TEXAS SENATE PUBLIC HEARING
Testimony for Select Interim Workers' Compensation Senate Committee
Thursday, April 29, 1:00 pm

Good afternoon, Mr. Chairman--I am pleased to introduce myself as the Director of Research and Education from the Foundation for Chiropractic Education and Research, a nonprofit foundation that in its 60-year history has provided both financial support and oversight for over $10M worth of pilot projects and stipends for postgraduate study in areas pertaining to the theory and practice of chiropractic healthcare. My background includes a Ph.D. in biochemistry from Harvard, clinical laboratory directorship at a Harvard teaching hospital and an affiliate of the Mayo Clinic, and extensive grants administration and development. I am here at the request of the Parker College of Chiropractic in Dallas.

I want to thank the Senate Select Committee on Workers' Compensation for hearing my testimony and particularly for its intention to more closely review some aspects of cost analysis which lurk behind healthcare costs and benefits, which appear to have eluded too many but thankfully not all individuals in policymaking positions. I fear that part of this problem are some flaws in the interpretation of data from the Workmens' Compensation Research Institute[1-3]--flaws which have suggested that chiropractic services have become a major cost driver of benefits in Texas within recent years. I ask the Committee's indulgence in focusing upon a few of these flaws in its deliberations.

1. Sampling frames have to be clearly identified: In the state of California, in which similar trends have been presented by the California Workers' Compensation Research Institute,[3] it has been suggested that the large number of visits observed can be attributed to just 3-5% of chiropractors who are responsible for 80% of the costs.[4] Until we see a complete set of data allowing us to verify that the sampling frame of chiropractors chosen is truly representative of all practitioners within the state of Texas AND what the distribution of the costs, number of visits, and numbers of procedures is within this sampling frame, we cannot draw any meaningful conclusions.

2. Data on actual comparative outcomes in comparison years is lacking: There is no indication in the WCRI data what the comparative levels of disability were at the workplace when the worker returned to his or her place of employment. Should the worker have returned in a shorter period of time and/or performed at a higher efficiency in the more recent years, the increase in WC payments would have been offset by higher worker productivity with lower costs for replacement training and long-term rehabilitation. This simply has to do with good medicine rather than simply closing the books on a claim at an arbitrary time point without validation.

3. Bundling and billing of services is problematical: Bundling of all germane costs for an episode of care remains elusive--whether for ancillary issues such as the actual costs of all medications, laboratory or hospital services or for indirect costs such as [i] workdays lost by patient, [ii] retraining for replacement labor, [iii] caregiver to assist in domestic duties, [iv] iatrogenic events associated with treatment, and [v] legal [malpractice] settlements and premiums. Previous studies have never fulfilled all these criteria,[5] although a recent report from CIGNA comes closer than most.[6] A report from a leading healthcare economist commissioned by the Ontario Provincial Government has concluded that, in a typical patient's visit to the office of an M.D., 20% of medical services lie within the office visit itself while 80% of the charges are billed to ancillary services. For visits to the chiropractor's office, these two percentages are almost diametrically opposed--as most costs are contained within the chiropractor's office.[7,8] The data from the WCRI studies[1,2] bear no resemblance to these proposed ratios and raise further questions as to precisely how they were calculated. The caveat is to avoid splitting up the actual treatments for non-D.C. patients into separate categories when in fact they are linked to the same episode and must consequently be bundled. Finally, surgical costs were omitted in one report[2] while drug costs, a notorious driver of the high costs of healthcare,[9-12] seem vastly underestimated as suggested by postings of $7 or "insignificant" amounts per episode in the state of Connecticut.[2]

4. Data on case severity and case mix are conspicuously lacking: Other than a general weighting of different states, there is no primary data evident which adequately defines the allocation of case mix and severity between provider groups or years being compared. Regarding back pain alone, one must ask for instance whether the **incidence of specific conditions or injuries** [such as herniated disc] changed from earlier to later periods. Should the more difficult cases such as herniated disc have appeared more frequently in later years, they would be expected to require the more exhaustive treatment periods and assortments of procedures reported.

5. Data on permissible scopes of practice in the comparison years are lacking: The increase in the number of procedures reported may have to do with changes in the permissible scope of practice during that period. Also, the number of procedures/case **for other healthcare professions** should be reported for comparison.

6. WC benefits paid to chiropractors represents a minuscule proportion of the total: From the WCRI's own sampling frame of 12 representative states, the actual distribution of medical payments per claim to chiropractors is a paltry 4% of the total, substantially less than the 31% given to physicians, the 10% allocated to PT/OTs, or the 36% earmarked for hospitals.[1] In Georgia, chiropractors workers' compensation cost recoveries were just 0.8% of the benefits disbursed to physicians in 1997 and 1998,[13,14] while low back pain costs have been estimated to consume between 16-33% of workers' compensation distributions.[15]

These are but a few of the issues with recent reports from the WCRI[1-3] which I have described elsewhere addressing the WCRI in particular[16] and workmens' compensation issues in general.[17] Accordingly, chiropractic interventions which produce tangible results, a commitment to research and documentation of the highest recognized quality,[18-20] high patient satisfaction, and cost-effectiveness should be given full consideration for optimal involvement in workmens' compensation benefits. In this presentation I request that the Senate Committee members display a commitment to working with us to both carefully study and achieve these goals with regard to establishing truly cost-effective healthcare over the long term.

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