February 3, 2014

Senator Glenn Grothman
Room 10 South
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Representative Dan Knodl
Room 218 North
State Capitol
P.O. Box 8952
Madison, WI 53708

Gentlemen,

Late last month, the members of the Worker's Compensation Advisory Council approved the final language for the 2013-2014 Agreed Bill. We appreciate your introducing the bill and holding a public hearing and look forward to your passing the bill.

This Agreed Bill is the result of nearly a year of deliberations by the Council. We thank you for your patience during this process as we carefully considered the input of far more people and groups than have historically weighed in on this issue.

The Agreed Bill as presented reflects the input of Labor, Management, and the Department. It reflects the input of the public, of LIRC, the Self-Insured Council, the State Supreme Court, and the Department of Justice. It reflects the input of each of you along with your colleagues. And it reflects the input of the Medical and Insurance liaisons to the Council.

From the beginning of our deliberations, we were challenged to address Wisconsin's competitiveness relative to other states. We were not going to rise to that challenge by making minor adjustments to the system. While our system may have been working, neighboring states have been doing far more than we were to address rising health care costs and other important issues facing their Worker's Compensation systems. In the end, we are of the opinion that the final agreement strikes a good balance between retaining and attracting businesses and retaining and attracting quality workers.

If there is anything we can do to provide greater insight into the deliberations or the agreement, please let us know. As always, thank you for your consideration and for your support of the Council.

Jeffrey J Beiriger
Chairperson - Management Caucus

Stephanie Bloomingdale
Chairperson - Labor Caucus

cc: State Senate
State Assembly
WC Advisory Council Members
John Metcalf, Administrator, DWD - WC Division

STATUTORY CHANGES APPROVED BY WCAC FOR 2014

1. Definition of "municipality" will be amended to "local governmental unit" that includes special purpose district, political subdivision and taxing jurisdiction of the state. s. 102.01 (2) (d)

2. Authorize technical colleges defined under ch. 38, Stats., colleges defined under ch. 36, Stats, higher education institutions and post secondary education institutions to accept WC liability for students performing services in work training and work experience. Exclusive remedy protection will be extended to employers who provide the work training or work experience. ss. 102.07 (12m) and 102.077 (1) & (2)

3. The weekly PPD rate will increase by $15 to $337 for injuries in 2014 after effective date and to $352 for injuries occurring in 2015. s. 102.11 (1)

4. The Department of Justice (DOJ) will be authorized to prosecute fraudulent activities by employees, employers, insurance carriers and health care providers. s. 102.125

5. Fees for providing medical records in electronic format will be limited to $26 per request. s. 102.13 (2) (b)

6. A treating practitioner's final report will not be required in cases where the claim is completely denied. s. 102.13 (2) (c)

7. The formula amount used to determine reasonableness of fee disputes is reduced from 1.2 standard deviations above the mean to .7 standard deviations above the mean. s. 102.16 (2) (d)

8. The Department will establish a medical fee schedule by June 30, 2015. The fee schedule will be based on group health average rates plus 10 percent, with five (5) geographic regions in the state. The fee schedule will be adjusted annually based on the medical CPI and will be reviewed each two (2) years by the WCAC. Data for the group heath payments will be from the Wisconsin Health Information Office (WHIO), Workers Compensation Research Institute (WCRI), group health insurers and plans and other credible sources. s. 102.423

9. The statute of limitations will be reduced to 9 years for traumatic injuries and remain at 12 years for occupational diseases. s. 102.17 (4)

10. ALJs will be authorized to issue prospective orders for vocational rehabilitation training for employees whose permanent restrictions cannot be accommodated to 85% of pre-injury earnings. s. 102.18 (1) (b) 2.

11. Appeals of orders awarding or denying compensation are to be filed only with LIRC and the standard for LIRC to review late appeals is clarified. s. 102.18 (3)

12. The time during which LIRC may set aside an order for further consideration runs from the date of LIRC's order. LIRC may send orders to the parties other than by mail in the future. s. 102.18 (4)

13. The party who files an appeal of a LIRC decision to the Circuit Court shall be named as the plaintiff and shall name as defendants LIRC and those persons or entities identified by LIRC in its decision as necessary to be named as a party for the appeal to court. s. 102.23 (1)

14. The process for political subdivisions of the state to become self-insured for WC purposes will be included in the statute. This change will clarify the Self-Insurers Council (SIC) is not involved with the self-insured status of political subdivisions. Political subdivisions will not be assessed for insolvent private sector self-insured employers and are not entitled to payments from the Self-Insured Employers Liability Fund. s. 102.28 (2) (bm) & (c)

15. All assessments made against private sector self-insured employers for insolvencies will be made on pro rata basis according to payroll. s. 102.28 (7)

16. The Department will have and maintain on its staff a medical expert.

17. When a prescription drug is dispensed outside a retail, mail order or institutional pharmacy the maximum reimbursement amount shall be calculated using the average wholesale price (AWP) set by the original manufacturer of the underlying drug which may not be the manufacturer of the repackaged drug. If the National Drug Code (NDC) of the underlying drug cannot be determined from the billing the maximum reimbursement amount shall be calculated using the lowest cost therapeutically equivalent drug. s. 102.425

18. The sunset will be extended for two (2) additional years on the provision that permits employees to work at part-time employment up to 24 hours per week while attending instruction for vocational rehabilitation training without an offset on retraining benefits. s. 102.43 (5) (c)

19. Supplemental benefits will be moved forward two (2) years to include injuries occurring in 2001 & 2002 with the maximum weekly benefit rate increased to $669. Reimbursement for supplemental benefits from the Work Injury Supplemental Benefit Fund (WISBF) will be permanently suspended. 102.44 (1)

20. Supplemental benefit reimbursements will be added to the Department's annual assessment, the reimbursement amount will be paid by worker's compensation insurance carriers and the Department will pay reimbursements to the insurance carriers from this revenue. s. 102.44 (1) (c)

21. There will be indexing for compensation for permanent total disability (PTD) after six (6) years that will be paid by insurance carriers and self-insured employers for injuries occurring on and after July 1, 2015. 102.44 (1m)

22. There will be indexing of payments for permanent partial disability (PPD) after 200 weeks. 102.44 (4m)

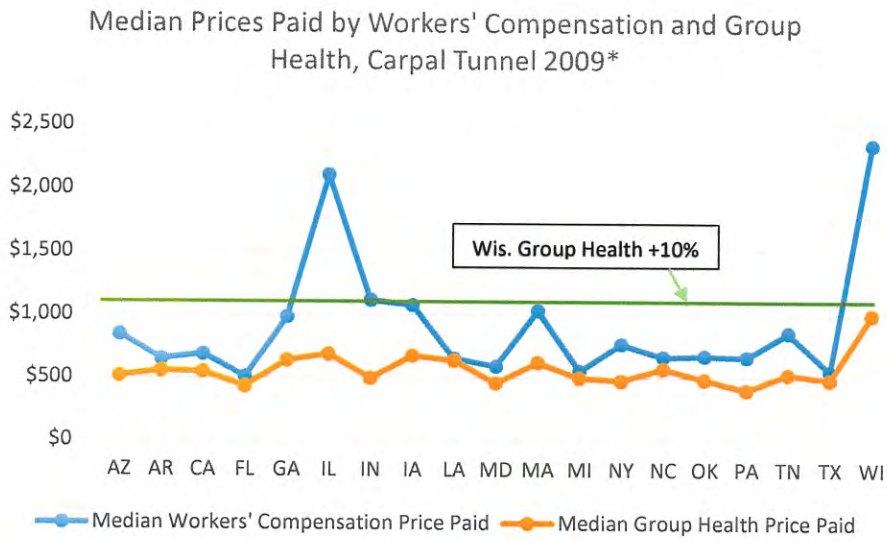
23. Beginning July 1, 2015 employers who provide health insurance coverage for employees at the time of injury will be required to maintain that coverage under the same conditions for the duration of an employee's healing period. 102.445

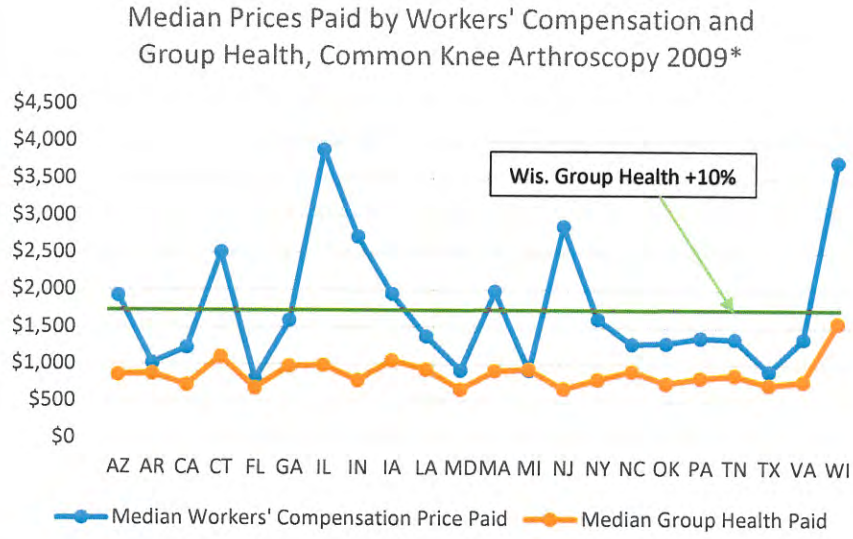
24. An added measure of solvency is created for the Uninsured Employers Fund (UEF) to make up for large claims in excess of $1,000,000 that are not covered by excess or stop-loss insurance. 102.81 (1) (c)

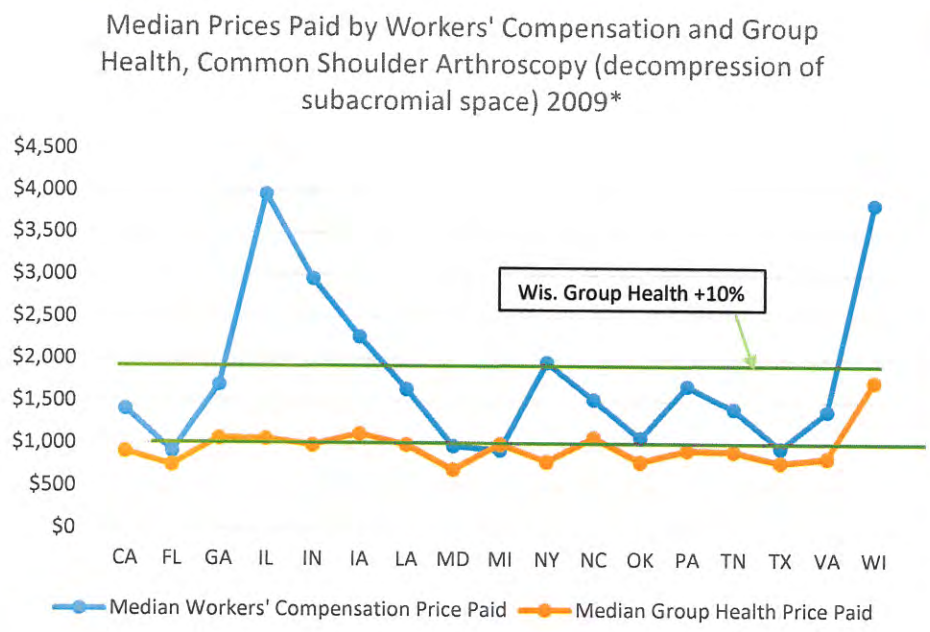
25. The WCAC will create a committee to review and evaluate treatment outcomes from health care providers.

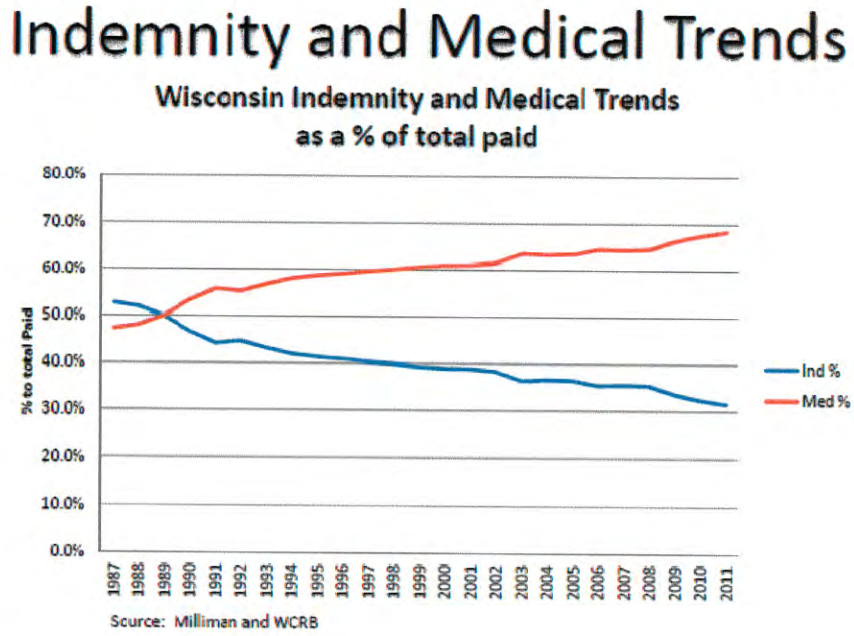
(JOM 1.8.14)

COMPARISON OF WISCONSIN WORKER'S COMPENSATION PRICES









*Source: Fomenko, Olesya, and Richard A. Victor. *A New Benchmark for Worker's Compensation Fee Schedule: Prices Paid by Commercial Insurers?. 2013 Workers Compensation Research Institute.*

1/30/2014 8:46 AM

Testimony Submitted to the Wisconsin State Assembly Committee on Labor

Re: An Act to Amend or Create 102.423 [Health Service Fee Schedule] and 102.45 (3)(am) [Fees for Repackaged Prescription Drugs Dispensed by Physicians]

By

Richard A. Victor, Executive Director

Sharon Belton, Senior Public Policy Analyst

Workers Compensation Research Institute

955 Massachusetts Avenue

Cambridge, MA 02139

February 4, 2014

This testimony is submitted to Wisconsin State Assembly Committee on Labor by the Workers Compensation Research Institute (WCRI). It is based on published peer-reviewed research studies by WCRI researchers. This testimony was authored by Dr. Richard Victor and Dr. Sharon Belton. Dr. Victor is WCRI's Executive Director, and received his J.D. and Ph.D. in economics at the University of Michigan. Dr. Belton is Senior Public Policy Analyst at WCRI, and received her Ph.D. in public policy from the University of Illinois-Chicago. Both have published numerous studies on health care and workers' compensation, as well as served as advisors to public officials of both parties.

WCRI is a not-for-profit public policy research institute founded in 1983 in Cambridge, Massachusetts. The Institute conducts studies on the workers' compensation benefit delivery system, not on insurance prices or the insurance markets. It does not make recommendations nor take positions on issues. In addition, WCRI is a membership organization with a very diverse membership, including the Wisconsin Department of Workforce Development, Wisconsin Compensation Rating Bureau, Wisconsin State AFL-CIO, and Sentry Insurance. In general, WCRI members are employers, insurers, managed care companies, labor organizations, and state governments in the U.S., Canada, Australia and New Zealand.

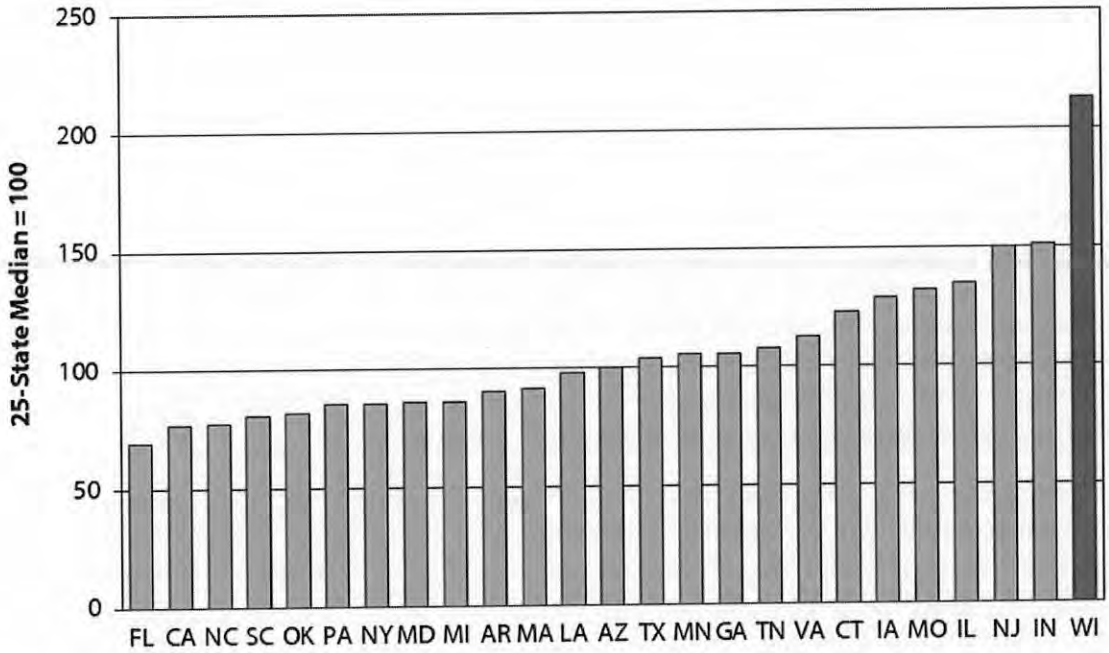
This document summarizes lessons from WCRI research for the Committee's consideration of an act to amend or create 102.423 [health service fee schedule] and 102.45 (3)(am) [fees for repackaged prescription drugs dispensed by physicians].

HEALTH SERVICE FEE SCHEDULE. 102.423 (1)(a)1 and 2 together provide that the maximum fee for each health service included in the schedule shall be set at 110 percent of the sum of (A) the average payment for that service under group health benefit plans and self-insured health plans and (B) the average copayment, coinsurance, and deductible payment for that service, under those same plans.

Relevant findings from WCRI studies include:

- Wisconsin had among the highest prices for workers' compensation medical services provided to injured workers.
    - For professional fees, Wisconsin had the highest prices—more than double the median state (Figure 1).
    - Moreover, the prices of professional services grew more rapidly than other states studied by WCRI.
    - For payments to hospitals for outpatient services, Wisconsin had third highest costs per surgical episode—39% above the median state.

Figure 1 Medical Price Index for Professional Services, 2012



Source: WCRI Medical Price Index for Workers' Compensation, Fifth Edition (2013).

- For common office visits, the median prices paid in Wisconsin by workers' compensation payors were higher than those paid by group health plans. For example, for the most common established patient office visit (CPT 99213), the median price paid under workers' compensation was 15 percent higher than that paid by group health plans (Table 1).
- For common surgeries, the median prices paid to surgeons in Wisconsin by workers' compensation payors were much higher than those paid by group health plans. For example, for the most common surgery (knee arthroscopy, CPT 29881), the median price paid under workers' compensation was 137 percent higher (more than double) than that paid by group health plans (Table 1).
- The median facility fees paid to hospital outpatient departments for common surgeries by workers' compensation was slightly higher than that paid by group health plans. For example, for the most common surgery (knee arthroscopy), the median price paid under workers' compensation was 5 percent higher than that paid by group health plans (Table 1).

Table 1 Comparing Median Prices Paid by Workers Compensation and Group Health Payors (2009)*

Type of Service		CPT Code	Median WC Price Paid	Median GH Price Paid	% Difference
Established Patient Office Visit	Professional Fee	99212	81	65	24%
Established Patient Office Visit	Professional Fee	99213	113	99	15%
Established Patient Office Visit	Professional Fee	99214	169	155	9%
Established Patient Office Visit	Professional Fee	99215	255	227	12%
Knee Arthroscopy	Professional Fee	29881	3728	1573	137%
Shoulder Arthroscopy	Professional Fee	29826	3849	1741	121%
Shoulder Arthroscopy	Professional Fee	29827	4909	2726	80%
Carpal Tunnel	Professional Fee	64721	2339	999	134%
Episode of Knee Surgery	Hospital Outpatient Services**	n.a.	6446	6150	5%
Episode of Shoulder Surgery	Hospital Outpatient Services**	n.a.	10222	9033	13%

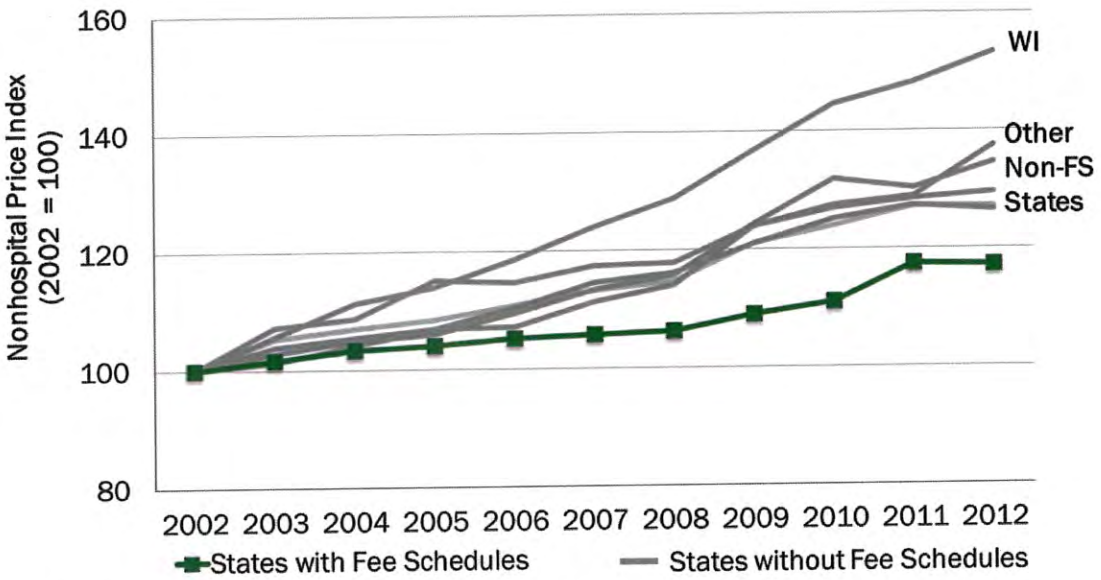
*2008 prices for hospital outpatient services.

**Largely facility fees for operating, treatment and recovery rooms.

Sources: A New Benchmark For WC Fee Schedules: Prices Paid By Commercial Insurers? (2013); and *Comparing Workers' Compensation and Group Health Hospital Outpatient Payments* (2013).

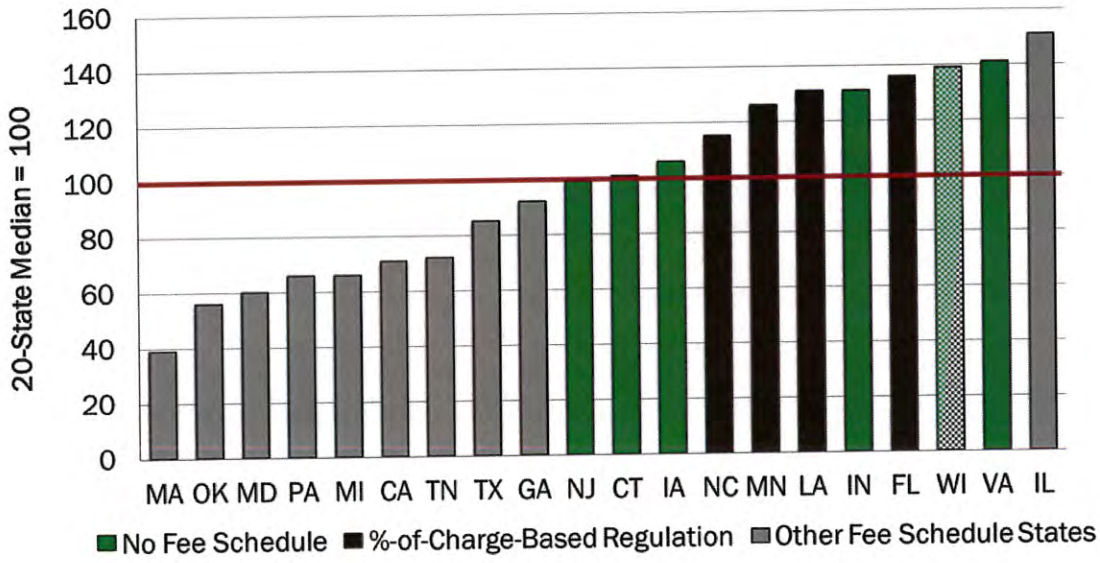
- Forty-three states regulate professional fees and 41 states regulate hospital fees.
- States seek benchmarks on which to base their fee schedules.
    - Two states have based their fee schedules on the group health rates in their states.
        - In Montana, the statute requires the five largest group health plans in the state to submit their rates on a confidential basis to the state workers' compensation agency. The agency averages the rates of the five plans for each service, and the average becomes the fee schedule. Taking the average has the advantage of protecting the confidentiality of proprietary competitive information of each health plan. The statutory language is provided in Attachment A.
        - In Oklahoma , the workers' compensation fee schedule was based on the prices paid by the State Employees Health Plan. The statutory language is provided in Attachment B.
    - No state has developed a group heath-based benchmark that requires computation of rates on a service by service basis from a database of individual claims and bills.
    - Many states use Medicare as the benchmark, although it is used differently in different states. The Medicare rates are published and do not require any computations from individual claim or billing data.
    - Some states use historic charges as the benchmark. WCRI studies find that charged-based fee schedules typically do not restrain the growth in medical prices (Figures 2 and 3).

Figure 2 Nonhospital Prices Paid Increased Faster in States without Fee Schedules



Source: WCRI Medical Price Index for Workers' Compensation, Fifth Edition (2013).

Figure 3 No Fee Schedule or Charge-Based Fee Schedule: Higher Facility Outpatient Costs per Surgical Episode



Source: Hospital Outpatient Cost Index for Workers' Compensation, 2nd Edition (2013).

- 102.423 (1) requires that Wisconsin be divided into 5 distinct geographic areas and a separate fee schedule be computed on a service by service basis for each area.
    - WCRI studies in Illinois show the limitations in the reliability of fee schedule computations for multiple geographic areas because the frequency of most procedure codes is not high and random errors are common from small sample sizes. This is unlikely a concern for the most common office visits or physical medicine procedures, but is likely to be a concern for many other services—even for the most common surgeries.
        - Illinois divided the state into 29 fee schedule areas (zones)—8 in the Chicago metropolitan area. Table 2 show an example of the results comparing two of the Chicago fee schedule zones that are 30 miles apart. The fee schedule amount for a common knee arthroscopy was 14 percent higher in Oak Park than in Bolingbrook, while a common shoulder surgery was paid 24 percent more in Bolingbrook than in Oak Park.

Table 2 Multiple Zones Produce Surprising Results In 2 Chicago Suburbs (31 Miles Apart)

	Bolingbrook, IL	Oak Park , IL
Shoulder Arthroscopy	$4,818	$5,489
Knee Arthroscopy	$4,156	$3,157

Source: Analysis Of The Workers' Compensation Medical Fee Schedules In Illinois (2006).

        - This was especially a concern in fee schedule zones with smaller populations. For example, the fee schedule amount for a carpal tunnel surgery was 50 percent higher in Elgin than in Evanston. The population of both fee schedule zones was less than 70,000 (Table 3).
        - It is also a concern for fee schedule zones with about 500,000 people. For example, for a lumbar steroidal injection, the fee schedule amount for Bolingbrook was 21 percent higher than in Downers Grove, a distance of only 13 miles (Table 3).

Table 3 Zones That Are Not Adequately Populated Produced Surprising Results

Areas	Service	Fee Schedule $	Population	Distance
Oak Park, IL	Shoulder Arthroscopy	$5,489	36k	17 miles
Evanston, IL	Shoulder Arthroscopy	$3,170	40k	
Downers Grove, IL	Lumbar MRI	$2,010	422k	23 miles
Chicago, IL	Lumbar MRI	$1,458	1.2M	
Bolingbrook, IL	Lumbar Steroidal Injection	$834	614k	13 miles
Downers Grove, IL	Lumbar Steroidal Injection	$688	422k	
Elgin, IL	Carpal Tunnel Surgery	$2,236	67k	31 miles
Evanston, IL	Carpal Tunnel Surgery	$1,488	40k	

Source: Analysis Of The Workers' Compensation Medical Fee Schedules In Illinois (2006).

PAYMENT FOR PHYSICIAN-DISPENSED REPACKAGED PRESCRIPTION DRUGS. 102.425 (3) (am) 1 establishes the maximum payment at average wholesale price (AWP) set by the original manufacturer of the medication plus a dispensing fee plus applicable taxes.

Relevant findings from WCRI studies include:

- 11 percent of prescriptions in Wisconsin in 2011 were dispensed by physicians. Most of these were repackaged drugs.
- Physician-dispensed prescriptions accounted for 16 percent of all prescription costs in Wisconsin.
- Pharmacies were often paid much lower prices for the same drug than when it is dispensed by physicians (Table 4).

Table 4 Comparing Average Price per Pill Paid for Generic Drugs between Physician- and Pharmacy-Dispensed Prescriptions for Top Five Common Drugs, 2011/2012

	WI
Hydrocodone-acetaminophen (Vicodin®)	
Price per pill paid for MDRx	$1.09
Price per pill paid for PDRx	$0.43
% difference	153%
Ibuprofen (Motrin®)	
Price per pill paid for MDRx	$0.41
Price per pill paid for PDRx	$0.27
% difference	54%
Tramadol HCL (Ultram®)	
Price per pill paid for MDRx	$1.61
Price per pill paid for PDRx	$0.73
% difference	122%
Cyclobenzaprine HCL (Flexeril®)	
Price per pill paid for MDRx	$1.15
Price per pill paid for PDRx	$1.02
% difference	13%
Meloxicam (Mobic®)	
Price per pill paid for MDRx	$5.20
Price per pill paid for PDRx	$3.49
% difference	49%

Notes: The underlying data included prescriptions for claims with more than seven days of lost time that had prescriptions filled over the defined period and paid for by a workers' compensation payor. 2011/2012 refers to claims with injuries occurring from October 1, 2010, to September 30, 2011, and prescriptions filled through March 31, 2012.

Key: MDRx: physician-dispensed prescriptions; PDRx: pharmacy-dispensed prescriptions.

Source: The Prevalence and Costs of Physician-Dispensed Drugs (2013), Table 5.1

- Wisconsin physicians dispensed a higher proportion of strong narcotics than physician-dispensers in most other states. Wisconsin physicians dispensed 21 percent of prescriptions for Vicodin (or its generic forms) compared to 14 percent in the median state in a 19 state study (Table 5). And they dispensed 10 percent of prescriptions for Percocet (and its generic forms) compared to 2 percent in the median state studied.
    - In 2011, Florida banned physician dispensing of these strong narcotics. In a study of the early impact of the ban, WCRI found that there was a drop in prescribing of narcotics as physician dispensers, on average, substituted weaker narcotics and especially NSAIDs (like ibuprofen) that they were allowed to dispense. There was no increase in pharmacy-dispensed narcotics from which we infer that fewer narcotic prescriptions were written by physician dispensers.
- Since 2007, 13 states have changed the reimbursement rules intended to reduce the prices paid for physician-dispensed drugs. Other states that, as of July 2013, have made law or rule changes include: Alabama, Arizona, California, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Michigan, Mississippi, Oklahoma, South Carolina, and Tennessee. Physician dispensing in Minnesota is permitted but uncommon due to certain regulatory requirements for physician dispensers.
- A common concern when prices paid to physician dispensers are reduced is whether that would limit patient access to needed medications. Two WCRI studies examine states that made changes similar to what is proposed in Wisconsin. In both studies, WCRI found significant physician dispensing after reforms, even at much lower prices paid (Table 6).

Table 5 Drugs That Were Commonly Dispensed by Physicians, 2011/2012

	CA[a]	CT[b]	FL[b]	GA[a]	IA	IL[b]	IN[b]	KS	LA	MD	MI[b]	MO	NC	NJ	PA	SC[b]	TN[b]	VA	WI	Median
Hydrocodone-acetaminophen (Vicodin®)	13%	10%	5%	14%	15%	16%	23%	8%	7%	3%	7%	15%	14%	1%	10%	19%	20%	17%	21%	14%
Oxycodone w/acetaminophen (Percocet®)	0%	6%	1%	1%	2%	0%	1%	2%	1%	2%	1%	2%	2%	0%	3%	4%	1%	5%	10%	2%

Notes: The underlying data included prescriptions for claims with more than seven days of lost time that had prescriptions filled over the defined period and paid for by a workers' compensation payor. 2011/2012 refers to claims with injuries occurring from October 1, 2010, to September 30, 2011, and prescriptions filled through March 31, 2012. Three states (Massachusetts, New York, and Texas) where physician dispensing is not allowed in general were not included in this table. Two other states (Arkansas and Minnesota) where physician dispensing was infrequent were also not included.

[a] Two states included in the study (California and Georgia) made rule changes for physician-dispensed prescriptions, effective March 2007 and April 2011, respectively. The data are post-reform for California and partially post-reform for Georgia.

[b] Seven states (Connecticut, Florida, Illinois, Indiana, Michigan, South Carolina, and Tennessee) recently adopted reforms aimed at reducing the costs of physician-dispensed prescriptions. The data presented here are pre-reform for these states. Note that we grouped South Carolina and Tennessee with the pre-reform states because the data for the two states are predominantly pre-reform. For these pre-reform states, the data show a baseline for evaluating the reforms.

Source: The Prevalence and Costs of Physician-Dispensed Drugs (2013), Table 4.1.

Table 6 Percentage of Physician-Dispensed Prescriptions before and after Reform

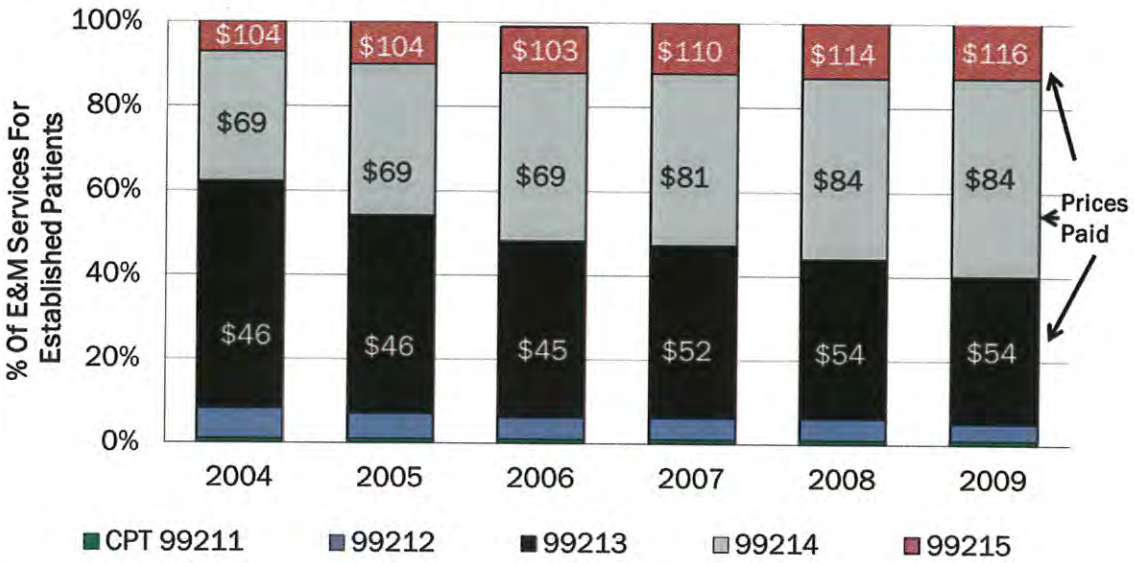
State	% of Rx Dispensed by Physicians	
	Before Price Change	After Price Change
California	55%	44%
Georgia	35%	28%

Source: Physician Dispensing In Workers' Compensation (2012) for California data; *Impact of Reform on Physician Dispensing and Prescription Prices in Georgia* (2013) for Georgia data.

A GENERAL OBSERVATION: When policymakers attempt to reduce medical prices by regulation or statute, providers, on average, change treating or billing practices to seek to retain revenue levels. This is supported by ample evidence in studies by WCRI and by other researchers. In fact, Medicare used to assume that 30-50 percent of a rate decrease was offset by changed in provider practices. Below are several examples from WCRI studies

- In California, the fee schedule for office visits was frozen for several years. In response, there was an increase in the percent of office visits that were coded by providers as the more intensive (hence more expensive) ones. This phenomenon is known as "up-coding." When the fee schedule was increased, the up-coding stopped. But it began again when the fee schedule amounts did not change (Figure 4).

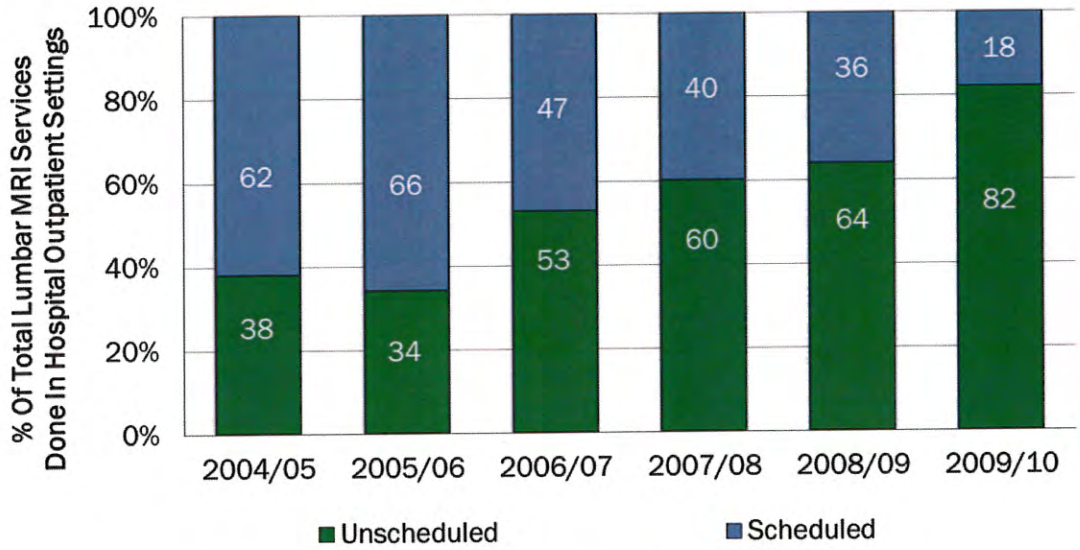
Figure 4 One Effect of Freezing Fee Schedule Rates



Source: CompScope™ Medical Benchmarks for California, 12th Edition (2012).

- In Florida, the fee schedule applicable to hospital outpatient radiology was reduced very substantially in 2003. A distinction was drawn between MRIs that were scheduled (fell under the fee schedule) and unscheduled (75 percent of charges which was often 3-4 times the fee schedule amount). Figure 5 shows that billing for scheduled MRIs became less common and billing for unscheduled MRI became the norm (Figure 5) after the fee schedule change.

Figure 5 Post-Fee Schedule Change: Lumbar MRI Paid More Often as Higher-Priced Unscheduled MRI in Florida



Source: CompScope™ Medical Benchmarks for Florida, 12th Edition (2012).

Attachment A
Montana Code Annotated (2011), 39-71-704b

(i) The department may not set the rate for medical services at a rate greater than 10% above the average of the conversion factors used by up to the top five insurers or third-party administrators providing group health insurance coverage within this state who use the resource-based relative value scale to determine fees for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy at least 1% of the market share for group health insurance policies as reported annually to the state auditor.

(ii) The insurers or third-party administrators included under subsection (2)(b)(i) shall provide their standard conversion rates to the department.

(iii) The department may use the conversion rates only for the purpose of determining average conversion rates under this subsection (2).

(iv) The department shall maintain the confidentiality of the conversion rates.

Attachment B
85 OS Sec. 327

A. For the express purpose of reducing the overall cost of medical care for injured workers in the workers' compensation system by five percent (5%), the Administrator of the Workers' Compensation Court is hereby directed to develop a new "Oklahoma Workers' Compensation Medical Fee Schedule" to be implemented by January 1, 2012. Thereafter, the Administrator shall conduct a review of the Fee Schedule every two (2) years. The Fee Schedule shall establish the maximum rates that medical providers shall be reimbursed for medical care provided to injured workers, including, but not limited to, charges by physicians, dentists, counselors, hospitals, ambulatory and outpatient facilities, clinical laboratory services, diagnostic testing services, and ambulance services, and charges for durable medical equipment, prosthetics, orthotics, and supplies.

B. Reimbursement for medical care shall be prescribed and limited by the Fee Schedule as adopted by the Administrator, after notice and public hearing. The director of the Oklahoma State Employees Group Insurance Board shall provide the Administrator such information as may be relevant in the development of the Fee Schedule. The Administrator shall develop the Fee Schedule in a manner in which quality of medical care is assured and maintained for injured workers. The Administrator shall give due consideration to additional requirements for physicians treating an injured worker under this act, including, but not limited to, communication with claims representatives, case managers, attorneys, and representatives of employers, and the additional time required to complete forms for the Court, insurance carriers, and employers.

WMC

WISCONSIN MANUFACTURERS & COMMERCE

TO: Senate Committee on Judiciary and Labor
Assembly Committee on Labor

FROM: Scott Manley, Vice President – Government Relations
Wisconsin Manufacturers and Commerce

DATE: February 4, 2014

RE: Assembly Bill 711 & Senate Bill 550, Workers Compensation Legislation

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Wisconsin Manufacturers & Commerce (WMC), the statewide chamber of commerce, with over 3,500 member companies from every corner of our economy, supports the legislation developed by the Workers Compensation Advisory Council (WCAC), Assembly Bill 711 and Senate Bill 550. Once enacted, this legislation will substantially reduce workers compensation expenses for Wisconsin employers by addressing the primary cost driver in the system – rapidly rising health care costs. It will bring our state in line with most other states, and it will maintain the high quality of care Wisconsinites have come to associate with worker's compensation treatments.

Make no mistake; there is much to be proud of in Wisconsin's worker's compensation system in Wisconsin. Started in 1911, the same year as WMC, the worker's compensation system has been a relatively stable system over the years, in a large part due to the policy setting of the WCAC. As the mandated exclusive remedy for workplace injuries, worker's compensation is an important system that protects employers from frivolous lawsuits and ensures injured workers receive the care they need in order to heal and return to work as quickly as possible. When looking at certain comparisons with other states, Wisconsin stands out as having a relative low number of claims with lost time greater than 1 week, a lower utilization of temporary disability, a lower utilization of services, and an average cost of all claims below the state median. These positive indicators are all testaments to the joint efforts of employers, providers, and workers at promoting a culture of quick return to work, workplace safety, and quality care.

Despite all that is good with our worker's compensation system, there are serious symptoms that must be addressed, and the WCAC legislation addresses those symptoms. Even while the number and severity of worker's compensation claims has decreased over the last 20 years, the medical cost portion of claims has continued to increase, capturing any savings that would otherwise have come about for employers from the lower indemnity costs. Today, according to the Worker's Compensation Ratings Bureau, nearly 70 cents out of every dollar spent in the worker's compensation system goes to pay for health care, a substantial increase over the last 20 years.

Also alarming to WMC members is the growing disparity between the medical costs of worker's compensation payments and group health payments. Our members find that some procedures can cost 2 or 3 times as much when billed through the worker's compensation system. This is due in

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part to the fact that worker's compensation insurance carriers and self- insured companies pay actual charges and are unable to negotiate discounts with health care providers. Wisconsin employers also see substantially higher worker's compensation medical costs when compared to nearly every other state. Those higher costs drive worker's compensation premiums upwards, making Wisconsin less competitive for businesses. When looking beneath the surface on the average cost per claim compared with other states, it is obvious that this is an issue in need of addressing. While the total average cost per claim is 4% below average, the average medical cost per claim is 21% above average, while the average indemnity is 32% below average. This is simple not sustainable.

To address these rising costs, the WCAC bill establishes a fee schedule based on the average payments under group health insurance, increased by 10 percent. In so doing, Wisconsin will be following the lead of 45 other states that have worker's compensation fee schedules in place. WMC has long advocated for a fee schedule in the worker's compensation system, and this proposed legislation is the best opportunity in over a decade to find real medical cost savings in the worker's compensation system.

According to the Workers Compensation Research Institute, an independent, not-for-profit research organization based in Cambridge Massachusetts, the imposition of this fee schedule could reduce cost to the system between 10 and 20 percent. That would save Wisconsin employers as much as $200 million per year. While there are benefit increases in the compromise bill, they are relatively modest and more than offset by the savings.

Finally, WMC reiterates our continued support of the 103-year old WCAC process as an instrument of policy making for the workers compensation system. The system involves a complex interplay between injured workers, employers, state agencies, private insurers, health care providers, and attorneys. The council process brings all parties into the discussion with the key interests - injured workers that receive the benefits and employers that pay the benefits - negotiating the final agreement. WMC has been involved with the council process since the system was established in 1911, and we continue to believe it serves the best interest of injured workers and employers alike.

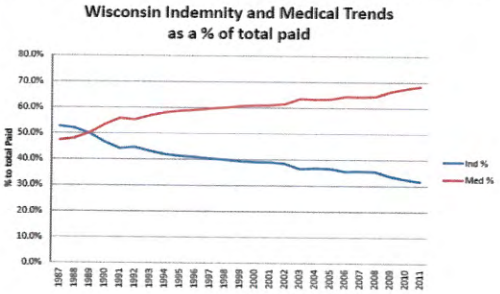
We respectfully request that the committees approve the WCAC legislation, as it does every two years.

Thank you.

Work Comp Medical Cost Trends

WCRB

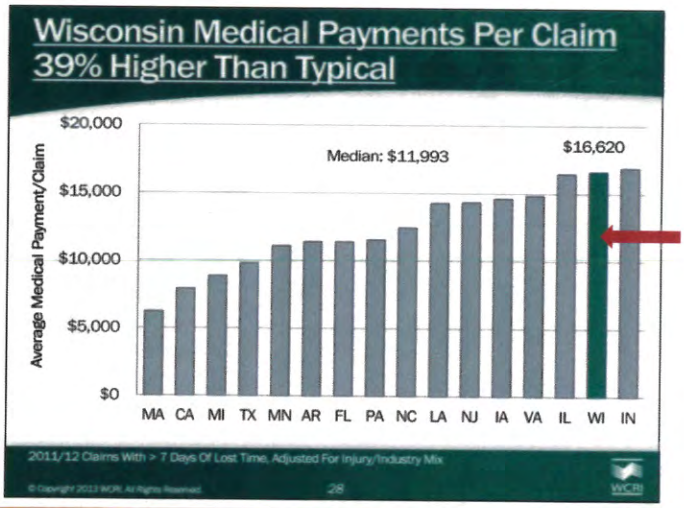
Indemnity and Medical Trends



Source: Milliman and WCRB

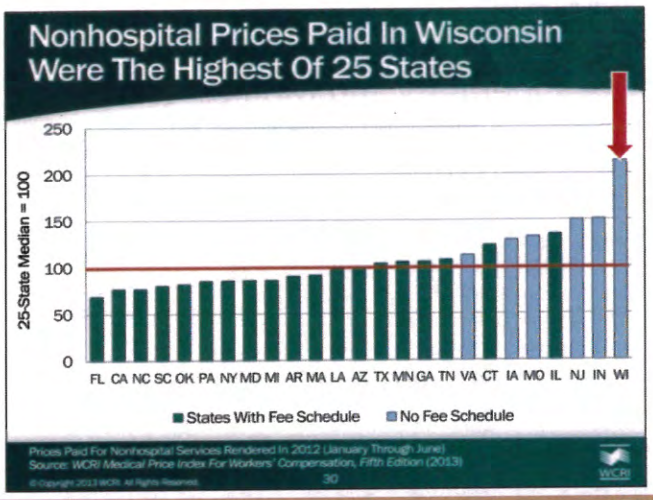
Wisconsin's Chamber WMC

Higher Medical Payments Per Claim



Wisconsin's Chamber WMC

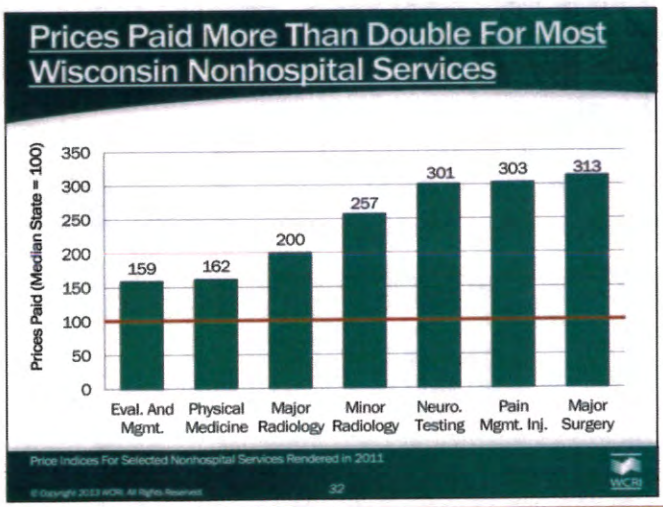
Highest Non-Hospital Prices



Wisconsin's Chamber

WMC

Much Higher Non-Hospital Services

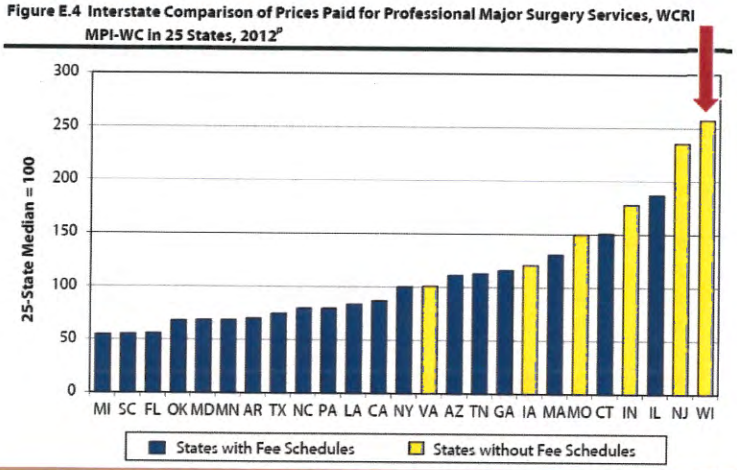


Wisconsin's Chamber

WMC

The Case for a Fee Schedule: Major Surgery Services

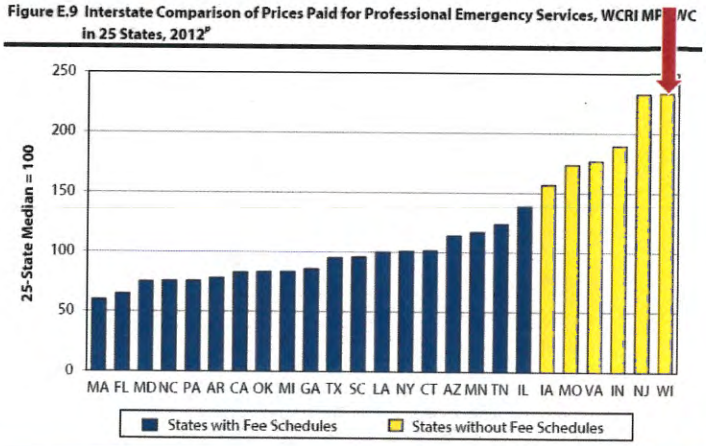
Figure E.4 Interstate Comparison of Prices Paid for Professional Major Surgery Services, WCRI MPI-WC in 25 States, 2012[P]



Wisconsin's Chamber WMC

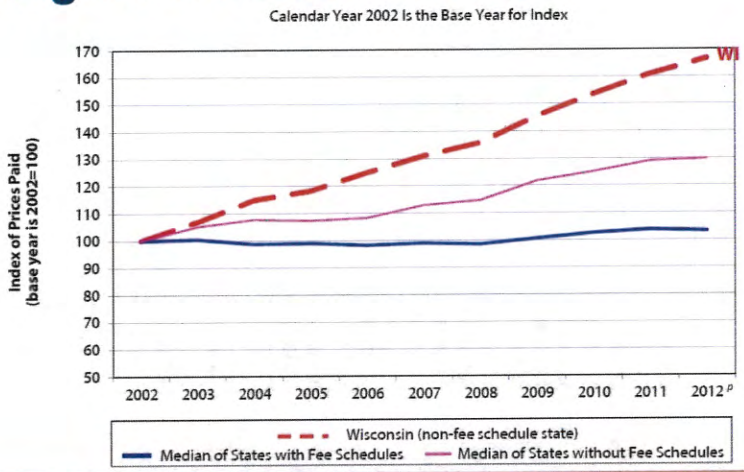
The Case for a Fee Schedule: Emergency Services

Figure E.9 Interstate Comparison of Prices Paid for Professional Emergency Services, WCRI MPI-WC in 25 States, 2012[P]



Wisconsin's Chamber WMC

The Case for a Fee Schedule: Surgical Services Trends



Wisconsin's Chamber WMC

The Bottom Line

Lower Indemnity Payments And Expenses Offset Higher Medical

Average Cost Per Claim	Wisconsin	Median State	WI Compared With Median State
Total	$34,762	$36,188	-4%
Medical	$19,619	$16,173	21%
Indemnity	$11,573	$17,079	-32%
Expenses/Claim With Expenses	$3,520	$5,139	-31%

2009/12 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix And Wages
Source: CompScope™ Benchmarks For Wisconsin, 14th Edition (2013)

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WCRI

Wisconsin's Chamber WMC

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Assembly Committee on Labor – Representative Dan Knodl, Chair
Senate Committee on Judiciary and Labor – Senator Glenn Grothman, Chair

FROM: Mark M. Grapentine, JD
Senior Vice President – Government Relations

DATE: February 4, 2014

RE: **Opposition** to Assembly Bill 711 and Senate Bill 550

On behalf of more than 12,000 members statewide, the Wisconsin Medical Society thanks the committees for this opportunity to share our opposition to Assembly Bill 711/Senate Bill 550, which require state government to mandate an artificial fee schedule for worker's compensation health care services. We urge you to help protect Wisconsin's model worker's compensation system and amend the legislation to remove sections 23 and 49 from AB 711/SB 550.

Injured workers in Wisconsin return to work faster than their counterparts in the rest of the nation – which benefits both the employee and the employer. These employees are also satisfied with their care – they see less need to hire an attorney to ensure their interests are protected. And despite Wisconsin's relatively poor rate of injuries happening in the workplace, Wisconsin's physicians and health care partners provide effective, efficient care at a cost below the national average for a worker's compensation claim. While prices for individual procedures may be higher in worker's compensation than in other areas, Wisconsin health care's quality means fewer visits are required per incident and fewer services are required per visit. That efficient utilization combined with the high quality of care results in costs-per-medical-claim that most other states can only envy.

In short, health care is fulfilling its part of the bargain when it comes to the state's worker's compensation system. Foisting an artificial fee schedule on the health care sector will likely result in less-available care delivered less efficiently, meaning potentially less-satisfied employees will be less productive and less likely to rejoin the workforce as soon as they do today.

A fee schedule flies in the face of current facts and data. It should be removed from the proposal.

The materials included in this packet contain a myriad of information related to Wisconsin's worker's compensation success story – we're pleased to provide it. If you have further questions, please feel free to contact the Society at any time.

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Wisconsin Medical Society

WHA
A Valued Voice

WPTA
Wisconsin Physical Therapy Association

WCA
Wisconsin Chiropractic Association

November 5, 2013

To: Members, Worker's Compensation Advisory Council (WCAC)
From: Health Care Liaisons to the WCAC
Subject: Health Care Liaison Proposal

EXECUTIVE SUMMARY

The Wisconsin Hospital Association, Wisconsin Medical Society, Wisconsin Chiropractic Association, and the Wisconsin Physical Therapy Association are pleased to present this proposal, which addresses the specific concerns identified by the WCAC, legislators, and others with an interest in the Wisconsin Worker's Compensation system. Our proposal provides both immediate cost savings within the program and identifies areas for better controlling future cost growth.

In Wisconsin, we enjoy a model system. Here, injured workers have access to and receive high-value health care and return to work faster and more satisfied than in any other state. This model system exists even as Worker's Compensation premiums are stable and costly litigation is rare. While some data indicate higher medical prices compared to certain other states, that narrow focus ignores the big picture. When prices are considered with Wisconsin's low utilization rates, efficient and high quality treatment, and excellent outcomes including return-to-work, Wisconsin's overall claims costs are significantly lower than average and our state's Worker's Compensation system continues to be a national success story.

We recognize there is room for improvement. Our organizations took a balanced approach when considering changes to the system in order to preserve the positive outcomes and decades of work accomplished by previous Councils. Our teams focused on several areas of the system in preparing this proposal, including *OUTCOMES, COST, and QUALITY.*

OUTCOMES: ***Data show that in Wisconsin, the period of time an injured worker is away from his or her job is lowest in the country; in fact, the period of disability is half the national average. This benefits the entire system and all of its participants, including the employer.***

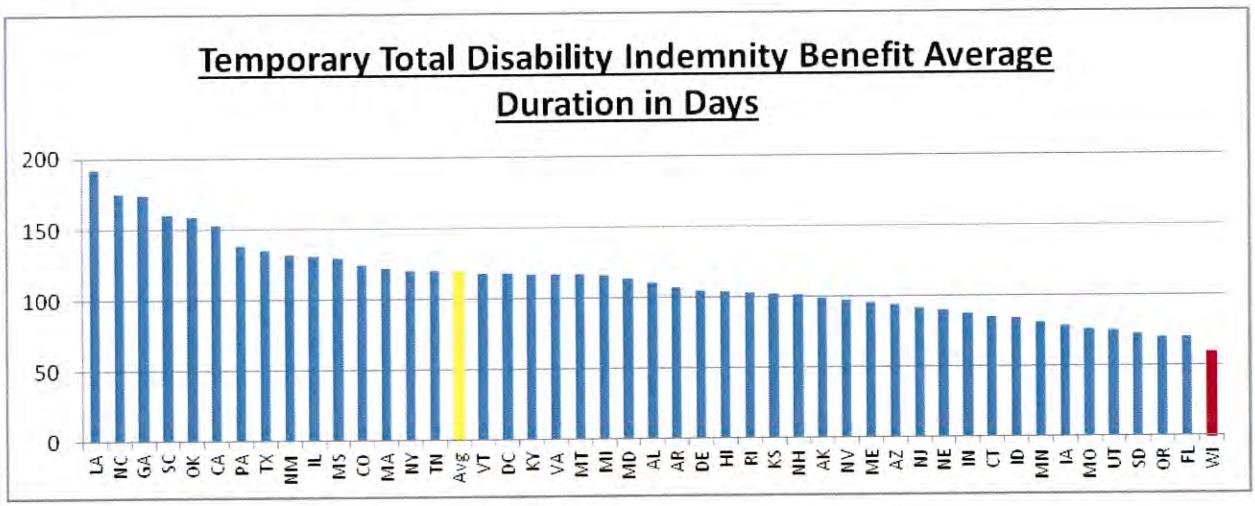
COST: ***While prices for some services are higher in Wisconsin compared to other states, the overall cost of medical care provided through the Worker's Compensation system is lower than average and lower than our neighboring states of Minnesota, Iowa, and Illinois. Wisconsin is also below the national average in overall claims costs.***

QUALITY: ***Wisconsin is ranked consistently among the best states in overall health care quality. The Worker's Compensation system benefits from our high quality, value based health care system, which truly is a competitive advantage for Wisconsin.***

We look forward to working with you to improve our system while preserving its many strengths.

Outcomes: Wisconsin's Worker's Compensation Success Story

Wisconsin employers and employees have access to one of the best health care systems in the country. Wisconsin health care providers are leading the nation in the way they do business, becoming leaner and more efficient in order to deliver excellent care at lower costs. Care is centered on the patient, helping that patient return to normal activities and stay healthy. In Wisconsin, when an employee is injured on the job, that employee receives high quality and efficiently delivered care and thus spends less time away from work. The data show exactly that. The period of time an injured worker in Wisconsin is away from his or her job is the lowest in the country. In fact, the period of temporary total disability is half the national average.



Source: NCCI Research Brief (August 2013, Table 3), published by the National Council on Compensation Insurance, Inc. (NCCI).

This reduces overall Worker's Compensation costs for employers and increases the productivity of Wisconsin businesses.

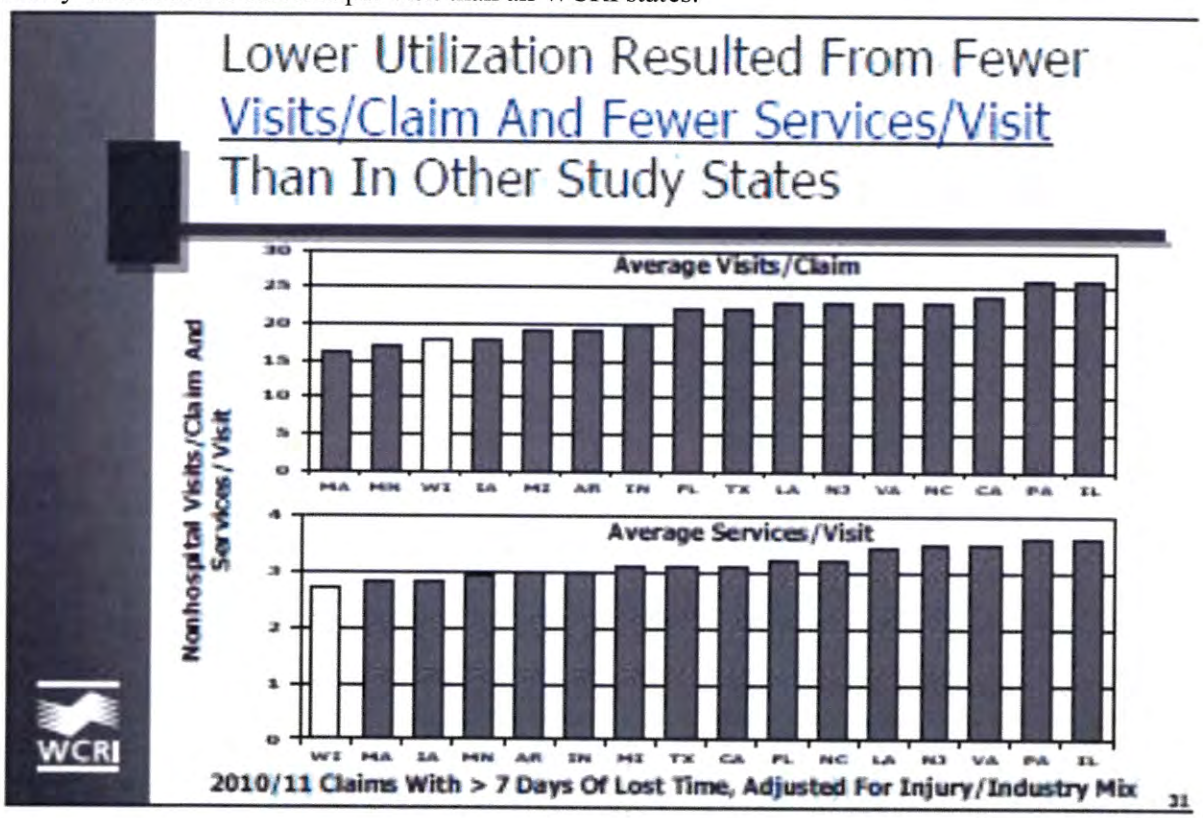
Health care leaders across Wisconsin are transforming health care to deliver even better value for an employer's Worker's Compensation dollar. As employers know, inefficient, poor quality health care can lead to lower productivity and higher Worker's Compensation costs, becoming a drag on a business' efforts to grow. Wisconsin businesses, however, benefit from a health care system that provides high quality health care efficiently.

Efficiency is an important part of health care value and health care value is everyone's goal. Efficiency is the product of medical procedure prices and the number of those procedures performed per injury. Considered as an equation, such a measure would look something like:

PRICE x UTILIZATION = EFFICIENCY

Much attention has been paid to individual procedure prices – and that is certainly a worthy area of discussion, but only if also compared with the other important variable in the value equation: utilization.

Luckily for those of us searching for ways to find improved health care efficiency, WCRI has a wealth of data in this area. Those data show that Wisconsin providers charge carriers for fewer visits per claim than nearly all and fewer services per visit than all WCRI states:

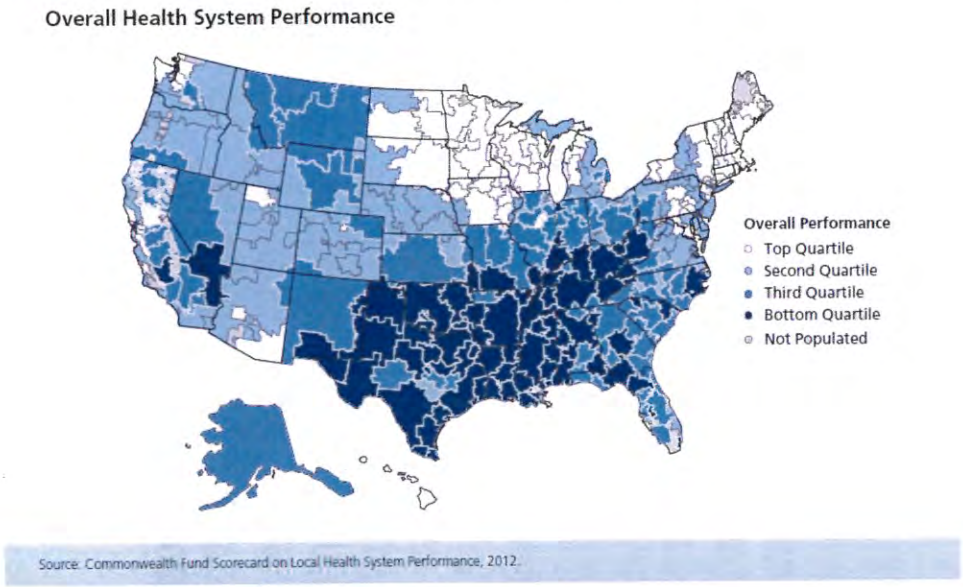


Source: CompScope™ Medical Benchmarks for Wisconsin, 13th Edition, Workers Compensation Research Institute (WCRI), February 2013.

EFFICIENCY +QUALITY = VALUE

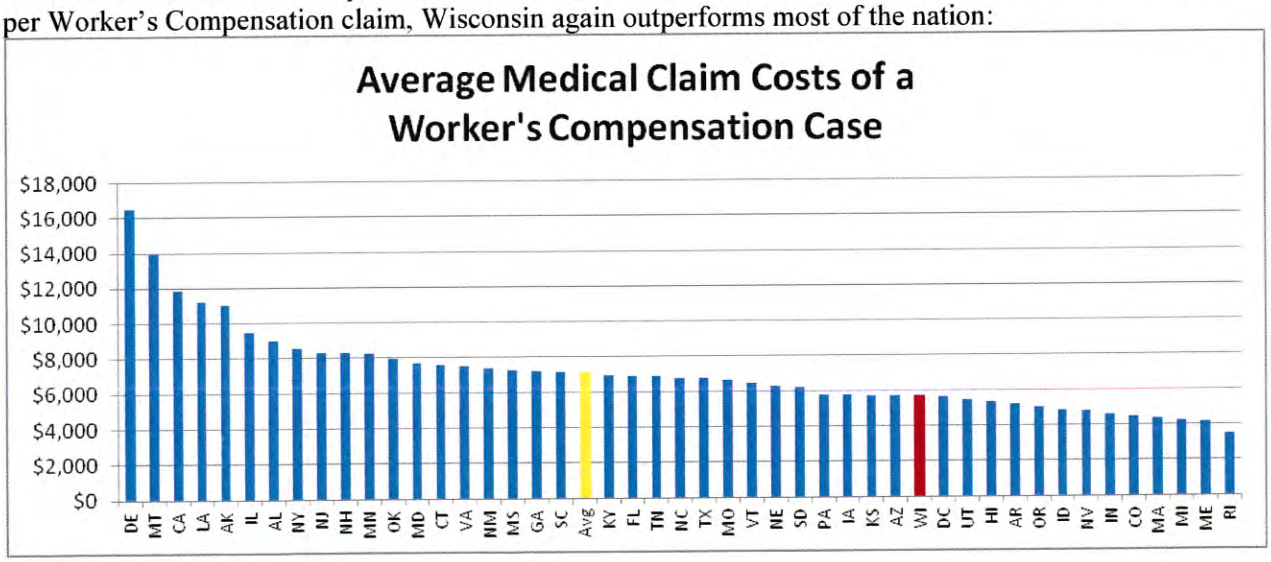
Efficiency is a worthy goal, but again not by itself: patients will not benefit from efficient health care unless the care they receive is high quality. Fortunately, Wisconsin excels in this area as well. The federal Agency for Health Care Quality (AHRQ) consistently ranks Wisconsin as one of the highest in the nation in overall health care quality scores based on the 171 measures the AHRQ uses to evaluate health care performance. The Commonwealth Fund ranks Wisconsin high in its recent report measuring the overall performance of a community's health care system.

This is Wisconsin



The map is a graphic representation of a basic truth: our health care system provides *VALUE* for each health care dollar, and that is a competitive advantage for Wisconsin.

But does that advantage also exist in the Worker's Compensation subset of Wisconsin health care? Again, the data seem to answer this question with an emphatic "yes." When looking at the average medical cost per Worker's Compensation claim, Wisconsin again outperforms most of the nation:



Source: Annual Statistical Bulletins (2010-2012, Exhibit XI), National Council on Compensation Insurance, Inc. (NCCI).

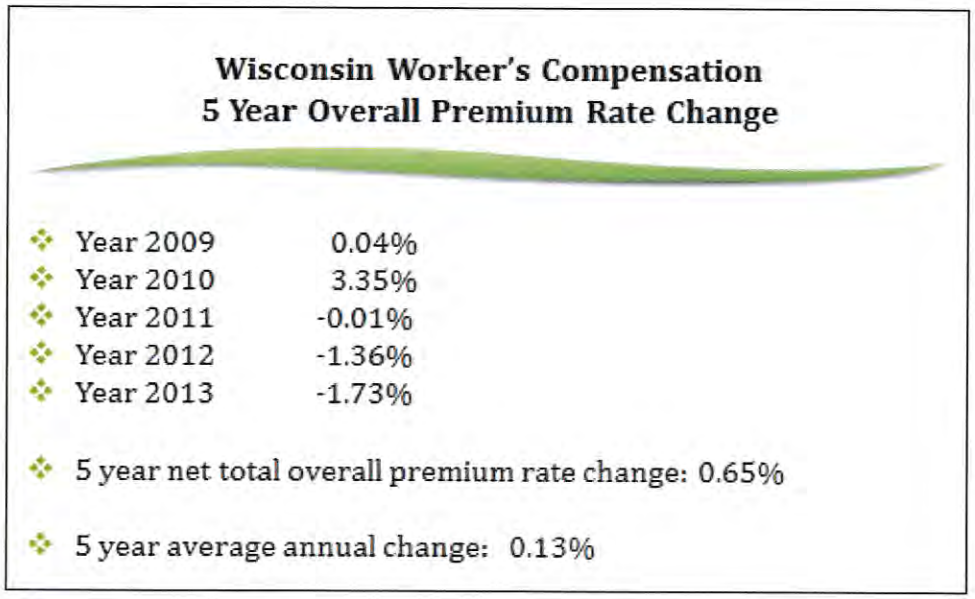
Wisconsin's higher than average quality and lower than average treatment costs are an important part of the shift from volume to value based health care. This shift permeates the Wisconsin way of providing health care.

The health care provider community encourages the Worker's Compensation Advisory Council to recognize and embrace this volume-to-value shift rather than propose short-sighted "cost-saving" methods that artificially influence the system away from its naturally efficient state. The experience and the data do not support imposition of government price controls for Worker's Compensation – commonly called "fee schedules." The vast negative experience of the two major government price controls in health care, Medicaid and Medicare, provide ample evidence why government-imposed price controls do not work.

Costs: Look at the Big Picture

Perhaps the most important examination of Worker's Compensation cost is the trend of what Wisconsin businesses are paying for Worker's Compensation insurance. Are rates dramatically rising, putting Wisconsin at a disadvantage?

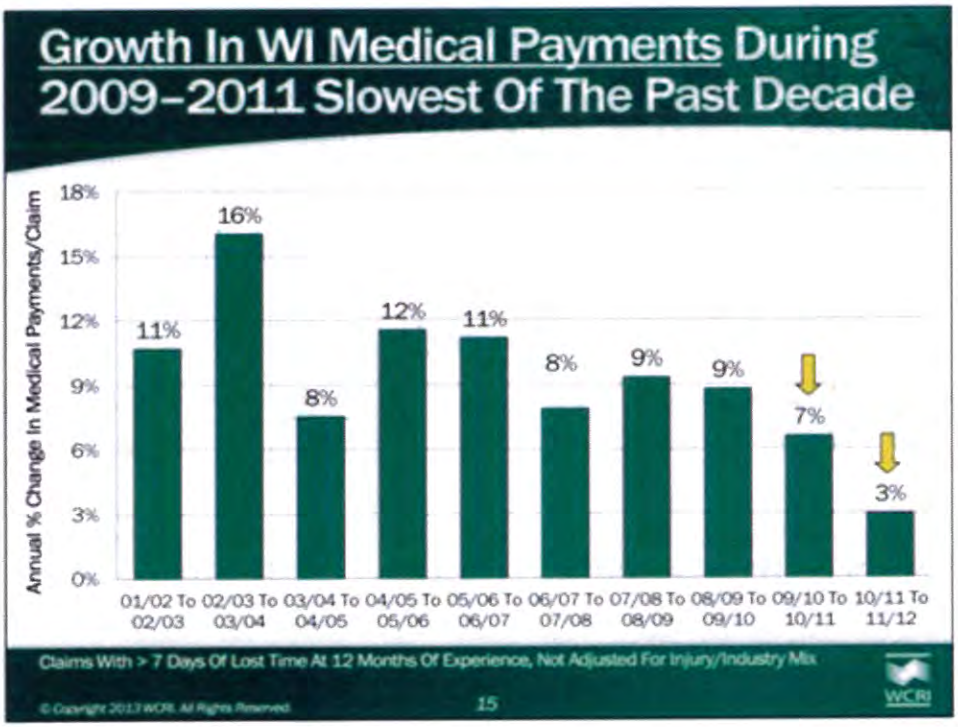
The data answer this question emphatically to the negative: as the Department of Workforce Development pointed out during its testimony to the Senate and Assembly's Labor committees at the Joint Informational Hearing on July 31, 2013:



Source: DWD PowerPoint Presentation to Joint Informational Hearing, July 31, 2013.

One could make the case that the story should stop right there: after all, these premium payments are the ultimate bottom line indicator about the state's Worker's Compensation "burden" to business. We can continue the discussion, however, as so much attention has been paid to rising health care costs as part of the system.

Like costs in other sectors of health care, Worker's Compensation costs have also risen at a steady rate, although the last two years have seen a dramatic reduction in the amount of annual increase:

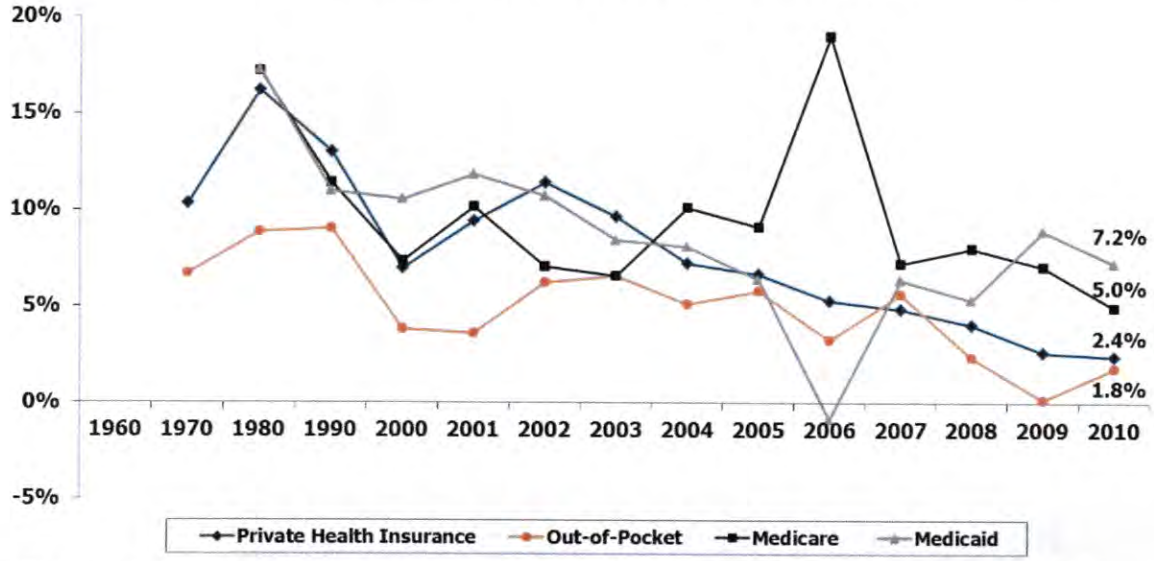


Source: CompScope™ Benchmarks for Wisconsin, 14th Edition, Workers Compensation Research Institute (WCRI), October 2013.

It is unclear why medical payments have stabilized in the last two years, but alterations to the WC program the last several years could be contributing factors. For example, DWD 81 – the administrative code chapter creating treatment guidelines for Worker's Compensation care – came about as part of the 2005-06 bargaining session creating the Health Care Provider Advisory Committee, which recommended creation of treatment guidelines for WC care. Those new guidelines were approved and took effect in November 2007. Just two bargaining sessions later, the WCAC made a major alteration to the formula determining reasonableness of medical fees: under 2011 Wisconsin Act 183, the State Legislature approved the WCAC's proposal to tighten the standard deviation calculation used to determine the cutoff point for charge reimbursement from 1.4 standard deviations above the mean to 1.2 standard deviations above the mean.

It is interesting to compare this chart with that looking a bit broader. Here is a chart showing the rate of national health care spending growth, divided into different spending programs:

Annual Percent Change in National Health Expenditures, by Selected Sources of Funds, 1960-2010



Notes: This figure omits national health spending that belongs in the categories of Other Public Insurance Programs, Other Third Party Payers and Programs, Public Health Activity, and Investment, which together represented about 20% of total national health spending in 2010. Medicare and Medicaid were enacted in 1965; by January 1970, all states but two were participating in Medicaid. Implementation of the Medicare Part D prescription drug benefit was the major cause of the 2006 increase in Medicare spending and decrease in Medicaid spending (Medicare replaced Medicaid drug coverage for dual eligibles).

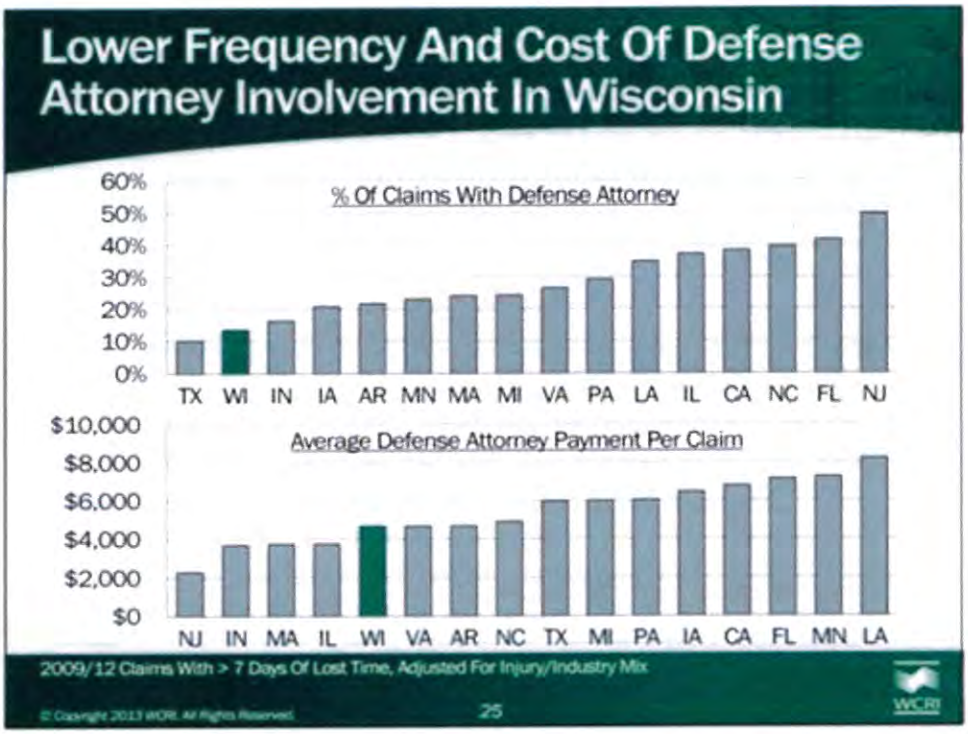
Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2010; file nhe2010.zip).

We believe it is important to note that the two highest areas of spending growth occur where government has intervened and created strict fee schedules: Medicare and Medicaid. Certainly there is more to this overall story, but the warning is stark: government fee-setting does not help control overall costs.

Quality: Patient Satisfaction Is a Key Indicator

The tremendously positive outcomes in Wisconsin manifest themselves in very important ways: quicker return to work, less repeat and extra medical care and patient satisfaction are all important measurements.

But this satisfaction shows up in other important areas as well that help increase the quality and efficiency, or the value, of the Wisconsin Worker's Compensation system. One area again emerges from the WCRI data: an extremely low level of "lawyering up" after suffering an injury on the job:



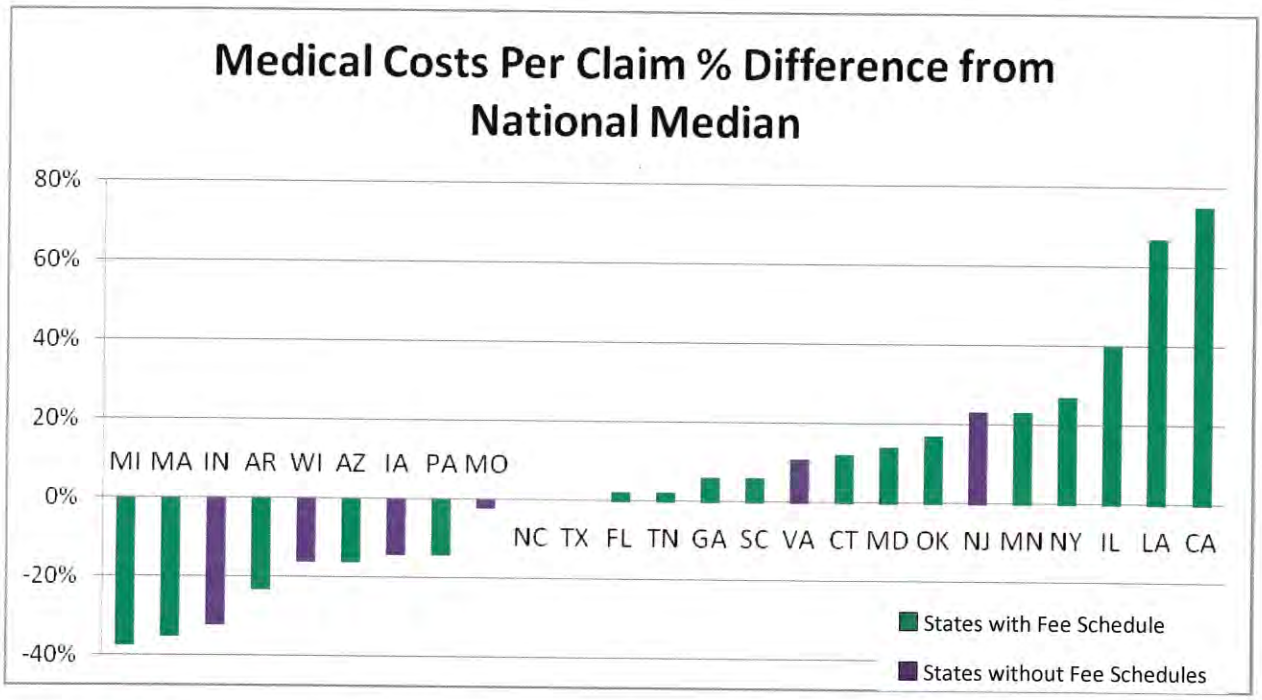
Source: CompScope™ Benchmarks for Wisconsin, 14th Edition, Workers Compensation Research Institute (WCRI), October 2013

A low litigation rate benefits all in the Worker's Compensation system by ensuring resources are used for returning the patient to health and providing the employer with a productive, satisfied employee sooner than the national average. Litigation is perhaps the most inefficient possible use of Worker's Compensation dollars.

To summarize, Wisconsin employees and businesses both benefit more than their national peers due to Wisconsin's Worker's Compensation health care efforts. The *Price x Utilization* formula results in health care that is more efficient compared to other parts of the country, meaning higher quality is obtained at a moderate price.

The WCAC Proposals

As with endeavors outside of health care, it is extraordinary for government, in effect, to establish basic contract terms between two private organizations via legislative mandate. Rate setting by the government, implemented through a fee schedule, is exactly that. At its core, Worker's Compensation is a private insurance program. Unlike Medicaid and Medicare – two of the few existing programs with government imposed health care fee schedules – and unlike Unemployment Insurance, the government is not the payer in the Worker's Compensation program. Wisconsin and some other states have benefitted from what has been limited government intrusion into the private negotiations and contracts between health care providers and Worker's Compensation insurers and self-insurers. The states with the greatest government involvement are often the states with the highest costs.

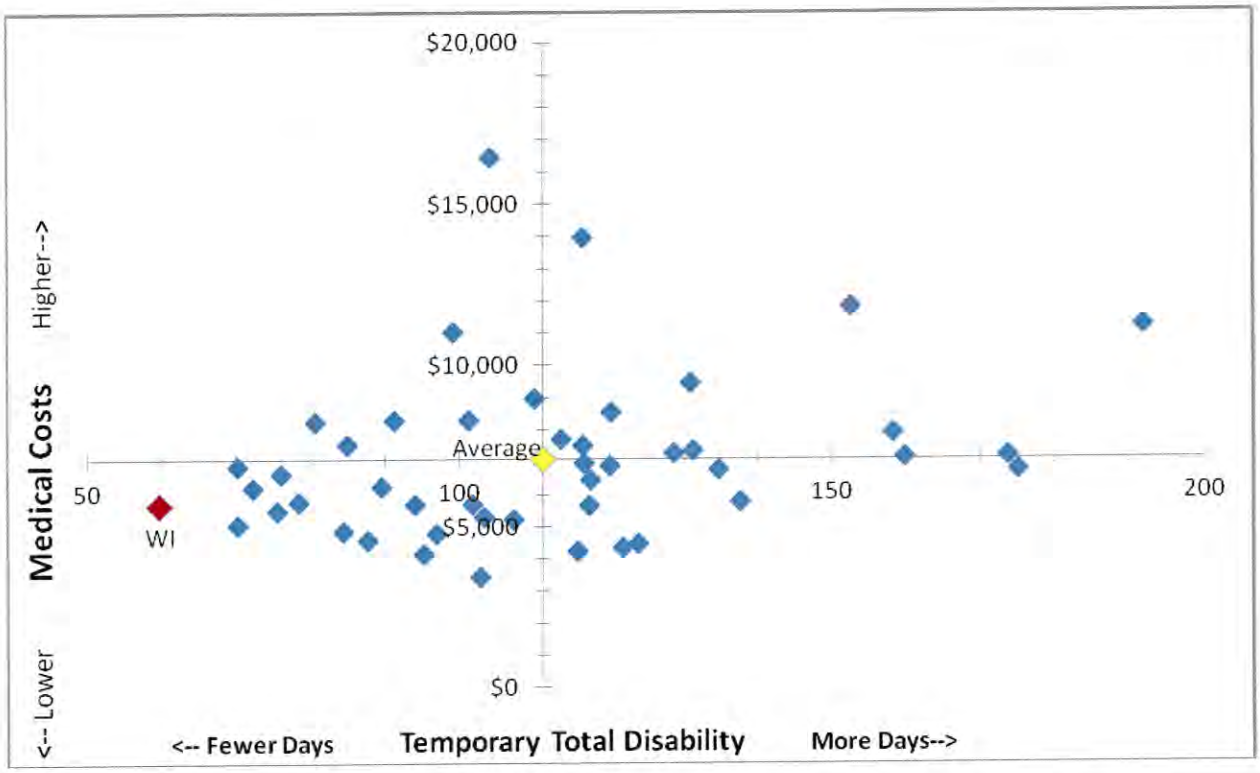


Key: States with fee schedule are indicated in green and states without fee scheduled are indicated in purple based on WCRI's labels. *CompScope™ Medical Benchmarks for Wisconsin, 13th Edition,* Workers Compensation Research Institute (WCRI), February 2013.
Source: Annual Statistical Bulletins (2010-2012, Exhibit XI), National Council on Compensation Insurance, Inc. (NCCI).

Wisconsin health care providers have long negotiated discounts and other incentives with private payers, including Worker's Compensation carriers and self-funded plans, in return for administrative ease and prompt payment. But instead of relying on private negotiations, the WCAC seeks to mandate specific contract terms, including the price for health care services provided to injured workers.

The health care provider organizations disagree with this approach. We are unable to name a program that has been improved by replacing a private sector, market-based system with government rate setting. As mentioned previously, the Medicare and Medicaid programs are good warnings of what happens when government mandates prices. The rate-setters for both programs every year search for the next tweak in the fee schedule that will solve the latest identified problem, whether that is costs that are too high, reimbursement that is too low, lack of access, or a new incentive to affect care. The Worker's Compensation system, instead, should rely on the excellent health care system that has evolved in Wisconsin and that has resulted in low overall costs with excellent outcomes.

The following chart draws from two different measures to plot where Wisconsin's Worker's Compensation system compares to other states: amount of time lost in the workplace due to injury and the average medical costs of a Worker's Compensation claim. The result is stark – high value medical care producing excellent results.



Sources: Annual Statistical Bulletins (2010-2012, Exhibit XI), National Council on Compensation Insurance, Inc. (NCCI). *NCCI Research Brief* (August 2013, Table 3), published by the National Council on Compensation Insurance, Inc. (NCCI).

Health Care Liaisons Proposal: Immediate Savings and Efficiencies

As stated by members of the legislature and as described above, our current Wisconsin Worker's Compensation system is not only far from broken, it is often seen as a nationwide model. Still, the health care providers have been asked to suggest ways to help contain health care costs, both immediately and in the future. The health care liaisons appreciate the Council's recognition that changes suggested in a vacuum could cause multiple unintended consequences and threaten the positive aspects of our system.

Simply put, changes to the system should rely on the system's current strengths instead of risking poorer outcomes in return for a short term or illusory reduction in cost. Establishing a fee schedule or other reimbursement formula ignores the strengths of the current system. If the Worker's Compensation system will define specific terms for the arrangement between providers and insurers, the providers encourage relying on traditional negotiated terms. For example, an insurer might negotiate provider discounts based on care management, prompt payment, and auditing restrictions.

Like price setting, the legislature, for the most part, has not mandated administrative and payment terms for the Worker's Compensation system. While Wisconsin Workers' Compensation insurers, self-funded plans, and WCAC members seek payment levels similar to those negotiated by health insurers or even lower, the Worker's Compensation carriers do not meet even the minimum payment and processing standards of the health insurance industry. For example, Workers Compensation claims dominate health care providers' aged accounts receivables. As any business knows, aged accounts receivables are a significant cost for a business. Any discount from a provider's charges must be linked to meeting prompt payment and other standards. Often, if a health insurer does not meet the payment term, the insurer loses

the discount. Worker's Compensation insurers and self-funded plans likewise should lose access to a discount if they do not meet specific administrative and payment terms.

Another cost driver in the Worker's Compensation system is the payers' reliance on paper based, antiquated payments systems. Our health insurance system relies almost exclusively on electronic claims submission and payments. Claims that are paper intensive for both the provider and the payer add significant costs to the program.

Proposal: Discounts in Payment
As is typical in negotiations between providers and payers, the provider proposal includes discounted prices for payers that meet administrative and payment standards. The providers propose the following schedule:

- Claim paid within 30 days: 10 percent off billed charges.
- Claim paid within 45 days: 5 percent off billed charges.

The providers also propose to require the insurers to move toward an electronic claims system, which can help facilitate the ability to make payment within the suggested time targets. To do business in the state, Worker's Compensation insurers and self-funded plans must be able to accept electronic claims submissions and make electronic claims payments by January 1, 2016.

We estimate that if insurers meet the prompt payment terms of this proposal, Workers' Compensation insurers and self-funded plans could reduce their exposure for medical costs provided to injured workers by $9 million to $24 million. (This estimate relies on a number of data sources and assumes, based on WCRB data, the total amount paid by Worker's Compensation payers for medical care provided to injured workers is $413 million in the most recent year available.) The actual savings for any one insured or self-funded plan would depend on its current negotiated discounts with providers and its performance.

Proposal: Maintain current payment limit
Payers, like under current law, would be allowed to reduce a provider's bill that is more than 1.2 standard deviations above the mean charge to the amount that is 1.2 standard deviations above the mean charge.

Proposal: Improved Database for Fee Disputes
As part of the proposal to maintain the current payment limit for charges greater than 1.2 standard deviations above the mean charge, the providers propose that DWD create a robust database for calculating the 1.2 standard deviations above the mean charge using data reported to the Worker's Compensation Ratings Bureau, the Wisconsin Health Information Organization, and the WHA Information Center.

Proposal: Drug Dispensing from a Physician Office
This item has been proposed by both Labor and Management, and was highlighted in the various state legislators' September 30, 2013 letter to the WCAC (see page 3, number 6). The health care liaisons believe this would be an acceptable efficiency in our WC system; we suggest the WCAC be watchful of any access issues that may develop with this change.

Proposal: Medical Record Copy Fees
This item, proposed by Labor (item no. 2), recognizes the special circumstances of a Worker's Compensation claim. To be consistent with the Disability Determination Bureau and the Social Security Administration, establish $26 as the rate for an electronic copy of the medical record requested by the injured worker.

Proposal: Adoption of ICD-10 Codes

The liaisons also urge the WCAC to adopt the Department's proposal (number 4) to amend DWD 80.72 (Health service fee dispute) and DWD 81 to reflect the national implementation of ICD-10 codes. Providers and payers would like to see the Workers Compensation program require ICD-10CM/PCS codes as of October 1, 2014. There are a bounty of reasons to embrace this change:

Code Maintenance – The four cooperating parties (CMS, NCVHS, AHA and AHIMA) that maintain the ICD system will no longer maintain the ICD-9 system. The last updates were effective October 1, 2013. As new conditions are identified and new care developed and rendered, the ICD-9 system will not be able to account for the changes.

Education and Training – All of the coding education is currently focused on ICD-10. Although it could be up to one year after 1/1/14-9/30/14 dates of service when claims can be resubmitted with ICD-9 codes, the coders and coding operations will be in a declining mode in regard to ICD-9. All efforts will be geared toward ICD-10. Trying to maintain coding accuracy under two systems for any length of time is unrealistic.

Systems – Vendors are changing their systems to accommodate ICD-10 only. Most vendors will not accommodate ICD-9 codes after 10/1/14 dates of service so it would be difficult to submit claims electronically.

Wisconsin Administrative Code – As caregivers become more entrenched in documenting for ICD-10, they will be challenged to meet the treatment guidelines that are ICD-9 code based in DWD 81. New providers, whether they are MDs, DOs, NPs, PAs, chiropractors, or physical therapists, will be taught to document for ICD-10 only.

Coordination of Benefits – All payers and clearinghouses that are HIPAA covered entities must accept and adjudicate claims in an ICD-10 format. It will be difficult for a Worker's Compensation carrier to coordinate benefits with a payer that must comply with ICD-10, as they will be using two different sets of codes if the Worker's Compensation carrier is using ICD-9.

Specificity – The greatest strength of ICD-10 is the granularity. If the Worker's Compensation program does not make the transition to ICD-10 the benefit of the granularity will not be realized by the program.

Health Care Liaisons Proposal: Future Savings/Improvements

The aforementioned letter from nine state legislators contained many thoughtful suggestions for how the Worker's Compensation system could be improved going forward. We greatly appreciate a theme that runs through many of those suggestions: relying on the expertise of the Health Care Providers Advisory Committee to craft potential changes to various aspects of Worker's Compensation. This recognizes that those most familiar with what it takes to provide high-quality worker's compensation care – actual health care practitioners – are in prime position to make recommendations that can improve our state's Worker's Compensation system without harming the stellar record of outcomes, access and patient satisfaction with that system.

We believe that many of the legislature's health care-related suggestions are sound and should become the HCPAC's agenda for their quarterly meetings. The committee could submit recommendations in the following areas for full WCAC consideration:

- **Review the treatment guidelines in DWD 81 (page 2, item 3).** While the data on Wisconsin's Worker's Compensation outcomes and value is overwhelmingly positive, there is always room for improvement. We believe the HCPAC is poised to examine how the current guidelines can be improved and/or serve as a way to ensure Worker's Compensation care is provided appropriately.

- **Review Disability Ratings in DWD 80.32 (page 2, item 4).** This area of Worker's Compensation procedure often does not garner the same level of attention as health care prices, yet this topic deserves periodic review for its long-range implications.

- **Opioid Treatment (page 3, item 3).** Opioids can be a powerful treatment for injured workers suffering with great pain. Improper opioid use can also lead to crippling dependency and possible abuse. This is not unique to just Worker's Compensation-related treatment – it is a problem in all spectra of health care. Injured workers throughout Wisconsin and the state's prescribers would all benefit from a thorough examination of opioid use and prescribing practices.

We also believe the HCPAC is well-positioned to make potential recommendations in other important areas:

- **Compounding Drugs**. Pharmacy compounding is the practice of combining multiple ingredients into one medication, often designed specifically for an individual patient. This is a newer area of science in medicine and could use expert review.

- **Causation and Return to Work Assessments**. While not explicitly in the letter, review of this area is similar in importance to the disability ratings suggestion above. Assessments made in these areas can lead to tremendous costs downstream, so additional attention to this area is warranted.

The legislators' letter also highlighted a situation that is clearly causing consternation in the business community: small employers who receive large Worker's Compensation premium increases despite having no claims in the previous year (see page 3, item 8). We urge the WCAC to voice its concerns in this area to the Wisconsin Compensation Rating Bureau to determine if any improvements can be made in this area. The insurance industry is a valuable partner in ensuring that all who participate in the Worker's Compensation system are aiding its fairness and efficiency.

The health liaisons appreciate the time granted for proper preparation of this proposal. The state's health care entities take tremendous pride in the many positive aspects of Wisconsin's Worker's Compensation system. Health care, at its core, is providing services to patients who need the right kind of care at the right time, delivered for an appropriate cost. The data show that few states – if any – provide higher quality care. This benefits the most important participant in any health care system: the patient.

Note:
The health care liaisons' proposals detailed above therefore would adopt, amend, or replace the following proposals:

Management:
2. Medical fee schedule
3. Employer directed care for the first 90 days
4. Reduce the statute of limitations from 12 years to three years
5. Implement treatment guidelines as treatment parameters
10. Maximum reimbursement for repackaged drugs

Labor:
2. Medical record copy fees
3. Maximum reimbursement for repackaged drugs
4. Surgical implant fee formula
11. Medical expense liability equity

Department proposals:
4. Adopt ICD-10 codes

Adopt:
Department proposal:
4. Adopt ICD-10 codes

Amend:
Management:
5. Implement treatment guidelines as treatment parameters
10. Maximum reimbursement for repackaged drugs

Labor proposal:
2. Medical record copy fees.
3. Maximum reimbursement for repackaged drugs

Replace:
Management:
2. Medical fee schedule
3. Employer directed care for the first 90 days
4. Reduce the statute of limitations from 12 years to three years

Labor:
4. Surgical implant fee formula
11. Medical expense liability equity

Workers Compensation
Research Institute

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December 26, 2013

Mr. John Metcalf
Division Administrator
Wisconsin Worker's Compensation Division
Department of Workforce Development
201 East Washington Avenue, Room C100
Madison, WI 53703

Dear Administrator Metcalf:

Thank you for reaching out for analysis by the Workers Compensation Research Institute. As we understand your request, it is to quantify the likely impact on medical costs in Wisconsin of a medical fee schedule set at "group health payments plus 10 percent." Given that the information is needed quickly, we limit our response to what is known based on existing studies, rather than conducting new research.

The available studies and data are quite limited, so any estimates necessarily require many assumptions to be made, hence we regard them as very "rough estimates." The assumptions are described below. We provide a range of estimates using a range of assumptions.

SUMMARY OF FINDINGS

This analysis responds to a request to make rough estimates of the impact of a fee schedule in Wisconsin set at "group health payments plus 10 percent." Because of the quick turnaround time required, the estimates are based on the limited evidence from published studies—largely by WCRI. There are many information gaps that have to be filled by indulging assumptions—and the results are certainly sensitive to the choice of assumptions. Hence we call them "rough estimates."

These rough estimates suggest that a fee schedule set at the median price paid by group health payors plus 10 percent would reduce prices paid to some providers—the reduction would be larger for surgeons and specialists. The estimated reduction in total payments for office visits would be by 3 percent, for surgeries by 50 percent, and for hospital outpatient surgical episodes (largely for facility fees) by 14 percent. Extrapolating to all services leads to a rough estimate of about a 20 percent reduction in medical prices for a fee schedule set at the median group health price paid plus 10 percent. Again, these estimates are sensitive to a number of different assumptions that were needed for the computation.

In practice the actual reduction in medical prices is likely to be less. It is likely that some providers who are paid below the fee schedule amount will raise prices to the fee schedule levels. In Illinois, for example, after the adoption of a fee schedule, network penetration rates fell (hence, prices rose for those dropping the network contracts).

It is unlikely that medical costs will fall by 20 percent even if the average price were to fall by 20 percent. There is ample evidence in workers' compensation and Medicare studies that billing and treatment practices typically do change after a fee schedule is introduced or changed. Historically, Medicare assumed that 30-50 percent of the potential savings were offset. NCCI assumes that, when a fee schedule lowered prices, 50 percent of the potential savings were offset.

Given the changes in provider practices after a fee schedule (as discussed in the prior 2 paragraphs), it is possible that the adoption of a fee schedule that produced a potential reduction in average prices of 20 percent could yield a reduction in medical costs of under 10 percent.

The above discussion assumes a fee schedule set at the median prices paid by group health payors plus 10 percent. A fee schedule set at the 75th percentile of group health prices paid plus 10 percent would produce smaller savings. One set at the 25th percentile plus 10 percent would yield larger savings.

WHAT DO WCRI STUDIES SHOW ABOUT HOW PRICES PAID BY WC AND GROUP HEALTH PAYORS COMPARE?

WCRI published two directly relevant studies. The first examined the median prices paid for common surgeries and office visits in more than 20 states, including Wisconsin.[1] The second examined average prices paid to hospital outpatient departments for a surgical episode for the most common surgeries (knee and shoulder arthroscopies) done on injured workers in 16 states, including Wisconsin.[2] Note the latter study includes only the payments to the facility, not to the surgeon.

Table 1 shows the comparisons.

- Workers' compensation payors paid much higher (median) prices for common surgeries—more than double what was paid by group health payors for 3 of the 4 common surgeries in the study.
- The median price paid by workers' compensation payors for common office visits was 10-25 percent higher than that paid by group health payors.
- The median payment to hospitals for common outpatient surgical episodes was 5-15 percent higher than the payments made by group health payors.

Table 1 Comparisons of Prices Paid in Wisconsin by Group Health and Workers' Compensation Payors, 2009[a]

Type of Service	Type of Fee Schedule	CPT Code	Median WC Price Paid	Median GH Price Paid	% Difference
Established patient office visit	Professional fee	99212	$81	$65	24%
Established patient office visit	Professional fee	99213	$113	$99	15%
Established patient office visit	Professional fee	99214	$169	$155	9%
Established patient office visit	Professional fee	99215	$255	$227	12%
Knee arthroscopy	Professional fee	29881	$3,728	$1,573	137%
Shoulder arthroscopy	Professional fee	29826	$3,849	$1,741	121%
Shoulder arthroscopy	Professional fee	29827	$4,909	$2,726	80%
Carpal tunnel	Professional fee	64721	$2,339	$999	134%
Episode of knee surgery	Hospital outpatient services[b]	n.a.	$6,446	$6,150	5%
Episode of shoulder surgery	Hospital outpatient services[b]	n.a.	$10,222	$9,033	13%

[a] 2008 prices for hospital outpatient services.

[b] Largely facility fees for operating, treatment, and recovery rooms.

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[1] Olesya Fomenko and Richard Victor, *A New Benchmark for Workers' Compensation Fee Schedules: Prices Paid by Commercial Insurers?*, June 2013.

[2] Olesya Fomenko, *Comparing Workers' Compensation and Group Health Hospital Outpatient Payments*, June 2013.

ASSUMPTIONS ABOUT A FEE SCHEDULE

A fee schedule set at "group health payments plus 10 percent" needs further specificity to conduct an analysis. We analyze three alternative scenarios for a fee schedule. The selection of these scenarios does not imply any endorsement of any specific fee schedule level. Rather, a range of scenarios was assumed to illustrate the range of potential impacts.

- The median price paid by group health payors plus 10 percent
- The 75th percentile of prices paid by group health payors plus 10 percent
- The 25th percentile of prices paid by group health payors plus 10 percent

Table 2 shows the amounts under each scenario for each for the services analyzed in the WCRI studies, for prices paid in 2008-2009.

Table 2 Illustrative Fee Schedule Scenarios (2009 Prices)[a]

			Group Health Price Measure Used		
Type of Service	Type of Fee Schedule	CPT Code	Median + 10%	75th Percentile + 10%	25th Percentile + 10%
Established patient office visit	Professional fee	99212	$72	$84	$58
Established patient office visit	Professional fee	99213	$109	$124	$99
Established patient office visit	Professional fee	99214	$171	$197	$153
Established patient office visit	Professional fee	99215	$250	$283	$215
Knee arthroscopy	Professional fee	29881	$1,730	$2,650	$1,379
Shoulder arthroscopy	Professional fee	29826	$1,915	$2,184	$1,392
Shoulder arthroscopy	Professional fee	29827	$2,999	$3,793	$2,269
Carpal tunnel	Professional fee	64721	$1,099	$1,536	$786
Episode of knee surgery	Hospital outpatient services[b]	n.a.	$6,765	$8,614	$5,244
Episode of shoulder surgery	Hospital outpatient services[b]	n.a.	$9,936	$14,936	$9,875

[a] 2008 prices for hospital outpatient services.

[b] Largely facility fees for operating, treatment, and recovery rooms.

ASSUMPTIONS TO EXTRAPOLATE PRICES PAID FROM 2008-2009 TO 2013

The WCRI studies use data from 2009 for professional services and 2008 for hospital outpatient episodes. We apply the following assumptions to adjust these prices to 2013 price levels.

- According to the U.S. Department of Labor, Bureau of Labor Statistics (BLS), the Consumer Price Index for medical services and commodities in the Milwaukee area grew by an average annual rate of 6.5 percent from 2009 to 2013.[3] We assume that the rate of price growth was the same for the group health prices for all services.[4]
- According to the WCRI Workers' Compensation Medical Price Index for Wisconsin, prices paid for professional services rose by an average annual rate of 3.8 percent for professional services from 2008-2012. The WCRI Hospital Cost Index for Wisconsin shows an average annual rate of 7.0 percent growth in prices for hospital outpatient services from 2008-2010. We further assume that the average annual rates of price growth were the same through 2013.

EXTRAPOLATING TO OTHER SERVICES

The WCRI studies examine common medical services, but for a limited set of services. In order to make rough estimates of the impact of a fee schedule set to group health payments plus 10 percent, we need to make assumptions about how to treat the other services. There are three groups of services covered by fee schedules—often the structures of the fee schedules are distinct for each group:[5]

- Professional services (e.g., physicians, chiropractors, podiatrists, physical therapists, etc.), including office visits, surgeries, radiology, physical medicine, pain management, etc.
- Hospital outpatient services (e.g., facility fees for operating and treatment rooms, radiology, lab work, physical therapy, etc.)
- Hospital inpatient admissions.

To extrapolate from office visits, surgeries and hospital outpatient surgical episodes, we need to make a number of stretch assumptions about the other services. We have no evidence-based foundation for making these assumptions, hence we call these "rough estimates."

In particular, we assume that the estimates for how workers' compensation and group health prices compare . . .

- For evaluation and management services, the relative prices paid by workers' compensation and group health payors are similar to the comparisons for the 4 common office visits analyzed.
- For all surgical services, the relative prices paid by workers' compensation and group health payors are similar to the comparisons for the 4 common surgeries analyzed.

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[3] Two limitations should be noted that make this less than perfectly comparable to the price inflation rates reported for workers' compensation. First, this measures prices across all payors—the largest of which is group health payors. Second, it shows price inflation for all medical services and commodities.

[4] There is evidence at the national level that hospital prices rose at double the rate as prices for professional services, but no data for Milwaukee are published.

[5] We exclude pharmaceuticals, durable medical equipment and other ancillaries that might be covered by a fee schedule.

- For all hospital outpatient surgical episodes, the relative prices paid by workers' compensation and group health payors are similar to the comparisons for the 2 hospital outpatient surgical episodes analyzed.
- The relative prices paid by workers' compensation and group health payors for office visits are similar to the same comparisons for physical medicine, lab/pathology, and supplies and equipment.
- The relative prices paid by workers' compensation and group health payors for surgeons' services are similar to the same comparisons for other invasive and specialty care like pain management, radiology, neurology, anesthesia, etc.
- The relative prices paid by workers' compensation and group health payors for the hospital outpatient surgical episodes analyzed are similar to the same comparisons for other hospital outpatient nonsurgical episodes and services.
- The relative prices paid by workers' compensation and group health payors for the hospital outpatient surgical episodes analyzed are similar to the same comparisons for hospital inpatient episodes.

MAKING ROUGH ESTIMATES

Computing the rough estimates of potential price reductions and cost savings from a fee schedule involves applying the assumptions listed above to the WCRI data from Tables 1 and 2 and . . .

- extrapolating the prices paid from 2008-2009 to 2013 for the limited group of services;
- extrapolating the estimated prices paid for the limited group of services to the other services for which there is no published data; and
- summing the effects of the fee schedule across all services.

Table 3 parallels Table 1 with prices extrapolated to 2013.

Table 3 Comparisons of Prices Paid in Wisconsin by Group Health and Workers' Compensation Payors, 2009[a], Extrapolated to 2013

Type of Service	Type of Fee Schedule	CPT Code	Median WC Price Paid	Median GH Price Paid	% Difference
Established patient office visit	Professional fee	99212	$99	$84	18%
Established patient office visit	Professional fee	99213	$138	$127	8%
Established patient office visit	Professional fee	99214	$206	$199	3%
Established patient office visit	Professional fee	99215	$311	$292	7%
Knee arthroscopy	Professional fee	29881	$4,549	$2,024	125%
Shoulder arthroscopy	Professional fee	29826	$4,696	$2,240	110%
Shoulder arthroscopy	Professional fee	29827	$5,990	$3,507	71%
Carpal tunnel	Professional fee	64721	$2,854	$1,285	122%

continued

Table 3 Comparisons of Prices Paid in Wisconsin by Group Health and Workers' Compensation Payors, 2009[a], Extrapolated to 2013 (continued)

Type of Service	Type of Fee Schedule	CPT Code	Median WC Price Paid	Median GH Price Paid	% Difference
Episode of knee surgery	Hospital outpatient services[b]	n.a.	$9,041	$8,426	7%
Episode of shoulder surgery	Hospital outpatient services[b]	n.a.	$14,337	$12,376	16%

[a] 2008 prices for hospital outpatient services.

[b] Largely facility fees for operating, treatment, and recovery rooms.

Table 4 parallels Table 2 with fee schedule amounts extrapolated to 2013.

Table 4 Illustrative Fee Schedule Scenarios (2009 Prices)[a], Extrapolated to 2013

			Group Health Price Measure Used		
Type of Service	Type of Fee Schedule	CPT Code	Median + 10%	75th Percentile + 10%	25th Percentile + 10%
Established patient office visit	Professional fee	99212	$92	$108	$75
Established patient office visit	Professional fee	99213	$140	$159	$127
Established patient office visit	Professional fee	99214	$219	$253	$196
Established patient office visit	Professional fee	99215	$321	$365	$276
Knee arthroscopy	Professional fee	29881	$2,226	$3,409	$1,774
Shoulder arthroscopy	Professional fee	29826	$2,464	$2,809	$1,790
Shoulder arthroscopy	Professional fee	29827	$3,858	$4,880	$2,919
Carpal tunnel	Professional fee	64721	$1,414	$1,976	$1,012
Episode of knee surgery	Hospital outpatient services[b]	n.a.	$8,703	$11,081	$6,746
Episode of shoulder surgery	Hospital outpatient services[b]	n.a.	$12,783	$19,215	$12,704

[a] 2008 prices for hospital outpatient services.

[b] Largely facility fees for operating, treatment, and recovery rooms.

Table 5 shows the impact of the fee schedule under the 3 scenarios by service groups.

Table 5 Rough Estimate of Savings

(% of medical costs in the service group)	Group Health Price Measure Used		
	Median + 10%	75th Percentile + 10%	25th Percentile + 10%
Office visit	3%	0%	10%
Surgery	50%	30%	60%
Hospital outpatient	14%	4%	20%

Table 6 shows the percentage of payments in each service group from a third WCRI study.[6] These numbers are used as weights to compute possible savings across the full group of services.

Table 6 Shares of Total Medical Costs

Type of Service	% of Total Medical Cost
Hospital	**45%**
Inpatient	12%
Outpatient	34%
Nonhospital	**53%**
Evaluation and management	5.1%
Emergency	0.7%
Physical medicine	9.5%
Supplies and equipment	2.2%
Surgery	15.6%
Major radiology	4.1%
Minor radiology	1.7%
Pain management injections	1.4%
Neurological/neuromuscular testing	0.7%
Anesthesia	3.4%
Other services	8.5%

[6] Sharon Belton, *CompScope™ Medical Benchmarks for Wisconsin, 13th Edition*, February 2013.

Table 7 shows the rough estimates of the impact on medical costs per claim of a fee schedule set at group health payments plus 10 percent under each of the three scenarios.

Table 7 Rough Estimates of Savings

	Group Health Price Measure Used		
	Median + 10%	**75th Percentile + 10%**	**25th Percentile + 10%**
% of total medical costs	20%	10%	30%

In practice the actual reduction in medical prices is likely to be less. It is likely that some providers who are paid below the fee schedule amount will raise prices to the fee schedule levels. In Illinois, for example, after the adoption of a fee schedule, network penetration rates fell (hence, prices rose for those dropping the network contracts).

It is unlikely that medical costs will fall by 20 percent even if the average price were to fall by 20 percent. There is ample evidence in workers' compensation and Medicare studies that billing and treatment practices typically do change after a fee schedule is introduced or changed. Historically, Medicare assumed that 30-50 percent of the potential savings were offset. NCCI assumes that, when a fee schedule lowered prices, 50 percent of the potential savings were offset.

Given the changes in provider practices after a fee schedule (as discussed in the prior 2 paragraphs), it is possible that the adoption of a fee schedule that produced a potential reduction in average prices of 20 percent could yield a reduction in medical costs of under 10 percent.

Sincerely,

Richard A. Victor, J.D., Ph.D.
Executive Director

Table D Ranking by Claim Frequency per 100,000 Workers Using Rating Bureau Information, Average of Policy Years 2006–2008

State	Average Claim Frequency, 3-Year Average
Nevada	6,495
Montana	6,493
Maine	6,491
Idaho	6,189
Oregon	5,750
Wisconsin	**5,586**
Pennsylvania	**5,551**
South Dakota	5,513
Alaska	5,450
Colorado	5,229
Utah	5,079
Iowa	**5,031**
Rhode Island	5,005
Vermont	4,949
Minnesota	**4,780**
New Hampshire	4,729
Kentucky	4,700
Indiana	**4,687**
Kansas	4,670
Oklahoma	4,656
Connecticut	4,636
California	**4,625**
Michigan	**4,557**
Tennessee	4,552
Arizona	4,536
Nebraska	4,451
New Mexico	4,414
Florida	**4,146**
Alabama	4,021
Delaware	3,888
Hawaii	3,839
Illinois	**3,781**
Missouri	3,774
Arkansas	3,756
New Jersey	**3,670**
Mississippi	3,655
Georgia	3,433
North Carolina	**3,423**
South Carolina	3,338
Massachusetts	**3,260**
Texas	**3,112**
Virginia	**2,918**
Louisiana	**2,907**
Maryland	**2,905**
New York	2,614
District of Columbia	1,294

Notes: These data are for first report and exclude claims payable under the USL&HW Act. CompScope™ states are shown in bold.

Source: National Council on Compensation Insurance, Inc., Annual Statistical Bulletins 2010–2012, exhibit XII (available electronically at http://www.ncci.com). Note that although NCCI publishes national comparisons of states, including those served by independent rating bureaus, it does so with the assistance of and clear attribution to those independent organizations.

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FOR IMMEDIATE RELEASE
DATE: December 17, 2013
Contact: Mike Cavanagh, 608-226-5239, michael.cavanagh@slh.wisc.edu

Nonfatal Work Injuries Increase in Wisconsin in 2012

The annual Survey of Occupational Injuries and Illnesses (SOII) reported nonfatal workplace injuries in Wisconsin increased 2% from 2011 to 2012, with 23,610 employees requiring days away from work. Conversely, nonfatal lost time injuries decreased by 2% nationwide in 2012.

Among all private, state, and local government sector employees in 2012, 4.1 per 100 full-time employees were injured at work in Wisconsin, which was higher than the national rate of 3.7.

SOII is the largest work injury data collection conducted nationwide. The Wisconsin SOII program collects data from a representative sample of 6,000 establishments in both the private and public sector.

Key findings for SOII 2012:

- The leading cause of lost time injuries in Wisconsin and the U.S. was overexertion and bodily reaction
- 40% of injuries involving lost work days were due to sprains/strains and tears in 2012
- Natural resources and mining industry had the highest injury-illness rate at 5.6 per 100 full time employees
- State-owned hospitals and care facilities in Wisconsin had markedly lower injury/illness rates than state-owned hospitals across the country
- Wisconsin's construction industry saw a substantial decline from 2011 to 2012 in building construction and specialty trade contractors from 8 to 5.8, and 6.8 to 4.7 injuries per 100 fulltime employees, respectively, while heavy and civil engineering remained steady at 4.5

For complete data profiles, charts, and analysis, please visit: www.slh.wisc.edu/bls or www.bls.gov/iif/oshstate.htm

The Wisconsin State Laboratory of Hygiene (WSLH), a part of the University of Wisconsin-Madison, is the state's public, environmental and occupational health laboratory. The WSLH's Bureau of Labor Statistics/Occupational Safety and Health Statistics Unit has a cooperative agreement with the U.S. Bureau of Labor Statistics to conduct their annual Survey of Occupational Injuries and Illnesses and Census of Fatal Occupational Injuries in Wisconsin.

NOTE: 2012 Census of Fatal Injury (CFOI) data for Wisconsin was released on 12/11/13 by the U.S Department of Labor/Bureau of Labor Statistics. The news release is posted at www.slh.wisc.edu/bls

Minnesota
Workers' Compensation System Report, 2011

MINNESOTA DEPARTMENT OF
LABOR & INDUSTRY
RESEARCH AND STATISTICS

Minnesota Workers' Compensation System Report, 2011

by
David Berry (principal)
Brian Zaidman

September 2013

Research and Statistics

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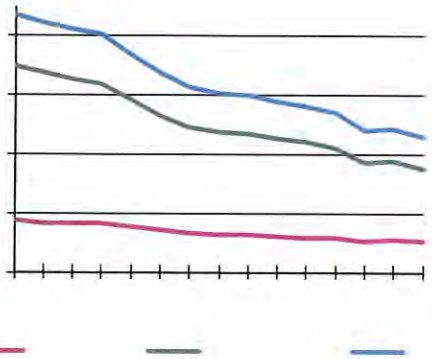
This report is available at www.dli.mn.gov/RS/WcSystemReport.asp. Information in this report can be obtained in alternative formats by calling the Department of Labor and Industry at 1-800-342-5354 or TTY at (651) 297-4198.

Claim rates

A starting point for understanding trends in the Minnesota workers' compensation system is the claim rate — the number of paid claims per 100 full-time-equivalent (FTE) workers. With one exception (for 2010), claim rates declined continually from 1997 to 2011.

- In 2011, there were:
  - 1.05 paid indemnity claims per 100 FTE workers, down 37 percent from 2000;
  - 3.5 paid medical-only claims per 100 FTE workers, down 45 percent from 2000; and
  - 4.6 total paid claims per 100 FTE workers, down 43 percent from 2000.
- The overall paid claim rate for 2011 was 48 percent below the rate for 1997.
- Since 1997, indemnity claims have made up 20 to 23 percent of all paid claims, while medical-only claims have constituted the remaining 77 to 80 percent.
- The dip in the claim rate between 2008 and 2009 coincides with the onset of the Great Recession.[8] Whether it was *caused* by that recession is uncertain.[9]
- Since 1997, the total claim rate has followed a similar trend to Minnesota's total reportable case rate from the Survey of Occupational Injuries and Illnesses.[10]

Figure 2.1 Paid claims per 100 full-time-equivalent workers, injury years 1997-2011 [1]



Injury year	Indemnity claims	Medical-only claims	Total claims
1997	1.74	7.0	8.7
2000	1.66	6.4	8.0
2007	1.19	4.4	5.6
2008	1.16	4.2	5.4
2009	1.07	3.7	4.8
2010	1.10	3.8	4.9
2011	1.05	3.5	4.6

1. Developed statistics from DLI data and other sources (see Appendix C).

- Because of the falling claim rate, the number of claims also fell. In 2011, there were 21,600 paid indemnity claims and 93,600 total paid claims, down 36 percent and 45 percent, respectively, from 1997.

[8] For 2006 to 2011, Minnesota's annual average unemployment rate was (as a percentage, by year) 4.1, 4.7, 5.4, 8.0, 7.4 and 6.5; for the same years, total unemployment-insurance-covered employment was (in millions) 2.68, 2.69, 2.68, 2.57, 2.56 and 2.60. Data from the Minnesota Department of Employment and Economic Development (www.positivelyminnesota.com).

[9] The literature has cited a number of ways in which an economic downturn may affect the claim rate. A downturn *may reduce* the claim rate because (1) lower production rates may lead to greater safety, (2) less-experienced (and more injury-prone) workers may be less often hired and more often laid off during a downturn and (3) injured workers who are employed may have a heightened fear of being laid off in response to filing a claim during a recession. However, a downturn *may increase* the claim rate if injured workers who have been laid off file a claim as a consequence (because of economic hardship or because lay-off is no longer a risk). See, for example, "Workers' Comp and the Business Cycle" (with editor's introduction) in *On Workers' Compensation,* vol. 3, issue 9, Nov. 1994.

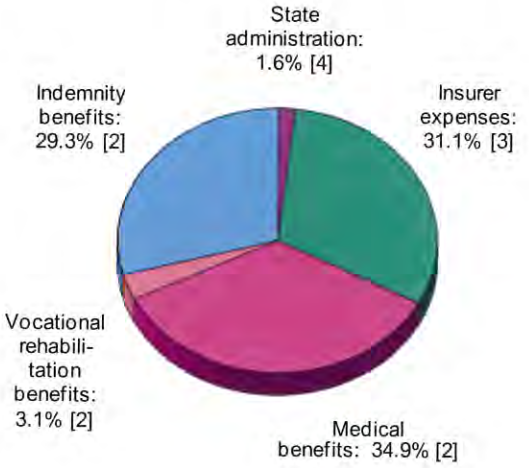
[10] This survey (the "SOII") is conducted jointly by state agencies and the U.S. Bureau of Labor Statistics. See www.dli.mn.gov/RS/DlisSaf1.asp for Minnesota injury and illness rates from SOII. See the *Minnesota Workplace Safety Report* (www.dli.mn.gov/RS/WorkplaceSafety.asp) for a description of the SOII itself.

System cost components

The largest share of total workers' compensation system cost goes to medical benefits.

- In 2011, on a current-payment basis, medical benefits accounted for an estimated 35 percent of total system cost, followed by insurer expenses at 31 percent and indemnity benefits other than vocational rehabilitation at 29 percent.
- Total benefit payments accounted for 67 percent of total system cost.
- As shown in Figure 2.7, the medical share of total benefits has increased since 1997.
- As shown in Figure 3.8, state agency administrative cost has declined relative to payroll since 1997.

Figure 2.3 System cost components, 2011 [1]



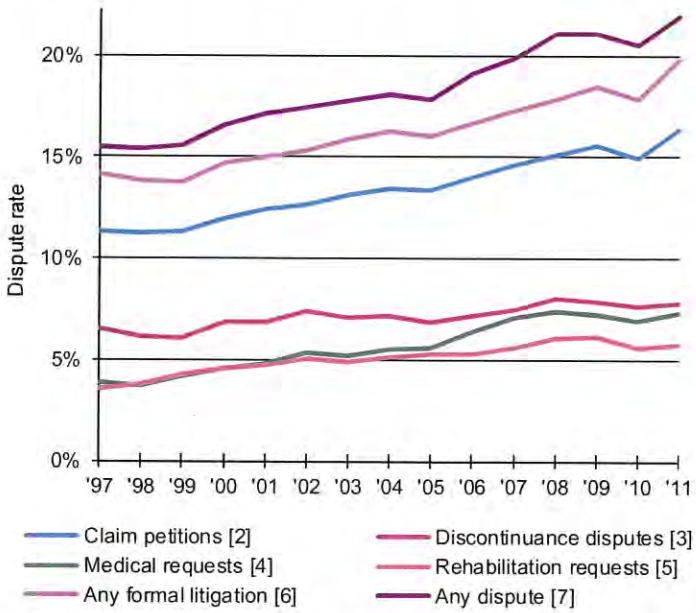
1. Estimated by DLI with data from several sources. These numbers are on a current payment basis, and therefore differ from others estimated on an injury year or policy year basis. Because these numbers follow a multi-year cycle, they are averaged over the most recent complete cycle (see Appendix C).
2. Indemnity and medical benefits include those reimbursed through DLI programs (including supplementary and second-injury benefits) and those paid through insurance guaranty entities (the Minnesota Insurance Guaranty Association and the Self-Insurers' Security Fund). Indemnity benefits include those claimant attorney costs that are paid out of indemnity benefits. Indemnity benefits here exclude vocational rehabilitation.
3. Includes underwriting, brokerage, claim adjustment, litigation, general operations, taxes, fees and profit. Litigation costs include defense attorney costs plus those claimant attorney costs that do not come out of indemnity benefits but are paid by the insurer. Excludes assessments on insurers and self-insurers because the benefits and state administration financed with those assessments are counted elsewhere in the figure.
4. Includes costs of workers' compensation functions in DLI, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals and the Department of Commerce, as well as the state share of the cost of Minnesota's OSHA compliance program. Excludes costs of benefit payments reimbursed by the Special Compensation Fund (such as supplementary and second-injury benefits). Costs are net of fees for service.

Dispute rates

The overall dispute rate showed a large increase from 1997 to 2011. The increase was most pronounced for the proportion of claims with medical requests.

- The overall dispute rate was 22.0 percent in 2011, 42 percent higher than in 1997.[41] From 1997 to 2011:
  - the rate of claim petitions rose 4.9 percentage points (44 percent);
  - the rate of discontinuance disputes rose 1.3 points (20 percent);
  - the rate of medical requests rose 3.5 points (89 percent);
  - the rate of rehabilitation requests rose 2.2 points (60 percent); and
  - the rate of formal litigation rose 5.6 points (40 percent).[42]
- The rates of discontinuance disputes, medical requests and rehabilitation requests seem to have leveled off during the past three years, but the rates of claim petitions and formal litigation are still showing increases.
- Since these figures are developed statistics, the ones for recent years are subject to change and should therefore be viewed as preliminary.

Figure 5.1 Incidence of disputes, injury years 1997-2011 [1]



Injury year	Dispute rate: Claim petitions [2]	Discontinuance disputes [3]	Medical requests [4]	Rehabilitation requests [5]	Any formal litigation [6]	Any dispute [7]
1997	11.4%	6.5%	3.9%	3.6%	14.2%	15.5%
1999	11.3	6.1	4.2	4.3	13.8	15.6
2007	14.7	7.5	7.1	5.6	17.3	19.9
2008	15.1	8.0	7.4	6.1	17.9	21.1
2009	15.6	7.9	7.2	6.2	18.5	21.1
2010	15.0	7.6	6.9	5.6	17.9	20.6
2011	16.3	7.8	7.4	5.8	19.8	22.0

1. Developed statistics from DLI data (see Appendix C).
2. Percentage of filed indemnity claims with at least one claim petition. (Filed indemnity claims are claims for indemnity benefits, whether ultimately paid or not.)
3. Percentage of paid wage-loss claims with at least one discontinuance dispute.
4. Percentage of paid indemnity claims with at least one medical request.
5. Percentage of paid indemnity claims with at least one rehabilitation request.
6. Percentage of filed indemnity claims with at least one dispute that leads to a hearing at OAH (unless the parties settle beforehand). This includes claim petitions, requests for formal hearing, objections to discontinuance, petitions to discontinue benefits and petitions for dependency benefits.
7. Percentage of filed indemnity claims with at least one dispute of any type.

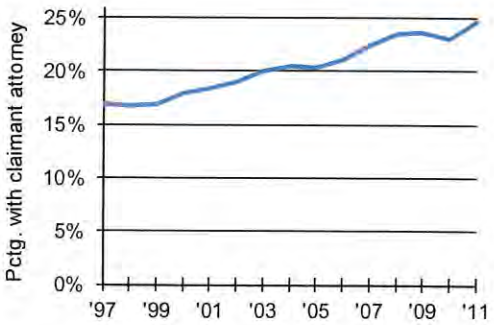
[41] See note 13 on p. 11.
[42] See not 6 in Figure 5.1.

Claimant attorney involvement

Claimant attorney involvement has increased substantially since 1997.[43]

- The percentage of paid indemnity claims with claimant attorney involvement rose from 16.9 percent for injury year 1997 to a projected 24.8 percent for 2011.[44] This is a 46-percent increase.[45]
- This parallels a similar pattern in the dispute rate (Figure 5.1).
- Total claimant attorney fees are projected at $51 million for injury year 2011.[46] These fees account for an estimated 3.2 percent of total workers' compensation system cost.[47]

Figure 5.2 Percentage of paid indemnity claims with claimant attorney involvement, injury years 1997-2011 [1]



Injury year	Percentage with claimant attorney
1997	16.9%
2007	22.4
2008	23.5
2009	23.7
2010	23.1
2011	24.8

1. Developed statistics from DLI data (see Appendix C). A claimant attorney is deemed to be involved if claimant attorney fees of any type are reported.

[43] DLI does not track defense attorney involvement.
[44] See note 1 in Figure 5.2.
[45] See note 13 on p. 11.
[46] All types of claimant attorney fees are counted here.
[47] This percentage was calculated with techniques similar to those for Figure 2.3 to reduce the effects of annual fluctuations in system cost.

THE ALLIANCE

August 12, 2013

Jeffrey Beiriger, Member
Wisconsin Workers' Compensation Advisory Council
Mail to: Association Management Services, Inc.
P. O. Box 594
Menasha, WI 54952

Dear Jeff,

Thank you for sharing your views and experience as a member of the Wisconsin Workers' Compensation Advisory Committee with members of The Alliance Health Policy Committee. We appreciate the candid discussion and look forward to working with you and other members of the Council to achieve meaningful workers' compensation reform this session.

Since our meeting, we've had discussions with our employer members, our internal provider contracting experts and other stakeholders. From those discussions we have developed the following suggestions that we believe are in the best interests of businesses and employees alike:

1. **Employers ask management representatives on the Wisconsin Workers' Compensation Advisory Council to aim high on cost containment.** Conversations with Advisory Council members and provider organizations involved in the Advisory Council process reveal a widely-held belief that businesses must always pay more for Workers' Comp claims than they do for group health claims. On the contrary, The Alliance has negotiated prices for employers on workers' compensation claims that are equal to the prices we've negotiated on behalf of employers for health benefits. This benefits both employers and their employees, and so we believe it is right that the Council use group health payment rates as a yardstick to evaluate proposed reforms.

   The Alliance has the data to help the council understand whether any proposed fee schedule or other arrangement is "in the ballpark." We offer to be a resource to the Council in this area.

2. **We agree that significant attention should be paid to eliminating the "hassle factor" that providers believe justifies higher payment rates.** Payers, workers and providers would all benefit from rooting out this waste and inefficiency as quickly as possible. A formal process should be established to work specifically on these issues in the near term, with a report due by a realistic date.

3. **We ask the Workers' Compensation Advisory Council to play a role in publicly identifying and rewarding high-value providers.** Employers and employees alike have an interest in identifying and utilizing health care providers that provide high quality care at a reasonable cost. In regard to Workers' Comp, the most relevant measure of quality may be a high return-to-work rate. We believe that providers who are

successful in returning injured workers to their jobs should be rewarded with higher payment rates and larger market share. Publicly reporting this information would go a long way in promoting value and encouraging improvement.

4. **Despite statements to the contrary, we find no correlation between the cost and quality of medical care delivered in Wisconsin.** The lack of correlation is evident in transparency initiatives run by The Alliance and well documented in several studies. A recent analysis of data by a company called Castlight confirms this as well. If payers had the ability to reward high-quality providers with greater market share through employer directed care, it should not be assumed that employees would view this as a negative. We understand through our work that employees value information and assistance from their employers when making decisions about their health care.

5. **We ask the Council to take care to avoid fee schedule pitfalls.** We applaud members of the Advisory Council that recognize the importance of analyzing the total cost of care versus a per-claim figure. If a fee schedule is implemented in Wisconsin, it is important to monitor provider billing practices to ensure that costs per episode do not increase at the same time per-claim costs decrease. Also, we see a possible scenario where a fee schedule imposed by the state on all workers' comp claims may increase rates for self-funded plans, assuming they were included in the fee schedule. While we welcome a fee schedule for self-funded employers when it delivers lower costs, we believe any fee schedule should be viewed as a "ceiling" so employers can continue to take advantage of more beneficial agreements that their networks may be able to negotiate.

6. **We support efforts to reduce the statute of limitations on workers' comp claims.** Wisconsin's twelve year claim window is clearly an outlier that puts employers at risk for claims for an excessively long period of time. We agree with management representatives and many others that the statute of limitations should be reduced to three years.

7. **Keeping employees safe is the best way to tackle workers' compensation costs.** Several Alliance members mentioned initiatives by their companies and insurers aimed at preventing workplace injuries in the first place. For example, some of our members are rewarding workers based on their safety records. Unfortunately, these initiatives have run into resistance from OSHA regulators that view them as method to suppress reports of workplace injuries. Regulators should recognize that the true intent behind these programs is to incentivize employees to keep safety foremost in their minds at all times. Our state should work to remove regulatory hurdles at the state and federal levels and encourage these types of initiatives to continue and grow.

Again, thank you for meeting with us and being open to these suggestions. We look forward to providing assistance to the council where we can and working with you to improve the workers' compensation environment for employers and employees alike.

Kind Regards,

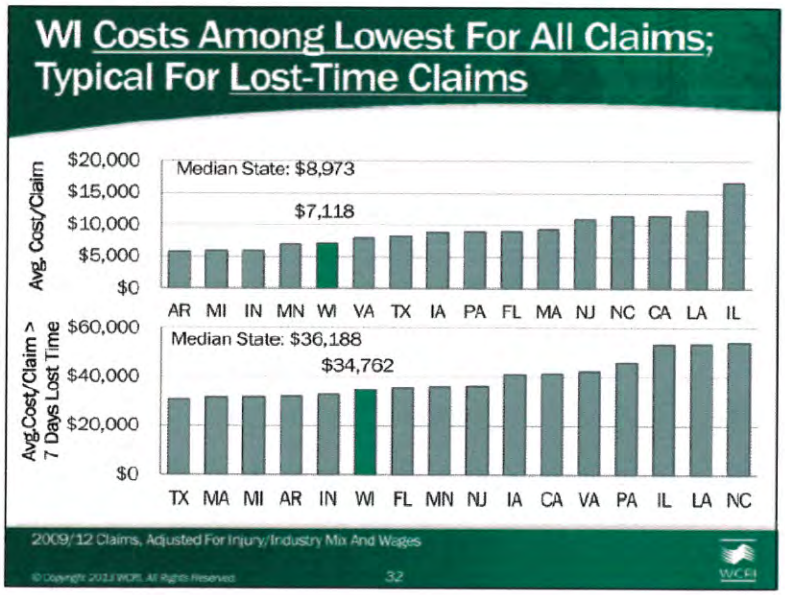
Cheryl a. DeMars

Cheryl DeMars
President and CEO

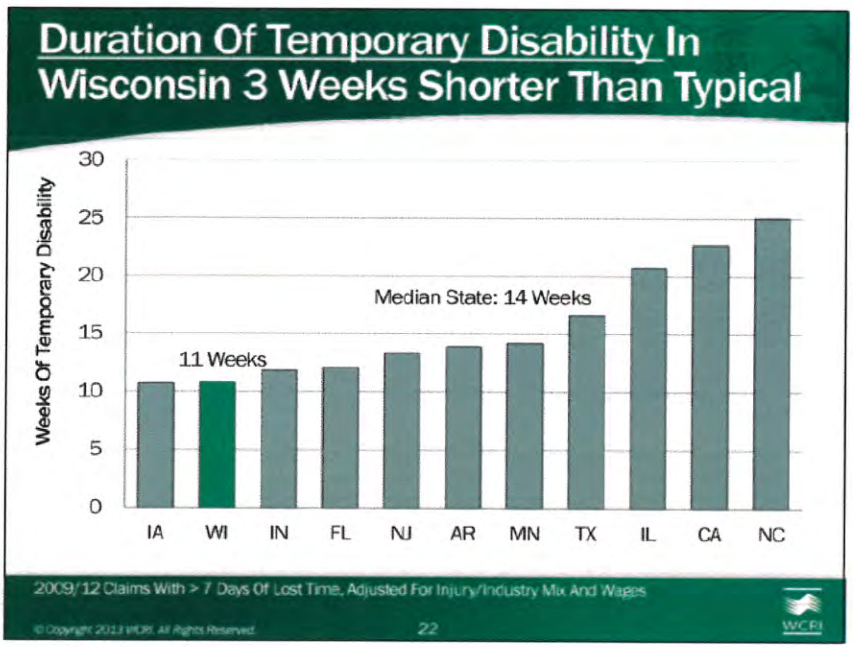
Wisconsin Chiropractic Association

Presentation to Assembly and Senate Labor Committees February 4, 2014
Testimony opposed to WCAC "Agreed upon" proposal on provider fee schedules
LRB 3729/2 AB 711 SB not yet numbered Section 102.423 Health service fee schedule
Dr. Jeffrey M. Wilder

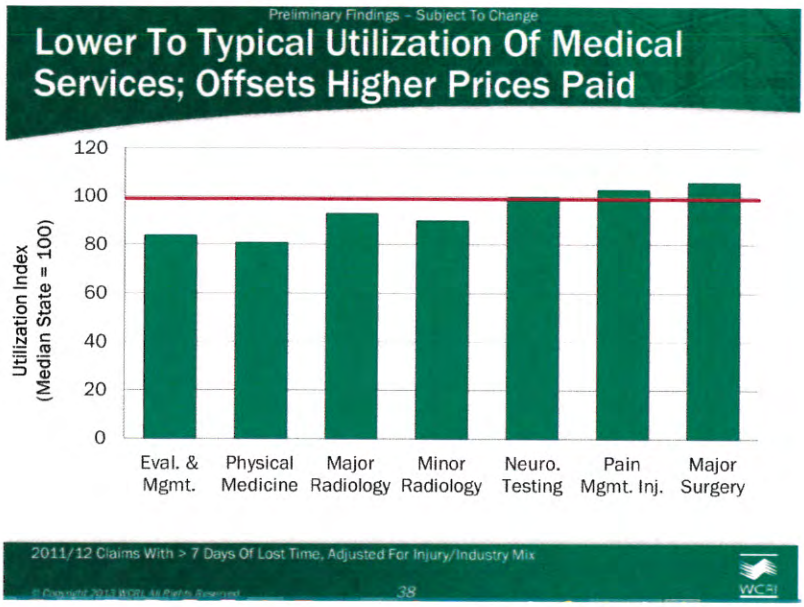
1. **Prices per medical procedure in Wisconsin are higher, but <u>overall costs are among the lowest</u>:** "One key point to emphasize about the Wisconsin Worker's Compensation system is that, when compared to other study states, **overall costs per all paid claims in Wisconsin were among the lowest of the 16 study states**." [WCRI]



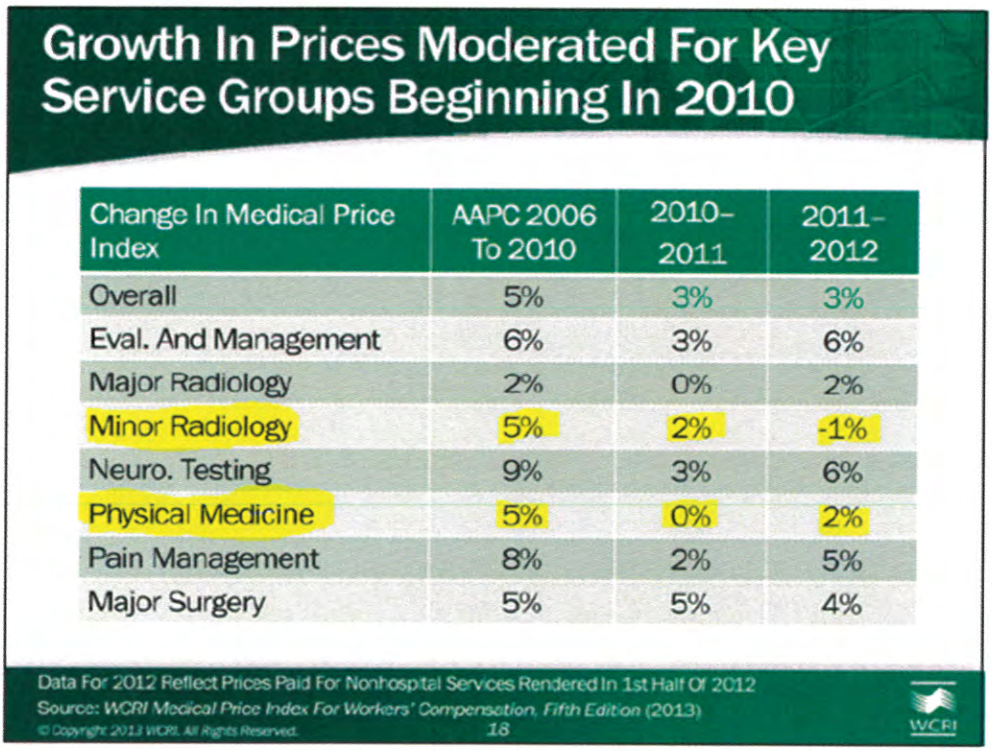
2. **<u>Wisconsin health care providers are more effective</u>, as measured by earlier return of injured employees to work.**
"Duration of temporary disability in Wisconsin 3 weeks shorter than typical." [WCRI]



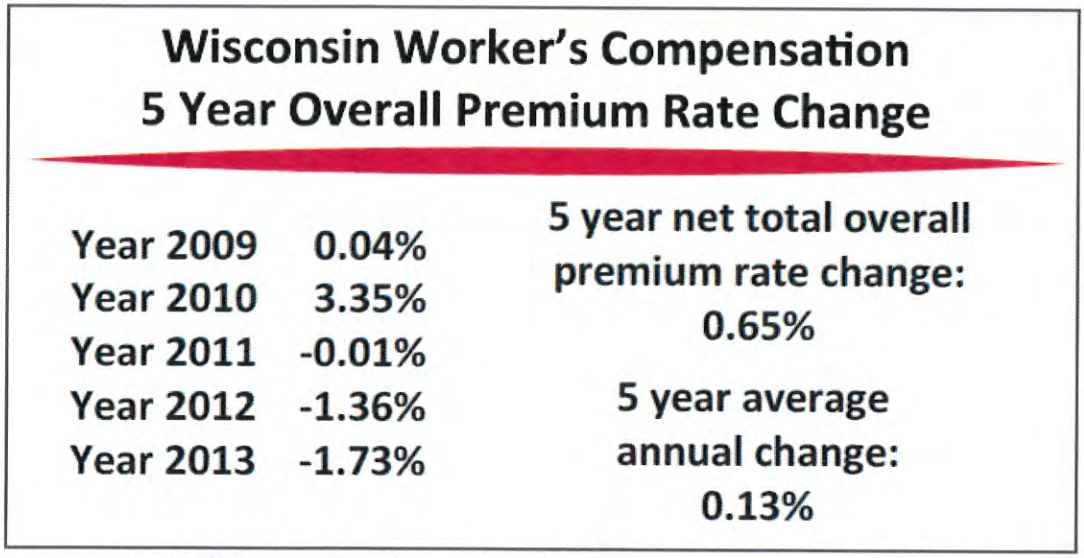
3. **Lower utilization of medical services in Wisconsin result in higher efficiency and lower overall cost, <u>even though the price of a specific medical service may be higher</u>.**



4. **Prices paid for physical medicine [chiropractic] have been flat to <u>falling,</u> not rising**



5. **Workers compensation premiums paid by employers have been <u>falling</u>, not rising.**



Source: DWD PowerPoint Presentation to Joint Informational Hearing, July 31, 2013.

6. **Wisconsin's health care providers have done a great job of providing excellent care to injured workers. However, more should be done to <u>prevent</u> workplace injuries. <u>Wisconsin is 6th worst</u> in the U.S. for workplace injury frequency.**

Table D Ranking by Claim Frequency per 100,000 Workers Using Rating Bureau Information, Average of Policy Years 2006-2008

State	Average Claim Frequency 3-Year Average
Nevada	6.495
Montana	6.493
Maine	6.491
Idaho	6.189
Oregon	5.750
Wisconsin	5.586
Pennsylvania	5.551
South Dakota	5.513
Massachusetts	3.260
Texas	3.112
Virginia	2.918
Louisiana	2.907
Maryland	2.905
New York	2.614
District of Columbia	1.294

Source: Annual Statistical Bulletins (2010-2012, Exhibit XII), National Council on Compensation Insurance, Inc. (NCCI).

7. **Worker's Compensation claims cannot be fairly compared to group health claims.**
    a. [Nearly] all Worker's Compensation cases are acute
    b. Worker's Compensation are more severe
    c. All Worker's Compensation cases involve management of work restrictions, TTD, PPD
    d. Group health patients pay significant, progressively increasing deductibles, copayments and coinsurances that are not paid by injured workers.
    e. Group health contract may "steer" up to 100% of patient flow to a doctor or clinic.

8. **The language of the proposed fee schedule** [Proposed 102.423 (1)(2)] **is incomplete and confusing.**
    a. Insurance and group plans have widely varying copayments, coinsurance and deductibles
    b. There is no restriction of how old this data may be.
    c. There is no mechanism to eliminate outlier data.

    Proposed 102.423 (1)(2): *"Set the maximum fee for each health service included in the schedule at 110 percent of the sum of the average payment for that service and the average copayment, coinsurance, and deductible payment for that service, as determined under subd. 1."*

9. **In other states, imposed fee schedules have led to poorer outcomes and increased overall costs.**

10. **WCAC has seriously overstepped its boundaries:**
    a. Management and labor, in conjunction with DWD, have traditionally developed "agreed-upon" bill on areas of mutual concern.
    b. Providers do not have a vote on the WCAC.
    c. Providers have voluntarily participated with WCAC in regulation of outliers prices for > 20 years.
    d. WCAC has persisted in claiming that provider "price" is a problem, in spite of a demonstrated history of overall lower costs and superior results.
    e. WCAC has rejected providers' current voluntary proposal to further control outlier prices.
    f. Management and labor have ignored major issues, such as Wisconsin's high rate of injuries, instead imposing a major fee reduction upon health care providers.
    g. This is the first time in memory that health care providers do <u>not</u> agree with the "agreed-upon" bill developed by the WCAC. We now seek relief from the Legislature.

Summary: **<u>The Wisconsin Chiropractic Association joins with other health care providers in strenuously opposing the fee schedule for health care providers in workers compensation as proposed in AB 711.</u>** We are committed to working with all stakeholders to develop fair and equitable cost-containment measures that do not negatively impact our ability to provide quality care to the injured worker, or jeopardize the outstanding results demonstrated in the Wisconsin Workers Compensation system.

Wisconsin Physical Therapy Association

TO: Chair Grothman and Chair Knodl, Members
Senate and Assembly Labor Committees

FR: Brett Roberts, Wisconsin Physical Therapy Association

DA: February 4, 2014

RE: Efforts to preserve the Successful Worker's Compensation System

Thank you Ladies and Gentleman of the Labor Committee for allowing me to testify today. My name is Brett Roberts, I'm a 2002 graduate of UW Madison's physical therapy program and have been a small business owner in Wisconsin since 2005. I currently serve as a director for the Wisconsin Physical Therapy Association and as the Legislative Committee Chair. As a member of the physical therapy profession I know that we take pride in rapidly diagnosing & treating musculoskeletal injuries such as low back pain, shoulder injuries and carpal tunnel syndrome. It is our role not only to eliminate pain but to strengthen or lengthen muscles & teach better movement patterns to safely return injured employees to work & prevent reinjury. We are also instrumental in preventing unneeded surgeries, over use of pain medication or prolonged disability. I've had an interest in caring for the injured worker since 1998. That year, just two years out of high school, I worked as a furnace tender at a local drop forge factory in Rockford, Illinois to pay for my college tuition in the fall.

During my time as a furnace tender I was able to witness firsthand the chaos that can be created, not only from the unfortunate injuries that were common in that industry, rotator cuff tears, eye injuries as a result of flying metal scale, or burns from working around the bar stock that was heated to 2,500 degrees before being compressed by 5 tons of downward pressure...but the chaos that was created when someone who was the sole wage earner from their family was unable to provide for their family as a result of their injuries.

It left an indelible mark on me and gave me an incredible amount of compassion for the men and women that continued to work there long after I had returned to school. Even before starting my journey through physical therapy school, I understood the importance of getting those workers back to their wage earning potential as soon as possible, allowing them to function not only at work, but to be able to enjoy time and be able to provide for their family.

As a business owner, I can appreciate the need in today's economy to be able to limit expenses to ensure the financial viability of one's business. Replacing the lost productivity of an injured worker and incurring and facing potential increases in Worker's

compensation expenses or premiums due to lost time claims over the next three years has a negative impact on a lot of businesses.

But it is often the unintended consequences that occur as a result of best placed intentions can permanently disrupt a business model, which in hindsight was running at an efficient and effective level.

I've personally made such a mistake, that fortunately my clinic was able to recover from. Our greatest expense in my industry is our labor expense. Shortly after opening my practice, I attempted to decrease our cost by changing our business model and outsourcing our billing department.

It made sense at the time, why increase our greatest expense when I could limit my exposure and increase my potential to generate a profit for Roberts & Associates? In the short term, outsourcing was cheaper as opposed to the more expensive daily cost of employing my own billing department. In the long term outsourcing was about as close to "business suicide" as Roberts & Associates has ever come. I'm a small business, we did just under $500k in gross revenue last fiscal year...my good intentions of attempting to control my expenses cost us approximately 20% of our annual gross revenue...dollars that we will never get back. The value of my in house billing staff far outweighed their cost! In hindsight, I wish we had never disrupted the business model that was working. It impacted customer service, cash flow, 3rd party relationships that took years to recover!

So why change our current work comp business model that is successful?

OUTCOMES: **Data shows that in Wisconsin, the period of time an injured worker is away from his or her job is lowest in the country; in fact, the period of disability is half the national average. This benefits the entire system and all of its participants, including the employer and their families. The less time an employee is off of work, the faster that employee can be productive at work and can be productive at home.**

COST: **While prices for some services are higher in Wisconsin compared to other states, the overall cost of medical care provided through the Worker's Compensation system is lower than average and lower than our neighboring states of Minnesota, Iowa, and Illinois. Wisconsin is also below the national average in overall claims costs. The curve of work comp premiums has flattened over the last 5 years and decreased over the last 3. It seems that the current business model is less about individual prices and more about the total cost!**

QUALITY: **Wisconsin is ranked consistently among the best states in overall health care quality. The Worker's Compensation system benefits from our high-quality, volume-based health care system, which is truly a competitive advantage for Wisconsin. Instead of making a sudden change in payment- how about repackaging data to show the total cost & the value proposition to both current & potential WI employers!**

So overall cost is less to system with a negative growth rate for premiums over the last 3 years, the quality of care is at an all-time high, allowing the injured worker to return not only to their line of work faster, but to their quality of life faster...

These are all trends that run counter to our surrounding states.

What are some potential issues that may be created by passing this legislation?

Consider for a minute the typical non-surgical low back pain patient. Currently when triaging patients and deciding who is able to be worked into a busy clinic schedule and who may be asked to wait for another day -a work comp patient is typically moved to the front of the line. This preference occurs for a multitude of reasons; including the understanding that the timing of care is critical and if a patient is able to be seen sooner, they will be able to return to work / life faster, use less pain medicine, and require less imaging. It also is given preference due to the relationships we have with all of the members of the work comp team, the employee, the nurse case manager, and the employer and the understanding that the current payment system justifies the added expense that is required to treat this injured worker.

Rehabilitating a Medicare or commercial insurance patient back to simple everyday life is far less complex than returning the to a specific job function with specific equipment and specific analysis of their work requirements. This added expense on the provider side includes both labor and non-labor expenses. Non-labor expenses include the increased amount of time that lapses between the time services are billed and the time payment is received. On the labor side, there is additional documentation required by the nurse case managers, interpretation of a job demands analysis to gain a better understanding of what physical demands the worker needs to meet to return to his prior level of employment, and the added inefficient steps of utilizing paper billing versus electronic billing for work comp services all serve to increase the overhead required to see an injured worker.

If the payment for services changes, as with any business model, the delivery of services will need to be analyzed to ensure a viable business model is maintained. The convention of "moving an injured worker to the head of the line" may not be a priority if the costs of delivering care are not offset by the ability to get paid as we charge. We will still provide quality care but the WC patient and their employer may not find the same responsiveness. I ask you today to amend AB 711 and SB 550 to remove the fee schedule and standard deviation changes. Rather than disrupting a business model that is already the example other states look to, we ought to look for solutions that prevent injuries on the front end and examine what truly increases overall costs to the system. Ultimately this will allow our workers to Get Working, Keep Working, and Enjoy Life.

Thank you for the opportunity to submit comments on AB 711 and SB 550. I would be happy to take any questions at this time.

ATI
PHYSICAL THERAPY

Testimony

To: Senator Glenn Grothman, Chair
Representative Daniel Knodl, Chair
Members of the Senate Committee on Judiciary & Labor
Members of the Assembly Committee on Labor

From: Jeff Rogers, Vice President of Product Management

Date: Tuesday, February 4, 2014

Re: Opposition to Assembly Bill 711 and Senate Bill 550
Opposition to Government Intrusion in the Marketplace

Good morning to the committee chairs, Senator Grothman and Representative Knodl – and members of the committees. Thank you for the opportunity to testify today.

I am Jeff Rogers and I am the Vice President of Product Management at ATI Physical Therapy. My job includes handling our in-house case management team that oversees our workers' compensation patient population to ensure quality outcomes and patient satisfaction. I also oversee, ATI Worksite Solutions, our employer injury prevention division. We have over 70 staff members in various blue chip employers doing injury prevention, injury triage, ergonomics and safety classes.

Our company started off with one clinic in Wisconsin 9 years ago. Today, ATI has 19 locations and over 300 employees in the State of Wisconsin. I have been with ATI for 7 years and prior to joining ATI I worked for one of the largest workers' compensation insurance companies doing business in the State of Wisconsin.

I want to share with you today some of the same things I discuss with new clinicians during new hire orientation.

First, our goal is to return the injured employee back to work as soon and as safely as possible. Therapists play the largest role in return to work once an individual has had surgery. Often I tell our employees we ultimately have the largest impact on the outcome for the injured worker and employer.

We talk about the difference between workers' compensation and the regular medical patient. At ATI we see over 9000 patients per day and 15% of those patients are workers' compensation cases.

In order for each therapist to remember the importance of managing workers' compensation cases we have reminder forms and a checklist in each chart.

The therapist is to find out such data as the employer name, job title and job description, and current work status. From there they are to determine the initial and return to work plan of care, determine if they would be a candidate for a work conditioning/hardening program or any other service that we may be able to recommend when the injured employee returns back to work.

They also have a checklist of things to do such as, contact the nurse case manager at the insurance company, discuss the plan of care with the nurse case manager and the injured employee, and send timely progress notes to all parties.

We discuss that there are many outside factors and individuals. We also discuss that all have different outlooks and most have different opinions. The therapist is to remain neutral and keep the patient focused on their rehabilitation and return to work.

Our services for the injured worker may include physical therapy, aqua therapy, hand therapy, occupational therapy, work conditioning/hardening and functional capacity assessments.

Our goal and how we measure ourselves is based on our ability to return a patient to their pre-injury well-being and back to a productive life. Unlike most insurance products we see, workers' compensation has the only dual-benefit system. What I mean by that is workers' compensation pays for both medical care and lost wages. Medicare, Aetna, Blue Cross Blue shield and others only cover an individual's medical care.

Medicare limits the number of sessions and only wants to cover therapy that will return a patient back to acts of daily living – such as walking, hygiene and other simple tasks which we some times take for granted. Commercial insurance carriers vary. Some will only pay for enough rehab to be able to do their acts of daily living while some of the more desired plans will pay for enough care to return them back to their pre-injury state.

Physical therapy is ordered and prescribed by a doctor and a therapist is to stick to the doctor's plan of care and protocols.

ATI is a private practice and we are not affiliated with any hospitals. Our referral source is most large orthopedic groups. While we do see the less severe cases our reputation has been built around our ability to handle post operative orthopedic cases. Over 50% of our workers' compensation patients are post surgical such as rotator cuff repair, ACL reconstruction, and lumbar surgeries.

Most of our therapists have a masters level degree in physical therapy and many have a doctorate degree. A lot of the physical therapy schools are moving to a doctorate degree

which is causing a shortage of physical therapists. The time commitment plus the cost has less people pursuing this career path. We are able to attract a lot of younger therapist from the surrounding states because ATI offers an attractive compensation package and continuing education dollars.

Even with these advanced degrees a lot of physical therapy training and protocols do not address the heavy physical demand levels that many patients who were hurt at work are required to perform. Having a patient lift over 20 pounds while in physical therapy was not common at one time. During the 1970's the rehabilitation profession was asked by employers and insurance carriers to help develop programs to help offset the 13 to 20 billion dollars spent annually on lost wages and wage replacement.

At this time a work hardening program was developed. It was usually done within a large warehouse where therapists attempted to recreate the job site. They had bricks, sand, wheel barrels, ladders etc.... Of course this type of set up was not scalable and during the 1990's therapists developed work conditioning programs. Work conditioning focused on cardio vascular endurance, strength, flexibility and overall endurance.

ATI's work conditioning and work hardening program has returned almost 300 Wisconsin injured workers back to pre-injury job status. This specialized program has differentiated our company from our competitors and has achieved savings for employers and insurance companies. Most importantly it has allowed injured workers to return to the quality of life they once had. Operating specialized programs as these incurs additional costs to ATI, specialized programs for workers' compensation that are not used for Medicare, Medicaid or commercial payors.

ATI-Physical Therapy Experiences in workers' compensation:

- **Administrative expenses are 4-times higher for workers' compensation.** ATI's operating cost for handling workers' compensation billing and collections is 4-times that of our largest commercial payor.
- **Workers' compensation makes up the majority of our bad debt/write off.** Workers' compensation is not supposed to be "charity-care." However, our history of collecting on workers' compensation is much more difficult than Medicare or group health.
- **ATI has additional practice expenses for handling workers' compensation**. This includes additional square footage for work conditioning/hardening, job simulation and strength equipment, functional capacity evaluation equipment. Also, workers' compensation injuries often require highly skilled therapists with greater experience with specific training in manual therapy and functional job retraining.
- **Comparing Medicare/group health therapy to workers' compensation is like comparing apples-to-oranges.** Rehabilitating a Medicare patient to acts of daily living that include being able to get in\out of a chair and accomplishing basic

hygiene is much different to the injured worker who needs to be able to lift 50, 75 or 100lbs before they can return to work.

- **Competition** – Competition drives good patient care and outcomes. Favorable reimbursement allows for competition amongst providers to occur which results in superior outcomes for Wisconsin employers...i.e. Wisconsin's temporary total disability average has the best outcomes according to NCCI. By arbitrarily cutting rates you will reduce competition.
- **The Illinois example:**
    - The 30% cut in the state fee-schedule resulted in a 7.4% premium reduction for employers in 2011, but there was premium increase of 3.5% in 2012.
    - According to NCCI the combined ratio for Illinois insurance carriers in 2012 was 99.5, which points to insurance carriers profiting from the fee-schedule they termed "reform." The point being the savings were not fully passed on to the employers nor the system.
    - According to WCRI, after the 30% cut, health care providers in Illinois terminated worker's compensation contracts and discounts. This government intrusion pitted employers and the medical community against each other. The government intrusion into the marketplace by mandating deep cuts in prices did interfere with providers and employers contracting with each other to create discounts and promote best practices/efficiencies.

I am here today testifying to this committee today to share our experiences as a company that has dealt with the varying payment methodologies, including fee-schedules. As a rehabilitation company I believe we play one of the largest roles in the outcome of a person's health. We continually remind our therapists that once the surgery is done the rest us up to you. Therapists have to work with the patient to focus on their capabilities and rehab, not their disabilities. Our professionals not only play a crucial role in the patient's rehabilitation, but they also play a crucial role in helping that patient who may be experiencing one of the lowest points in their life – that there is a light at the end of the tunnel and with perseverance and adherence to the therapy plan – their life will get better.

We face a lot of uncertainty in the health care world with a pending 26% cut in reimbursement from Medicare, complicated benefit plans, ever increasing deductibles and co-pays, an increase in demand and increase in severe injuries with an aging population, unknown workloads coming with national health care, a shortage in physical therapist – considerations that we ask you to take into account. Government intrusion into the marketplace often leads to less competition and reduced access, which we believe will jeopardize Wisconsin's record of quality care and superior outcomes. Our fear is that the proposed fee-schedule will ultimately have a negative affect for both the injured worker and the employer.

Thank you.

Marshfield Clinic

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Testimony of Marshfield Clinic
In opposition to AB 711/ LRB 4097/2
Before the Joint Committee on Labor
February 4, 2014

Chairman Grothman, Chairman Knodl and Committee members, thank you for holding this hearing on the workers compensation proposal before you.

My name is Vicky Strobel and I am the Director of Business Development for Marshfield Clinic and this is Ryan Natzke, our Director of State Government Relations.

Marshfield Clinic is a large multi-specialty group practice in central, northern and western Wisconsin. We employ over 8,000 physician and staff at our 50 locations, two hospitals and health plan. We also provide other services including lab, food safety and our "home grown" electronic medical record system. We are a non-profit corporation driven by our mission to provide excellent, accessible patient care while furthering developments in education and research.

We are here today to testify about our very strong concerns with regard to the current workers compensation proposal.

It is my role at Marshfield Clinic to negotiate and manage the contracts we hold with a wide variety of payors that we provide services to. This ranges from managing the contracts of the low rates we receive from government payors such as Medicaid and Medicare, to the negotiated discounts we provide to third party payors such as your typical commercial insurance product. It is important to note, the contracts of these negotiated discounts also apply to the commercial workers compensation program. In fact, approximately 90% of the patients we see today for workers compensation services are at a privately negotiated discounted rate.

The major provisions we are concerned with are: (1) the proposed government rate setting fee schedule; and (2) the dramatic changes to the standard deviation used in contested charges.

Please remember this program uses private money and not government dollars. As I'm sure you can understand, in the health care industry we have very strong concerns with the government taking over private medical service pricing for commercial workers compensation. This is a significant change from how the program currently works.

While the current program is not perfect and can always improve, Wisconsin is currently among the best in the country, if not the best, at getting injured workers back to work. Part of the cost of the workers compensation program is that it is administratively burdensome to process and reimbursement payments are typically very slow. However, the program is not completely broken as some portray it to be. As DWD testified several months ago, premiums for workers compensation have remained flat over the past five years and have actually declined over the past three years.

It is our hope the Committee will reject this proposal as long as it includes a government mandated fee schedule and negative alterations to the standard deviation.

Thank you for taking the time to listen to our testimony and for taking our thoughts into consideration. We would be happy to take questions.

ZINGEN & BRAUN
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Thank you Chairperson Grothman, Chairperson Knodl and members of the Senate and Assembly Labor Committees for holding a hearing on this important piece of legislation. My name is Dave Dunker I am the president of Zingen and Braun Insurance Agency located in Brookfield. I am also the President of the Independent Insurance Agents of Wisconsin, a trade association representing more than 5,000 independent insurance agents throughout the state. My colleague Skip Hansen and I come before you today to highlight why the council's 100 year process is important to us and why we believe this bill is good for the state's economy.

We don't love everything about it, but we respect the Workers Compensation Council's agreed upon bill. Our business's count on this stability in the market. It is essential for them to financially plan for their future. Without this stability, and the possibility of an unpredictable market that is based on whoever controls the legislature and whichever interest group holds the lynch pin, workers' compensation will likely become just like our health care system under Obamacare; where consumers are confused and businesses are frustrated by their inability to budget for future health care costs. This is what we want to avoid in our work comp. system and why the council process is so important to us.

Employers, our clients are constantly complaining about the high cost of Worker's Compensation premiums. Wisconsin has no means of control costs. Currently 45 states have a fee schedule; Wisconsin is one of 5 without.

This is why we are here today to ask you to honor the process and support this bill that is the best possible compromise for the state of Wisconsin.

Thank you,

SFM
The Work Comp Experts

Nick Marino, CPCU, AU, AAI, AINS
Wisconsin Business Manager
262-252-5335

Good morning. SFM is a mutual insurance company that writes only one line of coverage – Workers Compensation. We insure businesses and public entities in 16 states. 97% of our premium comes from our core Midwestern states of MN, WI, IA, NE and SD. SFM is the largest writer of workers compensation in MN. WI is our second largest state of operation with over 1,000 policyholders, $20MM in premium and over $1BB in Wisconsin payroll.

SFM began as the Minnesota State Fund in 1983 with initial capital and control coming from the MN legislature. This was due to the reluctance of insurance carriers to write workers compensation on a voluntary basis as a result of runaway cost and benefit structures.

My role is solely to manage SFM's WI operations including underwriting, loss prevention, claim and nurse case management services. I live in Menomonee Falls.

I am here today in support of the Work Comp Advisory Council's agreed upon bill for the current legislative session; in particular, the cost containment measures requested by the legislature.

In the 50 different state jurisdictions, workers compensation is a necessary and mandatory system. Except for self-insured employers, insurance companies pay the medical, disability income, rehabilitation and death benefits on behalf of employers for their employees' work-related injuries.

All 50 states have agreed that the non-medical benefits are statutory and therefore not determined by the free market. In WI, for example, the loss of a finger receives a defined benefit. This benefit is not subject to negotiation as this would lead to abuses and inequities for injured workers. Though benefit amounts vary by state, the manner in which they are determined does not. In WI, these benefits have remained stable, yet have fallen from 52% of all workers compensation expenditures to roughly 30%.

Since the medical component of workers compensation in WI has grown from 47% to nearly 70%, the legislature requested that the Advisory Council introduce cost containment measures into the negotiated bill. 44 other states have done so through some form of medical fee schedules. The Indiana legislature approved a fee schedule that will take effect in July of this year. All but two of those states have a fee schedule that is indexed to Medicare. Though a Medicare based fee schedule is clearly the country's strong preference, I think the Council has done a good job to find a middle ground with respect to the proposed price basis. I believe they have recognized all of the constituents within the workers compensation system in what is far from an extreme or drastic measure. In addition to being one of only 6 states without a fee schedule, WI is unique in that we are the only non-fee schedule state where the payer of workers' medical costs has no control over the choice of the medical provider or medical facility.

If one wants to make the argument that a Medicare fee schedule artificially sets prices below market, that argument cannot be made with respect to the Council's proposed bill. Currently, the free market determines the rates that WI health insurers pay for their members' services. The Council has proposed a 10% increase over essentially a prevailing market rate.

An excellent example of cost containment yielding benefits is found in the case of IL. In 2010, IL was the only state worse than WI in the Interstate Ranking for Price Index on Major Surgeries. After IL state reforms, WI has assumed the top spot at over 250% of a 25 state average for major surgeries. Further quoting the WCRI Study, "The prices paid in Wisconsin were the highest of the 25 study states, more than twice the median of the study states with fee schedules and about 50% higher than the median of the study states without fee schedules."

Without some sort of limits, the gap will continue to grow between what employers are forced to pay for medical care to injured workers in WI when compared to neighboring states.

MAJOR FINDINGS

Increasing prices for medical treatment for workers' compensation injuries have been a focus of public policymakers and system stakeholders. To help decision makers set priorities about system improvement by conducting meaningful interstate comparisons on prices, this study creates an index for prices paid for the most common professional services (i.e., nonhospital, nonfacility services) used in workers' compensation for each study state. In addition, the time-series price index by state reported in this study assists policymakers in monitoring the price trends in relationship to price-focused policy changes. This report includes 25 large states that represent nearly 80 percent of the workers' compensation benefits paid in the United States and covers 11 years from 2002 to 2012.[1]

The following is a summary of the major findings from this study. The discussion is organized into three major topics. The first topic explores several lessons from static cross-state comparisons on prices associated with policy differences. The second topic summarizes a few lessons from changes in prices by state over the study period. The last topic discusses the Illinois fee schedule reform in September 2011. Like earlier editions of this study, we discuss price changes associated with fee schedule reforms in some study states within the study period. The results in this fifth edition may be particularly interesting as they capture the actual price changes under the most recent fee schedule reforms in Illinois. Please note that this study does not intend to identify causal relationships; rather, it highlights possible policy implications by describing associations between observed empirical patterns and policy choices and changes.

LESSONS FROM INTERSTATE COMPARISONS

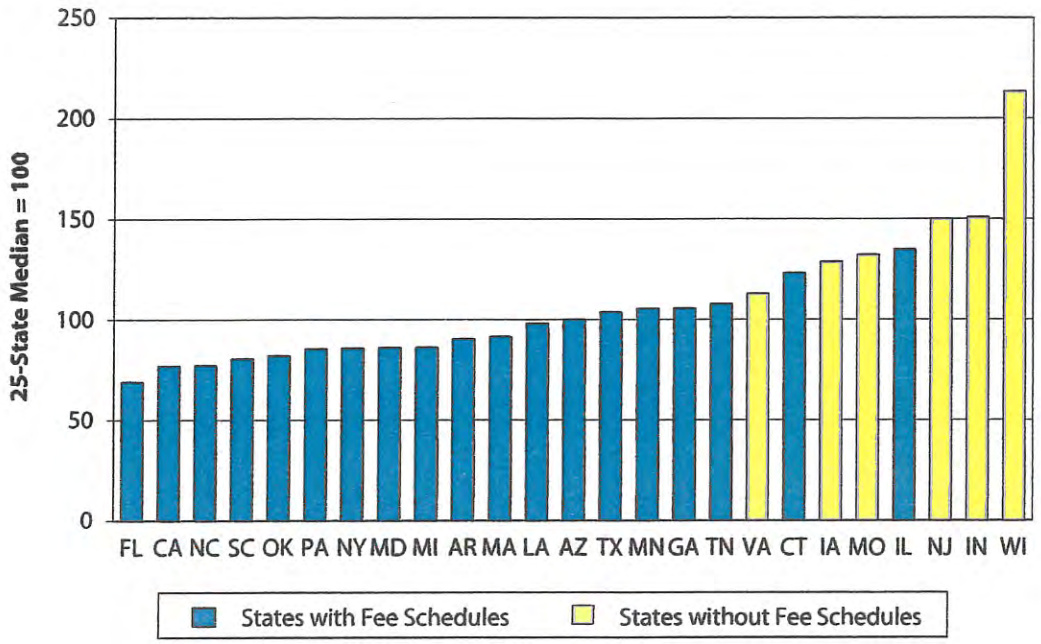
- Prices paid were higher in states without fee schedule regulations for professional services as compared with fee schedule states.
  - Six states included in this study had no fee schedules as of 2012, namely Indiana, Iowa, Missouri, New Jersey, Virginia, and Wisconsin (Figure 1). The prices paid for professional services in five of these states (Indiana, Iowa, Missouri, New Jersey, and Virginia,) were 25 to 67 percent higher than the median of the study states with fee schedules. The prices paid in Wisconsin were the highest of the 25 study states, more than twice the median of the study states with fee schedules and about 50 percent higher than the median of the study states without fee schedules.
- There were more variations in prices paid across states for major surgeries than for primary care services.
  - The relative difference (i.e., ratio) between the second highest and second lowest prices paid for major surgeries across the study states more than doubled that for primary care services, such as office visits (Table 1).[2] Compared with the 25-state median, the average prices paid for major surgeries were more than 100 percent higher in the states among the highest, New Jersey and Wisconsin, while the average prices in the states among the lowest, Florida, Michigan, and South

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

[2] To avoid basing the range computation on potential outliers, we used the second highest and second lowest values to discuss the variation in prices paid across study states. Note that the same qualitative conclusion holds for using the highest and lowest values.

Carolina, were more than 40 percent lower (Figure E.4). In other words, the average prices in those states among the highest were more than three times higher than the prices in those states among the lowest for similar surgeries. In contrast, for office visits, the average prices in the states among the highest (Minnesota and Wisconsin) were only double the prices in the states among the lowest (New York and North Carolina) for similar services (Figure E.2).

Figure 1 Interstate Comparisons of Price Index for Professional Services, 2012^{p}



Special notation:^{p} We use the notation *p* to indicate that the 2012 numbers are preliminary results based on half-year price data through June 30, 2012. Note that the half-year data likely provide a reasonable approximation for interstate ranking across states in 2012, based on results for earlier years from the prior editions of this study (see Figure TA.1).

Table 1 Description of Interstate Variations in Price Index for Office Visits and Major Surgeries, 2012^p

Measures	Evaluation and Management (office visits)	Major Surgery
Minimum price index value	67 (NC)	55 (MI, SC)
2nd lowest price index value	68 (NY)	56 (FL)
Maximum price index value	167 (WI)	258 (WI)
2nd highest price index value	133 (MN)	235 (NJ)
Ratio between minimum and maximum price index values	2.5	4.7
Ratio between 2nd lowest and 2nd highest price index values	2.0	4.2
Number of states with price index values within 25% of the median of study states	20	10
Number of states with price index values more than 25% higher than the median of study states	2 (MN, WI)	7 (CT, IL, IN, MA, MO, NJ, WI)
Number of states with price index values more than 25% lower than the median of study states	3 (CA, NC, NY)	8 (AR, FL, MD, MI, MN, OK, SC, TX)

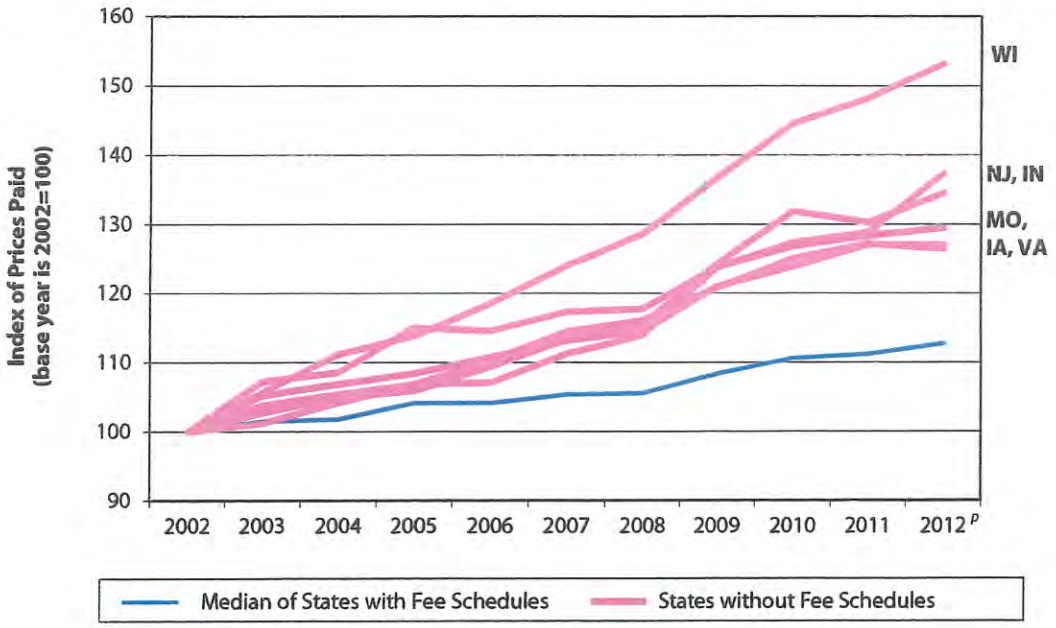
Special notation: ^{p} We use the notation *p* to indicate that the 2012 numbers are preliminary results based on half-year price data through June 30, 2012.

Note: In parentheses underneath the values are the states that correspond to those values.

LESSONS FROM TRENDS

- Prices grew more rapidly over the study period in states without fee schedules compared with states with fee schedules.
  - The average prices paid in Indiana, Iowa, Missouri, New Jersey, and Virginia increased 26 to 37 percent from 2002 to 2012, compared with a median growth rate of 13 percent for the study states with fee schedules (Figure 2). The average price in Wisconsin experienced the most rapid growth among the 25 states—a 53 percent increase over the 11 years covered in this study. This growth was not only more rapid than the typical growth in states with fee schedules, but also more rapid than the growth in the other study states without fee schedules.

Figure 2 Trends of Price Index for Professional Services, 2002 to 2012



Special notation: ^{P} We use the notation *p* to indicate that the 2012 numbers are preliminary results based on half-year price data through June 30, 2012. Note that the trend line for the median of states with fee schedules represents the median rate of growth of prices paid among states with fee schedules from year to year.

- In states with fee schedules, changes in actual prices paid were related to changes in fee schedules.
  - Prices paid remained fairly stable in states where fee schedules did not change. For example, fee schedule rates in North Carolina did not have any material change during the study period, and the average price paid remained stable from 2002 to 2012 (Figure A.17). In New York, fee schedule rates for most types of services covered in this study did not change from 2002 to 2010, and the average price paid remained stable during that period (Figure A.19).[3]
  - In states with fee schedule reforms, changes in the actual prices paid were associated with the policy changes. For example, Texas underwent multiple fee schedule reforms. In August 2003, fee schedule rates for surgery were decreased while fee schedule rates for office visits (i.e., evaluation and management) increased significantly. In March 2008, Texas increased fee schedule rates for most professional services, especially for surgeries. These regulation changes were followed by substantial changes in prices paid (Figure D.23). The average price paid for major surgeries decreased about 40 percent from 2002 to 2004, and the average price paid for office visits increased nearly 40 percent in Texas, after the 2003 fee schedule change. From 2007 to 2009, the average prices paid for office visits and major surgeries increased 12 percent and 24 percent respectively, after the 2008 fee schedule change.[4] Another example was Maryland. In September

[3] In 2011, fee schedule rates in New York increased for evaluation and management (office visits) and emergency services, and the prices paid for those services increased correspondingly.

[4] For comparison, the typical growth rates of prices paid for office visits and major surgeries in study states without fee schedules were about 4–5 percent per year from 2002 to 2004 and from 2007 to 2009 (Figures B.1 and C.1).

2004, fee schedule rates for office visits and physical medicine services were increased, while fee schedule rates for surgery were decreased. Following that change, the average prices paid for office visits and physical medicine increased nearly 30 percent, while the average price paid for major surgeries decreased about 40 percent from 2003 to 2005 (Figure D.12). In February 2006, Maryland increased fee schedule rates for neurological and orthopedic surgeries. The average price paid for major surgeries grew about 20 percent from 2005 to 2007.[5]

- Prices paid for services not covered by fee schedules grew more rapidly compared with services covered by fee schedules. For example, in Louisiana, the average prices paid for most types of services remained fairly stable from 2002 to 2012, as the fee schedule rates remained unchanged. However, for pain management injections, the average price increased 82 percent (Figure D.10). This may be related to the fact that many pain management injections were not regulated by fee schedule rates; instead they were determined under a *by report* method, which was based on factors such as payors' specific prevailing charges data, documentation submitted by medical providers, etc. Another example was Minnesota. Before 2010, many commonly used pain management injections were not covered by the state's fee schedule, and the average price increased nearly 50 percent from 2002 to 2009. This growth rate was more rapid compared with the price growth in other types of services that were covered by the fee schedule (Figure D.14). In October 2010, Minnesota updated its fee schedule and covered the pain management injections that were not regulated before. Following this change, the average price paid for pain management injections decreased nearly 40 percent from 2009 to 2011.

Illinois 2011 Fee Schedule Reform

- In September 2011, Illinois enacted new legislation that introduced a 30 percent decrease in the fee schedule rates across all types of services and discontinued its use of the 29 geo-zip areas for physicians and other providers in favor of four county-based regions. The prior 29 fee schedule rates ranged from a low of 115 percent above Medicare to a high of 219 percent above Medicare, a difference of 104 percentage points. This difference might create unintended incentives for providers to control revenue by moving the site of service. With the consolidation of the 29 geo-zip areas into the four county-based regions under the new fee schedule, the intrastate differences in fee schedule rates among regions in Illinois decreased noticeably. For example, for a common knee arthroscopy surgery (i.e., CPT 29881), the highest fee schedule rate among the 29 geo-zip regions was more than 100 percent above the lowest fee schedule rate before the 2011 reform. After the fee schedule change, the highest rate among the four regions was about 40 percent above the lowest rate. Therefore, one might expect the incentives to move the site of service would be undermined. This report captures the actual price changes at the state level under the new fee schedule.
- Following this policy change, the overall average price paid for professional services in Illinois decreased 24 percent from 2010 to 2012 (Figure 3). Furthermore, as of June 2012, the magnitudes of decreases in prices paid for most types of professional services were somewhat smaller than 30 percent (Table for

[5] For comparison, the growth rates of prices paid for office visits and physical medicine in the two non-fee schedule states neighboring Maryland, New Jersey and Virginia, were up to 4 percent per year from 2003 to 2005. For major surgeries, the growth rates were up to 6 percent per year from 2003 to 2005 and 4 percent per year from 2005 to 2007 in those two states (Figure D.17 and D.24).

Figure 3). For example, the average price paid for office visits decreased 25 percent from 2010 to 2012, and the decrease in average price paid for major surgeries was 23 percent. The only exception was neurological and neuromuscular testing services, where the decrease in average price paid was 34 percent from 2010 to 2012.

Figure 3 Illinois Trend in Professional Prices Paid by Service Group, 2002 to 2012

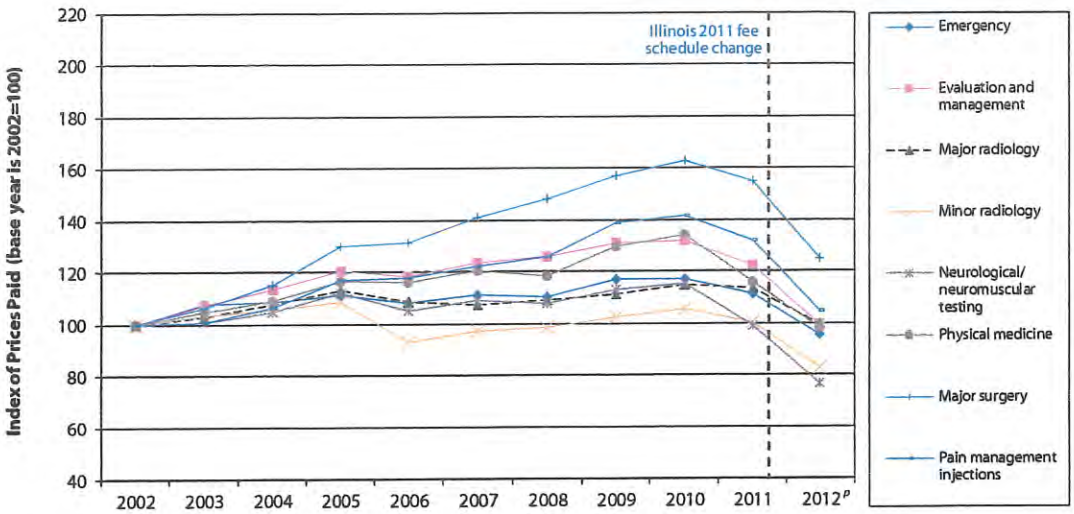


Table for Figure 3: Illinois Trend in Professional Prices Paid by Service Group, 2010 to 2012

	Overall	Evaluation and Management	Physical Medicine	Major Surgery	Pain Management Injections	Major Radiology	Minor Radiology	Neurological/ Neuromuscular Testing	Emergency
% change in prices paid from 2010 to 2012	-24%	-25%	-27%	-23%	-26%	-13%	-22%	-34%	-18%

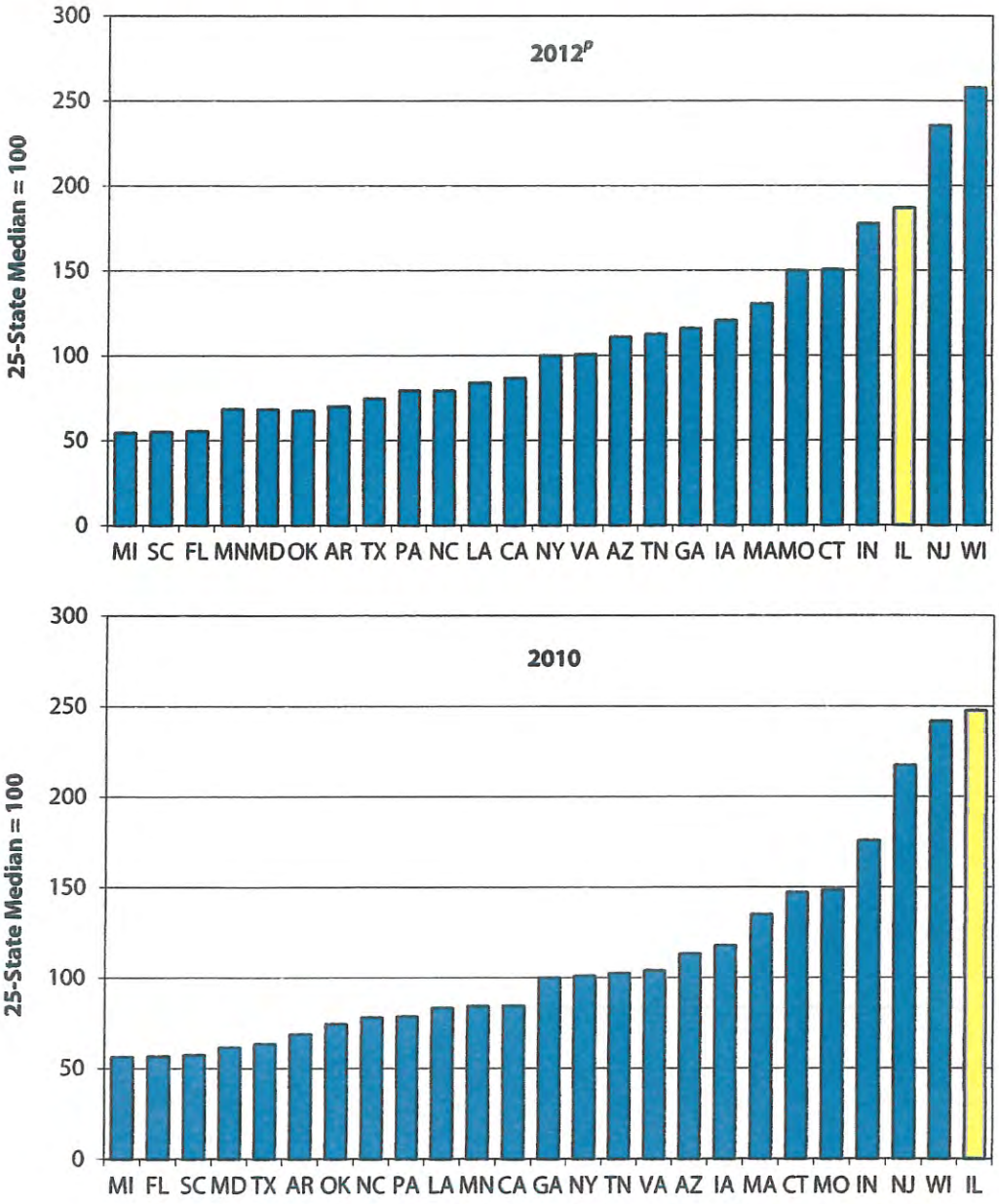
Note: For price index values for each year, see Figure D.8.

Special notation: ^{P} We use the notation *p* to indicate that the 2012 numbers are preliminary results based on half-year price data through June 30, 2012.

- Before the 2011 fee schedule change, the average price paid for major surgeries in Illinois was nearly two and a half times the 25-state median, the highest of the 25 states in 2010 (Figure 4). This was likely associated with the relatively higher pre-reform fee schedule levels for surgeries in the state. According to another WCRI study, *Designing Workers' Compensation Medical Fee Schedules*, the pre-reform fee schedule rate for major surgeries in Illinois was 443 percent above the Medicare rate on average in the state, one of the highest nationwide (Fomenko and Liu, 2012). After the 2011 fee schedule reform, the average price paid for major surgeries in Illinois was nearly two times the 25-state median in 2012, still among the highest of the study states.
- In contrast, for office visits, the average price paid for office visits in Illinois was 14 percent higher than the 25-state median in 2010 before the 2011 fee schedule change (Figure 5). According to *Designing Workers' Compensation Medical Fee Schedules*, the pre-reform fee schedule rate for office visits in Illinois was 33 percent above the Medicare rate in the state; the national median fee schedule rate for office visits

was 29 percent above the Medicare rate (Fomenko and Liu, 2012). After the 2011 fee schedule reform, the average price paid for office visits in Illinois became 18 percent lower than the 25-state median in 2012.

Figure 4 Changes in Interstate Ranking for Illinois on Price Index for Major Surgeries



Special notation: ^{p} We use the notation *p* to indicate that the 2012 numbers are preliminary results based on half-year price data through June 30, 2012. Note that the half-year data likely provide a reasonable approximation for interstate ranking across states in 2012, based on results for earlier years from the prior editions of this study (see Figure TA.1).

Comparison of Profit Provision and IRR

– *WCRB vs WCRIB of MA*

WISCONSIN

		10/1/2004	10/1/2005	10/1/2006	10/1/2007	10/1/2008	10/1/2009	10/1/2010	10/1/2011	10/1/2012	10/1/2013
1.	Loss and Loss Adjustment Expense	79.2%	79.3%	79.5%	79.8%	80.0%	79.8%	78.5%	79.0%	78.3%	78.4%
2.	Commissions	7.6%	7.8%	7.6%	7.5%	7.2%	7.2%	7.4%	7.3%	7.6%	7.7%
3.	Other Production Expense	3.8%	3.9%	3.9%	3.7%	3.6%	3.5%	3.7%	3.7%	3.8%	3.8%
4.	General Expense	4.6%	4.2%	4.2%	4.2%	4.4%	4.7%	5.6%	5.2%	5.5%	5.3%
5.	Miscellaneous	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
6.	State Premium Taxes										
	A. Tax 1 on Collected Premium	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	B. Tax 2 on Written Premium	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	C. Tax 3 on Collected Premium	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7.	Profit and Contingencies	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
	Total Provisions (Items 1 through 7)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
8.	Policyholder Dividends	7.7%	5.7%	6.5%	6.7%	7.8%	9.5%	10.8%	10.9%	11.2%	11.6%
9.	Uncollectible Premium	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
10.	Reserve-to-Surplus Ratio	2.58	2.62	2.56	2.57	2.48	2.36	2.27	1.92	1.90	1.93
11.	Post-tax Return on Assets	3.2%	3.8%	4.4%	4.4%	3.5%	2.8%	2.6%	2.6%	2.0%	1.9%
12.	Internal Rate Of Return	5.63%	8.11%	8.91%	9.00%	5.93%	3.82%	2.95%	2.89%	1.39%	1.25%

MASSACHUSETTS

		9/1/2003	9/1/2005	9/1/2006	9/1/2007	9/1/2008	9/1/2009	9/1/2010	9/1/2011	9/1/2012	9/1/2013
13.	Profit and Contingencies	-1.60%	0.93%		-3.23%	-4.27%		5.51%	5.96%	6.82%	
14.	Internal Rate Of Return	10.30%	9.68%		10.74%	9.08%		10.22%	9.50%	8.86%	

Note: Massachusetts information from 'https://www.wcribma.org/mass/Actuarial/rateFiling.aspx'
Massachusetts policyholder dividends range from 0.4% to 1.1% for the above rate filings.

Milliman

Diversified
Insurance Solutions
Property & Casualty · Benefits

- Employee Benefits
- Business Insurance
- Personal Insurance
- Retirement Services
- Executive Life & Disability

My name is Raymond "Skip" Hansen.

I am the co-founder of Diversified Insurance Solutions in Brookfield.

I, along with my 63 associates, consult with for profit and non-profit employers on their risk management and insurance needs including workers compensation.

Independent agents, like myself, have a unique view of the true costs of workers compensation insurance because we not only sell it, we buy it for our agencies.

Despite the fact Wisconsin has one of the best workers compensation systems in the country workers compensation medical costs are out of control.

This bill provides the legislature a unique opportunity to cut costs for employers across Wisconsin and help grow our economy.

I support this bill and here is why:

1) The fee schedule provision contained in this bill will bring our medical reimbursement rates in line with the rest of the nation.

2) Wisconsin is soon to be one of only 5 states with no limits on the amount healthcare providers can charge for workers compensation medical procedures and no ability for employers to help direct the employees care.

3) At the end of 2011 68.3% of every workers compensation claim dollar was consumed by medical costs. 25 years ago that percentage was 47.3%.

4) Employers have done a good job in reducing claim frequency. Reduced claim frequency should have resulted in reduced workers compensation costs for employers. This has not occurred.

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5) As a line of business most insurers loose money writing workers compensation insurance that is not be offset by investment income. To help offset these losses most insurers have reduced dividends paid to employers in the last two years.

12 years ago Diversified had an employee severely injure her leg in a fall at the office. We also had an employee sustain a similar leg injury playing sports outside of work. When we examined the medical bills paid by the workers compensation insurer to the bills paid by the health insurance insurer virtually all the workers compensation charges were higher.

Is it right health care providers can over charge Wisconsin employers for workers compensation health care services – the same employers whom we rely on to grow our economy and provide family supporting jobs in Wisconsin?

As you consider this bill I ask you to think about whether this is right.

I thank the members of the committee for the opportunity to appear before you today and ask for your support of this bill.

Wisconsin Independent Businesses Inc.
The voice of independent business in state government

Testimony submitted on Tuesday, February 4, 2014 before the

Senate Judiciary and Labor Committee and the Assembly Labor Committee

in support of

2013 Senate Bill (SB) 550/Assembly Bill (AB) 711

Chair Grothman, Chair Knodl, committee members, my name is Brian Dake, Legislative Director for Wisconsin Independent Businesses. On behalf of our small, independent business members, I am here to testify in support of 2013 Assembly Bill (AB) 711 and 2013 Senate Bill (SB) 550.

Every year we survey our members on legislative issues of interest and concern to guide our lobbying efforts. Last fall, we asked our members for their input and feedback on Worker's Compensation. Specifically, we asked for their responses to the following questions:

1. How much they paid in Worker's Compensation insurance premiums in 2012?

2. What changes to the state's Worker's Compensation program would they recommend to reduce the cost of Worker's Compensation insurance for small, independent businesses?

3. What changes to the state's Worker's Compensation program would they recommend to reduce waste, fraud and abuse?

Based on the survey responses, we offer the following general observations:

1. Worker's Compensation insurance is a major expense for small, independent businesses. A majority of the survey respondents paid more than $10,000 in Worker's Compensation insurance premiums in 2012.

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It is worth noting that this is not an optional expense for small businesses. By law, businesses who employ at least one worker on a full or part-time basis and who pay gross, combined wages of $500 or any calendar for work done in Wisconsin must carry Worker's Compensation insurance.

2. Medical costs are driving up the cost of Worker's Compensation insurance. By a significant margin, survey respondents believe medical cost containment measures are needed to control the rising cost of Worker's Compensation insurance.

3. Worker's Compensation-related fraud exists. Survey respondents believe rooting it our will require greater state government oversight.

WIB supports the unanimous recommendations of the Worker's Compensation Advisory Council (WCAC) set forth in AB 711 and SB 550. In particular, we support:

1. Reimbursement of medical providers for the treatment of Worker's Compensation related injuries on a fee schedule based on group health insurance rates.

   Credible research indicates that adoption of this provision would reduce the cost of Worker's Compensation insurance for Wisconsin employers by more than $100 million annually.

2. Authorize DWD to request the Department of Justice to assist in an investigation of suspected fraudulent activity related to worker's compensation. If, based on the investigation, DWD has a reasonable basis to believe that theft, forgery, fraud, or any other criminal violation has occurred, DWD must refer the matter to a local District Attorney or DOJ for prosecution.

   Worker's Compensation fraud cases are currently handled at the local level through the District Attorney's Office. Worker's Compensation is a state-administered program and state level prosecution of Worker's Compensation is warranted.

In conclusion, we respectfully ask for your support of this legislation. Thank you in advance for your consideration.

AMERICAN
INSURANCE
ASSOCIATION

February 4, 2014

WI AB 711 & SB 550 Statement

The American Insurance Association (AIA) supports a healthy and vibrant workers' compensation system and marketplace in Wisconsin.

Wisconsin's time-honored, agreed-to bill process for workers' compensation legislation, by which labor and management representatives on the Workers' Compensation Advisory Council (WCAC) confer to develop mutually approved legislation, has functioned productively and effectively for more than 100 years; we trust that this entity will continue its mission for the foreseeable future and look forward to working with its members.

Of urgent interest however is that based upon reported data, Wisconsin's medical costs are higher and growing faster than any other state. Notably, Wisconsin is one of only five states without a provider medical fee schedule (Missouri, New Jersey, Iowa and Virginia are the remaining four). The Workers' Compensation Research Institute (WCRI) has repeatedly documented that medical costs in states without fee schedules are not only higher, but that they accelerate faster than costs in states with fee schedules, particularly those states with Medicare-based fee schedules. WCRI's Medical Price Index for Workers' Compensation, released in June 2013, shows Wisconsin's costs were the highest of the 25 states surveyed (including the five states without any fee schedules), that physician service prices paid were more than twice the median of those in study states with fee schedules and about 50 percent more than those in the study states without fee schedules. WCRI also found medical cost trends to be most adverse in Wisconsin, with cost growth more rapid than in any other of the study states – a 53 percent increase over the past 11 years.

In response to this increasing cost trend, we strongly recommend the adoption of a medical provider fee schedule based on Medicare's Resource Based Relative Value System (RBRVS) with a uniform conversion factor applicable to all covered services (with no special carve-outs). Using the Medicare reimbursement standard creates numerous benefits, the most important being that the RBRVS's basis, developed by and unique to Medicare, is universal and incorporates a sound policy for valuing different medical disciplines. Multiple conversion factors destroy the internal rationality of the RBRVS and will politicize fee schedule policy, as each medical discipline lobbies for a better deal than others, but all at the expense, literally, of the workers' compensation system and the employers who foot the bills. Medicare also is updated regularly, so treatment codes are always current. Although states which have implemented Medicare based fee schedules can and sometimes do customize their systems for specific reasons, fewer state resources are necessary to implement and maintain an RBRVS system than are needed to design, implement and maintain a "home grown" fee schedule.

Secondly, with respect to the issue of physician dispensed pharmaceuticals, a growing cost-driver in workers' compensation systems across the nation, WCRI research, released in 2012, showed a notable increase in the prevalence and cost of physician dispensing in Wisconsin.

Among 23 states studied, in Wisconsin from 2008 to 2011, the amount of pharmaceuticals dispensed by physicians increased from 8 to 11 percent, a 38 percent increase! For the same time period, the amount of dollars paid to physicians for dispensed pharmaceuticals increased from 5 to 15 percent, a 300 percent increase! These are alarming signals which indicate that attention is warranted to fashion appropriate solutions. Hence, we also urge the adoption of a pharmaceutical fee schedule (for physician dispensed drugs) based upon a drug's (original manufacturer's) average wholesale price (National Drug Code or NDC), plus a modest dispensing fee, as has been recently done in IL (2012), IN (2013), and MI (2012), in order to effectively address this emerging cost driver in the state's workers' compensation system.

We believe it is important to address these duo cost driver trends with proven tools which are being utilized successfully in other states, for the benefit of employers and workers alike. As the legislature pursues the subject of further reforms to the state's workers' compensation system we encourage its members to consider the adoption a medical fee schedule based upon some percentage of reimbursement for Medicare services and to also implement a pharmaceutical fee standard similar to what has been recently adopted in neighboring states.

The Wisconsin workers' compensation system can be improved by reducing unnecessary costs while still providing fair benefits and high quality medical care. We are pleased to offer our joint support and resources to achieve that goal.

Thank you.

Stephen C. Schneider

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MEDICAL COLLEGE OF WISCONSIN

Office of Government and
Community Relations

TO: The Honorable Members of the Senate Committee on Judiciary and Labor
The Honorable Members of the Assembly Committee on Labor

FROM: Daniel DeBehnke MD, MBA
Chief Executive Officer, Medical College Physicians
Senior Associate Dean for Clinical Affairs
Medical College of Wisconsin

Marion R. Livingstone, MBA, CPC
Executive Director, Clinical Practice Services
Medical College of Wisconsin

DATE: February 4, 2014

RE: Testimony in Opposition to Assembly Bill 711 and Senate Bill 550, related to various changes to the worker's compensation law

Good morning Co-Chairs Grothman and Knodl, members of the Senate Committee on Judiciary and Labor, and members of the Assembly Committee on Labor. Thank you for hearing public testimony today related to Assembly Bill 711 and Senate Bill 550, legislation related to changes to Wisconsin's worker's compensation law.

We are here today representing the Medical College of Wisconsin's (MCW) strong opposition to the provision creating an arbitrary fee schedule equaling 110% of average regional group health rates, as well as the provision to reduce the current standard deviation reimbursement limit for disputed claims from 1.2 to 0.70 standard deviations above the mean for each service.

By now, you have likely heard from numerous stakeholders as to the rationale for-and-against the creation of a fee schedule. MCW opposes a fee schedule for the numerous reasons already mentioned, which likely included the following data:

- Wisconsin is the fastest state in the nation to successfully return its injured employees to work.
- Worker's Compensation Rates have held steady, only increasing a total of 0.65% over the last five years, and actually decreased 1.73% last year, and
- Wisconsin's average medical claim costs are below the national average.

These data points are truly a testament to the effectiveness of our state's overall health care delivery system. Today, however, we would like to focus our comments around the

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administrative costs associated with providing care within the worker's compensation program. In short, this legislation doesn't take into account the significant financial and administrative burdens our clinical practice professionals' shoulder in providing this critical care:

- Staff within MCW's Department of Clinical Practice Services, which is responsible for financial reimbursement processing, expends triple the time and labor on worker's compensation claims versus other medical claims. Additionally, medical providers and their office staff generally see a tripling of workload related to worker's compensation visits due to increased accounting, paperwork, and case-management.
    - These significant administrative burdens partially contribute to the necessity for higher worker's compensation fees.

- MCW's average commercial payer reimburses within 25 days; versus 80 days for worker's compensation payments. By nearly tripling the payment term, these payment delays create significant liquidity and cash flow challenges.
    - Longer payment terms effectively result in a reduction of our rate of return, which also necessitates higher worker's compensation fees.

- **WC Litigation**: 10% - 15% of MCW patients receiving worker's compensation care are involved in litigation relating to their injury. Since MCW does not receive reimbursement while these litigated cases are pending, reimbursement for our medical services often takes between one to three years. Again, these payment delays create significant liquidity and cash flow challenges.
    - Many times our physicians are also required to provide expert medical testimony for these litigated cases. This requirement further reduces clinical productivity – taking our physicians away from the care of our patients.
    - Again, these are significant reductions in rate of return, and necessitate higher worker's compensation fees.

Finally, without addressing the current administrative and payment inefficiencies referenced above, health care providers may be unable to continue to serve medical care to patients injured on the job. Like other government programs such as Medicaid and Medicare, health systems and providers may decide to close their doors to this population.

From injury to resolution, Wisconsin has one of the best worker's compensation programs in the nation. Yet this proposal seeks to dramatically change the structure of the program by forcing a fee schedule on the providers without an in-depth study of the issue or the consequences of the changes. MCW respectfully urges you to remove the fee schedule to allow for a more thorough review of not only the payment costs but administrative burden and the overall injury rate impacting Wisconsin workers. Please vote against this proposal, or amend the bill to remove these harmful provisions.

Thank you for your time and consideration. We are available if you have any questions.