SECOND REGULAR SESSION
112TH MAINE LEGISLATURE

JOINT STANDING COMMITTEE
ON LABOR

STUDY OF THE EFFECT OF MEDICAL COSTS IN MAINE'S WORKERS' COMPENSATION SYSTEM

MARCH 1986

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PREFACE TO THE COMMITTEE REPORT

A subcommittee of the Joint Standing Committee on Labor of the 112th Legislature, known as the Subcommittee to Study Medical Costs in Workers' Compensation, conducted this study from August, 1985 to February, 1986. Labor Committee chairs Sen. Dennis L. Dutremble and Rep. Edith S. Beaulieu served as co-chairs of the subcommittee. Sen. Henry W. Black, Rep. Richard P. Ruhlin and Rep. Ralph M. Willey also served as Subcommittee members. Gilbert Brewer, legislative counsel to the Labor Committee, served as the Subcommittee's staff.

The Subcommittee would like to thank the Maine Workers' Compensation Commission Chairman, Ralph Tucker and Counsel, Mark Reinhalter, the Maine Health Care Finance Commission, the State Personnel Department and the several representatives of the medical profession, labor, business and the insurance industry for their cooperation and assistance in this study.

SUMMARY RECOMMENDATIONS

1. The Committee recommends that the Workers' Compensation Commission adopt rules requiring a health care provider who is treating an individual's work-related injury to file a report with the Commission, the injured worker's employer and the employer's insurance carrier. The report should be very brief and simple to complete, containing only enough information to inform the recipient of the general nature of the injury and that the injured worker will be receiving treatment from the provider for the injury. The report should be required to be filed only for the initial contact a treating health care provider has with the injured worker.

2. The Committee recommends that the Workers' Compensation Commission distribute information regarding current requirements under workers' compensation law to those parties involved in the workers' compensation system in Maine.

3. The Committee otherwise recommends that the Legislature take no action in this area and allow the private sector to continue their own cost-control efforts and to allow the recent legislative amendments contained in the 1985 workers' compensation reform act to take effect, particularly the rehabilitation provisions of that act. If these efforts prove unsuccessful in containing medical costs in coming years, the Legislature may wish to reconsider the suggested reforms discussed in this report and presently rejected.

INTRODUCTION

During the First Regular Session of the 112th Legislature, the Joint Standing Committee on Labor considered a multitude of suggested amendments and additions to the Workers' Compensation Act. A number of those proposals were selected and eventually took the form of L.D. 1634, "AN ACT to Improve the Workers' Compensation System and Reform the Rate-making Process." That bill was enacted and signed into law by the Governor as P.L. 1985, c. 372.

In the course of its deliberations on L.D. 1634, the Labor Committee considered a suggested amendment that would have established a fee schedule limiting the maximum amount payable under workers' compensation for specific medical services. Objections were raised to its inclusion in the committee bill, stating that it was premature and that no documentary evidence existed to justify a need for the fee schedule. A study of the effect of medical fees in workers' compensation by a subcommittee of the Labor Committee was suggested. That suggestion was adopted and incorporated into L.D. 1634 in section 50 of Part A of the bill (reproduced as Appendix A of this report). That law directed the Subcommittee to study the effects of medical and other health-treatment fees on the cost of providing workers' compensation coverage in the State.

In compliance with that law, the Subcommittee to Study Medical Costs in Workers' Compensation was created in August, 1985. The Subcommittee conducted seven hearings at which over twenty witnesses testified and submitted information and data. Witnesses included representatives of the Maine Medical Association, the Maine Osteopathic Association, the Maine Chiropractic Association, the Maine AFL-CIO, Maine State Employees Association, Maine Chamber of Commerce and Industry, Maine Municipal Association, the City of Portland, Medical Care Development Corporation of Augusta, Medical Assessment Programs Inc., the Maine Health Care Finance Commission, the State Department of Personnel, the Maine Workers' Compensation Commission, Liberty Mutual Insurance Co., Aetna Life & Casualty, The Hartford Group, Penn General and several of the state's largest employers. The Subcommittee held several additional work sessions to consider the testimony and evidence presented at those hearings and to arrive at their recommendations before submitting their results to the full Labor Committee. This report is the product of that study.

I. CURRENT ROLE OF MEDICAL COSTS IN WORKERS' COMPENSATION

A. Testimony and evidence

P.L. 1985, c. 372 directed a subcommittee of the Labor Committee to "determine if rising medical costs are a contributing factor to rising workers' compensation costs as a whole, and if so, what specific aspects of treatment or fees are responsible for that increase." In accordance with the statutory directive, the Committee attempted to determine what role medical costs currently play in the workers' compensation system.

Testimony received by the Subcommittee generally indicated that medical costs accounted for approximately 15-20% of total workers' compensation costs in Maine. Actual figures received by the Subcommittee ranged somewhat higher. A spokesman for Bath Iron Works indicated that their medical costs ran from 21% to 27% of their total workers' compensation expenditures. He also testified that a study performed by the National Council on Compensation Insurance for the years 1980 through 1982 indicated a statewide average (for Maine) of 25%. Liberty Mutual's figures indicated that their medical costs were 23.7% of their total in 1985; in the previous 3 years this percentage had been, respectively, 21.8% in 1982, 23.8% in 1983 and 26.1% in 1984. Maine Municipal Association data showed that their percentage of medical costs fluctuated from 29.7% to 44.8% during 1978 to 1984, with the average being 34.8%.

The only breakdown received by the Subcommittee which indicated to whom this money was being paid was provided by Liberty Mutual. In 1982, 32.6% of the total workers' compensation medical costs was paid to individual health care providers. In 1983, this figure rose to 38.0% and in 1984 to 47.9%. Figures for 1985 showed a breakdown of 43% to individual providers, 48% for hospital services, and 1% for prescribed drugs with the remaining 8% going toward miscellaneous expenses. These figures represented the highest percentage among New England states being paid for hospital services and the lowest percentage going to individual providers. Combined with the data indicating that medical costs are about 25% of total workers' compensation costs, this indicates that approximately 10% of total workers' compensation expenditures goes to individual providers and 12.5% goes to hospitals.

The Committee had great difficulty in determining the present rate of increase for medical costs in workers' compensation; the necessary data was apparently unavailable in many instances. This difficulty was compounded by the different data storage systems and accounting techniques employed by various employers and insurers. The data actually received by the Subcommittee was inconclusive. The State

Department of Personnel provided statistics which indicated that their average medical expense per claim rose 17.3% from 1983 to 1984. From 1984 to 1985 that increase was 20.5%. On the other hand, data received from the Maine Municipal Association showed a decline in their average medical expense per claim from a high of $467 to $141 over the past 4 years. They attributed this decline to their own actions in managing claims more vigorously and the creation of an ambitious safety program. Liberty Mutual's data showed a 15.3% increase in 1982 through 1983, and an increase of 8.9% in 1983 through 1984. The most recent rate request filed for Maine carriers by the National Council of Compensation Insurers contains no mention of an excessive increase in medical expenses in Maine.

B. Committee findings

The Committee found that medical costs did account for a substantial portion of total workers' compensation expenditures in Maine, approximately 25%. Most of this total goes to hospitals, with a slightly lower percentage going to individual providers. However, the current rate of increase for those costs tended to vary widely depending upon the source of the data; some employers had a very high rate of increase, others' were moderate, while some actually showed a decrease in their average medical costs. The Committee further finds that increasing medical costs may create some minor degree of inflationary pressure upon workers' compensation costs, but the extent of that pressure is impossible to determine.

II. PRESENT PROBLEMS IN THE SYSTEM

A. Testimony and evidence

The problem of prohibitive costs for medical services is not confined to the workers' compensation area; the rapid increase in medical costs over the past several years is a well-documented general social problem. Many factors have contributed to this increase, including the increased use of expensive new technology or modes of treatment, a tendency toward more cautious treatment in light of the specter of malpractice suits and rising insurance premiums, and the general effects of inflation on medical services. In addition, the Subcommittee was told that the entire area of medical costs was experiencing a "revolution" of sorts. Medical services are entering a new era of competition as rising costs spur the growth of alternatives to traditional health care methods, including preferred provider organizations and the use of diagnosis-related groups. All of these factors influence the cost of providing medical treatment under the workers' compensation system but are beyond the scope of this study.

Hard data regarding present inflationary pressures for medical costs in workers compensation was not presented to the Subcommittee; much of the evidence which was received consisted of anecdotal experiences and generalized perceptions. These comments tended to center however upon the overutilization of medical treatment as opposed to overcharging for required treatment.

As the representatives for Maine Medical Association pointed out, medical costs are made up of two components:

1. What the price tag is--how much money is actually charged for a given service; and

2. Why the cost was incurred--meaning what method of treatment was chosen, or the frequency of that treatment.

Witnesses tended to agree that it was unlikely that individual providers and particularly, large hospitals, were in the practice of charging higher fees for the treatment of patients covered by workers compensation than for their other patients with similar injuries. Insurers testified that they had in fact experienced some degree of overcharging on workers' compensation bills, but that it was most often due to a simple clerical or typographical error. Many of the remaining instances of overcharging were attributable to the abuses of a few individual providers. There was no testimony offered to show that overcharging was a common practice in workers' compensation cases; in fact, it appears to be the isolated exception.

On the other hand, a great deal of testimony centered upon the possible price increases caused by overutilization. There are many potential causes of overutilization. Again, the fear of malpractice suits was raised as a reason for ordering "one more test" or "one more referral" at the employer or insurer's expense. Another cause may simply be ignorance of the availability and effectiveness of a lower-cost method of treatment. Additionally, the doctor's first responsibility is, quite properly, toward his patient. Absent outside constraints, he is obligated to continue treatment of his patient in an effort to obtain the best possible results. The question then arises as to who should restrain excessive treatment, if necessary. The medical profession representatives suggested that treatment guidelines could be imposed through legislation or a peer-review panel. A labor representative stated that he believed it was the treating physician's responsibility, while others suggested it was the employer or his insurer's responsibility to ensure that the treatment of an injured worker does not become excessive.

The lack of "constraints" was also often cited as a problem with regard to the injured worker in general. Under present law, an injured worker has the freedom to select his own health

care provider and method of treatment, and his employer or his employer's insurer must pay for all "reasonable and proper" (39 MRSA §52) treatment for that work-related injury. The price of this freedom is that the employee is thrust into the workers' compensation system with no guidance regarding the medical treatment of his injury. Several witnesses testified that they think the injured employee often is "lost" in the system; a "lost" worker may drift from provider to provider or receive repetitive treatments in an honest effort to obtain the necessary medical care for his injury. They suggested that some type of guidance mechanism would be useful to help the injured worker obtain the necessary quality medical care at the lowest possible price to the employer/insurer.

The "lost" worker's problem is exacerbated by a lack of communication among injured workers, employers, insurers, treating providers and the workers' compensation commission. None of the involved parties keeps track of what the employee is doing until after he has done it. Very often the first contact between members of these groups is after the commencement of litigation, when an adversarial position has already been adopted. The Subcommittee heard a great deal of testimony on the difficulties and delays in obtaining reports from providers, and also testimony by the providers on the unreasonableness or ill-advised methods by which employers and insurers requested reports, often asking for long narrative reports which are very time-consuming and expensive to complete. These reporting problems exist despite present law which requires providers to provide reports requested by an employer/insurer within 10 days of the request (39 MRSA §52-A (2)).

B. Committee findings

The Committee finds that any inflationary pressures upon medical costs that are peculiar to workers' compensation are almost certainly caused by overutilization rather than overcharging. Further, the Committee finds that a properly-handled workers' compensation case is unlikely to lead to unnecessary cost increases caused by overutilization. Rather, it is the case where an injured worker is "cut loose" in the system with no guidance that creates a situation where overutilization of medical services is likely to occur with a resultant increase in cost. Such a situation is often created where a lack of communication exists among the interested parties until after a dispute has already arisen and the sides are drawn. The Committee also finds that the employer/insurer is the proper party to monitor the medical treatment of injured workers and exercise the restraints upon unnecessary treatment in the workers' compensation system since he is the party who is financially responsible for the treatment.

III. CURRENT COST-CONTROL EFFORTS

A. Testimony and Evidence

The Subcommittee heard a great deal of testimony on what the various participants in the workers' compensation system are currently doing to reduce or hold down medical costs. This information will be considered in turn.

The Subcommittee was informed that both the Maine Medical Association and the Maine Chiropractic Association had recently created and currently maintain member committees on the containment of medical costs in workers' compensation. These committees are working on methods by which those professions can attempt to reduce unnecessary medical costs. The Maine Medical Association had recently conducted a study on general (not specifically workers' compensation) surgical utilization practices across the state and found that treatment methods for similar injuries varied widely by geographic location in some instances. Providers in one area of the state were using a more expensive, although no more effective technique, to treat injuries which were handled differently at a lower cost in other areas. As a result of this study, MMA is attempting to increase its members' awareness of the less-expensive alternative treatment methods revealed in the study. The chiropractors' representative testified that he had cooperated with some insurers and employers to develop a simplified reporting form which had improved communication among the parties and reduced costs in obtaining medical reports. Both of these committees are ongoing efforts which have only recently been created.

Some large, self-insured employers also testified to the Subcommittee on their attempts to reduce their workers' compensation expenditures by cutting medical costs. The Maine Municipal Association testified that their medical costs had actually dropped over the last 5 years, a fact which they attributed to their more aggressive claims management with a 3rd-party administrator and to their adoption of a safety program to reduce the incidence and severity of injuries. The City of Portland also testified that they had developed a comprehensive cost-cutting plan which had reduced their medical costs in workers' compensation. They testified that the future effectiveness of their program was dependent upon increased case management, beginning as soon after the injury as possible.

The three insurance carriers that testified directly to the Subcommittee spoke in some depth about their own cost-containment programs. These programs included the use of medically-trained personnel to review medical bills and treatment, use of 2nd opinions where necessary, prompt payment of hospital bills to take advantage of the 1% discount mandated by the Health Care Finance Commission, increased contact with the client-employer, increased use of the resources of their

general health insurance divisions and other measures. All of the insurers testified that they currently evaluate the "reasonableness" of fees by comparison with some standard fee schedule, either a schedule arrived at by averaging local fees for similar procedures or a standard schedule such as the California Reasonable Service Fee Schedule for medical procedures.

The last major cost-containment method studied by the Subcommittee was the State Health Care Finance Commission. The Commission's representative explained the cost-balancing theory behind the Commission's efforts. In the past, certain private and public health-insurance plans paid only a certain percentage of a hospital's actual fee for medical treatment. For instance, Blue Cross/Blue Shield might pay only 80% of the actual charge, or Medicare might pay only 60% of the charge. The hospital would then "shift" the unpaid balance of the charge to its full-paying private customers, including workers' compensation cases. The end result was that these full-paying patients ended up subsidizing the insurers who paid only a percentage of the actual costs. The Health Care Finance Commission is currently attempting to regulate the "discount" received by certain groups in an attempt to "balance" the cost of hospital health care. This "balancing" should work to the benefit of workers' compensation insurers since they are "full-payers" and eventually reduce their hospital care costs. This program has also become fully effective only very recently, so the benefits of the program are not fully known at this time. Another area in which the Commission's program might benefit compensation insurers is in their regulation of hospital discounts. Certain discounts are still available to insurers who meet certain requirements; one such discount is the prompt-payment 1% discount for payment of a bill within 30 days. However, two restrictions in the Commission's program are that they do <u>not</u> regulate utilization practices, only prices, and they only regulate hospitals, <u>not</u> individual providers.

<u>B. Committee findings</u>

The Committee finds that there are presently a great many cost-containment programs being implemented in the private sector to reduce medical costs in workers' compensation; these programs show great promise in their ability to reduce or limit cost increases. The Committee also finds that the great majority of these programs, as well as the Health Care Finance Commission's program and the Maine Occupational Health Program, have only recently been created and will need time to develop before their full effect can be properly evaluated. Further, the entire subject area of medical costs in general is presently in a state of flux, the effects of which on medical costs in workers' compensation cannot be properly evaluated at this time.

IV. POSSIBLE RESPONSES

A. Testimony and evidence

The enabling legislation establishing the Subcommittee directed the Subcommittee to study the feasibility of set fee schedules and a peer-review panel of health care providers, as well as any other methods of restraining increasing medical costs. These suggested cost-containment methods will be discussed in turn.

The Subcommittee heard a moderate amount of testimony in favor of fee schedules which would limit the amount payable for medical services in workers' compensation cases. This testimony generally took the form of comparisons to other states which presently employ fee schedules, apparently with some degree of success. Nineteen states currently employ some type of a fee schedule; the jurisdictions most often mentioned favorably in testimony were New York and Florida. Liberty Mutual also presented statistical evidence showing that Rhode Island and Massachusetts were generally the New England states with the lowest workers' compensation medical costs; both states use fee schedules. Testimony was conflicting over whether injured workers in those states which had adopted fee schedules had difficulty in obtaining the services of physicians for workers' compensation injuries. It was generally agreed that a fee schedule that provided too low a level of reimbursement would affect the availability of quality health treatment; Massachusetts's fee schedule was often cited as an example of a schedule that deprived the injured workers of access to certain providers. The issue was raised that Maine differs markedly from the large industrial states in which fee schedules are successfully used, particularly in that Maine has a much smaller population and is divided into more geographically discrete segments than the states with successful fee schedules. These factors would also tend to increase the administrative costs of maintaining a schedule, which even its proponents admit would be substantial. The Workers' Compensation Commission testified that a fee schedule would require substantial additional staff and appropriations to allow the Commission to properly administer the schedule. Liberty Mutual's spokesman reiterated that to be effective, the fee schedule would have to be carefully administered and updated. At least one insurer testified that a fee schedule was not an appropriate response to Maine's problem, given that so little of any cost increase was due to physician overcharging. This point was made by several other witnesses who argued that a fee schedule would do nothing to restrict overutilization but might restrict the injured worker's choice of physician by pricing out the specialists, a process more likely to happen in Maine than in other states because there are fewer specialists available within a given geographic area in Maine.

A second suggestion made to the Subcommittee was to create a peer review panel of health care providers who would act as a review board over medical-related disputes in the workers' compensation system. The Maine Chiropractors' Association presented a draft version of such a multi-disciplinary panel's bylaws and duties within the system. The panel could hear challenges brought by employers or insurers on overcharging or overutilization and decide the case without referral to a workers' compensation commissioner. It could also potentially operate as a review board resolving disputes over the degree of disability in compensation cases, or in setting up disability guidelines to be applied in individual cases. Objections were raised to such a panel in that it would create another level of bureaucracy adding time and expense to an already lengthy review and appeal process. Several witnesses questioned whether the State would be able to find enough health care providers to staff such a panel voluntarily, especially as the potential case load was so large.

A third suggestion was made to require a second opinion before allowing any surgery to be performed for a workers' compensation injury, except in emergencies. This would presumably identify cases where overutilization of surgery might otherwise occur. Since surgery is one of the most expensive medical procedures, the money saved by avoiding unnecessary surgery would exceed the additional cost of the additional medical examinations, assuming enough cases of unnecessary surgery were disclosed through the process. Objections to this suggestion were that a second opinion can be obtained under present law at any time upon request of the employer/insurer; if they fail to exercise the option, it is their own fault. Others argued that due to the inability to get timely medical reports, this option was not practical; it was impossible to request the second opinion before the surgery was actually performed because the employer/insurer has no notice of the impending operation.

Fourth, the Subcommittee investigated ways in which to improve communication among the participants in the workers' compensation system. These suggestions mainly centered upon requiring health care providers to report to employers/insurers on their treatment of an injured worker. Objections to adopting additional reporting requirements included the increased bureaucratic burden upon providers and the resulting antagonism toward the system and workers' compensation cases in general. Some witnesses cited the reporting burdens upon providers in litigated workers' compensation cases now and the problems associated with coordinating the various parties' schedules to allow depositions and testimony before a commissioner. Others questioned whether the providers would comply at all with the new requirement since there was no incentive to do so. Proponents of the additional reporting requirements argued that most of the overutilization problems could be addressed through present procedures by the employers/insurers if they only had better knowledge of the cases.

A similar suggestion was made that many of the problems brought up in testimony are already covered under present law. A major problem appeared to be innocent ignorance of present law and regulations. At least one major insurer was unaware of the mandatory 1% discount required by the Maine Health Care Commission for the prompt payment of hospital bills. Several providers were unaware of the 10-day reporting requirement in present law. A massive education process was suggested to improve awareness of existing law. Some steps have already been taken this way through the formation of the workers' compensation committees of the Maine Medical Association and the Maine Chiropractors' Association and similar efforts.

Finally, the Subcommittee heard testimony that the newly-enacted rehabilitation system may act to help provide guidance through the system for an injured employee. The requirement that a rehabilitation plan be developed in all cases where it is determined that an injured worker is unlikely to return to his previous employment will ensure at least some review of those workers' medical treatment. If the plan is implemented, that review will of course continue. This increased review is limited however, by the fact that most employees will not enter the rehabilitation program but will return to their job without rehabilitation.

B. Committee Findings

The Committee finds that a fee schedule would not be a cost-effective means of addressing Maine's health care cost problem in workers' compensation. It does not affect the area in which cost problems are most likely to occur (i.e. over-utilization) and would be an expensive bureacratic addition to an already overloaded Workers' Compensation Commission. Since a fee schedule would affect only payments to individual health care providers, it could only reach 10% of total workers' compensation costs. A fee schedule also carries the additional apprehension that it might affect the availabilty of quality health care to injured workers, even if it was to be set at a relatively high scale.

The Committee further finds that a peer review panel is not required in order to effectively control medical costs in workers' compensation. The Committee questions whether the panel would be workable on a volunteer basis, especially in light of the potential case load. Much of the panel's intended workload can be handled under present law through Petitions to Fix Medical Costs before the Workers' Compensation Commission.

The Committee further finds that requiring a mandatory second opinion before all but emergency surgery is not required in order to effectively control medical costs in workers' compensation. This option is currently available to employers/insurers and could be more widely used if they are able to obtain more timely information relating to workers'

compensation cases. A mandatory second opinion might also prove to not be cost-effective since it would also require second opinions to be performed and paid for in many cases where it is not necessary or helpful.

The Committee further finds that improving the knowledge of present law and improving communication among the participants in the workers' compensation system would be very helpful in assisting the participants to make their own efforts to reduce medical costs.

V. RECOMMENDATIONS

The Committee recommends that the Workers' Compensation Commission adopt rules, after study, that would establish additional reporting requirements for health-care providers. These rules should require a provider to file a report with the Workers' Compensation Commission, the injured employee's employer, and that employer's insurance carrier, if any, upon his initial contact with the injured employee if that injury was work-related. The report should be upon a form provided by the Commission, and should be very simple and easy to complete, and should contain only enough information to inform the recipient of the identities of the injured worker and the provider, the general nature of the injury and that the injured worker will be receiving treatment for the injury from the provider. The rules should also require the form to be filed promptly.

The additional reporting requirement suggested above will provide initial notice to employers, insurers and the Commission that the injured worker is seeking medical treatment. If the worker elects to receive treatment from several providers, either consecutively or concurrently, the notice requirement will function as a "tracking device" so the worker will no longer be "lost" in the system. With the knowledge of where to go for further detailed information automatically provided, the employer/insurer can more carefully manage its cases, preventing overutilization problems.

The ability of an employer/insurer to effectively manage its cases will still be somewhat subject to the willingness and ability of the provider to promptly respond to requests for medical reports. The Committee further recommends that the Workers' Compensation Commission attempt to provide information clarifying misconceptions or ignorance of present law. The Committee encourages the private organizations which are also providing information in this area to continue their efforts. The Committee also encourages further cooperation among employer/insurers, health care providers and the Commission in streamlining the reporting process.

The Committee further recommends that no legislative action be taken in this area at this time. As a part of the larger health-care cost revolution taking place, the Committee found that many creative and promising cost-containment measures have only recently been or are presently being implemented in the private as well as public sectors. These measures include some parts of the 1985 workers' compensation reform act, particularly the rehabilitation requirements. To the extent that these programs are already in place, it would be duplicative and possibly even disruptive for separate cost-containment programs to be developed within the Workers' Compensation System. The new internal cost containment programs of insurance carriers should be given an opportunity to work. Self-insured employers are already developing cost-containment arrangements of their own. Additional conflicting legislation or regulation should not be enacted which might impinge upon the initiative and creativity of employers or insurers seeking new methods to contain costs within the free enterprise system. Rather, assistance should be provided to these programs through the complementary requirement of an initial report, as suggested above. The Committee applauds the initiative and ingenuity of those responsible for the private sector responses to the medical cost problem as a whole, and encourages further development without legislative interference.

After the Workers' Compensation Commission becomes fully computerized, there will be better information available to more accurately assess the role of medical costs at that time. If it then appears that the recommendations made in this report are not sufficient to stem any rising medical costs associated with workers' compensation, then the Legislature might reconsider some of the suggestions discussed in Part IV of this report. But at this time, given the present status of medical costs generally, the Committee suggests that the private and public sector initiatives be given an opportunity to demonstrate their ability or lack thereof to deal with the problem before legislation is enacted.

APPENDIX A

Sec. 50. Medical cost study. The Joint Standing Committee on Labor is directed to conduct a study of the effects of medical and other health-treatment fees on the cost of providing workers' compensation coverage in the State. The study shall be completed by March 31, 1986, and shall include suggested legislation to be presented to the Second Regular Session of the 112th Legislature or suggested rules to be adopted by the Chairman of the Workers' Compensation Commission.

Study is needed to determine if rising medical and other health-treatment fees related to the treatment of employment injuries are a contributing factor to rising workers' compensation costs as a whole and, if so, what specific aspects of treatment or fees are responsible for that increase. If medical and other health-treatment fees appear to the committee to be a contributing cause of rising workers' compensation costs, the committee shall study methods of limiting the cost increases due to those fees. The committee shall study the feasibility of set fee schedules limiting the amount of payment for specific medical services and the feasibility of a peer-review panel of physicians and other health-care providers to review treatment of injured workers in contested cases. If either of these methods, or any other method, appears useful to the committee in limiting cost increases, the committee shall study and recommend specific methods of implementing those programs by rule of the commission or by legislation, if necessary. The study committee shall be composed of 5 members of the Joint Standing Committee on Labor who shall work with the Workers' Compensation Commission and other interested groups or associations. The study committee may contract with individuals or organizations for research or related work to be done regarding the study.