

STATE OF NEW HAMPSHIRE

Final Report of the
Commission to Recommend
Reforms to Reduce
Workers' Compensation
Costs

12/1/2014

TABLE OF CONTENTS

Commission Members	Page 2
Mission Statement	Page 3
Final Recommendations	Page 4
Minority Report	Page 8
Statements from Commission Members	Page 11
Summaries of Meetings	Page 29

COMMISSION MEMBERS

Roger Sevigny, Chairman, Commissioner of the New Hampshire Insurance Department

Brian Allen, Vice President of Government Affairs at HELIOS

Donald F. Baldini, AVP and State Affairs Officer at Liberty Mutual Insurance

Pamela Bronson, Administrator at Access Sports Medicine & Orthopaedics

Paul W. Chant, Partner at Cooper, Cargill Chant

James Craig, Commissioner of the New Hampshire Labor Department

Tammy Denver, Director of Claims & Coverage Programs at NH Public Risk Management Exchange

Edward Dudley, Executive Vice President/CFO of Catholic Medical Center

Mark Erdody, Director of New England Claims, Cove Risk Services

Marc Lacroix, New Hampshire Physical Therapy Association and Director of Specialty Services at Concord Hospital

David Lang, President of Professional Fire Fighters of New Hampshire

Mark MacKenzie, President of New Hampshire AFL-CIO

Peter McNamara, President of NH Automobile Dealers Association

Dr. Gregory Soghikian, Physician at New Hampshire Orthopaedic Center

Ben Wilcox, President & General Manager of Cranmore Mountain Resort

MISSION STATEMENT

The Commission to Recommend Reforms to Reduce Workers' Compensation Medical Costs was established September 4, 2014, by New Hampshire Governor Margaret Wood Hassan.

The Commission's mission:

1. Review data and information explaining the basis for high workers' compensation costs in New Hampshire;
2. Review laws, regulations and other efforts undertaken by other states to successfully reduce workers' compensation medical costs and other workers' compensation costs;
3. Review laws, regulations and other efforts undertaken by other states to ensure continued access by injured workers to high-quality health care providers;
4. Develop and recommend a comprehensive reform to reduce medical costs and premiums in New Hampshire's workers' compensation system while preserving access to health care for workers, and;
5. Make any other recommendations the Commission believes necessary to improve New Hampshire's workers' compensation system to reduce costs and premiums, improve the care to workers, and to help workers return to the job in a timely manner.

FINAL RECOMMENDATIONS

Recommendation (1): Develop Database (requires legislation)

The Commission recommends legislation to provide authorization for the New Hampshire Insurance Department to develop a database of Workers' Compensation charges and costs (incorporating a mechanism for funding or appropriation by the Legislature) for collection, analysis and a transparency tool to allow public access to the information developed.

Votes for: Brian Allen; Pamela Bronson; Paul Chant; James Craig; Edward Dudley; Marc Lacroix; David Lang; Mark MacKenzie; Roger Sevigny; Gregory Soghikian

Votes against: Donald Baldini; Tammy Denver; Mark Erdody; Peter McNamara; Ben Wilcox

Recommendation (2): Workers' Compensation Pharmacy Benefit Management Programs (requires legislation)

The Commission recommends legislation be introduced that allows self-insureds, employers, and insurers on behalf of employers to implement registered, accredited pharmacy benefit management programs within workers' compensation that allow for direction of care with some exceptions. The legislation should provide rule-making authority to determine the process for registration and accreditation and to define the exceptions to the directed care portion of the pharmacy benefit management programs. In addition, the legislation would require health care providers to educate patients on opioid use in the context of their care.

Votes for: Brian Allen; Donald Baldini; Pamela Bronson; Paul Chant; James Craig; Tammy Denver; Edward Dudley; Mark Erdody; Marc Lacroix; David Lang; Mark MacKenzie; Peter McNamara; Roger Sevigny; Gregory Soghikian; Ben Wilcox

Votes against: no member of the Commission voted against Recommendation 2

Recommendation (3): Continue the Commission's Work

Continue the Commission for up to one year with an interim report due June 1, 2015, to further investigate other recommendations leading to cost savings, premium savings and the improvement of worker outcomes. The Commission shall determine an approach to advance cost containment within workers' compensation. Its charge is to review information, data and data options, to compare New Hampshire to other states' workers' compensation cost-containment strategies, to look at both costs and benefits and the relationship between them, and to examine any other alternatives that would promote cost containment in the system.

The group would be authorized to look at the overall Workers' Compensation system, including but not limited to:

- Consider a medical fee schedule, based on the Montana law, using the current NH health care database to establish fair and equitable benchmarks.
- Consider a medical fee schedule, based on other possible methods.
- Consider maximum allowable reimbursement methodology rather than a pure fee schedule.
- Revise RSA 281-A:24, which currently provides for payment of full amount charged, rather than a reasonable amount.
- Allow direction of patients to providers (employer choice).
- Allow free market contracting within workers' compensation.
- Adopt global packaging, or bundling of costs, for treatment-of-care episodes.

- Increase indemnity benefits from 60% to 66 2/3%.
- Look at clinical outcomes.
- Develop treatment guidelines.
- Review outliers to determine whether costs are being driven by a minority.

The Commission feels that these further efforts should focus not only on the what, but on the how – that is, that any recommendations should look not only at reducing costs but also at promoting high-quality care, positive outcomes, return-to-work improvements, fair and equitable programs and processes, minimizing unintended consequences, not implementing broad changes too quickly, etc.

The Commission feels that those who continue this effort should use all resources and tools available to them, including a possible future workers' compensation database, but that the work should continue regardless of the information available at the time. The high workers' compensation medical costs in New Hampshire continue to burden New Hampshire businesses, and action should be taken to address this. Recommendations may be adjusted in the future, as new data provides further insight into the issue.

Votes for: Brian Allen; Pamela Bronson; Paul Chant; James Craig; Tammy Denver; Edward Dudley; Marc Lacroix; David Lang; Mark MacKenzie; Gregory Soghikian

Votes against: Donald Baldini; Mark Erdody; Peter McNamara; Roger Sevigny; Ben Wilcox

Recommendation of the full report:

Votes for: Brian Allen; Donald Baldini; Pamela Bronson; Paul Chant; James Craig; Tammy Denver; Edward Dudley; Marc Lacroix; David Lang; Mark MacKenzie; Roger Sevigny; Gregory Soghikian

Votes against: Mark Erdody; Peter McNamara; Ben Wilcox

MINORITY REPORT

Minority recommendation: Adopt a Fee Schedule Using NH Dept. of Insurance's CHIS Database as a Benchmark

This minority report recommends the adoption of a fee schedule which uses group health as a benchmark of appropriate medical charges as a viable first step in controlling workers' compensation (WC) medical costs.

The New Hampshire Insurance Department collects group health payment data in their Comprehensive Health Care Information System (CHIS) database. The CHIS database would be utilized to determine the reimbursement rate for every treatment provided to an injured employee. As some providers may face additional costs associated with treating workers' compensation patients, a premium would be added to a provider's rate if they demonstrate such increased costs.

This fee schedule would be fair to medical providers and not difficult or expensive to implement. If medical providers are accepting group health payments for non-work related injuries, what is the rationale for requiring workers' compensation payers to pay upwards of 200% or 300% more for the same treatment? Access to care will not be impacted since the reimbursement will be based on existing NH general health costs which represent 97% of all medical costs.

We also recommend that the Insurance Commissioner work with NCCI to determine if its existing medical data report which already captures WC medical information from the carriers can serve to address medical issues rather than a new, mandated and costly database.

The Data is clear and overwhelming: NH Workers compensation medical costs are out of line with NH, the region and the nation

Multiple presentations before the commission confirmed what Gov. Hassan stated upon its creation: "New Hampshire has become one of the most expensive states in the Nation for workers' compensation, a burden on business across the State."

The reports issued on 11/19/2014 by the Dept. of Insurance are very compelling. When medical charges for NH compensation claims are compared to charges for the same types of claims in regular NH health care, the report found that on average:

- Surgeons charge 156% more for WC surgeries
- Ambulatory surgery centers charge 263% more in WC surgeries
- Radiology charges are 107% higher in WC claims
- Physical Medicine charges are 110% higher in WC claims

Pulling out a few individual procedures codes is even more captivating:

- At an ambulatory surgical care center, repair of a ruptured rotator cuff (code 23412) costs 422% more. (\$10,442 vs. \$2,000)

- Application of a hot or cold pack (code 97010) is 305% higher in WC claims versus non-WC claims
- Shoulder arthroscopy is 170% higher in WC surgeries versus a non-WC surgery (\$2,355 versus \$872)

Not only are the WC costs astronomically high in comparison to NH general health care costs, but NH also outstrips WC costs in nearby states and the entire nation. Ins. Dept. actuary reports reveal WC medical claims were 58% more expensive than the surrounding region and 45% more expensive than nationwide. Surgical procedure payments have the highest cost disparity (83% more expensive the region and 108% above national rates)

The National Council on Compensation Insurance (NCCI) reported to the commission that studies indicate favorable results with respect to access to care in states with medical fee schedules including: strong physician participation rates, timely access to care, and high satisfaction of care for injured workers.

The Workers Compensation Research Institute (WCRI) reported to the commission that states without fee schedules had higher professional services prices and more variations in process for paid specialty services. Additionally, such states had faster price growth.

WCRI also reported that advantages of using group health as benchmark for WC fee schedules include the following: group health is the largest source of health insurance coverage; group health prices reflect what providers are willing to accept in order to see a large share of patients; and group health prices reflect negotiations with network providers.

NH's WC medical costs are clearly out of line with NH general health claims, as well as, the WC claims in the region and the country. These costs are driving our WC premiums, making us the 12th most expensive state in the nation which adversely affects NH businesses. Fee Schedules have been proven nationally to reduce WC medical costs and particularly reduce the ever-steady medical cost inflation.

The Majority Report is contrary to the purpose of the commission

Governor Hassan's charge in creating the commission was short, straightforward and built into its title: "Recommend Reforms to Reduce Workers' Compensation Medical Costs." The majority report has rejected recommendations that are proven to reduce costs and, instead, made recommendations that increase costs. As such, a minority report is necessary.

The Majority Report adds Costs

The Majority's primary recommendation mandating creation of a WC medical fee database in order to prove high costs is unnecessary and will add, not reduce, costs to employers and WC carriers. The 11/19/14 Dept. of Insurance report provides the very data sought by this recommendation. The database is unnecessary since the proof of outrageously high WC medical costs in NH was repeatedly provided to the commission by the Dept. of Insurance, NCCI and WCRI. Gov. Hassan even cited proof of the high medical costs in creating the commission.

The database will add substantial costs to the carriers that operate in NH since most do not track the claims in the manner expected by the commission. Additional software, staff and outside expertise would add to each carrier's operations. Finally, the database would take over 3 years to develop further delaying any attempts to fix a broken system.

Having the Dept. of Ins. work with NCCI, as mentioned in our above recommendations, is less costly and would capture the needed information.

The second recommendation – implementing a mandatory pharmacy benefit program – admittedly may result in lower costs if it is indeed implemented; however, pharmacy represents a very small percentage of the overall medical pie. A small bite out of a small slice will not impact the cost burden in any meaningful way.

The final recommendation echoes many other commissions and committees: more studying is needed. Ironically, several members of the commission commented during the process that they have been dealing with this issue for many years. Additional years of inaction are not acceptable.

It is important to commend Commissioner Sevigny and his staff for their time and efforts in organizing the commission meetings and bringing before us expert presenters including their own staff and representatives from NCCI and WCRI. Similarly, a thank you is owed to our fellow commission members for their time and efforts in participating in the commission.

Finally, we applaud Gov. Hassan for her courage in highlighting the worker's compensation medical cost crisis and hope that she continues to advocate for reforms.

Minority Report drafted by: Peter McNamara

Minority Report signed by: Donald Baldini; Mark Erdody; Ben Wilcox

STATEMENT FROM COMMISSION CHAIR ROGER SEVIGNY

As it stands, I cannot support the Commission's third recommendation, to continue the group's work. While I agree that more work needs to be done, I am concerned that the many methodologies and possibilities the group has committed to examining in this recommendation will make any future effort on the Commission's part unduly diffuse. Thoughtfully limiting any future Commission's scope is necessary if anything is to be accomplished.

It is undeniably clear that New Hampshire workers' compensation medical costs are out of line with those in the region and nation, and that those excessive costs are affecting businesses in the Granite State. As research presented to the Commission has demonstrated, fee schedules have proven to be an effective means of curtailing excessive costs. Should a future Commission be necessary to create a fee schedule, its efforts should focus on developing one that is fair – to New Hampshire insurers, to health care providers, and especially to the state's workers.

While I agree in principle with the Minority Report's recommendation to adopt a fee schedule using group health rates as a benchmark, I cannot sign on to the report because I do not fully agree with all of the report's assertions.

A fee schedule would help to reduce costs, but it must be well thought out and carefully crafted. It should make use of the state's Comprehensive Health Care Information System (CHIS) database, and allowances should be made to cover the additional administrative costs associated with workers' compensation.

I disagree with the Minority Report's assertion that developing a workers' compensation medical database is unnecessary. While the creation of such a database would be time-consuming, the information it eventually would generate would be invaluable to the ongoing examination of workers' compensation costs in New Hampshire. A database could be constructed in collaboration with the National Council on Compensation Insurance, which already collects related information from New Hampshire insurers: I believe we can and should take advantage of what is already in place.

Until such a database is constructed, however, we cannot afford to do nothing. Work should begin immediately on the creation of a fee schedule that is fair and based on the real costs of health care in New Hampshire.

STATEMENT FROM COMMISSION MEMBER BRIAN ALLEN

As a member of the Commission, I want to first thank Governor Hassan for the opportunity to serve and add our voice to the discussion on finding solutions to aid in reducing medical costs in the New Hampshire workers' compensation system. I also want to thank my fellow Commission members for their thoughtful discussion and thorough deliberations on the many issues we discussed. Governor Hassan assembled a strong group of individuals who each brought a unique perspective to the Commission and the collective talent on the Commission is up to the challenge of finding consensus in areas that still require further exploration.

Recommendation #1 – Develop a database: The goal of any serious policy maker is to make informed decisions. One of the areas that seemed to hamper discussion on the Commission was a lack of specific, procedure-level cost data for the workers' compensation system. To aid in the long-term management of New Hampshire's workers' compensation costs, we support the recommendation to secure specific procedure-level data. That goal can be achieved in a number of ways, but we would recommend using one of the following methods:

1. Implement the International Association of Accident Boards and Commissions (IAIABC) billing and data reporting standards. The IAIABC has invested considerable time in bringing stakeholders from the various segments of the workers' compensation industry together to develop billing and reporting standards. The billing standards are designed to create uniformity in the data elements that are included in medical bills from the various providers and across state lines. Uniform billing standards should be implemented before the reporting of billing data is required to ensure that the data being provided to the state is consistent and comparable. Nearly every state that has implemented a state reporting requirement has adopted the IAIABX standards.
2. A database could also be developed by initiating a "data call", asking each insurer and self-insured entity to report their medical claims paid data to the state. While there may be some differences in the data elements between reporting entities, in general there should be enough commonality to made adequate comparisons. This method could be done fairly quickly once authority was granted to the appropriate state agency by the legislature.

In either of these scenarios, there is a cost associated with collecting and analyzing the data. Authorizing legislation should include an appropriation sufficient to cover those additional costs.

It is important to note that the lack of this data today should not delay further discussion on implementing a fee schedule or other cost-containment strategy for medical services in the workers' compensation system. Between the NCCI data and the existing state group health all payer claims database, sufficient information exists to guide an educated decision. While we support this recommendation, we don't believe this recommendation should be used as an excuse to delay critically needed action on rationalizing some of the workers' compensation medical costs at both the facility and provider level. Our support of this recommendation is to create a data set that will aid in future refinement of cost-containment strategies that should be implemented in the short-term.

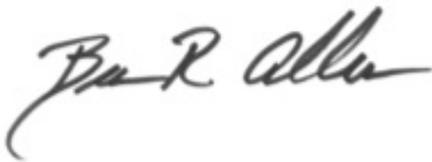
Recommendation # 2 - Workers' Compensation Pharmacy Benefit Management Programs: As a pharmacy benefit manager, Helios supports this recommendation. We take this opportunity to outline some best practices that should guide the development of legislation.

1. Statutorily authorize employers to implement a managed care pharmacy program. While this would not require every employer to implement a program it provides appropriate encouragement and establishes legislative support for the concept of managed pharmacy care.
2. Allow employers who choose managed care to require their injured employees to utilize the services of pharmacy providers that are within the managed care network with some exceptions to be defined by rule. Possible exceptions include:
 - a. Early fills – in the early stages of a claim an injured worker may require pharmacy care before the employer can get the pharmacy benefit card to the injured worker. Injured workers should be allowed to seek care from a qualified provider until they receive the pharmacy benefit information and can choose from a network provider that is convenient to them.
 - b. Pharmacy Proximity Issues – in certain rare cases an injured worker may live in an area where there is not a network pharmacy within a reasonable distance and a mail-order option is not feasible. Some allowance could be made for this type of circumstance.
 - c. Physician Dispensed Medications – limited physician dispensing may add a convenience factor for an injured worker receiving initial medical treatment following an injury. In some cases it may be easier for an injured worker to receive an initial fill of medication from the treating physician. If a physician chooses to engage in dispensing medications to injured workers, the medication dispense should be limited to a one-time initial fill that is no greater than a 14 day supply and should only be allowed at the time of the initial treatment following an injury. In no cases should refills be allowed. Additionally, if the physician dispenses repackaged medication, the reimbursement should be limited based on the cost of the original product used in the repackaging. If a physician wants to dispense medication beyond these limitations, the physician can seek to become an “in-network” provider for the pharmacy network.
 - d. Keeping as much care as possible within the network allows the pharmacy benefit manager to gain a greater and more immediate understanding of the scope of pharmacy care needed and aids in employing the best clinical tools to ensure the injured worker receives quality care that includes the right medication at the right time. The clinical tools also help steer injured workers and their doctors away from addictive or unnecessary medications and can also help identify potentially problematic claims before they become a big problem.
 - e. Some of the other benefits of using managed pharmacy care include network discounts, guaranteed payments to pharmacy providers, reduced administrative costs by streamlining processes and exchanging information electronically, screening out medications that are not related to the injury, educating injured workers on how to best use their medications, aiding in adherence to medication regimens, helping to enforce the generic mandate, and continual evaluation of pharmacy claims data to identify trends and areas of potential improvement and/or cost savings.

3. Reducing Opioids Using Clinical Tools – The PBM clinical tools are developed using evidence-based guidelines that are widely accepted in the treatment of injured workers. Allow the PBMs to implement their best clinical tools to reduce the use of opioids in the New Hampshire workers’ compensation system. While there are some cases where opioids are necessary for effective treatment of pain, far too often unfettered access to opioids creates more problems than it solves. A number of recent studies have shown that the use of opioids extends the life of a claim and inhibits return to work. Most workers’ compensation PBMs have strategies they employ to find suitable and effective alternatives to addictive and potentially harmful medications. The PBM clinical tools can also help reduce the use of high-cost compounded medications that have questionable efficacy.
4. Access to Care – Most workers’ compensation PBMs have large pharmacy networks. Based on our experience, there have not been any demonstrable access-to-care issues when injured workers are required to use a network pharmacy.

Recommendation #3 – Continue the Commission’s Work: We support this recommendation. While it may appear that some members of the Commission are “dug in” on a particular position, we believe that in a very short period of time further work by the Commission would bear fruit specifically as it relates to rationalizing costs in the general medical treatment of workers’ compensation injuries. As stated in #1 above, sufficient data exists to develop a recommendation that would have immediate impact and there seems to be enough “open-mindedness” that some solutions to address medical costs would emerge from the Commission in a fairly short period of time. Any recommendation implemented could and should be refined over time as better data is developed based on the first recommendation. We are happy to continue in the work of the Commission.

Respectfully submitted by:



801-230-8379

STATEMENT FROM COMMISSION MEMBER PAMELA BRONSON

Thank you for the opportunity to provide additional insight and information regarding the work of the Commission and the Final Report. The Staff suggested I submit the following requested changes to the Majority Report as part of a “personal position statement”. Please note that I do not believe these reflect personal opinions. These changes were requested as edits and additions to the Final report, submitted prior to the requested deadline and to be distributed to all the Commission members for consideration in the final report. While some of my proposed changes were accepted by Staff. The following changes were not included in the final report. These edits were provided to clarify and include additional detail for some of the representations made throughout the final report. All statements below in quotes below were not made by me. These statements were made by Presenters and may be confirmed by reviewing the minutes of each meeting date or reviewing the resources found as links online at:

<http://www.governor.nh.gov/commissions-task-forces/workers-comp/index.htm>

FINAL RECOMMENDATIONS:

Last Paragraph

“...The Commission feels that those who continue this effort should use all resources and tools available to them, including a possible future workers’ compensation database, but that the work should continue regardless of the information available at the time. The high workers’ compensation ~~medical~~ costs in New Hampshire continue to burden New Hampshire businesses, and action should be taken to address this. Recommendations may be adjusted in the future, as new data provides further insight into the issue.”

The term “medical” should be deleted from the last sentence in this paragraph. The representation that the high workers’ compensation costs in NH are specifically exclusive and related to medical costs is a conclusion that was not yet reached by the majority of the Commission members. If this conclusion was evident then recommendations to continue the Commission and to collect additional data would not be necessary.

SUMMARIES OF MEETINGS

SEPTEMBER 26, 2014

Representations made here as fact should be footnoted with the source of the data from which these percentages and conclusions are being drawn. The Presentation of Workers’ Compensation Medical Costs in New Hampshire was based exclusively on NCCI data representing 29 data elements in a voluntary 2013 data call from a limited set of carriers using aggregate data. It should be noted that this presentation and all NCCI data represents insured data only and excludes 1/3rd of NH Work comp in the self-insured market.

- Proportion of medical costs in NH has increased over the years, while countrywide has been relatively stable.

This statement should be clarified to note the 2003-2012 NH medical costs increased 9% and Country-wide experienced a 4% increase.

- The Oregon WC Premium Ranking reports NH at #12 in 2014 and was highlighted as the sole basis for concern that defines WC Premium Costs as high when compared to other States. However, it should be noted that there is no direct correlation between a State's Oregon WC Premium Ranking and whether or not a State has a Physician or other Fee schedule to control medical costs. This point is best highlighted when reviewing the Oregon Premium Ranking for each State without a fee schedule.
- NH (ranked 12 in the Oregon WC Premium Ranking) and is one of only 7 states without a Physician (clarification) fee schedule. Other States without medical cost fee schedules include:
Indiana (ranked 50), Iowa (24), Missouri(21), New Jersey (3), Washington (17) and Wisconsin (23).
- There is also no direct correlation between the WC Premium ranking and the Percentage of Medical Costs in WC Overall costs.
Indiana has 73% WC Medical costs and is Ranked among the top performers at #50 in the Oregon WC Premium Ranking

OCTOBER 9, 2014

Continuation of Presentation of Workers Compensation Medical Costs in New Hampshire
Sally MacFadden, Property & Casualty Actuary

- The DOL clarified that the Self Insured Market represents “62million of the 187million in Workers Compensation. (33%)”
- “Medical Costs in the Self-Insured Market are 65% while Medical Costs in the Insured Market are 73%.”
- “All NCCI Data contained in this presentation and others represent the Insured Market ONLY (2/3rds of the market).”
- The Self-Insured entities (in NH) “already have some kind of handle on their medical costs and worker’s comp costs overall.”

Presentation from the Workers Compensation Research Institute (WCRI)

Dr. Richard Victor, Executive Director, Ms. Ramona Tanabe, Deputy Director & Counsel

- “When a state reduces a fee schedule by 20% they assume they will get a 20% reduction in medical costs. I’ve never seen that happen, it’s always a smaller number.”
- Unintended Consequences: “The decision to have a fee schedule or not is a strategic one. Once you go down that road you cannot go back, like Pandora’s box. It generates behaviors.”

OCTOBER 23, 2014

Presentation from the National Council on Compensation Insurance
Natasha Moore, FCAS, MAAA, Practice Leader and Senior Actuary

In Texas:

WC patients “had to travel further or longer distance”

The States of California and Florida were also discussed as part of this presentation. These States were determined to be problematic and not necessarily States we may want to follow. There was a great deal of discussion about California and we were made aware they were scrambling to implement legislation to address the unintended consequences/results of previous legislation including fee schedules. The same issue was occurring in the State of Florida..

A Study by the University of Washington estimated a cost of \$349million within the first year of injury to WC California due to access barriers in the system post legislative changes.

• In Maine: It is important to note that Maine has just 46% of medical costs and yet is ranked #13 by Oregon WC Premium Index, just below NH at #12.

NOVEMBER 6, 2014

Presentation from the Workers’ Injury Law and Advocacy Group

Chuck Davoli, WILA Immediate Past President, Attorney, Labor Representative

- WC second most profitable line of insurance
- Operating decreased from 100.4 in 2011 to 93.8 in 2012, earning \$6.20 of profits for every \$100 of net premiums
- Investment gains are up every year from 2008 to 2012

With consideration of and the addition of the above points of clarification, I support the findings and recommendations of the Majority.

On a personal note, I would like to add that there was a significant issue overlooked and not discussed in the relatively short time the Commission had to review medical costs. While the costs and comparisons to other States WC costs and Group health costs were raised and discussed, the potential reasons the cost of treating injured workers may be higher was not discussed.

Providers cannot balance bill the employer, employee, or anyone for an accepted NH WC medical claim. This is not a restriction imposed on any other NH service provider or business. This restriction does not apply to any other non-contracted health insurer or payer. There is also no rule or expectation for when the provider should receive payment for services rendered on an accepted WC claim. Even Medicare pays interest to the Healthcare provider if there is a delay in processing a claim. This is not the case for WC. Our practice has contacted the Department of Labor for unpaid or underpaid claims and at times have been told they do not have the staff resources to assist us in getting payment from the carrier for an outstanding appealed claim. As the account ages, the provider ultimately will write off the unpaid or underpaid balances as bad debt. It is not an insignificant number.

If a fee schedule is implemented, then the providers need some ability to either get paid the fee schedule amount in a timely manner or balance bill. Appeals are not always effective and implementation of a fee schedule without establishing clear guidelines may only further stress what appears to be an already understaffed and overworked Department. I do not feel it is reasonable to expect the healthcare provider to accumulate a WC accounts receivable indefinitely without being paid for services and without any opportunity for recourse. It appears WC Carriers do not have any requirements or the State does not have the resources to enforce timely payment for services. There is no further recourse, and unpaid balances are written off as bad debt. This needs to be a consideration.

It is also important to note that unpaid claims do not appear anywhere in the data presented by NCCI. The data reported is on paid claims. Unpaid claims need to be factored into the average payment data. Implementing a fee schedule without fully exploring all the factors that drive up Overall WC premium costs will most certainly have unintended consequences. No other NH business is restricted in any way for collecting on services rendered. This is unique to Work Comp and needs to be considered as contributing to the cost along with continued research of other cost drivers.

This is exactly why I strongly support the work of the commission continue with specific timelines and expectations to continue our work and provide meaningful recommendations for positive change.

I sincerely hope the Governor supports the Majority recommendation and allows the Commission to continue this important work.

Thank you for the opportunity to respond to the final report and to participate in this Commission.

Respectfully Submitted,

Pamela Bronson

STATEMENT FROM COMMISSION MEMBER PAUL CHANT

I believe the Commission as a whole would be able to ultimately reach a consensus on a legislative fee schedule if given that opportunity. There is strong sentiment for change, but the majority wants to ensure that any proposed change will work effectively for injured workers and medical providers. The time provided for the Commission to render this report did not allow full examination of how effectively different models would work in New Hampshire.

STATEMENT FROM COMMISSION MEMBER EDWARD DUDLEY

The New Hampshire workers compensation system is complex and the Workers Compensation Commission has worked diligently for the last two months to identify all the various components of the workers compensation system that contribute to its complexity. While the Commission has benefited from presentations from nationally recognized experts and has reviewed a number of national workers compensation reports and studies, there is still more work to be done. In order for New Hampshire to develop a truly New Hampshire solution that takes into account all perspectives – the injured workers, employers responsible for paying premiums, carriers responsible for providing WC coverage, regulators responsible for carrying out the WC laws and providers responsible for treating the injured worker – the Workers Compensation Commission needs more time to continue the work that has begun. Rushing to a conclusion without thorough discussion of all aspects of the system, the potential consequences of a recommended system change and consideration of the safeguards necessary to achieve meaningful reform could lead to unintended consequences that will not result in achieving the Commission's stated objective.

The Commission's recommendation to develop a workers compensation claims database is critical to achieving this goal. There is no workers compensation claims data available in the public domain. The state of New Hampshire is a leader in the development of a similar database for health insurance claims so the expertise and infrastructure is readily available to expand the database to collect workers compensation claims in a reasonable amount of time with the current available resources.

The Commission has heard from providers on how the health care system is transforming with the movement away from fee-for-service medicine to a more value-based model. The way an injured worker is cared for will be affected by this system-wide transformation in care delivery. More discussion and consideration is needed by the Workers Compensation Commission to ensure that the injured worker continues to receive the highest quality of care that they have come to expect and deserve but with the appropriate incentives in place to ensure that they receive the right care, in the right place, at the right time and return to work as quickly as possible by employing state of the art outcomes measurements and back to work safety programs.

The Commission recommendation to implement a registered, accredited pharmacy benefit management (PBM) program is a positive step towards establishing a fair and effective vehicle for better management of pharmacy benefits under the workers compensation system.

I thank the Governor for asking me to serve on this important Commission and my fellow Commission members for their collegial efforts over these past few months to improve our workers compensation system in New Hampshire, and I look forward to continuing this important work.

STATEMENT FROM COMMISSION MEMBER MARK MACKENZIE

Workers Compensation reform should protect the rights of workers and provide adequate care in a timely way delivered through a comprehensive medical care system. It should also provide for indemnity benefits which replace the majority of the wages for insured workers and further provide for a system of rehabilitated care.

The rights of injured workers should not be dealt away in a reform proposal that attempts to limit the cost of the medical benefits by reducing benefits to the injured worker. Reforms must from the New Hampshire AFLCIO position be carefully structured.

The New Hampshire AFLCIO supports further study of the medical cost associated with the program and acknowledges the information regarding the costs presented to us. This however is only one piece of a comprehensive system and the interest of the others at the table must be flushed out with the same level of detail and research.

The pharmacy benefit programs presented to the Commission are designed to help control the use of prescription opioids by injured workers and the New Hampshire AFLCIO believes this has merit. The law should clearly state the requirements and provide sufficient detail to inform the rule making process as to the definition and accreditation of any such program.

The Commission did not take up the question of treatment of those injured workers who through no fault of their own find themselves experiencing difficulty with opioids use as a result of medical treatment. This will be a major challenge for the workers compensation system. Education and control of these substances is the first step but care of the injured worker should include a comprehensive approach to his or her care and should include a provision for substance use disorder treatment when appropriate.

STATEMENT FROM COMMISSION MEMBER GREGORY SOGHIKIAN

I had the opportunity to attend all of the Workers' Compensation Commission meetings. The individual presentations have been discussed at length, the varying opinions have been expressed, and the majority opinion is clearly stated. However, much of the information is in the discussions of each topic which is not easy to see unless you listen to the meetings. The summary of presentations does not outline all of the major data points that are pertinent and there are several topics that were not discussed or were only briefly discussed that warrant further discussion, so I do believe that there is some personal input that can be added to the ongoing discussion.

The first question is the question as to how much of a problem there truly is. In the Governor's charge she stated that New Hampshire was the ninth most expensive state for workers' compensation premiums as ranked by the Oregon rankings. This charge stemmed also from the original Workers' Compensation Advisory Committee information that dated back to the ranking of 2011. Since that time our rating has improved from ninth most expensive to twelfth. While this still puts us in the upper levels of workers' compensation premium costs, we are clearly moving in the right direction. It should also be noted that our workers' compensation premiums have been steadily decreasing since 2010 and a estimated 5% reduction is expected this year as well.

Looking at the cost, one of the numbers that is frequently repeated is how high our percentage of premium costs are on the medical side. This percentage is misleading because our indemnity costs are significantly low, and in fact are 30% lower than the national average. (Indemnity costs are the non-medical costs such as paying wages while out of work or paying for permanent impairments or for workers that do not return to their usual job.) Because our indemnity costs are very low, our percentage of premium that goes toward medical costs will obviously be higher.

Low indemnity costs is one indicator of the high quality of care our workers receive. High quality medical care results in outcomes that allow the worker to return to full regular duties relatively quickly and decreases indemnity costs. With any changes to the system we have to be very careful that those changes do not result in unintended consequences. Specifically, we want to be careful to preserve the high quality of care that is already being provided in New Hampshire, not only because the indemnity costs will go up as the quality of care goes down, but also the outcomes for the injured worker will also be affected directly. We need to remember that the medical care for our workers and the restoration or preservation of their health is the number one priority in all of this. We also need to make sure that if we do institute any changes that result in cost savings, those cost savings get passed along to the employer and to the injured worker, and do not simply disappear into the administrative costs of the carriers, legal costs or other administrative portions of the cost of workers' compensation care.

Although our premiums are high relative to many other states, New Hampshire is still a very favorable and attractive state for workers' compensation carriers to do business. The combined loss ratio in New Hampshire was only ninety-four percent vs. the nationwide loss ratio of about one hundred and ten percent. New Hampshire has been able to attract several new carriers to this state over the past several years. For the self-insured employers within the state I think there is

more of a direct cost issue. It should be remembered when looking at NCCI data that all of the data is only for those groups that are insured, their data does not include at all any of the self-insured groups, which compromises at least forty-percent of the market in New Hampshire.

In terms of some of the data that was reviewed by the Commission there are certain things that should be remembered when reviewing the summary:

1. For Texas the data is significantly skewed because Texas has a very large OPT out option that was not discussed or disclosed during the data presentation. One point to note in Texas was that when a Fee Schedule was imposed, not only did a large number of employers and carriers choose to opt out of the system, but twenty percent of their top quality providers left the system and dropped workers' compensation as a provider.
2. California was also reviewed in some detail. It should be remembered that California has a very different medical environment. They have a very large issue with undocumented workers and under reporting of workers' compensation issues, and that is something that is not applicable in general to the New Hampshire situation.
3. When you look at the summary of all states and what they have done with Fee Schedules, the vast majority of them are using a Medicare-based Fee Schedule. It should be remembered that WCRI (Worker Compensation Research Institute) said specifically that Medicare is not a good basis for a Fee Schedule for several reasons. The first is that it is a federal level determination of fees having nothing to do with an individual state's needs or conditions, that some of the regional adjustments are skewed, that the fees do nothing but go down over time, there is no cost-of-living adjustment, and there is no correlation to costs. It should also be noted that almost every single state that has a Fee Schedule also has the ability to negotiate outside (above) that Fee Schedule. In fact with certain states, such as Massachusetts, that is the main way that the system works is through an outside negotiated Fee Schedule care. The vast majority of high quality providers in Massachusetts negotiate separate rates on a case by case basis (that are substantially higher than the Massachusetts fee schedule and are fairly close to the usual and customary rates in NH). The problem with negotiated separate Fee Schedules is that it delays care for the injured worker, it adds tremendously to the legal burden of the system, and has a large amount of additional hidden costs that are not direct medical costs.(I have personally experienced this with patients that I have treated that have Massachusetts based coverage).

When looking at other states it is probably most pertinent to look at our neighbors, Vermont and Maine, as they are most similar to New Hampshire's mix of job types and workers within the system. In 2012 Vermont was ranked fourteenth most expensive in workers' compensation. Maine was tenth, and New Hampshire was the worst in Northern New England at ninth. Since that time both Vermont and Maine have instituted Fee Schedules (with outside negotiations as an option), and now in 2014 Vermont is ranked eighth most expensive; they moved up in expense by six positions. Maine has dropped from tenth to thirteenth most expensive, and New Hampshire is still between the two having improved from ninth to now twelfth position in terms of premium costs. We have done this without any Fee Schedule changes. Vermont clearly failed

to improve their relative position in spite of having a Fee Schedule. At this point, at \$2.18 per hundred dollars of payroll, we are just four percent above the New England average.

This commission spent almost all of its time discussing a Fee Schedule as a way to reduce medical costs and spent very little time discussing any other options. This, I believe, was partially due to the limited amount of time that we had to work on this complex issue. Our charge was to investigate medical cost savings, not just a fee schedule, but the focus was in reality a discussion of fee schedules. There are other ways to institute cost savings, and one of the reasons that the commission majority recommended continued investigation was that those other options were not investigated or discussed in any detail and could provide substantial savings with or without a fee schedule.

Before jumping straight to a Fee Schedule it would be appropriate to investigate other options. Most of these options have not been explored by the Workers' Compensation Commission. These are a few areas that I am aware of that are being discussed nationwide. I am sure that there are others as well.

1. Our drug rules: this is something that we have explored and intend to explore further as a very straight forward and well received area of potential costs savings. We did discuss instituting PBM or pharmacy benefit management. Two additional areas that we discussed briefly, but did not yet address under the drug rules, are the areas of repackaging of medications and the area of compounded medications.
2. The ability to direct care: To make sure that the workers get to the most appropriate medical care early on. Directed care has two potential benefits. The first is getting the injured worker to the best provider for their type of injury as early on in the process as is possible. It has been shown that when a worker gets to the right provider early on the worker's medical results are better, they are better faster, and the time lost and the final indemnity is lower. In addition to that benefit there is the benefit of lower costs through negotiated contracts. In order to maximize costs savings through negotiated contracts there must be the ability to direct care to quality providers who do contract directly with their workers' compensation partners. This is something that is already going on now within the state and frequently results in costs savings of ten to twenty percent from the usual and customary level of fees. When combined with directing care toward the specialists that are best able to treat the workers problem, it is a "win/win" situation where at a substantially lower cost the workers are provided with the highest quality of care most expeditiously speeding their return to work and their successful outcome.
3. Bundled payments: the ability to set a price for an episode of care rather than for each part of care. This is something that is already being explored with some group health carriers and with a limited number of workers' compensation carrier partners. Bundled payments could include anything from the initial evaluation of the patient all the way through to any type of imaging, surgery, physical therapy and rehabilitation, and their eventual return to work. These types of programs are again a "win/win" situation where there is significant costs savings, as well as improved outcomes. In addition, it makes it easier for the carriers to predict their medical costs and their reserve requirements.

4. Using treatment guidelines: to help guide our providers in the way that they approach each problem. Within treatment guidelines an attempt to get opioid medication prescriptions and management under direct control would be a huge step both for costs savings and improving long term worker health.

When looking at the data it is clear that for many procedures and services the average fee charged in the State of New Hampshire is significantly higher than it is in other states. Unfortunately, while we have very detailed data available to us within the group health realm, our workers' compensation data is limited. First, as stated above, it is limited only to those carriers that are not self-insured employers. Secondly, and more importantly, the data is aggregate data; meaning that it is all combined from all providers throughout the state. At this point we are unable to look at that data and see what the spread is of the range of charges and fees paid for procedures across the state. Our data is particularly lacking on the hospital side of what is billed and what is paid. It is likely that if we were able to look at the data specifically and see what the individual locations of charges were, that we would see a Bell Curve with some lower charges, a large group in the middle, and some outliers with significantly higher charges. If you then take that Bell Curve you would probably find that the top two standard deviations, or ten percent, significantly drive up the overall average of medical costs within the state. If that proves to be true, then it would be relatively straight forward to quickly bring medical costs into line with our neighboring states simply by placing a cap on charges at ninety percent of what the current average is. That alone would likely result in significant costs savings without punishing all providers in the state. However, it is difficult to know exactly what that impact would be without knowing what the Bell Curve is or what the individual providers and locations are charging and what they are being paid throughout the state. This is one of the reasons that a 2/3 majority of the commission called for legislation to get that information from the workman's compensation carriers in the state. When we have access to that type of detailed information we would be able to determine exactly who is driving the upper end of our fees so that we can directly address those outliers.

A Fee Schedule in itself is not something that is unacceptable to medical providers. Like many other things, the main concern is over exactly what that Fee Schedule will be, how it will be determined, administered, and updated on a year-to-year basis.

The problem with a Fee Schedule that is based on Group Health is that Group Health fees are based on a contract where most providers have absolutely no power to negotiate or control Group Health Fee Schedules and have no ability to change that Fee Schedule while the provider's expenses continue to skyrocket internally. Fifteen years ago orthopedic practices averaged 2.5 full time employees to support each physician. Now the average is over 4.5 fulltime employees, and that is in spite of spending huge amounts of money on mandated electronic health information systems. Much of that direct increase in support staff is additional employees to help get insurance company mandated authorizations for the treatments that our patients need. Our number one expense after salaries is health insurance for our workers, our health insurance premiums have increased almost every year by double digit percentages while our reimbursements rarely even have a cost of living adjustment. So a fee schedule based on group health schedules is not a long term solution.

If a Fee Schedule was to be imposed, my personal feeling is that the best basis would be a basis that starts with where we currently are with workers' compensation and adjust downward from that schedule in order to achieve the needed adjustments to bring us in line with our neighboring states without decimating the high quality of care that is currently provided in this state. As stated in the section above, if we knew where the outliers were in the system then we might even be able to achieve this without reducing fees to the majority of providers within the state. Smaller steps of change are also much less likely to have significant unintended consequences to a system that right now still works well and provides very high quality care to the injured worker.

I strongly believe, as does the 2/3 Majority opinion of the Commission, that while there is a medical cost problem it is by no means a crisis, and the next best step is to collect for workman's compensation the same type of detailed data that we now have on the group health side. From the data presented and reviewed, I personally feel there is tremendous opportunity for cost savings without risking the consequences of a randomly mandated fee schedule.

Respectfully submitted,



Gregory W. Soghikian, M.D.

Interstate comparisons of WC insurance costs: Oregon Dept of Consumer and Business Services, "2014 Oregon Workers' Compensation Premium Rate Ranking Summary." October 2014

Healthcare spending in NH vs nation: Kaiser State Health Facts. "Health Care Expenditures per Capita by State of Residence." NH: \$7,839. National average: \$6,815. <http://kff.org/other/state-indicator/health-spending-per-capita/?state=NH>

Medical and indemnity costs per lost time compensable injury, NH vs other NCCI states: Data distributed at NCCI State Advisory Forum, Sept 16 2014. Manchester, NH. Available online at https://www.ncci.com/documents/SAF_NH.pdf

Average insurance cost per worker and average wage: Insurance costs computed by applying Oregon's \$ per \$100 payroll figure to data on average annual wage in New Hampshire, found at Bureau of Labor Statistics, State Occupational Employment and Wage Estimates for New Hampshire

Claim frequency and cost trends: NCCI State Advisory Forum, Sept 16 2014.

STATEMENT FROM COMMISSION MEMBER BEN WILCOX

I want to start by thanking Commissioner Sevigny for his leadership during the Worker's Compensation Commission sessions. It was a pleasure to work with a talented group of diverse individuals on the commission who all seem to have a passion for the topic of worker's compensation. It was also a pleasure to work with Commissioner Sevigny's staff, all of whom brought a level of expertise to the sessions which was very helpful.

Operating a ski resort with 30 year-round and approximately 550 part-time employees, I am very aware of the financial impacts of worker's compensation. I first became aware of NH's high cost of worker's compensation when I compared my insurance plan and experience classification code costs to our co-owned and operated sister ski resort, Jiminy Peak Mountain Resort, located in western, MA. I found that our insurance costs and medical treatment costs were double to triple that of our neighboring MA resort. With this knowledge I was very anxious to roll up my sleeves with the commission to understand why our rates were so high.

After hearing several presentations at commission meetings it became clear to me that medical costs are the driver of our rates and the rates at ski resorts all over the state, not to mention all businesses state-wide. The presentations also provided proof that implementing a worker's compensation fee schedule would lower medical costs and this evidence is clear in states where it has been implemented. This makes it easy to understand why 42 states in the nation have implemented a worker's compensation fee schedule.

During the sessions I was impressed to learn what an extensive group health care cost database exists through the efforts of the Department of Insurance. This database clearly provides us with a benchmark that can make it possible to define a worker's compensation fee structure that can be fair for all individuals, including health care providers. When comparing this data to the NCCI worker's compensation cost data, it clearly reinforces the fact that our worker's compensation medical costs are egregiously high both regionally and nationally.

For all the reasons stated, I am supporting the submitted Minority Report which calls for the implementation of a fee scheduled worker's compensation program. The Majority Report calls for more data and more meetings and I think we have had enough meetings and are ready to formulate a working group that will establish a worker's compensation fee structure for the State of NH. The Majority Report mentions that a fee structure will be further explored, but I feel this combined with the long list of other ideas will stall the process and not meet the charge expressed by Governor Hassan, which is to address NH's high worker's compensation medical costs. By endorsing the Minority Report, medical costs will be addressed and lowered to meet the charge. Valuable time has been spent on this topic and I am convinced that the answer is right in front of us - therefore I can only hope that action will be taken now versus sometime in the future.

Lowering worker's compensation rates helps us preserve jobs by controlling costs and it lets us be competitive with our neighboring states. I would not want potential industries and businesses to shy away from our great state because of the egregious worker's compensation medical rates that are being charged.

Thank you for including me on the commission and let's hope we can make a difference by addressing the Governor's charge.

SUMMARIES of MEETINGS

Agendas and materials for all Commission meetings, as well as audio recordings of each meeting, may be found online at: <http://www.governor.nh.gov/commissions-task-forces/workers-comp/index.htm>.

SEPTEMBER 26, 2014

Presentation on Workers' Compensation Medical Costs in New Hampshire

Deborah Stone, Director of Financial Regulation and Sally MacFadden, Property & Casualty Actuary

<http://www.governor.nh.gov/commissions-task-forces/workers-comp/documents/wcc-09-26-2014-nhid-medical-cost.pdf>

- Overview of legislation related to workers' compensation since 2005
- Workers' compensation medical costs make up 73 percent of total WC costs in New Hampshire, as compared to 59 percent countrywide
- Proportion of medical costs in NH has increased over the years, while countrywide has been relatively stable
- Physician services cost an average of 18% more in NH than the surrounding region, and 16% more than countrywide
- Hospital outpatient surgical procedures cost 15 percent more in New Hampshire than in the region and 25 percent more than countrywide.
- Drug costs were 41% higher in NH than surrounding region, and 17% higher than countrywide (*Exhibit 7*)

- Overall, physician costs per claim were 39% more expensive in NH than in the region or countrywide.
- NH one of only 7 states without a fee schedule

OCTOBER 9, 2014

Continued: Presentation on Workers' Compensation Medical Costs in New Hampshire

Sally MacFadden, New Hampshire Insurance Department Property & Casualty Actuary

[Minutes \(Part 1\)](#)

Presentation from the Workers Compensation Research Institute (WCRI)

Dr. Richard Victor, Executive Director, Ms. Ramona Tanabe, Deputy Director & Counsel

<http://www.governor.nh.gov/commissions-task-forces/workers-comp/documents/wcc-slides-nh-commission-100914.pdf>

- States without fee schedules had higher professional prices and faster price growth
- In states with fee schedules, prices changed following fee schedule changes
- In states without fee schedules but with strong networks, the trends in prices paid can be affected by changes in network prevalence and discounts in negotiated prices
- Workers' compensation and group health hospital prices are correlated, but workers' compensation prices are much higher in some states
- Most states have enacted hospital fee schedules
- Most states have hospital outpatient fee schedules
- Most states with fixed-amount fee schedules had lower hospital outpatient payments
- States with no fee schedules had higher hospital outpatient payments

- States with charge-based fee schedules had higher hospital outpatient payments
- Most states have ASC fee schedules
- Possible fee schedule benchmarks:
 - Provider charges
 - Medicare rates
 - What group health insurers pay
- Prices are usually lower in states with certain types of fee schedules
 - Those that use “fixed dollar amounts” affect prices paid and price growth
 - Those tied to provider charges have little effect on average prices or the growth in average prices
- Policy makers design fee schedules hoping to balance cost containment with access to care
 - There is no ideal benchmark to use, although group health rates have some advantages

OCTOBER 23, 2014

Two presentations: from the National Council on Compensation Insurance, and on evidence-based medicine

Presentation from the National Council on Compensation Insurance

Natasha Moore, FCAS, MAAA, Practice Leader and Senior Actuary

<http://www.governor.nh.gov/commissions-task-forces/workers-comp/documents/wcc-10-23-2014-impact-fee.pdf>

- In Texas:
 - A relatively stable number of WC physicians
 - High WC physician retention rates
 - WC patients receive medical care quickly
- In Maine:
 - Average payments for hospital services decreased after the medical fee schedule change, and share of payments attributed to hospital services decreased
- Estimate of NH's HB 1468 proposed fee schedules at 150% of Medicare:
 - Overall medical costs will go down 17.6%
 - Overall costs will go down 13.1%
- Studies indicate favorable results with respect to access to care in states with medical fee schedules
 - Strong physician participation rates
 - Timely access to care
 - High satisfaction of care for injured workers
- Properly designed fee schedules are effective at controlling payments for medical services
 - Limits reimbursements
 - Reduces inflation rate for medical payments

Presentation on behalf of Concord Hospital: evidence-based medicine

Commission Member Marc Lacroix

[LBP Pilot Project](#)

- Virginia Mason study aimed to improve quality and reduce cost for employees with low back pain
- When care was redesigned to include same-day access to a physical therapist and a physical medicine physician, over the course of several years the study showed:
 - A 50% reduction in lost work time
 - \$2 million in savings
- Concord Hospital's mandate: Decrease MRI's (many deemed unnecessary). Outcomes:
 - Decreased imaging rates
 - Lower overall cost
 - Fewer visits in PT with decreased therapy cost
 - Outcome data supports positive outcomes
- Incentives to create best treatment and outcome models:
 - Narrow networks
 - Targeted fee schedule

NOVEMBER 6, 2014

Three presentations: Workers Compensation Advisory Council, Workers' Injury Law and Advocacy Group

Presentation from the Workers Compensation Advisory Council

Peggy Crouch, Chair

[Minutes \(Part 1\)](#)

- Council has been discussing problems since 2011 cost of medical treatment for WC claims in NH as compared to the region and WC claims in NH as compared to the region and countrywide.
- Unanimous agreement in 2011 that there was a problem, issue needed to be addressed.
- Recommendations led to the proposal of several pieces of legislation:
 - Amendment to current statute mandating the substitution of generic drugs
 - Amend statute to allow employer selection of provider for a specified period of time
 - Language regarding payment of medical bills: Current statute as written provides that employer shall pay the full amount of the bill
- Most of the proposed legislation was not successful.
- At end of 2012, Council had proposed subcommittee:
 - Met several times in 2013 and 2014
 - Heard various presenters
 - Ultimately, efforts stalled amid requests for more data
 - NHID's report on WC medical costs was provided at last subcommittee meeting and provided "much needed confirmation"
 - No report has yet been completed by subcommittee; report is on hold pending outcome of this commission

Presentation from the Workers' Injury Law and Advocacy Group

Chuck Davoli, WILA Immediate Past President, Attorney, Labor Representative

1:08:07, [Minutes \(Part 1\)](#)

- At a crossroads with the workers' compensation system
- Studies: Many work injuries go unreported
- WCRI, Oregon premium rate study: deals with the median, not the mean
- Workers' compensation came about for a reason: We need a system based on a concept of moral obligation
- Employee benefits nationwide: Employee benefits, employer costs have gone down
- Fee schedules: A lot of states aren't tied to Medicare reimbursement.
 - If you make the rules so onerous, providers will abandon the system.
 - Providers have to have a fair return for their services.
- Medical treatment guidelines are fine as long as providers are the promulgators

Presentation on NHID's medical claims data collection

Tyler Brannen, NHID Health Policy Analyst

[Minutes \(Part 2\)](#)

- NHID's HealthCost website: tell people more about how much it costs, depending on where they go and who they're insured by
- Gained national and local attention
- Healthcare reimbursement not straightforward: Services under several different codes
- HealthCost site uses "bundled" methodology
- Created site because of "market failure": suppliers and payers were not doing this for consumers at the time
- 2003 law requiring companies to send data to the State of New Hampshire

- New Hampshire's Department of Health and Human Services responsible for releasing data
- When using a new information source, such as raw claims data, there are a number of complexities: allow enough time to produce information that makes sense

NOVEMBER 13, 2014

Members spent the three hours discussing what recommendations to make. Audio recordings of the meeting are available online: [Minutes \(Part 1\)](#) , [Minutes \(Part 2\)](#). Members decided to include three possible recommendations in the draft report:

- *Recommendation (1):* Develop Database (requires legislation)
- *Recommendation (2):* Consider Mandatory Pharmacy Benefit Management Programs
- *Recommendation (3):* Continue the Commission's Work

NOVEMBER 20, 2014

Presentation on managing pharmacy care

Commission members Brian Allen, HELIOS Vice President for Government Affairs, Donald F. Baldini, AVP and State Affairs Officer at Liberty Mutual Insurance

[NH PBM Presentation - Final](#)

- Pharmacy Benefit Management (PBM) is the heart of managed pharmacy care
- Involves contracted rates with a pharmacy network and clinical management of pharmacy care

- Contains costs through contracted rates, preferred medications, adherence to generic mandate
- Provides clinical support through analysis of medication efficacy, recommendations to adjuster, physicians and clinical pharmacists, alternatives to opioids
- Uses predictive analysis to enable early identification of potentially problematic claims
- Supports injured workers with the right medications at the right time, convenience of using regular pharmacy or mail order service, and by monitoring and managing adherence
- PBM data support identifies trends
- Provides legislative/regulatory education and advocacy, identifies and manages loopholes
- Liberty Mutual's experience using HELIOS: Company's retail pharmacy spend is lower than industry average
- Liberty Mutual: Penetration percentage, generic efficiency percentage consistently very high
- Liberty Mutual: Large savings from medication strategies (medications not authorized at "point of sale")
- Liberty Mutual: Piloting predictive analytics to identify high-risk pharmacy claims for clinical interventions
- HELIOS: Opioid management and initiatives involve medication strategies, clinical alerts, clinical reviews, physician campaign, training curriculum, reports/audits on narcotic usage, and risk assessment/scoring

- Members spent the remainder of the meeting discussing what recommendations to make in the final report. Audio recordings of the meeting are available online: [Minutes \(Part 1\)](#), [Minutes \(Part 2\)](#)