WORKER'S COMPENSATION

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WORKER'S COMPENSATION

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MEMORANDUM

TO: Hillary Rodham Clinton August 5, 1993

FR: Chris Jennings

RE: Workers Compensation

Because the workers compensation issue has received so much interest, I asked Gary Claxton to provide some background information regarding this topic. Attached you will find a one paragraph summary of this policy, followed by a three page description, and a detailed backgrounder on this topic.

If you desire a briefing, I can ask Gary to come in. I hope that this information is helpful.

INTEGRATION OF WORKERS' COMPENSATION INSURANCE

Summary of Policy

Individuals would receive treatment from their health plan for work-related injuries and illnesses. Workers' compensation insurers (including self-funding employers) would be remain responsible for the costs of treatment (based on current law), and would reimburse the health plan for services provided. Reimbursement would be based on a fee schedule or on an alternative arrangement established by the alliance or negotiated between the workers' compensation insurer and the health plan.

A National Advisory Committee on the Integration of Medical Insurance Benefits would be created to study the feasibility and appropriateness of integrating the financial responsibility for work-related injuries and automobile accidents into the new health care system.

INTEGRATION OF WORKERS' COMPENSATION INSURANCE

Health plans provide treatment for individuals with work-related injuries covered under workers' compensation insurance.

Workers' compensation insurers (including self-funding employers) continue to be responsible for the costs of treatment based on current law and reimburse health plans for services provided. Reimbursement is based on a fee schedule or on an alternative arrangement established by alliances or negotiated between workers' compensation insurers and health plans.

To obtain state certification, a health plan demonstrates its ability to provide or arrange for comprehensive medical benefits for work related-injuries and illnesses, including rehabilitation and long-term care services.

- Health plans employ or enter into contracts with specialists in industrial medicine and occupational therapy.

- Health alliances are responsible for coordinating access to specialized health providers or centers of excellence in industrial medicine and occupational therapy.

- Alliances may enter into contracts with health care professionals and institutions that provide specialized services for the treatment of work-related injuries and illnesses on behalf of all health plans serving the alliance region.

Individuals enrolled in health plans within the alliance receive treatment for work-related injuries or illnesses from their health plans, although emergency treatment may be obtained from any provider.

State laws regarding choice of provider for workers' compensation cases are overridden with respect to individuals covered through health alliances. Exceptions may be necessary in cases of disputes.

Each health plan designates a workers' compensation case manager to coordinate the treatment and rehabilitation of injured workers. The case manager ensures that:

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- The plan of treatment for an injured worker meets appropriate protocols and is designed to assure rapid return to work.

- The plan of treatment is coordinated with the workers' compensation insurance carrier and/or the employer to facilitate rapid return to work.

- The health plan complies with medical and legal requirements related to workers' compensation.

- If the health plan is unable to provide a needed service to treat a work-related injury or illness, the workers' compensation case manager, in consultation with the workers' compensation carrier, refers the worker to an appropriate provider.

Health plans are reimbursed by workers' compensation insurance carriers or self-funded employers for work-related medical benefits in accordance to the fee-for-service schedule in the alliance.

- Alliance fee schedules include rehabilitation, long-term care and other services commonly used for the treatment of work-related injuries and illnesses.

- Alliances are permitted to adopt varying arrangements with health plans for providing work-related medical benefits, including negotiating per case capitation payments.

- Health plans are permitted to negotiate fees that vary from the fee-for-service rate schedule with workers' compensation insurers and employers.

Health plans and providers are not allowed to bill patients with work-related injuries or illnesses for additional charges beyond those covered by the health plan.

Information related to provider and health plan performance in treating work-related injuries and illnesses (including the health plan performance in facilitating injured workers' returning to work) are included in reporting information about the quality of care provided by the health plan.

Nothing in this policy alters or diminish the effects of state workers' compensation

laws as the exclusive remedy for work-related injuries or illnesses. [See language in OSHA 29 USC Sec. 653(b)(4)]. Disputes related to whether an injury or illness is work-related are resolved in accordance with existing state laws.

Health benefits for work-related injuries and illnesses continue to be defined by states.

For regional alliances, the federal requirements related to workers' compensation become effective two years after implementation of the state health reform program. For corporate alliances and federal workers' compensation programs, the federal requirements become effective in 1998.

Compensation programs under FECA, the Jones Act and the Longshoreman's Act are subject to similar requirements.

The Department of Labor and the Department of Health and Human Services study the feasibility and appropriateness of transferring the financial responsibility for all medical benefits (including those now covered under workers' compensation and automobile insurance) to the new health system. These departments report to the President, and present a detailed plan for integration if it is recommended, on or before July 1, 1995.

The Department of Health and Human Services and the Department of Labor are authorized to conduct a demonstration program in one or more states related to treatment of work-related injuries and illnesses.

- The Department of Health and Human Services and the Department of Labor, in consultation with states and experts on work-related injuries and illnesses, develop protocols for the appropriate treatment of work-related conditions.

- The Department of Health and Human Services and the Department of Labor enter into contracts with one or more alliances to test the validity of protocols.

- The demonstration may include the development of per-case capitation payments to health plans for the treatment of work-related injuries and illnesses.

ISSUES RELATED TO INTEGRATION OF WORKERS' COMPENSATION MEDICAL COSTS INTO THE NEW HEALTH CARE SYSTEM

INTRODUCTION

The purpose of this paper is to outline the primary options for integrating workers' compensation health benefits into the new health care system in the context of the key issues that must be addressed if integration is to occur. State experiments with what has been called 24-hour coverage in the workers' compensation area have been limited to date and generally have not considered the additional problems of a system in which employees, not employers, control the choice of health plan. This paper looks at each of the key issues related to integration and discusses how they would be addressed under each option.

SUMMARY OF ISSUES AND CONCLUSION

Summary

There are a number of ways to integrate the health benefits of workers' compensation into the contemplated health care system. The working group offered two primary options for integration.[1] The first is to partially integrate the two systems by keeping the risk for work-related health benefits with existing workers' compensation insurers but providing treatment for work-related injuries through the health plans chosen by workers under the new system. The second is to transfer the risk of work-related health benefits to the new system by placing the health plan chosen by a worker under the new system at risk for the treatment of any work-related injuries sustained by the worker. These two options are very different in terms of potential cost savings, complexity, and disruption of current arrangements.

The key factors in deciding between the two options would appear to be the complexity and lack of actual experience associated with transferring the risk to the new system, balanced against the inferior incentives and reduced potential for cost savings associated with the partial integration option.

The transfer of risk option has the advantage of placing

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[1]A third option, which would be a complete merger of workers' compensation health into the new system with no special treatment, was not recommended for reasons discussed in the next section.

health plans at risk for the total medical care needs of their enrollees, leading to a more integrated and cost conscious approach to treatment. At the same time, this option, especially in a system of employee-choice of health plan, involves the addition of complex new elements to the health care and workers' compensation systems. These include: (1) developing a method of capitating health plans for the risk of work-related medical benefits; (2) potentially modifying the comprehensive benefit package to include the additional medical benefits now provided in the workers' compensation system; (3) developing methods of coordinating back to work activities between health plans and workers' compensation indemnity carriers; (4) potentially developing a new premium collection method (that may be experience rated) for work-related injuries; (5) potentially developing a system for adjusting payments to health plans based on their success in facilitating early return to work for injured workers; (6) developing national benefits for work-related injuries and an administrative system to assure portability of work-related benefits across differing state systems; and (7) managing the potential for transfer of risk for large employers to small employers if larger firms are permitted to be outside of the alliance.

The partial integration model, in contrast, is much simpler and involves much less disruption of the current system. At the same time, its potential for cost savings is not as great because health plans are not put at risk for treatment of work-related injuries. Because risk remains with workers' compensation carriers and is funded through the current method, there is much less need to develop new systems or to address across state variations.

Recommendation

The transfer of risk approach, although very complicated, would appear to be the superior approach in the long run. The short-term implementation problems are severe, however, and additional problems with implementation will no doubt be discovered.

It is recommended that the partial integration approach be adopted as a short run -- injured workers would be required to receive treatment through there health plan and health plans would be reimbursed at rates that reflect the overall efficiency of the health plan. It is further recommended that a commission be appointed to report in two years to the President with a plan to transfer the risk of work-related injuries to health plans. The charge to the commission should be stated such that it is their job to develop a plan of implementation and not to debate the merits of that choice.

BACKGROUND

Workers' compensation programs represent a social contract, in which employees injured at work trade the right to sue their employers for negligence in return for a strict liability system that provides medical and cash benefits. Workers' compensation coverage is mandatory for most employers and 87 percent of all employees are covered. Gaps include domestic workers, agricultural workers, and some state and local government employees. Coverage is voluntary in New Jersey, South Carolina and Texas, although most employers in those states have coverage. In 1990, private insurers paid about 60 percent of workers' compensation benefits, state and federal funds paid about 20 percent, and self-insurers paid about 20 percent.

Workers' compensation provides first dollar coverage with no dollar limits for all necessary work-related medical treatment. Workers' compensation medical payments were $18-20 billion in 1992, about 40 percent of total workers' compensation expenditures. About 80 percent of workers' compensation claims are medical-only cases, which account for about 15 percent of workers' compensation medical costs. For example, in 1989 in Alabama, the average medical-only claim was $222; the average medical costs of a claim that involving lost wages was $bout $5,700.

Workers' compensation premiums are based primarily on occupation -- rating organizations establish premium rates, called manual rates, for about 700 industry classifications. For mid-size and larger employers, those rates are modified by the employer's claims experience. These experience modifications are applied prospectively, based upon the previous three years of claims experience of the employer. Large employers also are subject to retrospective experience rating, in which the employer's current-year premium are adjusted based on current-year claims.

Workers' compensation reserves are set up very differently than health insurance reserves. In workers' compensation, when an injury occurs, the insurer sets aside an amount intended to fund the entire losses that will occur as a result of that injury (i.e., the present value of future claims). Rates are set to provide sufficient funds for the insurer to reserve the entire amount of losses in the occurrence year. For health insurance, premiums are established to fund losses only through the current policy year. For example, under current workers' compensation practices, if premiums for the health component of workers' compensation for a firm were $10 in a given year, about $3.50 would go to pay for services in that year and $6.50 would be reserved to pay for services in future years.

SUMMARY OF OPTIONS

To assist understanding of the following discussion, the two options are briefly outlined below. Key variations to the options are shown parenthetically. A third option -- which involves a more complete merger of the two systems -- is also described because it is a preferred option of many advocates of 24-hour coverage. This option was not recommended by the working group because it potentially reduces benefits and transfers costs to workers.

Partial Integration

Under the partial integration model:

- Employers would continue to purchase workers' compensation insurance from workers' compensation insurers,[2] who would remain at risk for health and non-health workers' compensation benefits.

- Employees would receive treatment for work-related injuries from their health plans. State laws regarding choice of provider for workers' compensation would be overridden (exceptions would be necessary in cases of disputes).

- Health alliances would negotiate fee schedules with each health plan for the treatment of work-related (and probably automobile-related) injuries. The schedules should, to the extent possible, reflect prices and efficiency achieved by the health plan generally in treating non-work-related injuries.[3] The alliance would be free to negotiate DRG-type case payments with health plans. Workers' compensation insurers could negotiate separate arrangements with health plans if each agreed to a different reimbursement arrangement.[4]

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[2]Unless otherwise stated, the term workers' compensation insurer includes an employer that provides workers' compensation benefits through self-funding.

[3]In the case of the fee-for-service health plans, the alliance or state might want to establish the fee schedule to be used by fee-for-service providers. A number of states already have fee schedules for workers' compensation medical benefits.

[4]This is an area where market forces are not operating: employees have chosen the health plan for reasons not related to workers' compensation health benefits and the workers' compensation

- [Option. Each health plan would be required to have a workers' compensation case manager to coordinate the treatment and rehabilitation of injured workers. The case manager would be responsible for assuring that the health plan complies with medical/legal requirements related to the workers' compensation and that the health plan works cooperatively with the workers' compensation insurer and the employer to facilitate rapid return to work.]

- The workers' compensation insurer would be financially responsible for work-related health care costs and would establish reserves for a case at the time of injury (which is the practice today). If a worker with an injury requiring on-going treatment leaves employment or moves to another state, the workers' compensation insurer would continue to fund the needed medical care received by the worker in whatever health plan the worker chooses in his or her new state of residence.

- Injured employees of employers that self-fund for workers' compensation also would receive services through the health plans they select; the employer would be responsible for funding all future health claims related to the injury.

Transfer of Risk Option

Under the transfer of risk option approach:

- The risk for health benefits for work-related injuries would be placed with the health plan chosen by an employee for all of their health care needs.

- Each year alliances would collect sufficient funds from employers to cover the actual costs of treating work-related injuries in that year. This amount could be collected as a separate premium [which varies by occupation and/or employer claims experience] or it could be combined in the premium or payroll contribution which funds new system benefits [Note: the additional amount should be loaded entirely on the employer portion of the

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insurer has no ability to influence the employee's choice of provider for treatment. Thus, the health plan has no incentive to negotiate with the C insurer. The alliance, as the representative of payers and consumers, would have the incentive and the market power to negotiate with the health plan.

premium or contribution].

- Alliances would negotiate a per worker payment (i.e., capitation) each year with each health plan, which would fund the expected costs of treating work-related injuries for the specified year. Payments from the alliance would vary by occupation and other relevant factors. Health plans would bear the risk of providing treatment within the capitation amounts received. Payments from the alliance to health plans would be risk-adjusted to correct for differences in disability-status and other factors that would affect the need for work-related health benefits. The risk of certain high-cost cases could be shared within the alliance through a capitated reinsurance approach.

  [There are two alternatives for payment to health plans. Under the first alternative, the revenue raised to cover workers' compensation health benefits could be calculated only to provide the benchmark level of work-related health benefits to each employee. This benchmark amount would be provided to each health plan. Plans above the benchmark would collect additional amounts needed to fund work-related health benefits through premium contributions charged to wi choosing the plan.[5]

- Because individuals have the choice of changing health plans each year, reserving for work-related health benefits would be done on an annual rather than on an occurrence basis.[6] This would result in much lower workers' compensation premiums for health benefits in the first year of integration, with substantial increases each year until premiums reach current levels. A levelling system (in which wac than needed premiums are wi in early years and returned to employers in later

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[5]This type of distribution is complicated by the fact that the relative levels of efficiency of plans in providing general health care and in treating work-related injuries probably will not be the same.

[6]Under an annual funding method, premiums will cover only the yearly cost of treatment in that year. Under an occurrence basis, an amount equal to the full anticipated future health care costs is set aside when an injury occurs. Thus, under the annual method, each year's premium in part goes to fund treatments for injuries which occurred in previous years. Under an occurrence method, those costs are already funded through reserves held by an insurer.

years) would needed to provide for a smooth transition.

- Each health plan would be required to have a workers' compensation case manager to coordinate the treatment and rehabilitation of injured workers. The case manager would be responsible for assuring that the health plan complies with medical/legal requirements related to the workers' compensation and that the health plan works cooperatively with the workers' compensation insurer and the employer to facilitate rapid return to work.

- Alliances would develop target schedules for return to work and payments to health plans would be reduced or enhanced on the basis of the plan's performance in assuring timely return to work. Alliances would be required to develop a formal method of consulting with workers' compensation insurers on the schedule and on health plan performance in meeting it. The incentive payments would be handled through a withhold arrangement or adjustments to future payments.

- A uniform benefit package for work-related benefits would be developed. The federal agency would be charged with recommending benefits, which would be approved by the national health board or through legislation. The benefit package would be available for work-related injuries in all states.

- Eligibility of workers for the extra benefits provided for work-related injuries would be determined under the current laws in each state (state laws as to causation and eligible workers differ). Injured workers who change their state of residence would remain eligible for additional benefits, even if the injury would not have been considered work-related if it had occurred in the new state of residence.

Complete Merger Option

Some advocates of 24-hour coverage suggest folding the risk of workers' compensation health benefits into the new system and eliminating any determination of whether an injury was work-related. [An option would involve a determination of work-relatedness only when additional benefits (e.g., longer-term disability or long-term care) were warranted].

Under this approach:

- Health plans would take the risk for all health benefits,

no matter their source (e.g., this would include health costs v, from work-related and automobile accidents).

- Treatment for work-related and non-work-related health benefits would be handled in the same manner by health plans. Enrollees would be responsible for premiums and cost sharing for health benefits without regard to source of injury.

- [Option. Health plans would provide additional medical benefits now provided by workers' compensation carriers, including long-term rehabilitation and care services that are required to treat work-related injuries and illnesses. Health plans would be required to make a determination of whether an injury was work-related for the purposes of these extra benefits. Controversies could be handled through the traditional workers' compensation system.][7]

- Health plans would include the costs of treating work-related health benefits in their premium bids to the health alliance. These benefits would be funded as part of the premiums (e.g., per capita or payroll-based contributions) charged to employers and employees (with subsidies where appropriate).

This option was not recommended by the working group for a number of reasons. Although there is potential for administrative savings and simplicity with a complete merger, workers would (probably) perceive this approach as a reduction of the rights and benefits they receive wv current law. Potential problems for workers include:

- Workers could lose benefits under this approach as compared to the current system. For example, workers would be responsible for cost-sharing (i.e., co-payments and deductibles) that are not currently charged in workers' compensation system.

- Unless additional benefits are added to the comprehensive benefit package for work-related injuries, workers under this approach also could lose access to long-term rehabilitation or long-term care services now provided

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[7]Injuries involving these additional benefits would probably involve a claim for lost wages, so a determination of work-relatedness would probably need to be made in the workers' compensation system in any event.

under workers' compensation. Alternatively, those benefits could remain in the workers' compensation system, but some (maybe much) of the administrative cost-savings of integration would be lost if some medical benefits remain with workers' compensation carriers. Further, continuity of coverage and efficient treatment would be compromised if medical benefits are split across the two systems.

- Workers would be required to pay for part of the premiums for work-related injuries under this approach. Workers' compensation currently is entirely employer financed (with a few exceptions). Placing twenty percent of the burden on employees (and potential subsidy burdens on the government) would be a significant transfer of responsibility. Adding the costs to premiums also would require nonworkers to contribute to the costs of work-related injuries.

- This approach eliminates any option to have experience rating of employers for causing work-related injuries, which would lessen the incentives for workplace safety and could reduce employer incentives to return injuries workers to work.[8]

For these reasons, the working group did not view this option as viable. If it is considered, much of the discussion in the following section related to the transfer of risk approach would be equally applicable to this approach.

KEY ISSUES

There are a number of difficult policy and technical issues involved with integration. The following is a discussion of the key issues and how he two primary approaches to integration would address each issue.

1. Cost savings. The issue is to what extent either approach will reduce medical expenses for work-related injuries and illnesses.

   Workers' compensation medical costs are increasing faster than

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[8]Advocates of this suggest that the experience rating of the wage-loss protection is sufficient to encourage safety. This is true to some extent, although the relative importance of medical and wage-loss claims to experience rating modifications varies across industries.

general medical costs for several reasons. These include: (1) physician appear to charge more for work-related treatments paid by workers' compensation carriers than for comparable treatment paid by group health insurance;[9] (2) workers' compensation is overwhelming a fee-for-service system, which has little ability to manage volume or assure appropriateness of services; (3) workers' compensation is prone to fraudulent claims (apparently severe in a few states); (4) the adversarial nature of some severe claims; (5) problems in the economy that produce a greater number of wage loss claims (with accompanying medical expenses).

The partial integration model addresses several of these issues. The fee schedules address the problem of high physician charges for workers' compensation, and providing services through health plan providers should address the fraud issue, at least for integrated health plans. Advocates of integration also argue that providing for treatment of work-related injuries by a person's normal health plan will reduce the adversarial climate because both employers and employees will have more confidence in the diagnoses and treatment. This degree of trust does not exist if the physician is chosen after the injury by either the employer or employee (or the employee's lawyer).

The transfer of risk approach addresses the same issues as the partial integration approach, but with one important addition: health plans will be at risk for treatment of work-related injuries and therefore will have incentives to control utilization and reduce the amount of inappropriate treatment. Treating work-related injuries through managed care and integrated health plans appears (apparently) has produced significant savings in the few instances where it has been tried.

Both approaches should produce lower costs for treating work-related injuries. The transfer of risk approach has the potential for larger savings because the risk is transferred to providers and increased opportunities for managed care are present.

2. Benefit differences. The issue is how to address the fact

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[9]Because workers' compensation has the goal of returning injured workers back to their jobs, there will be some additional intensity of services in the workers' compensation system that result in legitimately higher charges.

that workers' compensation provides health benefits that may not otherwise be covered by the health care system. For example, workers' compensation health benefits include long-term rehabilitative therapy and custodial long-term care services for people injured at work. Workers' compensation benefits also are provided as first-dollar coverage (i.e., there are no copayments or deductibles) and there are no lifetime limits on medical services.

There are two parts to this issue: (1) cost sharing and (2) additional benefits for work-related injuries. With respect to cost sharing, some states that have authorized 24-hour coverage are applying health insurance-type cost sharing to work-related benefits. Others are not. From a technical standpoint, it is not difficult to waive cost sharing for work-related injuries for either type of integration. Waiving cost sharing reduces cost containment but maintains the advantages of the current system for workers. Also, many would argue that it is unfair to impose individual responsibility for costs that are work-related.

With respect to additional benefits, both partial or full integration are more rational if health plans provided the full array of medical benefits. If some benefits are provided by health plans and others left with the traditional workers' compensation system, coordination of care and overall efficiency would suffer. It would be possible to leave rehabilitation or long-term care benefits with the workers' compensation system, but it could lead to disputes regarding the point at which responsibility switches from the health plan to the workers' compensation insurer. However, if some medical benefits are left in the workers' compensation system, this is better handled by the partial integration approach because the workers' compensation carrier is at risk for all benefits.

3. Differences across states. The issues is how to recognize the significant differences among state workers' compensation systems. There are three key differences that affect the availability of health benefits across states: (1) different health benefits (there is not much variation); (2) different standards for causation (i.e., whether an injury arose out of and in the course of employment)[10]; and (3) different

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[10]State law regarding the circumstances under which an injury is considered to arise out of or occur in the course of employment varies tremendously

eligible populations[11].

These differences are important because injured workers might be eligible for additional benefits and because they relocate from state to state.[12] In the current system, injuries are fully funded at the time of injury according to the benefits and rules established in the state where the worker was employed (or in some cases, where the injury occurred, if different). This practice can continue under the partial integration model, because the workers' compensation insurer is financially responsible for all benefits, present and future.

Under the full integration model, however, a person's current health plan is responsible for providing benefits for past work-related injuries. If that person has relocated to a new state, the benefits to which they would have been entitled in their previous state of residence may not match the work-related benefits commonly provided in their new state of residence.[13]

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[11]About 13 percent of workers are not covered by workers' compensation as a result of various exclusions across the states. At least 20 percent of workers are not covered in at least nine states (estimate from John Burton, Rutgers). In three states, Texas, South Carolina and New Jersey, coverage is voluntary.

States have a wide variety of excluded categories of workers, including casual workers, farm labor, domestic workers, and real estate brokers.

[12]State differences also are important if workers' compensation health benefits will be funded with separate premiums, because it will be necessary to be able to classify treatment that is for a work-related injury.

[13]For example, take the situation of two people, Person A and Person B, who sustain exactly the same injury playing softball for their employer's softball team. In State X the injury is covered as a work-related injury and Person A is entitled to additional benefits (for rehabilitation beyond what would otherwise be covered). In State Y the injury is not considered work-related, so Person B is entitled to no extra benefits. Both workers now move to State Z (which would consider the injuries as work-related under their laws). How should the injuries be treated by the new health plan in State Z?

To make the full integration model work without correcting for all state variation (which would be a huge change to state workers' compensation systems), it would be possible to use the eligibility and causation determinations in the original state to determine eligibility for work-related benefits. This would mean that a person covered for an injury in California could receive benefits in Colorado even if Colorado normally would not have provided compensation in the injury had occurred there. In order to assure that benefits are available everywhere, however, we would need to move to a uniform system of health benefits for work-related injuries. This should not be too controversial because health benefits do not vary widely across states.

4. Coordination of work-related health benefits with coverage for lost wages. The issue is how to assure that integration does not actually increase workers' compensation costs in the wage loss area. The health and wage-loss components of workers' compensation are closely related because a person's medical status affects the amount of time the person is not at work, and hence the person's claim for lost wages.

   Workers' compensation insurers argue that these two risks must remain together so that the health and wage-loss risks can be coordinated to facilitate rapid return to work. The more successful carriers (including one HMO in the field) argue that by managing the total risk they can better work with employers to develop loss control programs and to arrange for light duty or other return to work options. Further, they are skeptical that health plans would provide the intensity of services necessary to facilitate rapid return to work, especially of the health is capitated and has a financial disincentive to provide any extra services.[14] They also want the leverage of payment over the medical provider to assure that the provider sees the patient quickly and fills out the necessary forms.

   Coordination between the health and wage-loss risks can be accomplished in either integration model. The partial integration model keeps all of the risk with the workers' compensation insurer and therefore best preserves the type of coordination that exists in the current system.

   In the full integration model, the health and wage-loss risk

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[14]They liken workers' compensation to sports medicine, where the goal is not medical recovery but recovery to a level where the patient can preform his or her prior function.

are separated, so additional methods are needed to assure desired coordination. One method would be to require each health plan to have a workers' compensation case manager who could work closely with the insurer of the wage-loss piece to coordinate treatment delivery and return to work. An additional component would be to adjust health plan reimbursement to place incentives on them to assure rapid return to work. Alliances also should build a formal method of consultation with workers compensation insurers so that protocols and targets can be developed by which to judge the performance of health plans in this area.

It is unclear whether the methods of coordination built into the full integration model would permit the level of total case coordination now claimed by the workers' compensation system. Dividing the risk among two insurers necessarily reduces control. It may be that states could give alliances greater authority in this area to bring both insurers together to focus their education efforts on employers.

5. Capitation of health plans. The issue is how, in the full integration model, to design payments to health plans for the risk of work-related injuries. With full integration, alliances would need to negotiate per-worker payments that capitate health plans for the annual costs of providing work-related health benefits. Since each health plan would attract a different percentage of workers and nonworkers as well as workers from a different mix of industries, these payments would need to vary at least by industry and occupation code.

Unfortunately, there is very little actual experience with health plans taking risk for workers' compensation costs, and no examples where annual capitation rates have been developed. Thus, the success of the full integration model depends, in part, on creating a new system of capitating workers' compensation costs. This problem may be especially acute for less-integrated health plans, who would not be in a good position to share the risk with health care providers.

This concern could be reduced, to some extent, by incorporating mandatory reinsurance into the model, at least for the early years. This would help spread part of the risk across all health plans and protect them from incurring unreasonably high losses. The risk adjustment mechanism also would protect health plans from attracting a disproportionate share of higher-cost enrollees.

This concern also could be reduced if the risk for work-related injuries were completely integrated into the risk

borne by the health plans

The partial integration model does not have this concern because the risk remains with workers' compensation insurers.[15]

6. Method and collection of premiums. The issue is whether work-related health benefits should be funded through separate contributions or whether their cost should be added to premiums or contributions already being collected by health plans. A related issue is, if separate premiums are collected, on what basis should they be assessed?

Workers' compensation currently is paid for entirely by employers. Premiums for workers' compensation insurance are based on a combination of occupational and experience rating. Employers in riskier occupations pay higher premiums than those with lower risk, and employers with poorer safety records pay additional premiums to compensate for their worse claims experience.

Under the partial integration approach, premiums could (and probably should) continue to be collected in the same manner as they are today. Since workers' compensation insurers would continue to bear the financial risk for work-related health benefits, there is no reason to disrupt the premium systems that exist in each state.

There are several options for collecting the needed revenue under the transfer of risk approach, including (1) assessing a separate premium on employers, which can either be community rated, rated based on industry and occupation, and/or experience rated; (2) assessing a surcharge on existing health or workers' compensation premiums; or (3) building the cost into the premiums assessed to pay for non-work-related health benefits.

Assessing a separate premium on employers has the advantage of being the most accurate -- the premium can vary to the extent desired to correspond to the risk imposed by the employer. For example, employers of different occupations can be assessed different premiums that recognize the different risks

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Alliances or workers' compensation carriers may wish to negotiate DRG-type payments with health plans for the treatment of specific illnesses. This type of risk transfer is not large enough to put health plans at jeopardy.

of injury. Experience modifications can be assessed (as under the current system) to reward employers with safe workplaces and assess extra costs to employers with poorer safety records. Experience rating also builds incentives for employers to assist return to work (by creating light duty opportunities, etc).

The key disadvantage to occupation and experience rating is that it is administratively complex -- a separate rate must be calculated for and collected from each employer. Since the employees of each employer are spread in different health plans, the employee data must be aggregated so that the employer's experience can be assessed. Alliances could use existing workers' compensation systems to perform this function, but the costs would clearly be higher than use of a more simple funding option. Alternatively, a simple community rate could be assessed (either as a per-worker assessment or a surcharge on the employer contribution). This would be much less costly than experience rating.

The second option, a flat assessment on the wage-loss portion of the workers' compensation premium, would also be a relatively simple way to fund the work-related health risk borne by the health plans. Unlike the separate premium option, this option would not involve a separate calculation for each employer. In addition, assessments on the wage-loss portions of workers' compensation premiums would reflect the experience rates paid by employers under that system, thereby reinforcing the incentive for workplace safety.

The disadvantage of this option is that it is not very accurate and, worse yet, it appears more accurate than it really is. The relationship between the workers' compensation wage-loss and medical risks varies across industries, which means that a flat surcharge on the wage-loss premium would not be an accurate reflection of the medical risk in many instances.

The third option, simply folding the risk into health plan premiums, was discussed above. This option would be simple because there would be only one premium for each health plan. The key disadvantage is that this method of funding would shift costs from employers to workers, nonworkers and the government (through subsidies).

The transfer of risk approach could be funded in any of these ways. The accuracy associated with the using separate, occupational and experience-rated premiums would protect the plan from criticisms that employers with safe workplaces are

being forced to subsidized those with poor safety records. The community rate or simple assessment options are simpler and cheaper options, although fairness and incentives for safety would be sacrificed.

7. Employers outside of the alliance. The issue is how integration would affect employers outside of the alliance.

A number of employers, especially larger employers, self-fund their workers compensation benefits. Unlike traditional health benefits, however, these self-funded arrangements are generally subject to state laws and regulations, including regulation of financial capacity.

Both integration approaches would affect large employers that self-fund for workers' compensation benefits by requiring that work-related medical benefits be provided through health plans. [Option: if non-alliance employers are not required to offer choice of health plans to employees, the partial integration approach could waive this requirement. This would preserve employee choice of provider for workers' compensation in states that permit it.]

In the transfer of risk approach, the risk for work-related health benefits would be transferred to the health plans chosen by employees, which could be the self-funded plan sponsored by the employer. It is necessary that non-alliance employers operate under the same rules that apply in alliances so that injured workers can be assured portability of benefits if they switch employers. Unfortunately, because of the annual funding of these benefits in the transfer of risk approach, it is likely that there will be a systemic transfer of costs from non-alliance employers to the alliances of the medical costs associated with totally permanently disabled workers and partially permanently disabled workers. This transfer occurs because disabled workers who leave their jobs are (presumably) likely to get their coverage in alliances, where their health plans would become responsible for funding on-going treatment of the disability.[16]

This problem could be addressed, in part, by surcharging non-alliance employer premiums to collect an amount equal to the transfer of costs. However, the problems of identifying which

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[16]An actuary at W.M. Mercer roughly estimated that up to one third of workers' compensation medical costs are incurred by disable workers after they leave the service of the employer that "caused" the injury.

employers to assess, the amount to assess, and which health plans to distribute the funds to, is very complicated. At present, we do not have a good answer for this problem.

CONCLUSION

The transfer of risk approach has the potential to fundamentally transform the incentives for treatment of workers' compensation medical injuries and to produce large savings for employers. It also has the potential to improve medical outcomes because treatment would be moved away (somewhat) form an adversarial process to a coordinated care setting. At the same time, it is new, untried, and extremely complicated.

The partial integration approach, on the other hand, will also produce savings and is much easier to implement because it involves much less disruption of current arrangements. It also could serve as a bridge to a more ambitious integration.

No. 650

ISSUE BRIEF

NATIONAL HEALTH POLICY FORUM

Workers' Compensation and Health Care Reform: Is There a Need for Federal Action?

Monday, June 6, 1994
1:00 to 5:00 pm
Quality Hotel Capitol Hill
Federal Ballroom

A workshop featuring

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Assistant Chancellor and Director, Occupational Health Program
University of Massachusetts Medical Center

Gary Claxton
Special Assistant to the Deputy Assistant Secretary for Health Policy
Department of Health and Human Services

John F. Burton, Jr., Ph.D.
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AFL-CIO

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The George Washington University
WASHINGTON DC

Workers' Compensation and Health Care Reform: Is There a Need for Federal Action?

In 1992, California Insurance Commissioner John Garamendi caught the attention of the health policy world by proposing a managed competition plan for controlling health care costs while providing universal coverage on a state level. One of the more intriguing aspects of his plan involved merging the medical components of workers' compensation and automobile insurance with traditional health benefits. Although the concept of merging medical benefits from different insurance systems had been under discussion for several years and Florida had passed enabling legislation, Garamendi's plan was the first comprehensive proposal to suggest that linking reform of these two systems could lead to cost savings that could pay for universal coverage and improved benefits.

The policy arguments made in favor of such a merger seemed compelling enough: it made little sense that a person injured as a result of a work or auto accident should receive different medical care than someone suffering the same injury at home. All citizens, regardless of the locus and cause of their injury, should receive the same high quality of medical care. Eliminating this unnecessary distinction, proponents argued, would generate a significant amount of savings from reduced service duplication, fewer liability disputes, and increased administrative efficiency. These savings could then be used to help finance universal health care coverage while improving disability benefits and rationalizing the entire system.

Although the Garamendi proposal died in the California legislature, the idea of coordinating or integrating all health benefit plans into a single benefit package was given new life by the Clinton Task Force on Health Care Reform, some of whose members had helped craft the original Garamendi plan. In addition to the policy attractions described above, there were political motivations for integrating workers' compensation medical care into a new health system. The task force had decided early on that the primary source of new money needed to finance universal coverage would come from mandated employer contributions toward the purchase of insurance for employees. The task force recognized that this employer mandate would meet stiff resistance from the employer community and was seeking ways to make the package more acceptable to this important constituency. At the same time, employers across the country were facing a workers' compensation cost crisis of historic proportions. In most states, the crisis was being fueled by workers' compensation medical costs that were growing, on average, more than 15 percent per year. If the Clinton health care plan could "fix" the workers' compensation medical cost crisis, it was hoped that employers would be more willing to accept the overall plan, mandates and all.

Meanwhile, other federal and state health care reform proposals had recommended coordination or integration of workers' compensation medical care (WCMC) with the traditional health care system. Early versions of the single-payer bill introduced by Rep. Jim McDermott (D-Wash.) and Sen. Paul David Wellstone (DFL-Minn.), for example, used savings from WCMC to help finance universal coverage. Recent reforms in Florida, Washington, California, Massachusetts, and Oregon have encouraged the application of managed care techniques to WCMC and pilot projects for delivery of 24-hour medical coverage.

Despite the attraction of the various proposals for coordination or integration, significant policy and political barriers exist, many of them analogous to those facing national health care reform. Regulation of workers' compensation insurance has traditionally been a state responsibility, and resistance to federalizing the system is significant. Some states, for

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example, have had recent successes in controlling the growth of WC costs and are concerned that federal intervention will impede their ability to create an attractive business climate. Some employers, feeling that they have been successful in controlling their costs, are not interested in the help of the federal government. The commercial insurers that sell workers' compensation policies are concerned about separating the responsibility for medical management from the financial responsibility for cash benefits and about losing control over the medical portion of the workers' compensation premium—a portion representing 41 percent of the overall premium, or approximately 20 billion dollars a year. And organized labor, a possible beneficiary of national standards for both workers' compensation and health care, is resistant to any reforms that would weaken the benefits now available to workers.

In considering proposals to coordinate or integrate these systems, federal legislators will be asked to understand issues and address questions not previously considered on Capitol Hill. This Forum session will examine (*a*) the relationship of the workers' compensation cost crisis to health care reform efforts and (*b*) reform options, including coordination or integration of WCMC with health care reform initiatives at the federal and state levels. Key issues to be discussed include system design, the role of the federal government, and lessons from state initiatives.

WORKERS' COMPENSATION SYSTEMS: A PRIMER

When states began to introduce workers' compensation laws early in this century, there was strong interest in a national and compulsory general health care insurance program. Early reformers sought to protect families from the poverty that might accompany illness and injury, both work- and non-work-related, and there was a general interest in providing workers and their families with some means to meet their medical expenses and cover their lost wages.

In the early 20th century, industrial activity was extremely dangerous, making disabling workplace injuries common. But limited financial support and legal remedies meant that injured workers found it difficult to receive compensation. Their only options were to seek charitable assistance or to attempt to recover in court. The latter was difficult and uncertain, since workers had to prove employer negligence, and employers successfully used several defenses to refute this charge. These defenses included (*a*) contributory negligence; (*b*) the fellow-servant doctrine (that is, that the injury was the result of negligence on the part of the workers' fellow employee[s]); and (*c*) assumption of risk (that is, the worker could not recover if the injury was due to an inherent hazard of the job which the worker had known or should have known about in advance). The tort system also meant uncertainty for employers, who could neither predict nor insure against jury awards to successful claimants.

By 1910, the deficiencies of the tort system as a vehicle for compensating injured workers were well known, and states began to enact workers' compensation statutes as alternatives to the common law remedy. Indeed, these state laws were the first major social insurance programs in the United States. By 1920, all but 6 of the 48 states had enacted such laws. By that time, however, interest in a national health insurance program had waned. The American Medical Association as well as the pharmaceutical and private insurance industries vocally opposed such reform, and public support was lacking. So, until recently, debates and reform initiatives in the workers' compensation and general health care systems have been pursued separately, although in many ways the systems are clearly linked.

State WC programs vary widely in coverage, benefit levels, and costs, but they share a common set of historical principles and goals. All are based on the assumption of employer liability for workplace injuries and illnesses, and all serve as the injured workers' exclusive remedy for compensation. These principles reflect the historic trade-off between management and labor in which employers assumed "no-fault" liability for compensating injured workers and workers gave up their right to sue in court. All state programs are meant to provide benefits to workers whose injuries arise out of or in the course of employment. These have come to include medical, rehabilitation, and wage replacement (indemnity) benefits. Thus, workers' compensation is meant to provide insurance for workers and employers alike. Workers are insured against lost income and medical expenses relating to a workplace injury, and employers are relieved of the uncertainty of tort proceedings and, to a degree, are able to pool their risks to insure against losses.[1] Because they make employers liable

[1]Employers' risks are pooled in that the basic premium (also known as the "manual rate") is determined by an employer's risk class and by total payroll. This manual rate is then modified by the particular employer's loss experience. Those employers with a better-than-average loss (fewer claims) are awarded a credit, while employers with poorer-than-average loss (more claims) will carry a debit rating.

to some extent for the costs of workplace illness and injury, workers' compensation programs—at least in theory—provide an economic incentive to prevent accidents and thus improve workplace health and safety. Today's experience-rated workers' compensation premium, in which the premium is adjusted to reflect the past claims experience of the policy holder, reflects this goal.

Similarities and differences in state WCMC programs abound. In most states, workers have "first-dollar coverage" for all reasonable and necessary medical, surgical, and hospital care, since co-payments and deductibles have been seen as inconsistent with the no-fault employer liability and safety incentive aspects of the program. States have different approaches, however, to the issue of physician choice. Some give employers and insurers the right to choose the physician providing treatment to the injured worker; others give injured workers the freedom to choose. Some states limit the amount of choice or the number of times employers and workers can switch providers. States also vary in terms of covered benefits; for example, some state programs cover prescriptions, home health care, medical equipment, and dental care while others do not. State lists and definitions of compensable occupational diseases also differ—as do the levels at which states compensate workers.

Workers' compensation insurance itself is provided in different ways across states. Employers can self-insure (20 percent of the workers' compensation benefits are provided by employers who do so), or they can purchase insurance from commercial property and casualty insurers or from state funds. Six states operate exclusive state funds to provide workers' compensation insurance to employers in the state, and 14 states have both a competitive state fund and a commercial insurance market.

THE 1972 WORKERS' COMPENSATION COMMISSION

By the 1960s, criticism about the inadequacies, inequities, and inefficiencies of the state-based workers' compensation system were widespread. Benefit levels (and associated costs) varied tremendously across states and were largely inadequate. Many workers lacked coverage; the system was bureaucratic; and rehabilitation was seldom emphasized. With social reform in the air, Congress not only revisited the health care needs of the poor and elderly but also heeded calls for change in the workplace, in 1970 passing the Occupational Safety and Health Act. In doing so, Congress noted the serious questions relating to workers' compensation and established the National Commission on State Workmen's Compensation Laws to determine if these laws were providing an "adequate, prompt, and equitable system of compensation."

The commission defined five objectives for a modern workers' compensation system:

- broad coverage of employees and of work-related injuries and diseases;
- substantial protection against interruption of income;
- provision of sufficient medical care and rehabilitation services;
- encouragement of safety; and
- an effective system for delivery of the benefits and services.

The commission made 84 recommendations, 19 of which were identified as essential to a modern workers' compensation system. Recommendations relating to the provision of medical care and rehabilitation services include:

- Workers should be permitted the initial selection of the treating physician, either from among all licensed physicians in the state or from a panel of physicians selected or approved by the state compensation agency.
- There should be no statutory limits on the length of time or dollar amount for medical care or physical rehabilitation service for any work-related impairment.
- The workers' compensation agency should have discretion to determine the appropriate medical and rehabilitation services in each case, and there should be no arbitrary limits by regulation or statute on the types of medical service or licensed health care facilities which can be authorized by the agency.
- Each workers' compensation agency should establish a medical-rehabilitation division, with authority to effectively supervise medical care and rehabilitation services.
- Every employer or carrier acting as an employer's agent should be required to cooperate with the medical-rehabilitation division when an employee needs rehabilitation services.

The commission noted that other programs and agencies, such as Medicare and the Veterans Administration, may provide medical benefits to injured workers where statutory limitations or settlement agreements create gaps in coverage. It also stated, however, that the assumption of medical costs for work-related injury by other programs "would be inconsistent with the central tenet of workmen's compensation—that the cost of work-related injuries and diseases should be allocated to the responsible source."

Since the 1972 commission report, many states have expanded their workers' compensation programs to address inadequacies in benefits, both medical and indemnity. Many arbitrary limits on the level and duration of medical treatment have been eliminated, and a fee-for-service medical care delivery system has evolved. But the commission's recommendations have not been fully implemented, and wide disparities in coverage and benefits still exist across states. In 1988, coverage remained less than universal. Many states exempt employers under a certain size from providing WC insurance. In eight states, less than 80 percent of the workforce is covered. In only three states does coverage extend to 100 percent of the workforce. In many states, indemnity benefits for total temporary disability remain well below the commission's recommendation that, by 1981, each state's maximum benefit be 200 percent of the state's average weekly wage. In efforts to control rapidly expanding costs, some states have begun to reduce benefit levels. Many states have not fully implemented the commission's recommendations regarding physician choice (only seven states provide workers with an unrestricted right to select their initial provider and change providers at any time), nor has rehabilitation received the attention suggested by the commission.

Moreover, all those involved in the system are increasingly dissatisfied. Employers believe they are paying too much and often receiving too little. Workers are frustrated by lengthy delays, claim denials, and by what they see as inadequate care and inequitable benefits. Providers are sometimes reluctant to participate in a system that is seen as overly bureaucratic and adversarial and that, in some cases, pays inadequate rates. Many also criticize the system for its handling of occupational disease. State definitions of occupational disease often make it hard for workers to establish that these illnesses are work-related and to obtain compensation.

Since the commission issued its report, there have also been broader societal changes relevant to workplace illness and injury. The workforce has changed: an increasing number of older workers, women, and disabled individuals present new challenges—both to employers, who by law must make the workplace safe for all of them, and to providers, who must care for their patients' frequently overlapping work- and non-work health problems. The workplace has changed: there are more offices and retail trade establishments and fewer factories. These changes have transformed the nature of workplace injury and illness. Although fatalities and acute traumatic injuries still occur, the proportion of physical and stress-related disorders associated with cumulative exposures and stressful working conditions is growing. Some of these disorders overlap or closely resemble ordinary diseases of life, making the distinction between work- and non-work-related illness much finer. With the growing sophistication of biological monitoring and genetic screening, it is now possible to identify at-risk individuals before adverse effects become apparent. Sophisticated exposure assessment now permits the measurement of workplace air contaminants in the parts per billion range. These changes can have important implications for workers' compensation and health care reform.

THE WCMC COST CRISIS AND COORDINATION/INTEGRATION

As in the general health care system, cost is the main force driving reform efforts in workers' compensation. Nationally, WC costs have grown from $2.1 billion in 1960 to an estimated $60 billion in 1992. Medical benefits are the major component of this cost growth, now comprising 41 percent of all benefits, compared to 33 percent in 1965. Growth of WC medical expenditures has exceeded cost growth in the general health care system since 1972. From 1985 to 1990, for example, national health care expenditures increased 9.5 percent per year; in workers' compensation, medical care expenditures increased at a rate of 15.6 percent annually. The rapid growth in WCMC costs has been attributed to several factors, including price discrimination (that is, charging a higher price for a service delivered within the workers' compensation system than for the same service delivered outside the system), overutilization of medical services, cost-shifting, and litigation.[2]

[2]The need to determine eligibility, impairment, disability, and work-relatedness results in a substantial portion of WC medical costs devoted, not to treatment, but to such medico-legal determinations.

In considering reform options, it is vital to recognize the differences between the medical care delivered under the workers' compensation system and that delivered in the general health care system. The vast majority of WC medical services are outpatient in nature; only 10 percent of WCMC relates to inpatient care. Because a goal of the WC system is the rapid restoration of function and return to work of the injured employee, medical benefits—including prescription drugs and rehabilitation—are generally unlimited. It is hoped that intensive medical care and rehabilitation services will limit the number of lost workdays and, thus, the amount of the wage-loss benefit. Indeed, some have argued that economizing on medical costs might increase overall WC costs by delaying return to work.

The logic behind the current movement to coordinate or integrate WCMC with traditional health benefits can be summarized as follows: Workers' compensation costs have been rising rapidly due largely to medical costs that are escalating even faster than general medical inflation. The workers' compensation medical cost problem has worsened as cost containment techniques have been applied increasingly to the non-WC medical market. This has resulted in price discrimination and cost-shifting from the increasingly constrained general health care market to the virtually unrestricted workers' compensation medical care system. Reform of the health care system with its increasing application of cost-containment strategies, such as global budgets and strictly managed care, will further expand the incentives for price discrimination and cost-shifting onto the WC system. Therefore, some sort of coordination of the health care and WC systems will be needed to prevent further increases in WCMC costs. Additional benefits, including overall system savings through increased efficiency and decreased litigation, may be achievable through full integration of all medical benefits into one system.

POTENTIAL RELATIONSHIPS BETWEEN THE TWO HEALTH CARE SYSTEMS

What currently happens when workers seek medical care for work-related injuries? In some states, employees see the physician or other health care provider of their choice. This may be their own primary care physician or, perhaps, a provider recommended to them by a co-worker, friend, or even their employer. In others, the employer may direct workers to specific providers for care of the injury. In some cases, these providers may be "company doctors" or members of a workers' compensation preferred provider network that have experience in workers' compensation and have developed relationships with specific employers. Most work-related injuries are minor, have a clear relationship to work (for example, a finger cut while operating machinery on the shop floor), require only routine medical care, and do not result in much time lost from work. In these situations, the WC system generally works well; it pays for the necessary medical care which, in turn, facilitates a rapid return to productive work for the employee.

In other situations, where the relationship to work is less clear (for example, low back pain) or where extensive time is lost from work, employers and insurers may contest compensability, extent of disability, and return-to-work issues. In these more ambiguous cases, a number of factors may affect whether workers (now patients) and providers attribute a particular injury or illness to the workplace. Workers lacking other disability or health insurance may have incentives to attribute a questionable case to the workplace to avoid its financial consequences. On the other hand, workers might not recognize that a particular disease, such as emphysema, is related to workplace exposures or may want to avoid confrontation with their employer, thereby shifting the case from workers' compensation onto the general health care system. Providers may shift a questionable case onto the workers' compensation system if they will receive better reimbursement or be subject to fewer limitations or less micro-management of the patient's care. Conversely, providers—because of ignorance, a desire to avoid the administrative hassles of the workers' compensation system, or a sense of loyalty to an employer/insurer—may shift a case onto the general health care system by refusing to acknowledge its relationship to work.

An additional problem is insurance-induced limbo for those patients whose WC claims are denied. Most, if not all, group health plans specifically exclude payment for medical expenses related to workplace injuries and illnesses, and WC insurers will cover only those injuries and illnesses they believe are truly work-related. Thus, patients whose cause of injury or illness is in question may find their claim rejected by both the WC insurer and their own health plan, leaving them at least temporarily without access to appropriate care. This may signal the entry of lawyers and the beginning of "doctor-shopping" and "dueling doctors" as workers and

employers seek support from the medical and legal communities either to obtain needed benefits or to limit their liability. Despite the overlap of providers in the WCMC and the general medical delivery systems, it is easy to see how the separate financing and benefit structures create confusion, tension, case-shifting, and legal confrontation.

John Burton, the chairperson of the 1972 National Commission on State Workmen's Compensation Laws, recently described four models that illustrate in a general way the possible relationships between the general health care system and the health care system used for work-related injuries and illnesses: (*a*) separate and unequal, (*b*) separate but not so unequal, (*c*) partial integration of delivery systems, and (*d*) total integration of the systems.

Model one, separate and unequal, would essentially preserve the status quo of separate financing and delivery systems for work- and non-work-related injuries and illnesses. However, the model would accommodate the use in this WC system of cost containment strategies similar to those used in the general health care system, for example, utilization review and the development of managed care organizations specifically for the delivery of WCMC. Several state reform efforts have taken this approach.

In model two, separate but not so unequal, the two health care systems are coordinated, particularly with respect to cost containment strategies. For example, identical fee schedules or diagnostic related groups (DRGs) hospital reimbursement rates could be used to reduce the financial incentive for providers to shift cases from one insurance program to the other. This model recognizes that, despite separate financing mechanisms, the delivery systems for workers' compensation and general health care frequently overlap and that coordination of payment approaches could decrease price discrimination and facilitate common cost-containment strategies. In Canada, for example, it is felt that the workers' compensation system has benefitted from the cost containment approaches used by the provincial health plans to control the costs of general medical care; the same negotiated province-wide hospital and provider fee schedules are used to pay for workers' compensation and general medical care.

Model three, partial integration, envisions a common delivery system for health care benefits, regardless of the origin of the injury or disease. The existence of separate financing mechanisms, however, would still require distinguishing between work- and non-work-related injury and illness. As described below, this model most closely resembles that proposed by Title X of the Clinton Health Security Act.

Finally, model four would involve the total integration of both the delivery and financing systems for work- and non-work-related injury and illness. This model, sometimes called 24-hour medical care, would transfer the financial responsibility for the medical costs of workplace injuries and disease to the health care system, while maintaining a residual workers' compensation disability system to pay for lost wages and permanent disability. The Clinton plan proposes a commission to study the appropriateness and feasibility of such an integration, called "24-hour coverage" by some. For our purposes here, 24-hour coverage refers to a system that provides medical benefits to injured workers without the need to distinguish work- from non-work-related conditions.

A fifth model, not described by Burton, would involve a full merger of the entire WC system with existing or newly developed social welfare programs. Under this model, it would no longer be necessary to make a distinction between work- and non-work-related injury, illness, and disability. At least one country (New Zealand) has moved in this direction, although it is not seriously being discussed in the United States. In addition to merging the health care delivery systems, this model would also merge work-related disability benefits with those offered under other public or private disability plans, such as Social Security and private disability plans.

THE CLINTON PROPOSAL

The Clinton administration was motivated by both policy and political considerations in its deliberations about coordinating or integrating WCMC with health care reform. The stated policy goals were to rationalize the delivery of health care services and to achieve costs savings and improved outcomes by decreasing duplicated services, avoiding unnecessary litigation, and applying managed care and other cost containment techniques to the WC medical system. On a political level, the administration hoped to attract support from businesses uniformly concerned about the growth of workers' compensation costs but possibly otherwise unsupportive of employer mandates for the purchase of health insurance as part of health care reform.

Initially, the administration's health care task force considered a Garamendi-style integration that would

use anticipated savings from the workers' compensation medical system to help finance universal coverage. However, it turned to a more limited approach to integration after encountering a number of technical and political obstacles.

As written, Title X of the Clinton Health Security Act proposes the coordination of the medical care delivery system by requiring each health plan offered through a health alliance to provide or arrange for the delivery of workers' compensation medical services for its enrollees. The employer, through the workers' compensation carrier, would retain financial responsibility and reimburse the health plans. Medical and indemnity benefits would continue to be provided in accordance with state law. Workers would choose the health plan from which they would like to receive their general medical care and would receive any WCMC through these same plans. Most individuals would receive their medical care through managed care organizations, although payment for WCMC would be made on a fee-for-service basis. Title X does, however, encourage the exploration of alternative payment mechanisms, such as capitation.

To enhance the coordination of WCMC with disability benefits, the Clinton plan requires health plans to provide case management services. Case managers would coordinate workers' medical treatment with the workers' compensation carriers and the employers. The Clinton plan would preempt state laws with regard to the choice or payment of providers and would prohibit worker cost-sharing for medical expenses for work-related injury and illness. Finally, it would create a commission to study the appropriateness and feasibility of transferring financial responsibility for all medical benefits (including those currently covered under workers' compensation and automobile insurance) to the health plans.

In the context of the models described earlier, the Clinton plan most closely resembles model three, partial integration of the delivery system for several reasons:

Benefits. Workers' compensation benefits would continue to be determined by state law. (Most states are committed to a wider range of workers' compensation medical benefits than those that would be required under the Clinton comprehensive benefit package.)

Specialized Services. In part because many states offer these broader benefits—for example, rehabilitation benefits—and in part because of the recognition of the specialized nature of certain workers' compensation medical services, the Clinton plan provides for the states to coordinate additional specialized services for injured workers that may not be provided by their health care plans as part of the general health benefit package.

Financial Responsibility. Since financial responsibility for medical treatment of work-related injury and illness would remain with the employer and WC insurer, providers and patients would still need to distinguish between work- and non-work-related causes.

What eventually emerged from the task force was a compromise between those who favored full integration and those who favored the status quo. The president and others in the executive branch have been enthusiastic when speaking to labor and business groups about this aspect of the plan. Organized labor is on record as favoring full-integration but has supported the Clinton proposal overall. According to Jim Ellenberger of the AFL-CIO, "It is essential that national health care reform include the medical portion of workers' comp to achieve the goals of effectiveness, cost containment, quality, and confidence in the system. Maintaining a separate medical delivery system for workers' comp, as we do now, will simply encourage medical providers, insurers, employers, claimants, and attorneys to continue behavior that will exacerbate current problems." Employers and WC insurers, on the other hand, are concerned about losing control of their ability to manage the workers' compensation system. For example, Robin Obitz, former chairperson of the U.S. Chamber of Commerce, has said, "Employers should have as much to say in the choice of physicians in comp as they do in other benefit programs. Control is very critical."

Indeed, the issue of control underlies much of the debate around integration. Employers and insurers fear losing control of the system. They believe that their control over provider choice and medical case-management is critical for containing costs, especially indemnity costs. Workers, on the other hand, believe that their control of provider choice will enhance their quality of care and inject more fairness into the system.

POTENTIAL IMPACT OF TITLE X

The WC insurance industry which, for the most part, has not offered non-WC health insurance products, has questioned the likely effectiveness of the

Clinton proposal in controlling costs and has expressed concern that total workers' compensation costs may actually increase. A 1993 policy memorandum issued by the Workers' Compensation Research Institute (a research organization supported by its members, derived largely from the insurer and employer communities) suggested that Title X of the Clinton plan may increase total workers' compensation costs because the effects of its cost-increasing components may outweigh those of its cost-saving features. They define the plan's cost-saving features as the use of medical fee schedules, greater use of capitated delivery systems, development and use of medical treatment protocols, and selective contracting with health plans by the corporate alliances. Cost-increasing features were identified as mixing fee-for-service and capitated payment, separating medical management functions from financial responsibility for wage replacement, and allowing for the use of specialized workers' compensation providers outside the health plans.

However, the International Association of Industrial Accident Boards and Commissions (IAIABC), while not specifically supporting Title X, has recognized the need for some level of coordination between the systems. In a 1993 position paper presented to the White House Task Force of Health Care Reform, the IAIABC stated:

> While the medical care component must be coordinated with various facets of a national health care policy to increase quality of care and to control costs, it must not be absorbed within a new and untried delivery plan that must first address the general health care needs, particularly of uninsured and underinsured. There must be carefully implemented strategies for addressing the unique set of linked goals from medical care to medical stabilization to work role recovery and productive employment. Further, a national health policy if well implemented and appropriately coordinated with workers' compensation will reduce current cost shifting into workers' compensation and will supply the impetus for the states to put in place strategies to achieve medical cost control and, at the same time, control of indemnity benefit costs.

Although an early attraction to integrating benefits was the hope of achieving savings that could be applied towards universal coverage and expanded benefits, the administration is not claiming any savings from the coordination phase of Title X, nor has the Congressional Budget Office validated any estimate of cost impact. Indeed, it is virtually impossible to predict the potential cost implications of Title X, and its initial impact would likely vary across states and employers, depending on their current WCMC cost structure and related programs. For example, in states with no workers' compensation fee schedules or with fee schedules that allow payments greater than average charges, the application of a Medicare-like fee schedule would likely lead to reductions in medical expenses. In states that currently have fee schedules substantially below the going rates for other payers or that promote selective and discount contracting, the application of a Medicare-like fee schedule might actually increase medical expenses.

OTHER APPROACHES FOR FEDERAL ACTION

Since considerable amendment to or wholesale revision of President Clinton's Health Security Act before passage is likely, the fate of Title X is unknown. Nevertheless, there is widespread recognition that the workers' compensation medical care system has serious problems, many of which spill over onto the general health care system and some of which may be amenable to federal action. Certainly, the federal government could completely take over the WC system, but there is significant resistance to this idea.

Alternatively, some advocate that the federal government exert more control over the system by establishing certain requirements or guidelines for the state-based WC programs. For example, the federal government could establish the floor for a basic benefit package in workers' compensation and could identify and require the delivery of other occupational health care services—such as occupation-specific screening and monitoring—by health plans. It could prohibit price discrimination and balance billing by providers caring for injured workers and require that a patient's plan-provided coverage continue without interruption in the event of a dispute about the work-relatedness of an injury or illness. If a Medicare-like national fee schedule were established for all health providers, the federal government could require its application to workers' compensation as well.

Others support a fall-back strategy that would give states more opportunity to experiment with WC and health care reform by amending the Employee Retirement Income Security Act of 1974 (ERISA). This could facilitate state experiments with merged systems and other creative approaches to reform.

Many health and safety professionals feel that federal and state reformers should not limit their

purview to questions of cost containment. In this context, the federal government could design strategies to optimize safety incentives and prevention initiatives in workers' compensation and in health care reform. For example, health and workers' compensation insurance claims could provide a wealth of data for injury and disease surveillance, as well as for possible educational or enforcement activities by state and federal agencies charged with workplace health and safety. The use of uniform medical data collection forms by health providers and plans could greatly enhance epidemiologic study of work-related illness and injury. The federal government could also require the prompt reporting of certain illnesses and injuries by health plans and providers to state or federal authorities. The potential for fashioning reform initiatives to complement and enhance workplace health and safety activities is significant.

STATE EFFORTS AT REFORM

What can federal legislators learn from state efforts to coordinate workers' compensation and health care reform? According to the National Council of State Legislators, the workers' compensation system has become the bane of state lawmakers, with rapidly escalating WC medical costs their number one concern. Workers' compensation costs are considered a major factor in determining a state's business climate, and interstate competitiveness and pressure from organized business groups have made cost control an issue in every state in the country. Often, states have relied on hospital and provider fee schedules and limits on employees' choice of physicians to control costs, but these approaches have not been demonstrated to be effective. Recently, some states have begun to experiment with managed care techniques and delivery organizations in new attempts to control WCMC costs.

There are, however, significant legal and political barriers to the use of managed care approaches in workers' compensation. State laws may hamper the development and use of managed care provider programs in WC. In states that allow workers to choose their providers, employers cannot force injured workers to receive care from a preferred provider, health maintenance, or managed care organization.

Generally, employers can pursue the use of managed care techniques in WC if the state laws do not expressly forbid it. These may include utilization review, medical fee schedules, hospital payment regulation, and bill review. As described below, recent state reforms have encouraged the use of new cost containment and managed care strategies for workers' compensation and pilot projects to test the feasibility of integration or 24-hour coverage.

Florida

Florida's 1990 WC reform allowed the state's Department of Insurance to initiate a pilot program to evaluate the potential cost savings of using managed care in workers' compensation. The pilot program looked at a health maintenance organization (HMO) and a preferred provider organization (PPO) model for delivering WCMC. Seventeen thousand state government employees in South Florida were divided into two groups; half received their WCMC through an HMO called CAC-Ramsay and the other half under the traditional fee-for-service arrangement. The preliminary results from this project, analyzed by Milliman & Robertson for the Department of Insurance and reported in April 1993, indicate that the HMO program reduced medical costs by 38.5 percent and treated claimants with a less complex and less costly mix of services. It is notable, however, that patients in the HMO were significantly less satisfied with the care they received and the control they had over decisions affecting their medical care. The cost-savings results of this project, although preliminary, have given momentum to reforms in other states promoting the use of managed care for treatment of work-related injuries and illnesses.

The second, PPO-based, pilot project was not as successful in controlling costs. This project involved 7,500 privately employed workers who received their WCMC either from a PPO established by Travelers Insurance Companies or who sought care outside the PPO. The initial analysis of this program suggests little difference in direct claims costs or claimant satisfaction between those who received their care within the PPO and those who went outside the PPO for their care.

Based on the results of these pilot projects, current proposals before the Florida legislature propose the mandatory use of managed care organizations (MCOs) and establishment of pilot programs in 24-hour coverage. However, it is not clear if the results of these pilot programs are generalizable state-wide, nor is it known how they might affect wage-loss costs.

Oregon

Oregon has been a leader in developing legislative strategies to address both workers' compensation and health care reform. In the 1980s, Oregon businesses

were reportedly paying among the highest workers' compensation premiums in the country. Major WC reforms in 1990 expanded administrative, enforcement, and education efforts, narrowed the scope of compensability, and reduced the need for litigation. In addition, new initiatives encouraged an early return to work, and the voluntary employer use of new MCOs was begun.

The Oregon MCOs differ from workers' compensation managed care organizations in other states in that employers and insurers are specifically restricted from establishing and controlling the organizations. Rather, the MCOs are established by various provider groups that, in turn, contract with self-insured employers and/or insurers to deliver workers' compensation medical services. The MCOs are certified by the state. Employees of firms that have contracts with MCOs for WCMC are required to be seen either by their preselected primary care physician or by providers within the insurer-contracted MCO. Initial results suggest that medical cost growth has moderated for those firms that have contracted with MCOs; full-scale evaluation of the impact of the MCOs is now under way. Currently, approximately 33 percent of all Oregon employees are working in firms covered by MCOs.

In 1993, Oregon passed a law to evaluate the feasibility of combining group health insurance coverage with the medical portion of workers' compensation. Under this initiative, several pilot projects were designed to test variations of the partial integration and total integration models, including capitated payment for WCMC. The pilot projects began operation in early 1994 and are scheduled to continue through 1998. It is important to note, however, that this and all other state experiments with 24-hour coverage can be pursued only with voluntary employer participation because self-insured health benefits are generally exempted from state regulation by ERISA.

Massachusetts

The 1991 workers' compensation reforms in Massachusetts included a number of medical cost containment provisions. Although employees retain choice of treating physician, they can change only once. If the employer or carrier uses a preferred provider arrangement for WCMC, the employee must, in most cases, first obtain treatment within this arrangement but then can change, once, to a provider of his or her choice. Treatment guidelines have been written, mandatory utilization review of medical claims has been implemented, negotiation of fees is permitted, and a procedure for reporting complaints about health care services has been established. No evaluation of the effectiveness of the medical cost containment provisions has been done. However, benefit reductions to workers and administrative reforms have been credited for the first workers' compensation rate reduction in 22 years.

Perhaps the most interesting aspect of the Massachusetts reform allowed for the development, through collective bargaining agreements, of new programs outside the existing workers' compensation system, so-called labor-management carve-outs. The first agreement under this provision was implemented between the Bechtel Corporation and the Pioneer Valley Building and Trades Council representing five construction unions working on a project in Springfield, Massachusetts, in 1993. This agreement provided for binding alternative dispute resolution, use of an exclusive workers' compensation PPO, provision of modified work for workers undergoing rehabilitation, and enhanced lost-wage replacement for injured workers. In essence, the workers agreed to binding arbitration instead of litigation to settle disputes. In addition, the workers accepted some limitation in provider choice by agreeing to seek care from physicians within the exclusive PPO. In return, the workers received improved wage-loss benefits, improved access to a medical care network, and quicker resolution of claims.

Initial analysis of this six-month pilot project showed that, although the number of recorded injuries remained unchanged, there was a significant reduction in the number of lost-time cases and a 56 percent decrease in total workers' compensation costs compared to historical controls. The success of this pilot program has led to similar legislation in Florida and California to allow carve-out agreements between management and organized labor.

Washington

Washington, through its Department of Labor and Industries, operates one of the six exclusive state workers' compensation funds in the country. (There is no commercial WC insurance in the state.) In 1985, the Washington State Fund was facing a major fiscal and political crisis after several years of double digit increases and a projected need for a 40 percent increase in premiums to maintain solvency. Reforms enacted since that time—including the repeal of mandatory vocational rehabilitation and the application of a variety

of health care cost containment methods, such as the use of hospital diagnosis related groups and prospective payment systems, fee schedules, and utilization and peer review—moderated premium increases and held health care cost increases to an average of 7.6 percent per year between 1985 and 1992.

The Washington Health Services Act of 1993 defined an implementation time line for state reforms through a system of managed competition among certified health plans similar to the Clinton plan. This act also created the Health Services Commission to govern the health system and, in coordination with the Department of Labor and Industries (DLI), to study consolidation options and develop a proposed plan for providing medical benefits under the state's workers' compensation program through the certified health plans, a single purchaser, or some other option. The Washington Health Services Act specifies that "a consolidated system must assure workers and employers of several things":

- Medical benefits for injured workers are at least equivalent to the benefits provided under the current law.
- Non-medical benefits, such as vocational rehabilitation, are not affected by consolidation.
- Employees who do not wish to participate can continue to have medical benefits covered under the current law.
- Employers may choose not to become part of a certified health plan.
- Workers will not be required to pay deductibles, co-payments, or other point-of-service charges.

In addition to the consolidation study and in anticipation of a reformed environment, the Washington State Fund is also developing managed care pilot projects expected to be implemented in August 1994. The objective of these projects will be to "provide reliable, objective information on which labor, business, and the state of Washington can make wise choices about managed care and the future of workers' compensation in a reformed health care system."

THE FORUM SESSION

During this Forum session, participants will address key issues relating to system design and regulatory structure that legislators will likely consider as they evaluate proposals for reform at the federal level.

System Design

Cost Savings. What would be the consequences of maintaining the status quo in workers' compensation medical care in the context of national health reform? How would various federal coordination and integration options affect medical care and total system costs? If cost savings are indeed achieved through coordination or integration of medical benefits, should these savings be 'captured' to help pay for expanding access to health care, or returned to employees and employers through the workers' compensation system?

Financial Risk. Will transferring financial risk from employers to health plans decrease employer incentives for workplace safety? Can appropriate incentives be designed for health plans and providers to participate in the rapid return to work of injured employees?

Covered Benefits. Should injured workers continue to receive a different medical benefit package than what might be offered under a national health insurance plan? In the interests of cost containment, should workers share in the costs of WCMC through coinsurance and/or co-payments?

Control and Choice. Is there justification for restricting workers' choice of providers for WCMC? How much control over medical care do employers and insurers need in workers' compensation?

Regulatory Structure

Role of the States. What lessons can be learned from current state programs involving WC and health care reform? What do states need from the federal government to proceed with their experiments and reforms? How much flexibility in workers' compensation should states retain in a coordinated medical delivery system? Will the goals of workers' compensation systems be enhanced by closer coordination or integration with the health care system?

Role of the Federal Government. If coordination of workers' compensation medical care is not included in federal health care reform, is other federal action needed to protect the workers' compensation system from medical cost inflation and to allow states to proceed with innovative reforms? Should the federal government link reform efforts in workers' compensation with its other workplace injury and illness prevention programs under the direction of the Department of Labor?

The session will begin with an overview of the issues by **Jay Himmelstein, M.D.,** assistant chancellor for health policy and director of the Occupational and Environmental Health Program at the University of Massachusetts Medical Center. Dr. Himmelstein was the medical director for the first negotiated labor-management workers' compensation program in the country, and works as a consultant to numerous entities involved in applying managed care techniques to workers' compensation. He is a former Robert Wood Johnson Health Policy Fellow and is a recipient of a grant from the foundation to evaluate various policy alternatives for the relationship between workers' compensation and the traditional health system. He has worked as a health staffer and consultant to the Senate Labor and Human Resources Committee.

Gary Claxton, special assistant to the deputy assistant secretary for health policy, DHHS, will explain the logic behind coordinating workers' compensation medical care and the mainstream medical system as proposed in the Clinton health reform plan. Mr. Claxton was a member of the Intergovernmental Working Group assisting President Clinton's health care task force, where he chaired the working group looking at insurance reform issues. He previously was senior policy analyst at the National Association of Insurance Commissioners, where he developed model legislation on health and long-term care insurance issues and analyzed federal legislative proposals related to health insurance, long-term care insurance, and employee benefits.

John F. Burton, Jr., Ph.D., will discuss the challenges inherent in merging the two systems and will comment on the Clinton plan. A leading scholar and consultant on workers' compensation issues, Dr. Burton is director of the Institute of Management and Labor Relations at Rutgers University. He has served as a consultant on workers' compensation to several states, including Florida and New York, and to the federal government, including the Clinton administration's health reform task force. He has written several books on workers' compensation and also edits the *John Burton's Workers' Compensation Monitor*, a newsletter, in which he has recently analyzed national health care reform and workers' compensation.

Sara T. Harmon, administrator of the Workers' Compensation Division, Oregon Department of Consumer and Business Services, will describe Oregon's experience with developing managed care systems for workers' compensation and a pilot project demonstrating the feasibility of 24-hour coverage. Before assuming her current position, she was the chair of the Washington Board of Industrial Insurance Appeals from 1987 to 1991. Previously, she served for five years as a workers' compensation hearings judge and mediation/review judge in Washington.

Linda Murphy, program manager, health services analysis, Washington Department of Labor Industries, will discuss that state's plans for coordinating workers' compensation care with its overall strategy for universal coverage. She heads up the health care cost containment and quality assurance program for the department, which is responsible for workers' compensation benefits for two-thirds of the state's workers. Under her direction, the department is carrying out mandates of the Washington Health Services Act of 1993 to study options for consolidation of medical benefits for injured workers with the state's reformed health care system. She is also responsible for managed pilot projects authorized by the act.

A discussion involving all present will incorporate comments from three others:

James N. Ellenberger, assistant director, Department of Occupational Safety and Health, AFL-CIO, serves as a member of the Labor Research Advisory Council to the Department of Labor. He is a founding member in the area of unemployment insurance of the National Academy of Social Insurance, an associate member of the IAIABC and a consultant to its Legislation Committee, and a member of the Advisory Board to *John Burton's Workers' Compensation Monitor*. He is a certified employee benefit specialist.

Kevin Haugh is a director at the Institute for Health Policy Solutions, a not-for-profit, nonpartisan health policy organization. He has experience in analyzing a wide range of health care access and cost containment issues. In recent years, Mr. Haugh has studied the medical component of the workers' compensation system and how it may fit into broader efforts to reform the health care system. He recently completed a project for the Henry J. Kaiser Family Foundation focusing on the workers' compensation medical system and health system reform.

Robert B. Steggert is vice president of casualty claims, Marriott International, Inc., where he is responsible for the company's worldwide property-casualty activity. However, the majority of his time is dedicated to its domestic casualty and occupational