Challenges in Reforming Workers Compensation & Group Healthcare

August 16, 2012

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CWCI: Background

Established in 1964;

Private, nonprofit organization of insurers representing Insured and approximately 80% of premium dollars and self-insured employers;

Dedicated to improving the California workers' compensation system through four primary functions:

- Education
- Information
- Representation
- Research

Website: www.cwci.org

Challenges in Reforming Workers Compensation & Group Healthcare

Agenda

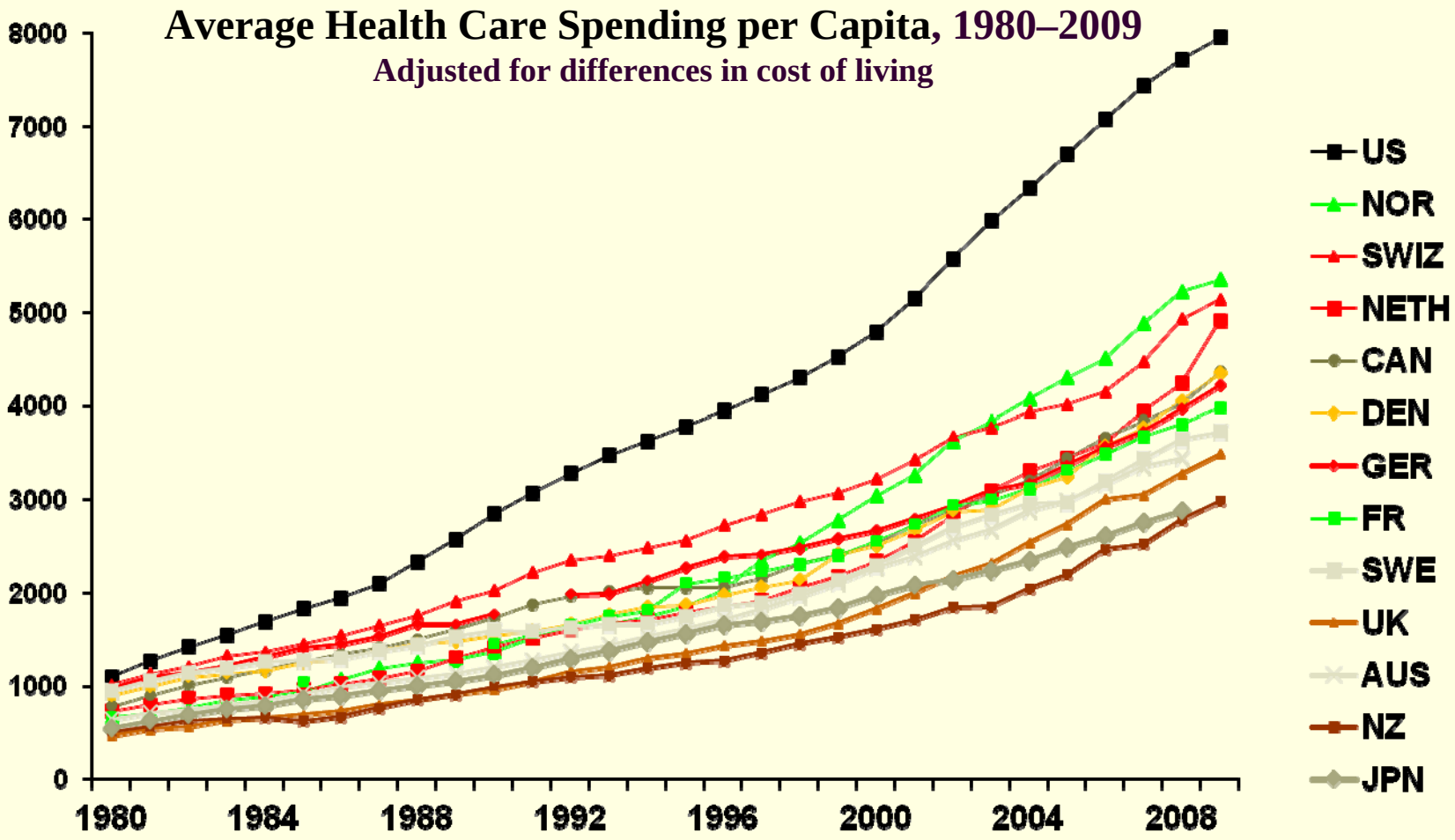
1. The Medical Management Paradigm
2. Affordable Care Act & Workers' Compensation
3. Medical Benefit & Cost Containment Trends
4. Increasing Pressure from Medicare

The Medical Management Paradigm

1. Cost and Quality of Care
2. Comparative Pricing
3. Coordination of Care

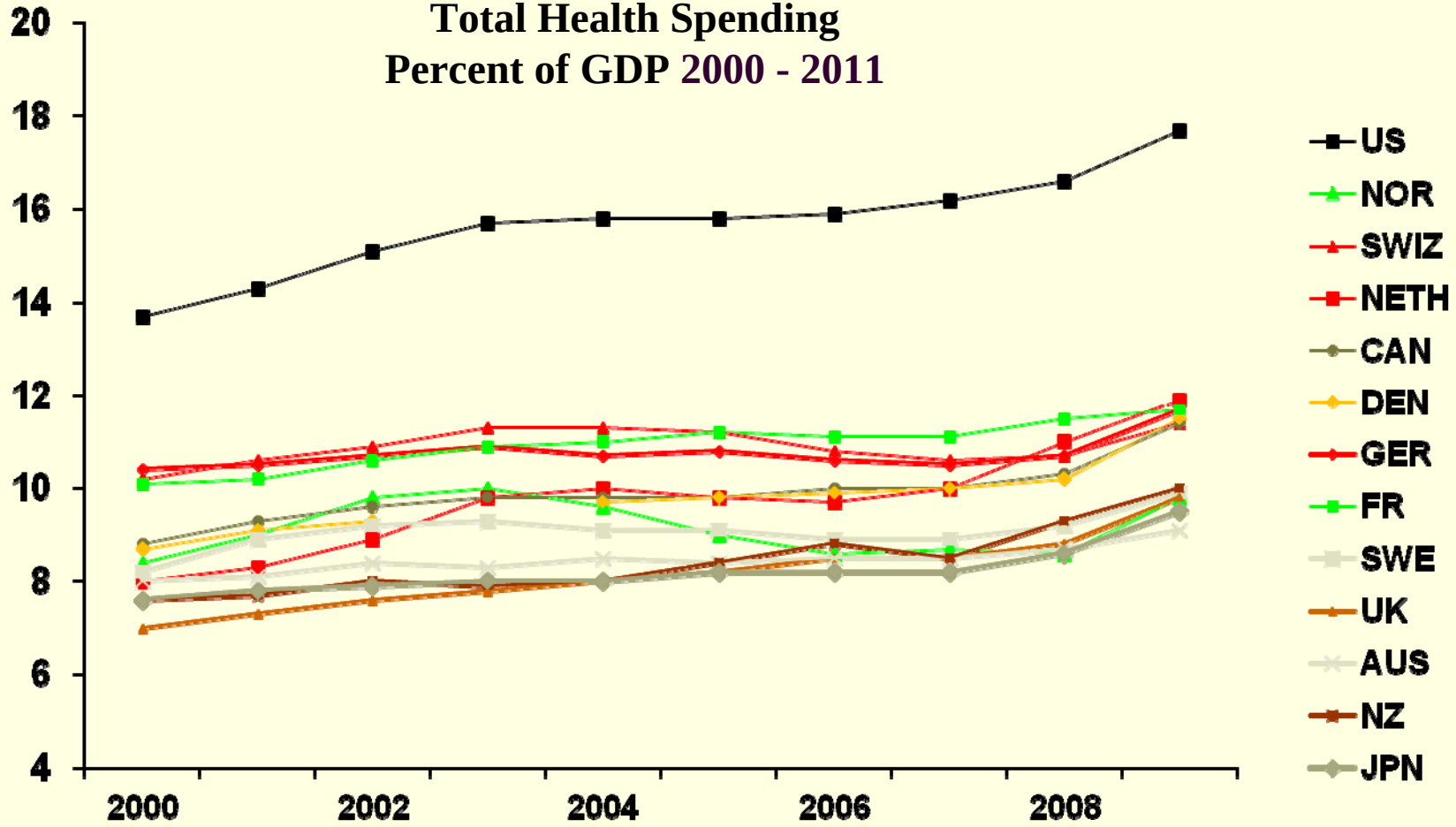
The Medical Management Paradigm

1. Cost and Quality of Care



The Medical Management Paradigm

1. Cost and Quality of Care



The Medical Management Paradigm

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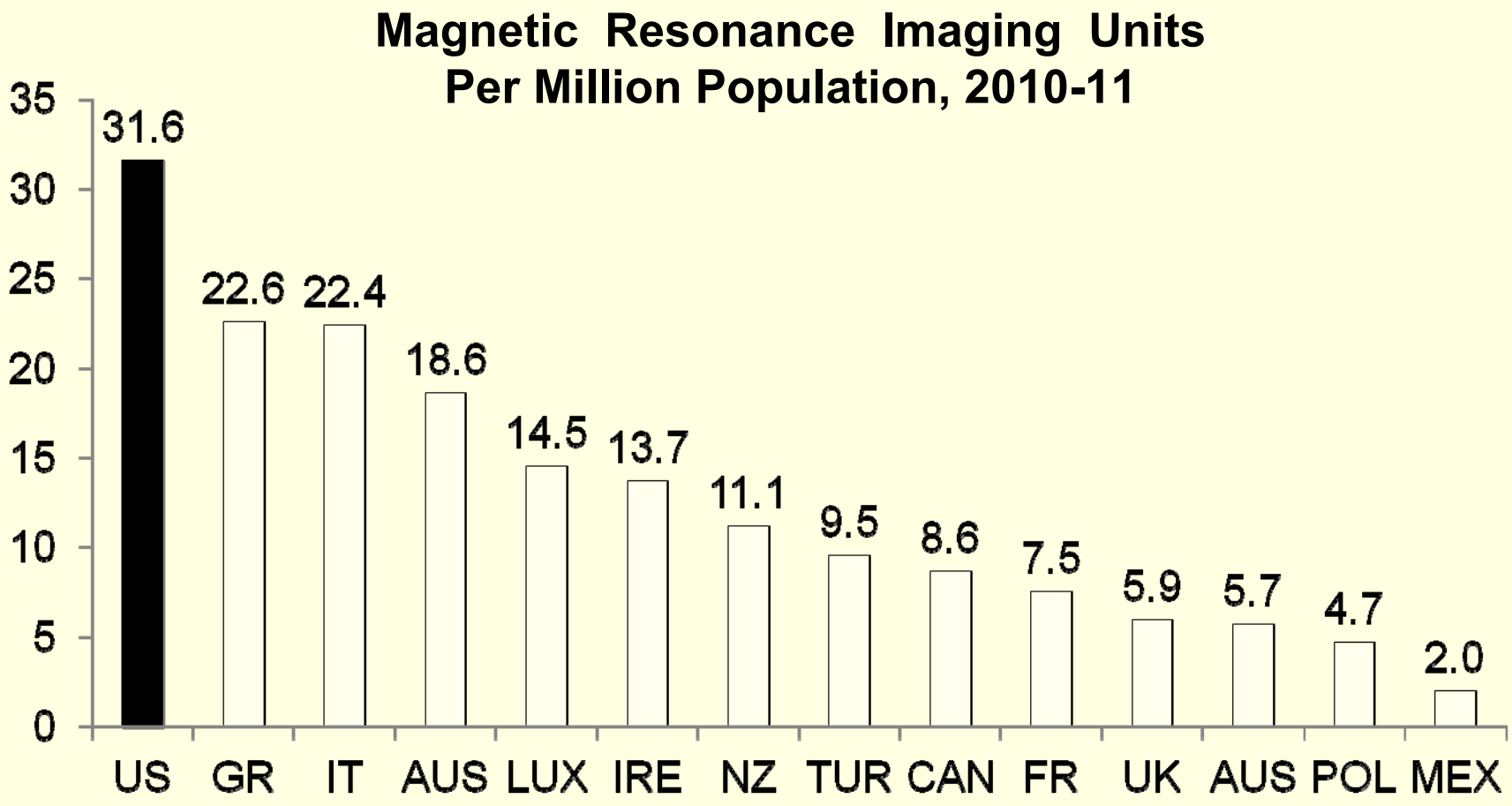


The Medical Management Paradigm
1. Cost and Quality of Care

6 categories account for between 21 and 47% of US health care spending in 2011:

- Failures of Care Delivery – includes medical errors, inefficient practice models
- Failures of Care Coordination – duplicate testing, avoidable readmissions
- Overtreatment – includes non-EBM treatments
- Administrative Complexity
- Pricing Failures – lack of transparency, unexplainable variation
- Fraud and Abuse

JAMA. 2012;307(14):doi:10.1001/jama.2012.362

The Medical Management Paradigm
2. Comparative Pricing

OECD concluded that US healthcare spending is higher because of:

- Prices charged by American doctors and hospitals are higher than they are anywhere else

Comparison Shopping

Average costs across public and private sectors, in dollars.

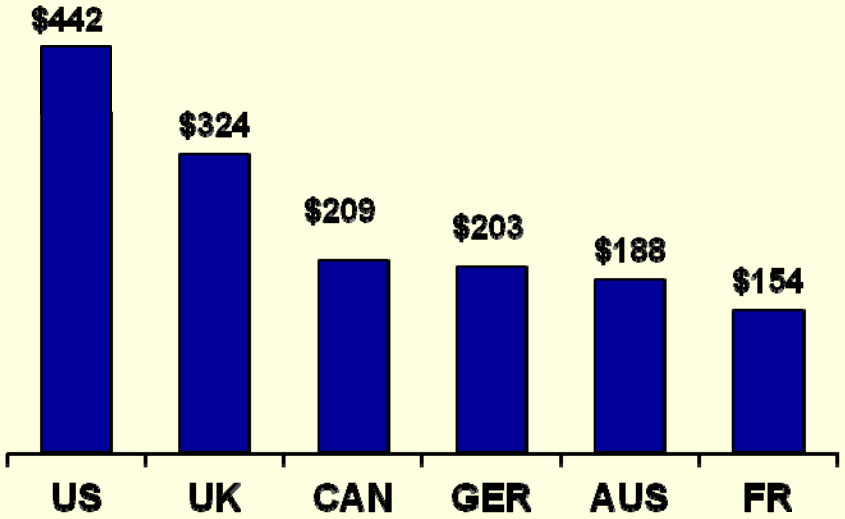
	Britain	Canada	France	Germany	U.S.
M.R.I. scan	$ 187	304	398	632	**1,009**
Normal childbirth	2,792	2,667	3,768	2,147	**8,435**
Appendectomy	3,456	3,810	2,795	3,285	**13,123**
Avg. hospital stay	N.A.	7,707	4,715	4,718	**14,427**
Cataract surgery	1,299	927	3,352	N.A.	**14,764**
Hip replacement	9,637	10,753	12,629	15,329	**34,454**
Bypass surgery	13,998	22,212	16,325	27,237	**59,770**

Organization for Economic Co-operation and Development (OECD), *Health at a Glance 2011: OECD Indicators*, OECD Pub.

The Medical Management Paradigm
2. Comparative Pricing

Physician Incomes, 2008 ($000s)
Adjusted for Differences in Cost of Living

Orthopedic surgeons

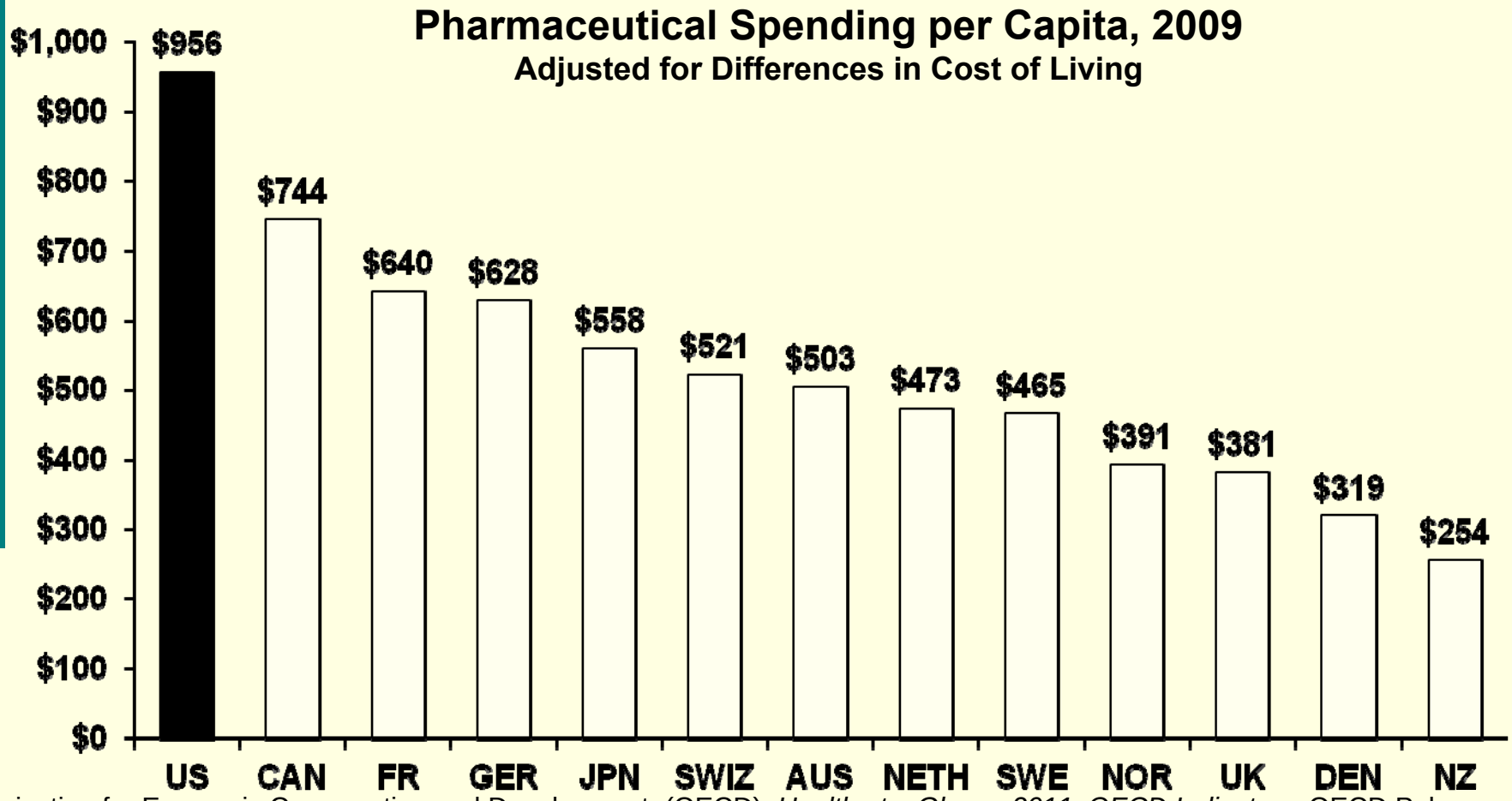


Primary care doctors

Source: M. J. Laugesen and S. A. Glied, "Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs,* Sept. 2011 30(9):1647–56.

The Medical Management Paradigm

2. Comparative Pricing



Organization for Economic Co-operation and Development (OECD), *Health at a Glance 2011: OECD Indicators*, OECD Pub.

The Medical Management Paradigm

2. Comparative Pricing (cont.)

Medical Tourism

	2009 Estimated Fees including Travel[1]				
Medical Procedure	**USA**	India	Thailand	Mexico	Costa Rica
Spine Fusion	**$100,000**	$14,000	$13,000	$8,000	$16,000
Knee Replacement	**$50,000**	$9,000	$14,000	$11,500	$12,000
Hip Replacement	**$43,000**	$10,000	$16,000	$13,800	$13,000
Hip Resurfacing	**$30,000**	$10,000	$18,000	$13,400	$13,000
Angioplasty	**$57,000**	$10,000	$9,000	$17,100	$14,000
Heart Bypass	**$144,000**	$10,000	$26,000	$21,100	$26,000
Heart Valve Replacement	**$170,000**	$30,000	$24,000	$31,000	$31,000

[1] From MedicalTourism.com: “Prices are approximate and not actual prices and include estimated airfare for patient and companion. Prices will vary based upon many factors including hospital, doctor’s experience, accreditation, currency exchange rates and more. Not included are costs for meals, miscellaneous expenses and any hotel costs or tourism costs”

The Medical Management Paradigm
2. Comparative Pricing (cont.)

OECD also concluded that US healthcare spending is higher because of:

- Health coverage which shields patients from price sensitivity
- Greater reliance on specialty care
- High tech care

Organization for Economic Co-operation and Development (OECD), *Health at a Glance 2011: OECD Indicators*

The Medical Management Paradigm
3. Coordination of Care

CBO Medicare meta-analysis[1] on cost and utilization control projects:

- Most programs did not reduce Medicare spending
- Demonstrations aimed at reducing spending & increasing quality of care face significant challenges from fee-for-service payment
- Little improvement in facilitating communication or coordination
- Results suggest substantial changes to payment and delivery systems are needed to significantly reduce spending and either maintain or improve the quality of care

[1]CBO Issue Brief, Jan 2012 Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment

Patient Protection and Affordable Care Act (PPACA) on Workers' Compensation

While PPACA does not formally combine WC medical treatment with general health care there is abundant debate on the indirect influence on:

1. Claim Frequency Debate: Up or Down?

- Lower claim frequency: if "everyone" has coverage, less likely to file a workers compensation claim)
- Raise claim frequency: may re-direct high severity claims from group health to comp;

2. Medical Cost Containment Debate:

- Unit Price: better ability to control unit price for those workers' compensation systems most closely tied to Medicare's fee schedules;
- Utilization: Greater emphasis on evidence-based medicine (aka comparable effectiveness in PPACA) adds leverage to workers' comp UR process.

Patient Protection and Affordable Care Act (PPACA) on Workers' Compensation (cont.)

3. Access to Care Debate:

- Increased demand for physicians and clinics, hospitals and general health care providers will accelerate projected primary care (more immediate) and specialist (longer term) access shortage.
- Likely expansion to roles and responsibilities of registered and licensed nurses and physician assistants;

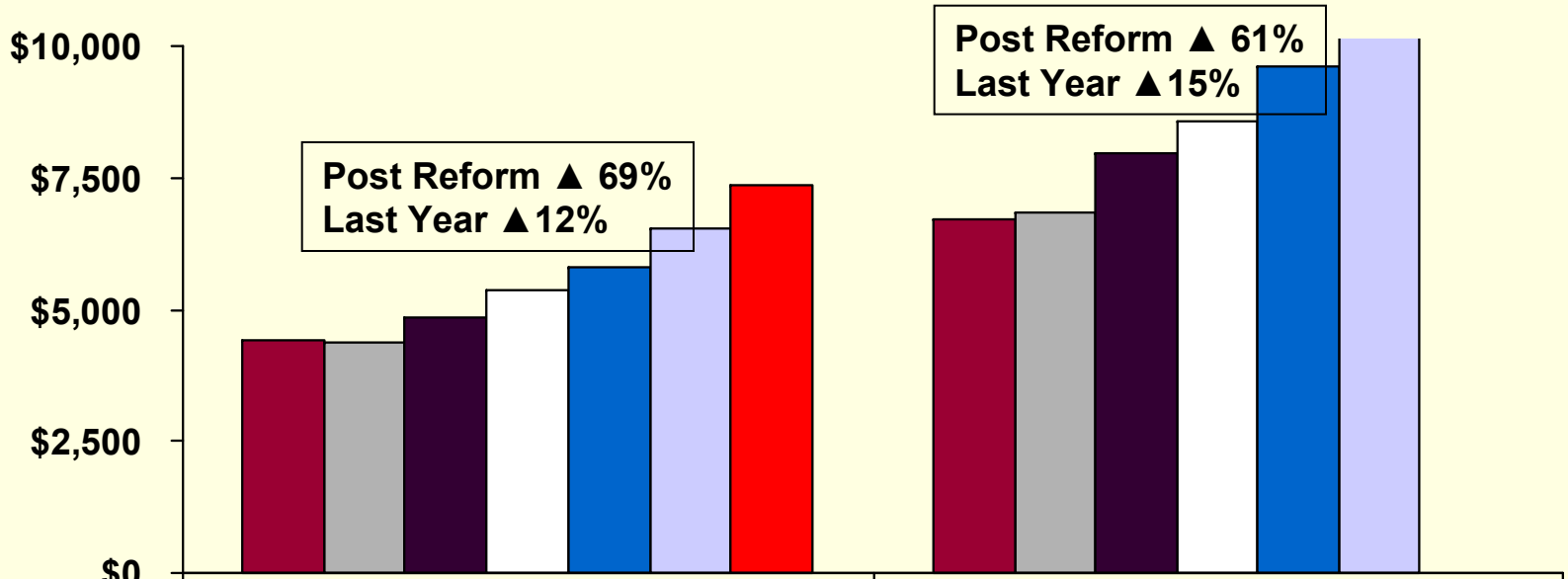
4. Greater Emphasis on Wellness and Prevention Debate;

- Likely decrease in demand for emergency room services;
- Wellness promotion may dampen co-morbidity growth rate;

Workers' Compensation: National Trends

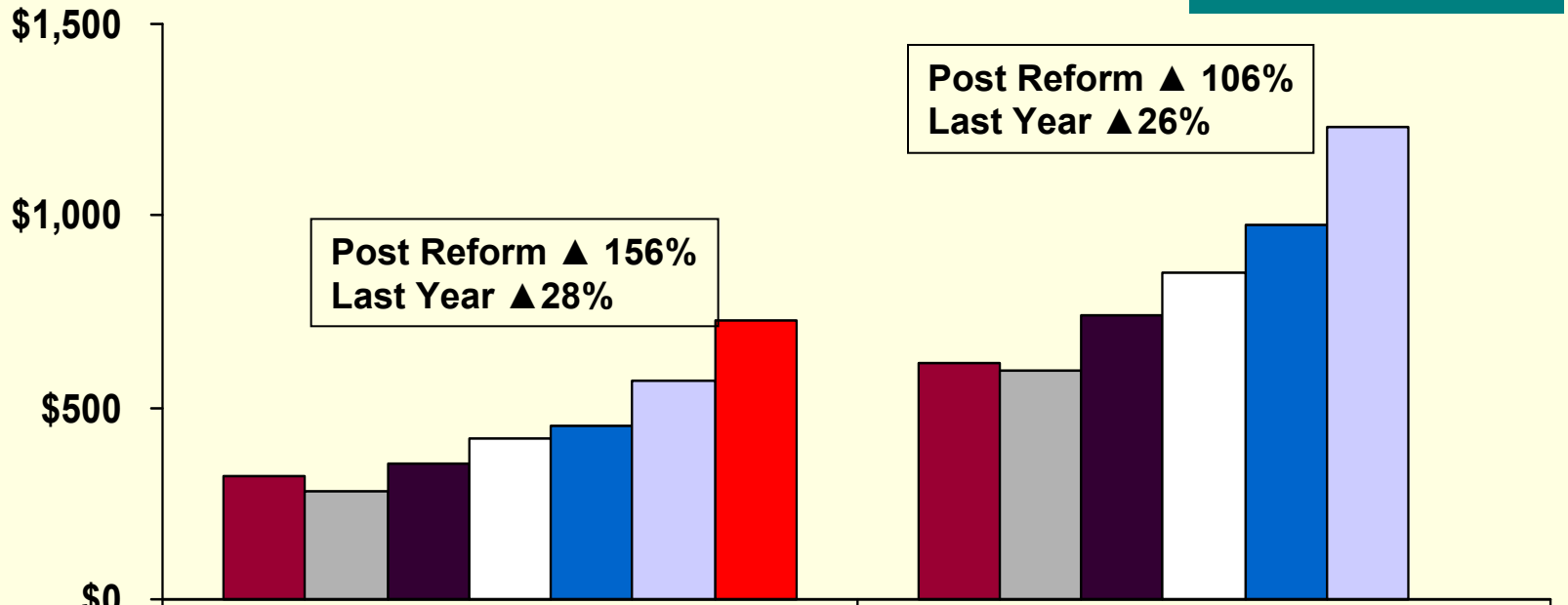
- Medical costs continue to rise faster than inflation
- Increased interest in guidelines
- Employer interest in limited networks
- Pharmacy issues predominated in 2011
  - Opioids
  - Physician dispensed drugs
- Private equity and medical equipment/ancillary services industries "discover" WC

Average Sub-Category of Medical Benefits Paid: Medical Treatment, Indemnity Claims



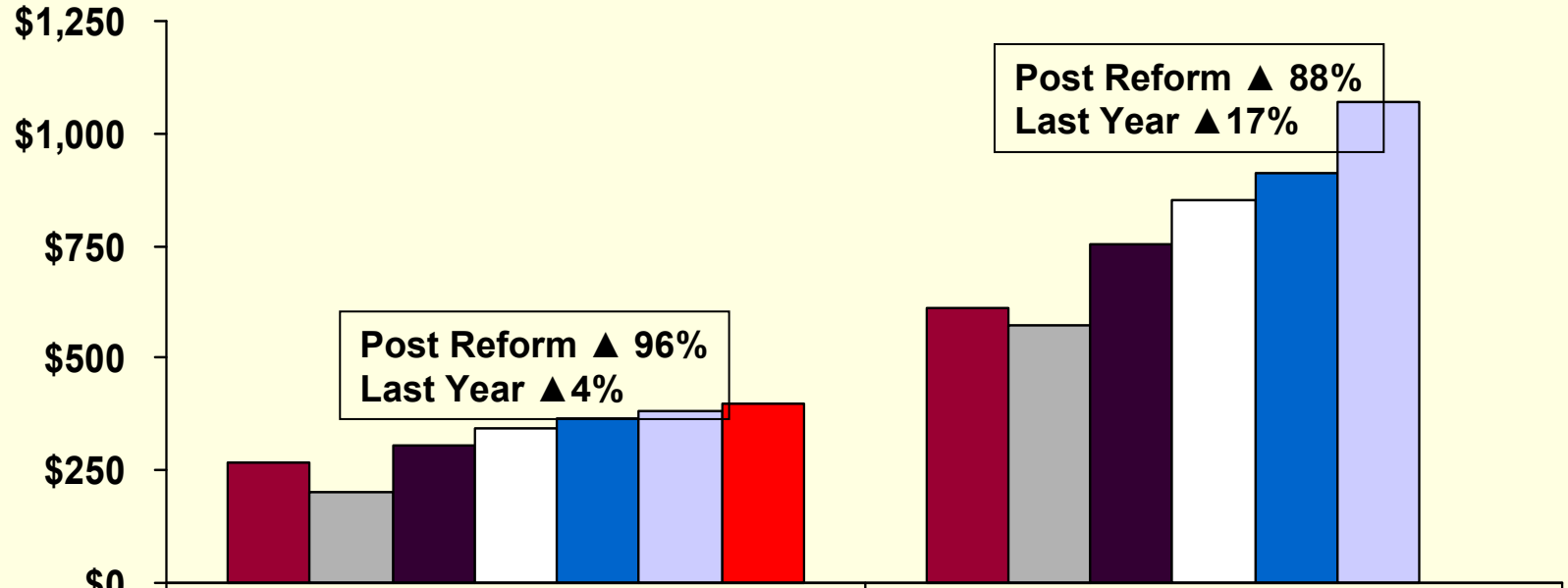
	12 M	24 M
2004	$4,431	$6,691
2005	$4,353	$6,851
2006	$4,842	$7,987
2007	$5,386	$8,554
2008	$5,813	$9,592
2009	$6,554	$11,008
2010	$7,369	

Average Sub-Category of Medical Benefits Paid: Pharmacy and DME, Indemnity Claims



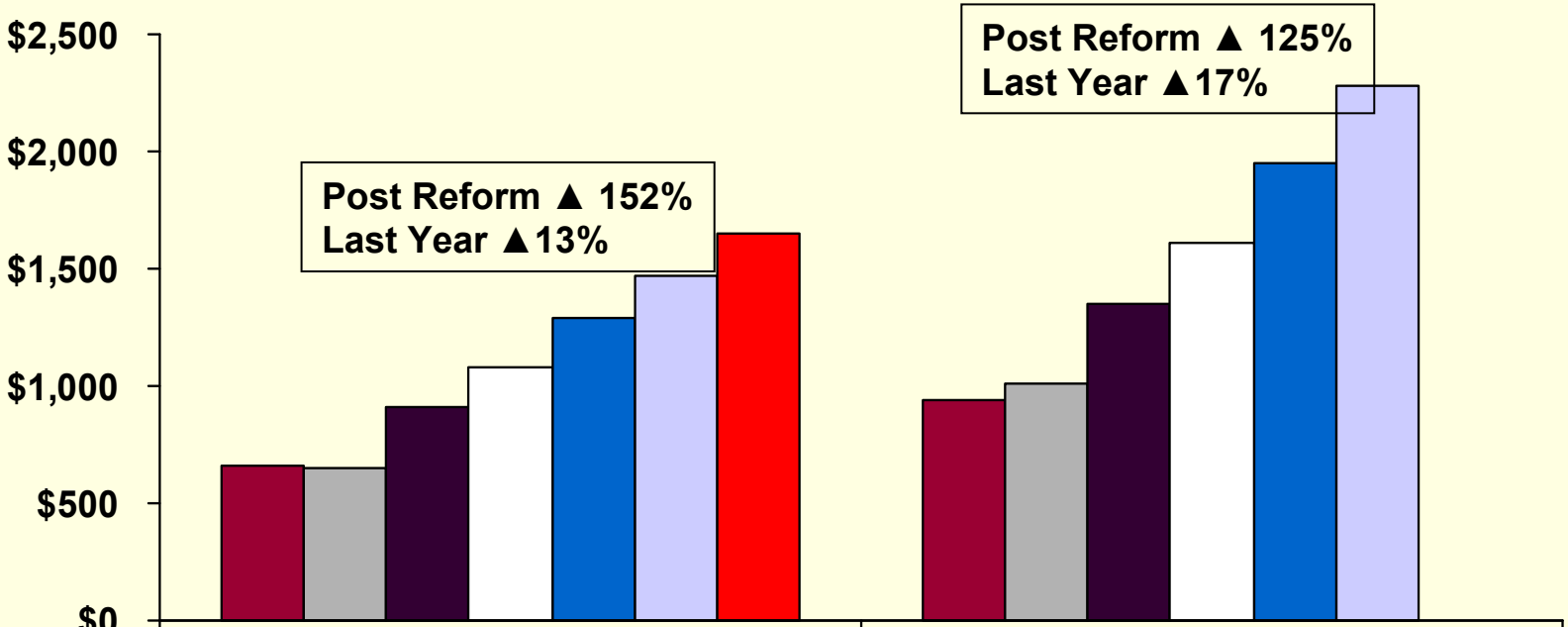
	12 M	24 M
2004	$323	$615
2005	$284	$599
2006	$355	$740
2007	$418	$849
2008	$450	$976
2009	$569	$1,234
2010	$728	

Average Sub-Category of Medical Benefits Paid: Medical Legal, Indemnity Claims



	12 M	24 M
2004	$267	$613
2005	$204	$571
2006	$308	$753
2007	$344	$850
2008	$364	$913
2009	$383	$1,072
2010	$400	

Average Sub-Category of Medical Benefits Paid: Medical Cost Containment, Indemnity Claims



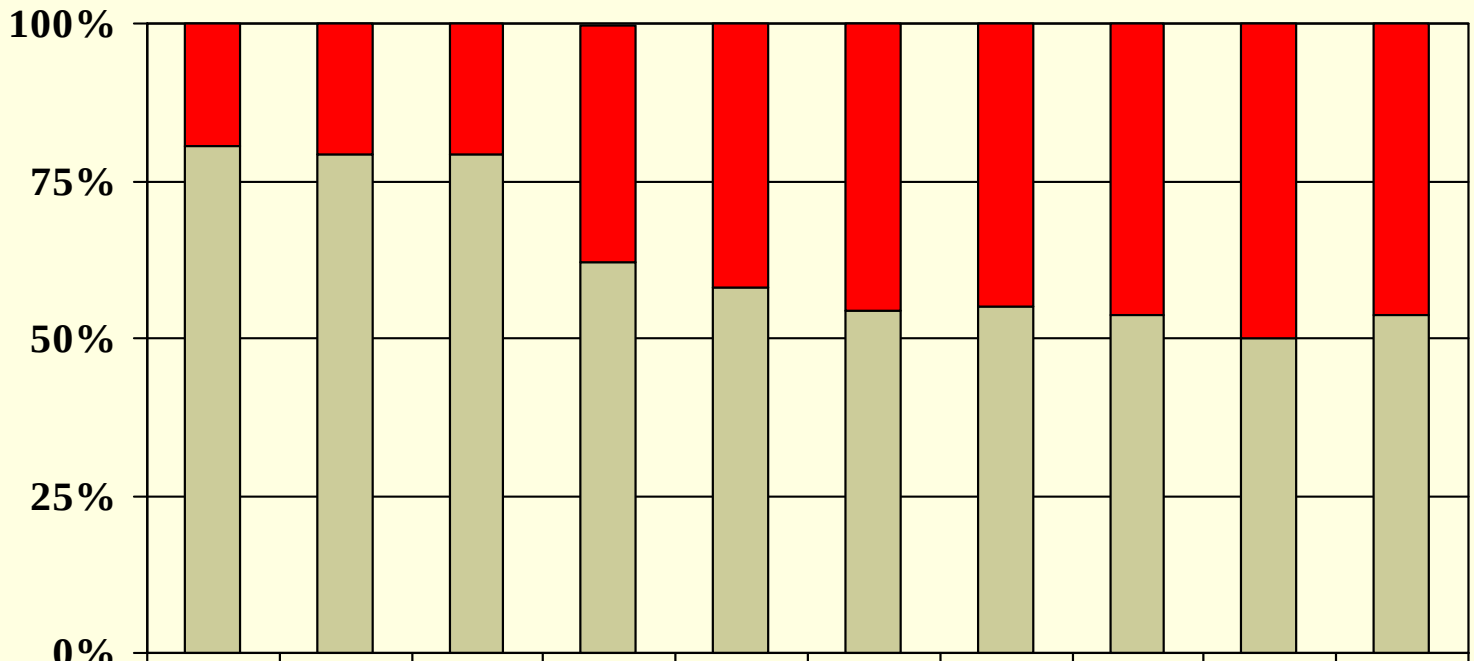
	12 M	24 M
2004	$664	$939
2005	$655	$1,013
2006	$909	$1,348
2007	$1,079	$1,614
2008	$1,287	$1,953
2009	$1,470	$2,279
2010	$1,655	

Medical Management

Is workers' compensation medical care harder to manage?

1. Differences in supply and demand side controls:
   - Co-payments & deductibles
   - Contractual language
   - Dispute resolution
2. Provider and network leverage
3. Liens
   - Combined effect on the OMFS and MTUS

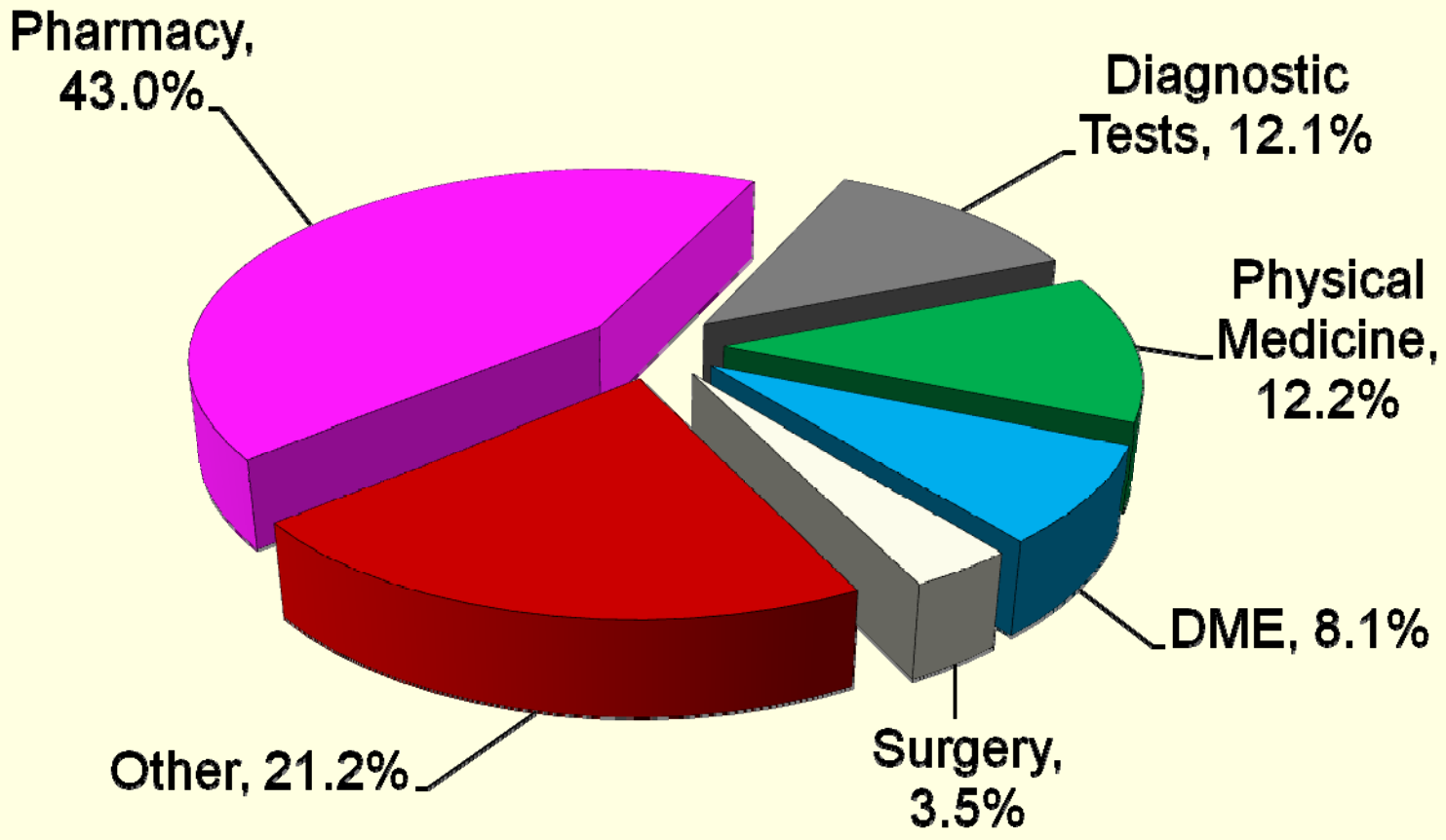
Average Sub-Category of Medical Benefits Paid: Components of Medical Cost Containment



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Utilization Mgt	19.3%	20.8%	20.8%	37.6%	42.0%	45.5%	45.1%	46.2%	49.9%	46.4%
MBR/PPO	80.7%	79.2%	79.2%	62.2%	58.0%	54.5%	54.9%	53.8%	50.1%	53.6%

The Role of Medical Cost Containment

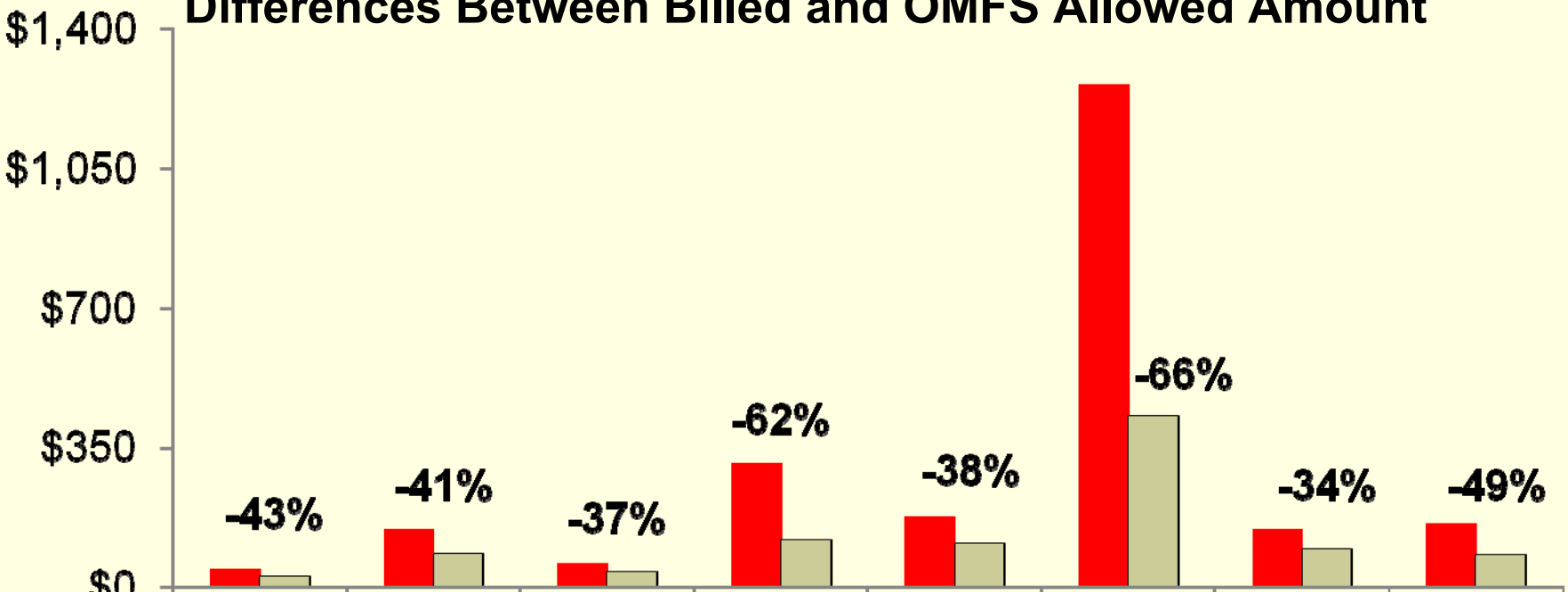
Utilization Review by Type (2011)



The Role of Medical Cost Containment

Medical Bill Review (2004-2011)

Post-Reform OMFS Effect
Differences Between Billed and OMFS Allowed Amount



	Phys Med	E & M	Spec Serv	Rad	Med Tx	Surgery	Sup/DME	All OutPt
Billed	$45	$145	$60	$309	$177	$1,259	$145	$159
OMFS	$26	$85	$38	$118	$110	$428	$95	$81

CWCI March 2012

Intersections and Uncertainties Between Medicare & Workers' Compensation

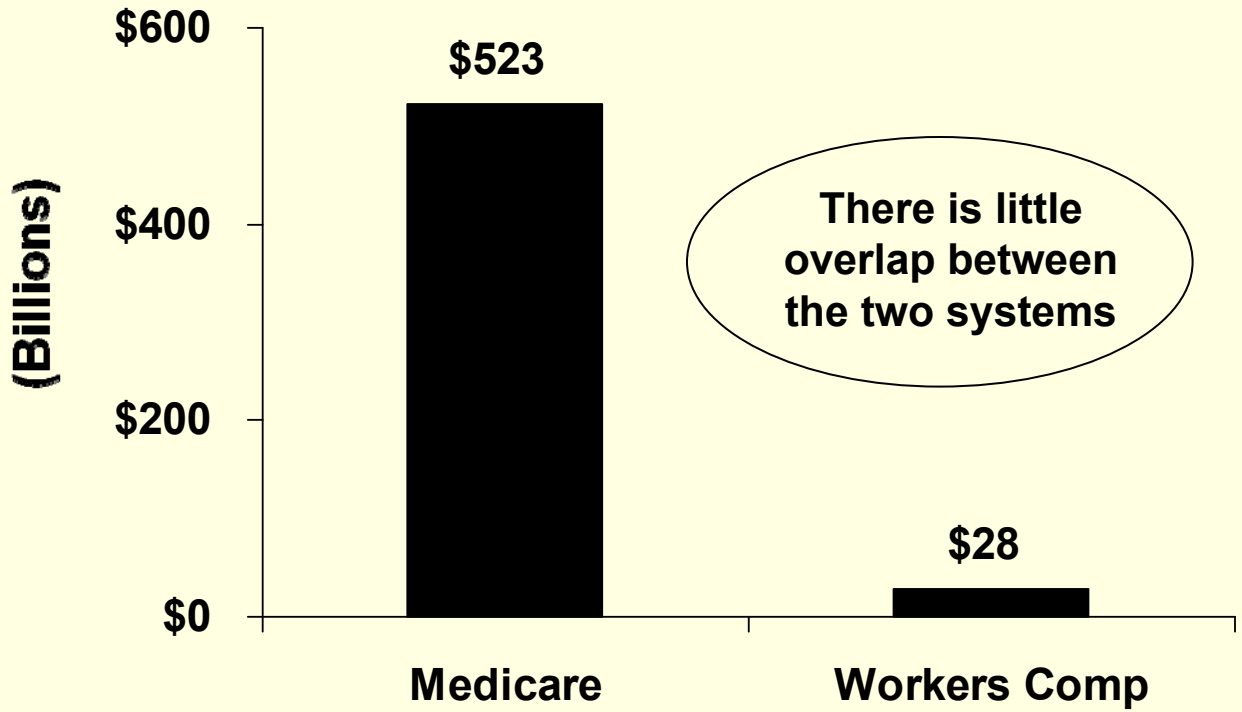
1. A Primer on Medicare and Workers Compensation
2. Section 111 Reporting
3. Medicare Set-asides

What is Medicare's Interest in Workers Compensation?

- Medicare is a Secondary Payer
- Workers Compensation Insurers are Primary Payers
- Medicare wants to insure that any payments that they made "conditionally" are recouped when a primary payer has been identified.
- Medicare also wants to insure that a primary payer "takes Medicare's interest into account" when future medical care is being settled.

Statutory authority; Future Payments 1980; 42 USC 1395y(b)(2)(A)
Conditional Payments 2007; 42 USC 1395y(b)(2)(B)

Medicare & Workers Comp Medical Annual Medical Spend (2010)



Most Frequent Medicare DRGs
- Septicemia
- Chest Pain
- Heart Failure
- Pneumonia
- Digestive Disorders

Most Frequent WC DRGs
- Spinal fusions
- Medical backs
- Joint replacement
- Rehab
- Lower extremity procedures

Intersections and Uncertainties Between Medicare & Workers' Compensation

1. A Primer on Medicare and Workers Compensation
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Section 111 Reporting
Discovery of Existing Claims

Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111)

1. Responsible Reporting Entities (RREs) mandatory reporting requirements

2. Effective reporting date: 1st Quarter 2011

3. Purpose; CMS to monitor
   - Conditional Payments
   - Future Payments

4. Concerns:
   - Use of information
   - Penalties
   - Ambiguities and inconsistencies in medical reporting requirements

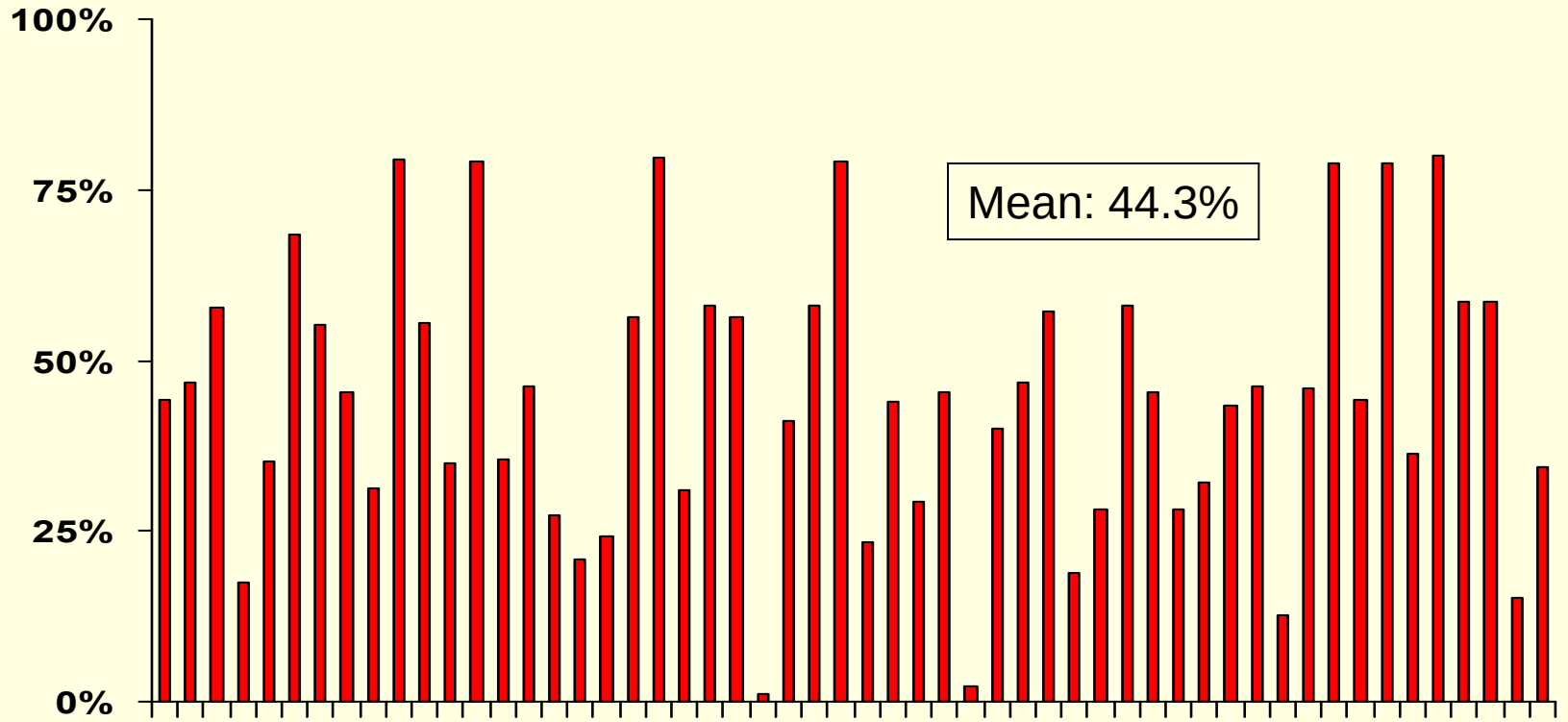
PRELIMINARY RESULTS
- DO NOT CITE -

Section 111

Analysis of Potential Over-Reporting

(Preliminary Results from a forthcoming CWCI Study)

Sample of 50 Medicare Eligible Indemnity Claims
Percentage of Paid Amounts Outside of Appropriate ICD-9 Codes



Intersections and Uncertainties Between Medicare & Workers' Compensation

1. A Primer on Medicare and Workers Compensation
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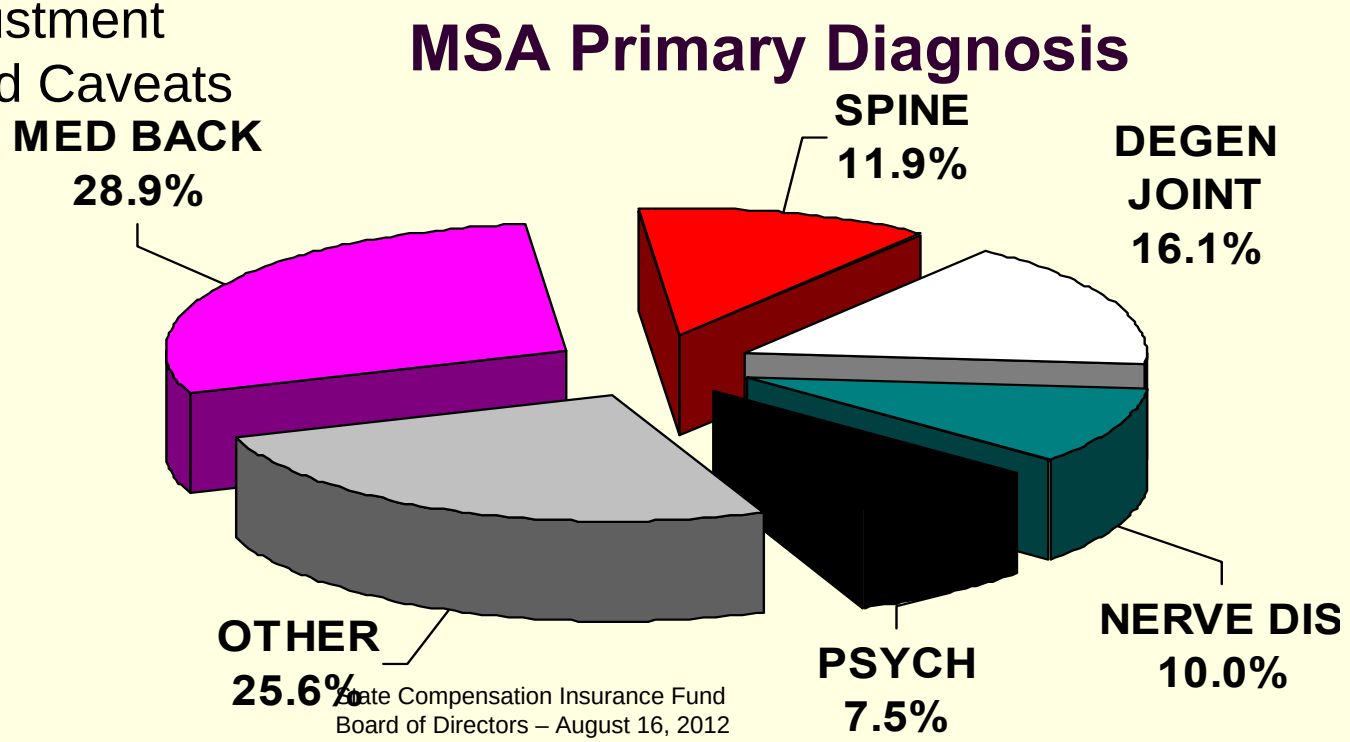
Medicare Set Asides
Forecasting Future Med Costs

- MSAs allocate a portion of the WC settlement for future medical costs.
- MSA is determined on a case-by-case basis and approved by CMS.
- Once approved set aside are exhausted, Medicare will pay for future medical costs related to the WC injury.
- Authorized treatment in the two years pre-settlement is presumed necessary for the life of the patient
- Payers must factor in all Rx authorized by MD including lifetime use of opioids, brand Rx (priced at AWP)

Medicare Set Asides - Forecasting Future Med Costs

(Preliminary Results from a forthcoming CWCI Study)

- Data sample
  - MSAs from Jan 2007 – June 2011
  - 7,437 Submitted MSAs
  - 1,147 CMS Approved MSAs
- Case-mix adjustment
- Limitations and Caveats

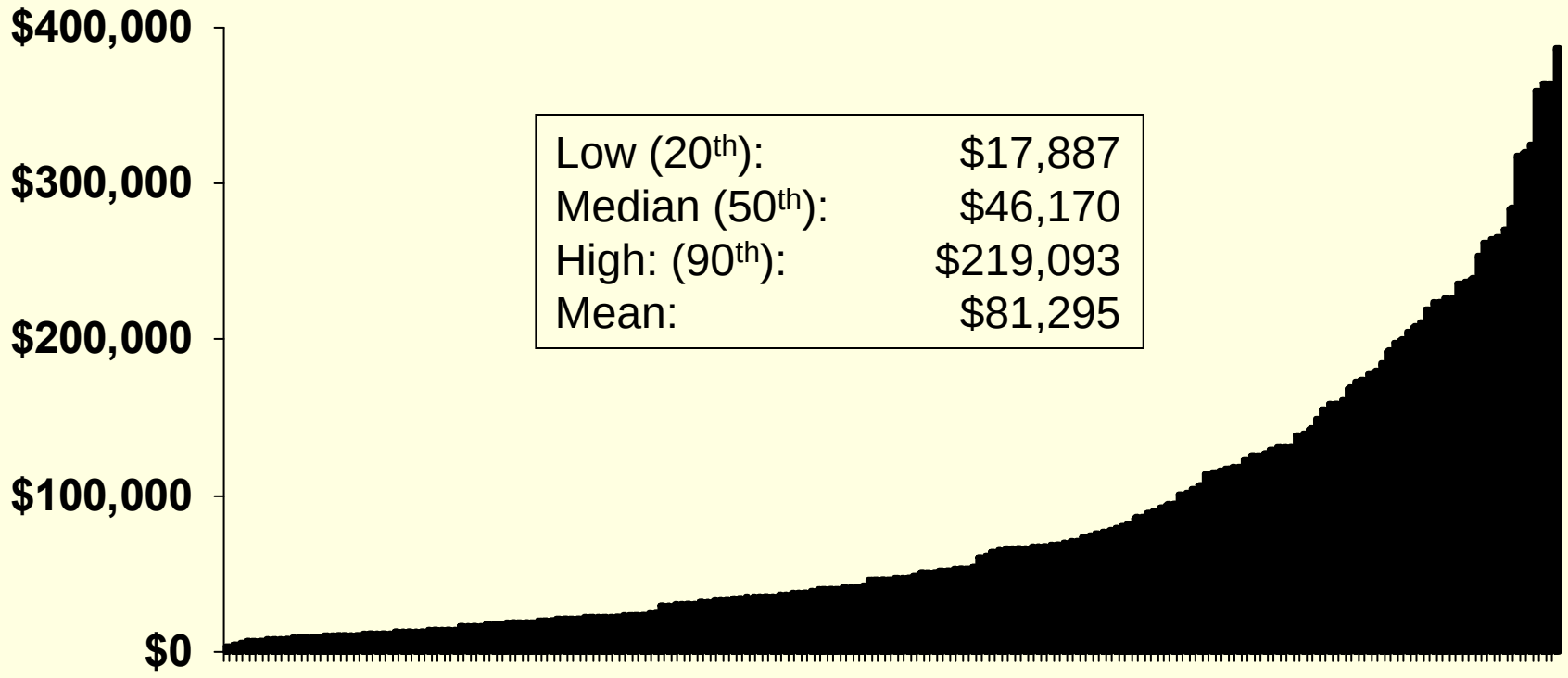


PRELIMINARY RESULTS
- DO NOT CITE -

Characteristics of Submitted MSAs

Variation in MSA Values by Injury Category

CMS Submitted MSAs
Medical Back Problems W/O Spinal Cord Involvement



(Preliminary Results from a forthcoming CWCI Study)

Reducing MSA Variability: Prospective Payments?

Lessons from the DRG Prospective Payment System

- Designed to accommodate all patient conditions
- Standardizes fees, increases predictability
- Allows for age, region, facility and other adjustments
- Reduces admin costs for payors and CMS
- Speeds payment cycle, reduces disputes

Balancing Cost and Quality

- Key driver in affordability debate
- We will never have perfect data, but we probably have enough to make hard decisions
- No discussion of cost can ignore quality, and no discussion of quality can ignore cost

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