Testimony Before the
Senate Special Committee on Workers' Compensation
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Thank you for this opportunity to review with the Committee some of the issues a self insured, self administered employer faces trying to administer Workers' Comp benefits in the State of Illinois.

My name is Anita Weir and I represent Safeway Inc./Dominick's, a retail grocer. By way of history, I have 30 years experience in workers' compensation from a national perspective providing clinical services, vocational services and management responsibilities for hospitals, employers, insurers and Third Party Administrators (TPA's).

Safeway is a fortune 50 company with over 186k employees in 26 states and Canada. We operate over 1750 retail stores, 17 distribution warehouses, and 33 manufacturing and processing facilities. Our Dominick's Division operates 80 stores, a distribution center and employs over 8000 persons in the State of Illinois.

We are a unionized company with contracts representing higher wages and benefits than most of our competitors and therefore, higher disability and settlement costs overall. Accident frequency is trending down due to rigorous safety programs, Return To Work programs and, of course, the unemployment situation nationwide. Safeway operations are very consistent from store to store, state to state.

My role with Safeway/Dominick's is to assure that our employees receive the highest quality medical care available - focused on rehabilitation and return to independent function and self sufficiency as soon as possible. We know our employees are our greatest asset and without them we cannot offer the high quality of customer service we are known to provide. We also know that healthy employees are productive employees who are able to build their own wealth and security over time.

My focus today will be on medical care costs. I will share data to demonstrate sources of high costs in the Illinois system vs. other states. I will focus on 3 specific cost drivers and recommendations to address them. Those cost drivers include:

- **Medical Care Access,**
- **Evidence Based Medicine & Utilization Review,**
- **The Fee Schedule.**

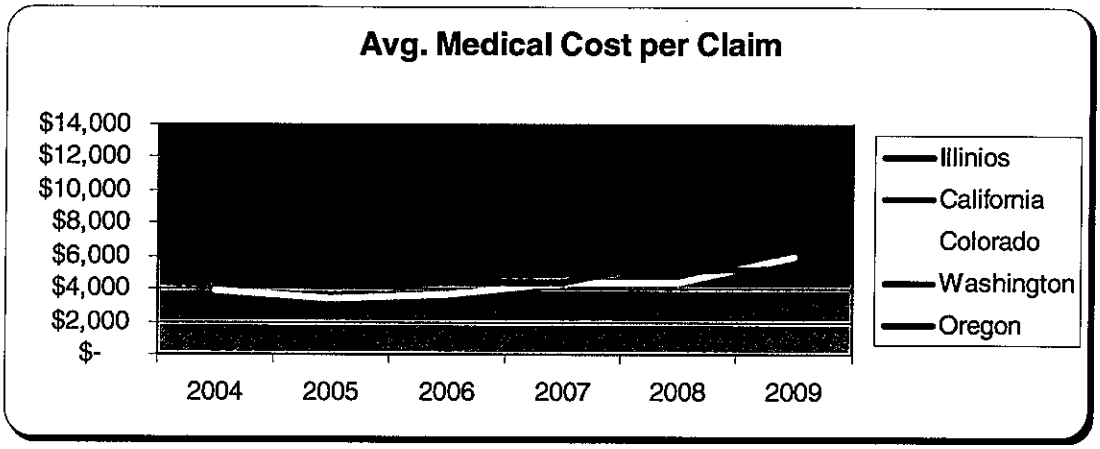
As you already know from prior testimony, studies and blogs, the cost of workers' compensation benefits in Illinois is among the highest in the nation. That is certainly true for Safeway/Dominick's book of business. It is vital that you understand that these high claims costs are not simply the result of insurers charging employers too much. The dollars spent in our claim data represents direct payments made without any overhead administrative costs. These costs also represent our best efforts to use all of the tools and best practices in claims management to control costs such as Utilization Review, Temporary Light-Duty Programs, Safety programs and so on. The results of these costs directly affect our bottom line and our ability to compete in the greater Chicago marketplace.

SAFEWAY / DOMINICK'S DATA

Workers' Compensation is the last full pay medical benefit in the United States....
This is good for our employee but.....

- allows any & all treatment, unlimited, without need to demonstrate value/benefit;
- difference in cost and lost time between a WC diagnosis and group health diagnosis is vastly higher;
- incentives in wrong places for everyone involved;
  - WC laws differ
  - Provider practices without accountability
  - Payment formulas differ
  - Fraud and abuse are more difficult to contain

A. Overall medical costs per claim for Safeway workers' compensation shows Illinois as our highest cost division. In 2009, our average Medical cost, for lost-time claims, was approximately $13,000 / claim. California was next with an average medical cost at $8,500 / claim. All other Safeway state data is lower than Illinois.



Trend lines in this graph demonstrate clearly the impact on California reforms of 2004. The dip in Illinois 2008 may be result of the initial fee schedule implementation but costs have now exceeded that reduction and the trend is accelerating faster than other states.

B. Medical care cost differentials by body part provides another look at the high Illinois cost as compared to other states where Safeway Inc. does business.

Review of these variances takes into account:

- Same work injury body part, severity and human anatomy
- Same technology is available to the physicians
- Same pharmaceuticals available
- All 4 states have University medical schools and centers of excellence
- All 4 states have union contracts in place for the employees with health benefits

What drives these wide variances not only in direct cost of care but also in the recovery time and utilization patterns of certain treatments and medications? These cost drivers carry across all diagnostic groups and Illinois leads in all areas.

Avg. medical Spend Per Claim Knee

	2003-2004	2008 - 2009
CA	$16,359	$9,788
CO	$13,286	$15,155
IL	$14,320	$28,280
OR	$7,565	$7,005

Avg. Medical Spend Per Claim Shoulder

	2003-2004	2008 - 2009
CA	$15,953	$10,092
CO	$17,688	$17,773
IL	$22,133	$21,082
OR	$13,829	$9,353

Avg. Medical Spend Per Claim Spine

	2003-2004	2008 - 2009
CA	$13,848	$6,130
CO	$6,796	$10,818
IL	$13,572	$11,332
OR	$5,842	$3,659

C. Conclusion from this data:

Regardless of the type of injury or body part treatment costs in Illinois is significantly higher than any of our other Divisions. This does not include the indemnity and legal costs.

There are obvious cost variances between the improvements California is experiencing and current Illinois programs. A simple table will clearly show where major differences in Regulations exist:

	Illinois	California
Medical Reports		
Required timeline	No	Yes
Specified content	No	Yes
Treatment guidelines	hinted, not defined	Specified and presumed correct
Certification required		
UR process	Not required	Mandatory
Medical decisions	PTP bias	EBM & guidelines presumed correct
Medical Access	Free choice	Within certified networks
Fee Schedule	Yes many exceptions	Yes - fewer exceptions

SUMMARY RECOMMENDATIONS

Medical Care Access: Physician Partnerships & Treatment Consistency

Freedom of choice the cornerstone of our democracy - and accepting the consequences of those choices was part of that equation. In workers' compensation, the employee and physician may choose and the employer is saddled with the direct and indirect consequences of that choice.

- **Treating Physician Accountability**
  The treating physician should be required to report to the payer at least every 45 days and include basic clinical content and plan of treatment with request for authorization. Outline the content required for these reports so that Subjective, Objective, Assessment, and Plan of Treatment (SOAP) is included in every report. Physician Assistant's must be identified as providing the evaluation and Plan of Treatment. This information would be a basis for payment authorization based on medical necessity on a timely basis.

In Illinois, unlike most other states, physicians are not required to report the status nor plan of treatment to the payer/employer until and unless they wish to be paid. Without knowledge of the plan of treatment, nor changes in diagnosis, we are left to manage the claim by chasing information. Reserves cannot be set accurately, RTW cannot be planned, trust and communication become thwarted and there is no way to prevent fraud and over utilization of goods and services. Currently, we receive medical reports sporadically, usually only when expensive procedures are requested, often on a rush basis or even after the fact. The reports often contain limited information – not enough to link the clinical findings with the plan of treatment. This lack of information pushes the extensive use of on-site case managers for nothing more than requesting current medical treatment information. Adapting this simple regulatory change could benefit everyone.

- **Medical Provider Networks Access**
  Allow employers to create provider networks, much like group health providers do, giving employees access to defined number and variety of providers in defined mileage radius who agree to provide workers' compensation care.

California reform in 2004 allowed employers to develop Medical Provider Networks (MPN) and select the providers. Some elected to just copy existing PPO networks which often include anyone licensed (or not) living (or not) with no regard to quality of care provided. Most of the self insured employers created their own specialty networks of top notch physicians, pay them fee schedule (sometime more), pay extended visits and authorize treatments within hours of requests. We know quality counts. With our MPN, we excluded 5 spine surgeons who had created 2 paraplegics, a quadriplegic, and many failed, multi surgery, chronic pain totally disabled people representing over $5m in direct care and settlement costs. In the 5 years since this MPN became effective, we have had not one catastrophic outcome from back surgery. Our employees, or their attorneys chose these poor practitioners without knowing the potential, ultimate high cost to their freedom. Employees now choose from panels of quality providers.

*Rand and CWCI has studied the effects of these MP Networks and do not find any reduction in access to medical treatment. I am called weekly by someone wanting to be included in our Network. We search for quality not discounts.

Evidence Based Medicine (EBM) & Utilization Review (UR)

Recognize that UR and pre-cert process is an established process in group health and Medicare and should be a required and valid part of the Illinois Workers' compensation medical practice as well. Identification of accepted treatment guidelines could level the playing field so that medical treatment is more consistent from state to state. ALSO, clarify how 2nd opinions and IME's are to behave relative to UR principals; i.e. *physician must use and identify EBM or national treatment guides for decisions (beyond "the way It's always done here" comments.) Must have timely responses/reports with complete standard content.*

The Illinois legislature wisely included UR in the 2005 reforms. But this process was largely ignored until recently. UR is not a new concept – developed by and for group health and Medicare in the 80's. Every physician who accepts group health contracts or Medicare are required to secure prior authorization for many of the services provided. And they have caps on what will be provided as part of the health insurance contract.

Evidence Based Medicine is also not new and these concepts are all over the news and research. While a single practitioner may see day to day outcomes from his "practices", EMB provides a perspective of scope and time no one physician could develop independently. Every patient benefits from the physician who is willing to un-learn and re-learn what interventions are actually most beneficial over time. In some cases, we learn that doing nothing is as effective as costly, invasive procedures.

Utilization Review is a tool to focus on identifying RIGHT CARE at the RIGHT TIME.

- level playing field between group health practices & workers' compensation;

- a "stop and think" moment - why do this treatment;
- re-learn best practice patterns by all parties: MD, PT, ER, Claims

UR Benefits the employee first in many ways:

- reduces unnecessary treatment and surgery
- reduces the wrong message re severity
- reduces delay to return to productive life activities & self-determination
- reduces perception of disability
- increases the teaching/consulting from the MD – resets expectations of med care
- refocus on personal participation in recovery (limits on PT, etc)

UR Benefits good physician practices:

- Supports their use of current best practice guidelines and EBM
- Reduces doctor shopping
- Reduces economic incentive to over treat

UR Benefits economy in general:

- Employer costs - direct impact
- Social Security disability and state disability programs
- Medicare Set Asides
- Tax payer burden

Fee Schedule

Ideally, a fee schedule will reduce medical costs without harming workers' access to medical care. We believe the Illinois Fee Schedule is no longer effective in reducing costs. Some of the identified reasons include treatment or equipment outside the fee schedule, too many variances based on zip codes, and over utilization. However, the experience of other states indicates that fee schedules are never perfect. In fact, they require continuing adjustment.

The legislation that created the fee schedule also created the Workers Compensation Medical Fee Advisory Board (WCMFAB) comprised of employee, employer, and medical representatives to advise the Commission on the fee schedule and to make recommendations for improvement. We ask that the Legislature call upon this Advisory Board to recommend meaningful changes to the Fee Schedule that address the immediate concerns of Illinois high medical costs, and ask the Legislature to create a framework for change that goes beyond the "Agreed-Bill Process" to allow for meaningful cost savings in the next year. The Board is already in place and we ask the Legislature to use this resource to bring about the needed change.

SUMMARY

We all have a responsibility to protect our co-workers and employers. We must struggle to find equitable solutions to providing medically effective and cost effective care and to limit fraud and over utilization as profit centers for unethical businesses. To not do this threatens business growth and jobs in the state of Illinois.

Respectively Submitted,
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Safeway Inc.