

One of the stated goals of the Medical Quality Initiative is to decrease overall claim costs. To support this goal, the Medical Team of the Information Management Division, Research and Analysis Section, has conducted an analysis of claim costs, specifically focusing on medical costs and its various components. The purpose of the analysis is to describe the current composition of medical costs within the workers' compensation system and to identify drivers of medical cost growth so that the advisory committee can formulate recommendations for external and internal review and adequately respond to questions and concerns directly related to medical cost data.

The following summary identifies key findings from the data analysis. Each statement is supported by an attachment which includes either descriptive charts or data tables. Questions or comments concerning the analysis can be directed to Bryan Skalberg (Bryan.L.Skalberg@state.or.us, (503) 947-7302) or Nathan Johnson (Nathan.Johnson@state.or.us, (503) 947-7194).

General claim costs overview:

<p><i>Total claim counts are decreasing by more than 5% per year.</i></p>	<p>Based on a review of Accepted Disabling Claims (ADCs) and Accepted Non-disabling Claims (ANCs) by injury year for 1999 to 2003, total claim counts are falling at an annual rate of 5.4%. More specifically, non-disabling claim counts are falling at a faster rate than disabling claims. From 1999 to 2003, non-disabling claim counts fell at an annual rate of 5.6% while disabling claim counts fell at an annual rate of 4.9%. (Non-disabling claims represented 77% of all claims and 29% of all first-year payments in 2003.) <i>See Attachment 1.</i></p>
<p><i>Total medical payments are increasing by nearly 4% per year.</i></p>	<p>While claim counts are decreasing, total medical payments continue to increase. Analysis of claims with injury years from 1999 to 2003 shows a 3.9% annual growth rate in total medical payments during the first year after date of injury. <i>See Attachment 1.</i></p>
<p><i>Average medical payments per claim are increasing by more than 9% per year.</i></p>	<p>A decreasing trend in claim counts and an increasing trend in aggregate medical payments equate to a substantial increase in average medical payments per claim. Analysis of claims with injury years of 1999 to 2003 shows that average medical payments per claim within the first year after injury are increasing at an annual rate of 9.4%. Average medical payments within the first year after injury for non-disabling claims increased at an annual rate of 9.9%. Average medical payments within the first year after injury for disabling claims increased at an annual rate of 8.8%. (These figures are not adjusted for inflation. From 1999 to 2003, the Medical Services component of the Consumer Price Index increased at an annual rate of 4.6%. Inflation-adjusted growth rates can be calculated by subtracting the inflation rate from the nominal rate.) <i>See Attachment 1.</i></p>

NOTE: Average annual growth rates were calculated over the time period specified and reflect the slope of the least squares line through the natural log of the annual data points.

Source: Dept. of Consumer and Business Services, Information Management Division
 Contact: Bryan Skalberg, 503.947.7302 or Nathan Johnson, 503.947.7194

<p><i>Claims with lower medical costs are declining faster than claims with higher medical costs.</i></p>	<p>From 1999 to 2003, the count of all claims by year of injury has decreased at a rate of 5.4% per year (non-disabling –5.6%; disabling –4.9%). Analysis of medical payments per claim shows that the median (mid-point) payment per claim is increasing faster than the average (mean) payment per claim for both non-disabling and disabling claims. These observations suggest that lower-cost claims are declining more rapidly than higher-cost claims in both the disabling and non-disabling groups of claims. <i>See attachment 2.</i></p>
<p><i>Average number of visits per claim and average number of services per visit are increasing. Increases in average visits per claim are driving the growth in average services per claim.</i></p>	<p>Analysis of claims with injury year from 1999 to 2003 and services provided within one year of injury shows the average number of visits per claim has increased from 6.0 in 1999 to 7.3 in 2003, an annual growth rate of 5.0%. Similarly, the average number of services provided per visit has increased from 3.1 in 1999 to 3.4 in 2003, an annual growth rate of 2.2%. The combination of these data equates to a 7.4% annual growth in the average number of services per claim. During this time, the average payment per service has increased at an annual rate of 4.8%, consistent with the Consumer Price Index for Medical Services, which has had an annual growth rate of 4.6%. <i>See Attachment 3.</i></p>
<p><i>Compared to the WCRI published 12-state median, Oregon has a slightly lower average medical cost per claim.</i></p>	<p>In an analysis of medical costs for claims with injury dates between October 1, 2000 and September 31, 2001 and with services evaluated through March 31, 2002, Oregon had an average medical cost per claim of \$1,582 compared to the WCRI published 12-state median average medical cost per claim of \$1,750. Utilization levels were comparable. <i>See attachment 4.</i></p>
<p><i>Medical payments are representing an ever-increasing portion of total claim costs.</i></p>	<p>Average costs at closure for Accepted Disabling Claims (ADCs) at notice of closure from 1997 to 2004 has increased at an annual rate of 6.3%. The medical component of total costs has increased at an annual rate of 7.4%. In 1997, medical payments represented 50% of total ADC costs. By 2004, this percentage had increased to 55%. <i>See attachment 5.</i></p>

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Medical Cost Drivers:

<p><i>Medical services by provider types medical doctors, physical therapists, radiologists, and pharmacy are contributing to medical cost growth.</i></p>	<p>Analysis of the growth in total medical payments by provider types from 1999 to 2003 identifies specific provider types that are either increasing or decreasing their contribution to medical payment growth. Those with an increasing contribution were medical doctor, physical therapist, radiologist, and pharmacy. Those with a decreasing contribution to medical payment growth were hospital outpatient, hospital inpatient, and chiropractors. Other provider types had a very small impact on growth. <i>See Attachment 6.</i></p>
<p><i>Evaluation and management¹ services are the leading cost drivers in the growth of medical doctor payments.</i></p>	<p>For medical doctors, the service category with the largest share of fee schedule payments in 2003 was evaluation and management, representing 36.7% of all fee schedule payments to medical doctors. A close second was surgery, representing 36.1% of 2003 fee schedule payments to medical doctors. Evaluation and management is the leading cost driver in the growth of medical doctor payments, representing 49.3% of total growth from 1999 to 2003¹. <i>See Attachment 6.</i></p>
<p><i>The service categories of physical medicine and evaluation and management are the largest contributors to the growth in fee schedule payments.</i></p>	<p>Analysis of the growth in total medical payments by fee schedule service categories from 1999 to 2003 identify specific service categories that are either increasing or decreasing their contribution to medical payment growth. Those with an increasing contribution were physical medicine, evaluation and management¹, radiology, and surgery. Those with a decreasing contribution to medical payment growth were those related to Oregon Specific Codes, anesthesia, medicine, and laboratory and pathology. <i>See Attachment 7.</i></p>
<p><i>Physical medicine billed as hospital outpatient is taking an increasing share of physical medicine cost growth.</i></p>	<p>While physical therapists accounted for the largest share of physical medicine payments in 2003 (42.9%) by provider type, hospital outpatient accounted for the largest share (36.0%) of the total growth in physical medicine payments from 1999 to 2003. Hospital outpatient is the only provider type that is increasing its share of physical medicine payments. Hospital outpatient physical medicine payments represented 24.6% of total physical medicine payments in 2003. <i>See Attachment 7.</i></p>

1. A portion of the increase in Evaluation and Management payments may be attributable to a 20% increase in the fee schedule conversion factor in July 2003. *See attachment 9.*

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<p><i>Review of medical costs related to the use of Managed Care Organizations (MCOs) is inconclusive.</i></p>	<p>A comparative analysis of claims that were enrolled in MCOs and claims that were not enrolled indicate that MCO-enrolled claims are increasingly more costly. This may be attributable to an insurer's tendency to enroll only the more complicated or severe claims. We are not able to effectively account for differences in claim severities. Therefore, our analysis of the impact of managed care on medical costs is inconclusive. <i>See Attachment 8.</i></p>
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Notes on the data used for the analysis:

Figures for the number of accepted disabling claims (ADCs) and estimated accepted non-disabling claims (ANCs) are from department publications and include all insurers (SAIF, private, and self-insured) in Oregon's workers' compensation system. ANCs are not reported to the department. They are estimated by creating estimates of the ratios of ANCs to ADCs. This is done using data from four sources. Medical billing data reported to the department are combined with the department's claim information system (CIS) to provide estimates for SAIF and some private insurers and self-insurers. National Council on Compensation Insurance (NCCI) data provides ratios of indemnity cases to medical cases for SAIF and private insurers. Also, on occasion SAIF has provided counts of claims with and without payments. The figures for ANCs are subject to revision.

A quality sample of data was selected from medical billing data to determine figures for average medical payment, median medical payment, average number of visits (number of individual days a service was provided), and the average number of services. The number of services per visit (number of services/number of visits), payments per visit (total payments/number of visits), and the payments per service (total payments/number of services) are also determined from the sample. The sample is comprised of insurers (notably SAIF and the Liberty Mutual group, along with other private insurers and self-insurers) that have reported billing data which has a high degree of correlation to the CIS. These insurers have reported billing data that matches 90 percent or more of the ADCs listed on the CIS as accepted by the insurers and have consistently reported valid medical service and payment data. The injury year in the sample consists of claims with injuries between January 1st of the injury year through December 31st. All services provided within one year (365 days) of the injury are used in the analysis. This time frame was chosen for analysis because a significant portion of services on a claim are provided over a uniform time frame. Furthermore, a one-year time frame allows for the use of the most recent data available. An exception are the figures on attachment 5 which are determined from total ADC costs for medical, time loss, and net PPD (permanent partial disability) as reported to the department at notice of closure. These total costs are the sum of the payments in each category. Total ADC costs are the sum of total medical, total time loss, and total net PPD costs.

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