Workers' Compensation Medical Care in California: **Costs** (2006 UPDATE)

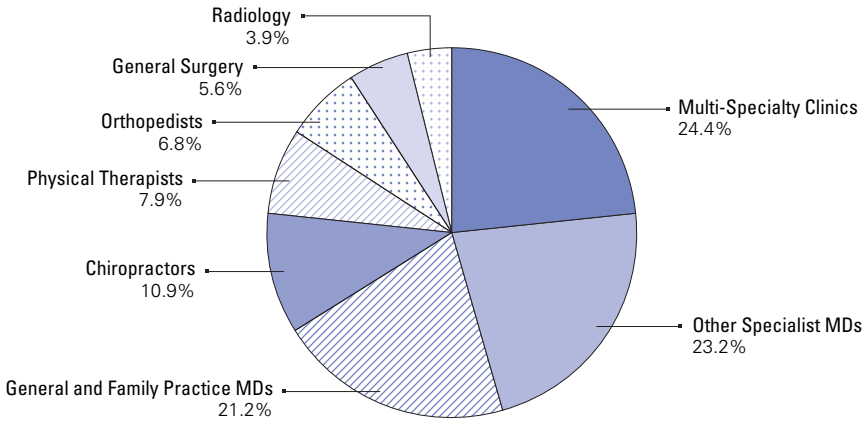
FACT SHEET

System Medical Costs

The total costs of California's workers' compensation (WC) system were estimated to be about $21 billion in 2005, consisting of medical care payments and wage replacement ("indemnity') benefits to injured workers, along with administrative expenses and adjustments to reserves.[1] Based on data from 2003 and 2004 for claims with more than seven work days, the Workers' Compensation Research Institute (WCRI) estimates that the median medical payment per claim was $8,211.[2] For California employers, WC insurance represents an average WC premium expenditure of $3.75 per $100 of payroll, as of March 2006.[3] That translates into an average annual premium of $1,580 per worker.[4]

About half of all WC benefit payments in California are for medical care expenses, with the majority of the remainder for indemnity benefits. In calendar year 2005, commercial WC insurers in California paid out $3.8 billion for medical care benefits (this does not include payments by self-insured employers, or reserves for future year payments).[5] Half (49.6 percent) of these outlays were for payments to physicians and other medical providers, with lesser amounts, proportionately, paid for hospital charges (27.3 percent), pharmaceuticals (11.4 percent), medical-legal evaluations (4.8 percent), and other medical services. Figure 1 shows the distribution of WC physician payments by specialty.

Figure 1. Distribution of WC Physician Costs, by Physician Specialty, 2005



Source: Workers' Compensation Insurance Rating Bureau (WCIRB), *2005 California Workers' Compensation Losses and Expenses,* June 2006.

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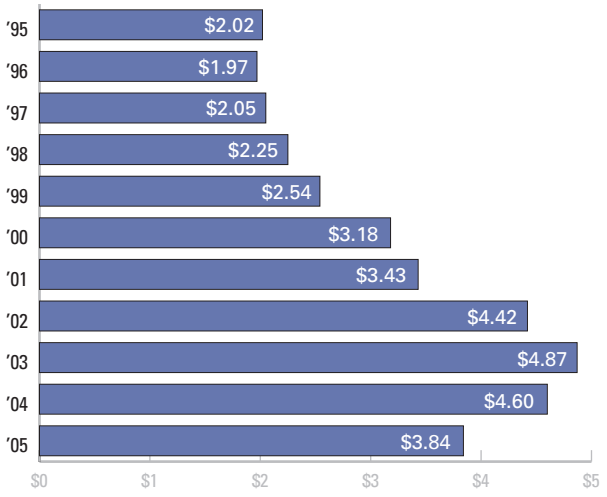
Recent Cost Trends

California WC costs increased sharply between the mid-1990s and the early 2000s. For example, total annual medical expenditures more than doubled between 1995 to 2002, growing from $2.6 billion to $5.3 billion during that period.[6] Likewise, the average ultimate medical loss per lost-time claim rose from $9,041 in 1993 to $25,560 in 2002, a rise of 283 percent in 9 years.[7] There were many factors contributing to the precipitous rise in costs experienced during those years including: substantial increases in prices for medical services; increased use of some services, especially chiropractic, physical therapy, and other physical medicine services; growth in outpatient surgery facility fees; and steep increases in use of pharmaceutical services and their associated costs.

The dramatic cost escalation in the late 1990s and early 2000s prompted reform legislation to be enacted between 2002 and 2004 that incorporated significant cost-containment provisions. Most notably, the new legislation repealed the treating physician's presumption of correctness for legal disputes involving WC claims and required that all care must conform to a utilization schedule to be developed by the California Division of Workers' Compensation (DWC). The DWC, as an interim measure, adopted the treatment guidelines established by the American College of Occupational and Environmental Medicine as the basis for its utilization schedule. That schedule became the accepted presumptively correct criterion for adjudicating WC medical disputes. In addition, the new legislation allowed employers to restrict care for injured employees to designated Medical Provider Networks (MPNs). To control utilization of services, legislation was passed that capped allowable chiropractic, physical, and occupational therapy visits to no more than 24 visits each during the life of any claim. Other provisions in the new legislation established an outpatient surgical fee schedule, required the use of generic drugs whenever possible, reduced reimbursement rates for physician services, allowed employers to obtain second opinions before authorization of spinal surgery, prohibited physician self-referrals to surgical centers in which the physician had a financial interest, and required physicians to use guidelines established by the American Medical Association for evaluating the extent of permanent impairment among injured workers.

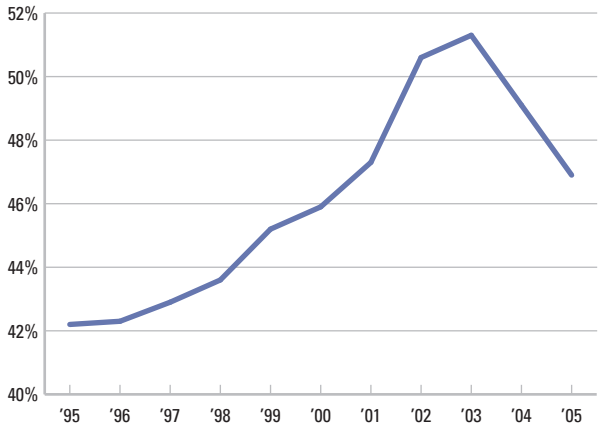
The net effect of these measures was to substantially curtail the rise in medical care expenses within the California WC system. As a result of the enactment of cost-containment legislation in 2002 and 2003, there has been a noticeable drop both in annual WC medical care payments (Figure 2) and medical payments as a percentage of all WC payments (Figure 3).[8] WC payments to California medical providers fell 10 percent to $0.93 per $100 of payroll from $1.03 per $100 pf payroll in 2004.[9]

Figure 2: Annual WC Medical Payments for Insured Employers, 1995–2005 (in billions)



Source: Workers' Compensation Insurance Rating Bureau (WCIRB). *Annual Reports of Losses and Expenses,* San Francisco: WCIRB, 1999–2005.

Figure 3: California WC Medical Payments as a Percentage of All WC Payments, 1995–2005



Source: Workers' Compensation Insurance Rating Bureau (WCIRB). *Annual Reports of Losses and Expenses,* San Francisco: WCIRB, 1999–2005.

Reaction to Cost Declines

The Workers' Compensation Insurance Rating Bureau estimates that ultimate WC losses (estimated benefits paid over the life of claims for accidents occurring in a particular calendar year) declined to $7.3 billion in 2005, compared to $10.8 billion in 2003 and $12.4 billion in 2002.[10] The WCIRB reports that the average medical cost of a WC claim (with more than seven days of lost time) increased only 4.4 percent between 2003 and 2002, after rising between 13.1 and 16.5 percent per year during each of the preceding three annual periods.[11] The success of WC reforms in lowering system costs has been touted by the California Chamber of Commerce and other business groups.[12]

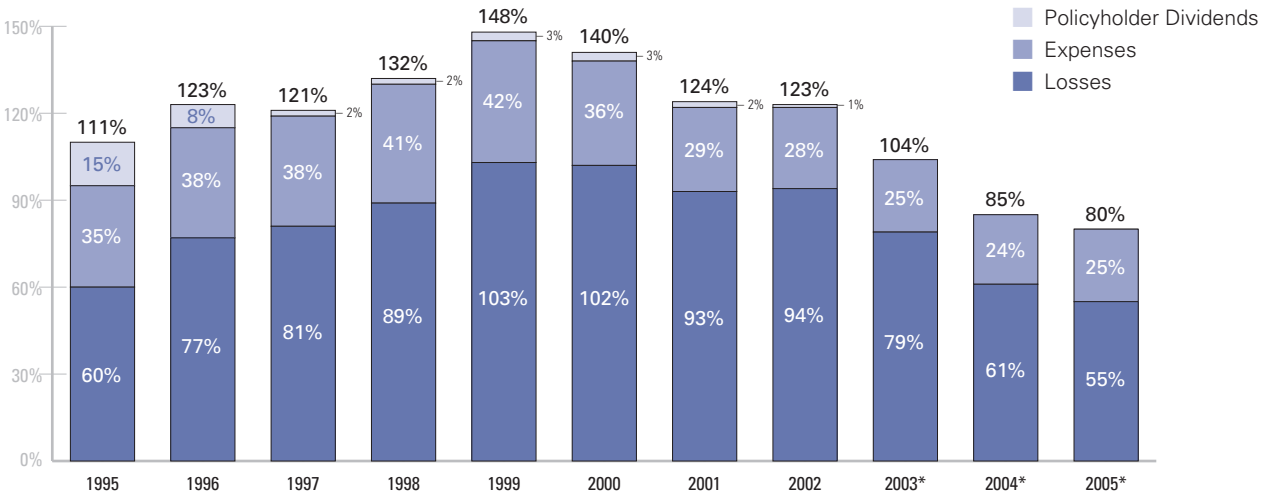
Some commentators believe, however, that the cost containment strategies enacted by recent legislation may be having a detrimental effect on injured workers' ability to obtain needed treatment.[13] Evidence suggests, for example, that some WC insurers and utilization management companies may have interpreted the legislative rules very narrowly, for instance, as a means to disallow payment for any medical services that are not explicitly covered by the American College of Occupational and Environmental Medicine (ACOEM) treatment guidelines.[14] New rules proposed by DWC in July 2006 clarify that "treatment cannot be denied on the sole basis that the condition or injury is not addressed by the ACOEM Practice Guidelines." The proposed rules further specify that treatments not covered by the ACOEM Guidelines should be authorized as long as they are "in accordance with other evidence-based medical treatment guidelines generally recognized by the national medical community and that are scientifically based."[14] The DWC is enacting a Utilization Review Oversight and Medical Survey process to monitor this issue, with substantial fines for non-compliance.

The underwriting experience of California's WC insurers has also dramatically improved since the passage of reform legislation, with loss ratios (loss payouts and expenses as a percentage of premiums paid to the insurer) plummeting from a high of 148 percent in 1999 to 80 percent in 2005 (Figure 4), with actual benefits paid in 2005 representing only 55 percent of premium.[15] This has sparked fears that cost savings derived from tightening eligibility for medical services may be merely increasing insurers' profits at the expense of injured workers and of the employers who pay the premiums.[16]

Future Cost Directions in the California WC System

It is still too early to say what the final effect of reform legislation will be on medical costs in the California WC system. Early evidence suggests that basing reimbursement for care on evidence-based treatment guidelines, capping utilization of high-volume services such as chiropractic manipulation, and restricting care within designated medical provider networks, has been

Figure 4: Trends in WC Insurers' Underwriting Experience in California, 1995–2005



*No policyholder dividends were distributed in these years.

Source: Workers' Compensation Insurance Rating Bureau (WCIRB). *2005 California Workers' Compensation Losses and Expenses.* June 23, 2006, p. 32.

effective in constraining WC medical care costs. A study published in January 2006 prepared by Bickmore Risk Service under contract to the California Department of Industrial Relations found that primarily due to the reform legislation, WC insurance rates have decreased by 46 percent.[17] The study estimates that the cost savings for California's WC system in 2006 owing to the reforms is $8.1 billion in comparison to 2003 and approximately $15 billion in comparison to what 2006 costs might have been absent the reforms. Moreover, the study concluded that 48 percent of the accrued savings are due to medical care initiatives, including the use of the evidence-based utilization schedule (27 percent of the savings), reductions in allowable medical fees (13 percent), and caps on physical medicine services (8 percent).

It is not yet known how these measures have affected the quality of care provided to injured workers or the likelihood for injured workers to recover and resume work successfully without residual symptoms or risk of reinjury. For example, prior to the reforms, some authorities feared that decreasing fees for physician services allowed under the state's official medical fee schedule would discourage some medical providers (especially physician specialists) from accepting WC cases. To date, there is little evidence to suggest that this has happened. Proposals are currently being considered to develop enhanced monitoring systems to ensure that that cost-containment measures do not compromise the quality of care provide to injured workers.[18]

Many of the factors that affect costs in workers compensation medical care are similar to those affecting costs in general (non-WC) medical care, for instance, the high cost of pharmaceuticals and the increased use of sophisticated diagnostic and therapeutic technologies. Thus, effective strategies to contain WC costs must consider and be coordinated with general care. As cost escalation continues in the general medical setting, initiatives will likely continue to be explored for more closely integrating or combining medical care delivery under WC and non-WC plans as a way of achieving better efficiencies in care delivery and further controlling costs. Recent legislation has been enacted in California to allow for pilot programs in so-called

"twenty-four hour" integrated (WC and non-WC) plans in some industries.[18]

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Additional fact sheets on workers' compensation medical care in California are available at either of the above two Web sites.