



NEWS

THE NEWSLETTER OF THE AMERICAN ASSOCIATION OF STATE COMPENSATION INSURANCE FUNDS

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INSIDE:

PRESIDENT'S LETTER
PAGE 2

INCARCERATION AND WC BENEFITS
PAGE 3

MEASURING COST SAVINGS IN
HEALTHCARE
PAGE 4

AROUND AASCIF
PAGE 7

The AASCIF News is published quarterly by the American Association of State Compensation Insurance Funds for its members and for others interested in state workers' compensation systems. This issue was edited by Michael Bourque of Maine Employers' Mutual Insurance Company.

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A Case for Ergonomics

A Different Approach in Washington State: Is Hazard-Based Rule Better Than Injury-Based Rule Proposed Nationally?

BY ELLIOTT FURST, SENIOR COUNSEL
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WASHINGTON STATE ATTORNEY GENERAL

"As the Director of the National Institute for Occupational Safety and Health (NIOSH), I am very pleased to provide testimony on the topic of workplace hazards and work-related musculoskeletal disorders (MSDs)... The bottom line is that we know enough now to prevent or reduce the severity of many of these disorders, and the Washington State Proposed Ergonomics rule is an effective and scientifically valid way to do so." Linda Rosenstock, MD, MPH (testimony)

"The bottom line is that we know enough now to prevent or reduce the severity of many of these disorders..."

NIOSH Director
Linda Rosenstock, MD

In May of this year, the Washington State Department of Labor and Industries (L&I) adopted a workplace ergonomics rule to establish requirements



for employers to identify workplace hazards that cause work-related musculoskeletal disorders (WMSDs) and to reduce employee exposure to these hazards. The rule was adopted pursuant to the Washington Industrial Safety and Health Act (WISHA), Washington's statute as a state plan as authorized by the federal Occupational Safety and Health Act (OSHA). To date, California is the only other OSHA state plan to adopt regulations in this

area. OSHA has proposed national rules, but they have not yet been adopted. This article explains some of the reasons why Washington adopted this rule.

Ergonomics is the science and the practice of designing jobs or workplaces to match the capabilities and limitations of the human body.

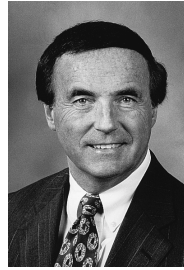
CONTINUED ON PAGE 11

PRESIDENT'S MESSAGE

BY JOHN T. LEONARD

PRESIDENT AND CEO, MAINE EMPLOYERS' MUTUAL INS. CO.

Well, it's time for me to pass the baton to Ken Bollier of California who now becomes President of our AASCIF organization. This is my last chance to share thoughts with you and it seems appropriate to reflect upon the current state of our marketplace.



The past two years passed far too fast, but a swing in the marketplace demonstrates the volatility in our line of work. During 1998, we were in the middle of a soft market with traditional carriers buying market share and hoping that the day of reckoning was a distant problem. Surprise! The industry quickly hammered itself into one of its worst years as the 1998 accident year combined ratio climbed to 127 percent only to be topped by 1999's AY of 134.6 percent, according to NCCI's most recent information.

Reality seems to have set in this year as many state funds find premiums swelling with the return or addition of accounts who, once again, have been abandoned by our competitors. As more traditional insurers react to their red ink, the value that our companies bring to the marketplace is clear.

Throughout the country, we continue to be a haven of stability for policyholders who recognize and appreciate the dedication and expertise that our employees bring to their accounts. Our collective performance has never been better with our insurance products available and affordable and the welfare of the injured workers intact.

This is a proud moment for my fellow CEOs and all of our employees. We will continue to be the stabilizing force in an otherwise unpredictable market that is driven by the elusive pursuit of profit. Our mission is clear and our performance is strong—we have a bright future!

In conclusion, I want to thank the members of the Executive Committee for their tireless efforts of the past two years. I think I speak for all the CEOs in recognizing the enormous contribution that Paula Saabye has made to this organization in her role as Secretary/Treasurer. Paula not only fulfilled the responsibilities of her office but became a very close friend of all of us within this association. A special word of thanks also to Karen Flaherty who helped us keep the books under control and to Michael Bourque, who has been instrumental in editing this newsletter which is an important communication vehicle for AASCIF.

Ken, I wish you nothing but the best in your new role as our President. I know from experience that the team stands ready to support you.



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Does Incarceration terminate WC benefits?

The Answer: It Depends on Your Jurisdiction, the Term and Other Factors

By JAMES O'CONNOR AND JEFFREY RITTER
NEW YORK STATE INSURANCE FUND

Many jurisdictions have addressed whether an injured employee is ineligible to receive workers' compensation benefits for any period during which he or she is incarcerated.

In New York, the rule barring workers' compensation benefits to incarcerated individuals has its origins in a statute (section 79-a of New York's Civil Rights Law) deeming as "civilly dead" a person sentenced to imprisonment for life.

New York's courts have barred compensation, however, in a broader range of cases than those only involving individuals incarcerated for life.

The New York rule was articulated by its Appellate Division, Third Department in *Bilello v. Eckert Co.*, 43 AD2d (1974). *Bilello* involved a laborer who received benefits for a head injury. Following the laborer's conviction for murder, the New York Workers' Compensation Board held him ineligible for further compensation. The Board determined that compensation should cease as of the date of the laborer's arrest, finding any loss of earnings after that date to have been due to incarceration and not to his head injury.

LAW COMMITTEE

The Third Department held that ineligibility for benefits should begin only upon the date of conviction absent a finding that the laborer was no longer disabled before that date. The Third Department concluded that to withhold benefits from an incarcerated defendant awaiting trial presented a constitutional question of equal protection under the law since it seemed to premise the right to compensation on whether the claimant could post bail.

The issue of the scope of ineligibility for benefits during periods of incarceration has also been addressed by New York's highest court, the Court of Appeals. In *Tallini v. Martino and Son*, 58 NY2d 392 (1983), the claimant, who had been classified as having a work-related permanent partial disability, was committed by an Italian court to a hospital for the criminally insane for a minimum of 10 years. The claimant had fatally shot two people and wounded a third. The Court of Appeals held that the commitment for a minimum term of years was not the equivalent of a criminal conviction and should not bar him from receiving benefits for his permanent disability.

Some states have enacted legislation to disqualify an incarcerated employee from receiving workers' compensation benefits. Legislation has been proposed in New York but has not yet been

adopted.

Washington originally passed such legislation in 1961. Revised Code of Washington (RCW) §51.32.040(3)(a), as most recently amended in 1995, provides as follows: Any worker or beneficiary receiving benefits under this title who is subsequently confined in, or who subsequently becomes eligible for benefits under this title while confined in, any institution under conviction and sentence shall have all payments of the compensation canceled during the period of confinement. After discharge from the institution, payment of benefits due afterward shall be paid if the workers or beneficiary would, except for the provisions of this subsection (E), otherwise be entitled to them."

In the consolidated cases of *Cain v. Department of Labor and Industries* and *Willoughby v. Department of Labor and Industries*, a Superior Court Judge (Washington's court of original jurisdiction) held RCW §51.32.040(3)(a) to violate state constitutional protections of due process of law and equal protection under the law in its application to two imprisoned claimants. *Cain* is an unmarried prisoner serving a 60-year sentence based on multiple convictions. He sustained the loss of three fingers on his right hand while working with a metal shear machine in a correctional industry plant. *Willoughby*, also unmarried,

CONTINUED ON PAGE 16

Measuring Savings in Healthcare

Continuum of Care Models Can Achieve the “Right Care at the Right Time”

By BRIAN J. BOON

ALBERTA WORKERS' COMPENSATION BOARD

Like many industries, workers' compensation insurance experiences business cycles. Most insurers have survived the financial crisis of the late 1980's and early 1990's, and in fact have rebounded with stellar financial performance. This rebound comes as a consequence of tremendous fund investment performance in the market and as a consequence of various cost containment efforts. On the cost side of the equation, healthcare costs are often cited as one of the primary targets for cost containment and therefore, intervention. This article will attempt to review and describe how traditional approaches to managing healthcare costs may no longer be appropriate, as many of those traditional direct costs may have been “squeezed out” already. Furthermore, it is sub-

mitted that “integrating” providers with one another and the insurer may compress time and, therefore, improve results along the chain of events post-accident. Collapsing time along the chain of events and ensuring each step in the service continuum is successful will drive out costs and enhance the value equation (improved outcomes for cost). Lastly, monitoring this effort and translating it into cost saving analysis can be measured. However, insurers

are only beginning to assess and examine cost savings in this new approach to true service integration.

Traditional Cost Savings Approach In Healthcare Management ¹

In the United States, between 1980 and 1993, the average annual growth in workers' compensation healthcare expenditures were 13 percent compared to 10 percent growth in national healthcare costs during the same period (Eccleston, 1996). In the period from 1981 to 1991, healthcare costs grew from less than 30 percent of total compensation to almost 40 percent (AWCBC, 1993). In some Canadian and U. S. jurisdictions these cost trends were experienced during a time of poorer than expected market returns and in an era of increasing claim costs. These factors contributed to a financial crisis in the compensation industry. This experience caused many insurers to focus on managing healthcare better or more precisely, cost containment strategies.

The first and earliest example of a cost containment exercise was the simple development and implementation of fee schedules for providers and hospital services. Fee schedules created the opportunity to contain variability in provider billings for services and imposed upper limit restrictions on bills submitted, therefore, contained costs. Further, based on the frequency of the type of service rendered, the insurer began to understand what providers and what procedures were driving up

costs in the system. Overall, the true effects of this approach were equivocal. Durbin and Appel (1991) determined in their study that scheduling the effects of this fee development model decreased medical costs anywhere from 3.5% to 5.4%. However, Boden and Fleischman (1989) found no correlation to medical cost reduction as a consequence of fee schedule development. It was observed by participants in the industry that this containment effort resulted in the “squeezed balloon” phenomena where healthcare expenditures surfaced in another cost category due to “creative” provider practice strategies directed to maintain their income (Roberts, 1994). Interestingly, none of the aforementioned approaches explicitly reference outcomes for dollars expended. Therefore, many strategies to manage costs resulted in another cost category absorbing the expenditure shift as a consequence of the providers income maintenance efforts.

Subsequent efforts to maintain costs include relying on a “discounted fee” schedule where providers are corralled into accepting predetermined and reduced compensation for specific services – often done through negotiation, either directly with the insurer or via a managed care company. Sometimes, suppliers of service (healthcare providers) would group together and offer a discounted fee in order to gain more of the market share for workers' compensation business. In either case, the consequence has been in some instances less than ideal. Providers who were highly competent and highly sought by patients and payors alike began to

CLAIMS MANAGEMENT

mitted that “integrating” providers with one another and the insurer may compress time and, therefore, improve results along the chain of events post-accident. Collapsing time along the chain of events and ensuring each step in the service continuum is successful will drive out costs and enhance the value equation (improved outcomes for cost). Lastly, monitoring this effort and translating it into cost saving analysis can be measured. However, insurers

see workers' compensation as a high maintenance effort with low return in terms of pay and therefore refused to deal with the workers' compensation case. In other instances the insurer would attract those providers who are more focused on market share rather than results. Additional administrative practices utilized to control healthcare costs included medical billing reviews, capitation-based reimbursement strategies, and "volume discounts" by way of example.

In the absence of any systematic healthcare management approach, all of these strategies are likely to benefit the insurer. In fact, many insurers have migrated from one strategy to the next in an effort to squeeze out more dollars out of the healthcare component of the compensation system. The risk is that little effort has been expended to look at the effects beyond discrete healthcare cost categories. It is important that the insurer explore and begin to understand the additional effects that a straight cost containment strategy may have on the rest of the business. For example, has the average duration of lost time claims gone up as a consequence of a simultaneous insurer-based cost containment effort? This event would lead to additional research and questions regarding the true effectiveness of the cost containment strategy. Following a contracted price reduction is the provider more or less compliant with the overall provision of service? While price in negotiations is extremely important, the blind pursuit of a price reduction may result in an increase in experienced "net landed cost" (Stern, 1999). The insurer wants the lowest net landed cost and in our business this means 'the

right service at the right time', 'no hassles', and service execution by providers that results in outcomes, all at a reasonable cost. In other words, you may have gotten the best price but in fact it is really costing you more and will surface in cost categories beyond those reflected in healthcare costs, such as administrative costs or other indemnity costs. The price may have come down, but the net landed cost to the insurer is actually up.

Beyond Strict Cost Containment – More Sophisticated Healthcare Management Approaches

In addition to the pure focus on cost containment as described above, more sophisticated strategies have been utilized in the workers' compensation insurance industry. Development and implementation of managed care principles and services in the U.S. market has been embraced because insurers have recognized some of the shortcomings of the straight cost containment orientation. In many jurisdictions, managed care services exist in a mandated or a regulated environment. In a mandated environment, managed care requires the insurer to provide healthcare to injured workers through a managed care arrangement. In a regulated managed care environment, managed care organizations must meet required elements of regulation for certification. Eccleston (1995) identified that 26 of 51 U.S. jurisdictions have an explicit policy for regulating the use of managed care plans.

The primary focus for managed care is to offer timely healthcare intervention within a comprehensive disability man-

agement strategy that combines the framework of indemnity cost containment and provider management. One of the first published managed care research pilots was initiated in Florida in 1990. That pilot demonstrated a 58 percent reduction in the average and direct workers' compensation costs (wage loss plus healthcare) for those participants who received healthcare services compared to a control group receiving a regular fee for service schedule (Appel and Borba, 1994). In another study, a protocol driven managed care model within workers' compensation found those approaches that encouraged early intervention increased healthcare costs related to treatment, however, the overall cost was less because cases resolved quickly (Matheson, 1995). In the Canadian experience, managed care approaches have not been explicitly utilized because of the predominant public healthcare system which is regarded as an icon to Canadian society. In Canada anything managed by an insurer is not only not understood but initially is not trusted. However, Canadian insurers have taken advantage of reform efforts in the public healthcare system and have introduced various managed care principles to address the issue of timely and appropriate service.

Another typical and common feature to a managed healthcare approach includes the identification of preferred providers, or authorized providers. The theory is that directing injured workers to providers who understand the system, specifically occupational rehabilitation within the framework of compensation insurance, will result in early intervention and outcome-based

CONTINUED ON PAGE 10

AROUND AASCIF



Around AASCIF is a regular feature of the AASCIF newsletter. It briefly covers items of interest submitted by AASCIF members. To ensure that your organization is included, send information to Ron Christensen at the California State Compensation Insurance. Fund 1275 Market St, Ste 1500, San Francisco, CA 94103 or e-mail to rchristensen@scif.com. He can be reached by telephone at (415) 565-1065 or by fax at (415) 703-7028.

Colorado

Fireman's Chosen: Pinnacol Assurance announced in late summer that it has reached an agreement with Fireman's Fund to offer other states coverage to Colorado policyholders. The partnership between Fireman's Fund and Pinnacol Assurance will allow Pinnacol to write workers' compensation insur-

ance in 45 states.

Pinnacol Assurance will select and price accounts based on Fireman's rates, and retains the ability to bind coverage and bind a quote within 48 hours. The partnership is non-restrictive; 100 percent of the policy risk remains with Pinnacol Assurance. Claims are simply administered by Fireman's Fund, rated A++ (Superior) by A.M. Best and based in California.

New Communications Director: Sandy Morris, formerly of Royal & SunAlliance Insurance Group, has joined the Pinnacol Assurance team. As communications director, her responsibilities include directing all department activities including public relations, marketing and employee communications

Maine

MEMIC Indemnity: New Hampshire-based MEMIC Indemnity Company, the new wholly-owned subsidiary of Maine Employers' Mutual Insurance Company begun writing insurance in September and was projected to reach more than \$2 million in premium in December. This is on-target with projection of \$6 million in its first year.

Montana

New Executive Team Named: In 2000, Montana State Fund has undertaken a comprehensive organizational redesign. The process is designed to fur-

ther enhance the company's customer focus, improve profitability, and introduce service delivery processes that are effective and efficient. The new organizational structure, which "went live" in early November, is built around six Operations business teams. These teams, each representing a segment of the business with assigned agency partners, will provide complete service to their customers including underwriting, claim management, and expanded loss control and marketing. Supporting the teams are Operations Support and Corporate Support. The new organizational structure is flatter than the old organization with fewer management staff. It focuses instead on employee empowerment and greater decision-making responsibility.

As part of this redesign, President and CEO Carl W. Swanson, has announced the members of his new executive team. This executive team assumed their new positions in early November. Mark Barry is the new Corporate Support Vice President. Barry has been with the State Fund since 1994, most recently as Senior Vice President Administration and Finance. Nancy Butler has been named the State Fund's General Counsel. She has been with State Fund since 1984, most recently as Vice President of the Legal Department. The new Operations Vice President is Laurence Hubbard. Hubbard originally joined the State Fund's Legal Department as a staff attorney in 1989. Hubbard has also served as Underwriting Vice President and Underwriting Manager. Jill Olson is State Fund's new Operations Support Vice President. Olson joined the State Fund in 1998 and previously served as Internal Auditor. Linda Goan continues as Special

Assistant to the President. Goan has served as Special Assistant to the President and as the President's Executive Assistant at the State Fund since 1994.

Nevada

Policyholder Website: Employers Insurance Company of Nevada policyholders now have secure, 24-hour access to their workers' compensation policy and claim information through EICN's new "E-Access for Policyholders" website at the internet address: www.policyinformation.com. The website gives policyholders confidential access through security software that provides authentication, access control and authorization of all users. Policyholders will be able to review detailed workers' compensation claims data, file claims on-line, locate network medical providers and much more. Employers Insurance Company will introduce additional on-line product and service offerings to its policyholders, agents and brokers in the near future.

Fraud Software: EICN has expanded its efforts to eliminate by installing Vericomp, a fraud and abuse detection system for workers compensation. The company cited Vericomp's use of the same advanced neural network detection capability that has successfully reduced credit card fraud losses by 20 percent to 50 percent. Vericomp, developed by HNC Software, Inc., continually monitors every claim over its entire life. It achieves accuracy by applying a neural network model to identify abuse.

New York

NYSIF Begins "Global Case Management": NYSIF has started Global Case Management (GCM) and announced its participation in a select study and training program for the treatment and prevention of chronic lower back pain. Under GCM, NYSIF nurses work directly with claims teams as full-time, on-site resources to establish early intervention programs and monitor treatment for injured workers. NYSIF is hiring nurses to expand GCM statewide.

NYSIF also is part of a study that includes a unique multi-disciplinary training program for treating lower back pain. NYSIF nurses completed training with the Occupational & Industrial Orthopaedic Center Model Clinic, part of the Hospital for Joint Diseases Institute of Ergonomics and Biomechanics at New York University, for the program.

Investment Diversification: NYSIF can now diversify its portfolio by investing in a wider range of stocks and bonds following the signing of Governor George E. Pataki's program bill that passed both houses of the State Legislature last summer.

Technology at Work: NYSIF is now using laptops for its field services, hearing representatives and audit personnel. The laptops give field staff real-time information to crucial data and help speed delivery of a greater variety of services. Hearing representatives use

CONTINUED ON PAGE 8

Around AASCIF

CONTINUED FROM PAGE 7

laptops along with a voice recognition software to dictate hearing notes, eliminating claims processing delays and costly transcription services.

Oklahoma

Fund Issues Record Dividend: The Oklahoma State Insurance Fund recently completed distribution of approximately \$30 million in dividend payments to 18,121 policyholders. The dividend is believed to be an unsurpassed refund of workers' compensation premiums to Oklahoma businesses. The dividend marks the third consecutive year a dividend has been paid by the State Insurance Fund. Dividends totaling more than \$52 million have been paid by the State Insurance Fund over the past three years.

Utah

Rating Affirmed: Workers Compensation Fund(WCF) received an A- (Excellent) rating affirmed by A.M. Best. According to Best, the rating not only reflects the company's financial strength, strong reserving practices and dominant market position, but its local presence and excellent reputation for a high level of service and profit sharing as well.

Name change: The Utah Legislature approved a name change for WCF. "Of Utah" has been officially dropped from

the end of Workers Compensation Fund. The change further insulates the state of Utah from any liability for WCF's operations and should also end the perception that WCF's name gives it a competitive advantage in the marketplace.

Streamlined Structure: To streamline operations, WCF has reorganized its underwriting department. The new structure has four distinct units to represent specific customers needs. The small business unit handles accounts under \$2,000. The middle market is responsible for accounts with premiums from \$2,000 to \$150,000. Multi-state manages middle market accounts with out-of-state exposures. Risk management handles all large accounts in excess of \$150,000.

Website updates: WCF and its subsidiary, Pinnacle Risk Management Services, launched new Web sites in October. The re-designed sites feature new interactive transactions. WCF customers are now be able to apply for insurance, complete audit forms and policy review forms, and change and add information to their online account. The sites can be accessed at www.wcf-utah.com and www.pinnaclerisk.com.

Legacy of Learning Continues: In its 11th year, WCF's Legacy of Learning program awarded more than 70 students scholarships of \$1,500. The students are spouses and dependents of workers who lost their lives in industrial accidents and were insured by WCF. The list of recipients for 2000

includes 14 families with more than one person receiving a scholarship. In addition to the Legacy of Learning scholarships, WCF awarded five graduate students pursuing degrees in industrial hygiene or safety and ergonomics "Safe Workplace" scholarships of \$2,000.

ManagedComp Agreement: WCF has entered into a software development project with ManagedComp of Waltham, MA. Under this agreement, WCF and ManagedComp are sharing costs to develop a 50 state capability for reporting claims via the Internet. ManagedComp is a premier workers' compensation company with operations around the country.

CANADIAN BOARDS

Alberta

Customer Connect: Following a successful pilot project, the Workers' Comp Board-Alberta undertook a realignment of staff to streamline processes for serving customers. This new way of connecting with its customers encompasses an alignment of staff from Claimant Services, Employer Services and Medical Services into teams. The teams are aligned by customer groups: industry, employer and severity/complexity of injury. This structure offers customers a single service point of contact with teams dedicated to specific

customer groups. Injured workers and employers will work closely with their teams as partners in reducing the impact of workplace illness and injury.

Partners in Injury Reduction (PIR) program: PIR is a workplace health and safety incentive program which is offered by WCB-Alberta in partnership with Alberta Human Resources and Employment and industry and safety associations. The WCB implemented a revised PIR program in 2000 that encourages even more employers to become involved. The new program creates heightened awareness around injury prevention and encourages more employers to build effective health and safety disability management programs. Enrollment in PIR remained relatively stable over the past few years, 1999 – 2101 employers, 1998 – 1958 employers, 1997 – 2059. However, changes to the program, coupled with an extensive marketing plan, saw participation rise approximately 35 percent to 3270 participants in PIR 2000. Early indicators are that participants in 2000 will enjoy refunds totalling \$12.4 million, compared to over \$2 million in 1999. The \$2 million in premium refunds were distributed to 438 employers, registered in the PIR program, for their excellence in workplace safety. 21 individual companies earned a total of \$1,555,579 and 11 groups, comprised of 417 small companies, earned a total of \$526,702.

AASCIF on the Internet

U.S. STATE FUNDS AND COMPANIES

Arizona	www.statefund.com
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Idaho	www2state.id.us/isif
Kentucky	www.kemi.com
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Maryland	www.iwif.com
Maine	www.memic.com
Minnesota	www.sfmic.com
Missouri	www.mem-ins.com
Montana	www.montanastatefund.com
New Mexico	www.nmmcc.com
New York	www.nysif.com
Ohio	www.ohiobwc.com
Oklahoma	www.okcomp.com
Oregon	www.saif.com
Pennsylvania	www.dli.state.pa.us/swif
Rhode Island	www.beaconmutual.com
South Carolina	www.state.sc.us/saf/
Texas	www.txfund.com
Utah	www.wcf-utah.com
Washington	www.wa.gov.lni
West Virginia	www.state.wv.us.bep
Wyoming	www.wydoe.state.wy.us

CANADIAN BOARDS

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WCB -Quebec	www.csst.qc.ca
SWCB-Saskatchewan	www.wcbsask.com
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WCB-NovaScotia	www.wcb.ns.ca
WCB- P.E. Island	www.wcb.pe.ca
WCHSB-Yukon	www.wcb.yk.ca
WHSCC-New Brunswick	www.whscc.nb.ca
WHSCC-Newfoundland	www.whscc.nf.ca
WCSIB-Ontario	www.wsib.on.ca

Savings in Healthcare

CONTINUED FROM PAGE 5

care management. This approach addressed insurers' concerns that at the earliest stage post-accident, some physicians and other providers did not embrace an appropriate intervention mindset in managing the case. As a consequence, some insurers restricted the choice and the ability to change providers for the injured worker. In other cases the employer or insurer is allowed to select a provider or institute a change of providers without restriction. Again, the results of these efforts in reducing healthcare costs is varied with some studies indicating restriction reduces healthcare costs (Eccleston, 1995), others show that limited the worker's choice contributes to higher costs (Durbin and Appel, 1991).

In conjunction with managed care is the utilization of a case management approach. The purpose of this approach is to create a system and processes that ensures all relevant factors of the workers' case are addressed with a view to access medical rehabilitation and vocational services within the context of return to work strategy. Often the case management function is conducted by a specially trained individual, such as a nurse. In half of the United States, case management is required in jurisdictions that regulate managed care. In other environments, such as Canada, the case management function and the person delivering this service may not be "specialty trained" (example: healthcare professional) but nevertheless must be trained in claims adjudication, case management and

understand utilization of healthcare, vocational services and protocols.

Lastly, one example of a "systems" driven approach to managing healthcare can be found in attempts to provide for 24 hour coverage or integrated care. This strategy identifies the opportunity to integrate occupational and non-occupational healthcare and indemnity benefits to provide for more timely and cost-conscious service. Many benefits were potentially identified with this strategy, such as a reduction in administrative redundancy, prevention of double dipping within the two disability systems by provider/service recipient, and minimizing the cost shifting between occupational and non-occupational services. While 24 hour coverage efforts have been trialed, this model has not rolled out as expected. Burton (1996) cautions that a careful evaluation of the impact of 24 hour coverage on indemnity costs, healthcare costs, and quality of service must be conducted to ensure that this approach is feasible in the workers' compensation environment.

An increasing focus on quality is a growing trend in general healthcare management, with workers' compensation healthcare being no exception. Quality requirements of providers by workers' compensation insurers may also include the accreditation of programs and services provided by healthcare providers. For example, in the United States the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on

Accreditation of Healthcare Organizations (JCAHO), or in Canada the Canadian Council on Health Services Accreditation are organizations commonly utilized by insurers as "third party reviewers" for services delivered to persons with work disabilities. There is a trend among many jurisdictions across North America to only accept and reimburse providers who are accredited. In some cases a premium reimbursement is paid to accredited providers for services rendered because the insurer does not absorb the administrative cost of insuring quality services to persons with disability because of the third party accreditation process – a cost borne by the provider. This allows the insurer to invest in managing the overall performance of the system, rather than focus its administrative resources on specific provider clinics.

Regardless of the healthcare management strategies employed, a more sophisticated approach to management recognizes that limiting or containing healthcare costs represents, potentially at best, short-term savings with perhaps longer term costs. As a consequence, insurers either directly or through relationships with managed care organizations are beginning to identify those features of quality healthcare that must be present in order that any investment in a healthcare expenditure is outcome oriented. In essence workers' compensation insurers have come to realize that an investment in timely, high quality and fair priced service will not only facilitate return to work for the worker, but lead to the termination of wage loss benefits and therefore contain overall costs. This outcome is essential in delivering an insurance product at a reasonable

cost to the policyholder – employer. The challenge to the insurer is to operationalize this strategy.

Executing A Healthcare Management Strategy

All insurers recognize the utility of a disability management continuum. The spectrum of this continuum includes the pre-accident, accident and post-accident phases. At the onset of an accident, timely claims adjudication and healthcare intervention are ideally simultaneous. Establishing an efficient disability management continuum presents as a logistics challenge. Many participants are involved in the complex chain of events that are outcome driven to sustained return to work. In the service continuum there is a series of “hand-offs” and intervention experiences that can dramatically impact progress or, ultimately, outcome. The role of healthcare providers and the relationship among providers is critical to achieving the desired end-state, which is sustained return to work. Healthcare providers, as a network of resources, represent an assembly of distinctive and complementary capabilities that should be exploited to achieve breakthrough levels of outcome and therefore customer service. If the collective service network focuses on its customers – the injured worker and their employer - and understand the execution of their component role within the service chain of events, and execute accordingly, the overall performance of the system is enhanced because of its focus on results. While this sounds like a theoretical exercise it can be operationalized through management intervention models. These intervention models are not discipline based or care management guidelines

that define specific procedures/interventions for medical conditions, often reflected in reimbursement rates. Rather, these care management models focus on the system or network of service delivery points from an integrated point of view along the potential continuum of care.

Collaboration With Providers

The most critical step in developing an integrated system of delivery is to ensure that the providers contribute to the development of the continuum of care intervention model. A continuum of care model is based on research regarding intervention points for discipline-based care and, therefore, provides for a joint road map to guide providers and insurers with respect to action and interaction. Potentially, continuum of care models ensure that the injured worker gets the appropriate treatment at the right time and that all parties strive to achieve some measurable fitness to work outcome. Commitment to outcome is half of the battle in this effort.

The continuum of care model reflects ideal intervention. At the Alberta Workers’ Compensation Board (AWCB) “soft-tissue” sprains and strains represents a significant percentage of claim frequency and costs. As a consequence, this continuum of care model was first developed and utilized by general practitioners, chiropractors, physical therapists and subsequent interdisciplinary intervention programs. Based on this particular model, medical management and chiropractic care are typically the two earliest forms of intervention post-accident. In Alberta, injured workers either self-select a physician or a chiropractor for immediate

treatment. Should the individual seek chiropractic care they will seek that attention from date of accident through to the maximum of six weeks. Medical management reflects physician-based care, which often includes ongoing ‘management’. Acute physical therapy treatment is conducted from one to three weeks and if required a more aggressive physical therapy care goes from four to seven weeks. If it is determined, for whatever reason, that intervention will not be successful the provider is given the authority to refer the worker to a work assessment center. This model assumes the insurer has delegated treatment authority to the provider thereby defining an integration moment between provider and insurer. The work assessment center will conduct a more comprehensive functional capacity evaluation to determine what additional barriers and therefore interventions may be necessary in the case. The outcome of a work assessment may be to refer the individual to additional diagnostic services, refer to a more intensive interdisciplinary occupational rehabilitation program (maximum of eight weeks) or potentially return to work.

Implicit in the model is that each provider participant understands the appropriate time for intervention and also recognizes their responsibility to ensure that if they are not successful they should engage the next provider along the service chain at an optimal time. Essentially, the system requires providers to stop when they do not expect they will be successful. This requires the network to be operationally more integrated. Further it influences providers to understand more about how

CONTINUED ON PAGE 12

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the network to be operationally more integrated. Further it influences providers to understand more about how they contribute to a stream of interventions, how they are the recipient of another providers' service, as well as the provider of services, and this enables the system to become more self-efficient and effective. All of these initiatives must be driven through the development of service standards (contracts) and contract management efforts such as monitoring of performance, continuous feedback, and reporting of results to each provider relative to benchmarks and best in class performance indices. The author does not want to understate the management effort in ensuring such an approach.

You will note the continuum of care model is rather simple yet managerially powerful. Based on research, there was agreement from all providers that this map fit to complement their individual skills as well as help guide optimal points of intervention. Essentially this model compresses time which not only results in timely and effective care, it drives to reduce costs. The continuum of care model can also be utilized to predict results and compare actual results to prediction regarding fitness for work outcomes and costs savings.

Measuring Cost Savings

Measuring cost savings from healthcare intervention presents as a challenge. It is a challenge because volume increases alone can drive up total costs, inde-

pendent of a cost management strategy. To address increased cost we have reviewed the various examples of cost containment strategies utilized by insurers. These strategies have included fee controls and other means to minimize duration and frequency of treatment, while focussing on return to work. However the ultimate litmus test for cost savings is a reduction in the number of cases being actively managed and paid wage loss. If investing in a healthcare strategy works, the average total cost per claim should be reduced mirroring a reduction in the average days of disability (wage loss) per claim to be monitored. Concurrent with these measures are average healthcare costs per claim, although a reduction here may not lead to duration reductions. Furthermore, outcomes (return to work) and satisfaction (injured worker/employer) are other critical indices of the overall effectiveness of system performance.

Again, catapulting from theory to practice, the AWCB decided that investing in healthcare would provide a return on investment. The investment outlined was the development of the healthcare services department (\$2.0 million) to manage the network and commitment to increase provider fees (example: chiropractors - 26%, physical therapists - 6.5%) to incent them to comply with service and performance targets. Further, financial incentives were also offered to providers for return to work placement, premiums were offered for timely access, and supplemental fees were provided for worksite visits. These incentives combined with the 10,000 soft-tissue injury cases managed on an annual basis represented a fairly substantial invest-

ment. What is the return on this investment?

To assess a return on investment the AWCB looked at the results through an approach known as survival curve analysis. This approach looks at the percentage of soft tissue cases on the books being actively managed and paid disability costs referenced against the number of weeks and the ideal period for type of intervention from a healthcare perspective. The objectives is to reduce the number of claims that survive week over week to 0 percent, which translates to total closure of all cases. Benchmark performance data (1994) prior to the development of the soft tissue continuum of care found that at the four-week period approximately 33 percent of the cases remained in the system, at eight weeks 21 percent, at 10 weeks 19 percent and at 18 weeks 9 percent remained active. According to the best available literature, AWCB identified ideal survival targets for system performance in order to accelerate the speed with which cases 'dropped off' along the curve. In essence the targets, based on research and management judgment, identified were 31 percent at four weeks, 8 percent at eight weeks, 6 percent at 10 weeks and 3 percent at 18 weeks.

The results, as a consequence of a comprehensive healthcare management strategy, determined that performance achieved by the system for the period of May 1997 through to April 1998 against target was 20 percent versus the target of 31 percent, 10 percent versus target of 8 percent, 7 percent versus a target of 6 percent, and 3 percent versus a target of .9 percent. While only one of the ideal targets

were hit relative to baseline, it is estimated that net of investment in healthcare services and increased fees, reducing the number of cases that “survive” along the continuum resulted in an actual savings of \$20.8 million. Savings are measured against actual system performance prior to the implementation of the continuum of care model. The projected savings were \$24.2 million. These savings are hard dollar savings. Furthermore, the overall average baseline disability days was reduced from 16.6 days to implementation of 12.2 days. The continuum also led to a decrease in the average number of total physical therapy treatments per claim from a 1994 high of 17.3 to a 1997 low of 13.3. Simultaneously in this period the duration of treatment in calendar days from assessment to last treatment was reduced from 65 days down from 29.5 days – time is money!

Performance analysis should also include a review of outcomes. Fit for work outcomes for physical therapy intervention remain at 76.1 percent with 85 percent of clients being satisfied with service. Further along the continuum, the average occupational rehabilitation cost per person dropped from approximately \$5,700 (1994) to \$4,000 (1997); with fitness to work rates going from 72 percent to 90 percent. When examining those cases that are soft tissue injury cases going beyond 18 weeks, and therefore can be considered “unsuccessful from an insurer/rehabilitation perspective”, only 70 percent of those cases received the right service and only 45 percent of them received them at the right time. The continuum of care model avails itself to identifying opportunities for

improving the system, a responsibility shared by provider and insurer. If the right service is not provided at the right time then fitness to work cannot be achieved and ultimately disability duration and costs will increase.

Next Steps

Managing in the workers’ compensation system requires that the insurer understand and engage a key supplier of service – the healthcare provider. Providers must be acknowledged as the vehicle to deliver outcomes and create value along the chain of service events. The insurer must create a new service delivery environment that shifts the focus from strictly managing service transactions to managing the relationships between the key participants in the disability management continuum. Aligning and utilizing those distinctive and complementary capabilities of healthcare providers in the workers’ compensation system will ensure results. It is important to understand that price alone, or a strict cost containment approach, does not necessarily contribute to the system containing overall costs. While the old adage may in fact be true – “sometimes you get what you pay for”, a singular cost-containment approach can confirm another experience – “sometimes you pay for what you get”.

Footnote: 1 The following utilizes a more comprehensive source regarding a healthcare management strategy found in an article written by Nikolaj and Boon, 1998

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A Case for Ergonomics in WA

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WMSDs are work-related non-traumatic disorders involving soft tissues such as muscles, tendons, ligaments, joints, blood vessels and nerves (for example, carpal tunnel syndrome and tendinitis) and exclude injuries from slips, trips, falls, motor vehicle accidents or being struck by or caught in objects.

A significant difference between Washington's approach to regulating in this area and the approach taken in both California's rule and OSHA's proposed rule, is that Washington's rule is not "injury-based." Washington's rule is not triggered by a workplace injury. Instead, Washington's rule is "hazard-based," and is triggered by the presence of certain exposures in the workplace, regardless of whether there have been reported injuries. By taking this approach Washington's rule intentionally avoids any overlap with the worker's compensation system, and avoids the potential that enforcement of the rule will turn into a dispute about the causation of an injury.

There is strong scientific evidence that jobs and tasks with various physical risk factors expose workers to preventable hazards that can cause or aggravate WMSDs. These risk factors include awkward postures; high hand force; highly repetitive motions; repeated impact; heavy, frequent, or awkward

lifting; and moderate to high hand-arm vibration.

The National Institute for Occupational Safety and Health has concluded that "A substantial body of credible epidemiologic research provides strong evidence of an association between

The rule applies to all industries and workplaces of all sizes, but specific employers are covered only where defined exposures are found.

musculoskeletal disorders and certain work-related physical factors when there are high levels of exposure and especially in combination with exposure to more than one physical factor (e.g., repetitive lifting of heavy objects in extreme or awkward postures." (Bernard, 1997)

The National Academy of Sciences has concluded that "there is little to shake our confidence in the thrust of our conclusions, which draw on converging results from many disciplines, using many methods: There is a higher incidence of reported pain, injury, loss of work, and disability among individuals who are employed in occupations where there is a high level of exposure

to physical loading than for those employed in occupations with lower levels of exposure." (NRC, 1999)

Because non-work activities can lead to MSDs it goes without saying that all of the workplace risk factors regulated by this rule can also be found outside the workplace. Individual risk factors such as age, gender, some systemic diseases, anatomic differences, and obesity have also been associated with MSDs. During the rule-making, L&I received comments from people who felt that these relationships render this rulemaking unnecessary, improper, or ineffective. However, the rule stays within statutory bounds by regulating only those risk factors that are present at work.

Likewise, it regulates only physical risks of jobs under the control of employers, not individual factors.

WMSDs are the largest category of injuries and illnesses affecting Washington workers. There are at least 52,000 WMSD workers' compensation claims for the neck, back and upper extremity accepted yearly in the State of Washington. The total annual direct cost of all WMSDs is more than \$410 million. Additional indirect costs such as lost productivity, absenteeism, and long term lost earning potential bring the total annual cost above \$1 billion. WMSDs account for about 30 percent of all workers' compensation claims and more than 40 percent of the total costs.

The average annual risk of all neck, back and upper extremity compensable WMSDs is 134 per 10,000 employees. These risks are much greater than for other workplace risks and far exceed any reasonable definition of “average risk.”

WMSD rates, along with other injury and illness rates, declined in Washington state during the 1990’s in the absence of a rule and a number of employers suggested that a rule is unnecessary. However, the rate of decline in WMSDs has been less than that for other injuries and has slowed in the past few years. In several important industry groups and for some types of WMSDs the rates have flattened completely or actually increased.

WMSDs are widespread among industries and occupations in the state. In some industries the risk to workers is especially great. Many “high risk” occupations or jobs are also contained within industries that might be classified as “low risk.” An L&I survey of 5,000 employers found that WMSD risk factors were prevalent in all industry types and sizes of workplaces. Many types of work involved some exposure to physical risk factors and a smaller subset of workers had prolonged exposures at levels likely to be hazardous.

After more than 10 years of working with employers and others on a voluntary basis, an L&I survey found that 60 percent of employers report no efforts to reduce WMSD hazards. Even among those employers who recognize that WMSDs have occurred in their workplaces 40 percent report no efforts

to reduce the hazards that may cause them.

L&I began the rule development process in October 1998. Before drafting the proposed rule, L&I actively engaged the business, labor and health professional communities in detailed discussions. These discussions included nine public rule development conferences in late 1998, followed by the work of two advisory committees in the first half of 1999. The proposed rule (which incorporates many of the ideas of the advisory committees) was issued in November, 1999, followed by fourteen formal public hearings in seven cities around the state. Two hundred forty nine witnesses testified. L&I received more than 850 post-hearing comments.

The rule applies to all industries and workplaces of all sizes, but specific employers are covered only where defined exposures are found. Workplaces without these risk factors are not covered. All exposed employees, therefore, receive protection without creating unnecessary burdens for employers.

The rule has eight key elements:

1. The rule applies only to employers with “caution zone jobs,” those where any employee’s typical work includes physical risk factors specified in the rule. “Caution zone jobs” are not prohibited and they may not be hazardous.
2. Employers with “caution zone jobs” must ensure that employees working in or supervising these jobs receive ergonomics awareness education. These

employers also must analyze the caution zone jobs to determine if they have hazards.

3. Employers may choose their own method and criteria for identifying and reducing WMSD hazards or may use the department’s specified criteria.
4. If jobs have WMSD hazards the employer must reduce exposures below hazardous levels or to the degree feasible.
5. Employers must provide for and encourage employee participation.
6. An extended implementation schedule based on industry type and employer size allows employers, especially small businesses, ample time to prepare for compliance.
7. The department will establish Demonstration Projects with employers and employees to test and improve ergonomics guides and models, industry best practices, and inspection policies and procedures.
8. Employers may continue to use effective methods of reducing WMSD hazards that were in place before the rule adoption date.

L&I determined that the rule is technologically feasible for several reasons. First, for the risks regulated by the rule, there is considerable evidence in the record that control technology is in general use and widely available. Sec-

CONTINUED ON PAGE 16

Incarceration and Benefits

Continued from Page 3

is serving a sentence for life without parole based on a conviction for aggravated murder. He lost part of his right index finger, also working in correctional industries.

The Court held that the statute in essence causes an illegal forfeiture of benefits by forever denying their receipt. Each claimant is under a sentence, which makes it at best unlikely, that they will ever be released from prison. They also have not beneficiaries or dependents that would be entitled to benefits in their stead. This lower court decision is subject to appeal to higher appellate courts in Washington.

Arizona passed a similar statute in 1997 (Arizona Revised Statutes ("ARS") §32-11031) which provides as follows:

A. Except as provided in subsection B of this section, beginning on December 1, 1997, payment of compensation under this chapter shall be suspended during the period of time that the employee has either:

1. Been convicted of a crime and is incarcerated in any state, federal, county or city jail or correctional facility.
2. Been adjudicated delinquent and is incarcerated in any state, federal, county or city jail or correctional facility.
- B. If any portion of an employee's payment of compensation under this chapter has been garnished to satisfy support obligations pursuant to title 25, chapter 5, article 1, the portion of the compensation that has been garnished shall be paid as provided in the court order.

Like Washington's statute, ARS §32-11031 has also been attacked on constitutional grounds. This issue is currently under litigation in Arizona.

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Ergonomics

CONTINUED ON PAGE 15

ond, there is very little need for new technology to comply with this rule. Adaptation and modification of existing technology should permit employers to achieve compliance. Third, experience has shown that employers, particularly working together with employees, have been able to devise practical and plain sense solutions. Fourth, L&I has provided a lengthy timeframe for compliance with this rule, easing an employer's ability to adapt to its requirements. Fifth, the rule makes allowance for those individual employers who find that a generally feasible hazard control method is not feasible in a particular workplace because of unique and specific circumstances.

L&I completed a Small Business Economic Impact Statement and a formal Cost-Benefit Analysis which estimates that the ergonomics rule will prevent 40 percent of WMSD injuries and 50 percent of WMSD costs once all the elements of the rule are fully effective. The estimated annual cost for compliance is \$80.4 million. The estimated annual benefit from the rule is \$340.7 million. The industry specific benefit-cost ratio for the worst case scenario of low benefits and high costs ranged from 1.14 for agriculture to 5.20 for non-durable manufacturing.

R E M I N D E R

AASCIF CEO and All-Committee Meetings
January 10 - 12, 2001 • Bally's Las Vegas

Wednesday, Jan. 10	6 p.m. - 10 p.m.	CEO Dinner
Thursday, Jan. 11	8 a.m. - 3 p.m.	CEO Meeting
Thursday, Jan. 11	Evening	Committee Dinners
Friday, Jan. 12	8 a.m. - 3p.m.	All-Committee Meeting

Questions? E-mail Paula Saabye (psaabye@memic.com)