ANNUAL REPORT

RESEARCH REVIEW

2016

WORKERS COMPENSATION RESEARCH INSTITUTE
It is an honor to have taken the helm of such a well-respected organization, whose mission is to be a catalyst for improvements in states’ workers’ compensation systems. In the short period of time that I have been at WCRI, I have witnessed the tremendous support that the Institute receives from its members and friends, and have been impressed with WCRI’s rigorous attention to data analysis and quality. Looking forward, I am excited about our research agenda, which includes timely issues and topics like worker outcomes, fee schedules, drug formularies, and opioids. As the systems continue to face changes and challenges in states across the country, the need for independent data and research could not be greater. As an objective source of information on the benefit delivery systems across a wide number of states, WCRI fills an important void in providing information to policymakers and other stakeholders regarding the performance of workers’ compensation systems.

Before WCRI and other research organizations came into existence, debates regarding workers’ compensation system reform were largely based on anecdote. In contrast, the information WCRI provides stakeholders is obtained through research studies and systematic data collection efforts, which conform to recognized scientific methods.

Over the past year, WCRI’s work was used often by public officials. Below are some abbreviated examples. More detail on these examples can be found on page 6.

➢ In California and North Carolina, WCRI’s research was used by policymakers as they contemplated adopting a drug formulary.
➢ In Illinois and Wisconsin, WCRI’s CompScope™ Benchmarks were used by legislators to ground debates concerning their workers’ compensation systems and help understand the impact of reforms.
➢ In Virginia, Louisiana, and Minnesota, WCRI’s research on fee schedules was used to help control medical costs.
➢ In Nevada and Massachusetts, WCRI’s opioid research was used in debates to better understand variation and long-term use across the country as well as to put in place measures to slow the opioid epidemic among injured workers.

We are proud of the work we have published to date and look forward to addressing the issues of the future. We stand ready to provide impactful research, and to improve upon the comprehensiveness and delivery of our research.

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

Respectfully yours,

John W. Ruser, Ph.D.
President and CEO
The Institute

The Workers Compensation Research Institute is an independent, not-for-profit research organization providing high-quality, objective information about public policy issues involving workers’ compensation systems.

The Institute’s work helps those interested in improving workers’ compensation systems by providing much-needed data and analyses that help answer the following questions:

➢ How are workers’ compensation systems performing?
➢ How do various state systems compare?
➢ How can systems better meet workers’ needs?
➢ What factors are driving costs?
➢ What is the impact of legislative change on system outcomes?
➢ What are the possible consequences of proposed system changes? Are there alternative solutions that merit consideration? What are their consequences?

Those who benefit from the Institute’s work include public officials, insurers, employers, injured workers, organized labor, and others affected by workers’ compensation systems across the United States and around the world.

Organized in late 1983, the Institute is independent, not controlled by any industry or trade group. The Institute does not take positions on the issues it researches; rather, it provides information obtained through studies and data-collection efforts that conform to recognized scientific methods, with objectivity further ensured through rigorous, unbiased quality control procedures.

The Institute’s work takes several forms:

➢ Original research studies of major issues confronting workers’ compensation systems (for example, permanent partial disability, litigiousness, and medical management)
➢ Studies of individual state systems where policymakers have shown an interest in change and where there is an unmet need for objective information
➢ Studies of states that have undergone major legislative changes to measure the impact of those changes and draw possible lessons for other states
➢ Studies to identify those system features that are associated with positive and negative outcomes
➢ Presentations on research findings to legislators, workers’ compensation administrators, industry groups, and others interested in workers’ compensation issues

The Need

The reports and testimony of WCRI act as a catalyst for constructive change in improving workers’ compensation systems throughout the U.S. and internationally. Too often, public policies are shaped by anecdote and emotion, not by objective evidence about current system performance or the consequences of proposed changes. As a result of WCRI research, policymakers and stakeholders can make information-based decisions that prove to be more enduring because they are more efficient, more equitable, and better designed to meet the needs of workers and employers.

Specifically, WCRI research meets the following important stakeholder needs:

➢ Measuring system results to encourage continuous improvement and move the system away from the historic cycle of crisis-reform-crisis that has frequently characterized workers’ compensation in the past.
➢ Examining disability and medical management by evaluating and measuring the outcomes of medical care. These studies provide regulators with information about managing workplace injuries, what regulatory barriers are unnecessary or counterproductive, and what regulatory protections are needed for injured workers to assure quality outcomes. These studies also help guide business decisions.
➢ Identifying system features that improve performance or drive costs and quantifying their impact on system performance. These studies focus attention on system strengths and opportunities for improvement. They also provide lessons from successful states that other states may adopt.

The Workers Compensation Research Institute provides reliable information to legislators, governors, state (provincial) and federal administrators, task forces and study commissions, industry groups, labor organizations, and others interested in improving workers’ compensation systems. The Institute’s research addresses the major issues confronting these systems today. Its public policy studies are disseminated to all interested parties.
Improvement in workers' compensation systems is a product of many factors. WCRI's research is one important factor. Policymakers continue to look to the Institute as a source of objective information to help them make informed decisions about legislation and administrative changes.

Below are some examples from the past year.

➢ WCRI's study, Impact of a Texas-Like Formulary in Other States, examined how a Texas-like closed drug formulary might affect the prevalence and costs of drugs in 23 other state workers' compensation systems that do not currently have a drug formulary. The following are some recent examples of states that used the study as they contemplated adopting a drug formulary:

- California: Legislation (Assembly Bill No. 1124) requiring the administrative director of the Division of Workers' Compensation to adopt a prescription drug formulary for workers' compensation benefits passed both houses on Sept. 11, 2015. In the bill analysis, WCRI research on prescription costs in California and Washington State was cited.

- North Carolina: Gov. Pat McCrory signed a drug formulary study bill into law on Sept. 18, 2015. The provision directs the Industrial Commission to study the state's annual prescription drug expenses in workers' compensation claims and assess the savings that would result from implementing a formulary. Previously, WCRI provided a copy of our study, Impact of a Texas-Like Formulary in Other States, to the Industrial Commission chair who recently requested additional assistance.

➢ WCRI's opioid and physician-dispensing studies identified substantial issues in many states having to do with usage, abuse, cost, and prescribing methods. These studies had and continue to have impact throughout the country. The following are some recent examples:

- Nevada: Gov. Brian Sandoval signed into law Senate Bill 231, limiting the amount of Schedule II and Schedule III drugs that physicians can dispense to a 15-day supply. WCRI's physician dispensing research was used in the debate.

- North Carolina: The Industrial Commission chair who recently requested additional assistance.

- Massachusetts: WCRI's longer-term use of opioids research was cited in the Fiscal Year 2014 Annual Report, prepared by the Massachusetts Workers' Compensation Advisory Council (WCAC). In the report, the WCAC made seven recommendations; the recommendation that "policymakers and stakeholders continue to focus on [opioids] and seek out innovative ways of addressing the problem" cited WCRI research.

➢ WCRI's fee schedule studies highlight some of the most important design choices public officials face in adopting, reforming, and updating a workers' compensation medical fee schedule. They are well used by public officials and system stakeholders to evaluate their own fee regulations. The following are some recent examples:

- Virginia: In 2015, the legislature passed House Bill 1820, which required the Virginia Workers' Compensation Commission to assemble a stakeholder group to discuss various approaches to determine fees for medical services. The group consisted of payors, providers, employers, and labor representatives. In August 2015, WCRI was invited to share the results of our research for Virginia with the group. Then, in December 2015, the Commission published the 2015 Report on Medical Fee Schedules in Workers' Compensation, which cited the WCRI briefing to the stakeholder group as well as other WCRI research.

- Minnesota: Gov. Mark Dayton recently signed House File 2193/Senate File 2056 into law, which will transition hospital inpatient reimbursement, currently based primarily on "usual and customary charges," to Medicare's Diagnosis Related Groups (or DRGs). WCRI's research was used in the debate.

- Louisiana: In July, WCRI staff were invited to brief the executive director of the Louisiana Office of Workers' Compensation to inform the process of updating their fee schedule. WCRI staff provided studies (including Designing Workers' Compensation Medical Fee Schedules and Fee Schedules for Hospitals and Ambulatory Surgical Centers: A Guide for Policymakers).

➢ CompScope™ Benchmarks studies, published annually, examine the impact of legislative changes and quantify differences in key metrics among study states. They continue to help policymakers identify key leverage points in their systems. The following are some recent examples:

- Wisconsin: In response to provisions of Gov. Scott Walker's proposed 2015-2017 budget bill that would potentially impact the administrative organization and functions of the Division of Workers' Compensation, several system stakeholders reached out to WCRI for information as well as copies of WCRI reports. A report issued by the Wisconsin Legislative Finance Bureau to the legislature's Joint Committee on Finance addressing the impact of the change to the administrative organization cited WCRI CompScope™ Benchmarks.

- Illinois: A hearing was convened by the Illinois Senate Committee of the Whole to discuss their workers' compensation system and the effects of the 2011 reforms. In response to a request from the office of the Illinois Senate President, WCRI provided information about our research findings, including CompScope™ Benchmarks studies, related to several recent policy debates. This information was shared with all the members of the committee and was referenced by others providing testimony to the committee.
To sustain and strengthen its impact, WCRI continues to expand its active and diverse membership, which elects the board of directors and is the source of representatives serving on key governance committees. Over one hundred fifty organizations support the Institute in 2016. (A list of members and associate members appears on the inside back cover of this report.)

Organizations may join the Institute as members or associate members. Membership in the Institute is open to insured and self-insured employers, insurers, reinsurers, national trade and professional associations, national labor organizations, universities, insurance brokers, third-party administrators, managed care organizations, other service providers, and law firms. Members have electronic access to key research findings from WCRI studies on WCRI’s web site. They also receive all publications from the Institute, preferred rates for registration to WCRI’s Annual Issues & Research Conference, and preferential invitations to other WCRI briefings. Member representatives participate in the governance of the Institute. Associate members have electronic access to key research findings from WCRI studies on WCRI’s web site. They also receive all publications from the Institute and preferred rates for registration to WCRI’s Annual Issues & Research Conference and to other WCRI briefings. Associate memberships are available in several categories:

- Associate member—public sector: available to state workers’ compensation agencies (except state funds), insurance commissioners, labor departments, and foreign entities
- Associate member—labor association: available to state labor organizations
- Associate member—rating organization: available to rating organizations

Governance

The responsibility for policymaking rests with the Institute’s board of directors—a representative group of members who are elected by the membership for staggered, three-year terms and meet three times a year. (A list of board members and officers appears on the inside front cover of this report.)

Operating responsibility is vested in the president and CEO by the board, with direction from the board and advice from committees established by the board.

The research committee, composed of representatives of member companies, gives the president and CEO guidance on the Institute’s research program.

Project advisory committees assist the research staff in the formulation and conduct of specific studies. These committees are made up of representatives of member companies, public officials, academic researchers, and others knowledgeable about the specific topics before them.

RESEARCH COMMITTEE/2016

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The Research Program

THE INSTITUTE’S RESEARCH PROGRAM FOCUSES ON THE MAJOR PUBLIC POLICY ISSUES CONFRONTING WORKERS’ COMPENSATION SYSTEMS. OUR RESEARCH MEASURES SYSTEM PERFORMANCE, IDENTIFIES COST DRIVERS, QUANTIFIES OUTCOMES RECEIVED BY INJURED WORKERS, EVALUATES THE IMPACT OF ALTERNATIVE SOLUTIONS, AND HIGHLIGHTS EMERGING TRENDS. THE LESSONS FROM WCRI STUDIES ARE USED TO FACILITATE ACTION-ORIENTED DECISIONS BY PUBLIC OFFICIALS, EMPLOYERS, INSURERS, WORKER REPRESENTATIVES, AND OTHERS AFFECTED BY WORKERS’ COMPENSATION, BOTH NATIONALLY AND INTERNATIONALLY.

Our current research programs are:

- CompScope™ Benchmarks Research Program
- System Evaluation Research Program
- Disability and Medical Management Research Program

CompScope™, WCRI’s multistate benchmarking program, measures and benchmarks the performance of a growing number of state workers’ compensation systems. Each year, CompScope™ studies quantify performance trends, benchmark improvement opportunities, and assess the effectiveness of policy changes. Using CompScope™, stakeholders and public officials can better manage change and avoid the historic pattern of crisis-reform-crisis that has frequently characterized workers’ compensation in the past.

Using special statistical methods, the Institute has created performance measures and interstate comparisons that are comparable across otherwise diverse states. By identifying either incremental or sudden large changes in system performance—trends that may signal either improvement or possible deterioration in system performance—goals for system performance can be set, improvements accomplished, and crises avoided.

The CompScope™ program is funded by employers, state governments, rating organizations, and insurers seeking to help achieve a more cost-efficient, stable, and equitable workers’ compensation system. To achieve the ambitious goals outlined above, continued, broad support and expanded funding are needed.

Among the diverse organizations that have provided funding for this important program are the following:

- ACE USA
- Advocate Health Care
- AIG
- Archer Daniels Midland Company
- Ascential Care Partners
- AT&T
- Chevron Corporation
- CNA Foundation
- Compensation Advisory Organization of Michigan
- Costco Wholesale
- Country Insurance & Financial Services
- Florida Department of Insurance
- Ford Motor Company
- Gallagher Bassett Services, Inc.
- Georgia State Board of Workers’ Compensation
- The Hartford Insurance Group
- Indiana Compensation Rating Bureau
- International Truck and Engine Corporation
- Kentucky Association of Counties
- Kentucky Department of Workers’ Claims
- Kentucky Employers Mutual Insurance
- Kentucky League of Cities
- Kentucky Personnel Cabinet
- Liberty Mutual Group
- Louisiana Department of Insurance
- Louisiana Department of Labor, Office of Workers’ Compensation Administration
- Marriott International, Inc.
- Massachusetts Workers’ Compensation Rating and Inspection Board
- Minnesota Workers’ Compensation Insurers’ Association, Inc.
- Mitsubishi Motors North America, Inc.
- Molloy Consulting, Inc.
- New Jersey Compensation Rating & Inspection Bureau
- New York Compensation Insurance Rating Board
- Nordstrom, Inc.
- North Carolina Rate Bureau
- Pennsylvania Compensation Rating Bureau
- Pubic Policy Institute of California
- Safeway, Inc.
- Sedgwick Claims Management Services, Inc.
- State of Maryland Workers’ Compensation Commission
- Target Corporation
- Tennessee Department of Labor and Workforce Development
- Texas Department of Insurance
- The Travelers Companies, Inc.
- United Airlines, Inc.
- United Parcel Service
- Virginia Workers’ Compensation Commission
- The Walt Disney Company
- Wisconsin Compensation Rating Bureau
- Zurich Insurance Company
- Zurich North America

The System Evaluation Research Program focuses on the major current public policy issues and long-term challenges confronting workers’ compensation systems. The breadth and diversity of this research adds significantly to the base of knowledge about workers’ compensation systems.

➢ The objectives of this program are to
  - evaluate workers’ compensation systems and identify best practices;
  - identify leverage points and quantify opportunities for system improvement;
  - measure outcomes experienced by injured workers;
  - provide comprehensive reference books to help understand key system features; and
  - measure the impact of reform.
As the cost of medical care continues to rise rapidly, many are asking how to identify high-cost medical care that may be delivering less than optimal benefits. The innovative Disability and Medical Management Research Program provides funds and establishes priorities for objective research that will improve public policy decisions about the management of work injuries.

The following are among the current topics for evaluation:

- Impact of a closed drug formulary
- Impact of mental health interventions on costs and patient outcomes
- Impact of physician dispensing
- Treatment guidelines and utilization review

Examples of studies published in the program include the following:

- Are Physician Dispensing Reforms Sustainable?
- Will the Affordable Care Act Shift Claims to Workers’ Compensation Payors?
- Why Surgery Rates Vary

Funding for this program comes from organizations committed to improving public policies on disability and medical management to help policymakers and others make more informed decisions about managing work injuries. Research priorities are established by a program advisory board that is composed of leaders in their fields.

Visit us at www.wcrinet.org to learn more about the work of the Institute and to quickly access over 500 WCRI studies. WCRI’s website is one of the most content-rich workers’ compensation research websites. The following are among the things you will find on our site:

- Abstracts and executive summaries of over 500 research studies
- Conference and webinar information
- Online ordering of books and recorded webinars
- Press releases
- WCRI benchmarks of system performance and utilization
In its 32nd year, the Institute published 41 major studies on a broad range of topics. This brings the Institute’s total to over 500 books on a wide variety of important workers’ compensation issues affecting a growing number of states.

**WILL THE AFFORDABLE CARE ACT SHIFT CLAIMS TO WORKERS’ COMPENSATION PAYORS?**

According to this study, hundreds of millions of dollars could shift from group health to workers’ compensation as Accountable Care Organizations (ACOs) expand under the Affordable Care Act (ACA).

Although many have written about “cost shifting” to workers’ compensation, a significant underappreciated effect of the ACA is “case-shifting” from group health to workers’ compensation. The ACA seeks to greatly expand the use of ACOs—where providers are rewarded for meeting cost and quality goals. This will expand the use of “capitated” health insurance plans. Under these plans, providers are paid a fixed insurance premium per insured regardless of the amount of care provided to a given patient during the year. Under traditional fee-for-service insurance plans, providers are paid for each individual service rendered.

The question the study addresses is to what extent do the financial incentives facing providers and their health care organizations that arise out of capitation (given that workers’ compensation pays fee for service) influence whether or not a case is deemed to be work-related.

The study found that a back injury was as much as 30 percent more likely to be called “work-related” (and paid by workers’ compensation) if the patient’s group health insurance was capitated rather than fee for service. The study can be extrapolated to different states—for example, the study predicts about a $100 million increase in workers’ compensation costs in a state like Illinois if the share of capitated patients rises from 12 to 42 percent.

When a patient is covered by a capitated group health insurance plan, the doctor and the health care organization to which that doctor belongs have very different financial incentives about key decisions, compared with treating a patient covered by a fee-for-service plan. For example, when the capitated patient has back pain, the provider and his or her health organization generally do not get paid for additional care since they were paid a fixed amount for that patient at the outset of the policy year. By contrast, if a group health fee-for-service patient has back pain, the provider and health care organization are paid for each new service rendered.

Case-shifting was more likely in states where a higher percentage of workers were covered by capitated group health plans. In a state where at least 22 percent of workers had capitated group health plans, the odds of a soft tissue case being called work-related were 31 percent higher if the patient was covered by such a plan compared with similar workers covered by fee-for-service group health plans. By contrast, in states where capitation was less common, there was no case-shifting seen.
This is more than just the result of having fewer capitated patients seeking care. It also appears that when capitation was infrequent, the providers were less aware of the financial incentives.

This study relies on workers’ compensation and group health medical data coming from a large commercial database. This database is based on a large sample of health insurers and self-insured employers. It includes individuals employed by mostly large employers and insured or administered by a variety of health plans. The database is unique in that, for a given employee, it contains information on both the group health services used and the workers’ compensation services used.


ARE PHYSICIAN DISPENSING REFORMS SUSTAINABLE?

After 18 states enacted reforms to limit the prices paid to doctors for prescriptions they write and dispense, this WCRI study finds that physician-dispensers in Illinois and California discovered a new way to continue charging and to get paid two to three times the price of a drug when compared with pharmacies.

According to the authors, when prices are reduced by regulation, the regulated parties—in this case physician-dispensers—sometimes find new ways to retain the higher revenues they had prior to the reforms. Although this study provides data from two large states, it raises questions for all states where physician-dispensing prices are regulated.

The study identifies the mechanism that allows doctors in Illinois and California to dispense drugs from their offices at much higher prices when compared with pharmacies. It involves the creation of an opportunity to, once again, assign a much higher average wholesale price (AWP) to a physician-dispensed drug—a practice targeted by the earlier reforms enacted in many states using language limiting reimbursement to a price based on the AWP assigned by the manufacturer of the original drug.

The study answers the question of how a new and higher AWP can be set for physician-dispensed drugs by asking the reader to consider a drug where the most common strengths are 5 milligrams and 10 milligrams. If a new strength, say 7.5 milligrams, comes to market, the manufacturer of that new strength can assign a new AWP that is much higher than the 5-milligram and 10-milligram AWPs set by their original manufacturers.

In Illinois, the average prices paid for cyclobenzaprine HCL of 5 and 10 milligrams ranged from $0.99 to $1.74 per pill. Prior to 2012, 7.5-milligram cyclobenzaprine HCL was rarely seen in the market. The 7.5-milligram product was introduced in 2012 and almost all prescriptions for the product were dispensed by physicians at an average price of $3.79 per pill in post-reform Illinois. The market share of physician-dispensed cyclobenzaprine HCL of 7.5 milligrams increased from 0 percent in the third quarter of 2012 to 21 percent in the first quarter of 2013.

Similarly in California, prior to 2012, 7.5-milligram cyclobenzaprine HCL was rarely seen in the market. The average prices paid for 5- and 10-milligram cyclobenzaprine HCL, the two common strengths, ranged from $0.35 to $0.70 per pill. Since the introduction of the 7.5-milligram product in 2012, the market share of physician-dispensed cyclobenzaprine HCL of 7.5 milligrams increased from 0 percent in the fourth quarter of 2011 to 47 percent in the first quarter of 2013, when it became the strength of the drug most commonly dispensed by physicians. The average price paid for the new strength was $2.90 to $3.45 per pill.

From these patterns, the study’s authors infer that the shift in strength was unlikely to be driven by new evidence about superior medical practices. Rather, it is likely that financial incentives drove some physicians to choose the strength for their patients. The study cites several reports that provide evidence of behavioral changes in response to price regulations.

The data used for this report came from payors that represented 46 and 51 percent of all medical claims, respectively, for California and Illinois. The detailed prescription transaction data were organized by calendar quarter so that for each quarter, all prescriptions filled for claims with dates of injury within 24 months of the observation quarter were included. On average for each of the quarters reported, WCRI included 219,572 prescriptions paid for 60,448 claims in California. The same figures were 43,034 prescriptions paid for 12,714 claims in Illinois. The detailed prescription data cover calendar quarters from the first quarter of 2010 through the first quarter of 2013.


HOSPITAL OUTPATIENT COST INDEX FOR WORKERS’ COMPENSATION, 4TH EDITION

Rising hospital costs have been a concern and focus of recent public policy debates in many states. To assist policymakers and business decision makers in managing this growth, WCRI has created this unique study, which is updated regularly, to compare hospital outpatient costs across states, identify key cost drivers, and measure the impact of reforms.

The hospital outpatient cost indices compare payments per surgical episode for common outpatient surgeries under workers’ compensation from state to state in each study year and the trends within each state from 2005 to 2013. To capture only payments for services provided and billed by hospitals, the indices exclude professional services billed by nonhospital medical providers (such as physicians, physical therapists, and chiropractors) and transactions for durable medical equipment and pharmaceuticals billed by providers other than hospitals. This study also excludes payments made to ambulatory surgery centers.

The following are some sample findings from the study:

- States with percent-of-charge-based fee regulations or no fee schedules had the highest payments to hospitals for outpatient surgical episodes for knee and
shoulder surgeries. In particular, states with no hospital outpatient fee schedules had 60 to 141 percent higher hospital outpatient payments per episode compared with the typical state with fixed-amount fee schedules.

➢ There was tremendous variation in the rates of change in hospital payments per surgical episode across states. From 2006 to 2013, South Carolina saw a reduction of 31 percent in this metric while in Alabama the average hospital payment per surgical episode grew by 81 percent. States with percent-of-charge-based fee regulations or no fee schedules had more rapid growth in hospital outpatient payments per episode than states with other regulatory approaches. In particular, most percent-of-charge-based fee regulation states that did not have updates to the reimbursable percentage of charges experienced growth in hospital payments per surgical episode that was 157–286 percent faster than the median of states with fixed-amount fee schedules.

➢ States with cost-to-charge ratio fee regulations had similar levels and growth rates in hospital outpatient payments per episode to states with fixed-amount fee schedules. Hospital outpatient payments per episode in states with cost-to-charge ratio regulations grew 10–25 percent from 2006 to 2013. This study covers 33 large states that represent 86 percent of the workers’ compensation benefits paid in the United States. They are geographically diverse and represent a wide range of industries and a variety of regulation choices for hospital payments under workers’ compensation. These states are Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, West Virginia, and Wisconsin.


WORKERS’ COMPENSATION MEDICAL COST CONTAINMENT: A NATIONAL INVENTORY, 2015

This study provides policymakers and system stakeholders with an inventory of the cost containment initiatives employed by 51 jurisdictions. This study updates the tables from the previous edition with the statutory provisions, administrative rules, and administrative procedures as of January 1, 2015. However, it does not provide written explanations of the initiatives in use by each state.

The report contains key features of each state’s cost containment initiatives, including

➢ medical fee schedules;
➢ regulation of hospital charges;
➢ choice of provider;
➢ treatment guidelines;
➢ utilization review/management;
➢ managed care;
➢ pharmaceutical regulations;
➢ urgent care and ambulatory surgical center fee schedules; and
➢ medical dispute regulations.

These initiatives aim to curb the cost of a particular service or to reduce the amount of services provided. Cost containment regulatory initiatives entail a balancing act of limiting the cost of services and inappropriate or unnecessary treatment without negatively affecting the quality of treatment or access to care for injured workers.


IMPACT OF A TEXAS-LIKE FORMULARY IN OTHER STATES

As policymakers and other system stakeholders seek to contain medical costs, part of the focus is on prescription drug costs. This study examines how a Texas-like closed drug formulary might affect the prevalence and costs of drugs in 23 other state workers’ compensation systems that do not currently have a drug formulary. With an evidence-based closed formulary, states have the potential to contain pharmaceutical costs while encouraging evidence-based care.

According to the study, physicians in the other 23 states may have similar or different responses to the closed formulary from Texas physicians. A Texas-like closed formulary limits access to some drugs by requiring prior-authorization for drugs not included in the formulary. The study provides multiple scenarios to the readers to illustrate the impact of the formulary based on how physicians respond.

One of the scenarios finds if physicians in the 23 other study states were to change their prescribing patterns like physicians in Texas, they could reduce their total prescription costs by an estimated 14–29 percent. Non-formulary drug prevalence is estimated to drop from 10–17 percent to 3–5 percent of all prescriptions. Larger effects can be expected in Connecticut, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, and Virginia.

The study found non-formulary drugs were as prevalent in the 23 study states as they were in pre-reform Texas. They accounted for 10–17 percent of all prescriptions and 18–37 percent of total prescription costs. The comparable numbers for pre-reform Texas were 11 percent and 22 percent, respectively. Non-formulary drugs were most common in New York (17 percent) and Louisiana (16 percent). The most commonly prescribed non-formulary drugs in the majority of study states were Lidoderm®, OxyContin®, Soma®, Valium®, and Voltaren®.

The data for the study are based on utilization and costs of non-formulary drugs among newly injured workers in Texas and 23 other states that represent over 70


The 23 states included in this study are Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Virginia, and Wisconsin.


INTERSTATE VARIATIONS IN USE OF NARCOTICS, 2ND EDITION

The dangers of narcotic misuse resulting in death and addiction constitute a top priority public health problem in the United States and are shared by the workers’ compensation community. This study gives public officials, employers, worker advocates, and other stakeholders the ability to see how the use and prescribing of narcotics in their state compares with others.

The study examines interstate variations and trends in the use of narcotics and prescribing patterns of pain medications in the workers’ compensation system across 25 states. The study found that the amount of narcotics used by an average injured worker in Louisiana and New York was striking.

According to the study, the average injured worker in New York and Louisiana received over 3,600 milligrams of morphine equivalent narcotics per claim (double the number in the typical state). To illustrate, this amount is equivalent to an injured worker taking a 5-milligram Vicodin® tablet every four hours for four months continuously or a 120-milligram morphine equivalent daily dose for an entire month.

Besides New York and Louisiana, the amount of narcotics per claim was also higher in Pennsylvania and Oklahoma (32–48 percent higher than the typical state). Michigan had the highest amount of narcotics per claim among the Midwest states included in this study. It is worth noting that Michigan was among the states with lower use of narcotics per claim compared with the typical state in 2008/2010.

The study found that narcotics are frequently used in the workers’ compensation system. In 2010/2012, about 65 to 85 percent of injured workers with pain medications received narcotics for pain relief in most states. A slightly higher proportion of injured workers with pain medications in Arkansas (88 percent) and Louisiana (87 percent) received narcotics. The study also reported a small reduction in the percentage of claims with pain medications that received narcotics in several study states, between 2008/2010 and 2010/2012.

The study is based on approximately 264,000 workers’ compensation claims and 1.5 million prescriptions associated with those claims from 25 states. The claims represent pain medications that received narcotics in several study states, between 2008/2010 and 2010/2012.

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


LONGER-TERM USE OF OPIOIDS, 2ND EDITION

The issue this study addresses is very serious, which is how often doctors followed recommended treatment guidelines for monitoring injured workers who are longer-term users of opioids. It helps public officials, employers, and other stakeholders understand as well as balance providing appropriate care to injured workers while reducing unnecessary risks to patients and costs to employers.

According to the study, there has been little reduction in the prevalence of longer-term opioid use in most states studied. In most states, the percentage of claims with opioids that received opioids on a longer-term basis changed little, within 2 percentage points, between 2008/2010 and 2010/2012.

The study examined the prevalence of longer-term use of opioids in 25 states and how often the services recommended by medical treatment guidelines were used for monitoring and managing chronic opioid therapy. The recommended services include drug testing and psychological evaluations and treatment, which may help prevent opioid misuse resulting in addiction and even overdose deaths.

The study found a sizable increase across states in the use of drug testing over the study period. However, in some states, the percentage of longer-term opioid users who received these services was still low. The study also reported low use of psychological evaluations, which remained low over the study period.
The study found longer-term opioid use was most prevalent in Louisiana, where 1 in 6 injured workers with opioids were identified as having longer-term use of opioids in 2010/2012. The numbers were 1 in 8 or 9 in New York, Pennsylvania, and pre-reform Texas. By contrast, fewer than 1 in 20 injured workers with opioids received opioids on a longer-term basis in several Midwest states (Indiana, Missouri, and Wisconsin) and New Jersey. The study is based on approximately 264,000 workers’ compensation claims and 1.5 million prescriptions associated with those claims from 25 states. The claims represent injuries arising from October 1, 2007, to September 30, 2010, with prescriptions filled up to March 31, 2012. The underlying data reflect an average of 24 months of experience.

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

**COMPSCOPE™ Medical Benchmarks, 16th Edition**

The factors behind trends of medical payments per claim in 17 state workers’ compensation systems and the impact of legislative and regulatory changes on those costs are examined in this edition of CompScope™ Medical Benchmarks. The studies examine trends in payments, prices, and utilization of medical care for injured workers. They provide a baseline of current costs and trends for policymakers and other system stakeholders, reporting how medical payments per claim and cost components vary over time and from state to state.

The reports are useful to identify where medical cost and care patterns may be changing. They also help identify where medical payments per claim or utilization may differ from other states. In addition, where there may be concerns about restrictions on access to care, the studies can help identify potential underutilization of medical services.

The following are among some of the findings:

- **California**: Medical payments per claim decreased 5 percent in 2013, likely reflecting the early impact of the 2012 workers’ compensation reform legislation, including reduced reimbursement rates for ambulatory surgery centers and elimination of separate reimbursement for implantables.

- **Illinois**: Medical payments per claim rose 4.1 percent in 2013, following decreases between 2010 and 2012 due to a 30 percent reduction in the fee schedule rates. Part of the 2013 growth in medical payments per claim was related to annual updates in the fee schedule rates, which are tied to the changes in the Consumer Price Index.

- **Indiana**: Medical payments per claim were higher than in most states studied and rising faster, mainly driven by higher and growing prices.

- **Louisiana**: Growth in medical payments per workers’ compensation claim slowed from 2011 to 2013, in part due to a decrease in utilization of hospital and nonhospital care.

- **New Jersey**: Medical payments per workers’ compensation claim were stable from 2010 to 2013, in contrast to rapid growth in the prior two years, due to a number of factors including increased use of networks, stable utilization of services by non-hospital providers, and decreased percentage of inpatient episodes.

- **Texas**: Medical payments per workers’ compensation claim rose 7 percent in 2013, largely driven by an increase in payments for hospital inpatient episodes. The trend in Texas was about twice the average annual increase from 2008 to 2012.

- **Virginia**: Driven primarily by prices, medical payments per claim were among the highest of the study states.

The studies cover the period from 2008 through 2013, with claims experience through March 2014. The 17 states in the study—Arkansas, California, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Texas, Virginia, and Wisconsin—represent more than 60 percent of the nation’s workers’ compensation benefit payments. There are individual reports for every state except Arkansas and Iowa.

**COMPSCOPE™ Medical Benchmarks, 16th Edition**


**COMPSCOPE™ Benchmarks, 15th Edition**

The factors behind changing costs in state workers’ compensation systems, including the impact of legislative and regulatory reform on those costs, are examined in this study. This comprehensive reference report measures the performance of 17 different state workers’ compensation systems, how they compare with each other, and how they have changed over time.

The report is designed to help policymakers and others benchmark state system performance or a company’s workers’ compensation program. The benchmarks provide an excellent baseline for tracking the effectiveness of policy changes and identifying important trends. They examine how income benefits, overall medical payments, costs, use of benefits, duration of disability, litigiousness, benefit delivery expenses, timeliness of payment, and other metrics of system performance have changed from 2008 to 2013, for claims with experience through March 2014.
The following is a sample of the key findings across the 17 states:

- Provisions from California Senate Bill 863 may have helped decrease medical payments per claim by 5 percent—an early impact of the reforms that was seen in 2015.
- Louisiana total costs per claim changed little from 2011 to 2013, following three years of 5 percent annual growth.
- The cost of Texas claims grew more slowly than the typical state.
- The average cost per claim was relatively stable in Michigan between 2009 and 2012, keeping total costs per claim among the lowest of the 17 states studied.
- Both medical and indemnity costs per claim in North Carolina changed little since 2009, and both had grown 8 percent annually between 2003 and 2009.

The 17 states in the study—Arkansas, California, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Texas, Virginia, and Wisconsin—represent nearly 60 percent of the nation’s workers’ compensation benefit payments. Separate state reports are available for 15 of the study states.


WCRI MEDICAL PRICE INDEX FOR WORKERS’ COMPENSATION, SEVENTH EDITION (MPI-WC)

Increasing costs for medical care for treating injured workers have been a focus of public policymakers and system stakeholders. This 31-state study will help them understand how prices paid for medical professional services for injured workers in their states compare with other states and know if prices in their state are rising rapidly or relatively slowly. They can also learn if the reason for price growth in their state is part of a national phenomenon or whether the causes are unique to their state and, hence, subject to local management or reform.

The following are among the study’s findings:

- Prices paid for a similar set of professional services varied significantly across states, ranging from 33 percent below the 31-state median in Florida to 124 percent above the 31-state median in Wisconsin in 2013.
- Medical professional prices in states with fee schedules were relatively lower—the prices paid in states with no fee schedules were 27 to 139 percent higher than the median of the study states with fee schedules.
- Growth in prices paid for professional services exhibited tremendous variation across states, spanning between negative 20 percent in Illinois and positive 28 percent in Wisconsin over the time period from 2008 to 2014.

States with fee schedules experienced slower growth in prices paid for professional services compared with most states with no fee schedules—the median growth rate among the fee schedule states was 6 percent from 2008 to 2014 compared with the median growth rate of 17 percent among the non-fee schedule states.

The MPI-WC tracked medical prices paid for professional services billed by physicians, physical therapists, and chiropractors. The medical services fall into eight major groups: evaluation and management, physical medicine, surgery, major radiology, minor radiology, neurological and neuromuscular testing, pain management injections, and emergency care.

The 31 states included in the MPI-WC, which represent nearly 85 percent of the workers’ compensation benefits paid in the United States, are Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.

WCRI Medical Price Index for Workers’ Compensation, Seventh Edition (MPI-WC).


COMPARING WORKERS’ COMPENSATION AND GROUP HEALTH HOSPITAL OUTPATIENT PAYMENTS

This study compares hospital payments for the same surgical procedure when paid for by group health versus workers’ compensation in 16 states. According to this study, a majority of the study states, workers’ compensation incurred substantially higher hospital payments than group health for the same surgical procedure. Some speculate that there is an additional burden associated with taking care of a worker injured on their job, such as uncertainty or delay in payments. If so, the question for policymakers and other stakeholders is, what additional reimbursement is necessary to get quality care for injured workers?

Rising hospital payments have been a focus of recent policy debates in many states.
Policymakers and stakeholders have considered various means of cost containment, with special attention devoted to implementation of and updates to workers’ compensation fee schedules. To set fee schedule levels, policymakers often seek a reference point or benchmark to which they can tie the state’s reimbursement rates. Increasingly, states rely on Medicare rates as a benchmark, while other states use some form of usual and customary charges in the area. This study uses group health reimbursement levels as an alternative benchmark. Group health has some important advantages as a benchmark for workers’ compensation fee schedules, including being the largest provider of health insurance with the most widely accepted reimbursement rates by medical providers.

Among the study’s findings are the following:

➢ In two-thirds of the study states, workers’ compensation hospital outpatient payments related to common surgeries were higher than those paid by group health, and, in half of the study states, the workers’ compensation and group health difference for shoulder surgeries exceeded $2,000 (or at least 43 percent).

➢ The workers’ compensation payment premiums over group health were highest in the study states with percent-of-charge-based fee regulation or no fee schedule.

➢ States with high workers’ compensation hospital outpatient payments were rarely states with above-average group health hospital payments.

➢ The hospital outpatient payments per surgical episode demonstrated substantially greater interstate variation in workers’ compensation than in group health.

This study compares hospital outpatient payments incurred by workers’ compensation and group health for treatment of similar common surgical cases in 16 large states, which represented 60 percent of the workers’ compensation benefits paid in the United States, and covers hospital outpatient services delivered in 2008. Given that most study states, except Illinois, North Carolina, and Texas, did not have substantial changes in their fee schedule regulations after 2008, the interstate comparisons should provide a reasonable approximation for current state rankings in workers’ compensation/group health payment differences.


PREDCITORS OF WORKER OUTCOMES

Four state-specific studies identified new predictors of worker outcomes that can help public officials, payors, and health care providers improve the treatment and communication an injured worker receives after an injury–leading to better outcomes. The states examined were Arkansas, Connecticut, Iowa, and Tennessee. The studies represent Phase 2 of a multi-phase study to examine worker outcomes.

All four studies found trust in the workplace to be one of the more important predictors that has not been examined before. To describe the level of trust or mistrust in the work relationship, the study asked workers if they were concerned about being fired as a result of the injury. Between 39 and 45 percent of injured workers reported that they were somewhat or very concerned that they would be fired or laid off after they were injured. The rest reported no such concern.

The studies also identified workers with specific comorbid medical conditions (existing simultaneously but usually independent of the work injury) by asking whether the worker had received treatment for hypertension, diabetes, lung conditions, and heart problems in the year prior to the injury. A sample of the findings for this predictor is as follows:

Arkansas:

➢ Hypertension was the most common comorbid medical condition reported (28 percent).

➢ Diabetes and lung conditions were reported by 8 and 6 percent of workers, respectively.

➢ Sixty-three percent of injured Arkansas workers reported having at least one comorbid medical condition or having smoked for 10 years or more; 22 percent of workers reported having more than one significant comorbid medical condition.

Connecticut:

➢ Hypertension was the most common comorbid medical condition reported (27 percent).

➢ Diabetes and lung conditions were reported by 11 and 10 percent of workers, respectively.

➢ Fifty-eight percent of injured Connecticut workers reported having at least one comorbid medical condition or having smoked for 10 years or more; 20 percent of workers reported having more than one significant comorbid medical condition.

Iowa:

➢ Hypertension was the most common comorbid medical condition reported (24 percent).
➢ Diabetes and lung conditions were reported by 9 and 7 percent of workers, respectively.
➢ Sixty-six percent of injured Iowa workers reported having at least one comorbid medical condition or having smoked for 10 years or more; 22 percent of workers reported having more than one significant comorbid medical condition.

**Tennessee:**
➢ Hypertension was the most common comorbid medical condition reported (36 percent).
➢ Diabetes and lung conditions were reported by 13 and 8 percent of workers, respectively.
➢ Sixty-six percent of injured Tennessee workers reported having at least one comorbid medical condition or having smoked for 10 years or more; 29 percent of workers reported having more than one significant comorbid medical condition.

The studies are based on telephone interviews with 4,915 injured workers across the following 12 states: Arkansas, Connecticut, Indiana, Iowa, Massachusetts, Michigan, Minnesota, North Carolina, Pennsylvania, Tennessee, Virginia, and Wisconsin. The surveys were conducted in 2013 and 2014 for injuries in 2010 and 2011. All workers who were interviewed had received workers’ compensation benefits and experienced more than seven days of lost time from work. On average, the injuries for the workers surveyed had occurred between 2.8 and 3.3 years prior to the interviews.


**AVOIDING LITIGATION: WHAT CAN EMPLOYERS, INSURERS, AND STATE WORKERS’ COMPENSATION AGENCIES DO?**

One goal of a workers’ compensation program is to deliver necessary medical care and income benefits to workers injured on the job without the uncertainty, delay, and expense of litigation. In many states, however, disputes and attorney involvement in the benefit delivery process are common.

Policy debates about attorney involvement have common themes from state to state. Workers’ attorneys argue that they help workers receive benefits that these workers would not be able to obtain themselves, help workers navigate a sometimes complex system, and protect workers from retaliation by the employer or insurer. Advocates for employers and insurers contend that attorneys are involved more often than necessary, that workers can often receive the benefits they are entitled to without representation, and that attorneys may even reduce the total amount of benefits that workers take home.

Some of the existing attorney involvement is inevitably unnecessary, such as cases where the worker would have received the statutory entitlement without resorting to hiring an attorney if unnecessary attorney involvement can be avoided, this would be a win-win-win scenario. Workers would receive benefits without the expense of paying an attorney and the delays of dispute resolution; employers and insurers would save the costs of defending the case; and increasingly resource-short state workers’ compensation agencies would have smaller caseloads to manage and would have to provide fewer dispute-resolution services.

This study identifies and quantifies some of the more important factors that lead injured workers to seek representation by an attorney, providing some key elements for employers, claims organizations, and state agencies to take away.

**Major findings:**

The study found that workers were more likely to seek attorneys when they felt threatened. Sources of perceived threats were found in two areas:

➢ The employment relationship: Workers believed they would be fired as a result of the injury, and/or workers perceived that the supervisor did not think the injury was legitimate.
➢ The claims process: The worker perceived that his or her claim had been denied, although it was later paid. This perception may have stemmed from a formal denial, delays in payment, or communications that the worker deemed to be a denial.

**Potential implications for employers, claims organizations, and state agencies:**

It is possible that attorney involvement can be decreased if employers, claims organizations, and state agencies reduce or eliminate unnecessary actions that workers interpret as threats. The suggested actions below, while logical implications of this study, are not themselves the findings of the empirical research:

➢ Train supervisors. Help supervisors create timely communications that focus on trust, job security, and entitlement to medical care and income benefits.
➢ Create state agency education materials and help lines. Provide written materials and an accessible help line that answers workers’ questions to help ease feelings of vulnerability and uncertainty.
➢ Communicate in a clear and timely fashion about the status of the claim. Prevent misunderstandings through unambiguous, timely communication from the claims manager so the worker does not mistakenly conclude that the claim has been denied.
➢ Eliminate system features that encourage denials or payment delays. Eliminating system features that discourage timely payments may help prevent a worker’s misconstruing a delay as a denial.

MONITORING TRENDS IN THE NEW YORK WORKERS’ COMPENSATION SYSTEM

This is the seventh annual report to regularly track key metrics of the performance of the state’s workers’ compensation system following the implementation of the 2007 reforms. The study helps policymakers and system stakeholders focus on objectives that are being met, objectives that are not being met, and any unintended consequences that have emerged.

The key reform measures increased maximum statutory benefits, limited the number of weeks of permanent partial disability (PPD), created medical treatment guidelines, adopted a fee schedule for pharmaceuticals, established networks for diagnostic services and thresholds for preauthorization, and enacted administrative changes to increase speed of case resolution.

The report noted that the changes have various effective dates and have been instituted over time. As a result, it will be several more years before the full impact of the reforms will be realized.

The following are among the study’s key findings:

➢ In 2011 claims evaluated in 2012 (reflecting 16 months of experience under the treatment guidelines), the number of visits per indemnity claim decreased notably for chiropractors and physical/occupational therapists compared with the prior year. There was a smaller decrease for physicians.

➢ From 2007 to 2010, for PPD/lump-sum cases at an average 24 months of experience, there was a nearly 15 percentage point decrease in cases that received PPD payments only (with no lump-sum payment) and a nearly 12 percentage point increase in cases with a lump-sum settlement only (with no PPD payments).

➢ From 2007 to 2011 (for claims at an average 12 months of experience), there was a 4 percent increase in the number of visits for major radiology services by nonhospital providers. The percentage of indemnity claims with major radiology services also grew over that same period, from 45 percent to 52 percent.

➢ There was little change in the average defense attorney payment per claim from 2009 to 2010, but an increase of nearly 9 percent in 2011.

The study uses open and closed indemnity and medical-only claims with dates of injury from October 2005 through September 2011, with experience as of March 2012. The data are representative of the New York system.


A NEW BENCHMARK FOR WORKERS’ COMPENSATION FEE SCHEDULES: PRICES PAID BY COMMERCIAL INSURERS?

In a typical year, 5 to 10 states have significant public policy debates about enacting new fee schedules or making major revisions to existing ones to regulate prices paid in workers’ compensation. Often, the central question debated is what price level is too low—that is, at which point good health care providers will not provide timely treatment to injured workers. In making such decisions, providers consider what they are paid by other payors. Prices paid by Medicare and commercial insurers are plausible benchmarks for policymakers to use since they are usually the largest payors in a given state.

This study provides the basic comparative data that policymakers can use to ground the debate. For example, if the maximum prices proposed were double those paid by commercial insurers, policymakers might be skeptical of testimony by providers that they would stop treating injured workers if the maximum prices were lowered by a modest amount. Similarly, if the maximum compensation fees were lower than what commercial insurers are paying, policymakers might be skeptical of testimony of payor representatives that the prices are too high and can be lowered without adversely affecting access to care for injured workers.

The following is a sample of major findings:

➢ Workers’ compensation prices are very much shaped by the state fee schedules or their absence. In states with higher (lower) fee schedules, workers’ compensation prices paid were typically higher (lower). In states without fee schedules, prices paid were generally higher. States without fee schedules in this study include Indiana, Iowa, New Jersey, Virginia, and Wisconsin.

➢ For common surgeries performed on injured workers, the prices paid under workers’ compensation were higher than the prices paid by group health insurers for the same surgery in almost all study states. In some states, the workers’ compensation prices paid were 2–4 times higher than the prices paid by group health insurers in the same state.
For office visits, the prices paid under workers’ compensation were typically within 30 percent of the prices paid by group health insurers. In nearly half of the states studied, the prices paid under workers’ compensation were within 15 percent of the group health price.

This study focuses on the median nonhospital price paid for five common surgeries and four common established patient visits in 22 large states for services delivered in 2009. These are the prices actually paid for professional services billed under a specific Current Procedural Terminology (CPT) code. This study also discusses how to generalize these results to later years.

The 22 states included in this study are Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia, and Wisconsin.


WORKERS’ COMPENSATION LAWS AS OF JANUARY 1, 2014

An essential tool for researching and understanding the distinctions among workers’ compensation laws in all U.S. states and certain Canadian provinces is done as a joint venture of the International Association of Industrial Accident Boards and Commissions (IAIABC) and the Workers Compensation Research Institute (WCRI). This report is a key resource for policymakers and other stakeholders to identify the similarities and distinctions between workers’ compensation regulations and benefit levels in multiple jurisdictions in effect as of January 1, 2014.

The publication is best used to understand macro-level differences and general tendencies across jurisdictions:

➢ How many states/provinces allow individual or group self insurance?
➢ How do the maximum and minimum payments for temporary and permanent total disability benefits vary?
➢ How many states cover mental stress claims, hearing loss, and cumulative trauma?
➢ How many jurisdictions allow the worker to choose the treating physician and how many allow the employer to do so?

In Canada and the United States, workers’ compensation is entirely under the control of sub-national legislative bodies and administrative agencies. As a result, it is easy to misunderstand subtle differences between jurisdictional laws and regulations. This survey gives you the ability to understand those differences.


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