Dynamic Chiropractic

Managed Care in the Workers' Compensation Environment -- Part I

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Introduction:

Workers' compensation costs are now medically driven. Workers' compensation has traditionally been viewed as casualty insurance or defined compensation for an unexpected event. Because of this, it has been written by property and casualty insurers. This made sense when "no fault" protection for on-the-job injuries was introduced in the early part of this century. Medicine could do very little for the injured worker. The main issue was compensating the disabled worker for future earnings loss, quickly and efficiently .

Medicine, surgery, and chiropractic have made incredible advances and health care now drives the cost of both wage replacement and medical care in each workers' compensation case. The primary physician's opinion of the case determines the length, extent, and permanence of disability according to statute. In stark contrast, the expectations of medical care far outpaces its ability to resolve the complex interactions between a worker's injury/illness, job satisfaction, labor relations, family and personal reactions to disability, and the legal system. Furthermore, there are differences in the way workers' compensation patients are treated and who treats them that magnify the problem even further. Employers, insurers, workers' compensation boards, and some employee advocates are increasingly concerned about the costs and quality of care rendered under the workers' compensation system in each state. They are also concerned about the appropriateness of much of the disability absence that occurs under the present system.

Causes of Cost Increases

Workers' compensation medical costs have been rising at an alarming rate. In 1988, it accounted for about $10.6 billion. This is only a small portion of the $580 billion in total health care costs in the United States (according to the social security administration). However, there are several aspects of the workers' compensation system that magnify the inflationary forces acting on the general health care economy. The rate of increase of workers' compensation costs has far exceeded the growth rate of non-work-related health and disability costs (the rate was twice the general medical inflation from 1984-1986). In addition, the medical component of workers' compensation drives a total compensation bill of $31.6 billion. The medical component accounts for almost 40 percent of total cost for private payers.1 Employers and property and casualty insurers who write workers' compensation insurance are caught in a crisis.

Economic Environment of Medical Care

Total health care expenditures in the United States have been rising at rates far in excess of inflation for over two decades. Total expenditures ($580 billion) exceed 11.5 percent of the GNP. It is expected to exceed 15 percent of the GNP by the year 2,000.[1] In response, Medicare has instituted the diagnostic related group (DRG) system of reimbursement or paying a set fee for an episode of a given illness. The Health Care Financing Administration (HCFA) has also restricted the

rate of increase for DRGs and other fees to a few percent a year. This pay schedule has been significantly below the rate of medical inflation. State and local funds have also resorted to reimbursement caps or discounted payment schedules in order to cope with rapid medical inflation and revenue shortfalls. Health care costs, in its various forms, can be compared to a balloon -- squeeze it in one place and it expands somewhere else. This is particularly true in the workers' compensation environment; it appears as if costs are being shifted from group health insurance to workers' compensation. This occurs in several ways:

1. Cost Shifting -- Certain government payments (Medicare) are paid at a set fee which is usually well below the cost of delivering that service (especially if you don't run an efficient office or if you have an exorbitant overhead). To compensate for these known low payment rates, providers may typically set higher fees than they normally would if everyone paid the same amount.[2] Full pay patients maintain an income level for the doctor. A perfect example of this is the NOOPE (no out of pocket) phenomenon. If your normal first day fees are $100 but your patient has a $100 deductible, you would waive (absorb) that first day's fee and any other part of the co-pay the patient is normally responsible for. Chiropractors who subscribe to this philosophy do so with the thought of decreasing patient resistance (removing the fee/money barrier) and increasing patient traffic (since the patient is receiving services seemingly "free"). It seems that these chiropractors believe they will make less on each patient but hope to make it up in volume.

One of the problems this philosophy brings is that since worker's compensation cases are often paid at first-day/first-dollar coverage, money "lost" on the NOOPE patients is shifted to the workers' compensation patient. These "full-pay" patients pay the "inflated" fee, allegedly to balance the budget or maintain an income level for the chiropractor. The NOOPE patients usually far outnumber the full-pay workers' compensation patients. Suppose that the NOOPE (discounted) patients account for two-thirds of the doctor's revenue; depending on how efficiently the doctor runs his office or what his revenue target is, the full-pay (workers' compensation) patients could be paying up to one-third more than the discounted patients. Since workers' compensation typically pays 100% in non-fee-schedule states, costs are loaded onto these patients. A Workers' Compensation Research Institute (WCRI) study showed that, in Florida, hospitals collect 74% of charges from all payers, but 91% from compensation insurers.[3] These are the full (inflated) charges which compensate for the anticipated charge reductions from other payers (government reimbursements and Blue Cross, for example).

2. Target Income -- As Florida hospitals have adjusted charges to meet a break-even or profit target, physicians, rehabilitation centers, and chiropractors (as well as other providers) seem to have set a conscious or unconscious target income.[4] When caps or fee schedules were imposed by some payers, full fees rose to compensate. I see and hear this phenomenon occur all too often. There is a practice management group that rewards its new clients for a "first month income achievement." The goal is to achieve a maximum dollar goal during your first month in business. Since many chiropractors enter a marketplace where there is stiff competition due to a surplus of chiropractors and increasing insurance copayments, I see the number of return visits per patients rising far beyond normal known healing parameters (e.g., having one patient return for 100 visits instead of having 10 patients return for 10 visits). It's not put to the new DC clients quite so coldly, but rather they receive subtle pressure that they should achieve a 63 visit patient average, for example. After all, workers' compensation is paying at 100 percent -- the patient's getting much needed (???) chiropractic care and the chiropractor is getting rich. Who's getting hurt? Ultimately, we all are. Another avenue that enhances target income is ancillary facilities.[5] This includes MRI facilities, rehabilitation facilities, diagnostic testing facilities, etc.

Workers Compensation Benefit Plan Structure -- Part of the Problem of Medical Cost Inflation

Most group health benefit plans have substantially large deductibles and co-payments to make the patient exercise some judgement before purchasing medical/chiropractic services. We are seeing more and more benefit caps and/or lifetime maximums on various types of coverage. Workers' compensation typically pays 100 percent of charges, except in fee schedule states. There is no lifetime maximum. There are also no defined benefits. Experience has shown that the group health benefits plan design has moderated increases in insurance costs better than workers' compensation. The designed benefits plans are contrary to the philosophy of the workers' compensation system, but they clearly reflect today's macroeconomic aspects of health providers and health consumer behavior. Mandated benefits, such as rehabilitation, were originally designed to address problems of underutilization. It has been my experience, however, that in practice, mandated benefits have been an open invitation to overprescription.

Non-Casually Related Treatment -- Many providers are obtaining maximum reimbursement, avoiding deductibles and copayments, and avoiding insurance review organizations by falsely claiming unrelated, on-the-job injuries and filing a workers' compensation claim.[6,7] An article in the October 1987 Business Week stated that "savvy employees and medical providers are using the workers' compensation system to pay medical expenses no longer covered by group health plans."

Litigation -- The involvement of attorneys has tended to increase both the amount of testing and treatment to "prove" the presence of an injury and to increase the amounts of settlements. In the state of Texas, the legislature has recently recognized this phenomenon. The "system" in Texas recognized two types of claims. In the first type, the injured worker has lost time from his job. The Industrial Accident Board, now known as the Texas Workers' Compensation Commission, automatically sets up a file and this claim is given a file number. In the second type, the injured worker has not lost time from his job, and the Texas Workers' Compensation Commission does not set up a file.

This seems like a workable system until a claim is controverted by the carrier and bills are cut. In the first lost-time type of claim, there is a mechanism to deal with the problem. There is a file, a hearing can be obtained and ultimately a compromise settlement agreement (CSA) can be entered into between the insurance carrier and the involved party. When there is no lost time and therefore no file, the Texas Workers' Compensation Commission immediately assumes that the claim stays open indefinitely with open medicals. There cannot be a move toward a compromise settlement agreement. The compromise settlement agreement closes the file and is composed of three parts: Past medicals or any outstanding bills would be paid or negotiated; future medicals would be paid or negotiated; and a cash settlement would be negotiated. Obviously, the compromise settlement agreement and the closing of the file is the optimum resolution of the case. The system seems to invite attorney involvement and the issuance of lost time when lost time may not be necessary. Certainly when the attorney is involved, it is in his and his client's best interests to have lost time so that a compromise settlement agreement can be negotiated.

In their wisdom, the Texas Legislature realized that there was a problem here and some changes took place on July 1, 1990. Other changes will be taking place on January 1, 1991 and still others will be taking place in 1993. One of the areas that the Legislature improved was the passage of a 10% cap on attorney fees in workers' compensation cases. Previously, attorney fees were at 25% of the compromise settlement agreement. Needless to say, the attorneys were having a field day and the system invited cost inflation on the plaintiff's side. There are numerous examples of attorney involvement creating an adversarial environment in the workers' compensation system. It is important to understand that there is a need for attorneys to ensure that the claimant gets every

benefit legally due him, but when the attorney controls the medical aspects of a case, one has to strongly question the motive behind their involvement.

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