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Observations on Medical Trends, Health Care Cost Drivers, and the Impact of Reforms

**Presented by
Harry Shuford**

CAS Ratemaking and Product Management Seminar
Trends in Workers Compensation Medical Costs
March 16, 2009
Chicago, IL



Impact of Reform:

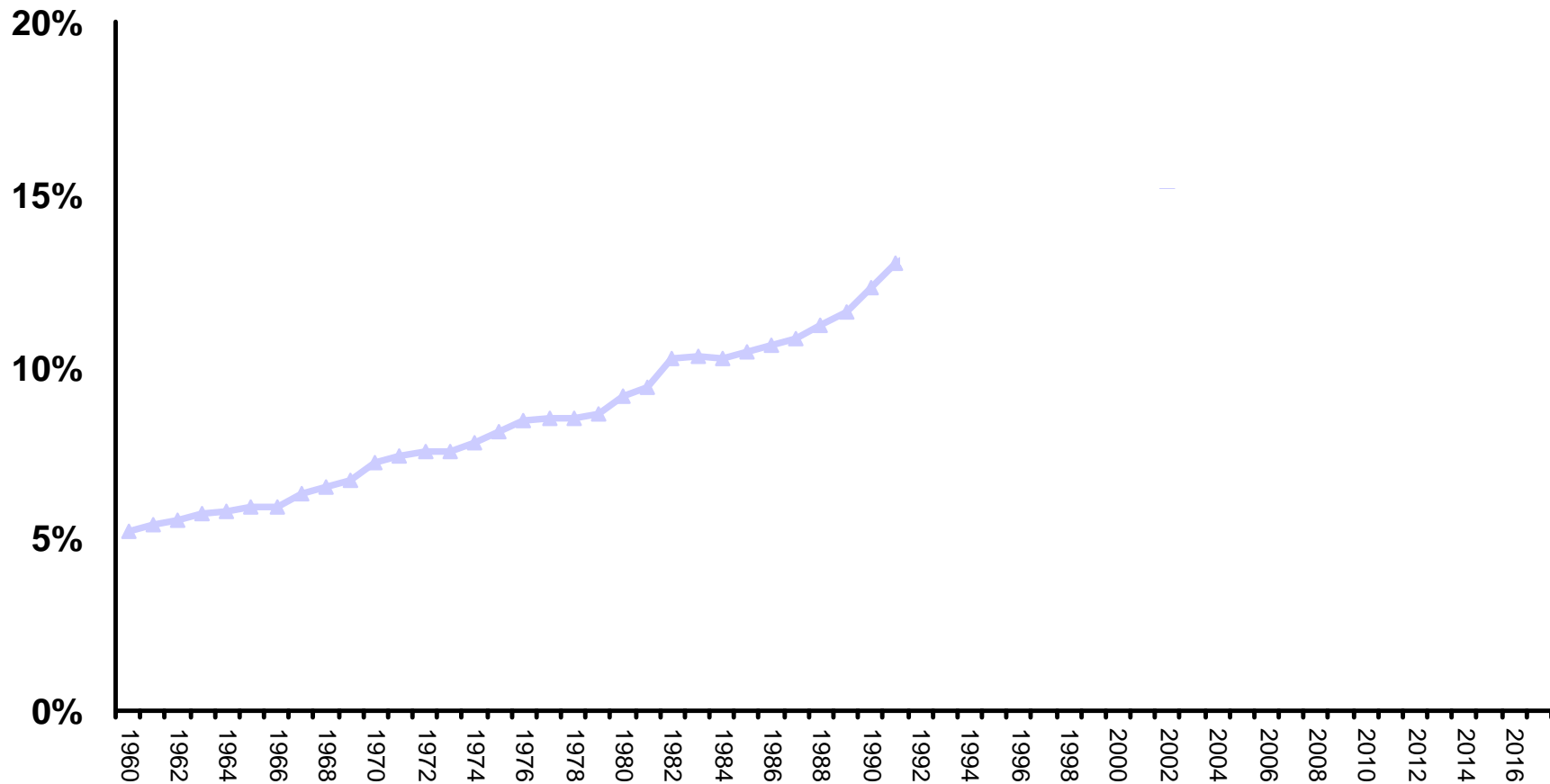


Impact of Reform:

Medicare Fees Schedules and Medical Expenditures in the US

RBRVS Eased the Growth in Medical Spending Countrywide (But Only Temporarily)

Healthcare Expenditures as Percentage of Gross Domestic Product (GDP)

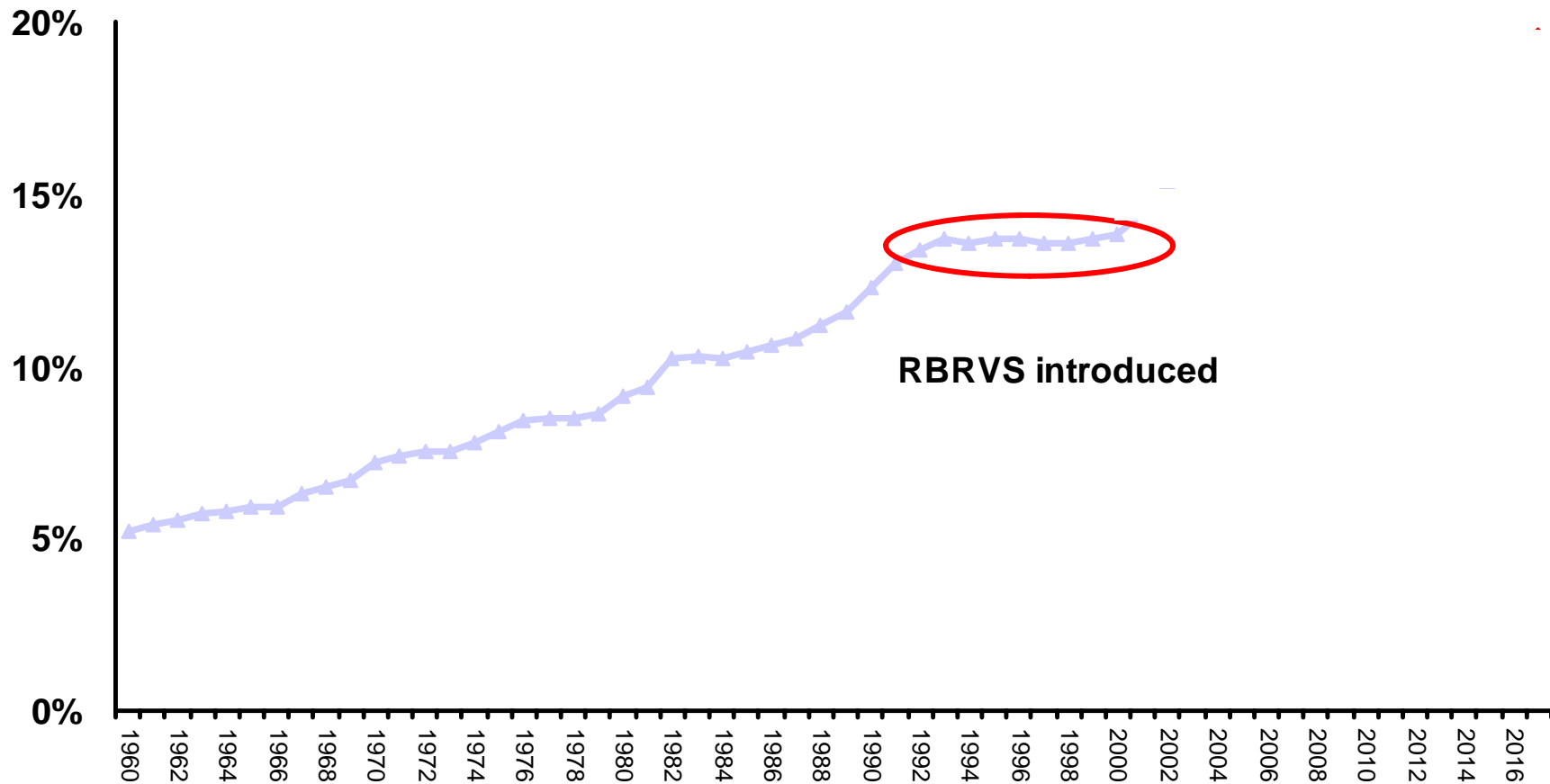


Source: Office of the Actuary, Centers for Medicare and Medicaid Services



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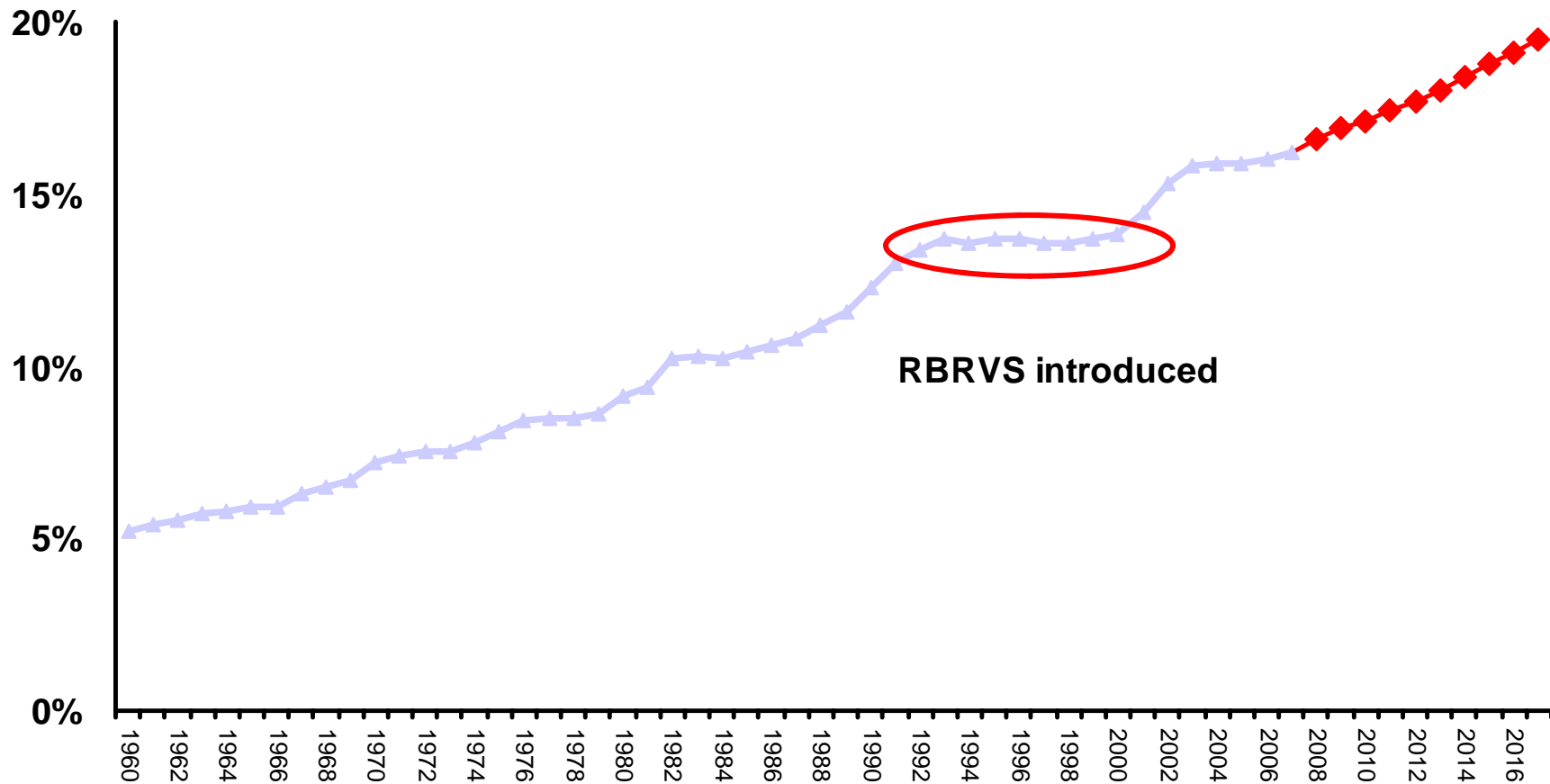


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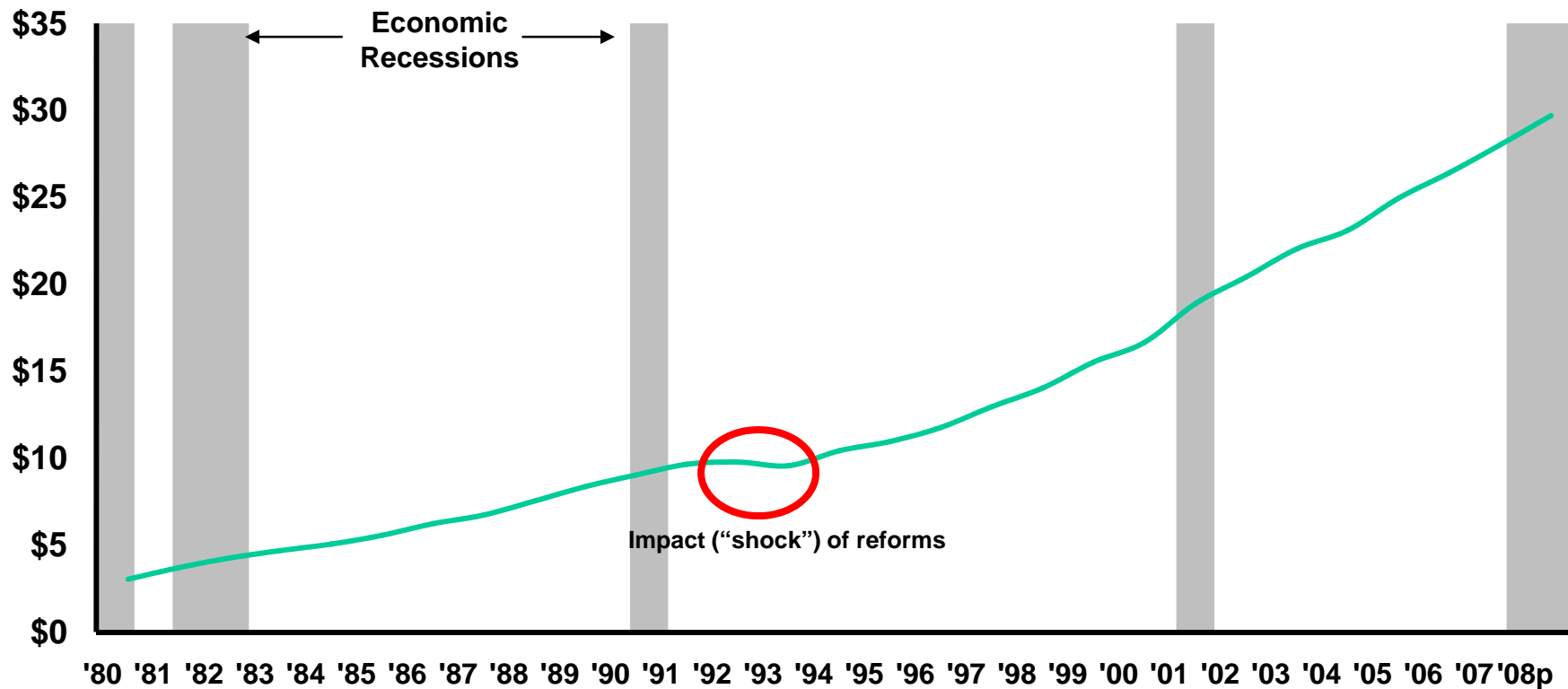




Impact of Reform on WC Medical Severity

The Growth in Medical Severity: Temporarily Checked Following Reforms in Early 1990s

Medical Cost per Claim (\$000)



2008p: Preliminary based on data valued as of 12/31/2008

1991–2007: Based on data through 12/31/2007, developed to ultimate

Based on the states where NCCI provides ratemaking services, including state funds

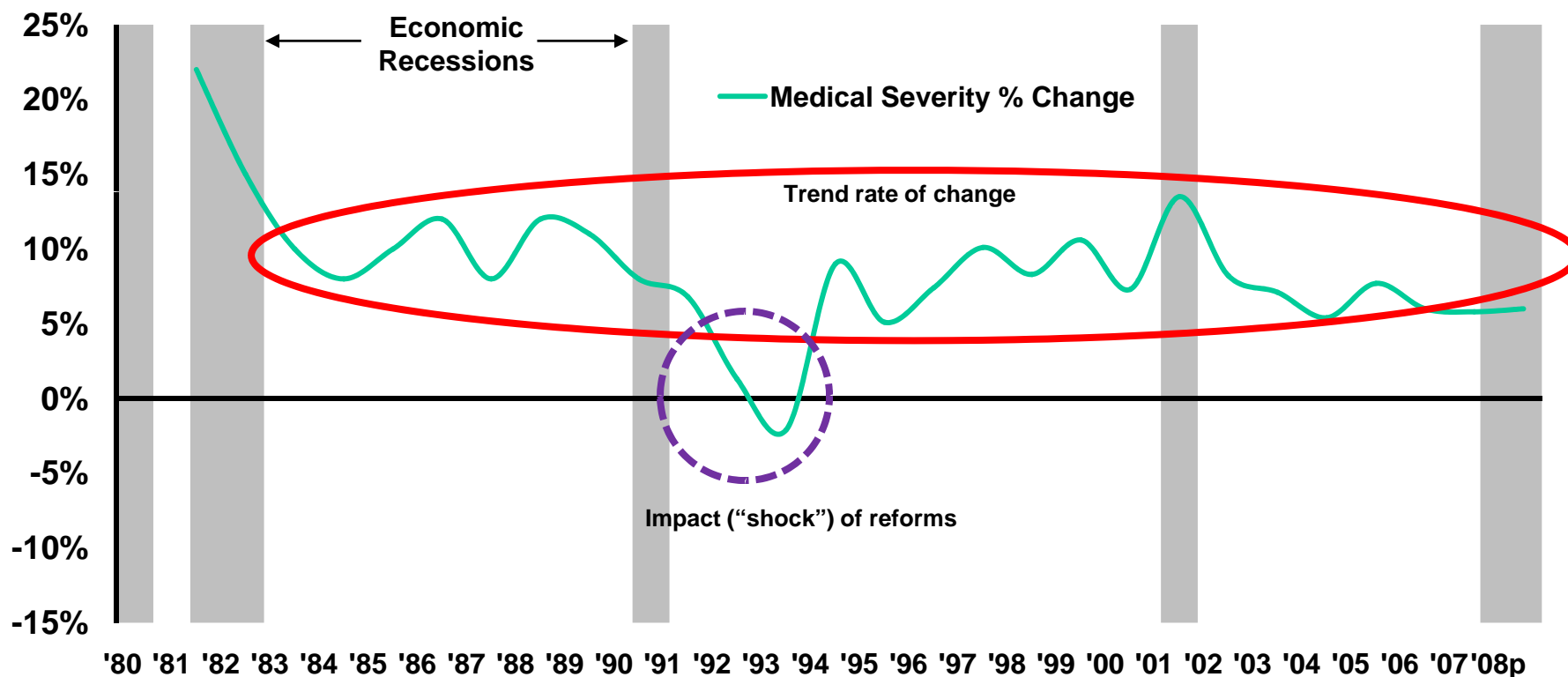
Excludes high deductible policies

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Medical Severity Growth Rates Show a Varied Response

Percent Change, Lost-Time Claims



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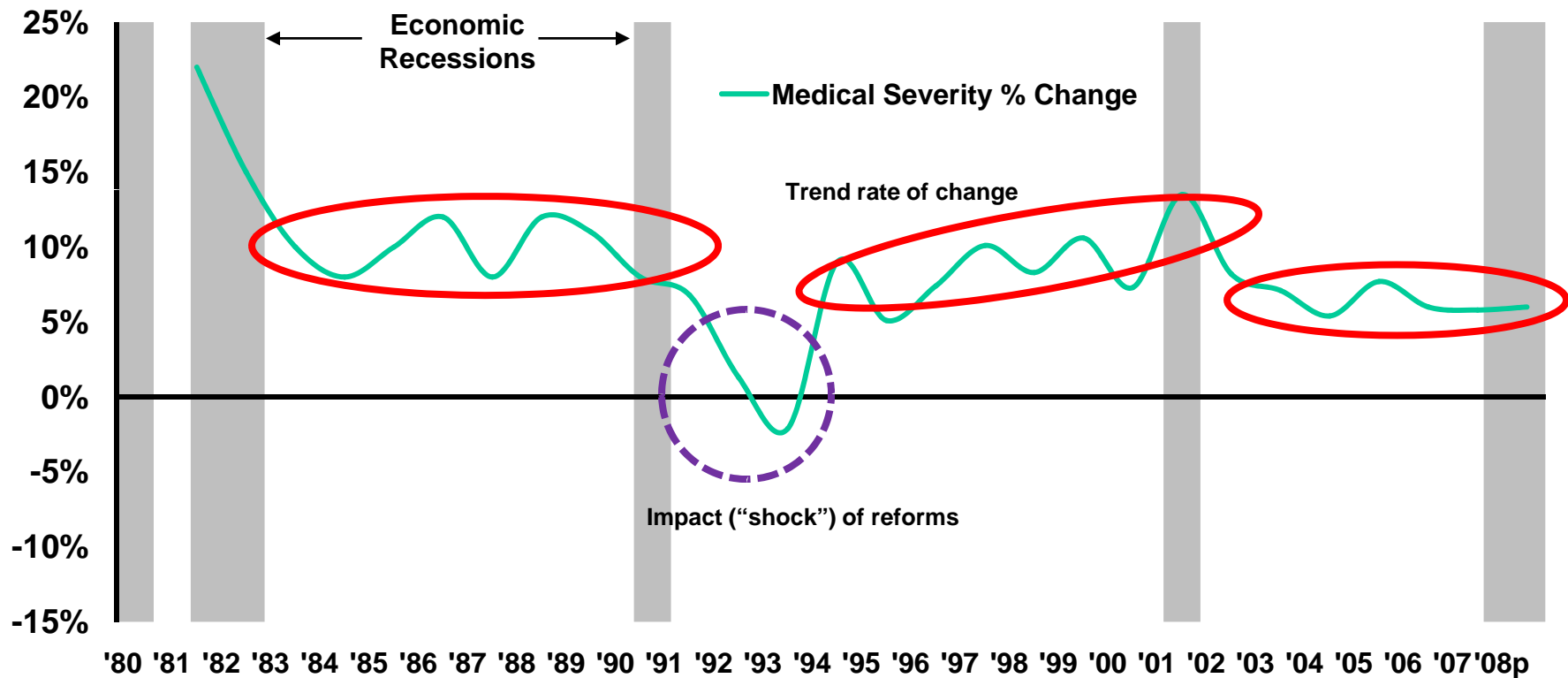
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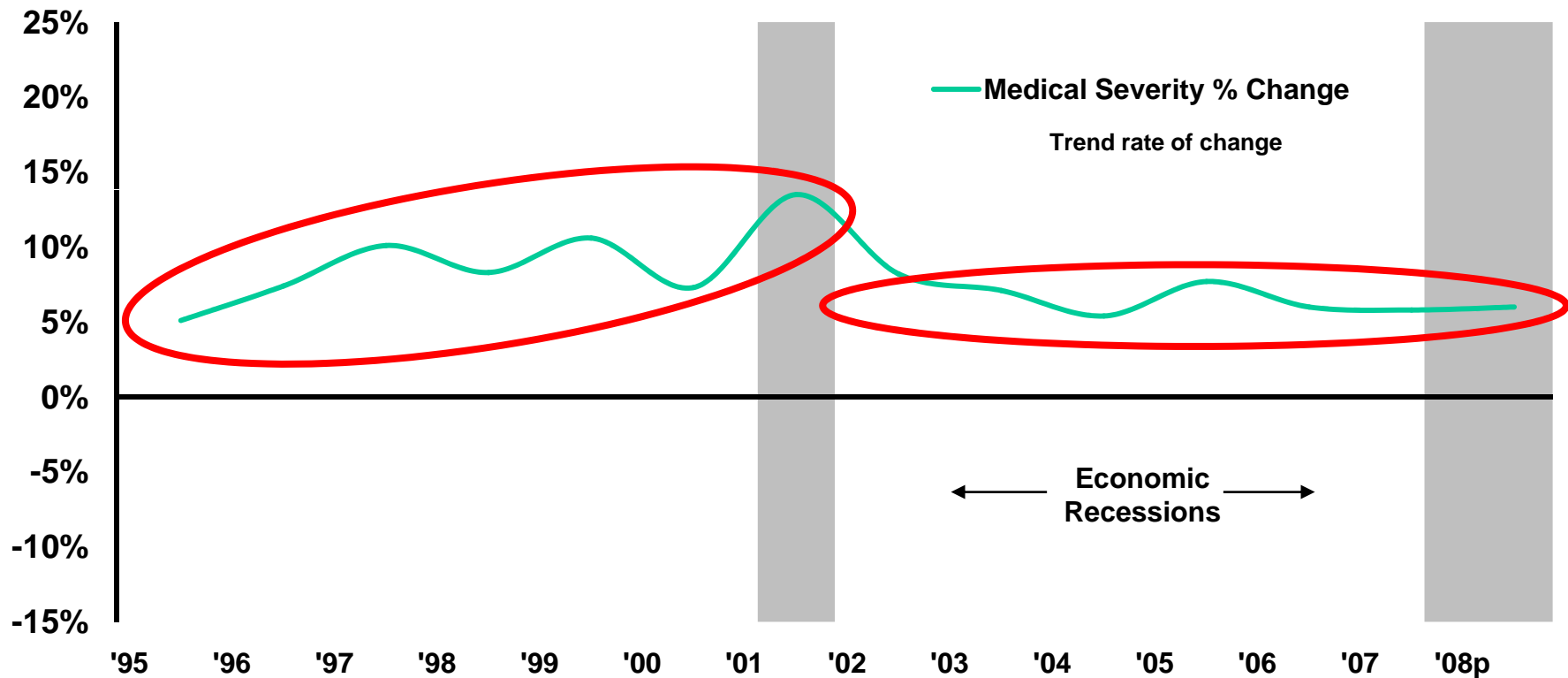
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Medical Severity Growth Rates Eased – Why?

Percent Change, Lost-Time Claims



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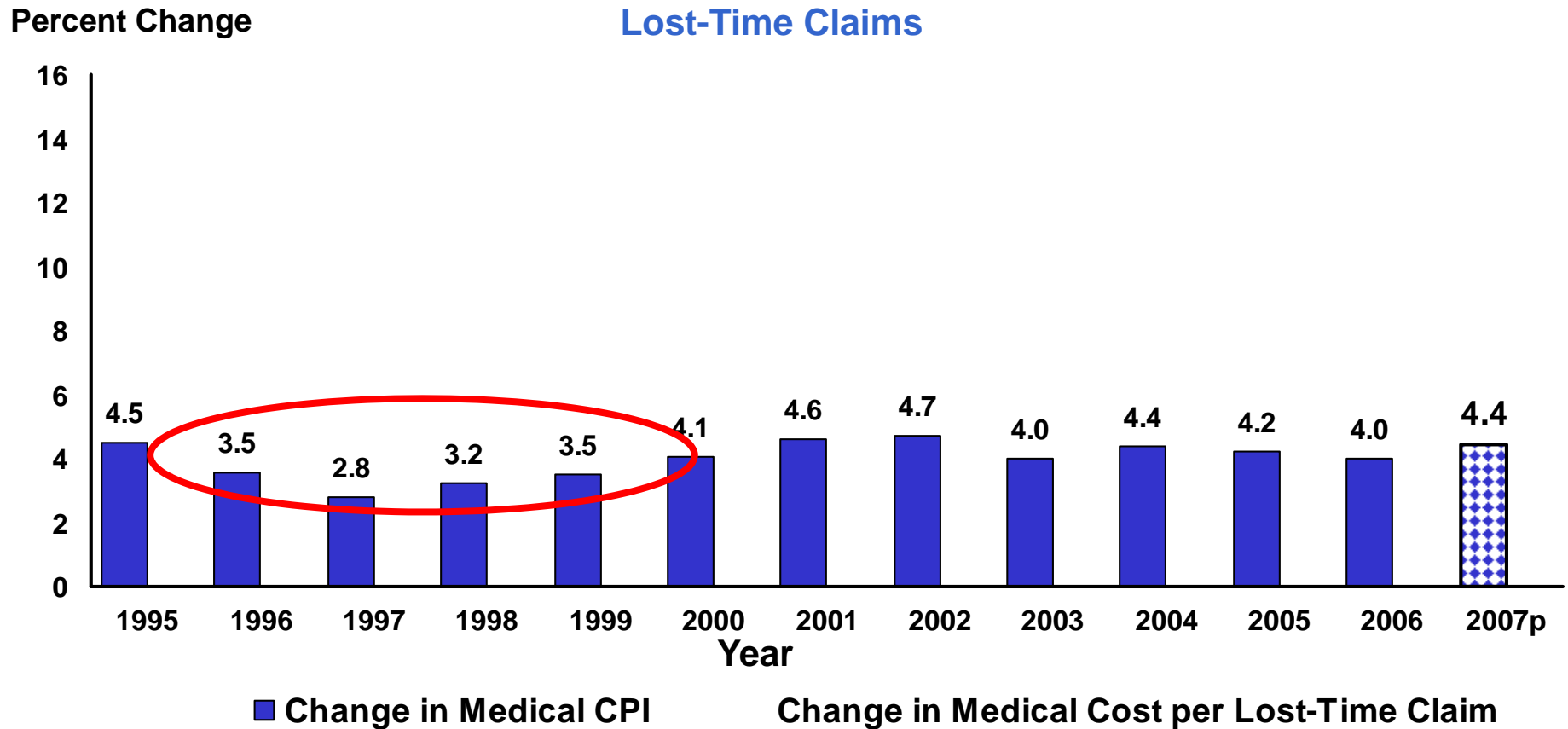
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WC Medical Severity Still Growing Faster Than the Medical CPI



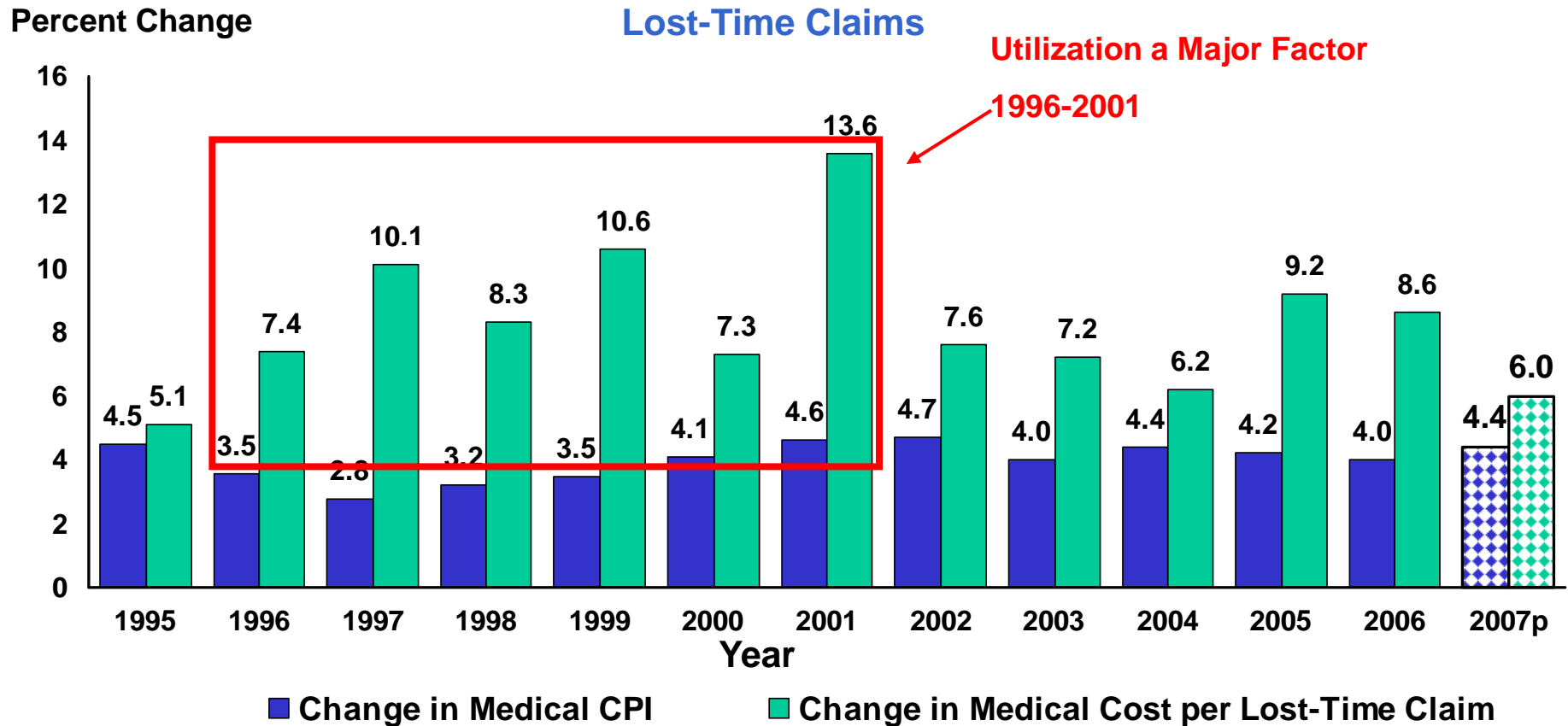
Medical severity 2007p: Preliminary based on data valued as of 12/31/2007

Medical severity 1995–2006: Based on data through 12/31/2006, developed to ultimate

Based on the states where NCCI provides ratemaking services, excludes the effects of deductible policies

Source: Medical CPI—All states, Economy.com; Accident year medical severity—NCCI states, NCCI

WC Medical Severity Still Growing Faster Than the Medical CPI



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Source: Medical CPI—All states, Economy.com; Accident year medical severity—NCCI states, NCCI

NCCI Research

Utilization:

Understanding why medical severity increased 70%
in the late 1990s.

NCCI Research

Utilization:

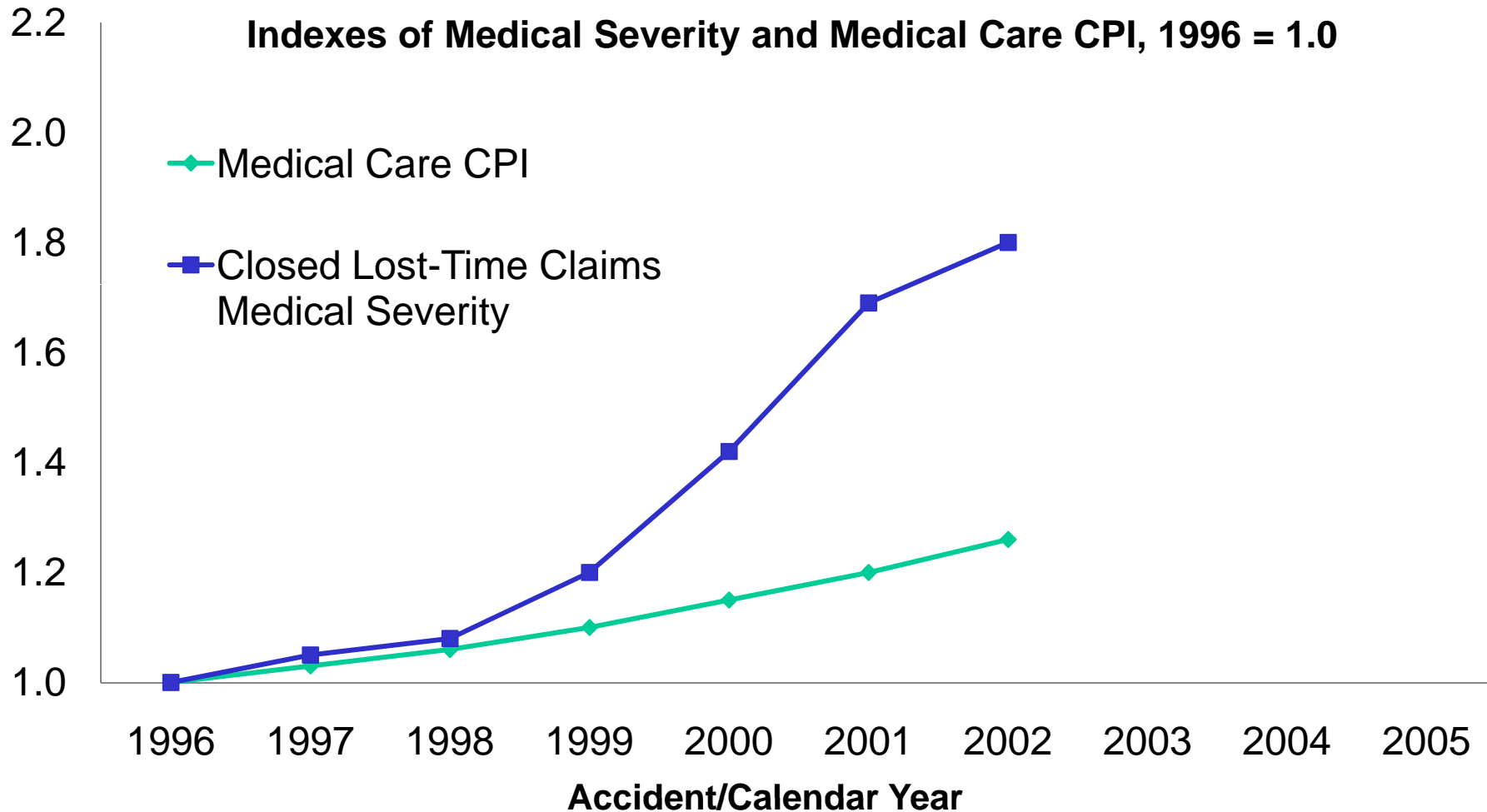
Understanding why medical severity increased 70%
in the late 1990s.

- Not Prices: Increases in WC costs per treatment tracked with the medical CPI
- Utilization surged: Due to the 35% increase in the number of billed medical treatments

Questions and More Information

- Two papers on this subject are available for download in the Research and Outlook Section on **ncci.com**
 - “Measuring the Factors Driving Medical Severity: Price, Utilization, Mix” posted in Spring 2007
 - “Factors Influencing the Growth in Treatments per Claim” posted in September 2008

Countrywide Medical Severity Is Outpacing the Medical Care CPI

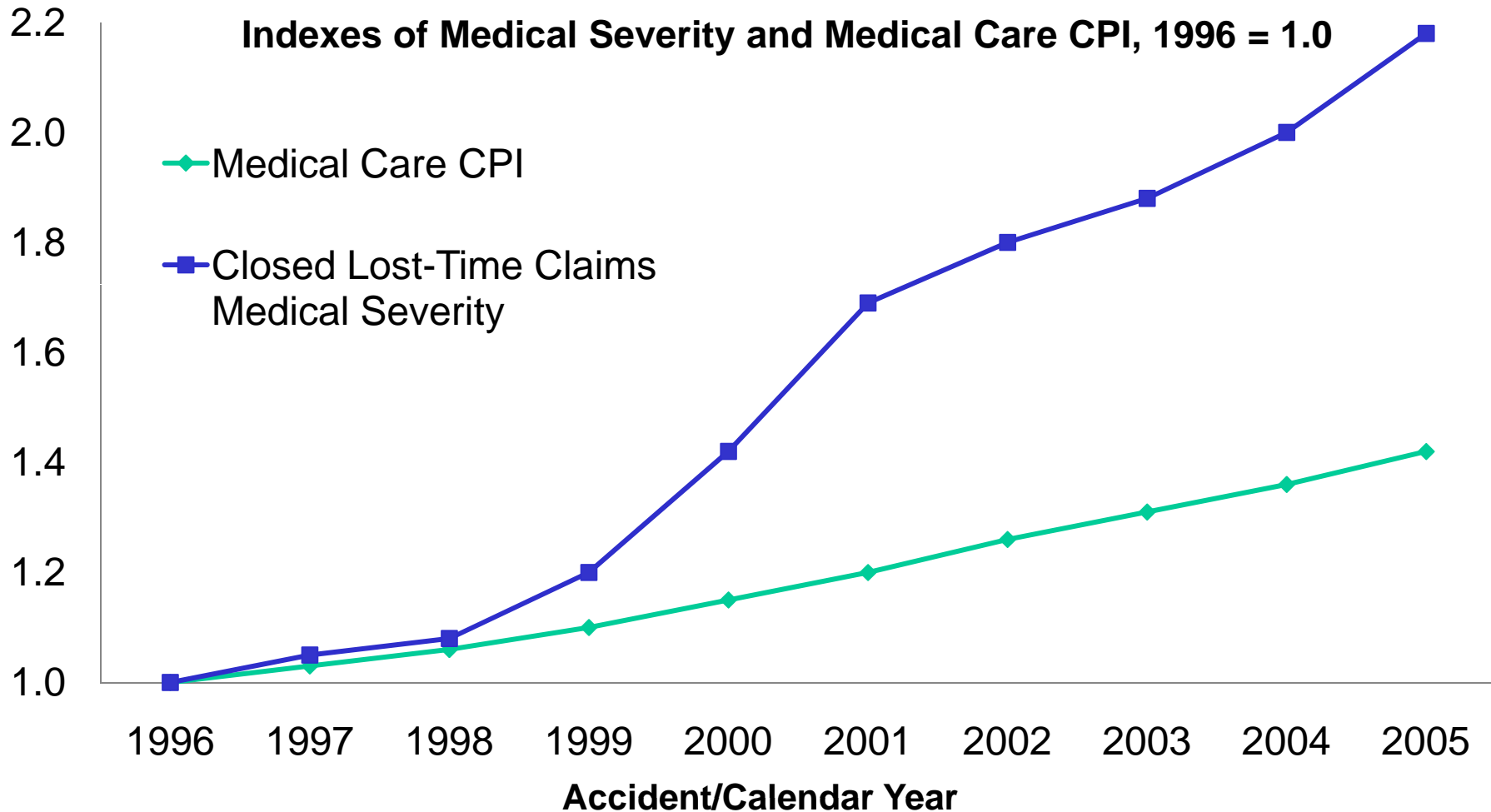


Accident year for medical severity; calendar year for Medical Care CPI
Lost-Time Claims Closed Within 24 Months of Date of Injury, NCCI States

Source: NCCI; US Bureau of Labor Statistics

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Countrywide Medical Severity Is Outpacing the Medical Care CPI

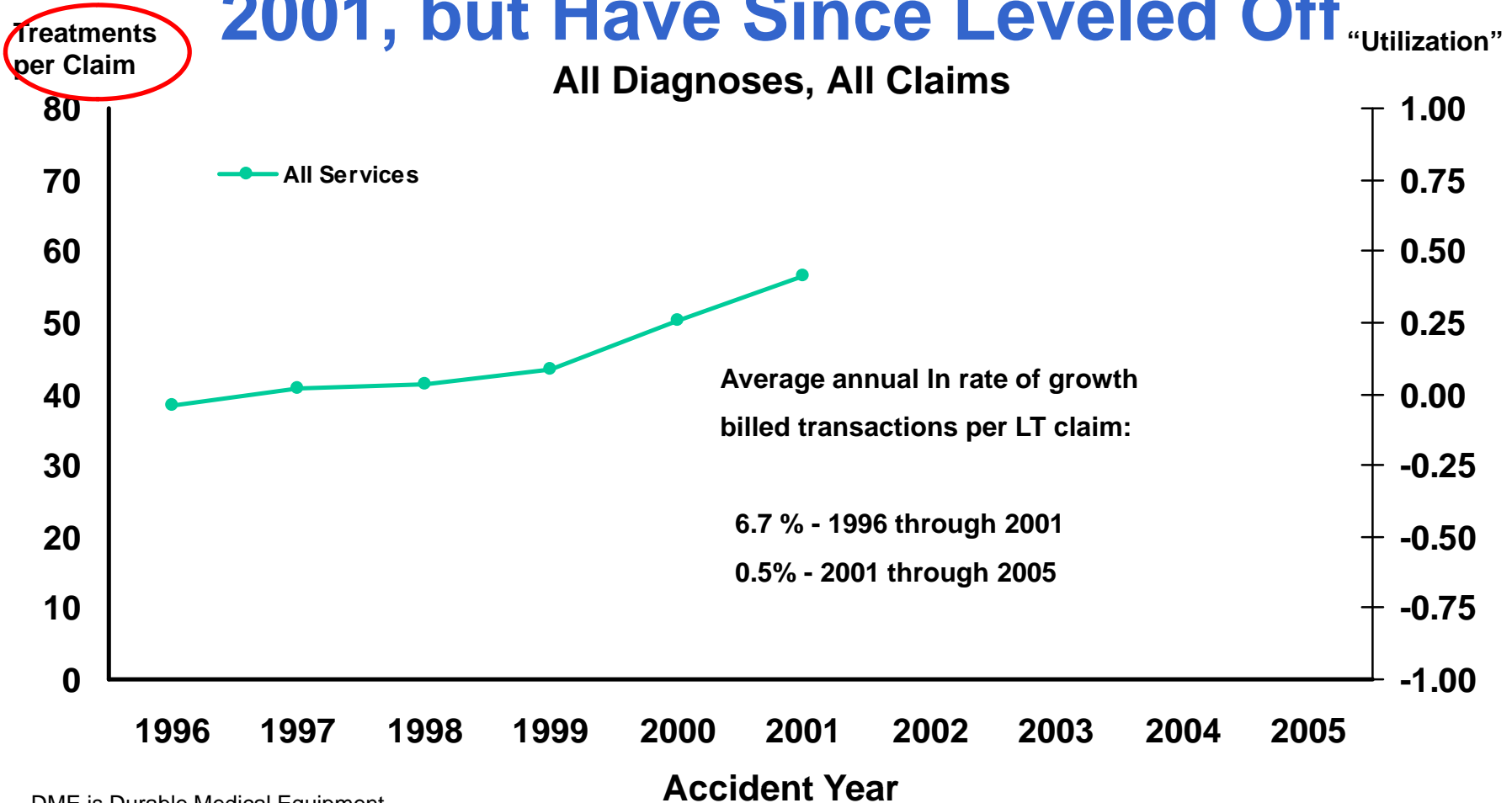


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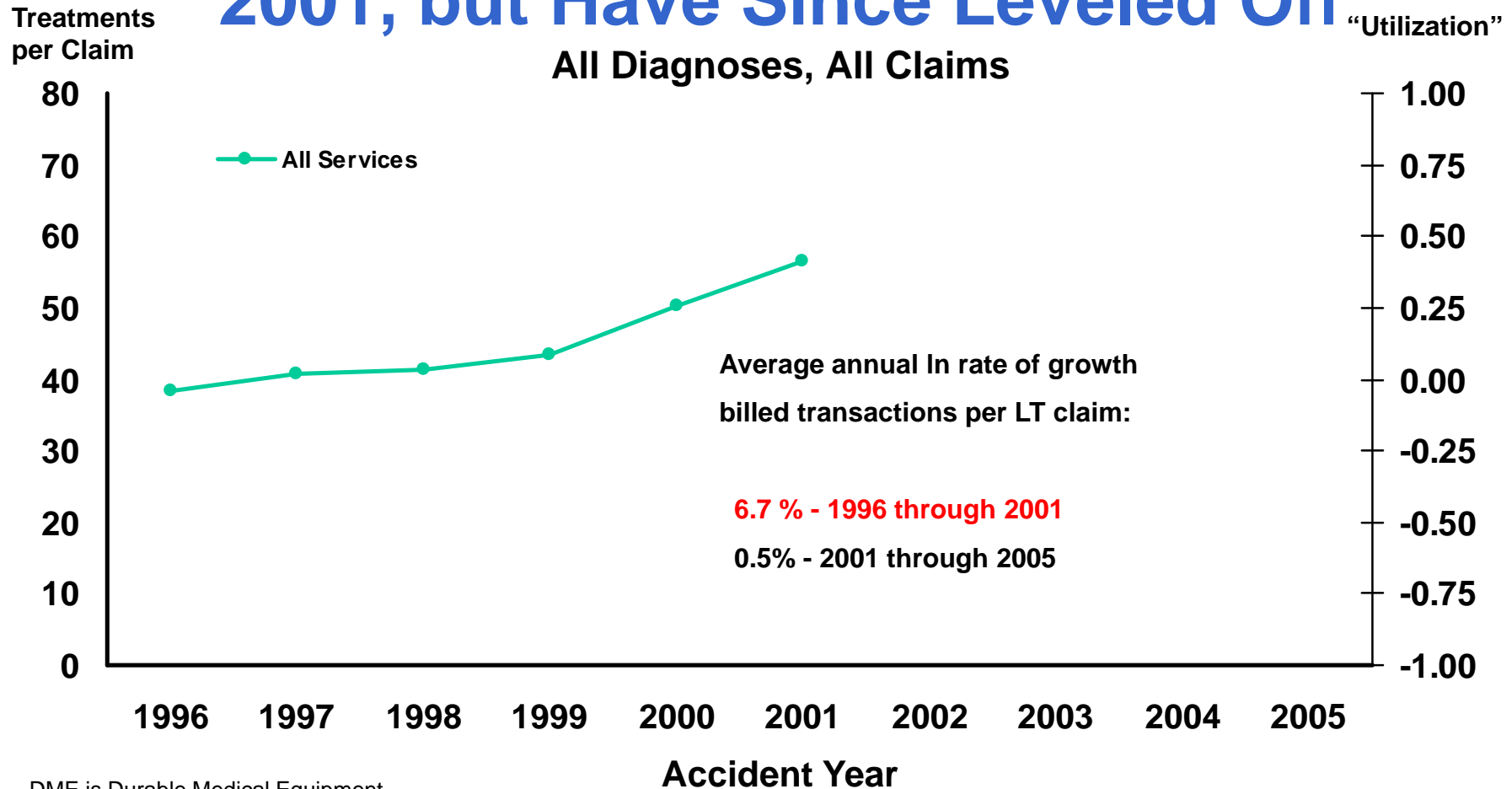
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Overall, Treatments per Claim Increased Significantly in 2000 and 2001, but Have Since Levelled Off



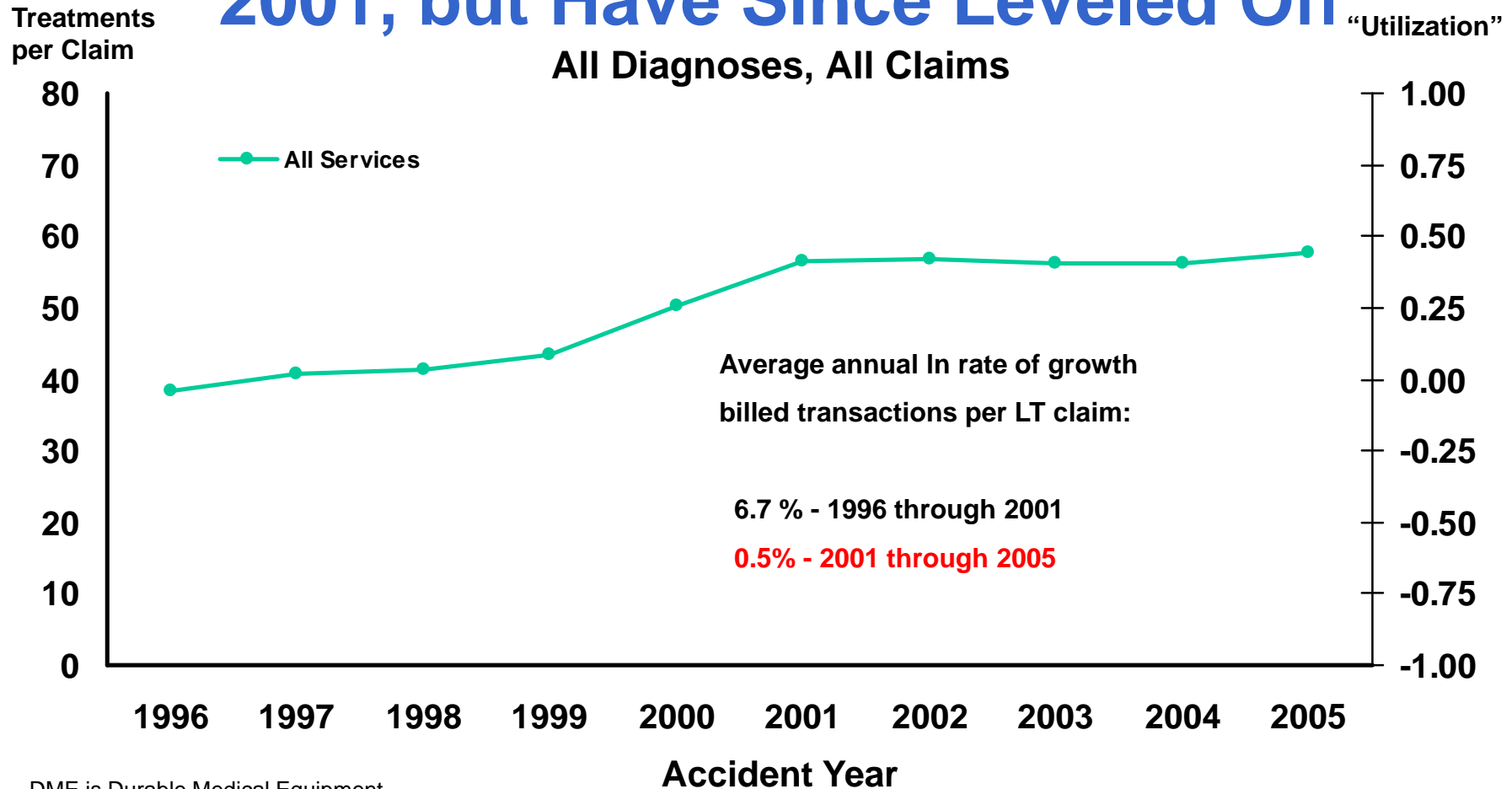
DME is Durable Medical Equipment
 Lost-Time Claims Closed Within 24 Months of Date of Injury, NCCI States
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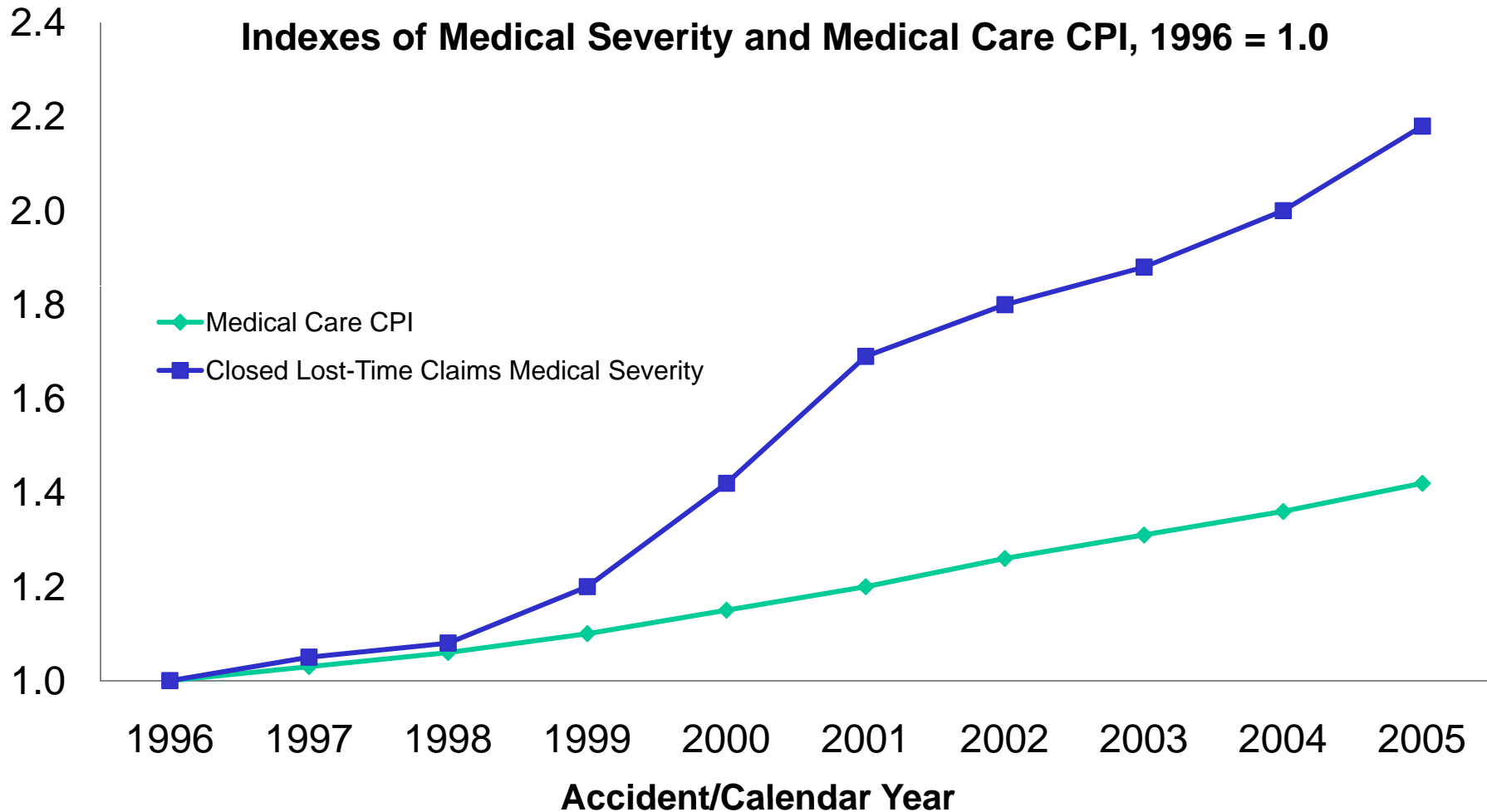
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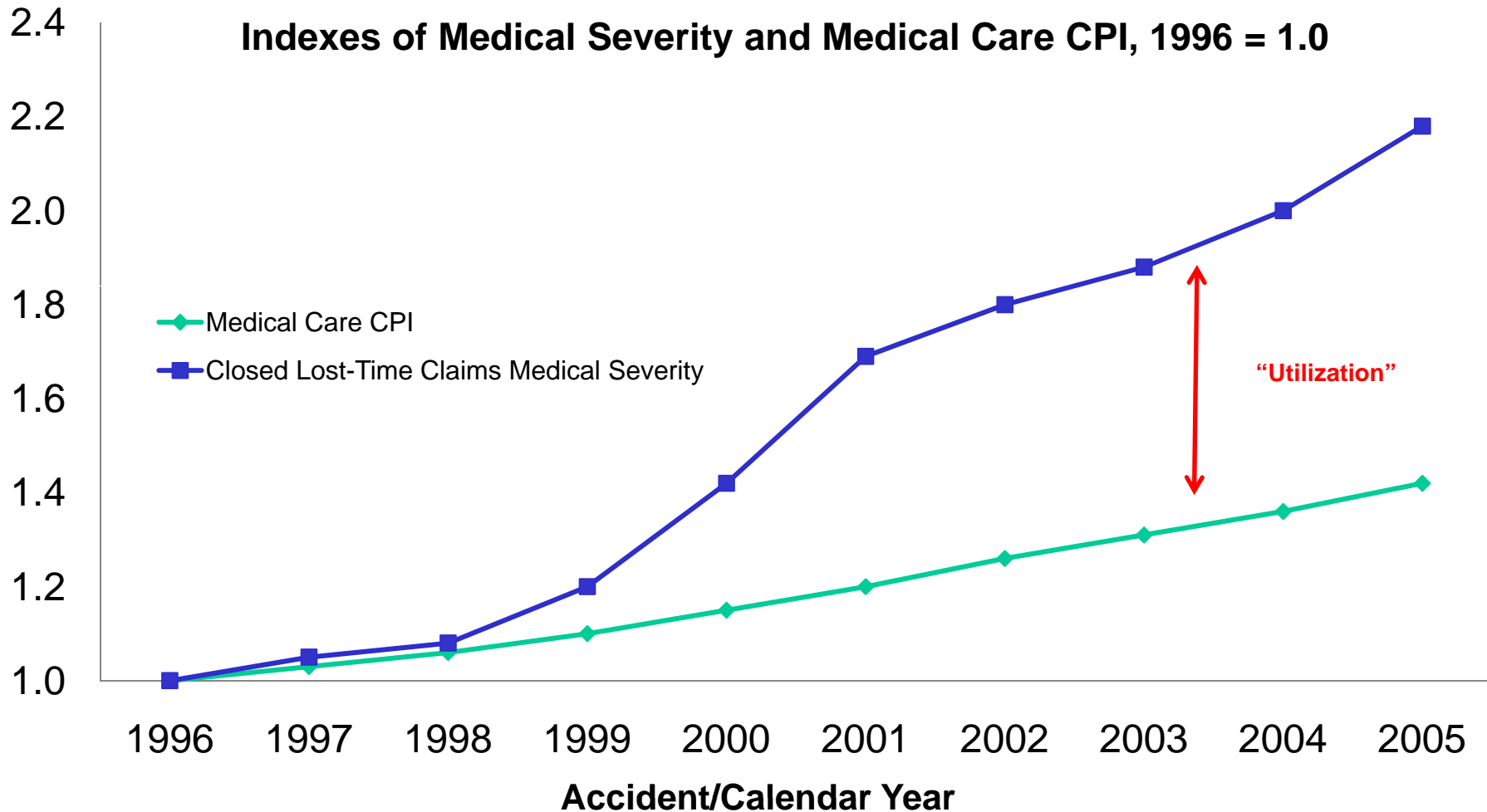


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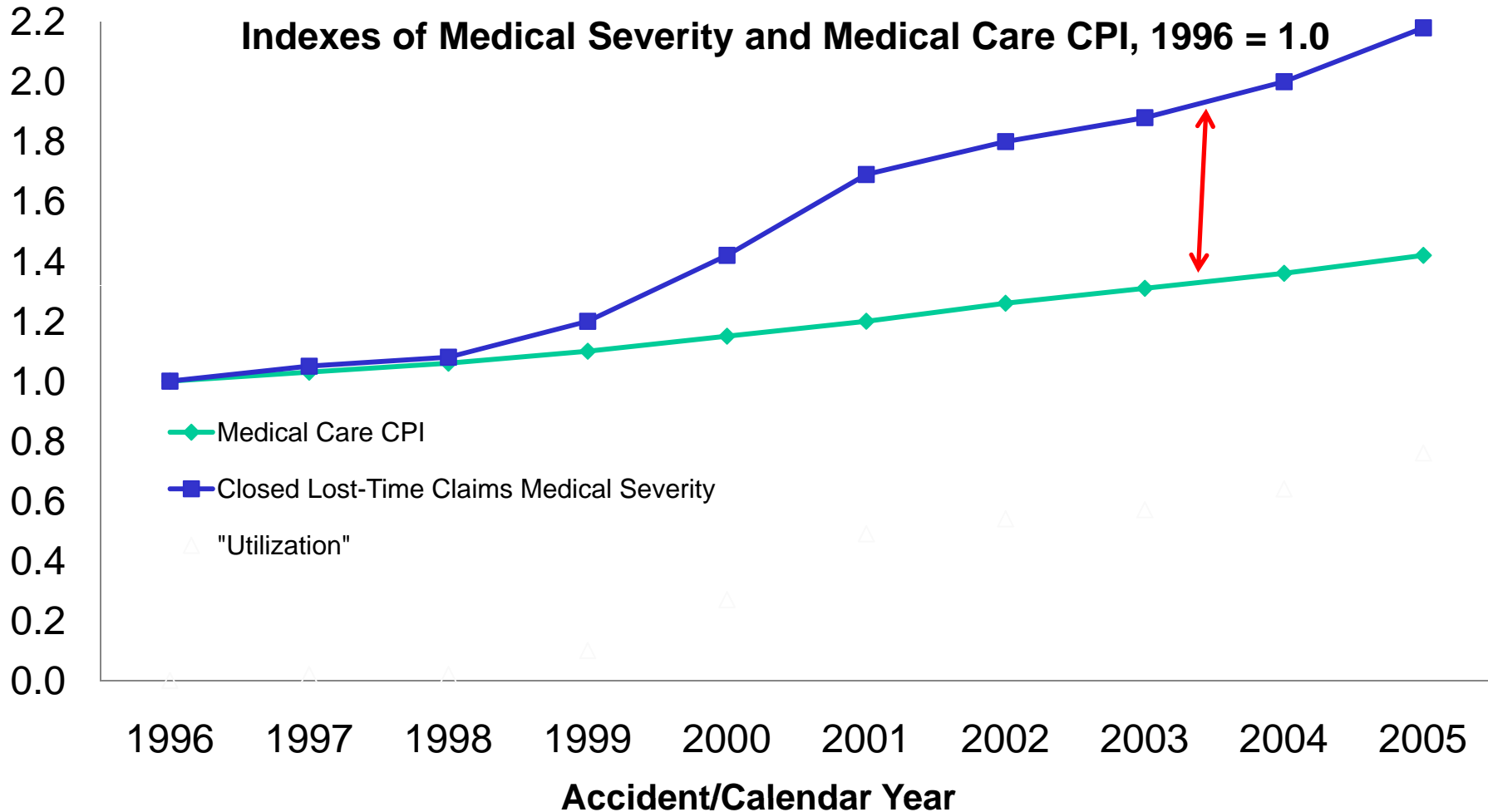


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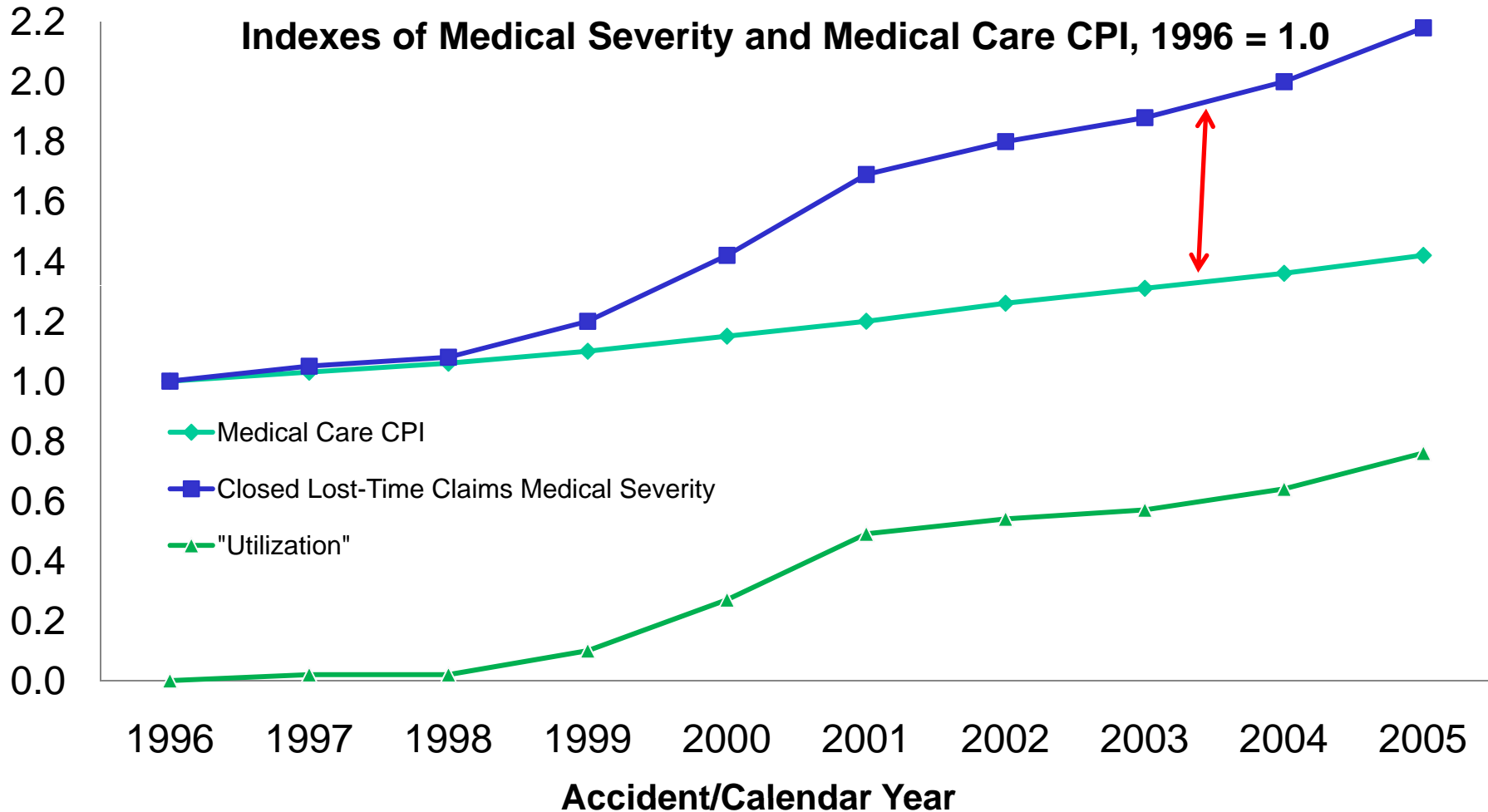


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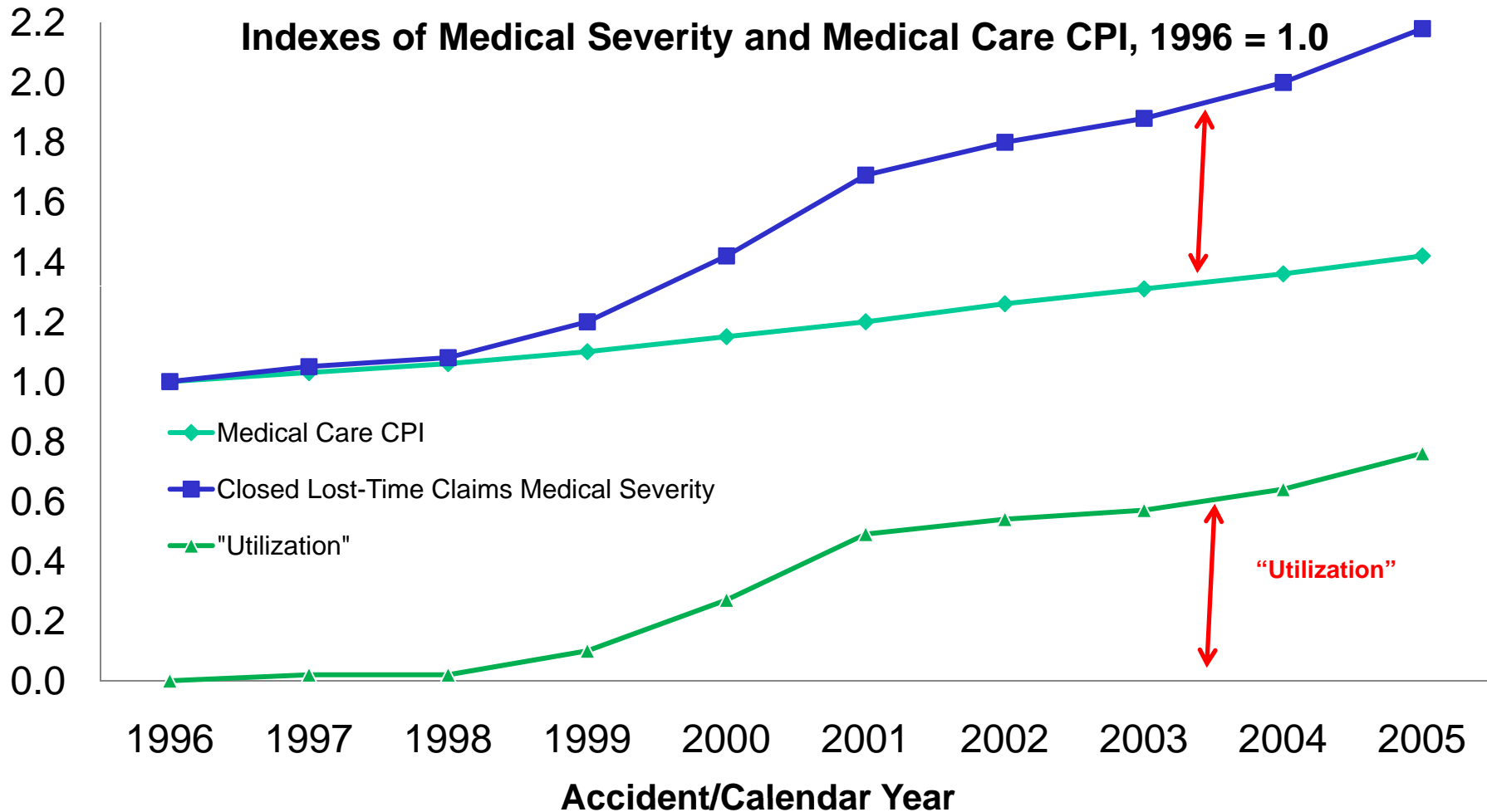


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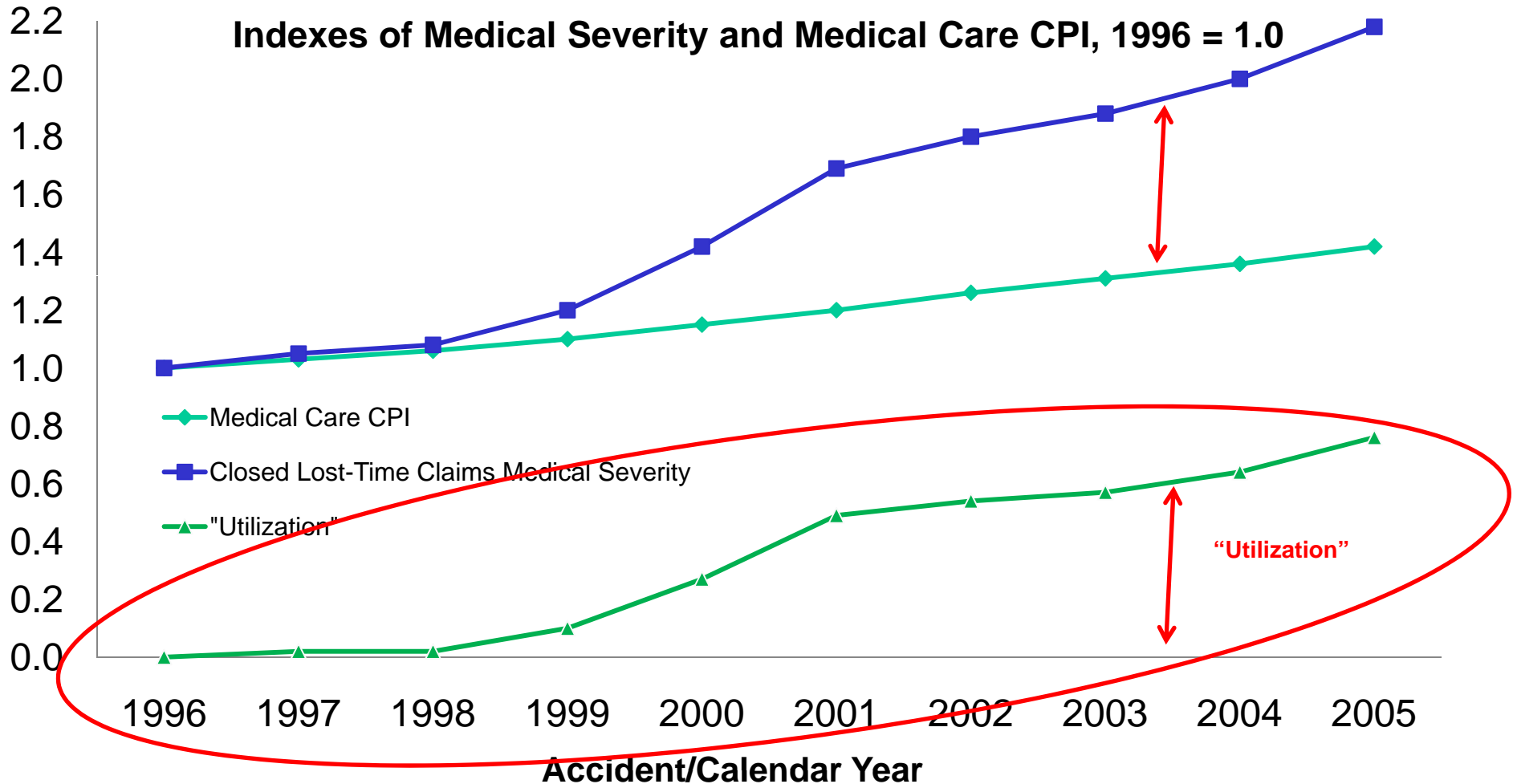


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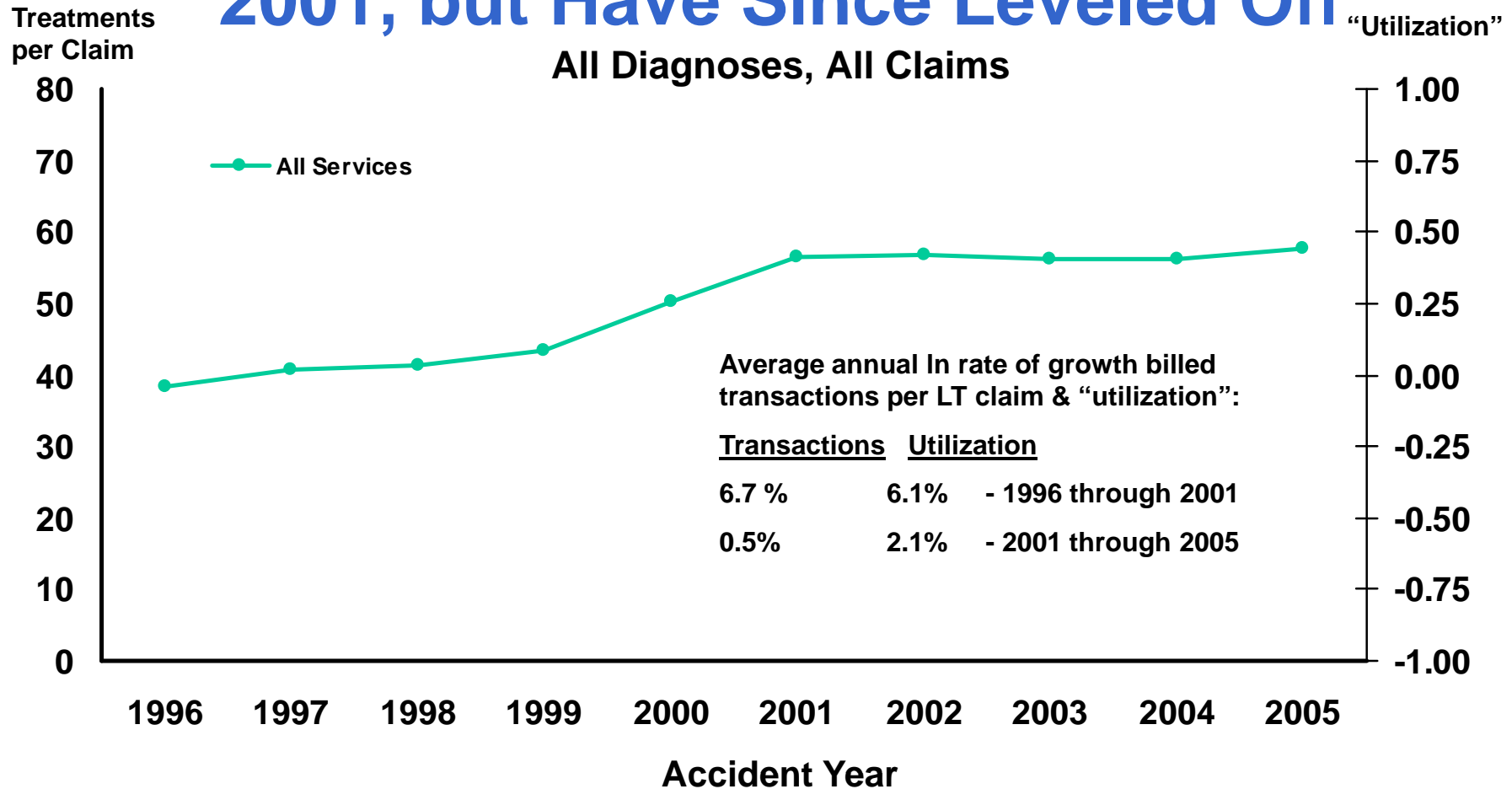
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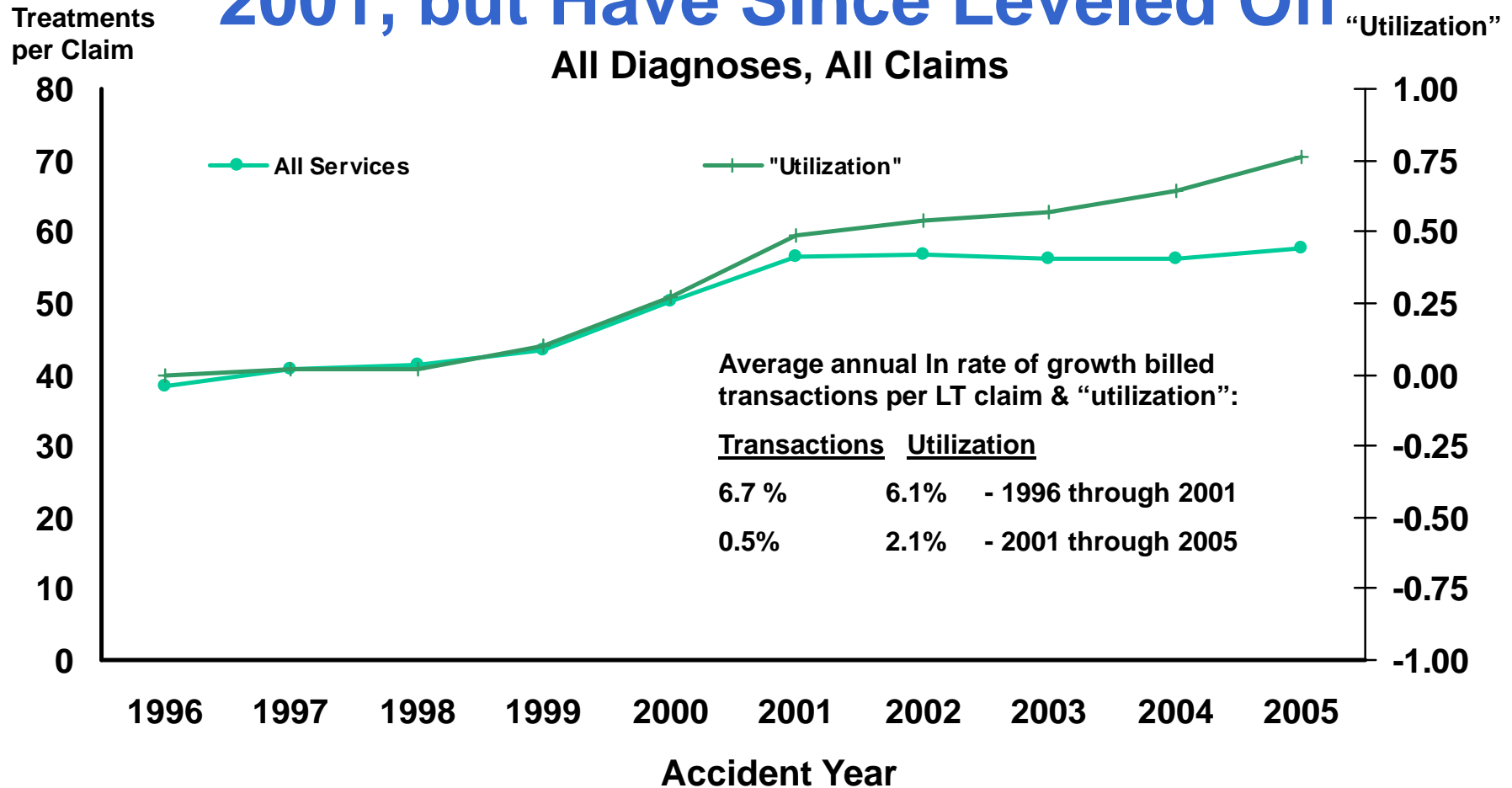
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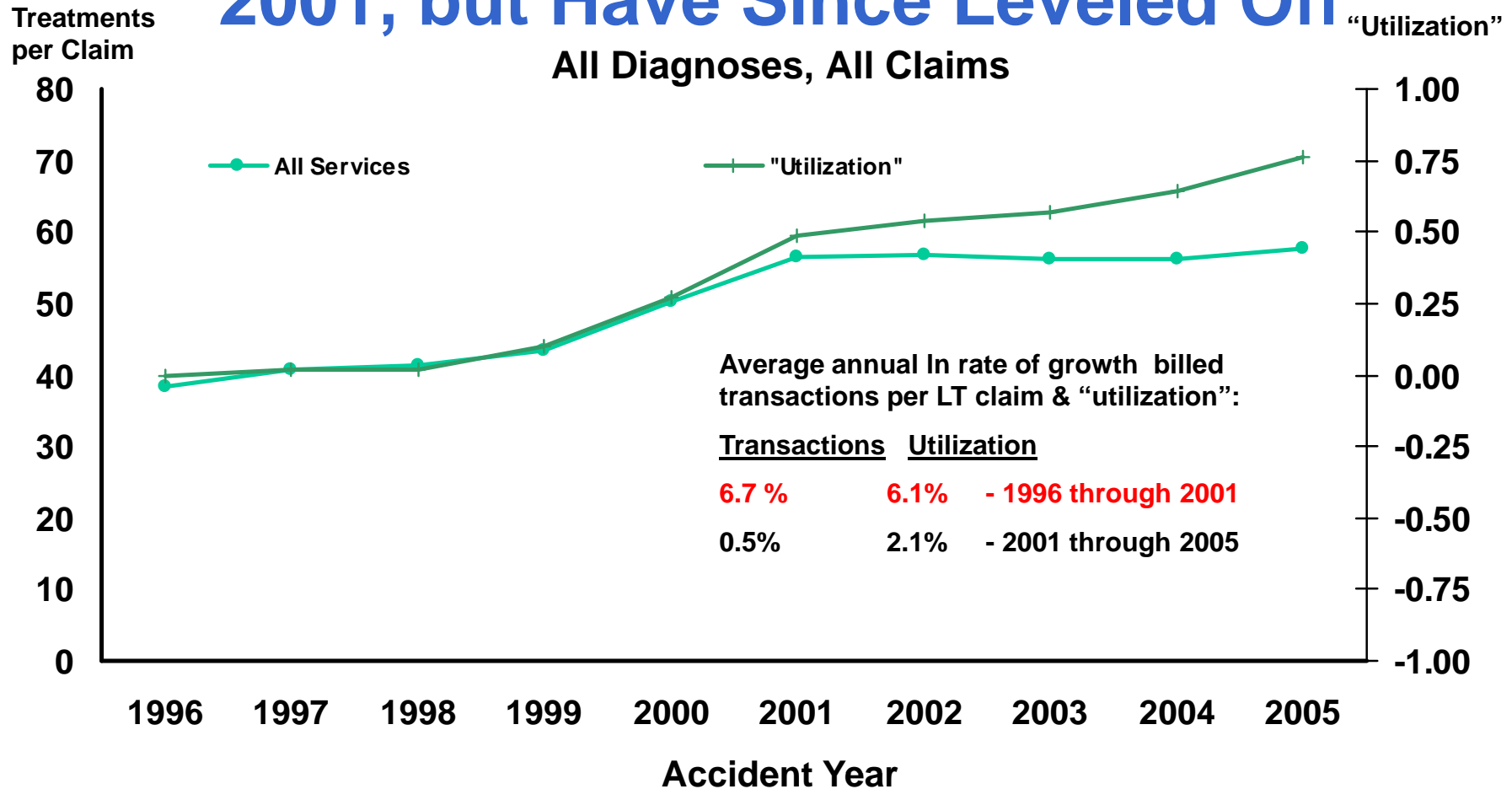


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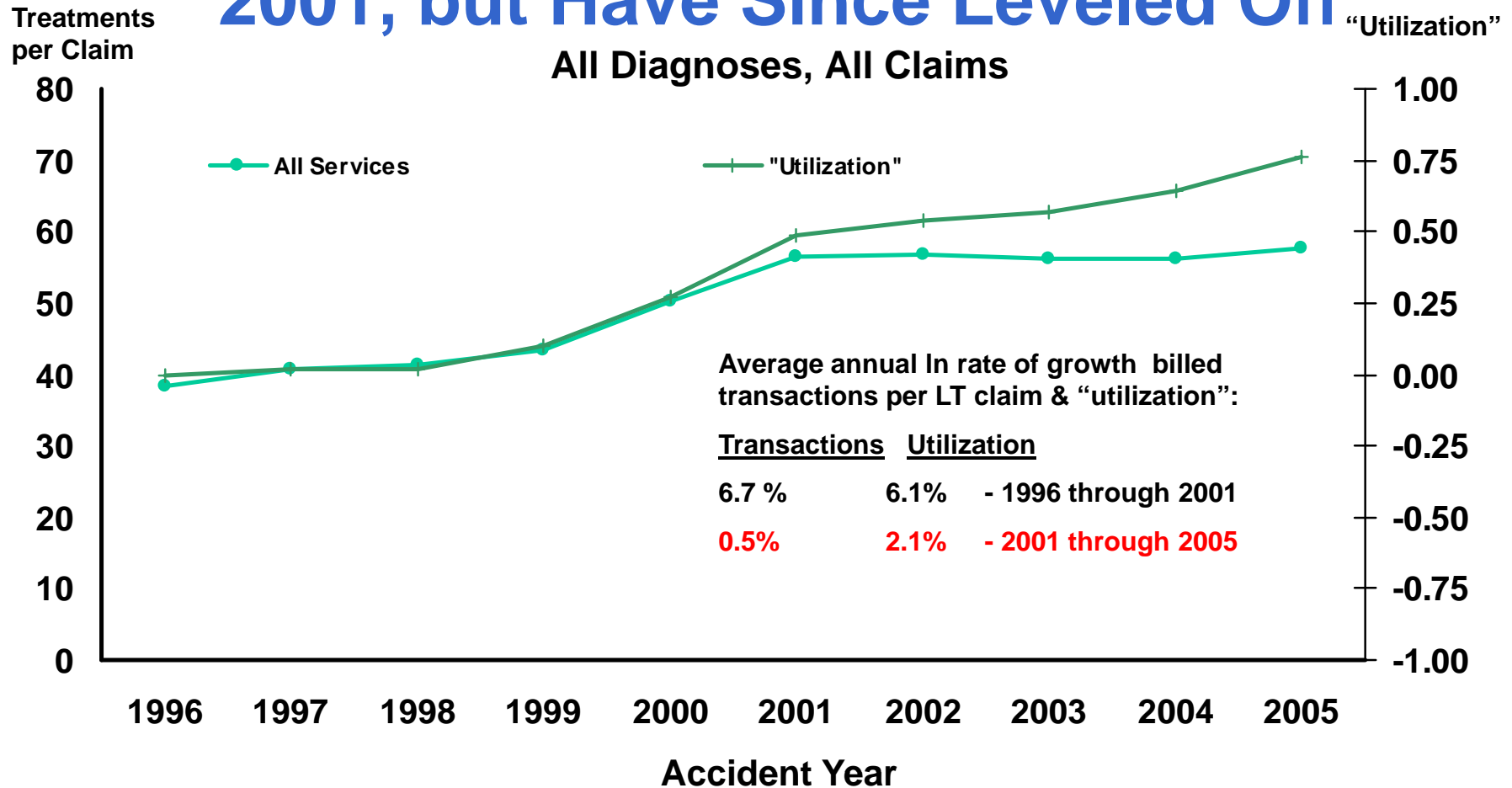
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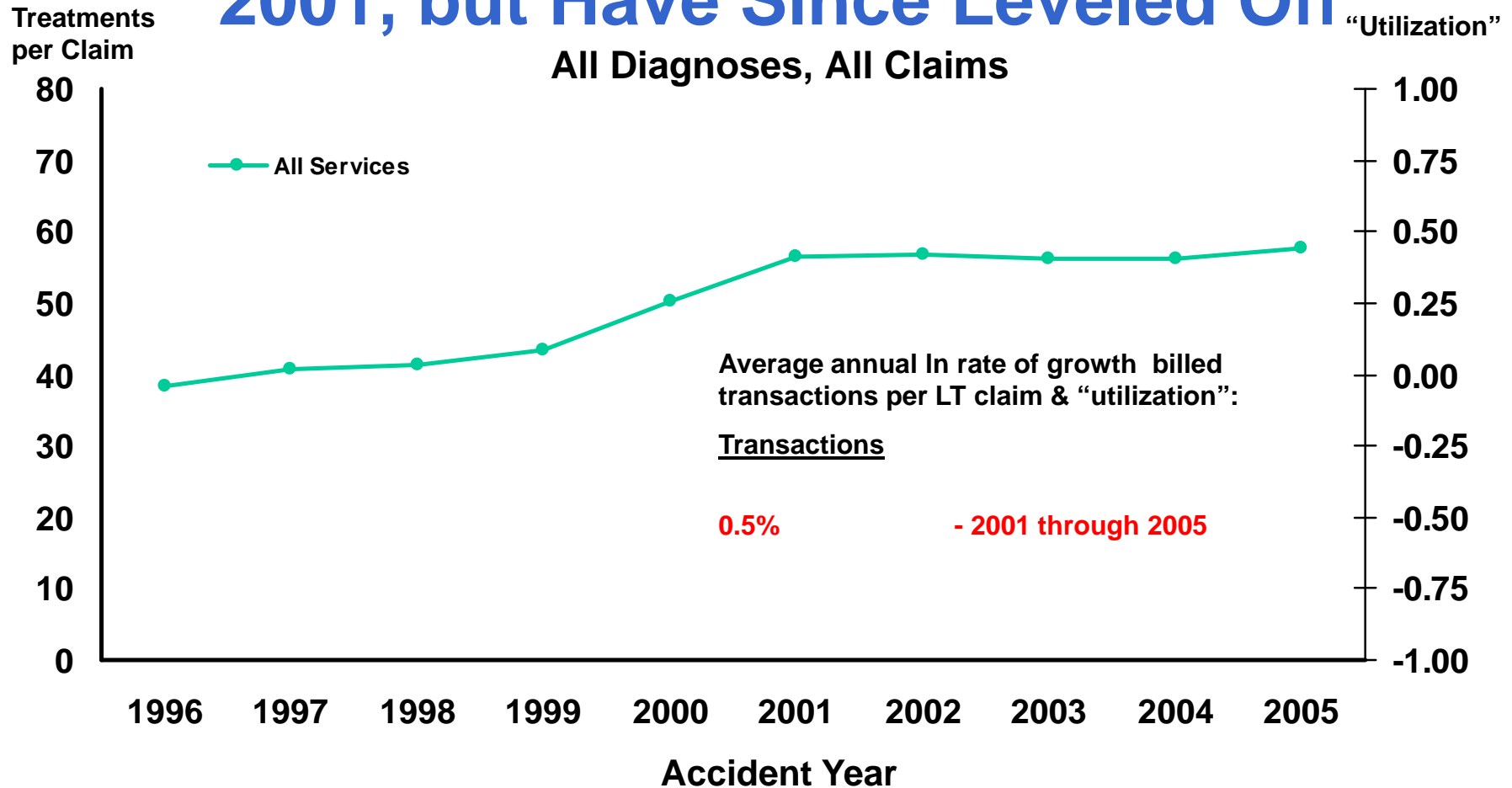
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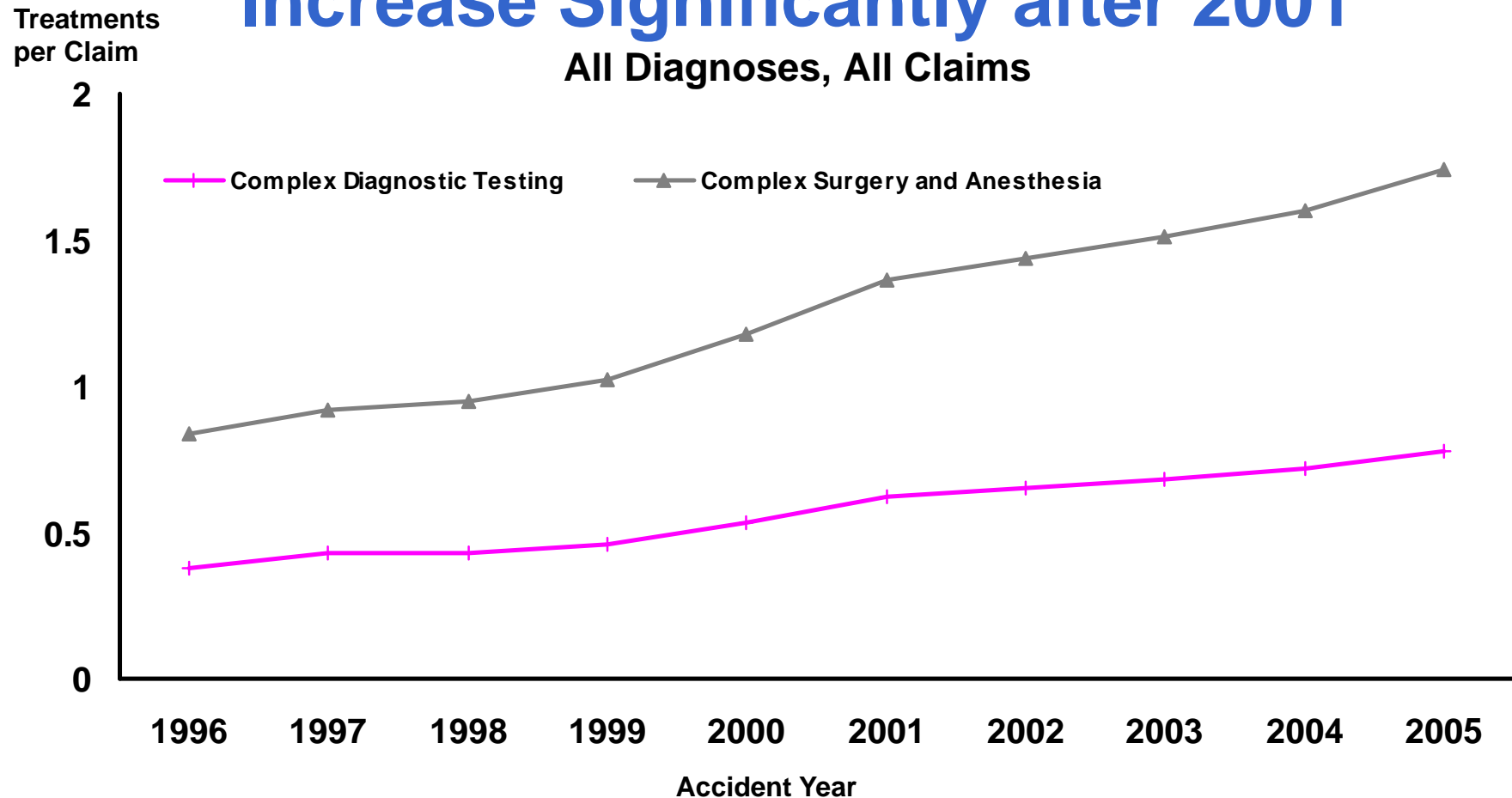
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High Cost Services

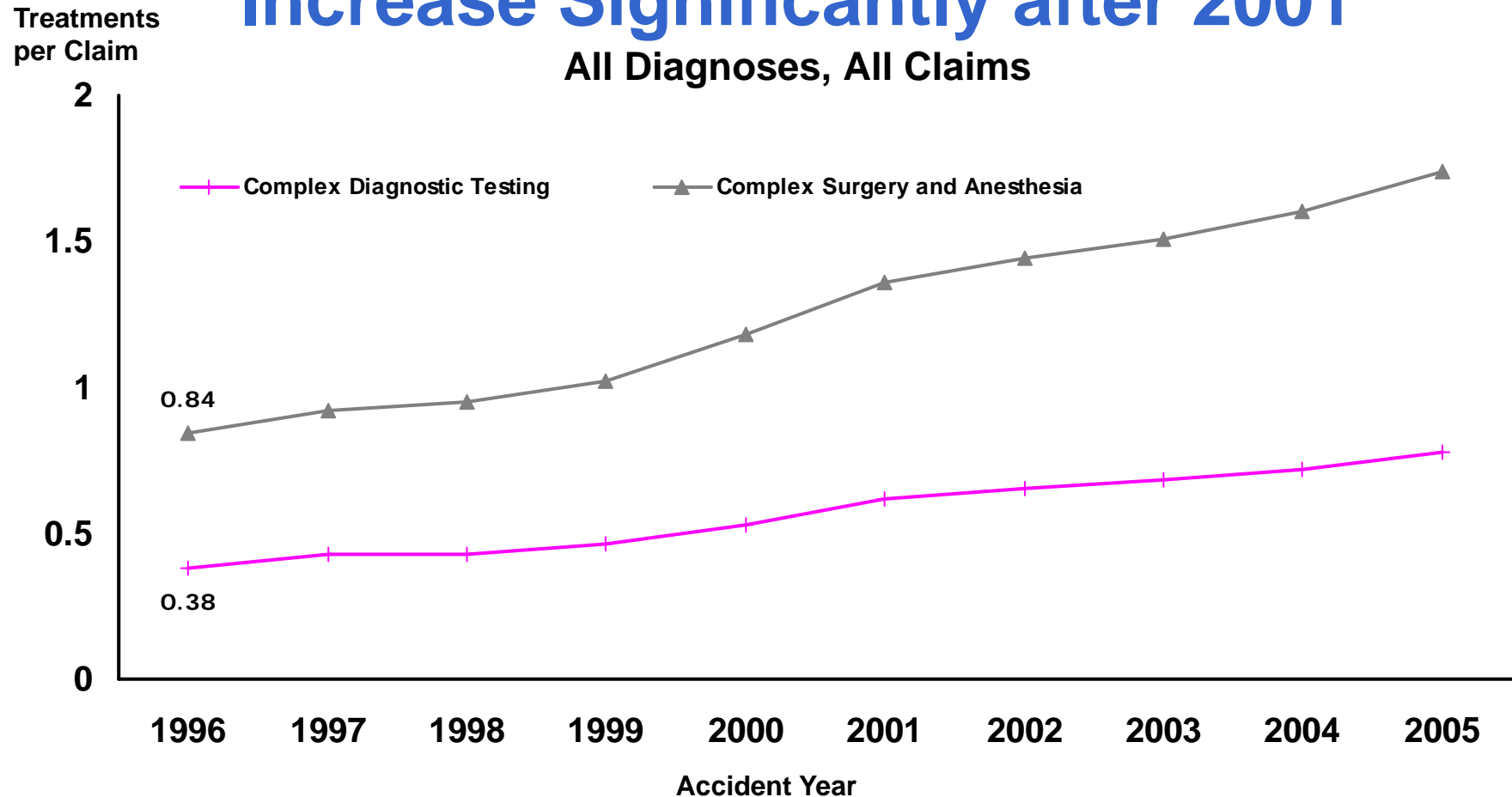
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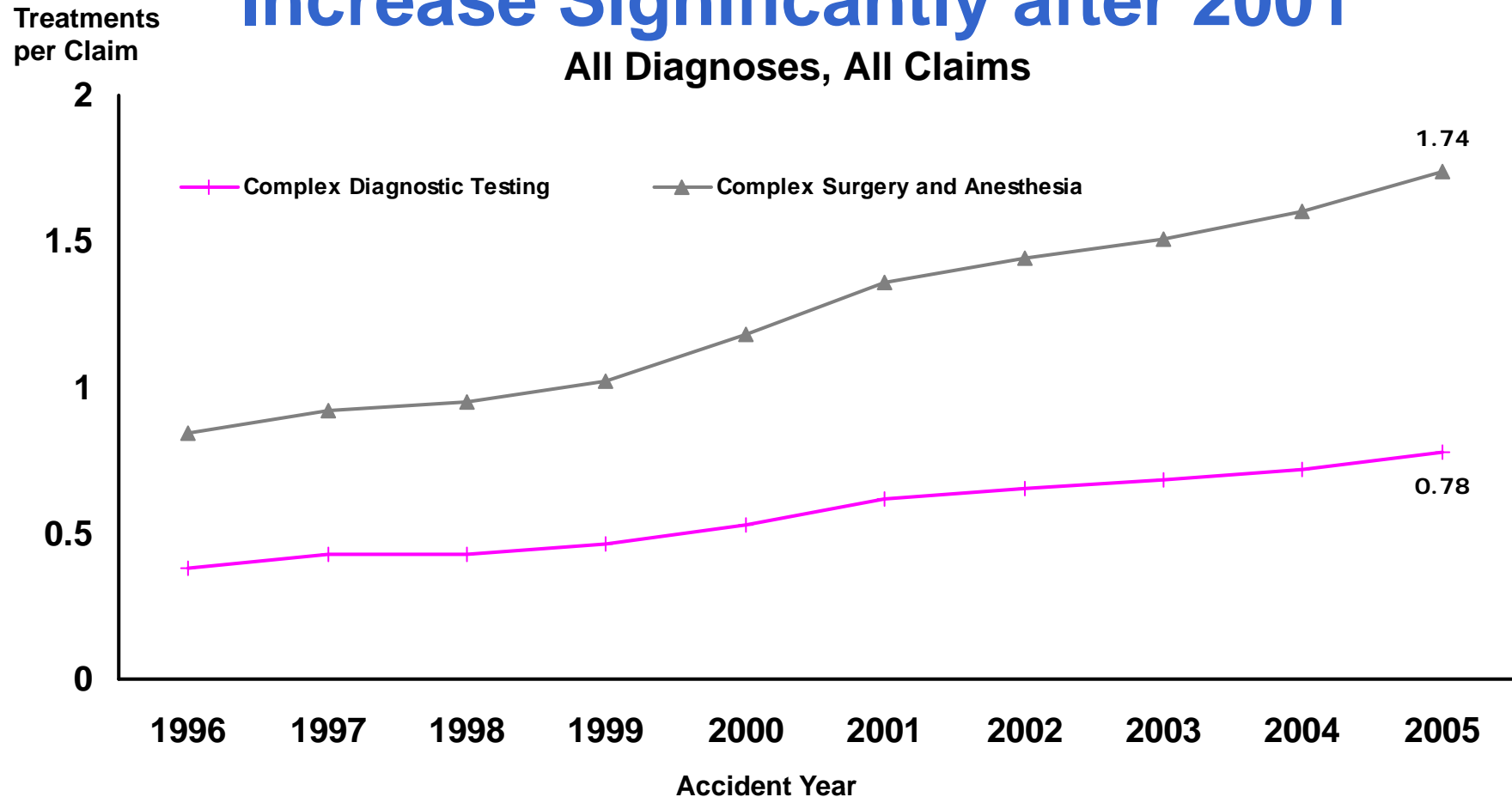
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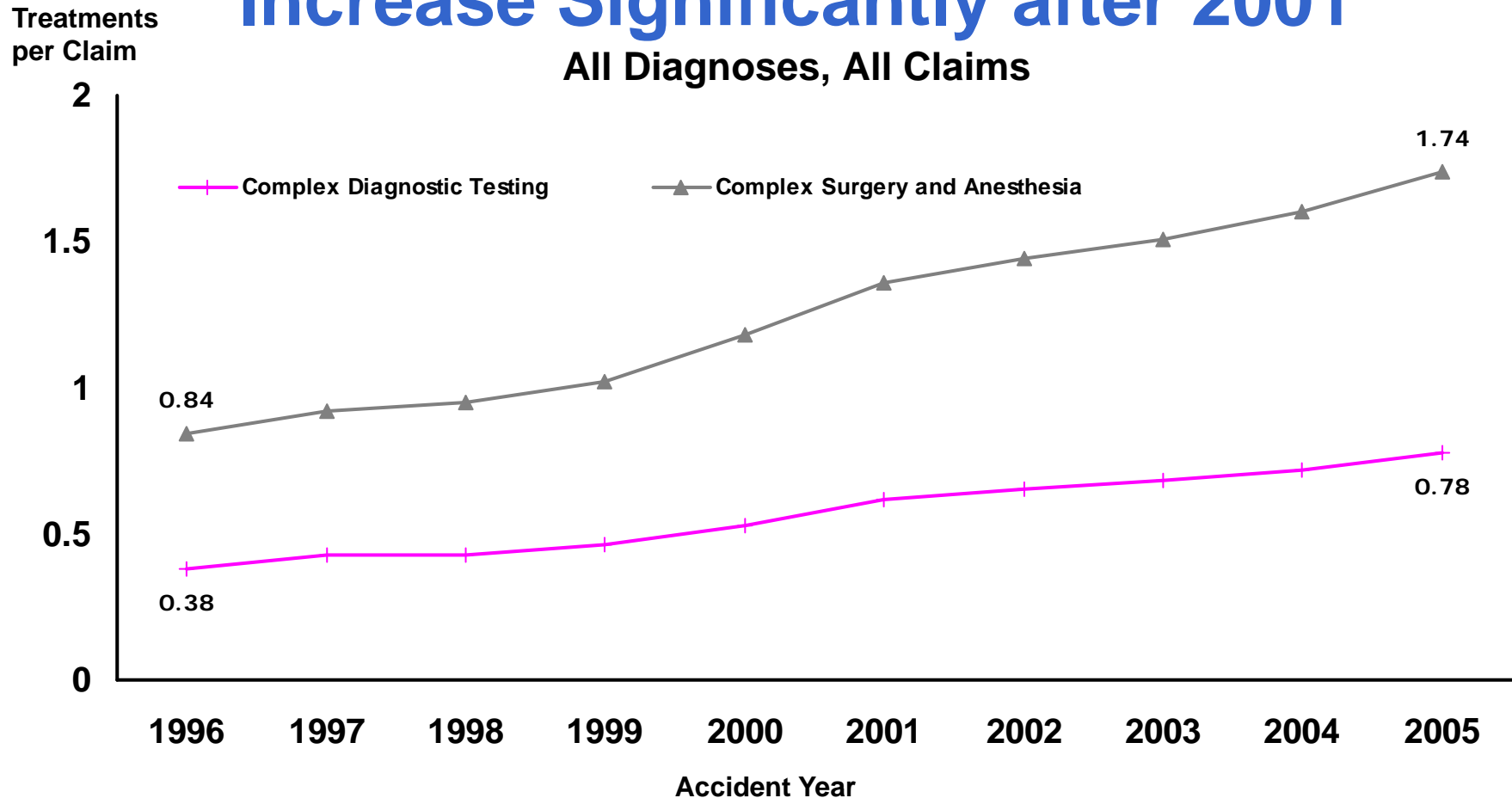
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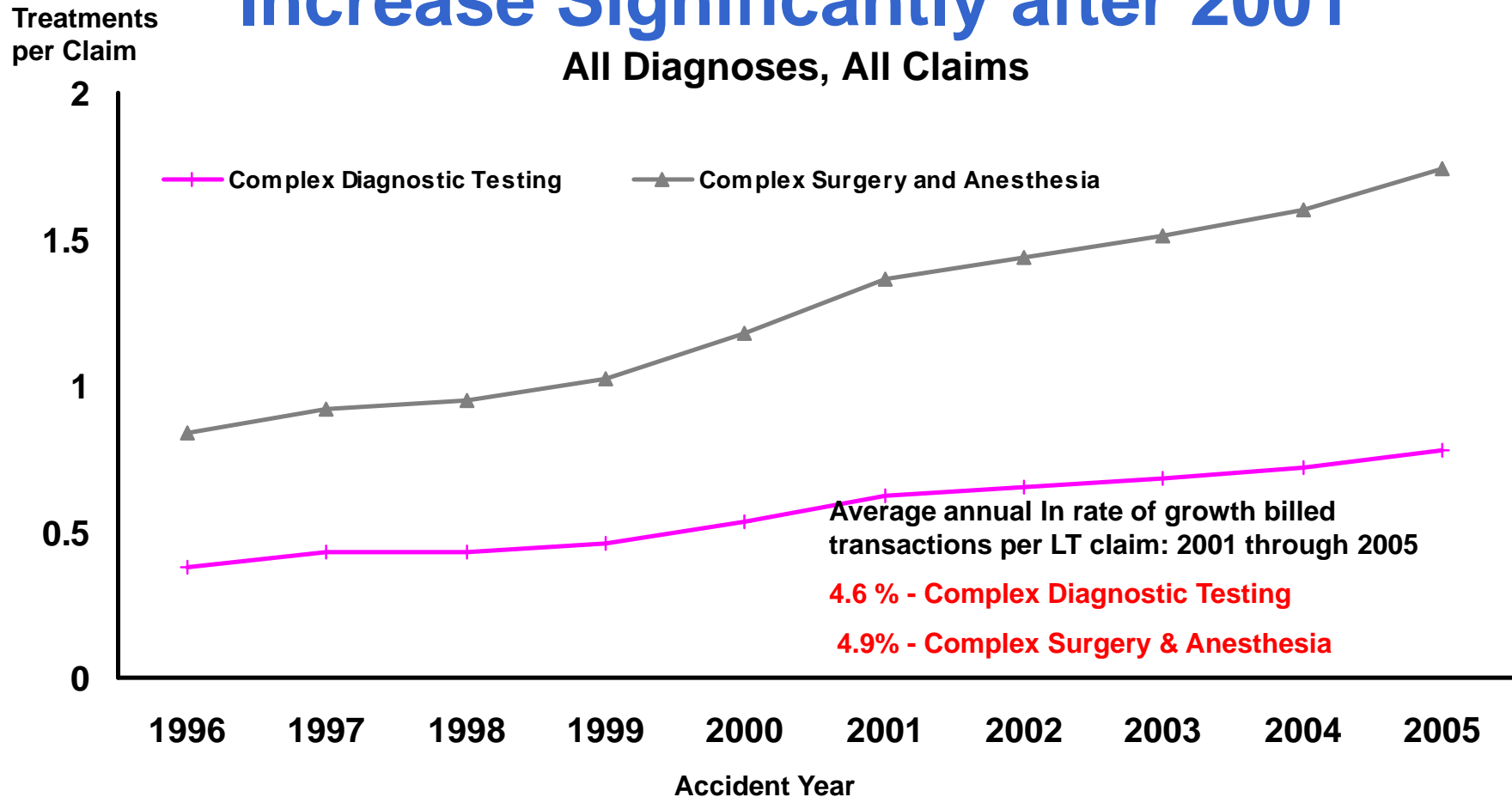


Lost-Time Claims Closed Within 24 Months of Date of Injury, NCCI States
Source: NCCI

High Cost Services

Treatments per Claim Continued to Increase Significantly after 2001

All Diagnoses, All Claims



Lost-Time Claims Closed Within 24 Months of Date of Injury, NCCI States
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Containing WC Medical Costs What Are We Doing Now

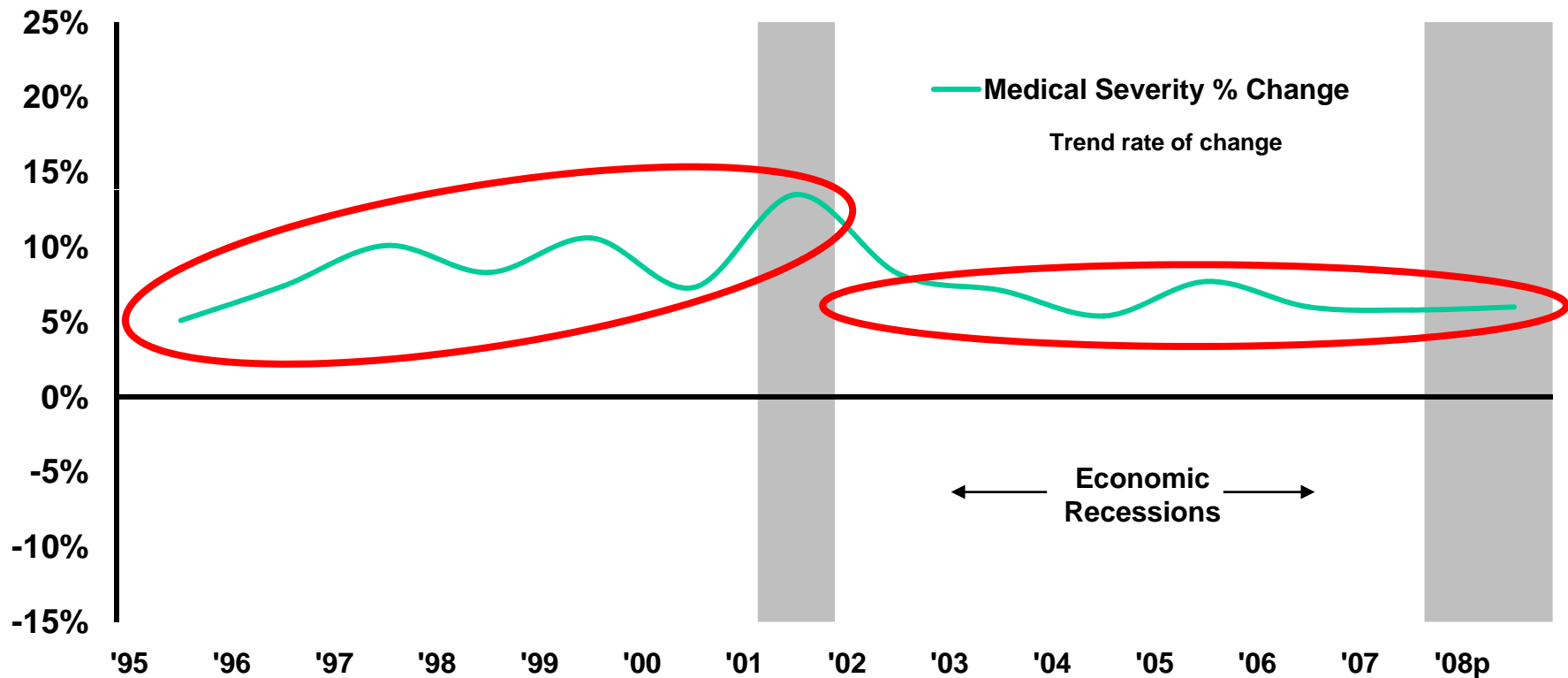
Containing WC Medical Costs

What Are We Doing Now

- How the system works now:
 - Cost containment via
 - Reimbursement rates/fee schedules
 - An incentive for providers to do more because they can't charge more
 - Increased utilization
 - Utilization reviews/prior approval

Medical Severity Growth Rates Eased – Why?

Percent Change, Lost-Time Claims



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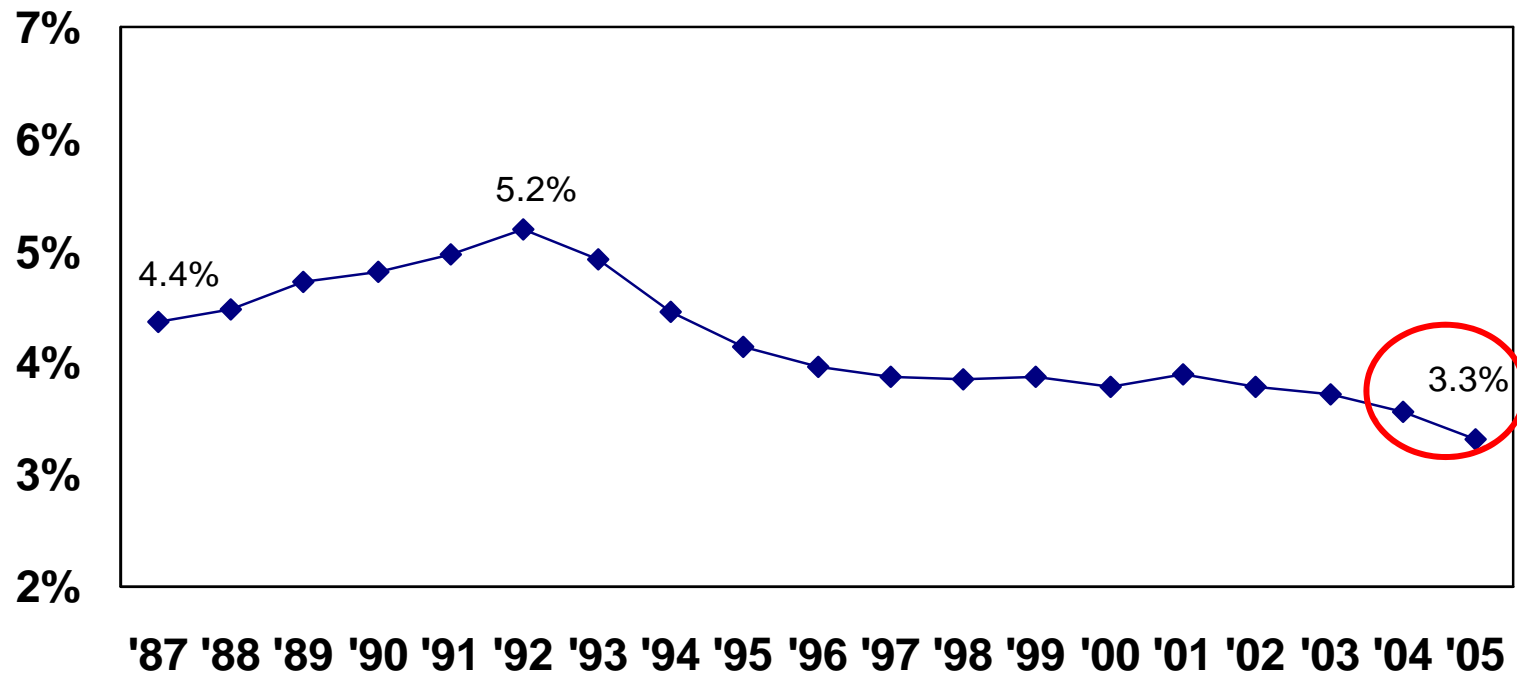


Containing WC Medical Costs What Else Can We Do?

**WC Likely Will Follow the Lead of Health Care Reform
Especially Medicare**


The **WC Share** of US Medical Costs: Small and Shrinking

Medical Benefits Paid Under Workers Compensation Have
Been Declining as a Share of Medical Care Spending



Sources: National Academy of Social Insurance (NASI); Centers for Medicare & Medicaid Services (CMS)





Politics and Policy: Workers Compensation and Health Reform

And This Growth Is Projected to Continue

- **Healthcare Reform – What Are the Problems?**
- **The Diverse Range of Possible Reforms**
- **Realigning Incentives - A Leading Opportunity and a Major Challenge**
- **WC and Health Care Reform**



Healthcare Reform – What Are the Problems?

The “Experts” Generally Agree

“Reforming American Healthcare,”
The Economist, June 27, 2009, p. 75-77

Problems:

- **Inadequate coverage**
- **Uneven quality**
- **Soaring costs**



Healthcare Reform – What Are the Problems?

Some Supporting Arguments

(offered by The Economist)

“Reforming American Healthcare,”
The Economist, June 27, 2009, p. 75-77

Coverage:

- **15% of US population uninsured**
- **Examples of Universal Coverage Mechanisms Outside the US:**
 - **Single payer systems:**
 - **UK**
 - **Canada**
 - **Sweden**
 - **Individual mandate**
 - **Switzerland**
 - **Netherlands**

**“Reforming American Healthcare,”
The Economist, June 27, 2009, p. 75-77**

Uneven quality:

- **Wide geographical variations in costs with no discernable differences in outcomes – Medicare data – research by Skinner**
- **Infant mortality high in US**


Costs – higher level likely due to:

- **High utilization due to the nature of incentives:**
 - **ESI (employer sponsored insurance) is subsidized => employers buy more generous coverage than otherwise**
 - **Low deductibles & copays => insureds consume more than otherwise**
 - **E.g., Routine care vs. catastrophic and chronic**
 - **Medical providers’ incentives under “fee for service” compensation => provide more services**



Reforming Healthcare in the US
Political Proposals to Change the System:

Consumer Driven Market Competition
or
Competition with a Government Option



The Elements of Health Care Reform

A Diverse Range of Possibilities

“Options for Slowing the Growth of Health Care Costs,” James J. Mongan, Timothy G. Ferris, and Thomas H. Lee, NEJM, April 3, 2008, p. 1509-1514

“Options for Slowing the Growth of Health Care Costs,” James J. Mongan, Timothy G. Ferris, and Thomas H. Lee, NEJM, April 3, 2008, p. 1509-1514

Greatest Potential for Cost Savings:

- **Payment reform:**
 - **Capitation/partial capitation**
 - **Pay for performance – to “augment” fee for service**
- **Electronic medical record systems**
- **Coordinated delivery – vs. current “fragmentation”**
 - **Focus on outcomes/effectiveness**
 - **Disease management – chronic disease (10% of patients => 70% of costs)**
- **Effectiveness reviews – of new technology**

“Options for Slowing the Growth of Health Care Costs,” James J. Mongan, Timothy G. Ferris, and Thomas H. Lee, [NEJM](#), April 3, 2008, p. 1509-1514


Intermediate potential for cost savings:

- **Manage “late in life” costs**
- **Alternative organizational approaches:**
 - **Conservative – Consumerism**
 - Larger deductibles and copayments
 - Health Savings Accounts
 - “Transparency” – prices, performance
 - Electronic medical record systems
 - **Liberal – single payer => reduce administrative expenses**

“Options for Slowing the Growth of Health Care Costs,” James J. Mongan, Timothy G. Ferris, and Thomas H. Lee, NEJM, April 3, 2008, p. 1509-1514

Low potential for cost savings:

- **Reform of medical malpractice**
- **Prescription drug pricing – formularies**
- **Prevention – better quality of life, not lower cost**
- **Rationing – Medicare uses fixed, all payer budget cap**
- **Medicare – from defined benefit to defined contribution**



Realigning Incentives: Challenges and Opportunities

Addressing High Costs of Health Care An Often Unrecognized Challenge

- **Medical Professionals as Business Owners:**
 - **Rent/mortgage payments**
 - **Finance costs for equipment – medical and office**
 - **Utilities and other overhead**
 - **Staff costs – medical professionals & administrative**
 - **Supplies – medical and office**

These typically follow an upward trend

- **Medical principals as business owners – anything left**



Perhaps the Most Notable Challenge

The “dominant fee for service model
rewards volume and intensity rather than value.”

Meredith B. Rosenthal, PhD, Harvard School of Public Health

“Beyond Pay for Performance – Emerging Models of Provider-Payment Reform,” Meredith B. Rosenthal, [NEJM](#), September 18, 2008, P. 1197-1200.



Addressing High Costs of Health Care

- **Market responses are already appearing:**
 - **Medical tourism**
 - **VIP medical practices**
 - **Importing Rx drugs from abroad**
 - **Outsourcing radiology interpretation**



Realigning Incentives

Pay for Something More than Services Rendered



New Approaches Designed to Get the Incentives Better Aligned

Proposed New Approaches to Get the Incentives Better Aligned

- Pay for performance
- Pay per episode
- Evidence-based medicine



Managing Provider Payments

No Reimbursement for “Never Events”

Introduced by Minnesota HealthPartners

(2005)

Adopted by Medicare

(2008)



Medical Reform and “Never Events”

- Medical problems that could/should have been prevented by reasonable care and procedures
- Examples:
 - Additional surgery to remove objects left in body during prior surgery
 - Major surgical errors: wrong patient, wrong body part
 - Bed sores (“pressure ulcers”)
 - Certain hospital associated infections (e.g. MRSA)

“Ending Extra Payment for “Never Events” – Stronger Incentives for Patients’ Safety,” Arnold Milstein, NEJM, June 4, 2009



WC Medical and “Never Events”

- **MRSA –**
- **Relatively minor work-related injuries or surgery followed by multiple surgeries to control what they assume to be HA (healthcare associated) MRSA infections.**
- **In a couple of cases the outcome has been total disability,**
- **They have not pursued subrogation against caregivers, because they don't expect success.**
- **Over the past year [this carrier] has paid on 5 very large multi-surgery MRSA cases**

WC Medical and “Never Events”


- **MRSA –**
- **They currently have 3 \$500k-plus claims involving MRSA complications.**

Even more important

It is clear that the patients – injured workers – and their families suffered enormous physical, financial and emotional loss.

Proposed New Approaches to Get the Incentives Better Aligned

- Pay for performance
- Pay per episode
- Evidence-based medicine



Reforming the Basis for Medical Reimbursement

The Primary Care/Medical Home Approach

“Beyond Pay for performance – Emerging Models of Provider-Payment Reform,” Meredith B. Rosenthal, NEJM, September 18, 2008, P. 1197-1200.

- **One robust alternative is the primary care/medical home:**
 - **Objective: coordination and management of care to improve outcomes and lower costs**
 - **Compensation/payment:**
 - **Case management fee (“case rate”) – likely “episode” based**
 - **Pay for performance**
 - a) Episode-based**
 - b) Protocol based on best practices**
 - c) Outcomes for preventative and chronic disease management**
 - d) Patient experience**
 - **Shared savings – cost effective performance relative to some benchmark of average costs**

“Beyond Pay for Performance – Emerging Models of Provider-Payment Reform,” Meredith B. Rosenthal, NEJM, September 18, 2008, P. 1197-1200.

- **“The prospects for payment reform, however, hinge more on politics than on economics.”**
- **To reduce costs – for example: a shift in emphasis and reimbursement from specialists to primary care physicians – expect “substantial resistance to even the best-designed plans.”**



How Much Healthcare Do We Want?



Higher Costs vs. Worse Outcomes
US Lifestyle Choices and Health Outcomes

Higher Costs/Worse Outcomes

Does the US Medical System Really Under Perform?

- A Comparison with Canada

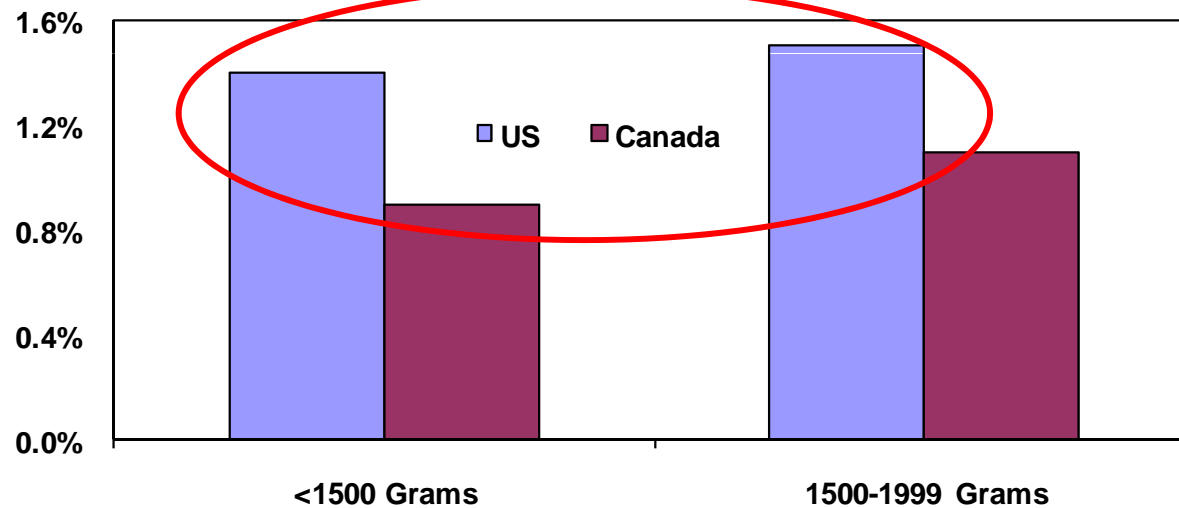
- Infant Mortality
- Life Expectancy

Higher Costs/Worse Outcomes

Infant Mortality

The US Has a Substantially Higher Rate of Low-Birthweight Babies

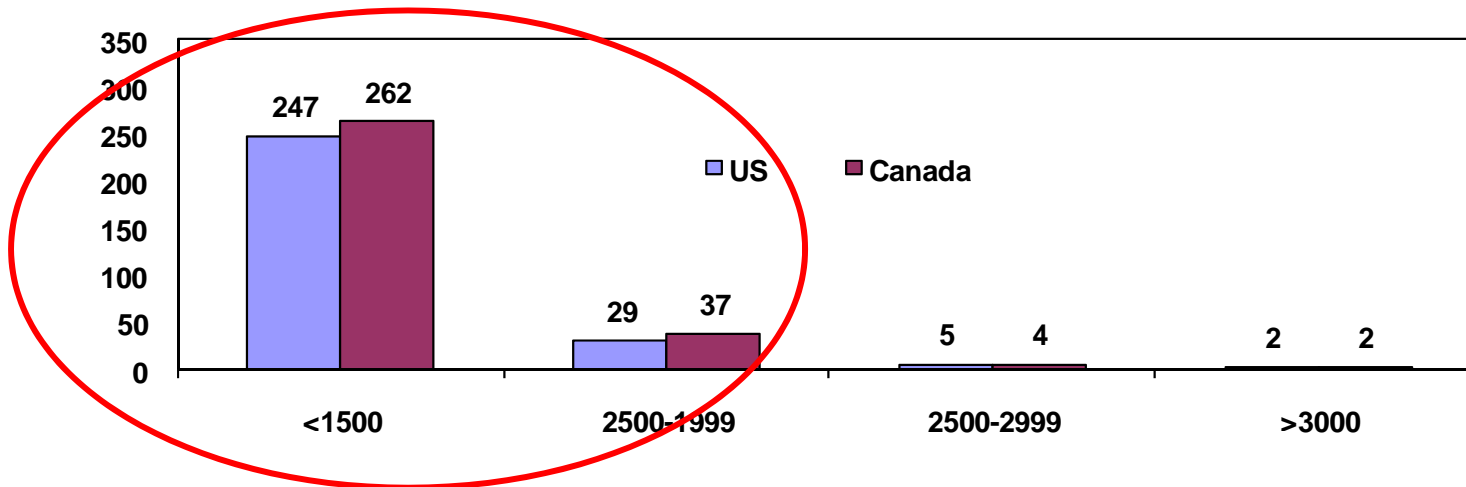
The Percentage of Low-Birthweight Infants is Substantially Higher in the US Than in Canada
Percent of Births for Infants with Known Birthweights



Source: "Health Status, Health Care and Inequality: Canada Vs. The U.S.", June E. O'Neill & Dave M. O'Neill, Working Paper 13429, National Bureau of Economic Research, September 2007

This May Explain Why the US Has Higher Infant Mortality Rates

Low-Weight Infants Have Very High Mortality; US Rate a Bit Less on a Weight-Specific Basis
Infant Mortality per 1,000 Live Births
(by Birthweight, in Grams)



Source: Table 2, "Health Status, Health Care and Inequality: Canada Vs. The U.S.", June E. O'Neill & Dave M. O'Neill,

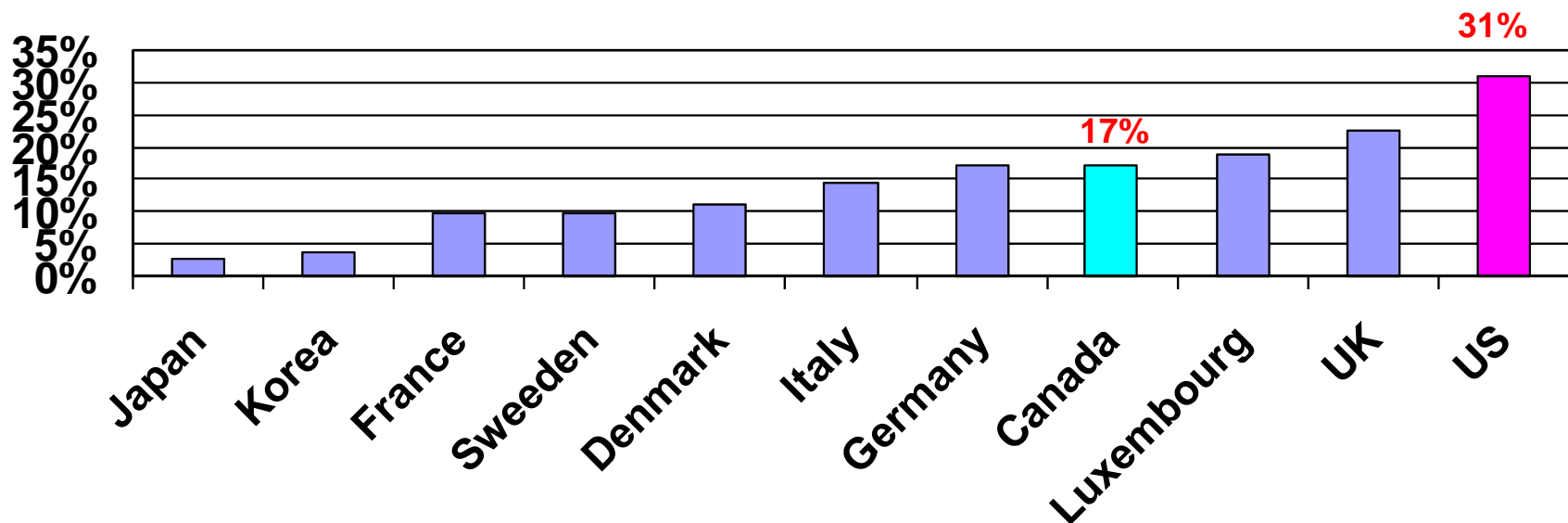
Source: "Health Status, Health Care and Inequality: Canada Vs. The U.S.", June E. O'Neill & Dave M. O'Neill, Working Paper 13429, National Bureau of Economic Research, September 2007

Higher Costs/Worse Outcomes

Life Expectancy

Might the US's High Rate of Obesity Contribute to Lower Life Expectancy?

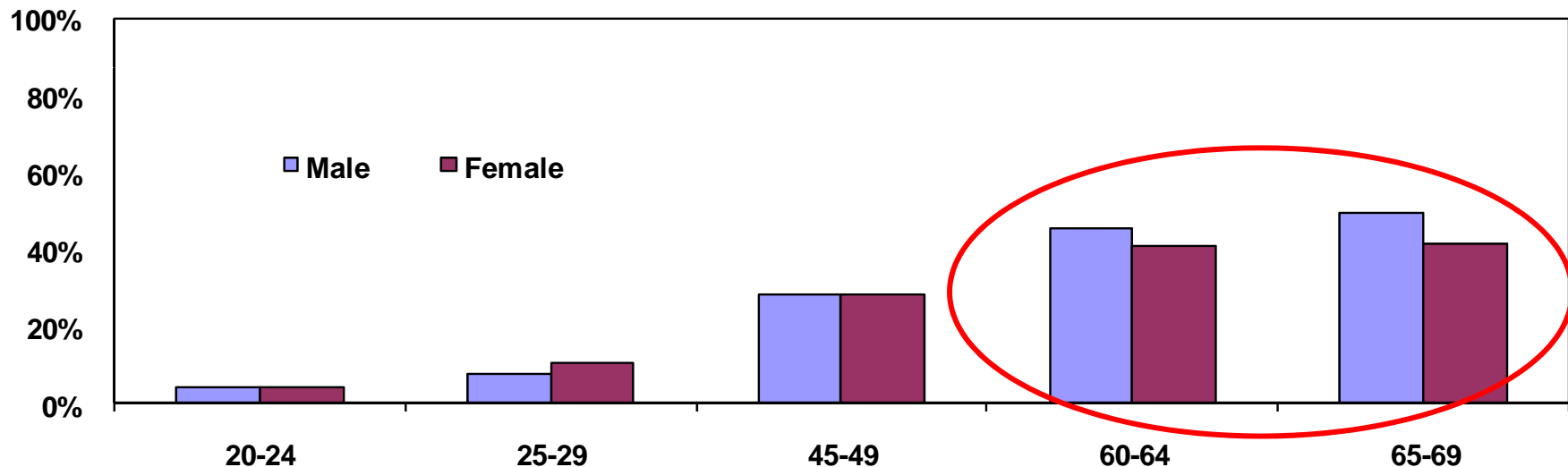
The US's Obesity Percentage Is Well Above That of Canada and Other Nations
Percent of Male Population with BMI of 30 or More



It Likely Plays a Role in the Death Rates Due to Heart Disease

Nearly Half of the Mortality Rate Difference Between the U.S. and Canada for Older Persons is Due to Diseases of the Heart

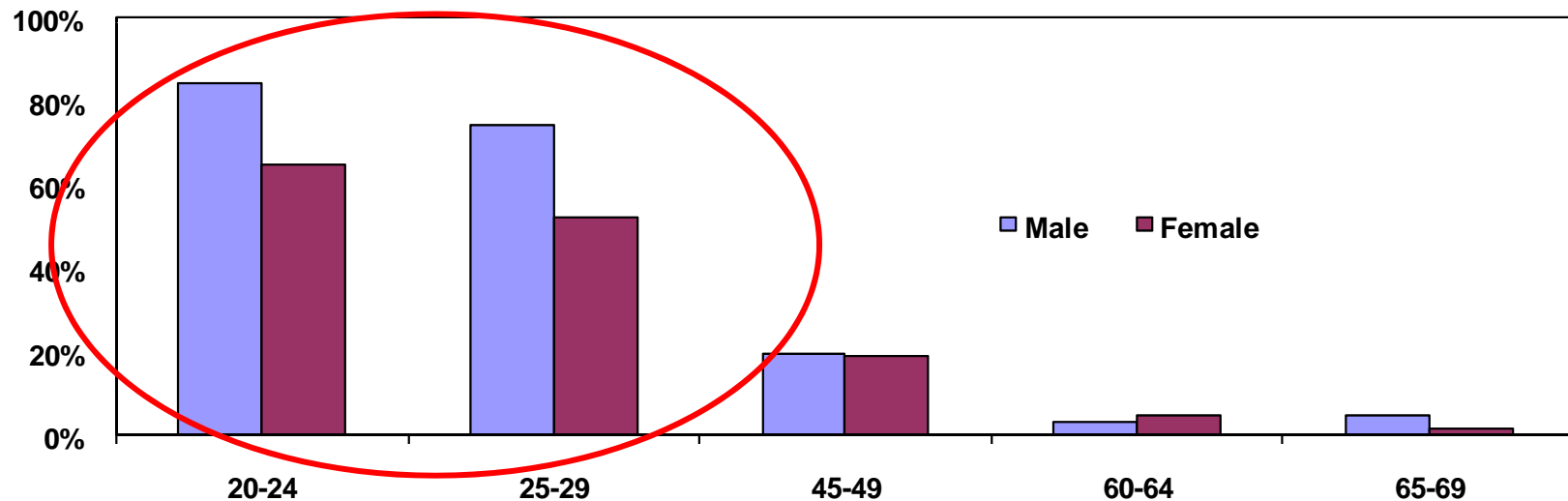
Percent of Mortality Rate Difference (US-CAN) Due to Diseases of the Heart



Source: Table 4, "Health Status, Health Care and Inequality: Canada Vs. The U.S.", June E. O'Neill & Dave M. O'Neill, Working Paper 13429, National Bureau of Economic Research, September 2007

And Homicides and Accidental Deaths Are a Big Factor in the Higher Mortality Rates of Young Americans

More Than 80% of the Difference in Mortality Rates Between the US and Canada for Younger Men Is Due to Homicides and Accidents



Source: Table 4, "Health Status, Health Care and Inequality: Canada Vs. The U.S.", June E. O'Neill & Dave M. O'Neill, Working Paper 13429, National Bureau of Economic Research, September 2007

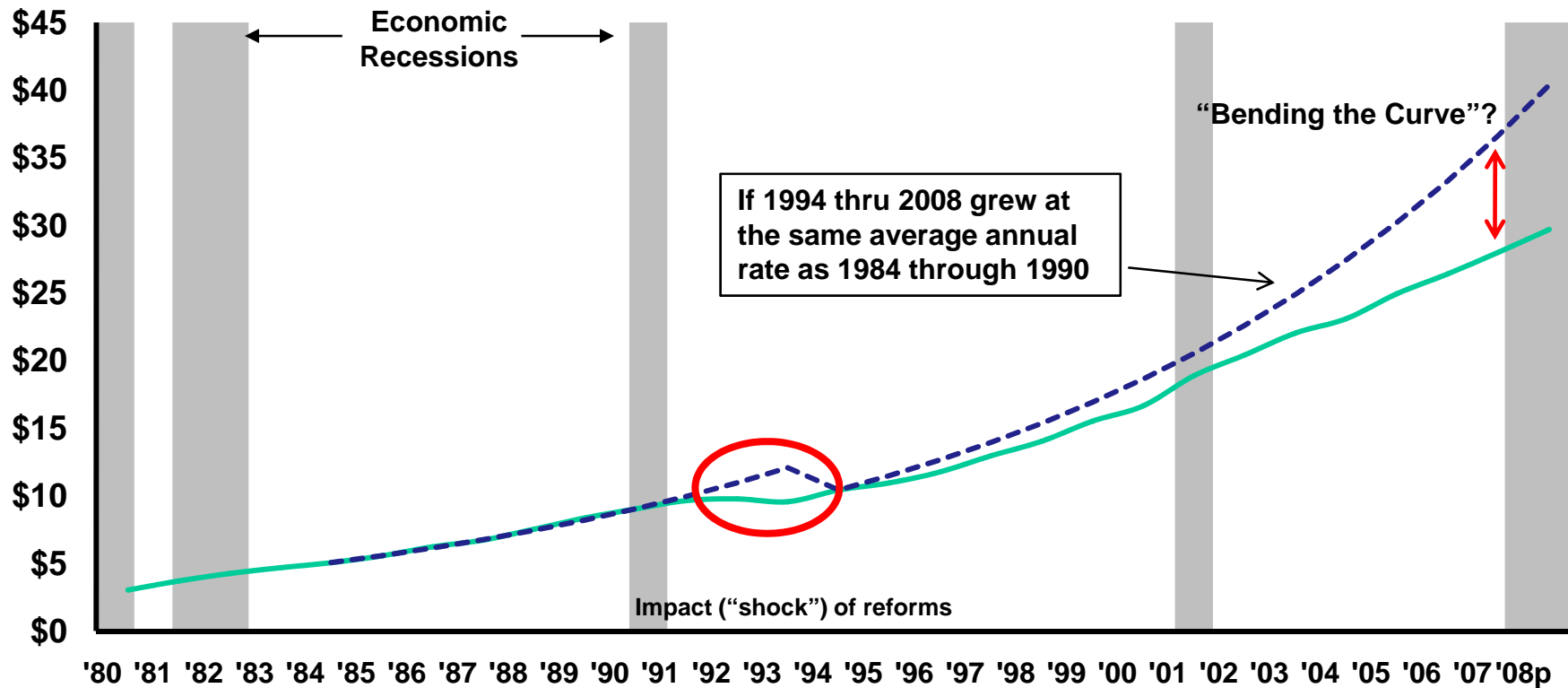
- **Moral Hazard/Personal Choice as a contributor:**
 - **Smoking down – a plus**
 - **Obesity up – arguably in part because the downside can be managed by medicine**
 - **hypertension,**
 - **cholesterol,**
 - **diabetes**



A Couple of Positives for WC Medical

The Growth in Medical Severity Temporarily Checked Following Reforms in Early 1990s

Medical Cost per Claim (\$000)



2008p: Preliminary based on data valued as of 12/31/2008

1991–2007: Based on data through 12/31/2007, developed to ultimate

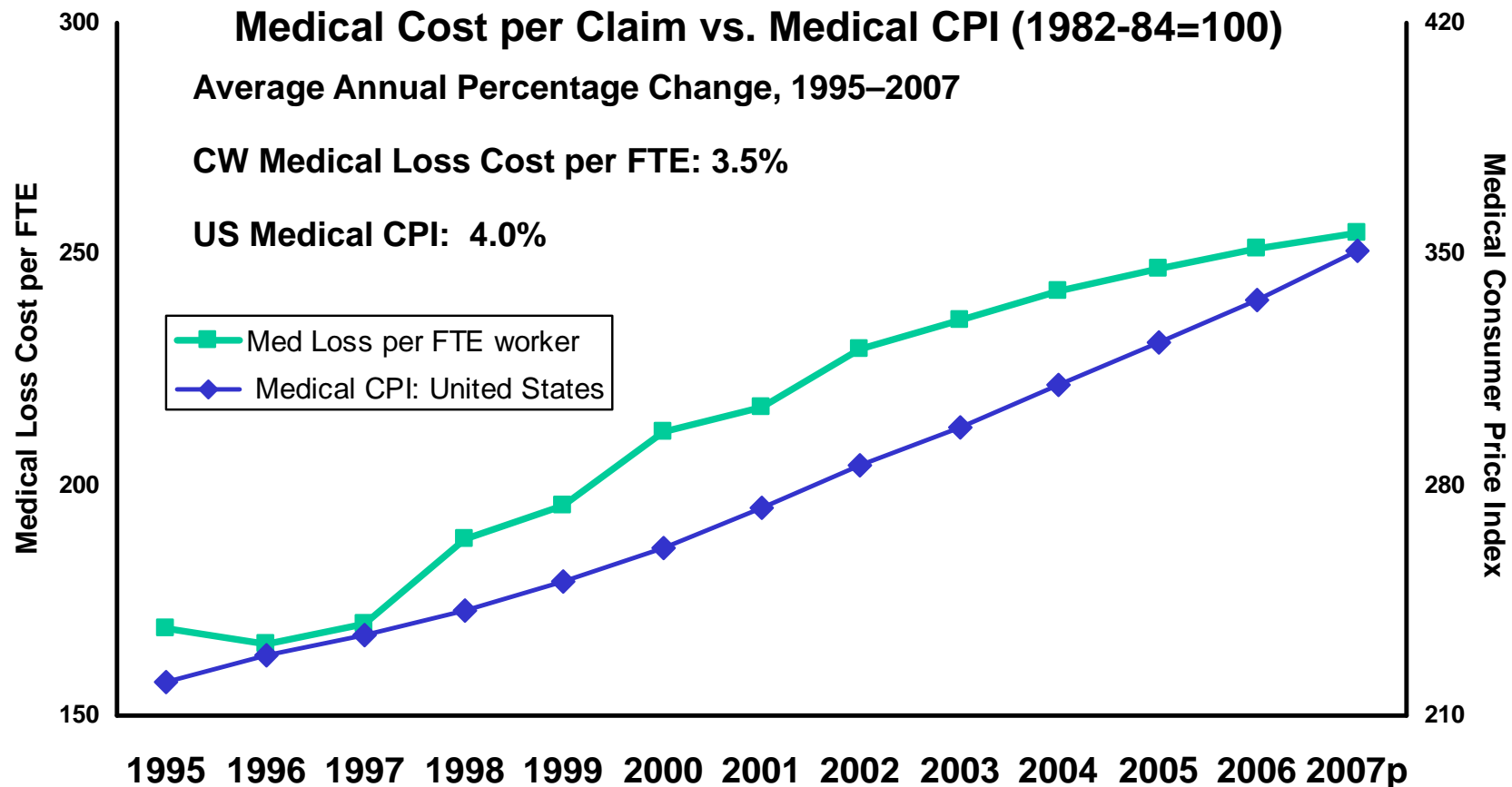
Based on the states where NCCI provides ratemaking services, including state funds

Excludes high deductible policies

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Countrywide Medical Cost per Covered Employee Reflects a Different Pattern



Medical severity 2007p: Preliminary based on data valued as of 12/31/2007

Medical severity 1995–2006: Based on data through 12/31/2006, developed to ultimate

Based on the states where NCCI provides ratemaking services, excludes the effects of deductible policies

Source: Medical CPI—All states, Economy.com; accident year medical severity—NCCI states, NCCI



WC and Medical Reform

- Medical trends in WC reflect what has been and what will be happening in health care nationally
- In particular workers compensation stakeholders must be prepared to evaluate and take advantage of the likely changes to the HC delivery system:
 - Medical home for coordination
 - Evidence based medicine
 - Pay per episode
 - Pay for outcomes
 - Case rates & reimbursement schedules



Thank You

Questions





**The Workers Comp Market as a
Model for Private Sector Health Care Delivery**

The Workers Comp Market as a Model for Health Care Delivery

- **Competitive market of private HC insurers**
- **Can accommodate:**
 - **Individual mandate**
 - **ESI “play or pay”**
- **Residual market to guarantee access**
- **Residual market pools to gain access to reinsurance**

The Workers Comp Market as a Model for Health Care Delivery

- **Able to accommodate current ESI structure:**
 - **Full coverage**
 - **Employer self insurance/large deductible**

The Workers Comp Market as a Model for Health Care Delivery

Consumer Protection via regulatory prior approval of basic health care policies/contracts, e.g.:

- **Conventional coverage**
- **High deductible/copay**
- **Small employer**
- **Personal purchase**

The Workers Comp Market as a Model for Health Care Delivery

- **Consumer and market competition promoted via rating agency filings:**
 - **Allows for competitive underwriting/experience rating in voluntary market**
 - **Community rating sufficient for health care residual market to breakeven**



Thank You

Questions



NCCI Holdings, Inc.

Politics and Policy: Workers Compensation and Health Reform

**Presented by Harry Shuford, PhD
Practice Leader and Chief Economist
Harry_Shuford@ncci.com
561-893-3033**

Meeting November, 2009

Healthcare Reform Proposals: What Are Some Key Features?

Healthcare Reform Proposals: Characterizing Some Key Differences				
	Market Competition Based (based on McCain Campaign Plan)		Expanded Federal Role (based on Obama Campaign Plan)	
Purpose:	Privatization of healthcare market		Comprehensive protection for all	
Goal:	Individual choice in a competitive marketplace		Universal Coverage	
Coverage	Guaranteed access to insurance pool for high risk, difficult to insure individuals Less comprehensive coverage offset by Health Savings Accounts		Creation of health insurance exchange to provide access to uninsured Mandate that all children be insured Elimination of risk based underwriting & premiums	
Most Controversial Change	Elimination of tax shelter on employer portion of health insurance premiums		Provision of public health insurance option to compete with private sector	
Financing	Elimination of tax shelter on employer portion of health insurance premiums		Employer mandate - provide ESI or pay a tax Payroll tax on high income individuals and families	

“The Real Health Reform Debate We Need to Have,” Drew Altman, NASI Annual Conference, January 31, 2008.

“The Partisan Divide – The McCain and Obama Plans for U.S. Health Care Reform,” Jonathan Oberlander, *NEJM*, August 21, 2008, p. 781-784.

Drew Altman, PhD, President and CEO, The Henry J. Kaiser Family Foundation

Jonathan Oberlander, PhD, University of North Carolina, Chapel Hill.



- Healthcare:
 - A “superior” good
 - Technology is adding to higher costs, but people want it

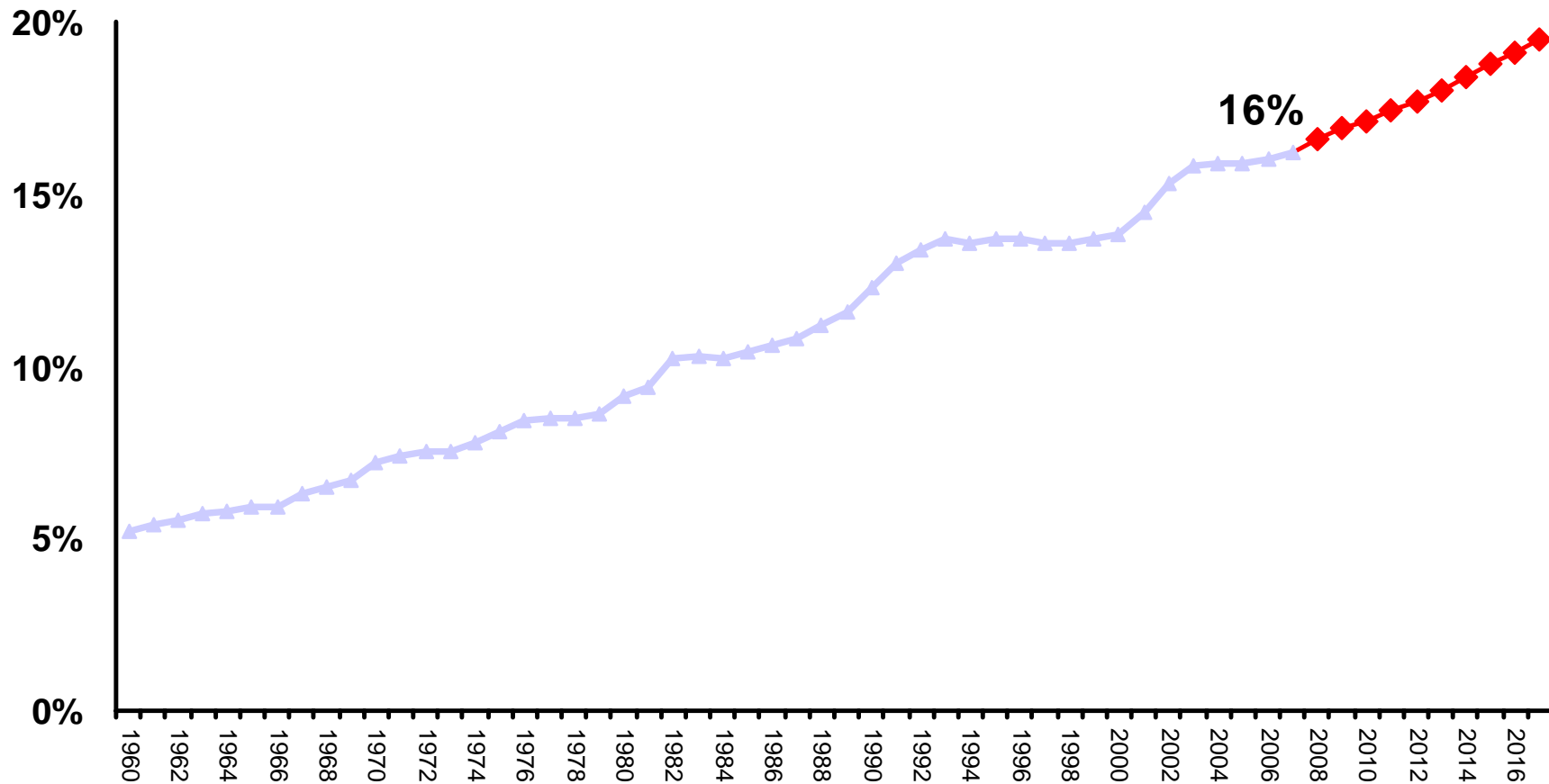
The Growth in Health Care Spending Is Projected to Continue

Medical Spending is 16% GDP and growing
– 33% by 2050?

What can be done about this?

Medical Spending Share of GDP Is Approaching 20%

Healthcare Expenditures as Percentage of Gross Domestic Product (GDP)



Source: Office of the Actuary, Centers for Medicare and Medicaid Services



- Whatever the nature of the ultimate reforms WC is likely to remain responsible for medical costs related to workplace injuries

- Precedents:
 - 1993 Clinton plan – was to be “coordinated” with WC and auto
 - MA – WC unaffected
 - Canada – funding of WC medical much like the US