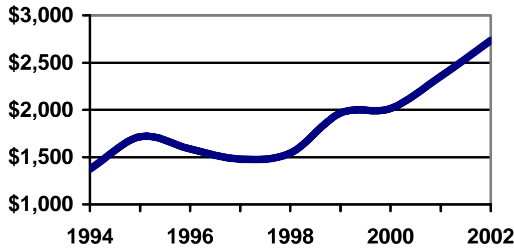
WORKERS' COMPENSATION BACKGROUND

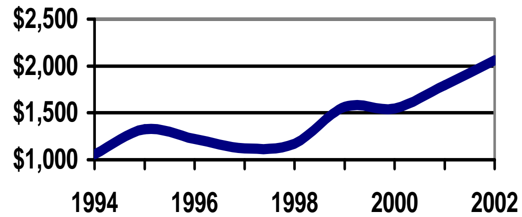
Since 1996, the Workers' Compensation Advisory Council (WCAC) recommended several law changes to the Legislature. This legislation generally passed with bipartisan support and signaled that the Advisory Council can monitor and manage the system. It can work as it was originally intended because the major structural reforms are complete. However, in four of those years, 1999, 2003, 2004, and 2007, the WCAC bill did not pass because an amendment was offered in committee or on the floor, one body blocked its passage, or the WCAC bill failed to receive a hearing. Offering an amendment broke the "no amendment" agreement made by the Advisory Council. In 1999, the amendment would have provided injured workers a civil remedy outside of the workers' compensation system if a safety violation was involved in the accident. The amendment also would have eliminated the exclusive remedy of the workers' compensation system because each workplace injury could be deemed a violation of OSHA's general duty clause. In 2003, the House passed the WCAC bill; however, no floor action was taken in the Senate. The bill was held up because senators who supported higher reimbursements for chiropractors did not want the bill to pass without their provision. In 2004, legislators who supported chiropractors and physical therapists blocked the bill's passage. Finally, in 2007 business and labor representatives on the Advisory Council unanimously agreed on the WCAC bill, however, the bill failed to receive a hearing in either body.

The 2000 Advisory Council bill was its most significant to date. The bill transferred $325 million of Assigned Risk Plan excess surplus to the Special Compensation Fund (SCF). This transfer financed some of the more than $1 billion of unfunded liabilities of the SCF and allowed the assessment that currently finances the SCF to fall from 30 percent of indemnity benefits paid to 20 percent. The drop in the assessment should have saved employers about $41 million per year. The 2000 bill also increased some workers' compensation benefits. The maximum and minimum weekly benefit amounts increased from $615 and $104 to $750 and $130, respectively. The last adjustment to these benefits occurred in 1995. In addition, the permanent partial disability (PPD) schedule was given a modest increase. The last adjustment to the PPD schedule occurred in 1983. The net result of the 2000 bill was anticipated to be a slight cost reduction to employers.

After the 2000 Advisory Council bill became law, a class-action suit was filed against the state claiming that the $325 million should not have been transferred and the excess surplus belongs to employers insured through the Assigned Risk Plan – the Danny's Tranny lawsuit. In 2001, the state settled the case for about $25 million. In 2002, the Legislature transferred $250 million from the SCF to the general fund to help balance the budget. This change caused the assessment rate to increase from 20 percent to 30 percent. In 2003, the Legislature transferred another $15 million from the SCF to the general fund. From 2002 to 2006, the assessment change will increase workers' compensation costs by a total of almost $130 million.

Medical costs: In 1992, the Legislature adopted several medical cost containment reforms, including provider fee reductions, mandatory treatment parameters and a managed care option. After an initial decline in medical costs between 1993 and 1994, costs have steadily risen. The following graphs show the average charge per claim and average payment per claim from 1994 to 2002. During that eight years, the average charge per claim increased by 99.5 percent while the average payment per claim rose 94.4 percent.

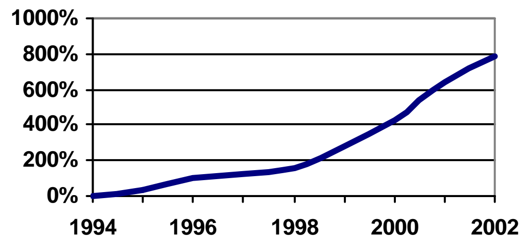




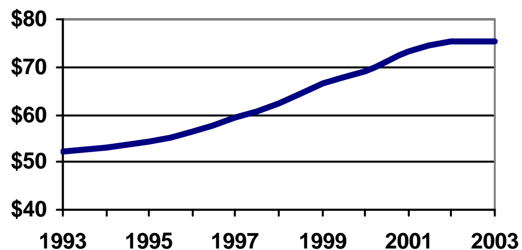
In addition, the Minnesota Workers' Compensation Insurers Association (MWCIA) reported in its 2003 rate-making report that workers' compensation medical costs were, for the first time, more than half of the total cost of the workers' compensation system. In its 2004 report, the MWCIA indicated that medical costs increased further to 56 percent of total costs.

In 2002, the Department of Labor & Industry made several medical cost containment proposals to the WCAC; however, no significant legislation in this area was forwarded to the Legislature because WCAC members did not have enough information on the various proposals. Rather, the department decided to create a task force to further study medical cost containment strategies. The task force is looking at pharmaceutical costs, the managed care system, the medical fee schedule, hospital costs and utilization review.

Pharmaceutical costs: In 2002, pharmacy costs represented 5.0 percent of workers' compensation medical costs; however, between 1994 and 2002, the growth of pharmacy payments has been staggering – a 790-percent increase. This increase is generally due to more drugs being prescribed, more prescriptions for new expensive drugs, and price inflation of existing drugs. The workers' compensation system pays 100 percent of the average wholesale price for pharmaceuticals plus a $5.14 dispensing fee. The Department of Labor indicated that, in 2001, the average reimbursement for health maintenance organizations that implemented pharmacy benefit management was 86 percent of the average wholesale price plus a $2.21 dispensing fee.



Managed care system: The number of certified managed care plans for workers' compensation has dropped from 10 in 1995 to four in 2003. The reason for the drop isn't clear; however, some believe the current managed care regulations are too stringent and make it difficult for managed care plans to control costs. For example, under Minnesota's managed care regulations, a managed care plan cannot negotiate rates with network providers. According to the Workers' Compensation Research Institute (WCRI), managed care networks can reduce workers' compensation health care costs by lowering utilization of services and negotiating price discounts. Costs are 16 percent to 46 percent lower if the treatment was provided exclusively within a network and up to 11 percent lower if predominately within a network. The WCRI also

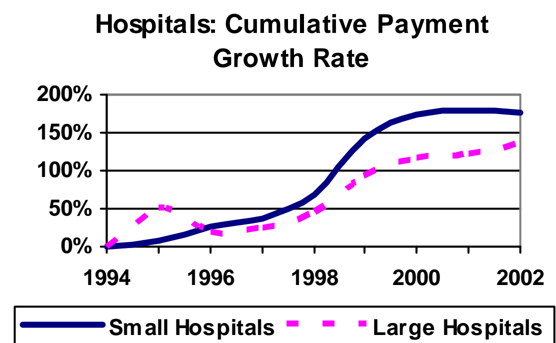


noted that injured workers who had medical care provided by a managed care network did not have higher indemnity costs.

Medical fee schedule: The Department of Labor adopted its workers' compensation medical fee schedule in 1993 after legislation directing the department to do so passed in 1992. The schedule sets the maximum fee for a service equal to the service's relative value unit (RVU) multiplied by a conversion factor. The RVUs used by the Department of Labor are calculated by Medicare and are designed to base reimbursements on the relative resources required to provide the service. The RVUs consider the time, intensity of effort, technical skill, staff, equipment, supplies and malpractice expense, among other things. RVUs have been updated three times since they were adopted in 1993; however, the Department of Labor has not kept up with annual changes in RVUs because the rulemaking process used to update them can be expensive.

The initial conversion factor was set at $52.05 – the level needed to generate a mandated 15-percent reduction in costs. The 1992 legislation also required the conversion factor to be adjusted annually by no more than the percentage change in the statewide average weekly wage (SAWW). In 2003, the conversion factor was $75.18 – a 44.4-percent increase from its 1993 level. Between 1993 and 2001, the commissioner of labor used the percent change in the SAWW to increase the conversion factor. In 2002, the producer price index for physicians was used which resulted in a smaller increase. In 2003, the conversion factor was frozen at its 2002 level. Most policy-makers agree that the SAWW is not an appropriate index to adjust the conversion factor. If the producer price index for physicians was used from 1993 to 2003, the conversion factor would have grown by 20.8 percent rather than 44.4 percent.

Minnesota's fee schedule also differentiates between provider types by applying "scaling factors." This results in similar services provided by physicians and chiropractor and physical therapists and chiropractors being reimbursed at different rates. Physicians argue that this system is justified because physicians face higher costs to provide services than other providers. On the other hand, chiropractors argue that similar services ought to be reimbursed at the same rate regardless of provider type. The Medical Services Review Board (MSRB) reviewed the different reimbursement systems and concluded that the scaling factors should be eliminated for chiropractic manipulation and physical medicine procedures. The MSRB also recommended that the scaling factors should be retained for radiology services and office visits. The MSRB recommendations would increase workers' compensation medical costs by 3.0 percent and total system costs by 1.1 percent.



Hospital costs: In 2002, payments to hospitals represented 42.5 percent of workers' compensation medical costs, up from 32.4 percent in 1989. However, to put workers' compensation payments to hospitals in perspective, they accounted for only 2.6 percent of total hospital payments in 2001. At present, there is a difference in reimbursements between large hospitals (100 beds or more) and small hospitals (fewer than 100 beds). For example, many outpatient services provided by large hospitals are reimbursed according to the workers' compensation medical fee schedule; however, no small hospitals services are subject to it. Outpatient services provided by large hospitals that are not covered by the fee schedule are reimbursed at 85 percent of the usual and customary charge while the same services provided by small hospitals are paid 100 percent of the usual and customary charge. Inpatient services for small and large hospitals are not covered by the fee schedule. Between 1994 and 2002, payments to large hospitals grew by 134 percent while payments to small hospitals grew by 176 percent.

Utilization review: Utilization, or the number of services per claim, is also a factor in workers' compensation medical costs. The WCRI recently studied the costs of similar workers' compensation claims in California, Connecticut, Florida, Massachusetts and Texas. In three of the five states - California, Connecticut and Texas - physical medicine costs in cases involving chiropractic care were 30

percent more than cases without such care. (Massachusetts also showed a cost increase but it was not statistically significant. Costs decreased in Florida.) The number of visits was a significant factor in the difference. There are a variety of ways to address utilization of services, including allowing employers to select the initial health care provider, defining more clearly what is a "reasonably required treatment," require judges and payers to apply the treatment parameters, and limiting the number of services an injured worker could receive for each injury.

Exclusive remedy. The debate surrounding the exclusive remedy began in 1998 with a news report of two workplace deaths. The report said that the "dirty little secret" of workers' compensation is that injured workers cannot sue their employer, i.e. workers' compensation is the exclusive remedy. In one of the deaths, there was a serious OSHA violation involved in the accident. Some policy-makers attempted to address these cases by introducing legislation to allow injured workers to sue their employers outside the workers' compensation system when a safety violation was involved. The Workers' Compensation Advisory Council debated and rejected the bill with all employer representatives and one labor representative voting against it.

These news reports did not give proper attention to the fact that the exclusive remedy is the foundation of the workers' compensation system in Minnesota and all other states. In 1913, Minnesota adopted its workers' compensation statute only after business agreed to pay wage loss and medical benefits to all workers injured in the course of employment regardless of fault, and labor agreed that the new workers' compensation system would be the exclusive remedy. Similar agreements resulted in other states adopting their workers' compensation statutes.

The Department of Labor & Industry also conducted a 23-state study of the workers' compensation exclusive remedy. It found that 14 states, including Minnesota, allowed lawsuits only in cases of willful and intentional conduct by the employer. In eight states there wasn't even an intentional tort exception. It was not clear by looking at the statute and case law whether the remaining state allowed any actions outside of the workers' compensation system. The department found a few states that allowed an increase in benefits if the employer failed to comply with any statute or lawful order. More states decreased benefits if the employee failed to obey a safety rule. Wisconsin allowed both. However, further research indicated that statutes allowing for benefit increases or decreases are rarely used. Kansas also cataloged each state's exclusive remedy rule and found that no state has a broad exception to the exclusive remedy.

Another distinctive statute was Alabama's. The Alabama Legislature codified a finding relating to litigation outside of the workers' compensation system. It stated:

> "The legislature finds that actions filed on behalf of injured employees against officers, directors, agents, servants or employees of the same employer seeking to recover damages in excess of amounts received or receivable from the employer under the workers' compensation statutes of this state and predicated upon claimed negligent or wanton conduct resulting in injuries arising out of and in the course of employment are contrary to the intent of the legislature in adopting a comprehensive workers' compensation scheme and are producing a debilitating and adverse effect upon efforts to retain existing, and to attract new industry to this state. … There is a total absence of any reliable evidence that the availability of such causes of action has resulted in any reduction of the number or severity of on-the-job accidents or of any substantial improvement on providing safe working conditions and work practices."(Code of Alabama, Section 25-5-14)

State rankings. The results of the 1992 and 1995 reforms are helping Minnesota employers to become more competitive with our neighboring states. According to Actuarial & Technical Solutions, Inc., the comparative cost per $100 of payroll for Minnesota manufacturers has dropped from $6.19 in 1992 to $4.40 in 2006 - down 29 percent. During this time, the state's national ranking improved from 34th out of 44 to 27th out of 45 (a ranking of 1 means the lowest cost per $100 of payroll). Furthermore, between 1992 and 2006, Minnesota's workers' compensation comparative costs decreased more rapidly than the costs in our surrounding states and the national average. However, since 2000, Minnesota's comparative cost has increased by 69 percent, showing that attention must be paid to workers' compensation costs in

order to preserve the benefits of the 1992 and 1995 reforms. (North Dakota was not included in the study because it provides workers' compensation insurance through a monopolistic state fund.)