RESEARCH UPDATE

Analysis of California Workers' Compensation Reforms

Part 4: Changes in Medical Cost Containment Payments

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EXECUTIVE SUMMARY

Medical cost containment (MCC) is a process that seeks to monitor and manage the unit price of medical services, and where feasible and appropriate, the use and volume of specific services based on clinical efficacy and need. The two elements of recent legislative reforms that most directly impacted medical cost containment payments were the repeal of voluntary utilization review (included in Senate Bill 228, the 2003 workers' compensation reform legislation); and the provision allowing employers to establish medical provider networks (MPNs) to direct their injured workers' medical care on or after January 1, 2005 (included in Senate Bill 899, the 2004 workers' compensation reform bill).

This analysis, which uses claims with 2002 to 2006 injury dates to track medical cost containment expenses at 12 and 24 months post injury, is the latest addition to CWCI's reform analysis series.

Key findings include:

- For all claims, the ratio of medical cost containment payments to medical benefits at 12 months post injury rose from 5.7 percent for AY 2002 claims to 9.8 percent for AY 2005 claims. Meanwhile, the ratio measured at 24 months post injury rose from 5.6 percent for AY 2002 claims to 9.4 percent for AY 2004 claims.
- For medical-only claims, the ratio of medical cost containment payments to medical benefits for medical-only claims at 12 months post injury more than doubled from 4.0 percent for AY 2002 claims to 8.6 percent for AY 2005 claims. A similar result was noted at 24 months post injury, as the ratio climbed from 4.2 percent for AY 2002 claims to 8.3 percent for AY 2004 claims.
- For indemnity claims, the ratio of medical cost containment payments to medical benefits for indemnity claims at 12 months post injury rose from 6.2 percent of AY 2002 claims to 11.1 percent for AY 2005 claims. At 24 months post injury, the ratio increased from 5.9 percent for AY 2002 claims to 10.1 percent for AY 2004 claims.

BACKGROUND

Workers' compensation MCC services have evolved in California over the last 20 years.

With the advent of a medical fee schedule, a medical provider's bill for a given procedure could be compared with the fee schedule allowance and adjusted accordingly. By the late 1980s and early 1990s, large hospital networks and provider panels began to take advantage of economies of scale by offering medical care at discounts to the fee schedule, and the use of preferred provider organization (PPO) networks in California workers' compensation flourished. Over the years, bill review evolved to include a review of applicable rules prescribed by the Official Medical Fee Schedule, statute or regulation, affecting the intensity of medical services delivered (for example, the "cascading" of multiple physical therapy services during a single visit). To ensure appropriate medical benefits, workers' compensation claims administrators began to utilize peer-review, medical case management, and second opinion programs modeled after group health managed care plans, and these formed the basis of the first utilization management programs.

Workers' compensation reforms legislated in 1993 began to experiment with more integrated models of managed care borrowed from group health. The legislative changes established Health Care Organizations (HCOs) that included guidelines for utilization review, quality assurance and peer review. The program also allowed extended medical control to a network of providers established by the program and approved by the Division of Workers' Compensation. The HCO program remains active, although enrollment has never reached a level sufficient to significantly influence the workers' compensation system. Likewise, the 24-Hour Pilot Program, a three-year experiment designed to combine group health and workers' compensation medical care, incorporated cost containment aspects of group health and further allowed the integration of group health and workers' compensation provider networks. Although extended for a year beyond the initial three-year period, the pilot program was allowed to sunset, in large part due to insufficient participation.

Senate Bill 228, the 2003 workers' compensation reform legislation, made several changes to the California workers' compensation system that more broadly institutionalized some of the early cost containment efforts. The change that had the most direct effect on medical cost containment and the associated costs was the repeal of the voluntary utilization review (UR) system in favor of a mandatory UR model. The mandatory UR model supports the implementation of the medical treatment utilization schedule (MTUS), which was given the presumption of correctness in the determination of appropriate medical treatment of work injuries. When a dispute over medical treatment arises, the utilization review process ensures that treatment plans are supported by high-grade medical evidence. The utilization review process, whereby a treatment plan is reviewed to determine compliance with the MTUS, has led to a growing number of UR organizations within the California workers' compensation system, which presumably has increased expenses associated with medical cost containment.

In 2004, state lawmakers passed Senate Bill 899, which called for additional changes to the California worker's compensation system. The SB 899 change most associated with medical cost containment was the introduction of Medical Provider Networks (MPNs), which were phased into operation beginning in January 2005. Prior to the introduction of MPNs, employers in California were given control over their injured workers' medical treatment for the first 30 days following the injury unless the worker had a predesignated personal physician or was a member of an HCO. SB 899 extended medical control for employers that offer MPNs from the pre-reform 30-day window to the life of the claim. Furthermore, because of their size and the volume of services rendered, MPNs are often able to offer discounted fees for many medical services typically used in workers' compensation, further helping contain the total cost of medical care in the system. As a result these networks have had a significant impact on medical benefit delivery and medical costs in California workers' compensation, and have expanded rapidly. As of January 23, 2008, the California Division of Workers' Compensation has approved more than 1,200 MPNs.[1]

In Part Three of this research series, "Medical Provider Networks and Medical Benefit Delivery," the Institute found that the network utilization rate for California workers' compensation medical treatment has nearly doubled since MPNs began operations in 2005. The latest figures show that in the first year following injury, nearly 62 percent of physician-based outpatient visits for work injuries occurring in 2006 were to network providers, compared to one out of three visits before MPNs became available. To the extent that network provid-

1 Current Issues With MPNs. Yu-Yee Wu, DWC Annual Conference Presentation, March 3, 2008.

ers offer medical fees below the official medical fee schedule maximums, medical cost savings and associated medical cost containment payments increase. On the other hand, to the extent that physicians participating in MPNs are able to demonstrate a high level of quality medical treatment in the workers' compensation system, and that high-quality treatment is rewarded with prior authorizations for medical services under prescribed circumstances, the need for utilization review may diminish.

DATA & METHODS

Using the ICIS database, the Institute compiled a sample of 944,215 open and closed California workers' compensation claims that had both medical benefit and medical cost containment (MCC) payment data. The sample included claims from five different accident years (dates of injury ranged from January 2002 through June 2006) and payment transactions were measured through November 2006. The calculations also were adjusted to normalize for differences across each payor's 2005 total medical benefit payments. The data sample contained medical payments of $3.7 billion, and medical cost containment payments of $262 million.

The Institute measured medical benefit payments and medical cost containment payments at 12 months post injury, as well as these same payments at 24 months of development for accident year 2002-2004 claims. The analysts then calculated the average amount paid per claim at both valuation points. The results were used to determine the ratio of medical cost containment payments to medical benefit payments (which contain medical cost containment fees) for each accident year at the 12- and 24-month valuation points.

RESULTS

All Claims

Table 1 displays the average amount paid per claim for medical cost containment and medical treatment at 12 and 24 months post-injury for all claims (medical-only and indemnity). The average amount paid per claim for medical cost containment at 12 months post injury climbed $60 from $166 for AY 2002 claims to $226 for AY 2005 claims, a 36 percent increase.

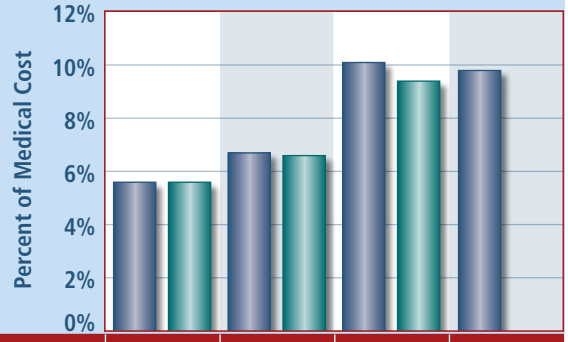
Table 1: Avg. Medical Cost Containment and Treatment Payments
AY 2002 - 2005 – All Claims

Accident Year	Avg MCC Paid at 12 Months	Avg MCC Paid at 24 Months	Avg Medical Benefits Paid at 12 Months	Avg Medical Benefits Paid at 24 Months
2002	$ 166	$ 250	$2,917	$4,494
2003	$ 199	$ 315	$2,958	$4,733
2004	$ 247	$ 342	$2,453	$3,618
2005	$ 226		$2,297	

At the same time, however, the average amount paid per claim for medical treatment at 12 months of development declined by $620 from $2,917 to $2,297, a reduction of 21 percent. The more developed data show similar changes, with average medical cost containment payments at 24 months post injury increasing $92 (nearly 37 percent) from $250 for AY 2002 claims to just under $342 for AY 2004 claims, while average medical benefits paid per claim fell $876 (about 20 percent) from $4,494 to $3,618.

Chart 1 shows the average amount paid per claim for medical cost containment as a proportion of the average amount paid for treatment at 12 months and 24 months post-injury for accident year 2002 through 2005 claims.

Chart 1: MCC to Medical Treatment Payment Ratios
AY 2002 - 2005 – All Claims



	2002	2003	2004	2005
12 Months Post Injury	5.7%	6.7%	10.1%	9.8%
24 Months Post Injury	5.6%	6.6%	9.4%	

The ratio of medical cost containment payments to medical treatment payments at 12 months post injury increased from 5.7 percent for AY 2002 claims to 9.8 percent for AY 2005 claims, a relative increase of 73 percent. Similarly, at 24 months post injury, MCC measured as a percentage of medical treatment rose from 5.6 percent for AY 2002 claims to 9.4 percent for AY 2004 claims, a relative increase of 70 percent.

Medical-Only Claims

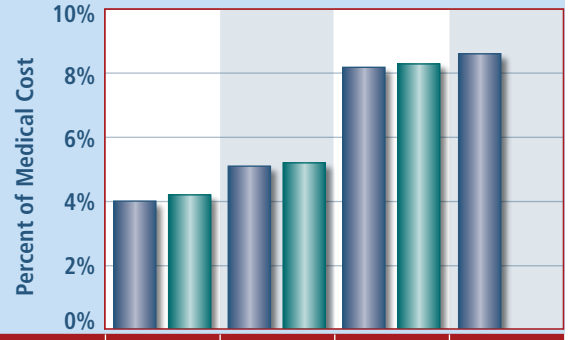
In medical-only claims, the injured worker typically receives treatment and returns to work with no lost time, making these the least severe and least expensive claims in the workers' compensation system. Table 2 displays the average amounts paid for medical cost containment and medical treatment for medical-only claims at 12 and 24 months post-injury by accident year.

Table 2: Avg. Medical Cost Containment and Treatment Payments AY 2002 - 2005 – Medical Only Claims

Accident Year	Avg MCC Paid at 12 Months	Avg MCC Paid at 24 Months	Avg Medical Benefits Paid at 12 Months	Avg Medical Benefits Paid at 24 Months
2002	$ 28	$ 32	$ 686	$ 756
2003	$ 36	$ 42	$ 707	$ 807
2004	$ 58	$ 65	$ 699	$ 783
2005	$ 62		$ 712	

For medical-only claims, average medical cost containment payments at 12 months post injury rose $34 (121 percent) from $28 for AY 2002 claims to $62 for AY 2005 claims. At the same time, the average amount paid for medical treatment at 12 months post injury on these claims rose a modest $26 (3.7 percent) from $686 for AY 2002 claims to $712 for AY 2005 claims. At 24 months post injury, average MCC payments on medical-only claims more than doubled from $32 for AY 2002 claims to $65 for AY 2004 claims, while the average amount paid for medical benefits edged up $27 (about 3.6 percent) from $756 to $783, reflecting the fact that in most medical-only cases, treatment terminates soon after the date of injury.

Chart 2: MCC to Medical Treatment Payment Ratios AY 2002 - 2005 – Medical-Only Claims



	2002	2003	2004	2005
12 Months Post Injury	4.0%	5.1%	8.2%	8.6%
24 Months Post Injury	4.2%	5.2%	8.3%	

Among medical-only claims in the study sample, the ratio of medical cost containment payments to treatment payments at 12 months post-injury increased from 4.0 percent for AY 2002 claims to 8.6 percent for AY 2005 claims – an increase of nearly 114 percent. Similarly, at 24 months post-injury, the ratio of medical cost containment payments to treatment payments nearly doubled from 4.2 percent for AY 2002 claims to 8.3 percent for AY 2004 claims.

Indemnity Claims

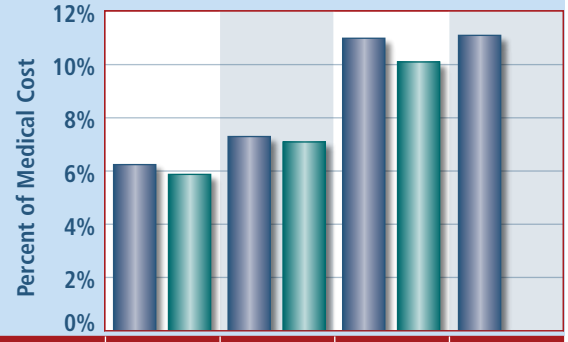
Indemnity claims are more serious cases in which the injured worker is either admitted into the hospital and/or unable to return to work within three days of the injury. They include both temporary disability as well as permanent disability claims. Table 3 displays the average amounts paid for medical cost containment and medical treatment for indemnity claims at 12 and 24 months post-injury by accident year.

Table 3: Avg. Medical Cost Containment and Treatment Payments
AY 2002 - 2005 – Indemnity Claims

Accident Year	Avg MCC Paid at 12 Months	Avg MCC Paid at 24 Months	Avg Medical Benefits Paid at 12 Months	Avg Medical Benefits Paid at 24 Months
2002	$ 433	$ 671	$ 7,033	$ 11,342
2003	$ 489	$ 791	$ 6,694	$ 11,085
2004	$ 668	$ 958	$ 6,085	$ 9,484
2005	$ 662		$ 5,974	

For indemnity claims, average MCC payments at 12 months post injury climbed from $433 for AY 2002 claims to $662 for AY 2005 claims, an increase of $229, or 53 percent. At the same time, average medical treatment payments at 12 months declined $1,059 from $7,033 to $5,973, a reduction of 15 percent. At 24 months post injury, average medical cost containment payments for these claims increased by $287 from $671 for AY 2002 claims to $958 for AY 2004 claims (+43 percent), while the average amount paid for medical treatment declined by $1,858 from $11,342 to $9484, a 16.4 percent reduction.

Chart 3: MCC to Medical Treatment Payment Ratios
AY 2002 - 2005 – Indemnity Claims



	2002	2003	2004	2005
12 Months Post Injury	6.2%	7.3%	11.0%	11.1%
24 Months Post Injury	5.9%	7.1%	10.1%	

The ratio of medical cost containment payments to treatment payments for indemnity claims at 12 months post injury rose from 6.2 percent for AY 2002 claims to 11.1 percent for AY 2005 claims, a relative increase of 80 percent. At 24 months, the ratio increased from 5.9 percent for AY 2002 claims to 10.1 percent for AY 2004 claims, a relative increase of 71 percent.

CONCLUSION

This preliminary analysis on the effects of recent California workers' compensation reforms shows that reform may be associated with higher medical cost containment payments. Although the analysis draws no direct correlation between higher MCC payments and particular elements of reform, and the analysis does not break out medical cost containment payments across the various MCC expense categories, one might conclude that increased utilization review resulting from the application of evidence-based medical treatment guidelines has contributed significantly to this observed MCC payment increase.

Another likely contributor to increased MCC payments is the increased use of network providers resulting from the implementation of Medical Provider Networks. Part 3 of this reform analysis series showed that following the introduction of MPNs in 2005, the use of network providers nearly doubled from AY 2002 levels. Payments for employer access to discounted networks (another element in medical cost containment) can be either a flat fee or based on savings derived from provider discounts – an amount that will increase with greater access to discounted provider networks. Because many MPNs were not established until well into the 2005 calendar year, this particular effect may not be significant in this analysis, but may become evident in subsequent studies.

RESEARCH SERIES

This research update is part of an annual series of analyses initiated by CWCI in 2006 to track changes in various aspects of the California workers' compensation system following the implementation of the 2002-2004 legislative reforms. This report concludes the current 4-part series, which has examined the following topics:

- **Part I: Medical Utilization & Reimbursement**
- **Part II: Temporary Disability**
- **Part III: Medical Provider Networks**
- **Part IV: Medical Cost Containment**

ABOUT CWCI

The California Workers' Compensation Institute, incorporated in 1964, is a private, non-profit organization of insurers and self-insured employers conducting and communicating research and analyses to improve the California workers' compensation system. Institute members include insurers that collectively write more than 87 percent of California workers' compensation direct written premium, as well as many of the largest public and private self-insured employers in the state.

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