

2017 California Hospitals Workers' Compensation Benchmarking Report



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Health Care

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Executive Summary

While the landscape of providing healthcare in the United States is seemingly in flux, the workers' compensation environment in California has been surprisingly stable over the last several years. Despite this stability, workers' compensation remains one of the most complex exposures for employers who must continue to look for ways to protect employees from injury and improve loss prevention programs. Given workers' compensation laws in California, it is imperative that employers continuously evaluate their workers' compensation program structure, ensuring a level of appropriateness based on claim frequency and severity as well as medical and indemnity costs. Our goal with this survey and report is to provide the fundamental healthcare industry benchmarks from which informed decisions related to managing workers' compensation can be made.

Keenan HealthCare and Milliman are pleased to present the 2017 results of our California Hospital Workers' Compensation and Payroll Benchmarking Survey. Data for the survey was collected in the 2nd half of 2016 and early part of 2017 from past participants and entities that expressed an interest in participating. In exchange for allowing the use of their data, participants receive an additional set of exhibits comparing their specific experience to that of the benchmark.

In the course of our work on the 2017 survey, we gathered data from 18 hospital systems and individual facilities within California (over 44 facilities altogether). In aggregate, they provided data on over 4,300 annual claims. Our analysis also relied on payroll and medical utilization information obtained from the California Office of Statewide Health Planning and Development (OSHPD) website. Unless otherwise stated, loss estimates herein reflect a \$1 million per occurrence retention.

We identified some general trends in the hospital sector, which include:

- Our prior version of this study projected a 2015 loss cost of \$2.20 per \$100 of payroll¹; the current study estimates a loss cost of \$2.02 for accidents occurring in 2015. The decrease as compared to our prior projections is largely driven by less than expected development in claim severity, while overall claim frequency has largely remained stable.
- We project a loss cost for accidents occurring during 2016 and 2017 of \$2.10 per \$100 of payroll.
 - Thirteen of the eighteen health systems / facilities in our study have projected loss costs within +/- 25% of the overall loss cost projection
 - There are three participants with a projected loss cost greater than 25% of the overall average (i.e., 2017 loss cost greater than \$2.625); all are located in the Los Angeles basin. The WCIRB annual State of the System Report supports this finding stating that the LA Basin has 30% higher frequency and 20% higher allocated loss adjustment expenses compared to the rest of the State.
- Losses paid per indemnity claim (i.e., severity) have increased at a 2.9% annual rate for the 10 years ending 2016.
 - Medical loss trends have abated in recent years, and indemnity loss trends have also been less than long-term averages. Combined, these have resulted in a lower annual rate of severity increase as compared to prior versions of this study.
 - However, annual ALAE increases have been significant during this time period, and ALAE represents an increasing share of the total cost of claims.

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.

- Looking forward, we expect longer term trend rates closer to 5% or 6% to prevail, with stronger medical and indemnity loss trends than the recent past, and ALAE trends remaining high.

We believe these key indicators will be valuable in developing plans to modify or adjust your program where necessary with the goal of improving your results. Your feedback is important to assure this report meets your needs and expectations. Please email your comments, thoughts and ideas to:

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We are eager for your feedback.

Respectfully,

Keenan HealthCare and Milliman

Source: WCIRB State of the WC System Report 2016 available at www.wcirb.com

Definitions

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

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

Exposure: Measure of potential liability; risk (e.g., payroll in \$00)

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

Loss Cost; or Pure Premium: Losses per \$100 of payroll

Severity: Average loss per claim

Paid: Loss amounts that have already been paid

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

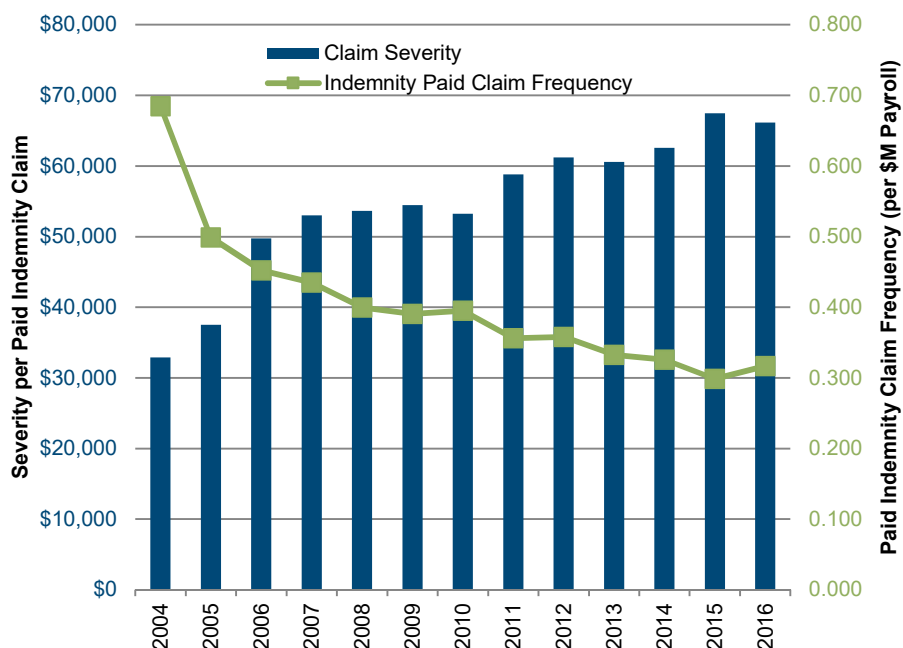
² Please note that the definition of a “lost-time” claim can differ by third-party administrator (TPA) and facility. In order to be consistent within this analysis, we have used an indemnity claim definition based on whether paid indemnity is greater than zero. This definition is typically more stringent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

Figures 1 through 3 provide a review of workers' compensation loss trends for California hospitals over the past thirteen years. They are based on benchmark participant claim experience, Milliman analysis of that claim experience, and payroll or full-time equivalent (FTE) employee information for benchmark participants as reported to OSHPD.

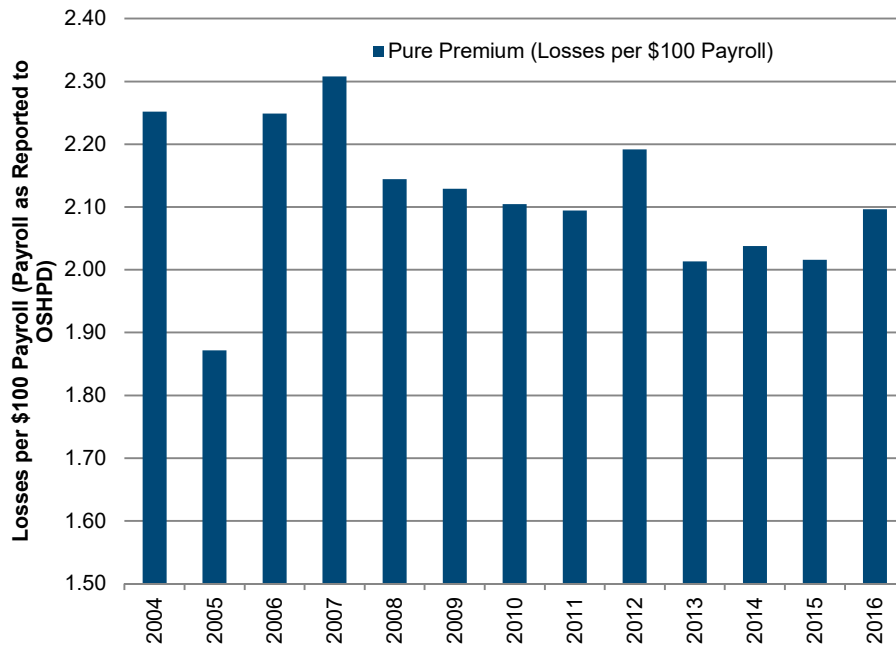
The first trend of note is that severity per paid indemnity claim—i.e., indemnity, medical, and allocated loss adjustment expense (ALAE) combined—showed an increase of approximately 2.9% annually in the period from 2007 through 2016. This may be seen in the bar chart in Figure 1. Severity climbed quickly in 2006 after the reforms of early last decade (following a steep one-time decline prior to 2004), but have since been more tempered.

Figure 1: Claim Severity and Frequency



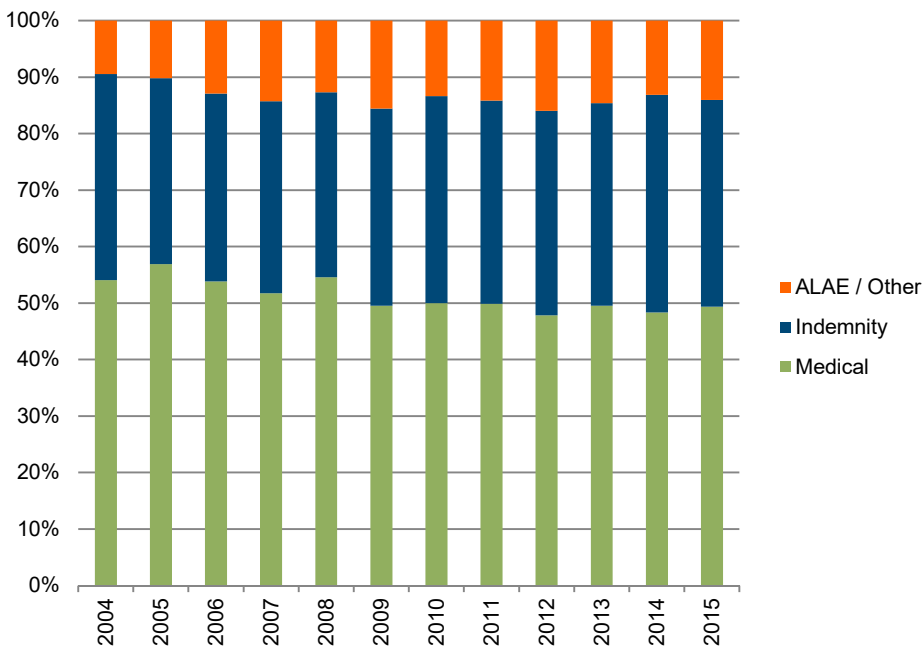
Our prior study proposed that, while still decreasing, the improvements in claim frequency were beginning to plateau subsequent to 2008. Now, with the benefit of approximately 18 months of additional data, it appears that claim frequency (represented by the green line in Figure 1) was still declining through 2015.

Figure 2: Losses per \$100 Payroll



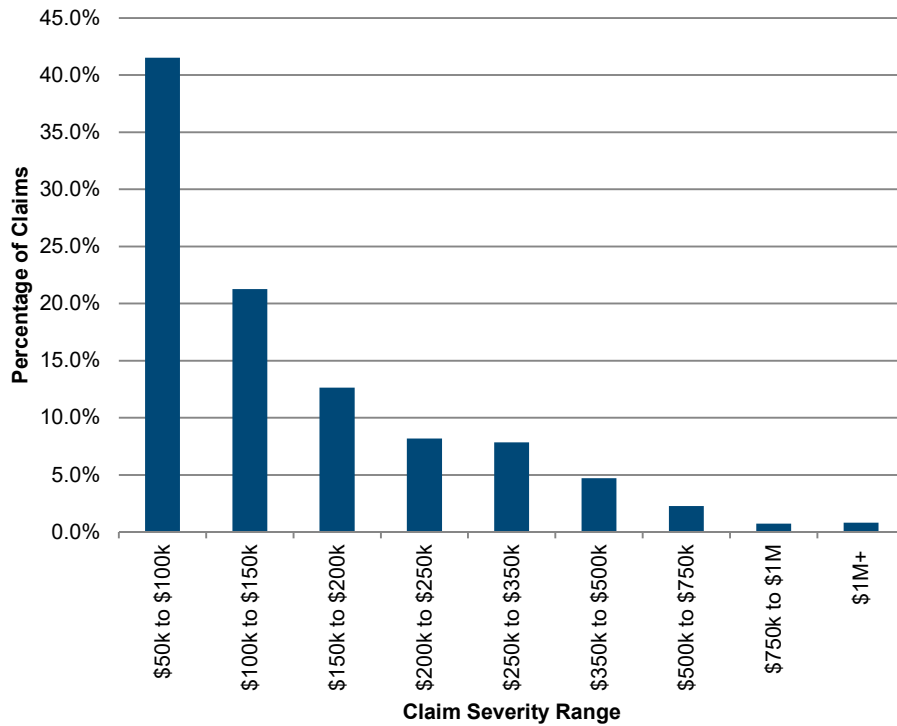
The combined impact of decreasing frequency and increasing severity has resulted in a largely flat trend in overall loss costs per payroll. As shown in Figure 2, estimated costs per payroll decreased in 2013 coincident with the effective date of SB863.

Figure 3: Percentage of Medical/Indemnity/ALAE Costs by Accident Year



The relative costs of medical and indemnity losses have been reasonably consistent over the past ten years. This occurred after a decrease in indemnity benefits and an associated increase in relative medical benefits after the prior reforms in the early part of last decade. While still the smallest component, ALAE costs have increased as a percentage of overall claim costs in recent years.

Figure 4: Distribution of Claim Amounts (Censored at \$50k)

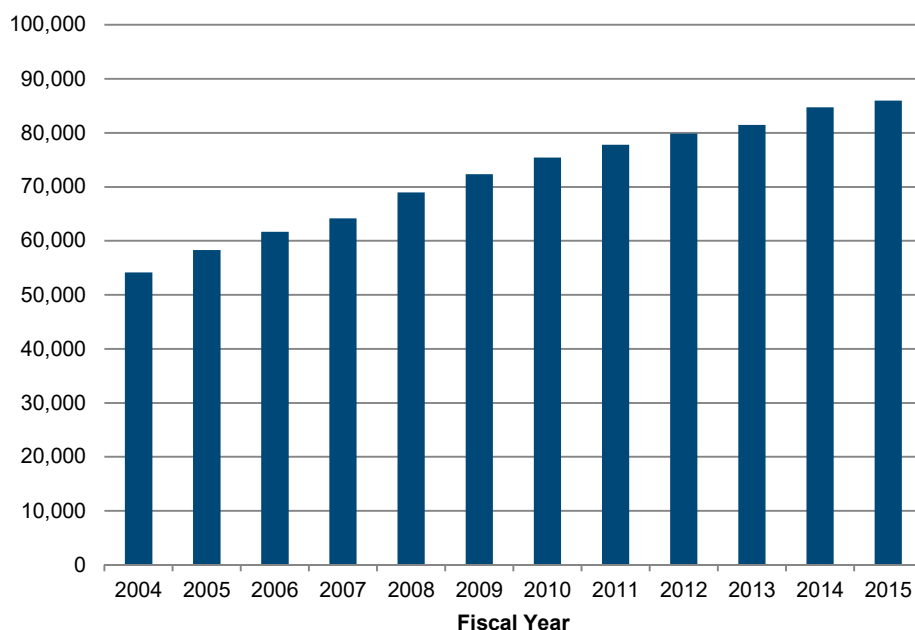


It is well known that claim values vary significantly, primarily related to the extent of the underlying injury. Only 0.5% of claims with paid indemnity (i.e., approximately 1-in-200) pierce \$1 million. While rare, these claims can have a disproportionate impact on overall results. The largest individual claim in the benchmark is reserved at greater than \$10 million, and still open with future development potential.

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.

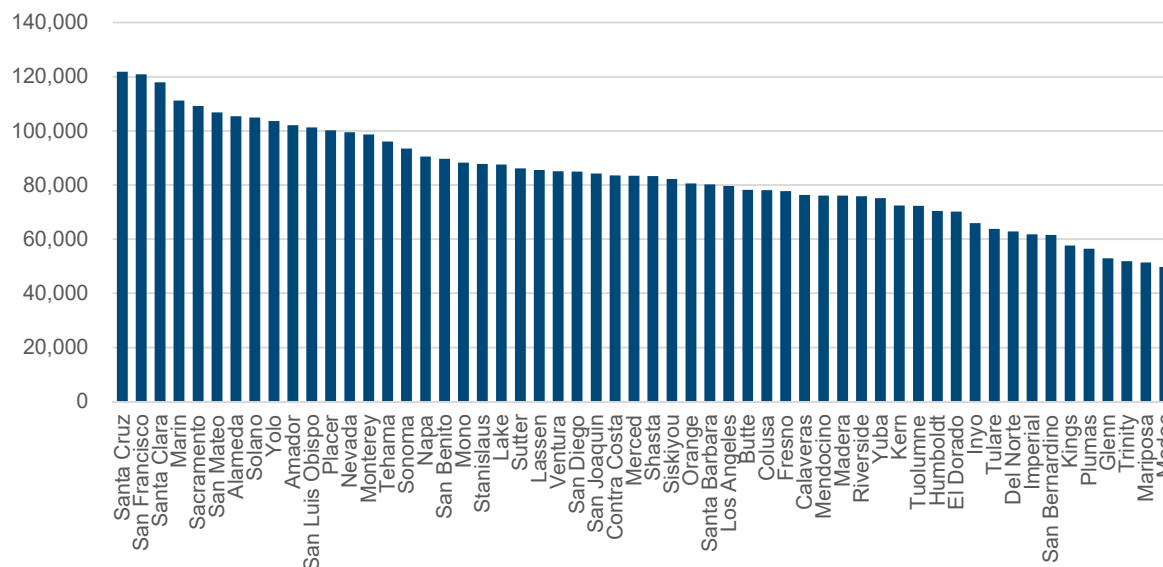
Figure 5: Payroll per Full-Time Equivalent Employee



Payroll per FTE has largely had a trend of steady growth. Hospital average wages have increased (3.4% per annum) at a faster rate in the last ten years relative to average wages in California all industries combined (2.5% per annum).

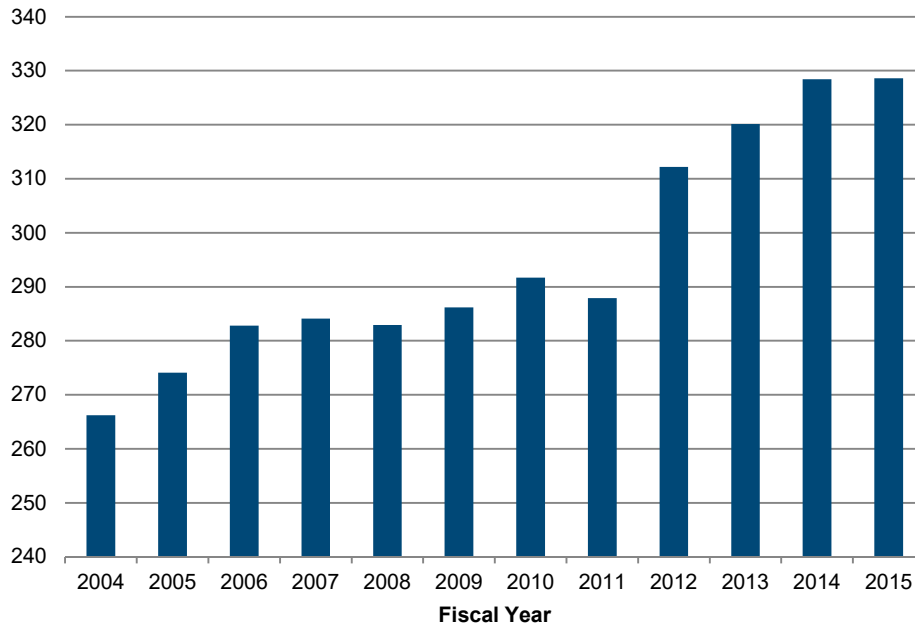
*FTE defined as 2,080 productive hours.

Figure 6: FY2014/2015 Payroll per Full-Time Equivalent Employee by County



As may be expected in such a large and diverse state as California, average wages vary significantly by county. Bay area counties tend to have the highest average wages while northern counties (Shasta Cascades) tend to have the lowest.

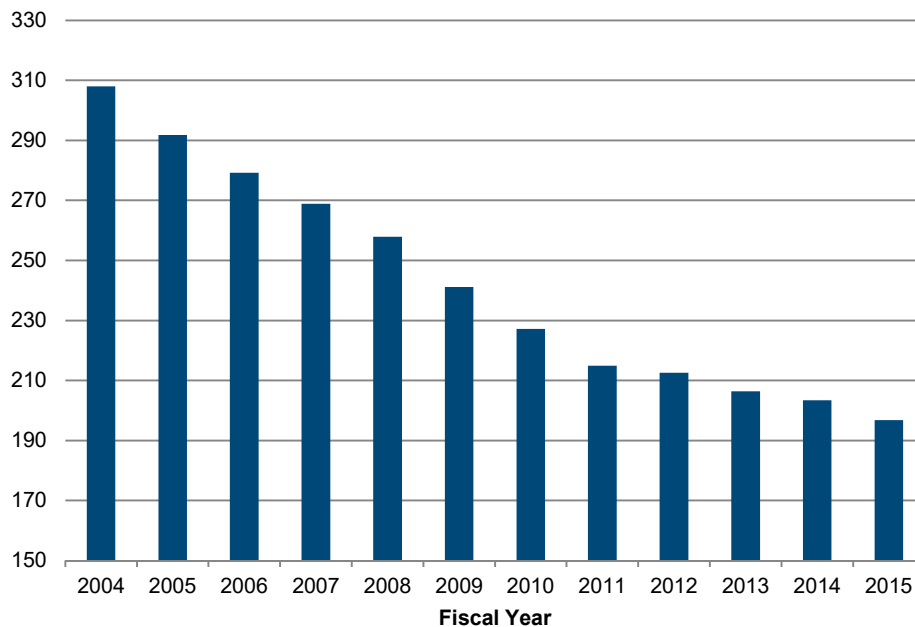
Figure 7: Patient Days per Staffed Bed



The number of patient days per staffed bed has been steadily increasing in California. However, these results need to be viewed with a finer detail as the number of patient days has been decreasing at a rate of approximately 1% per year since 2007, with decreases closer to 2% in each of the last three years. This is consistent with a national trend of decreases or stagnant levels of inpatient care, and increases in

outpatient care. However, California hospitals have reduced the number of staffed beds at an even greater rate, leading to increases in the number of patient days per staffed bed across the state seen in the chart.

Figure 8: Patient Days per Registered Nurse FTE*

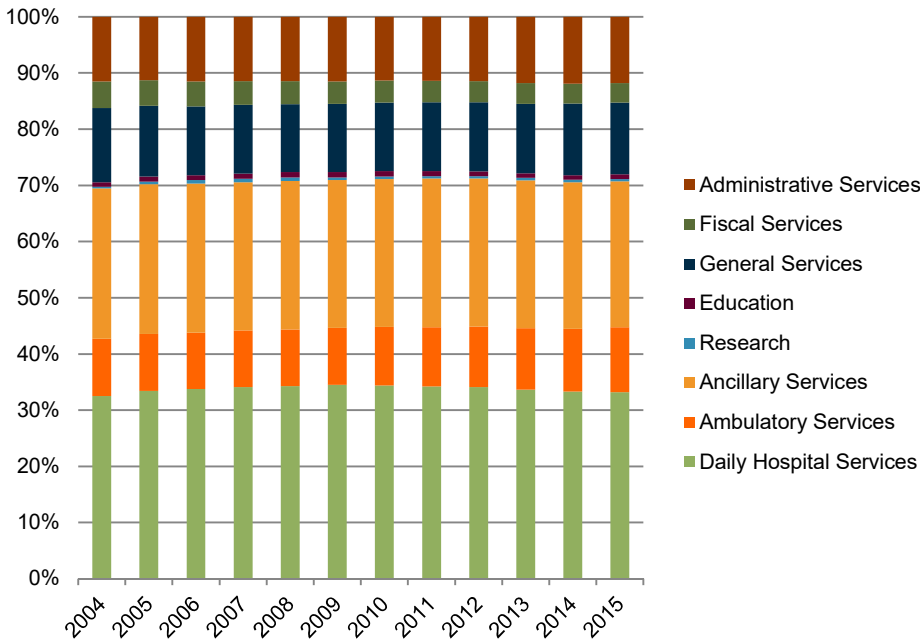


*FTE defined as 2,080 productive hours.

While the number of patient days and staffed beds has decreased, the number of Registered Nurses (RN)'s has increased 40% over the 2004 through 2015 period. Figure 8 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

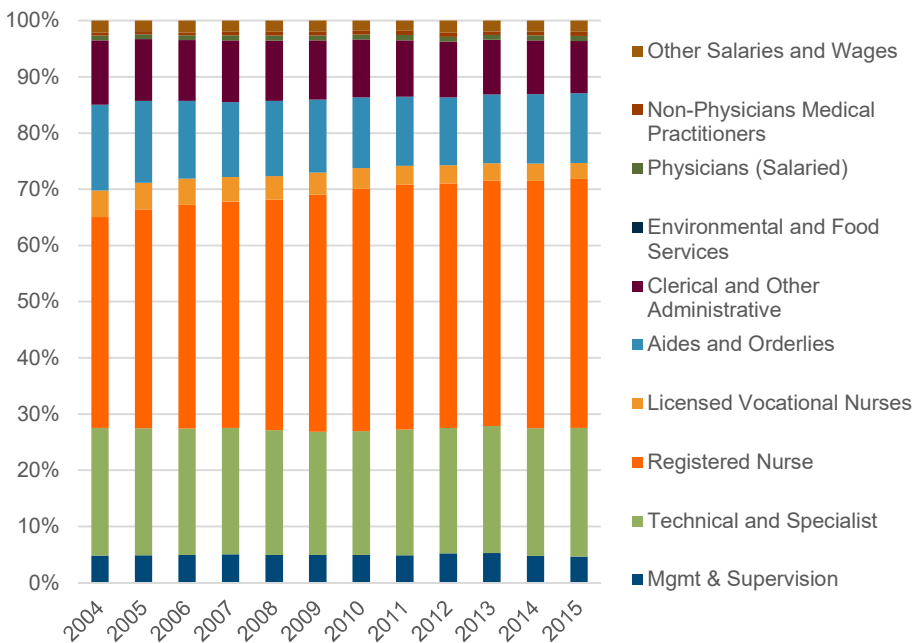
Nurses (LVN), which have decreased over 30% since a high point in 2005.

Figure 9: Payroll by Services



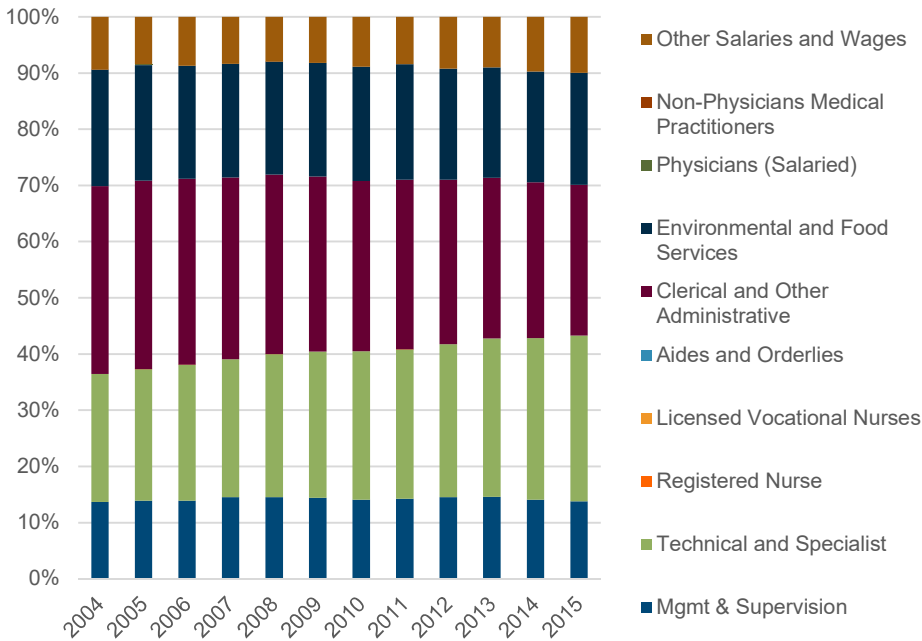
Figures 9 to 11 offer profiles of the patterns of payroll distribution, including by services, by productive hours (totaled up and also called out by both revenue-producing and nonrevenue-producing patient services). Figure 9 shows that daily hospital, ambulatory, and ancillary healthcare services have consistently accounted for approximately 70% of overall hospital payroll in California.

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



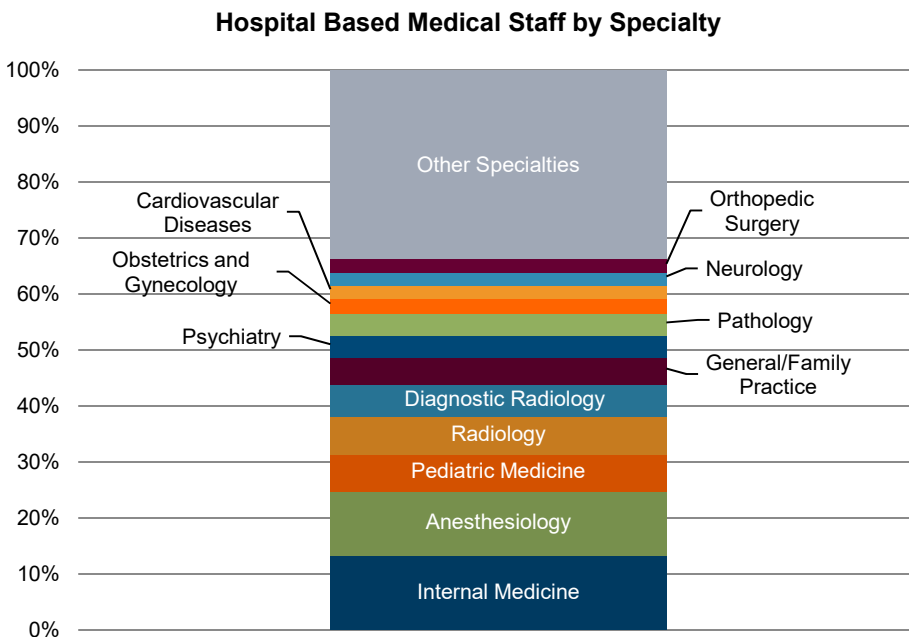
The 40% increase in overall RN FTEs has resulted in RNs having a greater total share of hospital employment during the past eleven years. Meanwhile, LVN and Aides and Orderly FTE have been comprising a lesser share of the total employed population

Figure 11: Productive Hours by Personnel (Nonrevenue-Producing Services)



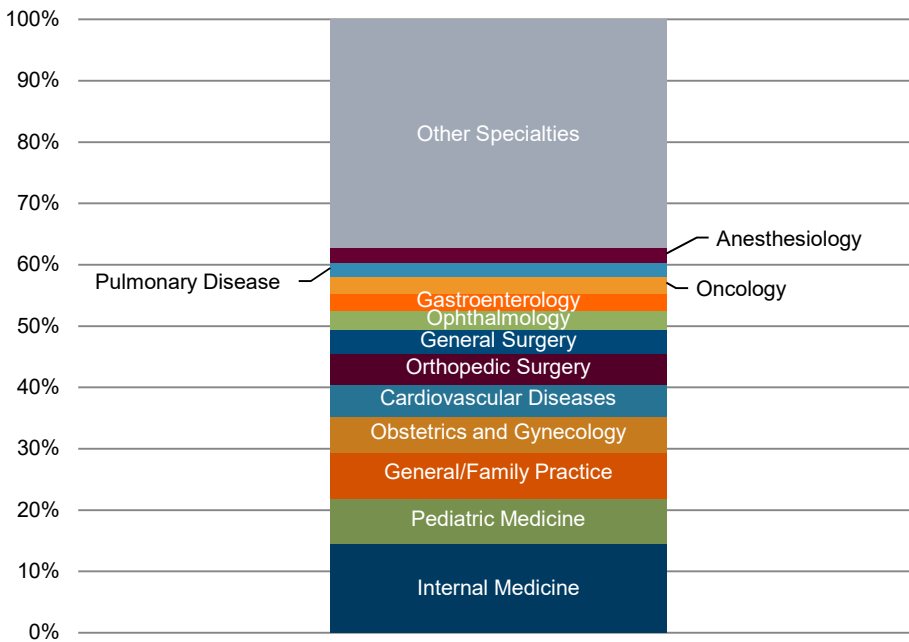
Clerical and Administrative personnel have had a flat FTE trend in the experience period, while most other employment categories have seen increases. As a result, the clerical and administrative category is contributing to less of the overall hospital employment.

Figure 12: Hospital-Based Medical Staff by Specialty



Figures 12 and 13 show profiles of California hospital medical staff profiles by medical specialty. Of hospital based physicians shown in Figure 12, Anesthesiology and Internal Medicine make up the largest percentage of hospital based physicians in California, combining for approximately one-quarter of the total.

Figure 13: Non-Hospital-Based Medical Staff by Specialty



Approximately 2/3 of all hospital medical staff in 2015 were considered not hospital based. Of those, Internal Medicine, Pediatric, and General/Family Practice physicians provide for nearly 30% of the total non-hospital based medical staff.

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). Losses developed to ultimate based on external factors, including but not limited to data from WCIRB.

Figure 2: Milliman estimates from benchmark participant claim experience and payroll as reported to OSHPD. Losses developed to ultimate based on external factors, including but not limited to data from WCIRB.

Figure 3: Benchmark participant claim experience.

Figure 4: Milliman estimates of benchmark participant claim experience. Losses developed to ultimate and adjusted to 2016 cost level based on external factors, including but not limited to analysis of WCIRB data.

Payroll and utilization charts

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

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