ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2022

NCCI estimates that the changes to the maximum reimbursement allowances (MRAs) in the Reimbursement Manual for Hospitals (RMH), 2014 edition, proposed to be effective July 1, 2022, would result in the following estimated impacts on overall Florida workers compensation system costs under each of the proposed scenarios:

Scenario	Estimated Impact on Overall Costs	
1	-3.8%	(-$146M[1])
2	-2.6%	(-$100M)
3	-3.2%	(-$123M)
4	-2.6%	(-$100M)
5	-1.1%	(-$42M)
6	+2.1%	(+$81M)

Please note that the estimated cost impacts are based on the provisions summarized below which may differ from the final implemented version. If the final version is different from the provisions included here, NCCI would perform an analysis based on the ratified rules and the impacts stated in this analysis may change accordingly.

SUMMARY OF PROPOSED CHANGES

The Florida Division of Workers' Compensation (DWC) requested that NCCI provide estimated cost impacts for six scenarios associated with updating the maximum reimbursement for hospital inpatient services. Currently, the MRAs are based on the 2014 edition of the RMH, which became effective January 1, 2015. The MRAs are based on per-diem rates that differ by type of stay:

Type of Stay	Current Per-Diem Rate
Surgical, Non-Trauma	$3,849.16
Surgical, Trauma	$3,850.33
Non-Surgical, Non-Trauma	$2,283.40
Non-Surgical, Trauma	$2,313.69

Inpatient stays with charges in excess of the stop-loss threshold are subject to a maximum reimbursement of 75% of charges. The current stop-loss threshold is $59,891.34.

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[1] Overall system costs are based on 2020 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. For each scenario, the estimated dollar impact is displayed for illustrative purposes only and calculated as the respective percentage impact multiplied by $3,847M. These figures do not include the policyholder-retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impacts assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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NCCI was asked to evaluate the impact of six alternative hospital inpatient scenarios outlined below. The stop-loss provision would be removed in all of the proposed scenarios. The following per-diem rates would apply.

	Per-Diem Rates by Scenario					
Tier[2]	1	2	3	4	5	6
Tier 1 – All other revenue codes	$5,000	$6,000	$7,000	$7,000	$8,000	$9,500
Tier 2 – Operating Room and Anesthesia	$10,000	$11,000	$10,000	$11,000	$13,000	$17,500
Tier 3 – Intensive and Coronary Care	$12,000	$14,000	$12,000	$13,000	$15,000	$19,500

Actuarial Analysis

NCCI's methodology to evaluate the impact of proposed medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
   - Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
   - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights. For hospital inpatient services, the observed payments by episode are used as weights.
2. Determine the share of costs that are subject to the fee schedule
   - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported in the Florida DWC medical data, to categorize payments that are subject to the fee schedule.
3. Estimate the price level change as a result of the revised fee schedule
   - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change. For non-physician fee schedule changes, a price realization factor of 80% is assumed.

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[2] The tiers would vary based on the revenue codes reported on the inpatient bill. Within each inpatient episode, tier 3 per-diems would apply to all days billed in intensive care or coronary care units, identified by revenue codes of 0200-0219. The acronym "ICU" will be used to collectively refer to intensive care and coronary care units. The remaining non-ICU portion of each inpatient episode would then be categorized as either tier 1 or tier 2. If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply. If the non-ICU portion of an inpatient bill does not contain a revenue code from tier 2, tier 1 per-diems would apply.

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In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data provided by the Florida DWC with dates of service between January 1, 2020 and December 31, 2020, including COVID-19 claims.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2018 and 2019 projected to the proposed effective date of the benefit changes.

Hospital Inpatient Fee Schedule

In Florida, payments for hospital inpatient services represent 24.5% of total medical costs. The overall change in maximums for hospital inpatient services is a weighted average of the percentage change in MRA by episode (Proposed MRA/Current MRA). The weights are based on Service Year 2020 observed payments by episode for Florida, as reported in the Florida DWC detailed medical data.

The current MRA for each hospital inpatient episode is calculated as follows:

- If the total trended charges (excluding charges for implants) are $59,891.34 or less,
  then Current MRA = current per-diem allowance x length of stay (LOS),
  otherwise Current MRA = total trended charges (excluding charges for implants) x 75%[3]

The proposed MRA for each hospital inpatient episode under Scenarios 1 through 6 is calculated as follows:

- Proposed MRA = proposed tier 3 per-diem allowance x ICU LOS
  + proposed per-diem allowance x non-ICU LOS

The proposed MRA for each inpatient episode is comprised of two components. Within each episode, any days spent in the ICU are subject to tier 3 per-diem rates. All non-ICU days in a stay will be subject to the applicable tier 1 or tier 2 per-diem rates.

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[3] In this analysis, current MRAs are calculated using the stop-loss provision where applicable. In 2019 as a result of the case of Zenith Insurance Company vs DWC a recommendation was issued to the DWC that the formula for calculating inpatient MRAs be adjusted to remove the stop-loss provision. As of this time no final order has been issued by the DWC to remove the stop-loss provision. Therefore, this analysis utilizes the existing formula which includes the stop-loss provision. Currently, 94% of payments are associated with episodes with charges exceeding the stop-loss threshold.

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For example, under Scenario 1 per-diem rates, for an inpatient episode lasting 7 days total with 3 of those days spent in the ICU and the remaining 4 days identified as tier 1, the proposed MRA would be calculated as follows:

- $56,000 Proposed MRA = $12,000 (Scenario 1 tier 3 per-diem rate) x 3
  + $5,000 (Scenario 1 tier 1 per-diem rate) x 4

Note that in cases where the amount charged by the hospital for an inpatient episode is less than the per-diem allowance, it is assumed in this analysis that the hospital will be reimbursed at the full per-diem allowance rather than the lesser charged amount. This is consistent with the reimbursement rules under the current RMH, 2014 edition which state: "If the charges for any day of hospitalization are less than the applicable per-diem allowance established in this Chapter, the hospital shall be reimbursed the per-diem allowance for the day(s) rather than the lesser amount charged by the hospital."

Additionally, note that implants are excluded from the above MRAs since they are reimbursed separately as a function of acquisition cost under both the current and proposed RMH.

The charge for each hospital inpatient bill was adjusted to reflect changes from past price levels to price levels projected to be in effect on the proposed effective date of the hospital inpatient fee schedule (July 1, 2022). The trend factor is based on the U.S. hospital inpatient component of the medical producer price index (MPPI)[4].

The estimated impact is then multiplied by a price realization factor of 80% to arrive at an estimated impact on hospital inpatient payments in Florida. This is then multiplied by the percentage of medical costs attributed to hospital inpatient payments in Florida (24.5%) to arrive at an estimated impact on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Florida (64%) to arrive at the estimated impact on overall workers compensation costs.

[4] Source: Bureau of Labor Statistics, series ID WPU512101.

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SUMMARY OF ESTIMATED IMPACTS

The estimated impacts due to the proposed hospital inpatient fee schedule changes are summarized by scenario in the following table:

Service Category – Hospital Inpatient	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Estimated Impact on Medical Costs	(D) Medical Costs as a Share of Overall Costs	(E) = (C) x (D) Estimated Impact on Overall Costs
Scenario 1	-24.0%	24.5%	**-5.9%**	64%	**-3.8%**
Scenario 2	-16.8%	24.5%	**-4.1%**	64%	**-2.6%**
Scenario 3	-20.5%	24.5%	**-5.0%**	64%	**-3.2%**
Scenario 4	-16.6%	24.5%	**-4.1%**	64%	**-2.6%**
Scenario 5	-6.9%	24.5%	**-1.7%**	64%	**-1.1%**
Scenario 6	+13.5%	24.5%	**+3.3%**	64%	**+2.1%**

THIS DOCUMENT AND ANY ANALYSIS, ASSUMPTIONS, AND PROJECTIONS CONTAINED HEREIN PROVIDE AN ESTIMATE OF THE POTENTIAL PROSPECTIVE COST IMPACT(S) OF PROPOSED/ENACTED SYSTEM CHANGE(S) AND IS PROVIDED SOLELY AS A REFERENCE TOOL TO BE USED FOR INFORMATIONAL PURPOSES ONLY. THIS DOCUMENT SHALL NOT BE CONSTRUED OR INTERPRETED AS PERTAINING TO THE NECESSITY FOR OR A REQUEST FOR A LOSS COST/RATE INCREASE OR DECREASE, THE DETERMINATION OF LOSS COSTS/RATES, OR LOSS COSTS/RATES TO BE REQUESTED. THE ANALYSIS CONTAINED HEREIN EVALUATES THE DESCRIBED CHANGES IN ISOLATION UNLESS OTHERWISE INDICATED; ANY OTHER CHANGES NOT INCLUDED IN THIS ANALYSIS THAT ARE ULTIMATELY ENACTED MAY RESULT IN A DIFFERENT ESTIMATED IMPACT. I, JON SINCLAIR, FCAS, MAAA, AM AN ASSOCIATE ACTUARY FOR THE NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC. AND THE ACTUARY RESPONSIBLE FOR THE PREPARATION OF THIS DOCUMENT. THIS DOCUMENT IS PROVIDED "AS IS" ON THE DATE SET FORTH HEREIN AND INCLUDES INFORMATION AND EVENTS AVAILABLE AT THE TIME OF PUBLICATION ONLY. NCCI'S FINAL ESTIMATED IMPACT MAY DIFFER FROM WHAT IS PROVIDED IN THIS ANALYSIS IF ADDITIONAL INFORMATION BECOMES AVAILABLE OR IF DATA NECESSARY TO ANALYZE PROVISIONS THAT WERE NOT EXPLICITLY QUANTIFIED PREVIOUSLY BECOMES AVAILABLE.

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ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2022

NCCI estimates that the changes to the maximum reimbursement allowances (MRAs) in the Florida Reimbursement Manual for Hospitals (RMH), 2014 edition, proposed to be effective July 1, 2022, would result in the following estimated impacts on overall Florida workers compensation system costs under each of the proposed scenarios:

Scenario[1]	Estimated Impact on Overall Costs	
7	-6.0%	(-$231M[2])
8	-6.0%	(-$231M[2])
9	-6.0%	(-$231M[2])
10	-2.3%	(-$88M[2])

Please note that the estimated cost impacts are based on the provisions summarized below which may differ from the final implemented version. If the final version is different from the provisions included here, NCCI would perform an analysis based on the ratified rules and the impacts stated in this analysis may change accordingly.

Summary of Proposed Changes

The Florida Division of Workers' Compensation (DWC) requested that NCCI provide estimated cost impacts for four scenarios associated with updating the maximum reimbursement for hospital inpatient services in addition to six previously priced scenarios. Currently, the MRAs are based on the 2014 edition of the RMH, which became effective January 1, 2015. The MRAs are based on per-diem rates that differ by type of stay:

Type of Stay	Current Per-Diem Rate
Surgical, Non-Trauma	$3,849.16
Surgical, Trauma	$3,850.33
Non-Surgical, Non-Trauma	$2,283.40
Non-Surgical, Trauma	$2,313.69

Inpatient stays with charges in excess of the stop-loss threshold are subject to a maximum reimbursement of 75% of charges. The current stop-loss threshold is $59,891.34.

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[1] Estimated cost impacts for scenarios 1 through 6 were provided as part of a previous request completed on 1/11/2022.
[2] Overall system costs are based on 2020 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. For each scenario, the estimated dollar impact is displayed for illustrative purposes only and calculated as the respective percentage impact multiplied by $3,847M. These figures do not include the policyholder-retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impacts assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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NCCI was asked to evaluate the impact of the four alternative hospital inpatient scenarios outlined below.

The stop-loss provision would be removed in all of the proposed scenarios. The following per-diem rates would apply.

	Per-Diem Rates by Scenario			
Tier	**7**	**8**	**9**	**10**
Tier 1 – All other revenue codes	$4,000	$4,000	$4,000	$7,000
Tier 2 – Operating Room and Anesthesia	$5,000	$9,000	$9,000	$11,000
Tier 3 – Intensive and Coronary Care	$11,000	$11,000	$11,000	$13,000
Trauma/Burn Add-On	–	–	–	$2,000

For all scenarios, the tiers would vary based on the revenue codes reported on the inpatient bill. Within each inpatient episode, tier 3 per-diems would apply to all days billed in intensive care or coronary care units, identified by revenue codes of 0200-0219. The acronym "ICU" will be used to collectively refer to intensive care and coronary care units.

For the remaining non-ICU portion of each inpatient episode the per-diems would apply in the following way for each scenario:

- **Scenario 7** – If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply to all remaining non-ICU days. If the non-ICU portion of an inpatient bill does not contain a revenue code from tier 2, tier 1 per-diems would apply.

- **Scenario 8** – If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply to a maximum of 1 day. Tier 1 per-diems would apply to any remaining non-ICU days.

- **Scenario 9** – If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply to a maximum of 1 day for 80% of episodes and to a maximum of 2 days for 20% of episodes. Tier 1 per-diems would apply to any remaining non-ICU days.

- **Scenario 10** – If the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, tier 2 per-diems would apply to all remaining non-ICU days. If the non-ICU portion of an inpatient bill does not contain a revenue code from tier 2, tier 1 per-diems would apply. Additionally, if an episode is billed with revenue code 0207 or revenue codes 0681-0683, the trauma/burn add-on of $2,000 per day would be applied in addition to any tier 1 through 3 per-diems for the duration of the stay.

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Actuarial Analysis

NCCI's methodology to evaluate the impact of proposed medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements

   - Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
   - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights. For hospital inpatient services, the observed payments by episode are used as weights.

2. Determine the share of costs that are subject to the fee schedule

   - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported in the Florida DWC medical data, to categorize payments that are subject to the fee schedule.

3. Estimate the price level change as a result of the revised fee schedule

   - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change. For non-physician fee schedule changes, a price realization factor of 80% is assumed.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data provided by the Florida DWC with dates of service between January 1, 2020 and December 31, 2020, including COVID-19 claims.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2018 and 2019 projected to the proposed effective date of the benefit changes.

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Hospital Inpatient Fee Schedule

In Florida, payments for hospital inpatient services represent 24.5% of total medical costs. The overall change in maximums for hospital inpatient services is a weighted average of the percentage change in MRA by episode (Proposed MRA/Current MRA). The weights are based on Service Year 2020 observed payments by episode for Florida, as reported in the Florida DWC detailed medical data.

The current MRA for each hospital inpatient episode is calculated as follows:

- If the total trended charges (excluding charges for implants) are $59,891.34 or less,
  then Current MRA = current per-diem allowance x length of stay (LOS),
  otherwise Current MRA = total trended charges (excluding charges for implants) x 75%[3]

The proposed MRA for each hospital inpatient episode under Scenario 7 is calculated as follows:

- Proposed MRA = proposed tier 3 per-diem allowance x ICU LOS
  + proposed per-diem allowance x remaining LOS

The proposed MRA for each hospital inpatient episode under Scenarios 8 and 9 are calculated as follows:

- Proposed MRA = proposed tier 3 per-diem allowance x ICU LOS
  + proposed tier 2 per-diem allowance x tier 2 LOS[4]
  + proposed tier 1 per-diem allowance x remaining LOS

The proposed MRA for each hospital inpatient episode under Scenario 10 is calculated as follows:

- Proposed MRA = proposed tier 3 per-diem allowance x ICU LOS
  + proposed per-diem allowance x remaining LOS
  + proposed trauma/burn per-diem add-on[5] x LOS

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[3] In this analysis, current MRAs are calculated using the stop-loss provision where applicable. In 2019, as a result of the case of Zenith Insurance Company vs DWC, a recommendation was issued to the DWC that the formula for calculating inpatient MRAs be adjusted to remove the stop-loss provision. As of this time no final order has been issued by the DWC to remove the stop-loss provision. Therefore, this analysis utilizes the existing formula which includes the stop-loss provision. Currently, 94% of payments are associated with episodes with charges exceeding the stop-loss threshold.

[4] For scenario 8, if the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, the tier 2 per-diem would apply to a maximum of 1 day. For scenario 9, if the non-ICU portion of an inpatient bill contains a revenue code of 0360-0379, the tier 2 per-diem would apply to a maximum of 1 day for 80% of episodes and a maximum of 2 days for 20% of episodes.

[5] The trauma/burn per-diem add-on only applies to episodes billed with revenue code 0207 or revenue codes 0681-0683.

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Note that in cases where the amount charged by the hospital for an inpatient episode is less than the proposed per-diem allowance, it is assumed in this analysis that the hospital will be reimbursed at the full per-diem allowance rather than the lesser charged amount. This is consistent with the reimbursement rules under the current RMH, 2014 edition which state: "If the charges for any day of hospitalization are less than the applicable per-diem allowance established in this Chapter, the hospital shall be reimbursed the per-diem allowance for the day(s) rather than the lesser amount charged by the hospital."

Additionally, implants are excluded from the above MRAs since they are reimbursed separately as a function of acquisition cost under both the current and proposed RMH.

The charge for each hospital inpatient bill was adjusted to reflect changes from past price levels to price levels projected to be in effect on the proposed effective date of the hospital inpatient fee schedule (July 1, 2022). The trend factor is based on the U.S. hospital inpatient component of the medical producer price index (MPPI)[6].

The estimated impact is then multiplied by a price realization factor of 80% to arrive at an estimated impact on hospital inpatient payments in Florida. This is then multiplied by the percentage of medical costs attributed to hospital inpatient payments in Florida (24.5%) to arrive at an estimated impact on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Florida (64%) to arrive at the estimated impact on overall workers compensation costs.

[6] Source: Bureau of Labor Statistics, series ID WPU512101.

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Summary of Estimated Impacts

The estimated impacts due to the proposed hospital inpatient fee schedule changes are summarized by scenario in the following table:

Service Category – Hospital Inpatient	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Estimated Impact on Medical Costs	(D) Medical Costs as a Share of Overall Costs	(E) = (C) x (D) Estimated Impact on Overall Costs
Scenario 7	-38.0%	24.5%	**-9.3%**	64%	**-6.0%**
Scenario 8	-38.2%	24.5%	**-9.4%**	64%	**-6.0%**
Scenario 9[7]	-37.8%	24.5%	**-9.3%**	64%	**-6.0%**
Scenario 10	-14.7%	24.5%	**-3.6%**	64%	**-2.3%**

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[7] The estimated impact for scenario 9 is calculated as the weighted average of the estimated impacts assuming up to one tier 2 day (80% weight) or up to two tier 2 days (20% weight) could be reimbursed under episodes reported with a tier 2 hospital revenue code.

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ANALYSIS OF FLORIDA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2022

NCCI estimates that the proposed changes to the maximum reimbursement allowances (MRAs) in the Reimbursement Manual for Hospitals (RMH), 2014 edition, would result in an estimated impact of -0.6% (-$23M[1]) on overall workers compensation system costs in Florida.

Please note that the estimated cost impact is based on the provisions summarized below which may differ from the final implemented version. If the final version is different from the provisions included here, NCCI would perform an analysis based on the ratified rules and the impacts stated in this analysis may change accordingly.

SUMMARY OF PROPOSED CHANGES

The Florida Division of Workers' Compensation (DWC) has requested NCCI to provide the cost impact for updating reimbursement for hospital outpatient services.

Currently, the MRAs are based on the 2014 edition of the Florida Workers' Compensation RMH, effective as of January 1, 2015. The manual contains three categories of reimbursement:

- Category 1 Scheduled, non-emergency clinical laboratory and radiology services are reimbursed based on the schedule of MRAs listed in the 2016 edition of the Health Care Provider Reimbursement Manual (HCPRM). In addition, any outpatient physical, occupational, and speech therapy service is reimbursed based on the listed MRA in the HCPRM.
- Category 2 The MRA for a scheduled surgical service is calculated as the base rate from Appendix C of the RMH, multiplied by the geographic modifier listed for the county of the location of service from Appendix A. For procedures with no specified MRA, the maximum reimbursement is 60% of usual and customary charges (UCC).
- Category 3 The MRA for a service other than scheduled surgical services is calculated as the base rate from Appendix B, multiplied by the geographic modifier from Appendix A. For procedures with no specified MRA, other than a scheduled surgical procedure, the maximum reimbursement is 75% of UCC.

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[1] Overall system costs are based on 2020 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. The estimated dollar impact is displayed for illustrative purposes only and calculated as the percentage impact multiplied by $3,847M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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The proposed RMH manual would make the following changes:

- Update the Appendix A geographic modifiers for all Category 2 and Category 3 services.
- Add base rates for new services in Appendices B and C. Base rates for services listed in the current 2014 edition of the RMH remain unchanged. For all services which are newly added to Appendices B and C in the proposed edition of the RMH, the DWC calculated base rates as 60% of the median of charges for scheduled surgical services and 75% of the median of charges for all services other than scheduled surgical services.
- Add Appendices B.1 and C.1 which include base rates for services not individually listed in Appendices B or C.

Actuarial Analysis

NCCI's methodology to evaluate the impact of proposed medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
   - Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
   - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.

2. Determine the share of costs that are subject to the fee schedule
   - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported in the Florida DWC medical data, to categorize payments that are subject to the fee schedule.
   - Any potential impact from the share of costs not subject to the fee schedule will be realized in future claim experience and reflected in subsequent NCCI rate filings, as appropriate.

3. Estimate the price level change as a result of the revised fee schedule
   - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change. For non-physician fee schedule changes, a price realization factor of 80% is assumed.

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In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data provided by the Florida DWC with dates of service between January 1, 2020, and December 31, 2020, including COVID-19 claims.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2018 and 2019 projected to the proposed effective date of the benefit changes.

Hospital Outpatient Fee Schedule

In Florida, payments for hospital outpatient services represent 17.5% of total medical costs. The overall change in maximums for hospital outpatient services is a weighted average of the percentage change in MRA by procedure code (Proposed MRA/Current MRA). The weights are based on Service Year 2020 observed payments by procedure code for Florida, as reported in the Florida DWC detailed medical data. The current MRAs are calculated as follows:

Current MRA = Base Rate x Geographic Modifier, or a Percentage of Trended Charges

> When there is no MRA, the charges are adjusted to the price levels projected to be in effect on July 1, 2022. The trend factor is based on the U.S. hospital outpatient services component of the medical producer price index (MPPI)[2]. If a procedure code is not listed in Appendix B or C of the RMH, the MRA is based on a percentage of charges. For scheduled surgical services, the MRA is calculated as 60% of the trended charges. For all other services, the MRA is calculated as 75% of trended charges.

The proposed MRAs are calculated as follows:

Proposed MRA = Proposed Base Rate x Proposed Geographic Modifier

The overall weighted-average percentage change in maximums for hospital outpatient services is estimated to be -6.3%. This impact is then multiplied by a price realization factor of 80% to arrive at an estimated impact of -5.0% on hospital outpatient payments in Florida. This impact is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in Florida (17.5%) to arrive at an estimated impact of -0.9% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Florida (64%) to arrive at an estimated impact of -0.6% on overall workers compensation costs.

[2] Source: Bureau of Labor Statistics, series ID WPU511104.

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SUMMARY OF IMPACTS

The estimated impact from the hospital outpatient fee schedule change, proposed to be effective July 1, 2022, is summarized in the following table:

Type of Service	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Estimated Impact on Medical Costs	(D) Medical Costs as a Share of Overall Costs	(E) = (C) x (D) Impact on Overall Costs
Hospital Outpatient	-5.0%	17.5%	**-0.9%**	64%	**-0.6%**

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