The Effect Of The Affordable Care Act On WC

Informed Speculations

About WCRI

- Not-for-profit public policy research organization in Cambridge, MA
- Diverse members includes payors, state governments, managed care companies, unions, etc.
- Do not make recommendations nor take positions
- Studies published if pass external peer review
- Research staff of PhDs, attorneys, statisticians
Comparing WC & ACA / Health Care Reform

- Workers’ Compensation
  - Mandatory for employers to provide for employees
  - First dollar coverage: No deductibles, copayments
  - Typically orthopedics and trauma
  - Workers may receive income benefits
  - No public subsidy
- Health Care Reform
  - Individuals must insurer or pay penalty
  - Employers must provide or pay penalty
  - Wide range of medical conditions
  - Liability only for medical care
  - Public subsidy

Will The Affordable Care Act Affect WC Systems And Costs?

- What the pundits say
  - Shortages of providers ➔ raises costs
  - Healthier injured workers ➔ lowers WC costs
  - Evidence-based care ➔ reduces unnecessary care and costs
  - Cost shifting to/from WC
Will ACA Expansion Of Coverage Produce Provider Shortages For Injured Workers?

1. Premature to know – informed speculation
2. Shortages of certain provider types will occur/worsen without the ACA
3. The ACA will exacerbate some of these shortages (differs from state to state)
4. In most states, WC will adapt to avoid or mitigate longer wait times for injured workers
5. WC prices paid will rise (effects differ from state to state)

Why?

Markets (supply and demand) adjust to external changes

- Demand for health care is increasing
  - Aging population
  - Worsening population health status (e.g., obesity)
  - ACA: expansion of coverage

- Supply of health care providers—limiting factors
  - Current shortages of certain types of providers
  - Aging physician workforce and growing retirements
  - Training programs: pipeline of new physicians and other providers
  - Low WC fee schedules
Likely Adjustment To Shortages

- Physicians raise prices—reducing discretionary demand
- Increased use of physician assistants, nurse practitioners, pharmacists, podiatrists, etc.
- Increased reliance on technology—the internet of everything
- Outsource certain services to providers in other countries

WC payors will raise prices paid to mitigate shortages
- WC payors have the strongest incentive to do this
- Canadian experience provides evidence

Canada: Paying Higher Prices To Get More Timely Care For Injured Workers

- Ontario, Canada has . . .
  - a single (government) payor health care system
  - a single (government) insurer for WC
- The Canadian health care system has longer wait-times than US
  - US: 6% waited more than 2 months for specialist appointment
  - Canada: 29%
- Ontario: The WC insurer pays more to providers for expedited access
State Barriers To Adjustment Will Exacerbate Shortages And Raise Costs

- State laws that limit:
  - Scope of practice for NP, PA, pharmacists, etc.
  - The use of technologies like telemedicine

- Increased demands on providers for nonclinical services
  - Government regulations
  - Corporatization of medical practice

- Higher state malpractice premiums

Where Will Provider Shortages Most Likely Be In Workers Compensation?

States with:
- Current shortages
- Older providers and smaller training pipelines
- Lower fee schedules
- More barriers to adjustment
In Most States: ACA Unlikely To Reduce Access To Surgeons By Injured Workers

Source: A New Benchmark For Workers’ Compensation Fee Schedules: Prices Paid By Commercial Insurers?

GH: Group Health; CPT: Current Procedural Terminology

* Implemented a double-digit fee schedule decrease for a common knee arthroscopy (CPT 29881) from 2009 to 2012.

Primary Care: WC Prices Likely To Rise In Many States To Retain Good Access To Care

* Implemented double-digit fee increase from 2009-2012. For comparison, the BLS reports that the CPI for professional medical services rose by 7% from 2009-2012.

** Implemented double-digit fee schedule decrease from 2009-2012.
Applying The Framework – Example #1

<table>
<thead>
<tr>
<th>Increased Demand</th>
<th>Florida</th>
<th>Median State</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>% uninsured</td>
<td>25%</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Medicaid expansion adopted?</td>
<td>no</td>
<td>----</td>
<td>yes</td>
</tr>
<tr>
<td>% population over age 60</td>
<td>24%</td>
<td>20%</td>
<td>19%</td>
</tr>
<tr>
<td>% rating health as fair or poor</td>
<td>17%</td>
<td>15%</td>
<td>11%</td>
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<table>
<thead>
<tr>
<th>Limiting Supply</th>
<th>Florida</th>
<th>Median State</th>
<th>Minnesota</th>
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</thead>
<tbody>
<tr>
<td># of primary care physicians/100k</td>
<td>77</td>
<td>82</td>
<td>96</td>
</tr>
<tr>
<td>% of physicians over age 60</td>
<td>29%</td>
<td>26%</td>
<td>27%</td>
</tr>
<tr>
<td># of physicians in training/100k</td>
<td>44</td>
<td>56</td>
<td>65</td>
</tr>
<tr>
<td>Retention rate at completion</td>
<td>high</td>
<td>moderate</td>
<td>moderate</td>
</tr>
<tr>
<td>Nurse practitioner scope of practice</td>
<td>restricted</td>
<td>restricted</td>
<td>restricted</td>
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<tr>
<td>Fee schedule for common office visit</td>
<td>$70</td>
<td>$83</td>
<td>$112</td>
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Vulnerability To Provider Shortages?

<table>
<thead>
<tr>
<th>Most Likely States?</th>
<th>Least Likely States?</th>
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<tbody>
<tr>
<td>California</td>
<td>Colorado</td>
</tr>
<tr>
<td>Florida</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Minnesota</td>
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<tr>
<td>Texas</td>
<td>Oregon</td>
</tr>
<tr>
<td>New Mexico</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td></td>
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</table>
What Is “Claim Shifting”?  
- Decision about work-relatedness of a medical condition  
- Influenced by both provider and patient preferences  
- Stimuli for claim shifting to WC inherent in the ACA  
  - Growth of ACOs and capitation shifts provider preference to WC  
  - Growth of large deductible plans in ACA shifts patient preference to WC

Provider Incentives: A Hint Of Powerful Claim-Shifting Incentives With ACOs

<table>
<thead>
<tr>
<th>Shipyard #</th>
<th>% Of Workers Covered By HMOs</th>
<th>WC Cost Per Worker</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>0%</td>
<td>$347</td>
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<tr>
<td>2</td>
<td>0%</td>
<td>$370</td>
</tr>
<tr>
<td>3</td>
<td>&lt;1%</td>
<td>$477</td>
</tr>
<tr>
<td>4</td>
<td>39%</td>
<td>$723</td>
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<tr>
<td>5</td>
<td>53%</td>
<td>$756</td>
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<tr>
<td>6</td>
<td>53%</td>
<td>$930</td>
</tr>
<tr>
<td>7</td>
<td>83%</td>
<td>$1,181</td>
</tr>
<tr>
<td>8</td>
<td>66%</td>
<td>$2,325</td>
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</tbody>
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Thank You!

- For comments/questions about the findings:
  
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  rvictor@wcrinet.org

- Follow WCRI on social media: