



“THE COMPREHENSIVE CHANGES IN THE CALIFORNIA WORKERS’ COMP LAWS NOW GIVE US THE CHANCE TO RESHAPE THE DELIVERY OF HEALTH CARE IN THE WORKERS’ COMP MARKETPLACE ...”

MADDY BOWLING wants to change the rules when it comes to workers’ compensation medical costs. The Chicago-based exec sees outcome-based measurements as the key to success.

● **COVER STORY**

Pushing a Revolutionary Agenda

Legislation in California has opened the door for a new paradigm in the workers’ compensation medical model. But to inspire this change, we need to ask some hard questions about our current discount-provider networks. BY MADDY BOWLING

Workers’ compensation medical costs continue to rise at double-digit rates, reaching such sky-high levels that they all but wipe out the reduction in the frequency of workers’ comp medical claims. Why?

Fundamentally, it’s because the system’s current medical model operates with the wrong motivation: to manage unit costs rather than keep total costs under control. There is little regard for how quickly the injured worker recovers and is back on the job. The preferred-provider networks that form the core of this medical model focus on

unit-cost discounts rather than ensuring the patient gets to the right doctor for the right type of care for the quickest recovery. In fact, the medical providers’ pricing and discounting structure can be manipulated to speed the rate of medical cost increases rather than restrain it.

But there is another way.

The comprehensive changes in the California workers’ comp laws now give us the chance to reshape the delivery of health care in the workers’ compensation marketplace by testing new ideas and even lessons learned from the group health

care model.

Most of us would probably agree that in the management of our own health care, the two highly interrelated keys to maintaining our well-being at reasonable medical costs are our attitude and the quality of our physician.

Is it any different when an employee experiences a work-related injury? Those of us enmeshed in this workers’ comp system have known for some time that medical and return-to-work costs and quality outcomes are very dependent upon employee attitude and the quality of the physician. Every stakeholder in the workers’ comp system would agree that all aspects of this system work better when we “get the injured employee to the ‘right medical provider’ at the right time.”

This, however, does not describe how our workers’ comp system operates. Our workers’ comp medical costs are neither reasonable nor trending downward. According to the most recent *State of the Line Report* from the National Council on Compensation Insurance, our medical costs continue to rise at double-digit rates. Additionally, there is clear evidence nationally that the continued cost hikes are driven by usage increases of both medical services and pharmaceuticals rather than unit-cost increases, which raises quality concerns as well. Clearly, our workers’ comp medical model is not working.

The current model is primarily built on the premise of large broad-based discount networks where each medical transaction is discounted below the state-regulated fee schedule or the location’s usual and customary rate. Discount networks have existed for 20 years, accompanied by penetration reports (the medical transactions or charges from a PPO-contracted provider that receive a discount) and savings reports (the dollars “saved” due to the PPO discounts-per-procedure code).

Most workers’ comp payers experience a charge penetration of more than 50 percent (meaning a

majority of their total medical charges were billed by PPO-participating providers) and see PPO savings of approximately 3 percent to 5 percent off originally billed charges. These PPO savings are in addition to the bill-review savings that result from repricing the medical bills to the state fee schedule or the usual and customary amounts (which typically generate savings of at least 35 percent to 40 percent off originally billed charges). While savings of 38 percent to 45 percent sound impressive, the industry reports indicate medical costs are not abating, begging some important questions:

- Although they are easy to measure, are savings from bill review and PPO discounts truly meaningful measures of how we are doing?

- Are the unit-cost discounts from PPOs saving us medical dollars, or have the system players become adept at manipulating our perceptions of medical savings?

- Can participating PPO medical providers offset their agreed unit-cost discounts, and therefore not really produce real-dollar savings, by increasing medical utilization (more visits and/or more services per visit)?

- By definition, broad-based discount networks seek to include as many providers as possible for higher charge penetration and savings results, but are these the providers who deliver the best workers' comp outcomes?

- Are the medical providers' financial incentives aligned with the claims outcomes we seek: lower loss costs and quicker, sustainable return-to-work rates?

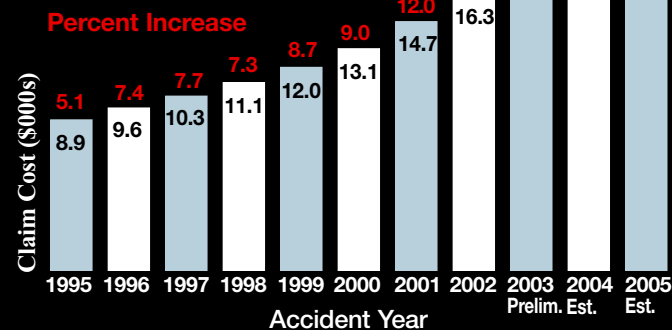
- Finally, given all of these questions, are we prepared to move away from bill-review savings and broad-based unit-cost discount networks?

When California passed SB899 in 2004, allowing employers to not only create networks of medical providers for their employees' work-related injuries but additionally to economically profile these providers, it set the stage for an industry paradigm shift from broad-based unit-cost discount PPO networks to outcomes-oriented employer-specific networks composed of the right medical providers.

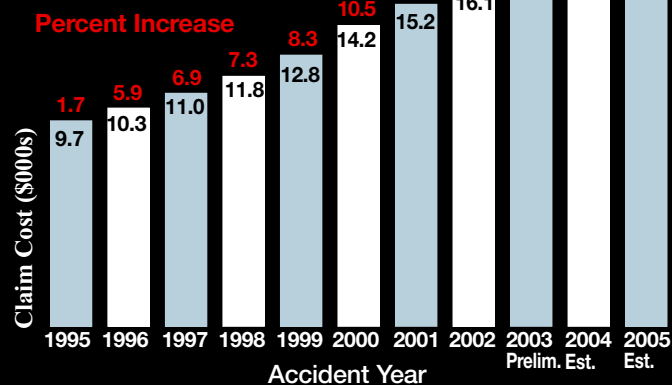
We have been given an opportunity to change the workers' comp landscape to achieve a medical model in which every aspect works better because we "get the injured employee to the 'right medical provider' at the right time" and medical provider financial incentives align with outcome expectations.

Are we taking advantage of this opportunity? There is an old saying, "If we do what we always did, we will get what we always got!" Many stakeholders in California, for instance, are simply renaming their former PPO or HCO network to become a "new" Medical Provider Network. If all we do is change the labels, we will get what we always got: claims of savings while actual

Workers' Compensation Medical Claims, Average Cost 1995-2005

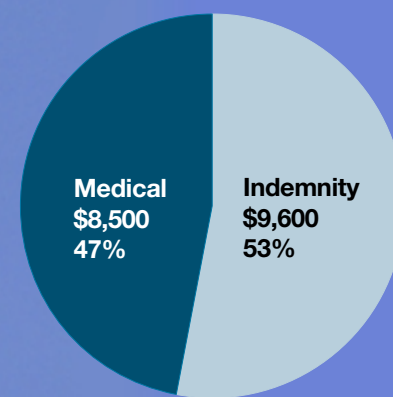


Workers' Compensation Indemnity Claims, Average Cost 1995-2005

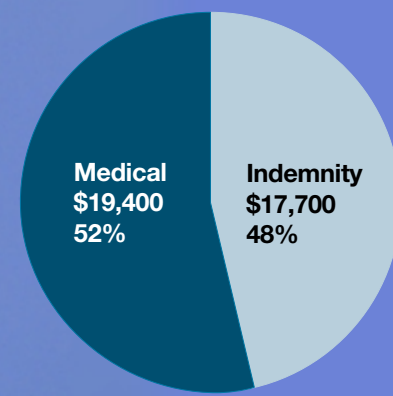


Source 1995-2003: 2004 State of the Line: Analysis of Workers' Compensation Results, National Council on Compensation Insurance, Inc.
Source 2004-2005: Sedgwick CMS, Inc. Business Intelligence Unit estimate

Workers' Comp Average Claim Cost Medical vs. Indemnity, 1994 & 2004



1994



2004 (est.)

Source 1994: 2004 State of the Line: Analysis of Workers' Compensation Results, National Council on Compensation Insurance Inc.
Source 2004: Sedgwick CMS Business Intelligence Unit estimate, Sedgwick CMS 2004-2005 Report & Outlook

overall medical and indemnity loss costs continue to rise.

What can you do if you want to actually shift the paradigm? Here are some steps you can follow.

ANALYZE REAL OUTCOMES

If you haven't analyzed your PPO network outcomes beyond the penetration and savings reports you typically receive, ask your network to do an analysis to answer the following questions:

- What is the average medical cost for claims treated in network compared to claims treated out of network?
- What are the medical utilization trends (number of visits, number of services per visit) for claims treated in network compared to claims treated out of network?
- What percent of all claims lose time and what is the average duration of lost time for claims treated in network versus those treated out of network?
- How do these comparisons differ jurisdiction to jurisdiction?

Your network organization will need to match claims data with clinical encounter data to answer these questions, but it should be able to do this analysis as part of its fee for standard results reporting. These two sources of data were until recently rarely compared. Claims data is the information about when, where, why and how workers were injured, when they returned to work, and their overall claims costs. Clinical encounter data is contained in the medical bill-review process

and details who treated the patient, their medical specialty, what the medical treatment entailed, duration of treatment and how much the various types of procedures cost.

The outcome of this analysis may surprise you. Your network should demonstrate to you real reductions in your overall paid losses and lost-time duration. But discount networks are, by virtue of their design, motivated by the number of treatments or visits, not the overall medical and indemnity cost or return-to-work results. Their revenue is generated from their portion of the discount on each medical transaction. Linking clinical encounter data with claims data, though, may allow us to develop a cost system based on the outcome of the workers' compensation incident in the broadest sense, keeping costs under control or hopefully reducing them.

IDENTIFY THE BEST

Your next step is to use that integrated information to develop a sophisticated network of the right medical providers who speak workers' comp fluently and achieve quick and sustainable return-to-work rates, and to eliminate those medical providers who are not delivering the best outcomes. Such a network could significantly reduce the cost of health-care delivery over both the short and long term. It is time we hold accountable the medical providers and their contracting networks for medical and return-to-work outcomes for our injured

employees.

Fortunately, the data and analytic capabilities now exist to identify and continuously scorecard individual providers or practices based upon best outcomes. Though each stakeholder may have a slightly different definition of "the right providers," there appears to be consensus on several of the key elements:

- Experience in occupational health or sports medicine;
- Demonstrated experience in disability management (being able to "walk the walk" to keep employees at work, and to evaluate and communicate physical capacities and restrictions to support transitional work assignments);
- Communication skills to inform and involve the employee and employer during the process;
- Understanding of the nuances of the workers' comp system;
- Timely access for injured workers, employers, claims examiners and registered nurses; and
- The best outcomes (e.g., functional improvement, return-to-work, lower total medical and indemnity costs, etc.)

Although you can design your own version of best outcomes, the following high-level metrics offer a good starting point to measure each provider:

- Average medical cost per claim (found in your claims database);
- Average lost work days per claim (found in your claims database);
- Percentage of claims with

litigation (found in your claims database);

- Employee satisfaction (measured through surveys done after closure or after provider visits);
- Percentage of referrals to specialists (found in your claims payment database); and
- Lag time to referral to specialists (found in the claim payment or medical bill review database).

Once you have your providers economically profiled in this way, you can rank those for whom you have enough data and choose the providers with the best overall outcomes to join your network. Essentially, you will be rating workers' comp medical providers based on their statistics and providing outcome comparisons to their peer group. The next step is to narrow your network to only those physicians and ancillary providers who will provide the best outcomes for your injured employees. For those physicians with not enough data or those on your "watch" list, you can continue to scorecard, educate and compare them to their peers.

DRIVE PRICE CHANGES

With our focus now on provider outcomes rather than provider discounts, it is time for a pricing change for your workers' comp network in California and, ultimately, beyond. Paying to get a provider bill reduced to the amount the state mandated for that particular medical transaction is ridiculous. We should expect providers in our outcome-oriented network to bill the right amount per the State Fee Schedule or Usual and Customary database.

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This would remove an enormous administrative burden on the industry and allow payers to better focus on returning injured employees to work.

In addition, paying for network access based upon a percentage of the provider's discount of the unit cost, which may or may not mean decreased medical and indemnity claim costs or quicker, sustainable return-to-work, is archaic and counterproductive. We must use this opportunity in California to drive change in the way we pay for access to the right medical providers.

There are many alternative options for pricing, including straight-access fees, capitated arrangements and the one most likely to drive our outcome focus: a pay-for-performance model. Although there are a few day rates and case rates in workers' comp, these models control the cost, not necessarily the quality.

The real pay-for-performance work is being done on the group health side of the house. The Leapfrog Group (www.leapfroggroup.org) is leading the health-care industry into a world where incentives and rewards provide for high-quality medical care and efficient use of resources, especially in the areas that represent a significant portion of

cost. Even the federal government has gotten into the pay-for-performance game with initiatives in Medicare to reward better and innovative care. With the new focus on clinical and disability-duration guidelines, integrated claims and detailed medical data, workers' comp can follow the group health industry's lead and build incentives for providers based on cost-effective, quality medical care that leads to return-to-work rates within nationally recognized disability-duration guidelines.

If we demand a change in this arena, our options for appropriate pricing will increase and we will finally be aligning our financial incentives with our expectations and driving the right behaviors and results. We will direct our employees to the best doctors, therefore paying for results in regard to improved functionality, return-to-work rates and lower overall claim costs.

BEYOND CALIFORNIA

Once we are successful in changing the model in California, where we have the support of new legislation, we need to export this new medical model elsewhere in the country.

Clearly, we have not been rewarding the right provider behaviors in our current model. It is only when we measure providers

on their overall outcomes in regard to return-to-work results and total costs, rather than the percent discount they are willing to offer each time they see your injured employee, that we will reward the right things. It has been demonstrated through network outcome analyses like those recommended above that many providers compensate for the offered discount by treating more often. The winners in our current scenario are the medical providers (who can earn as much as they did before the discount) and the providers' contracting network organizations (which earn a percentage of the savings from the discount every time the injured employee is treated). We need to be sure that the winner in the new model is the injured employee, who should receive the appropriate medical care at the right time in order to return to productivity.

We must realign the financial incentives to match our desired outcomes: quicker return-to-work rates and lower overall cost of claims. The California Medical Provider Network is a golden opportunity both for California and our workers' comp system nationwide. Let's take advantage of this opportunity to drive a paradigm shift in the workers' comp system and take control of our medical and indemnity costs once and for all.

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