GENERAL NOTES DAY 1

I. The Grand Bargain
   a. Don't start with the Grand Bargain. Start with the issue of helping people with misfortune
   b. There is a relevance to the five critical recommendations from the 1972 Federal Commission report. Safety, benefits for life, and broad coverage.
   c. There is relevance to the 5 critical elements, but how do we make people care.
   d. The five critical areas are important, but there is a great deal of ambiguity. And so what are the details.
      i. Definition is missing and critical points need fleshing out before there can be consensus
   e. What is the result that should be produced for people? People are fortunate to have workers' comp in this country. Too many people do not have the benefit that workers' compensation provides.
   f. What would a successful system look like?
   g. To have good government, take into account the multiplicity of interests. If we do not consider all the perspectives, we will struggle to have a construct.
   h. It is not about just medical and money, injured need more. Their reasonable needs must be met, to deal with disruption and get life back on track.
   i. Cannot tell the future. We have to consider the human element and the larger world view
   j. It is really about employer and employee
      i. Regulators need to know it is more than an insurance process. Insurance is just a collateralization of it and get a great deal of the focus.

II. Relevance of the 1972 report
   a. It is a different world today. The 1972 report is history. The economy, employment, and the country have changed. Start over today with what is needed today.
   b. Varied interests today. Many are uncertain / may disagree whether the system today is broken.
   c. Changing economy/evolution
      i. Manufacturing economy has evolved.
      ii. Are we focused interstate or intrastate?
      iii. What would be the best result for people?
   d. The Feds will use SSDI to enter the world of workers' compensation.
   e. All these vendors are in the system because of complexity – and they themselves may also make things more complex.
      i. There is a vendor explosion in which peoples' issues are compartmentalized. Specialization is decreasing the human element and the communication and effectiveness.
   f. The 1972 report stressed vocational rehabilitation, but this is seen as a different topic.

    i. Do we mean re-employ, or return to work and what is the level of effort?
    ii. The return to function and work is not mentioned in the five critical objectives of ‘72. This is good for both the employee and the employer. This should be clearly added to the critical elements.

g. There has been great change in the system and the world. Physics, the natural aging process, the aging work force, people wear out. Does, should, the employer have the 100% of the risk? Employers are paying all the costs of natural losses in capability / health over time.
h. What are the principles that are critical and relevant?
    i. The five are perhaps relevant, but are they the only / most critical ones?
i. What is the burden on employers, and is there room for a better balance?
    i. For example, is there a companion five to the 1972 critical 5, that were never mentioned and should be now?
    ii. Elements of interest to the employer?
    iii. The big one is tort immunity
j. There was no focus in 1972 re what medical or rehab works and what does not.
    i. We can now define what is medical success and what is not. This is a shift that is perhaps a critical element.
    ii. The ability today to define and refine medical care and progress and success is different today than it was in 1972 – because of scientific research advances since then.
    iii. Half of that progress has been made in developing and identifying which medical treatments are most effective (evidence-based medicine) , but the other half is the development of a better understanding of the kind of environment around the employee that fosters recovery.
k. Context has changed. Country was bluer in 1972 and unions were leading the debate. The employee does not now appear to be the driving force in the country. Business is driving the reforms.
l. The employee is not represented in discussions on the current state / future of workers comp
    i. This event is the first known time that injured workers have been involved in discussions
    ii. Involving non-injured employees requires finding those who are interested
    iii. The unions are representing fewer/smaller percentage of the workforce
m. The current statutory situation is a result of the 1972 report. It had a significant impact. Many states changed their laws as a result. The current laws are in part a reaction to the report and subsequent efforts since that time.
n. The DOL used to track compliance with the 1972 recommendations but stopped doing it in 2006. There were efforts at consensus on foundational requirements even before the 1972 report
    i. Efforts in the 1940s and 1950s
    ii. Efforts did not lead to unanimity
o. State laws do not agree on what an “employee” is. Criticism of the five critical objectives is that there is too much difference in “what is an employee.”
    i. Without clarity, agreement on relevance of objectives is difficult

p. We need better definition of the terms that we are using. Safety for example is a complex question. There is a lack of financial incentive for insurers to enhance safety.
q. What is missing from the 1972 report is that people care when they are incentivized to care.

III. Problems perceived
a. System is not totally broken. 80% of claims go through the system without a hitch.
    i. Instead of dealing with effectively with problem people and employers, we regulate for the minority and create a more cumbersome / unfriendly process for all the rest.
    ii. Majority suffers for actions of minority.
b. 20% of the actors/claims/participants are creating 80% of the issues.
    i. What is a better way to deal with the bad actors?
    ii. Ex. there are 10 doctors in CA responsible for thousands of UR requests.
c. The many varieties of vendor booths at conferences mean that there is a lot of friction in the system.
    i. Can we identify those friction points?
    ii. Friction creates costs.
d. There is concern about the opt-out alternative
    i. Concern about uncertainty in existing systems
    ii. Employers feel they are paying for claims they feel should be group health for slight aggravation.
        1. What is appropriate causation standard? 1% ?, 51%?
    iii. The opt out people are selling the education element.
        1. They believe that it is an attractive and compelling argument
        2. It is unclear why this education effort couldn't exist in the current comp construct.
e. Keeping up with the differing state distinctions is maddening.
    i. But more problematic is the artificial distinction of differing state laws
    ii. Equal protection is a problem when two people work for the same company, have the same event, but in two states so that one injury is compensable and the other is not.
f. With what can we get states to agree? Where is the baseline of agreement?
    i. Mandatory workplace posters differ in size, rapidly become outdated, information is flawed, and WC is a "nuisance" for employers. Just a "mandatory expense."
g. Retaliation in the workplace.
    i. Over safety complaints, or
    ii. Against employees that file workers' compensation claims.
    iii. There is at least a perception that retaliation is commonplace, an unacknowledged dirty underbelly.
    iv. So education on the right to file and the protection against retaliation is important.

1. Is this due to misaligned incentives for management generally or front line managers specifically?

h. There is a positive story of workers' compensation. Safety has been improving and frequency is down. This is a success story.
    i. Data bears that out; cost of workers' compensation has been a huge safety incentive.
    ii. Or, are people just not reporting the injuries and the accidents? Some feel under reporting exists, is it growing or is it consistent.
    iii. The comparison of OSHA logs with reported WC demonstrate significant degree of under-reporting, for example, 20-33% of work-related amputations did not enter the wc system -- documented in studies in MA and CA.
    iv. Organizations are perceived of burying their failures and not studying their failures.
    v. Industrial hygiene grew from the concept of WC.

i. Competition between states and the huge money incentive of states seeking business.
    i. States almost cannot help themselves in the competitive environment of states hungry for new business / jobs.

j. There is turnover in the system. People come and go.
    i. This leads to loss of personal connections for injured workers

k. The employer community bears the cost.
    i. They deal with personal health issues. Then with injuries, the employer bears the cost and aggravation to preexisting
    ii. The whole economy bears the costs of the system

l. WC should be between the worker and employer,
    i. There is room for interaction between participants and vendors or regulators.

m. The system has become too complex and involved
    i. What happened to working one on one with the injured workers and getting them back to work?
    ii. Where did this process become so complex and involved?

n. The focus left the worker (1972) and employer and now seems overly focused on process
    i. Some question if the claimant is even relevant to the claim today?
    ii. The emphasis seems instead to be some box on an obscure form has to be completed.

o. Regulatory standards are a burden.
    i. Employers that do the right thing face penalties and sanction
        1. The state faults an employer who is trying to do the right thing and pay doctors in excess of the state required payment.
        2. An employer who voluntarily pays 100% of wages while IWs are OOW have to fudge the data to make it "look compliant"
    ii. Should employer be allowed to overpay if they wish?
    iii. Should that be up to the employer or the carrier? Is there a difference?

iv. There are FTEs whose job is to document for regulators, instead of delivering services.

p. What is the model for decision making re: provider?
    i. Some use "who would you send you child/mother to?"
    ii. Some use "who has the deepest discount?"
q. How can system deliver the best medical care?
r. Responsibility for the whole medical condition, if 1% work related, but only 23% of employee time is at work for that employer
    i. 1% causation standard is viewed as troublesome.
s. Societally, there is a trend to use employers as a vehicle for delivery of services to employees, ACA, etc. Governmental expectations/burden.
t. Employees seen as replaceable commodities once they get hurt.
u. We become used to WC and it becomes a commodity and unappreciated.
    i. In poor image of the industry - one dissatisfied person tells 20 people and a satisfied employee tells no one.
v. The caps on benefits (like in Westphal case) can create a "gap" period and that gap is troublesome to the employees.
w. Is the concept of "employer" becoming anachronistic?
    i. Should there be reconsideration of the concept and the model.
    ii. Are employers being replaced by the Internet marketplaces that enable buyers and sellers of services/goods to deal directly? Are the "size of employer" concepts affecting a larger population? Or is self-employment or "gig" economy increasing
x. WC is as delicate balance of the interests of the stakeholders.

IV. Disconnects

a. There is a disconnect.
    i. People do not understand comp.
    ii. They are not sure where to look for help
    iii. We are not providing education and resources.
    iv. What it is and how it works is confusing.
    v. That costs us as a system and society.
    vi. Those without injuries or injured employees have no reason to care
        1. Getting people to put in shutters before the storm threatens –
        2. Focusing interest is difficult in the abstract
b. Administrators and employers all think they have a clear and understandable process, but their users/customers often do not agree
    i. Employer representatives and the state agencies need to do a better job educating.
    ii. There appears to be a lack of information available to employees
    iii. Employers who outsource and buy a package deal, tend to wash their hands of the whole process also.
c. Legislators and Regulators are perhaps as biased thinking their efforts are clear and understandable yet the system is not understood.
    i. What businesses get from the state is written in legalese and is insufficient
    ii. So successful business drafts their own roadmap for the employee to educate them and help them find their way through the system.

d. Turnover in industry and lack of new talent
    i. In the old days an adjuster would be the POC.
    ii. With servicing agents today there are instances of 4 adjusters in a year,
    iii. There is an avoidance of responsibility and there is a decrease in the idea of investment in people, and the personal relationships that used to be the model in the old days.
e. Asking doctors to do non-medical functions
    i. Disability
    ii. Causation
        1. No physician is trained in Med School or residency to determine causation.
        2. The doctor simply relies upon the statement of the worker.
        3. Only those few who are "expert" in wc will look at the injury and the contributing factors, then look at the legal standard (prevailing factor) and render an opinion.
f. How are employers involved and engaged?
g. How does the employee become a pariah? "No one calls me anymore."
h. The disconnect between employer and employee allows the worker to be alienated and they become ancillary to the process, feel lost, and then they suffer poor outcomes.
i. Is the solution for this engagement of the employer in the claims process?
j. Understanding of the problem comes from the interaction and human element.
k. Carriers and employers may not agree who plays which role
    i. Carrier's market the idea that they take care of good people when bad things happen.
    ii. Quality of care is an element.
    iii. Carrier may provide and prefer concierge service for the employee
    iv. But employers sometimes do not want it.
        1. Carrier cannot make the employer care ("there is a clinic a few miles down the road")
l. Definitions and other state v. federal interactions
    i. The ACA is defining who employers are. Employers have elected independent contractor status to avoid "employees" and the implications of the laws.
    ii. The states and federal government cannot agree on standards for defining "employee."
    iii. Medicare implications and burdens are an issue. They see efforts as cost-shifting. There is a necessity of double checking the ICD because accepting a diagnosis can lead to future liability in that context.
    iv. There is a perception of MSA process being too complex, and creating bureaucracy. There is a fear that SSDI being involved could lead to additional complex bureaucratic processes
m. There is an element of identifying and focusing on the things that "we can control," as there is a perception that much surrounding us is not within our control.
n. Large employers tend to be more educated/expert at managing work comp cases.

i. They have resources and expertise
    1. Vast majority of large employers do right by employees.
    2. Even if the sentiment of upper management is focused and appropriate
        a. There are possibly incentive issues in management,
        b. Front-line management is not always in synch with the desire and the sentiment of the company leadership.

ii. Managers in small companies cannot keep up with the intricacies so when an injury happens the manager cannot engage. They have no idea how the system works.
    1. 80% of employers have 10 or less employees.
    2. Attitude of smaller employers is that WC is a fixed business expense, not an issue to manage.
    3. How do we better understand the perspective of the smaller employer, and
    4. How do we get them to appreciate the value and the importance of WC?
    5. WC is always going to be a trivial issue for most employers. Most employers get through each year with no claims. Injuries are low probability events. The system needs to be nimble to respond on a just-in-time basis when those events dooccur.

iii. Where is the education for the smaller (and representing the majority of employees)?

iv. Are small employers interested?
    1. Will they "get away with anything that they can?"

o. WI has the highest medical cost, but WCRI found that they get people back to work more rapidly.
    i. Is medical cost saving creating other costs?

p. There is fundamental difference of opinion on grand bargain
    i. Employer responsible for injuries because "someone has to be"
    ii. Employer responsible for workplace and comp instead of tort
    iii. 17 percent of workers' compensation claims have some element of negligence.
        1. Implication is that this 17% is what would be otherwise compensated in tort
        2. Counter argument is that all could be tort by using OSHA's assertion that employer has a duty to maintain a safe workplace."
        3. There could be much negligence that is in the system, but it is never seen or documented because in the no fault system there is no reason to document. That may drive the issue.

q. There is a cost-shift.
    i. When people are hurt (but it's not really due to work) , who pays the cost of that?
    ii. It becomes a society burden.
    iii. Is it less of a burden on society if we shift it to comp?
    iv. Drive to control cost – so shift instead.

r. Communication in broad terms
    i. Are we setting up expectations with the terminology "workers' compensation;" shouldn't this be "workers' recovery?"
    ii. Is the communication personal and effective?
        1. There is an association of small employers whose claims administrator sends s a "warm fuzzy" letter that provides education and information about roles, rights and responsibilities of all parties

V. Where non-subscription is most popular,is in the service industry.

VI. Medical interaction in the process
a. Doctor has the personal contact. The doctor has to have the motivation to serve the patient.
b. There is the issue of directing care.
c. You have to treat the whole person, symptoms, the employer willingness.
d. Employer disconnect. Some will only take back employee if 100%; others will provide any work short of bed rest.
e. There is a distinction between the group health model and WC. There is a rarity to provide extra compensation and so doctors avoid the market of WC.
f. Physician selection drivers and effects
    i. Employee selection of physician has been show to negatively impact recovery and return to work. Most often, employers/payers attempt to direct care to providers who actually get people better. Historically prior to the 1972 report there was complete freedom of choice of providers in regular health care (group insurance) and in WC there was a plant or company doctor model. The regular health care marketplace has changed dramatically with limited / tiered provider networks, etc. so that interaction has changed the dynamics.
    ii. When the employer's choice of physician is only financially driven (who is cheapest?) the result may not be as good.
    iii. The appropriate metric is success, defined as recovery, return of function and return to work.
    iv. Another data source: If there is no family doctor, then outcomes are better with employer choice. If there is a family doctor, then the health outcomes are comparable with family doctor vs employer-selected physician.
        1. But RTW is often delayed with the family physician.
g. Physicians play several different roles in different phases of a claim:
    i. Causation = gateway
    ii. Treatment = different
    iii. RTW = different role
    iv. Impairment evaluation = different role.
h. Dissect the various roles, within and beyond the physician choice issues.
i. How do doctors perceive workers' compensation?
    i. Dr. Not trained in it, not their job to manage the impact of life,

ii. The designated guesser, irritated to be pushed into the middle'. Little to no science to support decision-making – or that supports their ability to predict RTW success. . There are those who see doctors as an obstacle to the disability evaluation process.
iii. Does universal healthcare change the whole dynamic
iv. The doctor does not see managing RTW / comp issues as part of medical practice / their concern.
v. Doctors perceive the employers do not understand what is and is not in the physician's purview. .

j. How do we deal with restrictions and in a clear manner so that the employer can accommodate.
i. Employers perceive that the doctors do not appreciate the impact of their opinions and decisions on the worker or the business.
ii. The capitalist and legal systems seem to get in the way of insurers / employers banding together to educate physicians so they perform better systemwide. . Employers think insurers should do it. Insurers don't want to help their competitors.
iii. Dichotomy between the focus of treating the patient, and providing the causation and restriction/opinions that are not relevant to treatment
iv. Get away from the loopholes and the doctor decisions become less complex and perhaps less contentious.
v. There is data that the mental health of the physician workforce is being negatively affected by the current state of the medical system generally = a growing "burnout" problem,.
vi. When selecting physicians, their philosophy of care is perhaps more important than the numerical data-driven outcome results (because of difficulties getting enough accurate data per physician to make a fair judgment).
vii. Are the doctors that want to be in the system the best doctors to treat WC patients?
viii. Changing evidentiary standards, such as Daubert, have had significant impact. Doctors are being asked to substantiate and prove the science.
ix. Why Daubert in what is a self-executing system. Outcome is more complex, but is the outcome better or worse.
x. Is Daubert a tool that substantiates the opinion to make the case, or is the nature of medicine not subject to this scientific distinction.
xi. Clearing people to return to work is an issue delegated to physicians, BUT they often do it by asking the patient if they are ready.
xii. Is there science behind the decision or is it realistically just up to the patient to decide to return to work – because their intentions have such a strong impact?
xiii.

k. What keeps the doctors out of comp? It is the regulation and the forms that they have to complete. The doctors feel like they are in the middle. The doctor is not prepared to be there and does not relish the disputes as they are antithetical to her/his purpose of healing

i. The “who pays” question is not as important / interesting to the doctors themselves.

VII. Complexity of systems
   a. If claim denied, you cannot get through the system without an attorney.
   b. Payers stress that they are trying to follow the law. They are not lawyers or doctors and they are relying on the experts in the system. The law results in conflict, and that is what pushes the burden onto the doctors.
      i. Issues like MCC are an effort to restrict coverage. This is a fundamental debate within the context and counsel thinks that the legislation is causing the problems.
      ii. Coverage disputes put people in pain and dysfunction. Group health will not cover until the WC system makes decisions. Pre-worked out indemnification agreements might help.
      iii. Statutory fix for no medical during dispute is perhaps unless and until the WC system determines it is, and then Group Health is on the hook.
         1. Despite mandatory healthcare, many have no group health
   c. There is a perception that they system drives people to doctors for opinions on things like RTW, how many people go to the doctor for permission to RTW after the flu
   d. Is or should certification to RTW be a critical element in the process.
      i. How do doctors know about the job that someone is being cleared to? Does it benefit doctors to see the job of the worker?
   e. Patient satisfaction surveys are a real issue because it influences physician decision-making. There is evidence that supports this is part of what drove the opioid epidemic.
   f. Pay and investigate provision, is seen as a “must pay until proof to deny.” Pay and investigate is seen as something of benefit in workers’ compensation.
   g. Washington did an experiment with doctors agreeing in advance to perform (and get paid) for specific best practices (new services and reports) known to improve outcomes. The experiment was so successful they are now rolling it out statewide. Washington is a state fund, which might drive some of the commitment. This program (the Centers for Occuaptional Health & Education or COHE) has had strong employer/employee support and has not been perceived as partisan.
      i. This is an intended driver for the appropriate engagement of physicians
      ii. One state expressed that this training requirement did not work, and the physicians have not engaged. Some feel that is the fault of the training and the trainers.
      iii. Some states are engaging in physician training. They have incentivized it. To be on a provider panel in some states, certification is required.
      iv. More doctors get trained when there is oversight and persistence in prodding doctors them to complete it.

VIII. Proactivity in return to work debate
   a. Employer incentives: Washington state has a stay at work program with the state funding 50% of the cost. To keep IWs at work and involved/engaged.