TRADITIONAL MANAGED CARE:
Does it meet the special needs of Workers' Compensation?

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The evolution of managed care in the United States over the past twenty years is an interesting case study in product design and development. It all started in the mid-1980's when health care inflation reached record levels and crossed into the double digits.

The health care insurance industry appropriately realized that they had some responsibility for this situation. Representing more than half of the medical payments in the United States, they had been the ones paying the bills. And that is more or less what they had actually done: hospitals and physicians and other medical providers performed services, submitted bills, and insurance carriers paid them. As it did not seem realistic that the actual providers of care would begin self-policing, the carriers stepped in.

Managed care was born. In those days, we called it "cost containment", because that was in fact what we were trying to do: our goal was to contain the costs of medical treatment for our policyholders. With that as the objective, the first thing we did was identify where we were spending the most money. What we readily found was that the majority of the payments were for in-patient hospital services and for surgeries.

The first generation of managed care programs was developed to address these costs through benefit plan restrictions and modifications. Weekend Admission, Outpatient Surgery, Pre-Admission Testing and Pre-Admission Review programs were quickly developed and implemented. Inpatient acute care costs quickly decreased, but total costs did not.

Further analysis showed that the gains in inpatient medical care were being offset by increases in both the cost of out-patient care and the cost of mental health care. Clearly, the hospital industry was responding to these cost containment efforts by determining which areas of their revenue were not being scrutinized and adjusting accordingly.

In response, the second generation of managed care programs was designed. As generalist pre-certification review programs were ineffective to address mental health concerns, carve-out specialty review services specific to the area of mental health care were developed. And catastrophic case management departments were developed. Staffed by nurses who intervened on key big-ticket diagnoses such as stroke, head injury and premature births, these nurse case managers acted as patient advocates, getting covered employees and their dependents through the hospital system as efficiently and cost-effectively as possible. They focused on discharge planning, home health care, and the acquisition of medical equipment at a case-by-case negotiated discount, to support convalescence anywhere but in the acute care hospital setting.

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It was about this time that carriers realized that prospectively negotiating discounts with their significant health care providers was an opportunity to save money more broadly. While there was a general understanding that accessing the “right” provider was the way to control costs, “right” being defined as the knowledgeable yet cost-effective practitioner, carriers were poorly positioned to identify who these “right” providers were. As the historical carrier orientation had been that of bill payer, they had not captured any significant level of data regarding more than to whom the check was paid. While this positioned the industry to ID their key payees, it did little to nothing to help determine who had good outcomes, or more specifically, who was effective at controlling costs.

In this universe, the obvious strategy was to negotiate the deepest discounts with as many providers as possible. Broad-based, deeply discounted preferred provider networks (PPOs) were developed. The next step was to provide patients with the incentive to use these now discounted providers. The group health world again changed benefit plans to accomplish this provider channeling, implementing new financial incentives, generally through further co-insurance level differences, e.g., 80% reimbursement if non-network hospitals and providers were used, 100% reimbursement if network providers were accessed. This proved to be quite effective and allowed insurance carriers to deliver the promised additional volume to their networks in exchange for the discounted fees.

By the early 1990’s, Group Health plans were benefiting from all of these managed care efforts. Medical inflation had decreased significantly, and managed care programs were now overseeing the complete complement of services over the complete continuum of time: prospectively, concurrently and retrospectively. Again, providers looked to areas where their costs were not being reviewed and discounted in order to maximize revenue, which brings us to Workers’ Compensation (WC).

WC claim payments cover two areas: medical cost payments and salary replacement. Historically, the majority of the total WC claim payments were for salary replacement. As such, workers’ compensation insurance programs emphasized rehabilitation – getting injured workers back to work. Insurance company-supplied on-site “rehab” nurses worked with injured employees, often accompanying them to doctor’s offices to insure that they were getting all the treatment and services necessary to regain functionality.

As Group Health medical managed care became more effective at containing costs, the workers comp medical experience worsened. Cost shifting to make up for reduced group health revenue directly impacted the workers’ compensation medical experience, and for the first time, the medical component of the claims payout exceeded the salary replacement component.

The obvious solution was to apply the programs that the group health managed care industry had developed to the workers’ compensation medical expense. But there were some problems. To begin with, workers’ compensation medical dollars are not spent in the same places and with the same specialties as the group health dollars. In WC, out-patient expenditures are significantly

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greater than inpatient expenditures. And the key group health diagnoses of maternity, mental health and chronic conditions such as diabetes and asthma are either non-existent or inconsequential in the WC world.

Conversely, many key WC specialties, generally related to musculoskeletal injuries, such as physical therapy, occupational therapy and chiropractic care are unimportant to the group health world, as the group medical objective is only oriented to reducing medical costs, not restoring functionality and effecting a return-to work.

This double objective of managing medical expenditures and returning injured employees to pre-injury functional status makes the process of identification of the “right” WC providers significantly more complex, as “right” means more than cost-effective: “right” means providing appropriate care that allows an injured employee to return to work, which often means more not less care.

It is also more difficult, even if the “right” providers can be identified, to provide WC patients with incentives to utilize these “right” providers. Group health participants have financial skin in the game: they generally contribute towards their premium payment and share in the cost of the services through deductibles, co-pays and co-insurance. Not so with WC where premium is always non-contributory from the employee perspective and benefits are generally “first dollar” with no employee deductible or co-pay. Statutory regulations, by state, determine when and where an injured worker can be channeled to a specific provider, and even where channeling is allowed, the ability of an injured worker to sue their employer for damages, which is not allowed in the group health arena, give employers some pause in their willingness to aggressively intervene in treatment decisions.

Finally, some easily solved group health medical cost management problems are significantly more complex in WC, e.g., prescription drugs. In the group health world, pharmacy cards are distributed and presented at the local drug store or retail chain. Medications are dispensed at significant discounts and drug interactions and consumption are monitored by the databases of large pharmacy benefit management (PBM) companies who receive detailed eligibility and utilization information. In WC, only the drugs that are associated with the specific workplace injury or illness are compensable, making the use of broadly dispensed pharmacy cards problematic. And WC insurance carriers do not maintain eligibility information on their insured population as such a small percentage of the insured population will ever present a claim.

So where does all of this bring us? For the most part, key group health managed care programs were modified in the mid-1990’s to address some of the specific needs of the workers compensation industry. PPOs were modified to eliminate the unneeded specialties (e.g., pediatrics, obstetrics and gynecology) and the critical additional specialties were added or improved, e.g., occupational medicine, PT, OT and Chiro. WC case management has evolved to be more telephonic in nature, mirroring the group health orientation. And group health pre-

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certification programs and treatment protocols have been directed to on-the job as well as off-work injuries and illnesses.

Results have been mixed. While some savings have been realized, generalist networks have been less effective in WC than in group for a few key reasons. First, in-network utilization levels are lower in WC due to regulatory channeling limits and the lack of financial incentives for the injured worker. While group health network penetration of 90+% is not unrealistic, national WC penetration levels beyond 50% are considered leading edge. Savings percentages in WC are also significantly less than in group health where the largest discounts are for in-hospital services. In fact, key WC expenditures are not unit cost driven, but are a factor of utilization – how many services are accessed. Discounted networks are an effective managed care tool for one-and-done treatments, but are largely ineffective for controlling the costs of utilization-driven treatments, such as physical therapy and chiropractic care.

Similarly, generalist pre-certification programs developed in the group health arena are limited in their applicability to WC and are only widely used in states that mandate their employment. Again, pre-certifying hospitalizations does not have the same importance in WC as in group. And most pre-certification programs do not have the in-depth clinical background to effectively manage the utilization of the key WC cost drivers, such as PT and Chiro. Without clearly effective programs, broad utilization has not been widely embraced.

Finally, while specialty managed care solutions that more specifically target the issues unique to WC have been developed, carrier and employer limitations regarding connectivity have limited their implementation. The group health industry modified their internal systems back in the 1980's to accommodate the new managed care initiatives. The WC industry began this process ten years later, with older legacy systems, and with more complicated managed care problems to solve.

The future of truly effective managed care in the WC arena is dependent on successfully utilizing technology and data to overcome all of these limitations. The benefits of these decade-old modified group health solutions have been realized. Increased savings will only be available to purchasers who are able to benefit from managed care programs that uniquely and specifically target the key drivers of WC medical costs to include unit price and utilization controls. Effective programs exist in a number of key areas and more are being developed as the depth of data required to craft these clinically-grounded solutions become available. Creative use of emerging technology to link legacy systems with specialty managed care companies and specialty integrators hold the key. The next few years in the evolution of specialty managed WC initiatives and their implementation into processing environments should provide carriers and employers with the kind of managed care successes that they have enjoyed for years in the group health arena.

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