significantly as well.

Now, when you look at some of these injury and illness, some of the data that's out there, you'll notice that in the last couple of years since we have gone to an automated system in Pennsylvania to electronic data to collect our claim-related information, those numbers may look a little higher than in previous years.

But in fact what we've done is, we're actually pulling in data now that we have not pulled in before for medical-only claims. And those medical-only claim data, that's going to provide us with some data that we can utilize to determine not only what type of injuries and illnesses are causing the lost-time claims but also for the medical-onlys, that in my eye, they were that far away from becoming a lost-time injury. So that data is a real good indicator to us.

Now, if you look at what we're going to do with that data in the future, you know, it's not uncommon now for private industry out there and some of the Fortune 500 companies to take that data and throw that data into a database and use some predictive modeling to really indicate where those injuries are going to take place, what counties, what demographics of individuals are going to have those.

And when you have that information at your hand -- you know, the Bureau of Workers' Compensation has 20 years of lost-time injury in their pocket -- that we can use that for predictive modeling, where we're going to be able to predict where the injuries are going to happen, who it's going to happen to, what sector of the industry, and we're going to be able to rule out training and, you know, training programs and things like that and proactive measures in those areas.

REPRESENTATIVE MACKENZIE: Great. Well, I'll wrap up my questions there. I know we have a number of other questions.

But I do want to thank you for your written testimony. I think there are a number of other good comments here that we can incorporate into new language going forward. So thank you.

MR. WEIANT: Thank you, Representative.

MAJORITY CHAIR GINGRICH: Thank you, Representative.

The next on the list is Representative Dush. But before I go to you, I want to apologize in advance. We're running out of time for this panel, and we have a lot of other valid information.

If any of the other Members have questions, please submit them and we will get your answers, follow up.

If you can respect that short timeline, Representative Dush, I would appreciate it.

REPRESENTATIVE DUSH: Certainly, Madam Chair.

Scott, going back to your reference of the reduction in numbers.

With the expansion of -- well, since the great recession in 2008, we have had a number of people dropping off of the workforce. And we've also seen expansion for a lot of other social programs where people that sometimes would be our largest claimants in a workers' compensation case would possibly find it easier -- well, in fact they are finding it easier to go onto the Federal Government system and not have to deal with the workers' compensation as a way of gaining money for not working.

I've been on both sides of this, both as an investigator for workers' compensation claims and as a claimant under the heart/lung program. And if you had asked me during the middle of the process, I would tell you -- that's another metric in your survey. If you were asking me in the middle of that process, no, I wouldn't, but I'm also one of those people who was, even though I still don't have any feeling in the outside of my right foot, I still came back to work.

There are people who will purposely try to get back to work and then there are others who aren't. But I

think what I would like to know is, those parts of the metrics, were those included in your calculations as to the reductions in the costs and then the reduction in claimants?

Also, since the workers are more likely to stay active and be in work, was that a factor in that study?

MR. WEIANT: This study is very specific in certain areas, Representative. It goes to the respect of the care and the satisfaction of the care.

It does not -- it's a random sample of just under 11,000 injured workers in this survey. And actually the respondents for the latest survey is about 1,949 respondents. It does not go into the detail level as which you were just indicating.

I can say this in reflection to the recession and the number of injuries and illnesses out there in Pennsylvania and the type of claimant historically in Pennsylvania that we have within the workers' compensation system. A lot of people, when I go out and speak on this, is that they are a little surprised that the age demographics of the most prevalent individuals that are going to be injured on work are between the age of 50 and 54. You know, for some reason, a lot of people think, well, it's going to be the younger person, the people in their twenties.

But the most prevalent age is the age between 50 and 54. And those are people, for the most respect, that are out there. They have established lives. They have established families. They're paying bills. You know, they have a mortgage and things like that.

Again I'll reiterate back to what I said previously, is that, you know, my experience in real life -- and I appreciate your real-life experience as well -- is that, you know, the majority of these individuals, they are hurt on the job; they want to get back to work.

Now, you know, we deal with those outliers as well in our program where, you know, some folks, we think that at times they may be stretching the program. But the majority of the people are good people and they really do want to get back to work and put an honest day's work in.

REPRESENTATIVE DUSH: I agree with that, and I would just like to have some more -- I'd like to see them drill down more, and specifically on the studies. But thank you very much.

MAJORITY CHAIR GINGRICH: Thank you, Representative.

Gentlemen, thank you very much. It's our pleasure to work well with the department, and we do appreciate your feedback, your data, and we will continue, along with the prime sponsor of the bill, to share that

information.

DEPUTY SECRETARY VOVAKES: Thank you all.

MR. WEIANT: Thank you.

MAJORITY CHAIR GINGRICH: Thank you.

Please hang around if you have time. This is very interesting information.

PANEL II:

HEALTH CARE

MAJORITY CHAIR GINGRICH: And I'll invite the new panel and do our switch with our health-care panel, also an equally important part of the dialogue. We had a lot of discussion now about safety and our improvements there and types of injuries, but now we're going to hear from people who see it all the time.

Once you're settled, I'll actually have you introduce yourselves so everybody will know who you are affiliated with and we'll be comfortable with your background.

Shuffle the chairs any way. Just make sure everybody can get to a microphone when we need to do so. This is a large panel.

Okay; we're going to have to watch our time on this panel, too. So let's help each other out in

respecting time, and we'll start with Scott, if you don't mind, and introduce yourselves so everybody knows who is on the panel.

MR. BISHOP: Sure. I'm Scott Bishop, Senior Vice President of Legislative Advocacy for The Hospital and Healthsystem Association of Pennsylvania.

MR. RHINE: I'm Mike Rhine. I am the Vice President of Operations for Concentra Urgent Care for the Northeast Region.

DR. MILLER: My name is Dr. Keith Miller. I'm the Co-Chair of the Legislative Committee for the Pennsylvania Chiropractic Association.

DR. McGLYNN: My name is James McGlynn. I'm an orthopaedic surgeon with Premier Orthopaedics in Delaware County and a member of the Pennsylvania Orthopaedic Society.

MS. DeWITTIE: I'm Kathy DeWittie, and I'm with the Pennsylvania Orthopaedic Society. I'm staff on this issue.

MR. BIGLEY: Go ahead and introduce me, too.

MS. DeWITTIE: Jonathan Bigley to my right, who is our governmental relations representative.

MAJORITY CHAIR GINGRICH: Okay. Thank you very much.

Now for the individual testimony and what you can

add of value to this conversation. If it's okay, we'll work our way down the panel, again, as we introduced ourselves. Thank you.

MR. BISHOP: Chairman Gingrich, Chairman Galloway, thanks for the opportunity to be here.

To respect the timing, I'm not going to read our testimony. You have it. I certainly don't want to be the guy that makes you to be physically removed from the room in a little while.

MAJORITY CHAIR GINGRICH: It may have happened to you before, Scott.

MR. BISHOP: Right.

So, you know, we're in a unique position. Just a couple of things.

You know, as hospitals, clearly we'd be on the health-care panel as one of the key components of the Commonwealth's health-care system, but also as a major employer. And as we note, hospitals either directly employ or support nearly 600,000 employees, and we contribute somewhere over the range of $110 billion to the State's economy. So we come at it from both perspectives, and we appreciate the opportunity to be here this morning.

So a couple of things. One, I think we do support the concepts that are contained in Representative Mackenzie's legislation to improve the workers'

compensation program with, I think, two points that we just really want to focus and emphasize on. And I think it goes to some of the comments raised by Chairman Galloway earlier and others, and that is, if we're going to use treatment guidelines for the purposes of caring for injured workers, then hospitals, I think, need to have a specific role in that process. Because we're not new to dealing with guidelines, with accreditation standards, with all these different kinds of things as part and parcel of what we do as health-care providers. But to the extent that the Commonwealth is going to use treatment guidelines, allow for modifications to those guidelines, we'd like to see hospitals having a very specific role in that process.

And the second thing, we would be remiss if in talking about improving care and talking about making sure costs are contained, we always want to talk about the opportunities to engage in telemedicine as a way to get to these goals. And so as this legislation would move forward in the process, we would look for opportunities to talk about how that as a way of caring for injured workers is a part of this process, because it can accomplish a lot of the things on both sides of this issue that folks are concerned about.

So with that, I'll turn it over to the other members of the panel. And again, thanks for the

opportunity to be here.

MAJORITY CHAIR GINGRICH: Thank you, Scott.

DR. RHINE: Good morning, and I just echo Scott's sentiments. And thank you for asking me to testify today.

In addition to being the Vice President of Operations for Concentra, I am also a Doctor of Physical Therapy and have treated patients in the State of Pennsylvania.

Just a brief background on Concentra. We are the largest provider of occupational medicine in the country. We treat about 30,000 patients a day in 300 locations across the country, and we have about 150 locations that are co-located with large employers.

Our presence in Pennsylvania is 13 independent locations with some co-located locations as well. We also treat about 1,800 patients a day, and those patients in our centers will receive, could receive, specialty care, primary and occupational medicine, physical therapy, x-ray, and including pharmacy as well.

So as it relates to our operations in States with evidence-based guidelines, we are not opposed to the guidelines as long as they do not create unnecessary administrative barriers to providing timely patient care. So as a company, we have strived to practice an

evidence-based approach, which we have done since our inception, to get the injured worker through the process of care.

This has not been impacted by guidelines in any other State, whether that be ODG, ACOEM, the State's independent own guidelines, or their mix of sort of the two where they have adopted that. In fact, it has actually supported what we have done and helped us continue to do that.

And just so everybody understands, we practice in acute care, sort of a sports-medicine approach. So you understand the care we give in our center, the patients walk into our center, and within a matter of weeks, they start treatment that day, but through the scope of their care and release, they receive in our center all the services I just mentioned. And we are able to do that in a very timely fashion without barriers in any of these States. So I just wanted to make that part clear.

One issue that we are concerned about is clinician education about the guidelines. Believe it or not, many of the clinicians in States that have guidelines are operating with no guidelines, no knowledge that the guidelines even exist. So if we were to introduce guidelines, it would be important that there is an extensive grassroots education program, especially for

those clinicians that are in more remote areas.

More broadly, we recommend that the Committee carefully define the issue it is attempting to solve with the implementation of guidelines. In our opinion, the primary goal for any treatment guideline should be to help patients obtain necessary medical care in a timely manner and return to normal function as soon as they are able.

As I mentioned before, we operate in States that follow ODG, ACOEM, as well as their own guidelines. Between the ODG and ACOEM, we do not have a strong preference either way. However, we have noted more States are currently using ODG than ACOEM.

With either of these choices, there's obviously incurrent costs to all parties involved in the process. An alternative to predefined guidelines is the approach taken by Colorado, which started in 1992. They developed their own State-specific guidelines. It was an intensive process with stakeholder input, particularly from physicians, in the development and implementation phases, as well as ongoing updates of their own guidelines. Other States have since adopted Colorado's guidelines to use for their own.

As it relates to the structure of the bill, we would suggest modifying the term of panel members to have a rotation of half the members every 2 years. And as it

relates to specialties, it's important to ensure a primary care occupational medicine doctor is on the board at all times.

So with that, I thank you guys for the opportunity of inviting me to testify today, and I'll wait for questions.

MAJORITY CHAIR GINGRICH: Thank you.

DR. MILLER: All right. Thank you for the opportunity to speak today on House Bill 1800, and I'd first like to thank everyone here for the opportunity to have stakeholders and the physicians talk about what our concerns are.

I would also like to thank the Department of Labor, who gave a really good synopsis of some of the challenges on the administrative side of the workers' comp.

First off, I want to say that House Bill 1800 really centers around evidence-based medicine. I would really strongly suggest that everyone here read my written testimony -- I'm not going to read it to you; it's rather long -- on the challenges of evidence-based medicine. I'm going to hit the highlights on it.

First, I would like to say, who wouldn't agree that we want evidence-based medicine. I'm a doctor. I mean, who wouldn't want to have medical care based on

science and research and give the best quality care for what science and current technology tells us.

We don't use leeches anymore; we use MRIs. We want science. We want research. It's a worthy goal.

Health care is not just a science, though; it's an art, and somewhere along the way, evidence-based medicine, while it sounds like a worthy goal, really usually is poorly implemented. And usually it's poorly implemented because of the type of research, and unfortunately, the research bias that exists out there; that pretty much over and over and over again, larger and larger bodies and more and more respected people are coming out and saying, we've got to stop and take a look at this.

I'm going to start off and make an analogy. Global warming; climate change. Okay? If I was in a panel right now in front of a different group and we had the World Wildlife Federation on my left and the coal producers on my right and we were discussing policy changes in the State of Pennsylvania, they would both have research. They would both have evidence. They would both sit down and talk about their scientists and whether it's made or not made by human beings. As we look at this panel here, all of you sitting there, I guarantee, we do not have a consensus of all of you here on which one of those two sides is right.

So whose evidence do we use? Whose science do we select? How do we select that science? Which research is good? The coal industry says this is all hooey. The World Wildlife Federation says that all the owls are going to die tomorrow unless we get rid of coal plants. They both have opposing views. How do we make policy? How do we pick that? It is the same problem we're having with HB 1800.

It's not just in Pennsylvania; it's across the country. Believing that all of a sudden we're going to just be like, oh, we're going to make these guidelines and we're going to use this great research; everything is going to be fine, it's just nonsense. It's nonsense.

Look at the opioid crisis we have right now in Pennsylvania, one of the largest issues on the campaign trail for President right now and all across the country right now we're talking about. The Governors meeting, the National Governors meeting; the largest thing they talked about was the opioid crisis.

In the Virginia primary - I'm sorry; the Vermont primary, what was the largest thing they talked about? The opioid crisis.

Guess what? Evidence-based medicine 15 years ago said that these drugs were great. They were safe. We should release them on the public. No, we shouldn't just

give them for cancer patients anymore. The evidence and the studies show that addiction is really low; it doesn't happen. We don't have to worry about these things. So what did we do? We opened up the floodgates. Well, Pennsylvania right now is the third largest distributor of opioid medications to workers' comp according to the Workers Comp Research Institute, the same people that the Department of Labor quoted.

Pennsylvania just, at the end of 2015, became the highest opioid-death State in the entire country. That was research that came out, and whose research was that? It was the Big Pharma. Big Pharma came out with all these studies.

They had these wonderful biased studies that said that all this stuff is safe; we should sell more of it. So we adopted the guidelines. And the insurance carriers changed the policies, and the doctors were forced to push out more drugs. And what happened? Private industry made money; the State is now picking up the check. And that was evidence, but it was biased evidence. And as we go through and look at all the guidelines out there, the evidence really is biased.

When we talk about -- the British Medical Journal. The British Medical Journal is arguably one of the most influential journals in the world. The American

Medical Association Journal; the New England Medicine. Okay? These are the three best journals in the world. And the recent editor, 25-year editor of the British Medical Journal just retired, just retired, Richard Smith, and he says, and I'm going to quote very shortly off of it, that most of what appears in peer-reviewed journals is scientifically weak. He goes on to make an argument that because of the cost of research today, that almost all research is funded by private industry, and when private industry funds research, be it the World Wildlife Federation or the coal industry, people are going to come up with very good science based on their funding.

The CDC -- the CDC, the Centers for Disease Control of the United States -- in June of 2015 published an editorial paper. The editorial paper -- and please read it in my submitted testimony, and I'm going to cut an excerpt in a little bit here -- they said, and this is the CDC:

"Evidence is mounting that publication in a peer-reviewed medical journal does not" support or "guarantee a study's validity. Many studies of health care effectiveness do not show the cause-and-effect relationships that they claim. They have faulty research designs. Mistaken conclusions later reported in the news media can lead to wrong-headed policies and confusion among

policy makers, scientists, and the public."

"Scientists, journalists, policy makers, and members of the public often do not realize the extent to which bias affects the trustworthiness of" health care "research."

"Systematic reviews of health care intervention studies show that half" -- half -- of all "...published studies use weak designs and are untrustworthy. The results of weak study design are flawed science, misconstrued policies, and potentially billions or trillions of..." dollars wasted.

This is the CDC. The CDC is telling us that you can't trust the research right now and everybody should take a deep breath and pause in the whole EBM debate and wait for the science to kind of figure it out to come up with national guidelines on how we use research and how we kind of figure out and get rid of the research bias.

I'll quote a couple other excerpts of some major studies recently:

"EBM...is not a valid basis for medical decision-making...and it does not acknowledge the role of experience, understanding and wisdom" in "medical decisions."

Here's another one from a major study:

"Since its introduction, health care costs have

increased while there remains a lack of high-quality evidence suggesting EBM has resulted in substantial population-level...gains."

"EBM's indiscriminate acceptance of industry" standard "generated 'evidence,'" in quotes, "is akin to letting politicians count their own votes. Given that most intervention studies are industry funded, this is a serious problem for the overall evidence base."

Again: "Scientific fraud reappears with alarming..." consequences. Several studies have found that it exists in more than 40 percent of surveyed researchers. "These kinds of results indicate that there exists a substantial problem. Fraud/misconduct can lead to study losing...credibility. Moreover, it can lead to ineffective or harmful" patient "treatment being available..." to patients and deny treatment access.

So the PCA is not against evidence-based medicine. We're not against research. We're not against science. The problem we have is, it's too early. Is it really right to make the injured workers of Pennsylvania be the guinea pigs in a very small panel of "unpaid," "when I have time to sit down and come up with guidelines" that the CDC itself says they really can't trust right now?

Who does the research? How is the research funded? How do we see if it's biased or it's valid? Who

selects that final evidence, and how are the policies then designed around them?

We talked -- and I'm going to kind of go to the Department of Labor discussion really quickly, and I'll sum up my notes after that.

We talked about UROs. We talked about the URO system. We already have a URO system, and the URO system right now, and I think everyone here would agree, pretty much uses evidence-based guidelines in the URO. It's an after-the-fact system, and it's not perfect, but it's working. And the costs are coming down, and people are happy, okay? But the problem is, there's abuse in URO.

I have a personal example. I had a URO that I lost, my first one in 10 years. And when you read the URO, the conclusions had nothing to do with my patient treatment. Not only did it not have anything to do with the patient treatment, the patient's name was "Bob," and the conclusions were about a patient named "Jane." So the reviewer copied and pasted a URO that had nothing to do with my patient, collected his check, and moved on.

That's one example, and obviously we could cherry-pick them out, but isn't evidence-based medicine going to do the same thing? Isn't it going to allow the URO system just to be a cookie-cutter, slap-it approach?

And then we're going to take a patient who works

on an assembly line, who may or may not speak English very well, and we're going to make that person then responsible for fighting an industry and a system that the lawyers and doctors have a tough time getting through.

And then who pays for that? Right now when a URO happens, the employer says, we're going to review this case. And when the employer reviews the case, the employer knows that I'm going after maybe not paying those bills, but I have to pay for the review. So there's a give-and-take, that there's a risk that the employer has in the game. They have skin in the game to do the URO, but they have the benefit, if they win, they don't have to pay. Who pays?

So every time an employee now has a problem, they have to file a URO? The URO system takes 30 to 90 days right now. If you're sitting there waiting for your cancer care, do you want to have to have a 30- to 90-day appeal period whether or not you're going to get your radiation? How long is that system going to be? How long is it? Who's going to pay for it?

And when a worker who is an assembly line worker or God knows what else looks at the system and says, I don't know what to do, they're going to go 1-800-SUE-ME. There's a million of those ads on TV, and they're going to call a lawyer because they don't know how to navigate the

system. So you're going to drive up the amount of people suing because they're going to have to.

How is this blue-collar worker who may or may not have even finished high school going to navigate a system that myself as a doctor has a problem getting through it? They're not; they're just going to sue you, and they're going to get a lawyer, and it's going to drive up costs.

We have a system that is not perfect. We'll all agree there's no such thing as a perfect system, but it's working. The Department of Labor -- the Department of Labor -- says that the 5-year average says everything is getting better, so why break it? Why take something that's working and break it?

The Representative said, how about the doctors do the reviews? Do you know how much paperwork I have? I go in at 8 a.m. and I come home at 10 p.m. I keep adding extra staff. My reimbursement rate has gone down. Blue Cross cut it 10 percent, okay? We just got told by Highmark, on March 18th, tomorrow, we're getting the new rate schedule that goes in for April 1st. They're cutting my rates again. I have had to hire two extra staff to do my paperwork.

I'm going to fight the UROs? You know what's going to happen? We're just not going to see you. We're going to drop out of the workers' comp system. Doctors

will flee, and you'll take that 90 percent approval rating and it's going to plummet, and it's all going to just wind up in litigation.

Some I'm going to conclude by saying the PCA is for science. We're for good treatment. We're for good medicine. But HB 1800 doesn't do any of that. It's vague. It doesn't create solutions; it just creates problems.

And one day the PCA would love to stand behind a commonsense bill, but a commonsense bill for the workers in this State is a conservative care-first approach, conservative care-first approach that doesn't put Pennsylvania third in the country to creating junkies on opioid medications. We feel there's enough scientific evidence and there's enough good social policy out there that conservative care-first approaches work.

When we look at the WCRI reports from 2014 that the Department of Labor quotes to as the best metadata out there, those reports show that when patients go to chiropractors first, that the overall cost of back and neck pain treatment is lower, that the number of surgeries is lower; that when a chiropractor is the first doctor they see, only 1.5 percent of patients wind up in surgery. When the first doctor they see is a surgeon, 42.7 percent get surgery.

So that's all I have to say. I thank you all for

your time, and I hope common sense prevails.

MAJORITY CHAIR GINGRICH: Thank you very much.

I'm glad you two gentlemen kept yours shorter and allowed your time to move on down the table.

I appreciate the information. For awhile, I thought you were talking about politics when you went off on the bias between the research and so on. We have our own situations with that, believe me.

Dr. McGlynn, let's hear from you before we go to questions, please.

DR. McGLYNN: Yes. Thank you.

Thank you, Chairwoman Gingrich and Committee Members for this opportunity to testify on House Bill 1800, and I will stick to the script today.

My name is James McGlynn. I'm the Chairman of the Pennsylvania Orthopaedic Society's Workmen's Compensation Committee, and I appreciate your willingness to hear our Society's views on this important legislation.

HB 1800 would require the use of treatment guidelines as part of the dispute resolution process in workmen's compensation cases. Given the large majority of cases in this WC system are not in dispute, HB 1800 would not have broad application in the workmen's compensation system. It would, however, have a significant impact on those injured workers who find their medical care under

dispute as well as the physicians who treat them.

The Pennsylvania Orthopaedic Society is engrossed in workers' compensation issues. From a medical professional viewpoint, orthopaedic surgeons treat more injured workers than any other type of physician. In addition, the patients we treat are often severely injured. We care deeply for our patients, and we hope this legislation will not adversely impact them or the relationship between the patient and the physician.

With that said, if properly implemented, treatment guidelines can be a benefit to the workers' compensation system. Many States have already adopted these guidelines, including Colorado, and Colorado's is considered by some provider groups as a national model. The POS welcomes the opportunity to work with you as the House Labor and Industry Committee deliberates this bill.

After reviewing HB 1800, our Society adopted three principles in regard to work treatment guideline legislation. This action was taken at our February board meeting.

First, lawmakers must understand that treatment guidelines should be merely that, guidelines. Pennsylvania Orthopaedic Society will not agree to legislation that imposes treatments and procedures upon patients and orthopaedic surgeons.

Although this is not the intent of the bill, we are concerned that some advocacy groups may see this legislation as a vehicle to prescribe treatment protocols in this system. Guidelines should also not become de facto policy on the part of insurers.

Second, treatment guidelines should be specific to Pennsylvania. HB 1800 calls for the adoption of national guidelines. These may be instructive for Pennsylvania policymakers, but they have limited value to the practicing physician who is treating these injured workers, each with their own set of nuances.

The POS suggests that the legislation establish a workgroup of health-care providers charged with the duty to develop Pennsylvania-specific treatment guidelines within a certain time period. The Secretary of Labor and Industry could then promulgate that work product as Pennsylvania's treatment guidelines.

We make this suggestion because HB 1800 requires the implementation of national guidelines within 60 days. A lengthy process of proposing modifications, public notice, and comment would begin thereafter. It would be far more efficient and less costly to delay implementation of any guidelines, allow a workgroup to modify existing State or national guidelines, and then implement one set of Pennsylvania-specific guidelines instead of two. All

parties in the workers' compensation system should have notice of one set of guidelines.

Lastly, treatment guidelines must be flexible enough to incorporate new or emerging techniques, procedures, and technology. This principle is obviously related to the first two. With innovation a constant in orthopaedics and other medical specialties, treatment guidelines cannot be static.

Pennsylvania's regulatory review process, however, is cumbersome. Pennsylvania-specific treatment guidelines should contain provisions that allow for the rapid application of these innovations in the delivery of care without wading through the State's daunting process. Obviously, this principle is in the best interests of the injured worker.

Our Society has seen in other contexts how guidelines can become de facto regulations or even outright bans on physician practices. At times, this is due to ensure reimbursement activities that deny payment for necessary and proper treatment that just happens to be more than they wish to pay. The Pennsylvania Orthopaedic Society does not want House Bill 1800 to become a tool for any player in this system to dictate the type of care provided to injured workers.

A troubling provision of House Bill 1800 is the

language on page 4, line 2. Currently in utilization review, the moving party is the employer or the insurer. House Bill 1800, however, shifts this burden to the injured worker. Our concern with this burden-shifting provision is that employers or insurers will be in the position of dictating care to injured workers and the physicians who treat them.

In fact, the bill reads in relevant part, quote, "An injured worker may challenge an employer's determination of reasonableness or necessity...." The POS firmly believes that employers or insurers are in the least able position to determine the reasonableness or necessity of medical treatment.

Employers already have the authority to require injured workers to seek care from employer-selected provider panels for 90 days. Giving employers the authority to select care and forcing injured workers to contest employers' determinations is inappropriate in regard to the delivery of quality care and will inevitably lead to more frequent and protracted litigation.

As you continue your review of this bill, please consider these relevant facts which demonstrate that Pennsylvania physicians' costs are lower relative to other States according to the Workers' Compensation Research Institute and their benchmark for Pennsylvania in

October of 2015, and they are as follows:

- Of the 17 States in the study group, the average physician payment per claim of the median State was $4,357. Pennsylvania ranked 15th of the 17 with an average payment claim of $3,605. However, Pennsylvania's average payment ranks for chiropractic and physical therapy were 1 and 4 respectively. The average chiropractic claim for Pennsylvania was $3,619 while the median State was $1,619. The average physical therapy claim for Pennsylvania was $3,648, while the median State was $2,719.

Secondly:

- Of the 17 States studied, Pennsylvania had the third highest average payment per claim for physical medicine. But for two of the most important provided physician services -- they include major surgery and the E and M, or evaluation and management codes -- Pennsylvania ranks 13.

As you can see, the physician compensation component of Pennsylvania workers' comp is well below what you may expect. POS members pride themselves on delivering the highest care within a reasonable reimbursement system. We hope to continue to do so.

The Pennsylvania Orthopaedic Society believes it is important to remember that House Bill 1800's provisions

would affect a limited number of cases and those cases in which medical treatment is in dispute. The creation of treatment guidelines, however, may have a larger impact upon the workers' compensation system depending on how employers and insurers decide to use them to determine the reasonableness and necessity of treatment. We ask the Committee to carefully consider our concerns as you review this bill.

In conclusion, the Pennsylvania Orthopaedic Society stands ready to work with Representative Mackenzie and your committee to craft reasonable and effective legislation regarding workers' compensation treatment guidelines.

Thank you for the opportunity to be here.

MAJORITY CHAIR GINGRICH: Thank you, Dr. McGlynn.

Thank you to all of the panel.

Again, we're facing time constraints here. I have five Reps now who have questions, and we want to get through as many of them as we can within 15 minutes.

So Representative Gergely, you have a question, I believe.

REPRESENTATIVE GERGELY: Thank you, Madam Chair.

Thank you, gentlemen and the lady, for testifying today.

This panel in particular is probably the most

important panel to speak on this issue. I respect the fact that our two doctors took the time today to come down and give us their perspectives. One of you gave an analogy. I have one.

If you can answer this for me. This has a lot of direction for me in the decisions I have to make whether HB 1800 is a worthwhile cause or not to undertake.

I have a Chief of Staff. I'm in session, and he's going to go to a fundraiser or an event for me back home, so he's technically working for the Commonwealth. And his wife goes with him, and they get in a car accident. They get injured.

We have 1800 implemented, so they have a guideline of care. The wife doesn't. She's under our health insurance plan; he's under the disability plan now because he was hurt while working for the Commonwealth. Can you assure me both of them are going to get the same exact standard of care, or will the guidelines affect the way my Chief of Staff is treated?

DR. MILLER: Right now, you would come to my office, and you'd have a PIP claim and a comp claim, two different acts -- Act 6, et cetera.

Right now, you'd both come in and you'd both be basically treated the same. The only difference is that workers' comp has a medical necessity-based payment and the

PIP claims in Pennsylvania right now have a set amount that a person buys for themselves. The State minimum right now is $5,000, which, by the way, on a separate issue, is one of the lowest in the entire country. That's a whole nother point. But depending on how much she purchased, she would be covered under PIP, and then once that exhausted, she would then move into her private insurance.

What would happen, once you create some kind of evidence-based guideline, if it was a cookie-cutter program, is we would be forced, almost like having an iPhone app out: Do you have this? Yes. Do you have that? No. Do you have this? Yes. Then do this. And the doctor is kind of cut out of the loop completely. We would have to follow what the guideline says. If not, we don't get paid.

Then when that happens, the wife in this case, in your analogy, would have to file a URO. Somewhere in 30 to 90 days, a review would come back, and then depending on how that review went, the costs then would get possibly shifted to the private sector from workers' comp into, say, Blue or Aetna or United.

So the system won't be saving money; we're just going to cost shift possibly who pays that money.

REPRESENTATIVE GERGELY: Will the standard of care be affected because of the guidelines, is more

important.

DR. MILLER: Well---

REPRESENTATIVE GERGELY: Or will the worker under the guideline, the Chief of Staff, have less of a standard of care because the guidelines are in effect, where you couldn't expand that because of identified needs?

DR. MILLER: The doctor---

REPRESENTATIVE GERGELY: Referring back to what you said is art.

DR. MILLER: Yeah. The doctor on the workers' comp, assuming we do this, would have to follow a certain guideline that may or may not be beneficial to that person, whereas the wife under the PIP guideline would have access to whatever care they needed based on medical necessity.

The standard of care usually does go down, and when you look across on the Workers Comp Research Institute, that's typically what happens. And that's metadata, as they said, of 17 of the largest major States in the player game, including California, Pennsylvania, et cetera.

DR. McGLYNN: Yes. In the hands of orthopaedic surgeons, both people would be treated exactly the same. If the injuries were serious and they wound up in the hospital, we're going to take care of that husband and

wife.

And the emergency care is the same; in the office, exactly the same. We're not really interested in how they got hurt. They were hurt, and we're going to help them.

It may become a problem if the treatment guidelines prohibit care further on down the line, especially in that severely injured person.

REPRESENTATIVE GERGELY: So the guidelines could affect the standard of care for the State employee?

DR. McGLYNN: Later, unless they are flexible enough.

REPRESENTATIVE GERGELY: It doesn't matter when, it could, correct?

DR. McGLYNN: In my opinion, later, yes.

REPRESENTATIVE GERGELY: Okay.

DR. RHINE: And just one point to keep in mind, too, is that it's already affected, because you've got a panel, right? So the wife and the husband may not be able to go to the same doctor---

REPRESENTATIVE GERGELY: Okay.

DR. RHINE: ---because of the panel that's already established.

So the goal is to have, you know, the same quality -- you know, great quality physicians at every

point of care on that panel. But that panel, depending where you are, will already limit, you know, so there's already some subject to decide what do the guidelines do and what happens, just because of where you enter the system differently.

MR. BISHOP: Right. And to follow up on Dr. McGlynn, there would be no change in treatment for either person presenting to an emergency department.

REPRESENTATIVE GERGELY: No; I wouldn't have assumed emergency. When you walk in the emergency room, you're going to get treated for your needs. But the follow-up with these guidelines is if the wife gets a better standard of care because the guidelines aren’t assessed to her but they are assessed to the State worker, that’s very problematic to me. We don't have that now. Why are we going to change that?

Thank you.

MR. BISHOP: Yeah.

MAJORITY CHAIR GINGRICH: I guess that's an answer we’ll have at the end of this whole process. Thank you.

Let's move on again -- I remind everybody of the time constraint -- to Representative Neuman, who missed out the last time in asking a question.

REPRESENTATIVE NEUMAN: Thank you, and I do

appreciate everybody's time being here. I think it just shows the need for another hearing. So this is a very complex issue that we do need to hear everybody's answers. And if you see, the cameras are on. I think the public and the working class needs to hear your answers as well.

My question first goes to Scott Bishop.

Your answer in supporting this bill deals with economics and not patient treatment, from what I gathered in your testimony.

MR. BISHOP: No, I wouldn't say that at all. I mean, I say we come at this from two perspectives, uniquely as a large employer and also as a key health-care provider. So that was a recognition that that's the hospital perspective on this.

And again, I think we are a long way from standards being suggested, guidelines in this legislation, and some of the outcomes that have been suggested. But our whole reason for being a part of the conversation is that if we are going to go down that road of having a set of guidelines or evidence-based standards, whatever they are -- modifications, that process -- that hospital specifically, because of our role as health-care providers, would have a specific role in that process to make sure that some of the outcomes that have caused a level of concern don't actually take place.

So it's not in the perspective -- we just happen to be, unlike some of our fellow panelists, we have a dual perspective.

REPRESENTATIVE NEUMAN: And with that dual perspective, your testimony quotes the number of jobs -- and we do appreciate your economic driver in our community -- quotes the number of jobs and employees in economics. My concern is that if you are a part of the guidelines, that dual role, is your fiduciary duty with the shareholders if you're private or maybe the Board Members, or is your fiduciary duty with the patients that will come to your hospital?

MR. BISHOP: Well, I don't think that changes the -- remember, at the end of the day, hospitals, we are 24/7, 365 providers of health care, and that doesn't change and that won't change. And having standards or trying to provide some structure to the treatment, I don't think there's an inherent conflict there.

I mean, when folks present to us -- again, remember, when they first present to us at an emergency department, we don't know if you're insured/not insured, working/not working. We're there to treat, stabilize, and that's our -- we have no flexibility there.

So I think there is not necessarily an inherent conflict being able to be a part of the kinds of care that

would guide this process. I think we can do that.

And again, we face that as facilities and institutions all the time.

REPRESENTATIVE NEUMAN: Yes, I agree, and I appreciate your answer.

To the doctors. Whenever you were in medical school, did they present a multiple-choice question that said, if you have a broken leg, you treat it this way, or was it an analysis of each individual human that you're going to treat and the treatment was going to be different based on the analysis of that human and their injury versus an injury and an answer A, B, C, or D?

DR. McGLYNN: I would like to tackle that question first.

I think at Georgetown University, we learned both techniques. You always have to keep the person, the whole person, in mind, holistic medicine, but you also have to be an expert in treating the problem. So if you incorporate both, you do that successfully.

REPRESENTATIVE NEUMAN: Okay. And since there are no specifics in the guideline, House Bill 1800 lacks complexity for you to be able to make, in my opinion, and I believe your testimony alludes to, for you to be able to say that you're going to support, definitely support 1800.

How will you deal with in your practice, either of you, if your treatment recommendations go against the guidelines?

DR. McGLYNN: Well, as I stated earlier, many of these guidelines will not be affecting almost 80 or more percent of our patients of injured workers. In those smaller percentage of situations, we're already answering to utilization review boards in many of these cases, and sometimes treatment is delayed until that is approved.

So we are already seeing that and view this as possibly a way of having a say instead of being on the bench.

DR. MILLER: I think the good doctor next to me would like this basic, because you asked about patients instead of problems.

I sometimes have a patient that comes in who can't sit, who is crying, who can't sleep. Pain is down their leg so severe they are telling me they want to cut it off. On their pain scale, it's an 11 out of 10. And then we get an MRI, and the MRI has an itty-bitty little disc bulge, that if I just saw the MRI and I never met the patient, I would have thought this wasn't a big problem.

Then I get a patient sometimes who has a sequestered disc blown out so large that the spinal cord is actually pushed out of the way. The only reason they got

the MRI is because they weren't getting better with conservative care. And their pain level might be a three or a four, and their only real neurological symptom is the back of their calf is burning.

So in one, you have an MRI, a clinical objective-based test, that says that their problem is not that bad but they're dying, and vice versa on the other one.

You see these all the time I'm sure, right?

DR. McGLYNN: Yeah.

DR. MILLER: So here's the problem: You now have a guideline that says if you have disc A, you do this; if you have disc B, you do that. That sounds really great, but it doesn't work. They're not cars.

You know, if my car doesn't start in the morning, I try to jump it. If it doesn't jump, I check the battery. If the battery doesn't work, I go to the alternator. If the alternator doesn't work, I take out a couple bolts, I slap in a new alternator, I start the car up, and we're good to go. That's cars. People ain't cars. And evidence-based medicine creates guidelines that if they're used as a flow chart of, try this first, and this is a good idea, and -- it's loosely set up.

You know, it's not a bad idea, and to be honest, that's kind of what we all do right now. But that's not

what happens. It's bias in the way these researches are done, on the selection of the patient outcomes.

The problem is, just like I talked about the opioid crisis, is that the Golden Rule is by who has the gold makes the rules, and all of us, we're fleas in the system. We're itty-bitty little people. We're not the billion-dollar companies, and the billion-dollar companies are the ones who eventually are going to make the guidelines.

The good doctor talked about chiropractors in the State of Pennsylvania, physical therapists in the State, and how we're slightly ahead of the averages. So they're talking about the numbers that we get paid on average in the State. Absolutely. We can get paid about $1,200 more than the average nationwide, but when you look across the board in the States that have higher chiropractic accessibility and utilization, the average claim is lower. When they see a chiropractor, the average claim is lower. They have less surgery. They have less long-term disability. The amount of people on opioid medication is lower.

So is paying me $1,200 more by giving me the flexibility and the freedom saving the system $100,000? Saving the social costs of a junkie in rehab and families destroyed and all the other problems going on?

REPRESENTATIVE NEUMAN: And I don't mean to cut you off---

DR. MILLER: Yeah; $1,200 is cheap.

REPRESENTATIVE NEUMAN: ---but I do know that the Chairman is kind of looking at me and wanting this to end.

MAJORITY CHAIR GINGRICH: Thank you, Representative.

REPRESENTATIVE NEUMAN: You know, I would suggest that these guidelines, to your analogy, are like a limited warranty for a vehicle, and nobody wants a limited warranty for a vehicle when you're talking about a human.

So thank you, Madam Chairwoman, for the leeway.

MAJORITY CHAIR GINGRICH: Thank you for the good question and for helping me out here, because we are limited on time, and I'm getting tired of saying we're limited on time.

A quick question from Representative Ward, and then we'll have to move on.

REPRESENTATIVE WARD: Sure. Thank you, Chairwoman.

My question is for Dr. McGlynn. A little background.

Before I came to the House, I'm a nurse by

training, and I worked in our family transportation business. I reviewed workers' comp claims with our risk manager. And wouldn't you say that most cases that come in, although the patient is unique, each person is unique, you start out the same place and you start down almost an algorithm, if you would, of care that you go through until you, as you get that patient better, you're working down pretty much an algorithm. Is that -- would that be accurate?

DR. McGLYNN: Yes, I think it is.

We start out with a good history. We hear what the person has to say. We do a good physical exam, prudent testing, and come up with a treatment plan. In many cases, it works. And if it's not working, then you need to reassess, reevaluate, and change, and that's essentially an algorithm.

REPRESENTATIVE WARD: Okay. All right. Thank you so much.

DR. McGLYNN: You're welcome.

MAJORITY CHAIR GINGRICH: Thank you, gentlemen, very much, and the lovely lady sitting at, you know, the ready in case they needed you, I guess.

Thank you very much. You know, the health issues related to our discussion today are very, very important, and I thank you for your time and for your enlightenment.

PANEL III:

LEGAL COMMUNITY

MAJORITY CHAIR GINGRICH: And we will move on to our legal panel. So if they are available to hop up.

And thank you. Please stick around if you can.

And again I say if there are any other questions from the Committee Members that we couldn't get to, please let us know. We'll get them answered for you.

Welcome, gentlemen.

MR. BRICMONT: Thank you.

MAJORITY CHAIR GINGRICH: Not quite as long a panel, but equally important. So if you don't mind introducing yourself to the group, and we'll let you get started immediately.

MR. BRICMONT: Thank you, Chairperson Gingrich and Minority Chair Galloway and the Members.

I'm Dan Bricmont. I'm Chair-elect of the Pennsylvania Bar Association Workers' Compensation Section, present today on behalf of the American Bar Association.

I'm joined by Mike Routch, who is Vice Chair of the section.

We represent the 68,000 members of the -- or excuse me; 28,000 members of the Pennsylvania Bar Association and are a part of the 650 members of the

Workers' Compensation Section Bar within the PBA.

I primarily represent injured workers. Mike primarily represents employers and insurers.

On behalf of the Workers' Compensation Section and indeed the Pennsylvania Bar Association, we oppose HB 1800 and we urge a "no" vote. Our members have significant concerns about this legislation. We view it as substantially altering how medical care will be delivered to work-injury patients.

We believe it may impair the doctor-patient relationship regarding treatment in favor of a guideline for governing those decisions. And we voice, again, comments you heard this morning that this is a solution in search of a problem in the sense that workers' compensation rates have been declining in Pennsylvania over the last several years.

As this panel may know, Act 44 of 1994 adopted medical cost-containment regulations which apply to workers' compensation injuries. There were several significant measures that have worked to save money for the system. You have heard reference to the 90-day panel provider rules, the utilization review process, and the cap on reimbursements of medical services to, I believe it's 113 percent of the Medicare rate.

These changes have provided powerful tools to

reduce costs yet still permit either the injured worker or the employer to obtain judicial review by a neutral hearing officer to challenge denials or concerns with excessive care. Those reviews currently are based on the actual facts of the specific patient's condition and injury.

Now, this is a process that satisfies due process concerns in the sense that it affords notice and an opportunity to be heard, both sides, and affords protections of cross-examination regarding the medical opinions that the judicial officer will be ruling on.

More recently, Act 184 of 2014 addressed physician prescription dispensing limits, and just recently the CDC has announced new guidelines on the prescription of opioids. So over the whole, we feel these recent regulations should be given additional time to show savings before new regulations are added on top of the existing system.

Now, further experience teaches that the new regulations may generate unforeseen results. Specifically, there was concern voiced earlier today about changes in the medical academic field that will drive new guidelines being developed and potentially approving new therapies of care, perhaps biologics or gene therapies, new care that may actually escalate costs if doctors are truly obligated to follow these guidelines, or drive an increase in the number

of utilization review filings, which have recently been on the decline.

Further, we are concerned medical providers may be less willing to treat work injury patients to avoid the interference and the limitations of these guidelines, and so that's really getting to a cost-shifting concern.

In addition, there is a concern of increased costs on either the claimant or the employer; the cost of challenging these determinations, which at least for claimants, they are frequently unlikely or unable to finance those challenges.

For these reasons and some additional reasons that Mr. Routch is going to address, the Pennsylvania Bar Association believes that a one-size-fits-all standard, which appears to be embodied in 1800, is wrong for both employees and employers, and again, we oppose it.

Let me introduce Mike Routch, who is Vice Chair of the Workers' Compensation Section.

MR. ROUTCH: Thank you.

Michael Routch, and I appreciate your attention this morning.

We note the primary feature of the proposed amendment is to delegate medical treatment decisions to a panel, and a panel chosen by the Department of Labor and Industry invariably becomes subject to the political

process.

And with all due respect, we do not believe that individual medical treatment decisions are best handled by the political process. We ask if the process would be equipped adequately to consider cutting-edge medications, assistive devices, or therapies. Is the department and a small panel equipped to become the dictator of treatment in a vacuum, and that concerns the members of the Bar.

When it comes to medical care for injured workers, a one-size-fits-all approach we believe creates legal pitfalls. Physicians are already obligated to treat specific patients based on defined enforceable medical standards, but they are required to treat the patient as they find him or her.

A doctor faces, we believe, potential malpractice issues if he or she fails to take the individual characteristics of the patient into account. There is often a theory noted the “eggshell skull” theory. You take the patient as you find them and you must respond accordingly. We believe the guidelines will hinder individual care.

Doctors should not face restrictions on care adopted from cost-saving guidelines while still bearing responsibility for a patient's health and well-being. While employers in workers’ compensation cases have

tort law immunity, medical providers who treat those patients do not. The current system has the flexibility to let physicians make the treatment recommendations for the specific patient while still permitting utilization review on a case-by-case basis.

How will this system account for the outliers who do not fit the profile? We believe the focus will shift away from the actual results of treatment to injured workers to expected results. There are patients who find success -- I've seen it in my practice -- with less conventional procedures.

The proposed legislation also places, we believe, added significance on pinpointing the correct diagnosis from the outset. Obviously, proper application of any treatment guideline depends on it, and I can speak from personal experience that I have seen delayed treatment due to delayed diagnosis. It is not too uncommon for a shoulder-sprain injury to become an impingement, then a tear, and even later, attributable to a cervical condition. We worry that the guides will limit flexibility in those circumstances based on the patient's true needs.

Ultimately, clinical observations, patient symptoms, and imaging studies come together to create the correct diagnosis, and one-size-fits-all guidelines should not limit care for the partially informed diagnosis.

From a litigation standpoint, the act currently allows claimants and employers' attorneys to challenge medical opinions on treatment and causation. And as Dan mentioned, we have the utilization review process that permits attorneys on both sides to question the bases for the opinions of the physicians.

As part of that process, I can tell you that I have referred to treatment standard guidelines as a way to cross-examine a particular expert in a situation. They are available to me as an employer's counsel, and I use them. But ultimately, I note the decision goes to an impartial workers' compensation judge who we as attorneys feel comfortable with in the present workers' compensation system. We believe that ultimately these decisions are best handled by the impartial hearing examiner or workers' compensation judge.

I worry about a situation as defense counsel, that I have noted in our remarks, about a situation in Wisconsin where all the way to the Supreme Court of Wisconsin, an employer counsel was denied the opportunity to specifically cross-examine an expert appointed by the department. That was barred, and in essence, the employer was left without the ability to challenge the conclusions of that expert.

While not exactly the situation presented here,

it leads us to become concerned that once the medical care evidence-based guidelines become part and parcel of the system, our ability to challenge them is diminished, and we believe that having adequate legal counsel on both sides adequately protects employers and claimants and gives them the right to assert any positions and challenge any medical conclusions within the workers' compensation system. Once the guidelines become part and parcel of the system, those rights are diminished.

As a defense lawyer, I do not wish to deny my employer clients the right to challenge any medical conclusion in a workers' compensation case, and as a defense attorney, I join with Mr. Bricmont and the PBA in urging you not to move this proposed legislation forward.

MR. BRICMONT: Thank you, Mike, and we agreed I would end with just a few more comments from a claimant-specific perspective.

We have some legal and procedural concerns on the claimant's side, because 1800 appears to place the burden on the injured worker to bring the challenge for denial of care. Claimants, particularly unrepresented claimants, are unlikely to have the sophistication to successfully bring this challenge.

And the panel should recall that many of the worker compensation claims do occur without lawyers. The

system was initially designed so that an unrepresented worker could get the care, move through the system, recover, and go back to work without ever being involved in the litigation process. We're concerned that this legislation places an additional burden on claimants to now make that address to the litigation system to challenge this care.

And that leads to the next substantial hurdle, which is the rules for obtaining a variance when exception of the guidelines are not spelled out in the draft of 1800. We're concerned what those standards would be; what types of evidence would be required to challenge or seek a variance on exception to the guidelines.

There is also concern about unaccepted claims. These are the claims in the system where at the time of injury or shortly thereafter, a carrier may deny covering the claim, viewing it as an unaccepted claim.

In those instances, frequently the worker will then treat with their own health insurance plan or government agency plan. The lawyers then get involved, litigation pursues through the system, a favorable outcome for the injured worker reaches a determination that the claim is a covered claim, and under the current rules, there is allowance for payment back to the health insurance plan from the workers' compensation insurance carrier once

the final determination of responsibility is made.

What happens under HB 1800 to those costs that were incurred beyond the care guidelines -- remember, the care guidelines would not have been in place while an unaccepted claim was initially being treated. But now that determination of compensability has been made, presumably there is going to be conflict between reimbursing a health plan for care that may have fallen outside of the guidelines adopted by HB 1800.

Now, this leads to the cost-shifting concern again on behalf of patients and claimants. I'm concerned that the denial of care under the evidence-based guidelines will likely promote shifting of health treatment to plans not subject to those limits. That, in turn, would increase copays, deductibles, and other out-of-pocket expenses to be absorbed by the worker, which under the current system, the worker is not supposed to bear.

If the worker can’t afford those copays or deductibles for denied treatment, treatment will be delayed, delaying their recovery, delaying their return to work, and we view that as an added expense to the system that is not warranted.

So again, on behalf of the PBA, we thank you very much for the opportunity to address you this morning, and we continue to urge a “no” vote on HB 1800. We’re

certainly available to answer any questions the panel may have.

MAJORITY CHAIR GINGRICH: Okay. Thank you. And I'm sure we do have a few questions here as well.

We'll start with Representative Topper.

REPRESENTATIVE TOPPER: Thank you, Madam Chair.

I feel as though we're setting up a straw man a little bit with this legislation and some of the testimony that I've heard, that there is absolutely no way that a panel such as been outlined could possibly prescribe any regulations that are flexible, like we're going to be imposing these immovable, inflexible regulations.

I mean, isn't there a way that this legislation has given some leeway so that we're not talking about things that are immovable or inflexible, or you just don't see any way that reasonable guidelines can actually be established?

MR. ROUTCH: I'm concerned, Representative. In 20 years of doing workers' compensation, I've seen so many different scenarios. You've got so many different possibilities that crop up in these cases.

I have a hard time believing that those types of guidelines are going to be able to account for all those. And if they do, I'm beginning to believe that they will be unwieldy and very difficult to follow by medical

practitioners.

MR. BRICMONT: And I would echo Mike's comments. I think the medical people call it comorbidities -- heart disease, diabetes, cigarette smoking history, alcohol use or abuse. These are types of things that obviously aren't work related but they significantly impact how a particular individual responds to medical treatment. We have seen that in our practice, and so it's, in my view, very difficult to formulate a guideline that’s going to be able to account for these personalized aspects of care that are best left in the hands of the physician.

REPRESENTATIVE TOPPER: But I just don't see that the guidelines can't take those things into account. I think the intent, and obviously the maker of the bill would be able to speak to this maybe better than I can, but I think the intent is still that there would be an allowance for those kinds of issues.

I mean, we’re still talking about patients seeing doctors. We're still talking about, as we heard testified, these doctors are going to look at and kind of go through what they normally would. I think there is some room for reasonable guidelines without saying nobody is going to be able to take into effect whether somebody was a smoker or not.

I think that's putting a little bit -- not giving

the ability to create some of these regulations enough credit. But I did want to hear your input on that.

MR. ROUTCH: Representative, I can't say that Attorney Bricmont and I would be too disappointed by this, but the broader the standard, the more litigation I think you're going to see, and I'm not sure that's ultimately what these guidelines are trying to do.

REPRESENTATIVE TOPPER: I wouldn’t think you would be disappointed with that at all, so.

MR. BRICMONT: Representative, as I read the current language, it appears that the utilization review is limited to what is in the guidelines. So I guess the magic is, what is the guideline? If it's not controlling, if it's advising the medical industry and not controlling the care, then I think your point may be well taken, because there's flexibility for the doctor to go beyond that care.

But as I read the language currently, it seems limited.

REPRESENTATIVE TOPPER: Thank you, Madam Chair.

MAJORITY CHAIR GINGRICH: Thank you, and thank you, gentlemen.

We have another question from Representative Neuman.

REPRESENTATIVE NEUMAN: Thank you.

MAJORITY CHAIR GINGRICH: He's very good at this.

REPRESENTATIVE NEUMAN: I guess.

My question is, I know that you're attorneys, so I'm going to ask you some legal questions.

Nobody here is claiming that the worker has ever been at fault for their injury. You agree with that, right?

MR. ROUTCH: It's a no-fault system.

REPRESENTATIVE NEUMAN: No-fault system to assume that the injured worker is not at fault. With these new guidelines and shifting the burden, doesn't it assume now that some level of fault is on the worker, because now they have to have -- they have to hire the attorney. They have to fight the guidelines. They are the ones that have the burden of essentially proof, even though it is assumed that they are not at fault?

MR. BRICMONT: Well, I do view it as moving the goalposts slightly, because again, it's changing the burden of proof subtly but importantly from an employer, an insurer-driven decision to challenge to an injured-worker burden to challenge.

I can't -- and I'm not sure "fault" is really the way I would characterize it. But we definitely have a concern about shifting goalposts for what are really usually unsophisticated, and I don't mean that in a derogatory term, but individuals who just simply haven't

had a lot of interference with the legal system or filling out the medical forms. So they're somewhat unsophisticated in the sense of going through utilization review without counsel.

REPRESENTATIVE NEUMAN: And what did the worker give up in order for the original workers' compensation law?

MR. BRICMONT: Well, the worker gave up their common-law right to bring an action directly against the employer and be compensated for all the elements of damage you would receive in a typical common law litigation -- pain and suffering, inconvenience, lost wages, and the actual medical expenses incurred.

MR. ROUTCH: And, Representative, it was a trade-off, because employers gave up their rights also in part to deny coverage if in fact a worker, say, was reckless or negligent. So it was a bargain for trade-off.

REPRESENTATIVE NEUMAN: And, I mean, that's the balance that we deal with between management and the workers.

MR. ROUTCH: Yeah.

REPRESENTATIVE NEUMAN: So I appreciate your comments, and Madam Chairwoman, I appreciate your indulgence.

MR. BRICMONT: Thank you.

MAJORITY CHAIR GINGRICH: Thank you very much.

Good questions. Great testimony. Thank you very much, gentlemen.

MR. ROUTCH: Thank you.

MR. BRICMONT: Thank you.

MAJORITY CHAIR GINGRICH: Thank you again. I'm glad to know you're willing to work through this with us.

PANEL IV:

BUSINESS REPRESENTATIVES

MAJORITY CHAIR GINGRICH: And we'll invite next the people who represent the people who supply the jobs that workers get to work at and hopefully not get injured at.

Gentlemen, welcome. And I'm going to have you do the same, if you will. Introduce yourselves so everybody knows who they're talking to and with.

MR. HALPER: Good morning.

Alex Halper, Director of Government Affairs for the Pennsylvania Chamber of Business and Industry.

MR. MARSHALL: Good morning.

Sam Marshall with the Insurance Federation.

MR. LESHER: Neal Lesher, Legislative Director for the National Federation of Independent Business.

MAJORITY CHAIR GINGRICH: Good to see you all.

If it works for you, we'll work our way down the panel.

MR. MARSHALL: You know what?

MAJORITY CHAIR GINGRICH: Either one.

MR. MARSHALL: Just because I'm old and grumpy.

MAJORITY CHAIR GINGRICH: All right; if you're old then. In case you might not last---

MR. MARSHALL: And I might not last. It has been a long morning.

MAJORITY CHAIR GINGRICH: ---we'll start with you, Mr. Marshall.

MR. MARSHALL: You know, I thought that I'd lead off. And you have my remarks and those of my colleagues.

You know, I'll be brief, because it has been a fascinating morning; you know, some of the fears about guidelines we've heard and some of the reasons that people have said, let's not do it.

You know, I'll start with the reason, let's not do it, because everybody says, hey, isn't the system great right now; rates are going down. Well, rates are going down because fewer people are getting hurt. That's a good thing, obviously, but that doesn't mean that the system can't be improved.

And where we're looking to improve the system is

not on the workplace safety deal. I mean, we're all working very diligently on that, and that's the reason the rates are going down.

What we're looking to do is to try to improve one relatively narrow but very important area, and that is, how are the standards that those who review questions or disputes on medical necessity, how are those standards arrived at? How do you have some level of consistency among the roughly 20-some utilization review organizations that get randomly assigned by the Department of Labor and Industry to handle those disputes? Where do you get that consistency in determining what is reasonable and necessary care?

The way you get that and what this bill does is to say here, everybody involved, you follow evidence-based guidelines. You take the randomness out of that decision.

We've heard a lot about, gee, we don't want one-size-fits-all. Well, at the same time, you really don't want whether care is reasonable or necessary, when it's reviewed for that purpose, you don't want the utilization review organizations, who are essentially judges on that, and then if there's an appeal from that, the judges themselves, you don't want them operating under unaccountable, unknown standards. You want there to be some level of consistency.

That's what these guidelines do. They're just that; they're guidelines. They are flexible. That's why they're called guidelines; not mandates, not constraints, or anything like that. And you're going to hear the gentleman who comes after us about how that's done.

But, you know, over the years -- I've been doing this a while -- we have seen on the insurance side, on the employer side, and frankly, on the injured-worker and the provider side, what happens when you have inconsistency and uncertainty in determining what's reasonable and necessary care. You end up having bad care, you know? And if you don't have some level of consistency in how that review is done, that's what you end up with.

And it's not just that it's a needless added expense. Sometimes you get genuinely dangerous care. There was some talk about opioids. Well, opioids and workers' compensation are -- I mean, Pennsylvania is, talk about outliers, Pennsylvania is a real outlier there. It's a real problem. It's one of the reasons that physician dispensing was addressed last session. This bill goes into that, too.

I would say, I mean, we ask for your support. I think there has been, you know, some constructive dialogue. But I asked for it, and, you know, we're not here saying that there's a crisis in workers' compensation and that the

rates are going out of the, you know, out of control and skyrocketing and that this will produce huge savings.

And if all we as a Commonwealth are going to do is crisis management, then that's a shame. What we're doing is trying to bring in some level of consistency, some level of accountability, in determining utilization review questions and determining what is reasonable and necessary care.

I don't see how that's bad for patients. I would think that they would want, you know, I would think they would want to take the randomness out of that review themselves. It's not bad for providers. They should want to take the randomness out of that review. And it's not bad for insurers and employers, because they, too, want to take that randomness out of the review.

Let's have the standards that utilization review organizations apply aboveboard, accountable to all, ongoing monitoring by the department with input from the provider community. We'd accept input from anybody, but make it aboveboard.

Right now, you have 20-some utilization review organizations that are certified by the Department of Labor and Industry, and they're not even -- I mean, frankly, if a health insurance company said, here, you know, we're going to use the UROs that they would have, there would be a

clamor to say, no, that's not enough.

I mean, the utilization review, that every other line of insurance does; that, you know, the UROs themselves have to be certified. They have to beat, going with what the bill talks about, they have to beat national accreditation standards.

Only in workers' comp do utilization review organizations not have to meet some form of national standards. Only in workers' comp is care reviewed, and when it's reviewed and there's a question about whether it's reasonable and necessary, only in workers' comp is there no question of cheating. Are decisions on that based on evidence, or are they just sort of based on, well, I don't know; that's what I felt on a given day. You want to take the randomness out of that decisionmaking process, out of that review process. That's good for everybody. That's why we support the bill.

And we appreciate this inquiry, but I would ask you not to say, gee whiz, aren't rates going down? They're going down for other reasons. It doesn't mean you can't improve and it doesn't mean you shouldn't improve the system.

Thank you.

MAJORITY CHAIR GINGRICH: Thank you, Sam.

Now let me ask, who's the next eldest to the old

man in the middle?

MR. HALPER: That would be me.

MR. MARSHALL: They're both so young relative to me.

MAJORITY CHAIR GINGRICH: I know; I can't tell.

MR. MARSHALL: Who can tell?

MAJORITY CHAIR GINGRICH: You know, I understood you, Sam. I can’t guess on these two.

Alex?

MR. HALPER: Thank you very much.

MAJORITY CHAIR GINGRICH: Thank you.

MR. HALPER: Thank you, Madam Chair, Chairman Galloway, and Members of the Committee. I appreciate the invitation to be part of the discussion today.

Getting to a couple of the questions that Chairman Galloway posed at the onset -- why are we looking to do anything when rates are going down and we’re not in a crisis -- and echoing Mr. Marshall's comments, generally speaking, yeah, that's true. We are seeing far fewer workplace accidents than we ever have. I think a lot of that is due to investments from employers to make safer workplaces. It's also just a natural evolution of our economy away from more dangerous professions to a more service-based. So yes, the number of accidents and injuries has been decreasing.

What we see at the same time, however, is the average cost of individual claims continues to increase. And when you sort of combine the two, they cancel each other out and mean that rates generally stay the same.

But I think it's very important to note that -- and again, with respect to treatment guidelines, as was noted by one of the medical professionals -- we're talking about really a minority of cases that would be impacted. And when you look at individual, individual businesses whose insurance premium rates are partially based on their experience, if they happen to be an employer who has one of those outlier cases where the costs for that claim just continue to increase for no good reason, then that individual employer is going through a crisis if their rates are increasing so exponentially.

We did a survey this past summer of Pennsylvania businesses, just put some numbers behind it and asked about workers' comp premium rates. About 40 percent said they were generally steady. Only 4 percent saw decreases, and the rest saw that their premium rates increased. So yes, when you look on average, in general statewide, as a similar around the country, we see rates relatively steady. But again, if you look at individual businesses, they may be going through a crisis if their rates are increasing.

So again, we look at why is the average cost of

individual claims increasing, and WCRI, Workers' Comp Research Institute, has been cited already several times today. They are a sort of nationally recognized authority on this subject. And we see different measures where Pennsylvania is, as was noted, an outlier State.

One of the measures that WCRI regularly tracks is litigation costs. Pennsylvania was the second to worst State in the study for average litigation costs per claim -- 60 percent higher than the median State. And this is, I think, a big reason why treatment guidelines comes into play. Right now, worker's comp says treatment is covered if it's reasonable and necessary, and it ends there pretty much. It's almost like if you all passed a law that said fraud is illegal and left it there.

Of course there's going to be constant litigation if each individual judge and jury is deciding for themselves what constitutes fraud. That's what we're seeing right now. Each individual URO, each individual judge, is coming up with sort of their own definition for what constitutes reasonable and necessary, and what that means is that litigation becomes a necessity to figure that out.

And again, those are costs that are not going to the purpose of treating patients. It's certainly not helping the business community. And again, we would

strive, we would love to be just an average State when it comes to excessive litigation costs, which are prominent in workers' comp and certainly in other areas.

WCRI also ranks Pennsylvania very high in terms of physical therapy visits per claim and has already been noted in opioid use, which I know is a high priority for many in the Legislature and something that is particularly acute in workers' comp.

So we do support House Bill 1800. We do support the idea of treatment guidelines. And we support workers' comp. I mean, we've talked about the grand bargain that workers' comp represents, and we support it. I think what frustrates employers sometimes is when you have proven strategies in health care that help contain costs without hurting patients, proven strategies that for some reason are not able to be or are not applied to workers' comp.

There was talk about treatment guidelines today. We have the benefit of Pennsylvania being a little bit late to the game. This is not hypothetical. This is not theory. Most States in the country have treatment guidelines, and we're able to -- we have the benefit of their experience, and we did not see, we did not see a mass exodus of doctors from workers' comp. We did not see patients being prescribed more opioids.

Quite the contrary. The opposite has occurred.

We've seen in treatment guidelines State outcomes improved. Opioid overutilization and overprescription has been mitigated.

So again, I appreciate the invitation to be here today, and I will just finally note that of all these States that have implemented treatment guidelines over the years and over the past decades, not a single State after implementing guidelines has reconsidered and gone back and decided they weren't good. Every single State has had a positive experience to the point that they've maintained the utilization of treatment guidelines in workers' compensation.

So thank you again for the opportunity to testify, and I'll be happy to answer any questions.

MAJORITY CHAIR GINGRICH: All right. Thank you very much.

I guess you get to be the young buck in the room.

MR. LESHER: Yes. And there's a benefit to going last.

MAJORITY CHAIR GINGRICH: There you go.

MR. LESHER: They've already covered all the salient points, so I can be very short.

MAJORITY CHAIR GINGRICH: You can wear that one all day on St. Patty's Day, right?

MR. LESHER: Thank you for having me, Chairman Gingrich and Chairman Galloway. Congratulations, and I look forward to working with you.

I'll be very brief, because I think Sam and Alex have covered all the points.

I would just reinforce, you know, particularly what Alex said. He cited to you the statistics from their study that 56 percent or the majority of their businesses are reporting that their workers' comp rates have actually gone up, and that's something that we point out in our testimony. Oftentimes we hear from some folks, well, hey, loss-cost filings went down, and therefore, everybody's premiums have been reduced by whatever that number is.

We just caution that, you know, it's a little bit more complicated than that. Certainly a loss-cost filing is the largest component of what goes into the rates, but that doesn't necessarily apply across the board for every industry or for every employer. And we tend to hear from those employers who continue to see their rates going up; you know, when we report back to them that we got physician dispensing done, you know, with bipartisan help in the Legislature, and they say, well, then why did my premiums go up again this year?

So I do think it's something that we hear from a lot of our small business members who are concerned about

workers' comp, and I'll give you one example, speaking with a member of ours who owns and runs a foundry in Butler County and has an identical foundry across the border in Ohio and called me the other day to say, you know, I just don't understand why I'm paying twice as much for the same number of workers in Pennsylvania as I am in Ohio; how can this be? And so it's an example, and he says to me, you know, we're looking at expanding our operations and we're taking a close look at all of our cost centers, and that's a significant cost center for us and could be one of the deciding factors for why we had more jobs in Ohio as opposed to our Pennsylvania facility.

So it is a job-creation issue, you know, what employers are paying for their workers' comp premiums and how many jobs they can afford to create here in Pennsylvania relative to other States.

I would also reinforce what Alex said about, you know, most other States have treatment guidelines. I mean, we don't have to get into a discussion on science, and I left my war-on-call folder back at the office so I won't go into that. But we do have examples. I mean, this is the great thing about, you know, the democracy that we live in and the States being able to be incubators of these types of policies.

The majority of other States have implemented

treatment guidelines. From the testimony that we heard already today, I didn't actually hear a single person reference pitfalls that were experienced in other States. I didn't hear a single testimony reference. You know, there's basically three models that are out there -- ACOEM, ODG, and the Colorado treatment guidelines, as I understand. There really wasn't any specific reference to specific problems with those treatment guidelines.

We heard a lot of theory about what could happen and we're worried and concerned about certain things, but there are specific examples out there when we reference national guidelines. They're out there and we can look at them, and, you know, I would just point out, I don't think we really heard any specific problems that have been identified that would be concerns. And if there are specific problems in those treatment guidelines, the bill does allow for a process with Pennsylvania-specific medical professionals to adopt, you know, amendments to those guidelines. So I think that it's appropriate.

I will also just, you know, quickly note, when you look at where Pennsylvania ranks nationally, too, our workers' comp prices are significantly higher than the average. We rank, according to the National Foundation for Unemployment Compensation and Workers Compensation, which put out a recent study, we're the 12th highest State in

terms of workers' comp premiums, 22 percent above the national median. So it gets back to my point earlier that, you know, it's a significant cost that small employers are looking at, whether they can create jobs here in Pennsylvania or are looking at other States.

So with that, I'll wrap up my comments, and we can answer any questions that you have.

MAJORITY CHAIR GINGRICH: Excellent. Thank you very much. And we do have some questions from Members.

And I will start with Representative Gergely.

REPRESENTATIVE GERGELY: Thank you, Madam.

Let's get some new information. NBC New York, March 15th, this year, an investigative report. A gentleman had -- they have an evidence-based medicine workers' comp system: 64 ophthalmologists, not one would take his case. The quote from one of the doctors: "You get challenged at every step" -- diagnosis, meds, and testing. That's a problem. That's a big problem. It goes back to a lot of the issues.

We could follow up on that. I see, Sam, you seem concerned.

MR. MARSHALL: Yeah. You know what? I'm appreciating it.

REPRESENTATIVE GERGELY: This is what I'm saying.

MR. MARSHALL: I'm appreciating that. You know,

if 64 of them won't do it---

I mean, this is where there's a little bit of a, you know, whether there are some red herrings being tossed or it's apples and oranges, but there's some confusion. Because you know what? I really want to look into that, because we don't see -- frankly, we use treatment guidelines in all other forms of health insurance right here in Pennsylvania right now and you don't see the problems.

You know, what we're talking about, Representative, is when you do -- right now in workers' comp, if there is a dispute between the insurer and the employer and the provider as to whether care is medically necessary, reasonable and necessary in the parlance of the act, that then is heard by one of 20-some utilization review organizations that are randomly assigned to the case---

REPRESENTATIVE GERGELY: Right.

MR. MARSHALL: ---by the Department of Labor and Industry. What we're talking about is trying to take -- they may be randomly assigned, but the standards that they apply shouldn't be random.

I would be fascinated to learn in that---

REPRESENTATIVE GERGELY: So why aren't we writing a URO review bill instead of this? Why shouldn't we do

that instead if we need---

MR. MARSHALL: Actually, I mean, I'm not in charge of setting what the picture in the bill is.

REPRESENTATIVE GERGELY: I'm just trying to get your input.

MR. MARSHALL: But as our remarks, what we're talking about are treatment guidelines that control the review of whether the care is reasonable and necessary. That review, that questioning, that deciding whether the care is reasonable and necessary in the first instance is done by the treating doctor. The doctor says, you know what? I think this care for Patient Smith is reasonable and necessary. He then submits a bill. Whether it's prior authorization or after the fact, he submits his claim, his bill, to the insurance company or employer.

The insurance company or employer looks and says, you know what; I agree, because that's what happens apparently in the overwhelming majority of cases. Case approved; claim paid.

But at times, the insurer or the employer will say, you know what? I don't agree with that. I don't think that that's reasonable and necessary care. I think the chiropractor wants to do 10 visits and only needs 6 or whatever the case may be.

In that situation, then the parties can say, you

know what? Okay, we didn't agree. We now go to the utilization review organization. Either party, you know, either side, can request that of the Department of Labor and Industry.

The Department of Labor and Industry has 20-some UROs approved. None of them are certified by any national organization, and frankly -- I think 3 out of the 20 some. What we're talking about here is having treatment guidelines so that everybody involved in that decisionmaking process, everybody involved in that review process, is working on the same page.

You don't want, of the 20 UROs out there, you don't want some doing it this way, some doing it that way. You don't want, frankly, you don't want insurers and employers saying, you know what? Some of us make this decision; some of us make that decision. You want -- you're never going to have one-size-fits-all. There's always going to be flexibility in it, but you want everybody at least looking at evidence. You want everybody making decisions that are evidence-based.

We have -- and the fellow who is going to follow us can talk about it, you know, about how the guidelines are developed and how they work. But everybody, I mean, the providers, have said, yeah, we live with guidelines. You live with them.

REPRESENTATIVE GERGELY: Okay.

MR. MARSHALL: I mean, health insurers do it, too.

REPRESENTATIVE GERGELY: Alex, you said that States haven't changed back from when they have adopted this, correct?

MR. HALPER: Correct.

REPRESENTATIVE GERGELY: Have States amended? changed? done anything significant to it, like Colorado or New York, from when they first implemented it to where they found fault in it and they've had -- because I don't believe every State has had a problem with keeping some of the doctors in the system, et cetera. Would you disagree or would you agree with that?

MR. HALPER: Well, my understanding is, there have been States that have attempted to create their own set of guidelines that have ultimately shifted to one of the nationally recognized guidelines. I'm aware of examples of that occurring, but not totally shifting away from an evidence-based model.

And again, you know, talking to some of our members with experience in this, I think they would, just as you stated, they would really describe this as a utilization review focus.

You know, as the gentleman from the Orthopaedic

Society said, you know, I think he said 80 percent. You know, in the vast majority of cases, treatment guidelines are not even relevant because they're clearly treating with their standard. It's how you go about justifying an exception to the rule, and as long as that ability to qualify for an exception is laid out, I think it's totally, it's completely appropriate. It's just putting some standards on how you do that.

REPRESENTATIVE GERGELY: I think, you know, I think there's room for us to have that expanded discussion on UROs, too, since we learned so much in this hearing.

One thing between Neal and yourself, Alex, and you haven't really had much to do with it, Sam, is, you know, we do a UCC, Uniform Construction Code, based on national standards and guidelines. How are we doing with that, guys?

We've created a bureaucracy we can't even get through this year. We've been doing 2012 standards. But we want to create a bureaucracy of guidelines for the medical health for humans in this State. We can't even get it for building codes.

This is troubling. That's one of the reasons why this implementation -- and this is the committee that handles this with the UCC codes. We can't even agree on that. We have our own board; we have national standards,

and we can't even implement it, and you guys know that. You're a part of that issue. But yet we want to come here and say we're going to create a whole new bureaucracy.

We already got a letter from radiologists wanting to be on this committee. We only have the six that Representative Mackenzie proposed. We need to take a step back and really evaluate this.

I appreciate the conversation. Sam, I appreciate the challenges that we face, but creating a whole new bureaucracy really is troubling to me.

MR. MARSHALL: You know, and I would caution you -- the fellow who follows us can talk about it in other States -- we're not in favor of a whole new bureaucracy either. We're the ones who absorb the cost of it. We're the ones who pay it. I mean, first we pay the operational costs of the Bureau of Workers' Compensation. Second, we pay it on a case-by-case basis. What we're trying to do is take a level of randomness that isn't fair to anybody in deciding whether care is reasonable and necessary.

Now, we're trying to make -- you know, we're trying to take that randomness out. It's not a one-size-fits-all, but we're trying to say, here, you know what? Let's all make sure that it's based on evidence. That's what the guidelines do. They're not, they're not the UCC.

MR. HALPER: Yeah. There is bureaucracy in health care right now whether we like it or not. I think our contention is, other forms of group health and Medicare and Medicaid and workers' comp in other States have figured out some ways to help bring some stability to the system, help control costs without impacting patient care, and we would at least like Pennsylvania to look at some of these proven strategies.

MR. LESHER: And just, I mean, it's a bit of a technicality, but I do think this would work differently than the UCC Board where, you know, with the UCC Board, they're going -- you know, you have annual updates that are coming out, and that committee is going through each one of those and deciding which ones they want or not.

As I understand the bill, it would ask that the department adopt the national guidelines, and then from that point, where there are adjustments needed, decisions would be made.

So I think the struggle right now going on with the UCC Board is, a year has now elapsed, and it is becoming incredibly complicated to try and publish a document. We're, you know, trying to get all those things to fit up, and we have a member that sits on that---

REPRESENTATIVE GERGELY: You realize, even on this board, though, you'll have divergent opinions.

MR. LESHER: Right.

REPRESENTATIVE GERGELY: An orthopod may have an opinion that his treatment is necessary, but the chiropractor doesn't agree because that might affect his bottom line, gentlemen.

MR. LESHER: Well---

REPRESENTATIVE GERGELY: You realize that, right?

This is not exact science, is my point. It's similar in that sense, that one versus the other may not agree on the changes because it will affect their bottom lines, with all due respect to each other.

My job is to protect the injured worker. Their jobs are going to, you know, protect their bottom lines. I'm looking out for them when I say those things, not---

MR. MARSHALL: And I think you'll hear the fellow who follows us and who can talk about how -- first of all, they're guidelines; they're not codes. And I know there's a difference, and that's one of the differences right then and there. But they are guidelines.

And we would agree. Protecting the injured worker, you know, this is not, gee whiz, insurance companies and employers are against injured workers. Frankly, we want them back to work as quickly as possible, too.

REPRESENTATIVE GERGELY: We all share that sentiment. You know that.

MR. MARSHALL: You know, it saves us. The quicker they're back to work, the quicker they're off of the claim.

So, you know, all of this is evaluated on whether the care works for the worker, whether it gets them back. We wouldn't be advocating this if it was going to set up some big complicated bureaucracy, because the one thing a big complicated bureaucracy does is it keeps the person out of work longer. I mean, it never gets them back to work quicker.

So, I mean, as you evaluate this, you know, let's be careful on that.

REPRESENTATIVE GERGELY: Thank you.

Thank you, Madam Chair.

MAJORITY CHAIR GINGRICH: Thank you, Representative.

Representative Mackenzie. I think you had another question.

REPRESENTATIVE MACKENZIE: Thank you, Madam Chair.

Yeah; I did just want to comment on Representative Gergely's statements.

First, I share your recognition of the importance

of looking at utilization review, and that is something that we highlight in the bill. It's on page 4 of the bill, and it's in the summary as well. So we do want them to be nationally recognized and the accreditation standards be met there, and so that's URAC. We are one of the few States that does not do that currently, so I think that needs to be updated.

And then just briefly on the UCC comparison. I mean, I think the national standards that start out each of those is about where the comparison ends, in my opinion. The adoption and review process is totally different in those two systems, and the recognition at the State level is drastically different as well.

So again, one point of comparison, but again, I think they are two totally different systems. But thank you.

MAJORITY CHAIR GINGRICH: Thank you very much for commenting on that aspect.

Representative Truitt, I believe you have a question.

REPRESENTATIVE TRUITT: Yes. Thank you, Madam Chair.

As I listen to the testimony, I wonder if my question might be more appropriate for the next panel, but I want to find out from you guys.

I mean, I happen to be a fan of alternative medicine, and what I'm hearing is a lot of concern about, you know, who's going to create these treatment guidelines and will there be bias in it and so forth.

I mean, I have had extraordinary luck with my chiropractor, is my favorite doctor, because I can walk in there and he can actually, when I walk out, I feel better. I would be worried as a worker that if I got injured on the job, because now I don't control which doctor I go to or what these guidelines are, that they might tell me I have to go to some, seek some kind of care other than chiropractic care.

Do you think there's room in the establishment of these treatment guidelines to ensure that there is at least equal, I don't know if we want to call it representation, but making sure that there are alternative medicine options available to patients as part of those treatment guidelines? So that if the panel doesn't -- you know, if you wind up with a panel that is developing these treatment guidelines, that it doesn't wind up biased in one direction or another? Is there a way that we can, you know, make it so that the treatment guidelines are developed -- when you say evidence-based, that scares me a little bit, because I worry about some doctors saying, oh, you know, chiropractic, that's not real medicine. But I know from my

personal experience, I've had good luck with it, so.

MR. MARSHALL: I think the fellow, the gentleman who will follow us, can talk about how the chiropractic community in particular has embraced the evidence-based guidelines.

Also, I hope people aren't afraid of having guidelines that are evidence-based, because, you know, I think rather they be evidence-based than not based on evidence. I mean, if the guidelines aren't based on evidence, they're probably not worth that much.

REPRESENTATIVE TRUITT: Yeah. Maybe I'm misstating it. I mean, I have a preference as a patient to go to a chiropractor versus a DO.

MR. MARSHALL: Each of them -- the only guidelines out there, the only nationally recognized guidelines out there, all recognize, you know, chiropractic care. They recognize physical therapy. They recognize a range of care, you know, and the different forms of care that can address the needs of an injured worker.

I mean, I think that the chiropractic fellow talked about -- you know, sometimes, and frankly, I think they may do a better job of it than the actual treating physician himself. I mean, I think the chiropractor talked about, if you go to a chiropractor, you know, you're probably not going to get surgery. If you go to a surgeon

-- you know, to a hammer, everything is a nail. You know, people tend to prescribe that which -- people tend to prescribe that which they can perform. And I think the guidelines actually, you know, help ensure that that doesn't happen, but again, that's probably best addressed by the fellow after us.

REPRESENTATIVE TRUITT: Yeah. And I found generally, like with my personal medical insurance, I get more pushback from the insurance company over our visits to the chiropractor.

You know, they never question our visits to any of the other doctors, but it seems like once a month I get something in the mail and they're saying, you know, you're only allowed to go see this guy six times over the next year. And, you know, I get more pushback with regard to his services, which are far more effective for me personally, than any of the other doctors that I see for various things.

So I'm hoping -- well, I guess we'll find out from the next panel whether there’s a way to ensure that the treatment guidelines adequately provide for the option to seek alternative medicines for a patient that prefers it, and I hope that you guys would be supportive of something like that if we go down that road.

MR. MARSHALL: Yep.

REPRESENTATIVE TRUITT: Thank you, Madam Chair.

MAJORITY CHAIR GINGRICH: Thank you, Representative.

I don't think I missed anybody?

I think we're all thankful to hear from you guys, and equally eager to hear whoever this gentleman who will follow us we have referred to about 10 times now, I think. So I think he has a name.

But thank you so much, gentlemen---

MR. HALPER: Thank you.

MR. MARSHALL: Thank you.

MR. LESHER: Thank you.

MAJORITY CHAIR GINGRICH: ---for your input and your continued input.

PANEL V:

INDUSTRY REPRESENTATIVES

MAJORITY CHAIR GINGRICH: We're down to a panel of one.

Last but not least -- it sounds like we have a lot of questions for you.

MR. EICHLER: That's a good thing.

MAJORITY CHAIR GINGRICH: This is Ken Eichler,

and he'll tell you more about himself. But I do want to point out to my colleagues and those of you who are looking for his testimony, it was not in your packet. It's green; it's laying with your info, so you'll want to refer to that.

And I have no idea whether you're speaking to that or speaking in broader terms, but welcome, and tell us a little bit about yourself.

MR. EICHLER: Madam Chairwoman, thank you.

Representative Galloway, Mr. Chair, Representative Mackenzie, thank you for including me and allowing me to join you today.

Let me tell you a little bit about my background, and then I'll jump into a presentation a little bit.

I did a little bit of a different presentation, as you see. I went with more of a PowerPoint style rather than a written testimony. When you're the last speaker in a 3-hour meeting, you fear what I refer to as the Charlie Brown syndrome. We've all seen that, you know, the comedy strip, "Wa wa, wa wa, wa wa." So hopefully I'm going to give you speaking points or thought points that you can take away.

I'm also going to give you some background on myself, on guidelines, and hopefully respond to some of the issues that have come up today. So if I'm going a little

too far abroad, please feel free to rein me in accordingly. I don't want to go off skew on the proceedings here today.

Who am I?

MAJORITY CHAIR GINGRICH: Security will be dragging you out.

MR. EICHLER: Been there, done that. No.

I am a claims professional. I have been licensed as an independent insurance adjuster in 5 of the 10 lines of New York, workers' comp being my specialization. I've been licensed since 1992.

I started out as a stakeholder. I got involved on the national scene when our short-term Governor Spitzer had the workers' comp reform package in New York. I was appointed, representing the Business Council. So I sat on the committees; I sat in the hearings. I was part of the group that decided on what guidelines were being implemented and what was happening. From that, I moved to the national scene.

I am the Vice President of Regulatory Affairs for Work Loss Data, who produces ODG, one of the national guidelines that has been adopted in most of the jurisdictions that have adopted the guidelines.

I have previously represented ACOEM, the American College of Occupational Medicine. And I have been very privileged to serve the IAIABC, and for those of you who

are not familiar with it, that's the association of workers' comp regulators across the US, Canada, part of the EU, Australia, and New Zealand.

I have had the pleasure of serving as Chair of the medical issues and the return-to-work committees for over 6 years, and I'm currently one of the handful of selected individuals appointed to the Advisory Council of Industry Members. So I'm here to help expose you to guidelines and to educate you a bit.

One of the most important things with guidelines is the guideline should focus on expediting and facilitating appropriate care for injured workers. We want consistent care. We want guarantees of care. And when I talk about injured workers, something that concerns me came up, and it comes up in all the jurisdictions, about, do we want State-specific guidelines?

And I question, do individuals get injured differently and does the body get injured differently in Pennsylvania? Does the body heal differently in Pennsylvania? Is there something different in the water or the air that I'm not quite aware of that would change the physiology in Pennsylvania? Because absent those findings, I question why guidelines would have to be just specific to Pennsylvania rather than to individuals and based upon medicine.

We talked about evidence-based medicine quite a bit today. What is evidence-based medicine?

Evidence-based medicine is the ranking of studies transparently from high to low with subcategories within. Most research that's out there is self-serving and self-promoting. We have to call it as it is. Who is it done by? It's done by Big Pharma; it's done by device manufacturers to get their products to market.

Who else is doing studies? Medical institutes; research institutes. Is that self-serving? Certainly is if it's not NIH. Why is it self-serving? You get the big names, you get the big studies, you get the big benefactors, and you get the big donors.

I had the pleasure of being a trustee of the largest health-care system in New York. It's now known as Northwell. It was North Shore-Long Island Jewish. We brought in the big researchers; we got the big donors. So it is self-serving.

So what is the responsibility of the guidelines? It is to take in all those articles, all the studies. I think it was the British Journal of Medicine, and please don't quote me on the source but it was out of the UK, that stated for a doctor to stay current on studies, they would have to review 19 studies per day. How do you review 19 studies per day and still practice medicine? It can't

be done.

Many of you, I'm guessing, are attorneys. Yes? No? No; okay. Many of you I'm hoping are familiar with Westlaw and LexisNexis. They are search tools to access legal information. Treatment guidelines such as ODG, such as Reed Group's ACOEM product, such as others out there, are search tools. It is our job to comb all the evidence that's out there to have independent rankings and transparent rankings and reviews of these studies to determine whether they are truly evidence-based, whether they are skewed, and rank them accordingly, so that one can rank and compare evidence to help make the decisions.

It's the guideline producer's responsibility then to give an overall summary, but to give one the ability, like Westlaw or LexisNexis, to drill down to the abstracts and the actual studies to support decisions for or against treatment and to help support the requests of treating physicians.

I've heard comments today about how well the system is doing here, and it's doing good, too. It's doing really great. But that would support, if it ain't broke, don't fix it. If we're supporting "if it ain't broke, don't fix it" in Pennsylvania or anywhere else, then we wouldn't have further development technology and further improvement.

Pennsylvania has been a leader in technology. You have got major institutions here. If they didn't -- if they adopted that, we wouldn’t have the forward thought that we do that's coming out of Pennsylvania.

We heard a lot about low costs in Pennsylvania. If you go down and drill down to the studies, a lot of the low costs are related to fee-schedule issues, not necessarily utilization issues.

I'm going to jump around for a second in my slide presentation here.

Last week I had the pleasure of being at the WCRI conference -- thought leaders from around the country. And some of the pieces that came out in WCRI, and one piece I’m quoting from 2015, was that “Pennsylvania had amongst the highest utilization of physical medicine services of the study states.” I believe there are 26 States in the study. “Pennsylvania providers of these services billed among the highest average number of visits per claim and services per visit of study states.” Interesting.

Long-term use of opioids. Opioids are a major problem, major, major problem, and we’re horrified that Pennsylvania ranks in the top three States for poor performance with opioids. What are those top three States? And there's no common thread. We’re looking for the common thread. It's Pennsylvania, it’s Louisiana, and it’s

New York. You have more overdoses and more prescribing in Pennsylvania than most other States in workers' comp. It's truly disproportionate. We owe it to the injured workers to help protect them.

Let's speak for a second about group health versus workers' comp, because I think it will address some of the issues and concerns and questions that came up.

In group health, you get what you pay for. You buy defined benefits, and you have associated premiums based upon the associated risk. It's the highest level of gambling there is in the world. The insurance carriers figure out what their premiums are based upon what the cost of medical is going to be.

In group health, if you don't buy the coverage, you're not covered; you don't get that care. That's not the case in workers' comp. Part of the grand compromise, the grand bargain: Over 100 years ago before workers' compensation was that an injured worker is entitled to any treatment, including medication, that is causally related and medically appropriate. There are no exceptions.

Guidelines do not deny care. Guidelines bucket treatment into two basic buckets. One bucket is that it's fast-tracked. It's low risk. It gives you the evidence to show what is, quote, "recommended" versus the bucket that is referred to often as "not recommended." But "not

recommended" does not mean the care isn't given. "Not recommended" means it needs further substantiation of medical necessity, and that is to protect the injured worker. It is not cost driven; it is blind to cost. It needs to be blind to cost.

But there is a small percentage of treaters out there, medical providers, that are the outliers. And it upsets me that we have to spend time and money and energy to control the outliers. But look at basic laws of society. Basic laws of society are set up to control the outliers. Most citizens are good citizens. They will follow inherently what's right for society. But we have rules, we have laws, we have regulations, we have statutes to control those individuals.

Well, those outliers on workers' comp are the outliers that drive the majority of the costs. It's not the injured worker that has a minor injury and goes back. It's not the Representative Dushes of the State who have neuropathy or lack of sensation post-injury and who goes back. It's not me who had back surgery secondary to a workers' comp case who goes back to work. It's those outliers who are uneducated medical consumers and become the pawn in the system.

We heard somebody testify today that the injured worker can't figure out their way through the system.

Well, then how the heck are they going to figure their way through medical care? They can't do it in group health; what makes you think they're going to be able to do it in workers' comp?

Treatment guidelines protect that injured worker. It guarantees them a certain standard of care, and with the proper documentation of the exceptions above and beyond the guidelines, that injured worker gets the care.

I think it's very naïve for folks to believe that treatment guidelines are not being used in this jurisdiction or any other jurisdiction in this country. If that was the case, then the utilization review professionals, the UROs, would be using what for some of us remember, Johnny Carson, the Carnac method. You would put on a turban, you would hold the file to your head, and you would guess what the decision is going to be.

Or they'd be doing random willy-nilly all over the place. Do you want that for your constituents, or do you want certain controls to guarantee that the proper evidence, which is updated on a regular basis, and I provided Representative Mackenzie with some comments from myself and industry folks on the tweaking of some of the language.

I think the language in the bill does need to get tweaked, and I think folks are very willing and open to

tweaking. But I think the guiding principles here -- and we have to look at the legislative intent versus the draft that's in front of us of the bill right now.

I believe the legislative intent -- and please, you know, Representative Mackenzie or others correct me -- but it is to ensure that consistent evidence-based medical guidelines can improve outcomes for injured workers with transparency, decrease transactional processes, and associated cost savings.

And forgive me if I get passionate about this stuff. I see what happens to injured workers across the country, and we've got to be there for them.

I also believe that folks are naïve when I say that guidelines are being used; evidence is being used. And I think if one applies the perspective, look, if you know you're going to have to go up against utilization review potentially at some point, you know in anything in life you're going to meet a certain hurdle, wouldn't you want to consider that hurdle from the onset of the race to know how to handle it and how to appropriately document, how to appropriately move things forward? That's what one does in group health.

You ask any doc; they have to know how the different carriers, the different payers in group health pay. Well, right now in Pennsylvania, they're kind of

guessing how the different payers handle things. Why not have that set road?

Because with consistent transparent utilization review criteria, regardless of who the payer is, everybody having the same criteria with disclosure for the criteria and the supporting evidence, the actual articles, physicians can apply that on the front end. They can know what they need to do in approaching the case, and they can know when they need to document what they need to document.

In California, the California Orthopaedic Society worked with us when guidelines were adopted, and what did we do? We worked with them to look, specifically with the Orthopaedic Society, subspecialty groups. The folks who do shoulders are doing about 10 or 15 procedures that require -- that cover most of their procedures, most of their billing.

So what did they do? They understood the guidelines. They understood the evidence. They used that conversely to hold the carriers to that standard. They documented accordingly. They cited the evidence. They cut and pasted the guidelines, and they knew what to state in their reports to make sure that patients were getting the authorizations they needed.

I think there were a lot of perceptions voiced

here today versus realities. I almost wish that for each person that came and testified, they were asked at the onset of their testimony whether or not they have actually looked at any of the national guidelines, whether they've looked at the specifics of the guidelines, and whether they have taken specific cases and run them through the guidelines to see what the implication and application of the guidelines would have been on the outcome of that case and the authorization of care for that injured worker. I bet you the testimonies would have been different if they had. And I challenge them and I welcome the opportunity to have folks learn about guidelines.

Folks are concerned about objective substantiation. Well, as I said, they need to objectively substantiate their positions and understand and take a test-drive. Would you make comments on a car without getting into it just by guessing, because you saw a commercial?

Unfortunately, injured workers make a lot of decisions based upon commercials, because when they're home injured, one of the two top advertisers they are seeing: Big Pharma, and plaintiff attorneys telling them that if you have a workers' comp injury, an auto accident, a slip and fall, or a med mal, you just hit the lottery. And those poor injured workers don't hit the lottery. They're

told they may, but they don't.

I hear about cookbook medicine and one-size-fits-all. Well, guidelines are a basis based upon the evidence, and evidence evolves and, therefore, needs to be updated on a constant basis as new evidence comes out, but that's not cookbook. That’s reviewing the evidence and allowing for exceptions and showing physicians how to document the exceptions and document the variances to, on a fast-track basis, get treatment authorized.

In Louisiana, prior to their adoption of guidelines, the dispute resolution on medical care, 18 to 24 months; currently, less than 60 days. Over $20 million saved the first year on decreasing the delays. So it’s not cookbook. It’s enabling and giving the tools.

Evidence-based decisionmaking versus nonevidence-based decisionmaking. Do you want Susie the Adjuster who just graduated college to make a medical decision on a workers’ comp case? I don’t. I want that driven by medical evidence. And I want the denial to require a medical professional to look at it, not Susie the Adjuster.

There was a commercial, and I get Susie the Adjuster, because there was a commercial a few years ago for one of the insurance carriers with Susie with her files piled up who didn't have a clue. I want docs and medical

-- and when I say docs, I should say medical providers making medical decisions. It's important.

We talked about controlling outliers. Those doctors are out there.

Guidelines need to be ranked and summarized and updated.

There was a concern about shifting the burden to the employer versus the payer. Well, you know what? The responsibility should be on the treating physician if they want an exception, if we're holding standards and it's an open hand of cards. It's not the employee; it's the doctor who has to make their medical decisions.

A couple of quick facts and figures.

I spoke about WCRI with the utilization and Pennsylvania ranking in the top three with opioid problems. I would encourage you to take a look at some of the studies on the CDC. The CDC just released their new opioid guidelines. Numbers are off the charts.

I encourage, if any of you have the opportunity, to attend the prescription abuse and heroin summit -- it's now "and heroin" -- in 2 weeks in Atlanta run by the Federal Government; very important.

Take a look at the map from CDC. Pennsylvania is in the second tier for the highest number of prescriptions per hundred. You're ranging between 82 and 96

prescriptions per 100 people in this State. It's out of control.

Opioids in New York, a neighboring State, also in the top three. Look at the study that the New York Times cited the data. Cost of a claim without opioids, $13,000. Cost of a claim with short-acting, $39,000. And by the way, short-actings on the drug formulary are approved for front-line use. Long-actings; those are your really dangerous ones: The cost goes up to 117,000.

What's the impact on other States? People need to look at that. Through the IA, we can facilitate communication with other agencies as well as other Legislators across the country, and I encourage you to take advantage of that.

But Texas did the best job of data collection in the country. They adopted guidelines and formulary. Formulary is the list of drugs. And again, it's two buckets: What's fast-track versus what needs substantiation. The addictive, dangerous medications need substantiation. They're not denied, but they need substantiation.

There was a 70-percent reduction in the use of those dangerous drugs in Texas.

Panic dust. We went to the docs: Why did you do it? How could you stop prescribing? Their answer was,

because you gave us the ability to say no. You got us out of the hot seat.

We talked about patient satisfaction surveys today. We all get them when we go to our doctor, don't we? Why do docs write the scripts? A lot of the time, they are afraid of patient satisfaction surveys. If you don't write the script for the pain meds, the pediatrician doesn't write the antibiotic script, or you don't write the diagnostic testing, what do you get? A negative patient satisfaction survey. What does that translate to? Lack of bonus to the doc, lack of contract renewal, and/or lack of raise.

Texas went to the point of introducing legislation two sessions ago to protect the doctors on those scenarios. The physicians substituted more appropriate medications, and costs, which aren’t important but are a benefit, medication costs for the opioids went down over 81 percent, with an overall 30 percent drop in the medication costs overall for workers’ comp.

Other State outcomes: North Dakota, also a State that was doing, quote, “real well.” Lowest premiums when they adopted it in 2005. Their costs dropped 40 percent while improving quality of care. Fifty-two million dollars in premium dividends were returned to the employers. That's major. That's one year.

Texas. Folks, lost time was down; work comp premiums down. Texas is now one of the best States to do business in. Workers comp translates to retaining -- good workers' comp translates to retaining business and attracting new business. Pennsylvania is fighting with New Jersey, New York, and other surrounding States, and Texas as well as others, that are trying to grab your industry where there are better tax structures. You've got to give them better workers' comp programs to do that.

Somebody talked about access of care. Access of care in Texas right now is up 42 percent over pre-guidelines. Doctors know the roadmap. They're not looking into a crystal ball anymore.

One of the Representatives, unfortunately who left the room, questioned why New York had a problem getting ophthalmologists? Well, what they didn't tell you was in New York State, in order to treat or do second-opinion exams, you have to be approved by the Workers' Compensation Board and you have to get an authorization number. No authorization number, no payment.

Ophthalmologists generally, if somebody wants to see an ophthalmologist and they can't find one, because not that many participate in workers' comp -- not because of guidelines but because of the administrative burden of

doing business in New York. And right now there's a group addressing administrative burden with the administrators in New York. It's ridiculous. Okay?

So what happens if somebody wants to see an ophthalmologist in New York? All that person had to do was call the Workers' Comp Board. They had the list of everyone authorized to treat in the State. And if you deny to take care and if you are on the authorized list, they drop you like a hot potato. They don't stand for it. So that when you hear these one-off stories, you have got to look at them in the bigger picture.

Oklahoma. They've gone through several different revisions. They adopted treatment guidelines, and costs are also down 22 percent.

I tried to hit on some of the highlights. I could go on for quite awhile. I recently met with the folks from North Carolina. They asked me for an hour meeting; they kept me on the phone for 2 ½ hours. Why? Because we really dove in. We looked at guidelines. We ran case scenarios. We got an understanding, and that's what I encourage you to do. Whether it's with the groups individually, whether it's having a hearing, whether it's having informal educational sessions, get informed, protect your injured workers, and please do the right thing.

MAJORITY CHAIR GINGRICH: Thank you. Thank you,

Ken.

I have to commend your ability to talk faster than almost anyone I know. And, and be clear and concise and understandable. So that's a real---

MR. EICHLER: Thank you, Representative.

MAJORITY CHAIR GINGRICH: Were you a communications major? You're good.

MR. EICHLER: No, but when you testify at hearings, you learn pretty quickly.

MAJORITY CHAIR GINGRICH: Practice makes perfect, right?

MR. EICHLER: Yes, ma'am.

MAJORITY CHAIR GINGRICH: We do have some questions.

Please.

MAJORITY CHAIR GINGRICH: And I appreciate your ability to speak quickly, so we kept the clock moving here.

We'll start with Representative Topper.

REPRESENTATIVE TOPPER: Thank you, Madam Chair.

Just so that I can be very clear on a back-and-forth also that I had earlier, and I want to ask you the same question.

MR. EICHLER: Please.

REPRESENTATIVE TOPPER: So just the fact that we have guidelines does not mean that medical professionals

will not be able to take into account whether their patient was a smoker or whether their patient has diabetes? I mean, just the mere fact that there are guidelines does not limit that kind of care, correct?

MR. EICHLER: You're 100 percent spot on, and let me give you -- because a smoker is going to have delayed recovery. After an orthopedic procedure, if there's bone healing, a smoker is going to have anywhere from a 30- to a 300-percent delay in healing. So yeah, that has to be factored in. That's going to allow for certain other devices. If they cite the guidelines properly and request it properly in advance, that will further the healing, the bone stimulators and the like.

Let's take something even more simple. Let's look at body habitus and age. Somebody who is 400 pounds versus somebody that's 120 pounds and both have the same age? Normal range of motion is going to be different for the two. That has to be factored in, because obviously somebody who's somewhat larger is going to have less range of motion so it becomes their new normal.

So the guidelines specifically allow for those factors and those variances, and in the guidelines there are procedures on how to document those exceptions, which then further get baked, hopefully, into the regulations that would be associated with the treatment guidelines

statute.

REPRESENTATIVE TOPPER: Perfect. Thank you.

Thank you, Madam Chair.

MAJORITY CHAIR GINGRICH: Thank you, Representative, and thank you for that answer.

Representative Truitt.

REPRESENTATIVE TRUITT: Thank you, Madam Chair.

And thank you for your testimony. It was really, really excellent.

My question is about the treatment guidelines and how they are developed. I mean, it seems to me that the success of this program is all going to come down to how well we -- you know, how good our treatment guidelines are and how good of a system we have in place for establishing them and modifying them.

And I was pleased; as I'm looking through the bill, I see that Representative Mackenzie has included that on the panel will be an occupational medicine, someone from occupational medicine, someone from orthopedic medicine, and then my favorite down there at the bottom, chiropractic medicine. So I feel like he's got good coverage on there to ensure that these treatment guidelines will be comprehensive.

Can you comment on how his proposal compares to what's done in other States, and is there anything else

that we should be including there?

MR. EICHLER: Yes, and I have actually provided some comments to Representative Mackenzie on that.

I do agree that a radiologist should probably be on there. I think you're going to want representatives of business as well as labor on the committee as well.

That's one of the things that we did well in New York, is we had good representation. You want to represent the disciplines that are treating, but also the stakeholders who are where the rubber meets the road.

You mentioned chiropractic care, and you asked about alternative medicine.

REPRESENTATIVE TRUITT: Yeah.

MR. EICHLER: And I don't know if you saw my head like a bobble, you know, thing in the back of the room.

Knowing the guidelines. When I said it's not cookbook medicine, both ODG and ACOEM present a laundry list of different treatments, and in ODG, we do it A to Z, and I'll take the back as an example. What's under "A"? "A" includes acupuncture. There are evidence-based studies to support acupuncture. There is no "Z" under low back, but we do have a "Y," and do you want to guess what the "Y" is? Yoga.

REPRESENTATIVE TRUITT: Oh; okay.

MR. EICHLER: Why? Because there are evidence-based studies that show that yoga is of significant benefit to somebody with chronic low back pain or other forms of muscle spasms, strains, sprains, and the like.

We had a situation recently where California adopted our chronic pain guidelines, and we got a call from the medical director. And by the way, both the editorial boards at ODG and ACOEM are shielded from outside contact. Both will accept as submissions of evidence from anyone who wants to submit it, but their review boards have to be shielded so that they can't be influenced in any way. They will then rank the evidence independently.

But one of the things we got challenged on is, why is there a positive recommendation for the use of green tea? Well, because there were truly evidence-based studies that weren't self-serving that ranked, that showed there was some improvement with the use of green tea for a certain condition. So it's in there.

So are the alternative treatments covered? A hundred percent. And if there's an alternative treatment that a physician can substantiate will benefit, it behooves the payer to pay for it and to authorize it. Why get into a dispute resolution that's going to cost a fortune and also turn the claim south, and I'm not talking about them

going down to Florida. I'm talking about them having a disgruntled employee who's not going to be motivated to go back to work, who's going to be angry at the system, who's going to be angry at their employer and not have a good outcome. So the goal is to have dispute resolution.

And hopefully if you go forward with the guidelines, something we encourage -- and as a guideline producer, we facilitate -- is communication between the payers and the providers. We tell the providers to identify their top payers and we tell the payers to identify good and outlying providers.

And on a non-case specific, sit down and have a dialogue. Facilitate the communication. Know what one party wants from the other so the communication can be done right the first time, because if it's not done right the first time -- and when we speak to doctors, what I've learned over the years is not only to speak to the physicians but to speak to the CFO and the practice manager as well who understand the process.

We all have to look at transactional processes. Every time there's a delay, it means the doctor's office have to go back and forth to the carrier, and their staff members probably will be making between 30 and 50 dollars an hour when you add on fringe and benefits at the level that can handle an insurance claim.

The same thing on the insurance side. So every time there is a problem, that problem is costing between 50 and 200 dollars to get resolved to the overall system. So we got to get it right the first time, and we have got to show people how to get the approvals.

REPRESENTATIVE TRUITT: Very good. Thank you.

MAJORITY CHAIR GINGRICH: Thank you.

And as we move down to our eviction time, I turn to Ryan Mackenzie.

REPRESENTATIVE MACKENZIE: To close?

MAJORITY CHAIR GINGRICH: Yes, to close, unless -- was there anything else? Oh, I'm sorry. I didn't see a question back there.

REPRESENTATIVE SNYDER: Thank you, Madam Chairman. I'll try to be brief.

A couple of things.

MR. EICHLER: Yeah.

REPRESENTATIVE SNYDER: First of all, Work Loss Data Institute. What exactly is your organization? Are you a nonprofit?

MR. EICHLER: No, we are for profit. We're a privately held company. And when people say, oh no, they're for profit, the ACOEM guidelines produced by Reed Group is also a for-profit company. They are owned by Guardian Life. We are privately held.

Why would you want a private company to do this? No State has been able to keep their guidelines updated. You need extensive staff, extensive cost.

Colorado's Medical Director, Dr. Katherine Miller, is a very dear friend of mine. We have traveled the country together for many years. Katherine tells States not to write their own guidelines unless they have the budget for a staff and an ongoing budget of 3 to 500,000 dollars a year. It costs money to review studies. It costs money to comb the evidence. It costs money to provide it in an electronic format.

One comment on cost, though, is if the guidelines are adopted with us, we allow the State to provide free versions of the guidelines on the State website at no charge to the State. If folks choose to buy the fancy tools, they can subscribe to that separate and apart. But there is no definitive cost for the adoption of the guideline through the State.

REPRESENTATIVE SNYDER: Okay. That leads me to my second question.

So this will cost Pennsylvania nothing to adopt the national guidelines. Is that what you're saying?

MR. EICHLER: It will cost them for the rollout as they would promulgating any new regulation or any new program. There are staff costs associated with that.

There is time. There is protocol development, things along those lines.

But as far as the---

REPRESENTATIVE SNYDER: Well, do you have a ballpark figure of what that would be for the Commonwealth?

MR. EICHLER: It varies by Commonwealth for what their administrative costs. Most, when the fiscal impact analysis is done associated with bills in most States, they state that there's no significant fiscal impact, because most agencies have budget for the adoption of new regulations, new rules, and new statutes on the rollout. There may be some costs.

But for the licensing fees for the use of the intellectual property, I couldn't speak to what ACOEM would charge the State if they would, but ODG does not charge the State anything for the use of the content. If people want the bells and whistles, they can pay for the search tools.

Why would somebody want to pay? It's time saving.

REPRESENTATIVE SNYDER: And did I understand you correctly when you said earlier that, do you think this legislation is fair in putting the burden on the employee?

And I do have some experience with workers' comp,

because my husband was a lineman for 34 years and he was seriously injured on the job, and I can't even fathom that he would have had to have taken on that burden.

MR. EICHLER: No, and he shouldn't be, but we have to think in terms of group health here.

When we want something approved in group health, it's the physician that has to request the authorization. If you want that MRI, they have to get the authorization and the precert. It's common practice. So it should be the physician's office who is communicating. They have the medical information. They are accustomed to going through this in group health.

And we've got to remember, why do physicians stay in workers' comp? Yeah, there's extra administrative burden, but the reimbursement is the highest reimbursement out there. And when we go across the States and we speak with the CFOs of the medical practices, they tell us if greater than 10 percent of the practice revenue is from workers' comp, they're not walking away from that high level of reimbursement.

REPRESENTATIVE SNYDER: But right now in Pennsylvania, it's the employer with the physician. This would shift it to the employee.

MR. EICHLER: But the employer would be paying for that. The way it's done in other jurisdictions is

basically the physician fills out a form, signs it. It goes into the administrative agency. They assign the case for utilization review.

But what's really happening in this State, before the payers say no, they're getting utilization review. It's either being done in-house by a nurse or a medical practitioner or a physician, or they're sending it out for unofficial review before they say no.

REPRESENTATIVE SNYDER: Well, thank you. I appreciate the testimony and appreciate the hearing.

MR. EICHLER: Thank you, ma'am.

REPRESENTATIVE SNYDER: I still have a lot more questions on this legislation. Thank you.

MAJORITY CHAIR GINGRICH: Thank you, Pam. I agree. It has been excellent.

And now we'll turn to the prime sponsor, Ryan Mackenzie, and let him wrap this up for us today.

REPRESENTATIVE MACKENZIE: Great. Absolutely.

Well, thank you, Madam Chair, and thank you, everyone, for joining us today.

I thought it was a terrific hearing, a lot of information shared, and we tried to make it as balanced as possible. We wanted to hear both sides, the good and bad, people's opinions on the issue.

At the end of the day, I still believe that the

concept is a good one to move forward with. Treatment guidelines have shown, and we have the data here from some of our testifiers today, that other States have seen great results.

In Texas, average lost time, down 34 percent. Return-to-work rates up across the board. Medical service denial rates down 50 percent, thereby reducing litigation costs. Lots of great results in other States as well, and some of our testifiers showed that information in Ohio and other places as well.

So again, it does seem like there is a benefit to going that route of treatment guidelines. No doubt some things that we're going to want to change and update in this legislation as we move forward. But again, I think it is important that we continue to look at our workers' comp system here in Pennsylvania.

Just briefly I do want to highlight, lots of our different testifiers cited the WCRI, the Workers Compensation Research Institute. Even those who didn't believe in research or data cited their research and their studies.

And all three or four people who cited it here today, the Work Loss Data Center cited WCRI, saying Pennsylvania had among the highest utilization for physical medicine services of the study States. The Orthopaedic

Society said that Pennsylvania's average payments for chiropractic is the highest in the country. And also finally, the Chamber says WCRI, citing the litigation expenses per claim, are, again, among the highest in the country, 60 percent higher.

So there are things that can be improved. And again, everybody has agreed that that data from WCRI is reputable, even those that opposed this legislation today.

So again, I think we have a basis to move forward. We want to improve our system for our injured workers and thereby helping reduce our costs as well.

So I do want to thank the Chair and thank everyone else for joining us today.

MAJORITY CHAIR GINGRICH: Thank you very much, Representative, for bringing this to our heightened level of awareness. I think we accomplished our goal today. We gathered a lot of information that’s going to help us move in a direction that is satisfactory and fair all along.

Have a great St. Patty's Day, and thank you to the entire committee and my new Chairman.

MINORITY CHAIRMAN GALLOWAY: You can’t say “St. Patty’s,” by the way. It has to be “St. Patrick's.”

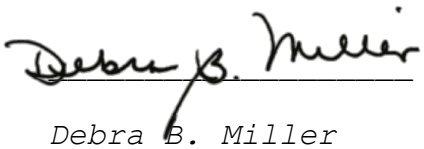
MAJORITY CHAIR GINGRICH: St. Patrick's.

MINORITY CHAIRMAN GALLOWAY: Thank you.

MAJORITY CHAIR GINGRICH: I want the blessing. Thank you.

(At 12:15 p.m., the public hearing adjourned.)

I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.



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