2013

Workers Compensation Research Institute

ANNUAL REPORT

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RESEARCH REVIEW

WCRI

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WCRI Annual Report

2013

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:

As we emerge slowly from the Great Recession, increasing health care costs, unprecedented partisanship, and difficult headwinds have kept the world economy in a state of uncertainty. At the same time, continued fiscal constraints challenge the capacity of state and local governments to deliver services to those in need.

This new normal continues to strain the ability of business to grow, negatively impacting job availability, and spurring regulatory attempts to control costs while maintaining good outcomes for injured workers.

In the midst of these difficulties, public officials and system stakeholders continue to turn to WCRI research as they debate legislative and regulatory changes. WCRI's work illuminates and clarifies the impact of reforms, emerging issues, the outcomes achieved by injured workers, and major cost drivers.

In response to this difficult climate, WCRI has produced new, impactful research and improved upon the comprehensiveness and delivery of our research. Here are some highlights of WCRI's impact and expansion:

- Our physician-dispensing study helped identify the issue of repackaged drugs as a cost driver, and a growing number of states enacted regulatory changes, relying in part on the WCRI findings.
- Our research on long-term use of opioids caught the attention of policymakers and stakeholders concerned about the opioid epidemic and contributed to the passage of recent legislation.
- WCRI expanded its unique tools to monitor and measure the outcomes of injured workers in 20 states in areas such as recovery of health, speed and sustainability of return to work, access to and satisfaction with care, and earnings recovery. The results from these studies assist policymakers in identifying regulatory changes that balance costs and worker outcomes.
- WCRI also expanded the reach of its most frequently used studies, the annual benchmarking (CompScope™) reports, to include even more states and an even more comprehensive set of metrics.

New challenges in workers' compensation arise regularly in the current economic and political climate. To meet these challenges, WCRI will continue to educate policymakers and system stakeholders and provide the sound research, credible data, and objective analysis that contribute to an informed debate while avoiding taking positions or making recommendations.

We thank our members for their generous support of our research through their data, funding, and expertise. WCRI would not be where it is today without your help. We are both well-prepared and well-positioned to inform the public policy debates ahead, and we look forward to continuing to work together towards this end.

Respectfully yours,

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

The Institute

"Though the legislation was dead in the house, WCRI's study/briefing helped revive the issue and contributed to the legislation's passage. The information was powerful and eye opening. It was obvious from the presentation that we could have an impact on the substance abuse issue by requiring docs to sign up and use the state's prescription monitoring program, which is currently voluntary with only 1,700 out of 40,000 docs using the database."

State Representative Nick Collins, Massachusetts House of Representatives

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.

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 systems away from the historic cycles of crisis-reform-crisis that have characterized workers' compensation for the past 30 years.
- *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.

"There are very few sources that we can rely on for meaningful workers' compensation data and information. We have found WCRI to be the most reliable and accurate source available. With WCRI data, we can get a good definition of what is being measured and run similar reports from our own data to make meaningful comparisons."

Katrina Zitnik, Director of Workers' Compensation at Costco

The Impact

Improving 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.

"The WCRI reports provide data that equip me, as a labor representative of the Louisiana Workers' Compensation Advisory Council, to identify trends in workers' compensation both statewide and nationally. These trends can help pinpoint threats to the system from both inside and outside sources, but they are also helpful in identifying opportunities for improving the system for injured workers. Since the primary goal of any workers' compensation system should be to improve outcomes for injured workers, which will ultimately benefit all stakeholders, WCRI's research continues to be a valuable source of information."

Julie Cherry, Secretary-Treasurer of the Louisiana AFL-CIO

For over twenty-nine 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 narcotics studies—including *Physician Dispensing in Workers' Compensation, Longer-Term Use of Opioids,* and *Prescription Benchmarks, 2nd Edition*—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 Illinois Workers' Compensation Commission voted in favor of rule changes regarding reimbursement rates for repackaged pharmaceuticals. WCRI research on prescription benchmarks and physician dispensing was actively used in the deliberations.
  - WCRI briefed over a dozen Massachusetts legislators on its *Interstate Variations in Narcotics* study. The research and the briefing were credited with reviving and contributing to the passage of legislation requiring physicians to register and use the state's prescription drug monitoring program.
  - WCRI provided testimony to the State of Michigan Joint Committee on Administrative Rules, which held a hearing on enacting new rules concerning reimbursement rates for prescriptions dispensed at physicians' offices.
  - Findings from WCRI's *Prescription Benchmarks for Florida, 2nd Edition*, were directly cited in the Analysis and Fiscal Impact Statement for Florida Senate Bill (SB) 668. SB 668 proposed to cap the reimbursement amount for prescription medication at the average wholesale price plus $4.18 for the dispensing fee.
  - WCRI provided testimony on its Longer-Term Use and Physician Dispensing studies at a public hearing of the Wisconsin Labor Management Advisory Committee.
  - WCRI provided testimony about the costs of repackaged drugs to the Florida Office of Insurance Regulation, which convened a hearing on workers' compensation rates. The estimated savings from reforming this practice are $62 million.
  - WCRI presented testimony about opioid abuse to the National Association of Insurance Commissioners Workers' Compensation Task Force. Following the meeting, the committee agreed to take a closer look at opioid abuse and potential legislation.

  - A proposal for workers' compensation reforms, offered by the Pennsylvania Chamber of Business and Industry, directly cited WCRI studies on pharmaceuticals in workers' compensation.

- 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 director of the Louisiana Office of Workers' Compensation used the CompScope™ Benchmarks for Louisiana in a major speech to the Louisiana Association of Self Insured Employers.
  - WCRI provided testimony regarding CompScope™ findings to the Labor/ Management Policy Committee of the Minnesota Chamber of Commerce.
  - The Michigan Association of Chiropractors, in testimony to the Senate Committee on Reform, Restructuring and Reinventing, directly cited CompScope™ Benchmarks.
- WCRI research is regularly requested by public officials at the federal level:
  - Request by the Government Accounting Office (GAO) for WCRI's Workers' Compensation Laws, as well as the National Inventory of Medical Cost Containment, to use in comparison for work the GAO is doing on the Federal Employees' Compensation Act (FECA) program.
  - WCRI provided several studies to a staff member with the U.S. House of Representatives Committee on Education and the Workforce.

State Impact

Institute research is widely disseminated to public officials, Institute members, and others interested in improving workers' compensation systems. Members of the Institute's staff have consulted and given testimony and presentations on their research findings to public officials in the following states:

Alabama	Idaho	Massachusetts	New Jersey	South Carolina
Arizona	Illinois	Michigan	New Mexico	Tennessee
Arkansas	Indiana	Minnesota	New York	Texas
California	Iowa	Mississippi	North Carolina	Vermont
Colorado	Kansas	Missouri	Ohio	Virginia
Connecticut	Kentucky	Montana	Oklahoma	Washington
Florida	Louisiana	Nebraska	Oregon	West Virginia
Georgia	Maine	Nevada	Pennsylvania	Wisconsin
Hawaii	Maryland	New Hampshire	Rhode Island	

"The WCRI provides an objective view of the performance of the workers' compensation drivers in many individual states as well as the comparison among the various jurisdictions. As changes continue to occur and evolve in many of these states' workers compensation systems, it is critical to have a tangible framework for all stakeholders to evaluate the outcomes. The analysis performed by WCRI is not only unbiased but informative and actionable to us."

Vincent Donnelly, CEO/Chairman at PMA Insurance Group

- The WCRI medical fee schedule study, which quantified the large differences among states in workers' compensation medical fee schedules, is well-used by public officials to evaluate their own fee regulations:
  - WCRI research on fee schedules was used by Florida stakeholders in comments filed on the Florida outpatient fee schedule. Statistics from WCRI's CompScope™ Medical Benchmarks and *Hospital Outpatient Cost Index for Workers' Compensation* were also cited in the formal comment process.
  - Staff of the Tennessee Department of Labor and Workforce Development asked to use material from WCRI's study, *Designing Workers' Compensation Medical Fee Schedules,* in their work on medical fee schedule amendments.
  - WCRI staff briefed senior decision makers at the New York State Workers' Compensation Board on WCRI research regarding medical fee schedules.
  - WCRI provided information to the Workers' Compensation Committee of the California Neurology Society about fee schedule payments for particular Current Procedural Terminology (CPT) codes so they could brief top state regulators.

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 29 million claims from insurers, state funds, and self-insurers and representing nearly 80 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 thirty-five organizations support the Institute in 2013. (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 vendors, 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 2013 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/2013

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Property Casualty Insurers Association of America

Kevin Brady
The PMA Insurance Group

William G. Carney
Accident Fund Holdings, Inc.

David Deitz
Liberty Mutual Group

Artemis Emslie
MyMatrixx

Ruth Estrich
MedRisk, Inc.

Matthew Nimchek
The Hartford Financial Services Group

Marla Perper
Zurich Services Corporation

James Scanlon
The Travelers Companies, Inc.

Kim Weisse
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Janine Kral, Vice Chair

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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.

System Evaluation, cont.

- The current research agenda includes the following studies:
  - Group Health Hospital Cost Index Compared with Workers' Compensation
  - Impact of Florida Ban on Physician Dispensing of Opioids
  - Worker Outcomes, 8th Edition
  - How Surgery Rates and Number of Participating Surgeons Change When the Fee Schedule Changes
- Recently published studies include the following:
  - *Impact of Treatment Guidelines in Texas*
  - *Return to Work after a Lump-Sum Settlement*
  - *Designing Workers' Compensation Medical Fee Schedules*
  - *Why Surgeon Owners of Ambulatory Surgical Centers Do More Surgery Than Non-Owners*
  - *WCRI Medical Price Index for Workers' Compensation, Fourth Edition (MPI-WC)*
  - *Workers' Compensation Laws as of January 2012*
  - *Monitoring the Impact of the 2007 Reforms in New York*

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:

- Usage patterns of pain clinics.
- Why do surgery rates vary?

Examples of studies published in the program include the following:

- *Longer-Term Use of Opioids*
- *Physician Dispensing in Workers' Compensation*

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.

Visit us at www.wcrinet.org to learn more about the work of the Institute and to quickly access over 300 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

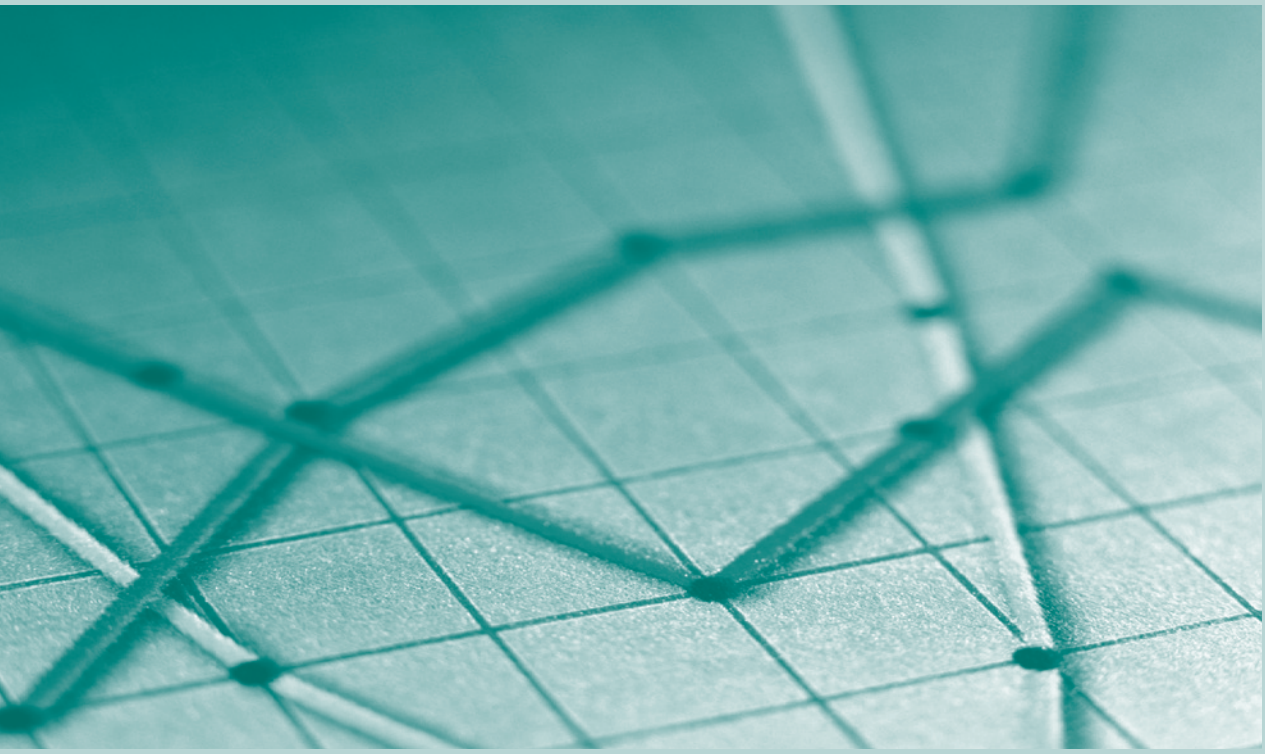
For all visitors:

- Powerful key word search of research studies
- Abstracts of over 300 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 29th year, the Institute published 38 major studies on a broad range of topics. This brings the Institute's total to over 300 books and 263 research briefs 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 2013.

PHYSICIAN DISPENSING IN WORKERS' COMPENSATION

This study examines the rapid growth of physician-dispensed pharmaceuticals for injured workers under state workers' compensation systems in 23 states. It finds that the frequency and costs of physician-dispensed drugs in many states grew rapidly. This raised costs to employers since the prices paid to physicians were typically much higher than what were paid to pharmacies for the same drug.

Selected major findings include:

- New regulations in a growing number of states limit the prices paid for physician-dispensed prescriptions and reduce costs, but they are unlikely to reduce patient access to prescription medications. This finding reflects the experience of California before and after reforms that are becoming a model for other states.
- Illinois: Nearly 2/3 of prescription payments were paid to physicians who dispense drugs at their offices—up from 22 percent in just three years.
- Connecticut: Nearly 40 percent of prescription payments were paid to physicians who dispense drugs at their offices—up from 16 percent in just three years.
- Pennsylvania: More than 1/4 of prescription payments were paid to physicians who dispense drugs at their offices—nearly doubling in just three years.
- Florida: Nearly 2/3 of prescription payments were paid to physicians who dispense drugs at their offices—second highest among the 23 states studied.
- Maryland: Nearly half of prescription payments were paid to physicians who dispense drugs at their offices—fifth highest among 23 states studied.
- In certain states where physician dispensing is common, physicians write prescriptions for and dispense certain drugs (e.g., omeprazole [Prilosec®] and ranitidine HCL [Zantac®]) that are available without a prescription in a drug or grocery store at a much lower price.

The study compares 23 states, including Arkansas, Connecticut, Florida, Illinois, Indiana, Iowa, Louisiana, Maryland, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Virginia, and Wisconsin. Five states (Arizona, California, Georgia, South Carolina, and Tennessee) recently adopted reforms aimed at reducing the costs of physician-dispensed drugs. The data include post-reform results for Arizona and California and pre-reform baselines for Georgia, South Carolina, and Tennessee. Also included are three states where physician dispensing is prohibited in general (Massachusetts, New York, and Texas).

The data used for this study include approximately 758,000 claims with more than seven days of lost time that received at least one prescription paid under workers' compensation—nearly 5.7 million prescriptions. The states in the study represent over two-thirds of the workers' compensation benefits paid in the United States. The data represent 21–47 percent of all cases, depending on the state, for the 23 states included in this study.

Physician Dispensing in Workers' Compensation. Dongchun Wang. July 2012. WC-12-24

TRENDS IN PHYSICIAN DISPENSING FOR 23 STATES, 2007/2008–2010/2011

State	Percentage of All Rx That Were Dispensed by Physicians		Percentage Point Change	Percentage of Rx Payments That Were Paid for Physician-Dispensed Rx		Percentage Point Change
	2007/2008	2010/2011		2007/2008	2010/2011	
Illinois	26%	43%	17	22%	63%	41
Connecticut	18%	28%	10	16%	37%	21
Florida	35%	45%	10	43%	62%	19
South Carolina[a]	12%	18%	6	10%	26%	16
Georgia[a]	30%	36%	6	32%	48%	16
Pennsylvania	17%	20%	3	15%	27%	12
Tennessee[a]	15%	20%	5	14%	25%	11
Maryland	33%	35%	2	36%	47%	11
Wisconsin	8%	11%	3	5%	15%	10
North Carolina	12%	14%	2	10%	18%	8
Indiana	17%	22%	5	9%	17%	8
Virginia	7%	10%	3	5%	12%	7
Michigan	23%	24%	1	15%	22%	7
Arizona[a]	27%	32%	5	23%	28%	5
Louisiana	11%	7%	-4	17%	19%	2
New Jersey	11%	18%	7	10%	12%	2
Iowa	16%	15%	-1	11%	12%	1
Minnesota	3%	4%	1	2%	3%	1
Arkansas	2%	4%	2	2%	3%	1
California[a]	56%	53%	-3	55%	52%	-3
Massachusetts[b]	n/a	n/a	n/a	n/a	n/a	n/a
New York[b]	n/a	n/a	n/a	n/a	n/a	n/a
Texas[b]	n/a	n/a	n/a	n/a	n/a	n/a

Notes: The underlying data include prescriptions for claims with more than seven days of lost time that had prescriptions filled and paid for by a workers' compensation payor over the defined period. 2010/2011 refers to claims with injuries occurring from October 1, 2009, through September 30, 2010, and prescriptions through March 31, 2011; similar notation is used for other years. Three states (Massachusetts, New York, and Texas) where physician dispensing is not allowed in general are not included.

[a] Five states (Arizona, California, Georgia, South Carolina, and Tennessee) recently adopted reforms aimed at reducing the costs of physician dispensing (see Appendix A for more detail). The data included are partially post-reform for Arizona, post-reform for California, and pre-reform for Georgia, South Carolina, and Tennessee. Lessons learned from California's post-reform experience are discussed in Chapter 6.

[b] In Massachusetts, New York, and Texas, physician dispensing is not allowed in general.

Key: n/a: not applicable; Rx: prescriptions.

TRENDS IN PRICES PER PILL PAID FOR PHYSICIAN- AND PHARMACY-DISPENSED PRESCRIPTIONS FOR SELECTED STATES[a]: HYDROCODONE-ACETAMINOPHEN (VICODIN®), 2007/2008–2010/2011

	2007/2008	2008/2009	2009/2010	2010/2011	Percentage Change from 2007/2008 to 2010/2011
Illinois					
Physician-dispensed Rx	$0.87	$1.13	$1.35	$1.44	66%
Pharmacy-dispensed Rx	$0.54	$0.55	$0.53	$0.53	-2%
Connecticut					
Physician-dispensed Rx	$0.93	$1.53	$1.47	$1.43	54%
Pharmacy-dispensed Rx	$0.41	$0.41	$0.36	$0.37	-10%
Florida					
Physician-dispensed Rx	$1.08	$1.11	$1.15	$1.08	0%
Pharmacy-dispensed Rx	$0.49	$0.49	$0.43	$0.43	-12%
South Carolina[b]					
Physician-dispensed Rx	$0.80	$1.11	$1.09	$1.20	50%
Pharmacy-dispensed Rx	$0.46	$0.46	$0.43	$0.41	-11%
Georgia[b]					
Physician-dispensed Rx	$0.96	$0.97	$1.11	$1.02	6%
Pharmacy-dispensed Rx	$0.51	$0.51	$0.49	$0.47	-8%
Pennsylvania					
Physician-dispensed Rx	$0.92	$0.78	$1.09	$1.13	23%
Pharmacy-dispensed Rx	$0.39	$0.37	$0.34	$0.35	-10%
Tennessee[b]					
Physician-dispensed Rx	$1.05	$1.01	$1.06	$1.11	6%
Pharmacy-dispensed Rx	$0.53	$0.53	$0.52	$0.52	-2%
Maryland					
Physician-dispensed Rx	$0.83	$1.03	$1.54	$1.48	78%
Pharmacy-dispensed Rx	$0.39	$0.37	$0.38	$0.36	-8%
Wisconsin					
Physician-dispensed Rx	$0.77	$0.86	$0.97	$1.14	48%
Pharmacy-dispensed Rx	$0.46	$0.46	$0.42	$0.41	-11%

Notes: The underlying data include prescriptions for claims with more than seven days of lost time that had prescriptions filled and paid for by a workers' compensation payor over the defined period. 2010/2011 refers to claims with injuries occurring from October 1, 2009, through September 30, 2010, and prescriptions filled through March 31, 2011; similar notation is used for other years.

[a] Included are the states where physicians' share of drug spending grew rapidly or very rapidly (see Table B).

[b] The data included are pre-reform for Georgia, South Carolina, and Tennessee, where the recent reforms were aimed at reducing the prices paid for physician-dispensed prescriptions.

Key: Rx: prescriptions.

DISABILITY AND MEDICAL MANAGEMENT, CONT.

HOSPITAL OUTPATIENT COST INDEX FOR WORKERS' COMPENSATION

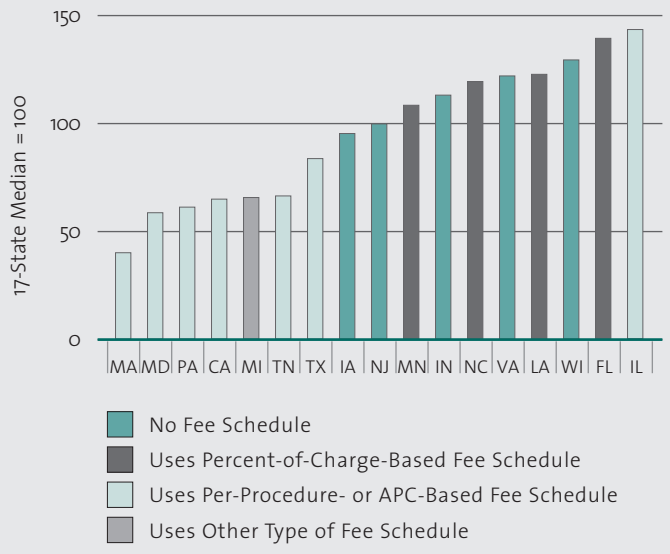
Rising hospital costs have been a concern of public policymakers and system stakeholders and a focus of recent policy debates in many states.

To help policymakers and stakeholders conduct more meaningful comparisons on hospital outpatient costs across states as well as evaluate the impact of reforms over time, this study creates an index for hospital outpatient and/or ambulatory surgical center (ASC) costs for a group of relatively homogeneous surgical episodes that are most commonly used in workers' compensation.

The major findings from this study are as follows:

- Fee schedules based on different approaches shape significant interstate variations in hospital/ASC costs for similar outpatient surgical episodes.
- States with no fee schedule regulation on reimbursement for hospital/ASC services had higher costs compared with states with fee schedules.
- States with fee schedule regulations that were based on percent of charges had higher costs compared with states with other types of fee schedules.
- States with per-procedure-based or ambulatory payment classification (APC)-based fee schedules had relatively lower costs among the 17 study states, except for Illinois.
- After fee schedule changes, growth in hospital outpatient/ASC costs resumed at faster rates in states with fee schedule regulations that were based on percent of charges.

HOSPITAL OUTPATIENT/AMBULATORY SURGICAL CENTER COST INDEX FOR COMMON SURGERIES, 2009



- After the short-term impact of fee schedule adoptions in both Illinois and Tennessee around the same time, the hospital outpatient/ASC costs in Illinois grew faster than in Tennessee in the long run.
- After the short-term cost decrease in both Florida and California due to fee schedule reductions around the same time, the hospital outpatient/ASC costs in Florida resumed at faster rates than in California.

This study includes 17 large states that represent 60 percent of the workers' compensation benefits paid in the U.S. and covers a seven-year period from 2003 to 2009. The states included in the study are California, Florida, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Tennessee, Texas, Virginia, and Wisconsin.

Hospital Outpatient Cost Index for Workers' Compensation. Rui Yang and Olesya Fomenko. January 2012. WC-12-01.

WORKERS' COMPENSATION MEDICAL COST CONTAINMENT: A NATIONAL INVENTORY, 2011

As costs for workers' compensation medical care continue to increase rapidly, the pressure on policymakers and other stakeholders to contain those medical costs also continues to increase.

This detailed report provides a comprehensive understanding of the strategies and regulations authorized and in use in all 51 jurisdictions as of January 2011—a valuable resource for policymakers and others.

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.

No other publication offers the same in-depth description of medical cost containment strategies in such an easy-to-use format. The tables may be purchased separately or as a group.

Workers' Compensation Medical Cost Containment: A National Inventory, 2011. April 2011. WC-11-35.

LONGER-TERM USE OF OPIOIDS

With opioid misuse a top public health problem in the United States, this report examined longer-term use of narcotics in 21 states and how often recommended treatment guidelines for monitoring injured workers with longer-term use were followed by physicians.

The monitoring includes services, such as drug testing and psychological evaluations, which can help prevent opioid misuse by injured workers that could result in overdose deaths, addiction, and diversion. However, the study found relatively low compliance with medical treatment guidelines in most states.

The information provided will help public officials identify means to strengthen the design or implementation of public policies related to narcotic use, and help payors target efforts to better manage the use of narcotics while providing appropriate care to injured workers and reducing unnecessary risks to patients and unnecessary costs to employers.

Among the study's findings:

- Among 2009/2011 claims with longer-term use of narcotics, 18–30 percent received drug testing in most states studied, with the 21-state median at 24 percent. Over the study period, the percentage of injured workers with longer-term use of narcotics who received at least one drug testing increased from 14 to 24 percent in the median state. However, the use of the service was still lower than recommended by treatment guidelines.

USE OF SERVICES RECOMMENDED BY GUIDELINES[a] FOR CHRONIC OPIOID MANAGEMENT, AMONG NONSURGICAL CLAIMS WITH LONGER-TERM USE OF NARCOTICS[b]

	21-State Median	Range for States between 20th and 80th Percentile for Each Measure		Range for All 21 Study States	
		Minimum	Maximum	Minimum	Maximum
% of claims that had urine drug testing					
2007/2009	14%	9%	24%	5%	30%
2009/2011	24%	18%	30%	11%	35%
% of claims that had psychological evaluations					
2007/2009	6%	4%	9%	1%	29%
2009/2011	7%	3%	9%	2%	27%
% of claims that had psychological treatments/reports					
2007/2009	6%	3%	7%	1%	11%
2009/2011	4%	2%	6%	1%	17%
% of claims that had active physical medicine[c]					
2007/2009	88%	85%	92%	57%	96%
2009/2011	90%	88%	92%	59%	98%

Notes: Included are nonsurgical claims with more than seven days of lost time that had prescriptions filled and paid for by a workers' compensation payor over the defined period. 2007/2009 refers to claims with injuries occurring in October 1, 2006, through September 30, 2007, and prescriptions filled through March 31, 2009; similar notation is used for other years.

[a] See Table 2.3 for the definitions of recommended services. Technical Appendix A summarizes the guideline recommendations for chronic opioid management.

[b] We identified the longer-term users of narcotics as those who had narcotics within the first three months after the injury and had three or more visits to fill narcotic prescriptions between the seventh and twelfth months after the injury. See Chapter 2 for more details.

[c] The reader should be cautioned that this measure for Louisiana might be somewhat understated to the extent that the state has some specific coding practices regarding physical therapy.

- The use of psychological evaluation and treatment services continued to be low. Only 4–7 percent of the injured workers with longer-term narcotic use received these services in the median state. Even in the state with the highest use of these services, only 1 in 4 injured workers with longer-term narcotic use had psychological evaluation and 1 in 6 received psychological treatment. Little change was seen in the frequency of use of these services.

The study is based on nearly 300,000 workers' compensation claims and 1.1 million prescriptions associated with those claims from 21 states. The claims represent injuries arising from October 1, 2006, to September 30, 2009, with prescriptions filled up to March 31, 2011. The underlying data reflect an average of 24 months of experience.

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

Longer-Term Use of Opioids. Dongchun Wang, Dean Hashimoto, and Kathryn Mueller. October 2012. WC-12-39.

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.

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

Increasing prices for medical treatment for workers' compensation injuries have been a focus of public policymakers and system stakeholders. To help decision makers evaluate the impact of price-focused policy initiatives and set priorities about system improvement, this study creates an index for prices paid for professional services (i.e., nonhospital, nonfacility services) that are most commonly used in workers' compensation.

The MPI-WC tracks medical prices paid in 25 large states from calendar year 2002 through June 2011 for professional 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.

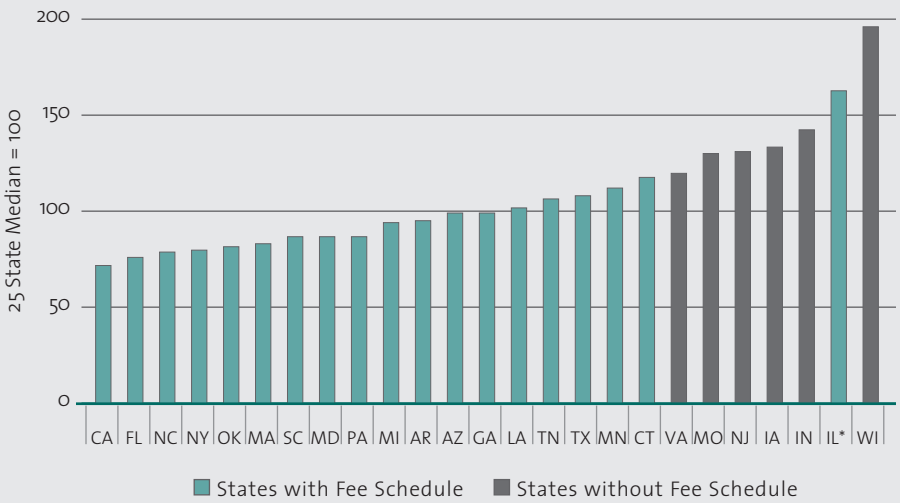
The 25 states included in the MPI-WC, which represent nearly 80 percent of the workers' compensation benefits paid in the United States, are Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.

DISABILITY AND MEDICAL MANAGEMENT, CONT.

The major findings from this study are as follows:

- States with no fee schedule regulations on reimbursement for professional services had higher prices paid and more rapid price growth over time compared with states with fee schedules. For example, the prices paid in Wisconsin, one of the six study states without fee schedules, were the highest of the 25 study states, more than twice the median of the study states with fee schedules. The growth in prices in Wisconsin was the fastest among the 25 study states, rising 50 percent from 2002 to 2011, compared with the median growth rate of 14 percent in the study states with fee schedules.
- Fee schedule changes were an important factor driving changes in actual prices paid. In states that did not have changes in their fee schedules for a while, prices paid remained fairly stable. For example, the fee schedule rates in North Carolina did not have any material change during the study period. The prices paid in that state remained stable from 2002 to 2011, with an overall increase of less than 3 percent.
- In states with fee schedule reforms, changes in the actual prices paid reflected the impact of the policy changes. For example, Texas underwent several fee schedule changes during the study period. One particular change in March 2008 increased the fee schedule rates for most professional services, including a large increase of about 40 percent for surgeries. As a result, the prices paid for surgeries increased nearly 40 percent from 2007 to 2009, tracking the fee schedule change closely.
- In states with certain types of services not covered by their fee schedules, often the growth in prices paid for those services was more rapid than for the services covered by the fee schedules. For example, in Louisiana, the prices paid for most types of medical services remained fairly stable from 2002 to 2011, as the fee schedule rates did not change during the period. However, the prices paid for pain management injections grew rapidly, about 60 percent. This was because many pain management injections were not regulated by fee schedule rates; instead they were determined under a *by report* method, which was based on factors such as payors' specific prevailing charges data, documentation submitted by medical providers, etc.

INTERSTATE COMPARISONS OF PRICE INDEX FOR PROFESSIONAL SERVICES, 2011[p]



[p] **Special notation:** We use the notation *p* to indicate that the 2011 numbers are preliminary results based on half-year price data through June 30, 2011.

* In September 2011, Illinois enacted a new legislation that introduced a 30 percent decrease in the fee schedule rates. The results in this report do not reflect that change.

WCRI Medical Price Index for Workers' Compensation, Fourth Edition (MPI-WC). Rui Yang and Olesya Fomenko. March 2012. WC-12-20.

COMPSCOPE™ BENCHMARKS, 13TH EDITION

The impact of the recession, legislative and regulatory reforms, and the growing costs of medical care on workers' compensation system performance are among the key developments addressed in this edition of CompScope™ Benchmarks.

The studies show how the performance of a state system compares with those of other states and how workers' compensation system performance changes over time. The reports are designed to help policymakers and others benchmark state system performance. The benchmarks also provide an excellent baseline for tracking the effectiveness of policy changes and identifying important trends.

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

Sample of major findings:

- Texas: Total costs per claim in Texas declined 4 percent in 2010 for claims at an average 12 months of experience. Costs per claim declined or were stable in many of the study states in 2010, but Texas decreased more than most states. The three main components of total costs—medical, indemnity, and expenses—contributed to that decline to varying degrees. Indemnity benefits accounted for slightly over half of the decrease in costs per claim, driven by a drop in duration of temporary disability. Medical and benefit delivery expenses contributed equally to the remainder of the decrease.
- Virginia: Costs per claim in Virginia grew 8 percent per year from 2005 to 2010 (claims evaluated as of 2011), including 2009 to 2010. By contrast, most study states showed little change or decreases in costs per claim from 2009 to 2010. Medical payments per claim were higher and growing faster in Virginia than in most of the 16 study states, accounting for nearly three-fourths of the increase in costs per claim from 2005 to 2010. Higher and growing prices mainly drove medical costs in Virginia.
- Massachusetts: Using data for injuries arising in 2010 and evaluated as of the first quarter of 2011, total costs per claim with more than seven days of lost time in Massachusetts decreased 6 percent. This reverses the trend during the early years of the Great Recession from 2007 to 2009, when total costs per claim rose, on average, 10 percent per year. The change prior to and after 2010 was driven mostly by indemnity benefits per claim; indemnity benefits were the largest component in total payments in Massachusetts. In 2010/2011, Massachusetts had the largest decrease in total costs per claim of all study states, in most of which the costs per claim remained about the same as in 2009/2010.
- New Jersey: Medical payments per claim represented the largest share of overall claim costs in New Jersey and were the main driver of the overall growth during the study period. In 2010/2011, medical payments per claim with more than seven days of lost time increased 10 percent in New Jersey, faster than in most other study

states, most of which had little change in medical payments per claim. The next edition of CompScope™ Medical Benchmarks will provide additional insight into how potential changes in the utilization of nonhospital services, and/or changes in hospital payments per claim, may have played a role in the recent growth in medical payments per claim.

The reports present 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; and defense attorney involvement and duration of temporary disability.

CompScope™ Benchmarks, 13th Edition. Sharon E. Belton, Evelina Radeva, Bogdan Savych, and Carol A. Telles. October 2012. WC-12-25 to 37

COMPSCOPE™ MEDICAL BENCHMARKS, 12TH EDITION

Rapid escalation in workers' compensation medical costs is a major driver of the overall increase in workers' compensation costs. For policymakers and stakeholders contending with this rapid growth, understanding the flow of payments—to whom and for what services—is essential.

CompScope™ Medical Benchmarks are indispensable for identifying where changes in treatment patterns may be occurring, where medical payments per claim or utilization may be atypical compared with other study states, or where, because of underutilization of medical services, there may be concerns about restrictions on access to care.

This report examines sixteen states (California, Florida, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Texas, Virginia, and Wisconsin), providing detailed measures of medical prices, payments, and utilization by provider type and service group. There are individual state reports for all states except Indiana and Iowa.

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:

- California: Medical payments per claim in California showed rapid growth of about 8 percent per year from 2005 to 2009 for claims with more than seven days of lost time. This followed a large decrease of about 30 percent from 2002 to 2005 resulting from the comprehensive reforms in the workers' compensation system.

- Illinois: Based on 2009 claims with experience as of March 2010, Illinois had, on average, 41 percent higher medical payments per claim than the median of the 16 states included in this analysis.
- Louisiana: Medical payments per claim grew 12 percent per year in Louisiana from 2007 to 2009. This rate of growth was fastest among the study states and faster than in the three previous years for Louisiana. Hospital payments per claim (especially hospital payments per inpatient episode) were the main driver of the recent growth in medical payments per claim.
- Texas: Earlier WCRI studies found that the higher medical costs per claim in pre-reform Texas were driven mainly by higher utilization of medical services by nonhospital providers—a major focus of HB 2600 and HB 7. As a result of the reforms, along with increased payor attention and effort on managing medical care, utilization of services decreased significantly in Texas.

CompScope™ Medical Benchmarks, 12th Edition. Sharon E. Belton, Evelina Radeva, Bogdan Savych, Carol A. Telles, and Rui Yang. May 2012. WC-12-02 to 15.

WHY SURGEON OWNERS OF AMBULATORY SURGICAL CENTERS DO MORE SURGERY THAN NON-OWNERS

The last two decades have seen substantial growth in the use of ambulatory surgical centers (ASC) and the number of physicians who have ownership interests in these centers. In Florida, this study found that orthopedic surgeons who owned ASCs did between 52 percent and 111 percent more surgery than orthopedic surgeons who were not owners.

To help policymakers and other stakeholders better understand the relationship between ASCs and surgeons, WCRI looked at several factors that contributed to owners doing more surgery, including financial incentives, previous surgery volume prior to ownership, and the ability to do more surgery in an ASC relative to a hospital.

The study examined 941 orthopedic surgeons—some of whom ultimately became owners of surgery centers—and compared the number of knee, shoulder, and wrist surgeries that each surgeon did before becoming an owner with the number performed after becoming an owner.

Sample of major findings:

- The average surgeon owner did substantially more knee, shoulder, and wrist arthroscopies and carpal tunnel release (KSWC) surgeries than the average non-owner. That difference ranged from an average of 44 to 103 surgeries annually.
- When surgeons increased their use of ASCs and reduced their use of hospital outpatient departments (HOPDs), they experienced an increase in efficiency that allowed them to do more surgeries. If the average surgeon shifted 10 percent of his or her surgery volume from HOPDs to ASCs, he or she would be able to do 1.3 to 3.5 percent more surgery.

OTHER STUDIES BY WCRI, CONT.

- The financial incentives from owning an ASC led surgeon owners to do more KSWC surgeries per year than they would have done had they not become owners. They increased their surgery volumes by 14 to 22 percent due to the financial incentives, or 15 to 25 surgeries per year for the average surgeon who became an owner (compared with the number of surgeries that each of these surgeons performed prior to becoming an owner).
- When surgeons changed the number of facilities at which they performed surgeries (the size of their network), they may have changed their capacity to do more surgery or expanded the geographic range of their patient population, impacting the number of patients seen. We found that an addition of one facility to a surgeon's network was associated with an 11 to 12 percent increase in KSWC surgeries per year.
- During the study period, both medical technology and market phenomena changed substantially. There were improvements to scope technology, increasing availability of ASCs, changes in patient preferences for less invasive surgeries, and changes in prices paid for these surgeries. Due to these technology and market trends, by 2004, the average surgeon did 46 to 54 percent more KSWC surgeries per year than in 1997.

Why Surgeon Owners of Ambulatory Surgical Centers Do More Surgery Than Non-Owners. Christine A. Yee. May 2012. WC-12-17.

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

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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 THE IMPACT OF THE 2007 REFORMS IN NEW YORK

This is the fifth annual report by the Workers Compensation Research Institute (WCRI), after the implementation of the statutory changes in New York, to regularly assess the performance of the workers' compensation system. This regular monitoring provides a foundation for evaluating the effect of the statutory changes to determine whether the changes were successful in their goals and to identify if any unintended consequences were observed.

Sample findings:

- Increase in Statutory Benefit Maximum: The maximum weekly benefit rose from $400 prior to July 1, 2007; to $500 on July 1, 2007; to $550 on July 1, 2008; and to $600 on July 1, 2009—a total increase of 50 percent. Not surprisingly, we found that the average weekly temporary total disability benefit increased 26 percent after the implementation of the three increases in the statutory benefit maximum.
- Duration Limits on Permanent Partial Disability (PPD) Benefits: From 2007/2008 to 2009/2010, for PPD/lump-sum cases at an average 12 months of experience, there was a 13.5 percentage point decrease in cases that received PPD payments only (with no lump-sum payment) and a 12-point increase in cases with a lump-sum settlement only (with no PPD payments).
- Pharmacy Fee Schedule: The implementation and subsequent change of the pharmaceutical fee schedule had the effect of decreasing the average price per pill 10–20 percent, depending on the drug and dosage. The initial fee schedule tied to Medicaid decreased the average price per pill, and the subsequent change increased the average price per pill slightly, but not to the previous levels.
- Diagnostic Testing: From 2007/2008 to 2009/2010, we observed a 4 percent increase in the number of visits for major radiology services by nonhospital providers. The percentage of indemnity claims with major radiology services also grew over that same period, from 45 percent to nearly 50 percent.
- "Rocket Docket": Defense attorney involvement increased from 2005 through 2007, but then fell by 4 percentage points by 2009, driven by cases with defense attorney payments of less than or equal to $500. There was moderate growth in the average defense attorney payment per claim from 2005 to 2007. However, from 2007 to 2009, the average defense attorney payment per claim grew 20 percent per year, mostly in cases with defense attorney payments greater than $500.

WCRI's Detailed Benchmark/Evaluation (DBE) database was used in the study. Analyses were performed using open and closed indemnity and medical-only claims with a date of injury from October 2003 through September 2009, with experience as of March 2010. The data are representative of the New York system, including private insurers, self-insured employers, and the state insurance fund.

Monitoring the Impact of the 2007 Reforms in New York. Carol A. Telles and Ramona P. Tanabe. October 2012. WC-12-22.

RECESSION, FEAR OF JOB LOSS, AND RETURN TO WORK

Recessions typically mean fewer job opportunities and a greater likelihood that an injured worker will not be able to find suitable return-to-work employment. In a particularly severe recession, therefore, we might expect that a larger number of injured workers will suffer longer-term unemployment.

Despite the severity of the current recession, which began in December 2007 and is deeper and longer than past recessions, this study suggests that some injured workers may speed up their efforts to return to work when they are concerned about their job security.

The study reported that if a recession is sufficiently serious that it generates an especially high level of fear of job loss, workers may behave differently by engaging in more aggressive efforts to return to work, offsetting a portion of the traditional negative effects of recessions on return-to-work outcomes of injured workers.

By connecting local economic opportunities, workers' concerns about job security, and the workers' return-to-work outcomes, this study provides a framework for predicting return-to-work outcomes when the unemployment rate rises and the fear of job loss is magnified.

The report may be useful to those who are trying to predict the impact of the current recession on return-to-work interventions and outcomes, as well as on workers' compensation claims and costs—especially for income benefits. It may also be relevant for predicting the impact of an economic recovery. As the economy strengthens and the unemployment rate falls, there will be more job opportunities, less fear of job loss, and perhaps less aggressive efforts by injured workers to seek reemployment.

Key findings:

- Workers who are afraid of being fired are less likely to become longer-term unemployed after an injury. These workers may be more aggressive in seeking return-to-work opportunities, making an extra effort to return to work earlier or to take steps to increase their chances that their job will exist after return to work.

- Injured workers in areas with unemployment rates that are rising or that are higher than normal for the area are more likely to fear losing their jobs. The greater the fear, the more likely it is that workers will more actively pursue returning to work, thus reducing the number of workers that experience longer-term unemployment.

Recession, Fear of Job Loss, and Return to Work. Richard A. Victor and Bogdan Savych. April 2010. WC-10-03.

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.

Workers' Compensation Laws as of January 2012. Ramona P. Tanabe. March 2012. WC-12-18.

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