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WAKE THE SLEEPING DOGS: THE CASE FOR CONTINUAL IMPROVEMENT IN PROGRAM DESIGN

BETSY ROBINSON AND BRANNON TRANSUE

In 2004, Toyota surpassed Ford and Mercedes Benz to become the world's top automobile brand, according to the annual Best Global Brands survey conducted by Interbrand. The Japanese automaker has held that position ever since, and it has risen to the sixth most valuable brand in any industry. The value of its brand continues to grow, increasing from \$18.5 million in 2001 to \$34 million in 2008.¹ One of the reasons for the company's increasing success is its commitment to *kaizen*, the concept of continuous improvement in all aspects of its business.

Sharper focus and a little *kaizen* could also support the success of an organization's workers compensation program. In a challenging economy and in the face of increasing medical exposure, it only makes sense to ensure that the program addresses the employer's unique risks — and continues to do so

as cost drivers change over time. Just as data analysis helps manufacturers to improve their processes, in-depth analysis of claims and managed care data can provide the insights necessary to develop and fine-tune a workers compensation program that meets the employer's goals, does so as cost-effectively as possible, and continues to deliver results over time.

IT DOESN'T PAY TO SETTLE FOR THE STATUS QUO

Many large employers today buy their workers compensation programs on a "bundled" basis, with claim administration and managed care services delivered either through a single entity or under a single contract through a third party administrator (TPA). Such an approach can be attractive. Bundled programs would seem to offer administrative convenience, and there may be savings associated with purchasing claims and managed care services from a single vendor. Theoretically, at least, this approach also can put all relevant data in a single location. The downside of bundled programs is that they tend to be standardized solutions. Most often, the clinical team and workflow are determined primarily by program size, which is based on claim volume and the ratio of medical-only to lost-time events, rather than on an in-depth analysis and understanding of the organization's true cost drivers and specific areas of risk.

On the other hand are employers who buy "unbundled" services with the goal of having a program that is more specifically tailored to their organizational goals, work force, and unique operational challenges. They purchase workers compensation claim management services from a third party administrator and managed care services separately from a stand-alone clinical supplier. This approach may give the employer greater control over program design, but buying from separate suppliers alone does not guarantee that the program's design will be custom-built to address the organization's unique risks. In some cases, the services purchased may not hit the employer's targets effectively; in other cases, the employer may wind up paying for unnecessary or excessive services to "solve" a "problem" that is not driving costs significantly. For example, not every claim needs clinical case management, but many contracts provide for it as a matter of course on certain claim types without regard for specific risk indicators and charge accordingly.

In either case — whether the employer has purchased a bundled program or unbundled services — it can be difficult to tell whether the program is truly providing optimal value. Just because a program seems to be delivering results does not mean that it is delivering a solid return on investment (ROI). For instance, an organization might experience a high return-to-

work (RTW) rate, but it's possible that the employer might get the same results without any clinical intervention. An analysis might reveal that factors other than case management are driving a strong RTW result and that RTW case management may be an unnecessary expense.

To achieve insight into cost drivers and to develop a program to address the findings requires an intimate understanding of the data. Looking at trends in claim spending is only the first step. To get the whole picture, it's necessary to use the managed care data to understand the cost drivers associated with the claims. If excessive medical expenses are a problem, are providers treating appropriately or is overutilization the key cost driver? Are geographical variances significant? The answers to questions like those should determine program design — whether the focus should be on network customization or a heightened emphasis on utilization review, for example. Are the issues that drive spending occurring everywhere, or do they differ in certain jurisdictions? Clinical staffing can be tailored geographically; networks can be changed regionally and even by employer locations. The answers drive not only staffing levels, but workflow and focus.

DIGGING BENEATH THE SURFACE IS CRITICAL

Organizations that need to get better control of workers compensation costs usually recognize the need to do so — but it is not uncommon to make mistaken assumptions about the cost drivers. Without comprehensive data analysis, it is easy to design a program based on faulty assumptions — and then to be disappointed in the results.

Take the case of one global employer with 135,000 employees.² The organization had managed care bundled under its TPA arrangement. The employer sought to improve RTW, believing that this was the key cost driver. In the absence of sufficient data, a traditional early intervention case management program with a focus on RTW and medical management was implemented in 2005. Initiatives included unbundling case management services, providing dedicated case management resources, and executing a workers compensation pharmacy benefit management program.

Within the program's first year, the claim trends did not change. Lack of improvement indicates a poorly performing program. A look at the data that had been generated in that year showed that the program did not address the real issue. For the most part, RTW processes were not in themselves problematic. The underlying issue was medical severity. The company had high medical and indemnity costs and overutilization issues. The employer, the TPA, and the case management provider worked together to refine the service model, focusing on reducing the prevalence of overutilization

of medical care while reducing the administrative resources necessary to support the program. Resources were realigned based on specific cost drivers. This involved tailoring the program to address unique needs in key jurisdictions — specifically, moving to an on-site utilization review model in California; in another jurisdiction, a hybrid model blends telephonic case management, utilization review, and field case management. Other improvements included implementation of location-specific RTW focus, improved focus on utilization of preferred providers whose care complies with evidence-based guidelines, and focus on RTW for injured employees.

As a result of the changes, lost-time claims decreased 23 percent, disability durations decreased 18 percent, and the average medical paid-per-claim decreased 20 percent.³

FIX ONE PROBLEM AND MOVE ON TO THE NEXT

Starting with a strong data set allows opportunity for continuous improvement. Resolving an issue opens the door to setting new priorities. The economic environment changes. Jurisdictional issues arise. Employers operate in a dynamic environment, and a workers compensation managed care program must keep pace with the changes.

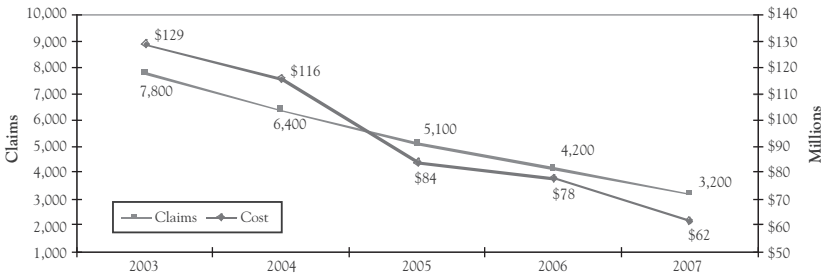
In 2003, a national employer with 50,000 employees identified occupational absence as a primary cost driver. The organization had a workers compensation injury incidence of 17.3 percent and a lost-time ratio of 50 percent. Total claim costs were \$129 million.⁴ The organization's bundled TPA program was an adjuster-driven model with deferred clinical interventions. The first priority was to understand why RTW was unsuccessful and to address the problem.

An in-depth analysis pinpointed operational resistance to transitional work; managers didn't know how or were unwilling to accommodate light duty. The employer changed the managers' rules. In addition to a renewed focus on safety, workers compensation allocations within the company were tied to incidence and duration and applied to the operational bottom line. Through the clinical resources available from the managed care supplier, RTW professionals implemented a transitional duty program at the local sites. Instead of deferred clinical interventions, the new model used risk-based case selection and immediate clinical interventions.

The approach worked. Claim volumes showed steady double-digit declines through 2008. Disability duration decreased by 38 percent. The workers compensation injury incidence dropped to 7.1 percent, the lost-time ratio decreased to 30 percent, and total claim costs were reduced by \$67 million.⁵

EXHIBIT 1

The graph shows the decline in the employers' workers compensation costs and claims from 2003 through 2007. The focused program was initiated in 2004.



Source: Intracorp.

Over time, in addition to reducing lost-time costs, it was also possible to lower managed care administrative costs. Between program inception and 2007, managed care staff was cut in half as demand decreased. Dedicated case managers and on-site RTW specialists have been reduced in tandem with the reduction in claim volume and associated risk.

Although the focus remains on improving RTW for disability-driven absences, primary efforts are now shifted to managing costs for medical-only claims, which data show are increasing and driving overall claims spending. Data are reviewed regularly to identify trends that might drive changes to triggers for clinical interventions and to provide a basis for customized clinical alerts. Other initiatives include using a preferred provider network to manage optimal treatment and to enhance specialty network coverage for ancillary services where costs had been excessive; implementation of a pharmacy benefit management program with a highly clinical focus, including a narcotics therapy management program; and other techniques to control medical unit cost and ensure appropriate utilization.

RESPOND TO THE CHANGING ECONOMIC ENVIRONMENT

The switch in focus from RTW to medical cost control may make sense for many employers. According to the National Council on Compensation Insurance (NCCI), the frequency of lost-time workers compensation claims has trended downward, decreasing a total of 52.3 percent in the years between 1991 and 2006.⁶ Across the board, employers' emphasis on safety is paying off with a significant reduction in minor injuries, but today more severe injuries drive up costs. For lost-time claims, the proportion of

medical costs to total costs continues to outpace medical inflation. In 1987, medical costs accounted for 46 percent of the total costs of an indemnity claim; two decades later, medical had risen to 59 percent.⁷

The nature of the workers compensation arena creates risk for overtreatment, particularly in utilization of specialty services such as radiology and physical therapy. Generally, utilization is a greater cost driver than price. In addition, prescription drug costs account for an increasingly large share of workers compensation medical costs — from 6.5 percent in 1997 to 13.1 percent in 2006.⁸ The impact of each of these and other drivers will, of course, vary from one organization to the next and from one jurisdiction to the next. Again, effective data analysis will point toward what tools should be applied and where.

THE BIG PICTURE GIVES THE BEST RESULTS

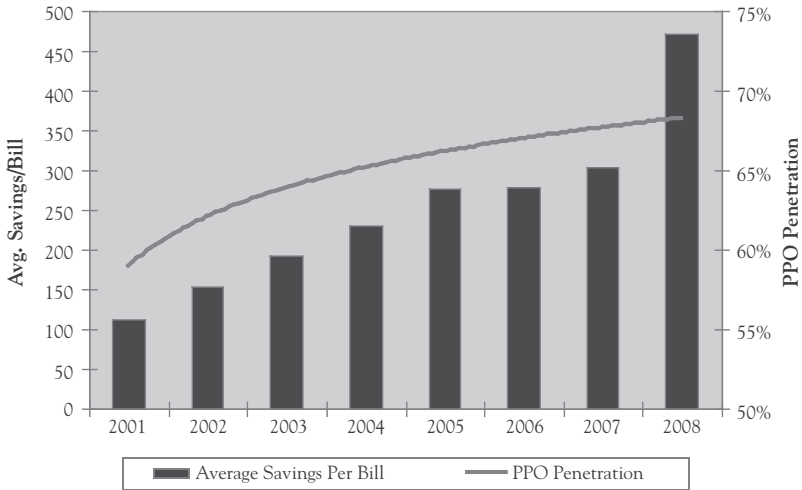
The key to focusing on the issues that will provide the greatest returns lies in looking at both the claims data and the medical utilization data at an intimate level of detail, as well as in understanding the organization and its needs beyond workers compensation. Over the long term, this approach can result in significant savings.

From 2001 to 2008, data-driven program adjustments resulted in total program net savings of \$8.68 million for a global retailer with 49,000 employees. Initially, the organization had a bundled TPA program with an adjuster-driven model. The data-driven approach for this organization included ongoing customization of provider networks as well as placement of dedicated RTW specialists and a team of telephonic nurse case managers who work in conjunction with the company's risk management team on site. The program includes a utilization review approach focused on key clinical drivers identified through data analysis. Regular review makes it possible to respond quickly to emerging trends and cost drivers. The program now takes a clinically driven approach that incorporates predictive modeling to identify cases for early intervention. It also leverages the ongoing medical utilization data to flag claims where the risk was not identified at the onset of injury.

Here, too, it was possible to reduce managed care costs. In this case, an analysis of utilization review in California showed that certain providers were always following best practices and therefore were always approved. In this case, it made sense to stop doing utilization review for these providers unless they started operating outside of guidelines; this could be monitored in the medical bill data. This approach not only generated an overall reduction in administrative expenses, but it strengthened the relationship

EXHIBIT 2

The graph shows a steady increase in average savings per bill as well as an increase in PPO penetration over time. This is largely due to the ability to fine-tune the program based on comprehensive analysis of claim and managed care data.



Source: Intracorp.

with the provider community.

Following implementation of the program and ongoing enhancements, the organization’s PPO penetration increased by 25 percent, with a gross savings improvement of 72 percent.⁹ The organization saw a RTW rate of greater than 98 percent. Lost-time claims decreased by an average of 5.4 days, bringing average disability duration down to 37.6 days.¹⁰

THE SAME OLD THING IS NOT THE RIGHT THING

In a roller-caster economy, employers must find efficient ways to pinpoint risks and reduce their exposure, cut costs, and obtain optimal ROIs. To do this requires being able to see the complete picture and to monitor it continuously in order to respond quickly to changing trends. It’s not enough to understand how claims are trending. To get the complete picture, it is necessary to mine the data to look at all potential cost drivers — addressing just medical costs may result in overlooked savings opportunities if lost time is a significant exposure and vice versa. Problems common in one jurisdiction may not occur elsewhere. It may be possible to reallocate or reduce resources. The difficulty does not lie so much in being able to combine medical utilization and claim data in a common database. The real

skill lies in being able to cull out the meaning, identify actionable items that drive recommendations, and implement a program. That perspective comes from experience in clinical case management, an understanding of the employer's industry, and the ability to become immersed in the employer's corporate culture.

Employers should insist on broad and deep metrics from the vendors, as well as ongoing review. For example, evaluating medical utilization data on a quarterly basis helps ensure that the program is addressing current issues. If a trend carries out over two quarters in a row, it may indicate the need for an adjustment to the program's focus. Comprehensive data reviews should take place at least annually. Such reviews should clearly explain not just claim trends, but what resources were applied, how the program has affected the employer's experience, and what steps will be taken going forward.

Some solutions will not involve managed care. Improved safety and operational buy-in to RTW initiatives can reduce the need for some case management interventions. Identifying these opportunities takes a vendor with a true sense of partnership — and one that is willing to provide best-practice recommendations even if the recommendations reduce revenue. One goal of a good workers compensation managed care vendor partner should be to reduce the employer's need for its services over time.

ENDNOTES

1. See http://www.interbrand.com/best_global_brands.aspx?year=2008&langid=1000, accessed April 5, 2009.
2. The examples utilized in this article are not intended to represent or guarantee that the same or similar results will be achieved. Individual program results may vary.
3. Intracorp, proprietary client data, October 2009.
4. Intracorp, proprietary client data, October 2008.
5. Intracorp, proprietary client data, October 2008.
6. NCCI Annual Issues Symposium 2008.
7. NCCI Annual Issues Symposium 2008.
8. NCCI Annual Issues Symposium 2008.
9. Intracorp, proprietary client data, January 2009.
10. Intracorp, proprietary client data, January 2009.

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