

Medical Fee Schedules and Their Impact on WC Costs

2011 Ratemaking & Product Management Seminar

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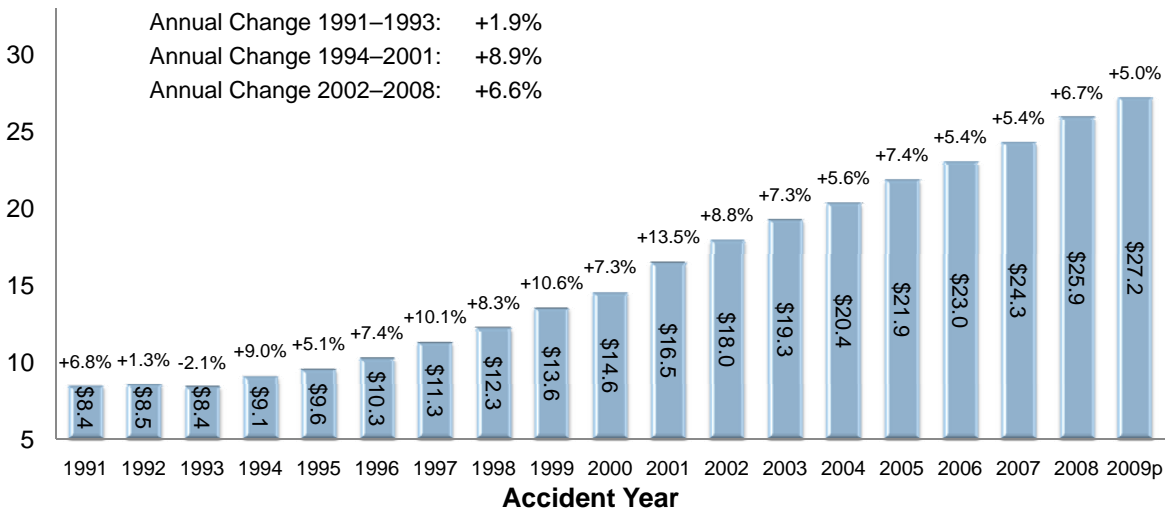
Agenda

- Why implement WC medical fee schedules and how do they get implemented?
- Overview of fee schedules in selected states
- Determining the impact of a fee schedule on costs
- Case studies
- Discussion of key considerations

Countrywide Workers Compensation Medical Claim Cost Trends

Average Medical Cost per Lost-Time Claim

Medical Claim Cost (000s)

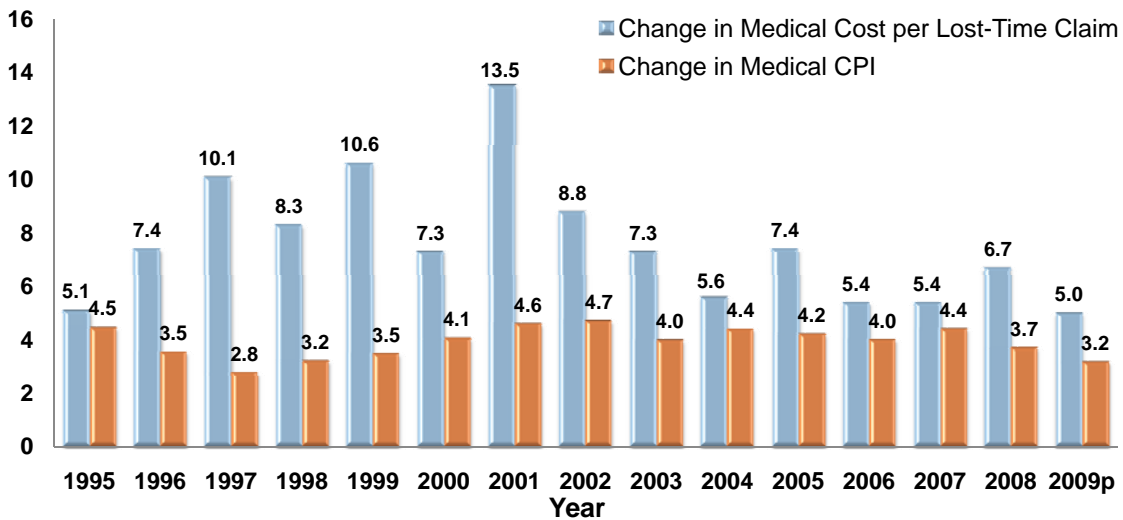


2009p: Preliminary based on data valued as of 12/31/2009
 1991–2008: Based on data through 12/31/2008, developed to ultimate
 Based on the states where NCCI provides ratemaking services, including state funds
 Excludes high deductible policies

Countrywide WC Medical Severity Is Still Growing Faster Than the Medical CPI

Average Medical Cost per Lost-Time Claim

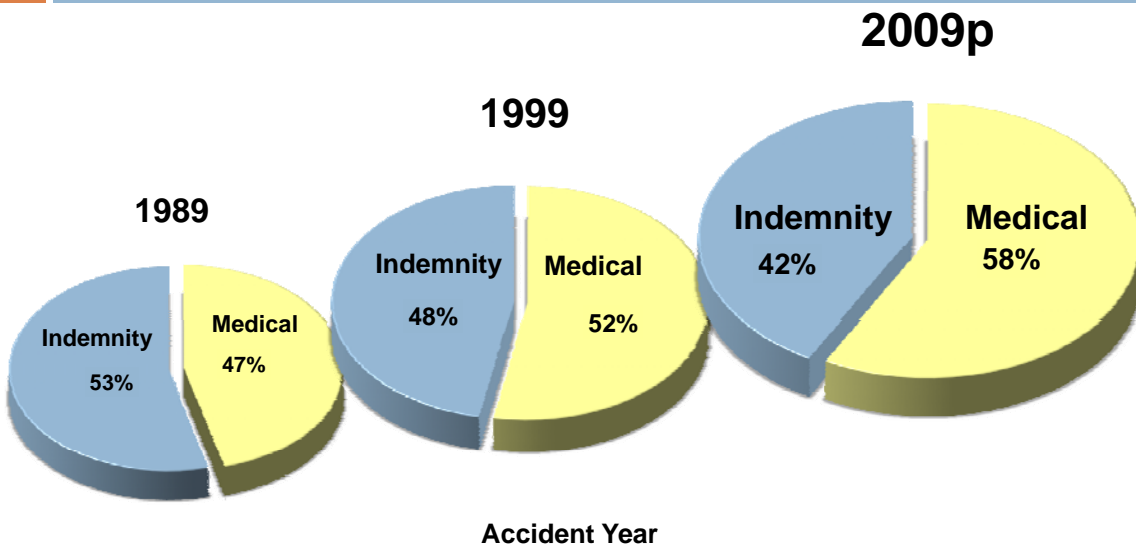
Percent Change



Medical severity 2009p: Preliminary based on data valued as of 12/31/2009
 Medical severity 1995–2008: Based on data through 12/31/2008, developed to ultimate
 Based on the states where NCCI provides ratemaking services, including state funds; excludes high deductible policies
 Source: Medical CPI—All states, Economy.com; Accident year medical severity—NCCI states, NCCI

Workers Compensation Medical Losses Are More Than Half of Total Losses

All Claims—NCCI States

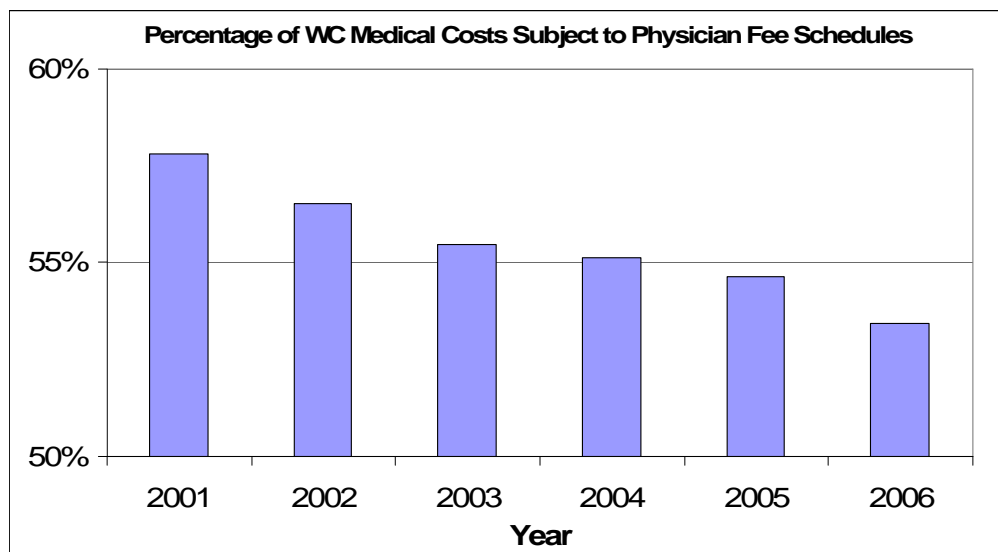


2009p: Preliminary based on data valued as of 12/31/2009
 1989, 1999: Based on data through 12/31/2008, developed to ultimate
 Based on the states where NCCI provides ratemaking services, including state funds
 Excludes high deductible policies

Fee Schedules are a Method to Contain Medical Costs

- WC fee medical schedules specify maximum allowable reimbursement (MAR) amounts for medical procedures covered under WC insurance.
- WC fee schedules are effective in controlling prices paid
- Prices for services not covered by the state WC physician fee schedule have generally increased at a faster rate than prices for covered services

The Share of WC Medical Costs Covered By Physician Fee Schedules Is Declining



How are Medical Fee Schedules Constructed?

- Some states specify their medical fee schedule in their statutes as percentages of Medicare
- Most states give authority to an agency such as the Department of Labor or Workers Compensation Commission
- May rely on an advisory committee or hire an outside consultant to draft a proposed medical fee schedule
- May base on costs prevailing in the community

What Types of Fee Schedules Are There?

- What services should cost based on special studies
 - Relative Value Scale (RVS)
- What providers are billing for services
 - Usual, Customary, and Reasonable (UCR)

Types of WC Physician Fee Schedules

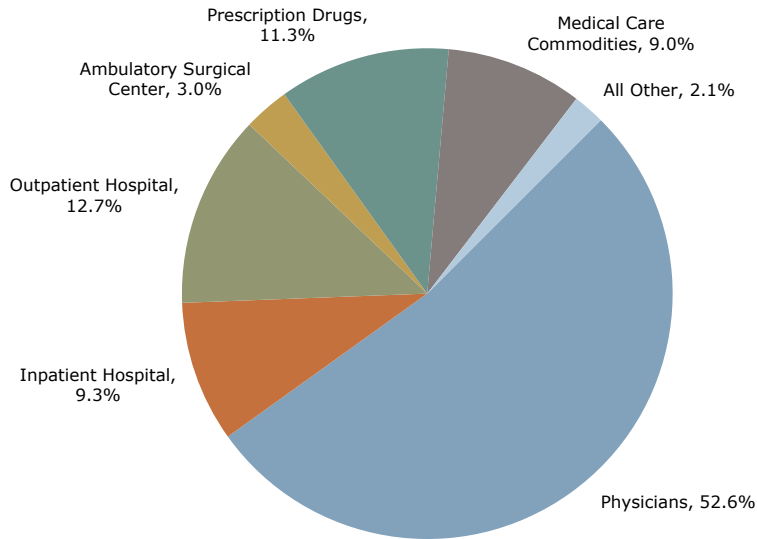
- Percentage of Medicare
 - Percentage can vary by service category
 - Updates depend on Medicare's updates to conversion factors and to RVUs
- Medicare RVU times WC Conversion Factors
 - WC CFs typically vary by service category
 - Updates depend on Medicare's updates to RVUs only
- Non-Medicare
 - Usual and customary charges
 - Ingenix Relative Value for Physician's

Concerns Raised with Implementation of a Medical Fee Schedule

- Will access to care be compromised if fees are too low?
- With WC claimants requiring more paperwork, will administration for the medical provider be more costly?
- Will rural areas have a limited number of certain types of specialists?
- Is the data used to establish a fee schedule sufficiently reliable for that purpose?
- Does the proposed medical fee schedule meet the standards set by regulation or statute?

Physician Costs Make Up Majority of WC Medical Costs

WC Medical Cost Distribution by Provider Type

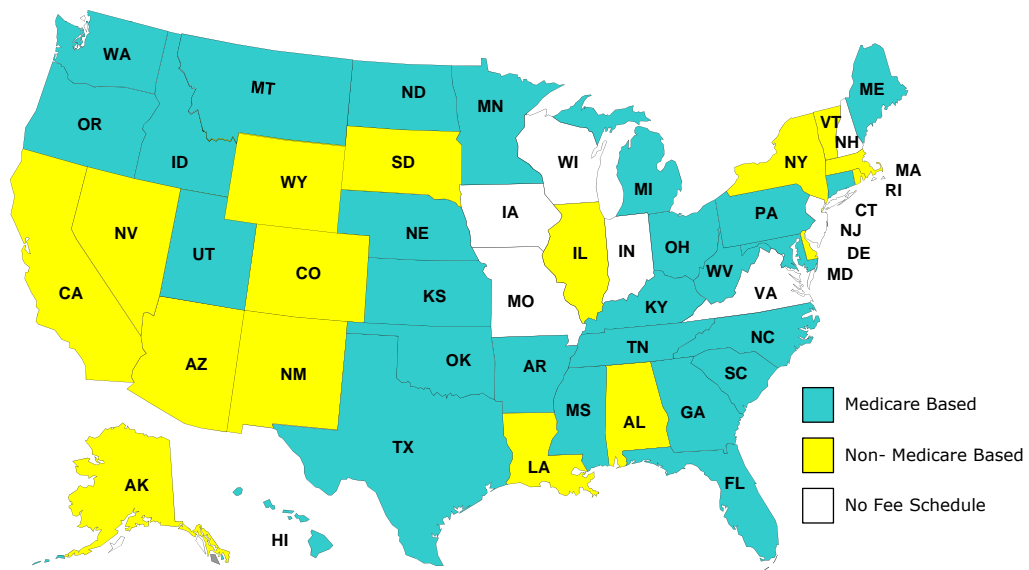


Source: WC medical transaction data licensed to NCCI for service year 2009

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States with WC Physician Fee Schedules



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Tennessee's Medical Fee Schedule

House Bill 3531 established a medical fee schedule for physician, hospital, pharmaceutical and ancillary services to become effective July 1, 2005

- The physician fee schedule is based on Medicare with varying percentages above Medicare by service category
- The inpatient hospital fee schedule is based on per diem reimbursements that vary by hospital category/procedure
- Outpatient hospital and ambulatory surgical center schedules are based on 150% of Medicare
- Pharmaceutical fees are:
 - ▣ Generic= average wholesale price + 10% + \$5.50
 - ▣ Brand name= average wholesale price + \$5.50

Illinois' Medical Fee Schedule

House Bill 2137 established a medical fee schedule for physician, hospital, and ancillary services to become effective February 1, 2006

- Fee schedules are based on 90% of the 80th percentile of medical charges
- Maximum reimbursement amounts vary by procedure code for the 29 3-digit zip code areas within Illinois
- For services where reimbursement amounts are not provided by the fee schedule, the maximum reimbursement amount is 76% of the charged amount

Fee Schedules in New York

- Physician Fee Schedule
- Hospital Inpatient Fee Schedule
- Hospital Outpatient Fee Schedule
- Chiropractor Fee Schedule
- Medical Treatment Guidelines

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Recent Changes

- Physician fees updated December 1, 2010
 - ▣ First update to physician fee schedule since 1996
- Access to care issues
- Raised evaluation and management services reimbursement levels by 30%
- Pricing: straight forward?
- Yes and no
- The challenge: data sources
- Future solution: Medical Data Call

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What is Needed to Price a Medical Fee Schedule Change?

- Estimate current costs by procedure code
- Estimate expected costs by procedure code
- Frequency distribution by procedure
- Percent of medical costs subject to the fee schedule

Pricing a Fee Schedule Update

1. Current Costs
= $\Sigma[(\text{Current Maximum}) \times (\text{Frequency by procedure code})]$
2. Expected Costs*
= $\Sigma[(\text{Revised Maximum}) \times (\text{Frequency by procedure code})]$
3. Fee Schedule Impact = Expected Costs/Current Costs - 1
4. Medical Cost Impact
= Fee Schedule Impact x Percent of Medical Subject to Fee Schedule
5. Overall Impact
= Medical Cost Impact x Percent of Overall Benefits that is Medical

* Reductions are offset by 30% to 50%, except surgical procedures

Basic Assumptions Underlying Method

- Percent change in maximums is a proxy for actual changes in reimbursements
- Frequency distribution by procedure code will be the same after the medical fee change
- Volume of services will be the same after the medical fee change
- Exception: offset for savings

Pricing Example

Procedure	Prior MAR	Revised MAR	Count	Current Costs	Expected Costs	Percent Change
Surgery	\$600	\$650	30	\$18,000	\$19,500	+8%
Radiology	\$400	\$420	55	\$22,000	\$23,100	+5%
Pathology	\$100	\$150	5	\$500	\$750	+50%
Physical Therapy	\$28	\$30	5,000	\$140,000	\$150,000	+7%
Office Visit	\$64	\$70	2,000	\$128,000	\$140,000	+9%
Fee Schedule Impact				\$308,500	\$333,350	+8%
Percent of Medical Subject to Fee Schedule						50%
Medical Cost Impact						+4%
Percent of Overall Benefits That is Medical						60%
Overall Impact						+2.4%

Pricing a Fee Schedule Implementation

1. **Current Costs = Trended Charges by procedure code**
2. Expected Costs*
= Sum[(new maximum) x (Frequency by procedure code)]
3. Fee Schedule Impact = Expect Costs/Current Costs - 1
4. Medical Cost Impact =
=Fee Schedule Impact x Percent of Medical Subject to Fee Schedule
5. Overall Impact
=Medical Cost Impact x Percent of Overall Benefits that is Medical

* Reductions are offset by 30% to 50%, except surgical procedures

Offset for Volume and Intensity Response

- Decreases reimbursement levels may result in changes in behavior to minimize loss of revenue
- In some states, the fee schedules only apply in the absence of a contract providing otherwise between the insurance carrier and the health care provider
- As a result, the calculated savings may not be realized
- Typically, an offset of 30% to 50% is applied to account for this
- The rationale for this and the size of the offset are based on a study performed by Medicare "Physician Volume and Intensity Response"
- NCCI has a study in progress to analyze the effects specifically on WC costs

Implementation Pricing Example

Procedure	Trended Avg Charges	New MAR	Count
Surgery	\$800	\$650	30
Radiology	\$500	\$420	55
Pathology	\$300	\$150	5
Physical Therapy	\$40	\$30	5,000
Office Visit	\$80	\$70	2,000

Implementation Pricing Example (Continued)

Procedure	Current Costs	Costs at MAR	Expected Costs*	Percent Change
Surgery	\$24,000	\$19,500	\$19,500	-19%
Radiology	\$27,500	\$23,100	\$25,300	-8%
Pathology	\$1,500	\$750	\$1,125	-25%
Physical Therapy	\$200,000	\$150,000	\$175,000	-13%
Office Visit	\$160,000	\$140,000	\$150,000	-6%
Fee Schedule Impact	\$413,000		\$370,925	-10%
Percent of Medical Subject to Fee Schedule				50%
Medical Cost Impact				-5%
Percent of Overall Benefits That is Medical				60%
Overall Impact				-3%

* Reductions are offset by 50%, except surgical procedures

Inpatient Hospital Fee Schedule

- New York Specific (i.e. not Medicare based)
- Revised December 2009
- Diagnostic Related Groups
- Old Method: AP-DRG
 - Base rate by hospital
 - DRG Relativity
- New Method: APR - DRGs
 - Severity Variable
- The challenge: Data

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The Pricing

- Data Source: NYS DOH
- Data was perfect. NOT!!!
 - Payor Code Issues
 - WC Indicator
 - Is it really WC? (Neonatal care records)
 - Mismatched DRGs
 - Spinal Fusion Exception
- Results approximately the same
- Outlier records

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NY Spinal Fusion Exception

- Statute provides for additional reimbursements for surgical implants
- Law expires March, 2011
- New method (with higher reimbursements) became effective December, 2009
- Double reimbursements in while law in effect

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Chiropractic Fee Schedule

- Change effective December 1, 2010
- Charging per visit → Charging per modality
- Rely on Workers Compensation Board estimate?
- Medical Treatment Guidelines

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Drug Repackaging

- Any Rx is uniquely identified by a National Drug Code (NDC)
- NDCs are specific not only to the product (including strength and formulation) and package size but also to the labeler (Labelers are manufacturers, repackagers, and distributors)
- WC Rx fee schedules are typically based on Average Wholesale Price (AWP)
- Since each NDC comes with a unique AWP, any firm that repackages a drug can set both a new NDC and a new AWP
- As a result, WC costs for repackaged drugs have grown out of proportion to the number of prescriptions written for repackaged drugs

Pricing Proposals Controlling for Repackaged Drugs

- Aggregate data by main ingredient for repackaged drugs and for drugs dispensed in its original packaging from the manufacturer
- Calculate the price difference by comparing repackaged costs to the cost for the original equivalent of these drugs (= fee schedule impact)
- Calculate repackaged drug share to overall medical costs (= percent of medical subject to fee schedule)
- $\text{Medical Cost Impact} = \text{Fee Schedule Impact} \times \text{Percent of Medical Subject to Fee Schedule}$
- $\text{Overall Impact} = \text{Medical Cost Impact} \times \text{Percent of Overall Benefits that is Medical}$

Summary

- Devil is in the Details
 - ▣ Each Fee Schedule can have its quirks / exceptions
 - ▣ Need to examine them carefully prior to pricing
 - ▣ Need to understand the rules of the fee schedule
 - ▣ Each state has special circumstances
- Data Challenges