(8) if an employee when injured is a minor, an apprentice, or a trainee in a **formalized** [FORMAL] training program, as determined by the board, whose wages under normal conditions would increase during the period of disability, the projected increase may be considered by the board in computing the gross weekly earnings of the employee[;]. **If the minor, apprentice or trainee would have likely continued that training program employment, then their compensation shall be on their average weekly wage at the time of injury rather than a "look back" average wage calculation;**

(9) if the employee is injured while performing duties as a volunteer ambulance attendant, volunteer police officer, or volunteer fire fighter, then, notwithstanding (1) - (6) of this subsection, the gross weekly earnings for calculating compensation shall be minimum gross weekly earnings paid a full-time ambulance attendant, police officer, or fire fighter employed in the political subdivision where the injury occurred, or, if the political subdivision has no full-time ambulance attendants, police officers, or fire fighters, at a reasonable figure previously set by the political subdivision to make this determination, but in no case may the gross weekly earnings for calculating compensation be less than the minimum wage computed on the basis of 40 hours work per week;

(10) if an employee is entitled to compensation under AS 23.30.180 and the board determines that calculation of the employee's gross weekly earnings under (1) – (7) of this subsection does not fairly reflect the employee's earnings during the period of disability, the board shall determine gross weekly earnings by considering the nature of the employee's work, work history, and resulting disability, but compensation

calculated under this paragraph may not exceed the employee's gross weekly earnings at the time of injury.

* **Sec.16** AS 23.30.041(k) is amended to read:

(k) Benefits related to the reemployment plan may not extend past two years from date of plan approval or acceptance, whichever date occurs first, at which time the benefits expire. If an employee reaches medical stability before completion of the plan, temporary total disability benefits shall cease and permanent impairment benefits shall then be paid at the employee's temporary total disability rate. If the employee's permanent impairment benefits are exhausted before the completion or termination of the reemployment **process** [PLAN], the employer shall provide compensation equal to 70 percent of the employee's spendable weekly wages, but not to exceed 105 percent of the average weekly wage, until the completion or termination of the **process** [PLAN], except that any compensation paid under this subsection is reduced by wages earned by the employee while participating in the **process** [PLAN] to the extent that the wages earned, when combined with the compensation paid under this subsection, exceed the employee's temporary total disability rate. If permanent partial disability benefits have been paid in a lump sum before the employee requested or was found eligible for reemployment benefits, payment of benefits under this subsection is suspended until permanent partial disability benefits would have ceased, had those benefits been paid at the employee's temporary total disability rate. If permanent partial disability **or permanent partial impairment** benefits have been paid in a lump sum before the employee requested or was found eligible for reemployment benefits, payment of benefits under this subsection is suspended

until permanent partial disability benefits would have ceased, had those benefits been paid at the employee's temporary total disability rate, notwithstanding the provisions of AS 23.30.155(j). A permanent impairment benefit remaining unpaid upon the completion or termination of the plan shall be paid to the employee in a single lump sum. An employee may not be considered permanently totally disabled so long as the employee is involved in the rehabilitation process under this chapter. The fees of the rehabilitation specialist or rehabilitation professional shall be paid by the employer and may not be included in determining the cost of the reemployment plan.

# ALASKA CHIROPRACTIC SOCIETY'S COMMENTS TO THE WORKERS' COMPENSATION AD-HOC COMMITTEE January 14, 2005

It is the Alaska Chiropractic Society's current understanding that the purpose of this Ad-hoc committee is to explore solutions to improve the Alaska Workers' Compensation system. The only document and information we have had the privilege to review at this point is the WCCA document authored by Dale R Walaszek, PA-C.

The Alaska Chiropractic Society (ACS) is encouraged by the "collective solutions-based approach" to bring about changes in the Workers' Compensation system that has been endorsed by the WCCA.

The ACS requests that you provide all data and information that is being presented and considered in your decision so that we may evaluate and provide another perspective. It is hoped that the ACS can continue to be an active participant in a legitimate dialog of pros and cons of various ideas. We would also like to know who the members of the Ad-hoc committee are and who they represent.

The following are some key areas that need to be addressed to have a comprehensive review, policy recommendations, and a positive outcome:

1) Significant detailed data is lacking.

2) Legislative funding of a study that provides significant detailed data.

3) Utilize a Chiropractic research scientist as part of the study setup and evaluation team.

It is noted that several states have been experimenting with a variety of cost-effective methods to deliver WC benefits efficiently and we may wish to emulate them. However, we should use caution and review the consequences of applying those changes to Alaska. Most importantly we should avoid the mistakes that other states have made and review studies performed by other states.

The ACS has provided an electronic copy of the complete Florida Worker's Compensation Study dated January 28, 2002. (found at www.mgtofamerica.com)

http://www.mgtamer.com/Reports/Workers%20comp/full%20report.pdf

We are additionally providing a color glossy of the executive summary and summary brochure for your review. The study showed:

- As the proportion of professional services provided by Chiropractic Physicians to specific cases increased,
  1) Medical and other claims costs substantially decreased,
  2) Claimants reached maximum medical improvement in significantly less time,
  3) Claimants returned to work in significantly less time.

- Based on estimated savings per claim, dramatic savings (possibly in the billions of dollars) may be possible with increased workers' compensation claimant access to chiropractic treatment for specific low back and other musculoskeletal conditions.
- Chiropractic treatment offers the added benefit of very low risk of negative side effects compared to surgical and/or pharmaceutical care for similar maladies.

The results of the Florida analysis indicate:

- Current Florida policy has clearly impeded workers' compensation claimant access to chiropractic care through a medical (M.D.) gatekeeper system, and should be revised to allow injured workers direct access to chiropractic care.
- Current policy appears to be based on a comparison of office visit costs between chiropractic versus allopathic care management, thus not factoring in the costs of pharmaceuticals, hospitalizations, surgeries referrals to allied health care providers for radiology and therapy services and work loss, in addition to other related disability costs.
- Allowing injured workers direct access to chiropractic care would be consistent with recently documented successes in improving delivery and reducing costs of health care within the U.S. military, the U.S. Medicare system, the Health Maintenance Organization of Illinois, and numerous workers' compensation systems throughout the nation and world.

The ACS is also providing a copy of the American Chiropractic Association's (ACA) recent "Chiropractic Research Synopses" which has short summaries along with the research cites under three categories; Patient Satisfaction, Return to Work/Indirect Costs, and Efficacy.

There is also a retrospective study (J Manipulative Physiol Ther 2004; 27:442-8) entitled: An Evaluation of Medical and Chiropractic Provider Utilization and Costs: Treating Injured Workers in North Carolina. They conclude: "These data, with acknowledged limitations of an insurance database, indicate lower treatment costs, less workdays lost, lower compensation payments, and lower utilization of ancillary medical services for patients treated by DC's."

Dale R. Walaszek, PA-C, in the WCCA document has done a good job of laying out some of the pro's and con's of various ideas put out for discussion. He also reminds us that the WC system guarantees employees compensation for medical costs and lost

income when injured at work while reducing litigation costs and removing uncertainties associated with a tort system (personal injury) liability.

Dale R. Walaszek, PA-C points out that, according to the NCCI, the average workers' compensation claim in Alaska was about $38,000 per claim in 2004. The associated medical expenditures were about 55 percent of the total cost. He states that although the escalating cost of medical care accounts in part for WC expenditures, it is the *utilization* of health care services that drives overall expenditures. The solution isn't simply to cut physicians fees, but rather to reasonably direct the utilization of services.

I believe that Dale R Walaszek, PA-C is well intentioned with his idea of directing the utilization of services. While this is a valid consideration it raises concerns about how others may interpret and carry this out given the historical discrimination against chiropractic care. Direction could be made toward increasing the utilization of chiropractic care given the research mentioned above, but it could also result in the opposite occurring based on historical biases. You can look at Chiropractic coverage under Medicaid as an example of this bias currently existing within the State of Alaska.

Managing the utilization issue by adopting medical treatment guidelines for the diagnosis, evaluation, and management of injured workers is something that has merit. Creating hard caps and gatekeepers would be ill advised and would raise severe concerns with the professionals and labor representatives. Some mechanism to avoid hard cap interpretations would be needed along with continuous updating as new clinical evidence and formal research evidence become available.

I see interdisciplinary guidelines, education, cooperation, and understanding as having the potential of improving efficiency and quality of care. Involving the employer in the educational process is also very important so they can set appropriate policies internally.

However, avoiding "unproven treatment methods" referenced in the WCCA document should not be defined as anything that has not been proven by double blind studies. State and National professional organizations should be involved in any standard discussion and decisions including the Alaska Chiropractic Society (ACS) and the American Chiropractic Association (ACA). You may even want to consult national college organizations like the National Association of Chiropractic Colleges (NACC). It would not be an appropriate role for a proposed medical director to unilaterally have authority to dictate and change a set of standards.

ACS has had members on the Alaska Carrier Advisory Committee (CAC) for Medicare and Nationally with Blue Cross Blue Shield in what is called the Blue Chip Program. They provide a vehicle for the professionals to provide input, and shape policy. The ACA has been involved with the Insurance Industry, the Veterans Administration, The Department of Defense and Medicare along with other individual States regarding chiropractic and research. The ACA can serve as a valuable resource as you go through this process.

With the formalization of ACA's Workers Compensation Committee in June 2004, ACA begins the outreach process by inviting worker compensation experts and insurers as advisors to its business deliberations. Committee goals center on outreach with workers compensation research organizations to better understand data perspectives and share information. The purpose is to advance an integrated approach on future studies where ACA acts as in an advisory capacity and assists in the creation of uniform data sets and provides data observations. ACS has included a copy of the **Workers Compensation Statement** ***"Access to Injured Workers"*** that the ACA board of Governors recently approved.

There are a number of questions regarding utilization and expenses that can only be answered with complete data and not speculation. Without the data and answers, recommendations may be premature and based on perception.

Are the increases due to one worker classification such as a logger -vs- a secretary? Is one sector increasing compared to others? Where is the breakdown of expenditures? Disability costs? X-ray? Surgery? Post surgical complications? Post surgical disabilities? Diagnosis? E&M? Office visits? Specialists? Paraprofessionals? Time loss costs? Rehab? Duplication of services?

What are the indemnity costs and how are those broken down? Have there been court rulings that affect costs? Is the problem Urban or Rural? Are there employer policies such as "no light duty work allowed" which are increasing costs? Do we have data that shows which employers have not had a claimant return to light duty such as the Alaska Marine Highway system?

Let me elaborate on this example. The Marine Highway system has some restrictions requiring able bodied seamen to be able to react in full capacity during emergencies as imposed apparently by the Coast Guard. This should be explored with the Coast Guard regarding any flexibility as to the percentage of the crew or number of crew that is required.

The Marine Highway System however, applies this "No Light Duty" policy to those working on the ship, including ship's stewards, even when the ship is sitting in dry-dock.

The WCCA Medical Cost Containment Subcommittee recommends that the legislature enact the following changes:
(1) Establish a Director of Workers' Compensation
(2) Medical Policy Unit hired by the director that would then develop guidelines
(3) Evidence-based medical guidelines developed by the Medical Policy Unit
(4) Fair price setting for prescription drugs
(5) Employer Choice of Physician
(6) Return to Work program

The ACS will address some of these ideas without being too redundant of Dale R Walaszek, PA-C comments since he has done a fair job of listing different perspectives.

**(1) Establish a Director of Workers' Compensation**

The details are important and would determine if there would be wide acceptance.
Does the director circumvent the State Board?
What will be the true Costs - vs - Gain?
Does this simply create another level of Bureaucracy?
What would the specific function and responsibilities be for this position?
How much unilateral power and authority would this position have?
Would there be limited or biased data collection?
You need to have physician (MD/DC) input.

A Director may help guarantee up to date research and annual report development utilizing consistent, clear, and comprehensive data. However from the WCCA document it looks like the current system is being funded for this task already.

***"The current annual report method contains many inconsistencies and unclear reporting formats. With annual expenditures now exceeding $210 million, one would think that adequate resources could be allocated to learn where the money goes, so that system inefficiencies can be administered more effectively."***

Is it a lack of a director, a matter of needing extra funding, or a lack of will and direction within the current system?

If the state chooses to create a medical director they should also establish a chiropractic director similar to Washington State. I would recommend you talk with Dr Robert Mootz the Chiropractic Director in Washington State since they have a state financed and controlled system without insurance carriers. It is not clear that we would get as much positive result as Washington, with us using a medical director, given Alaska's current system with separate outside insurance carriers.

**(2) Medical Policy Unit hired by the director that would then develop guidelines**

The following paragraph from the WCCA again raises concerns about the interpretation and abuse of "Guidelines".

> ***"Due to the extensive nature of the task to develop a system with cost containment programs such as medical treatment guidelines (implement, provide training regarding, and continually update), the WCCA Subcommittee believes that these services would best be performed and maintained by hiring a medical professional, who works for the Director. One of the core responsibilities of the medical director should involve coordinating training programs for area health care providers on the utilization of medical treatment and return to work guidelines."***

Are medical treatment guidelines a cost containment program? Or are they a way to bring consistent quality medical care and efficiencies that may, or may not, have some cost savings as a result? The implementation, training regarding, and continually updating

mentioned in the WCCA document is encouraging and would be a legitimate need with true evidence based medicine. If the state chooses to carry out this recommendation, the ACS would ask you to also hire a Chiropractor.

The Policy Unit needs to understand the difference between "guidelines" and "Best Practices" (evidence based practice and decision making). The state should look at considering Evidence Based Medicine vs Guidelines.

> ***"Evidence Based Medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that we individual clinicians acquire through clinical experience and clinical practice. By "Best Available External Clinical Evidence" we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannized by external evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best external evidence, practice risks becoming rapidly out of late, to the detriment of patients."***
>
> ***Sackett DL. Evidence-based medicine. Semin Perinatol 1997;21:3-5***

This Medical Policy Unit would need to include all stakeholders when creating guidelines.

What would initial costs to do this be and what would be the ongoing costs? Without first evaluating data it is impossible to determine if there is a cost benefit to doing this.

We would require chiropractic representation and consultation with the ACS, ACA, NACC, and a Chiropractic Research Scientist, etc.

**(3) Evidence-based medical guidelines developed by the Medical Policy Unit**

There will be a question of what evidence is used and what level of evidence should be required when you start to establish evidence-based medical guidelines.

Offsetting inconsistency in the interpretation & application of evidence…

- "Target users" are substantively involved in evaluating the evidence accounting for clinical realities and patient expectations (Quorum Document)

- Standardized instruments to evaluate and rate the published evidence.
- Formal consensus process to evaluate clinical experience where evidence is lacking.
- Broad dissemination to all stakeholders.

- The focus is on the *process* of care, *identification* of risk factors and case complexity, *techniques* of response monitoring, and *benchmarks* for intervening when the response is below average

The State needs to insure Evidence-based efficiency –vs- hard caps or guidelines used to arbitrarily cut cost. (i.e. Cost inment Program)

The use of both chiropractic and medical representatives would help encourage interdisciplinary cooperation.

If you are slow to update guidelines and take into consideration the current standard of care you will lack medical buy-in.

Review national standards that exist and those that are being created (CCGPP Best Practices Effort). What is the standard of care? What is taught in the accredited colleges?

"Guidelines" are not and should not be a definition of "reasonable and necessary" medical treatment. This is a legal definition.

**(4) Fair price setting for prescription drugs**
Directing some care to chiropractors could decrease drug use and costs.

**(5) Employer Choice of Physician**

The following paragraph in the WCCA document suggests creating a mechanism to establish evidence based medicine that works efficiently and motivates doctors to accept and utilize it. The goal should not be that the "Employer" has the "Choice" of physician.

***"Sending employees to medical providers that will accept and receive training in using the adopted guidelines is the most efficacious way to ensure that such guidelines are followed..." "The goal should be to seek quality health care decisions from the start, and avoid the complex issues involving delay of care while "authorization is approved" or denial of medical fees after the treatment is delivered."***

The establishment of efficient evidence based medicine and motivating doctors to accept and utilize it can happen through "buy in" and education and not employer directed choice. You need to preserve patient choice and consider other ways to get doctor buy-in and training. Things to explore are: certifying the doctors in workers comp by providing training; increased fee schedule reimbursement for those trained; involve them in the process, etc. This should not create a financial burden on the doctors and would need to address the needs of rural doctors.

If there are doctors that appear outside the norm, isn't there a mechanism in place to address this? (i.e. State Examining Boards, Peer Review, Insurance company reviews, legal system) A review of a doctor may be appropriate depending on the findings and appropriate training may be helpful in resolving future issues. This is where data would show us whether there is a broad based problem, isolated concerns, or no problem outside of the norms of medicine in other states. **Are we treating the Workers' Comp System before we have done some diagnostic testing?**

There may be difficulty with choice given the rural nature of Alaska and lack of doctors and specialists in some areas of the state.

ACS is concerned when you remove the patient's choice. This can create a negative impression that these are "Insurance Docs" hired to cut claims. It can create a negative environment that can cause employee resentment and may unnecessarily drag out a claim.

**(6) Return to Work program Policy Recommendations**

Chiropractic has a good record of returning patients to work and reducing the time loss expenditures as evidenced in the research referenced earlier. ACS is supportive of effort mentioned in the WCCA document below.

> ***From WCCA document:***
>
> *Provide an Internet example program for employers to utilize and consider cost incentives (on premiums) for employers who adopt such programs.*
>
> *System incentives are needed to ensure that employers support return to work initiatives; conversely, employee incentives are also necessary to encourage the goal of returning to work.*
>
> *The shared goal should be a maximum improvement of functional ability and return to the pre-injury workplace activities with or without temporary or permanent workplace accommodations.*

It also appears that our current vocational rehabilitation needs to be looked at given the following from the WCCA document.

> *So in effect, out of 457 eligible employees and $15.7 million spent for Voc Rehab, we know of 13 that actually completed the program and returned to work in that new occupation as intended.*
>
> *A new system must be based on the efficiencies and successes experienced by other states.*

Under the WCCA document "Conclusion" it states that, "*While medical costs have driven the expenditures up, it is* ***the over-utilization of medical care that is ultimately responsible*** *for one of the most expensive workers' compensation systems in the nation.*"

**We would like to see the data that this statement is based upon.**

ACS would agree with the following statement in the WCCA document:

> *"The care of injured workers is not any more or less important than military veterans (VA), military families (TRICARE), the poor (Medicaid), seniors (Medicare), indigenous people (ANH), or others covered under private health insurance programs." "Alaska workers' compensation can adopt system efficiencies, while maintaining the spirit of a "no-fault" system."*

*ACS would like to also point out that the Veterans Administration (VA), Department of Defense (DOD), seniors (Medicare), indigenous people in Anchorage (ANH), have been in the process of increasing their utilization of Chiropractic Care and decreasing barriers to seeking Chiropractic care..*

In the WCCA Appendix they mention options for medical cost containment, that may or may not be suited for Alaska, but have had an immediate impact in other states. These raise concerns to the ACS and we would like to participate in any serious attempts to adopt these:

### *Medical fee schedule changes (Cost Control)*

- *Medicare fee basis (125%?) vs. current 90th Percentile Fee Schedule*
- *Further research needed due to recent increased AK Medicare fee change*

***Benefits:***

- *Immediate impact on medical cost*
- *Medicare provides built-in cost multipliers for individual practice variables*

***Drawbacks:***

- *Studies show physician response is to increase utilization*
- *Studies show negative impacts on physician participation*
- *May provide another barrier to care in Alaska's challenged health care system*

### *Limiting compensability*

- *Pre-existing conditions*
- *Age related health changes such as arthritis*
- *Cumulative trauma disorders*

Does this mean limit treatment or permanent impairment, disability, or all of the above?

***Stricter evidentiary requirements***

We would like to see examples of what they have in mind? What is meant by stricter evidentiary requirements and of what? Is this for impairment only or for initial exam and treatment where symptoms may be more subjective? Does this mean greater use of outcome measures such as Oswestry Low Back Pain Index, Neck Disability Index (NDI), Pain disability Index (PDI) or other questionnaires that may be even more extensive? Appropriate reimbursement for the extended time to do such evaluations would encourage greater use if that is what you are looking for. However we should identify the problem we are trying to correct first.

***Stricter rules for permanent disability benefits***
***Discouraging fraudulent claim***

We need more information on what rules and what the problem is. What do you have in mind? The ACS is willing to help in clarifying perceived problems and helping to eliminate clear issues of fraud.

It is hoped that the ACS can continue to be an active participant in a legitimate dialog of pros and cons of various ideas.

Thank You for listening to our concerns.


**Dr William Pfeifer**
Alaska Chiropractic Society – Vice President
American Chiropractic Association – Alaska Delegate

2901 Baranof Ave
Ketchikan, AK 99901

Office 907-225-9090
Home 907-247-2267

family@ptialaska.net

Thank you for this opportunity to speak to you today. We have been discussing workers issues and assisting injured workers and their families. People who have worked all their lives are having life changing experiences in our Alaska Workers Compensation System.

In reality there are some serious choices here before us with regard to our current Workers Compensation System. We have many disadvantages already installed in the current statue. Were are at an important cross road and injured workers want the employers, insurance companies, and any one else who is injured that they are looking for indemnity for their claims not financial security for the rest of their lives. They would like to move on but with out access to information, they will not be able to.

We need to speak to injured workers and address their needs. I can assure you they won't bite, but we need to listen. Injured Workers can get really frustrated when they cannot be heard. We need to provide adequate benefits and contain costs. We have to depart from the bad habit of talking all around injured workers and see to the needs. Here are some suggestions that I think that would assist the problem:

Look at the deficiencies and learn from them.

Education should be required of department staff as well as insurance adjusters. Once educated, continuing education should be made part of the curriculum.

Review of the medical system as a whole, all the way down to the fee schedule. Develop attainable requirements and enforce them. This would include the drugs. Limiting healthcare and making drug lists is not the answer. We need competition and choice to keep the costs down. Starting this practice could monopolize and compromise services for injured workers.

We agree that doctors may need peer review. The board currently makes decisions on complex medical issues with out this expertise. We have second independent medical evaluators, but there is no one at the board level to decipher the information for their use and for injured workers.

We need good programs to police and enforce uninsured employers. At one point around 1998 thee was over 60% of Alaskan employers were out of compliance. We also need fair treatment of the uninsured employers. Make it a steps process and shut down those who continually re-offend by being uninsured.

We need access to legal council. There are only 8 attorneys assisting claimants and some are choosing not represent injured workers in favor of more profitable types of litigation. We need to police defense cost as well as injured workers attorney costs. Balance in legal fess will reduce costs.

Injured workers enjoy little or no protection of their privacy. Releases should relate to injures and not be on a quest to disclose all protected health information. This same

information should not be used for commercial purposes or to confuse and intimidate injured workers at a vulnerable time.

Program requirement and benefits available should be clear and not based on complex legal ease that most injured workers do not understand.

All settlements should be reviewed by the board to ensure fairness and eliminate impropriety

The Division of Workers Compensation should be required to work with the Division of Insurance to stop frivolous and unfair controversions. Since 1998 no new reports have gone to the division of insurance. There should be a way to complain about unpaid bills and have effective resolution process.

The adjudicative process should be left alone at present. We need to restore balance to the adjudicative process.

Working with non-profits to educate and assist workers is a good idea. But we have to eliminate the hate and bias to ensure fairness and assistance. By working together we will accomplish far more than if we fight about the issues.

Thank you for our time and attention to this very important matter.

Barbara Williams
Alaska Injured Workers Alliance.
907-278-3661

March 9, 2005

Honorable Con Bunde
Chair, Senate Labor and Commerce Committee
State Capitol, Room 506
Juneau AK 99801

Re: SB 130 – Workers Compensation

Dear Senator Bunde:

The Alaska State Medical Association (ASMA), represents physicians throughout Alaska, and is primarily concerned with the health care for all Alaskans.

ASMA strongly recommends that section 24 and 25 of SB 130 be removed and that we support a longer term study of the very complex medical issues involved with the workers compensation system.

The questions provided in ASMA's written testimony would provide a good start for the research needed for a long term study.

ASMA urges you to consider this recommendation of careful study of the complicated issues raised to avoid adverse impact on access to care.

Sincerely,

Paul Worrell, MD

By: Paul Worrell, MD President
For: The Alaska State Medical Association

cc: Senator Ralph Seekins
Senator Ben Stevens
Senator Bettye Davis
Senator Johnny Ellis

**Jane Alberts**

**From:** Lesa Johnson [lhjohnson@alaskaspineinstitute.com]
**Sent:** Thursday, March 10, 2005 12:15 PM
**To:** Sen. Con Bunde
**Subject:** FW: Document6

**From:** Lesa Johnson
**Sent:** Thursday, March 10, 2005 12:14 PM
**To:** 'senatorconbunde@legis.state.ak.us'
**Subject:** Document6

Honorable Senator Bunde,

We would appreciate your review of the issues we have outlined on the attached letter relating to the proposed workers compensation reform.

We thank you for your urgent attention to this matter.

Sincerely,

Lesa H. Johnson
Administrator
Alaska Spine Institute
(907)762-6340
lhjohnson@alaskaspineinstitute.com

March 10, 2005

Senator Con Bunde
Chairman, House Labor and Commerce Committee

As a well established, conscientious medical practice in Anchorage since 1976, we would like to outline some of our concerns related to House Bill 180 regarding Workers Compensation reform and its implications to the injured workers in the state of Alaska.

1. This bill significantly reduces healthcare access for injured workers due to the economic burden it places on physicians and their probable unwillingness to see the patients as timely and efficiently as needed.

2. Practice guidelines will limit access to new evolving technology in medicine and will also allow insurance company adjusters (employers) to manage the medical care of injured workers and make medical decisions based on law and regulation rather than sound medical judgment. This is a "gate keepers" exercise currently used by managed care insurance companies in the lower 48.

3. Allowing insurance companies (employers) to negotiate a lowest possible fee and directing patients to potentially low fee medical services will again produce a "gate keeping" phenomenon. The outcome is that the injured worker receives impaired medical care and this may be done over a protracted course.

4. There is no clear objective evidence that restriction of fee structure or practice guidelines will force the insurance companies to reduce the rates established today. Any financial losses which have occurred to date are a result of poor stewardship and financial management of their investment portfolio. The insurance company's bankruptcies are more the result of poor management than the result of the costs for appropriate medical care.

This bill places the burden of any cost containment squarely on the shoulders of the injured worker and reduces their opportunity for wise, high quality health care. It also limits their legal opportunity to remedy insurance company (employer) mismanagement of their injuries.

Sincerely,

The physicians and staff of the Alaska Spine Institute

ALASKA MUNICIPAL LEAGUE
JOINT INSURANCE ASSOCIATION, INC.
JIA

217 Second Street, Suite 200 Juneau, AK 99801
Tel 907.586.3222 Fax 907.463.5480 Toll Free in AK 1.800.337.4682 www.amljia.org

March 10, 2005

Senator Con Bunde, Chairman
Senate Labor and Commerce
Alaska State Capitol
Juneau, Alaska 99801

RE: SB130 – Workers' Compensation Reform

Dear Senator Bunde and Committee Members:

The Alaska Municipal League Joint Insurance Association (AMLJIA) supports Senate Bill 130.

The AMLJIA is a not-for-profit self-insurance pool for approximately 140 cities, boroughs and school districts organized under AS 21.76. Member local government entities self-insure for the first $300,000 of each workers' compensation loss and purchase reinsurance to statutory limits.

By its design, the pool is considered an efficient risk-financing mechanism because there is no pressure to generate shareholder profit. Rates are calculated to cover expected losses, loss development from prior years, any incurred but not reported losses, the cost of reinsurance and administrative overhead (claims handling, etc.).

The present workers' compensation system is in crisis, choking Alaska's economic growth. Costs for member municipalities and school districts have skyrocketed at a time when state-shared revenues have been eliminated and costs such as PERS/TRS fuel and health care continue to rise dramatically. The pressure has been more than some communities can bear. In December, the AMLJIA was forced to cancel 10 municipalities from the program because they were unable to pay for their insurance or stay current on payment contracts. Since that time, some additional members have also been canceled.

Senate Bill 130 offers some improvements to the current workers' compensation system that should help curb the double-digit increases Alaska's local government entities and businesses have been experiencing. As a representative of public employers, for example, the provision for offsetting workers' compensation for PERS/TRS occupational disability payments is very attractive. Other provisions such as permitting represented parties to stipulate to compromise and releases without a board hearing, streamlining the vocational rehabilitation process, permitting preferred provider lists and generic drugs, containing medical costs and eliminating the Second Injury Fund are all excellent ideas for curbing continued insurance rate growth.

The members municipalities and school districts encourage you and the members of the Senate Labor and Commerce Committee to support SB130.

Thank you for your consideration.

Kevin Smith
Executive Director

March 9, 2005

Senator Con Bunde
State Capitol, Room 506
Juneau, AK 99801-1182

Robert M. Sullivan
6635 Desiree Loop
Anchorage, AK 99507
Telephone: (907) 344-7588
E-mail:rsullivan@gci.net
Fax: (907) 349-8721

Re: HB 180 & SB 130

Dear Sen. Bunde,

I am a Vocational Rehabilitation Counselor in private practice in the state of Alaska, and I have been providing vocational rehabilitation services to Alaska workers' compensation claimants since 1985. Prior to coming to Alaska I worked as a vocational rehabilitation counselor in the state of Washington from 3/83 to 6/85. I hold an M.Ed. in School Counseling and Guidance and two national certifications, Certified Rehabilitation Counselor (CRC) and Certified Disability Management Specialist (CDMS). I have twenty years of experience working with injured workers in Alaska under two different workers' compensation statutes, and I was a member of the vocational rehabilitation committee responsible for assisting in the development of the vocational rehabilitation section of the current workers' compensation statute.

In **Sec. 15**. the revisions being proposed to AS 23.30.041, (f), Criteria for ineligibility of the workers' compensation statute has the potential to create some serious problems for injured workers in the state of Alaska. The proposed changes to AS 23.30.041, (f) will create an additional means for denying rehabilitation benefits to injured workers, who may have a legitimate need for these services, by purchasing future benefits through the proposed job dislocation program. If this legislation is enacted, a situation will be created where injured workers currently involved in a work injury will be encouraged by insurance carriers to give up professional and financial assistance to train for a new occupation within their lowered physical capacities, not only for their current claim, but for any future claims they may have. Should the employee be injured on a another job with another employer, he/she would not be eligible for work skills training, which they may need to return to work. This legislation can only lead to the creation of more dislocated, disabled workers with very limited means for obtaining new work skills they may need to be able to return to the Alaska work force.

Vocational rehabilitation is voluntary as it currently stands in the Alaska workers compensation statute, as it should be, because the participant needs to be motivated, if vocational rehabilitation is to be successful. However, many injured workers who may need rehabilitation services do not currently get a chance to choose the services, because of the tough eligibility criteria, of AS 23.30.041. HB 180/SB 130 will add another criteria for denying the opportunity for injured workers to choose rehabilitation services, and potentially increase the state's number of disenfranchised citizens, who are forced to survive on charity, welfare benefits, or other government programs.

In **Sec. 16**, Injured workers would generally be faced with the decision to proceed with reemployment benefits or accept a job dislocation settlement at a time when they are often suffering from painful medical conditions and may be under the influence of strong narcotic medications. Also, most injured workers I have encountered in my twenty years of experience, would likely be suffering from significant financial problems due to reduced family incomes, providing further negative impact upon their ability to make a rational decision.

The Alaska workers' compensation statute already provides a means for injured workers' who do not wish to pursue vocational rehabilitation benefits to sign a waiver of benefits form, relinquishing the benefit. Taking the proposed changes to AS 23.30.041, (f) and AS 23.30.041, (g) in HB 180/SB 130, separately, they appear on the one hand to be providing added financial incentive to injured workers to waive their vocational rehabilitation benefit in AS 23.30.042 (g), (2), which would probably be of benefit to the employer of record on a claim, by allowing him to avoid the higher cost that may be associated with the actual vocational rehabilitation process. On the other hand, in section in AS 23.30.041, (f), (2), the proposed changes deny future vocational rehabilitation benefits to persons who waive their current vocational rehabilitation benefit under the formula in AS 23.30.042 (g), (2). The sponsors of this bill seem to be equating the provision of extra settlement money with participating in a vocational rehabilitation plan. Receiving extra settlement money in lieu of vocational rehabilitation does not provide the work skills for less physical work that may be needed by the injured worker to return to the work force, either in his/her current claim or in a future claim from a work injury. The state of Alaska does not need any additional disincentives for injured workers to avail themselves of services that could assist them in returning to the work force, and we certainly do not need to create additional barriers for the injured workers, who are motivated to overcome their disability through vocational rehabilitation; there are plenty of disincentives and barriers in the current workers' compensation statute, without adding new ones.

The proposed changes in **Sec. 14** of HB 180/SB 130 appears to have serious potential negative consequences for the Alaska workers' compensation system and defies logic in some its concepts. On the one hand, Sec. 14 opens the system to unequal and unfair treatment of injured workers, by allowing the employer to stipulate to eligibility for some employees, while denying a stipulation to others without regard to whether or not an injured worker would actually be found to be eligible for the benefit under AS 23.30.041, (e), and (f). The first time an investigative reporter uncovers a case where an employer stipulated to eligibility for a friend or family member, it would surely go national, and Alaska's whole system of workers' compensation would come under national scrutiny. In order to ensure equal and fair treatment to all injured workers in Alaska, we must maintain an impartial process for determining eligibility.

After proposing a means to totally avoid the eligibility process, Sec. 14 goes on to describe a new process for referral for an eligibility evaluation, which eventually leads to mandatory referral by the Reemployment Benefits Administrator (RBA), when the injured worker has not returned to his time of injury work for 90 days following the injury. One of the problems with the existing statute is the 90 day stipulation for an injured worker to request an eligibility evaluation, because in most of the cases we see, the injured worker is still under the belief that he will not need vocational rehabilitation; after such a short time, and he is still thinking he will be able to return to his prior work if he can just get the right medical treatment. Additionally, in most cases the treating physician is not able to make a prediction regarding the injured worker's

potential to return to work within 90 days of injury, unless it is a simple injury that requires only a short period of treatment or rehabilitation.

The proposed changes in SEC. 14 also appear to require the RBA to either make a medical decision as to whether the employee's injury may preclude him/her from returning to the time of injury job or to personally conduct the AS 23.30.041, (e), (1) portion of the eligibility evaluation, before approving a request for an eligibility evaluation. By using the words "unable to return to the employee's employment at the time of injury" for the different bench marks for requesting the eligibility evaluation or the bench mark for making a mandatory referral for an eligibility evaluation by the RBA, a requirement is again set up for either the employee, employer, or the RBA to make a medical determination. Only a recognized physician can reasonably be expected to determine if an injured worker is "unable" to return to work because of his injury. Also, making an eligibility evaluation mandatory after 90 days from the injury will dramatically increase the costs to the workers compensation system, by referring injured workers who have not reached a point of medical stability that would allow a physician to make an intelligent and informed decision regarding the employee's ultimate ability to return to the jobs from his work history. Most of the injuries that result in a need for vocational rehabilitation also require a lengthy medical treatment that may include surgery. In any case Sec. 14 will erode the voluntary basis for vocational rehabilitation and increase costs by getting rehabilitation professionals and physicians involved in the vocational rehabilitation process with injured workers, who may ultimately be able to return to work at a later date without assistance. The way the system currently works, the injured worker would not normally be referred for an eligibility evaluation until he/she is approaching or has reached medical stability from his injury and treatment.

I can see that there are many other problems with HB 180/SB130 that would be more intelligently addressed by physicians and attorneys who work with injured workers, or insurance representatives and their attorneys.

I don't know who helped the governor put these bills together, but they must have very little knowledge of how the current statute works or the principles behind its development. What is being proposed in HB 180/SB130 would seriously reduce the workers' compensation system's ability to deliver fair and pertinent benefits to injured workers, create a situation where injured workers in need of vocational rehabilitation services would not be given an opportunity to receive them, qualify some workers over others without due process, increase the work burden of existing state employees involved in the system, create new commissions and employees that would need to be funded by an already overburdened state budget, and increase medical and vocational rehabilitation costs to the system, in order to deal with mandatory eligibility evaluations and early referrals to the eligibility process. In summary these proposed bills will do the exact opposite of what they propose to do.

Sincerely,

Robert M. Sullivan, M.Ed., CRC, CDMS
Rehabilitation Specialist, RS# 26600

SRS **Southeast Rehabilitation Services**

2219 Jordan Avenue • Juneau, Alaska 99801 • (907) 586-6462 • (800) 478-6462 • Fax: (907) 463-5454 • e-mail: srs@gci.net

March 9, 2005

Senator Con Bunde
State Capital, Room 506
Juneau, AK 99801

RE: Senate Bill 130

Dear Senator Bunde,

I am writing to express my disapproval of the proposed Senate Bill 130. I am a private business owner and have served injured Alaskans as a rehabilitation counselor for 23 years. I understand the need to remedy the burgeoning cost of workers' compensation in Alaska, and I sympathize with employers who must carry the lion's share of the economic burden of Workers Compensation (WC).

Unfortunately, the good intentions of the Governor and others to gain control over the rising cost of Workers' Compensation (WC) to employers while providing efficacious services to injured workers is not yet covered in the proposed legislation.

The data that was presented by Commissioner O'Claray depicting the distribution of WC costs for 2003 was not based upon valid and verifiable data. It is my understanding that the Division of Workers' Compensation relies solely upon the insurance industry to obtain this data. Further, the Division's reporting on the costs of vocational rehabilitation is significantly greater than what is reported by the Reemployment Benefits Administer. The Division did not ask me or other persons providing vocational rehabilitation to injured workers to submit data relative to our contribution to WC cost distribution. That being the case, how can anyone assume that other depicted cost ratios are accurate? Any analysis of an issue of this importance demands scrutiny that is beyond reproach.

I am also not convinced that the WC process and injured workers in particular will be best served by the proposed buy out of injured workers in lieu of vocational retraining. Implied in this is the notion that substantial cost reduction would occur to WC and our state economy. More likely, injured workers' who are financially desperate, most likely after their benefits have been terminated, will be compelled to take what they can get rather than fight an uphill battle and seek training to return to gainful employment.

I am a political conservative, voted and contributed to Governor Murkowski's campaign and agree that cost cutting is essential to support businesses in Alaska. Unfortunately, this bill is a misguided attempt to achieve this goal. A better analysis is needed, which needs to include a careful review of insurance carrier practices and procedures that, I believe, contributes greatly to the cost of WC in our state.

Respectfully,

Denise Van Der Pol, CRC CCM CDMS
Certified Rehabilitation Counselor


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# Murkowski angers workers' comp group

**BILL: Committee said it was assured governor would wait for its plan.**

By LARRY PERSILY
Anchorage Daily News

Published March 1st, 2005
Last Modified March 1st, 2005 at 05:31 PM

JUNEAU -- A longtime committee of labor and industry representatives is upset at the governor for not waiting on them to finish their work and deciding instead to introduce his own legislation to attack the problem of rising workers' compensation insurance rates.

"We've been basically fired," said Richard Cattanach, executive director of the Associated General Contractors of Alaska and a member of the 12-member nonpartisan committee selected by industry and unions.

Committee members charged in a Feb. 22 letter to Gov. Frank Murkowski that his Labor Department commissioner had told the committee several times that the governor would not introduce his own workers' compensation bill this year and would wait for the committee to draft a legislative proposal.

The committee had been working since September -- at the governor's request -- to draft comprehensive workers' compensation legislation covering medical costs, vocational rehabilitation,

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return to work and other provisions.

The AFL-CIO selects the six union members on the committee, and an industry group called the Workers' Compensation Committee of Alaska selects six members too, Cattanach said. The joint committee has been around almost 25 years, restoring itself to active duty whenever needed to work on legislation.

"All workers' compensation legislation since the early 1980s has been agreed to by labor and management through the ad hoc (committee) process," the committee said in its letter to Murkowski. "It has proven to be the best way to build consensus."

The governor lost patience with the committee, Cattanach said. Murkowski introduced his own bill Friday.

That's basically the same story being told by Labor Commissioner Greg O'Claray.

"The governor was fully aware of the commitments I gave on his behalf," O'Claray said. "We felt we could not wait another year," especially since postponing action until next year would have meant fighting the battle during an election year, he said.

"The goal is to arrest the galloping (insurance) rates by February 2007," O'Claray said.

After deciding two weeks ago to submit his own bill, the governor wanted it done quickly, O'Claray said, commenting on a short meeting he had with Murkowski on the issue. "What he told me was, 'Why are you standing here? Why aren't you drafting a bill?' " O'Claray said.

But bailing out on the committee process will cost the governor support for his legislation. "(We) regret that we cannot support it," the members said in their letter to Murkowski.

Committee members are not the only ones holding back their support.

Murkowski's proposal to roll back the reimbursement rate for medical services to December 1999 levels is not going over well with doctors. "It is troubling to be required to provide care with 2005 and later technology at 1999 prices," the Alaska State Medical Association said in a prepared statement within minutes of O'Claray's press conference announcing the

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governor's bill

"I think it is a very aggressive bill," especially the provision to pay for medical care at 1999 rates, House Majority Leader John Coghill said Monday. "As it goes through the process, it probably will be pared back some," the North Pole Republican said.

The tension between the governor and the labor and industry committee will not help the bill, he said.

"It sure doesn't make it any easier," said Anchorage Republican Sen. Con Bunde, chairman of the Senate Labor and Commerce Committee. Without organized labor pushing for passage of the bill, Bunde said, "I don't think this happens."

Regardless of who supports or opposes the 37-page bill, the 10 weeks left in the session will make it hard to move through such a complex and contentious issue as workers' compensation reform, Bunde said.

Lawmakers last year considered a workers' compensation bill sponsored by the governor, with senators approving it 11-9 before the measure died in the House in the final two weeks of the session. Another attempt died in last year's special session.

"I don't see any change in the House organization to predict a different outcome," Bunde said.

O'Claray said the governor cited a couple of reasons for submitting his own bill, rather than waiting for the committee to finish its work. He was getting pressure from the Legislature, the commissioner said.

Bunde confirmed he had told the administration he would start work on his own bill if the governor didn't submit a proposal by the end of February.

And the early February announcement that Anchorage's downtown La Mex restaurant was closing because, in part, of rising workers' compensation insurance costs "piqued the governor's interest" in the problem, O'Claray said.

Murkowski believed the committee's draft bill fell short by not addressing rising medical costs, an essential piece of any fix to workers' compensation rates, the commissioner said.

The average rate increase for employers was 21 percent last year and an additional 12 percent

this year, said Linda Hall, director of the state Division of Insurance, which must approve all rates charged to employers. The insurance covers medical costs, lost wages and, if needed, retraining.

Rates depend on employees' job classifications -- the cost is higher for more dangerous professions. And companies charge more to employers with higher on-the-job accident rates.

One problem is that so few companies write policies in Alaska, with just three companies handling most of the business, Hall said.

Cattanach acknowledges the committee's draft ... did not have answers for rising medical or vocational rehabilitation costs. Nor did it offer solutions for return-to-work problems, but neither does the governor's bill, he said.

Maybe the question should be to get a good bill, not a perfect bill, Bunde said. "Would you rather have 50 percent of something or 100 percent of nothing?"

Daily News reporter Larry Persily can be reached at lpersily@adn.com, or in Juneau at 523-9306.

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# ALASKA

# LABOR-MANAGEMENT

# AD HOC COMMITTEE

# ON WORKERS' COMPENSATION

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February 22, 2005

Via Facsimile
907.465.3532

The Honorable Frank Murkowski
Governor
State of Alaska

RE: Alaska Worker Compensation Ad Hoc Committee Legislation

Dear Governor Murkowski:

The members of the Ad Hoc Committee respectfully request that the Administration reevaluate its intention to propose workers' compensation legislation and honor the commitments made to the Ad Hoc process by submitting the Ad Hoc legislation as drafted. The Ad Hoc process was started almost 25 years ago and has been the process followed on all significant workers' compensation legislation since that time. The current Ad Hoc committee recognized that the major workers compensation cost drivers were not addressed in last year's legislation. Given the complexity of these issues, the Committee determined that additional time was required to recommend the necessary changes.

We would like to thank the Administration for its continued efforts on our behalf. Some of the Administration's commitments made to support the Ad Hoc process display the Administrations partnership with the ad hoc process:

1) In August 2004, at the AFL-CIO conference at the Captain Cook Hotel in Anchorage, Commissioner Greg O'Claray stated before the group of more than 200 labor leaders, that he was representing the Governor. He declared that the Governor was not going to introduce a Workers Comp bill in 2005; that he wanted the Ad Hoc Committee to address those issues.
2) On September 28, 2004, Commissioner Greg O'Claray affirmed that the Administration wanted the Ad Hoc Committee to reconvene.
3) At the annual Workers' Compensation Board meeting on October 7, 2004, Commissioner O'Claray said that he would support a bill negotiated by the Ad

Hoc Committee, a non-political, non-partisan group composed of members from both labor and management.

4) At an ASMA sponsored meeting on October 7, 2004 Commissioner O'Claray told 30 attendees that the Administration would support the Ad Hoc Committee because labor and management are the primary players in the workers' compensation system.
5) At a luncheon sponsored by the Ad Hoc Committee on December 10, 2004, Commissioner O'Claray told 30 plus legislators and their aides that he was fully committed to legislation formed by the Ad Hoc committee.
6) Administration staff has also stated their intention to honor Ad Hoc Committee legislation in several conversations with Alaska business and labor representatives, both privately and publicly.

The current Ad Hoc Committee convened in September, 2005, specifically at the request of the administration. We understood then that any legislation we negotiated would be supported by the Governor's office and the Administration. Representatives of the Administration have been party to, and have participated in, all meetings of the Ad Hoc Committee.

At a meeting of Ad Hoc representatives and the Administration in Juneau on Tuesday, February 15, 2005, it was announced that a bill not negotiated via the Ad Hoc process would be introduced this session. After discussion and consideration, the Committee has determined that it cannot support legislation not agreed to by both labor and management. This is not a matter of being inflexible but a matter of historical consideration. All workers' compensation legislation since the early 1980s has been agreed to by labor and management through the Ad Hoc process. It has proven to be the best way to build consensus and deliver the fairest set of standards for all participants in the system.

The bill proposed this session by the Committee is not meant to be comprehensive. It is intended to address those issues for which we had factual information on which to rely. While the following is not inclusive, all of these issues are addressed in the bill:

1) Adoption of insurance provisions that were included in last session's bill;
2) Processes that will streamline and make the Workers' Compensation system more efficient;
3) Provisions that allow the division to clearly address uninsured employer issues;
4) Modifications to current language that deals with the average weekly wage affecting temporary and seasonal workers;
5) Establishment of caps on compensation for out-of-state claimants;
6) Creation of a Medical Policy Advisory Committee to establish a prescription drug policy, among other things;
7) Enhancement of existing fraud language
8) Creation of a Workers' Compensation Board Policy Panel to hear appeals, establish precedent and consistency for the Board statewide;
9) Proposes to phase out the second injury fund.

There is additional work to be done, such as vocation rehabilitation, medical cost containment and a return to work program; however, the Committee prefers, as a legislator recently stated on another issue of concern, to "take a reasonable approach, not a Band-Aid approach, not a knee-jerk approach." We intend to continue to research and develop responses to those issues to ensure that we have the best programs available to submit in the next legislative session.

We will be disappointed if legislation is introduced that was not produced by the Ad Hoc process and regret that we cannot support it.

We appreciate your consideration and hope that the Ad Hoc draft legislation is the only legislation introduced this session.

Sincerely,

Richard Cattanach
Associated General Contractors
Of Alaska

Kevin Dougherty
Alaska Laborers

Judy Peterson
President WCCA
Northwest Technical Services

David Ford
Ironworkers Local 751

Laura Jackson
University of Alaska

John Giuchici
IBEW

David Koster
Ribelin Lowell Alaska USA

Barbara Huff-Tuckness
Teamsters

April Reilly
Rain Proof Roofing LLC

Jim Robison
Senior Alaskan

Tim Slabaugh
VECO

Jim Sampson
AFL-CIO

# Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)


March 8, 2005

Honorable Con Bunde
Chair, Senate Labor and Commerce Committee
State Capitol, Room 506
Juneau AK 99801

Re: SB 130 – Workers Compensation

Dear Senator Bunde:

The Alaska State Medical Association (ASMA), represents physicians throughout Alaska, and is primarily concerned with the health care for all Alaskans.

ASMA's primary concerns regarding SB 130 are the potential unintended consequences that would be harmful to an injured worker, would be harmful to the patient/physician relationship, create medical liability questions relating to standard of care, or would create burdensome paperwork that does not add value to patient care.

ASMA has more questions than suggestions at this time. The workers compensation system is complex and deserving of in-depth analysis. The following comments are in the order found in SB 130.

1. **Section 24 P. 19 lines 4 through 26**

   A. Subsection (n) creates a requirement for use of a generic drug unless the physician explains in writing the medical necessity of using a brand name drug. It also establishes a "preferred drug list" (PDL) and directs the department to establish a policy for departure from that list.

      1. Physician Assistants and Advanced Nurse Practitioners also prescribe. This language only refers to physicians. Does this mean that PAs and ANPs are not required to follow the same rules?

      2. Physicians do not have a financial stake in the sale of a prescription drug. Their interest is to get the most efficacious drug to the patient. The physician's stake in this process is the administrative / paperwork effort necessary to get a prescription filled. This adds additional hassle to the process with no discernable benefit to the patient. Departure from the PDL in the Medicaid program requires only that the prescriber state that the use of a particular drug is "medically necessary". This subsection also infers a pre-authorization process in the exception cases. This raises questions as to who will do the prior – authorization – an insurance company employee (clerk, nurse, pharmacist, doctor, etc), a department employee (clerk, nurse, pharmacist, doctor, etc.)? In

any event, an increased hassle factor is added with perhaps standard of care implications that might pertain to medical injury lawsuits.

3. The threshold question regarding establishing a PDL is whether or not a PDL is appropriate for the worker compensation system. The PDL developed for the Medicaid program may not be appropriate. If a PDL is appropriate for workers compensation, physicians specializing in treating workers compensation patients need to be an integral part in its development. The final questions are what are the projected cost savings for adopting a PDL and what is the impact on access to care?

B. Subsection (o) establishes the presumptive standard of care for treatment of an injured worker that must be followed for payment to be made for the medical services provided. The American College of Occupation and Environmental Medicine's (ACOEM) Occupational Medicine Practice Guidelines are adopted as the presumptive standard.

1. What is the evidence that the ACOEM guidelines are the definitive, presumptive standards? At its face, it is suspect that one book of guidelines can encompass every possible treatment scenario for every injured worker. California adopted the ACOEM guidelines about a year ago. Attached are copies of two letters from the California Medical Association (by Dr. Hertzka, CMA President) to Ms. Hoch, the Administrative Director of the California Division of Workers' Compensation, dated 1/06/2005 and 12/12/2004. You will note that CMA recommends to also include the practice guidelines developed by national specialty societies listed in the 1/6/05 letter. The concerns and recommendations made by CMA should be investigated as to their applicability in Alaska.

2. The CMA letter dated 12/12/2004 also states that 80% of services provided by physicians are not addressed in treatment guidelines. If that is the case in Alaska, what will be the cost savings impact?

3. What is the value added to patient treatment and care by the adoption of the ACOEM guidelines? Or is this just added hassle that may adversely impact assess to care and create standard of care implications in medical injury lawsuits?

II. **<u>Section 25 p 19 lines 27-31, p 20 lines 1-31, and p21 lines 1-15</u>**

A. AS 23.30.097 (a) would roll back the fees paid for treatment of an injured worker to the lesser of the fee schedule in place at 12/15/99 or an employer negotiated amount of payment.

1. It is presumed that the workers compensation system is primarily established to treat and care for an injured worker in an expeditious manner in order to get the worker back on the job. It would seem that a primary determination would be that optimal outcomes are achieved. How do outcomes in the Alaska Workers Compensation compare to other states? Will there be outcome studies in the future?

2. What are the cost savings estimated to be achieved by the fee rollback? What are the cost breakdowns for the last 5 years by type of medical care provider? What are the costs by CPT code for physician charges for the last 5 years?

3. What are the implications for access to care?

4. What are the implications in recruiting needed physicians to Alaska?

B. AS 23.30.097 (b) allows employers to establish a list of preferred physicians.

1. What are the cost saving to be achieved by forming groups of preferred physicians?

2. What would be the cost to the employer to negotiate such arrangements with individual physicians?

3. Will an employer become a co-defendant in any lawsuit pertaining to a medical injury allegedly caused by a physician on the preferred list?

C. AS 23.30.097 (c) allows an employer or groups of small employers to negotiate reduced fees with physicians.

1. Independently practicing physician may not jointly negotiate fees. How will the State oversee this process so that harmful monopsonic or oligopsonic situations do not occur?

2. Considering that employers will need to negotiate with individual physicians that would seemingly be costly, what are the anticipated savings projected by this provision?

ASMA believes that careful study is required of the complex issues raised in this testimony as well as others that come up in the course of your deliberations. Undue interference with the patient/physician relationship and adverse impact on access to care needs to be avoided.

Sincerely,

By: James Jordan, Executive Director
For: The Alaska State Medical Association

cc: Senator Ralph Seekins
Senator Ben Stevens
Senator Bettye Davis
Senator Johnny Ellis

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

**DIVISION OF INSURANCE**

*Frank H. Murkowski, Governor*

March 7, 2005

The Honorable Con Bunde
Senate Labor & Commerce
State Capital
Juneau, Alaska

RE: SB 130

Senator Bunde,

The Division of Insurance strongly supports the reforms contained in SB 130. The Division receives numerous calls from distressed employers who have seen their costs for workers' compensation insurance escalate to unmanageable levels. The increases in workers' compensation premiums have caused employers to evaluate whether they can afford to provide both health insurance and workers' compensation coverage to their employees. Since workers' compensation is mandatory, employers are indicating they will be forced to drop health insurance coverage for their employees. Other employers have called the Division and indicated they are evaluating whether they can stay in business with the dramatic increases in premiums.

Effective January 1, 2004 the average rate increase for workers' compensation insurance was 21.2% which included 17 classifications with rate increases over 50%. Effective January 1, 2005, the average rate increase was 12% with approximately 50 classifications increasing over 30%

The workers' compensation system is administered by the Department of Labor and Workforce Development. The Division of Insurance is tasked with promulgating insurance rates that adequately cover the costs of claims to ensure a viable, solvent insurance market. Reform is needed in order to stop the continuing increases in the costs of claims. Reduction in the cost of claims must take place to begin to have an effect on the cost of workers' compensation insurance.

Sincerely,

Linda S. Hall
Director

550 W. 7th Avenue, Suite 1560, Anchorage, Alaska 99501-3567
Telephone: (907) 269-7900 Fax: (907) 269-7910 Text Telephone: (907) 465-5437
Email: insurance@commerce.state.ak.us Website: http://www.commerce.state.ak.us/insurance/

Alaska Department of Labor and Workforce Development

# News Release

Frank H. Murkowski, Governor
Greg O'Claray, Commissioner

P.O. Box 21149
Juneau, Alaska 99802-1149
Telephone: (907) 465-2700
Fax: (907) 465-2784

**Date: February 23, 2005**
No: 05-49

**FOR IMMEDIATE RELEASE**
**Media Contact:** Dan Saddler, 632-1776

## Workers' Compensation Bill Offers Needed Reform

### Legislation Addresses Skyrocketing Costs of Employee Insurance

(Juneau) - Important reforms aimed at streamlining the delivery of workers' compensation benefits to injured workers, and easing the cost burden on Alaska businesses, will be sent to the Legislature this week by Governor Frank H. Murkowski.

"Workers' compensation rates in Alaska are the second-highest in the nation, imposing an unnecessary burden on our economy," said Greg O'Claray, commissioner of the Alaska Department of Labor & Workforce Development, which is taking the lead on the issue. "The reforms in this bill will make the workers' compensation system less expensive for employers and more efficient for workers."

State law requires employers to provide workers' compensation insurance so those injured on the job can get disability benefits while they recover, receive medical care and rehabilitation, and, if necessary, get retrained for a new line of work.

Private insurance companies base their rates on each industry's expense history, but in recent years rates have skyrocketed, increasing 36 percent on average over the past two years alone. Only California has seen rates increase higher than Alaska, increases that recently drove it to pass its own reform legislation, the governor said.

"We must act now to halt this dangerous trend in our state," Murkowski said. "It's clear the present system doesn't serve injured workers or employers as the original law intended. With legislative approval of my bill we could stabilize insurance rates by January 1, 2007. The longer we delay taking action, the more costs spin out of control."

O'Claray said costs for specific medical procedures demonstrate the trend. The cost for knee reconstruction surgery has nearly doubled from $5225 in 1999 to $10,697 in 2004, and back surgery to repair a ruptured disk has risen from $5,617 to $6,947 in the same period, according to information compiled in state medical fee schedules.

O'Claray presented details of the legislation at Copy Express, a small duplication and office supply business in Juneau, which he called one of the many Alaska enterprises being squeezed by steep rate increases. The company's workers' compensation costs have risen from $5,900 in 2002, to $10,232 in 2005.

- more -

Labor Department records show similar rates of increase for other industries. Costs for McGraw's Custom Construction, a Sitka construction company, have risen from $146,950 in 2002 to $315,110 in 2004. Costs for the Kodiak Island Borough have more than doubled from $43,275 in 2001 to $95,234 in 2005. At Central Peninsula General Hospital in Kenai, costs have more than doubled, from $390,566 in 2001 to $984,833.

"By dealing with these increases, and making other needed improvements to the system, the governor's bill will keep Alaska's worker compensation insurance system affordable for employers, effective for employees and efficient for the entire state," O'Claray said.

The bill's key elements include:

- Capping medical fees paid for injured worker services at the December 1999 level, and calling for a medical review committee to study the medical delivery system for workers' compensation and report to the labor commissioner by March 1, 2007
- Helping employers reduce medical costs by authorizing them to use a list of preferred providers and allowing employers to negotiate fee rate, while still letting employees choose providers outside the preferred list
- Adopting national peer-reviewed medical treatment guidelines
- Requiring physicians to use generic drugs - but allowing exemptions for medical reasons - and authorizing use of a preferred drug list
- Establishing an Appeals Commission to provide quicker, more consistent decisions of appeals than the Superior Court offers under current law
- Preventing workers from receiving more in combined disability benefits than they would earn if still on the job
- Streamlining the claim settling process by allowing parties to settle claims without requiring Workers' Compensation board approval, letting claimants opt for cash benefits instead of retaining benefits, and reducing delays in determining eligibility for retraining benefits
- Protecting workers against unscrupulous employers who fail to carry insurance coverage, by using fines collected from such violators to fund a pool to pay benefits to workers left uncovered
- Helping injured workers return to productive work more quickly

"The best workers' compensation is a good paying job on an accident-free workplace," Murkowski said. "But if someone is injured, these reforms provide needed help quickly and effectively. I encourage everyone interested in a healthy Alaska economy to work together with Commissioner O'Claray to craft a timely solution to a problem that has gone unresolved for far too long."

###

# Synopsis of 2005 Workers' Compensation Reform Act

*The Murkowski Administration's workers' compensation reform legislation provides much-needed reforms aimed at keeping Alaska's system affordable for employers, effective for employees and efficient for the entire state. It addresses five major elements of the system:*

## Medical Costs and Benefits

- Rolls back state rates for reimbursement of medical services to injured workers to December 1999 levels, pending a medical review committee's study of the medical delivery system for workers' compensation to be delivered to the labor commissioner by March 1, 2007
- Reduces medical costs by authorizing employers to use preferred providers and allowing employers to negotiate fee rates - while still letting employees choose providers outside the preferred list
- Requires physicians treating injured workers to take advantage of the cost savings from generic prescription drugs - but allows exceptions for medical reasons
- Authorizes physicians to prescribe from a preferred drug list, to obtain the same system-wide cost reductions that such a list provides to the Alaska Department of Health and Social Services
- Adopts national peer-review medical treatment guidelines established by the American College of Occupational and Environmental Medicine

## Workers' Rights

- Protects workers against unscrupulous employers who fail to offer insurance coverage, by using fines collected from such violators to fund a pool to pay benefits to workers left uncovered
- Eases worker access to legal advice, by allowing private attorneys to collect minimal fee ($300) to advise clients with workers' compensation issues
- Authorizes state to contract with non-profit organizations to provide legal assistance to worker claimants and receive reimbursement from state

## Workers' Compensation System

- Establishes Appeals Commission to provide state-wide consistency in workers' compensation claim decisions, while preserving Workers' Compensation Board hearing process to speed resolution of contested claims
- Eliminates Second Injury Fund, an indemnification mechanism no longer necessary to protect once-injured employees against hiring discrimination from subsequent employers
- Reduces delays in determining workers' eligibility for retraining benefits
- Allows injured workers the option to quickly receive cash benefits in lieu of retraining benefits
- Streamlines claim process by requiring immediate release of treatment records to employers
- Eases resolution of many claims by allowing parties with attorneys to settle cases without requiring review by workers' compensation board
- Protects worker and employer privacy, and system integrity by banning commercial use of workers' compensation division's records
- Speeds shut-down of uninsured employers by eliminating requirement for hearing before workers' compensation board
- Increases fines against employers that fail to provide insurance
- Combats insurance fraud by authorizing Division of Workers' Compensation to investigate fraud, and to refer violators for prosecution under an improved criminal statute

## Compensation

- Prevents workers from earning more in benefits than wages, by allowing coordination of benefits between employer-funded disability insurance and total disability compensation
- Caps compensation to nonresident workers at rate paid in Alaska, to Alaskans

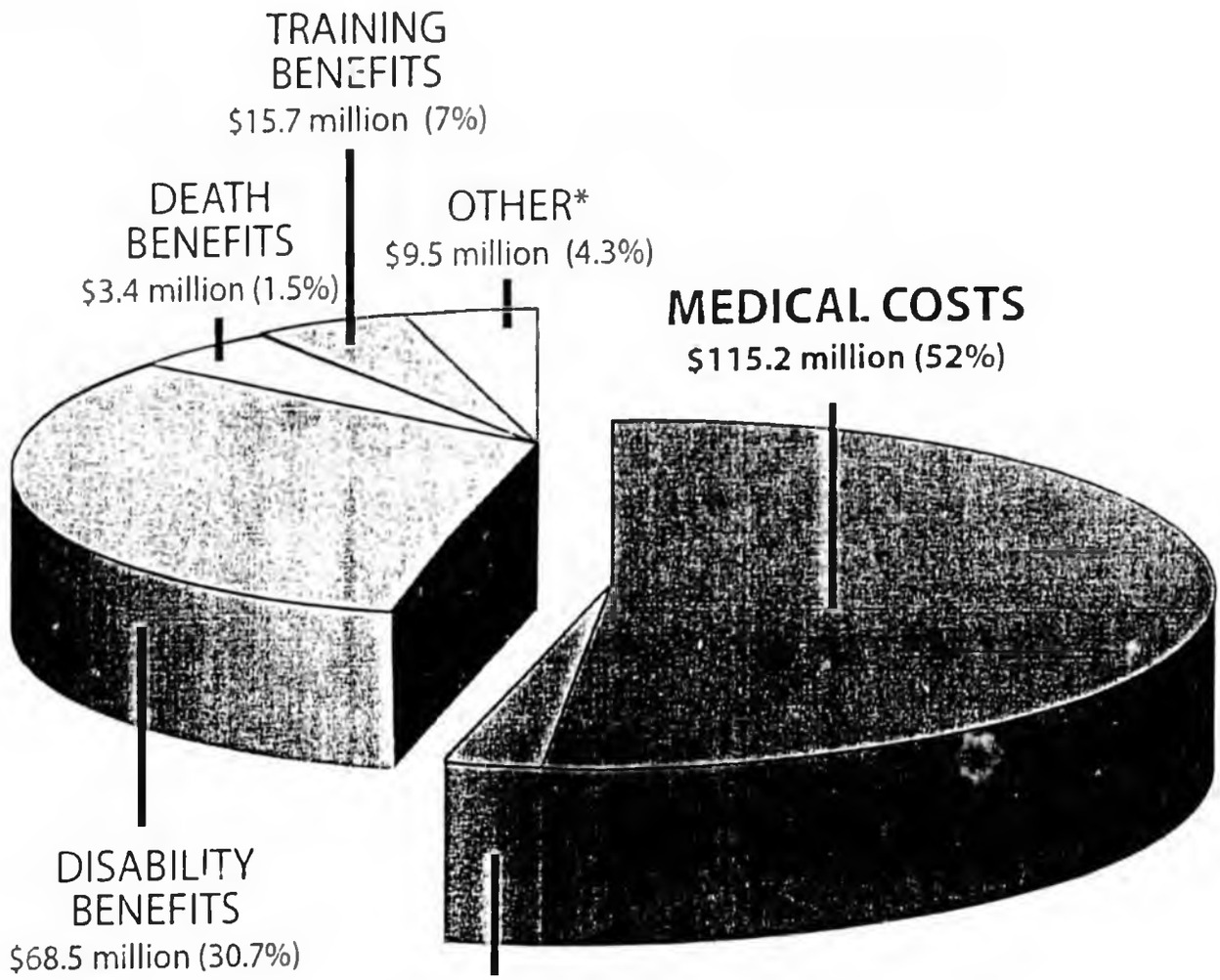
## Insurance System

- Improves robustness of state workers' compensation insurance system by requiring insurers to create bonding pool to protect against individual firms' insolvency
- Clarifies that employees of limited liability corporations may opt into state workers' compensation system

# Where Your Workers' Compensation Benefit Dollars Go

## 2003 Paid Costs/Benefits = $223 million

*Source: Workers' Compensation 2003 Annual Report*

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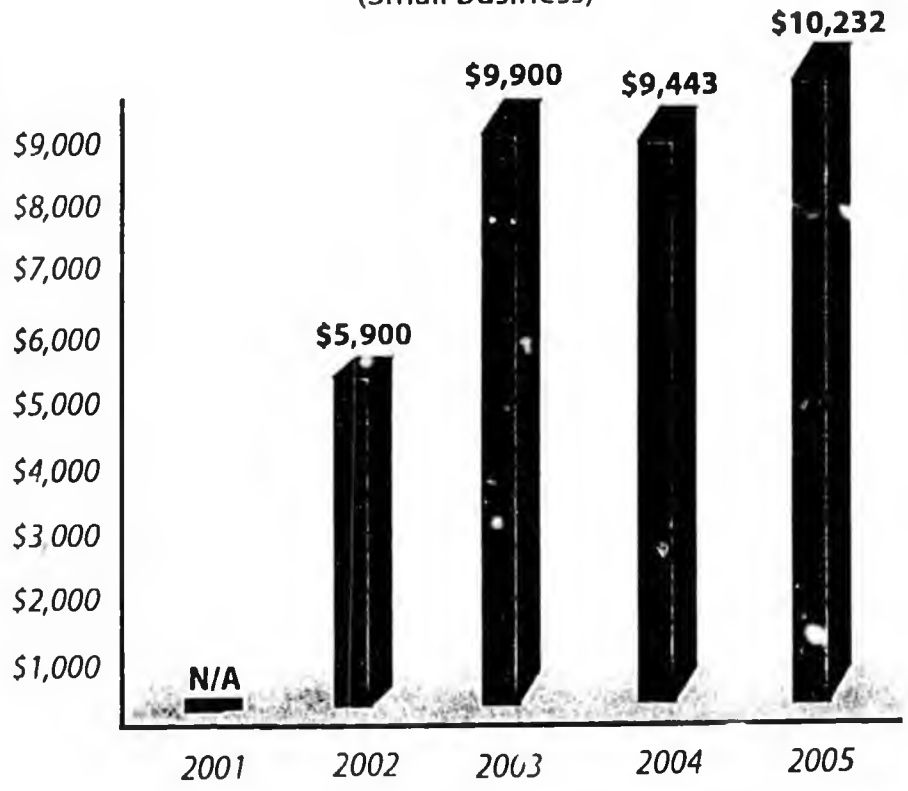
***& WORKFORCE DEVELOPMENT***

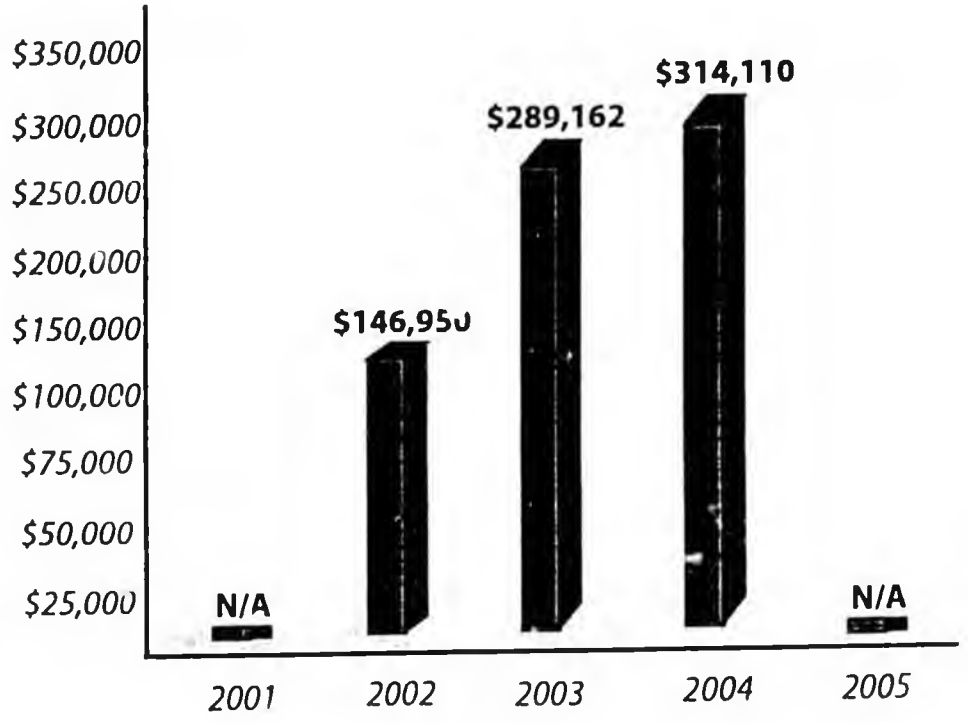
* Interest, Second Injury Fund, etc.

# Workers' Compensation Insurance Annual Premiums Paid

## Copy Express
(Small Business)




## McGraw's Custom Construction
(General Contractor)

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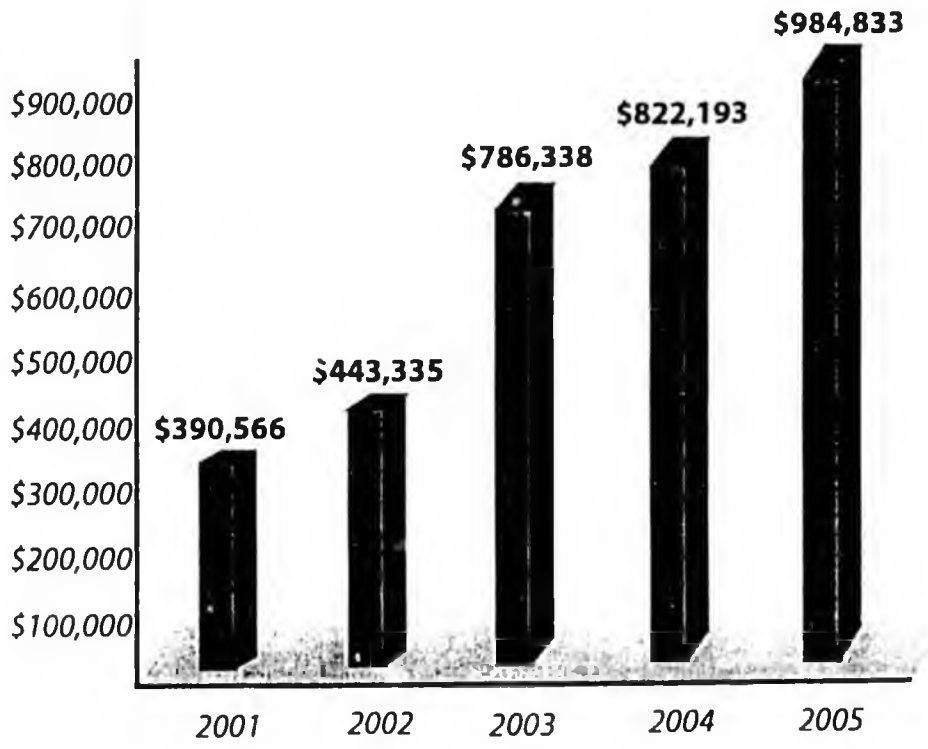
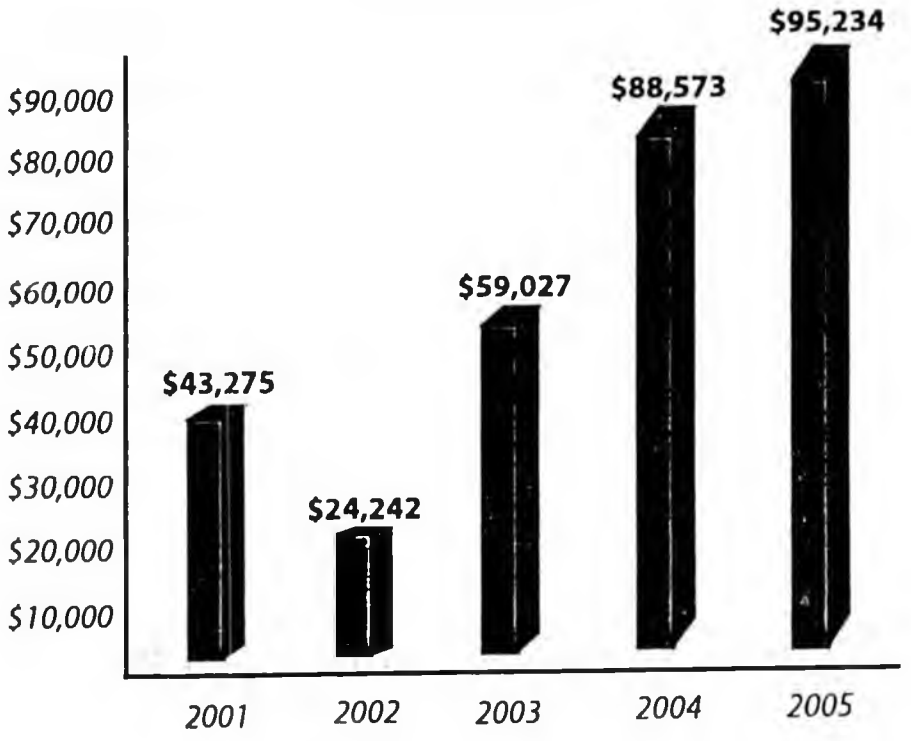
# Workers' Compensation Insurance Annual Premiums Paid

## Central Peninsula General Hospital
(Health Care)




## Kodiak Island Borough
(Government)




ALASKA DEPARTMENT OF LABOR
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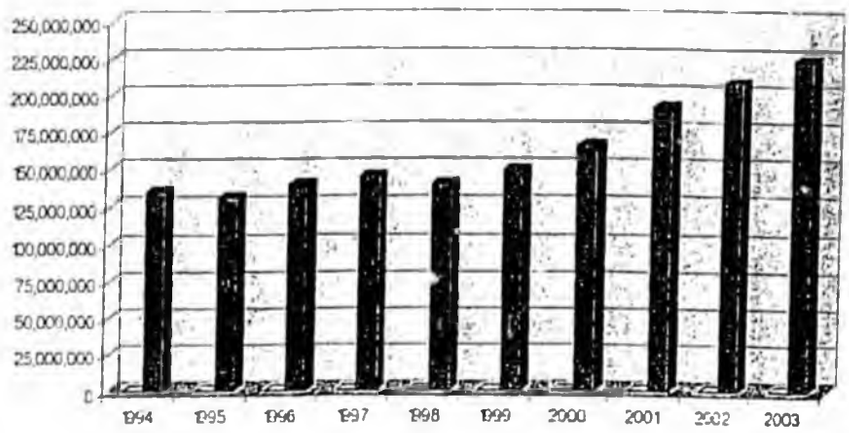
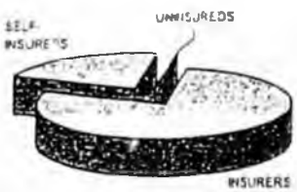
# WORKERS' COMPENSATION
# 2003 ANNUAL REPORT

Total Compensation Payments




A total of $223.0 million was paid in workers' compensation benefits during calendar year 2003. This is an increase of 7.01% over 2002's total of $208.4 million.

Of this amount, $174.4 million, 78.22%, was paid by insurance companies, and $48.6 million, 21.78%, was paid by self-insured employers.

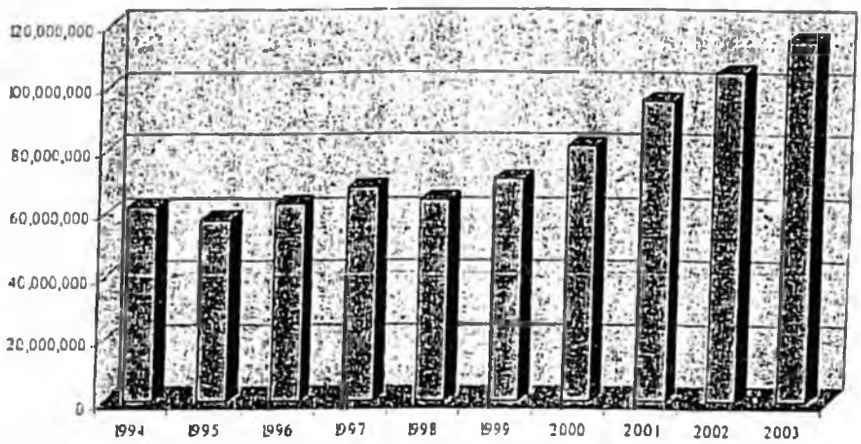



This compares to $162.1 million, 77.7%, paid by insurance companies and $46.4 million, 22.27%, paid by self-insured employers in 2002. Benefits reported by uninsured employers in 2003 totaled $24,891, compared to $33,123 in 2002.

In the past 10 years $1.63 billion has been paid out in workers' compensation benefits. Of this amount, benefits by insurance companies totaled $1.27 billion or 78.12% of total benefits paid, while self-insured employers paid $355.3 million, or 27.97% of total benefits paid. Benefits reported by Uninsured Employers totaled $521,062, or 0.15% of total benefits paid.

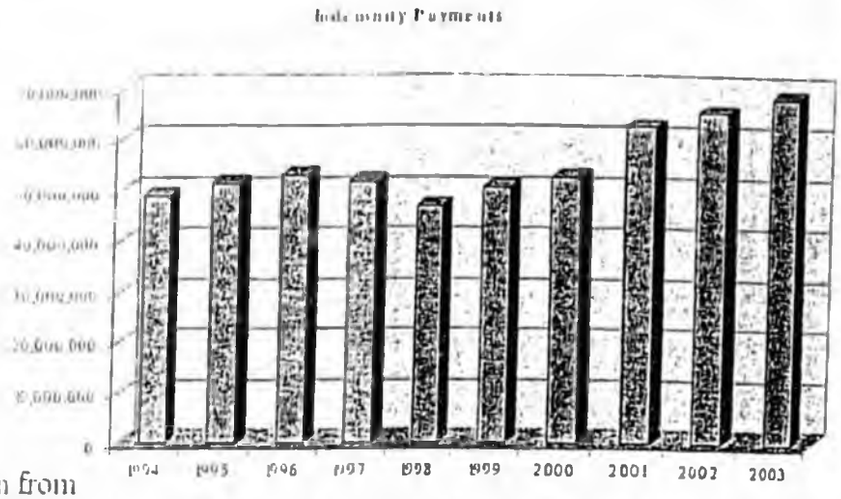
## MEDICAL BENEFITS

Medical Payments

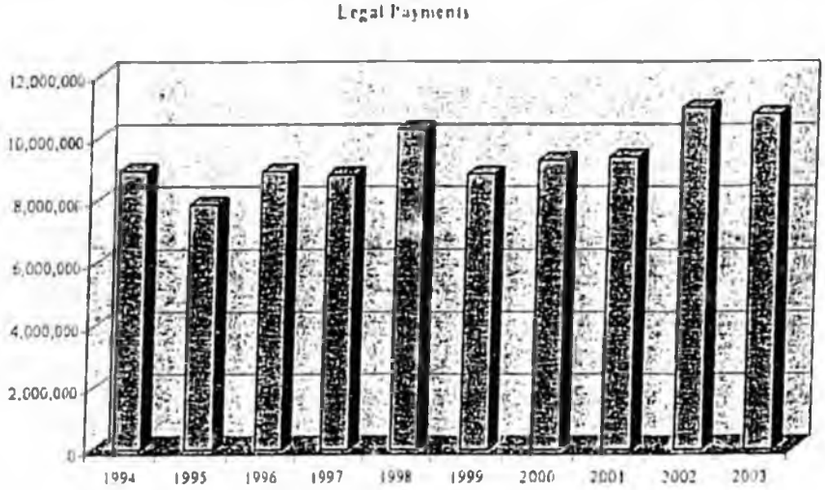



In 2003, medical benefits totaled $115.2 million, up 8.1% from $106.6 million in 2002. Medical benefits were 51.65% of total benefits paid, compared to 50.08% in 2002.

## INDEMNITY BENEFITS

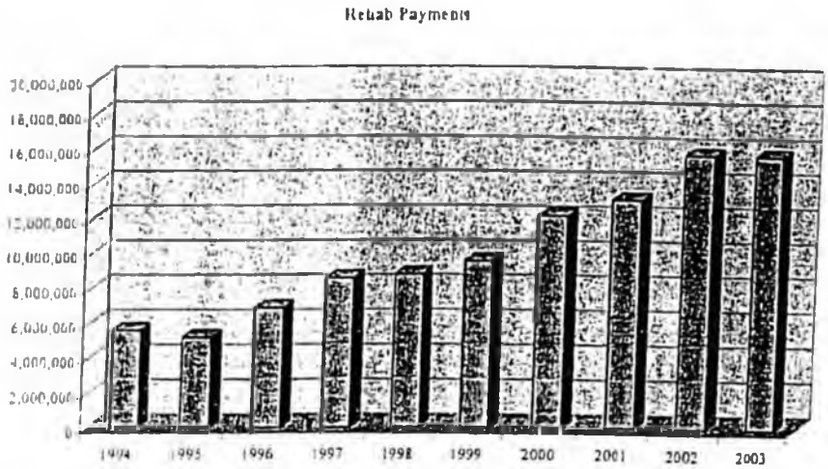



Year 2003 indemnity benefits (TTD, TPD, PPI, and PTD) totaled $68.5 million, up 4.95% from $65.3 million in 2002. TTD benefits increased 4.23% to $38.2 million from $36.7 million in 2002; TPD benefits decreased 3.72% to $1.43 million from $1.49 million in 2002; PPI benefits increased 5.95% to $23.7 million from $22.4 million in 2002; and PTD benefits increased 8.58% to $5.1 million from $4.7 million in 2002.




## LEGAL EXPENSES

Legal expenses decreased 1.94%, to $10.7 million in 2003 from $11.0 million in 2002. Employee attorney fees decreased 10.34% to $2.4 million from $2.7 million; employer attorney fees rose 1.98%, to $7.2 million from $7.1 million; and litigation costs decreased 6.21%, to $1.1 million from $1.2 million.

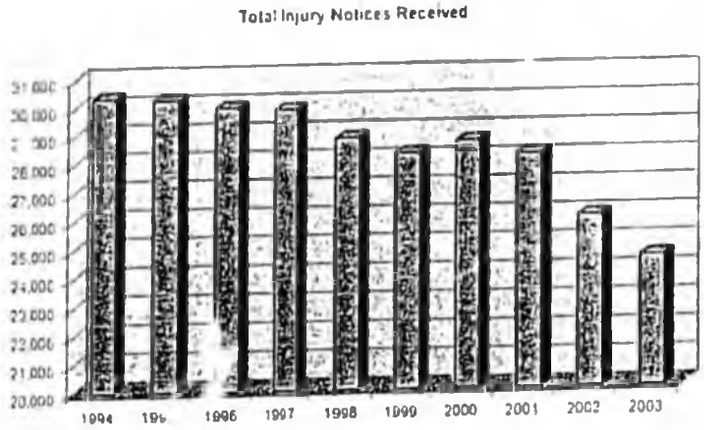



## REEMPLOYMENT BENEFITS

Reemployment benefit payments decreased .26% in 2003, to $15.71 million from $15.75 million in 2002. Wages paid while under rehabilitation, 041K wages, were the largest rehabilitation expense. 041K wages decreased 3.31%, from $10.7 million in 2002 to $10.3 million in 2003. Employee evaluation costs decreased 24.4%, to $1.3 million from $1.7 million. Rehabilitation specialist fees increased 36.8%, to

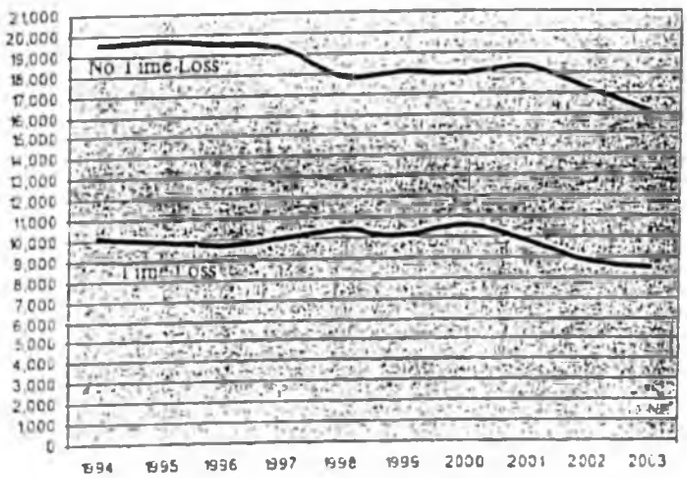
$1.2 million from $843,839. Plan development costs increased 4.51%, to $1.9 million from $1.8 million. Plan monitoring fees increased 47.11%, from $700,684 to $1.0 million.

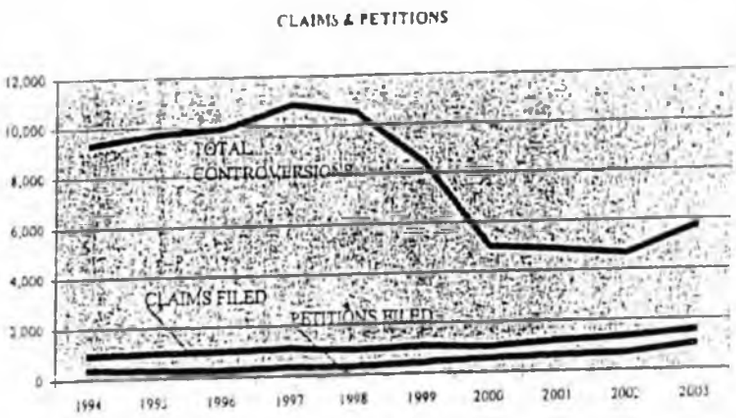
## ANALYSIS OF WORKERS' COMP CLAIMS



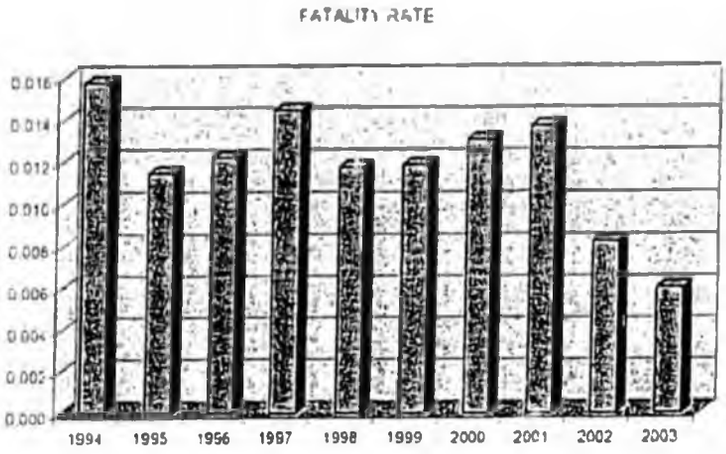

During calendar year 2003, the number of injuries and/or illness reported to the Workers' Compensation Division declined 5.53%, to 24,544, from 25,981 in 2002.

Of the case files set up by the Division in 2003, 16,032 were no-time loss cases, 8,472 were time-loss cases, 17 were fatalities, and 20 were jurisdictional claims.




For the year, the number of claims filed increased 15.9%, from 1,333 in 2002 to 1,545 in 2003. The number of petitions filed increased 46.0%, from 685 to 1,000, and the total number of controversions filed increased 22.6%, from 4,654 to 5,708.




Using the number of time-loss claims established by the Workers' Compensation Division, the time loss rate per 100 employees in 2003 was 3.0, compared to a loss rate of 3.13 in 2002.

Using the number of fatalities established by the Workers' Compensation Division, the fatality rate per 100 employees in 2003 was .0006, compared to .0008 in 2002, and the lowest rate in the past 10 years.

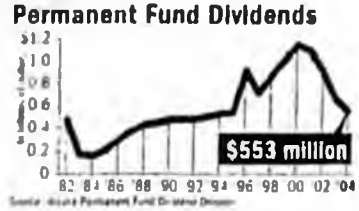
## OTHER

The top twenty insurers paid $163.2 million, or 73.2% of total workers' compensation benefits paid in 2003. This compares to $147.0 million or 70.5% in 2002.

The top five insurers by benefits paid in 2003 were Alaska National Insurance Co. at $51.8 million, up 17.8% from $44.0 million in 2002; State of Alaska at $16.1 million, up 20.0% from $13.4 million in 2002; Alaska Insurance Guaranty Association at $14.0 million, up 258.1% from $3.9 million in 2002, Commerce & Industry Ins Co (AIG) at $9.5 million, up 177.6% from $3.4 million in 2002, and Liberty Northwest Insurance Co at $7.0 million, up 107.1% from $3.4 million in 2002.

For fiscal year 2003, the Division of Insurance reported 157 companies writing workers' compensation insurance in Alaska, with total net premiums written totaling $238.2 million. This compares to 197 admitted insurers writing $156.3 million in direct premiums in 2002. During the year, voluntary market premiums increases averaged 3.5%, and assigned risk pool premiums increased 7.6%.

During calendar year 2003, there were several major insolvencies – Fremont Industrial Indemnity Co., Home Insurance Co., and Legion Insurance Co.




Average total annual payout, 1982-2004: $584 million

Total received per Alaskan, 1982-2004: $23,929.69

Average payment size since 1982: $1,040

# Labor costs kill downtown La Mex

■ **RESTAURANT:** Owner took over chain from parents in 1990; other two stay open.

By SARANA SCHELL
Anchorage Daily News

Anchorage's downtown La Mex restaurant, home of Grande Ronde and the Jalapeno Eating Contest during Fur Rendezvous, not to mention a major annual Cinco de Mayo party, is closed.

Owner Trina Johnson said she closed the location last week, after 30 years in business, because of rising labor costs.

La Mex's two other locations in Anchorage, in Spenard and on King Street in South Anchorage, remain open. They absorbed some of the downtown restaurant's 35 to 40 employees. Johnson laid off 26. She already had cut 12 positions after Christmas, she said.

"I feel bad," Johnson said, "but you have to start cutting your highest cost items."

Labor costs at La Mex went up $200,000 in 2003, the year the state increased its minimum wage from $5.65 to $7.15 an hour, Johnson said.

The cost of workers' compensation insurance is tied to a company's payroll, she said, and that went from $22,000 to $80,000 per year over the past two years.

A higher alcohol tax, a lowered legal breath-alcohol content limit and a smoking ban didn't help, Johnson said.

"People are drinking less," she said, and "your profit is in your alcohol."

La Mex raised prices by 5 percent two weeks ago, Johnson said, to offset rising food costs. She said she was reluctant to change menu prices.

"People are only going to pay so much for a taco," Johnson said.

To cut costs, the restaurants quit serving sizzle-making lemons with their fajitas, saving $500 a month, Johnson said, and started outsourcing kitchen prep work.

Tourist seasons were busy, Johnson said, but not enough to keep the largest of the three locations open.

"That's bad," said Jeramie Ford when he heard the restaurant on Sixth Avenue and I Street was closed. Ford, 28, said he started eating there as a 5-year-old, when he used to have to wait for a table. That hasn't been the case for years, he said, but Ford kept coming for the chicken fajitas.

"It's kind of sad to see it go," he said.

Johnson said her parents started La Mex in 1969 in a Mountain View log cabin that seated 12. There, she said, her mother made guacamole from scratch at customers' tables.

Johnson took over the business in 1990 and opened the South Anchorage location in 1999.

That location will take on the American fare that only the downtown restaurant carried, such as prime rib.

The Grande Ronde will be held at La Mex in Spenard this year, Johnson said, while the King Street restaurant will host Fur Rondy events and the Cinco de Mayo party.

■ Daily News reporter Sarana Schell can be reached at sschell@adn.com.

SB130

FRANK H. MURKOWSKI
GOVERNOR

GOVERNOR@GOV.STATE.AK.US

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

P.O. BOX 110001
JUNEAU, ALASKA 99811-0001
(907) 465-3500
FAX (907) 465-3532
WWW.GOV.STATE.AK.US

March 3, 2005

The Honorable Ben Stevens
President of the Senate
Alaska State Legislature
State Capitol, Room 111
Juneau, AK 99801-1182

Dear President Stevens:

Under the authority of article III, section 18, of the Alaska Constitution, I am transmitting a bill related to the workers' compensation system. This bill proposes discrete improvements to the current system. The goal of these changes is to increase the efficiency and flexibility of the current system, and significantly reduce some of its costs, in order to ensure that benefits will continue to be available in substantially the same form they are today without stifling employment opportunities.

The Legislature has consistently striven to have our workers' compensation system quickly and efficiently deliver fair and predictable benefits to injured workers at a reasonable cost to their employers. Despite those efforts, the current system has not kept pace with the pressures caused by a growing, ever-changing workforce and rising medical costs. In response to complaints regarding delays in resolution of claims and the increasing costs of maintaining the current system, the enclosed bill proposes improvements to several areas.

A significant change proposed in this bill is the creation of a workers' compensation appeals commission. Currently, appeals from Alaska Workers' Compensation Board decisions are heard on a rotating basis by individual superior court judges. The bill proposes to have appeals heard by a five-member commission. This commission, like the board itself, would consist of both lay members representing workers and employers as well as a chair with legal training and workers' compensation experience. Appeals would be heard by a panel both knowledgeable in workers' compensation matters and available to produce consistent, legally precedential decisions in an expeditious manner.

The bill also places increased responsibility for oversight of the system in the hands of the workers' compensation division. The bill would increase the division's ability to investigate fraudulent claims, pursue employers who fail to provide coverage for their employees, and oversee medical costs. Under the current system the division must refer suspected fraudulent claims to other state agencies for investigation. Under this bill, the division would be able to investigate fraudulent claims on its own. The bill would also allow the division to investigate and quickly close down employers who attempt to operate without workers' compensation coverage. The board is then empowered to assess fines for failing to insure and the bill creates a fund to receive those fines and use them to pay benefits to injured workers whose employers failed to insure.

In addition, the bill gives the division additional authority to address medical costs that are now approaching 60 percent of every workers' compensation benefit dollar paid in Alaska. Under this bill, the Commissioner of the Department of Labor and Workforce Development is authorized to empanel a medical services committee. The committee will review the medical benefit delivery system including current charges, as well as the causes for the sharp rise in charges and possible solutions, and make recommendations for appropriate improvements. The committee is charged with reporting its findings and recommendations by March 1, 2007; sufficient time for a thorough study of the costs and appropriateness of the delivery system.

To address the immediate impacts of the recent premium increases and rising direct costs to self-insured businesses, the bill "rolls back" maximum payments to those under the medical fee schedule in effect on December 15, 1999. The bill also authorizes the division to develop a preferred drug list and establishes a statutory preference for generic drugs unless a worker's physician specifies a name brand drug for medical reasons.

The division is assisted in this endeavor by input from employers, insurers, providers, and the use of national, peer-reviewed medical treatment guidelines. Under the current bill, employers, insurers, and providers may agree to charges for services in advance. Workers would be under no obligation to select a physician from this preferred provider list but the rates for these providers' services would be established by contract with the insurer or employer.

The bill also provides the division with guidance in overseeing the efficacy of the medical benefits system. The bill would adopt the American College of Occupational and Environmental Medicine's Occupational Medicine

Practice Guidelines as a benchmark for medical treatment. The Guidelines provide for quality care while promoting some standardization of medical services. However, if a condition is not addressed by the Guidelines or the worker's physician recommends alternative treatment, the physician has the opportunity to provide medical justification for treatment outside the Guidelines.

In addition, the bill provides workers and employers greater flexibility over certain portions of the worker's claim. Currently, parties may not settle any portion of a worker's claim without board approval. The bill would allow parties represented by legal counsel to more quickly resolve a worker's claim by agreement without board approval, thereby freeing the board to focus on settlements needing more scrutiny such as those involving minors or workers unrepresented by counsel. It would also allow the parties to stipulate to a worker's eligibility for reemployment benefits without the expense and delay of a reemployment eligibility evaluation while also making it easier to exchange unwanted reemployment benefits for a limited cash benefit. This greater flexibility will make the reemployment process more efficient and satisfactory to both parties.

The bill further enhances the efficiency of the current system by expanding workers' access to legal counsel and including a limited release of medical information on the report of injury form. The bill allows the division to contract with non-profit organizations to provide legal services to injured workers unable to obtain private legal counsel. It also provides a limited medical release for medical records of treatment for the reported injury on the initial report of injury form. This second change is aimed at reducing unnecessary delays in payment resulting from a lack of supporting medical documentation for an injured worker's claim.

The bill also reduces insurers' costs by phasing out contributions to the Second Injury Fund. That Fund represents a limited mechanism for reducing impediments to the hire of workers with certain listed physical limitations. That mechanism has become outmoded due to developments in contemporary employment standards including the Americans with Disabilities Act. The Second Injury Fund will not accept new claims and will be phased out as currently accepted claims are paid.

The bill would increase the coordination of benefits between the workers' compensation system and other disability systems. This would minimize the instances where double compensation results in a worker receiving combined disability benefits that exceed their take home pay. Finally, the bill would also

cap the compensation rates of workers residing outside the State of Alaska to bring them in line with that paid to Alaska resident workers.

This bill represents a major step in bringing the existing system up to date with the current State of Alaska's work force. These changes to specific parts of the existing law are vital to the continuing survival of the workers' compensation system and the availability of a full range of benefits for injured workers in the future.

I urge your prompt and favorable action on this matter.

Sincerely yours,

Frank H. Murkowski
Governor

Enclosure

## Section by Section Analysis of SB 130[1]

This legislation reforms the workers' compensation system, introduces new protections and a new benefit for injured employees, revises the timing for vocational rehabilitation eligibility, limits certain workers' compensation payments, restricts medical cost liability, and changes the appellate process.

This bill makes no sweeping changes to the Alaska Workers' Compensation Board and system of workers' compensation administration. The Alaska Workers' Compensation Board (board) retains responsibility for regulation and initial adjudication of claims and petitions arising under the act. There are some transfers of function included in this bill, but, in place of many statutory changes transferring administrative functions, this legislation gives the board general power to delegate executive functions of administration and enforcement to the director of the Division of Workers' Compensation (division). The roles of the commissioner of the Department of Labor and Workforce Development and commissioner's designees are clarified: the commissioner's designee on a hearing panel is a hearing officer, but the commissioner, who serves as chairman and voting member of the full board in its executive functions, is there permitted to designate any representative to serve in his or her place.

This legislation contains systemic improvements intended to promote settlement and speed the process of resolving cases. The bill permits settlement of cases without a hearing and board approval if all parties are represented by Alaska counsel, permits the Department of Labor and Workforce Development (department) to contract with a non-profit organization to represent employees otherwise unable to secure counsel, and provides for a consultation fee payable to attorneys without board approval.

This bill does not eliminate or reduce the reemployment benefit[2] but it does make changes intended to reduce costs associated with delays in the reemployment process. This legislation allows parties to agree that an employee is eligible for vocational rehabilitation, thus saving the cost of an eligibility evaluation and associated delay while an eligibility evaluation is done. This legislation eliminates the deadline for requests for eligibility evaluations from 90 days from the date of injury. Instead the right to request an eligibility evaluation is triggered by periods of consecutive days of absence from employment. In addition, an eligibility evaluation is mandated for employees who are absent

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[1] This document was prepared using the text introduced March 3, 2005 and denominated as 24-GS1112\A. This is a revised text, reflecting a change in the introduction text to correct erroneous use of an insurance term. No changes are made to the sectional analysis.

[2] These benefits are often called vocational rehabilitation or retraining benefits.

due to injury for 90 consecutive days from their employment. These changes are intended to bring the process of vocational rehabilitation planning closer to the point that the employee has experienced significant absence from work. Finally, for those employees found eligible for reemployment benefits, this legislation provides a job dislocation cash benefit if the employee elects not to undertake reemployment planning.

Another significant cost to the system is addressed by a series of changes designed to lower medical costs. Generic drugs are required unless medical necessity justification is provided in writing. The department is directed to create a "preferred drug" list or formulary, a common feature of group health insurance plans. Again, off-list drugs may be dispensed if medical necessity justification is provided. Employers are given permission to form groups to negotiate "preferred provider" lists – but use of the listed physicians by workers is voluntary. Fees for medical treatment and services, which are subject to regulation, are capped at the usual, customary, and reasonable rates in effect in 2000.[3] Finally, in order to address the subject of medical costs in the future, the Commissioner is empowered to appoint a committee, which is directed to study the subject and to make a report to the commissioner and Governor by March 1, 2007.

Other deficiencies in the current system are addressed. The director is given stronger enforcement tools, including power to issue stop orders against uninsured employers without hearing, provided an investigation has revealed substantial evidence that the employer is uninsured. The stop order may be followed by a hearing before the board to assess substantial civil penalties against uninsured employers. The director may also petition the board for a stop order. The civil penalties will be paid to a fund used to pay claims of injured workers employed by uninsured employers. In order to prevent "mining" of workers' compensation division records, the division is also prohibited from assembling or providing otherwise public information on claims to persons for commercial purposes unrelated to the purposes of the workers' compensation act.

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[3] Rates are determined by the Board by regulation, defining what is "usual, customary and reasonable". The Board set the "usual, customary, and reasonable" rate at the "90th percentile of the range of charges" (8 AAC 45.082(i)).

The 90th percentile of range of charges means that in a community for which charges in a given period vary between $50 and $150 for a service, with two providers charging less than $90, seven providers charging $90 to $120, and only one provider charging $150, the "90th percentile" does not refer 90% of the difference between the highest and lowest, nor the number of providers charging any amount, nor 90% of any charge. It is an artificial number to which 90% of all charges in the community will be equal or less. In this community example, the 90th percentile could be any number below $150. The result of this method is that the 90% percentile rises as charges increase.

The director is also given substantial powers to investigate fraud. Persons who report fraud are granted immunity, and other persons are required to report known fraud. The criminal statute relating to workers' compensation fraud is improved by the addition of definitions and rewording so as to limit ambiguities.

Two changes to compensation benefits are included in the bill, which will not apply to most employees. First, compensation paid to non-residents is capped at the rate that would be paid if the recipient resided in Alaska. Second, for workers whose employers belong to the Public Employees Retirement System (PERS) or Teachers Retirement System (TRS), an offset for PERS or TRS disability benefits is allowed against workers' compensation total disability payments, so that the combined benefits do not exceed 100% of the employee's spendable (after tax) wages. The cap on combined offset benefits is reduced to 80% of the employee's spendable wages when the employee is receiving reemployment benefits instead of compensation. Permanent partial impairment compensation is not reduced or offset, unless the employee is in a reemployment process receiving weekly payments of permanent partial impairment compensation at the temporary total disability rate under AS 23.30.041(k). In that case, the weekly permanent partial impairment compensation would be paid at the offset temporary total disability compensation rate. A similar off-set is permitted for workers who receive a disability benefit through an ERISA trust or employer contribution funded plan, provided the trust or plan does not already take an offset for workers' compensation. This eliminates "double dipping" by employees whose combined benefits exceed their wages.

Another feature of this bill is the elimination of the Second Injury Fund – a pre-statehood mechanism intended to encourage hiring workers with certain listed conditions.[4] The list, which includes conditions as varied as polio, varicose veins, and the bends, has not been altered since its inception. The fund will be phased out, with delayed

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[4] The fund was intended to encourage hiring employees with certain conditions by mitigating, to a limited extent, a potential employer's concern that hiring an employee with a listed condition would result in a greater liability if the employee were injured. The fund reimburses an employer for compensation payments made after two years of disability benefits have been paid, if the employee suffers a "second" injury that "aggravates, accelerates, or combines with" the listed condition to bring about a greater disability. The fund does not reimburse medical or other benefits. The fund also requires the employer to have written knowledge of the condition before hiring or retaining the employee. Court interpretation of fund eligibility qualifications, subsequent legislative changes in other parts of the act, and the impact of the Americans with Disabilities Act have led to inconsistent application of the fund's benefits among employers and the expansion of its possible liabilities beyond its capacity to assess insurers and self-insured employers.

amendments eliminating the fund once all liabilities incurred by the deadline established in this bill are satisfied.

This legislation also changes the appellate process to encourage consistency in legal interpretation and reduce delays on appeal. A commission acts as an appellate body with broad powers of review. The commission is balanced by appointment of two citizen representatives of employees and two citizen representatives of employers and a single chairman who acts as the executive of the commission. The chairman is an exempt employee. The commission's decisions are published and binding on the hearing panels. The commission's decisions may be appealed directly to the Supreme Court, without review by the Superior Court. Its jurisdiction is confined solely to appellate review of board decisions.

Finally, changes are made in the insurance statutes to exempt reciprocal insurers from participation in the assigned risk pool, require special deposits of insurers, and permit the director to seize and release the deposits to the Alaska Insurance Guaranty Association for claims payment in the event of insurer insolvency.

The workers' compensation act is lengthy and complex and this bill addresses a number of subject areas. Care should be taken to review all provisions in a subject area, and to read this bill in the context of the unamended act. This legislation also contains a number of what are essentially conforming amendments, delayed amendments, or transitional provisions.

**Section 1** is a declaration of legislative intent to reform the workers' compensation insurance system to ensure payment of benefits when an insurer becomes insolvent and reduce the costs of workers' compensation premiums to employers. This expression of intent applies only to sections 2 through 4 of the bill.

**Section 2** creates new statutory provisions, AS 21.09.090(e) and (f), which provide additional financial protection for Alaskan workers in the event that a workers' compensation insurer becomes insolvent and unable to pay claims. Under these new provisions, insurers who are authorized to transact workers' compensation insurance in this state must maintain in the state a separate deposit for the protection of persons covered by workers' compensation insurance issued by the insurers that is in addition to the deposit required of insurers under AS 21.09.090(b). This new deposit will be based on collateralization of an insurer's loss reserves, but will not be less than $100,000.

**Section 3** creates a new statutory provision, AS 21.24.130(f), which provides that if an insurer becomes insolvent in any state, the insurer's deposit in Alaska, provided in Section 2 above, will be immediately available to the director of

the division of insurance for release to the Alaska Insurance Guaranty Association to pay workers' compensation claims of eligible employees covered under policies issued by the insolvent insurer. No part of the deposit may be paid to an insolvent insurer's receiver until all workers' compensation claims under the insolvent insurer's policies have been paid. This revision provides additional financial protection for Alaskan workers in the event that workers' compensation insurer becomes insolvent and unable to pay claims.

**Section 4** amends AS 21.39.155(a) to exempt all reciprocal insurers from the requirement of participating in the assigned risk pool, not just reciprocal insurers formed by a group of municipalities or non-profit public utilities. This change will mean that reciprocal insurers formed by certain industry groups will not be required, like other insurers, to insure employers in the assigned risk pool.

**Section 5** amends AS 23.30.05.067(a)(1)(B) to remove a reference to the second injury fund. This amendment conforms to the repeal of AS 23.30.205 at section 49 below. It will not be effective until the commissioner of the Department of Labor and Workforce Development certifies that all Fund obligations are satisfied. See section 59 below.

**Section 6** codifies a statement of legislative intent relating to the workers' compensation system. Subsections 1 through 3 replicate earlier statements of legislative intent that the workers' compensation laws ensure a quick, efficient, fair and predictable delivery of benefits to injured workers, at reasonable cost to employers, that cases be decided on their merits, and that the chapter not be construed to favor either party. Subsection 4 emphasizes the intent that proceedings be impartial and fair and that all parties be afforded due process.

**Section 7** amends AS 23.30.005(a) to require that a hearing officer [instead of any person] be designated by the commissioner to sit as the commissioner's representative on a hearing panel when the commissioner does not sit on the panel. The section is also amended to provide that the board shall by regulation provide procedures to avoid conflicts and the appearance of impropriety in hearings. This change directs the board to expand the scope of its regulations beyond the provisions of the Executive Ethics Act, AS 39.52, applicable to members of boards and commissions, to address avoiding "the appearance of impropriety" as well as conflicts of interest.

**Section 8** amends AS 23.30.005(b) to again clarify who may be appointed to represent the commissioner on a hearing panel (a hearing officer) while retaining the commissioner's broad discretion to designate a person to represent him as chairman and executive officer of the full board. The amendment also clarifies that hearing officers are not members of the full board.

**Section 9** adds two new statutory provisions to AS 23.30.005. New subsection (m) authorizes the department to contract with a non-profit organization to provide

employees information regarding workers' compensation proceedings and legal representation in proceedings before the board and commission. The intent is to provide some legal services to those persons unable to secure representation from attorneys practicing in the field.

**Section 10** adds three new statutory provisions. The first, AS 23.30.007, establishes a new workers' compensation appeals commission within the Department of Labor and Workforce Development, with jurisdiction to hear appeals of board decisions arising under the workers' compensation act. The commission consists of five members who are appointed for staggered terms of five years. The members are appointed by the governor and confirmed by a majority of the legislature. The governor may make appointments to fill vacancies in the same manner for the completion of the vacant term. A majority of the members is a quorum. Four members are citizen members, compensated for their service at $200/day. The citizen members are equally drawn from those who represent employees and those who represent employers. Member qualifications are described. In addition to meeting member qualifications, the chair must be licensed to practice law in Alaska and have five years experience of workers' compensation law. The chair is a full time exempt service employee paid at Range 27. All members shall take the oath of office. Reasons for removal by the Governor of a commission member are set out, as well as an opportunity to respond to the Governor's charges. Reasons for removal include: misconduct in office, ethical violations, conviction of a felony, conviction of a misdemeanor regarding workers' compensation, inability to serve or handle the caseload, incompetence, and failure to meet the requirements of office. A panel of two citizen members (one employee representative and one employer representative) and the chair will hear appeals. To conduct other business, the chair and equal numbers of employee and employer representatives must be present. Reasons for disqualification for conflicts are set out in detail, as well as a general disqualification if the member is unable to fair, impartial, and unbiased toward an appeal participant. To prevent delay in the appeal process, if the chair is disqualified, or unavailable for more than ten days, the commissioner of labor may appoint a chair *pro tem*. The commission must be housed separately from the division to mark the separation of the appeal process in the workers' compensation system from the board and division's administrative and enforcement process.

Section 10 also, in the new statutory provision AS 23.30.008, sets out the powers and duties of the new workers' compensation appeals commission and, in AS 23.30.009, the powers and duties of the chair of the commission. The commission replaces the superior court as the body hearing administrative appeals in the workers' compensation system, and its decisions will be binding and have the force of legal precedence. The commission's decisions are final

and conclusive, except that the Supreme Court may review the commission's decisions. The commission indexes and publicizes its formal decisions. The commission has the power to adopt regulations drafted and proposed by the chair, as well as rules of procedure for hearings and appeals, to adopt an official seal, and generally to carry out the powers and duties expressly granted or necessarily implied by the Act. The commission shall award attorney fees to successful appellants, but, as currently is the rule, attorney fees may not be awarded against an employee unless the appeal was frivolous, unreasonable or taken in bad faith.

The chair of the commission exercises general supervision of the office of the commission. The chair has the power to employ and supervise staff, assign work, and members to hearing panels, establish a time management system, manage the calendar of hearings and prepare the annual budget of the commission. The chair must prepare and make public an annual report of the commission's performance. The chair is barred from other employment and may not hold any other public or tribal office, nor hold office or position in a political party.

**Section 11** amends AS 23.30.012 relating to settlement of claims. It divides the current statute into two subsections. It transfers from the board to the director the power to approve the form of settlements. New provisions require that settlements be filed in the division, and, upon filing with the division, makes the settlement effective and enforceable as an order of the board. This is a change from current law, which requires all workers, regardless of representation or circumstances, to obtain board permission to settle their claims and approval of the negotiated terms.

However, a new provision requires that in cases where workers are not represented by an attorney licensed to practice in this state, or where a beneficiary is a minor or incompetent, the settlement must be reviewed by a hearing panel and may be approved when it is in the best interests of the worker or beneficiary. The hearing panel may hold a hearing and require an impartial medical examination before deciding whether to approve a settlement. This amendment parallels court practice in requiring review of minor or incompetent settlements.

**Section 12** amends AS 23.30.015(e) to eliminate a reference to payments to the second injury fund. As provided by section 59 of this bill, this amendment is not effective until the liabilities of the fund have been fully satisfied.

**Section 13** amends AS 23.30.041(a) to reassign from the board to the director power to employ the reemployment benefits administrator and to authorize the administrator to employ a staff. This transfers hiring and oversight of the

administrator and staff to the director of the division of workers' compensation.

**Section 14** repeals and reenacts AS 23.30.041(c) to substantially change the timing of eligibility evaluations. As unamended, current law requires an injured employee to request an evaluation to determine eligibility for re-employment benefits within 90 days of injury. This deadline may be forgiven if the employee shows "unusual and extenuating circumstances". In practice, such circumstances are frequently found to exist, as where the employee's physician did not tell him or her that a return to work may not be possible or did not predict the employee will have a permanent impairment. As a result, there are lengthy delays in the return to work process. As reenacted, this section contains a new provision allowing employers and employees to agree that the employee is eligible for retraining, without incurring the cost of an evaluation or waiting for a permanent impairment prediction. Also new, the administrator is required to notify injured employees of the right to an evaluation if the employee sustains 45 consecutive days of total disability. There is currently no requirement that employees be notified of their right to an evaluation before the deadline expires. Without regard to time after the date of injury, a right of the employer or employee to request an evaluation is triggered by 60 days of consecutive total disability and, if an employee is totally disabled by the injury for 90 consecutive days, an eligibility evaluation is required. The standards for eligibility are not changed. The intent of this section is to reduce costs by encouraging agreements, promoting early attention to the issue of potential need for retraining by employees, employers, and physicians, and assuring that employees with serious, disabling injuries are provided evaluations as soon as possible.

**Section 15** amends AS 23.30.041(f) to add an additional disqualification for reemployment benefits. This section provides that if an employee is found eligible for reemployment benefits, (which necessarily includes a physician's prediction of inability to return to the employment at the time of injury), and the employee declines reemployment benefits in favor of a job dislocation benefit (see section 16), the employee will be ineligible for reemployment benefits in the future if the employee returns to work in the same or similarly demanding occupation as when previously injured and is injured again. This subsection parallels the current disqualification of an employee who recieves reemployment benefits but who returns to work in the same or similarly demanding occupation as when previously injured and is injured again.

**Section 16** amends AS 23.30.041(g) to provide that an employee who is eligible for reemployment benefits but elects not to use the benefits may take a job dislocation benefit instead. The intent of this section is to encourage employees who are eligible for retraining to seriously consider their options

and encourage prompt entry into plan development, and, by making the alternative to retraining less attractive, to provide a disincentive to the practice of delaying plan development in hopes of increasing the settlement value of reemployment benefits, or of beginning plans the employee has no real interest or inclination to pursue in order to continue receiving payments. Finally, it provides a small benefit not previously available to those employees who genuinely desire to retire from the active labor market or to pursue plans of their own without direction from the workers' compensation system.

**Section 17** amends AS 23.30.041(j) to modernize the language.

**Section 18** amends AS 23.30.041(p) to replaces the board with the director as the holder of a public meeting to select a proposed date on which a new edition of the US Department of Labor's Dictionary of Occupational Titles shall be implemented. The department replaces the board as the agency selecting the date proposed and the director replaces the board as the person giving notice of the selected date.

**Section 19** amends AS 23.30.041(q) to replace the board with the division as the agency receiving filed waivers of rehabilitation benefits and serving notices of the waivers. The amendment also replaces the board with the director as the agency proscribing or approving the form of such waivers.

**Section 20** amends AS 23.30.080(d) regarding proceedings to obtain stop work orders against uninsured employers. The amendment provides that the director may petition the board for a stop work order, replacing the general grant of authority of the board to issue a stop work order. The amendment clarifies the role of the director and the form of procedure to be used - one pursuant to the board's petition process provided in regulation (8 AAC 45.050) instead of one based on a notice of accusation.

**Section 21** creates two new statutory provisions relating to penalties against uninsured employers and stop orders. New subsection AS 23.30.080(e) authorizes the director to issue a stop order after an investigation by a department officer reveals substantial evidence that the employer is not insured or has no self-insurance certificate. The director must dissolve the stop order on receipt of proof of insurance or a self-insurance certificate. In addition, the director may petition the board to assess a civil penalty if the employer fails to obey the stop order.

New subsection AS 23.30.080(f) authorizes the division to petition the board for a civil penalty of up to $1,000/day of employment per uninsured employee. New subsection AS 23.30.080(g) permits the director to declare an employer in default if the employer fails to pay a civil penalty under subsection 080(d) (failing to comply with a board stop work order, $1000 per day), subsection 080(e) (failing to comply with a director stop work order,

$1000 per day), or subsection 080(f) (failure to insure employee $1,000 per employee per day) within seven days of the date ordered. Upon filing a certified copy of the penalty order and a declaration of default with the clerk of the superior court, the court shall enter judgment for default. The attorney general, as requested by the director, shall take appropriate action to collect on the default judgment, and a writ of execution may be issued on the judgment. The person against whom the judgment is issued may seek court review of the judgment as allowed by the Civil Rules.

**Section 22** creates a new section, AS 23.30.082, establishing a workers compensation benefits guaranty fund to assist injured employees of uninsured employers. The fund is established in the general fund, comprised of the civil penalties paid under section 080, income earned by investment, money deposited in the fund by the department and appropriations to the fund. The fund may be used to pay claims, expenses of the fund, and legal expenses. The Department of Revenue shall inform the division of the fund balance and interest income. Subsection (c) provides for injured employees to file a claim against the fund and preserves the rights of the fund to defend claims. Subsection (d) provides that the fund is subrogated to all rights of the employee, and is assigned all rights of the employee against the uninsured employer to the extent of payment by the fund. Money collected shall be paid to the fund. Claims will be paid in the order made against the fund. Finally, the division is authorized to contract for adjustment of claims against the fund.

**Section 23** amends AS 23.30.095(j) to reassign from board to the commissioner authority to appoint a medical services review committee or contract with organizations to assist and advise the department and the board in matters respecting medical care under the workers' compensation act.

**Section 24** amends AS 23.30.095 to add two new subsections. The first, subsection (n) requires pharmacists to dispense generic medication where a generic is available and the prescriber does not provide written justification of medical necessity for the brand name product. This subsection also requires the department to establish a preferred drug list for use under this subsection, but also allowing prescribers to depart from the list when medical necessity justifies departure. The department shall make a regulation for the process to establish medical necessity.

The second new subsection, (o), for purposes of determining what medical treatment or services the employer is liable for under AS 23.30.095(a), establishes a rebuttable presumption of correctness of the recommended treatment guidelines of the American College of Occupational and Environmental Medicine in effect at the time treatment is provided. The presumption may be rebutted by a preponderance of scientific evidence that a variance is reasonably required. For injuries not covered by the guidelines,

the board may adopt other scientific, evidence-based guidelines generally recognized by the national medical community.

**Section 25** creates a new statutory section, AS 23.30.097, dealing with payment of medical benefits. This section provides that all fees and charges for medical treatment or services under the act are subject to board regulation and that an employee may not be required to pay a fee or charge covered by the workers' compensation act. The fee or charge may not exceed the lesser of the usual, customary, and reasonable fee published on December 15, 1999 (and in effect to March 2001), or the payment negotiated by an employer under the preferred provider process. Provision is made to allow employers or groups of employers to negotiate with physicians to establish preferred provider lists and fees for services, but the selection of a physician on the list is voluntary and an employee must be so advised. No attempt to influence treatment or rating decisions can be made in negotiating the list. Selection of a physician for inclusion on the list does not affect the employer's right to chose an independent medical examiner. Subsection (d) of this provision parallels former AS 23.30.095(*l*), repealed in section 48 below, and provides that payment of bills for medical treatment must be made within 30 days after the date that the employer receives the bill or a completed report as required by AS 23.30.095(c), whichever is later. Subsection (e) of this provision duplicates former AS 23.30.095(m), repealed in section 49 below, relating to payment of pharmacy and travel charges, and reimbursement of third party payers such as health insurers.

**Section 26** amends AS 23.30.100(b) to require that the notice of an injury or death given under the workers' compensation act contain a consent by the employee to release medical records of treatment of the injury or death to the employer's adjuster and the board. This "release" is limited solely to records of treatment of the reported injury or medical records of the death, and does not replace the consent to release information contained in AS 23.30.107. The intent of this amendment is to speed the process of payment of medical expenses by allowing adjusters to immediately request treatment records for the reported injury and encourage physicians to comply with AS 23.30.095(c) by making reports of treatment to the employer and the board.

**Section 27** amends AS 23.30.107(b) to add the division and commission as the agency where workers' compensation files are maintained. The amendment also adds the division and commission as agencies that may release records as provided by the statute and adds the commission as an agency authorized to discuss records in a decision.

**Section 28** amends AS 23.30.107 by adding a new subsection that prohibits the division from assembling or providing information contained in individual workers' compensation files for commercial purposes outside the scope of the workers'

compensation act. The intent of this provision is to prevent "mining" of division records for commercial purposes, such as investment solicitations, credit agencies, and the like. It is not intended to prohibit disclosure of, for example, public record information regarding a specific claim to a newspaper reporter, an insurer seeking the names of employers who are uninsured for purposes of soliciting contracts to provide workers' compensation insurance, or an investigator for a law firm representing an injured worker asking for public information regarding other similar claims filed against the same employer. This provision does not alter other subsections providing that medical and vocational reemployment records in a claim are not public records

**Section 29** repeals and reenacts AS 23.30.122, relating to determinations of the credibility of witnesses. As provided by the former statute, the board has the sole power to determine credibility of witnesses, but the amendment removes language relating to the conclusiveness of the board's findings regarding the weight of the evidence. Section 31 transfers to the commission the authority to make conclusive findings concerning the weight of evidence.

**Section 30** repeals and reenacts AS 23.30.125 relating to review of compensation orders. It replaces superior court review of board decisions with commission review of compensation orders. The amendment sets a date on which compensation orders are final unless review is undertaken. It makes explicit that the commission has the power to review board decisions and orders, and that orders may not be suspended, reconsidered or set aside except through the commission process. This amendment also creates a provision for stays of orders pending appeal. It requires a party seeking a stay to produce evidence of irreparable damage. If a party seeks a stay of continuing periodic compensation payments, the party seeking the stay must demonstrate that the appeal is likely to be decided adversely to the compensation recipient. The commission may allow a hearing on the stay on three days notice to the parties in interest.

**Section 31** creates three new statutory provisions relating to commission review of board decisions, commission procedure on appeal, commission authority to review and judicial review of commission proceedings. The first new statute, AS 23.30.127, establishes the basic procedure for appeal to the commission. This provision allows the director to intervene in an appeal. If a party does not have legal representation and the order appealed concerns an unsettled question of law, the director may file an appeal to obtain a ruling. The intent is that the director would not represent the party, but, in order to insure that the unsettled issue of law of importance to the system is fully examined, would be able to exercise discretion to file an appeal. This provision sets a 30-day period for appeal of a compensation order or a director decision. It

describes the documents that must be filed with the commission to initiate an appeal and a cross-appeal. It authorizes the commission to charge a fee up to $100 for filing appeals and cross appeals, but exempts the state and political subdivisions of the state from the filing fee. It authorizes the commission to require an appellant to pay costs of preparing a transcript and preparing the record on appeal. Cross appellants and intervenors may be required to share in the costs. This provision grants the commission general authority to make rules and orders for the prompt fair and just disposition of appeals and authorizes the commission to require written briefs.

The third new statutory provision, AS 23.30.128, establishes the commission's authority to review and act on appeals. The commission hears appeals in panels of three members, the chair, and one citizen member representing employees, and one citizen member representing employers. The panel decision is the decision of the commission. The commission may review de novo all exercises of discretion, factual findings, and legal conclusions below, except that board findings regarding the credibility of a witness who appeared in the hearing is binding on the commission. Other finding, including the weight given expert evidence, may be set aside by the commission. If not set aside, the board's findings are conclusive. This statute provides that the commission review will be on the record, except that briefs and argument shall be allowed. The exception is that the commission may receive evidence in applications for a stay of a decision by the board, attorney fees and costs of appeal, waiver of fees for indigent appellants, and dismissal of appeals for failure to prosecute or settlement. This provision also gives the commission wide discretion to act on appeal. The commission may expedite appeals. It may affirm, reverse or modify a decision; remand matters it determines were improperly or insufficiently developed, or remand for further action without relinquishing jurisdiction. The commission members who heard an appeal must decide whether to grant reconsideration. The commission may reconsider its decisions on specific grounds listed in subsection (f): misapplication or failure to apply directly controlling law; overlooking or misconceiving a material fact; misunderstanding a material question in the case presented on appeal; or, applying law that has subsequently changed. AS 44.62 does not apply to proceedings of the commission. This provision balances shorter time for appeal and reconsideration (30 days) with sufficient time for collegial consideration of the merits of the appeal before a commission decision (90 days). This provision sets out clearly when a decision of the commission is final, to avoid confusion as to dates of finality.

The third new statutory provision exempts the commission from the grant of superior court jurisdiction over judicial appeals of administrative agency decisions contained in AS 44.62.590 and states that commission orders may

not be otherwise appealed to the superior court. The purpose of this provision is to eliminate appeal to the superior court, and to provide that decisions of the commission may be appealed directly to the Supreme Court. This provision withdraws workers' compensation appeals from the jurisdiction of the superior court, which the legislature may do by law. See Art. IV, Sec. 1 of the Alaska Constitution, see also AS 22.10.020(d). It does not encroach on the judicial power reserved to the courts under Art. IV, Sec. 15, because incidental effects of substantive change do not trigger Art. IV, Sec. 15 requirements. See, *Wienegardner v. Greater Anchorage Borough Bd. Of Equalization*, 534 P.2d 541, 547 n. 18 (Alaska 1975). This provision does not affect the right to seek declaratory judgment in superior court on matters affecting workers' compensation law, as, for example, to declare a regulation invalid or to require coverage under an insurance contract. This provision also establishes the standard of review for commission findings of the weight to be accorded witness testimony, undisturbed findings of the board, and commission findings of fact, which must be supported by substantial evidence in light of the whole record.

**Section 32** creates a new statutory provision, AS 23.30.175(b)(5), which caps compensation paid to non-resident recipients at the compensation rate the recipient would receive if residing in Alaska. The effect of the amendment is to allow compensation rates paid to a non-resident to decrease by cost of living adjustments for the recipient's area of residence, but caps any increase due to a cost of living adjustment in the recipient's area of residence so that the recipient's compensation rate does not exceed what he or she would receive in Alaska.

**Section 33** amends AS 23.30.175(c) to transfer the authority to provide cost of living comparisons from the board to the department and to replace annual redeterminations of cost of living comparisons with redeterminations every three years.

**Section 34** amends AS 23.30.205(e) to replace the commissioner with the director for receipt of notice of award or adjudication respecting the second injury fund.

**Section 35** adds a new subsection (g) to AS 23.30.205 setting a final deadline for filing of claims for reimbursement against the second injury fund, thus limiting the fund's liabilities and phasing out the fund. The fund is granted a period in which to accept or claims filed, and pending claims may be included by decision by the board.

**Section 36** adds a new section providing for coordination of certain disability benefits and workers' compensation payments. For employees benefiting under AS 39.35 or AS 14.25, the employer's liability for total disability compensation under AS 23.30.180 or 185 is limited to the lesser of the

difference between the employee's spendable weekly wages and the disability benefits the employer payable to the employee under AS 14.25.130, or AS 39.35.400 or 39.35.410 or the maximum compensation rate. The intent is that the combined workers' compensation and disability benefit should not exceed the employee's after tax wages, and that an "off-set" is allowed for disability benefits against workers' compensation payments. The employee whose workers' compensation and disability benefit, combined, do not exceed his or her spendable weekly wages should continue to receive the workers' compensation to which the employee is otherwise entitled. For employees who are not receiving total disability compensation, but who are receiving benefits under AS 23.30.041(k), the employer's liability is limited to the lessor of the combination of the AS 23.30.041(k) benefit and disability benefits up to 80 percent of the employee's spendable wages or 105 percent of the state average weekly wage (i.e. AS 23.30.041(k) benefit). Thus, the disability benefit is off-set against the employer's liability for AS 23.30.041(k) benefits. Similar provisions are also included for employees who are eligible for disability benefits from an employer-contributed union or group insurance plan or welfare trust, provided, however, that the benefit from the plan or trust does not make an off-set for workers' compensation benefits paid to the employee. The purpose of this provision is to eliminate the circumstance of employees receiving employer-funded disability benefits and workers' compensation, tax free, that together exceed what they would have received, after taxes, had they not been injured. This section does not limit the employee's benefits on account of private disability insurance or group disability insurance procured through other means (such as membership in trade or professional organizations) than those specified in this provision.

**Section 37** amends AS 23.30.240 to include members of limited liability companies in the catch line and replace the director of the division of workers' compensation for the commissioner as the person approving executive officer waivers.

**Section 38** amends AS 23.30.240 to add a new subsection providing that members of limited liability companies are not employees, except at the affirmative election of the company, which must specify the member for the period of coverage. When the coverage lapses, the specified member's inclusion as an employee also lapses and must be affirmatively renewed by the company to continue.

**Section 39** amends AS 23.30.247(c) to eliminate a reference to the second injury fund. As provided in section 59, this amendment does not take effect until the liabilities of the fund are fully satisfied.

**Section 40** creates a new section relating to fraudulent acts or false or misleading statements in workers' compensation. Provisions for civil reimbursement for benefits obtained through fraudulent acts or false or misleading statements,

formerly in AS 23.30.250(b), are moved to this section, and the standard of proof of fraudulent acts or false or misleading statements is clarified. The form of the statute conforms to modern usage.

This section also provides civil immunity for a person who furnishes information regarding fraud in good faith to law enforcement officials, the division, the division of insurance in the Department of Commerce, Community and Economic Development, or an insurer or risk manager of a self-insured employer. The immunity is not extended to those whose liability is the result of reckless, willful or intentional misconduct. In addition, an insurer, adjuster or risk manager is required to report information about suspected fraud to the director, and is immune from civil liability for making such a report. The provision grants the director authority to investigate reports of fraud, and, if the director finds credible evidence of fraud, to refer the facts to a prosecutor and to the affected insurer. If the fraud was perpetrated against the division, the director may seek an order of forfeiture against the person, precluding the person from future benefits. The director's investigations are made confidential, unless a court directs public inspection. The director is given power to obtain information outside the state, through other state's officials, and to cooperate with officials outside the state. Definitions are provided of "fraudulent acts", which include actions by persons other than an employee.

**Section 41** amends AS 23.30.250, relating to criminal penalties for fraudulent acts or false or misleading statements. The section is reserved to the criminal statute, incorporating former AS 23.30.250(a), and civil restitution is moved to a new section. (See section 40, above.) A new subsection (b) incorporates definitions to assist the prosecution of fraud under this section.

**Section 42** amends AS 23.30.260 to add a new subsection (b) that provides that an attorney may charge up to $300 for one-time only consultation with a claimant. This provision gives statutory authority for a regulation that presently exists allowing such fees.

**Section 43** amends AS 23.30.395 to add new subsections defining the commission, director, department, commissioner, and division.

**Section 44** amends AS 37.05.146(c) to include the workers' compensation benefit guaranty fund in the list of accounts within the general fund.

**Section 45** amends AS 39.25.110 to include the chair of the commission in the exempt service.

**Section 46** amends AS 39.25.120(c)(14) to remove a reference to the board and substitute the division as the employer of the rehabilitation administrator.

**Section 47** amends AS 39.50.200(b)(31) to add the commission.

**Section 48** repeals AS 23.30.095(f), 23.30.095(*l*) and 23.30.095(m). The complete provisions of AS 23.30.095(*l*) and 23.30.095(m), and portions of AS 23.30.095(f), are now contained in new statutory section AS 23.30.097 (see section 25 above).

**Section 49** repeals sections creating, operating, or relating to the second injury fund: AS 23.30.015(c), 23.30.040, 23.30.205, 23.30.395(27), and AS 37.05.147(c)(12). The intent is that upon the effective date of this section (see section 59 below), the second injury fund is fully disestablished.

**Section 50** creates a new provision of uncodified law that provides that the cap on rates paid to out of state claimants shall apply only to injuries occurring after the effective date of the provision establishing the cap.

**Section 51** creates a new provision of uncodified law setting the initial terms of the commission to achieve staggered terms as provided in AS 39.05.055.

**Section 52** creates a new provision of uncodified law permitting the director to lend staff temporarily to the commission for a period of six months after the effective date of the provision creating the commission.

**Section 53** creates a new provision of uncodified law that provides for continuation of effect notwithstanding a transfer of function from the board to the director or the institution of the commission as an appellate body for workers' compensation appeals. This provision also continues in force all regulations, orders, decisions, or certificates issued by the board until revoked, modified or vacated under the provisions of this bill; continues in effect all contracts, rights, liabilities or obligations.

**Section 54** creates a new provision of uncodified law permitting the director of insurance in the Department of Community and Economic Development and Department of Labor and Workforce Development to proceed to adopt necessary regulations to implement this bill, but not before the effective date of the bill.

**Section 55** creates a new provision of uncodified law directing that any money remaining in the second injury fund shall be transferred to the general fund. The effective date of this section is delayed until the full satisfaction of the fund's liabilities. See section 59 below.

**Section 56** creates a new provision of uncodified law directing the commissioner to appoint a medical services review committee pursuant to AS 23.30.095(j), as amended by this act, to make a study of provision of medical treatment and services, and the cost of such benefits, and to report its findings to the commissioner by March 1, 2007.

**Section 57** provides that the cap on compensation paid to out-of-state recipients applies only to persons injured after the effective date of the section establishing the cap.

**Section 58** provides an effective date of September 1, 2005, for the insurance provisions (sections 1-4), the cap on benefits paid out-of-state recipients, and the directive to appoint the medical services review committee.

**Section 59** provides a delayed effective date for the repeal of the second injury fund (see section 49) and amendments to delete references to the second injury fund. The delayed effective date is the date the commissioner certifies that all remaining liabilities of the fund are satisfied.

**Section 60** provides an effective date of August 1, 2005 for all other provisions of the act.

ORIGINAL INVESTIGATION

# Comparative Analysis of Individuals With and Without Chiropractic Coverage

## *Patient Characteristics, Utilization, and Costs*

*Antonio P. Legorreta, MD, MPH; R. Douglas Metz, DC; Craig F. Nelson, DC, MS; Saurabh Ray, PhD; Helen Oster Chernicoff, MD, MSHS; Nicholas A. DiNubile, MD*

**Background:** Back pain accounts for more than $100 billion in annual US health care costs and is the second leading cause of physician visits and hospitalizations. This study ascertains the effect of systematic access to chiropractic care on the overall and neuromusculoskeletal-specific consumption of health care resources within a large managed care system.

**Methods:** A 4-year retrospective claims data analysis comparing more than 700 000 health plan members with an additional chiropractic coverage benefit and 1 million members of the same health plan without the chiropractic benefit.

**Results:** Members with chiropractic insurance coverage, compared with those without coverage, had lower annual total health care expenditures ($1463 vs $1671 per member per year, $P<.001$). Having chiropractic coverage was associated with a 1.6% decrease ($P = .001$) in total annual health care costs at the health plan level. Back pain patients with chiropractic coverage, compared with those without coverage, had lower utilization (per 1000 episodes) of plain radiographs (17.5 vs 22.7, $P<.001$), low back surgery (3.3 vs 4.8, $P<.001$), hospitalizations (9.3 vs 15.6, $P<.001$), and magnetic resonance imaging (43.2 vs 68.9, $P<.001$). Patients with chiropractic coverage, compared with those without coverage, also had lower average back pain episode–related costs ($289 vs $399, $P<.001$).

**Conclusions:** Access to managed chiropractic care may reduce overall health care expenditures through several effects, including (1) positive risk selection; (2) substitution of chiropractic for traditional medical care, particularly for spine conditions; (3) more conservative, less invasive treatment profiles; and (4) lower health service costs associated with managed chiropractic care. Systematic access to managed chiropractic care not only may prove to be clinically beneficial but also may reduce overall health care costs.

*Arch Intern Med. 2004;164:1985-1992*

*From the Department of Health Services, UCLA School of Public Health, Los Angeles, Calif (Dr Legorreta); American Specialty Health Plans, San Diego, Calif (Drs Metz and Nelson); Health Benchmarks Inc, Woodland Hills, Calif (Dr Ray and Chernicoff), and Department of Orthopedic Surgery, Hospital of the University of Pennsylvania, Philadelphia (Dr DiNubile). Dr Metz is a corporate officer of American Specialty Health Plans.*

In the United States, back pain is the second leading cause of physician visits and is second only to childbirth for hospitalizations.[1] It is also the most prevalent chronic medical problem, the number one cause of long-term disability, and the second most common cause of restricted activity and use of prescription and nonprescription drugs.[2-4] Ten years ago health expenditures for chronic back pain were estimated to be $50 billion to $100 billion annually,[4] and studies[1,3] suggest expenditures have risen exponentially since that time. Epidemiologic studies also indicate an upward trend for back pain in both men and women,[5] a trend that is likely to continue as the average age of the US population continues to increase.

*For editorial comment see page 1953*

## EFFICACY AND SAFETY OF CHIROPRACTIC CARE FOR BACK PAIN

There is evidence supporting the efficacy of chiropractic care for back pain.[1,3] A comprehensive review[6] of the literature evaluating the efficacy of chiropractic treatments for low back pain and other conditions reported that randomized control trials "show spinal manipulation to be better, and no trial finds it to be significantly worse, than conventional treatment."[6(p2120)] Despite a number of methodologic limitations in some of the investigations,[6] an overview of the literature, including clinical trials, case-control studies, and meta-analyses, reflects favorably on the efficacy of chiropractic care relative to conventional medical treatment for back pain.[1,3,5,7-14]

Although serious complications from spinal manipulation therapy have been re-



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ported in a small proportion of chiropractic patients,[13] for most of the population, chiropractic treatment is associated with a relatively low risk level, on par with conventional medical treatments.[3,10] On the other hand, comprehensive overview of the literature reveals that it is essentially unanimous in reporting that chiropractic care is associated with significantly higher patient satisfaction compared with patients who receive conventional treatments.[17-20]

## COST EFFECTIVENESS OF CHIROPRACTIC CARE

Several studies[3] have produced preliminary evidence demonstrating cost-effectiveness of chiropractic compared with medical management. A series of studies by Stano and colleagues[21-24] and one study by Dean and Schmids[25] report cost benefits of chiropractic care compared with conventional medical treatment for neuromuscular conditions in a review of current literature (mostly workers' compensation studies). For instance, a 1996 cost comparison study,[23] which adjusted for demographic, insurance, and condition variables, revealed higher total (30% to 217% higher) and outpatient (27% to 94% higher) mean payments of medical treatment relative to chiropractic treatment. These later studies support the applicability of findings to managed health care settings by including large sample sizes and examining existing fee-for-service health claims data.

In contrast, a study by Carey et al[26] found significantly higher health care costs for patients with chiropractic or orthopedic care for back pain (secondary to a greater number of visits) than for patients who received their back pain care from a primary care physician at a health maintenance organization. Patients were interviewed over the telephone for up to 24 weeks to assess use of health care services and outcomes of care. Patients who received care from doctors of chiropractic care (DCs) paid more per episode than patients who received care from primary care physicians (69% in urban setting and 3% in rural setting). However, in this study the analyses were limited to outpatient costs rather than total costs; the costs were estimated using average statewide charges for a large insurance carrier; and, although the analyses adjusted for sciatica, baseline functional status, and duration of pain,[20] the study did not specifically adjust for the variables comorbidities, severity, and type of diagnosis.

Another study[6,27] that compared cost of care for episodes of back pain between various kinds of medical practitioners (orthopedists and chiropractors) found differential costs for care compared with care provided by a general medical practitioner. This study, however, based analyses on data collected up to 25 years ago and thus may not be applicable to today's health care market. In addition, these studies were characterized by small sample sizes, increasing the probability of type II errors (failure to find a real difference between groups). Given the discrepant cost-effectiveness findings and significant methodologic differences that limit study comparisons, the issue of the benefit of chiropractic care in today's health care system remains unresolved.

## ACCESS TO CHIROPRACTIC CARE

Chiropractors now represent the third largest segment of health care practitioners in the United States[1] with 50000 practitioners in 2000 according to the Bureau of Labor Statistics.[28] According to the American Chiropractic Association, an estimated 21 million to 28 million people now receive chiropractic services each year, with approximately 192 million annual visits to DCs: between 1990 and 1997, chiropractic use increased from 10% to 11%.[29] With growing public demand,[30] the profession is also expected to increase 21% to 35% by 2008.[16]

A recent study[31] of employers in large companies shows that chiropractic insurance coverage is now being offered to most American workers who are covered by health insurance and is increasingly being offered in all health plan types. This and other studies[32] note that although health insurance for chiropractic services is expanding, insurers often restrict coverage to manage risk.

Chiropractic coverage is often limited in terms of referral restrictions, conditions covered, number of visits, maximum annual dollar benefit, requirement for physician referral, and amount paid per visit. Some plans do not provide covered benefits but instead offer a network program in the form of discounted services. Health plan designs may impede appropriate access to chiropractic clinical care and may diminish the strength DCs have in treating neuromusculoskeletal (NMS) disorders.

The disconnect between evidence regarding the efficacy and safety of chiropractic care, consumer demand, and the limited research on cost of chiropractic care in applied settings has served to hinder integration of chiropractic coverage in traditional health care services. To help bridge this divide, improve access to appropriate chiropractic services, and promote best practices of chiropractic care, there is a need for community-based research to ascertain the effect and benefits of chiropractic care and the associated utilization of health care resources.

The data analyzed in this study were obtained from a natural experiment setting. A natural experiment is an experiment conducted in real-life setting rather than the controlled environment, where researchers "rely on truly naturally occurring events in which people have different exposures that resemble an actual experiment."[33(p150)] In this case, the data were collected and analyzed from a naturalistic setting rather than a laboratory setting. Although this is not a true experiment, such an approach is common in health services research because of the high external validity and generalizibility of the results obtained from studies that used natural experiment methods.

This study was conducted to identify and describe the demographics, disease, and utilization patterns of individuals with access to chiropractic care compared with individuals without such coverage. Toward this end, this study compared members of the same health plan, both with and without an additional chiropractic benefits rider. This natural experiment offers a particularly rich opportunity to understand the effects of supplemental chiropractic coverage on utilization of medical care because it employs members of the same health plan as a comparison group. Both groups studied were members of the same



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large managed-care system with access to the same physician network; with the same or similar covered benefits; with the same rules on referral to specialty care, high-cost diagnostic tests, and hospital and surgery approval guidelines; and with the same exclusions and limitations.

## METHODS

### STUDY POPULATION

This 4-year study (April 1, 1997, to March 31, 2001) used administrative claims data from a large regional managed-care network in California. These data included inpatient and outpatient data for more than 1.7 million continuously enrolled members containing demographic and enrollment information in addition to diagnosis and procedure codes as classified under the *International Classification of Diseases, Ninth Revision* (*ICD-9*) and the *Current Procedural Terminology, Fourth Edition*. Administrative claims data from the largest chiropractic health plan in California, American Specialty Health Plans, were used to subsequently identify approximately 700 000 of the 1.7 million patients enrolled in the large managed-care organization who also received additional chiropractic coverage through an American Specialty Health Plans benefits rider. These 700 000 members who were enrolled in both plans and had access to a medical and chiropractic network of practitioners were compared with the 1 million members who were enrolled in the managed care network only. For those members enrolled in both plans, the administrative claims data from the 2 networks were merged into one unique administrative file, thereby creating 2 main comparative cohorts from the same large health plan: one with access to chiropractic care and the other without. The former group had benefits covering direct access to a DC without the need of a physician referral. Under this benefit plan the patient copay for a chiropractic office visit was the same as it would be in a medical clinic. The benefit allowed for a maximum of 40 office visits to a DC per year.

### STUDY DESIGN

This study applied a retrospective, longitudinal, quasi-experimental, participant-nonparticipant design. The carve-out feature of the chiropractic insurance coverage offered by the managed-care health plan as an option to its employer groups was used to create retrospective control cohorts at 3 different levels. At the first level, managed care members with chiropractic insurance coverage were compared with the members in the same health plan without chiropractic coverage. At the second level, we compared members with and without chiropractic coverage but only if they had had NMS claims at any time during the study period. At the third level, we compared episodes of care for members with NMS conditions receiving care only from DCs against members with NMS claims receiving care only from medical doctors (MDs).

The effect of adding a chiropractic benefit on the health plan's overall resource consumption was assessed over a typical horizon for employer-sponsored health insurance. To achieve this, the observation period and analyses were annualized to a study period from January 1 to December 31, 2000, when assessing group differences in demographics, comorbidities, and total plan claim expenditures.

However, to comprehensively compare the effects of treatment for NMS conditions between DCs and MDs, a longer observation period was appropriate, because NMS conditions are typically time limited but recurrent and can manifest over multiple episodes spanning a longer period. Therefore, we expanded our analysis period across 4 years from April 1, 1997, to March 31, 2001, to study the costs and utilization patterns associated with NMS episode–specific care.

To enable meaningful comparisons of utilization and costs of medical and chiropractic care for categories of NMS disorders based on anatomic and clinical similarity, a classification system grouping individual *ICD-9* codes for NMS conditions into more aggregative diagnosis groups was developed for this study. The classification also took into account the severity of specific conditions such as neck and lower back diagnoses. A total of 654 *ICD-9* codes, identified by separate panels of DCs and MDs as NMS conditions most commonly treated and eligible for insurance coverage, were sorted into the following categories: neck, lower back, thoracic spine and rib disorders, headache, upper extremity, lower extremity, myalgias or arthralgias, latent effects, and other. Additionally, severity distinctions were made for neck and lower back diagnoses by sorting into complicated and uncomplicated conditions, thus extending the diagnostic groups to 11. The *ICD-9* codes for these diagnostic groups were comprehensively reviewed for possible inclusions, exclusions, and crossover by a panel of DCs and medical NMS experts.

To maximize comparability between medical and chiropractic coding, a subanalysis was performed to examine a small group of codes that would be equally applicable to chiropractic and medical practice. This set of codes was selected for its high frequency of occurrence in both medical and chiropractic cohorts. To level the playing field between chiropractic and medical care for these low back pain–specific analyses, cases that were associated with any claims for back surgery were excluded from the subanalysis, because such cases are likely to have complications for which chiropractic care would not be appropriate.

### DEFINING EPISODES OF CARE

In addition to encounter-specific comparisons, entire episodes of care were of interest in the study. For each member with at least 1 NMS claim or a sequence of NMS claims, an episode of NMS care was determined by the diagnosis group of the sequence of claims and an allowable gap between any 2 consecutive claims of less than 45 days. Claims separated by 45 days or more were considered separate episodes. The 45-day interval was derived from a previous study[20-22] that used the 9 most common *ICD-9* codes for low back pain to evaluate the percentage of treatment encounters that were captured using different intervals to terminate an episode. The study found that for the most common *ICD-9* code (724.2) an interval of 6 weeks (42 days) captured 86% of all encounters, and the remaining 8 diagnoses yielded values ranging from 42 to 49 days. A sensitivity analysis of these values demonstrated that there was little change in the overall study results if these values were moved upward or downward. Based on these results and on the clinical consensus of an expert panel of both DCs and MDs, a value of 45 days was judged to be appropriate. For neck- and back-related episodes, which were stratified into complicated and noncomplicated diagnosis groupings, any switch in diagnosis between uncomplicated and complicated neck-related conditions during the 4-year sample period triggered the entire sequence of claims to be identified within the complicated neck diagnosis grouping.

### OVERALL EXPENDITURES AND UTILIZATION

The primary health care expenditures considered for this study were total health care claim expenditures, individual components of total health care claim costs such as those associated with inpatient and outpatient services, and costs associated with NMS care at the episode level. Utilization metrics included the following: outpatient services, plain radiographs, magnetic resonance (MR) images, lumbar spine surgical procedures, and in-



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patient stays. Health risk characteristics, based on demographics and comorbidity rates, were used to compare the risk profiles for different groups. The health plan expenditures from inpatient, outpatient, and chiropractic outpatient paid amounts were used in the calculation of health care costs and reflect the dollar value of the payers' resource consumption in providing access to medical and chiropractic care to its members. Prescription claims and physical therapy claims were not included during this phase of the ongoing study, and therefore pharmacy and physical therapy costs were not included in health care costs.

### STATISTICAL ANALYSIS

Descriptive statistics, including mean values, standard deviations, and column percentages, were computed and average differences between groups were evaluated. We used $\chi^2$ tests to evaluate differences between categorical variables. This included variables with proportional values, such as sex, proportion of patients in the comorbidity and diagnosis groups, and proportion of complicated episodes. To test the difference in mean values for continuous variables, such as age and costs, and to account for the skewed distribution of variables, we applied nonparametric analysis of variance instead of conventional parametric tests such as *t* tests. We applied the Wilcoxon test when comparing 2 cohorts and the Kruskal-Wallis test when comparing 3 cohorts.

A semilogarithmic regression model was also used to estimate the effect of chiropractic insurance coverage on total annual health care expenditures. The total health care costs of plan members with positive utilization during calendar year 2000 were regressed on their chiropractic coverage status, after adjusting for their demographic, NMS, and comorbid characteristics using the following specification:

$$\text{Log}[(\text{Total Health Care Costs})_i/(\text{Total Health Care Costs})_i > 0] = \alpha + \beta_1(\text{Chiropractic Coverage})_i + \beta_2(\text{Female})_i + \beta_3(\text{Age})_i + \beta 4(\text{Comorbidity Score})_i + \beta_5(\text{Neuromusculoskeletal})_i + \varepsilon_i.$$

The logarithmic transform of the total health care costs was used as the dependent variable to correct for nonnormality and heteroscedasticity in the cost distribution. The comorbidity score, computed as the number of comorbid conditions that a member was identified with during the annual period, was used as a risk adjuster in addition to age, sex, and presence of a NMS condition. The primary independent variable of interest was the dummy variable, which was equal to 1 if the member had chiropractic coverage during the period and equal to 0 if otherwise. The antilog of the estimated regression coefficient, after accounting for its variance, was used to estimate the effect of chiropractic coverage on the annual total health care costs of the health plan as follows[34]:

$$\xi = \exp\left(\hat{\beta}_1 - \frac{1}{2}\text{Var}(\hat{\beta})\right) - 1,$$

where $\text{Var}(\hat{\beta})$ is the squared standard error of the estimated regression coefficient $\hat{\beta}_1$.

## RESULTS

### COMPARISON OF MEMBER COHORTS

Year 2000 claims for 707690 health plan members with chiropractic coverage and 1001995 members without chiropractic coverage were compared. Demographic characteristics and comorbid conditions for members with and without chiropractic insurance coverage are displayed in the **Table**.

Members with chiropractic coverage were younger (mean age, 33 years) than members without chiropractic coverage (mean age, 36; $P<.001$). The cohort without chiropractic coverage contained a slightly higher percentage of female members (52.1% female) than the cohort with chiropractic coverage (51.6% female, $P<.001$).

Members with chiropractic coverage also were less likely than members without chiropractic coverage to have comorbid medical conditions. The proportions of members who had specific comorbid conditions, including hypertension, diabetes, cardiac arrhythmias, heart failure, and nutritional disorders, ranged from 0.6% to 6.5% in the population with chiropractic coverage and 0.9% to 7.3% in the population without coverage ($P=.001$ for each comparison). In particular, heart failure (0.6% vs 0.9%), cardiac arrhythmias (1.6% vs 2.0%), and hypertension (6.5% vs 7.3%) were lower in relative occurrence in the member population with chiropractic coverage. Annual total health care claim costs of the member populations with and without chiropractic coverage for year 2000 are presented in **Figure 1**. The per-member-per-year (PMPY) cost of members with chiropractic coverage was $1463, which was $208 lower ($P<.001$) than the PMPY cost of members without the coverage ($1671). This translates to a 12% reduction in annual costs incurred by the managed care organization on members with chiropractic coverage.

### COMPARISON OF NMS PATIENT COHORTS

The 141616 patients with NMS conditions who had chiropractic coverage were also compared to 189923 NMS patients without chiropractic coverage. As with members with and without chiropractic coverage, NMS patients with chiropractic coverage were younger (mean age, 41 years) than NMS patients without chiropractic coverage (mean age, 44 years; $P<.001$). Similarly to members with and without chiropractic coverage, NMS patients with chiropractic coverage were less likely than NMS patients without chiropractic coverage to have comorbid medical conditions ($P<.001$ for each of the comorbid conditions previously mentioned).

The overall medical expenditures of the patients with NMS conditions during the year 2000, including the major components of the expenditures, are presented in **Figure 2**. The PMPY cost of NMS patients with chiropractic coverage was $2345, which was $361 lower ($P<.001$) than the PMPY cost of NMS patients without the coverage ($2706). This translates to a 13% reduction in annual costs incurred by the health plan on NMS patients with chiropractic coverage.

Annual per capita hospital cost for NMS patients with chiropractic coverage ($1224) was $210 lower or 15% ($P<.001$) than that for NMS patients without chiropractic coverage. The annual per capita ambulatory cost for NMS patients with chiropractic coverage ($1121) was 12% lower ($P=.01$) than the corresponding cost for NMS patients without chiropractic coverage ($1272). The annual per capita cost of providing chiropractic care was



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Table. Baseline Demographics*

| Demographics | Members With ASHP Coverage, % | Members Without ASHP Coverage, % | P Value |
|---|---|---|---|
| Age group, yr | | | |
| 0-17 | 32 | 26 | .001 |
| 18-21 | 5 | 4 | .001 |
| 22-35 | 15 | 19 | .001 |
| 36-55 | 34 | 33 | .001 |
| 56-64 | 8 | 8 | >.05 |
| ≥65 | 6 | 10 | .001 |
| Medical condition | | | |
| Congestive heart failure† | 0.55 | 0.86 | .001 |
| Cardiac arrhythmias† | 1.56 | 1.97 | .001 |
| Valvular disease† | 0.59 | 0.69 | .001 |
| Pulmonary circulation disorders† | 0.05 | 0.06 | .001 |
| Peripheral vascular disorders† | 0.40 | 0.55 | .001 |
| Hypertension† | 6.46 | 7.26 | .001 |
| Paralysis† | 0.15 | 0.17 | .001 |
| Other neurologic disorders† | 0.49 | 0.56 | .001 |
| Chronic pulmonary disease† | 3.96 | 3.78 | .001 |
| Diabetes† | 2.77 | 3.01 | .001 |
| Hypothyroidism† | 1.54 | 1.51 | .07 |
| Renal failure† | 0.21 | 0.28 | .001 |
| Liver disease† | 0.29 | 0.31 | .03 |
| Peptic ulcer disease excluding bleeding† | 0.16 | 0.19 | .001 |
| HIV/AIDS† | 0.06 | 0.16 | .001 |
| Lymphoma or leukemia† | 0.12 | 0.14 | .001 |
| Cancer or tumor† | 1.76 | 2.10 | .001 |
| Rheumatoid arthritis or collagen vascular diseases† | 0.63 | 0.65 | .04 |
| Coagulopathy† | 0.17 | 0.19 | .01 |
| Nutritional or metabolic disorders (obesity or weight loss)† | 1.58 | 1.65 | .001 |
| Anemia† | 1.29 | 1.44 | .001 |
| Alcohol and other drug abuse† | 0.22 | 0.23 | .14 |
| Psychoses† | 1.09 | 0.91 | <.001 |
| Depression† | 1.93 | 1.64 | .001 |
| Tobacco† | 0.44 | 0.43 | .32 |

Abbreviation: ASHP, American Specialty Health Plans.
*Members with chiropractic coverage were younger, overall and in the 65-year and older group, and had lower comorbidities for 20 of the 25 conditions.
†Statistically significant at $P<.001$.

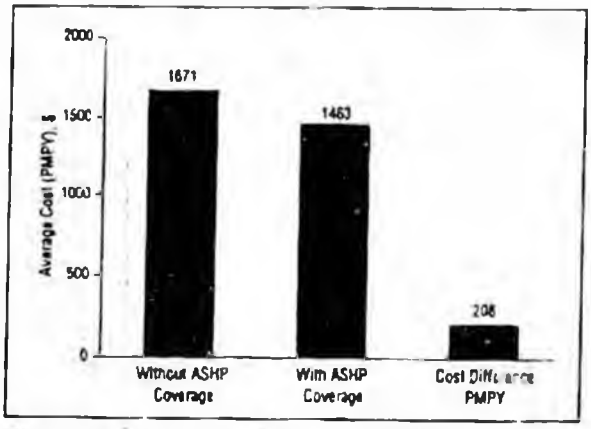


Figure 1. Annual total cost reduction. Members with chiropractic coverage were associated with $208 lower per-member-per-year (PMPY) total health care expenditures for the year 2000 ($P<.001$). ASHP indicates American Specialty Health Plans.

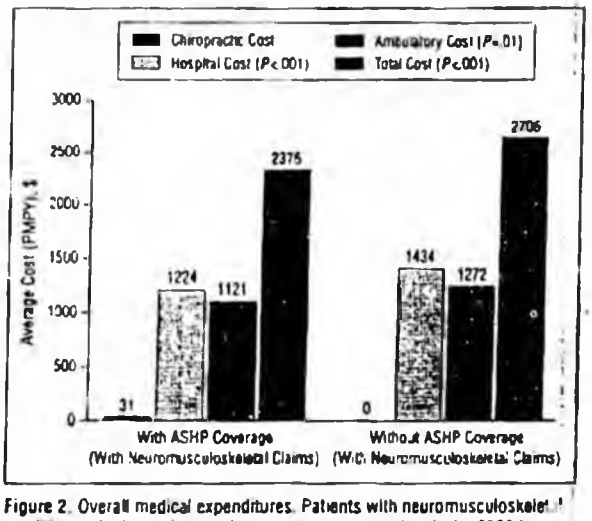


Figure 2. Overall medical expenditures. Patients with neuromusculoskeletal conditions who had chiropractic coverage were associated with $330 lower per-member-per-year (PMPY) total health care expenditures for the year 2000. The lower cost is derived from both lower hospital cost by $210 and lower ambulatory cost by $151. *P* values were determined using the Wilcoxon test. Further regression analysis will be conducted. Hospital costs include outpatient hospital services, emergency department visits, and inpatient services. Total costs include hospital costs and ambulatory costs. ASHP indicates American Specialty Health Plans.

$31, which amounted to only 1% of the total dollar value of resources consumed ($2376) by NMS patients between the 2 cohorts.

To adjust for age, sex, presence of an NMS condition, and comorbidity differences between cohorts, a semi-



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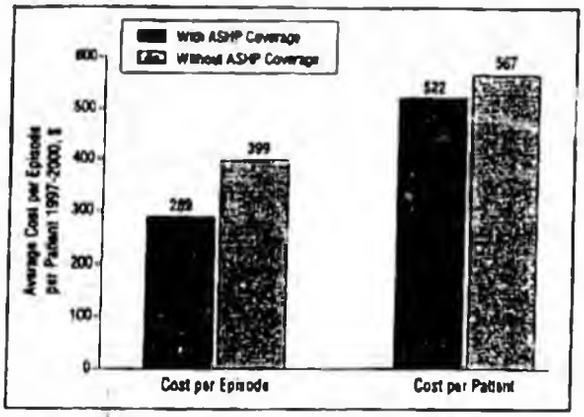


**Figure 3.** Episode of care utilization analysis for back pain patients. Presence of chiropractic coverage was associated with a $110 reduction in cost per episode and a $45 reduction in cost per patient for all expenditures related to neuromusculoskeletal care during the 4-year period (April 1, 1997, to March 31, 2001) ($P<.001$). ASHP indicates American Specialty Health Plans.

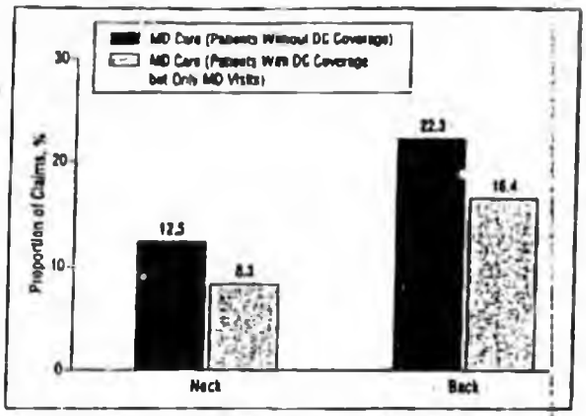


**Figure 5.** Medical care substitution. Presence of chiropractic coverage was associated with a shift in the case distribution away from medical doctors (MDs) to doctors of chiropractic care (DCs) for neck and back problems, indicating a substitution of chiropractic for physician care. All proportional differences are statistically significant at the $P<.001$ level.

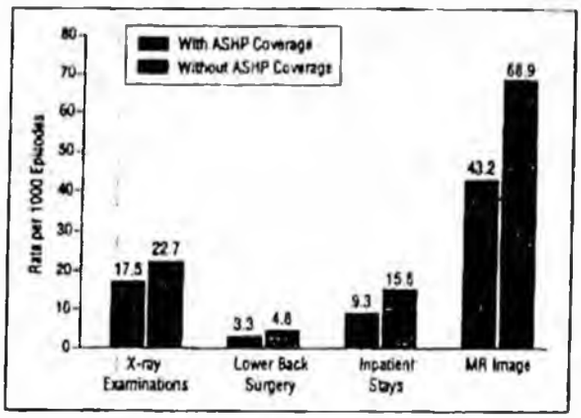


**Figure 4.** Breakdown by high-cost items. Access to chiropractic care was associated with lower rates of high resource-utilizing components of neuromusculoskeletal care ($P<.001$). ASHP indicates American Specialty Health Plans; MR, magnetic resonance.

log regression analysis was also used to estimate the impact of chiropractic care as a covered benefit on total health care costs of the health plan for year 2000. The estimated coefficient for chiropractic coverage indicator ($\beta_1$) was −0.0162. The regression results indicate that the presence of chiropractic insurance coverage was systematically associated with an approximately 1.6% lower ($P=.001$) average total health care cost of members, after controlling for differences in age, sex, and the number of comorbidities. The 1.6% reduction in total health care costs per member is equivalent to approximately 13% of the $208 PMPY observed cost difference reported in Figure 1. This translates to an approximately $27 PMPY potential cost saving that can be attributed to the presence of chiropractic insurance coverage in the plan, after accounting for differences in demographic and comorbidity risks of the members.

## BACK PAIN–SPECIFIC TREATMENT

**Figure 3** presents data related to the cost of providing care for back pain, at an episode level, for the 4-year period (April 1, 1997, to March 31, 2001). The average cost per back pain episode for patients with chiropractic coverage was $289, which was $110 or 28% lower ($P<.001$) than for back pain patients without chiropractic coverage. Aggregating episodes for each patient during the 4-year period, the average cost of back pain treatment for patients with chiropractic coverage was $522, which was $45 or 8% lower than the corresponding back pain treatment cost for patients without chiropractic coverage.

Furthermore, the proportion of complicated back pain episodes was only marginally higher (10% vs 8%, $P<.001$) for patients who received care only from MDs compared with the patients who received care only from DCs.

Utilization rates for back pain episodes presented in **Figure 4** indicate significantly lower utilization of resources across all major high-cost areas for NMS patients with chiropractic insurance coverage compared with those without. Back pain patients with chiropractic coverage had fewer inpatient stays than did those without chiropractic coverage (9.3 vs 15.6 stays per 1000 patients, $P<.001$). The MR image rate was also lower for back pain patients with chiropractic coverage compared with those without chiropractic coverage (43.2 vs 68.9 MR images per 1000 patients, $P<.001$). The rate of lower back surgery among patients with chiropractic coverage was lower as well (3.3 vs 4.8 surgical procedures per 1000 patients, $P<.001$). Back pain patients with chiropractic coverage also received fewer radiographs (17.5 vs 22.7 per 1000 patients, $P<.001$) than did back pain patients without chiropractic coverage.

## SUBSTITUTION EFFECTS

**Figure 5** presents the distribution of NMS claims reported for neck and back pain episodes during the 4-year period. This table compares 2 groups of patients, both who sought care for NMS complaints from MDs only. However, members of one of the groups were limited by the absence of access to chiropractors within the plan due to lack of chiropractic insurance coverage. The proportion of neck complaints seen by MDs for patients with chiropractic coverage was 8.3%, 4 percentage points lower ($P<.001$) than for the corresponding proportion for patients without chi-



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ropractic coverage. Similarly for back pain, the proportion of complaints seen by MDs for patients with chiropractic coverage was 16.4%, 6 percentage points lower ($P<.001$) compared with patients without coverage. Correspondingly, a very high rate (approximately 60%) was also observed for the proportion of neck and back complaints seen by the network DCs during the same period. This suggests a substitution of DC care for MD care for neck and back complaints.

## COMMENT

The high prevalence and recurrent incidence of back pain, as well as the heavy economic and disability burden that it imposes on society as documented in the literature, point to a major area of public health concern. Simultaneously, there is growing evidence for the low risks associated with chiropractic spinal manipulation in most cases and favorable evidence for its effectiveness in treating low back pain. In addition, patients treated for back pain by DCs tend to be more satisfied than patients treated by MDs. However, despite this evidence for safety, effectiveness, and growing public demand, health insurance coverage for chiropractic care continues to remain restricted, relative to other health services, particularly in the managed care sector.

This restriction of access to health insurance for chiropractic care is not due to a lack of DCs, however. Rather, chiropractic care is becoming increasingly prevalent in the American health care system. The increasing acceptance of chiropractic care as a source of comprehensive complementary care for NMS problems is reflected in that the chiropractic field is the fastest growing among all doctoral level health professions.[17]

To date, there has been little research linking chiropractic and medical utilization data at a patient level. Thus, a powerful opportunity to compare the effects of chiropractic and medical management of costly NMS conditions, such as back pain, in a real-world managed care setting has been underused. This study integrated and analyzed comprehensive administrative data from a large managed medical care organization and the chiropractic care plan that provided an additional chiropractic benefit to more than 40% of its members. By comparing members within the same medical managed care plan both with and without direct access to chiropractic care, this study provides additional information on the effect of chiropractic insurance benefits on the resource utilization within a managed care network.

For the managed care plan studied, the presence of a supplementary chiropractic insurance option was associated with favorable member selection by the plan. This is evident in that members with covered chiropractic benefits were significantly younger and had less comorbidity burden. This favorable selection could have been an artifact of 2 factors that reflect employer and employee preferences. The larger companies in particular, in the interest of maintaining a large productive workforce, may have been likely to offer additional benefits, such as supplementary insurance, to attract younger and healthier individuals. At the same time, potential employees, particularly those who maintain a healthier lifestyle may have been more likely to seek employment in companies that offer benefits covering complementary care (eg, chiropractic or acupuncture) that can be perceived as less aggressive treatment modalities.

This study found that members with chiropractic coverage had a 12% lower annual medical care cost, not adjusting for member risk characteristics. After controlling for the cost-saving effects associated with favorable demographic and medical risk factors, the regression analysis found a statistically significant 1.6% reduction in total medical care costs that can be isolated to the presence of chiropractic coverage. Most of this 1.6% reduction in the plan's total medical costs is likely derived from the 13% reduction in the total medical costs observed for the subset of members with NMS conditions who also had chiropractic coverage. In our study population of 0.7 million members who had chiropractic coverage in the medical plan, we estimated an annual reduction of approximately $16 million as a result of lower utilization of high-cost items. This is a conservative estimate of the cost savings for the plan that can be associated with members in the medical plan using their supplementary benefits to seek chiropractic treatment of their NMS problems. The estimated cost saving appears to more than offset the amount spent to cover the associated costs of the chiropractic benefit.

The analyses related to NMS episodes elucidate sources of these cost savings relating to chiropractic treatment of common NMS complaints, such as neck and back pain. Focusing on low back pain diagnoses that were selected specifically for comparability between medical and chiropractic practice, our analysis found that patients with chiropractic coverage had significantly lower rates of use of resource-intensive technologies, such as x-ray examinations, MR image, and surgery, and lower use of more expensive patient care settings, such as inpatient care. This is reflected in the significantly lower cost, at both the episode level and the patient level, of providing care for back pain. The difference in episode-specific and patient-level resource utilization did not seem to be due solely to a difference in severity of cases seen by DCs and physicians, since the estimated 2% difference in severity between chiropractic and medical patients of back pain did not constitute a clinically meaningful difference. In addition, the substitution of chiropractic for physician care evident from the shift in the case distribution between physicians and DCs when chiropractic coverage was present also contributed to the conservation of health care resources.

Although the results from the study may carry policy implications in the managed care industry, the limitations of this study are worth noting, especially since they also open up avenues for future research. This study only analyzes effects of chiropractic coverage in a large but specific managed care population. Future research covering geographically diverse populations across several plans is needed to ascertain and validate the effect of a chiropractic benefit on utilization patterns and cost effects, after controlling for differences arising from factors, including location, plan-specific benefit design, industry type, and other undetected biases, such as patient burden of disease. Comorbidity score and demographic characteristics such as age were controlled for in the regression model. However, the significantly more favorable profile of the plan mem-



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bers who selected chiropractic coverage poses some concern regarding the generalizability of the results to a sicker, older population. Especially as the average age of the American population continues to increase in the next decade, the safety and appropriateness of chiropractic care for elderly patients will need to be more thoroughly evaluated. Further research is also necessary to quantify utilization and costs associated with DC vs MD care for other NMS conditions, and to ascertain clinical outcomes for specific NMS conditions.

The substitution of chiropractic utilization for medical care is central to the issue of providing cost-effective care for NMS conditions in a managed care environment, since the provision of chiropractic benefits as supplementary insurance raises the possibility of induced demand for medically unnecessary care. This study found evidence that a substantial portion of the chiropractic care sought by the members with insurance coverage was more often substituted for medical care rather than add-on care. Further research is needed to quantify this substitution effect. The effects of substitution of chiropractic care utilization for medical care could be further pursued by analyzing data on patients with episodes of NMS care comanaged by DCs and MDs, which was beyond the scope of this study. Although most back pain patients have nonspecific syndromes, a few back pain cases are caused by severe underlying conditions. Accurate diagnosis and appropriate referral are essential for this subset of low back pain cases and demand an integrative approach. This point is especially important in light of the substitution between DCs and internists found by this study. Finally, questions continue to remain regarding the effectiveness of chiropractic care relative to the cost of care and quality of the health care received. Future research using patient surveys (quality-of-life and patient satisfaction measures) in conjunction with medical record review are warranted to further evaluate the cost-effectiveness of chiropractic care in managed care settings.

This study provides additional information regarding the economic benefits and utilization patterns associated with systematic access to chiropractic care. Furthermore, it offers an integrated baseline (combining chiropractic and medical utilization claims data for a common cohort of members) for future research evaluating the effect of alternative clinical management approaches to medical conditions (ie, back pain specifically) with high direct and indirect consumption of medical resources and a high derivative societal cost given the absenteeism and burden of disease associated with them.

*Accepted for publication November 7, 2003.*

*Correspondence: Antonio P. Legorreta, MD, MPH, Health Benchmarks Inc, 21650 Oxnard St, Suite 2150, Woodland Hills, CA 91367-4975 (alegorreta @healthbenchmarks.com).*

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## *REPORTER* SEEKS WCAB DECISIONS FROM READERS

Readers are urged to send the *Reporter* a copy of any WCAB panel decision that is believed to be of interest to the workers' compensation community. A copy of the petition for reconsideration, the answer to the petition, and the report and recommendation on reconsideration should also be sent if important to an understanding of the case. The address is CWCR, P.O. Box 975, Berkeley, CA 94701.

***Here, . . . the guidelines are inapplicable according to the terms of the guidelines themselves. Scientific evidence is required only when seeking to rebut an ACOEM standard.***

guidelines themselves. The scientific evidence is required only when seeking to rebut an ACOEM standard. Since there was nothing to rebut, the issue did not exist.

A panel of Commissioners O'Brien and Brass, with Commissioner Murray concurring but not signing, adopted the WCJ's reasoning and summarily denied reconsideration.

*Editor's Note: A week previously, a panel of Commissioners O'Brien and Murray and Chairman Rabine had denied reconsideration in a similar case decided by WCJ Webber.* Taylor v. State Comp. Ins. Fund, *STK 183276, Sept. 10, 2004 (Order Denying Reconsideration). In* Taylor, *which involved a 2002 low back injury, SCIF made the additional argument that the ACOEM guidelines applied to treatment over three months after the injury. In response to that argument, WCJ Webber quoted the second paragraph on page 287 of the guidelines as follows:*

> *Recommendations on assessing and treating adults with potentially work-related low back problems (i.e., activity limitations due to symptoms in the low back of less than three months duration) are presented in this clinical practice guideline.*

*The panel agreed that this language did not allow an interpretation other than that the guidelines apply only to injuries of fewer than three months' duration.*

*The decisions in* Hamilton *and* Taylor *will come as no surprise to readers of* The Bulletin of The California Society of Industrial Medicine and Surgery. *In Brakensiek,* Some Thoughts on Medical Utilization and Treatment Guidelines, *CSIMS Bulletin, Vol. 25, No. 1, p. 1, the author said at page ten that the first and second editions of the ACOEM guidelines were focused primarily on acute and subacute injuries. Acute is defined as "around the time of an injury." Chronic means beyond either the period of tissue recovery or some agreed period, such as three months. Subacute is the period between acute and chronic.*

*Brakensiek explained that roughly 90 percent of medical costs in workers' compensation cases are incurred for chronic injuries for which the ACOEM guidelines are largely inapplicable. He added, however, that insurance industry representatives claimed that the ACOEM guidelines cover two-thirds of all workers' compensation treatment. If that is industry's position, it explains the argument made by SCIF in* Taylor *and suggests that litigation of the issue is not likely to end with WCJ Webber's decisions.*

*In a subsequent article,* Feinberg, Surviving U.R.–Part 2, *CSIMS Bulletin, Vol. 25, No. 4, p. 1, Dr. Steven Feinberg provides advice to PTPs on how to avert and deal with nonconcertification of requested tests and treatment by utilization review physicians. He suggests that a collegial peer-to-peer discussion with the review physician will frequently resolve questions about properly justified requests. He warns, however, that*

> *if the claims examiner and the UR physician are not going to listen to reasonable and cogent arguments in favor of [the] recommendation, there is not much [the PTP] can do short of referring the issue to the applicant attorney.*

*it can be safely predicted that utilization review will be a continuing source of litigation.*

### WCJ Holds CIGA Not Liable for Sanctions Imposed Against Insolvent Insurer

#### *WCAB Rescinds; Sanction Award Is "Covered Claim"; No Applicable Exception*

[*Rasmussen v. Paula Ins. Co.*, SAC 234289, Aug. 20, 2004, Order Granting Reconsideration and Decision After Reconsideration]

A Board panel has rescinded a trial judge's finding that the California Insurance Guarantee Association is not liable for sanctions imposed against an insolvent insurer pursuant to *Labor Code §5813* because payment of expenses under that section is not a "covered claim" provided in *Insurance Code §1063.1*. Although *§1063.1(c)(8)* provides that "covered claims" include neither amounts awarded as punitive or exemplary damages nor any amounts awarded pursuant to *§5814* or *§5814.5* because of delay by the insolvent insurer, the panel said, that paragraph does not exclude expenses ordered paid under *§5813*.

*Relevant Facts and Proceedings*

Applicant Betty Rasmussen was injured in the course of her employment by J & J Maintenance, Inc. During 2001, applicant's attorney and defendant Paula Insurance Company, the employer's insurer, agreed on a physician to examine applicant and prepare a comprehensive medical report resolving medical issues then in dispute. On September 24, 2001, Paula withdrew from the agreement.