WORKERS' COMPENSATION REFORM IN ALASKA: SIX KEY REFORMS

WCCA COST CONTAINMENT COMMITTEE

22 JULY 2004

PREFACE

The mission of the Workers' Compensation Committee of Alaska (WCCA) is to ensure the quick, efficient, fair and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the Alaska Workers' Compensation Act. WCCA believes that the workers' compensation laws must not be construed by the courts in favor of any party and the cases be decided on their merits.

The intent of this paper is to explore solutions to improve the Alaska Workers' Compensation system. The issues and views expressed herein do not constitute a final position statement of the Workers' Compensation Committee of Alaska (WCCA), or any of its members.

The WCCA endorses a "collective solutions-based approach" to bring about changes in the Workers' Compensation system. We recommend that this paper be used as a springboard to spur discussion among all stakeholders involved, including physician/health care provider groups, labor unions/employees, the insurance industry, chambers of commerce, political leaders, lawyers, government departments, and all public/private employers. Whenever an organization makes an effort to develop solutions to such complex social issues, it is too easy for those passionately involved to sit back and become vocal critics, while it takes true effort develop better solutions.

Extensive effort was made to verify and document the sources of the contained data and statistics, while discussing them within proper context. We would appreciate it if you would contact us in the event you find any data that does not match the referenced sources, or if you find additional relevant research to add. No monetary support was received to develop this report, and the time and effort was voluntary.

Thank you to all who provide effort to make this system work, and to all who make an effort to improve it.

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I. INTRODUCTION

Workers' compensation should provide injured workers with reasonable and cost-effective health care, lost wage reimbursement when necessary, and promote a rapid return to work.

But it does not. The workers' compensation system in Alaska is inherently flawed.

In fact, Governor Frank H. Murkowski has called the current workers' compensation system a "crisis."

It is that and more.

Although it is not federally mandated, all 50 states have workers' compensation systems (hereafter WC). Because each state has its own WC system, workers' compensation systems vary from state to state. Over the years, several states have been experimenting with a variety of cost-effective methods to deliver WC benefits efficiently. Those effective state experiments should be emulated and integrated into Alaska's WC system.

The basic idea of WC is that employers will pay the cost of workplace injuries. They will pay the medical costs (medical) for injured workers, and they will pay workers for a portion of lost income (indemnity). They may also provide compensation for permanent injuries separately from income loss (permanent partial or total impairment).

The WC system is mutually beneficial for employee and employer – and it gives both incentives for supporting such a system. The WC system guarantees employees compensation for medical costs and lost income when injured at work. For employers, WC reduces litigation costs and removes the uncertainty associated with a tort system (personal injury) liability.

A BASIC REVIEW OF ALASKA'S WC SYSTEM

When an employee is injured on the job, the incident is reported to the supervisor. In Alaska, the injured employee chooses which medical provider to see. Together the provider and patient decide the level of disability and the course of treatment. In Alaska, unlike other states, Alaskan doctors do not consult medical guidelines, which would detail appropriate diagnosis, treatment, and reasonable work restrictions for an injury. Alaska regulations have very few restrictions regarding medical treatment or associated costs; the medical tests and treatment are left to the prerogative of the doctor and patient. Next, an insurance adjuster examines the employee's medical care documentation to determine whether WC insurance regulations apply to the reported injury. If the insurance administer believes that the medical treatment prescribed by the doctor is inappropriate or falls outside the

regulations, they may request that the employee see a company-selected doctor (Employer Independent Medical Evaluation) for a second opinion. When both doctors concur, insurance obviously pays the medical bills, but when the second doctor offers a dissenting opinion, then the insurer has the option to controvert a claim. When the claim is challenged, the employee can appeal to the Alaska Workers' Compensation Board for a hearing. When a company disputes a claim, Title 23 of Alaska state law, the Labor and Workers' Compensation, provides for a board – the Alaska Workers' Compensation Board – that adjudicates claims between employee and employer. The Alaska Workers' Compensation Board may order a third opinion (Second Independent Medical Evaluation), where a third physician would then see the injured employee. Following that examination, the Alaska Workers' Compensation Board weighs the evidence of the three doctors and determines if the employee receives the disputed compensation for the work-related injury. The board is not compelled to follow the opinion of its own SIME physician, but it must weigh all available evidence in rendering its decision. The resulting decision is based on "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."

A State Comparison

Unlike most other health benefit systems, the workers' compensation system in Alaska has minimal system efficiencies including little or no quality control, no utilization guidelines, no group purchasing power, and essentially no effective cost controls.

In Alaska, we have very little control over the utilization of health care services in the workers' compensation system. In fact, court decisions have accepted unproven, highly questionable, or excessive medical treatments beyond the scope of what is acceptable in other health benefit systems. But our state law allows for it.

Over the past thirty years, safe work practices have been implemented and are continually improving. As a direct result, industrial injury rates have significantly dropped over time. Meanwhile, according to the NCCI, the average workers' compensation claim in Alaska was about $38,000 per claim in 2002. The associated medical expenditures were about 55 percent of the total cost. We see an inverse relationship – as injury rates decline, the average severity of claims continues to grow. According to the Alaska Economic Trends June 2004 report, the consumer price index for medical care has steadily risen since the mid-90s. Over the past ten years, the cost of medical care in the United States has soared, increasing about 53 percent and 63 percent in Anchorage. According to a 2001 report by the Division of Medical Assistance, medical care costs are 25.3 percent higher in Alaska than the U.S. on average. The NCCI data indicates that in Alaska, physician fees account for the largest portion of WC medical expenditures (roughly 50 percent), while on a national basis the medical expenditures are about equally split between physicians, hospitals and "other". Although the escalating cost of medical care accounts in part for WC expenditures, it is the *utilization* of

health care services that drives overall expenditures. The solution isn't simply to cut physicians fees, but rather to reasonably direct the utilization of services.

Other state systems deftly manage the utilization issue by adopting medical treatment guidelines for the diagnosis, evaluation, and management of injured workers. Educating and requiring physicians to follow treatment guidelines may assist injured workers in receiving cost-effective yet high quality care. Our system should, of course, discourage health care decisions based primarily on cash-generating schemes or unproven treatment methods.

Workers' compensation costs are one area of expense that significantly affects the bottom line of business in Alaska. Workers' compensation insurance premiums rose more than twenty percent statewide in 2004. While medical and indemnity expenditures are not the only reason for this increase, the rates must be set to help cover the expenses. According to the NASI, the number of Alaskan workers covered by WC insurance from 1997 to 2001 increased by 9 percent, while the benefits paid out increased by 33.7 percent. One method to take into account both the number of workers and prevailing wage levels in the state is to divide total benefits by total wages of covered workers. This method shows if a large increase in benefits paid is due to growth in the state's population of covered workers and covered payroll, rather than benefit increases alone. The NASI reported that from 2000 to 2001 alone, Alaska WC benefits rose by 17.4 percent, while the benefits per $100 of wages rose from $1.65 to $1.82, which is a 10.3 percent increase in a single year. This indicates that Alaskan WC benefit increases are not only due to increased wages or increased employment. Despite experiencing decreased injury rates, either the injuries sustained by workers are becoming more severe, or the methods to provide care are becoming more costly and/or less effective for recovery. Alaska is the third highest state nationwide in the amount of WC benefits paid per $100 of wages earned, and has highest rate of increases relative to wages for the last four years.

These costs will significantly impact not only private industry, but also local and state government agencies as well, for they too pay higher labor rates as the WC costs rise. As a result, the cost of Alaskan labor, Alaskan products and Alaskan government will go up, which increases consumer cost and our ability to compete in national and international markets.

When compared to both the national average, and a western regional average, Alaska has one of the highest workers' compensation packages. The NCCI places Alaska in a "western NAIC zone" with Montana, New Mexico, Arizona, and Oregon. According to the NCCI data, the most dramatic differences are found in regards to Permanent Partial Impairment cases (PPI). PPI is defined as a "case of impairment partial in character but permanent in quality, and not resulting in Permanent Total Disability." An example of this would be the permanent loss of function (based on AMA disability guidelines) that an injured worker has after recovery from a shoulder surgery. In Alaska, such cases account for the majority of the total costs. The NCCI data indicates a total average cost of PPI per

100,000 employed workers is $78 million in Alaska, $26 million nationally, and $26 million in the western region.

But workers' compensation reform isn't merely a discussion of job-related injuries; reforming the workers' compensation in Alaska would significantly decrease the cost of doing business. If we want businesses in Alaska to develop and further expand, then labor costs must be affordable and controllable.

We reviewed several options for medical cost containment that can be found in other worker's compensation and health benefit systems nationwide. If adopted, our six key reforms would greatly reduce Alaska's WC medical and indemnity costs and nurture a greater focus on high quality and cost effective medical treatment.

The WCCA Medical Cost Containment Subcommittee recommends that the legislature enact the following changes: (1) establish a Director of Workers' Compensation who would then employ a (2) Medical Policy Unit that would then develop (3) Medical Treatment Guidelines for the care that injured workers receive. Nationally, prescription drugs account for about 9.6% of total medical expenditures in workers' compensation; however, it is both the costs and the utilization that has driven these expenditures upward. Developing evidence-based medical guidelines and (4) fair price setting for prescription drugs will ultimately lower the impacts of prescription drug expenditures. (5) Employer Choice – allows the employer rather than the employee to choose the physician. And finally, the State should devote much-needed attention to a (6) Return to Work program, looking to Oregon and Texas as models. Oregon's Return to Work programs ensure that injured employees return to work as soon as possible and gives employers incentives to bring back injured workers.

II. POLICY RECOMMENDATIONS

A. ESTABLISH DIRECTOR OF WORKERS' COMPENSATION

AS23.30.005 (h) and (i): The Alaska Workers' Compensation Act states that the Department of Workers' Compensation (hereafter department) may adopt regulations concerning the medical care provided for in this chapter and are only effective after approval by a majority of the full board.

However, the department has yet to put forth suggestions for containing medical costs for the board to consider and vote on. The board only meets at an annual meeting, with little time spent assisting the department in developing solutions to ongoing issues. Currently, the chairman and executive officer of the board is the Commissioner (or a designated representative).

Reform legislation should designate the Director as the chairman of the board – as currently practiced – and should also outline clear functions and responsibilities of the Director.

This solution would enable the Director to have power to adopt changes to the administration of worker's compensation, to include the development of a Medical Policy Unit.

One key responsibility of the Director should also include the ability to commit necessary resources for research and annual report development. The current annual report method contains many inconsistencies and unclear reporting formats. With annual expenditures now exceeding $210 million, one would think that adequate resources could be allocated to learn where the money goes, so that system inefficiencies can be administered more effectively.

B. MEDICAL POLICY UNIT

The Medical Policy Unit may include hiring (part or full-time) a Medical Director, an epidemiologist, and an administrative assistant to develop necessary medical programs or administrative rules. Due to the extensive nature of the task to develop a system with cost containment programs such as medical treatment guidelines (implement, provide training regarding, and continually update), the WCCA Subcommittee believes that these services would best be performed and maintained by hiring a medical professional, who works for the Director. One of the core responsibilities of the medical director should involve coordinating training programs for area health care providers on the utilization of medical treatment and return to work guidelines. A rough budget estimate of cost for a Medical Policy Unit is $400,000, based upon a similar undertaking in Colorado. But a Medical Policy Unit is well worth the initial cost. According to studies from other states, implementing scientific evidence-based medical practices yielded a 15-20% system savings. A mere 5% savings would result in a $10.5 million reduction for our system.

C. MEDICAL TREATMENT GUIDELINES

Workers' compensation medical treatment guidelines would ensure that our injured workers receive high quality, cost effective medical care. There are two basic methods other states have used to obtain medical treatment guidelines.

The first method – a method employed by both Colorado and Washington – coordinated input and development assistance from local medical providers. This method ensured "buy-in" from area physicians, who now have "ownership" in the guideline selection and development. Without detailing

the entire development process here, suffice it to say that the process has been quite effective.

The drawback to the Colorado method is its labor-intensive nature. It requires a full-time medical professional to coordinate the program with the ongoing assistance of an epidemiologist to assist in research and literature review, which must be continually updated. The current Colorado guideline was slowly and methodically developed over the last 8-10 years. Several other states have recently dropped their state-based treatment guidelines in favor of nationally accepted evidence-based standards, such as the ACOEM, ODG, or AHRQ guidelines.

The second example comes from California's method of implementing medical treatment guidelines. California recently adopted the ACOEM's "Occupational Medicine Practice Guidelines." These guidelines were developed by a team of nationally recognized occupational medicine specialists, with input and review from a wide array of national medical specialist organizations. It is a well-written text containing valuable information pertaining to, among other things, return to work principles, disability duration guidelines, causality assessment, and specific treatment guidelines for common occupational injuries.

But the California method, too, is not without its disadvantages. The guidelines may not be updated frequently enough to address rapidly developing medical research or new treatment modalities. Local medical providers may also lack the "buy in" required to ensure proper utilization, since they had no involvement in the process of constructing the guidelines.

We recommend a hybrid of the methods, with legislative wording or a program that utilizes the ACOEM, ODG, or AHRQ guidelines as "presumably correct on the proper diagnosis and treatment of work-related injuries", which provides Alaska with a definition of "reasonable and necessary" medical treatment. Meanwhile, the Medical Policy Unit could work to address more specific or unique medical treatment issues with the input of local health care providers, which would then supplement the guidelines.

D. PRESCRIPTION DRUGS

Data from the National Council on Compensation Insurance indicates that prescription drug expenditures are rapidly increasing in the workers' compensation benefit system. The workers' compensation system pays more for the same drugs than even the private insurances sector. It has been long established that prescription drug costs are a significant cost driver in every medical benefit system, including Medicare, Medicaid, the VA, TRICARE, Native Health, and private health care benefit systems. These health benefit systems, however, have cost containment, including "drug formularies," "group purchase" plans, "cost sharing" incentives, and "utilization review,"

unlike WC. According to the NCCI, Workers' compensation systems pay roughly 125% of the Average Wholesale Price (AWP) of prescription drugs; Group Health (GH) only pays 72%. Therefore, WC paid 74% more than GH for the identical drugs. Following evidence-based medical treatment guidelines can reduce the over-utilization of expensive name-brand prescriptions. Once again, a dedicated Medical Policy Unit could address prescription drug usage patterns and expenditures. Specific guidelines could be adopted such as the appropriate use of pain medications, generic equivalents, and over the counter options when clinically indicated. Prescription drug costs could be immediately impacted by adopting a revised fee schedule of maximum allowable reimbursement above the Average Wholesale Price. Texas currently utilizes a formula of 1.09 X AWP + $4.00 (fill fee) to set reasonable rates. Alaska should evaluate this further with a focus on ensuring accessibility to pharmacy drugs while paying a more reasonable price.

E. EMPLOYER CHOICE

Approximately 40 percent of the fifty states – excluding Alaska – have "employer choice" systems whereby employers select the physician that the injured worker sees for the work-related injury. In an employer choice system, the employer selects the doctor or allows their employee to select from a list of doctors. Employer choice results in lower medical costs. In fact, the Workers' Compensation Research Institute estimates that changing a state's system from employee choice to employer choice would reduce medical costs by 7 to 10 percent.

Several states including Colorado, California, and Washington have adopted "employer choice" systems; this system ensures high quality and cost-effective delivery of health care to injured workers and reduces the cost of workers' compensation claims. **Sending employees to medical providers that will accept and receive training in using the adopted guidelines is the most efficacious way to ensure that such guidelines are followed.** Medical treatment guidelines are only a best practice guide to assist medical providers in evidence-based medical decision-making. Authors of the guidelines expect that approximately 5-10% of patients will require treatment other than what is found in such a framework; **in those rare situations, we should defer to the expertise of the physician.**

Several versions of "employer physician choice" do exist, and should be further evaluated. Further discussion is necessary on such issues as the employee's request for changing physicians, qualifications of selected physicians, and factors limiting such choices in remote areas. Legislative incentives for "employer choice" exist in some states. Only the self-insured can direct physician choice in Washington State, for example. In others, only employers that offer personal health care coverage can direct physician choice.

The government and public have been seeking solutions for the lack of basic private health care coverage, particularly for our workforce. One idea could be to allow more control of our workers' compensation expenditures, so more businesses can afford basic private health care premiums. Building reasonable and cost effective incentives is a goal worth exploring.

Another method to ensure medical guideline usage is to enact a method of medical arbitration review process, or utilization review, which is how other health benefit systems address these challenges. The Washington WC system has had success with a utilization review process based on adopted medical treatment guidelines. This method may not be the best solution for Alaska because of administrative costs, economy of scale (system size), or the potential to drive our already few medical providers away from delivering workers' compensation care. This method may be less speedy and efficient than simply trusting the employer-chosen physician to make high quality and cost-effective treatment decisions. Further research would be necessary for support of a medical arbitration method or utilization review system to serve Alaska's unique health care system. The goal should be to seek quality health care decisions from the start, and avoid the complex issues involving delay of care while "authorization is approved" or denial of medical fees after the treatment is delivered.

F. RETURN TO WORK PROGRAM

I. Provide an Internet example program for employers to utilize and consider cost incentives (on premiums) for employers who adopt such programs. The current Vocational Rehab unit, or the aforementioned Medical Policy Unit, has the capacity to develop this necessary resource. Many other states, such as Texas, have this resource readily available.

II. System incentives are needed to ensure that employers support return to work initiatives; conversely, employee incentives are also necessary to encourage the goal of returning to work. In order to keep work performance expectations high and easy to manage, some employers currently follow the adage "full duty or no duty." This practice prevents or delays an early return to work, which consequently places the employee at greater risk for a poor functional recovery. Some employers (also physicians and employees) are hesitant for an employee to return to work because they fear re-injury, while other employers cannot afford, are not willing, or do not know how to make reasonable modifications to the work environment. We recommend a detailed examination of Oregon's Preferred Worker and Employer-at-Injury programs.

The Preferred Worker Program (PWP) provides permanently impaired injured workers with a package of employment incentives in an effort to persuade employers to hire them. The Employer-at-Injury Program

(EAIP) encourages early return to work by providing financial incentives for employers to bring their injured workers back to the workplace for light duty work. Oregon has experienced a significant decline in Voc Rehab costs after adopting this system.

III. Replace or augment the Second Injury Fund and Voc Rehab Plan with the above.

Our current vocational rehabilitation simply needs massive reform to ensure a return on investment. What is the measure of success in vocational rehabilitation? Is the program producing the desired results? Do we have the necessary data to know? The incentive for participation is often based on increased wage support while enrolled, but the state data clearly shows poor outcomes in all but a small handful of cases. Employees often later re-engage in the same workplace activities from which they were once medically restricted. This raises the question of why vocational rehabilitation was necessary based upon a perceived permanent disability. The outcome of following the above listed recommendations should result in lower rates of overall disability. The medical providers will be chosen based on their effectiveness to provide high quality, cost-effective care, while supporting a safe and early return to work. The shared goal should be a maximum improvement of functional ability and return to the pre-injury workplace activities with or without temporary or permanent workplace accommodations.

In an effort to reduce the monetary motive for application in Voc Rehab, the designated benefits could be set aside and placed in a fund for a period of time (five years?), and given out (quarterly?) only if the employee is actively participating, and only if the health condition has no further sign of significant improvement. This "fund approach" would allow a better method of tracking the success or failure of Voc Rehab. This would also provide some allowable time frame for the employee utilizing the benefit in the event of extraneous life factors that may prevent active participation. No more "extensions." If the benefit is not utilized, or only partially utilized during this set period of time, a refund of the remaining amount should be returned to the employer. Not allowing individuals to "cash out" with the Voc Rehab benefits should be considered. The purpose of such a benefit is to provide vocational skills training for gainful employment, not a monetary cash incentive to serve any other purpose.

Based on the limited data available from DWC annual report, 457 employees were found eligible for Voc Rehab benefits, 431 engaged in plan activity, 119 of those resolved the claim by settlement in 2002. Of the employees who did not settle, 28 completed the Voc Rehab plan. Based on available survey results, 7 reported return to work in the plan goal, 3 reported return to work in "other goal", and the remainder either

did not return to work or could not be found for survey. We also know of 6 employees that settled for the benefits but completed the plan and returned to work. So in effect, out of 457 eligible employees and $15.7 million spent for Voc Rehab, we know of 13 that actually completed the program and returned to work in that new occupation as intended.

There simply should be no further delay to reform this faulty Voc Rehab system. A new system must be based on the efficiencies and successes experienced by other states.

III. CONCLUSION

The workers' compensation system in Alaska has rightly been called a crisis. It is a crisis that afflicts more than just labor relations between employee and employer. Although multifaceted and complex, workers' compensation has a significant impact on the cost of doing business in Alaska. Alaska has some of the highest claims costs for injured workers among the fifty states, and has the highest rate of benefit increases. Clearly, businesses will find other states, including "outside" contract labor, with less taxing business climates if we continue to leave our workers' compensation system unreformed.

Medical prices nation-wide have dramatically increased, but they do not account for the entire upward trend in workers' compensation expenditures. While medical costs have driven the expenditures up, it is the over-utilization of medical care that is ultimately responsible for one of the most expensive workers' compensation systems in the nation.

Although woefully complex, six key reforms would easily curb costs in the state of Alaska. Firstly, the legislature should establish a Director of Workers' Compensation to, secondly, develop a Medical Policy Unit, which would be comprised of a Medical Director, an epidemiologist, and an administrative assistant. Central to containing costs, the Medical Policy Unit would develop and establish medical treatment guidelines that guide doctors on appropriate treatment for occupational injuries. By implementing a Medical Policy Unit and medical treatment guidelines, other states have saved as much as 15-20% in workers' compensation claims. The cost of prescription drugs has exponentially increased and has been another prime expenditure driver in workers' compensation claims. Again, the costs have increased, but it is the over-utilization of prescription drugs that is responsible. Cost controls can be established by setting prices based on a fair percentage above the Average Wholesale cost. Medical treatment guidelines would outline the appropriate medicines when indicated, thereby effectively containing the expenditures on prescription drugs. Fifthly, the legislature should enact Employer Choice. Under Employer Choice, an injured worker sees an industry-selected doctor. The state of Alaska currently allows the injured worker to pick their physician for consultation. Employer Choice has shown to eliminate unnecessary costs in workers' compensation systems. And finally, the legislature

must reform the Vocational Rehab regulations. The state of Oregon has effectively reformed Oregon's Return to Work laws by giving employers incentives to bring back injured workers; their reforms also encourage injured workers to return to work as soon as possible.

The care of injured workers is not any more or less important than military veterans (VA), military families (TRICARE), the poor (Medicaid), seniors (Medicare), indigenous people (ANH), or others covered under private health insurance programs. Each and every one of these programs have adopted similar system efficiencies and cost containment strategies. Alaska workers' compensation can adopt system efficiencies, while maintaining the spirit of a "no-fault" system.

The legislature has the power to reform this crisis. Reforming the workers' compensation system will reap rich rewards for both employees and employers; the six key reforms that we've outlined will dramatically reduce costs for businesses, which include state and local government employers.

Reforming Alaska's workers' compensation system is necessary to ensure further business growth and development in the great state of Alaska.

APPENDIX A

Options for medical cost containment, that may or may not be suited for Alaska, but have had an immediate impact in other states:

Medical fee schedule changes (Cost Control)

- Medicare fee basis (125%?) vs. current 90th Percentile Fee Schedule
- Further research needed due to recent increased AK Medicare fee change

Benefits:

- Immediate impact on medical cost
- Medicare provides built-in cost multipliers for individual practice variables

Drawbacks:

- Studies show physician response is to increase utilization
- Studies show negative impacts on physician participation
- May provide another barrier to care in Alaska's challenged health care system

Limiting compensability

- Pre-existing conditions
- Age related health changes such as arthritis
- Cumulative trauma disorders

Stricter evidentiary requirements

Stricter rules for permanent disability benefits

Discouraging fraudulent claims

ANNOTATED BIBLIOGRAPHY

STATISTICAL REFERENCE DATA

Note: Some studies provide data regarding multiple categories.

Alaska Workers' Compensation 2002 Annual Report

Alaska Department of Labor Statistics

Are Medical Care Costs Higher? Division of Medical Assistance, Health Care Project, November 27, 2001

Fried, Neal, and Dan Robinson. *The Cost of Living in Alaska.* Alaska Economic Trends, June 2004

National Academy of Social Insurance (NASI), July 2003 Report. Available: http://www.nasi.org/
A quality report for those who may not be familiar with workers' compensation systems.

NCCI State Advisory Forum, July 21, 2004

ESTABLISH DIRECTOR

Consider legislation similar to CO language:
http://www.coworkforce.com/DWC/WC_Act_2003.asp or California:
http://www.dir.ca.gov/chswc/Section-by-section-Review-of-SB899.pdf

"The director has the power to adopt reasonable and proper rules and regulations relative to the administration of articles 40 to 47 (insert Alaska administration sections) of this title and proper rules and regulations to govern proceedings and hearings of the division, and the director has the discretion to amend said rules and regulations from time to time."

And...

"The director shall promulgate rules establishing a system for the determination of medical treatment guidelines and utilization standards and medical impairment rating guidelines for impairment ratings as a percent of the whole person or affected body part based on the revised edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment", in effect as of July 1, 1991."

And...

"The director shall appoint such employees as are necessary to carry out the duties and exercise the powers conferred by law upon the division of workers' compensation and the director."

MEDICAL POLICY UNIT

Bernacki EJ, Tsai SP. "Ten years' experience using an integrated workers' compensation management system to control workers' compensation costs." *J Occup Environ Med.* 2003;5:508-16.

This work presents 10 years of experience using an Integrated Workers' Compensation Claims Management System that allows safety professionals, adjusters, and selected medical and nursing providers to collaborate in a process of preventing accidents and expeditiously assessing, treating, and returning individuals to productive work. The hallmarks of the program involve patient advocacy and customer service, steerage of injured employees to a small network of physicians, close follow-up, and the continuous dialogue between parties regarding claims management. The integrated claims management system was instituted in fiscal year 1992 servicing a population of approximately 21,000 individuals. The system was periodically refined and by the 2002 fiscal year, 39,000 individuals were managed under this paradigm. The frequency of lost-time and medical claims rate decreased 73% (from 22 per 1000 employees to 6) and 61% (from 155 per 1000 employees to 61), respectively, between fiscal year 1992 and fiscal year 2002. The number of temporary/total days paid per 100 insureds decreased from 163 in fiscal year 1992 to 37 in fiscal year 2002, or 77%. Total workers' compensation expenses including all medical, indemnity and administrative, decreased from $0.81 per $100 of payroll in fiscal year 1992 to $0.37 per $100 of payroll in fiscal year 2002, a 54% decrease. More specifically, medical costs per $100 of payroll decreased 44% (from $0.27 to $0.15), temporary/total, 61% (from $0.18 to $0.07), permanent/partial, 63% (from $0.19 to $0.07) and administrative costs, 48% ($0.16 to $0.09). These data suggests that workers' compensation costs can be reduced over a multi-year period by using a small network of clinically skilled health care providers who address an individual workers' psychological, as well as physical needs and where communication between all parties (e.g., medical care providers, supervisors, and injured employees) is constantly maintained. Furthermore, these results can be obtained in an environment in which the employer pays the full cost of medical care and the claimant has free choice of medical provider at all times.

Green-McKenzie, J., J. Parkerson, and E. Bernacki. "Comparison of workers' compensation costs for two cohorts of injured workers before and after the introduction of managed care." *J Occup Environ Med.* 1998; 6:568-72.

A comprehensive safety and managed care initiative was instituted in 1991 at a large self-insured medical center in an effort to reduce workers' compensation costs. It features an on-site case management team, a preferred provider organization, and safety engineering efforts and ergonomic controls used proactively to aggressively identify and abate workplace hazards. Two worker populations were followed up longitudinally for three years before and after the

initiative. Costs incurred by each cohort were compared. A 50% reduction in total expenditures was seen in the managed care cohort. The hospital component of the system saw a decrease in compensation of 62% for temporary total disability and 38% for permanent partial disability. Medical expenditures decreased 50%. Dramatic reductions in costs are achievable, without compromising quality of care, when managed care principles and safety efforts are emphasized.

Kyes KB, Wickizer TM, Franklin G. "Employer satisfaction with workers' compensation health care: results of the Washington State Workers' Compensation Managed Care Pilot." *J Occup Environ Med.* 2003; 3:234-240.

Developing more effective approaches to disability prevention has been a longstanding challenge for the workers' compensation system. A major obstacle to this goal has been the lack of communication and interaction between employers and physicians who care for injured workers. From 1995 through 1997, the Washington State Department of Labor and Industries sponsored a major demonstration program, known as the managed care pilot (MCP), to assess the effects of managed care on medical and disability costs, patient satisfaction and employer satisfaction. We developed a telephone survey and administered it to 243 employers as part of the MCP evaluation. Topics covered in this survey include satisfaction with treatment rendered, duration of lost work time, work modifications, and satisfaction with communication received during the employee's recovery period. Employers in the intervention (managed care) condition were more satisfied with the managed care/occupational medicine system than the employers in the comparison group were with the fee-for-service system. MCP employers were satisfied particularly with the frequency and quality of communication received from the health care provider regarding return to work and work modification issues. Improved employer-provider communication may foster early return to work and thereby have a beneficial effect on health and employment outcomes for injured workers.

Kyes KB, Wickizer TM, Franklin G, Cain K, Cheadle A, Madden C, Murphy L, Plaeger-Brockway R, Weaver M. "Evaluation of the Washington State Workers' Compensation Managed Care Pilot Project I: medical outcomes and patient satisfaction." *Med Care*. 1999; 10:969-71.

Workers treated through managed-care arrangements were less satisfied with their care, but their medical outcomes were similar to those of workers who received traditional FFS care. The current workers' compensation system in Washington State affords injured workers great latitude in choosing providers. If provider choice is substantially restricted by managed care, worker satisfaction is likely to diminish.

Johnson WG, Baldwin ML, Burton JF Jr. "Why is the treatment of work-related injuries so costly? New evidence from California." *Inquiry*. 1996; 1:53-65.

There is growing evidence that workers' compensation insurers are charged substantially more than health insurers for the treatment of similar injuries. The

first study of the problem, conducted in Minnesota in 1987, found that both over utilization of services and price discrimination contributed to the charge differential. This article applies the Minnesota model to 1991-1993 data on health care charges and payments from California. Approximately 13,000 persons with work-related injuries are compared to approximately 3,600 persons with similar injuries that occurred off the job. Despite important differences in the populations and workers' compensation laws in California and Minnesota, workers' compensation insurers are charged more than health insurers for the treatment of similar injuries in both states. The difference in California's payments is attributable to using more health care providers and services to treat workers' compensation patients. The results do not support the hypothesis that work-related injuries cost more to treat because they are more severe than similar injuries occurring off the job.

Johnson, WG, Burton JF Jr., Thornquist L., and Zaidman B. "Why does workers' compensation pay more for health care?" *Benefits Quarterly*. 1993; 4:22-31.

An analysis shows that health care providers charged substantially larger amounts for treatment of workers' compensation cases than for the treatment of similar patients insured by Blue Cross.

Nikolaj S, and Boon B. "Health care management in workers' compensation." *Occup Med.* 1998; 2:357-79.

A high-performing, effective health care delivery system is critical to the recovery of injured workers within a workers' compensation insurance system. Timely and effective health care has the potential to minimize indemnity costs and therefore contribute to the insurer's financial state. While costs remain a concern to insurers, cost-containment initiatives within the health care arena have evolved from a strict "deep discount" approach to more sophisticated heath care strategies that follow managed care-style models. In the future, health care strategies are likely to become more integrated within the business operations of workers' compensation insurance systems. The next evolution of health care strategy within workers' compensation will likely include consensus-based contracts with providers that stipulate the role and function of each party while reinforcing a continuous improvement mindset. It is probable that a component of this evolving system will include shared risk and reimbursement that is based on performance. Insurers who begin to evaluate the true impact of a comprehensive health care strategy will find it necessary and advantageous to modify their business relationship with health care providers. Those who are able to articulate a business strategy that capitalizes on the skills of the health care community are likely to gain a competitive advantage. Most importantly, this bridging of intellectual capacity across the insurance and health care domains will result in a delivery system that is valued by, and contributes to, its key participants – the employers and the injured workers.

Victor, Richard A. "Evidence of Effectiveness of Policy Levers to Contain Medical Costs in Workers' Compensation – A WCRI Professional Paper." Cambridge, MA: Workers' Compensation Research Institute, 2003. Available: http://www.wcrinet.org/cgi-

bin/test.cgi?url=/home/httpd/wcrinet.org/studies/public/abstracts/prof_paper_policy_levers-ab.html&title=prof_paper_policy_levers.

This paper reviews the empirical evidence from the scholarly health policy literature about what works to contain health care costs. Some of this literature involves health care in workers' compensation and much of it draws on the literature involving the general health care system – those covered by either Medicare or group health insurance. After reviewing the evidence on what drives workers' compensation medical costs – and whether these cost drivers differ from state to state – the paper examines the evidence about the effectiveness of different tools that policymakers have to contain medical costs:

- Non-hospital fee schedules
- Hospital price regulation
- Laws that control the choice of provider
- Networks of providers
- Case management
- Utilization review and treatment guidelines
- Limits on visits to chiropractors

The paper concludes that

- The evidence from existing empirical literature is uneven, depending on the cost containment tool.
- There is a growing body of empirical knowledge about the impact of price regulation on costs, but little on price regulation and worker outcomes. The studies of the impact of Medicare price regulation on costs suggest that provider behavior to retain revenues offsets a significant part of any regulatory reduction in medical prices. One study shows that hospital prices are lower when there is more competition.
- The strongest area of empirical evidence in workers' compensation involves the impact of medical networks. There are a number of solid studies covering diverse states and time periods. All find that networks reduce medical costs. A few examine the impact on duration of disability or recovery of health, finding that workers that receive care from network providers are equally healthy and do not have longer durations of disability. Several studies also find that workers report higher levels of satisfaction with non-network care.
- There are a few studies of the impact of provider choice laws on costs. The evidence is mixed, although recent studies suggest that network penetration is lower in states where the employee controls the selection

of providers. As discussed above, lower network penetration means higher medical costs.

- Studies of utilization review and treatment guidelines in workers' compensation provide sketchy evidence of their impacts. Combined with evidence from Medicare and group health, the studies suggest fewer hospital admissions, shorter lengths of stay and fewer surgeries. A survey of physicians highlights a major limitation on the effectiveness of utilization review – 39 percent of physicians report that, at least sometimes, physicians do not provide accurate information for utilization review. One recent Australian study found that compliance with treatment guidelines led to better outcomes for workers with acute low back pain – better perceived physical health and reduced pain.

- We found little evidence on the effectiveness of case management.

Public officials are often frustrated in their efforts to enact legislation or promulgate regulations to contain medical costs. It is indeed a difficult problem – made more difficult by the complexity of the problem, the inherent emotionality of the subject matter ("our health"), the absence of a consensus about how to ration care, and the very large amounts of money involved – hence the fierce politics that surround proposed legislative change that will reduce revenues to health care providers or redistribute monies from one group to another. None of this is made better by the too-often inadequate empirical foundation for making trade-offs between higher costs and better worker outcomes.

Moreover, past successes in reducing the rate of growth of medical costs have been transitory. The next round of medical cost containment will be much more difficult to achieve since the much of the low lying cost containment fruit was harvested in the cost containment activities of the 1990s. The next round will require more careful empirical analysis of the opportunities and a greater political will than required for the reforms of the 1990s.

However, there is another, often overlooked, way to frame the legislative debate. Invariably, there must be no shortage of opportunities to reform the financing and delivery of medical care in ways that improve outcomes for injured workers without materially raising costs to employers – or to reduce costs to employers without materially affecting the outcomes for workers. The best opportunities for constructive change in workers' compensation, in our view, will come from these "win-wins". Empirical research should begin immediately to identify where they exist and to disseminate these opportunities to employer representatives, worker advocates and public officials. Reform proposals driven by win-wins for workers and their employers, and supported by a solid base on evidence on employers' costs and workers' outcomes, should be hard to resist.

Wickizer TM, Franklin G, Gluck JV, and Fulton-Kehoe D. "Improving quality through identifying inappropriate care: the use of guideline-based utilization review

protocols in the Washington State Workers' Compensation System." *J Occup Environ Med.* 2004; 3:198-204.

Utilization review (UR) is widely instituted to ensure that medical treatment is clinically necessary and appropriate. UR programs have been criticized for their failure to promote quality and for relying on proprietary review criteria that are rarely subject to external, independent evaluation or validation. In fashioning its UR program for workers' compensation, the Washington State Department of Labor and Industries sought to address these shortcomings. Working collaboratively with the state medical association, the Department of Labor and Industries developed treatment guidelines and then used these guidelines to formulate review criteria for UR. From 1993 through 1998, 100,005 UR reviews were conducted, half of which used the guideline-based review criteria. We analyzed these reviews to examine the patterns of denied requests. The overall denial rate for the guideline-based reviews was 7.3%. The highest denial rates were for thoracic outlet syndrome surgery (19.1%) and lumbar fusion (17.7%). The use of guideline-based UR protocols may improve the effectiveness of UR as a tool to identify potentially inappropriate care.

Wickizer TM, Lessler D, Franklin G. "Controlling workers' compensation medical care use and costs through utilization management." *J Occup Environ Med.* 1999; 8:625-31.

Little is known about the performance of utilization management (UM) programs, which are now widely used within the workers' compensation system to contain medical costs and improve quality. UM programs focus largely on hospital care and rely on preadmission and concurrent reviews to authorize hospital admissions and continued stays. We obtained data from a large UM program representing a national sample of 9319 workers' compensation patients whose medical care was reviewed between 1991 and 1993. We analyzed these data to determine the denial rate for hospital admission and outpatient surgery and the frequency of length-of-stay restrictions among hospitalized patients. The denial rate was approximately 2% to 3% overall, but many of the denials were later reversed. On average, the UM program reduced the length of stay by 1.9 days relative to the number of days of care requested. The estimated gross cost savings resulting from reduced hospitalization time and decreased outpatient care was approximately $5 million. UM programs may offer a viable approach to cost containment within the workers' compensation system. Their value as a tool to improve the quality of care for workers' compensation patients remains to be demonstrated.

MEDICAL TREATMENT GUIDELINES

http://www.coworkforce.com/DWC/Medical_Treatment.asp

http://oempress.com/cgi-bin/VirtualCatalog3/CatalogMgr.pl?cartID=b-5552&SearchField=partnumber&SearchFor=23085&template=Htx/template-b.htx

PRESCRIPTION DRUGS

"Prescription Drugs: Comparison of Drug Costs and Patterns of Use in Workers Compensation and Group Health Plans." National Council on Compensation Insurance, Inc. Available: http://www.ncci.com/media/pdf/rx.pdf.

In recent years, the costs for pharmaceuticals rose more rapidly than any other type of medical cost. Pharmaceutical costs now represent a larger percentage of the total medical costs for workers compensation claims as well as for commercial health insurance.

In 2001, the cost of prescription drugs rose an alarming 15.7% over 2000. Nationally, spending on prescription drugs comprises roughly 10% of total spending on health care and total drug spending may reach $200 billion this year. Based on The Centers for Medicare and Medicaid Services prediction that drug expenditure growth rates will be maintained, it can be expected that prescription drugs will comprise nearly **15%** of total national health care spending by the year 2011.

Medications play an important role in health care—for example, they can replace expensive surgeries or other invasive procedures. However, increasing prices, increased utilization, and the availability of newer, higher-priced drugs have contributed to the concerns over rising costs.

Compared to other industries, pharmaceuticals earn the highest rate of profit. For example, profits as a percent of revenue for pharmaceutical manufacturers compared to all Fortune 500 firms were four times the median rate in the late 1990s, rose to 18.6% compared to 4.5% in 2000, and totaled 19% compared to 3% in 2001.

However, manufacturers are one of many stakeholders at play in the prescription drug arena—including workers, employers, insurance carriers, policy makers, pharmacies, and Pharmacy Benefits Managers (PBMs). Finding a solution to the problem of rising drug costs that will satisfy **all** stakeholders is a significant challenge.

- Prescription drug share of medical costs by accident year in Workers Compensation (WC) grew from 6.5% in 1997 to 9.6% in 2001.
- Utilization has a greater impact on WC drug costs than price.
- WC pays roughly 125% of the Average Wholesale Price (AWP) of prescription drugs; Group Health (GH) pays only 72%. Therefore, WC paid 74% more than GH for the same drugs.

- Generic equivalents are prescribed when available 79% of the time for WC claims. A total of 56% of WC costs are associated with drugs that have no generic equivalent. Therefore, savings opportunities from using generic equivalents are only available for approximately 8% of total WC drug costs.
- Painkillers represent 55% of the cost of prescriptions in WC.

EMPLOYER CHOICE

Bernacki, EJ, and Tsai SP. "Managed care for workers' compensation: three years of experience in an 'employee choice' state." *J Occup Environ Med.* 1996. 11:1091-7.

Managed care techniques are becoming increasingly available to manage the medical indemnity losses associated with injuries paid for under the workers' compensation system. The authors describe 3 years' experience of identifying and abating workplace hazards and medically managing cases utilizing a preferred provider organization established solely for workers' compensation cases. In the model described, the occupational physician/nurse case-management team coordinates the entire process, from prevention of accidents to facilitated return to work. During the study period (1992 to 1995), per-capita losses were reduced by 23% from $241 in fiscal year 1992 (the year before the managed care initiative), to $185 in fiscal year 1995. (Hereafter, each year referred to indicates that fiscal year.) In 1992, 22 lost-time cases per 1000 employees occurred, whereas the number of lost-time cases in the years 1993 to 1995 averaged 12 to 14 per 1000 employees. The rate of "medical only" cases dropped significantly from 155 per 1000 in 1992 to 96 per 1000 in 1995. The per-capita amount of monies spent on medical care decreased from $81 in 1992 to $63 in 1995. The most significant savings in medical costs related to claims associated with new occupational injuries, injuries that occurred during the fiscal year. In 1992, the per-capita loss on such cases was $23 and in 1995 it was $14, a 43% decrease. The number of temporary/total days dropped significantly from 163 per 100 employees in 1992 to 70 days in 1995. Concurrently, the per-capita loss for temporary total disability was reduced from $53 in 1992 to $26 in 1995. Per-capita administrative costs, as well as other indemnity losses (predominately permanent partial disability), decreased slightly over the study period ($58 to $54 and $60 to $51, respectively). We feel that these results indicated that environmental-risk management and medical-care management can be integrated to produce substantial savings. It also suggested that managed-care techniques, which are becoming more available to employers, can even be applied in states that do not have managed care legislation.

Victor, Richard A., Dongchun Wang, Philip Borba. "Provider Choice Laws, Network Involvement, and Medical Costs." Cambridge, Massachusetts: Workers' Compensation Research Institute, 2002.

Should the law give employers or employees the right to select the treating provider? This question is subject to frequent public policy debates. Treating

providers have considerable influence over the course of medical care, the outcomes experienced by injured workers, decisions on return to work and the payment of permanent disability benefits. Advocates for injured workers argue that retaining control over the choice of provider ensures quality care and favorable outcomes. Advocates for payors maintain that employer control is consistent with quality medical care and is an essential tool to manage costs.

Focusing on cases that begin treatment within a network, this study examines the impact of state provider choice laws on the extent of network involvement and the resulting effect on medical costs. The impact of the provider choice laws on quality of medical care and other outcomes experienced by injured workers, an important part of the debate, is beyond the scope of this study.

Key Findings

- Network involvement is significantly higher where the state law mandates employer control over decisions to change medical providers. As Figure A shows, employer control raises network involvement by 15 to 20 percentage points for treatment given at 4 to 9 months after an injury and increases to 25 to 30 percentage points after 10 months.
- A rough estimate of the cost impact of changing a state's law from "employee choice" to "employer choice" is to reduce medical costs by 7 to 10 percent.
- Previous WCRI studies have shown that greater network involvement reduces medical costs, largely because fewer medical services are used by network providers. Despite fewer services, the studies conclude that duration of disability is not extended nor are indemnity costs higher – a "win" for workers and employers alike. Studies also show that worker satisfaction with medical care from network providers may be lower.

Workers' Compensation Research Institute *The Impact of Workers' Compensation Networks on Medical Costs and Disability Payments*. Dr. William G. Johnson, Dr. Marjorie L. Baldwin and Steven C. Marcus. November 1999. WC-99-5.

One significant change in the delivery of medical care over the past decade has been the emergence of workers' compensation networks—organizations of health care providers that contract with workers' compensation insurance companies to provide services, sometimes at a discounted price. Few studies to date have examined how these networks affect medical costs, utilization and income-benefit costs. This study provides substantial evidence on these issues and serves as the basis for improved public policy and business decisions.

Based on analyses of more than 160,000 closed workers' compensation claims in three large and diverse states—California, Texas and Connecticut—this study is the largest and most comprehensive of its kind.

The study addresses three central questions:

- Do workers' compensation networks lower the cost of medical care?

- If so, is this due to lower prices or lower utilization of services, or both?
- Do lower medical costs come at the expense of higher indemnity costs?

Our analysis found that workers' compensation networks are associated with much lower costs and that those savings do not increase either the duration of disability or income-benefit costs. Although some of the differences in costs can be attributed to networks charging lower prices, most cost savings result from network providers using fewer services than nonnetwork providers when treating similar claims. The study did not measure the quality of care nor workers' satisfaction with care, two important issues that will be the subject of future WCRI research.

After controlling for medical diagnosis and injury type, the worker's age, state of residence, gender and the type of claim, our research found large cost differences between network and nonnetwork claims in medical costs. In California and Texas, network costs are generally 30 to 50 percent lower than nonnetwork costs. Less dramatic but still significant are cost savings in Connecticut, where network costs are 10 to 50 percent lower than nonnetwork costs.

Additionally, we found that indemnity costs for claims treated in workers' compensation networks were not higher than the indemnity costs for nonnetwork claims. This was true in every injury type and across all three states and was also true for the duration of disability payments.

Workers' Compensation Research Institute. *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 1998-1999.* Ramona P. Tanabe. December 1998. WC-98-7.

An emerging trend to measure policies implemented during the last half dozen years and evaluate "what works?" signals a noticeable shift in focus. Unlike the early years of this decade when jurisdictions rapidly embraced new regulatory strategies in an attempt to stem skyrocketing medical costs, this report found that few new regulatory strategies are being adopted.

The report found some jurisdictions are considering or piloting efforts to determine the impact of cost strategies on the quality of care for injured workers. Some examples of these efforts include: development and pilot testing of a patient survey (California); measurement of the effect of treatment guidelines on medical outcomes and costs (Colorado); and identification of measurable indicators to determine the effect of managed care plans on the quality of care (Florida).

Designed to give policymakers and practitioners a rich understanding of the regulations and policies in all 51 jurisdictions, this reference book was first published in 1990 and updated regularly since then. The report is divided into two distinct sections. The first examines various medical cost containment strategies: managed care, treatment guidelines, physician fee schedules, utilization management, bill review, choice of provider and direction of care, and the

regulation of hospital charges. The second contains individual state summaries that detail the regulatory policies in each jurisdiction.

Among our findings:

- Most of the activity in implementing cost control measures occurred before January 1997; virtually no new initiatives occurred between January 1997 and March 1998.
- The most common cost containment measure, in place in almost every jurisdiction, is the restriction on an employee's ability to choose or change medical care providers.
- Forty of 51 jurisdictions have medical fee schedules, although only 16 are enforced with a state bill review program. Medicare's resource-based relative value scale is the leading basis for designing fee schedule reimbursement.
- Interest in developing strategies that attempt to control utilization appears to be slowing. These strategies include mandated and regulated managed care, mandated utilization review programs, and the development of treatment guidelines.

Number of jurisdictions with common cost containment regulatory strategies in workers' compensation 1990-1998

	1990	91-92	92-93	95-96	97-98	98-99
Limited Initial Provider Choice	21	21	22	24	25	25
Limited Initial Provider Choice Via Managed Care Organizations only	*	*	*	11	12	12
Limited Provider Change	39	40	41	32	33	32
Limited Provider Change via Managed Care Organizations only	*	*	*	4	6	12
Medical Fee Schedule	26	27	32	40	40	40
Hospital Payment Regulated	18	22	28	35	36	35
Mandated Managed Care	*	*	*	8	6	6
Mandated Utilization Review	9	14	15	21	20	20
Mandated Bill Review	11	13	13	16	16	16
Treatment Guidelines	*	*	*	12	21	21

* Not recorded

RETURN TO WORK

On Developing Return to Work Programs:

"Developing a Return to Work Program." Texas Workers' Compensation Commission, Medical Review Division. 2003-2004. Available: http://www.twcc.state.tx.us/commission/divisions/rtw/rtw_guide_03_04.pdf.

Texas legislative language:
http://www.cbs.state.or.us/external/wcd/rdrs/rau/returntowork.html

Research on Return to Work

Bernacki EJ, Guidera JA, Schaefer JA, and Tsai S. "A facilitated early return to work program at a large urban medical center." *J Occup Eviron Med.* 2000; 12:1172-7.

An Early Return to Work Program was initiated at The Johns Hopkins Hospital and Associated Schools of Medicine, Hygiene and Nursing in Baltimore, Maryland, in April 1992 as part of a comprehensive effort to control the incidence and cots of work-related illnesses and injuries. The program was similar to others that incorporate employee and supervisory training and job accommodations, but it also included an industrial hygienist trained in ergonomics to facilitate the placement of individuals with restrictions. The return to work program was studied over a 10-year period, comparing the number of lost workday cases, lost workdays, and restricted duty days before (1989 to 1992) and after (1993 to 1999) initiation of the program. A significant decrease (55%) was observed in the rate of lost workdays cases before versus after the return to work program. Furthermore, the number of lost workdays decreased from an average of 26.3 per 100 employees before, to 12.0 per 100 employees after, the return to work initiative, and the number of restricted duty days went from an average of .063 per 100 employees to 13.4 per 100 employees (a twenty fold increase). This study suggests that a well-structured early return to work program is an integral part of a comprehensive effort to control the duration of disability associated with occupation injuries and illness. It also indicates that to be most effective, an early return to work program must include participation by medical providers, safety professionals, injured employees, and supervisors. Our work suggests that even with these elements in place, the effectiveness of return to work program may be increased by including an individual trained in ergonomics to facilitate the job placement process.

Workers' Compensation Research Institute *What Are the Most Important Factors Shaping Return to Work? Evidence from Wisconsin.* Dr. Monica Galizzi and Dr. Leslie I. Boden. October 1996. WC–96–6.

One of the most important functions of workers' compensations systems for both workers and employers is returning those injured on the job to productive employment in a timely manner. Workers benefit because when return is delayed, workers can lose more than earnings: skills may deteriorate; the job may be filled by a replacement; and future employers may view the worker as a less valuable employee. Employers also benefit from a speedy return to work through lower costs and less disruption of the work force because of additional hiring or reorganization of the remaining workers.

This report quantifies the most important factors that affect return to work. The study, which was based on our analysis of the highly regarded Wisconsin system, concentrated on workers who were away from work at least one month. Although these workers comprised only 52 percent of the workers in the study, they

accounted for 98 percent of the time away from work and 94 percent of the income benefits paid.

This WCRI study answers some of the questions about the attributes of injured workers and their employers that affect return to work and describes the longer-term effects of spells off work on the employment of injured workers. Among the key findings:

- Duration of time off work and periods of subsequent unemployment are lower for injured workers who return to their pre-injury employer than for those who change employers. Most workers with at least one year's job tenure return to their pre-injury employer, but for those who do not, time off work is lengthened by a factor of two to three.

- Workers with an intermittent employment history before the injury stay off work longer. In general, about half of injured workers are back at work within 30 days and three quarters by three months. Workers who had one period of unemployment in the year prior to injury took 34 percent longer to return to work than those who did not.

- Employees at smaller firms are less likely to return to the pre-injury employer (and thereby incur longer periods off work) than those at larger firms. This is a consequence of fewer opportunities for providing modified jobs and the higher cost to smaller companies of holding injured workers' jobs open for a long period of time.

Employer Size and Return-to-Work Patterns

Number of Employees	Percentage of Injured Workers not returning
1-50	21
51-25	16
251-1,000	10
over 1,000	7

- Increasing benefits slows return to work by a small amount on average. Prior studies by WCRI and others have found that benefit increases lead to a delayed return to work. This study finds that a 10 percent increase in weekly benefits slows return to work by two days for a two-week injury and by almost a day for a three-month injury. It does not find that a large number of workers find the increase in benefits sufficiently attractive to stay out of work for very long periods.

- Workers returning to jobs at pre-injury wages go back to work an average of 2.6 days sooner.

The study also examined employment experience after the injured employee returned to work. It found that the duration of time off work has lasting effects on post-injury employment. For workers who returned to work within one month after their injuries, we found unemployment one year later to be about 6 percent. Those who remain off work for 6 months or longer, however, have unemployment rates of 14 percent or more. Thus, policies that promote early return to work have

a double benefit for the worker. Not only do they return to full wages sooner, but they also decrease the odds of unemployment after return to work.

Eccleston, Stacey, Aniko Laszlo, Xiaoping Zhao, Michael Watson. "Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2001-2002." Cambridge, Massachusetts: Workers' Compensation Research Institute, 2002. Available: http://www.wcrinet.org/cgi-bin/test.cgi?url=/home/httpd/wcrinet.org/studies/public/abstracts/fee_sched_01-02-ab.html&title=fee_sched_01-02.

Workers' compensation medical fee schedules are the policy tools most often used by states to contain medical costs. Used by forty-two jurisdictions in 2001, these fee schedules dictate the maximum reimbursements that providers can receive for specified services. The designing or updating of fee schedules, often subject to political pressure from payors and providers, involves a delicate balance. If fees levels are set too high, their effectiveness as a cost savings tool is limited; if fee levels are too low, access to quality care may be in jeopardy.

To ground political debates in fact rather than partisan rhetoric, this report provides two important benchmarks:

- workers' compensation provider fee schedules in 40 states
- provider fee schedules compared to Medicare's resource-based relative value scale, a system that reflects the relative differences in providers' costs to deliver services across states and across service types

Among Our Key Findings:

- WCRI's analysis found that the substantial variation in fee schedules among the states is unrelated to the cost to health care providers to deliver medical services. This discrepancy between provider costs and fee levels may create unequal financial incentives for providers to over-utilize or under-utilize certain medical services.
- Some state fee schedules reimburse providers at or below Medicare levels (Florida, Massachusetts, Maryland). In five states (Nebraska, Connecticut, Oregon, Idaho, Alaska) the fee schedule is nearly double or even triple the state's Medicare rates.
- State fee schedule premiums over Medicare vary greatly across different service groups within a state. In general, the greatest interstate variation and largest premium over Medicare reimbursement rates occur for surgical services and radiology. Fee levels are closest to, and sometimes even less than, Medicare levels for physical medicine and evaluation and management services (office visits).
- A significant number of state fee schedules may be higher than necessary to support the delivery of quality care, based on (1) the large variation between states, (2) the low correlation between fee levels and provider

costs, and (3) the large differences between workers' compensation fee levels and the Medicare benchmarks for each state. At the same time, in states where the fee schedules are below Medicare reimbursement levels, there may be concerns about access to primary care services.

"Occupation vs. Non-Occupational Benefits." Integrated Benefits Institute. April 1999. Available: http://www.ibiweb.org/publications/research/21.

To help employers manage their occupational and non-occupational benefit programs, IBI analyzed benefit costs and utilization across occupational and non-occupational benefit programs for 300 unionized employers with identical benefits. The comparison analyzed only injuries common both to occupational and non-occupational settings opening and closing between 1992 and 1995, a time of high unemployment in the affected industry. Benefit levels differed significantly across programs: employee benefits for workers' compensation were more generous than for non-occupational benefits. STD was limited in duration and no LTD benefits were provided. The collective bargaining agreement limited the number of weeks a worker could work before returning to the hiring hall. Employers provided no vacation or sick pay, and their workers' compensation premium was unaffected by their individual experience. The analytical power from the detailed data allowed IBI far more insight than earlier studies of data from multiple employers with varying benefit programs. Those studies reported only aggregate medical treatment results without being able to consider disability costs and utilization.

"Return-to-Work Programs in Oregon and Their Applicability to Texas." Texas Department of Insurance. August 1997. Available: http://www.tdi.state.tx.us/company/roc/rtw_or.html.

Returning an injured worker to employment that is commensurate with his or her abilities is one of the most important goals of any workers' compensation system. Unfortunately, the post-injury employment experience of injured workers in Texas has not been too encouraging. Research has shown time and again that a significant number of injured workers with permanent impairments are having difficulty getting back to work in Texas. For instance, a recent study by the Research and Oversight Council on Workers' Compensation (ROC) found that nearly one-third of the permanently impaired workers injured in 1993 were not working in November 1996 due to their injury, and 17 percent of these workers had never returned to work following their 1993 injury.

This report summarizes the results of previous return-to-work studies in Texas and provides details and outcomes data on two innovative return-to-work programs currently in place in Oregon: the Preferred Worker Program and the Employer-at-Injury Program. Finally, the report addresses the applicability of the Oregon programs to the Texas workers' compensation environment.

Whittington, Glenn. "Changes in workers' compensation laws in 2003." *Monthly Labor Review*. Jan. 2004:30-36.

In 2003, major legislative reforms occurred in California, Florida, Montana, Nevada, and West Virginia. Maximum burial expenses increased from $5,000 to $7,500 in Florida and Iowa, and from $3,200 to $5,500 in Ohio. In California, the vocational rehabilitation provisions were repealed and replaced with a "supplemental job displacement benefit," up to a maximum of $10,000. Also, in California, chiropractor and physical therapy treatments were limited to 24 visits for the life of the claim, while Florida increased chiropractic treatments from 18 visits to 24 visits, and the number of weeks of treatment from 8 to 12.

Workers' compensation coverage was expanded to include search and rescue workers in Main and members of the State defense force in New Mexico. In Maryland and Massachusetts, students in work-based learning experiences now are covered. In West Virginia, the Second Injury Fund was abolished, and the length of time a person may receive temporary total disability was reduced from 208 weeks to 104 weeks. In Montana, the waiting period for temporary total disability benefits was reduced from 40 hours (or 5 days) to 32 hours (4 days) of wage loss, and the permanent partial disability benefit maximum increased from 350 weeks to 375 weeks.

The study is a State-by-State summary of changes in workers' compensation law.