



“Longshore and Harbor Workers’ Compensation Act: Time for Reform?”

Senate Subcommittee on Employment and Workplace Safety

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Testimony from

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My name is Richard Victor and I serve as the executive director of the Workers Compensation Research Institute (WCRI) in Cambridge, Massachusetts. I have conducted research on the performance of workers’ compensation systems for 27 years, first at the Rand Corporation in Santa Monica, California, and subsequently at WCRI. This written testimony is based on studies that my colleagues and I have conducted, and I would be happy to answer any questions now or at some later date. My expertise pertains to state workers’ compensation systems, not on the Longshore and Harbor Workers’ Compensation Program. The experience of those state systems may be instructive for the Longshore system. Each state has a workers’ compensation system that seeks to meet many of the objectives of the federal Longshore workers’ compensation system. My comments will focus on the efforts of state policymakers to control medical costs paid by employers while ensuring the delivery of quality care to injured workers in their time of need.

There are three lessons that I would like to bring to your attention:

1. Although regulating medical costs is one of the most complex things that state policymakers do in workers' compensation, state policymakers do use a number of significant policy tools.
2. There is wide variation in the practice of medicine to treat injured workers. It is unlikely that all of these practices are high quality and cost-effective.
3. The policy debate about a key leverage point for cost containment and the quality of medical care—who should select the treating provider—often misses a very important point.

THE CONTEXT

The rapid growth of workers' compensation medical expenditures in the early 1990s led many states legislatures to enact new workers' compensation medical cost containment laws and regulations, most between 1992 and 1997. Many of these changes were focused on regulating medical prices. Some states also enacted or authorized tools to help payors to better manage utilization. In the first half of this decade, two important states (Texas and California) made major changes to their health care financing and delivery systems for workers' compensation. Prior to making these changes, based on studies by WCRI and others, policymakers in the two states had learned that (1) employers in both states paid much higher medical costs per case than typical; (2) workers in both states received more medical services than typical; and (3) workers in both states reported similar or poorer outcomes than typical. Since medical prices in both states were already lower than average, the legislation focused on how to reduce unnecessary care while improving patient outcomes.

COMMON POLICY INSTRUMENTS

The legislation of the 1990s employed what I would call “first generation policy instruments.”

- Fee schedules that set maximum provider fees, often tied to the state's Medicare rates. An analysis of these fee schedules can be found in Eccleston, et al., *Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2001-2002*.

- Legislation to encourage contracting arrangements between payors and providers to establish mutually agreeable fee levels, service expectations, and treatment protocols. An important focus of most of these contracts was provider prices that were established below the state fee schedule or the usual and customary fee paid to the provider. Studies by WCRI and others have found that such contracting arrangements (often called “networks”) significantly reduce medical costs without adversely affecting patient outcomes—although patients report higher satisfaction with non-network care.¹
- Legislation to authorize the use of utilization review—whereby proposed or rendered treatments are reviewed for medical necessity and appropriateness.
- Legislation to adopt or permit payors to use treatment guidelines that articulate standards for reimbursement of appropriate care. However, the 1990s versions were often based on a negotiated consensus-process involving medical providers, stakeholders, and public officials—not on a transparent and disciplined process for assessing the strength of the scientific evidence about different types of medical care.

Descriptions of these tools and a state by state summary are found in Tanabe and Murray, *Managed Care and Medical Cost Containment in Workers’ Compensation: A National Inventory, 2001-2002*.

In many states that enacted some or all of these tools, medical costs—especially medical prices—were lower than they would otherwise have been. However, after a few years, the rate of growth often re-accelerated—driven by growing utilization. Little information exists about the impact of these enactments on patient outcomes.

The recent legislative enactments in California and Texas have the potential to define the “second generation policy instruments.” I say “potential” because both states are in the early stages of implementation of the legislation and supporting regulations. It is premature to assess their impacts on payors’ costs and patients’ outcomes.

¹ R. Victor, D. Wang, and P. Borba, *Provider Choice Laws, Network Involvement, and Medical Costs* (Cambridge MA: Workers Compensation Research Institute, 2002); S. Fox, R. Victor, X. Zhao, and I. Polevoy, *The Impact of Initial Treatment by Network Providers on Workers’ Compensation Medical Costs and Disability Payments* (Cambridge, MA: Workers Compensation Research Institute, 2001); and W. Johnson, M. Baldwin, and S. Marcus,

What characterizes this second generation of policy instruments? There are a variety of elements from the first generation that were preserved or improved—like provider fee schedules that were lower than the typical state and were made much more comprehensive in coverage than their predecessors. The principal new elements were:

1. A policy decision that ensured prompt access to care at the outset of the case. Sometimes workers were unable to obtain care (or providers risked nonpayment) until the payor accepted liability for the claim—that is, that the worker truly suffered a work-related injury or disease. This could take weeks or months after the injury occurred, and especially a consideration for repetitive trauma conditions, like back pain or carpal tunnel syndrome. In California, the new law requires that the payor is responsible for medical care rendered from the time the claim is filed until the time when a case is either accepted or denied, subject to a maximum liability of \$10,000. Texas recently enacted a similar provision with a maximum liability of \$7,000.
2. A policy decision that defined quality medical care based on nationally recognized evidence-based treatment guidelines. In California, such guidelines can only be rebutted by scientific medical evidence. The state began by adopting the guidelines issued by the American College of Occupational and Environmental Medicine—as an interim measure while the state agency was developing a broader set of guidelines. In Texas, payors may adopt their own treatment guidelines as long as they meet minimum statutory requirements, especially that they are evidence-based, scientifically valid, and outcome-focused.
3. A policy decision that workers could select providers who were part of a network of providers, where the providers in the network were designated by the payor. One important exception was that a worker could see a non-network provider if the worker pre-specified a provider with whom he or she had a preexisting relationship. The California legislature adopted this approach to substitute from the prior rule whereby the payor controlled the choice of provider for the first 30 days after injury, and the worker controlled the choice of provider thereafter. The Texas legislature adopted a similar system to replace the prior system whereby the worker controlled the choice of provider.

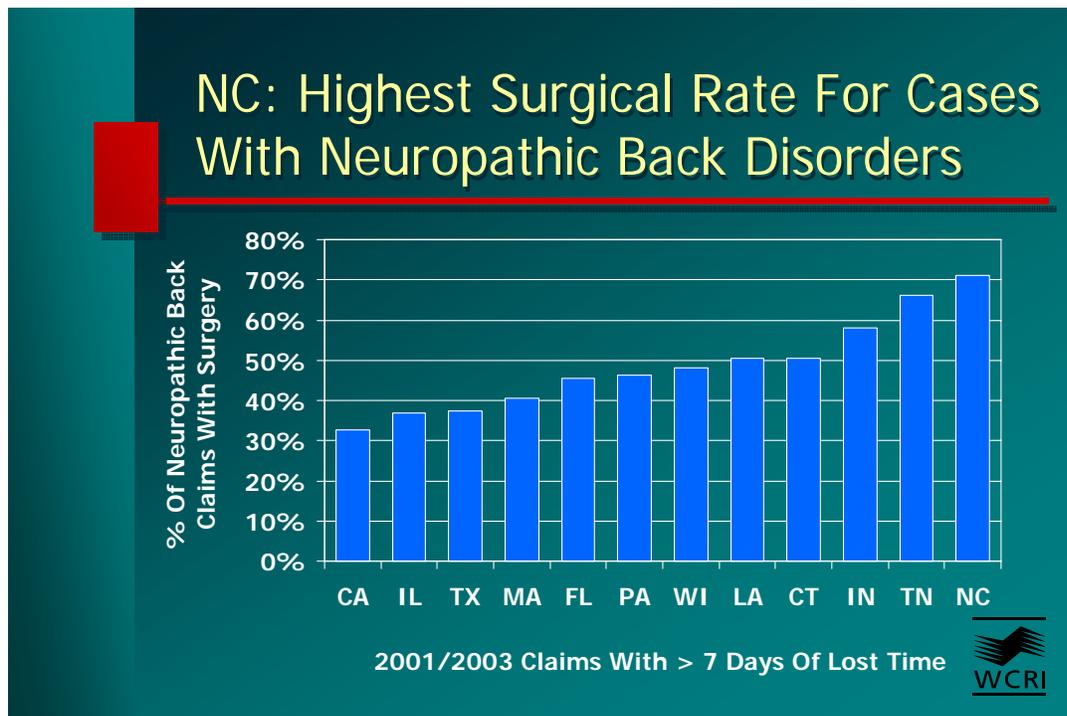
The Impact of Workers' Compensation Networks on Medical and Disability Payments (Cambridge, MA: Workers Compensation Research Institute, 1999).

Number 3 above is probably one of the most important strategic changes in both states.

WIDE VARIATION IN MEDICAL PRACTICE FROM AREA TO AREA

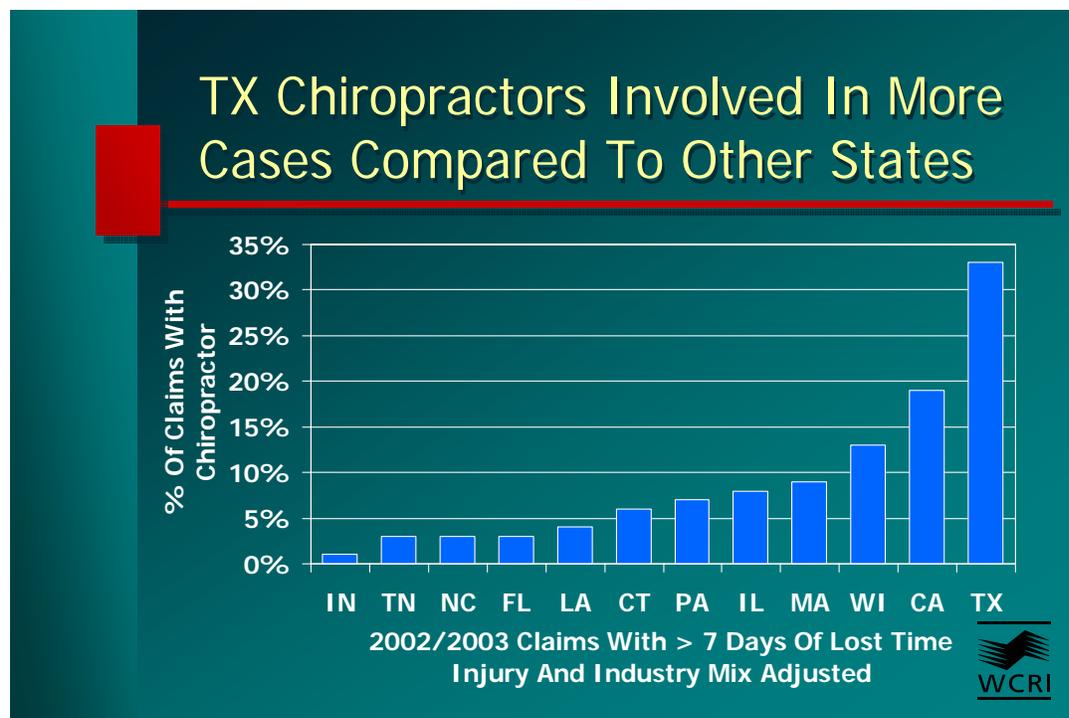
There is wide variation in the medical practice patterns to treat injured workers. It is unlikely that all the disparate practices are high quality and cost-effective.

Below we cite two of many examples contained in Eccleston and Zhao, *The Anatomy of Workers' Compensation Medical Costs and Utilization*.² Surgery rates vary widely from state to state. For example, for workers who have back pain with nerve involvement, fewer than 40 percent have surgery in California, Illinois, and Texas, while more than two-thirds have surgery in Tennessee and North Carolina. We cannot determine for certain whether there were unnecessary surgeries performed in North Carolina and Tennessee, but these statistics raise that possibility.



² See, for example, S. Eccleston and X. Zhao, *The Anatomy of Workers' Compensation Medical Costs and Utilization in North Carolina, 5th Edition* (Cambridge, MA: Workers Compensation Research Institute, 2005).

A second example shows that about one-third of injured workers in Texas saw a chiropractor. But in a typical state, 5–10 percent saw a chiropractor. In Texas, workers who saw chiropractors averaged nearly 40 visits per case, while in most states, chiropractors treated with about 20 visits. And in some states, chiropractors were rarely involved in providing care. Although we cannot tell for certain if there is excessive chiropractic care in Texas, or inadequate access to chiropractic care in states like Indiana, this slide raises those possibilities.



IMPACT OF PROVIDER CHOICE

The health care provider plays many critical roles in the outcome of a workers' compensation case. Those roles bear directly on most aspects of a worker's claim for medical and income benefits, and include diagnosing the condition and assessing its cause, which can affect the compensability of the claim; prescribing and providing a course of treatment and disability management practices, which can influence whether the worker returns to work and how quickly; assessing whether the worker's condition has reached maximum medical improvement, whether the worker is left with a permanent impairment or disability, and the extent of the impairment; and judging whether a preexisting condition contributed to the degree of

impairment. From the perspective of either the employer or the worker, any of these decisions by the health care provider can be sufficiently important to warrant being able to control the selection decision. Thus, the selection of that provider is an important matter for all parties of interest.

Worker advocates argue that the choice of the treating provider should be left to the worker. At a minimum, they argue that workers should be treated by those whom they trust and whose interests align with the workers'—interests that encourage prompt return to work, but only as medically indicated, and the fullest restoration possible of physical capacity. In contrast, employer advocates believe the choice of provider should be made by the employer, arguing that employer choice ensures that incentives exist for keeping the costs of care reasonable and appropriate, employer choice helps avoid excessive services and treatments, and providers familiar with the employer's workplace can use that knowledge to expedite return to work.

A recent study published by WCRI found that a critical consideration was missing from the arguments of both groups of advocates.³ That is, on average, workers appear to have poorer information about the quality of providers when they select providers who they have never seen before. Compared to when the employer selects the provider, a worker selecting an unfamiliar provider can be expected to have poorer outcomes and the employer can be expected to pay higher costs for the care. However, when workers select providers with whom they have a prior treating relationship (e.g., their family doctors), it appears that the costs are not significantly higher than when the employer selects the doctor, and most patient outcomes are also similar. Among the most important findings of this study are:

- Compared with cases in which the employer selected the provider, cases in which the worker selected a provider who had treated the worker previously for an unrelated condition (a “prior provider”) had costs that were similar. And patient outcomes did not appear to be very different between cases with employee-selected prior providers and those with employer-selected providers, except that satisfaction with overall care was higher when the worker saw a prior provider.

³ R. Victor, P. Barth, and D. Neumark, *The Impact of Provider Choice on Workers' Compensation Costs and Outcomes* (Cambridge, MA: Workers Compensation Research Institute, 2005).

- Compared with cases in which the employer selected the provider, cases in which the worker selected a provider who had not treated him or her previously (a “new provider”) had much higher costs and poorer return-to-work outcomes, generally no differences in physical recovery, and higher levels of satisfaction with overall care.