THE FUND REPORTER

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WORKERS' COMPENSATION BOARD SHIFTS COSTS TO THE FUNDS

by Abraham Popish

We are all painfully aware of the adverse effect on benefit funds when claims that should be the responsibility of Workers' Compensation carriers are instead shifted to benefit funds. Recent changes in the administration and adjudication of claims by the Workers' Compensation Board have spread deep concern among benefit fund managers about a possible new influx of such claims.

Hernia claims are perhaps the most familiar example of shifted claims. Before medical benefits became widely available through benefit funds, the great majority of hernia claims were processed under the Workers' Compensation Law. Of course, this involved difficulties to both the worker and the health care provider. Pre-operative weekly benefits were difficult to obtain. Providers not only had to get prior authorization from the carrier to perform surgery, but they were paid in accordance with a rather conservative fee schedule. Workers' Compensation claims were filed nevertheless, because no other forms of insurance were available. As soon as benefit funds came into existence, hernia claims gravitated to the funds. At the present time nearly all hernia claims are paid by the various funds even though they were precipitated by heavy lifting at work.

It has always been so difficult to pursue legitimate claims for occupational disease that most workers and health providers don't bother to file Workers' Compensation claims. Nearly all such claims are controverted; they involve protracted litigation, sometimes lasting for years. Workers have to make many appearances and are uncertain of the outcome. Doctors do not want to testify before the Board nor do they want to wait extended periods of time to get paid. The path of least resistance has been to bypass the Workers' Compensation system completely, and instead file claims with a benefit fund.

Workers' Compensation claims are still filed for accidental injuries because benefits are available beyond a limited number of weeks and there is a fixed schedule of awards for permanent injuries to extremities, for loss of vision or hearing or for facial disfigurement. In some cases there are lump sum settlements. However, if the anti-worker atmosphere presently permeating the Workers' Compensation Board continues, even these claims will be charged to benefit funds.

Concerned persons have already expressed great alarm at the continuing and steady erosion of Workers' Compensation benefits. There has been a consistent downgrading of disabilities by the Board's Medical Department. Subjective complaints are being minimized or ignored. Administrative changes promulgated by Board Chairman Robert Steingut have eliminated remedies previously available to injured workers or their representatives to overcome unfavorable reports from Board doctors. Workers can no longer request reexamination by a Principal Medical Examiner (a more experienced Board doctor). Their right to produce direct evidence from their own doctor has been taken away, and they are now limited to cross examination of the Board doctor with whose conclusions they disagree.

In the near future a pilot project to eliminate hearings on finger and toe cases is being instituted, along with a quota system instructing examiners at the Board to close 20 per cent of all other cases on motion calendars without hearings. Many workers who now attend hearings and get schedule awards will no longer receive these payments. Chairman Steingut has instituted evening hearings, which are scheduled without regard to the injured worker. Single parents with children find it almost impossible to attend evening hearings. Many others will not attend because of their fear of using the subway system during evening hours. This fear will be magnified when the Board moves shortly from the World Trade Center to downtown Brooklyn.

If changes like these are permitted to continue, then workers hurt on the job will take their business elsewhere—to the benefit funds. Claims for accidental injuries will join hernia and occupational disease claims in a flight from the difficulties of the Workers' Compensation system to the ease of collecting from a fund. Fund managers should join with all other interested groups in opposing the anti-worker attitude that brought about these recent changes at the Workers' Compensation Board.

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HEMORRHOIDS

by Arthur A. Levin, M.P.H.

Hemorrhoids are a problem that may affect as many as 50 per cent of middle-aged adults. The severity of the problem varies, and many people never seek medical help. However, when they do, there are several alternatives for treatment—and among these the least expensive and invasive may produce the best results.

Why so many people suffer from hemorrhoids is a question still debated. The name for the condition means "flowing blood" and was coined by the ancient Greeks. Some believe that the problem, which is rarely seen in quadrupeds, is the result of homo sapiens standing up rather than using all-fours like most other animals. Others hold that it is due to straining during defecation which reduces the tone of certain muscular tissue.

There are two major classifications of hemorrhoids: internal and external. Internal hemorrhoids are rarely painful and are graded into four classifications:

(1) bleeding upon defecation
(2) bleeding with prolapse (internal hemorrhoid protrudes externally) that reduces spontaneously
(3) prolapse that can be reduced manually
(4) irreducible prolapse

The major symptom of internal hemorrhoids is bleeding and/or prolapse. If a prolapsed hemorrhoid becomes strangulated it can cause severe pain. External hemorrhoids are usually very painful and evidence of bleeding may be found on toilet tissue. External hemorrhoids often disappear spontaneously, or they can rupture and bleed.

Hemorrhoids can be safely treated symptomatically after examination has ruled out any more serious disease or problem. As long as the individual is willing, self-care is probably the safest and most effective. It is generally agreed that a high-fiber diet will reduce straining and irritation. There is evidence that such a diet has many other benefits in preventing disease.

Anyone concerned about avoiding or relieving hemorrhoids should eat whole grain cereals and bran as well as vegetables and fruits. Foods to avoid include highly refined cereals (white rice, Cream of Wheat and farina), other refined foods such as cakes, pastries, pies, macaroni and ice cream. The latter foods tend to be constipating and can cause the straining that many believe produces the problem.

Other advice includes eating at regular hours and establishing a regular time for bowel movements. Since prolonged toilet sitting can cause problems, get rid of the magazine rack in the bathroom. Witch hazel is recommended to relieve local discomfort. Commercial preparations containing an anesthetic such as benzocaine are not recommended because of side effects and possible adverse reactions. Some experts recommend regular sitz baths to relieve discomfort.

Hundreds of thousands of hemorrhoidectomies—the most invasive and expensive treatment—are performed annually. A very good alternative to surgical excision of hemorrhoids is called Baron ligation or rubber band treatment. This method is not indicated for external hemorrhoids (too painful) and is not for people taking anticoagulants or who have chronic liver disease that could affect clotting. The rubber band method consists of "tying off" the hemorrhoid with a rubber band so as to strangulate the vein. The vein and band are usually sloughed off after four to seven days. As a rule the pain is

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PPO— PREFERRED PROVIDER ORGANIZATION

by Roxanne Young, *Associate Editor*

The preferred provider organization (PPO) is the latest development in controlling health care costs, a new kind of organizational structure between a group of health care providers and a group of potential patients. PPOs are already functioning in a number of states, and trustees and administrators of labor-management benefit funds across the country are trying to decide whether PPOs are "state of the art" or just another fad. No complete medical/hospital PPO has yet been created in the metropolitan New York area, but a few are in the development stage and more will surely follow.

Over the years some benefit funds, unions, fraternal organizations and insurance companies have tried to control health care costs by negotiating with providers for reduced fees for their members or participants. These arrangements were difficult to negotiate, since there were relatively few providers and most of them already had as many patients as they needed. Today the balance of power in the medical marketplace is changing, and conditions have never been better for benefit funds to negotiate with providers for reduced fees. The supply of physicians has increased, and is particularly concentrated in a few urban areas. Economic pressures have reduced the occupancy rates at many formerly high-demand hospitals. Both doctors and hospitals are willing to make more concessions in order to establish a relationship with a group of potential patients.

There are already several ways that funds can deal with groups of doctors. There are staff model HMOs such as Health Insurance Plan of Greater New York (HIP), which provide all physician services in exchange for a capitation fee for each covered fund participant. Closed panel doctor groups are paid on a fee-for-service basis, but agree to accept a reduced fee schedule as payment in full. In these arrangements, no other surgical/medical benefits are available to the patient unless treatment is needed outside the panel's geographic or medical scope, or in an emergency. Dual choice or open panel doctor groups agree to a reduced fee schedule as payment in full, but patients are free to choose other more costly doctors and pay the difference in fees out of pocket. The higher the fee schedule, the larger the panel; the Blue Cross Blue Shield WrapAround Plus panel includes about 60 per cent of the practicing doctors in the New York City area. Group Health Insurance (GHI) has a similar program and panel.

Each of these arrangements has its weaknesses. Most of them include only doctors, with no hospitals or other health care providers available. Participants may be uneasy about the quality of care if they have little or no choice of providers. They may be inconvenienced by long distances or long waits to be treated at a staff model HMO or a closed panel union health center. Fee-for-service panel doctors may try to offset reduced fees by ordering more tests, more office visits or more surgery.

The PPO structure is designed to eliminate these problems and can be especially attractive for labor-management funds and their participants. Offered as an option along with a fee schedule, the PPO means reduced fees from a range of providers who accept assignment. Any deductible or co-insurance is usually reduced or eliminated so that participants have very little or no out-of-pocket expense. For those funds that supplement Medicare benefits for retirees, the PPO structure can reduce supplemental benefit costs and alleviate the impact of deductibles and co-insurance on retirees.

Unique to the PPO and important to both fund and participant is systematic protection from inappropriate or substandard care. PPOs include a whole array of programs designed to monitor participating doctors and hospitals, so that quality care will be provided at affordable prices. These cost and quality controls include:

(1) credential review of providers to ensure proper licensing, training and experience
(2) on-site visits to doctors' offices to review medical records
(3) pre-admission approval programs
(4) second opinion programs
(5) retrospective review of hospital admissions, laboratory and diagnostic testing
(6) billing audits and review
(7) statistical review of procedures and referrals
(8) educational programs for patients

The PPO structure also examines physicians' practice styles before and after they are recruited into the PPO. Different schools of medicine teach different ways of responding to a particular set of symptoms, and some doctors respond more strongly to economic pressure than others. Major health insurers have statistics in their data banks that demonstrate these differences, but they are usually unwilling to make the information available. PPO organizers attempt to recruit physicians with so-called conservative practice styles—doctors who have displayed an awareness of costs as well as quality of care. PPOs also monitor practice styles within the organization by maintaining detailed statistical records on each provider.

With the prospect of reduced fees and all these monitoring systems, why should a doctor or hospital choose to participate in a PPO? In a word, competition. There are more doctors practicing today than ever before, and the supply is concentrated in areas like metropolitan New York. Many hospitals, including some with impressive reputations, are faced with sagging occupancy rates. Both physicians and hospitals are beginning to see the advantages to them of PPO participation: a guaranteed pool of patients, ease of billing and prompt payment, plus the prospect of referrals from satisfied PPO-covered patients.

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FOLLOW-UP ON THE NEWS

HOSPITAL BOARDS: In a recent issue of *The Fund Reporter* we outlined the problems associated with hospital boards that exclude labor-management health and welfare fund trustees. Only one state, West Virginia, mandates union representation on the boards of all non-profit and local government hospitals.

The West Virginia law took effect July 1, 1984. It requires that 40 per cent of each hospital board be made up of "consumer representatives" from unions, small businesses, the elderly, and persons whose income is less than the national median. Special consideration must be made to include women, handicapped persons and racial minorities.

The hospitals sought and failed to have the law declared unconstitutional. The U.S. District Court for Northern West Virginia declared that the hospitals and their associations failed to show irreparable harm, or that community and union representatives were less capable of managing the affairs of hospitals.

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Hemorrhoids

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mild if only one vein is banded at a time, although some people will experience considerable pain. The only major complication is bleeding after the vein and band have sloughed, which occurs in two per cent of all cases. After banding it is important for people to follow the self-care advice described earlier.

Another treatment for internal hemorrhoids is the injection of a sclerosing agent. While this treatment has fallen out of favor, it may be useful for people who cannot undergo banding or surgery. It is not indicated for external hemorrhoids.

Cryodestruction of internal hemorrhoids has been touted by some as the alternative to surgery. This method uses freezing to destroy the problem hemorrhoid. Initial reports were that this method was relatively pain free, effective and allowed for return to normal activity far more quickly than did surgery. Subsequent trials showed that there was often pain, healing could be prolonged and often included considerable draining, and return to full activity was delayed. The costs of equipment and of the procedure means it would have to prove superior to banding in order to be cost-effective. Such proof has not been forthcoming and, aside from several enthusiasts, the majority of people writing in the medical literature no longer seem to consider cryodestruction a good alternative.

People with external thrombosed hemorrhoids will usually have considerable pain. Often the thrombosis is resolving spontaneously by the time they seek medical help. If the pain continues without signs of abating, then the hemorrhoid can be evacuated in an office procedure.

Surgery is the last option available for those who have not been successfully treated by the other methods described, and for whom the condition limits activity. Surgery necessitates hospitalization for several days, and a recovery period that often lasts weeks. Discomfort during subsequent bowel movements, urinary retention and pain are complications that can occur. A possible major complication is bleeding that occurs seven to ten days after surgery which may require resuturing. This happens in two per cent of cases.

Given the availability of self care and less invasive medical techniques to relieve symptoms, in-patient surgery for hemorrhoids is a procedure that may be performed too often.

Arthur A. Levin is director of The Center for Medical Consumers and Health Care Information, Inc.

FREE HEALTH LIBRARY

The Center for Medical Consumers maintains a free library of health and medical materials open to the public. The library is located at 327 Thompson Street, between West 3rd Street and West 4th Street, just south of Washington Square Park. Open 9 to 5 Monday through Friday (and until 7 P.M. on Wednesday evenings) the library offers you a chance to become better informed about your health and medical care. Books range from scientific and medical texts to consumer guides. Journals, magazines and a clipping file system provide the consumer with sufficient information to judge the quality of care he or she is receiving, or what to do about a minor condition before it requires a physician's attention. You can research the side effects of the drug you have been prescribed, or look up a physician to see if he or she is board certified. Center staff is available to help you find the right materials for your problem.

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Preferred Provider Organization

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What other kinds of providers does a PPO include? A PPO should include nursing home, home care and alternative health care options as well as hospital affiliations. Discount hospital rates are as important as reduced professional fees. The status of negotiated discount hospital rates for self-insured groups in New York State will be determined by the outcome of *Rebaldo v. Cuomo* (see *The Fund Reporter,* November-December '83 and following). A PPO must include a variety of specialists and vertical structure within a hospital in order to maintain continuity of care for a given patient. If a patient being treated by a PPO internist needs referral to a surgeon, for example, the surgeon should be at the same hospital as the internist.

How does a PPO come into being, and who pays for its development? PPOs can be sponsored by labor-management trust funds, by hospitals, by doctors or by professional administrative parties. If a fund does not create its own PPO it can join one, paying either an all-inclusive annual fee or a fee for each participant who accepts the PPO option. A PPO can be designed as profit-making or non-profit, but in either case must be able to generate enough income to provide its own financial integrity and support services. The providers pay an annual fee and special charges to cover the costs of quality and cost control programs. Depending on the structure of the PPO, the providers may also underwrite all or part of the marketing expense and may be charged for certain administrative and billing services.

The metropolitan New York area is far behind the rest of the country in PPO development. A properly designed PPO assures that "preferred" providers are easily accessible to participants, and are providing high quality care in the appropriate amounts. No PPOs have been created in this area that have the full array of features needed to make them worthwhile: an independent entity to administer and service the PPO, a broad base of physicians and other providers, hospital affiliations including discount rates, and thorough utilization review. Labor-management benefit funds may want to consider developing their own PPOs in order to reap the potential benefits for their participants.

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