WASHINGTON RESEARCH COUNCIL
Policy Brief

PB 09-03
January 15, 2010

MAINSTREAMING WORKERS' COMPENSATION: REFORMS FOR 2010

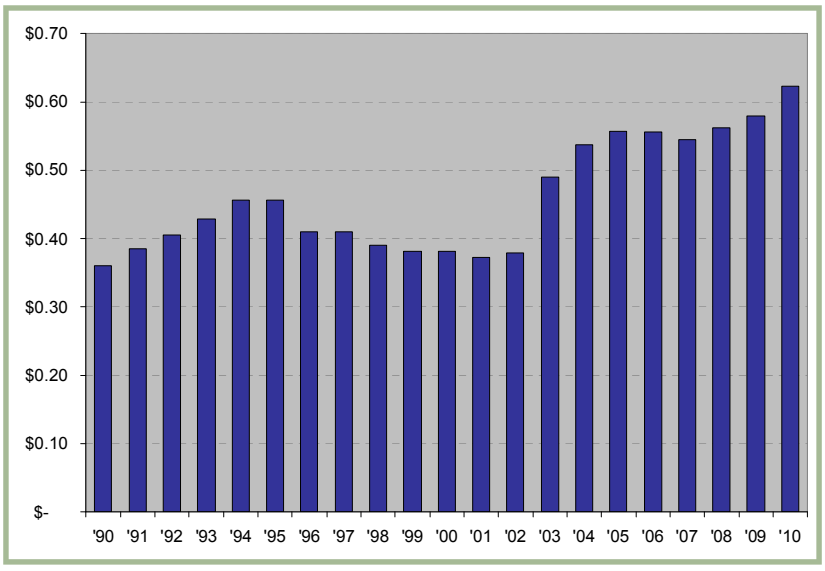
BRIEFLY

Three reforms will provide immediate cost savings in the workers' compensation system without reducing injured workers' benefits. They will improve patient care, without detriment to patient satisfaction or access to qualified health care providers. These cost-effective reforms that could bring Washington into the competitive mainstream cannot be ignored or postponed.

Even as workers' compensation claims decline in Washington, system costs are increasing, leaving an uncomfortable and unsustainably low balance in the overall contingency reserve of $545 million at the end of June 2009. This balance leaves overall reserves at just 5 percent, well below the 8.7 percent bottom of the target range for reserves set by the Department of Labor and Industries (L&I 2009).

Increasing 64 percent since their most recent trough, rates have grown from $0.38 in 2000 to $0.62 in 2010 (Chart 1). The recent 7.6 percent increase is only one third of the increase L&I's actuary actually recommended. Given the current economic stress and the sorry state of reserve funds, more rate increases are certain to be proposed in 2010 on the basis of restoring actuarial soundness.

Chart 1: Workers' Compensation Composite Rate



Past Decisions, On-Going Consequences

Increasing benefit costs, even in the face of declining claims (see Chart 2), are due in large part to the unhappy and on-going consequence of 1975 legislation that requires automatic annual adjustments to cash benefits injured workers are eligible to receive. As noted in a Washington Alliance for a Competitive Economy 2006 report, rather than peg these adjustments to the cost of living, Washington tied them to the state's growth in average wages. Growing well ahead of cost of living this benchmark is aggressive and led to an immediate and steep increase in cash payments owed to injured workers. (WashACE 2006)

Reserve Solvency Drives Rate Increases

Not surprisingly, the portion of the contingency reserve which is most unhealthy is that which is held for the Accident and Pension Funds. Totaling a mere $49 million this reserve is less than one percent of liabilities that it was created to cover, dangerously below the bottom of the 7.4 percent target range (L&I 2009).

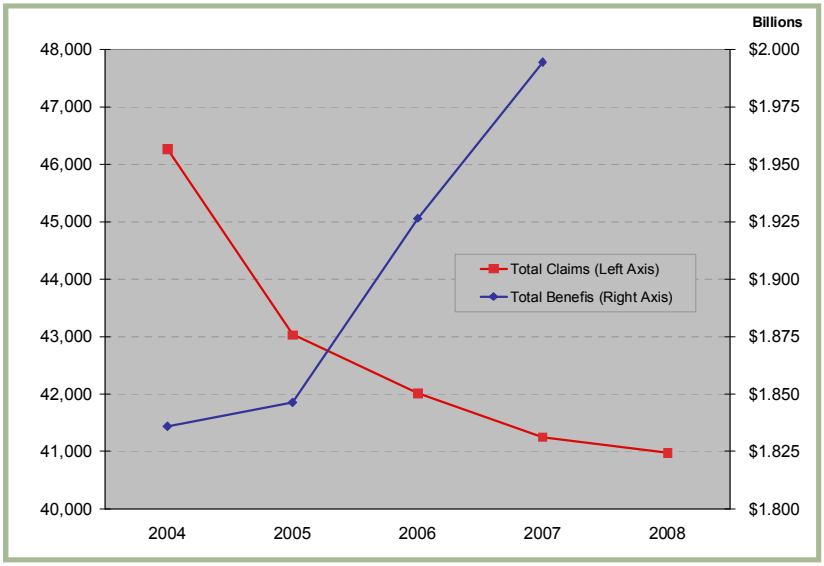
In a recent audit of the workers' compensation program, the State Auditor's Office contracted with an independent actuarial firm to review the soundness of various reserve accounts. With specific regard to the Accident Fund the outside actuary estimates "a 74.4 percent chance of insolvency...within two years, 81.4 percent within three years and 89.5 percent within five years." It calculated that a 33 percent rate increase would be necessary in order for the Accident Fund to break-even. This is 10 points more than L&I's own estimate of a 23.3 percent rate increase. According to the SAO, "the Actuarial

WASHINGTON RESEARCH COUNCIL
16300 Christensen Road, Suite 207
Tukwila, Washington 98188
206-467-7088
www.researchcouncil.org

firm believes the Department's estimate is outside a range of reasonable estimates" (SAO 2009).

Cost-Saving Reforms Necessary Now

Chart 2: Claims and Benefits in Washington State



In Washington, which has one of the most costly workers' compensation systems in the country, everything needs to be done to avoid further increasing the burden employers face as they try to replace jobs in a still struggling economy.

Although there are numerous changes that could improve workers' compensation in Washington and bring down both state-fund and self-insured employer costs, this paper concentrates on just three. These three changes are non-controversial, common practice around the country, and have been proven to save considerable money immediately in states where they have been implemented. They do not reduce benefits for injured workers, nor do they require rate hikes. These changes would bring Washington into the mainstream on these specific workers' compensation provisions.

Final Settlement Agreements

On-going payments to workers with permanent total disabilities are very expensive. If awarded, they provide on-going payments – or pensions – to workers until their death – beyond, in cases where spouses or children continue to receive payments (WashACE 2006).

Although pension awards are relatively rare in other states (based on a 36-state average), Washington pension awards "nearly tripled from 1996 to 2003," according to a 2008 study published by the Upjohn Institute for the Washington State Legislature. The average incidence in other states, according to Senior Economist H. Allan Hunt, is about seven such claims annually per 100,000 workers. If this average held for Washington state, it would result in less than 200 pension claims per year. Instead, Washington had 1,771 pension claims in 2009 – nearly eight times this amount – and two to four times the level of the highest states (CA, MT, and FL) (Hunt 2008).

A number of factors contribute to Washington being so out of step. Upjohn's Hunt concludes:

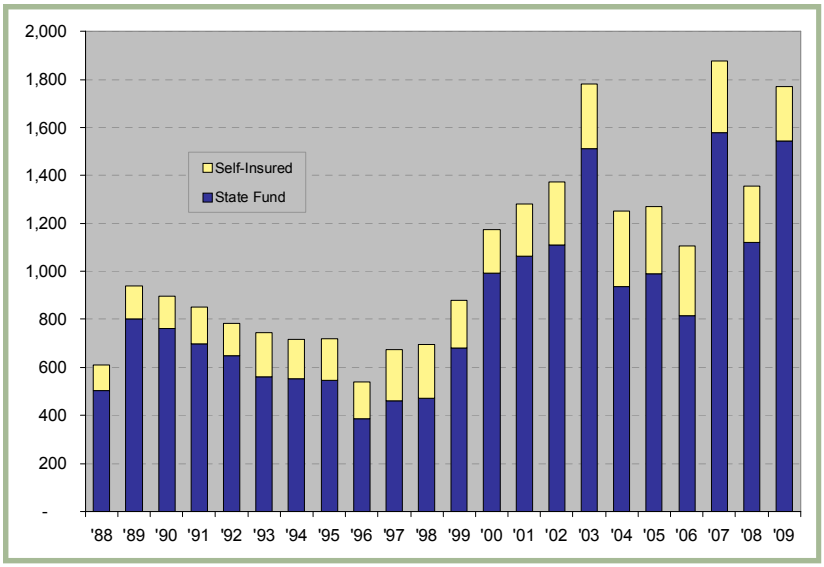
> Washington offers only two relatively extreme options (to address situations where a minor injury results in major income loss), a low impairment rating with consequent small benefit, or a total permanent disability pension, with no compromise in between.

As shown in Chart 3, Washington's state fund awarded 1,542 pensions in fiscal year 2009, nearly quadruple the number of pension awards in 1996, when the state fund began its climb in pension awards.

Oregon, by comparison, has reduced its number of pensions from just 11 in 1996 to only nine in 2008. L&I acknowledges that claims staying open for three years or more have a 50 percent chance of resulting in a pension

award. (L&I 2009)

Chart 3: Total Permanent Disability Pensions by Fiscal Year



Pensions are one of the largest factors contributing to Washington's high percentage of cash (*or indemnity*) benefits. In other states, where cash benefits' share of total benefits has been declining for the last decade, they accounted for about 50 percent of total benefits (cash plus medical) in 2007. In contrast Washington's cash benefits were nearly 64 percent in 2007. In Oregon, by comparison, cash benefits were just 47 percent of total benefits in 2007.

According to a recent report from the Upjohn Institute,

> Washington is different from most of the other states in that its workers' compensation program does not allow for compromise and release agreement for indemnity benefits to decisively close claims.

Such final settlement agreements provide a significant cost-saving opportunity for Washington, while bringing it into the mainstream of state workers' compensation provisions. Upjohn authors estimate that Washington is one of only eight other states not allowing compromise and release agreements (Barth 2008). Just a few of the advantages of such an option include:

- Providing injured workers and employers a proven middle-ground of an *optional* claims closure approach, currently unavailable in Washington;
- Financial certainty and emotional closure for disabled workers;
- Equitable settlements, which can be cost-effectively assured by oversight, review, and approval by an appeals board judge;
- Reduced legal costs for disabled workers, who currently give up to 30 percent of any on-going award to his/her attorney;
- Financial certainty for employers;
- Administrative simplicity;
- Reduced incidence of unnecessary and time-consuming litigation for all parties;
- Reduced long-term claims costs, which account for most of the system costs;
- Reduced or mitigated need for future rate increases.

Occupational Disease

Occupational diseases – diseases arising from a worker's exposure in the workplace – are rightfully covered by workers' compensation insurance. Their compensability makes sense conceptually. The challenge for states has been drawing a line between diseases that are "common to humankind" or "ordinary diseases of life" and those "not distinctively associated with" or "peculiar to or characteristic of a particular trade or occupation" (LWCL 2000).

In Washington laws defining "occupational disease," do not adequately distinguish those instances of workplace illness that are necessarily work-

related. Consider Washington's current definition (RCW 51.08.140):

> "Occupational disease" means such disease or infection as arises naturally and proximately out of employment under the mandatory or elective adoption provisions of this title.

While every state has language defining "occupational disease," other states go into much greater detail to outline what is referred to by some as the "arising" test. In states like Virginia, Illinois and Indiana, for example, statute states that the term "occupational disease" means a disease "arising out of and in the course of the employment, but not an ordinary disease of life to which the general public is exposed outside of the employment. A disease shall be deemed to arise out of the employment only if there is apparent to the rational mind, upon consideration of all the circumstances" noted below:

- There's a direct causal connection between the conditions under which work is performed and the occupational disease;
- The occupational disease follows as a natural incident of the work as a result of exposure occasioned by the nature of the employment;
- The disease can be fairly traced to employment as the proximate cause;
- The disease is not one to which an employee may have had substantial exposure outside of his employment; nor any condition of the neck, back or spinal column;
- The disease is incidental to the character of the business and not independent of the relation of the employer and employee; and
- The disease had its origin of risk connected with the employment and flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction.

Several states use language to define not only what "occupational disease" includes, but to list what diseases or conditions it specifically excludes. In Virginia, for example, "any condition of the neck, back, or spinal column," hearing loss and carpal tunnel syndrome are excluded and deemed to be "ordinary diseases of life."

Florida statute requires that a claimant satisfy a multi-pronged test including the following:

- The disease must be actually caused by employment conditions that are characteristic of and peculiar to a particular occupation;
- The disease must be actually contracted during employment in the particular occupation;
- The occupation must present a particular hazard of the disease occurring so as to distinguish that occupation from usual occupations, or the incidence of the disease must be substantially higher in the occupation than in usual occupations; and
- If the disease is an ordinary disease of life, the incidence of such a disease must be substantially higher in the particular occupation than in the general public.

In Oregon, "occupational disease" means:

> any disease or infection arising out of and in the course of employ-

> ment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death…

Oregon's statute goes on to list several specific requirements:

- Any disease or infection caused by ingestion or, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances;
- Any mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death;
- Any series of traumatic events or occurrences, which requires medical services or results in physical disability or death.

Washington's vague and ambiguous statutory language is open to subjective interpretation that may or may not reflect legislative intent. This language is expensive both in its direct costs of paying for otherwise non-qualified medical and wage claims and in the legal fees, administrative costs, and time required to clarify what situations should and should not be covered. Greater detail and legislative precision in articulating Washington's occupational disease policy will help guide practitioners and stem the rising costs associated with controversial claims.

Medical Provider Networks

Medical provider networks or MPNs have been tested and proven cost effective in numerous states throughout the country, including next-door neighbor Oregon. According to a study by WCRI, "medical networks are generally associated with much lower medical costs: 16 to 46 percent lower if the injured worker is treated by network providers and up to 11 percent lower if the worker is treated predominately, but not exclusively by network providers." (WCRI 2001)

MPNs have similar objectives to Washington's pilot health standards studies begun 10 years ago by the DL&I at the Renton Center for Occupational Health Excellence (COHE) and they provide even more positive results in states across the country.

One national employer reviewed in an article on medical risk management experienced the following results after adopting the MPN model in 2005 in California: (Stiles and Transue 2009)

- 27 percent reduction in average services per claim;
- 24 percent reduction in average physical service per claim;
- 17 percent decrease in average number of providers per claim;
- 10 percent reduction in average treatment duration;
- 9 percent reduction in number of visits per claim;
- 23 percent decrease in lost-time claims; and,
- 18 percent reduction in average disability durations.

Traditional medical network models in both workers compensation and regular health insurance have featured discounted reimbursement rates as the primary cost-saving mechanism. These systems over time have been slow to raise rates in order to keep up with inflation. As a result many networks have seen an erosion of qualified providers. This has been especially

true for key specialists often required in workers' compensation cases, due to rising costs of medical malpractice insurance. While higher provider rates, especially for key specialties, are likely part of the solution, a successful model has to include:

> Reasonable access to the right providers who have a record of positive outcomes; and who are willing to work with employers on return to work. It also requires on-going monitoring to ensure continuing quality (Stiles and Transue 2009).

While most states (44 states, WCRI 2009) allow some form of MPN, a smaller number (at least 27 states, WCRI 2009) require injured workers to participate and use physicians and other providers with the "record of positive outcomes," discussed by Stiles and Transue. Among the more recent states to adopt MPNs are Florida (2003), New Jersey (2003), West Virginia (2005), Texas (2005) and California (2005) (WCRI 2009).

In the first year of Florida's reform WCRI reported that:

- Average total cost per claim fell nearly 5 percent;
- Major cost components – medical, indemnity, and benefit delivery expenses per claim – decreased or plateaued after years of increases;
- Cash benefits per claim with more than seven days of lost time fell 11 percent; and
- Duration of time loss fell about 8 percent. (WCRI 2008)

Due to medical fee increases Florida has had to give back some of its savings in the second year of its reform.

In California major reforms were made between 2003 and 2004, including authorizing MPNs. Separating the beneficial effects of MPNs, which were first introduced in January 2005, is therefore somewhat difficult. A WCRI study in 2008 compared California to 13 other states. Based on this work, California costs per claim dropped by 15 percent in 2005 driven by rapid decreases in:

- Medical costs per claim (14 percent); and
- Cash benefits per claim with more than seven days of lost time (8 percent) including;
  - 9 percent decline in duration of temporary disability;
  - 6 percent decline in frequency of permanent partial disability/ lump sum claims;
  - 14 percent decline in the average PPD/lump sum payment per claim.

These decreases in frequency and payments per claim were the largest ones among all the states reviewed by WCRI (WCRI 2008).

As well, access to medical providers in California was "within the requirements imposed on MPNs":

- Most injured workers traveled 15 miles or less (86%) or 30 minutes or less (92%) to see their first provider; and
- Most also traveled 15 miles or less (82%) or 30 minutes or less (89%) to see their main provider (i.e., the provider most involved in their care)
- Most were able to get specialty care (92%); physical therapy (94%) and prescriptions (99%);

- The vast majority (82%) of injured workers had access to quality care and were satisfied with their care; and,
- Levels of satisfaction appeared unchanged from a similar study done in 1998 (Kominski et al, 2006).

The Texas Department of Insurance has released research that compares network and non-network medical outcomes for 34 workers' compensation networks certified by the department (TDI 2009).

- Networks had higher average medical costs than non-networks;
- Network injured workers tended to use professional services and pharmaceuticals more than those in non-networks;
- Overall, with some exceptions, non-network injured workers reported quicker care and greater satisfaction with their care;
- Overall, network injured workers reported higher return-to-work rates than non-network injured workers;
- All network injured workers had higher physical functioning scores than non-network injured workers; and
- Overall, the mental functioning scores of network injured workers are higher than non-network injured workers.

And finally, next door, Oregon authorized managed care organizations (MCOs) in 1990. By 1998 reductions in claims costs due to managed care coverage included (DCBS 1999).

- Medical cost at 12.4 percent;
- Time loss cost at 9.9 percent;
- Permanent partial disability cost at 17.5 percent; and
- Total claims cost at 12.9 percent.

Mainstreaming Makes Sense

With the challenging and economically stressful times currently facing Washington's businesses and workers, now is not the time to saddle them with costs that are any higher than absolutely necessary.

This paper presents three areas of workers' compensation system reform that will provide immediate cost savings. Such opportunities can relieve significant and unnecessary cost burdens without reducing injured workers' benefits. As research from around the country demonstrates, these cost saving reforms improve patient care, without detriment to patient satisfaction or access to qualified health care providers.

At a time when other states are doing everything possible to position themselves for positive economic growth as the national economy begins to recover, these kinds of cost effective, long-term reforms that can bring Washington more fully into the competitive mainstream cannot be ignored or postponed.

References

Barth, Professor Peter, et al. 2008. Washington Pension System Review. Upjohn Institute Technical Report No. 08-025. November 12.

Hunt, Dr. H. Allan. 2008. Total Permanent Disability in Washington, W. E. Upjohn Institute for Employment Research. October.

Kominski, Gerald F., Nadereh Pourat, Dylan H. Roby, and Meghan E. Cameron. 2006. Access to Medical Treatment in the California Workers' Compensation System, 2006, UCLA Center for Health Policy Research. December.

Larson's Workers' Compensation Law (LWCL). 2000. 52.03(2). May.

L&I Public Affairs (L&I). 2009. Facts about workers' comp, Department of Labor and Industries. October.

Research and Analysis Section (RAAS). 1999. Managed Care in the Oregon Workers' Compensation System, Oregon Department of Consumer and Business Services. April.

Stiles, Dean and Brannon Transue. 2009. Is there a Doctor in the House? Provider Trends in Workers Compensation, The Journal of Workers Compensation, Vol. 18, No. 3. Spring.

Texas Department of Insurance. 2009. Workers' Compensation Network Report Card Results, Workers' Compensation Research and Evaluation Group, http://www.tdi.state.tx.us/reports/wcreg/documents/2009reportcard2.pdf.

Washington Alliance for a Competitive Economy. 2006. Workers' Compensation 2006. September 20.

Workers' Compensation Advisory Committee. 2009. 2010 Proposed Rate Discussion (slide presentation), Department of Labor and Industries. September 21.

Workers' Compensation Research Institute (WCRI). 1997. Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 1997-1998, by Stacey M. Eccleston and Carter M. Yeager.

———. 2001a. Impact of Initial Treatment by Network Providers on Workers' Compensation Medical Costs and Disability Payments, DM-01-01, by Sharon E. Fox, Richard A. Victor, and Xiaoping Zhao. August.

———. 2001b. Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002, WC 01-04, by Romona P. Tanabe and Susan M. Murray. December.

———. 2008a. Monitoring 2002-2004 Reforms in California: CompScope Benchmarks, 8th Edition. March.

———. 2008b. Monitoring 2003 Reforms in Florida: CompScope Benchmarks, 8th Edition. May.

———. 2009. Workers' Compensation Medical Cost Containment: A National Inventory as of January 1, 2008, WC-09-15. February.