MEMORANDUM

DATE: July 28, 2009

TO: Worker's Compensation Advisory Council

FROM: Wisconsin Chiropractic Association
Wisconsin Hospital Association
Wisconsin Medical Society

SUBJECT: Response to the Wisconsin Insurance Alliance's Analysis of Provider Proposal

We have reviewed the Wisconsin Insurance Alliance's analysis of the Provider Proposal and respond below to their explicit concerns. Before responding, however, putting the Provider Proposal in context is important. Over the course of nearly four years, the providers have heard three consistent complaints from management and have responded in detail to each. Our responses have included presentations, requested by the WCAC, with detailed facts and data which management often did not attend. Declaring that one has not heard a response to one's complaints does not mean that there has not been a response. Following are the major management complaints together with provider responses:

- Worker's Compensation health care prices per CPT code in Wisconsin are higher than in other states.
  - Response: We believe that management has "cherry picked" certain CPT codes for their shock value in demonstrating price differentials between states. To do a legitimate analysis of the cost of health care claims, one cannot look solely at individual CPT code prices. This perspective is akin to worrying about the price of the steering wheel in a car rather than the cost of the entire car. The cost per claim in Wisconsin is average. This average cost is the cost reflected in the insurance premiums charged to employers. And, most importantly, we achieve this with the best outcomes in the country.

- Worker's Compensation health care prices are higher than the negotiated prices paid by health insurance.
  - Response: First, as demonstrated through a presentation last session by physicians who treat Worker's Compensation patients, Worker's Compensation has administrative requirements that add significant cost to providing treatment. In order to keep the best providers in the program, the program has to pay for the extreme "hassle factors."

    Second, group rates reflect the benefit of a bargain – negotiated rates in return for access to a restricted group of injured workers. There has been no such offer to providers during the negotiations and such an offer would be contrary to the Wisconsin Worker's Compensation tradition of maintaining choice of and access to providers – or "freedom of choice."

Freedom of choice has a cost. Imposing fee reductions without a corresponding economic benefit will cause some providers to drop out of the program. The result will be a Worker's Compensation program without free choice – achieved without a direct vote of the Council or the knowledge of the legislature.

- The rate of growth in the program is higher than in the other WCRI states.
    - Response: The Provider Proposal specifically addresses this concern by freezing current rates and limiting growth to the national medical CPI. There are state- specific reasons for the higher-than-average rate of increase in Wisconsin. And the providers agree with Jeff Brand's comments that as the slowed rate of growth impacts providers' rates there is the chance that some providers may opt out of the system. That said, the Provider Proposal is an effort to be helpful in what has been a nearly six-year impasse. In fact, if the Council had accepted the Provider Proposal when first proposed, we already would have saved approximately $150 million dollars in provider payments. Whether or not those savings would have been passed on to employers by Worker's Compensation insurers is unknown.

Finally, toward the end of the WCAC deliberations last session, in a letter to a number of providers, management described the disagreement concerning how to address increasing health care costs as a technical issue:

> As the WCAC has examined various policy options for some type of fee schedule or other cost control limit, a major complicating factor is that for any given health care service there is often wide variation in what is charged across providers. So if current charges are used as the basis for setting a limit, the fundamental question becomes where in the range of charges for a given service to set the limit. If it is set at the high end of charges, the concern is that all providers currently charging less than the published limit for a given CPT-DRG will increase their charges to the limit. […] Most of the disagreement between those representing health care providers, labor and management has been over this technical issue and how to resolve it.

While providers strongly disagree with management's assumption, the Provider Proposal also addresses the "rush to the top" concern. Further, the Provider Proposal is based on current charges, the *theoretical* base of the current system. And we say theoretical base because while eyes have been focused on provider costs and the fear that providers might find some way to take advantage of the system, the reality has been that the insurers have been taking advantage of the system by admittedly relying on suspect and incomplete databases to set payment rates. We hope that the WCAC and DWD staff are concerned by and intend to address this activity in the program they are charged with overseeing.

The following are our responses to the specific concerns raised by the Wisconsin Insurance Alliance about the Provider Proposal.

First, the proposal does not state how the amount for a procedure should be established if there are different charges for the procedure by the same provider in the base month, i.e., is the mean or median of different values to be used?

When the “snapshot” of prices is taken, the most recent price for a CPT or DRG code will be “frozen.” Because not every service will have been performed for the month in which prices are frozen, prior data will have to be considered. The number of months for which prior data will be allowed will have to be discussed.

Second, there is absolutely no existing mechanism for collecting this sort of detailed information from thousands of providers and verifying the accuracy of the data. The collection of this data would likely cost hundreds of thousands of dollars. Verifying its accuracy would require additional resources. Finally, assembling and publishing a database with hundreds of thousands of fee limits would require careful consideration by a vendor.

The insurers state that “there is absolutely no existing mechanism for collecting this sort of detailed information.” Given the existing databases that collect every inpatient and outpatient claim made by every hospital in the state (for all payers), the information collected by the Wisconsin Health Information Organization, and the requirements of the “certified data bases” it is clear that such databases can and do exist. An RFP or RFI would answer the cost question – which we believe given the current experience would be reasonable.

Third, each provider would have his or her baseline charges set as the payment amount in the first year. This would mean that the relatively high charging providers who are currently restricted by the 1.4 standard deviations from the mean ceiling would no longer be subject to that limit. These outlier providers would be paid in full in the first year and their extreme charges would be escalated in future years by the chosen index value.

This reflects a misunderstanding of the Provider Proposal. The Provider’s Proposal states: *The maximum allowable charge shall be calculated for each individual provider and hospital in Wisconsin* ***as the lesser*** *of the provider/hospital charges or the maximum allowable charge as established by the audited database selected by the department.*

Fourth, because the database is established using only one month of data, it is quite possible that many procedures will not have been billed for by a given provider in that month. This would be particularly true for high cost specialty care. No mechanism is specified for how these many voids for procedure amounts in the baseline data would be handled.

As stated above, because not every service will have been performed for the month in which prices are frozen, prior data will have to be considered. The number of months for which prior data will be allowed will have to be discussed.

Fifth, a strong incentive is created for providers to ramp up their charges once the initiative is passed until the effective date of the fee schedule in order to maximize the allowable charge during the baseline month. Using only one month of data to establish the baseline will not provide statistically sufficient information.

While the providers disagree with the assumption that the Worker's Compensation program drives providers' pricing, the providers are willing to discuss a reasonable retroactive date to avoid this problem.

Sixth, how are out of state providers and new providers to be treated in the database?

The provider proposal does not address nor are we concerned with how out of state providers are paid for their services.

New providers will be free to set their prices in any manner they choose. However, the maximum allowable charge for CPT codes or DRG codes cannot be no more than the lesser of the provider charges or 1.4 standard deviations from the mean for the 3 digit ZIP code in which the provider or hospital is located plus the increase in the medical consumer price index (MCPI) for the United States as published by the U.S. Department of Labor Bureau of Labor Statistics as published by the Department.

Seventh, how are new procedures and codes to be updated into the data?

A new procedure may well use existing CPT codes. When new CPT or DRG codes are established providers will set their prices based on market conditions. In subsequent years, the increase in price will be limited to the increase in the medical consumer price index (MCPI) for the United States as published by the U.S. Department of Labor Bureau of Labor Statistics as published by the Department.

Finally, while we have not seen management's anticipated proposal on fees, we feel that it is important to state opposition to any fee schedule that builds upon the current system. As the Wisconsin Insurance Alliance has admitted in its critique of the provider proposal, the existing databases used in adjudicating Worker's Compensation claims are deeply flawed. In addition, we are aware that a number of insurers do not use these flawed databases, and instead rely on re-pricers - a practice that is not allowed by current Wisconsin Worker's Compensation rules. Any fee proposal that relies on the current flawed system would be based on a very shaky foundation.

We welcome any further comments and questions concerning the Provider Proposal.