Worker's Compensation in Milwaukee: Analyzing Spending Increases

by Amber Hyman, Andrew Snyder, and Angie Sweeney

Executive Summary

In 2001, the City of Milwaukee spent almost $7 million on worker's compensation, a large increase from previous years. Expenditures in 1999 and 2000 had been around $5.5 million and prior to that expenditures were $4.7 million or less. Officials in the city's Department of Employee Relations and the Budget Office do not fully understand why spending on worker's compensation has increased so precipitously. Our task was to identify the sources of the spending increase and suggest some courses of action to avoid future high-cost years.

Between 1998 and 2001 the city received about 3,500 new worker's compensation claims each year (slightly fewer – about 3,100 in 1999). While the number of new claims has remained relatively consistent, costs rose 23 percent from 1998 to 1999, retreated slightly in 2000, and rose 25 percent in 2001, resulting in a $2.3 million increase in spending over the four-year period.

Medical costs constitute approximately 75 percent of the city's total worker's compensation spending. While doctor and hospital spending are the two most expensive categories, spending on physical therapy and medication has grown rapidly, and in excess of inflation, every year. This may suggest that Milwaukee is experiencing a growth in service utilization. The city is faced with the same number of claims, but injured workers are seeking or being prescribed additional medical services and medicines. Medical costs nationally have also risen, compounding the expense of increased utilization.

The Police, Fire, and Public Works departments make up 93 percent of Milwaukee's worker's compensation expense. Public Works spending has grown only slightly in the last four years. The Police and Fire departments, on the other hand, have experienced approximately 65 percent increases in spending over this time period. This may be explained by the fact that Public Works Department employees face a set of injuries that stay relatively the same from year to year, such as back or muscular injuries, while police and firefighters face injury risks that tend to be less predictable and more severe.

We identified four lines of inquiry that this study does not have sufficient data to address, but that the city should pursue to order to identify the cause of the spending increase: 1) Was there was a dramatic increase in severe, very costly injuries in one of the high-risk departments? 2) What are the effects of the city's cost-containment partnership with the preferred provider network CorVel? 3) What can the city do about the state's usual and customary rates, which may be inflating medical expenses? 4) Has there been an increase in utilization of medical services?

We recommend that in order to answer these questions, the city should improve its data collection and analysis. In particular, data is needed on the total number of claims filed and carried over each year, the number and type of claims filed in each department, average costs per claim and data on service utilization. In addition, the city may want to use this data to lobby the state for a change in the Usual and Customary Rates Schedule as well as a limit on employees' choice of medical providers. On the front end, the city should continue to implement "return-to-work" measures as well as pursue work-safety strategies that prevent injuries from occurring. These recommendations should provide the city with a more complete and detailed understanding of how to reduce future worker's compensation spending.

Chapter 2

Worker's Compensation in Milwaukee: Analyzing Spending Increases

by Amber Hyman, Andrew Snyder, and Angie Sweeney

In 2001, the City of Milwaukee spent almost $7 million on worker's compensation, a large increase from previous years. Expenditures in 2000 had been around $5.5 million, as they had in 1999, and prior to that expenditures were $4.7 million or less. The city's Department of Employee Relations and the Budget Office do not fully understand why spending on worker's compensation has increased so precipitously. Our task is to identify the source (or sources) of the spending increase, and suggest some course of action to avoid future high-cost years.

Background

The $1.5 million increase in worker's compensation spending between 2000 and 2001 could be the result of a single factor or the combination of several factors. It must be recognized that the city's worker's compensation program operates in a national environment of rising health care costs. In May 2001, the *New York Times* reported that medical costs increased 10 to 15 percent in the first quarter for the biggest insurance companies after averaging 5 percent to 6 percent for a decade. Rising costs come from both new and traditional sources. In many regions, hospitals have become more powerful and demanded major increases in payments. For example, hospitals in Waukegan and Evanston, Illinois, have asked for increases of 40 percent to 60 percent for some services. Prescription drug costs increased nearly 19 percent nationally in 2000, and analysts expect further increases in 2002. Sophisticated diagnostic treatments also drive up costs as more patients receive more sophisticated, and expensive, treatment. Finally, medical malpractice insurance premiums are soaring, forcing doctors to push additional costs on to consumers (Freudenheim 2001).

This backdrop of higher costs affects everything else in our study, and could itself be a reason for the increased spending worker's compensation, since the obligation of the Worker's Compensation Administration to pay the medical bills of injured city workers constitutes the majority of worker's compensation expenditures. Spending that the city classifies as "medical spending" constitutes almost 75 percent of total expenditures by the Worker's Compensation Administration. The city contracted with a preferred provider network in January 2000 in an effort to contain medical expenses.

There could also be a Milwaukee-specific reason for the increase. First, the number of claims in 2001 could have risen. Simply put, if more people get hurt, then it is likely that worker's compensation expenditures will rise. Second, there could be a change in the composition of claims that worker's compensation receives. It is possible an unaddressed safety problem exists that systematically affects some city workers. There could be a small number of extremely serious and expensive injuries, perhaps among employees in high-risk professions such as firefighting and policing. Finally, there could have

been a larger number of long-duration injuries from 1999 or 2000 that have medical or legal costs that spill over into 2001.

Understanding what drives worker's compensation costs will allow the city to forecast budget needs accurately and implement cost-saving strategies. A first step in doing that is to understand better the composition of worker's compensation spending in Wisconsin. From there, we can turn to the details of the Milwaukee program, and then to the problem that the city faces.

The Composition of Worker's Compensation in Wisconsin

Wisconsin operates under worker's compensation legislation (Wisconsin Statutes, Chapter 102) that covers a range of employees similar to those covered in other states: all employees working for an employer with three or more employees, as well as for smaller employers and farmers that meet certain criteria. As of April 2000, the law covered more than 2 million workers employed by 144,000 employers. All of the City of Milwaukee's employees are covered by the minimum provisions of the Wisconsin worker's compensation statute, and employee unions have successfully bargained for provisions which are more extensive than those guaranteed by the law.

Worker's compensation generally covers physical harm, mental harm, accidental injury, and disease incurred as a result of work done at the workplace. Worker's compensation benefits break down into two broad categories: medical reimbursement and indemnity—that is, reimbursement for lost wages caused by temporary and permanent disability.

Medical Reimbursement

All of an employee's reasonable and necessary medical costs—those for surgery, hospital, doctor bills, medicines, medical supplies, crutches, artificial limbs, etc.—arising from a work-related injury must be paid by the employer, unless the claim is settled through a legal compromise agreement. Under current Wisconsin law, employees are entitled to seek treatment with any licensed doctor of their choosing. The Wisconsin Department of Workforce Development uses a "usual and customary rates" database that determines the reasonableness of fees charged. If an employer believes that a fee is unreasonable, he or she can bring a claim demanding that the fee be reviewed (Wisconsin Department of Workforce Development, *Wisconsin Worker's Compensation Guide*).

Indemnity Payments

Indemnity payments are of four distinct types: temporary total disability (TTD), temporary partial disability (TPD), permanent partial disability (PPD), and permanent total disability (PTD). The two most commonly used are TTD and PPD. TTD is usually paid during the period immediately following an injury, when an injured employee is absent from work because of the incident—but which, in the case of the city, is in most instances replaced with the city's "Injury Pay" provision (which pays out a higher benefit). PPD is paid when an employee can return to work but has permanently lost some work capacity as a result of an injury. Wisconsin provisions for all four types (taken from Wisconsin Department of Workforce Development, *Wisconsin Worker's Compensation Guide*) are shown in the Table 1.

In regard to injury pay and TTD, the fact that benefits are paid if the employer cannot provide appropriate work is important in the case of Milwaukee, as the Milwaukee Fire Department and the Department of Public Works do not have many light-duty jobs for injured workers to return to.

Table 1. Types of Disability Pay

	Temporary Total Disability (TTD)	Temporary Partial Disability (TPD)
Description	Paid immediately after injury, before it can be determined whether or not there is any permanent disability. Paid when the employee is unable to work and has a total loss of wages, or when employee is able to do some work, but the employer cannot provide appropriate work.	Paid when an employee is working at a lesser paying job or is working fewer hours because of the temporary effects of an industrial accident or disease. TPD benefits are paid in proportion to the wage reduction.
Duration	Until condition has stabilized and treatment and convalescence are not likely to result in additional improvement.	While the employee is working at a lesser paying job or working part-time until the employee's condition becomes stabilized, and treatment and convalescence is not likely to result in additional improvement.
Amount	2/3 of average weekly wage, up to a maximum of $549 (in 2000).	Varies according to amount of wage loss.
	Permanent Partial Disability (PPD)	**Permanent Total Disability (PTD)**
Description	Permanent disabilities, including loss or partial loss of particular parts of the body, or physical or mental capacities, are compensated after the temporary injury has healed.	In case of an extremely serious injury which prevents the employee from performing any gainful employment, the law provides that weekly benefits be paid for life.
Duration	Determined in one of two ways: Number of Weeks Paid According to a Schedule of Losses [or] Nonscheduled Injuries are Paid as a Percentage of 1,000 Weeks.	PTD payments are paid for life.
Amount	Two-thirds of a maximum average permanent partial weekly wage provided for in the law at the time of injury.	PTD benefits amount to two-thirds of the employee's own average weekly rate subject to the maximum amount specified by law.

Source: Wisconsin Department of Workforce Development, 2000 pp. 10-12.

Spending Patterns for Wisconsin

In 2001, the Workers' Compensation Research Institute (WCRI), based in Cambridge, Massachusetts, released a study of the worker's compensation programs in eight states, chosen for their size of workforce or number of industrial workers: California,

Connecticut, Florida, Georgia, Massachusetts, Pennsylvania, Texas, and Wisconsin. Of these eight, Wisconsin ranked at the bottom for average worker's compensation claim cost per claim through the 1990s, although the total cost for all paid claims has grown since 1994.[1] As the authors state, "A major reason why claim costs have been rising is a steady increase in PPD claims from 1994 and 1998, including a nearly 3-point increase from 1996 to 1998" (Telles et al., 2001, p. 137). Wisconsin pays more, on average, for PPD medical benefits per claim, but less for indemnity benefits, so the benefit-per-PPD claims were average when compared to the other seven states studied (Telles et al., 2001, p. 141).

Wisconsin keeps its worker's compensation costs down by having low indemnity benefits per claim, low benefit delivery expenses, and low levels of litigation for disputed claims. As of 1998 (the last year studied by the WCRI), however, Wisconsin had not widely instituted medical cost containment procedures, such as bill review, utilization review, case management, and preferred-provider networks, which are possible avenues for further reducing medical costs (Telles et al., 2001, pp.137, 262). One of the reasons that Wisconsin has not utilized cost-containment widely is that it has limited the amount that doctors and hospitals can charge worker's compensation programs for medical services. Since 1993, Wisconsin has relied on division-certified databases that list formula amounts for medical reimbursement—the state's "Usual and Customary Rates" (UCR). Fees below formula amounts are considered reasonable.

Relying on this database, rather than allowing employers greater leeway to use cost-containment strategies, has the potential to create problems for Wisconsin. The formulas allow fees that are up to 1.5 standard deviations above the average charge-for-service. Thus doctors and hospitals have little incentive to charge less than the maximum allowable amount, and the "ceiling" of the UCR can easily become the floor. As the database is updated biennially, then, the "ceilings" can continue to increase. In a second study, the WCRI found that Wisconsin's average medical payment per claim grew consistently from 1996 to 1999 (the last year studied), and its payment per service was the highest among the eight states studied. This high per-service expense was offset by the state's low level of utilization. The study cited Texas as a state that had witnessed large increases in utilization, especially in chiropractic and physical therapy, over their study period, and Texas had the highest per-claim expense—$2,413, compared to Wisconsin's $1,391 (Eccleston et al., 2002).

Overview of Milwaukee's Worker's Compensation Program

The Employee Benefits Division oversees the management of the Worker's Compensation Section in the City of Milwaukee. In 2000, the city covered 7,842 workers in over 20 departments. As illustrated in Table 2, the Police and Fire Departments employ almost 50 percent (3,695) of all workers.

Milwaukee's worker's compensation program is financed through a self-insurance program. The city has a unique (to Wisconsin) way of compensating employees for work-related injuries. There is a worker's compensation fund as well as an injury pay policy.

[1] The study did not examine how states performed in terms of cost *per worker*, citing the difficulty of comparing per-worker measures across states which have differences in industry mix, wage levels, and system performance (WCRI, August 2001, p. xxiv).

Table 2. Department Workforce by Number of Employees and Percent of Total Workforce, 2000

Department	*Number of Employees*	*Percent of Total Workforce*
Fire	1,105	14
Police	2,595	33
Public Works (excluding Water Works)	1,911	24
Other	2,231	29
TOTAL	7,842	100

Source: Authors' calculations, based on City of Milwaukee, Department of Employee Relations, Visual Organization Inventory, April 2001.

Injury pay provides employees with indemnity coverage for 2,000 hours over the duration of the employee's appointment. It pays 80 percent of the worker's usual salary, and this amount is free from federal income taxes. The funds used to pay for this program come out of each department's budget. Once an employee exhausts his or her injury pay hours, the indemnity costs are paid out of the worker's compensation fund at a rate of 66 2/3 percent of the weekly wage. This amount is also exempt from income taxes. However, there are exceptions to the injury pay program: police officers are paid per injury, and as part of the bargaining unit's collective bargaining agreement, some administrative departments pay 70 percent of the usual salary of the employee.

Because most of the indemnity costs are paid for through injury pay, medical costs represent the majority of the worker's compensation payouts. In 2001, medical costs constituted almost 75 percent of the total worker's compensation budget. In an attempt to contain medical costs, the City of Milwaukee's Worker's Compensation program contracted with a preferred provider organization (PPO) on January 1, 2000. The PPO that the city subscribes to is CorVel, and this network provides the city with several cost-containment mechanisms. In addition to supplying the city with a network of hospitals and physicians, CorVel also provides utilization review, return-to-work assistance, and risk management services.

Utilization review is charged at a rate of $68 per hour and includes information not limited to reviews of in-patient admissions, authorization for referrals outside the network, feedback to physician on utilization data, and discharge planning (Office of the City Attorney, 1999). In terms of return to work assistance, CorVel employees work with Milwaukee's return-to-work coordinators to assess the employee's ability to return to work. Risk management services provided by CorVel include training sessions, distribution of handouts to employees, and assisting in preparation of job analyses (Office of the City Attorney, 1999). There is no additional charge to the city or injured workers for these risk management activities.

Section 102.16 of the Wisconsin statutes provides for the establishment of a formula to determine whether a fee charged by a health care provider is "reasonable." In the agreement between the city and CorVel is an explicit statement that CorVel "will not bill or expect payment in excess of allowance under Section 102.16" (p. 5). According to the contract, the city pays CorVel 20 percent of the total savings. It is important to note that the Worker's Compensation Section cannot dictate which doctor an injured employee

uses, although the network includes approximately 90 percent of doctors most frequently utilized by City of Milwaukee employees (Hudson, 2002). The agreement also states that "increases in CorVel fees in the second and third year of this Agreement will be limited to the annual adjustment of the Consumer Price Index" (p. 12). The agreement between the city and CorVel is set to expire December 31, 2002.

Worker's Compensation, 1998–2001

Similar numbers of claims have been filed each year, but with the exception of 2000, total expenditures have risen every year. Increasing expenditures might suggest that there has been a change in injury severity or worker's compensation utilization patterns over the years. Expenditure increases could occur if city employees are suffering more serious injuries that result in more expensive claims. Alternatively, even if the composition of injuries remains unchanged, claimants may be seeking additional or more expensive medical treatment for their injuries. Our goal is to determine the reasons for rising expenditures per claim.

Table 3 shows that between 1998 and 2001 the city faced about 3,500 new claims per year, with a slight decrease in 1999. As Table 4 shows, however, spending increased dramatically between 1998 and 1999, retreated slightly in 2000, and surged upward again in 2001, resulting in a $2.3 million increase in spending over the four-year period. Overall, spending increased approximately 50 percent in the last four years.

Table 3. New Claims Filed, 1998–2001

Period	1998	1999	2000	2001
First quarter	807	855	862	1,022
Second quarter	885	711	818	881
Third quarter	957	863	882	886
Fourth quarter	803	736	873	689
TOTAL	**3,452**	**3,165**	**3,435**	**3,478**
% Change		-8	9	1

Source: (1998, 1999): City of Milwaukee Annual Report of Occupational Injuries & Illnesses; (2000, 2001): Milwaukee Worker's Compensation Administration.

Table 4. Expenditures on All Claims, 1998–2001 (in nominal dollars)

Type	1998	1999	2000	2001	% Change
Medical	$3,206,725	$4,096,509	$3,684,788	$5,071,642	58
Indemnity	$1,278,313	$1,417,110	$1,592,637	$1,600,606	25
Administration	$170,426	$205,668	$299,818	$317,038	86
TOTAL	**$4,655,463**	**$5,719,287**	**$5,577,243**	**$6,989,286**	**50**
% Change		23	-2	25	

Source: Milwaukee Worker's Compensation Administration.

Another noteworthy feature is that indemnity and administrative spending were consistently on the rise through all four years. Between 1999 and 2000, administrative

costs rose from 3.6 percent to 5.4 percent of total spending. Medical spending, however, is by far the largest portion of worker's compensation spending. When it decreased in 2000, worker's compensation expenditures also showed a net decrease.[2]

If we combine the information in Tables 3 and 4, we can arrive at an estimate of expenditures per worker's compensation claim. This is shown in Table 5. The claims data in Table 3 include only new claims—those where the injury occurred in the current year. The expenditure data, however, include spending on both new claims and those continuing from previous years.

Table 5. Estimated Expenditure per Claim, 1998–2001 (in nominal dollars)

Type	1998	1999	2000	2001
Medical	$929	$1,294	$1,073	$1,458
Indemnity	$370	$448	$464	$460
Administration	$49	$65	$87	$91
TOTAL	**$1,349**	**$1,807**	**$1,624**	**$2,010**
% change		34	-10	24

Source: Authors' calculations, based on Milwaukee Worker's Compensation Administration data.

The expenditures per claim are more responsive to the medical expenditures in any given year than they are to the number of claims. For example, in 1999, when the number of claims actually dropped, the per-claim expenditure went up, but in 2000, when claims returned to the1998 level, the per-claim expense declined in response to the drop in medical spending. This may indicate that the city's worker's compensation spending is more sensitive to the *type* of claims that it receives than to the *number* of claims. Since our measure of claims does not include claims that continue from past years, however, it is impossible to rule out the possibility that the presence or absence of more expensive claims that linger for several years affects total medical expenditures.

The city categorizes as "medical" all payments to health care providers, including money spent on doctors' visits, hospitalization, physical therapy, chiropractic care, and medication. These five categories of spending were the five most expensive in 2001, and have been consistently expensive since 1998 (see Table 6).

Fees paid to doctors and hospitals are the largest spending categories and indeed make up most of worker's compensation expenditures. Spending on physical therapy and medication, however, has grown rapidly every year. Although the Medical Services Consumer Price Index in the Milwaukee-Racine metropolitan area grew by 2.5 percent in 2000, spending for physical therapy went up by 4 percent, and spending on medication grew by 29 percent. In 2001, the CPI rose 3.5 percent, but spending on physical therapy and medication far outstripped inflation, rising by 22 and 23 percent, respectively.[3]

[2] Adjusting the figures in Table 4 for inflation (using the Consumer Price Index for Urban Consumers [all goods, year-end figure]) does not have a large impact on the magnitude of the year-to-year changes. The change from 1998 to 1999 is 20%; 1999-2000: -6%; 2000-2001: 22%.

[3] For comparison, the medical CPI calculated for the entire nation increased by 13% over the period 1998-2001.

Table 6. Medical Expenditures in Selected Categories, 1998-2001 (in nominal dollars)

Pay Type	1998	1999	2000	2001	% Change
Doctor	$1,283,804	$1,707,685	$1,717,496	$2,058,742	60
Hospital	$1,087,895	$1,519,079	$1,276,529	$2,002,843	84
Physical therapy	$523,655	$644,675	$667,625	$812,581	55
Chiropractor	$76,779	$76,688	$71,082	$118,721	55
Medication charges	$46,021	$53,633	$69,354	$85,460	86

Source: Milwaukee Worker's Compensation Administration.

This suggests, perhaps, that Milwaukee is experiencing a growth in service utilization—that is, the city is faced with the same number of worker's compensation claims, but the injured workers are seeking, or being prescribed, additional medical services and medicines. In the context of Wisconsin's worker's compensation framework of traditionally high costs per service (because of the usual and customary fee schedules) but low utilization, a continued increase in utilization would mean rising worker's compensation spending in future years.

The Worker's Compensation Research Institute (WCRI) found that the average medical payment per worker's compensation claim for the state of Wisconsin grew 6.6 percent per year between 1996 and 1999, the result of increased prices for all providers as well as increased utilization of chiropractors. In comparison, the city's worker's compensation medical spending grew an average of 18 percent annually from 1998 to 2001.

Another useful way to look at the problem of rising medical costs is to examine the city departments where worker's compensation spending is highest. Three departments—Police, Fire, and Public Works (which includes infrastructure, buildings and fleet, sanitation, forestry, and sewer maintenance)—make up 94 percent of Milwaukee's worker's compensation expense in 2001 but only 76 percent of the city's workforce.

Public Works has consistently been the most expensive department overall, but the city's spending on Public Works has grown least over the four years. If we adjust for inflation, Public Works expenditures grow by only 21 percent.[4] It is reasonable to think that this is because jobs in Public Works have a set of risks (back strain, sprains, contusions from activities such as lifting garbage cans and clearing brush) that stay relatively the same from year to year, and that the city has made progress in instituting proactive measures to prevent injuries. In contrast, police and firefighters may face injury risks that are less predictable yet more acute. For example, Table 7 shows that in 1999, total worker's compensation spending on Fire Department employees increased by $600,000, and the city's overall spending for worker's compensation went up by 23 percent. The Police Department experienced a similar jump in 2001. It is conceivable that the 2001 city-wide increase of $1.5 million (25 percent) can be explained by a few very bad and expensive injuries to police officers. If we divide total worker's compensation expenditures by the number of employees in each department (Table 8), it is clear that spending on police and firefighters has increased dramatically over the period of interest.[5]

[4] Adjusting spending on MFD and MPD for inflation lowers the four-year increase to 52 percent, "other departments" to 36 percent, and the total growth to 38 percent.

[5] Data on number of employees in 2001 was not available as of this reporting; this estimated 2001 figure per employee is obtained by using the employment figures for 2000. We believe it to be a conservative

Table 7. Changes in Expenditures in Selected Departments, 1998–2001 (in nominal dollars)

City Department	1998		1999		2000		2001		%Change 1998-2001
	Dollar Amount	% of Total Spending	Dollar Amount	% of Total Spending	Dollar Amount	% of Total Spending	Dollar Amount	% of Total Spending	
Public Works	$1,928,242	41	$2,088,241	37	$2,181,343	39	$2,534,546	36	31
Police Department	$1,382,866	30	$1,660,272	29	$1,603,324	29	$2,285,472	33	65
Fire Department	$1,060,060	23	$1,676,223	29	$1,624,552	29	$1,747,640	25	65
Other Departments	$284,295	6	$294,552	5	$168,024	3	$421,628	6	48
TOTAL:	$4,655,463		$5,719,287		$5,577,243		$6,989,286		50

Source: Milwaukee Worker's Compensation Administration.

Table 8. Expenditures in Selected Departments per Employee, 1998-2001 (in nominal dollars)

Department	1998	1999	2000	2001	Change, 1998-2001
Public Works	$978	$1,111	$1,141	$1,326	36
Police	$500	$615	$618	$881	76
Fire	$963	$1,520	$1,470	$1,582	64

Source: Authors' calculations, based on Milwaukee Worker's Compensation Administration data and Visual Organization Inventory.

In order to explore this issue fully it would be necessary to look at the composition of costs-per-claim in the Police, Fire, and Public Works Departments. Currently, we are unable to do so because the city does not regularly tabulate worker's compensation claims volume by department. The closest proxy we could use, the occupational injury, illness, and fatality data that the City must furnish to the Occupational Safety and Health Administration (OSHA), which is tabulated by department, is unsatisfactory for several reasons. First, different filing requirements for OSHA-recordable injuries and compensable claims under worker's compensation mean that the OSHA figure is far below the claims volume figure. Second, the two measures do not appear to move together. For instance, the 9 percent rise in claims in 2000 is not reflected in the OSHA measure, which actually fell by 11 percent in that year. This makes the OSHA measure a poor indicator for how the number of Police and Fire Department claims change over time. In addition, it would be beneficial to have information on either severity or type of injury broken down by department. At this time, however, the city does not report this kind of data.

Explaining the Increase

Now that we have characterized the framework of state legislation and medical costs in which the city operates, and have started to examine the particular nature of the $1.5 million increase in worker's compensation expenditures, it should be clear that we have been unable to obtain the more detailed data necessary to pinpoint the causes of the

assumption because city employment has been shrinking. Adjusting spending for inflation brings the four-year increase down to: DPW - 25%; MFD - 51%; MPD - 62%

.

increase in spending. Instead, we have identified the following questions that need to be answered in order to determine the reasons behind the recent $1.5 million increase in worker's compensation expenditures:

- Have severe, expensive injuries occurred in the Police and Fire Departments?
- What are the effects of the city's new partnership with CorVel?
- What can the city do to affect Wisconsin's "usual and customary rate" fee schedule?
- Has there been increased utilization of medical services and sophisticated treatments for worker's compensation claims?

Injuries in the Police and Fire Departments

The Police and Fire Departments are both high-risk areas for injuries. Looking only at costs, these two departments made up approximately 60 percent of the 2001 worker's compensation budget and comprised about 50 percent (MFD - 13 % and MPD - 34%) of the city's total workforce in 2000. The reason that we are concerned about these departments is that their costs have increased at a much faster rate than worker's compensation expenses of Public Works workers. The information we currently have, however, does not allow us to draw firm conclusions about the Police, Fire, and Public Works Departments.

If the number of injuries has increased or if there have been more serious injuries within these departments, there are several work-safety policies that could mitigate the situation. The city does have safety personnel available in these high-risk departments. In 1993, the city comptroller conducted an audit of the occupational safety and health programs. At that time, three full-time safety specialists worked in the different Public Works divisions, one full-time safety director was with the Police Department, and a safety supervisor and specialist was in the Department of Employee Relations. The report suggested that the Sanitation Division in the Department of Public Works hire a full-time safety specialist, and they agreed. The Fire Department did not have any sort of safety specialist in place, but the report recommended that the department create an injury analyst position. According to Deputy Chief Smerz, the Fire Department did not follow the recommendation. He did indicate there is a safety officer but this position is loosely defined and regulated and does not focus on injury prevention. The deputy chief acknowledged the importance of a full-time injury prevention specialist, and indicated that the department has applied for federal grant money to create this position. Finally, Jim Michalski, Internal Audit Manager, stated that the comptroller intends to begin a new audit of occupational safety in the near future.

Effects of the City's NewPpartnership with CorVel

Burma Hudson, worker's compensation administrator, reports that in 2000, the CorVel arrangement saved the city more than $481,000, and in 2001, more than $871,000 (Hudson e-mail, 15 April 2002). CorVel has an incentive to reduce spending because they receive 20 percent of the cost savings. Unfortunately, we do not have more detailed information on where the city is realizing these savings. They may be instituting structural changes, like bill review, that contests more claims (and thus dissuades frivolous claims in the future), which will result in continued cost savings in subsequent years. The

changes could be shorter term, however, and thus the city may not continue to realize a benefit from those changes in the future. For instance, if the savings are being achieved by lowering doctors' fees, these savings can be taken only to a certain point before the macroeconomic forces pushing medical costs upward take over, and the fees begin to rise again.

Moreover, it is possible that reducing costs in one arena may raise them in another. For instance, contesting more claims may reduce the amount paid in doctor's fees but increase the amount the city pays to litigate disputed claims. Given that the contract with CorVel is set to expire at the end of 2002, it is in the city's best interest to evaluate the PPO's performance critically.

Ways to Influence Wisconsin's "Usual and Customary Rate" Fee Schedule

Wisconsin's worker's compensation law requires that health providers charge "reasonable" medical fees. Section 102.16(2) of Wisconsin statutes, establishes a formula to determine whether a fee charged by a health care provider is reasonable: the fee must be at or below the mean fee for the health service procedure, plus 1.5 standard deviations from that mean, as shown from a database that is certified by the Wisconsin Department of Workforce Development. This formula is referred to as a "usual and customary rate" fee schedule (DWD, *Reasonableness of Fees*).

The Workers' Compensation Research Institute study mentioned above found that out of the eight states studied, Wisconsin has the highest average payment per service overall. The study linked these high payments to Wisconsin's usual and customary rate schedule. The other states studied set fees based on relative values from existing scales, combined with state-defined conversion factors. Fee levels in these states are generally developed through a review of charges and the advice of panels and committees. Wisconsin, on the other hand, authorizes private companies to create UCR databases calculated using the average medical rates charged in different localities. As mentioned above, the allowable fee varies rising up to the 1.5 standard deviation of the mean (Eccleston, et al., 2002).

Wisconsin's usual and customary rate system creates an incentive for service providers to charge up to the maximum fee allowable—the UCR's "ceiling" price can easily become the "floor" amount charged; this likely disadvantages employers and increases worker's compensation spending. In fact, both Mike Brady, employee benefits manager in the city's Department of Employee Relations, and Burma Hudson, worker's compensation administrator, pointed to the state's fee system as one reason for high worker's compensation spending. There is no data currently available to study the impact of the state's fee system on Milwaukee's spending. Except for the report produced by WCRI, which pointed to Wisconsin's fee schedule as the culprit for Wisconsin's high average payment per service, there is little research in this area.

Utilization of Medical Services and Treatments for Worker's Compensation Claims

One possible explanation for high spending in Milwaukee is increased utilization of medical services as compared to other areas of the state. The WCRI report found that overall, Wisconsin's average cost per claim was in the middle of the eight states studied even though service fees were the highest. Less utilization of medical services balanced the claim costs. In Milwaukee, there may be a recent increase in utilization of medical services, in particular physical therapy, chiropractic treatment, and more expensive drugs.

Increased utilization combined with high service fees may explain why spending is high overall.

Recommendations

These recommendations were selected based on their ease of administration, their relative low cost in implementation, and the likelihood that direct, positive results will be generated by their implementation. In discussing each recommendation, we also suggest any possible negative consequences generated by its adoption.

Improve Data Collection and Analysis

The only way to determine definitively the reasons for rising worker's compensation costs is to collect more detailed data. In order for the city to provide a comprehensive picture of worker's compensation spending the following data should be reported:

- Data on the department of origin of each worker's compensation claim. These data would allow the city to study worker's compensation expenditures attributable to each department. It would help answer the question of whether a small number of acute, very expensive accidents are influencing spending. In particular, departments with high-risk jobs such as firefighting and policing can be studied.
- Data on the average costs of worker's compensation claims. This report compiles incomplete figures in this area from data that includes only new claims each year. In order to know the true average cost per claim, data must be compiled that includes both the number of new claims each year and claims carried over from previous years.
- Data on the average cost per medical visit and service. This data is necessary to report on average service fees in the city. This data can then be compared to service fees across Wisconsin as well as other states. These reports are necessary to persuade the legislature that service fees in Wisconsin are higher than in other areas.
- Data on injuries by age. This data will provide useful information for developing appropriate strategies to reduce injuries in various age groups. Given that the workforce is aging, more attention must be given to the age of workers.
- Data on the connection between utilization and injury pay. If indeed utilization of medical services is increasing, this may result in employees returning to work at a faster rate. If this is true, then the savings of increased services will likely be seen in indemnity spending. It will not, however, be reflected in the worker's compensation budget, but in the injury pay program. Both areas should be studied to see if increased spending in medical services is decreasing employees' time away from work and, therefore, realizing cost savings in the injury pay program.
- Data on best practices in other states. Wisconsin's usual and customary fee system should be compared to fee systems in other states. In addition, other data can be compiled on best practices including return-to-work measures, injury prevention, and limiting service providers.

- Data on the potential cost savings generated from the above. The data compiled from the recommendations above should provide useful information on effective cost saving strategies. In addition, the data will indicate specific departments in need of aggressive cost-containment measures. These reports can be studied to determine the best policy options for the city and the state.

In addition, the city should network and cooperate with other local governments as well as with private employers. Together and armed with persuasive data, these groups should be able to provide a strong lobbying force in the legislature.

Strengthen or Implement Return-to-Work and Light Duty Programs

As long as employees are out of work because of injuries, they are visiting physicians who assess their capability to return to work. The city could implement "return to work" strategies such as contracting with medical providers who specialize in occupational medicine. Such providers could offer better strategies for returning to work or suggestions about modifying an employee's work plan. Given the current state statute, the city is not in a position to instruct their employees to use specific medical providers. In addition, employers should take an active role in encouraging an employee to return to work. A supervisor who actively shows concern for an injured worker and monitors his or her progress may motivate the employee to return to work faster. One author suggests contacting the injured employee at least once a week (Atkinson 1999). Finally, it is necessary for supervisors to keep close track of workers who return to their job, especially those who have been away from work for a long period of time. There is a greater risk of re-injury for those who return to work after a long period off (Atkinson, 1999).

The city should also consider improving its light duty program. Light duty positions allow employees to return to work before they are able to perform fully all of the functions of their regular job. An example of a light duty job might include administrative or supervisory tasks. The city's collective bargaining agreement with the Fire Department employees, however, prohibits light duty jobs for their injured employees (that is, the employees must be fully recovered before they can return to work), and Public Works has only a few of these positions (Hudson interview, 26 February 2002). In order to create more positions within these departments, the DER should work closely with the personnel units in each department to explore whether more light duty jobs can be created. Continental Airlines has developed a job bank system in which supervisors from all departments can list light duty jobs; these jobs can be filled by anyone seeking a transitional position (Atkinson, 1999). Collective bargaining agreements may make this solution impossible for the city, but it is worth investigating.

Research Additional Managed Care Options

Under current Wisconsin law, employees have the freedom to choose any doctor for treatment of their work-related injury. An option that the city could explore is lobbying the state for more freedom to limit medical care to a smaller group of providers. This would allow the city to contract with a narrower preferred provider network, thus potentially reducing hospital and doctor costs by getting a larger discount than the one they currently receive from the CorVel network The network may include occupational medical specialists who will develop the "return to work" strategies discussed above.

Several states, including Washington, Florida, Ohio, California and New Hampshire, have implemented managed care pilot programs. Studies suggest that, on average, managed care can reduce total worker's compensation claims costs by 20 percent to 30 percent, with savings on both medical and indemnity payments. The effect of discounted fee schedules can be expected to have the greatest impact in states that have relatively high provider fees. In addition, changes in utilization patterns to eliminate unnecessary or inappropriate services can produce a cost decline compared to previously unmanaged fee-for-service contexts (Dembe 1998).

Contracting with a smaller network, however, will affect employee's current statute-provided freedom in selecting a medical provider and could affect quality of care. Treatment in worker's compensation is unique because of its focus on eligibility for compensation benefits and return to work. The medical services provided in worker's compensation cases have significant implications for labor relations and employment litigation. Studies have consistently demonstrated that worker's compensation patients treated in managed care plans are less satisfied with their medical care (Dembe 1998). Further analysis is needed to determine whether this is a policy change that the city would want to pursue.

Investigate Health and Safety Measures

An alternative to seeking change in statewide policy is for the city to attempt to limit worker's compensation claims by preventing them before they happen. First, the Fire Department should consider implementing the comptroller's 1993 recommendation to create a permanent, full-time injury analyst position, especially if new data collected by the city on best practices shows that the Milwaukee Fire Department is doing worse than fire departments in similarly situated cities. It is important for the city that this department, which has high costs and high risks, actively take whatever steps it can to reduce injuries on the front end.

Because of the unpredictable risks of firefighting, however, the Fire Department may not be as good a candidate for implementing increased front-end safety measures as Public Works. As stated earlier, the Department of Public Works most likely faces a more stable and predictable set of risks than the Police and Fire Departments. One of the benefits of increased data collection on the source and nature of worker's compensation claims is that it can allow the city to undertake some detailed analyses of the injuries occurring to the employees in one department and experiment with programs that specifically address the sources of increased claims. For instance, if a detailed longitudinal examination of injuries in the Department of Public Works found that older employees were more likely to be injured or to have longer spells off work when they are injured, the city could test the effect of increased safety training, personal protective equipment, or redesigning work tasks for these older workers based on the number of claims filed in subsequent years.

Conclusion

Spending on worker's compensation increased 25 percent between 2000 and 2001, and this large spike in spending defined our task. We aimed to discover the source or combination of factors driving this increase and to offer the City of Milwaukee suggestions on how to curb future worker's compensation increases. After analyzing the compo-

sition of worker's compensation claims and spending, we identified several questions that need to be answered in order to determine the reasons behind the recent $1.5 million increase in worker's compensation expenditures: 1) Have there been severe, expensive injuries in the Police and Fire Departments? 2) What are the effects of the city's new partnership with CorVel? 3) What can the city do to affect Wisconsin's "usual and customary rate" fee schedule? 4) Has there been increased utilization of medical services and sophisticated treatments for worker's compensation claims?

We recommend that in order to address these questions the city improve its data collection and analysis. In particular, data is needed on the total number of claims filed and carried over each year, the number and type of claims filed in each department, average costs per claim, and data on service utilization. In addition, the city may want to use this data to lobby the state for a change in the usual and customary rates schedule and try to limit employee's choice of medical providers. On the front end, the city should continue to implement "return-to-work" measures as well as pursue work-safety strategies that prevent injuries from occurring. These recommendations should provide the city with a more complete and detailed understanding of how to reduce future worker's compensation spending.

Acknowledgments

We would like to thank Burma Hudson and Mike Brady in Milwaukee's Department of Employee Relations for their gracious time and energy in meeting with us, answering our continual questions, and sharing their data and documents. We would also like to thank Dennis Yaccarino and Eric Pearson in the city's Budget Office for providing direction in their comments and suggestions on our drafts. Last, but not least, we would like to thank Professor Reschovsky for his continual support and help in shaping our analysis.

Bibliography

Atkinson, William. "Curbing Workers' Comp Claims and Costs." *Business and Health*, August 1999.

Brady, Michael, Employee Benefits Manager. Interviews by authors, 8 and 25 February 2002, Milwaukee. Interview notes available from authors upon request.

City of Milwaukee. *2002 Plan and Budget Summary.* Milwaukee, 2002.

City of Milwaukee. Office of City Attorney. "Agreement Between the City of Milwaukee and CorVel Corporation." Milwaukee, 2000.

City of Milwaukee. Office of the Comptroller. "Audit of Occupational Safety and Health Programs," by W. Martin Morics, City Comptroller. Milwaukee, July 1993.

City of Milwaukee. Department of Employee Relations, Employee Benefits Division. "Audit of the City of Milwaukee Injury Pay Program," by W. Martin Morics, City Comptroller. Milwaukee, 1999.

———.Visual Organizational Inventory. Milwaukee, 2001.

City of Milwaukee. Department of Employee Relations, Employee Benefits Division, Worker's Compensation /Safety Section. *Annual 1998 Report of Occupational Injuries & Illnesses.* Milwaukee, 1998.

———. *Annual 1999 Report of Occupational Injuries & Illnesses.* Milwaukee, 1999.

———. Internal data, worker's compensation payments by type and department, 1998–2001. Received by fax from Burma Hudson, 26 February 2002.

———. Internal data, volume of worker's compensation claims filed, 2000–01. Received by e-mail from Burma Hudson, 9 April 2002.

DeClercq, Neill, Professor of Occupational Safety and Health, University of Wisconsin–Extension. Interview by authors, 15 February 2002. Madison. Interview notes available from authors upon request.

Dembe, Allard E. *Occupational Medicine: State of the Art Reviews* 13, no. 4 (1998).

Eccleston, Stacey M., Igor Polevoy, Xiaoping Zhao, and Michael Watson. *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 1996-1999.* Cambridge, Massachusetts; Worker's Compensation Research Institute, February 2002.

Hudson, Burma, Worker's Compensation Administrator. Interviews by authors, 8 and 25 February 2002, Milwaukee. Interview notes available from authors upon request.

Michalski, Jim, Internal Audit Manager. Interview by authors, 19 February 2002, Milwaukee. Interview notes available from authors upon request.

Smerzs, Andy, Deputy Chief, Milwaukee Fire Department. Interview by authors, 26 February 2002, Milwaukee. Interview notes available from authors upon request.

Telles, Carol A., Te-Chun Liu, Andrew Kowalczyk, and Ramona P. Tanabe. *CompScope™ Benchmarks: Multistate Comparisons, 1994-1999.* Cambridge, Massachusetts; Worker's Compensation Research Institute, August 2001.

Wisconsin Department of Workforce Development. Reasonableness of Fees. Internet document, available online at http://www.dwd.state.wi.us/wc/medical/reasonableness_of_fees.htm (last accessed 25 April 2002).

———Wisconsin Worker's Compensation Guide (R. 4/2000). Publication number WKC-7580. Available online at http://www.dwd.state.wi.us/wc/about_us/publications/WKC-7580.htm (last accessed 25 April 2002).