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MEDICAL COST CONTAINMENT IN THE WISCONSIN WORKERS' COMPENSATION MARKET

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ABSTRACT

MEDICAL INFLATION in the workers' compensation market has outpaced that in either group health or Medicare. In Wisconsin, in particular, workers' comp medical claims have rapidly outpaced those in other states, including those both with and without a published medical fee schedule. This paper draws on recent research from NCCI Holdings, the Workers Compensation Research Institute and the Wisconsin Insurance Alliance on some of the drivers behind this trend, as well as discussing potential options for reform.

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INTRODUCTION

THE MANDATORY NO-FAULT system of workers' compensation benefits that has evolved in 49 states and most American territories has broad implications for the national economy. Because state mandates for employers to provide both medical and indemnity benefits to workers injured on the job or made sick by employment-related conditions are so broad, premiums charged to transfer the risk of these claims to insurance companies, state compensation funds and other third parties are, broadly, a part of the cost of doing business – and subsequently, the prices charged to consumers—across nearly all industries.

The Massachusetts Taxpayers Foundation explored some of these effects in a 2003 paper that looked at the results of major workers' comp reforms implemented by the commonwealth in 1991.¹ The legislation created incentives for injured employees to return to work, capped the size of benefits and limited their duration, and called upon impartial medical professionals to review treatments. Average workers comp costs per \$100 of payroll were 51 percent higher than the national average in 1989, before the reforms were passed, but by 2002 had fallen to 20 percent below the national average. As a result of the changes, the state shot up in the Foundation's rankings of states with the lowest cost to do business.²

Given the central role the workers' comp market plays, cost trends can have ripple effects that impact employment and economic growth more broadly. This paper uses the case example of Wisconsin, drawing from data on both state and national trends, to examine whether workers' comp cost containment strategies might help to produce broader economic growth.

1. Massachusetts Taxpayers Foundation. 2003. "Fragile Progress: Reining in Massachusetts' High Business Costs."

2. Ibid.

BRIEF HISTORY OF WORKERS' COMP

THE EARLIEST RECORDED system of workers' comp is generally traced to North American privateers of the 17th century, who were compensated by pirate ships for wounds suffered in the course of sea battles and hand-to-hand combat. The payment schedule – which included 100 pesos for loss of an eye and 600 pesos for loss of a right arm – was roughly consistent with inflation-adjusted accident and dismemberment payments today.³

“Wisconsin passed its own Workmen’s Compensation Act in May 1911, and the Wisconsin Supreme Court upheld the constitutionality of the law in November of that year.”

The first national workers' comp system was instituted in Otto von Bismarck's Prussia between 1881 and 1884, followed by the United Kingdom's own Workmen's Compensation Act in 1897. In both cases, the new systems were “no fault” regimes that replaced earlier, costly tort systems that relied upon the court's to adjudicate employer liability for workers' injuries and illnesses.⁴

Similar efforts to shift the United States from a tort-based liability to a “no fault” system of compensation proceeded in Maryland, Massachusetts, Montana, and New York between 1902 and 1910, but all four initially were struck down as violating the Due Process Clause of the U.S. Constitution. Initially, these laws were opposed by labor union leaders who feared the introduction of a socialized system of compensation and care would diminish the value they provided to workers.⁵

However, the March 1911 Triangle Shirtwaist Co. fire in New York City served to turn the tide of public opinion in favor of

workers' comp reform. Wisconsin passed its own Workmen's Compensation Act in May 1911, and the Wisconsin Supreme Court upheld the constitutionality of the law in November of that year. New York state subsequently passed comprehensive and compulsory workers' comp in 1914, which was upheld by the U.S. Supreme Court's 1917 decision in *New York Central Railroad v. White*.⁶ The U.S. Supreme Court later upheld Wisconsin's law in its 1926 *Booth Fisheries Co. v. Industrial Relations Commission of Wisconsin* decision, thus making Wisconsin's the oldest constitutional workers' comp law in the United States.⁷

By 1948, when Mississippi became the last of the then-48 U.S. states to pass a similar law, workers' comp had become the law of the land across the entire country. Texas is currently the only state that permits employers to voluntarily choose whether to offer workers' comp benefits, or opt for tort-based liability, although public employers and those engaged in public construction and building projects must offer workers' comp.⁸

Because workers' comp laws were adopted independently on a state-by-state basis, there is great diversity in how they are applied across the states. What is universal is that:

1. Except for Texas, all other states require that employers must indemnify workers for workplace related injuries and illnesses, regardless of liability. However, unlike tort claims, benefits do not include compensation for pain and suffering or punitive damages.
2. Benefits come in two types: indemnity payments to compensate a worker or his or her family for lost wages, and medical benefits for care related to injuries suffered or illnesses contracted on the job.
3. Most employers transfer their risk to third parties through insurance provided either by a state-sponsored entity or by private carriers. However, there are significant differences between the medical benefits provided by workers compensation carriers and those offered by group health insurers, Medicare or Medicaid.

Over the years, there has been a marked shift in the balance between indemnity and medical payments in workers' comp. In a 2009 study, NCCI Holdings Inc. – the largest provider of workers' comp data – found that over a 20-year period, the

3. Krzysztof Wilczynski, "Injury Compensation," *PiratesInfo.com*, http://www.piratesinfo.com/cpi_Injury_Compensation_537.asp

4. Christopher J. Boggs, "Workers' Compensation History: The Great Tradeoff," *Insurance Journal*, July 29, 2008. <http://www.mynewmarkets.com/articles/91833/workers-compensation-history-the-great-tradeoff>

5. Ibid.

6. *New York Central R. Co. v. White* - 243 U.S. 188 (1917) <http://supreme.justia.com/cases/federal/us/243/188/>

7. *Booth Fisheries Co. v. Industrial Relations Comm'n*, 271 U.S. 208 (1926) <http://supreme.justia.com/cases/federal/us/271/208/case.html>

8. Texas Medical Association, "The Workers' Compensation System in Texas," <http://www.texmed.org/template.aspx?id=2339>

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the fee schedule will be accompanied by an open comment period in which representatives of the business, labor and insurance communities, as well as the general public, are granted an opportunity to weigh in on such issues as whether sufficient and reliable data was used in establishing the schedule; whether particular fees are so low as to compromise access to care; and whether fees meet standards established by state laws and regulations.

EFFECTIVENESS OF WORKERS' COMP FEE SCHEDULES: NCCI'S FINDINGS

IN ITS 2009 technical paper, NCCI Holdings Inc. found that workers' comp insurers typically pay more than group health insurers for comparable injuries and illnesses, with the greatest differences found in specialty areas such as surgery and radiology.¹⁰ For 21 fee schedule states that use NCCI claims data, the study found that workers comp reimbursement levels for surgery and radiology were above those for group health, while they were roughly at the same levels for physical medicine, general medicine and evaluation and management.

Both group health and workers' comp reimbursements were higher than those for Medicare. In NCCI's study, MAR amounts in the state with the highest average workers' medical fee schedule averaged about 215 percent of Medicare reimbursements, with the average actual workers' comp reimbursements in that state representing about 160 percent of average group health reimbursements.

Moreover, NCCI found that utilization of services in workers' comp is higher for those services where workers' comp insurers pay more than group health insurers; that reimbursements for care provided in hospitals and other facilities is more likely to exceed the MAR amounts than for care provided in doctors' offices; and that reimbursements are more likely to be below the MAR amounts when they are provided through a network. NCCI also concluded that the proportion of workers' comp medical benefits subject to fee schedules is declining about one percentage point each year.¹²

NCCI also tracked a long-term trend of physician reimbursement rate fee schedules applying to a shrinking proportion of workers' comp cases as more treatment is moved from doctor's offices to hospitals and other facilities. They attribute the trend to the conflicting incentives of the hospital's

attending physicians, who would benefit if patients are hospitalized for longer stretches, and the billing procedures of Medicare, which discourages longer hospital stays.

In most states with workers' comp fee schedules, medical services are coded using the current procedural terminology (CPT) code, while the National Drug Code is used to classify and regulate prescription drug costs. In contrast to these classifications by medical procedure, Medicare billing assigns Diagnosis Related Group codings to inpatient care and Ambulatory Payment Classifications to outpatient care that offer payment based not on procedure, but on treatment for specific conditions.

In response to these incentives, a growing number of hospitals have put staff on salary, while many primary care physicians have opted to hand off hospitalized patients to hospital staff, as there is less incentive for them to follow patients in the hospital. A greater number of services being billed by facilities can circumvent CPT codes that are geared for private practice doctors, NCCI found. Workers' comp insurers also frequently negotiate hospital billings as a percentage of billed items, thus making it more likely that specific reimbursement will not follow fee schedules. It also remains unclear what effect the Patient Protection and Affordable Care Act's ban on the construction of new physician-owned hospitals will have on these trends.

THE WISCONSIN EXPERIENCE

THE STATE OF Wisconsin does not have a traditional medical fee schedule for workers' compensation claims. However, in 1992, the state adopted a certified database system for use in resolving disputes about the reasonableness of medical fees. Two years later, the state's Department of Workforce Development established a separate database for radiology services, in response to what was viewed as an unusual number of anomalies in the certified database.

Wisconsin's workers' comp insurers use the databases in ways similar to a medical fee schedule, with maximum medical payments set at 1.2 standard deviations from the mean for any given medical coding. The maximum variance previously had been 1.4 standard deviations, but legislation reducing the variance passed during the 2012 legislative session in an effort to control costs. However, while states that have adopted traditional fee schedules have experienced, on average, less severe medical inflation in workers' comp claims, data from the Workers Compensation Research Institute clearly demonstrates that Wisconsin continues to see medical inflation at elevated rates, surpassing even states without fee schedules.¹³

13. Rui Yang, Workers Compensation Research Institute, "WCRI Medical Price Index for Workers' Compensation, Third Edition (MPI-WC)" August 2011.

10. Barry Lipton, Dan Corro, Natasha Moore, and John Robertson, "Technical Paper: Effectiveness of WC Fee Schedules A Closer Look," NCCI Holdings Inc., February 2009.

11. Barry Lipton, Dan Corro, Natasha Moore, and John Robertson, "Technical Paper: Effectiveness of WC Fee Schedules A Closer Look," NCCI Holdings Inc., February 2009.

12. Ibid.

FIGURE 2: WCRI DATA ON MEDICAL PRICES PAID FOR NONHOSPITAL SERVICES

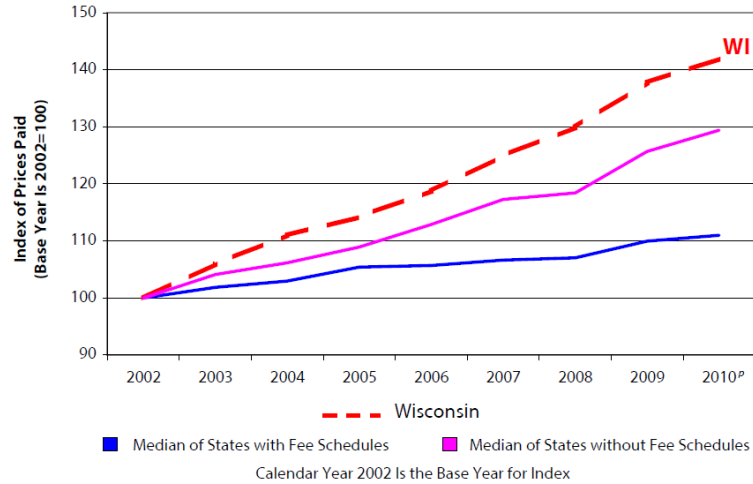


FIGURE 3: WCRI DATA ON MEDICAL PRICES PAID FOR NONHOSPITAL EVALUATION & MANAGEMENT SERVICES

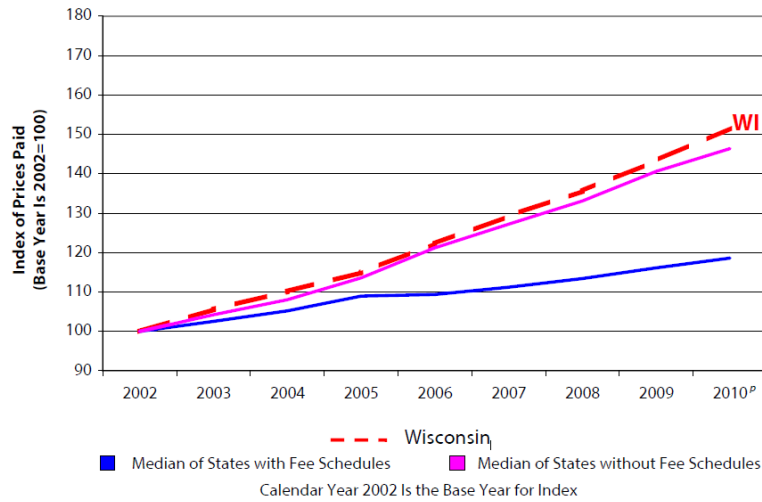


FIGURE 4: WCRI DATA ON MEDICAL PRICES PAID FOR NONHOSPITAL SURGERY SERVICE



In a 2009 data call of its members, the Wisconsin Insurance Alliance found that payment levels within the certified database were nearly 200 percent of the maximum medical payment amounts in bordering states, while actual payments were made at a percentage of 134 percent of neighboring states' fee schedule amounts.¹⁴

Among the study's findings in specific codings:

- For physical therapy and chiropractic codes like therapeutic exercise, massage, manual therapy, and treatment for the spinal form of Charcot-Marie-Tooth disease, the alliance found that the state formula stood at 199 percent of neighboring states' fee schedules for the physical therapy codes and 181 percent for chiropractic codes. Average payment levels were 116 percent of neighboring states' fee schedules for physical therapy codes and 113 percent for chiropractic codes.

“The WIA concluded the existing certified database system had minimal impact on medical cost control, in part because they are not supported by published rules that would help with application of the fee amounts”

- For professional surgical codes like shoulder decompression, meniscectomy, chondroplasty, rotator cuff repair, and carpal tunnel, the Wisconsin formula stood at 228 percent of neighboring states' fee schedules and average payment levels for those codes were at 150 percent of neighboring states' fee schedules.
- For professional radiology codes like interpretation of spinal X-rays and MRIs, the Wisconsin formula stood at 205 percent of neighboring states' fee schedules and average payment levels for those codes were at 147 percent of neighboring states' fee schedules.

14. Wisconsin Insurance Alliance, Workers' Compensation Medical Data Call: A Baseline Analysis and Recommendations for a Medical Fee Schedule. August 24, 2009. http://dwd.wisconsin.gov/wc/councils/wcac/WCAC_Modifications_090409_Final.pdf

The WIA concluded the existing certified database system had minimal impact on medical cost control, in part because they are not supported by published rules that would help with application of the fee amounts. WIA also posited that that re-pricing of services was likely a major driver of the inflation trend. This would include the application of commonly accepted coding conventions, such as multiple surgical cutbacks and reductions based on modifier usage, and the application of specific coding guidelines such as those provided by the NCCI.

Medical payments made by Wisconsin workers' comp insurers averaged between 83 percent and 89 percent of charges, which further suggested that agreements to negotiate billed terms – as would be common from a preferred provider organization (PPO) in the group health market – is in evidence.¹⁵ Wisconsin employees have free choice of medical providers, but all of the state's major payors affiliate with one or more medical networks to take advantage of PPO-style discounts.

OPTIONS FOR CONTROLLING WISCONSIN'S MEDICAL CLAIMS INFLATION

THE STARK DIFFERENCE between the rates of growth in workers' comp medical claims in Wisconsin in comparison to other states, and particularly those with medical fee schedules, suggests that a shift to a more explicit, published fee schedule system could serve as a check on rampant medical inflation.

Among the advantages a fee schedule could offer are reduced administrative burdens for both medical providers and workers' comp insurers to validate payment amounts; a reduced burden on Department of Workforce Development to adjudicate fee disputes; and reduced need for bill audits.


However, the NCCI research demonstrates that fee schedules, while potentially a useful tool in curbing medical inflation, would not be a panacea. The long-term national trend of physician reimbursement rate fee schedules applying to a shrinking proportion of workers' comp cases suggests that existing trends in Wisconsin for payors to take advantage of PPO-style discounts, particularly for billings from hospitals and other facilities, would not be directly abated by a switch to a published fee schedule.

Another option for reform, particularly in light of the Patient Protection and Affordable Care Act's incentives for creation of Accountable Care Organizations, might be to take advantage of the trend for workers' comp insurers to seek PPO-style agreements with health care networks, and more closely align the structure of works' comp benefits with those of group health. For decades, group health insurers have made

15. Ibid.

standard a variety of cost control techniques that are particularly applicable to the hospital care model, including deductibles and co-payments. It should be noted that permitting the introduction of such structures into the workers' comp arena would undoubtedly require legislative intervention.

“NCCI’s data shows that workers’ comp reimbursements trend higher than those for group health across a broad range of procedures.”



The advantage of moving in the direction of group health-style cost containment would lie not only in discouraging overutilization by patients. It also could serve to address the broad cost-shift from group health to workers' comp. NCCI's data shows that workers' comp reimbursements trend higher than those for group health across a broad range of procedures, which suggests that providers may be charging higher rates to workers' comp patients to compensate for discounted rates negotiated by group health insurers.

But moreover, NCCI found that utilization of workers' comp is higher for those services where workers' comp reimbursements are higher. This further suggests that some patients that might otherwise be treated under a group health system are being shifted by providers into workers' comp. Better equalizing reimbursement rates – either through an explicit schedule or from carriers adopting the strategies and techniques of group health – could go a long way toward avoiding these kinds of shifts.

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