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Medical costs in workers' compensation insurance: comment

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Abstract

Professors Baker and Krueger ignore some costs associated with workers' compensation. Because of these costs, the contention that physicians willfully exploit the workers' compensation system for their own gain is questioned. © 1997 Elsevier Science B.V.

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Professors Baker and Krueger (1995) present evidence that medical charges for injuries and illnesses to patients covered by workers' compensation (WC) are higher than medical charges for diagnostically identical injuries and illnesses to similar patients not covered by WC. Two explanations are offered. First, it could be that the WC patients receive better or more intensive services that ''get workers back to work sooner and thus reduces indemnity costs'' (Baker and Krueger, 1995). Second, it could be that physicians price discriminate against WC patients, provide medically unnecessary services, and generally exploit the WC system for their own pecuniary gain.

This comment suggests a third explanation, and in so doing, questions the amount of price discriminating that takes place. The relatively high charges for WC may reflect a compensating wage to physicians and other health care providers for agreeing to treat WC patients.

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Many health economists have friends, relatives and spouses who are physicians. As a discussion of WC would likely confirm with these friends and relatives, WC cases are regarded as especially burdensome. The reason involves the paperwork and litigation that frequently accompanies these cases. The chance of litigation may convince the physician to require extra procedures to meet an imagined legal standard. Although litigation costs have grown considerably over the past 15 years, they have always been a part of WC in every state (Falaris et al., 1995). In California, litigation costs totalled US$2.2 billion in 1992 and have increased by 50% every 2 years since 1984 (Falaris et al., 1995).

More specifically, the WC system presents several problems for physicians.

(1) There is the problem of credibility of the patient. Physicians (like all of us) want to believe that the patient is truthful. In WC cases there is a chance that the patient might, willfully or not, misconstrue or misattribute events surrounding the injury or illness. If the patient and physician have had a long relationship, this chance is likely to be minimal. If the patient is unfamiliar to the physician, there may be a greater chance. Hence, many physicians will take a WC case only if they know the patient.

(2) There is a colossal amount of paperwork associated with WC cases.

(3) There are the additional responsibilities of understanding WC law, and (4) rendering judgments that have profound effects on patients lives. Consider these quotes relating to WC from the editors of *Patient Care* (Pearson et al., 1996), a leading journal for primary care physicians:

> ...the required communications with insurers and other agencies may drive you screaming into the street. You'll need to become something of an information specialist (p. 52).

> ...A series of physician-generated reports, submitted at state-designated intervals to the employer and the workers' compensation system describe the event; the symptoms, diagnosis, and immediate and anticipated treatment... Copies of these reports may be requested by patients or their lawyers (pp. 52, 53).

> ...a reasonable command of state workers' compensation rules is useful (p. 52).

> ...you'll be expected to judge whether occupation is more likely than not to have affected the patient's health (p. 53).

> ...Patients' livelihoods hinge on your observations (p. 53).

> ...employers...view the workers' compensation process with similar dislike (p. 53).

(5) There is the problem of being 'on call' to provide testimony. When physicians are asked for opinions in depositions and hearings they are, of course, paid. But these payments must be 'usual and customary', e.g., they must be in line with other physician legal consulting fees. Some states, such as California, have a cap on that pay.

(6) Finally, there is the question of whether the physician might be sued for malpractice. We are not familiar with any studies investigating whether more malpractice suits originate with WC patients as opposed to others. However, the fact that WC practice is intimately involved with WC law and lawyers suggest that physician fear of malpractice might be higher for WC cases than others (Billauer, 1985).

The Baker and Krueger study gives the impression that physicians who specialize in WC cases probably generate especially handsome salaries. This is not the case. They make more (a compensating wage) than primary care physicians, but make less than almost all other specialists. The American Medical Association collects and ranks earnings data on 44 specialties. In recent years, occupational medicine specialists have been fifth or sixth from the bottom in earnings (Center for Health Policy Statistics, 1995).

Moreover, despite the pay for preparing WC reports, providing depositions and testimony, many doctors eschew WC cases. Most physicians prefer to spend time caring for patients as opposed to writing reports or talking to lawyers.

Some economists appreciate the additional burden WC cases represent to the typical physician. Leslie Boden (1983) wrote:

> Many physicians do not like to testify in such hearings and most are not prepared by their training or experience to assume this role. Their expertise may be challenged; moreover, they may be confused by the different meanings of legal and medical terminology (p. 443).

The market structure for physicians who supply services to WC patients provides additional evidence for the compensating wage hypothesis. Typically, in any given locale, a few physicians specialize in WC cases. Most of the other physicians in that same locale take only a few WC cases or none at all. This bifurcated market structure is the result of the substantial fixed costs associated with learning WC law, becoming familiar with which reports are required at which time, improving report-writing skills, learning how to spot bogus claims, and so on. If the fixed costs were not so great there would be less bifurcation in the market.

It is unlikely that any of the analysis in Baker and Krueger (1995) would remove the compensating wage effect. For example, the sub-analysis of medical-only claims data would not remove the compensating wage effect. At the time the physician agrees to take the WC case, it is not known whether the case will or will not involve indemnity payments. Moreover, even medical-only claims require paperwork, understanding the law, and, sometimes, litigating (Falaris et al., 1995).

Because of the additional burden (cost) associated with WC patients, physicians may charge more for the same service. This third explanation somewhat undermines the contention that physicians willfully exploit the WC system for their own profit.

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