2014

ANNUAL REPORT + RESEARCH REVIEW

WCRI

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Workers Compensation Research Institute

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WCRI Annual Report

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OUR MISSION: TO BE A CATALYST FOR SIGNIFICANT IMPROVEMENTS IN WORKERS' COMPENSATION SYSTEMS, PROVIDING THE PUBLIC WITH OBJECTIVE, CREDIBLE, HIGH-QUALITY RESEARCH ON IMPORTANT PUBLIC POLICY ISSUES.

To WCRI Members and Friends:

I am pleased to report that WCRI has made a quantum leap in the past 24 months. The Institute's work has been actively used and impactful in a record number of states and on a growing breadth of issues. Our membership has grown significantly and with it, revenues and staff capacity to meet the increasing demand for information produced by WCRI. The Institute has never been in better shape.

A number of factors explain this leap.

- A major cultural shift has occurred in public policy debates, and it has increased the demand for research studies. In the early days of the Institute, public policy debates about the delivery system were informed largely by partisan anecdotes and cost figures provided by payors. As more research was done, those involved in the debates saw the impact of objective research on decision-making, and demand began to grow. Today, it has become almost a reflex action for public officials and stakeholders to look for hard data to inform the debate, and the more credible the data, the more impactful. WCRI research was instrumental in stimulating this change, as was the fine work of many other organizations, including CWCI, NCCI, CHSWC, RAND, and others. Over the past decade, the demand leaped, and WCRI and others responded.

- WCRI developed and deployed a powerful suite of benchmark studies and tools that are used to regularly monitor and measure the performance of an expanding group of state systems—tracking trends and highlighting lessons from interstate comparisons. The tools include well-known studies—CompScope™, WCRI Medical Price Index, WCRI Hospital Cost Index, Worker Outcomes Benchmarks, State Laws Inventory, National Inventory of Medical Cost Containment, Prescription Drug and Opioid Benchmarks, and others. Together they provide a robust picture of system performance and opportunities for improvement. These tools have been the engine for much of the impact that WCRI findings have achieved. Collectively, we call them WCRI Core Benchmark Studies.

- Revenues to help meet the increasing demand came from a growing and diverse list of members. Revenues have grown, despite freezing the cost of membership since 2008 and the impact of the Great Recession. Last year, our employer membership doubled. And the number of states funding CompScope™ studies continues to grow, as does the number of payors and service providers that fund our disability and medical cost management research program.

Looking forward into 2014 and beyond, we are grateful for WCRI's exceptional foundation that enables us to conduct this research. The core of that foundation remains the same: (1) amazing member support with data and funding for studies, (2) a top-notch staff to produce and deliver actionable and high-quality research, and (3) leadership from the Board and other governance groups that are committed to protecting and nourishing the Institute's credibility.

We thank you all for your support. We will continue to work diligently and creatively to justify your trust.

Respectfully yours,

Richard A. Victor. J.D., Ph.D.
Executive Director

The Institute

The Workers Compensation Research Institute is an independent, not-for-profit research organization providing high-quality, objective information about public policy issues involving workers' compensation systems.

The Institute's work helps those interested in improving workers' compensation systems by providing much-needed data and analyses that help answer the following questions:

- How are workers' compensation systems performing?
- How do various state systems compare?
- How can systems better meet workers' needs?
- What factors are driving costs?
- What is the impact of legislative change on system outcomes?
- What are the possible consequences of proposed system changes? Are there alternative solutions that merit consideration? What are their consequences?

Those who benefit from the Institute's work include public officials, insurers, employers, injured workers, organized labor, and others affected by workers' compensation systems across the United States and around the world.

Organized in late 1983, the Institute is independent, not controlled by any industry or trade group. The Institute does not take positions on the issues it researches; rather, it provides information obtained through studies and data-collection efforts that conform to recognized scientific methods, with objectivity further ensured through rigorous, unbiased quality control procedures.

The Institute's work takes several forms:

- *Original research studies of major issues* confronting workers' compensation systems (for example, permanent partial disability, litigiousness, and medical management)
- *Studies of individual state systems* where policymakers have shown an interest in change and where there is an unmet need for objective information
- *Studies of states that have undergone major legislative changes* to measure the impact of those changes and draw possible lessons for other states
- *Studies to identify those system features* that are associated with positive and negative outcomes
- *Presentations* on research findings to legislators, workers' compensation administrators, industry groups, and others interested in workers' compensation issues.

"WCRI has enabled me as a union leader to have a voice and give suggestions on how to better workers' compensation in the Commonwealth of Virginia, which is a right-to-work state, and doesn't usually offer many venues to hear from the folks that represent working people. As a member of WCRI's Advisory Committee in Virginia, I am able to meet with the people that have a lot of input on the workers' compensation laws, including the commissioners, providers, insurance companies, labor representatives, and, of course, the WCRI representatives. This all gives me a chance to speak and share how all the laws and policies concerning workers' compensation truly effect the working people that they were originally set up to protect."

Vance Ayres, Washington D.C. Building Trades Council (Representing D.C., Maryland, and Virginia)

The Need

The reports and testimony of WCRI act as a catalyst for constructive change in improving workers' compensation systems throughout the U.S. and internationally. Too often, public policies are shaped by anecdote and emotion, not by objective evidence about current system performance or the consequences of proposed changes. As a result of WCRI research, policymakers and stakeholders can make information-based decisions that prove to be more enduring because they are more efficient, more equitable, and better designed to meet the needs of workers and employers.

Specifically, WCRI research meets the following important stakeholder needs:

- *Measuring system results* to encourage continuous improvement and move the system away from the historic cycle of crisis-reform-crisis that has frequently characterized workers' compensation in the past.
- *Examining disability and medical management* by evaluating and measuring the outcomes of medical care. These studies provide regulators with information about managing workplace injuries, what regulatory barriers are unnecessary or counterproductive, and what regulatory protections are needed for injured workers to assure quality outcomes. These studies also help guide business decisions.
- *Identifying system features that improve performance* or drive costs and quantifying their impact on system performance. These studies focus attention on system strengths and opportunities for improvement. They also provide lessons from successful states that other states may adopt.

The Workers Compensation Research Institute provides reliable information to legislators, governors, state (provincial) and federal administrators, task forces and study commissions, industry groups, labor organizations, and others interested in improving workers' compensation systems. The Institute's research addresses the major issues confronting these systems today. Its public policy studies are disseminated to all interested parties.

"WCRI provides an extraordinary service. Their clear, comprehensive, and impartial data analysis and reports are vital to Wisconsin policymakers and program administrators. They help us in our ongoing efforts to provide the most cost-effective, efficient service for workers, their families, and employers. We rely on WCRI heavily as we work to maintain the stability and integrity of our workers' compensation system; provide protection for workers and their families; and ensure both a vibrant, healthy workforce and economy."

John Metcalf, Wisconsin Worker's Compensation Division Administrator

The Impact

"As we experience changes within the workers' compensation arena, the importance of research and published analyses on industry trends becomes even more critical. WCRI provides the data and resources needed to navigate individual state workers' compensation systems. The WCRI studies are an invaluable tool for evaluating the impact of a specific state reform and providing unbiased, factual data on outcomes, which legislators and other stakeholders need to understand the merits of a bill."

Barbara Sandelands, Senior Vice President of Workers Compensation at Chubb Insurance

Improvement in workers' compensation systems is a product of many factors. WCRI's research is one important factor. Policymakers continue to look to the Institute as a source of objective information to help them make informed decisions about legislation and administrative changes.

For over thirty years, Institute studies have helped public officials and stakeholders better understand how to improve system performance, what the impacts of proposed legislative changes are, and what the consequences of proposed solutions are. These studies provide much-needed, objective information on which to base decisions.

- WCRI's opioid and physician-dispensing studies identified substantial issues in many states having to do with usage, abuse, cost, and prescribing methods. These studies had and continue to have impact throughout the country. The following are some recent examples:
  - WCRI studies were actively used by the Indiana legislature in the debate over House Bill 1320, which capped prices on repackaged drugs. The legislation was signed into law by the governor.
  - In a recent video interview, State Senator Alan Hays of Florida referenced the key role WCRI research played in the passage of Senate Bill 662, which put a cap on repackaged drugs and, some have said, could decrease costs to the workers' compensation system by $20 million each year.
  - WCRI testified before the Pennsylvania House Committee on Labor & Industry regarding legislation that would change their reimbursement for physician-dispensed drugs. Several WCRI studies that discuss physician dispensing were used in the presentation.
  - Legislative leadership in Maryland communicated with WCRI regarding physician dispensing and were provided with relevant studies in preparation for an anticipated debate on the issue in the upcoming legislative session.
  - California's Department of Insurance requested and was provided with a copy of the recent WCRI study, *Impact of Reform on Physician Dispensing and Prescription Prices in Georgia*, for a memorandum they were writing regarding use and misuse of opioids, including how the issue is addressed in other states.
  - WCRI's work was used extensively by legislators and other stakeholders in Wisconsin during policy debates, including a joint hearing held by the Wisconsin Assembly and Senate labor committees, about whether to place caps on prices for repackaged drugs.

- CompScope™ Benchmarks studies, published annually, examine the impact of legislative changes and quantify differences in key metrics among study states. They continue to help policymakers identify key leverage points in their systems. The following are some recent examples:
  - Findings from CompScope™ Benchmarks and CompScope Medical™ Benchmarks, 13th Edition, were cited in testimony provided by a broad representation of speakers at a joint hearing of the Wisconsin Legislature's labor committees.
  - WCRI provided testimony to the Senate Committee on Labor and Commerce in Virginia during hearings on House Bill 1612, which sought to create a Medicare based medical fee schedule. The testimony consisted of findings from WCRI's CompScope™ and fee schedule studies.
  - Discussions concerning a revised approach to Louisiana's hospital reimbursement are in process. Findings from *CompScope™ Benchmarks for Louisiana, 14th Edition* have been used in the debate.
- The WCRI medical fee schedule studies, which quantify the large differences among states in workers' compensation medical fee schedules, are well-used by public officials to evaluate their own fee regulations. The following are some recent examples:
  - WCRI studies were actively used by the Indiana legislature in the debate over House Bill 1320, which was signed into law by the governor and establishes a hospital fee schedule.
  - North Carolina's governor signed House Bill 92 into law in July 2013. The law charges the Industrial Commission with establishing a new fee schedule, including periodically reviewing and updating it. Discussions are underway about recommended approaches, and WCRI studies are actively being used.
  - The chairman of the Wisconsin State Assembly Committee on Labor invited WCRI staff to brief him and a group of legislators on how medical costs in the Wisconsin workers' compensation system compare with those in other states. The Assembly is anticipating a proposal that will call for a medical fee schedule.
  - WCRI briefed legislative leadership, senior public officials, and other stake-holders in Connecticut where the issue of hospital fee schedules is currently being debated.
  - The Hawaii Legislature asked the Hawaii Office of the Auditor to help revise the state workers' compensation fee schedule and develop ways to make such revisions in the future. WCRI was invited to provide information and briefed them on two studies: *Designing Workers' Compensation Medical Fee Schedules* and *Workers' Compensation Medical Cost Containment: A National Inventory, 2013*.
  - At their request, Minnesota's Department of Labor and Industry were provided with numerous WCRI studies to assist them in preparing their response to the Minnesota Legislature's request for information about hospital reimbursement.

"WCRI provides meaningful, actionable and timely data and analysis on the health of workers' compensation at the national and state level. The published reports are also very helpful in identifying trends or issues that I can benchmark my program against. Actionable data + benchmarking = positive program impact."

John Smolk, Principal Manager - Workers' Compensation at Southern California Edison

– Discussions concerning a revised approach to Louisiana's hospital reimbursement are in process. Findings from various WCRI studies, including the *National Inventory of Workers' Compensation Fee Schedules for Hospitals and Ambulatory Surgical Centers*, have been used in the debate.

To support our research programs, WCRI has developed the largest, most comprehensive, most representative claims database in use today, the Detailed Benchmark/Evaluation (DBE) database, containing over 26 million claims from insurers, state funds, and self-insurers and representing nearly 75 percent of the workers' compensation benefits paid nationwide. This resource is a unique asset for WCRI and the workers' compensation community and allows WCRI to respond quickly to requests from public officials and other stakeholder groups with detailed, timely analysis of important issues.

Membership

To sustain and strengthen its impact, WCRI continues to expand its active and diverse membership, which elects the board of directors and is the source of representatives serving on key governance committees. Almost one hundred forty organizations support the Institute in 2014. (A list of members and associate members appears on the inside back cover of this report.)

Organizations may join the Institute as members or associate members.

Membership in the Institute is open to insured and self-insured employers, insurers, reinsurers, national trade and professional associations, national labor organizations, universities, insurance brokers, third-party administrators, managed care organizations, other service providers, and law firms. Members have electronic access to key research findings from WCRI studies on WCRI's web site. They also receive all publications from the Institute, preferred rates for registration to WCRI's acclaimed Annual Issues & Research Conference, and preferential invitations to other WCRI briefings. Member representatives participate in the governance of the Institute. Annual membership assessments are based on organization size.

Associate members have electronic access to key research findings from WCRI studies on WCRI's web site. They also receive all publications from the Institute and preferred rates for registration to WCRI's Annual Issues & Research Conference and to other WCRI briefings. Associate memberships are available in several categories:

- *Associate member—public sector:* available to state workers' compensation agencies (except state funds), insurance commissioners, labor departments, and foreign entities
- *Associate member—labor association:* available to state labor organizations
- *Associate member—rating organization:* available to rating organizations

Governance

The responsibility for policymaking rests with the Institute's board of directors—a representative group of members who are elected by the membership for staggered, three-year terms and meet three times a year. (A list of 2014 board members and officers appears on the inside front cover of this report.)

Operating responsibility is vested in the executive director by the board, with direction from the board and advice from committees established by the board.

The research committee, composed of representatives of member companies, gives the executive director guidance on the Institute's research program.

Project advisory committees assist the research staff in the formulation and conduct of specific studies. These committees are made up of representatives of member companies, public officials, academic researchers, and others knowledgeable about the specific topics before them.

RESEARCH COMMITTEE/2014

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The Research Program

THE INSTITUTE'S RESEARCH PROGRAM FOCUSES ON THE MAJOR PUBLIC POLICY ISSUES CONFRONTING WORKERS' COMPENSATION SYSTEMS. OUR RESEARCH MEASURES SYSTEM PERFORMANCE, IDENTIFIES COST DRIVERS, QUANTIFIES OUTCOMES RECEIVED BY INJURED WORKERS, EVALUATES THE IMPACT OF ALTERNATIVE SOLUTIONS, AND HIGHLIGHTS EMERGING TRENDS. THE LESSONS FROM WCRI STUDIES ARE USED TO FACILITATE ACTION-ORIENTED DECISIONS BY PUBLIC OFFICIALS, EMPLOYERS, INSURERS, WORKER REPRESENTATIVES, AND OTHERS AFFECTED BY WORKERS' COMPENSATION, BOTH NATIONALLY AND INTERNATIONALLY.

Our current research programs are:

CompScope™ Benchmarks Research Program

System Evaluation Research Program

Disability and Medical Management Research Program

COMPSCOPE™ BENCHMARKS RESEARCH PROGRAM

CompScope™, WCRI's multistate benchmarking program, measures and benchmarks the performance of a growing number of state workers' compensation systems. Each year, CompScope™ studies quantify performance trends, benchmark improvement opportunities, and assess the effectiveness of policy changes. Using CompScope™, stakeholders and public officials can better manage change and avoid the historic pattern of crisis-reform-crisis that has frequently characterized workers' compensation in the past.

Using special statistical methods, the Institute has created performance measures and interstate comparisons that are comparable across otherwise diverse states. By identifying either incremental or sudden large changes in system performance—trends that may signal either improvement or possible deterioration in system performance—goals for system performance can be set, improvements accomplished, and crises avoided.

The CompScope™ program is funded by employers, state governments, rating organizations, and insurers seeking to help achieve a more cost-efficient, stable, and equitable workers' compensation system. To achieve the ambitious goals outlined above, continued, broad support and expanded funding are needed.

Among the diverse organizations that have provided funding for this important program are the following:

ACE USA

Advocate Health Care

AIG

Archer Daniels Midland Company

AT&T

Chevron Corporation

CNA Foundation

Compensation Advisory Organization of Michigan

Costco Wholesale

Country Insurance & Financial Services

Florida Department of Insurance

Ford Motor Company

Gallagher Bassett Services, Inc.

The Hartford Insurance Group

Indiana Compensation Rating Bureau

International Truck and Engine Corporation

Levi Strauss & Co.

Liberty Mutual Group

Louisiana Department of Insurance

Louisiana Department of Labor, Office of Workers' Compensation Administration

Marriott International, Inc.

Massachusetts Workers' Compensation Rating and Inspection Board

Minnesota Workers' Compensation Insurers' Association, Inc.

Mitsubishi Motors North America, Inc.

Molloy Consulting, Inc.

New Jersey Compensation Rating & Inspection Bureau

Nordstrom, Inc.

North Carolina Rate Bureau

Pennsylvania Compensation Rating Bureau

Pubic Policy Institute of California

Safeway, Inc.

Sedgwick Claims Management Services, Inc.

State of Maryland Workers' Compensation Commission

Target Corporation

Tennessee Department of Labor and Workforce Development

Texas Department of Insurance

The Travelers Companies, Inc.

United Airlines, Inc.

United Parcel Service

Virginia Workers' Compensation Commission

The Walt Disney Company

Wisconsin Compensation Rating Bureau

Zenith Insurance Company

Zurich North America

SYSTEM EVALUATION RESEARCH PROGRAM

The System Evaluation Research Program focuses on the major current public policy issues and long-term challenges confronting workers' compensation systems. The breadth and diversity of this research adds significantly to the base of knowledge about workers' compensation systems.

- The objectives of this program are to
  - evaluate workers' compensation systems and identify best practices;
  - identify leverage points and quantify opportunities for system improvement;
  - measure outcomes experienced by injured workers;
  - provide comprehensive reference books to help understand key system features; and
  - measure the impact of reform.

- The current research agenda includes the following studies:
  - Benefit Adequacy
  - State Laws Inventory for 2014
  - Worker Outcomes, 8th Edition
  - ASC Comparisons: Cost, Price, Utilization
- Recently published studies include the following:
  - *Comparing Workers' Compensation and Group Health Hospital Outpatient Payments*
  - *Workers' Compensation Medical Cost Containment: A National Inventory, 2013*
  - *Hospital Outpatient Cost Index for Workers' Compansation, 2nd Edition*
  - *Monitoring the Changes in New York after the 2007 Reforms*
  - *WCRI Medical Price Index for Workers' Compensation, 5th Edition (MPI-WC)*

The research in this program is funded by members and associate members of the Institute. Representatives of member organizations serve on the board of directors and on key governance committees. A list of current members and associate members appears on the inside back cover of this report.

DISABILITY AND MEDICAL MANAGEMENT RESEARCH PROGRAM

As the cost of medical care continues to rise rapidly, many are asking how to identify high-cost medical care that may be delivering less than optimal benefits. The innovative Disability and Medical Management Research Program provides funds and establishes priorities for objective research that will improve public policy decisions about the management of work injuries.

The following are among the current topics for evaluation:

- Impact of physician dispensing and ban on opioids
- Impact of provider choice

Examples of studies published in the program include the following:

- *Prevalence and Costs of Physician-Dispensed Drugs*
- *Physician Dispensing in the Pennsylvania Workers' Compensation System*
- *Physician Dispensing in the Maryland Workers' Compensation System*
- *Impact of Reform on Physician Dispensing and Prescription Prices in Georgia*
- *Impact of Banning Physician Dispensing of Opioids in Florida*

Funding for this program comes from organizations committed to improving public policies on disability and medical management to help policymakers and others make more informed decisions about managing work injuries. Research priorities are established by a program advisory board that is composed of leaders in their fields.

PROGRAM ADVISORY BOARD / 2014

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Visit us at www.wcrinet.org to learn more about the work of the Institute and to quickly access over 400 WCRI studies using a powerful key word search. WCRI's web site is the most content-rich workers' compensation research web site.

VISIT OUR WEBSITE:
www.wcrinet.org

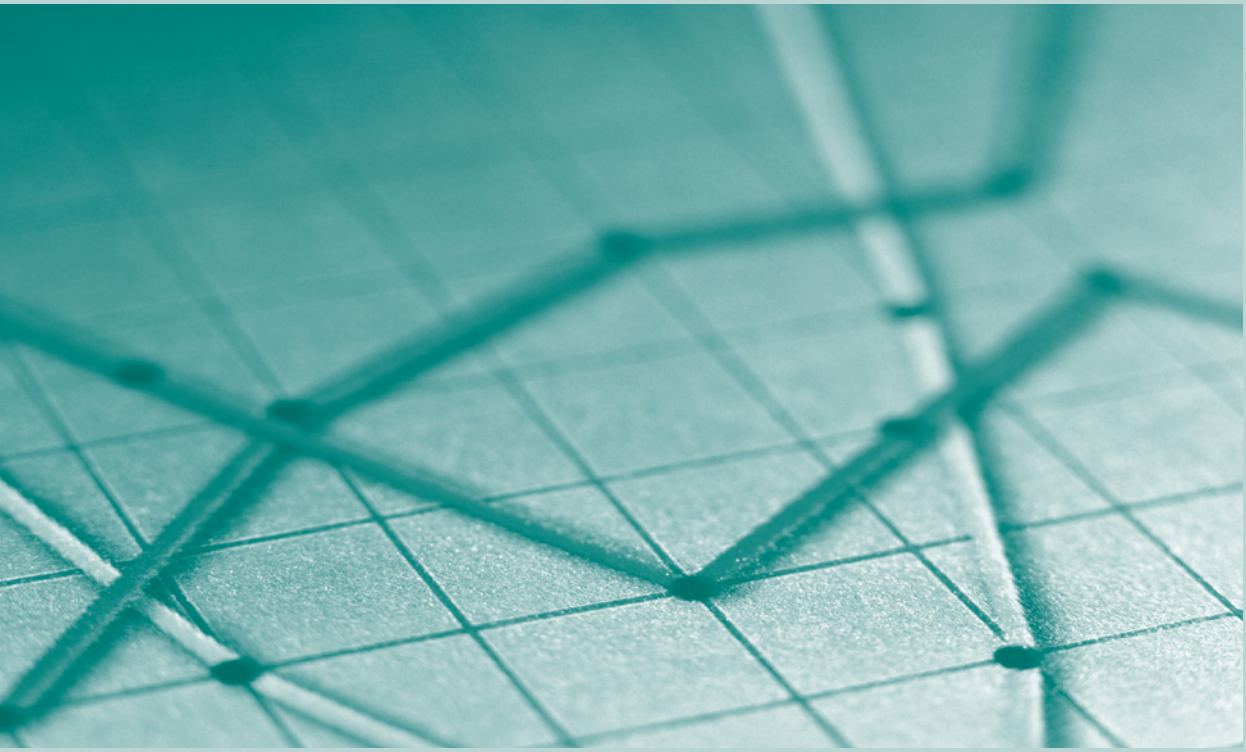
For all visitors:

- Powerful key word search of research studies
- Abstracts of over 400 research studies
- WCRI benchmarks of system performance
- WCRI benchmarks of medical cost and utilization
- Press releases
- Conference and seminar information
- Online ordering of books, video briefs, and recorded webinars

For members only:

- Detailed WCRI benchmarks of system performance and medical use
- Executive summaries of research reports
- Key tables and charts from research reports
- Slide presentations

Research Review



In its 30th year, the Institute published 39 major studies on a broad range of topics. This brings the Institute's total to over 400 books on a wide variety of important workers' compensation issues affecting a growing number of states. At present, the Institute has 13 reports in progress and will launch other studies during 2014.

THE PREVALENCE AND COSTS OF PHYSICIAN-DISPENSED DRUGS

In many states across the country, policymakers are debating whether doctors should be paid significantly more than pharmacies for dispensing the same drug. This 24-state reference book will allow policymakers to see how their state compares with others, as well as what actions other states have taken with regard to this issue.

This report describes the prevalence, prices, and costs of physician-dispensed drugs in 24 study states, which represented 70 percent of the total workers' compensation benefits paid in the United States. It also compares prices paid for physician- and pharmacy-dispensed prescriptions for the same drugs and tracks changes in prices for drugs commonly dispensed by physicians to injured workers.

According to the study, most states allow physicians to dispense prescription drugs at their offices directly to the patient. Previous WCRI studies reported considerably higher prices paid for physician-dispensed prescriptions when compared with prices paid to pharmacies for the same drug. These studies also reported rapid growth of physician dispensing in several study states.

In 2007, California became the first state to change reimbursement rules with the intention of equalizing the prices paid for physician- and pharmacy-dispensed prescriptions. A 2012 WCRI study found that the 2007 change in California reduced the average prices paid for physician-dispensed prescriptions to close to the prices paid to pharmacies for the same drug. After the reform, many physicians continued to dispense in California—nearly half of all prescriptions were dispensed at doctors' offices in post-reform California.

Since then, a number of states have adopted reforms similar to those in California. As of July 2013, at least 13 other states have made law or rule changes with the intention of reducing the prices paid for physician-dispensed drugs, while continuing to allow physicians to dispense drugs directly to their patients. These states include Alabama, Arizona, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Michigan, Mississippi, Oklahoma, South Carolina, and Tennessee. Florida also made law changes, effective July 2011, that were aimed at eliminating so-called pill mills by prohibiting all Florida physicians from dispensing Schedule II and III narcotics.

Few states have sought to prohibit or severely limit physicians from dispensing prescription drugs directly to their patients. In the United States, six states prohibit physician dispensing in general; three of them are included in this study (Massachusetts, New York, and Texas). The other states that prohibit physician dispensing are Montana, Utah, and Wyoming. Louisiana limits physician dispensing of narcotics to a 48-hour supply.

The data used for this reference book came from 24 states with more than 600,000 claims and 4.8 million prescriptions, focusing on claims with more than seven days of lost time with prescriptions filled and paid for by a workers' compensation payor. The data collected from the payors represented 26–58 percent of the claims in each state. The study covers claims with injuries arising from October 1, 2007, to September 30, 2011, with prescriptions filled through March 31, 2012.

The Prevalence and Costs of Physician-Dispensed Drugs. Dongchun Wang, Te-Chun Liu, and Vennela Thumula. September 2013. WC-13-39.

HOSPITAL OUTPATIENT COST INDEX FOR WORKERS' COMPENSATION, 2ND EDITION

As states across the country debate whether to implement or update a fee schedule, this study will help policymakers and system stakeholders identify and better understand the implications of different types of fee regulations on hospital outpatient costs, compare hospital outpatient costs across states, identify potential key cost drivers, and monitor the impact of reforms.

This study creates an index for hospital outpatient costs for a group of relatively homogeneous surgical episodes. The analyzed surgical episodes are constructed around the most commonly used outpatient surgeries in workers' compensation. This study includes 20 large states that represent 65 percent of the workers' compensation benefits paid in the United States and covers a six-year period from 2005 to 2010.

The states included in this study are California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia, and Wisconsin.

Sample of major findings:

- States with hospital outpatient fee regulations based on a percent of charges had higher costs compared with states with "fixed-amount" fee schedules. "Fixed-amount" fee schedule refers to the type of regulation that assigns specific reimbursement amounts for each procedure or group of procedures. Four study states—Florida, Louisiana, Minnesota, and North Carolina—set their fee regulations for hospital outpatient services related to surgeries mainly based on percent of charges. The hospital outpatient costs in these states were 61 to 91 percent higher than the median of the study states with "fixed-amount" fee schedules.
- This study also found that states without fee schedules for hospital outpatient reimbursement had higher hospital costs for common surgeries compared with states with "fixed-amount" fee schedules. Six study states—Connecticut, Indiana, Iowa, New Jersey, Virginia, and Wisconsin—had no fee schedules as of 2010. The hospital outpatient costs in these states were 39 to 98 percent higher than the median of the study states with "fixed-amount" fee schedules.
- States with "fixed-amount" fee schedules had relatively lower costs among the 20 study states. As of 2010, nine study states—California, Georgia, Illinois, Maryland, Massachusetts, Oklahoma, Pennsylvania, Tennessee, and Texas—had "fixed-

amount" fee schedules for hospital outpatient services. The hospital outpatient costs in the median of these states was 45 percent lower than the median of the study states with fee regulations based on percent of charges, and 40 percent lower compared with the median of the study states with no fee schedules. Illinois was an exception among states with "fixed-amount" fee schedules. The hospital outpatient costs in that state were significantly higher than the other study states with the same type of regulation as of 2010. Illinois enacted new legislation in September 2011, which reduced the fee schedule rates by 30 percent. Future editions of this study will look at results for Illinois after the policy change.

Hospital Outpatient Cost Index for Workers' Compensation, 2nd Edition. Olesya Fomenko and Rui Yang. January 2013. WC-13-01.

WORKERS' COMPENSATION MEDICAL COST CONTAINMENT: A NATIONAL INVENTORY, 2013

As the cost of medical care for injured workers continues to grow, this study provides policymakers and system stakeholders with an inventory of the cost containment initiatives employed by 51 jurisdictions. This study updates the tables from the previous edition with the statutory provisions, administrative rules, and administrative procedures as of January 2013. However, it does not provide written explanations of the initiatives in use by each state.

The report contains key features of each state's cost containment initiatives, including

- medical fee schedules;
- regulation of hospital charges;
- choice of provider;
- treatment guidelines;
- utilization review/management;
- managed care;
- pharmaceutical regulations;
- urgent care and ambulatory surgical center fee schedules; and
- medical dispute regulations.

These initiatives aim to curb the cost of a particular service or to reduce the amount of services provided. Cost containment regulatory initiatives entail a balancing act of limiting the cost of services and inappropriate or unnecessary treatment without negatively affecting the quality of treatment or access to care for injured workers. The 2013 edition includes new information about ability to settle costs of future medical care and whether there is a finite period of time for medical care.

Workers' Compensation Medical Cost Containment: A National Inventory, 2013. Ramona P. Tanabe. February 2013. WC-13-02.

IMPACT OF BANNING PHYSICIAN DISPENSING OF OPIOIDS IN FLORIDA

This study finds that the Florida law banning physician dispensing of stronger opioids reduced the use of opioids prescribed for injured workers. The law banned physician dispensing of stronger opioids (except in very limited circumstances) but did not restrict physician prescribing of these medications. Rather, the stronger opioids could only be obtained from pharmacies.

According to the study, the average Florida physician-dispenser continued to dispense pain medications after the ban but increased the use of less addictive pain medications like ibuprofen and tramadol. The physician-dispensers could have continued to prescribe the stronger opioids (e.g., hydrocodone-acetaminophen) but would have been required to send the patients to pharmacies. The study reports no material change in the percentage of patients who received stronger opioids from pharmacies.

The ban on physician dispensing of stronger opioids, House Bill 7095, went into effect July 1, 2011. The study examined the medical care received by injured workers with injuries occurring prior to the law change and after the law change. Patients' prescription histories were analyzed for the first 3–6 months after the injury.

The study found a high rate of physician compliance with the ban. After the law change, only 0.5 percent of injured workers received physician-dispensed stronger opioids, and most of these fit within the limited exceptions provided by the law.

The study also found that the overall use of stronger opioids dropped after the law change. Looking at evidence from 3–6 months of treatment after the work injury, the percentage of workers receiving stronger opioids was 14.5 percent before the ban. This fell after the law change to 12.4 percent.

The researchers expected little change in the percentage of patients getting stronger opioids—only a change from physician dispensed to pharmacy dispensed. Instead of finding an increase in pharmacy-dispensed stronger opioids, the study found no material change. Rather, there was an increase in the percentage of patients receiving physician-dispensed nonsteroidal anti-inflammatory medications (e.g., ibuprofen)—from 23.8 percent of patients to 26.0 percent. There was a smaller increase in the use of weaker opioids—from 9.0 to 9.8 percent of patients.

The policy debate in a growing number of states has been focused on the much higher prices charged by physician-dispensers than pharmacies for the same medication. The debate has not focused on whether the economic incentives attendant to physician dispensing (like any form of physician self-referral) lead to prescribing and dispensing of unnecessary medications.

WCRI is planning an additional study that examines patients at a greater length of time from injury to provide more definitive information.

Impact of Banning Physician Dispensing of Opioids in Florida. Vennela Thumula. July 2013. WC-13-20.

INTERSTATE VARIATIONS IN MEDICAL PRACTICE PATTERNS FOR LOW BACK CONDITIONS

Back pain is a common source of disability, both from work-related injuries and from injuries that occur outside of the workplace. Annually in the United States, over $15 billion is spent for the treatment of low back pain and disorders, and approximately 15 percent of the costs in workers' compensation medical care are for low back pain cases.

This study focuses on care provided or directed by physicians and addresses the following questions:

- What are the patterns of medical care for workers with common low back conditions in the 16 states studied?
- How do these patterns vary across states?
- How do the patterns of medical practice in the study states compare with evidence-based treatment guideline recommendations?

Overall, we found that workers with similar low back conditions received very different care, depending on the state. These interstate differences were most noticeable for cases with non-specific low back pain in the areas of diagnostic services and pain management injections. For disc cases, the interstate differences were most notable in the utilization of nerve testing, pain management injections, back surgery, and physical medicine. Large interstate differences in the timing of care were also seen for both types of low back conditions.

We also identified several areas of service and a number of states where the patterns of care were inconsistent with evidence-based treatment guidelines. The inconsistency was seen in the frequency of use and early use of X rays and MRIs, especially for non-specific low back pain, and in the early timing of back surgery and injections for disc cases.

Among our findings:

- X rays and MRIs were used more often and earlier than recommended by evidence-based treatment guidelines, especially for cases with non-specific low back pain. For example, the percent of cases with X rays ranged from 42 percent in Massachusetts to 77 percent in Louisiana. When provided, 78–91 percent of first X rays were performed early—within four weeks postinjury.
- Nerve testing was used typically in 20–26 percent of disc cases among the 16 states, higher in pre-reform California, Pennsylvania, Michigan, and pre-reform Texas (28–32 percent) and lower in Arkansas, Connecticut, Indiana, Massachusetts, North Carolina, and pre-reform Tennessee (10–17 percent).
- Workers with disc conditions in Georgia and Indiana were twice as likely to receive injections as workers in Massachusetts and Connecticut. While 40–50 percent of disc cases had injections in most states studied, the figure was higher in Georgia and Indiana (59–62 percent)—double that in Massachusetts and Connecticut (31 percent).
- The percentage of disc cases with surgery was the highest in Arkansas and pre-reform Tennessee (40–45 percent)—double that in pre-reform California, pre-reform Florida,

and pre-reform Texas (17–22 percent). The surgery rate was also higher than typical of the 16 states in Georgia, Indiana, Louisiana, and North Carolina (33–37 percent).

- In Arkansas, North Carolina, and pre-reform Tennessee, workers with disc conditions were not only more likely to receive surgery but also had surgery performed early—within six weeks postinjury. More frequent early surgery in those states was inconsistent with evidence-based treatment guidelines that recommend surgical options being considered only for patients with severe and persistent radicular symptoms after 4–6 weeks of conservative care.
- Utilization of medical services (X rays, MRIs, nerve testing, injections, and surgery) was consistently higher in Louisiana than in the other study states for both types of low back cases. Conversely, utilization of the same services was consistently lower to typical in Connecticut, Illinois, Maryland, Massachusetts, and Wisconsin.

The 16 states in the study (Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, North Carolina, Pennsylvania, Tennessee, Texas, and Wisconsin) are geographically diverse and represent differences in fee schedules, choice of provider, and other key aspects of workers' compensation systems. For California, Florida, Tennessee, and Texas, the results are largely or entirely pre-reform, providing a baseline for monitoring relevant reforms in these states.

Interstate Variations in Medical Practice Patterns for Low Back Conditions. Dongchun Wang; Kathryn Mueller, MD; Dean Hashimoto, MD; Sharon Belton; and Xiaoping Zhao. June 2008. WC-08-28.

THE IMPACT OF PROVIDER CHOICE ON WORKERS' COMPENSATION COSTS AND OUTCOMES

Health care providers play many important roles in the outcome of workers' compensation cases, from diagnosing the condition and assessing its cause through medical management practices to assessing maximum medical improvement and making decisions on the degree of impairment. The perspective of either the employer or the employee on these decisions can be important and warrants being able to control the selection decision.

Workers and their advocates have argued that the choice of treating provider should be left to the worker, allowing the worker to be treated by those whom they trust and whose interests align with those of the worker—return to work that is medically appropriate and restoration of physical recovery that is to the fullest possible extent. Employer advocates argue that employer choice would ensure that incentives exist for keeping the costs of care reasonable and would help avoid excessive treatment. They also contend that providers familiar with the employer's worksite could use that knowledge to expedite return to work.

This study, which analyzes data from employee interviews in California, Texas, Massachusetts, and Pennsylvania, examines whether costs (medical and indemnity) and outcomes (return to work, duration of time away from work, perception of recovery from the work injury, and overall satisfaction with the health care provided) are affected by who selects the health care provider.

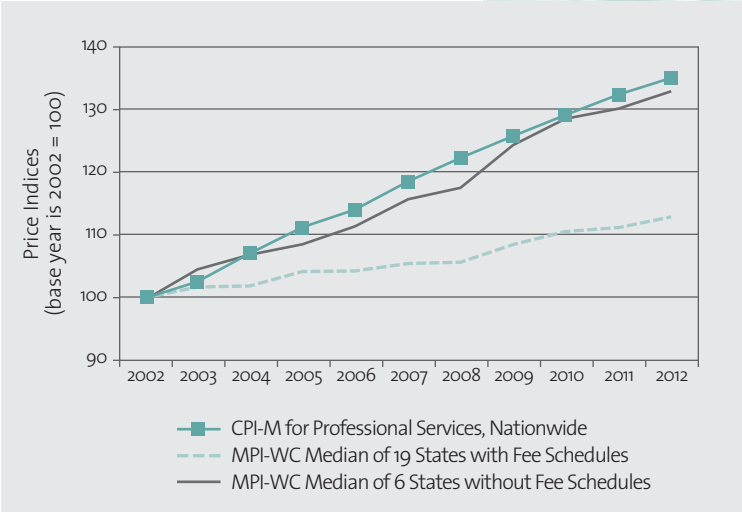
Among our findings:

- Comparing cases in which the worker selected the primary provider with otherwise similar cases in which the employer selected the provider, the study found that costs were generally higher and return-to-work outcomes poorer when the worker selected the provider. In these same cases, workers reported higher rates of satisfaction with overall care but similar perceived recovery of physical health.
- When the worker selected a provider who had treated him or her previously for an unrelated condition (a "prior provider"), the cases may have had higher costs, but the evidence was weak. Satisfaction with overall care was higher when the worker saw a prior provider, but other outcomes did not appear to be very different between these cases and ones in which the employer chose the provider.
- When workers selected a new provider, the cases had much higher costs, poorer return-to-work outcomes, generally no differences in physical recovery, and higher levels of satisfaction with overall care than when employers chose the provider.
- Comparing cases in which the employee selected a prior provider with similar cases in which the employee selected a new provider, the study found that the worker treated by a new provider was less likely to return to work, returned to work more slowly if he or she did return, had lower levels of satisfaction with overall care, and experienced no better physical recovery.

The Impact of Provider Choice on Workers' Compensation Costs and Outcomes. Richard A. Victor, Peter C. Barth, David Neumark. A Joint Publication: Workers Compensation Research Institute and Public Policy Institute of California. October 2005. WC-05-14.

WCRI MEDICAL PRICE INDEX FOR WORKERS' COMPENSATION, FIFTH EDITION (MPI-WC)

This WCRI study is designed to help public policymakers and system stakeholders understand how prices paid for medical professional services for injured workers in their states compare with other states and know if prices in their states are rising rapidly or relatively slowly. They can also learn if the reason for price growth in their states is part of a national phenomenon or whether the causes are unique to their states and hence, subject to local management or reform.



Unlike the Consumer Price Index for medical care (CPI-M), which measures general prices paid for medical services, WCRI's *Medical Price Index for Workers' Compensation, Fifth Edition (MPI-WC)* focuses only on the prices paid for the medical care that injured workers receive under their state's workers' compensation system. The CPI-M for professional services poorly tracked the workers' compensation price trends for states with fee schedules. For states with no fee schedules, growth in CPI-M was fairly similar to workers' compensation price trends.

The following are among the study's findings:

- Prices paid were higher in states with no fee schedule regulations for professional services as compared with fee schedule states.
- There were more variations in prices paid across states for major surgeries than for primary care services.
- Prices grew more rapidly over the study period in states with no fee schedules, compared with states with fee schedules.
- In states with fee schedules, changes in actual prices paid followed changes in fee schedules.
- Prices paid for services not covered by fee schedules grew more rapidly, compared with services covered by fee schedules.

This report includes 25 large states that represent nearly 80 percent of the workers' compensation benefits paid in the United States and covers 11 years from 2002 to 2012 for nonhospital, nonfacility services billed by physicians, physical therapists, and chiropractors. The medical services fall into eight major groups: evaluation and management, physical medicine, surgery, major radiology, minor radiology, neurological and neuromuscular testing, pain management injections, and emergency care.

The 25 states included in the MPI-WC are Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.

WCRI Medical Price Index for Workers' Compensation, Fifth Edition (MPI-WC). Rui Yang and Olesya Fomenko. June 2013. WC-13-19.

COMPSCOPE™ MEDICAL BENCHMARKS, 13TH EDITION

The cost drivers of medical care in state workers' compensation systems, the impact of legislative and regulatory changes on medical costs, and trends in payments, prices, and utilization of medical care for injured workers are examined in this edition of CompScope™ Medical Benchmarks.

The report is designed to help policymakers and other system stakeholders benchmark the performance of state systems in providing medical care for injured workers. The report also provides an excellent baseline for tracking policy changes and identifying important trends. The interstate comparison among 16 states analyzes medical payments per claim and cost components.

The 16 states in the study—Arkansas, California, Florida, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Texas, Virginia, and Wisconsin—represent nearly 60 percent of the nation's workers' compensation benefit payments.

Questions addressed:

- How do medical prices, payments, and utilization per claim differ across states for similar injuries and workers?
- How have medical prices, payments, and utilization per claim changed over time within each state, and what are the major drivers of those changes?

Sample findings:

- Payments for hospital outpatient services in North Carolina stabilized following 2009 reforms, but ongoing growth in charges could mean resumption of growth in payments.
- Growth in payments for medical care of injured workers in Pennsylvania slowed recently.
- The report for California provides a baseline for monitoring the 2012 reforms, which are expected to affect both price and utilization of medical care by most types of providers.
- The cost of medical care for injured workers in Michigan is among the lowest of the study states.

CompScope™ Medical Benchmarks, 13th Edition. Sharon E. Belton, Roman Dolinschi, Laure Lamy, Evelina Radeva, Karen Rothkin, Bogdan Savych, Carol A. Telles, and Rui Yang. February 2013. WC-13-03 to 15.

COMPSCOPE™ BENCHMARKS, 14TH EDITION

This comprehensive reference report measures the performance of 16 different state workers' compensation systems, how they compare with each other, and how they have changed over time.

The report is designed to help policymakers and others benchmark state system performance or a company's workers' compensation program. The benchmarks also provide an excellent baseline for tracking the effectiveness of policy changes and identifying important trends.

The study examines how income benefits, overall medical payments, costs, use of benefits, duration of disability, litigiousness, benefit delivery expenses, timeliness of payment, and other metrics and system performance have changed per claim from 2007 to 2012.

The 16 states in the study—Arkansas, California, Florida, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Texas, Virginia, and Wisconsin—represent nearly 60 percent of the nation's workers' compensation benefit payments. Separate state reports are available for 14 of the 16 study states.

Among the major findings are the following:

- Medical payments per claim in Illinois declined, likely due to a reduction in the fee schedule rates.

COMPSCOPE™ BENCHMARKS, CONT.

- Costs per claim in Louisiana were higher than in most states and growing rapidly, mainly due to longer and increasing duration of temporary disability and higher and growing hospital payments.
- Overall costs per claim declined in Texas following reforms aimed at containing medical costs.
- Growth in total costs per claim moderated in Pennsylvania after rising in prior years.

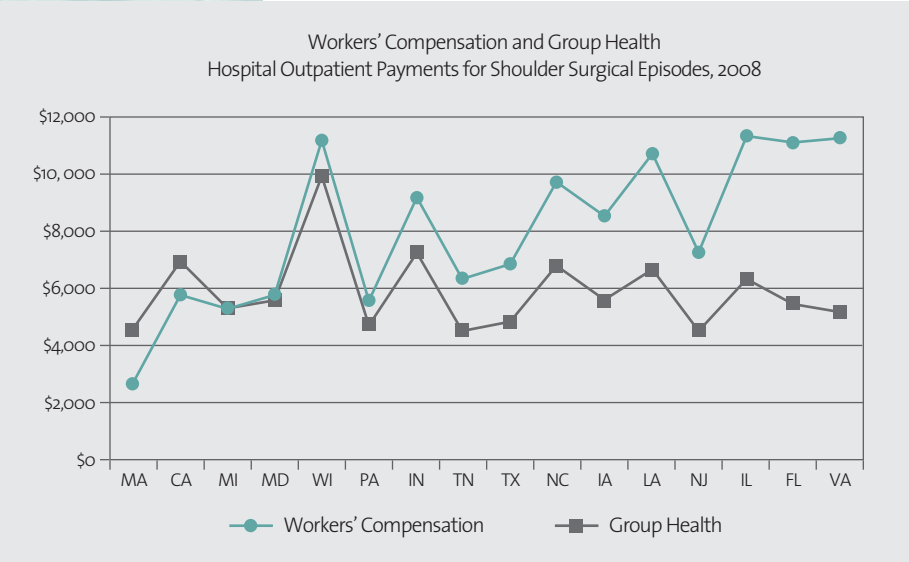
The report presents various measures in several areas, including time from injury to payor notice of injury and first indemnity payment; average total cost per claim, average payment per claim for medical benefits, and average payments per claim for indemnity benefits and components (temporary disability benefits, permanent partial disability benefits, and lump-sum settlements); vocational rehabilitation use and costs; benefit delivery expenses per claim; defense attorney involvement; and duration of temporary disability.

CompScope™ Benchmarks, 14th Edition. Sharon E. Belton, Roman Dolinschi, Evelina Radeva, Karen Rothkin, Bogdan Savych, Carol A. Telles, and Rui Yang. October 2013. WC-13-25 to 38.

OTHER STUDIES BY WCRI

COMPARING WORKERS' COMPENSATION AND GROUP HEALTH HOSPITAL OUTPATIENT PAYMENTS

This study compares hospital payments for the same surgical procedure when paid for by group health versus workers' compensation in 16 states. According to this study, in a majority of the study states, workers' compensation incurred substantially higher hospital payments than group health for the same surgical procedure. Some speculate that there is an additional burden associated with taking care of a worker injured on their job, such as uncertainty or delay in payments. If so, the question for policymakers and other stakeholders is, what additional reimbursement is necessary to get quality care for injured workers?



Rising hospital payments have been a focus of recent policy debates in many states. Policymakers and stakeholders have considered various means of cost containment, with special attention devoted to implementation of and updates to workers' compensation fee schedules. To set fee schedule levels, policymakers often seek a reference point or benchmark to which they can tie the state's reimbursement rates.

Increasingly, states rely on Medicare rates as a benchmark, while other states use some form of usual and customary charges in the area. This study uses group health reimbursement levels as an alternative benchmark. Group health has some important advantages as a benchmark for workers' compensation fee schedules, including being the largest provider of health insurance with the most widely accepted reimbursement rates by medical providers.

Among the study's findings are the following:

- In two thirds of the study states, workers' compensation hospital outpatient payments related to common surgeries were higher than those paid by group health, and, in half of the study states, the workers' compensation and group health difference for shoulder surgeries exceeded $2,000 (or at least 43 percent).
- The workers' compensation payment premiums over group health were highest in the study states with percent-of-charge-based fee regulation or no fee schedule.
- States with high workers' compensation hospital outpatient payments were rarely states with above-typical group health hospital payments.
- The hospital outpatient payments per surgical episode demonstrated substantially greater interstate variation in workers' compensation than in group health.

This study compares hospital outpatient payments incurred by workers' compensation and group health for treatment of similar common surgical cases in 16 large states, which represented 60 percent of the workers' compensation benefits paid in the United States, and covers hospital outpatient services delivered in 2008. Given that most study states, except Illinois, North Carolina, and Texas, did not have substantial changes in their fee schedule regulations after 2008, the interstate comparisons should provide a reasonable approximation for current state rankings in workers' compensation/group health payment differences.

Comparing Workers' Compensation and Group Health Hospital Outpatient Payments. Olesya Fomenko. June 2013. WC-13-18.

FACTORS INFLUENCING RETURN TO WORK FOR INJURED WORKERS: LESSONS FROM PENNSYLVANIA AND WISCONSIN

Against a backdrop of high unemployment, some injured workers may face even greater challenges in returning to work, leading to potential increases in the duration of disability. Although injured workers in Pennsylvania and Wisconsin have typically reported better return-to-work outcomes than workers in other states, the economic downturn has diminished the impact of selected workers' compensation system features that facilitate return to work for longer-term injured workers in these two states.

According to the study, poor economic conditions have made it more difficult for some employers to offer light, transitional, or modified duty to assist their injured workers in returning to sustainable work or to provide permanent job accommodations for workers with restrictions.

While recognizing that employers and injured workers play a central role in the return-to-work process, the study used a case-study approach to identify the features of the Pennsylvania and Wisconsin workers' compensation systems that promote timely, safe, and sustainable return to work, as well as those that create barriers. The study's findings can provide lessons for other states seeking to facilitate return to work.

Sample of major findings:

- Wisconsin's clear standards and processes for terminating temporary disability (TD) benefits—when effectively communicated by employers and insurers and well-understood by injured workers and their medical providers—establish early, upstream expectations about benefit termination. These expectations prompt workers to focus on their recovery and return to work rather than on benefit continuation. In Pennsylvania, however, unilateral termination is generally not permitted; instead, there is an agreement approach which is intended to ensure due process. While such an approach creates strong financial incentives for employers to return injured workers to work, it also may delay return to work for some workers if a dispute arises, as workers do not typically return to work during the litigation process.
- Statutory standards and processes for TD benefit termination can encourage employers to offer injured workers safe and suitable light-, modified-, or transitional-duty work during the healing period. If injured workers accept such offers, it may minimize their detachment from the workforce and reduce the likelihood of a longer-term absence from work, also reducing indemnity benefit costs for employers.
- Medical providers play a key role in facilitating return to work. Public policy decisions regarding the delivery of workers' compensation medical care can also directly or indirectly impact indemnity benefits by influencing the return to work process.
- Public policy decisions about the transition from TD to permanent partial disability (PPD) benefits represent key opportunities to impact return to work for longer-term unemployed injured workers.

Workers with permanent restrictions are especially vulnerable to difficulties and delays in return to work. The difficulties these workers face are magnified further in the economic downturn and put a public policy spotlight on how workers' compensation systems address workers who are unable to return to work with the pre-injury employer—particularly in the areas of lump-sum settlement practices and the availability of vocational rehabilitation and retraining benefits.

Factors Influencing Return to Work for Injured Workers: Lessons from Pennsylvania and Wisconsin. Sharon Belton. November 2011. WC-11-39.

AVOIDING LITIGATION: WHAT CAN EMPLOYERS, INSURERS, AND STATE WORKERS' COMPENSATION AGENCIES DO?

One goal of a workers' compensation program is to deliver necessary medical care and income benefits to workers injured on the job without the uncertainty, delay,

and expense of litigation. In many states, however, disputes and attorney involvement in the benefit delivery process are common.

Policy debates about attorney involvement have common themes from state to state. Workers' attorneys argue that they help workers receive benefits that these workers would not be able to obtain themselves, help workers navigate a sometimes complex system, and protect workers from retaliation by the employer or insurer. Advocates for employers and insurers contend that attorneys are involved more often than necessary, that workers can often receive the benefits they are entitled to without representation, and that attorneys may even reduce the total amount of benefits that workers take home.

Some of the existing attorney involvement is inevitably unnecessary, such as cases where the worker would have received the statutory entitlement without resorting to hiring an attorney. If unnecessary attorney involvement can be avoided, this would be a win-win-win scenario. Workers would receive benefits without the expense of paying an attorney and the delays of dispute resolution; employers and insurers would save the costs of defending the case; and increasingly resource-short state workers' compensation agencies would have smaller caseloads to manage and would have to provide fewer dispute-resolution services.

This study identifies and quantifies some of the more important factors that lead injured workers to seek representation by an attorney, providing some key elements for employers, claims organizations, and state agencies to take away.

Major findings:

The study found that workers were more likely to seek attorneys when they felt threatened. Sources of perceived threats were found in two areas:

- *The employment relationship.* Workers believed they would be fired as a result of the injury, and/or workers perceived that the supervisor did not think the injury was legitimate.
- *The claims process.* The worker perceived that his or her claim had been denied, although it was later paid. This perception may have stemmed from a formal denial, delays in payment, or communications that the worker deemed to be a denial.

Potential implications for employers, claims organization, and state agencies:

It is possible that attorney involvement can be decreased if employers, claims organizations, and state agencies reduce or eliminate *unnecessary actions* that workers interpret as threats. The suggested actions below, while logical implications of this study, are not themselves the findings of the empirical research:

- *Train supervisors.* Help supervisors create timely communications that focus on trust, job security, and entitlement to medical care and income benefits.
- *Create state agency education materials and help lines.* Provide written materials and an accessible help line that answers workers' questions to help ease feelings of vulnerability and uncertainty.

- *Communicate in a clear and timely fashion about the status of the claim.* Prevent misunderstandings through unambiguous, timely communication from the claims manager so the worker does not mistakenly conclude that the claim has been denied.
- *Eliminate system features that encourage denials or payment delays.* Eliminating system features that discourage timely payments may help prevent a worker's misconstruing a delay as a denial.

Avoiding Litigation: What Can Employers, Insurers, and State Workers' Compensation Agencies Do? Richard A. Victor and Bogdan Savych. July 2010. WC-10-18.

MONITORING CHANGES IN NEW YORK AFTER THE 2007 REFORMS

This is the latest edition of an annual report to regularly track key metrics of the performance of the New York workers' compensation system following the implementation of the 2007 reforms.

This regular monitoring of system performance helps policymakers and system stakeholders to focus attention on objectives that are being met, objectives that are not being met, and unintended consequences that have emerged.

The report noted that the changes have various effective dates and have been instituted over time. As a result, it will be several more years before the full effects of the reforms will be realized.

The major components of the 2007 reforms were

- an increase in the maximum weekly benefit;
- caps on permanent partial disability duration;
- medical treatment guidelines to be created and implemented;
- adoption of a pharmacy fee schedule;
- creation of networks for diagnostic services and thresholds for preauthorization; and
- administrative changes to increase speed of case resolution.

The following are among the study's key findings:

- The average weekly temporary total disability (TTD) benefit increased 26 percent after the implementation of three increases in the benefit rate between 2007 and 2009.
- The percentage of permanent partial disability (PPD) cases with no lump-sum payments at an average 24 months of experience fell 13 points from 2007 to 2009, while there was a 10.5 point increase in cases with lump-sum settlements but no PPD payments.

- The implementation and subsequent change of the pharmaceutical fee schedule decreased the average price per pill by 10 to 20 percent, depending on drug and dosage.
- Defense attorney involvement increased from 2005 through 2007, was relatively stable from 2007 through 2009, and then increased by about 2 percentage points in 2010, driven mainly by cases with defense attorney payments of less than or equal to $500.

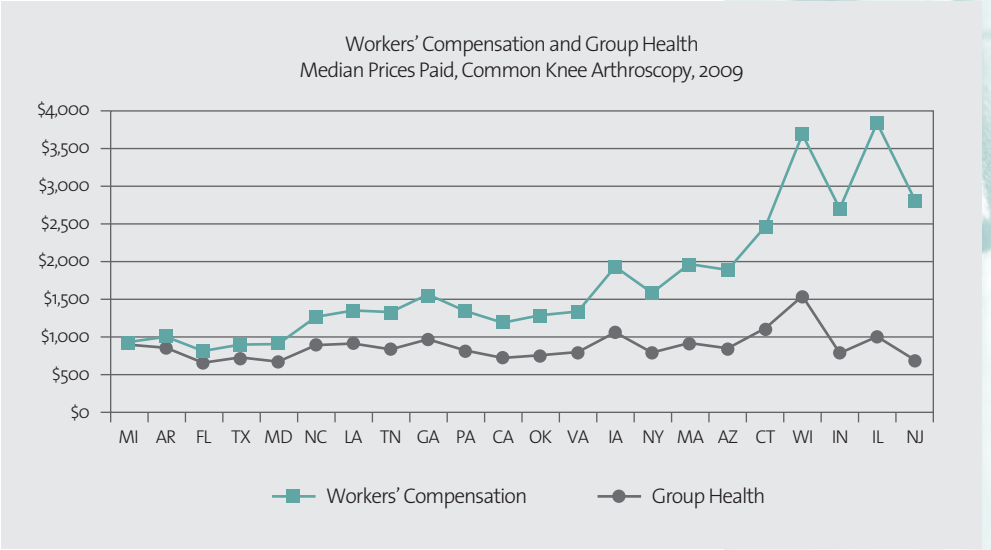
The study uses open and closed indemnity and medical-only claims with dates of injury from October 2004 through September 2010, with experience as of March 2011. The data are representative of the New York system.

Monitoring Changes in New York after the 2007 Reforms. Carol A. Telles and Ramona P. Tanabe. October 2013. WC-13-24.

A NEW BENCHMARK FOR WORKERS' COMPENSATION FEE SCHEDULES: PRICES PAID BY COMMERCIAL INSURERS?

In a typical year, 5 to 10 states have significant public policy debates about enacting new fee schedules or making major revisions to existing ones to regulate prices paid in workers' compensation. Often, the central question debated is what price level is too low—that is, at which point good health care providers will not provide timely treatment to injured workers. In making such decisions, providers consider what they are paid by other payors. Prices paid by Medicare and commercial insurers are plausible benchmarks for policymakers to use since they are usually the largest payors in a given state.

This study provides the basic comparative data that policymakers can use to ground the debate. For example, if the maximum prices proposed were double those paid by commercial insurers, policymakers might be skeptical of testimony by providers that they would stop treating injured workers if the maximum fees were lowered by a modest amount. Similarly, if the maximum workers' compensation fees were lower than what commercial insurers are paying, policymakers might be skeptical of testimony of payor representatives that the prices are too high and can be lowered without adversely affecting access to care for injured workers.



Sample of major findings:

- Workers' compensation prices are very much shaped by the state fee schedules or their absence. In states with higher (lower) fee schedules, workers' compensation prices paid were typically higher (lower). In states without fee schedules, prices paid were generally higher. States without fee schedules in this study include Indiana, Iowa, New Jersey, Virginia, and Wisconsin.
- For common surgeries performed on injured workers, the prices paid under workers' compensation were higher than the prices paid by group health insurers for the same surgery in almost all study states. In some states, the workers' compensation prices paid were 2–4 times higher than the prices paid by group health insurers in the same state.
- For office visits, the prices paid under workers' compensation were typically within 30 percent of the prices paid by group health insurers. In nearly half of the states studied, the prices paid under workers' compensation were within 15 percent of the group health price.

This study focuses on the median nonhospital price paid for five common surgeries and four common established patient office visits in 22 large states for services delivered in 2009. These are the prices actually paid for professional services billed under a specific Current Procedural Terminology (CPT) code. This study also discusses how to generalize these results to later years.

The 22 states included in this study are Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia, and Wisconsin.

A New Benchmark for Workers' Compensation Fee Schedules: Prices Paid by Commercial Insurers? Olesya Fomenko and Richard A. Victor. June 2013. WC-13-17.

WORKERS' COMPENSATION LAWS AS OF JANUARY 2012

An essential tool for researching and understanding the distinctions among workers' compensation laws in all U.S. states and certain Canadian provinces is done as a joint venture of the International Association of Industrial Accident Boards and Commissions (IAIABC) and the Workers Compensation Research Institute (WCRI).

This report is a key resource for policymakers and other stakeholders to identify the similarities and distinctions between workers' compensation regulations and benefit levels in multiple jurisdictions in effect as of January 1, 2012.

The publication is best used to understand macro-level differences and general tendencies across jurisdictions:

- How many states/provinces allow individual or group self insurance?
- How do the maximum and minimum payments for temporary and permanent total disability benefits vary?
- How many states cover mental stress claims, hearing loss, and cumulative trauma?
- How many jurisdictions allow the worker to choose the treating physician and how many allow the employer to do so?

In Canada and the United States, workers' compensation is entirely under the control of sub-national legislative bodies and administrative agencies. As a result, it is easy to misunderstand subtle differences between jurisdictional laws and regulations. This survey gives you the ability to understand those differences.

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