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Program Report

Improving Workers’ Compensation Health Care

A new grant program tests and evaluates ways to contain costs and improve quality in workers’ compensation health care.

by Allard E. Dembe, Jay S. Himmelstein, Beth A. Stevens, and Michael P. Beachler

The Robert Wood Johnson Foundation (RWJF) established a new national program in October 1995, the Workers’ Compensation Health Initiative (WCHI), to support demonstration and evaluation projects that test new models for containing costs and improving the quality of workers’ compensation health care. The WCHI became the first major grant program in the field of occupational health care to be sponsored by a national philanthropic foundation.

Creation of the initiative followed a period of rapid cost escalation during the late 1980s and early 1990s, when outlays for workers’ compensation medical services grew at a faster rate than total health care expenditures. The rise in workers’ compensation costs stimulated state legislators and regulators, health care providers, insurance carriers, employers, and labor groups to develop proposals for significant changes in the financing and delivery of medical care afforded to injured workers.

But cost is not the only factor driving the development of new approaches to workers’ compensation health care. Control over the delivery of care and selection of providers, intense competition for market share by suppliers of workers’ compensation services, workers’ demands for improved care, and employers’ efforts to streamline benefits administration are equally important.

The WCHI has provided a setting for fostering innovative workers’ compensation health care programs and evaluating the impact of recent changes in health plan design on costs and quality. Through the initiative increased attention is being placed on understanding the differences between workers’ compensation health services and general medical care—for example, workers’ compensation’s greater emphasis on disability management and its coordination of health insurance with income replacement protection. The WCHI also will provide new information on the complexities of integrating workers’ compensation and general health care into a single “twenty-four-hour” coverage arrangement, similar to that envisioned in 1993 under Title X of the Clinton administration’s proposed Health Security Act.

State government agencies, employers, labor unions, insurers, health care providers, and researchers are eligible for grants under the WCHI. The initiative is restricted to projects that deal with the health care aspects of workers’ compensation. Because the initiative is designed to test and evaluate significant new models of workers’ compensation health care, the foundation prefers that projects cover a large number of employers and employees. However, the WCHI is not intended to provide seed money for the development or marketing of commercial products.

In November 1996 RWJF awarded the first ten grants, totaling about $3 million. A second funding cycle to award an additional $3 million is now under way, with an application...
deadline of 5 September 1997, and RWJF ex-
pects to announce those awards in March
1998. This report provides a summary of key
findings from the first round of funding and a
description of some of the central policy con-
siderations confronting future attempts to
improve workers’ compensation health care.

Drivers Of Change

Submissions to the WCHI illustrate many
of the principal factors underlying the move-
ment to develop new models for workers’
compensation medical care.

COSTS. Employers’ outlays for workers’
compensation in 1993 were approximately
$57.3 billion, an increase of 64 percent since
1984, after adjusting for inflation. During
the 1980s and early 1990s, workers’ compensation
costs became a significant business expense,
representing approximately 2.4 percent of
private-sector payroll in 1991, up from 1.7 per-
cent in 1984. Cost increases hit small busi-
nesses and those in high-hazard industries,
such as construction and heavy manufactur-
ing, hardest. As a result, pressure mounted for
political reform and private-market solutions.
During the late 1980s and early 1990s, major
workers’ compensation reform legislation
was enacted in more than twenty-five states,
and policymakers increasingly began to look
at modifications in the financing and delivery
of workers’ compensation medical care as one
important element in this reform movement.

MEDICAL VERSUS OVERALL COSTS. Be-
tween 1980 and 1993, expenditures for the
medical care component of workers’ compensa-
tion grew at an average annual rate of 12.6
percent, outpacing the average annual growth
in general health care costs of 10.2 percent. In
the early 1990s, as medical costs continued to
escalate, expenditures for indemnity (income-
replacement) benefits and other nonmedical
components of workers’ compensation began to
decline in response to tightening of benefit eligi-
bility criteria, restrictions on litigation, and
other provisions of state reform measures. As a
result, the relative proportion of medical expen-
ditures to overall compensation costs continued
to increase, accounting for approximately 52
percent of total workers’ compensation benefits
in 1994, up from 42 percent in 1984.

MANAGED CARE. Traditionally, workers’
compensation medical care has been fur-
rished in a fee-for-service environment with
few restrictions on choice of provider or type
of care. As costs mounted, reformers have
looked increasingly to managed care strategi-
ges used in the general health care setting as a
model for how to control workers’ compensa-
tion medical expenditures. As of 1995, twenty-four states had either authorized or
mandated the use of managed care organiza-
tions (MCOs) by injured workers. Fifty-nine
percent of employees are now covered by
workers’ compensation insurance that con-
tains some type of managed care arrangement.
Most states have adopted medical fee sched-
ules and regulated hospital charges. Few
studies have yet assessed the effect of such
measures on the cost or quality of workers’
compensation health care.

NATIONAL HEALTH CARE REFORM. The
well-publicized efforts of the Clinton admini-
stration between 1993 and 1994 to get a na-
tional health care reform plan adopted
brought increased attention to ideas for
changing the structure of workers’ compensa-
tion medical care. Title X of the Clinton
Health Security Act would have required that
employees receive all of their health care
through the same insurance plan, regardless
of whether the injury or illness occurred at
home or at work. These events provided addi-
tional momentum for states and the private
sector to develop initiatives linking workers’
compensation and general health care under
some form of twenty-four-hour coverage. The
possible benefits of such a linkage include
streamlined and more cost-effective admini-
stration, reduced cost shifting, coordination
of insurance financing and benefits, and im-
proved communication among providers.

CHANGES IN TRADITIONAL WORKERS’
COMPENSATION INSURANCE PLANS. In an
effort to lower premiums and reduce premium
taxes, many employers in the past decade
have moved from traditional workers’ com-
penetration insurance plans to self-insurance or
other forms of risk retention. The proportion
of employers moving from a traditional insurance policy to self-insurance increased from 18.1 percent in 1980 to 30.3 percent in 1992. The use of large deductible plans, retrospective rating, and other loss-sensitive mechanisms in workers’ compensation has also grown substantially. As a result, many employers now bear more of the direct costs associated with the payment of medical benefits and, consequently, have a greater interest in the way cases are managed.

**Current Innovations**

The WCHI has attracted proposals representing most of the major types of public- and private-sector innovations now being pursued in workers’ compensation health care. These efforts can be summarized as follows.

**PROVIDER NETWORKS.** Both the private and nonprofit sectors have been active in setting up new provider networks specializing in workers’ compensation care. These networks typically contract with insurance carriers, third-party administrators, or directly with employers. In some states the employer or insurer can insist that injured workers obtain care from within the provider organization. Many of these new organizations attempt to integrate primary health care with specialty and hospital services. Most incorporate a variety of managed care elements, including discounted fees, medical case management, and the use of treatment guidelines, and participate in utilization review, bill review, and other cost containment programs.

**STATE-APPROVED MANAGED CARE PROGRAMS.** Various managed care techniques are now being applied in workers’ compensation health care throughout the United States. Some states mandate that utilization review (twenty-one states), bill review (sixteen states), and treatment guidelines (eleven states) be used in workers’ compensation cases. Other states have explicitly permitted the voluntary use of such techniques. One of the most closely watched developments is the movement toward allowing workers’ compensation health care to be provided within health maintenance organizations (HMOs) and other MCOs. In one of the ten projects funded in the first round of the WCHI, researchers from the University of Washington and a state agency are evaluating the impact of Washington State’s managed care pilot program, involving networks of occupational physicians paid on a capitated basis. In another project, investigators from Stratis Health, a nonprofit research group, are examining the effect of Minnesota’s mandatory treatment parameters for low back pain. The American College of Occupational and Environmental Medicine, with support from the WCHI, is disseminating newly developed voluntary treatment guidelines covering a variety of occupational ailments.

**CASE MANAGEMENT.** Case management has emerged as one of the most prominent strategies for improving workers’ compensation health care. A distinctive feature of workers’ compensation is the need for close monitoring and supervision of patient care throughout the course of medical treatment, rehabilitation, physical and occupational therapy, and vocational retraining. Since wage replacement is a compulsory part of workers’ compensation coverage, medical care and reimbursement for medical services must often be coordinated with disability management activities and indemnity payments. Extensive coordination and communication are needed among the employer, the injured worker, health care providers, the employer’s insurance carrier, lawyers, therapists, and others. Many organizations are developing new models of workers’ compensation–oriented case management that bridge the demands for medical case oversight, disability management, patient advocacy, communications, and claims administration.

**TWENTY-FOUR-HOUR PLANS.** Since 1993 several states (including California, Maine, and Oregon) have authorized pilot programs to test combined twenty-four-hour health coverage. Efforts are now under way in seven other states to launch similar programs. So far, progress in these programs has been slow, and employer enrollment has fallen short of expectations. Declining workers’ compensation costs since 1994 have undoubt-
edly contributed to the sluggish growth of twenty-four-hour programs. Nevertheless, state-sponsored and private-market initiatives to explore combined workers’ compensation and non-compensation health care continue to appear. In one WCHI-funded project, the Minnesota Health Partnership is pursuing a model that blends the medical care and disability benefits traditionally provided through group health and workers’ compensation coverages. Another grant supports a state-administered twenty-four-hour pilot program being developed by the State of Maine Bureau of Insurance. WCHI funding was also awarded to researchers from the University of California, Los Angeles, Center for Health Policy Research, who will collaborate with RAND and other investigators to evaluate California’s twenty-four-hour pilot program. An interesting variation on integrated medical services is being tested by the New York State Department of Civil Service, which is developing a combined prescription drug program for New York State employees.

ALTERNATIVE ARRANGEMENTS. A few states allow employers to develop special plans for conferring medical and indemnity benefits to injured workers that deviate from those allowed under standard workers’ compensation laws and regulations. In Texas and South Carolina, for instance, employers are not required to carry conventional workers’ compensation insurance. As a result, some employers in those states have developed individualized approaches for meeting financial obligations that may be incurred as a result of workplace injuries or illnesses. In several other states, including California, New York, and Hawaii, collective bargaining agreements may be used to create alternative systems for providing medical and disability benefits that differ from those permitted under conventional state workers’ compensation law. For example, in one WCHI-sponsored project, the Electrical Employers Self Insurance Safety Plan is developing a union/management health plan under New York State’s alternative dispute resolution legislation that will provide twenty-four-hour health care and disability benefits for more than 15,000 electrical workers in the New York City metropolitan area. The Union of Needletrades, Industrial, and Textile Employees received a WCHI grant for developing alternative financing arrangements to ensure that union members receive basic diagnostic testing and medical care for cumulative trauma disorders even if the work-relatedness of their condition is contested by the employer’s workers’ compensation insurer. WCHI funding was also awarded to researchers from the University of California, Los Angeles, Center for Health Policy Research, who will collaborate with RAND and other investigators to evaluate California’s twenty-four-hour pilot program.

EDUCATION AND COMMUNICATIONS. Proposals submitted to the WCHI suggest that inadequate education and communications is a major force driving up costs and adversely affecting medical outcomes. Most employees and many employers have a poor understanding of how the workers’ compensation system works—for example, what benefits are available through the system and how to obtain appropriate medical care. Several proposals submitted to the WCHI suggest new approaches for improving communications among health care providers, insurance carriers, injured workers, and employers concerning the status of a case, extent of disability, alternatives for modified work, and plans for rehabilitation. The WCHI funded a project in which the Mid-America Coalition on Health Care is developing a new “workability reporting form” and other techniques to facilitate communications among affected parties in the Kansas City area.

Major Policy Considerations

Many practical and political challenges will confront future attempts to improve workers’ compensation medical care. Initial experience in the WCHI has revealed some of the principal issues facing reformers. These
include the need for key stakeholders to be involved in system design and implementation, how to ensure employee involvement in the selection of providers and provider organizations, preserving the existing emphasis on vocational rehabilitation and disability management, protecting workers’ rights to full coverage of medical care for job-related conditions, and providing the medical tests and special services required for administration of workers’ compensation cases. Ensuring high-quality workers’ compensation medical care is especially important given the increasingly restricted opportunity for injured workers to “vote with their feet” when confronted with what they perceive as inadequate medical care. This grant program should provide new knowledge about what constitutes high-quality workers’ compensation health care and how it can best be measured. It is becoming evident that quality cannot be assessed adequately by considering merely the direct costs of medical care and wage replacement, or the length of time needed for an injured worker to return to work. It is also critical to measure the impact of care on a wide range of indirect outcomes such as the likelihood of reinjury, long-term job retention, participants’ satisfaction, and the worker’s earning capacity, social and physical functionality, and mental health.12 In several WCHI-sponsored projects, new survey instruments and other methodological tools are being developed to collect and evaluate this information.

NOTES

3. Ibid., 2.
6. B. Llewellyn, “Workers’ Compensation Costs and Profitability” (Paper presented at the National Symposium on Workers’ Compensation, East Lansing, Michigan, 17 July 1996); Burton, “Workers’ Compensation Benefits and Costs,” 7; and Insurance Services Office, Inc., Health Care Costs in the Property/Casualty Insurance Industry (New York: ISO, December 1993). Because of differences in methodology, the estimates provided by Burton and the ISO are consistently about five to ten percentage points less than those provided by Llewellyn and the National Council on Compensation Insurance, which provides rate-making and information services to state workers’ compensation agencies and to insurance carriers.
7. See Eccleston, Managed Care and Medical Cost Containment in Workers’ Compensation; and “States Vary Widely on Approaches to Managed Care,” Workers’ Comp Managed Care (March 1996): 6.
10. Workers’ compensation managed care initiatives for each state are described in Eccleston, Managed Care and Medical Cost Containment in Workers’ Compensation.