The Inherent Insurance Company Conflict of Interest: Providing Benefits vs. Making Money for Shareholders

To Whom It May Concern:

Recently I noted that Bess Shapiro in an insurance industry publication quite correctly noted that a shift in the PD schedule to reflect the findings of objective research of the RAND study to more fairly compensate workers injured in the workplace would move the system away from the current schedule which uses the AMA guidelines. She neglected to say that the AMA guidelines are now used to measure PD levels even though the guidelines themselves state they were in no way intended to be used to measure workplace impairment.

She states, "But for some on the industry side it harkens back to the old schedule and old cost drivers."

When she implies that the payment of benefits to injured workers is a "cost driver", she is correct. In our current system, it is true that an insurance company's primary "cost drivers" are, generally speaking, payments to or on behalf of working people who have been injured at work and need help.

Our society's rules encourage and protect the inherent conflict of interest between the insurance company, the main purpose of which is to make money for it's shareholders, and the people to whom the company is supposed to be providing benefits, the "cost drivers". These are people who have been hurt by their work and are often either no longer able to work at all or no longer able to work in the same job that caused the injury.

I do not propose a solution to this dilemma. I only wish to point out that the conflict of interest exists. The main purpose of an insurance company is not to provide benefits legally owed, but to make a profit. It seems of little interest to the managers of companies whose main goal is to make a profit that they do so by making it very difficult for people who are injured to receive timely medical attention and compensation enough to allow them to live a life of dignity after their injury.

Having been forced to go to trial yet again because an insurance company used a schlock "medical UR report" to justify the unreasonable delay of medical treatment, in this case physical therapy prescribed by a treating doctor to a person who received bilateral joint operations, I am again reminded that by using the letter of the law, and ignoring its intent, to refuse reasonable treatment to injured workers who need it, insurance companies make money. The more the companies refuse to provide reasonable medical treatment in a timely fashion, the more money they make.

Insurance companies heir defense firms to force people like me, attorneys who represent injured workers, to spend hours without pay reading medical reports, UR reports, writing demand letters, filing DOR's, preparing witnesses, taking doctors' depositions and ultimately appearing at the Board with witnesses in tow only to hear, again and again, "Well, we'll authorize that treatment after all." Right. Thanks.

Unfortunately the now "authorized" treatment is 4 months late and my client generally has a higher permanent disability as well as what can best be described as an "attitude" because of the failure to have access to the reasonable medical treatment prescribed by their doctor when it was needed. Bad feelings are generated between the worker and their employer. Bad feelings are generated between the worker's doctors and the insurance company. Bad feelings are generated all around.

Unfortunately, "Bad feelings" do not appear immediately on the insurance companies' bottom lines. The insurance company management apparently makes the monetary calculation that not all injured workers are going to be able to have the luck to find an attorney who is willing to invest *pro bono* time and money to defeat an unreasonable denial of medical care. And so they continue to use people who will do anything for money, people who are not necessarily licensed doctors in the State of California, to review the recommendations of the treating doctors who ARE licensed in California in order to find some excuse to deny treatment. (They misquote the ACOEM guidelines, they argue that "measurements" have not been taken, where no measurements are required to be taken, they require the treating doctors to do more paperwork and thus less treatment, all to deny the authorization for reasonable medical treatment prescribed by the injured workers' doctors.)

At this point, only a few of the thousands of people who are subjected to the "legal", but probably "immoral", mistreatment of wrongfully delaying medical care are able to find attorneys to take their cases. The insurance companies and the people who work for them hire people with medical training, though they need not be medical doctors or licensed physicians in California, to act as advocates to prevent or delay the medical care prescribed by their doctors needed by workers who are hurt at work. I am especially irritated with these so called medical professionals who basically use their skill and their training and their knowledge and their experience to write reports that cite, often incorrectly, ACOEM guidelines to prevent the timely administration of reasonable medical care to people who need it.

I have concluded that these so called medical professionals, many of whom do not live in California, know what they are doing and they are willing to do it, to hurt people, for the money paid to them by insurance companies. The reason I have come to this conclusion is that when I try to take their depositions to ask what reports they have seen, what documents they have been given, what facts

they have considered, what experience they have had with this type of treatment, what are the basis of their conclusions, what is the amount of time that they have spent on the case, they, for lack of a better term, "scurry" into the darkness.

They do not wish to have their depositions taken. The lawyers hired by the insurance companies do not wish to allow me to take their depositions. The insurance companies themselves do not want their minions having their depositions taken. They do not want to allow due process to the injured workers. They do not want the light of fairness and honesty and justice to shine anywhere near these goings on because they know they will not withstand the scrutiny of the light of day. They know that they are, in general, cheating people and doing damage to people to allow insurance companies and their managers to make money.

I know that the insurance company "hope" is that the injured workers of California will find some other way to pay for the medical care they need. Many have used private insurance provided by their company or their spouse. Many are forced to use MediCal. Some actually have to use their own funds to get the medical care, physical therapy for example, in a timely fashion. This saves the workers compensation insurance companies at least hundreds of thousands of dollars each year. This money is saved at the expense of the health and the welfare of the people who are hurt and denied timely medical treatment.

Unfortunately, there are thousands, if not hundreds of thousands of people who must rely on the provision of medical treatment by their employer's workers compensation insurance companies. These people are being treated badly. They do not get timely treatment. They are denied diagnostic treatment like MRI's. They are denied the timely provision of helpful medical treatment such as physical therapy. They are even denied the timely provision of benefits as simple as the pulling of a broken tooth because there was "no evidence" that a 17 foot fall caused the broken tooth. The dental care was successfully delayed four months while the injured worker had to live with the pain of a broken tooth.

Simple math provides the answer. The less an insurance company has to pay to meet its obligations to workers in California, the more money is made for the shareholders and the greater the salaries of the company's management teams. If delay and forcing the injured worker into the very complex world of having to fight for medical care befuddles an injured California worker, so much the better because that worker will be one less worker who becomes a "cost driver" against the company's bottom line.

Yes, this viewpoint is short sighted. It is very much like a pyramid scheme that will ultimately fail, or a dot.com bubble that will ultimately burst. But that will not stop the great majority of insurance company managers from choosing money over people.

The less that goes out, the more there is for the bottom line and isn't that what the insurance company and the conflict of interest is all about?

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