Testimony to the House Labor and Industry (H)
Concerning Proposed House Bill 1141

Worker's Compensation Act Reform
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Position Statement In Opposition to HB 1141

Increase in Worker's Compensation Medical Expense to Employers

Section 1 of this Bill defines "healthcare provider" to specifically exclude any entity which is not licensed by an agency of the Commonwealth to perform healthcare services and which does not have a national provider identifier. It then goes on, in the proposed amendment to § 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 healthcare 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% of worker's 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 expense and to benefit taxpayers.

The WC 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 (s)he 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 the 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.

Increase in Worker's Compensation Medical Expense to Insurers

All Pennsylvania WC insurers utilize discounted PPO networks and specialty networks for medical cost containment. Even the State Workers' Insurance Fund (SWIF) mandates network usage in its service contracts. Even through discounted physical therapy networks alone, PA employers are paying just $110-$150 per day. Under this Bill, without discounted networks, employers would pay $300-$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% of all medical bills associated with WC 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 and 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 healthcare provider in order to obtain discounts below the Pennsylvania WC 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 of 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 (EOR) 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 WC 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 WC medical cost to employers to promote high employment levels in the Commonwealth as other industrial states had already done before 1993.

The Enhancement of the Competitive Advantage of UPMC Health Benefits and UPMC Work Partners

The University of Pittsburgh Medical Center (UPMC) is the only licensed healthcare provider in Pennsylvania which also owns and operates its own for-profit workers' compensation insurance carrier (UPMC Health Benefits) and its own for-profit third party administrator (TPA), (UPMC Work Partners). HB1141 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% discount for medical services provided by UPMC practices, 14% for outpatient and inpatient medical services at UPMC hospitals, and a 25% discount off of billed charges for medical services provided by UPMC accredited trauma and burn center hospitals (40% if the billed charges are in excess of $50,000). MRI discounts range from 34.2% to 92% when provided by UPMC-owned hospitals, and range from 35.1% to 68.2% 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 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 WC insurer can compete 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 WC insurance as an industry in Pennsylvania.

The Easy Solution for Providers

Providers have a choice about whether or not to join a discounted network. Healthcare providers typically enter into a contract to accept discounted rates below the Pennsylvania WC 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 healthcare provider entered into a contract to accept payment below the PA WC 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 WC Bureau. If the Provider is correct, the WC Bureau will determine administratively that it should be paid the full fee schedule amount plus 10% interest. Where else can a provider get 10% interest?

The Downside for Providers

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.

Crippled Fee Review System

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 those individual contracts with providers? A very 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 assessments

Elimination of Ability to Compromise Disputes

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% of their usual and customary fees in a trauma case. That level of reimbursement is at least 3 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 involves 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 it's bill would subject the insurer/employer to penalties and attorney's fees. It should be pointed out that there is no data base to determine whether a provider's "usual and customary charge" for particular trauma services is truly its usual charge in non-WC 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% to 50% plus legal fees is properly reserved to injured workers in cases in which insurers/employers have violated the Act or failed to present a reasonable contest. This Bill would punish insurers/employers with 50% 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.

No Benefit to Injured Workers

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 fourteen years during which time treatment was governed by the present PA WC Act and Regulations, found that workers' satisfaction with the care they received was 83.9%. 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 Worker's Compensation system.

Respectfully Submitted,

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