COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HOUSE LABOR & INDUSTRY COMMITTEE HEARING

STATE CAPITOL
IRVIS OFFICE BUILDING
ROOM G-50
HARRISBURG, PENNSYLVANIA

TUESDAY, SEPTEMBER 13, 2016

IN RE: HOUSE BILL 1141
WORKERS' COMPENSATION PROVIDER ISSUES

BEFORE:

HON. MAUREE GINGRICH, MAJORITY CHAIRMAN
HON. LEANNE KRUEGER-BRANEKY, ACTING MINORITY CHAIRMAN
HON. STEPHEN BLOOM
HON. JIM COX
HON. SHERYL DELOZIER
HON. CRIS DUSH
HON. MARK GILLEN
HON. SETH GROVE
HON. RICH IRVIN
HON. FRED KELLER
HON. RYAN MACKENZIE
HON. STEVEN MENTZER
HON. DAN TRUITT
HON. JUDITH WARD
HON. DANIEL DEASY
HON. MARIA DONATUCCI
HON. FRANK FARINA
HON. DANIEL McNEILL

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ALSO IN ATTENDANCE:

JOHN SCARPATO, EXECUTIVE DIRECTOR, REPUBLICAN CAUCUS
GREG MORELAND, RESEARCH ANALYST, REPUBLICAN CAUCUS
VICKI DiLEO, EXECUTIVE DIRECTOR, DEMOCRATIC CAUCUS

JEAN M. DAVIS, REPORTER
NOTARY PUBLIC

I N D E X

TESTIFIERS

P R O C E E D I N G S

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MAJORITY CHAIRMAN GINGRICH: I'm going to bring this hearing to order. We've waited five to let everybody find their way in here. There may be more coming. I do want to acknowledge that. Please do not think we're rude as people arrive. They'll join us for this public hearing this morning on House Bill 1141.

So I want to thank in advance everyone for being here, for the members who came in for a pretty rigorous couple days of important public hearings here at the Capitol. I took you out of some beautiful weather. Thanks for being here, as well as all the testifiers, in advance.

I'm going to ask for roll call right now, not that we're voting, but just so we keep record of who's here. And then I'll tell you a little bit more about how the morning will proceed.

Ann.

(Roll call)

MAJORITY CHAIRMAN GINGRICH: Thank you, Ann.

And thank you again for being here. And a special thanks to our stand-in Minority Chair for today. That's Representative Leanne Krueger-Braneky. And there's no sense we wait years to let you sit in as a chairman on your first term. It's a good experience, especially with

the topics we'll have today.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you.

MAJORITY CHAIRMAN GINGRICH: A couple of reminders. I just had to remind myself, please silence your cell phone and anything else that might make noise in here. Also I will let you know that we are being recorded and we'll be broadcast on PCN, just for your behavior purposes.

I also do want to talk a little bit about testimony, John, that came in that we won't be hearing from in person, correct?

MR. JOHN SCARPATO: Correct.

MAJORITY CHAIRMAN GINGRICH: We have submitted written testimony that everyone shall take some time to read from Linda Schmac of the Premier Comp Solutions and our Workers' Compensation Advisory Board. So while we won't be hearing from them directly, please know -- and the Chamber as well. We did get testimony from the Chamber as well today.

So those will all be distributed to you if you don't already have them. Please read them.

Now, the bill we have before us now, as I mentioned, is House Bill 1141. And we're lucky enough to have the prime sponsor here, Representative Stan Saylor.

We're going to have John, our Executive Director,

John Scarpato, go over the bill briefly to give you a little of the technical structure of the bill. And then I would like to have some words from the creator of the bill.

John, go ahead.

MR. JOHN SCARPATO: House Bill 1141 is Representative Saylor's bill. It amends the Workers' Compensation Act. The bill adds definitions of case management and National Provider Identifier. It amends the definition of health care provider, prohibits employers from listing a provider without a National Provider Identifier on the 90-day period list in workers' comp, it prohibits providers from being reimbursed for an amount less than the fee schedule unless the provider has executed an agreement to accept a lower fee, and it provides penalties for that.

And these penalties, you'll see, when I say provides penalties, it's kind of consistent throughout the bill. The penalties are 25 percent annual interest, 50 percent penalty if the insurer's position is found to be unreasonable and cost and attorney's fees.

The bill requires insurers and self-insured employers to accept electronic reports and bills from providers. It requires insurers and self-insured employers to accept and implement the updated fee schedule by January 2nd each year. And it provides penalties for failing to do

that.

It provides penalties when a fee review of the department finds in favor of a provider, as in the provider has not been paid on time or paid in the correct amount. It prohibits insurers and employers from stating or implying that there will be negative economic consequences, a reduction in patient access, or reimbursement repercussions if the provider does not agree to accept a discounted rate. It allows providers to petition a workers' comp Judge for relief and enforcement of certain payment issues.

And finally it requires that providers treating an injured employee receive copies of the notice of compensation payable and the injury report.

MAJORITY CHAIRMAN GINGRICH: Thank you, John.

That was the framework of the bill. At this point since we are privileged to have the prime sponsor of the bill, Chairman Saylor, Representative Saylor, as well, please join us. If you want to take just a few minutes, Stan, to share with the members and our guests today the genesis of the bill and your perspective.

Thanks.

REPRESENTATIVE SAYLOR: Thank you, Chairman.

I want to thank Chairman Gingrich and Chairman Galloway for holding this hearing on this bill.

For many years, health care providers have advocated for a simple common sense change to the Workers' Comp Act, which would benefit injured workers. The medical community and the business community all have interest in this legislation, I'm sure.

Last session I worked with leadership and committee staff to craft legislation that involved the vexing but easily remedied concerns presented to me. I'm proud to sponsor House Bill 1141 and hope that this Committee will consider reporting it this session.

As I noted, House Bill 1141 is a reasonable and common-sense approach to self-evident problems with the workers' comp system. Please consider the challenges that our workers' compensation health care providers face. How can a physician accurately treat a work-related injury without access to the first report of injury form?

House Bill 1141 would provide health care providers with access to the relevant information necessary to treat a work-related injury. How can a health care provider properly submit a reimbursement claim without a claim number or other information? House Bill 1141 again would give providers access to claim numbers, the injury description, and other information.

How can health care providers' workers' comp payers increase the efficiency and accuracy of

reimbursement claims if they still must use a paper-based claim system? House Bill 1141 again mandates an electronic billing system and provides options for workers' compensation payers to meet this obligation.

While most health care providers accept discounted fees if they have no contractual relationship with a workers' comp payer offering the discounted reimbursement, House Bill 1141 requires bona fide treatment -- I'm sorry. It requires bona fide contracts between providers and payers before a discounted schedule fee can be imposed.

While most providers attempt to resolve fee disputes through the Act's current review system when the penalties are so low as to provide no incentives for workers' compensation payers to meet their statutory obligations, House Bill 1141 again increases fee review penalties as a means to give health care providers a meaningful mechanism to vindicate their rights.

Why does the law require workers to seek care from an employer-provided panel when in practice some panelists may merely be network administrators and not real physicians or other health care providers? House Bill 1141 requires all six employer panelists to be true health care providers.

My legislation does not seek sweeping changes to

the workers' comp system. It simply aims to bring common-sense reforms where they're needed, as you will see as our panel of health care providers will give you more details on House Bill 1141 and its elements.

I'm also sure that members of the second panel will tell you that these provisions will drive workers' comp costs even higher. But ponder the questions I posed to you above as I go through my comments today.

I want to thank the Committee and the members for coming today on a beautiful day. It might be nice to be outside. But I want to thank the Committee and everybody. And I apologize if you see me walk out of here. I am dealing with a case of kidney stones. I apologize if I walk out, but I may need to go outside to scream.

Thank you, Committee.

MAJORITY CHAIRMAN GINGRICH: Thank you. We appreciate you not screaming in here because there's not a darn thing we can do about it but give you our sympathy and some of us our empathy.

Thank you so much for being here. While we didn't allow time for questions right now -- hopefully you can stay as long as you're able -- we'll see that you get all the feedback we get.

REPRESENTATIVE SAYLOR: Thank you.

MAJORITY CHAIRMAN GINGRICH: We would like to

start with our first panel. This panel represents health care industry workers' comp payment issues that we're dealing with today.

I have on my list -- and I'm looking forward to hearing from -- James McGlynn, Dr. McGlynn; and Charles Artz, from the Artz McCarrie Health Law Firm; and James Foreman, who I just met, owner of ProCare Physical Therapy.

Is Dr. Stephen Morganstein here?

STEVEN MORGANSTEIN, D.O.: Yes.

MAJORITY CHAIRMAN GINGRICH: We haven't met yet. Good to have you here.

This is quite a panel of, I'm sure, knowledge and experience, but also in number. So I would like to remind those testifying that we do have some time constraints here. I know when we invited you to bring your experience before us, we talked about five minutes.

Please don't feel like you have to read your testimony. We do have it and are very appreciative of it. You certainly may summarize to hit your, you know, most cogent parts for us to understand.

Now, I'm not even sure how you're seated here. Would you prefer a certain order, Dr. McGlynn? I understand you have a brief PowerPoint to share with us; is that correct?

JAMES McGLYNN, M.D.: It's going to be up and

more or less summarizes what I will be saying.

MAJORITY CHAIRMAN GINGRICH: Well, let's start with you.

JAMES McGLYNN, M.D.: Okay.

MAJORITY CHAIRMAN GINGRICH: Thank you very much.

JAMES McGLYNN, M.D.: Thank you, Chairman Gingrich and your Committee members, for this opportunity to testify on House Bill 1141.

I'm James McGlynn, Chairman of Pennsylvania Orthopedics Society, Workers' Compensation Committee. I appreciate your willingness to have me back before the Committee to hear our society's views on this important legislation.

As you know, House Bill 1141 brings common-sense reforms to the workers' compensation system. For many years, the Pennsylvania Orthopedic Society has worked with committee staff to craft legislation designed to clarify and enforce existing law.

We are not seeking grand modifications. We're merely attempting to make the system work for injured workers and the health care providers who treat them. The POS is grateful that Representative Saylor has been our champion for the past two legislative sessions.

The POS is deeply involved in workers' compensation issues. From a medical professional

viewpoint, orthopedic 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 that this legislation will enhance the patient/physician relationship.

House Bill 1141 is designed to correct important longstanding information access and reimbursement issues that have plagued medical professionals. The legislation represents comon-sense changes that will streamline the processing of bills, will prohibit reimbursement discounting without a bona fide contract, and ensure timely payments to providers. I am sure that you agree that this bill is reasonable in its approach to resolving issues.

The first topic I would like to discuss is that currently providers do not have access to certain basic information about the injured worker's claim. This lack of basic information, first of all, the claim number, second of all, the description of the work-related injury and the injury for which the insurer will pay, often leads to improper billing and administrative inefficiencies for the insurer and the provider.

This occurs because the law does not confer standing on providers to receive the documents and forms pertaining to the injured workers, even though the providers are vital to the system.

You may believe that a work-related injury would be obvious to the physician, and it may be, but other ailments that are discovered in the course of the examination and treatment may not be work-related.

Generally speaking, we treat our patients as they present themselves and many times they may only have a work-related injury. But in far too many cases, an injured worker will have both work- and non-work-related injuries for which we will treat.

Without access to the description of injury for which the insurer has accepted liability, we may submit a workers' compensation bill for all treatments. Then begins the process of correction, which is time-consuming for both the providers and the insurers.

House Bill 1141 fixes that problem by allowing providers electronic access to the appropriate data fields within Pennsylvania's workers' compensation automation and integration system. The injured worker's claim number and description of injury for which the insurer has accepted liability appears on the first report of injury. Provider access to this report simply makes common sense.

Physician access to information will not result in reduced care to these injured workers but it will enhance the care of the injured workers. As noted in this testimony, currently we treat all of the injured workers'

injuries or ailments regardless of whether they are work related. By permitting health care providers to know what is work-related and what is not, this will allow proper treatment of bills for the work-related injury as well as proper treatment for the insurers.

Next, obviously access to first report of injury will improve the accuracy of the bill. Electronic billing will improve how we transmit bills to those insurers. Believe it or not, many workers' compensation carriers do not accept electronic billing. The statute does not mandate it. And therefore we still must submit paper claims. We are well into the 21st Century and we still must use a 20th Century system.

In contrast to electronic billing to Medicare and other payers, workers' compensation billing is cumbersome and costly to process, an expensive burden on both providers and insurers. Not only does the paper claim method add cost to the system for providers and insurers, it directly leads to another ill that House Bill 1141 will cure, the lack of prompt payment.

With mandated electronic billing, providers and insurers will save money, reimbursements will be processed faster, and corrections can be made in a timely fashion. Again, this is a common-sense improvement to the workers' compensation law.

In addition to improving these process issues, the POS asks that you correct certain practices of the insurer/employer community and their agents.

The Workers' Compensation Provider Reimbursement Fee Schedule is set in the statute. Pursuant to the law, the fee schedule is annually adjusted according to the average weekly wage. The statute only authorizes coordinated care organizations to deviate from the mandatory fee schedule. There are no CCOs presently operating in Pennsylvania.

Current law also allows insurers and employers to contract with third parties to perform case management. There are two conditions under which providers may legally be paid at amounts less than the mandated fee schedule.

First, providers may agree to contract to accept workers' compensation reimbursement that is less than the mandatory fee schedule by signing an agreement with an employer, insurer, or third-party representative to process in the insurer or employers' provider network.

Second, health care insurers routinely include all product clauses in the contracts signed by providers in their networks. This contractual relationship requires a physician to be a member of all of an insurer's preferred provider networks if the physician wants to be a member of any of the insurer's provider networks.

Although physicians generally are dissatisfied with these arrangements, the contractual relationship exists; therefore, a workers' compensation fee schedule discount may occur.

Silent discounting occurs when a physician receives a discounted reimbursement but has no contractual relationship with the party that is providing the discounted reimbursements. In some cases, a third party directly works with a self-insured employer or insurer and literally sends a discounted payment to the physician on a take-it-or-leave-it situation.

A physician is left to accept a discounted fee or fight a fee review dispute with a third party with whom the physician has no relationship. Silent discounters essentially work outside the bounds of the Workers' Compensation Statute.

The POS has no quarrel if the provider agrees by contract to accept reduced reimbursement. We firmly believe, however, that a bona fide contract must exist before discounted reimbursement can be offered. House Bill 1141's provision to ban silent discounting is, again, a common-sense method to insure that payors comply with the current law.

In similar fashion, using facsimile and other means, providers are inappropriately coerced into accepting

amounts different from the mandatory fee schedule. Such cohesive tactics include threats that providers will be eliminated from the provider networks, they will not receive workers' compensation patient referrals, or will accept discounts on all future payments. This bill bans coercive solicitation and is a common-sense way to end this odious practice.

House Bill 1141 will increase penalties on providers who do not comply with the Workers' Compensation Statute of prompt pay and fee schedule update provisions. Currently, the penalties are inadequate incentive for insurers and others to fulfill their obligations under this law.

Attorney Artz will go into further detail on these provisions but suffice it to say, POS believes these provisions are common-sense reforms.

The Workers' Compensation Statute requires that every employer health care panel must include at least six providers, three of whom must be physicians. Providers have found that employers sometimes list a provider network organization as a panel provider. Such organizations are not providers but rather agents of employers working to solicit providers into a network, often without a contract, and designed to drive injured workers into an employer-controlled provider network.

Changing the definition of health care provider in the Act does correct this problem by requiring that a provider performing health care services must have a Pennsylvania license to do so and must possess a valid national provider identifier.

Employers are permitted by statute to contract with any individual, partnership, association, or corporation to provide case management and coordination of services for injured workers. The POS believes it necessary to define case management according to national standards.

Therefore, House Bill 1141 defines case management as case assessment; developing, implementing, and coordinating a care plan with providers, the injured worker, and the injured worker's family; management of health care treatment and utilization control; referral to vocational rehab services; and planning for return to work.

These case management activities contribute to optimum medical care and cost-effective outcomes. I will defer to our fellow panelist from ProCare for more detail on this issue.

In conclusion, the POS again thanks Representative Saylor for leading the way for these common-sense reforms. We stand ready to work with the Committee to move this important issue forward.

Thank for the opportunity to be here today.

MAJORITY CHAIRMAN GINGRICH: Thank you very much. Dr. McGlynn.

We'll go very quickly to Mr. Artz. And I'll issue a reminder once again. We want to have time for some questions and answers. So summaries are great, if you can.

Thank you.

MR. CHARLES ARTZ: Thank you, Madam Chairman.

My name is Charlie Artz. I've been practicing health care law for 27 years. I represent the Orthopedic Society, orthopedic surgeon practices, medical practices, large medical groups, and other health care providers.

I'm just going to focus quickly on two aspects of the legislation, the silent PPO discount and the procedural reforms that we're looking for in the fee review petition litigation process.

So let me move quickly. Let me just try to explain legally how the silent PPO issue arises. So you have a company that they call themselves a network. But the question is, do they really have a network? And the answer is, well, if you have a network, are you really a preferred provider organization that's registered and licensed with the Insurance Department? The answer is, no, they're not. So they're unregistered. They're unlicensed PPOs. And they make deals with workers' comp payers. That

includes self-insured companies, workers' comp carriers, third-party administrators. So they make these deals and they have undisclosed fees in these deals.

Then they approach providers and they say, hey, you be on our network and you take a discount. What really happens -- and I've dealt with no fewer than five of these different companies in the last three weeks so it's pretty timely where they will say to a provider, you take this deal. You take this discount or, you know, you're on the panel now, we're going to get you off the panel because we control the insurer.

We control or have a deal with the employer and we're going to get you off this panel and you're going to lose access to the patients that you already have access to through our own efforts and your good marketing and your own great medical work. We're going to knock you off that panel unless you take this discount. That happens all the time.

So that's sort of how it sets up. They take the discount or you're off the panel. That's the cohesive element that we're trying to stop in this legislation.

Again, let me make clear that the Orthopedic Society has no concern and no problem with any legitimate network that enters into a legally binding contract with any health care practice for a discount below the workers'

comp rates as long as, No. 1, the workers' comp payers are disclosed in the contract, so if I'm going to contract with this network, I want to know what payers are in there. That's only fair, right?

If you have a legitimate PPO network, you know what that is. But in the silent discount networks, you have to clue. And they wouldn't tell you a lot of times. I've been through these notifications -- again the last couple weeks. They wouldn't tell you who's in there. They won't change the contract.

The second thing we want to do is not only tell us what payers are in the network or what self-insurers are in the network now, but if you're going to add somebody, don't hide it. Tell us so that we can negotiate, yes, I'd like to be in. No, I don't want to be in with that employer. No, I don't want to be in with that self-insured employer or carrier because I already have access to those patients. You know what, if you want to let us negotiate, fine. But don't hide the ball and then force the discounts.

In my testimony, I've cited two Federal Court cases where there's litigation against silent PPOs. The first case is from Illinois Federal Court where the judge called it a silent PPO kind of abuse. The second case is from the Southern District of Mississippi where there

happens to be a lot of litigation. This is a brand-new case from just a few weeks ago where a health care provider happened to be a physical therapy practice suing in a class action context against these silent PPOs.

You can see on page 2, if you have a chance to read my testimony, I described -- what I just summarized is exactly what is described in that Federal Court case. Now the Federal Court Judge in that case refused to allow the provider's racketeering claims to go forward but they did allow a breach of contract claim. They did allow a claim for disgorgement to go forward and civil conspiracy. So there is ongoing active litigation.

Our point is with this legislation, who needs to litigate like that in that type of massive Federal Court type of case? Why don't we just get some reforms now? Let us contract with whoever we want to contract with, know what the deals are.

I've had two cases. I have it highlighted in my testimony but in the interest of time, it takes a ton of effort to stop these cases. The details are listed. But in one case it was a practice with 120 physicians. We finally figured out why we're losing certain money on claims and workers' comp claims. We figured it out.

We went to the PPO and said we're terminating these contracts. They refused to terminate the contracts,

kept it going. I sent another litigation demand and another litigation demand and a final letter saying that's it. We're going to Federal Court. And they said, well, okay, we'll terminate your contract as you have requested. But we have to have all 120 physicians sign a termination letter or we're not going to do it.

You know what I mean? It's just brazen, brazen violations of law. And that's how they operate.

And in another practice with a specific orthopedic practice, we chased around probably 15 different ones of these entities around the country trying to get back money. We never really got back much money but we finally got the discounts stopped.

The only way to address that right now is in the fee review petitions system in the workers' comp system. So you have to file a fee petition. You have to know who all the players are. And then what do you get in the fee review petition system, you know, it's okay. It's fine. I've used it a lot. My clients have used it a lot.

But all you get is the amount of your bill that was supposed to be paid and interest. There's no attorney's fees. There's a Commonwealth Court decision that says no attorney's fees in the fee review petition system. So what incentive does a workers' comp carrier have to play ball? They don't.

So anyway, the reforms that we've asked for are all summarized. Representative Saylor summarized and I think Dr. McGlynn did as well. So I'll skip over what we're trying to do.

I just wanted to make one other point. We are asking for specific clauses that say if you don't have a contract with negotiated terms, the contract is null and void and then there's enforcement mechanisms. But there's also a provision prohibiting companies from referring, recommending, steering, or directing injured employees without performing bona fide case management services. And we have criminal sanctions and penalties.

Now, what we did was took the criminal sanctions and penalties out of the existing workers' comp law that applied to physicians. So physicians engaging in any kickbacks or improper recommendations or steering, they're subject to all these criminal sanctions. We took those and put them into legislative language as well.

Let me close quickly with the fee review petition system. I'll just give you a classic case. Nine months ago we filed a fee review petition because a workers' comp carrier refused to pay one of my orthopedic clients the full amount of reimbursement that was due pursuant to a Workers' Comp Judge's decisions. So there was some other litigation underlying whether the case was going to be a

work-related injury, the claimant wins that case. Then we tried to get paid. And the workers' comp carrier says, no, I'm not going to pay you. So we go through the system. We go through litigation. We have to prepare briefs, pre-hearings. There's multiple claims involved. There's a lot of money involved.

And the point I want to make is that in 2003, the Commonwealth Court issued -- it was a statewide binding Court of Appeals -- a decision explaining the factual parameters that were absolutely identical to this case saying why my client, my orthopedic practice client, should be paid this certain amount of money based on the workers' comp fee schedule.

The insurance company in that case had no defense, zero defense. It was not only unreasonable, it was absolutely bad faith. And so we had to litigate that until the eve of trial. And then on the eve of trial, they say, okay, well, we'll pay X percent, which was almost all the bill.

And what did I have to do? I might well take it and avoid that extra percentage being eaten up in my legal fees to litigate this case that we had an absolute guarantee to win. Why did they push it off that far? Because there's no deterrent. If there's no chance for any attorney's fees or penalties, why not just string it out as

long as you can and see if you can get the provider to take a discount?

That's the only point of that extra sanction in the legislation. There's no deterrent right now for attorney's fees or sanctions.

Now, while I understand that the Labor & Industry Department is going to oppose the legislation and indicate that Workers' Comp Judges shouldn't have this additional authority, you know what? Legally, I'm fine with having to agree with that and having it move, having the legislation amended to move that to the fee review Judges.

Those fee review Judges are really smart on coding documentation and billing issues. They know what they're doing. They can tell if the dispute is reasonable or unreasonable. If the dispute is reasonable, there's no attorney's fees and there's no sanctions. If it's a close call, it's just like anything else.

And the second thing apparently they're going to say is it's going to increase costs. Well, you know what, it won't increase costs to the system unless the insurance company is taking an unreasonable or bad-faith position. The words that are in House Bill 1141 are exactly the same words that exist in the claim petition litigation process for injured workers now.

So if an insurance company takes an unreasonable

position and the injured worker's lawyer files a penalty petition and they win and show that the insurance company had an unreasonable position, they get all the money that they're entitled to, attorney's fees, and a 50 percent penalty. So we're just taking the same systematic deterrent approach from the claim and litigation process, putting it into the physician provider litigation process because we have no deterrents.

So thank you very much.

MAJORITY CHAIRMAN GINGRICH: Thank you very much, Mr. Artz. It's very hard to summarize important information. I know that. But we also don't want to run out of time.

Before we move on to James Foreman, I want to recognize that Representative Ryan Mackenzie has joined us.

Did anyone else join us? Oh, Sheryl Delozier. Representative Delozier snuck in. I didn't know that. I'll try to keep up with the folks coming in.

Mr. Foreman, would you like to share with us, please. You're from ProCare Physical Therapy. And again, I'll issue the reminder to summarize as best you can.

MR. JAMES FOREMAN: Thank you.

Chairman Gingrich and members of the Committee, good morning. Thank you for the opportunity to provide testimony this morning.

My name is Jim Foreman. I'm a partner and one of the founding members of ProCare, which started in 1994. We operate therapy facilities throughout Pennsylvania. We have been directly involved with workers' compensation as a provider for over 20 years.

You have my written testimony. I've made references to the excerpts of the law about what I'm going to speak to. I'm speaking specifically to the designation of a health care provider and why it's important to have this clarified.

The practice of establishing the list of designated health care providers has become very popular amongst many employers and insurance carries. We actively serve as a panel provider for a large number of employers and have done so successfully for many years.

The concept of us having preestablished knowledge as a provider and having familiarity with the employer allows us, as a provider, to better understand the work environment and the specific job demands of an injured employee before an injury occurs, allowing us to provide appropriate rehabilitative care.

Oftentimes we visit workplaces. We do tours of facilities. We get on trucks. We go in coal mines. We do a lot to really understand what the injured worker is facing and the conditions to which they need to return.

When good panels are established and practices like what I've described happen, there is a team approach. It includes working with the insurance carrier, the nurse case manager, the injured employee, the employer, to make sure we provide a good, safe, and sustainable return to the workplace.

Enter the networks. In the late 1990s and the early 2000s, we were approached with the concept of joining networks. The pitch was very simple. The networks represented that they represent themselves as having contracts with many large, undisclosed to us, employers and they were looking to create some streamlined efficiencies.

They were going to do that by working with a select number of providers or, so we were told, in a market area who had expertise in workers' comp and could treat injured workers in the ways that I previously described.

So we bit. We decided to do it. The exchange was that we would concede to a minor discount in our reimbursements, but the claims would be paid quickly and directly by the networks versus the carriers. It seemed good. But it turns out those contracts with the employers were non-exclusive contracts and that they didn't have to do it and other networks could also come in.

We became discouraged with that. We found that there was low screening criteria for anyone to be a network

provider. You just had to have a license. So we exited the networks. The idea that the network sat as a middleman between the providers, us, and the carriers and the adjusters and the nurse case managers who really have something effective to say and do with helping to get people back proved to be cumbersome and we decided to leave the networks.

Several years later we got repitched that there was drastic improvement and the contracts were now with the carriers largely versus the employers. The required discounting was more severe but there was an innuendo of being blocked out if we weren't to go in. So we rejoined what I call the ever-evolving networks. That turned out to be a big mistake again.

There is or were continuing non-exclusive agreements across various networks and insurance carriers. It was referenced earlier in some of the testimony in a process called stacking where networks are aligned or loaned or leased or somehow have control and you don't even know who you're signed up with.

There's references and sometimes there's no references because you did A, you did B, if C. It's very confusing and almost impossible for to us fight through. Just paralleling the testimony of Dr. McGlynn and the attorney.

Many times we've had to delay treating patients because multiple networks have contacted us after a referral was made, both claiming that they were the network. We were actually delaying and inhibiting care while they sort of duke out who's actually due the fee.

And the reason for all of this is because the carriers have allowed the networks to enter in and basically be the middleman or facilitator of coordinating care. And it's not case management. It's scheduling. We internally refer to them as scheduling networks.

A bell sort of went off in our head. We got thinking about this -- and this is years now -- and in all likelihood it's our belief that the carriers, the insurance carriers, like using networks because it lightens the workload, allows them to sort of offload, in the case of physical therapy, the process of scheduling and keeping up, which is all well and good, but it doesn't really happen well where the rubber meets the road. We see that day in, day out.

The bottom line is employees do not necessarily get better care. What they do get is the cheapest price per visit care. We end up becoming subject to or defined by our most desperate competition, many of whom enter into agreements unwittingly or certainly not with good economics out of the fear and the coercion tactics that occur about

being blocked out. And I stand here as a witness that that happens on a regular basis.

Despite all the concerns about the inner workings of the network operations and the financial bonanzas they seize at the expense of the system, networks are not illegal. Nothing prevents an employer, a carrier, or medical provider from contracting amongst themselves.

However, networks, with the insurance carriers' knowledge, have designated themselves as health care providers and in doing so have inappropriately represented themselves on the panel for the employers, oftentimes without the knowledge of or description to the employer themselves.

So these networks will facilitate the panels going out to an employer as part of a package or renewal package with the carrier. And the employers are none the wiser. They're often told this is the way it has to be with the insurance or the TPA service that you've contracted for. Again, I can cite many examples where that happens.

House Bill 1141 correctly defines health care provider to include a National Provider Identifier, or NPI. It's very common. And it's required amongst all health care providers. It's underlying based on the requirement to be licensed under Medicare. Medicare obviously is a

prerequisite to us even being here talking about workers' compensation.

Again, nothing illegal about the networks. But they're clearly not health care providers. It's our belief a remedy for their involvement would be for them to consult with the employers and the carriers with whom they contract and then designate which of their network participating health care providers are going to serve that employer in a geographic region and then simply list those providers as being the panel providers. They can be in the network. It's perfectly fine. We have no issue with that.

To further amplify the need for this type of remedy, the Workers' Comp Act specifically states the requirement for a panel provider's name, address, phone number, and it must be geographically accessible. It has to be in the area. I've referenced that in the written testimony of the excerpts of the law for you.

Members of the Committee, please carefully consider your support of House Bill 1141. It rebalances the overreaching, which networks have done with the apparent approval of certain insurance carriers. If pushed on the arguments that networks save employers and the Commonwealth significant money by being hard-lined negotiators of medical care services, I would ask you to seek transparency on the net payments to the providers, us,

versus the corresponding amount being charged to the employers in the Commonwealth.

You will likely see significant imbalance in the fees paid to the health care providers who are actually providing the medical care versus the fees paid to or retained by the networks. The Pennsylvania Workers' Compensation Act has set limits on reimbursements to health care providers. That system is very well established and easily researched.

If interested in pursuing the financial aspects of these various relationships, we would welcome the opportunity to open and have transparent discussions and explorations of who's getting what percentages and amounts of money, of the employers' monies, that are being designated through premiums for physical therapy costs.

Thank you for the opportunity to present my testimony. A special thanks to Representatives Saylor and Ward for their support.

MAJORITY CHAIRMAN GINGRICH: Thank you, Mr. Foreman.

I'll recognize Representative Cox, who is entering and joining us now. He has a little catching up to do here.

We will look for a conclusion in this panel from Dr. Morganstein, Dr. Steven Morganstein, and hopefully have

time for a little bit of questions.

Please use the mike.

STEVEN MORGANSTEIN, D.O.: Thank you, Chairman Gingrich and Committee, for even allowing us to be here and have a discussion about this important issue. And thank you, Representative Saylor, for being the go-to champion for this cause.

I'm going to try to just give some specific examples as a provider. I think everyone on the panel has done a good job summarizing everything from the legal end and where all the things that they had talked about represented.

My name is Steven Morganstein. I'm a private practice physician in the area. I'm a specialist as a physiatrist in the field of physical medicine and rehabilitation. My practice, we have an office in Harrisburg, Mechanicsburg, and in York. We take care of a large number of workers' compensation patients. We're not surgeons.

We get to see the patients oftentimes even on a long-term basis and get to manage their care, oftentimes because of a lot of providers that are no longer in my specialty even performing this type of work anymore. We're there hopefully to still provide access and quality care for the patients and hopefully be able to have your support

for House Bill 1141 to allow us to continue to do so.

Again, just to give a couple of examples and not reiterate some of the specifics that were so greatly already identified. First is I was with a previous practice when I came to the area in 1994. There was a discounted workers' compensation contract signed at that time. I've since been with three separate practices.

In our own practice now when we're doing billing for some of our workers' compensation, I'm still being held accountable for the contract that was signed back in 1996. I have a contract there. It's a different tax ID number. We're still being told that we need to be using that contract and the fees that we were getting paid way back then despite multiple efforts to try to, No. 1, obtain the contract to even see what it said. And once we were able to obtain that, to try to make that null and void and move forward with a more appropriate, more updated contract there, that's not been accepted at all. We're still being paid at a 15 percent discount, even though there is a mandated fee schedule that was negotiated 20 years ago.

Along with that I have a new physician who was hired. And we decided what we do in the office is we'd see other patients that aren't workers' compensation. We do other hospital work where we take care of patients in the hospital with strokes and spinal cord injuries and

traumatic brain injuries. And to have her become part of the panel, have her become contracted under these insurances, she's been told, we've been told, that she has to be on the same plan that we were, again back in 1996.

Right now she doesn't have access to take care of those types of patients in our office or in a hospital setting because we don't want to be able to accept that previous workers' compensation contract and the fees that are involved with that way back in 1996.

On top of that, part of our practice is taking care of patients that use narcotics and opioid medications. And as we know, that's a very important issue these days. We do a very, very thorough job in screening these patients, managing these patients, following through making sure they're compliant with their medications.

Part of that involves doing urinary drug screens, which we do in our office. And with that, based on getting fairly quick and accurate information, we are able to make sure that patient is compliant with their medications so we can provide them with more prescriptions.

Under the workers' compensation fee schedule, there is a code that's available that we can charge for that, as we do for any other case or any other insurance that we have. And we've literally gotten nine so far and several others that are pending coming back with an actual

penny that's been attached onto there. That's how we've gotten paid, one cent, one penny, for reimbursement for these screens, which allows us to either say that I guess they don't want us to screen these patients and follow them, leading to potential problems with their use, or even if we do have to send them out, maybe there's some other place that they get sent out but leads to a longer time getting information back on, is it appropriate to continue to provide these medications?

We think it's really important and, again, going back to this original contract and how they're using this information, just not fair and appropriate and really shameless for someone to stick a penny on something and send it back to a provider with a cost that we have, my staff, the agents to do the testing, the information we need.

I have other providers in the office who I'm still having to pay on a contractual and an hourly rate. And we're left with dealing with a one cent reimbursement for those things.

Next, with the mandated fee schedule, the understanding is that every January a new fee schedule comes out. It's typically not until March or April, if we're lucky, that the actual insurance companies will now be using that new fee schedule. So in the meantime,

they're paying us at the previous rate, less the discount, of course. And then we're left with trying to do the fee review for the service we provided. The onus is on us, not on the insurance company or the carrier, to get involved with trying to collect that difference that would be there. And oftentimes that process drags out even further. Before you know it, it's the next year. There's a new fee schedule that's coming out and we're still waiting to deal with the same problems that we've been dealing with prior to that.

And then we already discussed some of the electronic billing and the same problems we run into dealing with the electronic billing where other carriers, Medicare, dealing with the electronic billing. It's a fairly simple and easy process, not too time consuming or overburdened for a small practice, dealing with the paperwork system.

We're left with sending things over, oftentimes getting information back to say that it was never received. Then we have to resend it again, usually certified, to make sure and maybe somebody within the office has it, but the person who is the one who's responsible to send out an EOB and do the payments still claim that they never received that. Then we run into the risk sometimes of untimely filing or have this prolonged set period of time before

we're able to collect on that.

I think the electronic system here in 2016 moving forward is a quicker, easier, safer, more effective way, more efficient way of getting the providers paid, as they should, just as all the other insurances and all the other places. That's how they do that and operate it that way.

Finally again, I'd just like to thank again the Chairman and the Committee for taking the time for us. I'd be happy to answer any other questions when we get to the question part about specifics that way as well.

MAJORITY CHAIRMAN GINGRICH: We are there.

STEVEN MORGANSTEIN, D.O.: Thank you.

MAJORITY CHAIRMAN GINGRICH: The question part. We're hoping we have enough time to get through a few of them.

We've talked a lot about fee schedules, fee reviews, specialty networks, and so on. So you're going to have a lot of questions coming your way.

I'm going to start with the Acting Minority Committee Chair today, that's Representative Krueger-Braneky, if you have a question. And then I'll move through the list as they come in.

Thank you.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you so much, Madam Chairman.

Thank you, all of you, for your testimony, first of all, and for joining us here today.

I've got two questions. My first, whenever we're talking about revisions to the workers' comp system, you know, I think the purpose of this system is to support workers who are injured on the job through no fault of their own.

And I've heard plenty of stories from folks in my District who have been through horrifying challenges. And the bureaucracy that they face in the system is sometimes very challenging for them.

So can you tell me, first -- I've heard a lot about the provider experience, the network experience -- how would this legislation help injured workers? How would it make their experience easier?

MR. JAMES FOREMAN: I'll dive in.

As it relates to the networks and clarity between the employer and the employee, when you have a scheduling network and you call, they oftentimes don't yet have a provider lined up. The allowance of that panel is for -- other than immediate medical emergencies, which you then don't have to abide by the panel for that period of time. Injured employees can seek out health care providers immediately. They get in. We know we're on the panel. They know we're on the panel. We go immediately to

treating, whether it's physician, surgical, therapy, whatever. In the case of scheduling networks, there's oftentimes delays imposed.

Additionally, and if you talk with constituents or injured workers, the 90 days -- it was 30. It's now 90 days that someone must treat within the panel, unless a specialty sits outside of that. At the end of the 90 days, it's the employee's right to seek care wherever they want.

We regularly have injured employees who, through the networks, are told even at or after 90 days they can't leave and the suggestion is that it might be at your own expense or you might get in trouble.

Injured employees are fearful. They're fearful. They shouldn't be. But they're fearful of job loss. They're fearful of retribution in the workplace. They're afraid of the insurance company and maybe appropriately so the way it's played out right now.

So this makes it crystal clear particularly as it relates to designating who is a health care provider.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you.

And the second question. There is a lot of talk about cost savings here. And I'm actually unclear when there's a discount negotiated between the network and providers who actually benefits from that discount. Is it the worker? Is it the employer? Is it the fund? Who gets

to keep the difference?

MR. JAMES FOREMAN: I can speak -- sorry. I don't mean to steal the microphone.

Typically what happens with the network -- and the carriers are here, so they can speak to it. But typically the networks sit as the middleman. And they have contracts, oftentimes non-exclusive.

REPRESENTATIVE KRUEGER-BRANEKY: Okay.

MR. JAMES FOREMAN: We send our bill. There's a required form, depending on the type of provider you are. We send our bill with our NPI number to the network. The networks remove our tax ID number. They place their tax ID number with our NPI number. They submit the claim to the carrier. The carrier pays the network. The network takes their fee. And then that network is to pay us.

I'll be happy to share ballpark numbers of what those retainers or the fees are.

REPRESENTATIVE KRUEGER-BRANEKY: Okay.

MR. JAMES FOREMAN: So the employers are seeing little to no discounting. The savings are being largely held by the networks. I would challenge any of the networks to disclose -- we'll open our books. At least I'll speak for our company. We'd be happy to open our books to the economics of that.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you very

much.

MAJORITY CHAIRMAN GINGRICH: Thank you.

We'll move to Representative Dush, if you have a question.

REPRESENTATIVE DUSH: Thank you, Chairman.

And thank you, all, for your testimony.

First of all, as somebody who was a former insurance investigator, as well as somebody who's had a workers' compensation claim, I know both my orthopod and my physical therapist before they were.

That being said, I have one major question. I have a couple, but I'll just keep it to one right now.

Dr. McGlynn, you said over and over again when you were discussing the electronic submissions, common sense. I'm going to have a hard time going back to my employers and talking about common sense when we're in the middle of Appalachia where I have a lot of business owners who are still doing their books on ledgers, handwritten ledgers. They do not have access to the Internet.

You're going to ask me to go back and hold a gun to their head and tell them that they're going to be in violation of the law immediately simply because they don't have the ability to submit those forms electronically or to make and receive the electronic payments.

I don't see any common sense in that.

MS. KATHY DeWITTIE: We understand that there are small carriers, insurance carriers, small insurers that wouldn't be able to do that. However, there are clearinghouses just like you have in the mandated electronic submission of bills to Medicare. You also have those types of practices that don't have access to the Internet.

But in answer to that, there are organizations called clearinghouses or intermediaries which receive the paper bill or a semi-electronic bill, whatever form the practice or, in your case, the insurer is able to submit it. The clearinghouse then communicates electronically with the insurer.

REPRESENTATIVE DUSH: That's actually not where I was going. I was talking about my employers, the employers of the insured. My problem is that our median income has dropped $1,100 a year in my District. I'm losing jobs left and right.

My employers are part of that who are losing money. They don't have the ability to pay a clearinghouse. They don't have the ability to do these electronic forms because they can't afford the satellite links in order to get online to do that.

JAMES McGLYNN, M.D.: Representative, the intent of the legislation is to make that electronic transaction

apply between the health care provider and the insurance company.

REPRESENTATIVE DUSH: That's not what it says. It says the employer several times.

JAMES McGLYNN, M.D.: Right. That's how the Workers' Comp Act is structured. We can work on a mandatory language to make that clear. But as the Act is structured, the insurance company stands in the place of the employer throughout the --

REPRESENTATIVE DUSH: But the employer has to get the forms to the insurer.

MS. KATHY DeWITTIE: The way the legislation is written, I believe -- and if we need to correct it, we will -- it's the insurer, the insurance company, the self-insured employer, or their agent.

REPRESENTATIVE DUSH: That's not what the legislation says. But we'll leave it at that and look towards something else. I know there are other questions.

MAJORITY CHAIRMAN GINGRICH: Thank you.

Those are good points certainly to be considered as we look at the bill moving forward.

Representative Keller, you have a question.

REPRESENTATIVE KELLER: Thank you, Madam Chairman.

Thank you for your testimony to the panel. I

just want to say that it is a tragedy when any employee gets injured at work or anybody gets injured, period. Having been an employer, you know, you really do care for your employees.

I just have a question. A lot of the contracts that we're talking about between providers and an insurance company or a panel, do they run on a calendar year? If I'm an employer that negotiates my insurance and, you know, works on this panel, my year might run from April to April.

Is that the case that sometimes they don't always run by the calendar year?

MR. CHARLES ARTZ: You mean the contracts?

REPRESENTATIVE KELLER: Yes. The negotiated rates and so forth.

MR. CHARLES ARTZ: They run from whenever the contract is negotiated and an effective date is created in the contract for a year or however long.

REPRESENTATIVE KELLER: Okay.

I want to get back to page 8 and 9 of the bill. And it says, an insurer or employer who fails to implement the reimbursement update required by this subparagraph by January 2nd. So if I'm an employer and I've negotiated a contract for a length of time that doesn't necessarily coincide with the 2nd of January, would they then be subject to penalties because they're adhering to the

contract that they negotiated?

MS. KATHY DeWITTIE: I think I understand your question. The Workers' Comp Act requires that the fee schedule be updated by the statewide average weekly wage increase or decrease every year by January 2nd. That's how it's written right now.

So if there's a contract in place, let's say, between a network and an employer, and let's say that discount is for 10 percent, if the change in the fee schedule on January 2nd comes in the middle of that contract, then the 110 percent would be multiplied by the new fee that is required as of January 2nd.

REPRESENTATIVE KELLER: So as a business trying to make sure that I look at my costs, my costs could potentially change by things that are out of my control in the middle of my contract?

MR. JAMES FOREMAN: Yes. That's been the law since 1995.

MS. KATHY DeWITTIE: Exactly.

REPRESENTATIVE KELLER: The thing I would like to point out is the statewide average weekly wage based on the statistics has increased every year since 1970. I mean, they haven't had a decrease.

MS. KATHY DeWITTIE: No. I was simply stating the law as it's written. There has not been a decrease,

correct.

REPRESENTATIVE KELLER: Okay.

Again, I just think there's some concerns when we look at contracts and the timeliness of them. I'm not saying that people shouldn't be paid fair for their services and so on. But I just think we need to be mindful that we don't, you know, interrupt contracts that are made between private parties.

I have other questions. Maybe I'll get with the panel individually later. I appreciate the time.

Thank you.

MAJORITY CHAIRMAN GINGRICH: Thank you very much for the courtesy, Representative Keller.

Representative Ward, question.

REPRESENTATIVE WARD: I would also like to thank our panel here. It's been very informative.

I do have a question for Mr. Foreman. Can you give us a case that would illustrate your point to what -- because it's very complicated. Can you give us how this has affected your practice and patients in your practice?

Thank you.

MR. JAMES FOREMAN: Sure.

Typically pre-networks, we, as a workers' compensation provider, would meet with employers in our area. As I mentioned in my testimony, we would oftentimes

visit or tour their facility, particularly if the work environment carried something peculiar or unordinary or unusual, police officers, like I mentioned, coal miners, whatever.

When we treat, say, for example, a Medicare patient, we restore them to normative levels, activities of daily living. Can they shower? Can they go to the grocery store? Can they get to church?

When we're dealing with an injured worker, there's a lot more at stake. And it's harder. There's more to do. To do it right requires more work. There's the potential for legal getting involved, depending on that. So it definitely requires more work.

One of the things that was clear and to the benefit of the employers was to establish a panel so that there was -- as I mentioned in my testimony, there was an established relationship. And we're on the side of the facts. If an injured employee presents themselves and there's legitimate injuries and an employer is sort of breathing down us to get them back, no, they are not going to go back until they're fully, safely rehabilitated.

And vice versa, if an injured employee has concerns or whatever, we're working with the employer, with the nurse case manager and adjuster to come up with a good, effective, sustainable solution.

So in those cases, Representative Ward, we are able to actually develop a relationship with all parties involved and get them back to work safely and sustainably.

When we have the networks, we don't know who the employer is. The employer does not know who we are. We're oftentimes, most times, not even allowed to correspond with the nurse case manager, who is the real case manager, because of this middleman, this network.

So we have employees who are in rehabilitative care and there's this protracted, disjointed system. It's purely there for economics. And injured employees, then the fear sets in for them about what's happening.

Again, their rights are violated. I can give you a real example recently where an injured employee came to one of our therapists concerned about work, whatever.

We had advised them, you need to talk with your nurse case manager or whatever. At the end of 90 days, you can seek care wherever you want.

They had contacted the network to make them aware of this. They were basically shut down. They came back to us and said, oh, I think I'm going to get in trouble.

I don't want to pass along hearsay or whatever. All I can tell you is it's a prevailing problem and it happens all the time. All the time.

Does that answer your question?

REPRESENTATIVE WARD: It does. Thank you.

MR. JAMES FOREMAN: You're welcome.

REPRESENTATIVE WARD: Thank you.

MAJORITY CHAIRMAN GINGRICH: Thank you, both.

And we do have one more question.

I want to thank Representative Donatucci. Please be sure your question gets answered later. You're kind enough to wave off.

Representative Grove, question.

REPRESENTATIVE GROVE: Thank you, Chairwoman.

Workers' comp is pretty paper intensive. Do providers feel they can handle the administrative burden that comes along with all the requirements under workers' comp? Do you think you should be reimbursed for the administrative costs between the silent PPO and the carrier?

MS. KATHY DeWITTIE: I'll take the second part first.

Typically the piece -- the compensation by a third party is equivalent to the 10, 15, or 20 percent discount that is taken. The fee schedule in the Act is mandated at -- you know, there's a formula. It's mandated. And that's what the provider is supposed to receive.

What we're simply asking for is that if there's going to be a discount, we want there to be a contract

between the employer and the insurer and between the network -- no. Wait -- yeah, between the network and the employer and the network and the physician or provider.

Does that answer it?

REPRESENTATIVE GROVE: Yes.

MAJORITY CHAIRMAN GINGRICH: Okay. Thank you.

I think we've covered the questions. I have some myself but, of course, I can contact you individually and the maker of the bill.

It's our understanding and clear that the specialty networks are designed as a cost containment, certainly to the expense to the UC. All of your input is welcome on recommendations and ways to do that without spiking the cost to workers' comp.

We cannot put that aside because we want quality care and we want to be able to afford together to provide that quality of care.

I really appreciate the testimony from the panel. Thank you. You're welcome to stay and listen to the next panel. I will say thank you again.

I will ask our next panel to -- we didn't do too badly for as many folks as we had to share experience today. We did fairly well with our time. We are running a little behind as we say hello to our testifiers from the insurance and network manager payment side of this

discussion.

Coming forward is Sam Marshall, who is the President of the Pennsylvania Insurance Federation, and Robert Holden, Statewide Associates, the American Association of Preferred Provider Organizations, PPOs.

If you can get settled and have a microphone available to you, we are most interested.

Sam, does it work to start with you?

MR. SAM MARSHALL: Sure.

MAJORITY CHAIRMAN GINGRICH: Okay.

Welcome. Thank you for being here.

MR. SAM MARSHALL: Pleasure.

We don't agree with the bill. I mean, thank you for having us here but we don't agree with the bill. We think it will raise the cost of medical care and workers' comp without improving the quality of that care or the access to it.

But listening and learning and, you know, not only today and in experience, we do agree that this raises an issue that needs addressing by the General Assembly. We think that the medical provisions in the Workers' Comp Act need to be updated, need to be revised, need to be revisited.

We had pushed for that, as a number of you know, in House Bill 1800 that would establish treatment

guidelines and would have approved the utilization review system. That was tabled back in June. I'm an optimist so I hope that tabling is not quite the same as rejecting. And I'd like to think that this hearing and your ongoing interest in the medical end reflect your willingness to revisit that part of the Workers' Comp Act.

I realize workers' comp rates overall are flat. I think, though, as you heard today, there are concerns on all sides. And as you heard with House Bill 1800, there are concerns on all sides with the medical cost containment. It's really not a solution in search of a problem. It's a problem that can be addressed even as the overall workers' comp rates are flat.

The gist, as we read House Bill 1141, the part that alarms us, is that it will make it difficult to have rates, you know, fees paid to providers that are below the statutory fee schedule, that that all of a sudden can't become part of a general network arrangement, that it has to be a separate sidebar contract between a provider who joins a general network.

What that's going to do is make it difficult to have rates that are paid to providers that are less than the fee schedule. We've heard that complaint. And frankly, we've heard that complaint for several decades.

I'll offer some perspective and history on

networks and their rates. First, we have been using networks. We, in the employer community, have used them to revive physician panels in the Workers' Comp Act. We have done that since physician panels were established in Act 44 of 1993. They have payment schedules that are generally lower than what the statutory fee schedule in the Workers' Comp Act is.

There's nothing hidden or secretive about that. It's all disclosed. I will grant you that you may join a panel and not know every employer that comes into it, much the same as when as a provider you join a panel at Aetna or Independent Blue Cross or Highmark, you don't know every employer or every employee that is going to become an insured of one of those insurance companies.

I mean, you take them as they are. Panels are used and separate rates are used. I appreciate that the provider community doesn't like those discounted rates. Nobody likes it if you're the one being -- that they would rather be paid at the fee schedule rate.

And the gist of this bill as we see it, the problem we see in the bill, is that it will get them. They can join a general network but for workers' comp they still get the more generous fee schedule.

I know the feeling. I mean, we all wish we could pick and choose who we treat, what work we do, and what we

get paid. Life doesn't work that way. It doesn't work that way for insurers. It doesn't work that way for providers.

I think that's part of negotiation. And I don't think that that really is proper for legislative intervention. I think if there's a problem in the way networks and physicians are working together entering into things, that's something to be, you know, revisited. I don't think that getting involved with putting a bar on discounts is necessarily the proper subject of legislative intervention.

A lot of what we've heard today and what we've heard in years past goes to an underlying concern with the Workers' Comp Act that I think we have as well. And that's the fee schedule itself. I mean, you've heard a lot of talk today about, you know, we don't like those discounts below the statutory fee schedule.

You know, the real question is, how is that fee schedule? Is that the right fee schedule? From our perspective as insurers and employers, we think the fee schedule is screwed up. The provider community obviously doesn't. The question you have on both sides is why?

I'll give you some history. The fee schedule in workers' comp was arrived at in 1993. It came from Governor Casey. It was a bipartisan reform effort. It was

set at 113 percent of Medicare. You know, it wasn't -- the number wasn't particularly scientifically arrived at.

It was purloined from the auto law in 1990, which set a fee schedule at 110 percent of Medicare. And an added 3 percent was added, you know, to reflect what Representative Grove talked about, some added administrative costs which might be present in workers' comp.

It was done back then with a last minute amendment and twist in that. It said, okay, we're going to have that Medicaid-based fee schedule, but we're going to freeze it as of December 31st, 1994. And all future increases will be the statewide average weekly wage, which have not only increased all the time through that, but there's also been the miracle of compounding and how that's been done.

Twenty-two years later from 1994 the problem is that the 1994 Medicare fee schedule is obsolete everywhere but here. You know, fee schedules are commonplace. Everybody uses them. Medicare tends to be the cornerstone of them, as you might imagine. It's the largest payer of provider services in the country.

But nowhere else in the country is 1994 Medicare used. Only in Pennsylvania has time stood inexplicably still. As a result, you've had a couple of things that

have resolved. Two things. First, dealing with 1994, Medicare is increasingly illogical. We have new procedures, new facilities. The medical profession was not what it was in 1994.

You know, second, and most relevant for today, that fee schedule has worked out to be inordinately generous to certain pockets of providers. Under that fee schedule, providers get paid -- you know, certain providers get paid 200 percent or more of what Medicare pays.

It's obviously a lot higher than anywhere else. I mean, it's more than double what Medicare pays. It's substantially more than what the State pays for Medicaid. It's more than what we as health insurers generally pay. It's more than what auto pays.

Workers' comp, that fee schedule, because of that 1994 oddity is now not only an administrative problem, but it is paying at levels that have no rationale in relation to what the providers get generally for those treatments, you know, or what anybody across the country is getting.

In that spirit, I'll make an offer, if you want the statutory fee schedule to be the floor, if you want to make it very difficult for a provider to take a discount below that, that it has to be a separate sidebar, get rid of the discount. You don't need it. You still have networks, but you don't need the statutory discount.

Update the fee schedule. Go with 113 percent of current Medicare.

It's still going to give them more than what they get through Medicare, through Medicaid, through auto, and through most health insurers. But it's going to be a very common-sense form.

You know, we heard a lot today about the hassling of the fee review system. We have auto insurers and, just as it works out, workers' comp and auto insurance, you know, overlap. In the world of auto insurance, we pay at 110 percent of Medicare. We don't have billing problems. We don't have accessibility problems. We don't have delay problems on either side. It works. Everybody knows how to handle Medicare.

The fee schedule that is in place in workers' comp because of that 1994, going back that far every year as it becomes more and more obsolete -- frankly, the number of people who really know 1994 Medicare, you know, like the back of their hand gets fewer and fewer. It's just an administratively cumbersome system.

If you went with current Medicare, you know, the provider community is very used to it. The insurance community is very used to it. Every network is very used to it. So why not set it at 113 percent of Medicare?

I would say that as you focus on the medical side

in workers' comp, I think the first question that was asked was a very important one. How does it impact injured workers? You know, as insurers, our goal is to get injured workers better. And in workers' comp, that's a very objective measurement because it means they're back to work. That's how you judge whether somebody got better.

We have every interest in getting the patient better, getting the injured worker better. We feel that networks provide a valuable service in that. We don't think that there is quite the fear or the uncertainty of them or the danger of retribution.

You know, generally we're going to have providers join networks, not kick them out. We don't feel that they have a -- I'm surprised to hear that somehow they were resulting in delayed care. We don't hear that as a complaint. You know, I don't think that they have hurt accessed care. That's certainly not been our experience.

But what I do think that we need in our workers' comp system, yes, we need a payment level that's a fair payment level. I think going with 113 percent of current Medicare would be that fair payment level. We need to make sure that there is consistency in quality in the way the care is done. I think that's treatment guidelines.

And I think we need to make sure that the review of that care is done by the highest standards and that's

making sure that utilization review organizations that are involved with all of that, you know, meet the gold standard, which would be that they be certified by an outfit called Urach National Crediting outfit.

So again, I'm happy that you're interested in the medical component of workers' comp. I think it does need reform. While we don't agree with the specific reforms, I mean some of them and some of the procedural questions, we're happy to talk further with the provider community on them.

But we do hope -- I think at the root of a lot of the problem is this bizarre 1994 based Medicare fee schedule. And I would hope that you take a look at that because there's just no rational reason for it.

Thank you.

MAJORITY CHAIRMAN GINGRICH: Thank you very much.

And then we'll turn to you, Mr. Holden, to share with us, please.

MR. ROBERT HOLDEN: Thank you, Chairman Gingrich.

My name is Robert Holden. I'm here on behalf of the American Association of Preferred Provider Organizations.

Many of our members are workers' comp networks. One of the comments that I'd like to agree with was something Dr. McGlynn said earlier, which is that a silent

PPO is someone trying to access provider discounts without a contract. If they don't have a contract, they're not a network and they shouldn't be taking a discount. And so we certainly agree with that.

Our members have contracts with providers. And our concerns with this bill are not that it would impact silent PPO access without a contract. It's that they directly impact legitimate, bona fide networks that do have contracts.

They do that in a few ways. Some of those are technical issues that could probably be corrected. But others are more fundamental to the bill. And I'll just address some of the technical issues, the idea that you can't reference a network unless they have a provider identifying -- or a Nation Provider Identifier or they are licensed to provide health care services by the State. Our networks are approved by the Insurance Department and the Department of Health and regulated.

So again, we understand the need for regulation and they are. But that NPI is specific to individual providers. And networks simply don't have those. So right off the bat you're taking legitimate, bona fide networks out of the equation.

The other issue -- and again this goes to the fundamental issues we have with the bill -- is the idea of

a direct contract. Our networks work with insurers. They work with employers. They also work with managing general agents and underwriters and TPAs to provide services again to insurers and to employers.

And they also work with each other. Networks have bounds. They have specific providers. They have specific areas in which those providers exist and support injured workers. They need the ability to contract with each other to provide an adequate network. Networks have contracts with each other. They have contracts with these other entities.

And while I agree there needs to be transparency there, this would, again, categorically limit their ability to do that. That inhibits their ability to create an adequate network. And it also eliminates their ability to manage a network, which, again, is a changing group of providers over time. Even within the planned year, you're going to have folks that are no longer in practice, moot practice. You've got to be able to adjust. And renegotiating individuals contracts is not necessarily going to be the way to do that every time.

Finally, I think that some of the specific requirements and terms of turnaround time are very, very short, 72 hours in instances, 10 days to place on a website. Again, there are national standards for these

that are much, much longer, 30, 45 days in some instances. And some of the reporting is unclear as to who would be reporting at least under the terms of the statute.

We've laid this out in our written comments. I'm pleased to answer questions. Just in terms of brevity, I wanted to identify those issues that we have the most problems with with this bill.

Thank you.

MAJORITY CHAIRMAN GINGRICH: Thank you very much.

I'm not putting aside all the issues that you mentioned, which are several. But since the current law requires payment being made in 30 days -- this is a side question -- that's a reasonable expectation. Why are providers experiencing problems with that timeline?

MR. SAM MARSHALL: Frankly, I'm surprised that they are. There's a lot of talk about fee review. There's no incentive because it doesn't have attorney fees. I don't know that attorney fees are always a great incentive for things. But, you know, we regard the fee review process as actually more favorable to providers than us. You know, we can make a decision to say, hey, you know, we're not even going to discuss it. We're just going to submit a fee review and the Bureau does all the work.

But I think, you know, timely payments, there's no incentive from an insurance company's perspective to

delay on payments. You know, I know at one point years and years ago there was talk, oh, companies like it because they get the float while they hold the money. With interest rates where they are now, I don't think anybody is floating very well.

You know, we're trying to get payments out the door and process them quickly. That's why if there are procedural aspects, you know, if there are problems in the process where all of a sudden some provider is finding, hey, I'm not getting paid for 45, 60 days, that's something to revisit.

I would say that some of challenge goes to the antiquated fee schedule. You know, one of the gentlemen before talked about having to wait until March. I don't know that that's standard. But every year we have to wait to get the statewide annual weekly wage increase. Sometimes we get it a little bit before Christmas; sometimes we get it a little after New Year's. But it applies on January 1.

So all of a sudden we have to start putting that in. And it's every year that reprogramming aspect where you have to make that revision. You know, that's a challenge. You know, we do things electronically. I represent fairly hefty insurance companies.

I appreciate Representative Dush's concern.

Actually, I thought you were going to go in a different direction, which is that not all providers submit electronically. I mean, there's still providers that don't do it. And they don't all do it the same way. I mean, if you want to have a uniform electronic format, I'm happy to engage in that discussion.

But if you noted one of the oddities in the bill, we have to accept electronic billing. It's not that every provider has to submit electronic billing. You know, therein lies a bit of the difference.

But I would say, you know, one of the gentlemen before said here we are. We're well into the 21st Century and we're -- he was referring to the electronic billing aspect -- stuck back in the 20th Century. I'd say the same thing about the fee schedule. You know, here we are in 2016 and we're stuck with 1994 Medicare.

And I think if you were to update that fee schedule, a lot of these problems would go away.

MAJORITY CHAIRMAN GINGRICH: I hear you. Addressing that is a major issue. There are a lot of procedural tentacles. I appreciate that. But we certainly don't want any delays that are required in the current bill. We just need to make that as robust as we can.

I'll go to the gracious Representative Donatucci, who has a question for this panel.

REPRESENTATIVE DONATUCCI: Thank you, Madam Chairman.

And, Sam, you already answered my first question about the 1994 fees, so I'll move on to something else.

We hear a lot from the insurance industry and others that the procedures and processes need to be more efficient. How is this bill not a plus for the workers' compensation system?

MR. SAM MARSHALL: How is it -- I'm sorry?

REPRESENTATIVE DONATUCCI: Not a plus for the workers' compensation system.

MR. SAM MARSHALL: I don't see where it's -- it's not a plus because what it's going to do is increase the cost that we pay without improving the care. It's not going to -- you know, we're not finding in our patients -- our injured workers that we insure aren't having problems with access. You know, when we look at the core of the bill, it is to say, you know, we're going to make it very difficult to give discounts. That's our main concern.

If there are some information ends, you know, that the panel before talked about, you know, about needing certain access to, you know, the patients, you know, report an injury and things like that, that's something to talk about. I mean, there's some confidentiality concerns, some privacy concerns that enter into that. I'm not sure every

injured worker wants his panel provider to have access to that information.

I mean, what this does is, you know, as we look at it, is it further locks us into an antiquated fee schedule. And I think anything you do on that is going to make the workers' comp system more of an outlay or more of an administrative burden, more of an excess cost without a benefit corresponding to it.

You know, that's why, you know, the text that was correctly pointed out, what's the benefit to injured workers? I don't think this is going to make care better for injured workers. What's a benefit for employers and insurers? It isn't going to lower our costs. We wouldn't be opposing it if it were. What's the benefit to providers? I understand that some providers are going to get more money, you know, going to get better pay.

We're not suggesting that they be paid any less than what is standard throughout the rest of the health care industry. Medicare, Medicaid, conventional health insurance, auto insurance is the major payment sources. You know, what we want is their pay be in line with all those other major payment sources.

If there are ways to improve the administrative handling working with the Bureau, happy to engage in that. Don't see that in the bill.

REPRESENTATIVE DONATUCCI: Yes.

MR. ROBERT HOLDEN: I just wanted to make a brief comment. I mean, we would agree that -- again, our issue is this would represent a sweeping change and not just a minor technical issue. It would require us really to renegotiate almost all the contracts we have and call into question how we're organized, vis-à-vis a lot of the other license entities in the Commonwealth. So again it would require a cost without again any apparent benefit.

MAJORITY CHAIRMAN GINGRICH: Does that answer your question, Representative?

REPRESENTATIVE DONATUCCI: Yes, it does.

MAJORITY CHAIRMAN GINGRICH: All right.

We have a question from Representative Krueger-Baneky.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you, both of you, for testifying today.

I've got the same question I had for the last panel. In your opinion, how will this bill affect, hurt, or help the injured workers that our system was designed to protect?

MR. SAM MARSHALL: As I mentioned, I don't think it helps injured workers. I don't think it necessarily hurts injured workers. But it makes -- I don't see that it makes access to care better. I don't see that it makes the

quality of care that they get better. I think it just makes it more expensive.

REPRESENTATIVE KRUEGER-BRANEKY: So you draw on the worker impact?

MR. SAM MARSHALL: I think probably over -- you know, where I would differ from the panel before, there was a presumption in the panel before that networks are somehow bad, that overall they don't do a good job, so you need a lot of regulation of them just to make sure that they really don't cut corners or anything like that.

I actually think that networks do a good job. I don't think that they delay care. I think that they improve care. I think that certainly to the extent that we use networks as insurance companies, we use networks to get patients better and back to work quicker. I mean, that's how you measure quality treatment in workers' comp.

So I think that trying to put anything that has a chilling effect on the use of networks or physician panels I think ultimately hurts injured workers as well as the people who pay the premiums.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you.

Mr. Holden.

MR. ROBERT HOLDEN: I would agree with those sentiments. I would also add from our perspective -- I mean, you're talking about -- particularly with some of the

technical issues, you want access to providers. And the networks are a very good way of allowing access to a wide variety of folks that injured workers are going to look to.

This again changes that dynamic and really limits, I think, how that access is presented to individual workers. So from that context, I would just add that to his comments.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you, both of you.

MAJORITY CHAIRMAN GINGRICH: Thank you.

And I believe we have a question from Representative Ward.

REPRESENTATIVE WARD: Thank you both for being here.

My question is, can you help me understand who benefits from the networks, the discounts that the networks provide? Is it the employers? I mean, it wouldn't be workers. Who benefits?

MR. SAM MARSHALL: The employer who pays the premium. When you have a network discount that's less than the fee schedule, that results in lower premiums.

MR. ROBERT HOLDEN: And I would add again from our perspective, the network is not only competing to work with employers and insurers but also competing to have access to providers. They're negotiating with providers to

get that access.

So there is a benefit to the provider as well. There's direction of business. There's all sorts of benefits that accrue to providers again on the payment side. Is that going to be uniform from network to network? No. They're in competition with each other as well.

And I think that both the injured worker providers and the employers all benefit from that.

REPRESENTATIVE WARD: Thank you.

MAJORITY CHAIRMAN GINGRICH: Thank you.

Did I hit all the questions? We were just talking up here. It was alluded to a little earlier about addressing some of the very critical issues we have with prescription medication, the opioids and the drugs. The Governor has made it a focus for us in a special session. I just don't ever want to lose sight of the fact that this is all going to be incorporated into the workplace. When we look at costs, we're going to need to look at those.

Do you have any thoughts on that? I'm just talking about what I'm thinking about.

MR. SAM MARSHALL: I appreciate it.

And I know a number of you were part of the Joint Committee, House Republican and Democrat House and Senate Policy Committee hearings on the opioid problem.

We have talked about opioid problems at length

because in workers' comp, opioid use in workers' comp is higher than it is elsewhere in the health insurance arena. And in the Pennsylvania workers' comp system, opioid use is higher than across the rest of the country.

This bill doesn't address it. I think that's a very real problem. This bill doesn't deal with that. The pitch that I made, I mean, we were obviously disappointed when you tabled House Bill 1800 with treatment guidelines. We would hope that at least for treatment guidelines related to opioid use in establishing drug formularies that you would revisit that.

And I believe Representative Mackenzie has been working on something just targeted to the opioid area. That is in the area of workers' comp. Frankly that's a very real and immediate problem. You talk about, you know, injured workers and, you know, what can you do to improve the care of injured workers?

You know, do I think updating the fee schedule will help in some tangential way? Yes. Do I think we should keep networks involved? Yes. But if you were really to say here, what can we most do in the immediate sense that will benefit injured workers and workers' comp? you would sit there and you would put the brakes on opioid prescriptions and use in workers' comp.

The fact that Pennsylvania is tops in the

country, No. 1 -- and that's not the insurance industry pointing that out. That's the Workers' Comp Research Institute, which is as an objective a source as you can ever find. To not do something on that is a crime for injured workers.

That's where you see -- I mean, I know people -- some people cried, you know, treatment guidelines, oh, it's one size fits all. No. It's actually setting a very high bar in terms of what the treatment should be. It's not a low bar. It's not the lowest common denominator. It is raising the practice to a highest common denominator.

And to not have treatment guidelines in opioids is a shame. It's something you can do quickly, immediately, and the Bureau can implement equally quickly and immediately.

MAJORITY CHAIRMAN GINGRICH: Thank you.

I can't help but think about the impact on the workplace as we deal with all these labor issues.

Thank you both very much. Thank you to the members for their good questions and interest.

And we will invite our representatives now to the table please from Labor & Industry if they are still here and haven't lost interest.

The seats are warm. Just find a mike. Good morning. It's not afternoon yet.

DEPUTY SECRETARY MICHAEL VOVAKES: Good morning.

DIRECTOR SCOTT WEIANT: Good morning.

MAJORITY CHAIRMAN GINGRICH: Fortunately we haven't done too awfully bad with our time. So we're still all ears and attentive to what you may want to share with us.

We have Mike Vovakes, our Deputy Secretary for Compensation and Insurance at L&I and Scott Weiant, who is the Director of the Bureau of Workers' Comp.

So share with us your experience and wisdom and thoughts on this bill.

DEPUTY SECRETARY MICHAEL VOVAKES: Good morning, Chairman Gingrich. We will try and keep you on time as well. Representative Krueger-Braneky, thank you for filling in for Chairman Galloway.

Committee members and committee staff, thank you for having us this morning. I appreciate the opportunity to testify before the House Labor and Industry Committee regarding House Bill 1141 and payments to health care providers under the Workers' Compensation Act.

My name is Michael Vovakes. I'm the Deputy Secretary for Compensation and Insurance in the Department of Labor and Industry. And today with me is Scott Weiant, the Director of the Bureau of Workers' Compensation.

House Bill 1141 seeks to make significant changes

to the way in which health care providers in Pennsylvania obtain payment for treatment provided to injured workers. The impact of this legislation on all participants in the workers' compensation system would be extensive. Notably the cost to the Department related to the implementation of this proposal would be substantial and indeed some would say that this is a solution looking for a problem.

This legislation places additional burdens on both the Bureau of Workers' Compensation and on the Workers' Compensation Office of Adjudication. The Bureau would be required to make considerable additional investments in information technology infrastructure in order to develop the required system to allow providers electronic access to injury reports and to notices of compensation payable.

The development of such a system, including the appropriate security protocols, is estimated to be a cost of $5 million over the next two years. And that's just the cost to the Bureau of Workers' Compensation. That does not include costs that will be incurred by the other parties and stakeholders in the workers' compensation system to get their systems compatible.

The bill further requires that the Bureau develop and implement this system within 30 days after its effective date or just something that is quite simply not

feasible because of the changes that are required.

Equally concerning is the impact that this legislation would have on the Workers' Compensation Office of Adjudication. This bill expands the role of Workers' Compensation Judges, creates new causes of action, and incentivizes litigation.

And fundamentally this bill appears to make Workers' Compensation Judges responsible for enforcing or avoiding private contractual agreements between providers and networks. It's not the role of the workers' compensation adjudication system to resolve private contractual disputes.

Those disputes are properly within the jurisdiction of the judicial system, not an administrative tribunal as the Workers' Comp Office of Adjudication and the Judges are.

The bill creates new causes of action before Workers' Compensation Judges by allowing health care providers to file penalty petitions and obtain substantial interest in penalties from insurance carriers or other responsible parties, amounts that in some cases exceed the penalties available to injured workers whose benefit payments are delayed.

The bill also imposes deadlines for the conduct of hearings and the rendering of decisions on petitions for

violations of the provisions related to health care providers that exceed deadlines on petitions filed by or decisions involving injured workers and therefore appears to give precedence to the reimbursement of health care providers over the determination of benefits due to injured workers.

The availability of significant interest penalties and fines, some of which are not discretionary, from insurers or other responsible parties would increase litigation before Workers' Compensation Judges and tax the adjudication process that determines the claims of injured workers.

It's also unclear how this proposal would impact the Uninsured Employer Guaranty Fund and whether the statutory exemption to the payment of penalties from the UEGF would extend to the penalties that are created by this bill.

Additional ambiguity exists in the legislation in terms of responsibility for enforcement of criminal provisions related to referral of an injured employee to a health care provider without bona fide case management or coordination of care services and the prohibition of solicitation of a provider to accept discounts below fee schedules by threat of negative economic patient access or reimbursement consequences.

If it is expected that the Department will participate in enforcement of these provisions, such responsibility will also increase the Department's overall costs of administering the workers' compensation system.

This legislation contains many other provisions that will increase costs for Pennsylvania employers and insurance carriers which I'm confident that other witnesses before this committee -- well, they have explained it in great degree.

However, it's worth noting that the costs to the insurance industry will be sizable, as carriers will not only have difficulty availing themselves of network discounts and therefore pay a resulting increase in medical expenses, but they will also encounter significant increases in litigation costs, penalties, and interest.

In addition, they will also face mandates to implement changes to IT systems. Inevitably the increase in expenditures will be passed on to Pennsylvania employers in the form of higher premiums. In addition to those obvious costs, this bill also creates a substantial risk of adverse impact on the ability of claimants to receive treatment for work-related injuries.

It appears from the provisions of House Bill 1141 that providers wish to verify the eligibility of a claimant for workers' compensation benefits before rendering

treatment. However, in many cases, a first report of injury may not have been a comprehensive injury description at the time that the treatment is sought.

The possibility that a provider might refuse treatment for an injury that has not yet been determined to be work related is concerning. Because of the substantial costs associated with this legislation, the incentives for additional litigation that it creates, the ambiguity of certain provisions, and the possibility that it could impact the care provided to injured workers, the Department of Labor & Industry opposes the passage of House Bill 1141 in its current form.

The existing workers' compensation system in Pennsylvania is designed to keep the cost of injury and care in check. The provision 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 insuring 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 is proof that Pennsylvania's workers' comp system is on the correct path.

To conclude, I would like to thank this Committee for the opportunity to testify today regarding House Bill

1141 and health care provider payments. The Department of Labor & Industry will remain devoted to working with injured workers, employers, insurance carriers, and providers to find meaningful improvements in the workers' compensation system that benefit all stakeholders.

MAJORITY CHAIRMAN GINGRICH: Thanks so much, Mike.

Scott.

MR. SCOTT WEIANT: I really am here to answer questions. In reflection of time and the time constraints, I'll just defer to the previous panels who so eloquently explained the process to everybody. I can just defer for questions.

MAJORITY CHAIRMAN GINGRICH: Great. And I'm really happy you're here to answer questions. We have some, I believe.

I want to start with a quick one for you. This falls under your purview.

DEPUTY SECRETARY MICHAEL VOVAKES: Yes.

MAJORITY CHAIRMAN GINGRICH: How do we, SWIF, use the networks currently? We've had a lot of talk today about cost containment measures and the value but then the flip side of it from other folks involved in its use.

How is it used in SWIF?

DEPUTY SECRETARY MICHAEL VOVAKES: The State

Workers' Insurance Fund does avail itself to discounts available through certain networks. We do, of course, follow the normal course of medical bill pricing. We do try and manage our pharmacy costs using a pharmacy that provides us with discounts. I'm trying not to say the name.

MAJORITY CHAIRMAN GINGRICH: Right.

DEPUTY SECRETARY MICHAEL VOVAKES: But we do work with these folks in order to manage costs of care to those insured by SWIF.

MAJORITY CHAIRMAN GINGRICH: So you would have the firsthand knowledge of its advantages or complications?

DEPUTY SECRETARY MICHAEL VOVAKES: That's probably a -- yes, I have some firsthand knowledge that detail, if you want to boil it down, resides within the leadership.

MAJORITY CHAIRMAN GINGRICH: It's interesting to know how it's used internally by our operations.

DEPUTY SECRETARY MICHAEL VOVAKES: Sure.

MAJORITY CHAIRMAN GINGRICH: Thanks very much.

DEPUTY SECRETARY MICHAEL VOVAKES: You're welcome.

MAJORITY CHAIRMAN GINGRICH: We have a few other questions.

Representative Dush.

REPRESENTATIVE DUSH: Thank you, Madam Chair.

Scott, you had said that this legislation will incentivize litigation. Two-part question. One, do you see that as an immediate and substantial increase in the litigation and the costs? And also Sam Marshall had mentioned about our going back to just a flat 113 percent of current Medicare, not to the 1994 fee schedule kind of thing. Do you see that as a much simpler and more direct way to contain those costs?

DIRECTOR SCOTT WEIANT: Just for clarification, I'm Scott. He's Michael.

REPRESENTATIVE DUSH: Right. I'm sorry.

DIRECTOR SCOTT WEIANT: I can handle that. I'll take that question. We think there would be an immediate increase in the litigation as a result of the bill, not only the cost that Deputy Secretary Vovakes provided to you. Those are the $5 million for the costs that we're looking at for upgrades to the workers' compensation automation integration systems solely.

Additionally, to the cost from the infrastructure upgrades that we would have to make to comply with the statutes within the legislation, we would also have additional personnel costs. We have some calculations on those personnel costs as well .

We're looking at possibly -- and this is on, you

know, just looking at potential petitions filed. It's all the best guesstimate that we can provide out there from the unknown. But we're looking at increasing the number of judges by three and clerical staff and on and on and on.

So we're also looking at personnel costs of about a million dollars as well just in relation to the anticipated increase in hearings.

REPRESENTATIVE DUSH: And as to that second part of the question, do you think something simple like that 113 percent, would that actually put Medicare on the fee schedule, just go revert to that? Would that give us the kind of savings that this is actually looking for?

DIRECTOR SCOTT WEIANT: I can tell you that we've had preliminary discussions back and forth, just very, very preliminary discussions on the issue with the fee schedule. I cannot tell you factual based on some of the comments made by the Insurance Federation. I can tell you we're willing to talk with all of the stakeholders, including the Federation, on what may make the fee schedule a better system from an administrative and a cost perspective on that front. So, yes, we're always willing to talk to those folks about that.

MAJORITY CHAIRMAN GINGRICH: Thank you both.

Thank you, Scott and Mike. We have a couple more questions.

Representative Krueger-Braneky, you have a question.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you so much for joining us, especially the Deputy Secretary. Very clear in the answer to the question that I've asked the previous two panels. You're very clear on your impact on workers. So I'm curious, in your opinion, for those of us on this Committee who are really motivated by wanting to serve injured workers, is there another issue that you'd recommend this committee take up related to workers' comp?

DIRECTOR SCOTT WEIANT: Well, you know --

REPRESENTATIVE KRUEGER-BRANEKY: I didn't give you this question ahead of time. So I'm asking you to speak off the cuff.

DEPUTY SECRETARY MICHAEL VOVAKES: I'm going to have Scott answer that.

DIRECTOR SCOTT WEIANT: You know, I can tell you that within the workers' compensation system in Pennsylvania, I don't think anybody is proud of the statistical data that Mr. Marshall finely eloquently communicated in relation to the opioid situation in Pennsylvania. I see those statistics as well.

From the stats that I see in the bottom three, I'm not sure if it's first or last. Either way, it's not good. I don't think that anybody is proud of that. And

we're always willing and we want to work to try to curb those problems that are out there in relation to that.

I think that probably of a number of things on my radar, that's probably the top issue that I see right now as well.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you.

DIRECTOR SCOTT WEIANT: You're welcome.

MAJORITY CHAIRMAN GINGRICH: Thank you both.

In conclusion, I'll quickly go back to that payment issue. You know, as we talk about the fee process and so on, can you talk or comment on the Department's record of enforcing these payment issues that we've heard about?

DIRECTOR SCOTT WEIANT: Chairman Gingrich, I can tell you that in the Bureau of Workers' Compensation, on an average year, we do about 32,000 or so medical fee reviews. I do not have the statistics in front of me to let you know who is the successful party in the majority of those. But I can tell you that we do our due diligence to process those medical fee reviews. I can get back to the Committee with statistics on that.

MAJORITY CHAIRMAN GINGRICH: It's just an interesting aspect of getting the money out where it can reasonably be expected in a reasonable time with everything that goes into doing it.

So thank you. I think we've answered all the questions. We certainly, certainly garnered a great deal of information today.

I want to thank Representative Stan Saylor for all the work he put into this bill and for bringing it to the Committee for discussion. I think a lot of points came up that we can certainly build on.

I would say thank you again to everybody here. And go out and enjoy a little bit of this beautiful day in Pennsylvania.

The meeting is adjourned.

(The following written remarks were submitted by Alex Halper, Director, Government Affairs, PA Chamber of Business and Industry:)

Dear Chairpersons Gingrich and Galloway:

On behalf of the Pennsylvania Chamber of Business and Industry, I write regarding House Bill 1141, legislation amending Pennsylvania's Workers' Compensation Act, which is scheduled to be the subject of a House Labor and Industry Committee hearing today.

This legislation includes various provisions that amend different sections of the Workers' Compensation Act, a number of which are consistent with concepts we believe have merit.

For example, the bill calls for the workers'

compensation system to fully transition to electronic billing and payment, a proposal endorsed by the PA Chamber Workers' Compensation Committee several years ago, which we still support, provided that all parties have a reasonable time frame for implementation.

We also believe it makes sense to enhance health care providers' access to claim information that is relevant to their treatment of patients and maintains appropriate safeguards.

House Bill 1141 also imposed penalties on insurance carriers for failing to pay claims or implement the updated workers' compensation fee schedule. While we do not oppose efforts to hold accountable any party within the workers' compensation system, it is important to recognize and avoid inconsistencies with penalties that are currently applied if a carrier fails to pay a claim.

Penalties also already exist for failing to implement an updated fee schedule, though I would note that such occurrences are not always attributable solely to the carrier and therefore the law should ensure that innocent carriers are not unjustly held responsible or penalized.

Finally, the bill includes provisions related to so-called silent discounting and prohibiting the use of any threat or coercion. We have strong concerns with these provisions, which we believe impede on contractual matters

and general engagement between parties.

The fact is, threats and acts of coercion are a part of everyday life, whether you're a business trying to coerce better service from a vendor by citing its competitors or a customer threatening to leave if the price isn't lowered. Attempting to prohibit this type of interaction could be problematic and trigger negative unintended consequences.

Thank you for considering our views on this matter.

(The following written remarks were submitted by Lawrence R. Chaban, Co-Chair, Workers' Compensation Advisory Council:)

Dear Chairpersons Gingrich and Galloway:

At its meeting on July 20, 2016, the Workers' Compensation Advisory Council reviewed House Bill 1141. After a thorough discussion, it was unanimously decided that the Council would oppose House Bill 1141. These changes to the Pennsylvania Workers' Compensation Act would not improve the administration of the law.

Instead, it would add another layer of bureaucracy that is unnecessary and create an additional, undue burden on the Administration Fund from which the system operates.

House Bill 1141 appear s to be intended to

address delays in payment of medical bills under the Workers' Compensation Act. There is already a well-developed process for fee review under the Workers' Compensation Act, which provides all parties appropriate due process.

The procedures proposed in House Bill 1141 would undermine that process which is available to all health care providers when there are billing disputes.

The Workers' Compensation Act currently requires that overdue payments on medical bills come with an automatic 10 percent per annum interest. This has been true for decades, that such bills should include the interest payments.

The process of the Workers' Compensation Act already provides that if the interest is not paid, there are remedies to obtain payment. The Council does not see a need to change these longstanding procedures to increase the interest to a rate higher than the injured worker would receive.

The Council has been advised that these changes would cost the Department of Labor & Industry up to $5.5 million over the next two fiscal years in personnel and information technology changes, which in our view cannot be justified. These costs would be necessary to staff and computerize the necessary documentation that House Bill

1141 requires.

Given the present ability of the Department to address billing issues through the fee review process, requiring these changes would be a wasted expense to the Administration Fund.

The rights given the health care providers in House Bill 1141 are far beyond those given by any stakeholder currently in the system. The mandatory penalties and interest is beyond what injured workers are entitled and the workers' compensation system is the safety net for them.

As it now stands, all penalties go to the injured worker. This would deprive the injured worker the penalty for the problems associated with medical coverage when payments to the providers are delayed. Instead, this bill would create a windfall for health care providers, at the expense of the injured worker.

The health care provider would be able to jump on a one-day delay in payment to obtain interest of 25 percent, penalties of 50 percent, and attorney fees for litigating such a minimal delay.

Further, House Bill 1141 removes any discretion from the Workers' Compensation Judges regarding such delays as being worthy of such interest, penalties, and attorney fees. We see a potential for a due process issue by

removing such discretion from the Workers' Compensation Judges and making their decisions purely ministerial.

The criminal provisions are particularly draconian in the workers' compensation setting. As for the injured worker, it would criminalize the referral by the work's attorney to a treating physician.

The attorney would receive compensation by way of fees for representing the injured worker without the predicated case management services or coordination of care. Who is more familiar with the physicians in the area where the injured worker resides than the attorneys who practice in the field daily?

It could also criminalize the creation of required panel providers by employers where rates were negotiated with those providers who are on the panel. As the injured worker must treat with the panel provider for 90 days and the employer would receive compensation with reduced charges, House Bill 1141 would criminalize such conduct. This upsets the carefully crafted provisions that permit panel providers.

Overall, the Workers' Compensation Advisory Council believes this legislation is a solution in search of a problem. If the health care providers make use of the fee review process in a prompt manner, then the questions that House Bill 1141 appears to raise would be timely

addressed.

For the foregoing reasons, the Workers' Compensation Advisory Council would ask that the Committee not report House Bill 1141 to the Floor of the House.

(The following written remarks were submitted by Julian Roberts, President and CEO, American Association of Preferred Provider Organizations:)

Dear Chairwoman Gingrich, Chairman Galloway, and Committee members:

Thank you for the opportunity to submit comments concerning House Bill 1141. The American Association of Preferred Provider Organizations is the leading national association of the preferred provider and workers' compensation organizations. Through our members, we work on behalf of thousands of injured workers throughout the country, including in the Commonwealth of Pennsylvania.

We are concerned that House Bill 1141 proposes changes to the workers' compensation system in Pennsylvania that will unnecessarily disrupt employee access to a broader selection of health care providers and that will needlessly increase costs to employers by adding additional steps to contracting for the formation and maintenance of a bona fide provider network.

While we appreciate Representative Saylor's efforts, we strongly believe the application of these

proposed policies will fundamentally upend a system that has historically allowed the State to keep workers compensation costs low.

In addition, the proposed legislation would create numerous unnecessary administrative costs and burdens on insurers and providers within the State. The impact of this will ultimately create undue burdens for injured workers.

Additionally, AAPPO is concerned with the fee review system proposal. Under this bill, the Workers' Compensation Bureau would have the responsibility of reviewing every contract between every medical provider, carrier, and employer. Additional staff and resources would be necessary to support this initiative, therefore incurring additional costs which would be passed to Pennsylvania employers.

Network contracting and access to providers. In changes to Section 306, House Bill 1141 amends the types of providers that may be listed as designated health care providers by specifying that various entities listed, including networks, must be licensed and have a National Provider Identifier, or NPI.

While we have no specific expertise in some of the other entities referenced, the requirements on networks need to be amended in light of other Pennsylvania law.

First, the Commonwealth approves networks through applications to the Insurance Department and Department of Health, but does not issue a license.

Furthermore, networks do not receive NPIs. These requirements should be clarified to accept agency approval in addition to licensure and that NPIs be required when applicable.

Of greater concern to us are amendments to Section 306 regarding case management and coordination of services. While the amendments acknowledge the application utility of a bona fide provider network, the contracting requirements contained in those amendments appear to severely limit the ability to structure and maintenance of adequate networks.

The amendments require direct and exclusive provider agreements between the employer or insurer or their agent and the provider. While we agree that access to providers must be contractual, the definition of what constitutes a direct contract is critical.

Our concern stems from the number of necessary instances in which a provider agreement with a bona fide provider network may not meet the requirements under these amendments.

For example, a network may have acquired contracts under a different name through a merger or

acquisition. Similarly, a network may partner with another network to offer the injured workers access to increased provider choice. If networks are not allowed to acquire contracts through acquisition or to work with subnetworks this legislation will impair their ability to assure adequacy and access to providers in a changing environment.

Furthermore, clarifications on the meaning of direct are necessary given the frequency that employers and insurers utilize the services of third-party administrators, managing general agents, and managing general underwriters. All of these entities, licensed by the Commonwealth, typically have contractual relationships with networks for the benefit of their clients.

We are concerned that these arrangements may be prohibited if not deemed direct, which would cause a significant change in the market by limiting injured workers access to providers and reducing competition.

Fee review and reporting requirements. Finally, AAPPO is concerned about the tight deadlines and ambiguity concerning reporting arrangements with the Department of Labor and Industry. Given the severe penalties contained in the legislation, we are concerned about the short 72-hour time period that insurers and employers have to notify the Department about their arrangements with entities assisting them with case management and

coordination of services, and to whom that would apply.

Nationally, notification to a state agency is not required and changes would be posted on a website within 45 days of the contract being accepted. This represents a significant intrusion into private contracting by the Commonwealth.

In closing, we strongly encourage the Labor & Industry Committee to withdraw House Bill 1141 or remove the contractual provisions in the bill. We believe that if House Bill 1141 is passed, there will be significant and unnecessary challenges to providers, insurers, and injured workers throughout the State.

Thank you for your consideration.

(The following written remarks were submitted by Linda J. Schmac, President, Premier Comp Solutions, LLC:)

Section 1 of this bill defines health care provider to specifically exclude any entity which is not licensed by an agency of the Commonwealth to perform health care services and which does not have a National Provider Identifier.

It then goes on, in the proposed amendment to Section 306(f.1)(1)(i), to prohibit employers from including on their panel of medical providers any entity which is not licensed by the Commonwealth to perform health care services. The obvious purpose is to exclude the use

of PPO and specialty networks on employer panels.

Thus, the chief byproduct of this Bill would be to vastly increase the cost of workers' compensation for Pennsylvania employers' medical expense represents well over 50 percent of workers' compensation loss expense. This Bill would prohibit employers from using discounted specialty and PPO networks to provide medical services for injured workers.

Employers would lose the considerable savings derived through the use of such networks. No other state in the nation prohibits the use of discounted specialty and PPO networks. Both private sector and public sector self-insured employers mandate the use of discounted networks for workers' compensation cost containment and require their workers' compensation service providers, including third-party administrators, to access discounted specialty and PPO networks to achieve the goal of medical cost containment.

Employers in the public sector, notably the Commonwealth of Pennsylvania itself, Allegheny County, the City of Philadelphia, the City of Pittsburgh, SEPTA, the Port Authority of Allegheny County, and many smaller political subdivisions all access discounted networks to save medical expenses and to benefit taxpayers.

The Workers' Compensation Act permits employers

to direct injured workers to practitioners of the healing arts for treatment of their work-related injuries for the first 90 days of that treatment during which time the vast majority of injuries resolve.

This direction is accomplished through the use of posted provider panels which must meet designated standards for specialties and locations. There are several panel development/maintenance and case management companies which provide panel services for Pennsylvania insurers/employers.

These companies derive revenue from their network discounts so they need not charge insurers/employers for panel development, panel maintenance, appointment scheduling, and injury management services. There is no commercial software on the market that an insurer/employer could use to develop functional provider panels that would integrate with case management, as would be required by this Bill, leaving insurers/employers to attempt to develop such software on their own or to forego altogether the savings generated and good medical outcomes obtained by their panel providers and by medical case management.

Many employer panels include a telephone number for the injured worker to contact in the event that he/she requires specialty services such as an MRI or physical therapy.

This prevents the injured worker from accessing

the prompt scheduling services provided by these specialty networks and eliminates the ability of employers to monitor medical care based on the frequently updated status reports provided by members of the specialty networks for use by employers.

Discounted networks typically do not charge for scheduling and for status updating services and are key to medical cost containment in workers' compensation. MRIs and physical therapy are routinely prescribed treatment for orthopedic work injuries.

No other state in the nation has such a provision in its workers' compensation law. So this Bill would effectively prohibit insurers and employers from using discounted specialty networks to provide medical services for injured workers.

The Bill also causes a budgeting nightmare for employers who need certainty in expenses so that they know how much to charge consumers for their products and services. The higher cost environment caused by this Bill is likely to cause price increases for consumers and make PA products less competitive with those of other states and countries.

All Pennsylvania workers' compensation insurers utilize discounted PPO networks and specialty networks for medical cost containment. Even the State Workers'

Insurance Fund mandates network usage in its service contracts.

Even through discounted physical therapy networks alone, PA employers are paying just $110 to $150 per day. Under this Bill, without discounted networks, employers would pay $300 to $500 per day for the exact same services if those services were provided by a cost-based Medicare Part A physical therapy provider.

It must be remembered that fully 40 percent of all medical bills associated with workers' compensation injuries in Pennsylvania are for physical therapy and other rehabilitation services. The loss of the considerable savings derived through the use of discounted networks by insurers would have to be borne ultimately by employers, consumers, and taxpayers.

This Bill would require Pennsylvania workers' compensation insurers to increase their rates. It is likely that the loss of discounted specialty PPO network savings to insurers would be over $100 million annually. Insurers would need to raise insurance rates by applying for much higher loss cost multipliers for calculation of rates. This does not really hurt the insurer, except in the short run until rates are adjusted. But the loss of savings from discounted networks will make its products much more expensive.

This Bill would require each employer/insurer to enter into separate written contracts with every individual health care provider in order to obtain discounts below the Pennsylvania workers' compensation fee schedule.

This Bill would also require that such contracts be submitted to the Commonwealth. The Bill does not even suggest what the State is to do with these contracts, nor what the State is to do with the information contained therein. Presumably, regulations would require the State to develop software in order to police payment by insurers and employers to assure that payment is in accord with those individual contracts.

Most likely the State would delegate that responsibility to insurers and employers so that employers would end up paying the cost of developing software, which does not now exist, to pay provider bills in accordance with all those individual contracts.

Using pharmacy bills as an example, each insurer and self-insured employer would have to negotiate a separate contract with every conceivable pharmacy from which a worker could obtain prescription medication. The insurer and/or employer would then have to develop software to pay those bills at levels which could vary significantly among the many Pennsylvania pharmacies.

Insurers and employers would then generate an

explanation of reimbursement showing the discount below fee schedule. This would in turn require in-house repricing via software capable of analyzing pharmacy contracts to extract the correct pricing required under each contract.

Insurers and self-insured employers would have to endure the expense of software development which would need to be updated almost daily, and they would have to hire personnel capable of in-house repricing. Out-sourced repricing, which is prevalent today, would become prohibitively expensive at best and simply unavailable at worst.

Under this Bill, insurers/employers would also be required to develop and manage their own provider panels. Organizations which presently develop and manage panels for insurance carriers and employer clients without charge would have to obtain revenue to pay for these services.

Such revenue is presently derived from discounted specialty networks. Without network revenue, insurers and employers would be forced to start their own panel development/maintenance and case management departments while, at the same time, paying higher medical bills because of the loss of savings derived from discounted networks.

However, there is no commercial software available on the market that an insurer/employer can use to

develop functional provider panels that would integrate with case management. Insurers and employers would have to develop their own software.

Individual insurers/employers do not have the group health type of purchasing power to negotiate significant, or even worthwhile, discounts below the PA workers' compensation fee schedule, with every single hospital, physician, pharmacy, chiropractor, physical therapist, and/or diagnostic facility in Pennsylvania.

This fact alone would necessarily increase the cost of workers' compensation medical care, contradicting the medical cost containment purpose of the 1993 Act 44 and 1995 Act 57 amendments to the Pennsylvania Workers' Compensation Act and frustrating the intention of the Legislature to reduce workers' compensation medical costs to employers to promote high employment levels in the Commonwealth as other industrial states had already done before 1993.

The University of Pittsburgh Medical Center is the only licensed health care provider in Pennsylvania which also owns and operates its own for-profit workers' compensation insurance carrier health benefits and its own for-profit third-party administrator. House Bill 1141 would enhance the competitive advantage already enjoyed by the UPMC insurer and UPMC TPA over other Pennsylvania

insurers and TPAs.

UPMC controls a significant majority of the hospital beds in its geographical market area, owning more than 20 hospitals and 400 clinical locations in western Pennsylvania.

UPMC has 5,500 affiliated physicians, including 3,500 who are directly employed by UPMC. UPMC Health Benefits and UPMC Work Partners, through UPMC, have access to UPMC's exclusive PPO agreement with its affiliated and employed physicians for discounted services, which are well below the workers' compensation fee schedule.

For example, UPMC has obtained a 20 percent discount for medical services provided by UPMC practices, 14 percent for outpatient and inpatient medical services at UPMC hospitals, and a 25 percent discount off of billed charges for medical services provided by UPMC accredited trauma and burn center hospitals, 40 percent if the billed charges are in excess of $50,000.

MRI discounts range from 34.2 percent to 92 percent when provided by UPMC-owned hospitals, and range from 35.1 percent to 68.2 percent for radiology services provided by UPMC physicians who read the MRIs performed at UPMC-owned hospitals.

Thus, the only insurer that benefits from this Bill is UPMC Health Care Benefits and therefore, their

insured employers. The only self-insured employers that benefit from this Bill are those who have contracted with UPMC Work Partners for TPA services.

In the long run, no other Pennsylvania workers' compensation insurer can complete in western Pennsylvania with the UPMC insurer and will necessarily be priced out of the market. The same is true for TPA services. This could eventually cripple workers' compensation insurance as an industry in Pennsylvania.

Providers have a choice about whether or not to join a discounted network. Health care providers typically enter into a contract to accept discounted rates below the Pennsylvania workers' compensation fee schedule rates in order to increase their patient volume.

If a provider who has joined a network believes that it would have obtained the same patient referrals without participation in a network, the provider can renegotiate its contract or decide against future participation in the network.

Providers need only evaluate the network which has invited the provider to join. Providers should reject back door retrospective-type discounted networks. The better networks are proactive ones, meaning that the networks actually schedule patients with providers before the negotiated discount may be applied.

This Bill refers to silent discounts. There really is no such thing. Either a health care provider entered into a contract to accept payment below the PA workers' compensation fee schedule or it did not.

Bottom line, if a provider does not want its bills discounted because of its participation in a network, the provider should not sign a network contract. It's that simple. Remember, too, that PA fee schedule is almost double Medicare reimbursement levels, suggesting that a discount below fee schedule is not onerous.

If an insurer/employer applies a PPO discount to a provider's payment and the provider does not have a contract with the network for those discounts, the provider need only exercise its right to file an Application for Fee Review with the Workers' Compensation Bureau. If the provider is correct, the Workers' Compensation Bureau will determine administratively that it should be paid the full fee schedule amount plus 10 percent interest. Where else can a provider get 10 percent interest?

This Bill would prohibit medical providers from using typical billing agent arrangements to do their billing and collections. No hospital, physician group, or other provider could use a billing company to do its billing and collections under the billing agent's tax identification number.

The use of billing agents is widespread throughout the Pennsylvania medical provider community. Elimination of outsourcing of the billing and collection function would require each provider, even small one-provider practices, to hire individuals with the capability of performing the billing and collection function raising the question of whether or not the billing function would remain economically feasible.

Under this Bill, the Bureau's present fee review system would be crippled. The Bureau does not have the capability of accessing every carriers' and employers' contracts with every single medical provider, including pharmacies, in order to determine whether a provider was paid correctly in accordance with fee schedule and discounts therefrom.

Did the insurer apply the correct discount according to each of these individual contracts with providers? A much larger Bureau staff would be necessary to even attempt to answer that recurring question.

It must be remembered that any additional cost incurred by the Pennsylvania Workers' Compensation Bureau is passed on to Pennsylvania employers who ultimately fund the Bureau through assessment s.

This Bill prohibits any effort that an insurer may want to take to settle a legitimate dispute with

respect to the level of payment to providers. As an example, in the instance of trauma center bills, the question of whether or not a trauma situation even exists under the American College of Surgeons Field Triage Guides is frequently at issue.

Level 1 and Level 2 trauma centers are to be paid 100 percent of their usual and customary fees in a trauma case. That level of reimbursement is at least three times the level of fee schedule reimbursement and could be more than 100 times over fee schedule, depending upon the length of stay. So the threshold issue of whether a trauma situation actually existed involved considerable, if not massive, amounts of money.

Too often, trauma centers bill any treatment provided in a workers' compensation case as trauma with little, if any, basis for the assertion that the patient's condition was immediately life-threatening or urgent as the Act requires.

With this Bill, any attempt to settle with the trauma center regarding its bill would subject the insurer/employer to penalties and attorney's fees. It should be pointed out that there is no database to determine whether a provider's usual and customary charge for particular trauma services is truly its usual charge in non-workers' compensation cases so that even the billed fee

for trauma services is a moving target.

Trauma bills are frequently considered by insurers to be highly inflated. No wonder they would like to try to negotiate a compromise. The law has always favored settlement of disputes. This Bill prohibits any attempt at settlement and subjects the insurer/employer who attempts to negotiate a bill to significant penalties. This puzzling provision is unworthy of serious consideration.

As previously noted, providers have a simple and adequate remedy under the present Act for collection of bills that are improperly paid. Medical providers, unlike impecunious injured workers, can afford to pay their own legal fees if use of an attorney becomes necessary. The current penalty level of 10 percent to 50 percent plus legal fees is properly reserved to injured workers in cases in which insurers/employers have violated the Act or failed to present the reasonable contest.

This bill would punish insurers/employers with 50 percent penalties and payment of legal fees in favor of providers, but it would not have providers pay insurers/employers penalties or legal fees where the provider has violated the Act or failed to present a reasonable contest.

Nothing in this Bill provides any benefit to

injured workers. It is interesting to note that in a study published in the Journal of Occupational and Environmental Medicine, it was found that injured workers in Pennsylvania are already overwhelmingly satisfied with the medical care they receive.

The survey of injured workers, conducted for 14 years during which time treatment was governed by the present PA Workers' Compensation Act and regulations, found that workers' satisfaction with the care they received was 83.9 percent. It follows then that there is nothing in the Act to fix on the medical side from the perspective of the injured beneficiaries of the PA workers' compensation system.

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

Jean M. Davis
Notary Public