Managed Care and the Law of Unintended Consequences

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Overall workers compensation medical costs will likely exceed $29 billion in 2003. Driven by rapidly rising hospital and prescription drug costs, medical expenses are increasing at an annual rate of 15 percent, almost twice as fast as they were in the late nineties. Once again, workers compensation medical costs are the subject of intense scrutiny by regulators, insurers, and employers alike. How did this happen?

Didn't many states institute managed care programs? Isn't the injury trend rate continuing its decade-long decline? Don't almost all carriers, employers, and TPAs use managed care programs? Aren't bill review and PPO programs the norm rather than the exception?

The answer to all these questions is yes. Yet despite these steps, and all the work poured into regulations, programs, and operational changes, the reality is that medical costs are once again the most significant problem in workers compensation. No small contributor to the significant financial difficulties experienced by many carriers and reinsurers, health care costs appear to be an intractable, insoluble problem.

Doesn't managed care work? Rising medical costs have been enough for some in the industry to throw up their hands and abandon managed care. Just as well, for the work required to truly manage the medical component of workers compensation can be far more complicated than these individuals wish. Their desires for quick, easy answers that require little change to operations, for cookie-cutter solutions to complex issues, and their simplistic focus on per-unit savings rather than concentrating on total medical costs and outcomes has, in large part, contributed to their medical cost problem.

The reality is that most attempts to address health care costs have been of the blunt instrument variety. Vendors and payers alike have tried to fix a highly complex and diverse problems with a single generic solution. And in so doing, they have actually made the problem worse.

The Law of Unintended Consequences

The least subtle of the blunt instruments is the workers compensation fee schedule. Regulators á enthusiastically backed by employers and carriers instituted fee schedules that limit the amount paid for
a unit of medical service, ostensibly to contain medical costs. The unintended consequence is that not only do fee schedules do nothing to control total medical costs, they may actually help drive up medical costs.

If the fee schedule theory worked, then states with the lowest fee schedules would have the lowest medical costs and the converse would be true. The theory doesn't work.

Florida has the lowest fee schedule, but its average medical cost for lost-time claims is slightly ABOVE a 12-state median (source: WCRI, The anatomy of Workers’ Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 1996-1999). On the other hand, Connecticut has one of the highest fee schedules in the country and its average medical cost for lost-time claims is almost 30 percent BELOW the median.

Examining WCRI’s research, one finds no correlation between fee schedule levels and total medical costs. Despite that, PPO firms and their customers remain committed to the low fee schedule model. The reason is simple: it's profitable for the PPOs and, until now, accepted by the market.

PPOs contract with providers to deliver services at a discount. Most PPOs get paid a percentage of the savings that is delivered by that discount, typically 15 to 22 percent of the savings. So, the more the PPO saves, the more it makes. On the surface, this sounds good: the system rewards the PPO for saving money and does not pay it when it delivers no savings.

However, a closer look reveals that when the PPO vendors win, the payer loses. The ugly head of the Law of Unintended Consequences emerges again.

At the most basic level, health care costs are driven by a relatively simple equation:

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\text{Price per Unit} \times \text{Number of Units} = \text{Total Costs}
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Under a percentage-of-savings arrangement, reducing total cost is ignored in favor of saving money on unit costs. The PPO gets paid for savings on individual bills. Therefore, the more services that are delivered and the more bills generated, the greater the savings and the more money the PPO makes.

The system encourages over utilization because it is in the PPO's best interest financially to have numerous providers generate lots of bills for lots of services. Also, the providers, squeezed by a per-unit
fee schedule that is lower than fee schedule/Usual and Customary Rates (UCR), have a perverse incentive to make up for that discount by performing more services.

The industry has been hit, and hit hard, by the Law of Unintended Consequences. Two of the top managed care "fixes" fee schedules and PPOs with pricing based on percentage of savings encourage over-utilization, a major cost driver for workers' compensation.

It's no wonder that most PPOs like this model, but why would any of their customers? The simple answer is that managed care departments at many carriers and third party administrators (TPAs) are evaluated on the basis of their network penetration (the percentage of dollars that flow through a network provider) and network savings (on a per-bill basis). Their internal and external customers have bought into the per-unit discount model, and measure the success of their managed care programs on the dollars and/or bills that flow thru the network, and the savings below fee schedule or UCR delivered by the network.

The fact is few carriers, TPAs, or employers have realized that per-bill savings is the wrong way to assess a managed care program. And unless senior management changes their evaluation methodology, their managed care departments will have no incentive to change their program to one that actually does reduce total costs.

Studies Show Smaller, Experienced Networks Produce Better Results

A study recently authored by Alex Swedlow and Laura Gardner of the California Workers Compensation Institute indicates that a relatively few expert providers deliver by far the best outcomes and lowest medical costs for workers compensation cases. The report, entitled Provider Experience and Volume-Based Outcomes in California Workers Compensation, is the result of an exhaustive study of almost 1.1 million claims over an eight-year period treated by some 40,000 separate providers. While the entire study is worthy of careful and detailed analysis, several findings are particularly important.

- The medical costs of claims treated by the highest-volume workers compensation providers are LESS THAN HALF that of their peers who treat the fewest workers compensation cases. Providers with only one claim in the study period averaged $19,856 total cost per claim, compared to providers with more than a thousand claims, who averaged $8,707.

- For temporary disability claims, the average length of disability for the highest-volume providers was less than half that of the lowest-volume providers, (17.2 days vs. 35.9). This differential was
consistent for permanent disability claims, with the highest-volume providers' length of disability some 71 days less than that delivered by the lowest-volume providers

• The more workers compensation experience a provider had, the lower the likelihood of attorney involvement in their claims.

• Even when claims were litigated, the highest volume providers delivered total claims costs 54.8 percent lower than the lowest volume providers

Perhaps most telling from a network strategy perspective, only 2.2 percent, or 880 providers, accounted for almost 2/3 of all claims. These claims showed the best outcomes and had the lowest total claim costs. This compares to the low-volume providers, where 25,840 providers handled just over 42,000 claims, or less than 3.9 percent of all claims in the study.

The study, the first of its kind to review a large population over a long period, clearly indicates that the more workers compensation experience a provider had, the better the outcomes for their patients. Conversely, less experienced providers delivered significantly poorer results in all categories.

The CWCI study has been replicated, albeit on a much smaller patient population base, in Florida by a Health Strategy Associates client. In the Florida study, high-volume providers' cases also closed much faster, had lower attorney involvement and showed significantly lower total case costs. Interestingly, the client's business model is not predicated on a percentage-of-savings basis, nor does it seek deep discounts from most of its providers.

Clearly, for employers and carriers interested in total cost per claim, it is better to use a smaller network of providers who treat a lot of workers compensation claims. It's counter-productive to have a large provider panel; the additional network savings generated by discounts below fee schedule will be outweighed by their overall lower performance. Therefore, large networks of lots of providers likely INCREASE a payer's claims costs. Ideally, carriers should contract with a selected number of experienced providers, and direct as much care as possible to those providers.

Equally significant, the percentage-of-savings model encourages PPOs and managed care staff to NOT direct injured workers to high-volume providers. While experienced workers compensation providers are associated with low total claims costs, are adept at keeping attorney involvement rates low, and reduce litigation expenses, they don't contribute to PPO revenues as much as low-volume providers do.
Diagnose, Then Treat

Until now we have concentrated on the overall problems inherent in the large deep-discount PPO model – a generic discount strategy, flawed pricing methodology, and counter-productive approach to contracting. It would be fortunate indeed if these were the only problems, but that is not reality.

The delivery of medical care services in workers compensation is an incredibly complex, diverse issue. Unfortunately, PPOs are generic solutions to this diverse problem. While the PPO cure works for some of the ills of the health care system, it actually exacerbates some of the more serious problems.

Like a physician confronted with diagnosing and treating a complex medical condition, managed care decision makers face a multifaceted problem. They first need to understand the condition, and then develop a treatment plan.

Some of the conditions facing the managed care decision maker are a broad range of provider types, levels of expertise, and business models driven and affected by outside forces such as Medicare reimbursement, jurisdictional rules, fee schedules, provider market structure, staff shortages, and medical malpractice insurance availability. The factors driving one component of the business may, or more likely may not, have the same impact on another sector. The blunt instrument of blanket price control, in the form of PPOs, is not appropriate for managing all types of medical expenses in workers compensation. That's not to say that there is no place for large PPOs; they can be quite useful in reducing some specific types of expense.

The Workers Compensation Research Institute's analyses show that not only are there significant variations in medical expenses among states, but they also point out areas that are problems in some states, but not others. One of the more notable issues is physical therapy (PT) and the broader category of physical medicine. Physical medicine is the largest single component of workers compensation medical expense, representing between 20 and 30 percent of all medical costs (specific percentage varies by state). In addition, physical medicine is involved in the majority of lost-time claims, and thus is associated with the relatively few claims that drive most of the loss cost.

Historically, workers compensation payers dealt with PT expenses through a combination of broad-based, deep-discounted PPOs and occasionally PT utilization.
PPOs typically contract with facilities, individual clinics and hospitals for PT at a percentage off fee schedule, charges or UCR ranging from 10-20 percent. While these discounts seem reasonable at first blush, the savings they deliver is illusory.

The problem with PT is not the price per service but the amount of services delivered, something generic PPO arrangements can't control. Typically, PT treatment courses can run from 12-18 visits. At $75 per visit (post-PPO discount) total costs can easily hit $900 - $1,350 per case. Clearly the broad-based PPO may help reduce costs on a per-bill basis, but does nothing to address utilization. For that, one would then turn to pre-certification.

Unfortunately, many payers don't believe it pays to require pre-certification of PT since the cost per service or even per day in PT is relatively low. Those that do often find that the commercially-available treatment guidelines are too broad, certifying a wide range of visits as appropriate and remaining silent on what treatments should be delivered during those visits. Therefore, the ROI for most PT pre-certification is marginal at best. The reason? Actually, there are two. First, the recommended number of visits is quite broad, e.g. 10-18 visits, and therefore not terribly helpful. Second, most of the commercially available guidelines are seriously lacking in the science needed to back up tighter limits on PT. Without that solid foundation, adjusters are reluctant to push providers too hard to accept limits on PT. Again, most of today's PT precert programs are broad-brush solutions to problems that require an approach specific to the nuances of PT in workers compensation.

While PT is predominantly a utilization issue, there can be significant differences between and among states. The Workers' Compensating Research Institute, a Cambridge Mass. organization that is one of the pre-eminent sources of timely, in-depth research information about all aspects of the workers compensation industry, publishes a variety of reports focused on cost drivers in workers compensation. One study, entitled the "Anatomy of Workers Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 1996 - 1999," indicates the delivery of physical medicine varies widely around the country. No wonder then that generic managed care programs are failing to deliver returns. It is a safe bet that they are directing resources to attack problems that don't exist, while ignoring areas that are much more problematic.

In Florida, PT utilization in non-hospital settings is a comparatively minor contributor to medical costs. Even still, significant savings (double that available through broad generalist networks) can be obtained through the use of specialty managed care networks focused on PT. Utilization in hospital-based PT is also relatively low, however it is quite expensive on a price-per-service basis. Therefore, while it may
not pay to pre-cert non-hospital PT in Florida, the ROI on pre-cert for PT provided by a hospital should be quite good.

By comparison, physical medicine expense in Texas is primarily a utilization issue. The number of services delivered in Texas is significantly higher than in the other 11 states in the CompScope analysis. In addition, Texas does not require utilization review for precert. This high utilization correlates with higher costs for physical medicine; Texas' costs are significantly above the average. However, Texas has certain regulations that make it highly cost-effective to retrospectively manage PT. A retrospective Utilization Management (UM) program that examines each bill and denies charges that are not supported in the treatment notes and records can deliver savings in excess of 30 percent.

Clearly, Florida requires a different solution than Texas. Resource allocations should reflect this, by emphasizing programs that take advantage of any cost management opportunities available, while not wasting resources on generic programs unsuited to individual states.

**Hospital costs**

The single fastest growing component of overall health care costs, hospital expenses are once again coming under scrutiny. In this case deep-discount networks clearly shine, as their large patient volume and contracting power can deliver significant discounts. PPOs also derive much of their revenue and profit from discounts at hospitals, so workers compensation payers can be sure that most PPOs will pay close attention to this area.

The area gaining the most attention in the hospital sector is ambulatory surgery. Hospitals and health care systems have adapted to changes in reimbursement quite effectively, as evidenced by the increasing use of ambulatory surgery centers. Again, a large, deep-discount network, coupled with a tightly managed pre-cert program will help manage both costs and utilization. Remember, the discounts are likely a percentage off the fee schedule, and therefore the perverse incentives discussed above still exist.

**Prescription drugs**

Prescription drugs are becoming an increasingly important component of medical expense in workers compensation. Rising at double digit rates each year, drugs now account for almost 10 percent of medical costs. Here, traditional deep discount concept works well. However, even in this relatively simple situation, it is necessary to select a specialist to glean the most benefit. For pharmacy management, cost per script is a key issue, with utilization gaining in importance recently.
The ideal choice is a large Pharmacy Benefit Management (PBM) firm with both workers' compensation and group health contracts with pharmacies. The group health contracts buy name recognition and deep discounts while the workers compensation specialty ensures that the appropriate rules will be followed in the dispensing of the drug. Utilization controls take the form of drug formularies and Drug Utilization Review (DUR) programs, where clinician-developed automated UR systems review the prescription instantly.

The Finger in the Dike

Given the prevalence of the large deep discount PPO, and their contribution to utilization, in the workers compensation industry, it is not surprising that payers have looked for programs and methods designed to attack over-utilization. By and large, the most common tool used to fight over utilization is a nurse-based utilization management (UM) program. The mandate for these programs is clear: reduce inappropriate utilization of medical services.

Nurses work with treating providers and adjusters to reduce, or ideally eliminate, unnecessary treatments, procedures, and admissions. The tools at their disposal include software workflow applications, medical guidelines and criteria sets, disability duration guidelines, peer review services, and their experience in the field. They use their experience, supported by the science embedded in their guidelines, criteria, and research, to suggest, encourage, cajole, or outright badger the provider into adopting appropriate utilization patterns.

For some procedures and in selected jurisdictions, this is undoubtedly effective. High-cost services such as radiology, surgery, and inpatient admissions can, and sometimes are, effectively managed by UM tools. These tools are markedly less effective in states such as Texas, which do not require providers to abide by UM determinations.

While these tools are undoubtedly helpful in some jurisdictions, as discussed earlier, they are arrayed against a set of financial incentives that are quite powerful. At its core, UM is an effort to combat the financial incentives of the provider, the PPO, and the senior management of the managed care department. While successes occur in the form of procedures avoided and admissions averted, these will be costly.

Nurse and peer review time are expensive and limited commodities and have to be judiciously applied. They are typically only employed in those instances where there is a particularly egregious example of
inappropriate treatment, and even then, have only limited success in changing treatment patterns. For the vast majority of services, there is no reason to perform UM as the services are either too cheap (who wants to pay a nurse $65 an hour to attack a cold pack treatment in PT?). More commonly, there is little to no science supporting the denial or approval of payment for that procedure in that circumstance. Moreover, provider practice patterns vary so widely across the nation, that what is viewed as acceptable in one area is unheard of in another. There is just as much evidence supporting one position as the other, so what standard does a UM department use in assessing the efficacy of the treatment, and potentially the payment for it. Most commonly, the answer is none.

**Is Managed Care Dead, Then?**

While it may appear that the purpose of this article is to disabuse any and all of any interest in any form of managed care, that is not the case. In fact, managed care, done intelligently, can do much to save us from the problems we have created for ourselves. Now that we have a better, albeit not complete, understanding of the present situation, we can begin to implement programs that will actually reduce total medical costs, and not just improve vendors' bottom lines.

Clearly, the large generalist workers compensation managed care firms have run their course. While there is considerable disagreement about their real effectiveness, they have been able to demonstrate significant PPO savings and publish attractive ROI statistics for bill review and case management. Unfortunately, workers compensation payers' savings levels across the nation are actually declining while network penetration rates are leveling off. As a consequence, their results are diminishing, along with the value they are delivering to their clients. Meanwhile, a whole new branch of the industry has sprung up almost unnoticed, until it is now poised to take over a significant share of the workers compensation managed care market.

**Specialty Managed Care**

It is easiest to define specialty workers compensation managed care companies by talking about them in the context of their more common and usually better known big brothers, the generalist workers compensation managed care firms. Traditionally, generalist firms provide a full range of services, such as networks, bill review, telephonic and field case management, and related services across several, or most states, to carriers, TPAs, and self-administered employers. Their sales pitch focuses on the idea that integrated services are easier to administer than fragmented services.
The truth is not every network company provides the best network in every state, not every claims adjuster is closely linked to a case manager, and not every case management determination finds its way into the bill review system. Up till recently, the obvious benefits inherent in specialty companies' tight focus and special expertise were (in the minds of some) outweighed by the challenge of working with multiple vendors. That has changed, as workers compensation carriers, employers, and claims payers are revisiting that calculus and finding that specialty workers compensation managed care programs are highly cost-effective.

The recent decisions by carriers such as Zenith, AIG, Zurich, Liberty Mutual, and CNA, TPAs including Sedgwick and Cambridge, MCOs including Genex and Diversified, and employers such as Aramark to carve out PT networks in some states, provide compelling evidence of the sea change occurring in managed care decision criteria. When other changes, such as the carve-out of prescription drug management by Liberty, Hartford, Travelers and others; Supervalu's decision to utilize a Florida-specific MCA, and the rapid rise in popularity of imaging-specific networks are considered, the trend becomes clear: specialty managed care in workers compensation is growing rapidly.

There are two general types of specialty firms: those that are geographically focused and those that concentrate on a type of care or provider. A specialty company might be expert in the management of physical therapy, catastrophic cases, or radiology. It may know a particular state, or a type of provider, better than anyone. Specialty firms may have networks, bill review, and/or case management and referral management, or just one of these services. Their specialization enables them to deliver better outcomes defined as improved patient functional status and lower costs than their broad-based competitors.

**Geographic Specialty**

Typically, geographic firms provide network access, and sometimes other services such as bill review and case management, in a state. Their local knowledge and presence has several significant advantages:

- Strong ties to and knowledge of the provider community enables them to negotiate more intelligently and effectively, driving down costs and delivering the best providers.

- Ability to work with local claims and policyholder staff to educate them on and interface with the provider community
• Local experience helps identify the providers that are most attractive, lending credibility to the network

• Deep knowledge of state regulations and the legal environment is invaluable to adjusters

• Local knowledge ensures they are on top of changes in the regional health care community, such as mergers, alliances, and ventures that will impact patients and insureds.

• Good access to and relationships with local regulators and officials, streamlining regulatory approvals and the like.

Because they are more attuned to local conditions, these firms often are better able to adapt to changes. For example, recent legislative changes in Florida will have a significant impact on contracts and relationships with both hospitals and physicians. Local MCAs have shown themselves able to adapt quickly, meeting with their contracted providers to educate them on the changes, beginning the re-contracting process to address impending changes in the fee schedule, and working with claims payers to ensure they are prepared to meet new regulatory requirements. While national firms could certainly follow this path, few appear to have moved as quickly as the local firms.

Medical Specialty

Specialty firms concentrate on a type of care or medical specialty and usually operate in multiple states. They may work in the imaging, physical therapy, occupational medicine, or pharmacy sectors, among other niches. Their strengths include:

• Extensive in-house expertise in their niche - PTs, pharmacists, radiologists etc.

• Unique or specific business models that are highly relevant to their niche

• Highly effective technology solutions that enable integration of their program into broad-based programs

• Strong data collection, analysis, and reporting orientations

• Medical management programs that address the unique nature of their niche, e.g., Drug Utilization Review (DUR) for pharmacy; utilization management tools for PT.
• Systems connectivity capabilities that facilitate integration of their program into a payer's overall managed care offering

• Ability to deliver value to providers in the form of technology, billing management, connectivity, medical guidelines, cash flow management tools

The key to their success is their expertise in their chosen area. As noted above, WCRI's research clearly indicates that not all health care is the same. These firms have a deep understanding of their niche, and use that understanding to deliver solutions customized for that niche.

The Ideal World

The complexities of the health care delivery system, coupled with workers compensation reimbursement regulations makes managing medical costs in workers compensation a dynamic and difficult problem. Generic, big box solutions still have their function. Most deep-discount PPOs deliver large savings on hospital bills, and hospital discounts make significant contributions to overall savings. And, for workers compensation payers that are either not able to direct injured workers to specific physicians, or constrained by regulation from directing, large PPOs can deliver some savings in the form of per-bill reductions below fee schedule/UCR. However these large PPOs must be used judiciously so as to not create more problems than they solve.

Ideally, employers and other payers will integrate generic deep discount networks with smaller provider organizations with deep expertise in defined areas such as prescription drug management, physical medicine and other medical specialties, and/or a particular geographic jurisdiction. The discounts that large PPOs can bring to the table can certainly help reduce medical expenses, but only if the care that is delivered through those PPOs is managed by providers with who treat high volumes of workers' compensation patients.

There will be resistance from some of the larger firms, but this can be overcome. If they want to remain significant players in this sector, they must adapt to meet the demands of the market. Fortunately, a growing awareness of the importance of total medical costs and the demonstrated results delivered by specialty managed care firms promises a renewed future for managed care in workers compensation.

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