BULLETIN

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Mandating group medical managed care in workers' compensation -- including cost shifting to employees -- could reduce work injury treatment expense, though savings would be moderated by differences in medical benefits and delivery between the two systems, according to a new Institute study.

Advocates of "24-hour coverage" proposals mandating merged coverage of group medical and workers' compensation medical envision lower treatment costs through use of group medical managed care, benefit design and delivery mechanisms to treat work injuries. Such plans anticipate potential administrative economies, reduced frictional costs in determining injuries to be work related, and lower treatment costs through managed care. However, much of the dialogue on mandatory 24-hour coverage has occurred without reliable data to quantify the costs and savings from key elements of the plans.

Earlier Institute research estimated the initial step in any 24-hour system -- mandatory merged medical benefits for employees and nonworking dependents -- would boost employment-based benefit costs in California $8 billion to $16.9 billion per year. The new study, the third in CWCI's 24-hour coverage series, uses an integrated health care database created by William M. Mercer, Inc. to quantify the costs and savings of applying group medical managed care (deductibles, coinsurance and copayments) in workers' compensation.

The analysis suggests group medical managed care would dramatically change patterns of treatment and utilization of medical services for work injuries. Depending on the type of health care organization used and other assumptions (e.g., limits on certain types of treatment), the study projects mandatory group medical managed care in workers' compensation could save $755 million to $1.138 billion per year in work injury treatment costs. HMOs offer the greatest potential savings, but would entail a significant reduction in chiropractic coverage. Fee-for-service plans, preferred provider organizations and point-of-service plans would produce lower savings, but would entail different levels of utilization.

In addition to reducing utilization, the study estimated adoption of group medical deductibles, coinsurance and copayments would shift $250 million to $292 million per year in workers' compensation medical costs to employees. Treating work injuries in a group medical HMO would shift 10 percent of employer costs to employees, compared to 11 percent if the merged plan was a PPO, 12 percent if it was a point-of-service plan, and 16 percent if it was a fee-for-service plan.

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Because group medical is a contractual system, while workers' compensation is a statutory program, several factors could be expected to blunt potential savings from imposing group medical managed care in workers' compensation. For example, any cost/savings analysis must account for the impact of the "liberal construction" doctrine in workers' compensation, as well as the risk of increased litigation because of due process considerations. In addition, policymakers need to consider different mandates of treatment under the two systems and recognize that workers' compensation involves fewer coverage restrictions, more regulation and less flexibility in defining benefits. The study also notes policymakers must weigh political implications of applying deductibles and copayments for workers' compensation medical, and restricting employee choice of provider and services such as chiropractic care that are currently available under workers' compensation.

A copy of the report, "Managed Medical Care in Workers' Compensation," is enclosed. Additional copies are available for $6.90 each, including tax and shipping. For more information on this or other Institute studies, contact CWCI at 415-981-2107.

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