

2014/2015 California Hospitals Workers' Compensation Benchmarking Report



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Executive Summary

The issues that hospitals and other facilities are facing today are more complex and continuously changing. The risks of providing medical care and the costs of protecting against those risks alone, including the protection of your employees from injury or illness in the delivery of that care, require hospitals to look closely at questions related to taking fully insured, partially self-funded or self-insured positions. As these facilities are well aware, workers' compensation laws in California make the choice increasingly complex—and important.

Keenan HealthCare and Milliman are pleased to present the 2015 results of California Hospital Workers' Compensation and Payroll Benchmarking Survey. Our hope with this survey and report is to provide industry-wide benchmarks in terms of the fundamentals from which informed decisions related to workers' compensation and maintaining appropriate risk can be made: claim frequency and severity, medical and indemnity costs, and allocated loss adjustment expense (ALAE).

In the course of our work on this survey, we gathered data from 17 hospital systems and/or individual facilities within California (over 35 facilities altogether). In aggregate they provided data on over 3,500 annual claims. Additionally, to facilitate analyzing data on a consistent basis among all participants, we relied on payroll and utilization information obtained from the California Office of Statewide Health Planning and Development (OSHPD) website.

As a result, we identified some general trends in the hospital sector which include:

- The trend in overall losses per \$100 of payroll has remained flat over the ten years ending 2014; however, we identified two noteworthy trends: 1) Severity of claims is on the rise, increasing by approximately 5.5% annually from 2005 to 2014, and 2) Claim frequency has been continually declining, although the rate of decline has slowed since 2008.
- Our estimates of costs per indemnity claim (i.e., severity) for accidents occurred 2011 and subsequent has decreased approximately 10% from the prior version of this analysis reflecting less than anticipated loss development overall on this recent accidents.
- The projected 2015 loss cost per \$100 of payroll¹ comes to \$2.20. Directly related to the decrease in ultimate severity estimates and a slowing of projected future cost increases, this estimate is approximately 15% less than the projection of 2014 costs as made in the prior version of this study.

This report is divided into sections with charts providing results on an overall basis as well as in specific areas. The first section looks at some of the broad trends as well as others identified in the overall survey results. In the next section, we present numerous charts illustrating trends in specific areas of interest, including payroll and utilization, age, litigation status, and future medical (FM).

We believe these key indicators will be valuable in developing plans for improving your results. Your feedback is important to assure this report meets your needs and expectations. Please email your comments, thoughts and ideas to:

Bill Poland, Marketing Director-Property & Casualty at bpoland@keenana.com

¹ It is important to note that OSHPD payroll only includes payroll under the hospital name; it does not include payroll of clinics, home health, or other associated entities and services. Therefore, loss costs described here and elsewhere in this report will be overstated relative to loss costs that include those payroll sources, and should only be considered valid for benchmarks within the context of this report.

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We are eager for your feedback.

Respectfully,

Keenan HealthCare and Milliman

Definitions

Total incurred: The loss that has been paid plus case reserves

Case reserve: Amounts set on individual claims by case adjusters for future payments

Exposure: Measure of potential liability; risk

Frequency: Number of claims per workforce unit, usually stated either in terms of payroll dollars or number of employees

Indemnity (lost-time) claim: A claims that has incurred an indemnity payment²

Limits: All claim amounts within this benchmark report are on a ground-up and unlimited basis

Losses: The total of indemnity, medical, and allocated loss adjustment expense (ALAE) amounts

Severity: Average loss per claim

Pure premium: Losses per \$100 of payroll

Paid: Loss amounts that have already been paid

Ultimate estimate: Estimate of total cost of claims after all payments are made

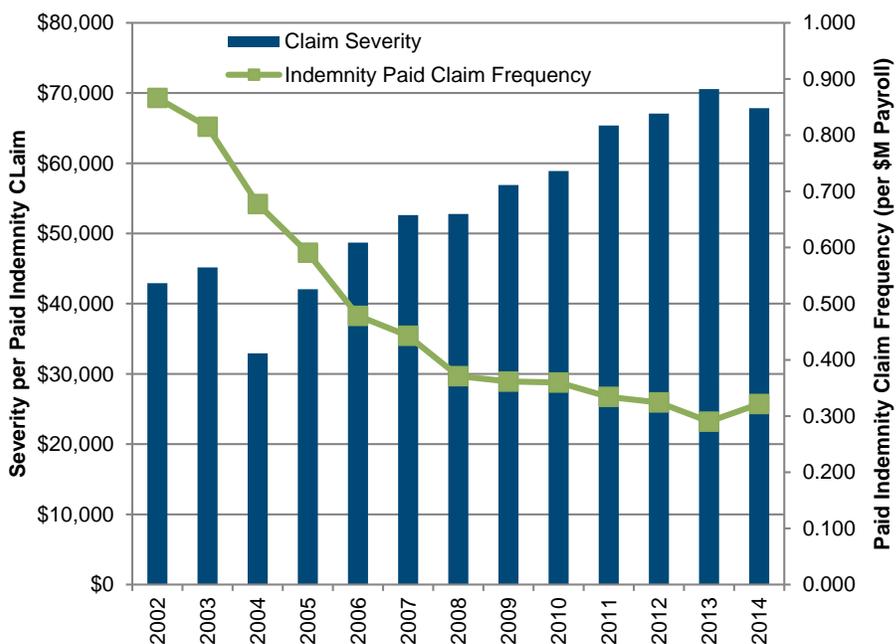
² Please note that the definition of a “lost-time” claim can differ by third-party administrator (TPA) and facility. In order to be consistent within this analysis, we have used an indemnity claim definition based on whether paid indemnity is greater than zero. This definition is typically more stringent than the definition of a lost-time claim used by most TPAs or facilities and results in fewer claims used in frequency statistics.

Overall results

The big picture for workers' compensation in California today is not necessarily the right one. The overall results of our survey disclosed two interesting hidden trends, which together paint a picture that is a little different from what it first appears. The exhibits in this section, Figures 1 through 6, provide a review of workers' compensation loss trends for California hospitals over the past decade. They are based on benchmark participant claim experience, Milliman analysis of that claim experience, and payroll or FTE information for benchmark participants as reported to OSHPD.

The first trend of note is that severity per paid indemnity claim—i.e., indemnity, medical, and allocated loss adjustment expense (ALAE) combined—showed an increase of approximately 5.5% annually in the period from 2005 through 2014. This may be seen in Figure 1. Note how the drop off in claim severity that occurred from 2003 to 2004 (represented by the blue bars in Figure 1) actually did little to halt the trend of increasing severity. The drop off was the result of the enactment of reform laws, which provided only short-term measures to halt that trend. The effect was a one-time downward shift in severity with otherwise no effect on the year-to-year upward trend. However, comparing results one-year forward for recent accidents shows a slowing of the claim severity trend with overall average claim severity estimated at nearly \$70,000 per paid indemnity claim for accidents occurred in 2014 versus our prior report estimating costs of nearly \$80,000 per claim.

Figure 1: Claim Severity and Frequency

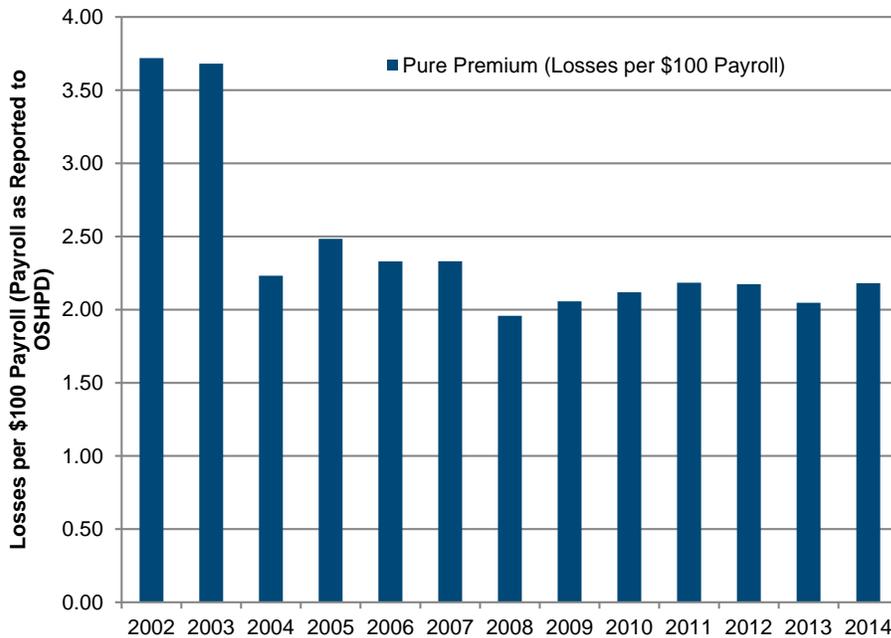


At the same time, however, the indemnity claim frequency (represented by the green line in Figure 1) was declining dramatically. This continued until about 2008, after which the decreases have slowed. The net effect of these two trends combined has been that overall losses per \$100 of payroll have been largely consistent across the past ten years.

In reality, while it may appear there has been little change in overall costs, there has actually been quite a bit of upward change in severity and downward change in frequency of claims.

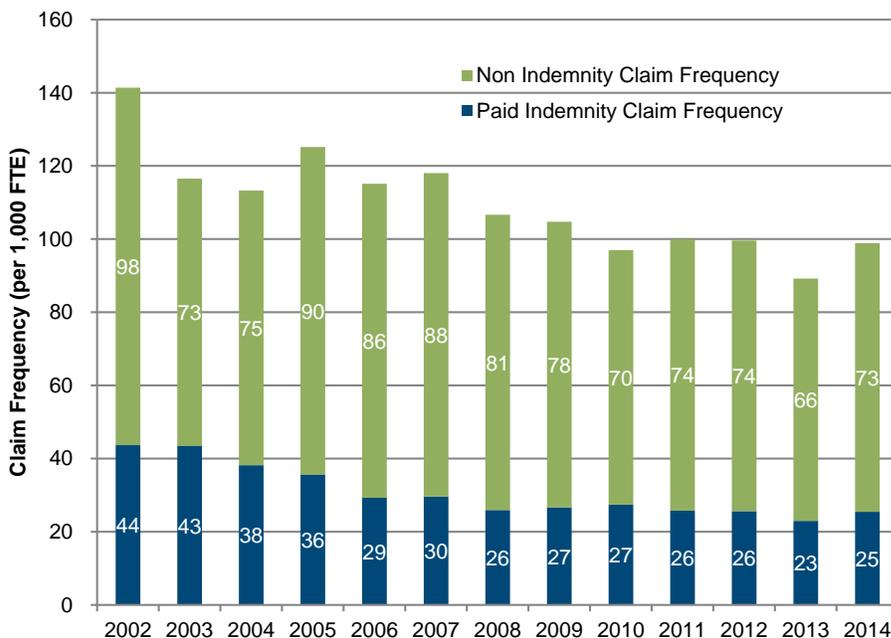
The effects of the 2003 and 2004 reforms can be more clearly observed along with the combined impact of the frequency and severity changes in overall costs in the interim period in Figure 2.

Figure 2: Impact of Reforms on Losses per \$100 Payroll



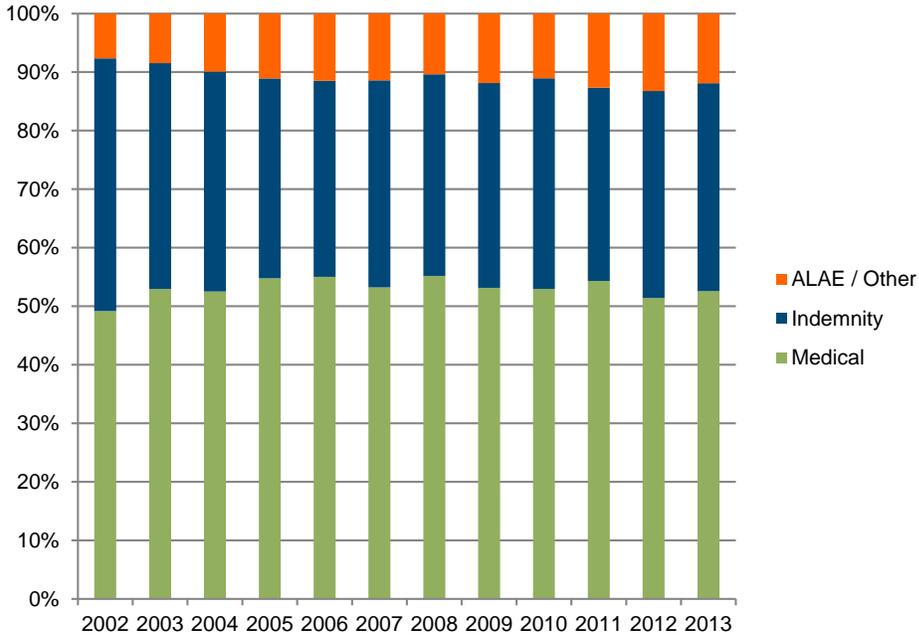
After a dramatic tumble subsequent to last decade's reforms, losses as a function of payroll appear to have hit their low point in 2008. Since 2008, frequency decreases have been notably less dramatic and the impact of continual increases in severity has begun to slowly increase overall costs per \$100 of payroll.

Figure 3: Combined Indemnity and Non-Indemnity Claim Frequency



The decline in claim frequency has been seen both in claims that incur an indemnity payment and in medical-only claims. Figure 4 shows the relation between them, with both types of claims seeing significant reductions over the experience period.

Figure 4: Percentage of Medical/Indemnity/ALAE Costs by Accident Year

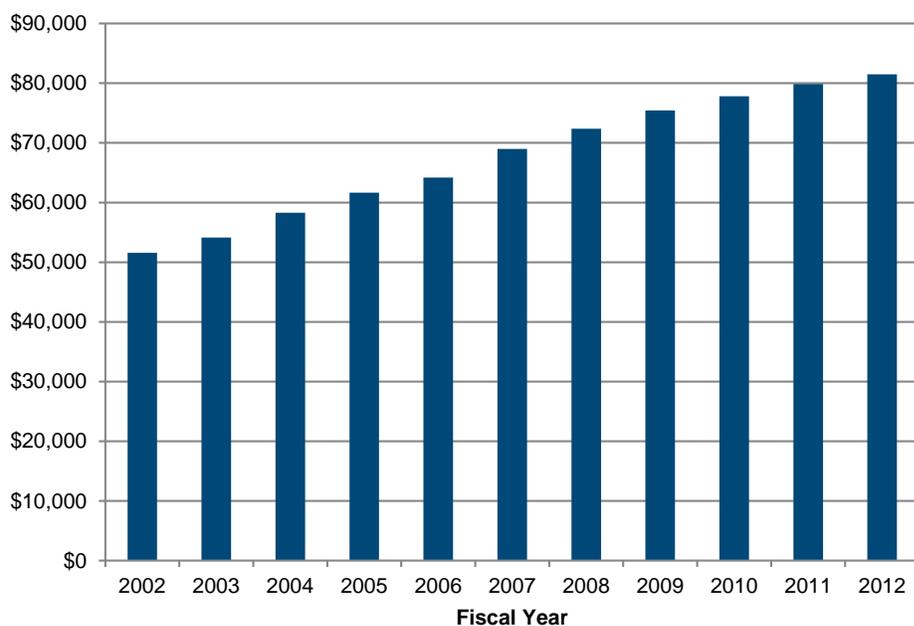


The relative costs of medical and indemnity losses along with ALAE has been reasonably consistent over the past ten years after a decrease in indemnity benefits and associated increase in relative medical benefits after the 2003 and 2004 reforms. While still the smallest component, ALAE costs have increased as a percentage of overall claim costs in recent years.

California Hospital Profiles

Figures 5 through 14 provide summaries of average wages, patient days, personnel, and medical staff characteristics across California hospitals. This information is based on data reported to OSHPD for all California hospitals.

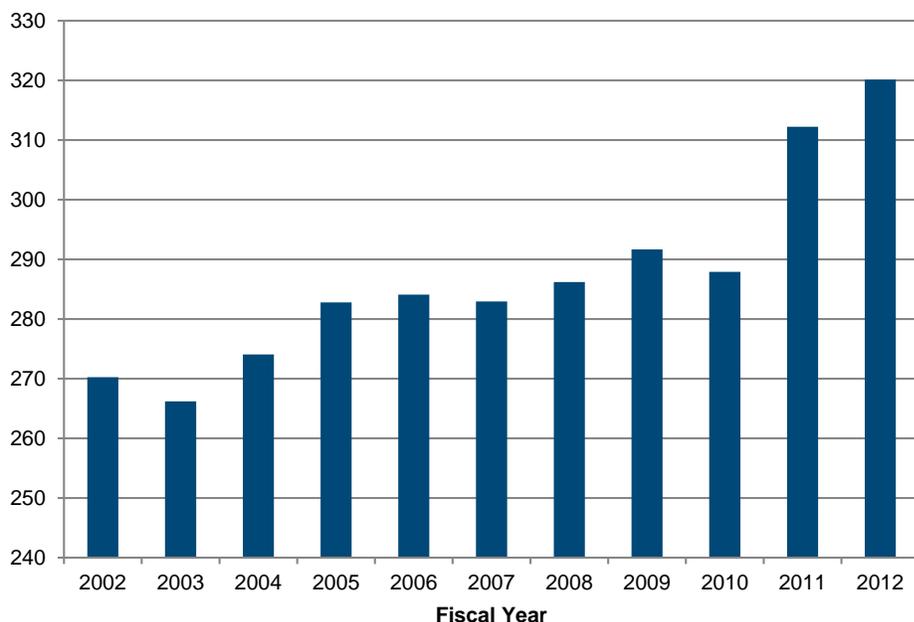
Figure 5: Payroll per Full-Time Equivalent Employee



*FTE defined as 2,080 productive hours.

Though it has been slower at some points than others, such as during the years 2008 and 2009, average payroll per FTE has largely had a trend of steady growth. Hospital average wages have increased at a faster rate in the last ten years relative to average wages in California all industries combined (all industry wage information from WCIRB).

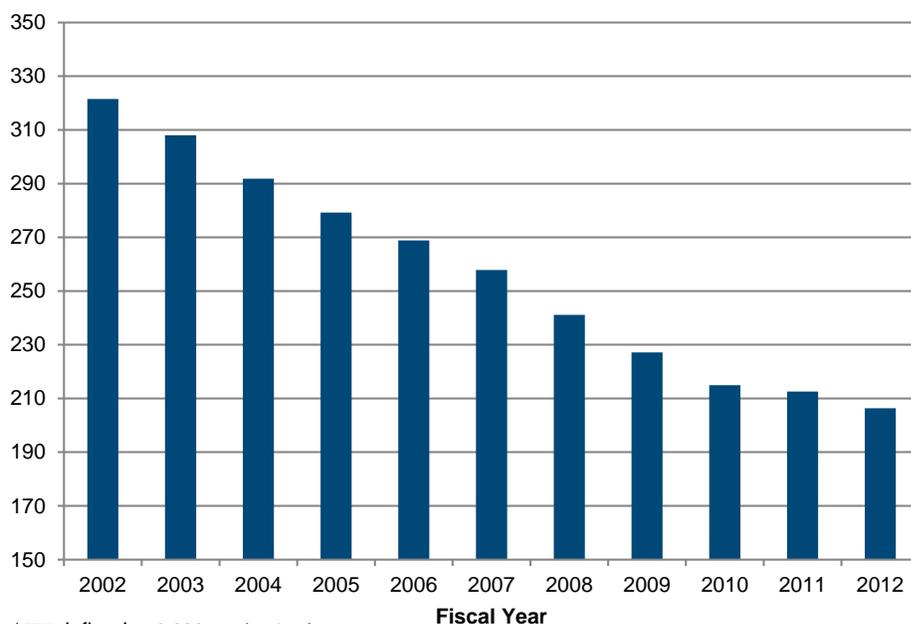
Figure 6: Patient Days per Staffed Bed



The number of patient days in California hospitals has been decreasing at a rate of approximately 1% per year since 2007, consistent with a national trend of decreases or stagnant levels of inpatient care; however, California hospitals have reduced the number of staffed beds in their facilities by an even greater percentage.

California Hospital Profiles (Cont'd)

Figure 7: Patient Days per Registered Nurse FTE*

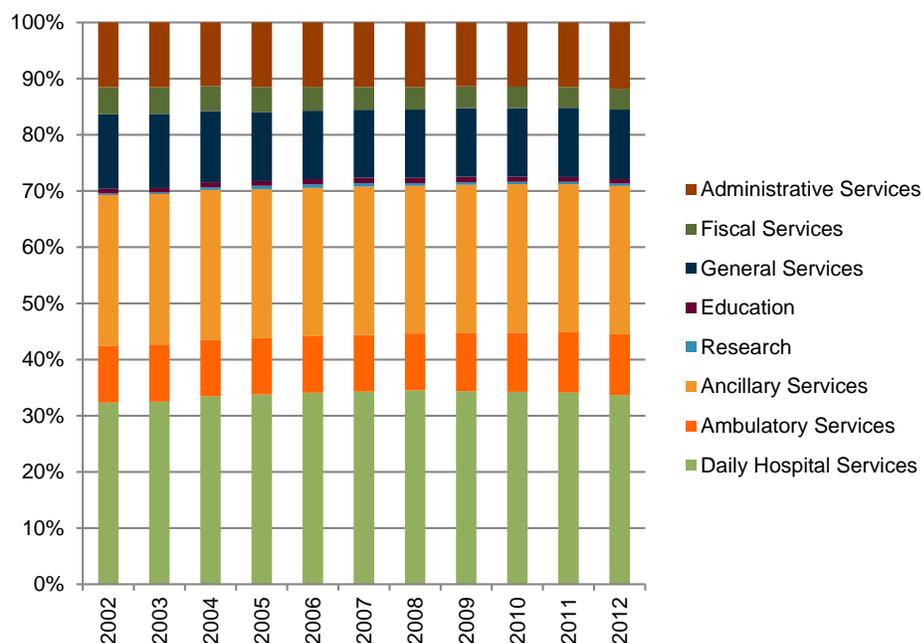


*FTE defined as 2,080 productive hours.

While the number of patient days and staffed beds has decreased, the number of Registered Nurses (RN)'s has increased 45% over the 2002 through 2012 period, indicating that hospitals are focusing efforts on other aspects of care. Figure 9 shows that patient days per hospital nursing staff has generally been on a steady downward trend. Note that while the number of RN

FTE has steadily increased, the opposite is true of Licensed Vocational Nurses (LVN), which have decreased nearly 25% since a high point in 2005.

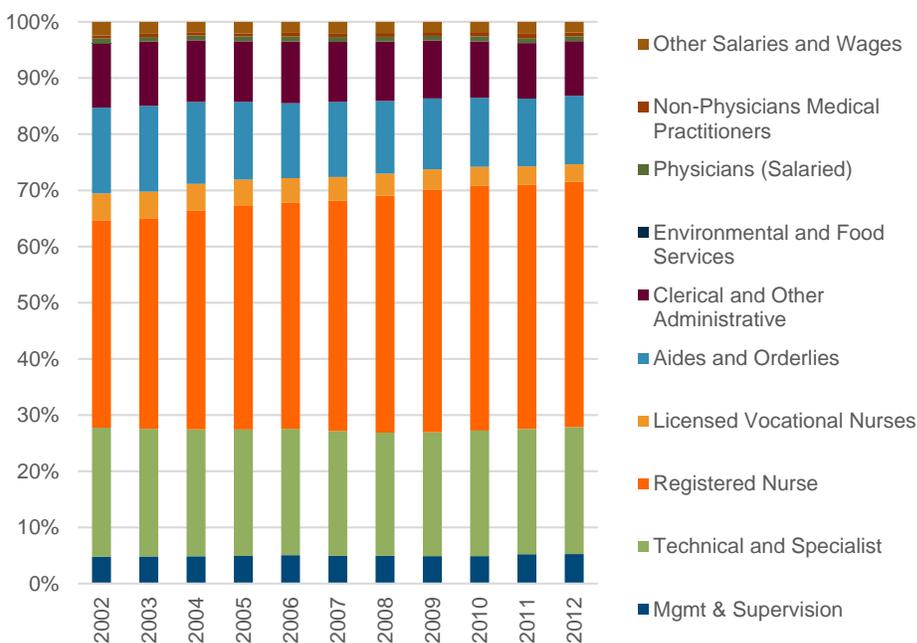
Figure 8: Payroll by Services



Figures 8 to 10 offer profiles of the patterns of payroll distribution, including by services, by productive hours (totaled up and also called out by both revenue-producing and nonrevenue-producing patient services). Figure 8 shows that daily hospital, ambulatory, and ancillary healthcare services have consistently accounted for approximately 70% of overall hospital payroll in California.

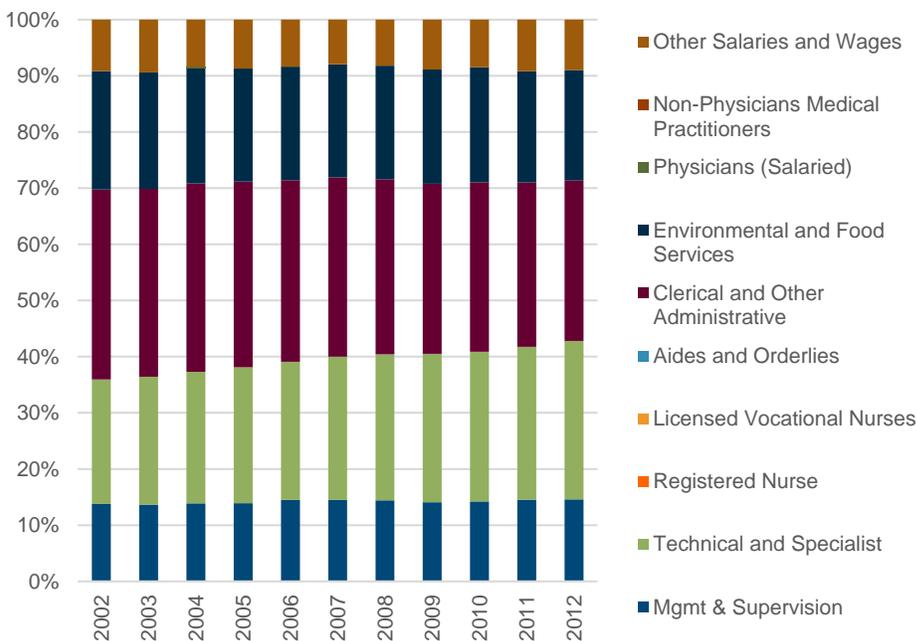
California Hospital Profiles (Cont'd)

Figure 9: Productive Hours by Personnel (Patient Revenue-Producing Services)



The 45% increase in overall RN FTEs has resulted in RNs having a greater total share of hospital employment during the past eleven years. Meanwhile, decreasing LVN and Aides and Orderly FTE has resulted in those personnel categories being less of the total employed population

Figure 10: Productive Hours by Personnel (Nonrevenue-Producing Services)

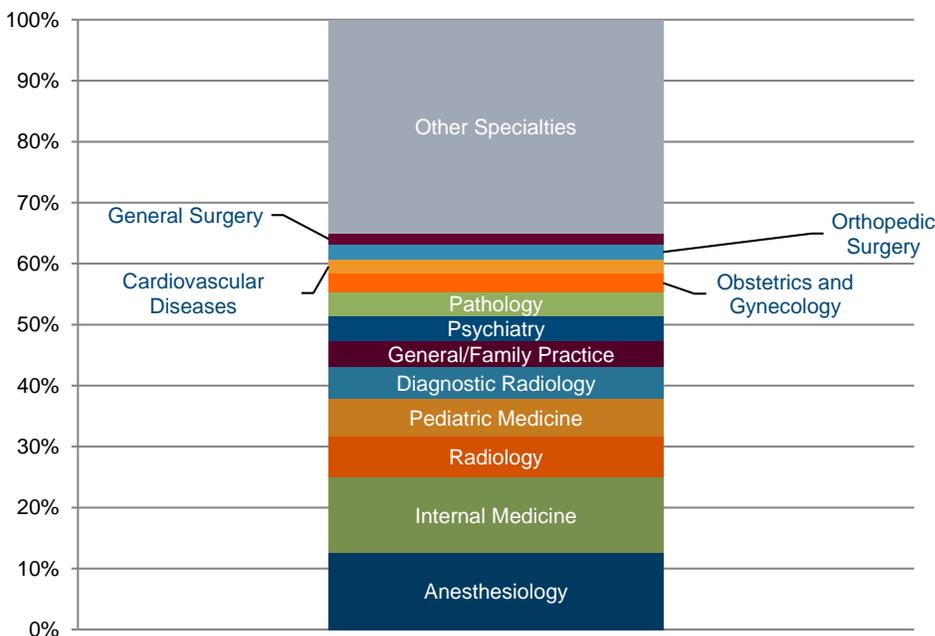


A greater percentage of total hours for the Technical and Specialist personnel category (from 35% of total hours in 2002 to 40% of total hours in 2012) are being coded as nonrevenue producing services. Of the other nonrevenue producing services, Clerical and Administrative personnel have had a flat FTE trend in the experience period and as a result contribute to less of the overall

hospital employment.

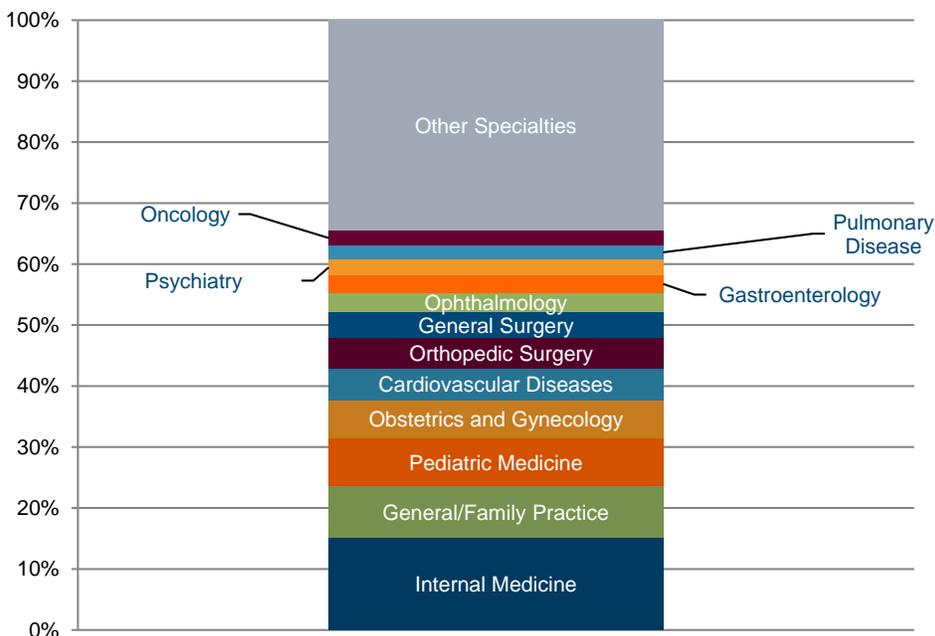
California Hospital Profiles (Cont'd)

Figure 11: Hospital-Based Medical Staff by Specialty



Figures 11 and 12 show profiles of California hospital medical staff profiles by medical specialty. Of hospital based physicians shown in Figure 11, Anesthesiology and Internal Medicine make up the largest percentage of hospital based physicians in California, combining for approximately one-quarter of the total.

Figure 12: Non-Hospital-Based Medical Staff by Specialty

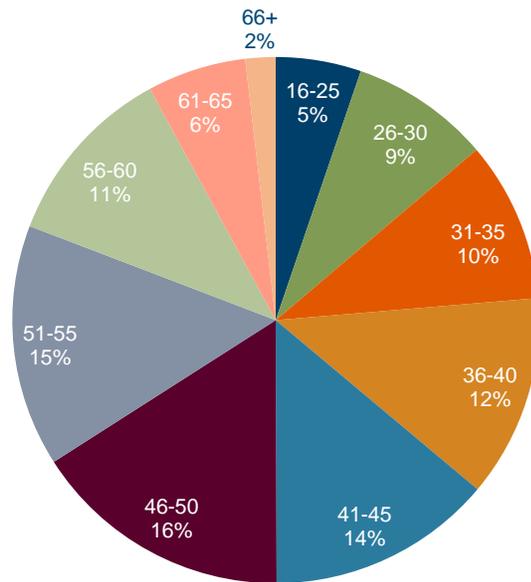


Approximately 2/3 of all hospital medical staff in 2012 were considered not hospital based. Of those, Internal Medicine combined with General/Family practice physicians provide for just under one-quarter of the total non-hospital based medical staff.

Age of Injured Employee

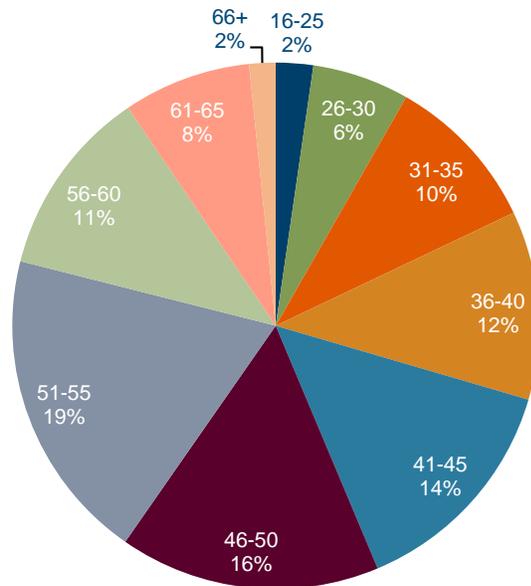
This section offers charts illustrating results of benchmark participant claim experience in terms of age of the injured employee.

Figure 13: Paid Indemnity Claims by Age



In terms of number of paid indemnity claims, ages 36 to 55, account for well over half of the population considered.

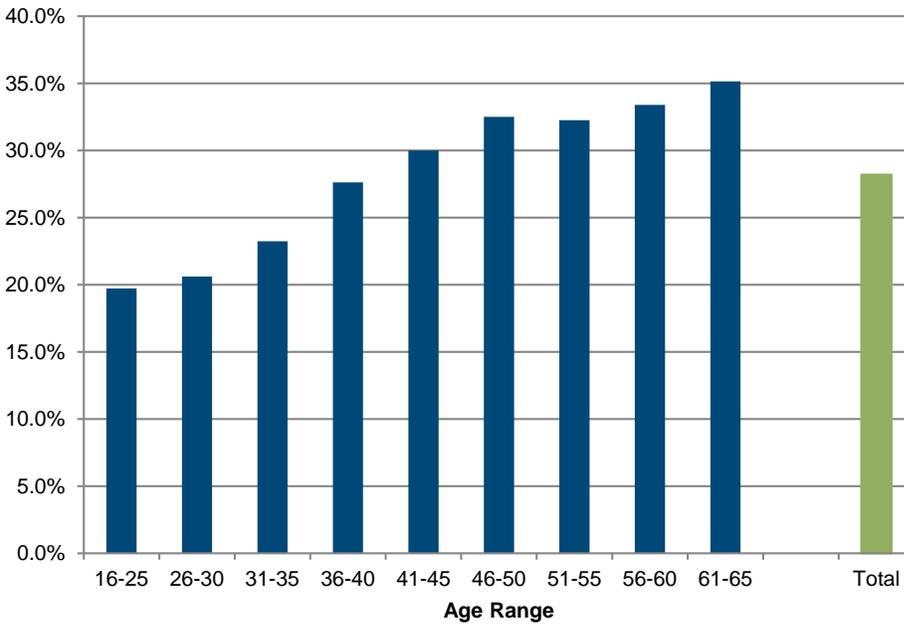
Figure 14: Incurred Losses by Age



The share of overall losses for each age range is less than its share of overall claims for ages 30 and younger, indicating lesser average severity of indemnity claims for younger workers.

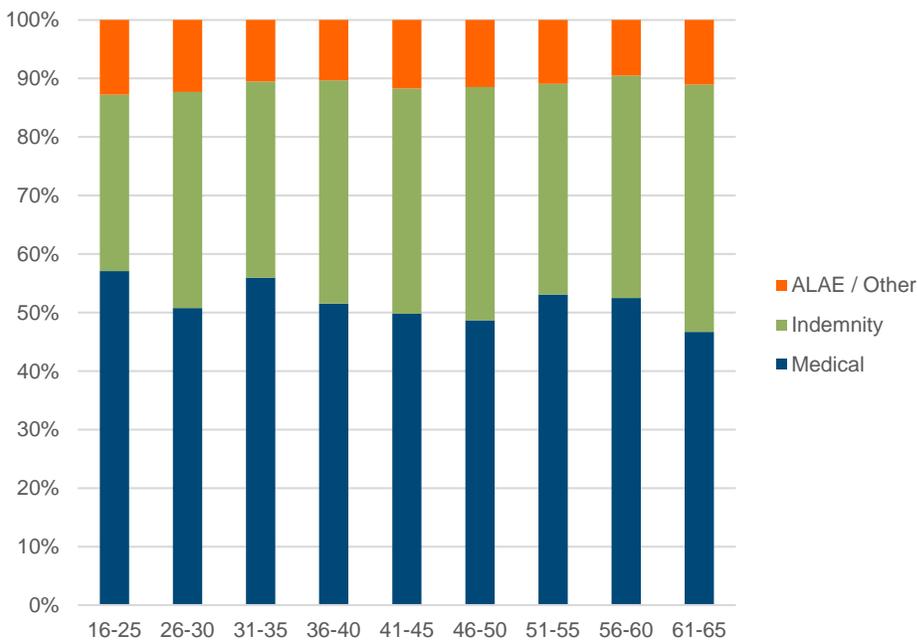
Age of Injured Employee (Cont'd)

Figure 15: Percentage of Claims with Indemnity by Age



In addition to higher average costs per indemnity claim for injured employees over age 30, Figure 15 also illustrates that as workers age a given workers compensation incident is more likely to result in an indemnity payment.

Figure 16: Percentage of Medical/Indemnity/ALAE Costs by Age



While not a smooth progression by age range, Figure 16 shows how younger workers generally spend more in medical care relative to total costs, whereas older workers tend to have larger relative indemnity losses.

Litigation status

This section offers charts illustrating results of the survey in terms of litigation status.

Figure 17: Paid Indemnity Claims by Litigated Status

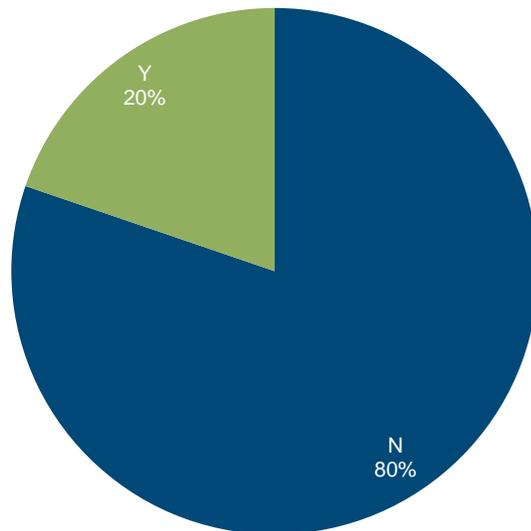
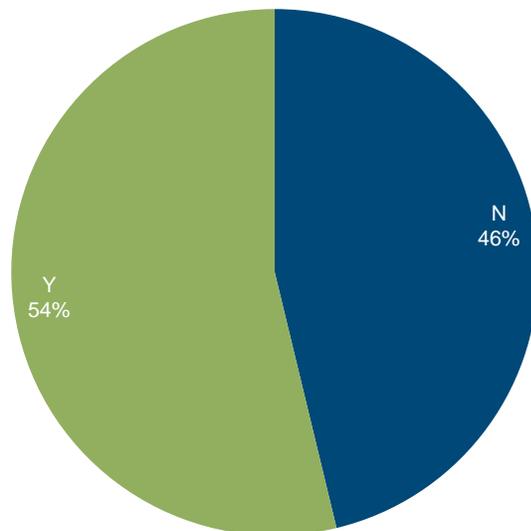


Figure 17 shows that between 20% and 25% of claims with paid indemnity are litigated.

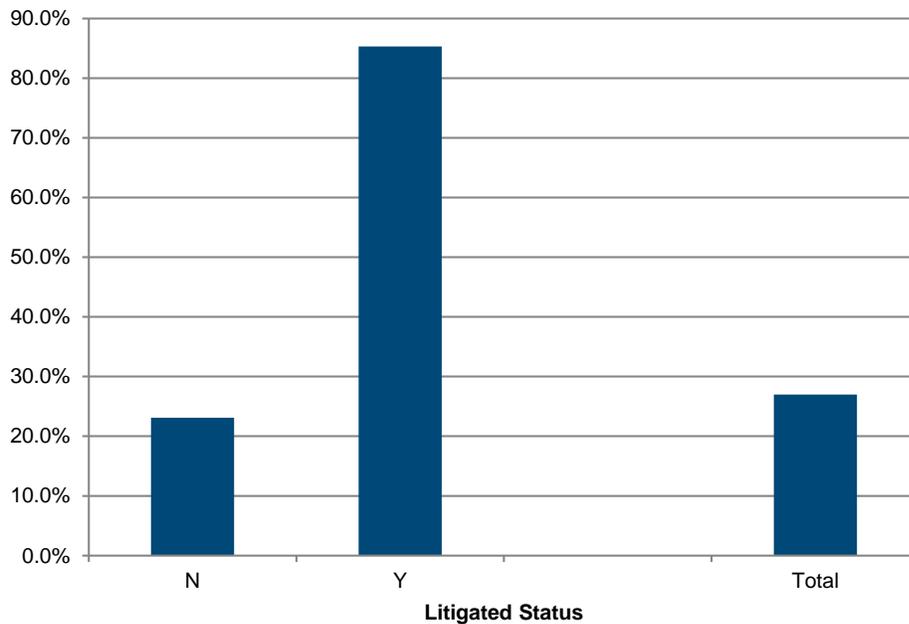
Figure 18: Percentage of Claims with Indemnity by Litigated Status



While litigated claims contribute only 20% of the total claims with indemnity payment, they account for approximately 54% of total incurred losses, as litigated claims exhibit significantly higher average claim severity.

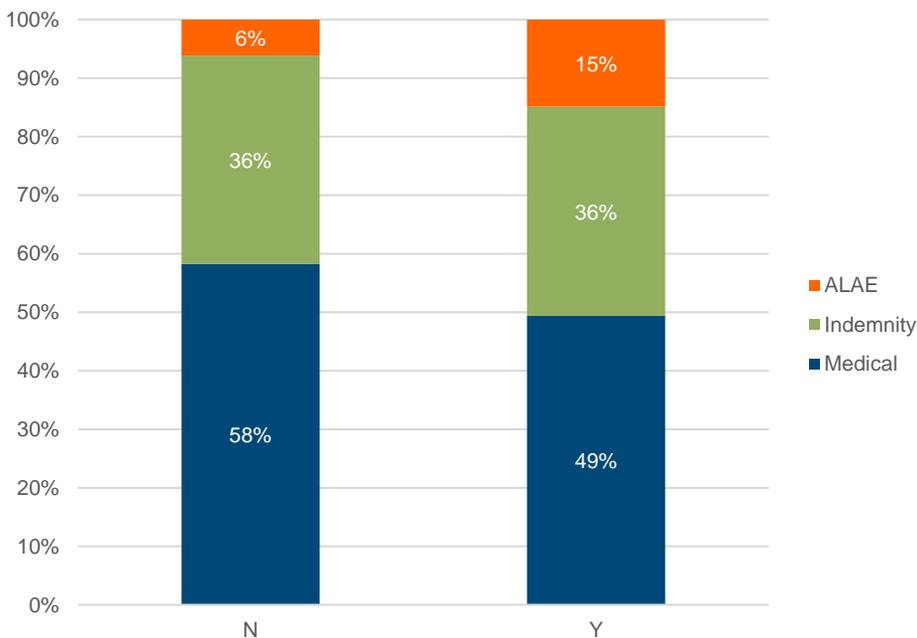
Litigation Status (Cont'd)

Figure 19: Percentage of Claims with Indemnity Paid by Litigation Status



While approximately 25% to 30% of overall workers compensation incidents result in paid indemnity, almost 85% of claims that are litigated have indemnity payments.

Figure 20: Percentage of Medical/Indemnity/ALAE Costs by Litigated Status



As would be expected, litigated claims incur significantly more relative ALAE costs than non-litigated claims. However, Figure 20 also shows that comparing only medical and indemnity losses that non-litigated claims tend to have more relative medical and less relative indemnity benefits than claims that are litigated.

Future Medical (FM)

This section offers charts illustrating results of the survey in terms of future medical status.

Figure 21: Paid Indemnity Claims by Future Medical Status

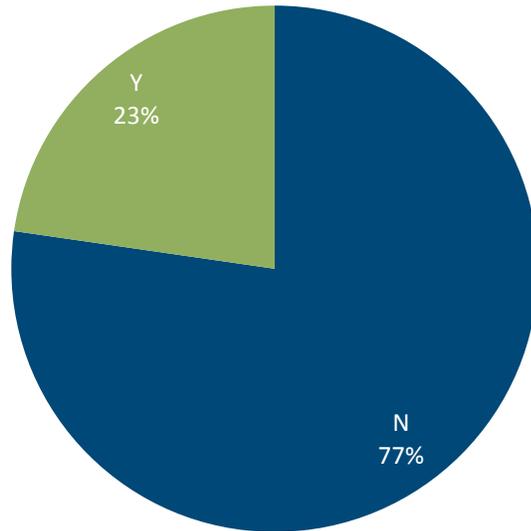


Figure 41 shows that slightly less than one-quarter of claims with paid indemnity are coded as future medical—that is, indemnity benefits are finished but the claim remains open for continuing medical care.

Figure 22: Incurred Losses by FM Status

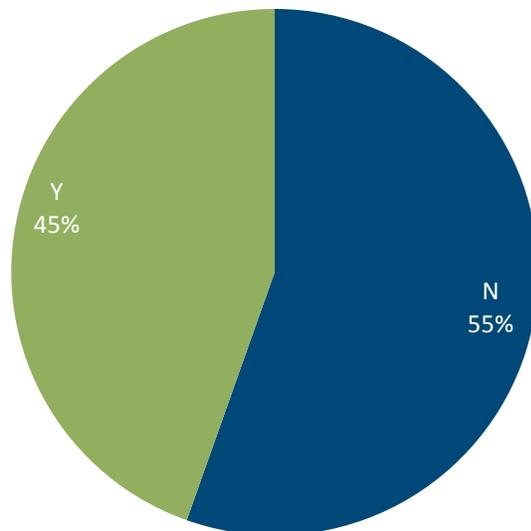


Figure 22 shows that claims coded as Future Medical incur approximately 45% of total losses, indicating a much larger average claim severity relative to only 23% of total claims.

Sources

Overall Charts

Figure 1: Milliman estimates from benchmark participant claim experience and payroll as reported to the California Office of Statewide Health Planning and Development (OSHPD).

Figure 2: Milliman estimates from benchmark participant claim experience and payroll as reported to OSHPD.

Figure 3: Milliman estimates from benchmark participant claim experience and payroll or full-time employee (FTE) as reported to OSHPD.

Figure 4: Benchmark participant claim experience.

Payroll and utilization charts

All data as reported to OSHPD for California hospitals; excludes Kaiser facilities.

Age, litigation status, and future medical (FM) charts

All data based on benchmark participant claim experience.

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