

Approved February 27, 1992  
Date

MINUTES OF THE Senate COMMITTEE ON Labor, Industry and Small Business

The meeting was called to order by Alicia L. Salisbury at  
Chairperson

1:30 ~~xxx~~ p.m. on February 19, 1992 in room 254-E of the Capitol.

All members were present except:

Members present: Senators Daniels, Ehrlich, Feleciano, Martin, Morris, Oleen, Petty, Salisbury, Sallee, Strick and Thiessen

Committee staff present:

Jerry Donaldson, Legislative Research Department  
Gordon Self, Revisor of Statutes Office  
Mary Jane Holt, Committee Secretary

Conferees appearing before the committee:

Bill Curtis, Assistant Executive Director, Kansas Association of School Boards  
Brad Smoot, Legislative Counsel, American Insurance Association  
Jim Schwartz, Consulting Director, Kansas Employer Coalition on Health,

The Chairman inquired if there were any other conferees on **SB 606** - Amendments to employment security law relating to limited liability companies, disqualifications for benefits and shared work compensation. There being no other conferees, the hearing on **SB 606** was closed.

Senator Morris moved to report SB 606 favorably for passage. Senator Oleen seconded the motion. The motion passed.

Continuation of Hearing on HB 2196 - Workers Compensation, employee choice of health care provider.

Bill Curtis, Assistant Executive Director, Kansas Association of School Boards, testified the Kansas Association of School Boards Worker Compensation Fund opposes **HB 2196**. The fund has assisted school districts in negotiating with health care providers for a controlled cost for various procedures. To give the employee the choice takes away the economy of numbers and the ability of the school districts to negotiate with medical providers, see Attachment 1.

Brad Smoot, Legislative Counsel, American Insurance Association, informed the Committee **HB 2196** is not good for the employer, the employee and more importantly not good for the workers compensation system. He said the Workers Compensation system is struggling with escalating costs which are born by employers and taxpayers. He submitted a letter from the National Council on Compensation Insurance concerning a study of the impact of employer choice of physician. The study found that, on the average, employer choice of physician can lower medical costs between 5.3% and 7.9%. Conversely, a switch from employer choice to employee choice would result in an increase in costs in the same amounts. He also distributed copies of a report on "The Impact of Fee Schedules and Employer Choice of Physician", see Attachment 2.

Senator Feleciano questioned the credibility of the rate filing of the NCCI.

Jim Schwartz, Consulting Director, Kansas Employer Coalition on Health, stated it would be hard to find a bill more damaging to employers' cost-containment efforts. He said all employers, large and small desperately need help containing health care costs. He stated what is needed is a fee schedule and authority to designate preferred providers, see Attachment 3.

The Committee meeting was adjourned at 2:30 p.m.





Testimony on HB 2196  
before the  
Senate Committee on Labor, Industry and Small Business

by

Bill Curtis, Assistant Executive Director  
Kansas Association of School Boards

February 13, 1992

Madam Chair and members of the committee,

We appreciate the opportunity to present the views of the 167 school districts that are members of the KASB Workers' Compensation pool on HB 2196. HB 2196 gives the choice, in the first instance, of a health care provider for medical benefits under workers' compensation to the employee.

The KASB Workers' Compensation Fund opposes HB 2196. It would add to the costs of workers' compensation for employers by giving the employee the choice of health care provider. Our fund has worked hard with school districts to control health care costs under workers' compensation as they reflect the same increases as the health care industry. To counter those increases, we have assisted school districts in negotiating with health care providers for a controlled cost for various procedures. To give the employee the choice takes away the economy of numbers and the ability of the school district to negotiate.

We appreciate the attention of the committee. We ask that the committee not take favorable action on HB 2196.

*SLD, SB*  
*2/19/92*

*Attachment 1*

# BRAD SMOOT

ATTORNEY AT LAW

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**Statement of Brad Smoot, Legislative Counsel,  
American Insurance Association to the Senate Labor, Industry  
& Small Business Committee regarding 1991 House Bill 2196**

**February 19, 1992**

Madam Chair and Members:

I am Brad Smoot representing the American Insurance Association, a trade association of more than 200 insurance companies providing worker's compensation insurance to Kansas and across the country. We appear today in opposition to 1991 House Bill 2196.

As you know, this measure would grant to employees the absolute right to select their health care provider in the event of a work related injury subject to the worker's compensation laws. For the following reasons, we believe such a measure is not good for the employer, the employee or overall workers' compensation system:

\* The worker's compensation system is struggling with escalating costs which are born by employers and taxpayers. We should be searching for ways to reduce costs rather than increase them. Attached, please find a recent letter from NCCI to the Kansas Insurance Department summarizing the results of a recent study reviewing the impact of employer choice of physician. As you can see, a switch to employee choice is estimated to increase medical costs from 5.3% to 7.9%. Also provided with my statement is a copy of the report upon which those numbers are based. Beyond the numbers and studies, common sense suggests this proposed change in procedure may be costly. Compare this proposal with the trends in health care insurance where the selection of provider is being limited under indemnity plans and HMO plans. Current workers' compensation laws and health insurance trends recognize that employer or carrier choice helps in negotiating fees, controlling utilization and costs. In a state, like Kansas, where a medical fee schedule has not yet been developed, such cost containment methods are even more important.

\* Current law does not absolutely restrict employee rights since the law permits: a) the employee to seek a second opinion, for which the employer must pay up to \$350, and b) the employee may request a different physician if he or she is dissatisfied. I am advised that such changes are routinely granted.

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*Attachment 2-1*

\* Because multiple injuries to employees are rare, employees do not develop expertise in selecting the best physician in a particular field. Employers and insurance carriers, on the other hand, keep up to date lists of specialists for various types of injuries. Specialists in workers injuries can quickly and efficiently treat and evaluate the patient and his or her injuries.

For these reasons, we urge the committee to reject the amendments offered by H 2196 and maintain the current employer choice system.

I would be pleased to respond to any questions from the committee.

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Attachment 2-2



National  
Council on  
Compensation  
Insurance

Post-It™ brand fax transmittal memo 7671		# of pages ▶ 1
To <i>BRAD SMOOT</i>	From <i>Michael Taylor</i>	
Co.	Co.	
Dept.	Phone #	
Fax #	Fax #	

February 14, 1992

VIA FACSIMILE TRANSMISSION

Mr. John V. Spain  
Fire and Casualty Policy Examiner  
Kansas Insurance Department  
420 S.W. 9th  
Topeka, Kansas 66612-1678

Re: House Bill 2196

Dear Mr. Spain:

Last year, we reviewed the provisions of the above bill and were unable to accurately estimate the impact due to incomplete information. We did offer some ideas based on anecdotal input from carrier claims representatives, however, it was inconclusive as to the actual effect.

Since that time, the NCCI has commissioned a study by Milliman & Roberts to review the actual impact of employer choice of physician. This study found that, on the average, employer choice of physician can lower medical costs between 5.3% and 7.9%. Conversely, a switch from employer choice to employee choice would result in an increase in costs in the same amounts.

I trust this is helpful, however, please feel free to contact me if you have any questions or would like further information regarding this study.

Sincerely,

Michael A. Taylor  
Director  
Government, Consumer and Industry Affairs

MAT:ah

cc: Larry Magill, IIAK  
Terry Leatherman, KCCI  
Brad Smoot, AIA  
Mark Skinner, AIA

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*Attachment 2-3*

# The Impact of Fee Schedules and Employer Choice of Physician

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Attachment 2-4

by DAVID DURBIN and DAVID APPEL

David Durbin is a consulting economist at Milliman & Robertson, Inc.

David Appel is Director, Economic Consulting at Milliman & Robertson, Inc.

medical costs have also increased dramatically. Almost \$10 billion were paid out in workers compensation medical benefits in 1987 (the latest year available), a 15 percent increase over 1986.<sup>1</sup>

The ramifications of both phenomena are enormous. On the one hand, the scarcity of economywide resources portends continued and growing market distortions in the overall provision of medical care. The availability and quality of affordable care are growing concerns. In the case of workers compensation, rising insurance costs impact industrial competitiveness and profitability and thus affect employment, savings, and ultimately economic growth and development.

A particularly disconcerting piece of the medical care cost puzzle in the United States concerns the quality of care and the efficacy of health care expenditures. Unfortunately, there is little evidence to suggest that health status has been improved by the enormous increase in spending. Although per capita health expenditures in this country, both in dollar terms and as a percent of total economic output (GNP), are greater than

It is no longer news that medical costs in the United States have been skyrocketing. The most recent data show that in 1989, national health care costs rose 11 percent to \$604.1 billion, accounting for 11.6 percent of GNP. Only slightly less publicized is the fact that workers compensation

in any other country, health status as measured by traditional indicators is not particularly impressive. According to the National Center for Health Statistics<sup>2</sup>, the U.S. ranks only eighteenth in the world in infant mortality rates, while males in the U.S. have only the fifteenth highest life expectancy at birth and women the eleventh highest.

Similarly in workers compensation, the tremendous explosion in medical expenditures has not been matched by improvements in health status.

due to work-related injury or illness.<sup>3</sup>

A number of reforms have been suggested with the aim of slowing the spiraling trend in both economywide medical care costs and workers compensation medical costs without sacrificing access to or quality of care. Although documentation of the magnitude of the problem is fairly extensive, the empirical evidence on the effectiveness of such reforms, particularly for workers compensation, is sparse. The analysis presented in this article addresses this void and considers two widely cited cost containment initiatives: use of medical fee schedules and allowing the employer the initial choice of treating physician. This article updates preliminary results from a study reported at the Workers Compensation Congress in 1989 and reprinted in NCCI DIGEST.<sup>4</sup>

The paper proceeds as follows: Section I provides a brief overview of medical cost trends in the economy and for workers compensation, and highlights some of the underlying dynamics affecting the rising costs. Section II develops an economic model that considers several important economic and demographic characteristics thought to impact the growth in workers compensation medical costs. This discussion also includes such features as fee schedules and choice of physician. Section III contains the results from statistical models which are designed to measure the net impact of cost containment initiatives after consideration of the important economic and demographic characteristics that affect workers compensation medical costs. Section IV contains some concluding comments and observations.

Based on data compiled from the Call for Detailed Claim Information, the average temporary total spell has been virtually unchanged through the 1980s. In addition, the proportion of claims resulting in permanent disability has remained constant. According to the Bureau of Labor Statistics, while the frequency of occupational injuries and illnesses has fluctuated through the 1980s and is at basically the same level (8.6 injuries or illnesses per 100 full-time workers) in 1989 as 1980, the severity of those injuries has increased almost 14 percent. In 1989, there were 74.2 work-days lost per 100 full-time workers

## I. OVERVIEW: MEDICAL COST TRENDS

The workers compensation system provides income replacement in the form of cash benefits, virtually unlimited coverage for medical care, and rehabilitation services for injuries or illnesses that arise out of and in the course of employment. Traditionally, indemnity benefits have made up the major part of total program costs. However, in the past two decades medical costs have risen dramatically. Medical expenditures, which were approximately one-third of total costs in the early 1970s, now comprise 40 percent or more of total incurred workers compensation benefits, with a level in excess of 50 percent not uncommon in individual states.<sup>5</sup> Medical payments per covered worker have increased at an average annual rate of 11 percent over the past decade<sup>6</sup> compared to an economywide 9 percent annual growth in per capita medical expenditures.<sup>7</sup> Average medical costs per lost-worktime claim are estimated to be more than \$3,400 in 1989, which is double the level in 1980.<sup>8</sup>

While workers compensation medical costs have grown slightly more rapidly than overall health costs, a number of the underlying dynamic forces driving the two are similar. Among the determinants of health care inflation, several are particularly germane to workers compensation. The most widely cited factors include:

- lack of cost sharing
- demand creation
- fee-for-service-based reimbursement practices
- technological advances
- surplus of physicians

- medical malpractice insurance
- demographic changes

These factors have been discussed extensively elsewhere.<sup>9</sup> Even though all these factors play a role in workers compensation, there are some important differences between workers compensation medical care expenditures and non-workers compensation medical care expenditures. These differences have important implications for cost containment initiatives.

The most significant difference between medical treatment in workers compensation and the general economy is the role of the medical provider in a system that provides both medical benefits and income support.<sup>10</sup> The provider may be called upon to determine when the injured worker should return to work. This may be antithetical to the usual patient-provider relationship because the provider may have a conflict of interest between medical and financial incentives.

The other significant difference between workers compensation and general medical care expenditures concerns cost sharing, especially the increase in cost sharing that is taking place in other health insurance programs while workers compensation remains essentially a first-dollar provider. There are incentives for both medical providers and injured workers to shift costs to the workers compensation system. The lack of a formal monetary price to medical care from the individual injured worker's perspective is in fact one of the major impediments to implementing cost containment controls in workers compensation.

Many of the cost containment initia-

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tives appearing in the general health sector rely on controlling the demand for medical services by increasing the level of cost sharing on the part of consumers. This takes the form of increased deductibles or co-insurance. The strategy is straightforward: an increase in out-of-pocket expense costs to consumers should reduce the demand for and consumption of medical care.<sup>11</sup>

The lack of a direct role for prices in rationing medical service in workers compensation creates special problems in containing workers compensation expenditures. Cost sharing is currently not a viable alternative in workers compensation. As a consequence, much of the cost containment effort in workers compensation has centered on the supply-side or producer-side initiatives.

#### a. WORKERS COMPENSATION COST CONTAINMENT

Workers compensation cost containment strategies have been essentially twofold. First, the provision and utilization of services may be scrutinized to ensure that only necessary services are rendered. This managed care approach includes concurrent and retrospective review, preadmission certification and prior authorization for nonemergency treatment, as well as the use of case management, including establishing standards for initial patient contact and timing of progress reports. The idea is to limit treatment to clinically proven procedures rendered in the most cost-effective manner.

Another method for controlling the utilization of services involves the selection of the treating physician. The underlying concept is that if the

employer has the initial selection, then physicians who offer discounts or who practice conservative medicine can be selected. That is, incentives should exist for employers to select providers who render cost-effective treatment. However, this practice has not been unanimously endorsed and there is no formal research that directly tests the effectiveness of this strategy.<sup>12</sup>

In addition, states differ on the implementation of employer-selected physicians. For example, included among the jurisdictions with employee choice are Connecticut, Washington, D.C., and New York, which actually have limited free choice in the sense that employees must choose from a list of physicians provided by the state workers compensation agencies. In Georgia, Tennessee, and Virginia, the employee selects the physician, but from a list maintained by the employer. For this study these latter three states are considered employer-choice states. In California, Michigan and Pennsylvania the employer has the right to choose, but after a pre-specified period the employee has free choice.

#### b. FEE SCHEDULES

The second widely used cost containment strategy is that the price of services may be regulated by a schedule of fees corresponding to the kind and nature of treatment. These medical fee schedules will typically stipulate the maximum fees for services performed by a variety of medical care providers such as physicians, osteopaths, chiropractors, physical therapists, and so on. Hospital services may also be subject to fee schedules. The actual schedules may be based on some percentile of the usual and

customary fee or may be based on a relative value scale which accounts for the time, skills and intensity of the service rendered.

There is conflicting evidence about the effectiveness of fee schedules. On the one hand, the expectation is that states with fee schedules may have lower costs since insurers have control over maximum reimbursement levels. An alternative result of a fee schedule may be the overutilization of services. This may occur as physicians attempt to maintain income levels by overprescribing services with the highest returns. Previous work, from

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The current analysis is an extension, found that instituting a fee schedule will save from 3 percent to 7 percent of costs in the long run. On the other hand, research by the Workers Compensation Research Institute<sup>13</sup> found little support for the effectiveness of fee schedules, not unlike some of the research findings relating to Medicare fee schedules.”

which the current analysis is an extension, found that instituting a fee schedule will save from 3 percent to 7 percent of costs in the long run. On the other hand, research by the Workers Compensation Research Institute<sup>13</sup> found little support for the effectiveness of fee schedules, not unlike some of the research findings relating to Medicare fee schedules.

It is likely that the conflicting results on the impact of fee schedules are due to differences across states in the area of implementation, compliance and monitoring of the schedule. Borba<sup>14</sup> provides details of some of the important differences between states in the ways they compute their

fee schedules as well as the oversight and monitoring of the schedules. For example, Florida statutes (at least prior to the enactment of the Comprehensive Economic Development Act of 1990) are very specific, requiring a three-member panel consisting of the insurance commissioner, as well as employee and employer representatives. Not only does the Florida statute require the panel to consider prevailing charges for similar treatments, but it is also required to consider the impact of the schedule upon employers and the health care system. New York uses a relative value scale, which is adjusted to reflect regional differences in prices between urban and rural areas. California requires the administrative director to establish a fee schedule after holding public hearings no less than biannually.

In contrast to these apparently well-monitored schedules, a survey of administrative features of workers compensation systems performed by the NCCI Research Division (and which forms the basis for this study) provided information on states that may have less effective schedules. For example, according to a member of the Rhode Island Accident Board, even though Rhode Island has had a fee schedule since 1982, the allowable fees were not updated and enforced until 1989.

As mentioned, standards vary by state in establishing a fee schedule. Although 27 states currently use some sort of fee schedule for physician charges, there is no one prototype schedule. The WCRI illustrates this by considering the range of allowable fees for several common work-

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Attachment 2

ers compensation procedures. It is not uncommon for some states to have fee schedules for the same procedure that are two and three times higher than other states.<sup>15</sup>

The research on the effectiveness of fee schedules in workers compensation is in its infancy. For example, while the WCRI research does document the nature of the medical care cost problems, there is no attempt to fully model the host of factors thought to drive costs. Thus, the WCRI did not consider changes in medical costs over time and, more problematic, did not consider other economic and demographic factors affecting medical costs.

The underlying rationale behind utilization and price controls is clear. The first seeks to control medical expenditures growth by controlling the mix and intensity of services to make sure the treatment is appropriate for the injury. The second seeks to control expenditures by restraining prices. The use of fee schedules in this regard is, of course, only appropriate to the extent that fees are lowered on average. As mentioned above, one common practice is to set fees at some percentile of the usual and customary charge. If that percentile is greater than the mean or average cost, the result could actually be a net increase in medical expenditures.

Questions remain concerning the effectiveness of such programs in containing workers compensation medical expenditures. Equally important, and in some ways more problematic, are questions about the implications of these cost containment programs on the availability and quality of care injured workers receive. This paper attempts to answer only the first set of questions. Namely, the principal issue is: Are costs lower under certain workers compensation medical cost containment strategies? Questions on the availability and quality of care are more difficult and await further research.

## II. DETERMINANTS OF WORKERS COMPENSATION MEDICAL COSTS

### a. MODEL

There is a small but growing body of research that seeks to explain workers compensation costs—both indemnity and medical—by examining the underlying economic and demographic conditions of the various state markets for workers compensation. Since workers compensation is a state-mandated program that is administered and regulated by individual states, it is appropriate to consider each state as a separate market for workers compensation.

Following models in the workers compensation literature, average workers compensation medical costs are investigated as a (log) linear function of benefits, wages, and variables representative of current and expected future economic conditions. Based on models from the health care literature,<sup>16</sup> demographic and education controls are also included, as these factors have been found to influence

the demand for and consumption of medical care. There are also some controls to represent other aspects of workers compensation systems.

There are three additional factors included given the interest in cost containment in workers compensation. First, given that workers compensation medical expenditures comprise only a small portion of total medical expenditures (roughly 1.7 percent), the influence of the total health care market is obviously quite strong. Thus, a control for the average cost

per inpatient stay in a hospital is added to the model; the intent is to control for outside forces that influence overall medical care costs.

The last two factors are those of principal interest to this investigation. Controls are added for whether a state uses a medical fee schedule in workers compensation and for whether the employer or employee has the initial choice of physician. The strategy for the empirical analysis is to control for as much variation in workers compensation medical costs as possible due to the economic and demographic factors. Then the net impact of the cost containment strategies can be ascertained.

Table 1 contains a list of variables used in the analysis and indicates the expected impact on workers compensation medical costs. The rationale for the expected signs is contained in the next section.

### b. ECONOMIC EXPECTATIONS

The underlying premise of the model used in the analysis derives from the notion that workers make decisions based on an evaluation of expectations about their economic well-being. The two principal variables that relate to this "expected utility" framework are the average weekly wages and expected temporary total benefits. Wages are expected to be negatively related to medical costs: higher wages imply a higher opportunity cost to being on a claim, and therefore a more rapid return to work. On the other hand, benefits are expected to be positively related to medical costs. Higher benefits, all else the same, imply a lower opportunity cost to being on a claim. The result would be more claims filed and the extension of the durations of claims. A second order effect may be observed if the incentives to file claims are stronger than those to extend the duration and those new claims are relatively less expensive. In that case, average costs may actually decline.

The interest rate variable captures the cost of workplace safety improvements and is expected to have a positive sign. As interest rates rise, investing in safety improvements becomes more costly, and in addition, firms have incentives to substitute labor for capital in their production processes. The result is higher anticipated workers compensation medical costs.

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VARIABLE	DEFINITION	SOURCE	EXPECTED SIGN
LCPIAVGM	Average workers compensation total medical costs, deflated by the Consumer Price Index (CPI), in logs	Unit Statistical Plan Database.	
LCAVGHF	Average hospital costs per day for nonprofit, nongovt. orgs., deflated by the CPI, in logs	American Hospital Association, "Hospital Statistics."	+
LWAIT	Waiting period for income benefits, in logs	"Analysis of Workers' Compensation Laws," U.S. Chamber of Commerce.	+
LDRATE	Annual discount rate for 3-month treasury bills, in logs	"Business Conditions Digest," U.S. Department of Commerce, Bureau of Economics Analysis.	+
LCPIWG	Ratio of wage and salary employment disbursements, to total nonagricultural employment, by state	Wage and salary data—U.S. Chamber of Commerce, Bureau of Labor Statistics. Nonagricultural employment data—"Employment & Earnings," U.S. Bureau of Labor Statistics.	-
TIME	Series for 1 to 20, 1965 = 1, 1984 = 20		+
TIME2	Square of TIME		+
CHOICE	Equals 1 for employer choice of physician, 0 otherwise	NCCI Survey of Individual State Accident Boards, 1989, requesting choice of physician and fee schedule rules for 1965-1984.	-
FEE	Equals 1, if fee schedule is in place, 0 otherwise	NCCI Survey of Individual State Accident Boards, 1989, requesting choice of physician and fee schedule rules for 1965-1984.	-
LCONSTR	Ratio of construction employment to total nonagricultural employment, by state, in logs	"Employment and Earnings," U.S. Bureau of Labor Statistics.	+
SELF	Equals 1 if state allows self-insurance, 0 otherwise	"Analysis of Workers' Compensation Laws," U.S. Chamber of Commerce.	+
LEXPBEN	Expected temporary total benefits, deflated by CPI, in logs	"Analysis of Workers' Compensation Laws," U.S. Chamber of Commerce and calculations based on NCCI standard wage distribution.	+

TABLE 1  
DATA SOURCES AND DEFINITIONS

Since the unit of observation in this study is the average medical costs in a given state and year, the characteristics of the labor force will have an important influence on the number and costs of workplace accidents. To control for this, a variable has been constructed that represents the proportion of total employment in construction. Since construction is typically a more risky industry, it is expected that the sign on this variable will be positive. As the proportion of employment that is engaged in risky

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occupations increases, workers compensation medical costs should also rise.

Another state-specific variable considered is whether a state allows group self-insurance. Since the workers compensation average medical cost data relates only to those purchasing insurance, and since firms that self-insure do so because they think they can insure more cheaply than in the market, the expected sign is positive. The allowance of self-insurance should leave the relatively worse risks in the market, i.e., those with higher losses.

The health economics literature suggests that the level of education is an important determinant of the

amount of medical care individuals consume. Interestingly, the literature suggests more highly educated individuals may actually consume less medical care because they live lifestyles conducive to better health. However, in this instance, the investigation relates to consumption of medical care given an injury. More education is expected to lead to higher workers compensation medical costs as people will be more informed and more likely to demand treatment for injuries. Previous research also suggests that education is positively related to the propensity to litigate workers compensation claims which will tend to increase claim durations and medical care costs.<sup>17</sup>

Average inpatient hospital costs per day represents a control for inter-jurisdictional differences in overall medical costs not otherwise captured. The expectation is that this will have a positive impact on average workers compensation medical costs. The waiting period (the amount of time before receipt of indemnity benefits), a control for differences in state workers compensation systems, is also expected to have a positive impact on claim costs as a longer waiting period will tend to exclude shorter duration, less costly claims from the system. In addition, longer waiting periods may give rise to increased utilization of medical care as a justification for receiving indemnity benefits. Thus it is expected that higher duration and cost claims will remain.

Finally, there are two dichotomous or dummy variables (i.e., zero/one indicator variables) introduced that represent whether the state uses a fee schedule to regulate workers

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STATE	FEE SCHEDULE	CHOICE OF PHYSICIAN	
Alabama	No	Employer	Employee
Alaska	No		Employee
Arizona	Yes		Employee
Arkansas	No	Employer	
California	Yes	Employer	
Colorado	Yes	Employer	
Connecticut	No		Employee*
Delaware	No		Employee
District of Columbia	No		Employee*
Florida	Yes	Employer	
Georgia	Yes	Employer	
Hawaii	Yes		Employee
Idaho	No	Employer	
Illinois	No		Employee
Indiana	No	Employer	
Iowa	No	Employer	
Kansas	No	Employer	
Kentucky	No		Employee
Louisiana	No		Employee
Maine	No		Employee
Maryland	Yes	Employer	
Massachusetts	Yes		Employee
Michigan	Yes	Employer	
Minnesota	Yes		Employee
Mississippi	No		Employee
Missouri	No	Employer	
Montana	Yes		Employee
Nebraska	Yes		Employee
New Hampshire	No		Employee
New Jersey	No	Employer	
New Mexico	No	Employer	
New York	Yes		Employee*
North Carolina	Yes	Employer	
Oklahoma	Yes		Employee
Oregon	Yes		Employee
Pennsylvania	No	Employer	
Rhode Island	Yes		Employee
South Carolina	Yes	Employer	
South Dakota	No	Employer	
Tennessee	No	Employer	
Texas	Yes		Employee
Utah	Yes	Employer	
Vermont	No	Employer	
Virginia	No	Employer	
Wisconsin	No		Employee

\* Employee choice in these jurisdictions is limited in that employees are required to select physicians from lists prepared by the State Agency.  
Source of data for physician rules was U.S. Chamber of Commerce, "1989 Analysis of Workers' Compensation Laws."

TABLE 2  
STATE ADMINISTRATIVE PROFILE  
(EXCLUDING MONOPOLISTIC STATE FUNDS)

compensation medical costs and whether a state allows the employer the initial choice of physician. The expectation is that both of these variables will have negative signs, i.e., the use of these strategies should lower average workers compensation medical costs.

### C. DATA AND ANALYTICAL TECHNIQUES

Data on workers compensation costs<sup>18</sup> and economic and demographic factors have been assembled for 33 states from 1964-1984, a time of significant increases in workers

compensation medical costs. This time period covers both economic expansions and contractions as well as significant changes in the composition of the labor force. In addition, the selection of states and years in the sample contains a number of states with and without fee schedules, with and without employer choice of physician, and contains states that have had changes with respect to either program. The breadth of the data should allow insights and comparisons on the effectiveness of fee schedules and choice of physician. Table 2 contains the results from the NCCI Research Division survey on

states' use of fee schedules and choice of physician rules. Changes in these respective programs are also identified. Given data availability on workers compensation costs and other control variables, 33 states are used in the analysis.

Two analytical techniques are employed. The first is a comparison of workers compensation medical costs from 1965-1984 (and their rate of growth) between the two sets of categories (fee versus nonfee and employer choice versus employee choice) under investigation. In this manner, we can readily observe if there have been any cost differences between states employing fee schedules or where the employer is allowed the initial choice of physician. Any differences in costs that are observed will be tested to see if they are statistically meaningful.

The second technique involves multivariate analysis using the economic model described above. This will allow a measurement of the net impact of the cost containment strategies after consideration of relevant economic and demographic information and will provide an estimate of how much costs differ in states that allow these cost containment initiatives.

## III. EMPIRICAL RESULTS

### a. DESCRIPTIVE STATISTICS

As mentioned in Section I, workers compensation medical payments have increased at an annual average rate of 11 percent over the past decade. For the states in the sample, average incurred medical costs increased at an annual average rate of 10.8 percent from 1964 to 1984. This corresponds to an annual growth rate

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of 5.6 percent in excess of the general rate of price inflation as measured by the Consumer Price Index. The average yearly nominal and real (i.e., excess of inflation) medical costs for the sample are presented in Table 3 and depicted in Graph 1. The yearly growth rates are also presented. Since 1973, nominal workers compensation medical costs have had double-digit yearly increases.<sup>19</sup>

Table 4 contains average medical costs split by whether the state uses a medical fee schedule. In every year, fee schedule states had average costs less than states not using a fee sched-

ule. Further, the difference between the two sets of states has grown from 5.5 percent in 1964 to 17.9 percent in 1984 with differences in excess of 20 percent observed in the early 1980s.

The averages may be slightly misleading since several states instituted fee schedules during the same period; therefore, growth rates may be more meaningful. On average over the same period, average medical costs in fee schedule states increased at a 10.6 percent annual rate; nonfee schedule states increased at 11 percent annually. Although this difference is small, because it is an annual

YEAR	AVERAGE MEDICAL		AFTER INFLATION	
	AMOUNT	% CHANGE	AMOUNT	% CHANGE
1964	208.83		249.69	
1965	213.00	2.00	257.03	2.94
1966	231.43	8.65	264.24	2.81
1967	251.07	8.49	279.54	5.79
1968	270.02	7.55	292.05	4.48
1969	300.27	11.20	309.49	5.97
1970	339.04	12.91	326.27	5.42
1971	372.61	9.90	346.34	6.15
1972	399.98	7.35	358.20	3.42
1973	446.26	11.57	367.36	2.56
1974	531.65	19.13	381.17	3.76
1975	637.35	19.88	416.34	9.23
1976	731.72	14.81	456.20	9.57
1977	808.75	10.53	485.34	6.39
1978	900.74	11.37	504.68	3.98
1979	1005.81	11.66	517.03	2.45
1980	1135.17	12.86	534.92	3.46
1981	1306.79	15.12	577.23	7.91
1982	1490.50	14.06	640.42	10.95
1983	1664.13	11.65	716.74	11.92
1984	1635.01	-1.75	745.25	3.98
Total Percentage Change		682.94		198.47
Annual Average Pct Change		10.84		5.62

TABLE 3  
GROWTH IN WORKERS COMPENSATION MEDICAL COSTS

average rate the cost differences will compound over time. In addition, the difference in average costs between fee and nonfee schedule states is statistically significant. The probability that the observed difference in costs is due to chance alone is less than 5 percent.<sup>20</sup>

Graph 2 shows the difference in average medical costs for fee and nonfee schedule states. Notice that even though fee schedule states have lower costs, the rates of increase have been similar. The difference in costs becomes noticeable in the mid-to-late 1970s and has grown since then.

YEAR	FEE	NON-FEE	% DIFF
1964	199.68	211.43	-5.56
1965	204.07	215.31	-5.22
1966	212.52	236.22	-10.03
1967	229.80	256.54	-10.42
1968	245.06	275.79	-11.14
1969	273.53	306.76	-10.83
1970	300.32	349.95	-14.18
1971	322.27	387.43	-16.82
1972	348.95	415.21	-15.96
1973	396.65	462.00	-14.15
1974	485.16	546.11	-11.16
1975	586.87	652.16	-10.01
1976	665.42	750.55	-11.34
1977	724.58	832.40	-12.95
1978	772.62	937.58	-17.59
1979	827.17	1057.23	-21.76
1980	915.63	1200.60	-23.74
1981	1087.58	1373.61	-20.82
1982	1280.03	1559.37	-17.91
1983	1399.18	1754.41	-20.25
1984	1486.90	1699.34	-12.50
Total Percentage Change	644.64	703.74	
Annual Average Pct Change	10.56	10.98	

TABLE 4  
AVERAGE MEDICAL COSTS:  
FEE V. NONFEE STATES

Table 5 contains average medical costs disaggregated by whether states have employer or employee choice of initial physician. In every year, employer choice states had lower average medical costs with the difference growing throughout the sample period. In 1964, employer-choice states had average medical costs of \$203.24 compared to \$239.35 for employee-choice states. That is, employer-choice states had 15 percent lower average medical costs. This difference in medical costs grew from 15 percent in 1964 to 36.5 percent in 1984.

The annual average growth rate for employer-choice states was 10.2 percent compared to 11.8 percent for employee-choice states. Thus not only were costs lower on average for employer-choice states but the rate of growth was also lower. The difference in medical costs between employer- and employee-choice states is statistically significant: the probability that this difference is due to chance alone is less than .01 percent.<sup>21</sup>

Graph 3 illustrates the differences in medical costs between employee- and employer-choice states. Up until about 1972-73, average costs between the two were fairly stable. Since 1973, employer-choice states have had much lower medical costs, with this difference becoming more significant.

On the basis of some simple statistical analysis and casual observation of average costs and their growth rates, it appears that both medical fee schedules and employer choice of physician are associated with lower average workers compensation medical costs. However, there are a great many factors that influence workers compensation medical costs and

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these simple observations may not be generalizable. For example, if either of these initiatives is systematically related to some of the other important cost drivers, then the effectiveness of the initiatives may be indeterminate. The multivariate analysis attempts to control for such situations.

**b. MULTIVARIATE ANALYSIS**

The structure of the data requires some care in the multivariate analysis. A variant of regression analyses is employed that controls for the fact that the data are both time series and cross-sectional in nature: i.e., average

medical costs are observed for 21 years and 33 states. The Appendix contains a technical discussion of the analytical technique.

The results from the regression analyses are contained in Table 6. Two different specifications are reported. The first contains the estimates from the basic economic model and variables discussed above. The second contains the results from a model which includes the original variables plus controls for the increasing trend in medical costs that has been observed over time. The idea is to test whether the economic and policy

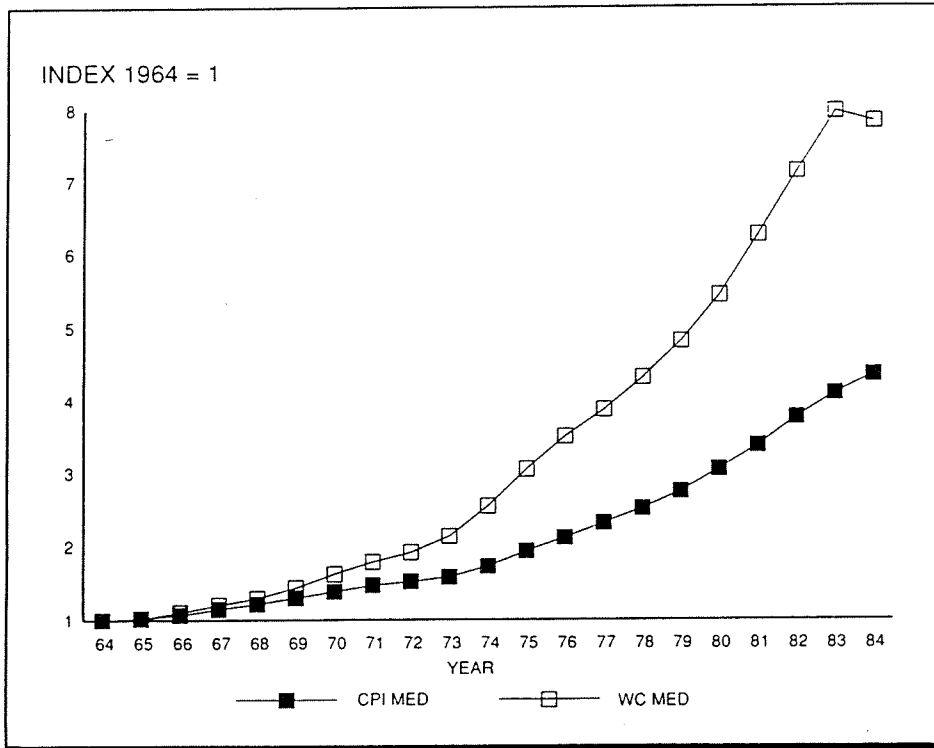
variables are distinct from secular forces known to affect time series data. For example, it is well-known that economic time series data tend to exhibit a positive trend which can obscure the statistical results of regression analyses. As mentioned previously, the models follow those in the literature and are specified such that the coefficients may be attributed as elasticities; i.e., each coefficient represents the percentage change in average medical costs given a percentage change in the individual variable holding constant all other factors.

Column (1) of Table 6 contains the

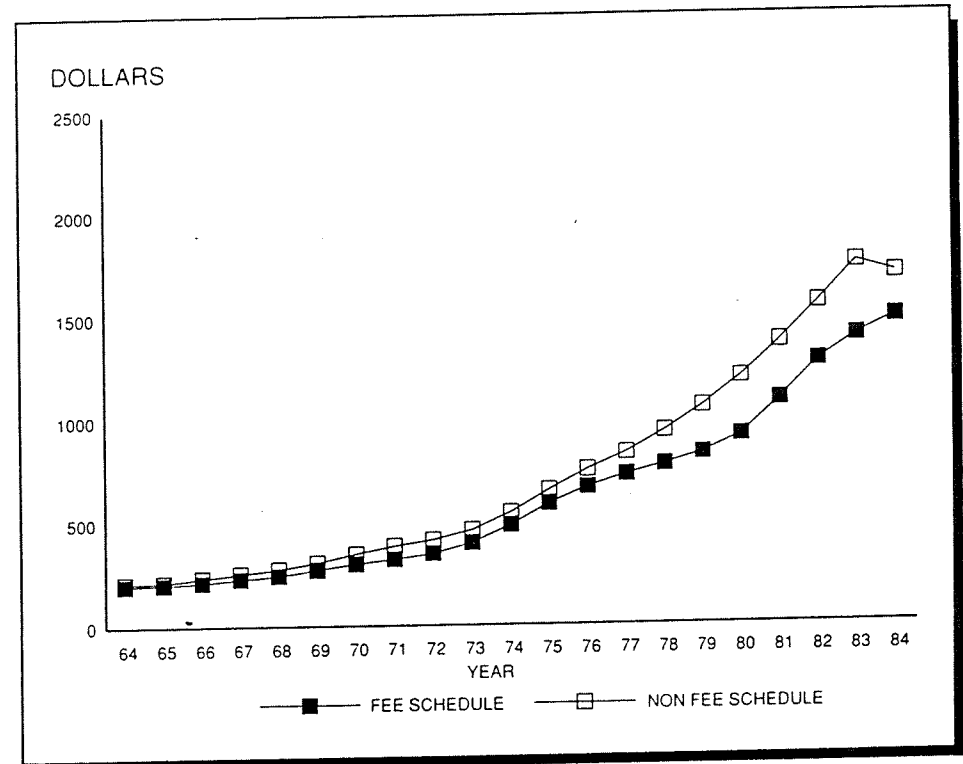
results from the basic model specification. Two general comments are worth noting. First, each of the variables is correctly signed; that is, each confirms prior predictions. Second, each is statistically significant. The two important policy variables, the variable representing whether a state uses a fee schedule and the variable representing employer choice of physician, are both associated with lower average medical costs.

The fee schedule coefficient is  $-.035$ . The interpretation is that, all other factors in the model considered, states with fee schedules will have 3.5 percent lower average medical costs

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**GRAPH 1**  
**WORKERS COMPENSATION GROWTH IN MEDICAL COSTS**



**GRAPH 2**  
**WORKERS COMPENSATION AVERAGE MEDICAL COSTS**

than states without a fee schedule. The coefficient on the choice of physician variable is  $-.082$ . The interpretation is that states with employer choice of physician will have 7.9 percent lower average medical costs.<sup>22</sup> These results are reinforced by the models that include the time controls contained in Column (2) of Table 6. With a couple of exceptions, the estimated parameters again conform to the predictions and are statistically meaningful. The fee schedule coefficient is  $-.056$  which translates into 5.4 percent lower average costs in states with the schedules. The choice of physician coefficient is  $-.054$

which translates into 5.3 percent lower average costs in states that allow employers to select the initial physician.

The two main variables that comprise the expected utility framework are wages and benefits. The wage coefficient is negative and significant as predicted. The coefficient is  $-.399$  in column (1); thus, a 10 percent increase in wages will give rise to almost a 4 percent decrease in average medical costs, everything else held constant. This variable represents the greater opportunity cost to being out of work. As wages rise, and benefits are held constant, the implicit cost to being on a workers compensation claim rises and hence workers will choose to file fewer claims, and once injured, stay on a claim for shorter durations.

The benefit variable represents income when on a claim. As benefits increase, with wages held constant, the opportunity cost of being on a claim decreases. The estimated coefficient is small but positive. The coefficient is  $.009$ ; thus, a 10 percent increase in benefits will give rise to a .9 percent increase in average medical costs.

A brief review of the remaining variables shows that an increase in overall hospital costs gives rise to an increase in workers compensation medical costs.

Similarly, increases in interest rates, the waiting period, the proportion of construction employment, the allowance of group self-insurance, and the education level are all associated with higher average medical costs. Other than the group self-insurance variable, which is similar to the fee and choice of physician in that it takes on values that are either zero or one

to indicate the presence of the factor, all other coefficients may be strictly interpreted as elasticities.

In Column (2), the estimated parameters on the time controls are also as might be expected. The positive sign on both time and the square of time indicate that medical costs have been rising at an increasing rate, at least over the sample period. This is certainly consistent with the observations in Section I, but it is significant in that other economic controls are considered. The expected utility framework is verified although there is some ambiguity with some of the remaining economic variables. Sta-

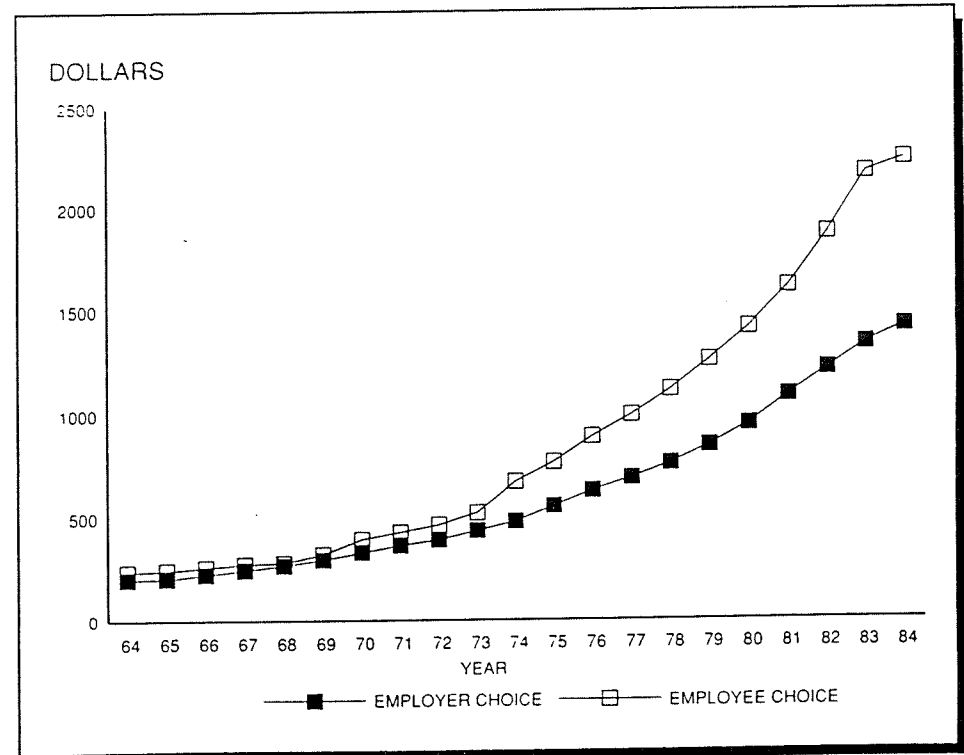
tistically, the models perform well explaining a significant amount of the variability in average medical costs.

Combining the results from the two multivariate models, it is clear both fee schedules and employer choice of physician lower costs. Averaging the two models suggests that fee schedules appear to lower average costs by approximately 4.5 percent when economic factors are considered. Recall, the simple descriptive statistics also found fee schedule states to have lower costs and lower growth rates over time. It seems that price controls do reduce costs and that this reduction is not compromised by an increased

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YEAR	EM- PLOYER	EM- PLOYEE	% DIFF
1964	203.24	239.35	-15.09
1965	207.24	246.25	-15.84
1966	226.56	260.05	-12.88
1967	247.02	275.16	-10.23
1968	267.64	281.75	-5.01
1969	295.48	322.47	-8.37
1970	330.31	394.44	-16.26
1971	364.05	428.06	-14.95
1972	389.95	463.05	-15.79
1973	434.72	522.09	-16.73
1974	478.67	672.00	-28.77
1975	552.74	765.73	-27.82
1976	628.13	888.82	-29.33
1977	687.91	993.32	-30.75
1978	758.29	1116.10	-32.06
1979	844.07	1258.87	-32.95
1980	946.71	1414.00	-33.05
1981	1087.63	1612.12	-32.53
1982	1216.40	1874.49	-35.11
1983	1336.55	2170.87	-38.43
1984	1419.89	2237.07	-36.53
Total Percentage Change	598.63	834.64	
Annual Average Pct Change	10.21	11.82	

TABLE 5  
AVERAGE MEDICAL COSTS:  
EMPLOYER V. EMPLOYEE CHOICE



GRAPH 3  
WORKERS COMPENSATION AVERAGE MEDICAL COSTS

utilization of services. This is not to say that increased utilization does not occur. Rather, on average, costs are lower in fee schedule states even after consideration of other relevant factors.

The initial choice of physician appears to have a larger impact on medical costs than fee schedules. On average across both specifications, employer-choice states have 7 percent lower costs than employee-choice states. In

some ways this is not surprising since employer selection may be based on both price and utilization controls. This finding is also consistent with the descriptive statistics whereby employee-choice states were observed to have higher average costs and larger growth rates.

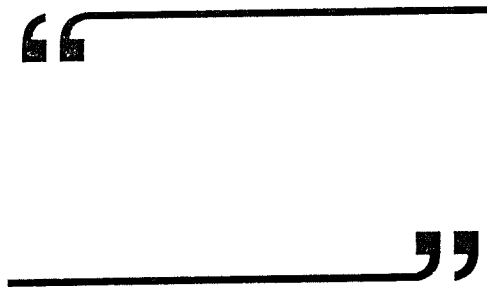
#### IV. CONCLUSIONS AND FUTURE RESEARCH

In the initial phase of this study, fee schedules and employer choice of physician were found to lower workers compensation costs.<sup>23</sup> This follow-up report confirms those findings but refines the estimates of the magnitude of the cost savings. The models presented here are expanded to consider additional economic and demographic considerations, and more importantly, the statistical techniques are specifically suited for the kind of data used in the analysis. The data used are quite extensive: information on workers compensation costs, administrative structure, and economic and demographic characteristics have been assembled for 33 states and 21 years.

The results from the present analysis are that fee schedules lower costs by between 3.5 and 5.4 percent. The previous analysis suggested that fee schedules lower costs by up to 11 percent in the long run (over a period of time). This is not inconsistent with the descriptive statistics presented above. The simple average difference in costs between fee schedule and nonfee schedule states over the 1964-1984 period was 14 percent. The multivariate analysis presents the net impact after consideration of factors that may give rise to the institution of fee schedules in the first place, e.g., high costs or other economic considerations, and

suggests that the marginal impact of moving to a fee schedule will be in the range of 3.5 to 5.4 percent.

Similarly, although greater in magnitude, employer choice of physician lowers medical costs by between 5.3 and 7.9 percent. The previous analysis suggested that the long-run effect of employer choice of physician on costs was 13 percent. This too is consistent with the observations on the differences in costs and growth rates presented in the section on descriptive statistics.



While one of the strengths of the present study is the breadth of the data combined with an appropriate analytic technique, it is also ironically a weakness. The use of aggregate statewide data can obscure distributional or individual claimant considerations. For example, it is well-known that individual claim data for workers compensation claimants is highly skewed; there are relatively few very expensive claims that comprise a large percentage of total costs. Use of statistics like average costs will not capture this phenomenon. Clearly, one aim of future research should be to assess the effectiveness of these and other cost containment strategies using individual claim data.

One additional caveat concerning the

analysis in this paper should be recognized. The use of dichotomous or dummy variables to capture differences in whether a state has a fee schedule or is an employer- or employee-choice state is an oversimplification of the different systems that actually exist. Capturing and quantifying these differences pose significant problems for future research.

Finally, this study did not attempt to address the important issues of availability and quality of care. These issues are especially important given the historical role of workers compensation. These issues will also need to be addressed with specially designed studies and individual claim data.

These caveats notwithstanding, the results presented have a basis in economic theory and support the effectiveness of fee schedules and employer choice of physician in containing workers compensation medical costs. While it remains for future research to refine the extent of the cost savings, both fee schedules and employer choice of physician do appear to offer medical cost savings for workers compensation.

#### APPENDIX

Formally, the Parks method of the TSCS procedure in SAS was used for the analysis. This procedure is essentially an error components model. Statistically, the error structure of the regression model may be affected by the nature of the data. In particular, the disturbances across the states in each time period are likely to be heteroskedastic and perhaps correlated. It is also expected that the disturbances of the cross-sectional units

VARIABLE	(1)	(2)
Intercept	5.967 (38.261)	1.196 (10.710)
Choice	-0.082 (37.888)	-0.054 (23.892)
Fee	-0.036 (14.835)	-0.056 (14.638)
Lcavghp	0.676 (108.55)	0.300 (42.903)
Lwall	0.003* (1.658)	-0.0001* (.087)
Ldtrate	0.009 (6.027)	-0.013 (17.522)
Lconstr	0.024 (8.000)	-0.016 (3.176)
Self	0.037 (37.968)	-0.0001* (.056)
Lexpben	0.009 (11.392)	0.006 (23.791)
LCpiwg	-0.399 (25.215)	-0.301 (23.791)
Lhseduc	0.006 (18.937)	-0.001 (5.541)
Time	—	.008 (14.597)
Time2	—	.001 (97.226)

All variables significant at .01 unless otherwise noted.

TABLE 6  
WORKERS COMPENSATION  
MEDICAL COST REGRESSIONS:  
COEFFICIENTS WITH  
T-STATISTICS IN PARENTHESES\*  
(N = 660)

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over time are serially correlated. A generalized least squares procedure is employed to handle these problems.

The procedure essentially entails three steps. In the first step, an ordinary least squares regression procedure is applied to all pooled observations. Estimates of the residuals are used to obtain estimates of the autocorrelation coefficients, which are in turn used to transform the data. Ordinary least square regression is then applied to the transformed data

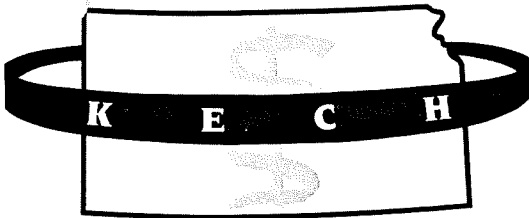
and the estimated residuals from the regression are used for an estimate of the variance-covariance matrix. The variance-covariance matrix is used in the last step, which is a generalized least squares procedure. Estimates obtained using this methodology are unbiased, consistent, and asymptotically efficient, and hence can be used to draw inferences about the determinants of average workers compensation medical costs across all states.<sup>24</sup>

## NOTES

1. *Social Security Bulletin*, Annual Statistical Supplement, 1989, U.S. Department of Health and Human Services, Social Security Administration, table 8.B1, 310.
2. *Health, United States, 1989*, National Center for Health Statistics, Department of Health and Human Services, Publication No. 90-1232, Hyattsville, Maryland, March 1990.
3. *Monthly Labor Review*, U.S. Department of Labor, Bureau of Labor Statistics, November 1990, table 51, 101.
4. "Cost Containment," *NCCI DIGEST*, Volume IV, Issue IV, Dec. 1989, 25-56.
5. National Council on Compensation Insurance, *Annual Statistical Bulletin*, 1990 edition.
6. *Social Security Bulletin*, Annual Statistical Supplement, 1990, U.S. Department of Health and Human Services, Social Security Administration, table 8.B1.
7. Levit, Katharine, Mark Freeland and Daniel Waldo, "National Health Care Spending Trends: 1988," *Health Affairs*, 92, Summer 1990, 171-184.
8. National Council on Compensation Insurance, *Issues Report*, 1990, 13.
9. For a thorough theoretical discussion of the rationale behind these problems, see "Cost Containment," *NCCI DIGEST*, Volume IV, Issue IV, 25. For a recent inventory of individual state practices concerning cost containment, see Boden et al., "Medical Cost Containment in Workers' Compensation: A National Inventory," *Workers Compensation Research Institute*, WC-90-4, November 1990. Also see Pozzebon, Silvana, *Health Care Cost Containment: A Review of the Literature*, a background report to the Minnesota Legislature for cost containment in the workers compensation system, 1990.
10. See Boden et al., *ibid*.
11. This prediction is supported by empirical observation. Significant research from the Rand Health Care Experiment beginning in the mid-1970s found that consumers were responsive to changes in the price of medical care. Medical care was found to be similar to other "normal" goods; as the price to the consumer increases, the demand for medical care does decrease. The Rand health experiment estimated demand

elasticities that ranged from  $-1$  to  $-2$ ; the "non-experimental" literature reports elasticities from  $-1$  to  $-2.1$ . The interpretation of an elasticity of  $-1$  is that a 10 percent increase in the price of the good or service in question will cause a 1 percent decline in the demand for that good or service. Thus cost sharing through deductibles and coinsurance can significantly impact the demand for medical services. In addition, the Rand experiment found that the type of medical service is sensitive to cost sharing reimbursement practices. For example, the impact of cost sharing was stronger for outpatient care than inpatient services. See Willard G. Manning et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," Feb. 1988, The Rand Corporation, Santa Monica, CA.

12. Appel, David, and David Durbin, "Long Duration Workers' Compensation Claims," *NCCI DIGEST*, Volume I, Issue I, 1987, observe that for long duration claims employee choice of physician may decrease costs. They hypothesize that this finding may be due to the specialized nature of their sample and was not the central theme of their analysis. John Lewis (1989) finds, based on a limited sample of claims from Illinois, Colorado, Texas and California, that employees are infrequently referred to their treating physician by the employer.
13. Victor, Richard B., and Charles Fleischman, "How Choice of Provider and Recessions Affect Medical Costs in Workers' Compensation," Cambridge, MA, Workers Compensation Research Institute, 1990.
14. Borba, Philip S., "The Impact of Medical Fee Schedules?," *NCCI DIGEST*.
15. Boden, Leslie I., Joan M. DeFinis and Charles A. Fleischman, "Medical Cost Containment in Workers' Compensation: A National Inventory," *Workers Compensation Research Institute*, Cambridge, MA, WC-90-4, November 1990.
16. Grossman, Michael, "The Demand for Health: A Theoretical and Empirical Investigation," NBER Occasional Paper 119, National Bureau of Economic Research, New York, 1972.
17. Borba, Philip S., and David Appel, "The Propensity of Permanently Disabled Workers to Hire Legal Services," *Industrial and Labor Relations Review*, April 1987.
18. The data on workers compensation medical costs are based on first report Unit Statistical Plan policy year data from NCCI and provided by WCRI for non-NCCI states. The policy year data have been converted to an accident year basis for comparisons with the economic and demographic data. The details of the conversion are available upon request.
19. The one exception is 1984 where the growth rate is negative. This is somewhat misleading: 1984 data is incomplete due to the technique of transforming policy year data to an accident year basis.
20. A T-test of the differences in mean medical costs yields a  $t=1.75$  which is significant with  $p=.0405$  in a one-tail test.
21. A T-test of the differences in costs between employer- and employee-choice states yields a  $t=5.37$  with  $p=.0001$ .
22. It is well-known that in logarithmic models, elasticities on dummy variables =  $\exp(B) - 1$ .
23. "Cost Containment," *NCCI DIGEST*, op. cit.
24. See Kmenta, Jan, *Elements of Econometrics*, Macmillan Publishing Company, New York, 1971, 512-514.



## Kansas Employer Coalition on Health, Inc.

1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

**Testimony to Senate Committee on Labor, Industry and Small Business**

**on HB 2196**

**(Giving workers' compensation claimants first choice of medical provider)**

by James P. Schwartz Jr.  
Consulting Director  
February 19, 1992

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is 100 employers across Kansas who share concerns about the cost of health care for our 350,000 Kansas employees and dependents.

The Coalition strongly opposes HB 2196. Of all the health-care legislation we've monitored in Kansas during the past nine years, it would be hard to find a bill more damaging to employers' cost-containment efforts.

On the surface HB 2196 seems a desirable bill. After all, who wouldn't like to have unrestrained choice of medical provider? The reality of present-day health care, though, is that completely unrestrained choice of provider has become a luxury that fewer and fewer purchasers can afford. Not only is it a luxury, but it's sometimes harmful because it opens the door to poor-quality providers. For those reasons, health insurance plans are gravitating toward HMOs, PPOs and similar arrangements that restrict patients' choice of provider. It's estimated that by 1995 the vast majority of health insurance plans will involve some form of "managed care" arrangement. For the same reasons, work-comp insurance is heading in the same direction.

HB 2196 has been pitched as a pro-labor bill. Let's take a look at who the real winners will be if this legislation passes. The crisis in health-care costs, of which work-comp is a part, is every bit as much a labor problem as a management problem. Work-comp costs are part of total compensation. When those costs go up, there's less money for wage increases and other benefits. In the last 10 years, the widening gap between wages and cost of living results almost entirely from the skyrocketing cost of health care. Labor knows this. Everyone knows that resolving the health-care crisis will involve sacrifices

*B. L. J. + J. B.*  
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by every party. In a national survey last year, labor leaders were asked what sacrifices they would be willing to make in the interest of an improved system. Their most agreeable solution was "to be required to belong to managed care plans...using limited panels of doctors, hospitals and other providers." Labor has, albeit reluctantly, given the green light to managed care as a relatively benign way to allocate limited health-care dollars.

So, if this is not really a labor bill, let's see who else stands to benefit. Requiring wide-open choice of provider is clearly a bonanza to providers, especially those who tend not to be preferred by organized systems of care. And it's a spectacular bonanza for work-comp specialists who relish the guarantee of unfettered charges and practice styles, with patients shielded from any hint of expense.

Let's expose this bill for what it is: an attempt by some providers to reinstate 1970s-style medicine, with all the elements that have gotten us into the fix we're in today. A look at the list of proponents will support this contention.

If enacted, HB 2196 would represent a **huge step backward** for health care purchasers in Kansas. And the timing couldn't be worse. We just absorbed a 24% increase in rates, and I understand we are looking at a requested increase of another 30% in 1992.

Some may argue that the passage of the medical fee schedule for work comp two years ago removes the need for directing patients to preferred providers. Let's be clear about this. The fee schedule helps small employers, who are less likely to have access to a preferred provider network. On the other hand, the authority to direct care is the **main cost-containment tool of large employers**. All employers, large and small, desperately need help containing health-care costs. That's why we need both the fee schedule **and** authority to designate preferred providers. You must know, too, that the birthing of the fee schedule seems hopelessly mired in the bureaucracy.

Perhaps employers wouldn't feel so strongly about this bill if workers' compensation were just another fringe benefit that companies could place on the bargaining table. We realize, though, that we can't negotiate this type of entitlement, and we can't walk away. The state relies on corporate Kansas to maintain this type of social insurance, and we, in turn, rely on government to do its share to keep it affordable.

The minimum we need from you is to refrain from passing this bill.

*S.L.D. v. S.B.*  
*2/19/92*

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