Introduction to Workers' Compensation: Containing Costs and Managing Outcomes

By James G Smith, CPCU, ARM

Across the country, the cost of workers' compensation insurance is soaring at the highest rate in nearly a decade. This is adding yet another heavy burden on the public sector already struggling with budgets. Nationwide, the average cost of workers' compensation insurance has risen 50 percent in the last three years, according to Robert P. Hartwig, the chief economist at the Insurance Information Institute, a trade group in New York. Workers' compensation claims cost generally account for more than 50% of an organization's total cost of risks related to legal liabilities. The actual percent will vary significantly by state and type of industry or type of government.

The primary focus of this symposium will be managing outcomes after an accident. We will also explore the cost drivers and some of the reasons that costs can vary widely by state and from employer to employer. In addition to more than half-a-dozen original papers, we will also present recent reports available from three highly respected organizations in the world of workers' compensation. Reports from the National Council on Compensation Insurance (NCCI), the International Association of Industrial Accident Boards and Commissions (IAIABC), and the Workers Compensation Research Institute (WCRI) will provide insightful analysis and information on the leading cost drivers in workers' compensation.

Our paper and supplemental report line-up for the week looks like this:

Monday, Dec. 8

- Introduction to Workers' Compensation: Containing Costs and Managing Outcomes, by James G. Smith, CPCU, ARM
- Four Practical Steps to Successful Cost Workers' Compensation Cost Analysis, by Peter Rousmaniere

Additional material that will be available on PERI's Web site:

- *State of the Line: Analysis of Workers Compensation Results*, National Council on Compensation Insurance
- *Critical Issues Facing Workers Compensation*, by Stephen J. Klingel, President and CEO, NCCI Holdings, Inc.

Tuesday, Dec. 9

- Constructing Return to Work Programs: Building for Better Returns, by Dennis L. Chandler, President, Day-1 Systems, Chandler Consulting, Inc.
- Top Ten List as to Why Injured Workers Retain Attorneys, By Alan S. Pierce, Alan S. Pierce & Associates

Additional material that will be available on PERI's Web site:

- *IAIABC 2002 Supplemental Guides for Rating Permanent Impairment,* International Association of Industrial Accident Boards and Commissions

Wednesday, Dec. 10

- Internet Technology Improves Workers' Comp Results, by Randy Wheeler, CEO, Valley Oak Systems
- Prescription Drugs: Comparison of Drug Costs and Patterns of Use in Workers' Compensation and Group Health Plans, by Jeanne Edmond and Barry Llewellyn, NCCI

Additional material that will be available on PERI's Web site:

- *CompScope Benchmarks: Multistate Comparisons, 1994-2000*, Workers Compensation Research Institute
- *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 1996-2000*, Workers Compensation Research Institute

Thursday, Dec. 11

- National Issues Impacting Worker's Compensation, by Eric J. Oxfeld, President, UWC-Strategic Services on Unemployment & Workers' Compensation
- Changes in the Service-Provider Mix of Workers' Compensation Medical Claim Expenditures, NCCI

Additional material that will be available on PERI's Web site:

- Brief on Medicare Set-Aside and Workers' Compensation, International Association of Industrial Accident Boards and Commissions (IAIABC)
- Discussion Paper on Privacy Implications of HIPPA, October 11, 2001, IAIABC
- HIPAA and Workers' Compensation: A Response Plan for State Administrative Agencies, IAIABC

Friday, Dec. 12

- How Federal Occupational Safety and Health Regulations Can Help Local Governments Provide a Safer Public Workplace, by Claire Reiss, J.D., ARM, Deputy Executive Director, Public Entity Risk Institute

Overview of Workers' Compensation

Workers' compensation is our oldest social insurance program; it was adopted in most states, during the early 1900s. It is a no-fault system, meaning that injured employees need not prove the injury was someone else's fault in order to receive workers' compensation benefits for an on-the-job injury. Fault on the part of the employer and/or the employee is largely immaterial, although a body of cases has arisen over such issues as horseplay, intoxication, and willful disobedience to the instructions of the employer.

The injured employee is entitled to all health care reasonably required to treat the work-related injury or illness. The employee also receives indemnity/disability income payments, which are calculated as a percentage of the employee´s pre-injury salary, up to a maximum set by law and paid for a period of time based on the severity of the injury. If an employer has workers´ compensation insurance or is certified to self-insure, these benefits are the employee´s exclusive remedy, except in cases in which an employee is killed and the death was caused by the employer´s intentional act or omission or gross negligence.

The workers' compensation system is premised on a trade-off between employees and employers: employees are supposed to promptly receive the limited statutory workers' compensation benefits for on-the-job injuries, and in return, the limited workers' compensation benefits are the exclusive remedy for injured employees against their employer, even when the employer negligently caused the injury.

An employee is automatically entitled to certain benefits whenever the employee suffers from an accidental personal injury (or in some states occupational disease) arising out of and in the course or scope of employment. There are differences among the states as to the exact language employed to qualify the injured worker for benefits, with some states having peculiar meanings to some of the same wording. The word "accident" is interpreted differently between the states. The meanings of the phrases "arising out of" and "in the course" or "scope" of employment are also different between the states.

In the past few years, the cost of almost all kinds of insurance has been rising sharply. But workers' compensation insurance, which pays for treatment of on-the-job injuries and lost wages, is a particular problem because it is mandatory in all states except Texas. Public entities cannot simply trim or reduce their workers' compensation coverage to save money. Every employee must be fully covered either by a commercial insurer, qualified self-insurance group known as a risk pool, or be individually self-insured.

The particular coverage financing method (insurer, pool, or self-insured) can have some impact on the current year annual operating costs. However, the specific risk financing method will have little difference on the overall long-term costs if the major cost driver (losses) are not effectively managed at the source (the public entity) and within the claims administration processes (claims administrator) used to manage and pay claims. Incurred losses will generally account for 80% to 85% of the workers' compensation costs of risk budget, with frictional costs for claims administration and excess protection adding an additional amount equal to 15% to 25% of every claim dollar incurred.

When an occupational injury happens, many claims do not require any time off from work and these cases place minimal burden on the employer. When an occupational injury requires missed work, the longer the employee is out the higher the costs. Forty-eight percent of most lost time cases involve fewer than six days lost time from work. In most cases, what an employer or its claims administrator does after a disabling injury is first reported contributes to more than 50% of the ultimate costs. The vast majority of workers' compensation claims are handled expeditiously and are administered without dispute or litigation. These are, for the most part, the smaller claims -- those in which only medical care is provided and those in which the injured worker is disabled for only a few days. These smaller claims account for more than three quarters of all workers' compensation claims.

Litigation and Disputed Cases

About 25% or less of claims involve significant periods of disability or permanent disability; these claims account for the vast majority of costs and litigation. In these more serious cases, litigation is common. Most disputed or "litigated" cases are settled without a decision being rendered by a workers' compensation referee. Most case dispositions are compromise and release settlements, settlements in which all future liability is released in return for a stipulated amount.

In most cases, it is also rather easy to determine the appropriate period of time for which the employee is entitled to temporary total disability (TTD) payments. In most states, the employee is usually entitled to such payments in an amount of 66-2/3% of his or her regular salary for that period of time when he or she is unable to return to work. In most instances, an employee is anxious to return to work so that he or she can resume earning his or her full salary. The employer, while anxious to return the employee to productive work, has no great incentive in forcing the employee to return to work at a time when he or she may be susceptible to additional injuries.

While a determination of the proper amount of medical care and rehabilitation payments or TTD payments are relatively easy to determine, there are no easy answers or consistent references in determining permanent partial disability (PPD) amounts due under most state WC Acts. At a hearing before a referee/arbitrator, physicians present oral or written testimony. Typically, the physicians differ on their analysis of the severity of the injury and its effect on the future work performance of the particular employee. An extremely interesting and highly informative report from IAIABC (International Association of Industrial Accident Boards and Commissions) on the issues and challenges of occupational injury impairment ratings used in the different states will be made available on PERI's Web site during the symposium. IAIABC welcomes your feedback on the recommendations offered in the report in the four part report.

Also on Tuesday, Alan S. Pierce, an experienced attorney representing injured workers shares some interesting reasons why employee seek legal representation for workers' compensation injuries.

Permanent Partial Disability – Major Cost Driver

Cases that fail to resolve in a relatively short period of time and usually end up in some form of "dueling docs" are a key driver of workers' compensation costs. Twenty-two percent of all lost time claims involve more than 30 days lost from work and account for the majority of all workers' compensation costs. Claims that have a duration of more than 180 days within this over-30 day group account for the lion's share of the costs of all lost time claims.

If a worker's injury has diminished his or her ability to compete in the open labor market, but the worker is not permanently totally disabled, then that worker has a *permanent partial disability*. Permanent partial disability claims represent the largest share of losses in many states and are among the most complex benefits to deliver. According to NCCI, a national WC data collection organization, permanent partial disability losses account for nearly 60% of all benefit costs (medical plus indemnity) and, on average, cost approximately $49,000 per case. In many cases permanent partial disability claims account for less than 15% of the claims frequency.

Another 20% of claims usually involve temporary disability resulting in lost time from work with payment of medical bills and wage replacement benefits usually 66.6% of the employee's weekly wages. These lost time injuries without permanent disabilities can account for 20-30% of the total costs. A worker is considered temporarily disabled until the worker has returned to their usual and customary work, or until the condition has become permanent and stationary or reached "maximum medical improvement". An injured worker who cannot work at their usual job, or at modified work assignments, is entitled to temporary total disability benefits.

Return to Work Programs

One of the most important functions of workers' compensations systems for both workers and employers is returning those injured on the job to productive employment in a timely manner. Workers benefit because when return is delayed, workers can lose more than earnings: skills may deteriorate; the job may be filled by a replacement; and future employers may view the worker as a less valuable employee. Employers also benefit from a speedy return to work through lower costs and less disruption of the work force.

While successful return-to-work programs benefit both employers and workers, some experts advise companies to present the program as another employee benefit. These experts also recommend that employers provide assurances that the employee's treating doctor will be consulted before assigning modified job duties. Employers also have been cautioned against forcing employees to accept unwanted alternative work duties, as such cases may develop into contentious situations or even lawsuits. Employee orientation and safety training sessions are ideal opportunities to educate employees on the purpose and importance of the employer's return-to-work program.

Dennis Chandler, President of Day-1 Systems, Chandler Consulting Inc. will provide a thoughtful analysis and discussion on best practices in implementing effective "Return to Work" programs in a paper presented on Tuesday.

State and Federal Laws that Directly or Indirectly Affect Workers' Compensation

Each state enacts its own law, and there is no Federal control over individual states' workers' compensation laws. In general, each states' workers' compensation law provides disability benefits and medical care for individuals injured in the course of job connected activities. Workers' compensation benefits varies from state to state, but there are many features that are fairly common to a typical workers' compensation statute.

Eric J. Oxfeld, President of Strategic Services on Unemployment & Workers' Compensation (UWC), an association exclusively devoted to advocacy for business on national workers' compensation and unemployment insurance public policy will provide important information on the many legislative and regulatory developments and proposals at the Federal level that directly or indirectly impact the state-oriented workers' compensation system. Two of these developments and proposals include: Federal regulation of medical privacy -- including providers who treat injured workers (HIPAA), and Federal procedures to protect Medicare's interests before settling workers' compensation claims.

According to the HHS, OCR HIPAA Privacy Policy revised in April 2003, the HIPAA Privacy Rule does not apply to entities that are either workers' compensation insurers, workers' compensation administrative agencies, or employers, except to the extent they may otherwise be covered entities. However, these entities need access to the health information of individuals who are injured on the job or who have a work-related illness to process or adjudicate claims, or to coordinate care under workers' compensation systems. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by the Privacy Rule. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers' compensation systems to have access to individuals' health information as authorized by state or other law. Due to the significant variability among such laws, the Privacy Rule permits disclosures of health information for workers' compensation purposes in a number of different ways. This policy update will also be available during the symposium.

The IAIABC provides a paper directed at state workers' compensation administrators. It advises them on the potential changes that HIPAA compliance efforts by medical providers may have on the flow of medical information previously expected in handling claims for compensation. It also suggests areas in which state agencies might be proactive in assisting covered entities in understanding and meeting the needs of state workers' compensation laws.

How Workers' Compensation Benefit Structure Drives Costs

The typical Workers' Compensation statute has a benefit structure that defines what injured workers are entitled to receive when they sustain an injury "arising out of and in the course of" their employment. There are five basic types of workers' compensation benefits available, depending on the nature and severity of the worker's injury:

(1) medical care,
(2) temporary disability benefits,
(3) permanent disability benefits,
(4) vocational rehabilitation services, and
(5) death benefits

Medical Treatment

Workers' compensation is a medically driven system. It is designed to provide injured workers with medical treatment, vocational rehabilitation, income maintenance allowance, and other indemnity benefits (benefits that compensate, in part, for hurt, loss, or damage). The term "medically driven" means that medical information is used to guide key decision points in the system, including entry into the system.

Medical treatment is an important benefit to workers in the compensation system. Medical treatment must be provided by an employer which is reasonably required to "cure or relieve" from the effects of the occupational injury. The medical benefit includes both treatment that is needed currently as well as treatment that may be required in the future even after the claim has been settled.

Generally, all reasonable and necessary medical care required by the injured worker is covered, including prescriptions, medical appliances, etc. Needless to say, the medical condition requiring treatment must be causally related to the injury. Some states regulate the amounts the medical care providers may charge for treatment, and make charges in excess of the permitted amounts unenforceable by the medical care provider. States differ on the right of the injured worker to choose the person(s) who will provide his/her medical care, with some states leaving this choice entirely up to the claimant and other states heavily regulating it by requiring that physicians be chosen from panels or selected by the employer.

Any discussion on workers' compensation cost containment must take a look at usual suspects behind medical cost inflation in workers compensation :

- Medical providers delivering more units of treatment or using more expensive treatments,
- Injured workers themselves may be more resistant to recovery,
- Employers may be procrastinating at return to work, indirectly prolonging care, and
- A plaintiff attorney may be more active in promoting more medical usage by clients as part of a strategy to increase impairment ratings

Each of these cost drivers is plausible and plays a significant role in the double digit cost increases being experienced in WC medical costs annually; these medical costs now account for 48% to 52% of total WC costs.

Medical costs in some state's workers' compensation systems – such as California -- are estimated to be 50% to100% higher than in group health insurance such as in California. According to a 2001 study by the California Commission on Health and Safety and Workers' Compensation, California employers were paying outpatient surgery fees that were 230% of

what Medicare paid for hospital outpatient surgery fees and 370% of what Medicare paid for free standing outpatient surgical facilities.

The major difference is not usually in the unit price of service, which is fixed by most states' medical fee schedules, but in the lack of meaningful controls on utilization. Over the years, statutory provisions and case law have given the primary treating physician the presumption of correctness over all treatment issues. This has left some workers' compensation payors (claims administrators) powerless to enforce clinically accepted treatment standards and protocols that not only ensure high quality care, but curb excess treatment as well.

In general, the amount of medical treatment (often called treatment utilization) and the length of medical treatment (often called treatment duration) provided to injured workers account for the majority of these cost differences between state workers' compensation systems and other health care delivery systems. Five medical treatment areas account for the majority of total payments made in most workers' compensation systems, although results will vary by state and region:

- Hospitalization/surgery,
- Physical medicine (e.g., manipulations, therapeutic exercise, hot and cold packs, etc.),
- Office visits (with primary and referral health care providers,
- Diagnostic testing (e.g., MRIs, CT scans, plain x-rays, electrophysiology testing), and
- Pharmaceutical drugs.

The medical treatment guidelines of many state WC systems do not generally contain quantifiable amounts of care (e.g., number of therapeutic exercise sessions per week for a specified number of weeks). Vague treatment guidelines and lack of adequate medical expertise at all levels within the WC systems make it difficult to resolve medical disputes, especially disputes over medical treatments that have been deemed not medically necessary. Other sensitive medical treatments involve possible defense strategies by the injured worker's attorney to increase the impairment ratings -- which has a direct impact on the amount of permanent partial disability awards and associated legal fees.

In addition to over-treating injured workers with the same kinds of injuries for longer periods of time and paying more for medical treatments and pharmaceutical drugs, there are other issues that contribute to workers' compensation medical cost. A small percentage of workers' compensation claims are responsible for the majority of costs. Twenty percent of claims account for 80 percent of total medical costs in most states, although this will vary on a state-by-state basis. Generally, a small number of health care providers will be responsible for the majority of workers' compensation medical costs in a state or given region. Less than ten percent of health care providers, including M.D.s, chiropractors, osteopaths, physical therapists, etc. will usually account for 80 percent of professional service medical (i.e., non-hospital medical costs) costs in a given state's WC system. If analyzed further, it has been suggested that an even smaller number of doctors (M.D.s, chiropractors, and osteopaths) can be characterized as "high dollar/high volume" providers, since they treat most of the expensive workers' compensation claims and will comprise roughly 5 percent of the doctors who submit workers' compensation medical bills in a given state/region for any given year.

Although surgery and physical medicine treatments (such as manipulations and therapeutic exercises, among others) are commonly used by doctors to alleviate pain and promote physical recovery, an analysis of workers' compensation medical data has shown that these treatments do not seem to statistically improve overall medical outcomes (i.e., an injured worker's physical recovery or ability to return to work). High workers' compensation medical costs can also be attributed to variations in the way that individual insurance carriers, risk pools, and claims administrators review proposed medical treatments and pay medical bills.

While the responsibility for most of medical cost trends may largely fall to health care professionals who provide the medical care, claims administrators whose responsibility it is to review the appropriateness of care and pay medical bills must also take responsibility for the coordination and consistent monitoring of medical costs. There are many health care provider practice patterns that differ for occupational and non-occupational injuries and it is essential that the claims administrator use the best available resources and practices to work within the given state's WC medical treatment guidelines to help contain costs.

Ineffective claims administration review practices can include :

- accepting medical diagnoses without clinical validation,
- using "screening lists" that search for key words rather than reviewing the medical necessity of treatments using the worker's natural medical history and clinical evidence,
- misapplication of the medical screening criteria (i.e., the proprietary treatment guidelines claims administrators use to screen for the medical necessity of treatments),
- lack of training for staff in areas such as anatomy, physiology, and the clinical evidence that supports the claims administrators' screening criteria, and
- inadequate provision, collection, and management of information on a worker's clinical condition, physical limitations, and work status to help determine the medical necessity of certain types of treatments and services (e.g., work hardening/conditioning or therapeutic treatments).

Medical care claim costs in the workers' compensation industry reflect a broad combination of factors, including (1) the mix of claim-related outlays for service providers and commodities (e.g., pharmaceuticals and equipment) used in providing treatment, (2) the frequency of use of those medical services and commodities, (3) the type of services and medical care-related commodities provided (reflective of the type of injury), and (4) the unit price (or other relevant price measure) of medical care goods and services. The NCCI article on *Changes in the Service-Provider Mix of Workers Compensation Medical Claim Expenditures* (presented on Thursday) focuses on the first of the above factors. NCCI examines how the mix of outlays for workers' compensation service providers (to include medical-care-related commodities) has changed over time. The article also compares the mix of workers' compensation provider-based claim expenditures to the mix of medical care expenditures for consumers in general.

In NCCI's *Prescription Drug Study* report, the organization examines the cost and use of prescription drugs in workers' compensation. Areas studied include: what share of workers' compensation medical costs arise from prescription; what factors affect the cost of prescription drugs; and what types of prescription drugs are being used and their relative costs

Temporary Disability Payments

An injury can cause a worker to be temporarily disabled. A temporary disability prevents the worker from performing all or part of his or her job. An injured worker who cannot work at his or her usual job, or at modified work assignments, is entitled to temporary total disability benefits. An injured worker who is able to perform modified work assignments is considered to have a temporary partial disability and may be compensated for a portion of the difference between normal wages and any reduction the disability has created, either in pay rate or in hours worked. A worker is considered temporarily disabled until the worker has returned to his or her usual and customary work, or until the condition has become permanent and stationary or reached "maximum medical improvement."

Temporary disability is not paid to the injured worker for the first three to seven (depends on state) days of missed work unless he or she is hospitalized or misses more than 14 days of work. Payments usually must begin within 14 days of the employer's knowledge of the claim, unless the employer contests the claim. The employer has a stated period of time in each state from notification of the injury to contest the claim.

In most states, compensation is paid at two-thirds of the employee's average weekly wage, not to exceed statutory weekly maximums above which no worker is entitled to be paid. It is not unusual for an employee's temporary total disability weekly benefit to be capped by these statutory maximums. These replacement wages are non-taxable. Employees don't pay federal, state, or local income taxes on TD benefits or pay Social Security taxes, union dues, or retirement fund contributions on these benefits.

Disputes often arise both on the issue of whether the injured worker is, in fact, disabled from work and on the issue of whether maximum medical recovery has been reached. States differ on how they treat situations where the employee is released to light duty work, but the employer will not offer light duty, or those situations where the employer declines to permit the injured worker to return to his or her job, even after a full duty release.

Employers sometimes provide supplemental income replacement benefits (or salary continuance) to temporarily disabled workers. This practice is often mandated among public employers, especially for certain types of employees such as public safety employees.

The Workers Compensation Research Institute found that a strong association exists between the duration of temporary disability benefits and the probability that a case will result in the payment of permanent partial disability (PPD) benefits. This suggests that if temporary disability duration were reduced in the high PPD states such as California and Texas by resolving cases more promptly and returning workers to employment more rapidly, fewer PPD cases and lower system costs may occur.

A few states do not use the permanent and stationary or (maximum medical improvement) standard as a basis for ending temporary disability. The absence of maximum medical improvement can lengthen the duration of claims and increase the use of lump-sum

settlements. High PPD rates are frequently associated with soft tissue injuries (e.g., back sprains and strains), which are among the most difficult to diagnose and evaluate

Permanent Disability Payments

After a work-related injury or illness, most workers are able to return to work after a short period of temporary disability. However, some workers sustain some level of permanent disability. A substantial number are not able to return to their original jobs. Most workers who are not able to return to work during a period of temporary or permanent disability must rely heavily on their workers' compensation payments. If a worker's injury has diminished his or her ability to compete in the open labor market, but the worker is not permanently totally disabled, then that worker has a *permanent partial disability*. A worker with a permanent partial disability will receive weekly payments for a period of time determined by the date of injury and the extent of the disability

Permanent partial disability benefits (PPD) are the most expensive, complex, and litigated component of many workers' compensation systems. In many states, PPD costs to employers and insurers are several times larger than for temporary disability claims.
How the award is calculated for permanent claims differs from jurisdiction to jurisdiction. In some state jurisdictions, permanent injury benefits are awarded only on the direct physical loss. Other state jurisdictions compensate to some measure for expected wage loss, the loss of employment options, extra expenses for accommodating the disability, or perhaps an implicit award for psychological loss and pain. In some jurisdictions, the permanent benefit is statutory and has no medical or clinical basis.

One of the ongoing challenges in workers' compensation is to define how permanent physical loss is calculated in a defensible and consistent way. Most often, physical loss is defined and measured as an impairment. Clinical impairment is the loss of a body part, or the loss of use of a body part, system or function. The degree of clinical impairment is measured by an independent doctor at the point of maximum medical recovery. Disability is a person's decreased capacity or loss of ability to meet the demands of the job. Some jurisdictions have separate processes for: (1) making a finding of impairment, and (2) calculating the impairment rating. Findings of impairment are done by physicians. Insurers or self-insureds then rate the impairment by applying state adopted rating standards to the findings.

Nearly 50% of all California's workers' compensation indemnity claims result in some level of permanent disability as compared to the next worst state at 25%. California's system of determining permanent disability is so subjective and unpredictable that it is virtually impossible for employers, employees, and insurers to rely on any rating. The result is that California has one of the most litigious workers' compensation systems in the country.

Conversely, Oregon and Wisconsin have low rates of litigiousness. This was accomplished by implementing system features that (1) created certainty about what is owed, (2) stimulated prompt payment by employers and insurers, and (3) discouraged the use of partisan experts in favor of treating physicians. Features that combine to reduce litigation in Oregon included the following:

- Written guidelines or standards that create greater certainty about payments due,
- The use of state-employed evaluators to translate medical reports into disability ratings,
- Required evaluations by treating physicians, based on the standards, and
- Incentives to use treating physicians' evaluations rather than those of partisan experts.

The technical aspects of coming up with an impairment score for benefit calculation is an administrative function and becomes a major conflict point within the delivery of benefits when the employee and employer disagree on the benefit calculation. The inconsistencies inherent in many state rating systems used to calculate an injured worker's residual loss or impairment can be frustrating for injured workers, physicians, risk managers, state administrators, payers on behalf of the employer, and the employer.
One of the major problems with impairment ratings, and therefore a significant injued worker and administrative burden, is the lack of consistency between physician-raters of impairments. Unfortunately, this variability becomes a source of dispute, which is both costly to the employer and stressful to the employee.

Permanent impairment or permanent disability benefits in most states provide some form of compensation to the injured employee for certain categories of permanent injury. There is a great deal of variance among the states as to the type of injuries which qualify for permanent impairment or permanent disability benefits, as well as the amounts of money allowed for permanent injuries. Some states' workers' compensation laws may permit the employee to be compensated for disfigurement or scarring, frequently in the absence of any actual impairment, and sometimes in addition to actual impairment

Each state has some form of Permanent Disability Rating Schedule guidelines that specify standard percentage ratings for permanent impairments and limitations, and provides for the modification of these standard ratings based on the injured worker's age and occupation. The standard rating may be adjusted for age by lowering the rating for younger workers and increasing it for older workers on the theory that it is easier for younger people to adjust to a permanent handicap. The standard rating may also be adjusted for occupation by increasing the rating if the permanent impairment or limitation will be more of an impediment in performing the worker's occupation, and lowering the rating if it will have a lesser impact. The particular process and methods varied from state to state.

Physicians play a critical role in determining whether a worker will receive temporary or permanent disability payments, as well as how large the permanent disability payments will be. A worker is considered temporarily disabled until the worker has returned to his or her usual and customary work, or until the condition has become permanent and stationary or reached "maximum medical improvement." Physicians who make findings of impairment ratings and those who calculate them must understand the basic and universal principles of workers' compensation law to understand the medical and clinical issues of rating the permanent residual consequences of work-related injury or disease.

A worker's medical condition is considered permanent and stationary after it has medically stabilized (this is sometimes called "maximum medical improvement," although some slight medical improvement might be anticipated in the future), or when the condition has been

stationary for a "reasonable period of time". The judgment that a condition is permanent and stationary is usually made by the treating physician, but when the treater's determination is disputed, an evaluating physician's opinion is also sought. This often leads to the infamous expression of "dueling docs" and contributes to increased costs as attorneys are usually involved at this point.

Several recent studies have shown that disputes in PD claims don't tend to focus on the cause of injury, but rather on the nature and extent of injury, a situation exacerbated if a state has too much subjectivity in its permanent disability rating schedule guidelines.

Higher levels of attorney involvement appear in cumulative injuries, multiple physical injuries, and back injuries, where disability raters often rely heavily on subjective work capacity guidelines to determine the worker's level of impairment, drawing attorneys from both sides into the claim with their "dueling docs."

The percentage of permanent disability is determined by using some form of Permanent Disability Rating Schedule and an assessment of the injured worker's permanent impairment and limitations. The assessment of the injured worker's permanent impairment and limitations is made by either the treating physician or evaluating physician with a final decision usually rendered though some dispute solution process.

Permanent partial disability (PPD) claims represent the largest share of losses in many states and are among the most complex benefits to deliver. According to NCCI's Annual Statistical Bulletin, 2002 Edition, PPD losses account for nearly 60% of all benefit costs (medical plus indemnity) and, on average, cost approximately $49,000 per case.

In 2002, NCCI sent a PPD questionnaire to contacts in all states and D.C. focusing on the following main categories:

- Healing Period
- Schedule vs. Non-Schedule Compensation
- Impairment Ratings
- Benefit Payments
- Dispute Resolution
- Attorney Fees
- Termination of Benefits
- Claim Closure/Reopening

Among the survey results, NCCI found:

- All states provide temporary total disability benefits during the healing period.
- 41 states pay compensation for certain injuries on a schedule basis, 43 states on a non-schedule basis, and 38 states pay benefits on a schedule and non-schedule basis.
- 27 of the 43 states that pay compensation on a non-schedule basis provide for compensation based on "certain number of weeks payable related to the impairment rating of the whole person."

- 29 states use a "modified impairment rating system" – final disability rating based on medical impairment rating and other factors (age, education, etc.).
- 20 states base final disability ratings solely on medical impairment ratings.
- 39 of the 42 states that permit/mandate use of objective guidelines in determining medical impairment ratings use the AMA Guides. 34 of the 39 "AMA Guide" states noted the particular edition that is used: 16 states use "the most recent edition" of the Guides (13 by mandate, 3 in practice), 9 states use the 4th edition, 5 states specifically require use of the 5th edition (another 2 states mentioned use of the 5th edition), and 2 states use the revised 3rd edition.
- 44 states place limits on the number of weeks payable or total dollar payout for PPD.
- In 29 states, plaintiff's attorney fees are paid out of the compensation award; in 5 states attorney fees are paid in addition to the compensation award.

For an overview of a state's PPD benefit structure, click on the link in the chart below for that particular state. The materials are provided by the NCCI, and are in Adobe Acrobat PDF (you'll need Adobe Reader installed on your computer in order to call up these materials). For your convenience, each file contains the name and phone number of the contact person for that state.

AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL
GA	HI	ID	IL	IN	IA	KS	KY	LA	ME
MD	MA	MI	MN	MS	MO	MT	NE	NV	NC
ND	NH	NJ	NM	NY	OK	OR	PA	RI	SC
SD	TN	TX	UT	VT	VA	WA	WV	WI	WY

Vocational Rehabilitation Services

Injured workers who are unable to return to their former type of work are usually entitled to vocational rehabilitation services if these services can reasonably be expected to return the worker to suitable gainful employment. Once an injured worker is determined unable to return to his or her previous type of work, the employer and worker jointly select a rehabilitation counselor who will determine whether vocational rehabilitation is feasible, and if appropriate, develop a suitable rehabilitation plan.

The worker must be expected to be permanently disabled as the result of the injury. That is, the disability, by itself or in combination with pre-existing disabilities or other factors such as the worker's age, will permanently keep the worker from engaging in the usual occupation, or in the position performed at the time of the injury. Usually the primary treating physician determines if and when an injured worker is medically eligible for vocational rehabilitation. In many cases the physician does not need to wait until the patient's condition is permanent and stationary to declare a worker medically eligible for rehabilitation.

The goal of a rehabilitation plan is to return the injured worker to "suitable gainful employment" -- employment or self-employment that is reasonably attainable and which offers an opportunity to restore the injured worker as soon as practicable and as near as possible to

maximum self-support. This includes the development of a suitable plan, the cost of any training, and a maintenance allowance while participating in rehabilitation.
When factors like age, education, skills, and prior disability are taken into account, the worker can be expected to benefit from vocational sources, that is, to compete for employment that is economically feasible after completing the vocational rehabilitation plan.

The goal of vocational rehabilitation is to enable an injured worker to return to suitable gainful employment, in other words, to employment that can be reasonably attained and is consistent with the worker's residual disability, vocational interests and aptitudes, and pre-injury earning capacity (although the new job is not required to match previous earnings). The employer may fulfill vocational rehabilitation requirements in some states by offering the worker a reasonable modified or alternative work assignment, once the physician has determined that an injured worker is medically eligible for vocational rehabilitation.

A maintenance allowance payable to an injured worker while in rehabilitation is, like temporary disability benefits, designed to replace two-thirds of lost earnings, but the maximum weekly amount is usually lower. The worker may, however, supplement the maintenance allowance with advances of permanent disability benefits up to the point where the worker is receiving the same weekly amount as he or she received in temporary disability benefits.

Vocational rehabilitation is an integral part of many workers' compensation programs. According to supporters, rehabilitation serves workers by helping get them back to work sooner; and it serves employers and insurers by reducing their potential liability. Critics point to rapidly escalating costs and raise questions about the over-utilization and cost-effectiveness of vocational rehabilitation, especially in states where it is mandatory.

Death Benefits

Death benefit payments are made to surviving dependents of a worker who dies from. And occupational accident. The maximum death benefit will vary based on the number of surviving dependents. The total aggregate amount of support payments depends on the number of dependents and the extent of their dependency. There is great variability among the states on who can qualify as a survivor entitled to be compensated for the death of the worker and how much the survivors are entitled to receive. In the event a worker is fatally injured, reasonable burial expenses, up to specified state amount are paid.

Most states provide some form of compensation for survivors of workers who are killed as a result of job related accidents. Most often the compensation is an effort to replace the lost stream of income to the decedent's surviving dependents. These payments are generally payable in the same manner and amount as temporary disability benefits, but the minimum rate of payment can vary from state to state on a per week basis.

It is important to note that unlike a civil damage claim in the Court system, in workers' compensation the focus is not upon grief, mental pain and suffering, or loss of society and companionship. The focus in workers' compensation is upon the loss of income being produced by the deceased worker for the surviving beneficiaries.

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About the Author

James G Smith, CPCU, ARM is a highly accomplished senior insurance executive with more than 30 years of leadership experience in the property-casualty business. During his career, Mr. Smith has built a respected reputation for implementing creative and effective programs in strategic direction and change leadership within the public sector alternative insurance markets and Workers Compensation state funds. He currently serves as the Director of Enterprise Services for the Public Entity Risk Institute and is also responsible for the PERI Data Exchange, a national benchmarking and performance database for Workers Compensation and Liability.

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About the Symposium

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Four Practical Steps to Successful Workers' Compensation Cost Analysis

By Peter Rousmaniere

Water, water everywhere and not a drop to drink. Anyone who has spent some time trying to control workers' compensation costs knows this frustration. Despite the huge amount of data flowing into and piling up in accident and claims databases, the really practical information we need isn't usually available. We might be able to extract it, but at great effort and risk that no one would rely on it. Much of the data we pass around on injuries and losses don't incite us to action. Using Mark Twain's quip, the data are all lightning bugs but no lightning. But I firmly believe that we can bottle the lightning and create truly powerful cost containment analysis, with little expenditure of resources. In this brief paper I hope to show how.

For about 18 years I have worked in various capacities in the field of workers' compensation cost containment. In a prior career I had worked in the public and nonprofit sectors. I've had the opportunity to see many workers' comp projects succeed, and an equal number fail. I have also witnessed whole workers' comp systems, such as in the states of Massachusetts and California, rise or fall in costs.

Several practical elements – four in number – are present whenever cost containment within an employer works. The first two elements presented below deal with the techniques of organizing data. The second two elements deal with inducing two powerful interest groups – operating departments and the workers comp' claims staff – to behave in a way that promotes rather then distracts from effective cost analysis.

If these elements are in place, there is at least a 80% chance that not only is cost containment working but that it is working as well as it can within the legal and other social constraints of the environment. But if one, or two, of these elements are not present, cost containment efforts are compromised, possibly fatally.

Create a Model of Cost Drivers

Don't start thinking about data analysis until you have developed a "model." You need to create, or borrow, a model of how workers' comp costs go up and down. A model is a deliberate effort to capture the key truths underlying the complex real world. It provides a context in which you can predict and explain phenomena. That DNA spiral of Crick and Watson is a model of genetic structure. The ingenious Will James, the inventor of statistical analysis of baseball, has created a model of how baseball teams win or lose. (The Oakland and Boston teams have bet the farm on this model.)

Every person involved in risk and insurance, or more narrowly in workers' compensation, has a mental model of what causes workers' comp costs to rise or fall. The restless mind brings the model to us often unchecked. A lot of thinking about workers' comp costs is not housed

within a clear model, resulting in poorly developed propositions and torturous explanations of actual data.

Many people implicitly rely upon very incomplete models. Here are some examples. A simplistic safety-oriented approach to worker injuries focuses entirely on prevention. This simplistic approach fails to shed on light on why, when there are injuries, some last longer than others. Again, a simplistic actuarial approach to worker injuries focuses on final total costs of injuries. These costs are not known for years, so by the time they are known the world and the workers' comp climate has turned many times.

Some wag said the all models are wrong, but some are useful. I wish to propose a barebones model that I think is useful. It goes like this:

- Most injuries arise out of exposures; most exposures involve a combination of hazards and behavior.
- Efforts to contain exposures have mixed results.
- Most injuries can be addressed using well-established "best practices." If these best practices fail, there are ways to remedy failures. Therefore a life history of a worker injury is a sequence of best practices and, possibly, remedies.
- Total workers' compensation costs can be reasonably explained by successes and failures in containing exposures and treating injuries.

While this statement of a model may seem very unremarkable it has subtle and important aspects that can be overlooked. This model is "dynamic" in that one event leads to another that leads to another. The sequence and the connective mechanisms, like railway cars coupling against one another, need to be carefully identified, leaving none out. Data need to be collected for each of the steps (i.e., railway cars).

There is never too much data, but by the time we collect all we may want, we will have retired if not gone to heaven. I am currently working (Fall, 2003) with an insurer which has data warehoused an extraordinarily amount of data. It requires PhDs to extract and present it in readable formats. I love the experience but also know that much good analysis can be done with much less, and that using large databases is fraught with danger. It is extremely easy for academically trained analysts to go onto wild goose chases. That is usually because the analysts are not employing a clear model of cost drivers.

My experience with workers' comp claims systems and safety records suggests that most employers have "good enough" data to fill the model I have suggested above The data need to reasonably describe the rate of success of interventions, whether in loss prevention or injury management/claims handling. I have found that there are several major categories of interventions, none of which should be overlooked, and I turn to them next.

Use a Few Credible Performance Measures

Some years ago while engaged on a review of vocational rehab in the state of Ohio, I came up with a simple mnemonic that captures performance measures virtually everyone will

agree with: PADRE. The idea is to analyze the rate of success for each of these five performance measures, individually and collectively.

	What it means	One example of how to measure
P	**P**revention of injury	# injuries/100 FTEs
A	**A**voidance of lost time	No lost time injuries / all injuries
D	**D**uration of lost time	% of lost time injuries exceeding: 7 calendar days, 30 days, 60 days, 180 days
R	**R**ecurrence	% of Return-to-Works (RTWs) ending with a return to disability within 90 days
E	**E**conomic recovery	% of lost time injured workers who recover to their pre-injury wage income levels within 2 years post injury.

Each performance measure is both easy and complicated to manage. "Prevention" seems easy except for the fact that many soft tissue, repetition-associated injuries are preceded by weeks or months of discomfort. Do you wish to record these discomforts? "Avoidance of lost time" is hard to measure fairly without a good grasp of how alternative duty is arranged.

"Duration of lost time" measurement is based on the idea that one can compute from indemnity payments in a claims information system a duration of injury. I have never run into a claims system that cannot enable this. Below is an estimate of durations of lost time, based on experiences of many employers and insurers in the late 1990s:

1. For lost time compensable TTD claims (at least 7 days lost time)			
	30 days	60 days	180 days
low	30%	40%	75%
ave	50%	60%	85%
high	55%	70%	90%
best practice	75%	85%	95%
2. For all lost time injuries (OSHA)			
	30 days	60 days	180 days
low	45%	55%	80%
ave	65%	75%	90%
high	75%	90%	95%
best practice	85%	90%	98%

This table says, for instance, that if you include all injuries with at least one day lost time, best practice indicates that 85% of these injuries should RTW within 30 days, and 98% within 180 days.

"Recurrences" may be somewhat difficult to pick up from prior claims data. "Economic recovery" is an extremely important but usually overlooked performance goal of workers' compensation. It may be very difficult to track consistently.

As you peruse this "PADRE" list of performance measures, consider how the data collection and data verification practices of the employer can greatly affect the numbers. For example, if an employer from time to time shoves many one or two day lost time injuries into sick leave, it may not be able to come up with consistent figures for many of these measures. It is important not so much to insist on strict adherence to one method of original recording but rather on good faith in adjusting data to standard definitions for common performance reports. The importance of controlling for divergent patterns of original recording leads to my third element in successful analysis of cost containment.

Allocate Workers' Compensation Costs Judiciously Among Operating Units

Within public entities, especially state and local general government, are numerous departments with very different safety and health cultures and injury experiences, not just divergent ways of recording safety and injury related data. These centrifugal forces threaten to cripple efforts to analyze workers compensation costs. Creating reliable cost analysis requires all departments to participate in good faith and with skill. I have found that where departmental officials do not understand, or do not agree with, or do not feel affected by, the allocation of workers' comp costs, then the required level of participation declines or simply disappears. There are simply too many ways to subtly sabotage enterprise wide, multi-departmental cost analysis. The opportunities for mischief are greater within governmental than private sector enterprises due to the nature of governmental budgetary accounting.

Some time ago I went in search of a "best" way to allocate costs among operating units. I identified a method used by United Technologies as the best, applicable to public entities, and consistent with the PADRE method of measuring performance. Because of the importance of getting the allocation method right, I will describe this allocation protocol.

The public entity would value its claims shortly after the close of a period, such as a fiscal quarter. The total value of new claims for an operating unit is computed as a percentage of the new claims value of all operating units. The entire entity then applies this percentage to an actuarially set total "premium" cost for the entire entity, and allocates each operating unit its proportional share.

This approach allocates 100% of "premium" to operating units. This can an important goal as many governments want to maximize indirect cost reimbursement from grants, which have strict guidelines on indirect cost accounting. The focus on new claims cost promotes cost reduction. Even stronger incentives to reduce the cost of risk can be bolted on. For instance, to encourage reducing claims frequency, a government using this approach could base the premium

allocation on a blending of an operating unit's share of total new claims valuation and share of new claim volume. What about large single losses? Adopt a provision to cap large losses so that rare events do not wreak havoc on departmental budgets.

This protocol has ingredients which risk managers say they want in their allocation method.

- The allocations link to new claim trends. Departmental executives have a clear incentive to prevent and manage new claims.
- The methodology is acceptable under federal standards for charging risk costs to contracts and grants.
- Allocations can be computed frequently based on recent experience.
- 100% of the cost of risk can be allocated to operating units.

This approach has yet another, perhaps most important virtue: it is easy for departmental executives to understand.

Insist on Claims Staff Accountability

One of the big puzzles in workers' compensation is how a key player in cost containment, the claims staff, is allowed to take a walk away from cogent cost analysis. Almost every customer of workers' comp claims services articulates an interest in containing workers comp claims costs; very few actually hold the claims staff accountable, for example to produce PADRE type data and pursue a PADRE-like performance targets. I have yet to understand this reluctance on the part of customers. Whatever the reason, it compromises cost analysis because so much of the analysis draws upon data that is collected by the claims system, or by an interfacing medical bill review system.

One way to spark a stronger sense of accountability by claims staffs is to note that each adjuster is responsible for a very large amount of loss dollars, and that these dollars can be high or low in part due to the performance of the adjuster. Among insurers and TPAs a lost time claims adjuster might be responsible for about 150 *new* lost time compensable claims a year. That amounts to, in standard claims costs, close to $4 million in losses. Depending on the success of other cost containment, that final figure could plausibly be as low as $1 million or as high a $8 million. The swing is of course not just the responsibility of the claims adjuster, but she or he is "keeping the books" so to speak and key to some critical claims decisions. How many other state or local government employees have a play in such a range of financial outcomes?

Conclusion

Consider how you can adopt these four elements of successful cost containment analysis. I hope I have explained how do-able it is, and how productive it can be.

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About the Author

Peter Rousmaniere is a consultant, entrepreneur and educator in the field of workforce disability prevention and management. He works with insurers, employers, service providers and information technology firms in the United States. He also is experienced with the Canadian and Australian workers compensation systems. Rousmaniere writes often on risk and insurance topics, most recently on performance benchmarking, treatment of chronic pain patients, and information technology. He is a regular columnist for Risk & Insurance Magazine. He has participated in a number of successful innovations in disability prevention and management since the mid 1980s. Peter earned a BA and MBA at Harvard University. He can be reached at pfr@rousmaniere.com.

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