



State of Vermont
Agency of Administration
Health Care Reform
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REPORT TO THE VERMONT LEGISLATURE

Integration or Alignment of Vermont's Workers' Compensation System with Green Mountain Care

In accordance with Act 48, Section 8(b)

Submitted to
House Committee on Health Care
Senate Committee on Health and Welfare
Senate Committee on Finance

Submitted by
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Introduction

Green Mountain Care was created by Act 48 of 2011 as a publicly financed health care program delivering affordable, high-quality health care coverage to all residents of Vermont. Under Section 8 of Act 48, the Commissioner of Labor, in consultation with the Commissioner of Vermont Health Access (DVHA) and the Commissioner of the Department of Financial Regulation (DFR), were charged with engaging interested stakeholders to evaluate the feasibility of integrating or aligning Vermont's workers' compensation system with Green Mountain Care, including providing any covered services in addition to those in the Green Mountain Care benefit package. After evaluating various models of integration, it is recommended that the Department of Labor and the Department of Financial Regulation work together to provide greater administrative alignment prior to Green Mountain Care implementation in order to ensure that Vermont's workers' compensation system maintains workers' rights while capturing potential administrative efficiencies to be gained with the implementation of a publicly financed universal health care program.

Interested Stakeholders

Representatives from the Agency of Administration, Department of Labor and the Department of Financial Regulation reached out to various stakeholders during the writing of this report through public meetings and individual contact. Representatives from the Department of Financial Regulation met with individuals representing the property and casualty insurers in September 2011 and held a public meeting for insurers, brokers, and employers in April 2012. The administration held a public meeting for providers in June. No providers attended the meeting. The administration followed up with an occupational physician for a provider perspective. Representatives from the Agency of Administration and Department of Labor met with a labor union representative, a labor union lobbyist, individuals from the Vermont Workers' Center, and several workers' compensation scholars in June. In July, a representative from the Agency of Administration contacted former Rep. Jim Eckhardt for the employer perspective on this issue. The Agency of Administration met with the Vermont Workers' Center, a physician, and a workers' compensation scholar in September. In January, the Agency of Administration met with two workers' compensation attorneys and two labor union representatives.

Vermont's Workers' Compensation System

Under the current workers' compensation system in Vermont, an employer must purchase workers' compensation insurance unless approved by the Department of Labor to self-insure.¹ The Department of Labor and the Department of Financial Regulation oversee various aspects of workers' compensation, but workers' compensation insurance is provided exclusively through the private sector by about 25 insurance companies actively providing plans.²

¹ 21 V.S.A. 687.

² WorkersCompensationShop.com, "Vermont Workers Compensation Programs," <http://www.workerscompensationshop.com/workers-comp-programs/vt-workers-comp-programs.html>.

The health benefits provided under workers' compensation differ from those provided under health insurance. Workers' compensation is also event-based, meaning coverage is dependent on the event of the injury and extends for as long as treatment of the injury occurs, as opposed to current health insurance, which is treatment-based and coverage extends for the length of the plan, regardless of cause of injury. Workers' compensation is an exclusive remedy. In exchange for waiving the right to sue their employers, workers have the right to no-fault, unlimited third party medical and indemnity payments with no deductible or copayments, including:

- Reasonable surgical, medical and nursing services and supplies, including prescription drugs and durable medical equipment³
- Assistive devices and modification to vehicles and residences that are reasonably necessary to an injured worker who has or is expected to suffer a permanent disability⁴
- Reasonable hospital services and supplies, including surgical, medical, and nursing services⁵
- Reasonable expenses related to travel for evaluation and treatment, including transportation expenses, meals, lodging.⁶

The goal of medical treatment under workers' compensation is to return the worker back to work as quickly as possible. At times, this goal may result in treatment that is more aggressive and costly than under health insurance.⁷

The employer chooses the physician for the initial visit, but the employee may choose the physician for subsequent visits after providing the employer with a written notice of the reasons the employee is dissatisfied with the employer's chosen health care provider.⁸ If the employee chooses another health care provider, the insurer may exercise its right to schedule an independent medical exam with a medical expert of its choice to address any issue related to the work injury, such as causation, medical end result, reasonableness and necessity of treatment, work capacity, or impairment.

From the provider perspective, most administrative functions, such as billing codes, are the same under workers' compensation as for health insurance.⁹ The provider payments under workers' compensation, however, are often more generous than under health insurance plans.¹⁰

³ ERISA § 640(b).

⁴ Ibid. at § 640(a).

⁵ Ibid. at § 640(a).

⁶ VT Workers' Comp. Rule 12.2000.

⁷ Dr. Nelson Haas, Occupational Medicine, telephone conversation with author, December 18, 2012.

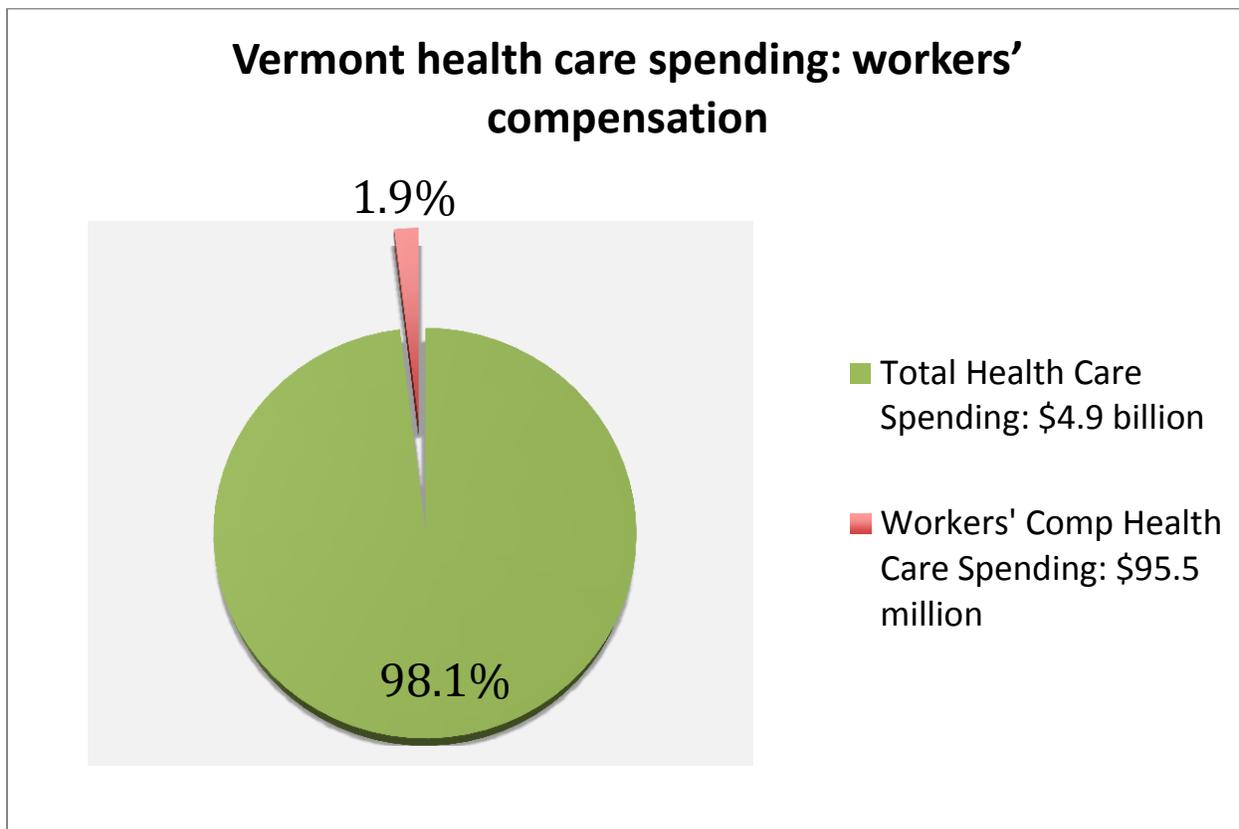
⁸ VT Workers' Comp. Rule 12.1000.

⁹ Dr. Haas telephone conversation.

¹⁰ Ibid.

In addition, workers' compensation insurers tend to deny more services than health insurers, but this may also be a function of requesting more services due to the goal of getting the employee back to work.¹¹

In terms of costs, workers' compensation is a fraction of Vermont's overall health care costs, totaling 2.3% of Vermont's health care spending in 2009.¹² For employers, workers' compensation accounts for \$2.07 for every \$100 of wages.¹³



Background for Integration

The Clinton administration's national health care reform plan proposed that employees receive all of the health care through one health insurance plan, regardless of whether the injury was work-related.¹⁴ At its broadest definition, 24-hour coverage would "ignore causation in

¹¹ Dr. Haas telephone conversation.

¹² Green Mountain Care Board, "2010 Vermont Health Care Expenditure Analysis," revised March 2012, available at <http://gmcboard.vermont.gov/sites/gmcboard/files/2010EA040212.pdf>.

¹³ Oregon Department of Consumer and Business Services, "2012 Oregon Workers' Compensation Premium Rate Ranking Summary," available at http://www.cbs.state.or.us/external/dir/wc_cost/files/report_summary.pdf.

¹⁴ Robert Wood Johnson Foundation, "Workers' Compensation Health Initiative: Program Results Report, Feb. 23, 2004," available at: <http://www.rwjf.org>.

compensating for medical care or lost wages.”¹⁵ Despite the failure of the Clinton plan, there was still momentum to integrate workers’ compensation with health insurance, fueled, in part, by increased workers’ compensation premiums at that time. Ten states¹⁶ passed legislation authorizing 24-hour pilot programs, and five other states¹⁷ discussed 24-hour care as an option.¹⁸ Despite the fact that several states authorized pilot plans, only pilot plans in Oregon and California became operational.

Oregon

In 1994, Oregon provided a pilot plan offered by Blue Cross/Blue Shield HMO and the State Accident Insurance Fund Corporation (SAIF) which provided services to nine employers with a total of approximately 2,200 covered employees.¹⁹ Under this plan, the employer received two separate contracts, but the insurer and the health plan used the same managed care network and physician payment rates, providing seamless delivery to the covered employees.²⁰ Under a pilot plan that was a partnership between Kaiser Permanente HMO and self-insured employers, the HMO accepted capitated payments for all services, and the 900 members in the program received all their medical care from the HMO. By 1997, Oregon had expected 10,000 to 20,000 employees to participate in the pilot plans, but only 3,600 had been recruited. The low recruitment rate was explained by less interest in the programs due to lower workers’ compensation rates at that time.²¹ Oregon also reported that fully integrating the operations of workers’ compensation and health insurance was “difficult” and that “pricing advantages did not materialize.”²² The pilot plans reported that obstacles to full integration included: claims handling, because workers’ compensation involves payment of disability benefits in addition to health care; and financing, because workers’ compensation and health insurance are priced “very differently.”²³ In the end however, these plans were able to produce a product that integrated workers’ compensation with health insurance. The pilot plans reported that provider reimbursement and lost-time duration management were areas that could be successfully integrated.²⁴ Towards the end of the program, in 1997, there was no interest integrating health

¹⁵ American Legislative Exchange Council, “Understanding 24-Hour Coverage,” *The State Factor*, Vol. 17, No. 11 (October 1991).

¹⁶ These states were California, Florida, Georgia, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Oklahoma, and Oregon.

¹⁷ These states were Hawaii, Iowa, Montana, North Carolina, and Washington.

¹⁸ The California Commission on Health and Safety and Workers’ Compensation, “Preliminary DRAFT CHSWC Background Paper on Twenty-Four Hour Care,” available at: http://www.dir.ca.gov/chswc/CHSWC_24hCare.pdf.

¹⁹ Vance A. Hughey, Nevada Legislative Counsel Bureau, “24-Hour Coverage and Workers’ Compensation,” Jan. 1997, available at: <http://www.leg.state.nv.us/Division/Research/Publications/Bkground/BP97-05.pdf>

²⁰ *Ibid.*

²¹ *Ibid.*

²² Robert Wood Johnson Foundation, “Oregon Tests Concept of Combining Workers’ Compensation Insurance with Health Insurance: Grant Results, March 1997,” available at <http://pweb1.rwjf.org/reports/grr/020229s.htm>

²⁴ *Ibid.*

insurance and workers' compensation into one plan and very little interest in providing coordinated care under separate health insurance and workers' compensation policies.²⁵

California

In 1993, California established provisions for four countywide pilot plans of 24-hour care. The plans involved integration of medical benefits only. Employers paid a monthly capitation fee that was separate from health insurance fees. The physicians had access to patients' occupational and nonoccupational medical records. As with Oregon, worker participation was voluntary and workers' compensation rates had decreased, resulting in only 8,000 workers enrolled in the pilot plans as of 1997.²⁶ This number at least provided a significant sample population from which researchers could draw empirical findings. Those findings included a 20-34 percent increase in the average medical claim for the pilot plan than similar claims in comparison-group firms. In the end, pilot firms paid 47.5 percent more in premiums than firms in the comparison group.²⁷ It should be noted that sample group was self-selective and tended to include enrollees who were older and more likely to have a chronic medical condition than those in comparison groups.²⁸ A companion study found no statistical difference in employee satisfaction between the pilot plan than comparison plans.²⁹

The outcomes of initiating 24-hour care programs in Oregon and California prove that integration of workers' compensation with health care is possible, but fail to provide a solid basis from which Vermont can evaluate potential costs or savings of integration.

Massachusetts

Massachusetts has not integrated workers' compensation into its health care system, but it has achieved near-universal health care through its recent health care reform. As a result of increased health insurance coverage, workers' compensation claims have decreased 5-10 percent.³⁰ A similar, if smaller, decrease may happen under Green Mountain Care.

Overarching Issues in Integration

While the interests of workers and employers must be weighed when considering various models for integrating workers' compensation, some issues come into play no matter what the integration model. These issues include safety incentives, the Employee Retirement Income Security Act (ERISA), and administrative savings.

²⁵ Ibid.

²⁶ Donna O. Farley et al., "Assessment of 24-Hour Care Options for California," RAND Institute for Civil Justice, 2004, pg. 26, available at: http://www.rand.org/content/dam/rand/pubs/monographs/2004/RAND_MG280.pdf

²⁷ Ibid. (citing Kominski et al., 2001)

²⁸ Ibid (citing Kominski et al., 2001)

²⁹ Ibid (citing Kominski et al., 2001), citing Rudolph et al., 2000

³⁰ Paul Heaton, "The Impact of Health Care Reform on Workers' Compensation Medical Care: Evidence from Massachusetts," RAND Corporation, 2012, available at: http://www.rand.org/pubs/technical_reports/TR1216.

Safety

One argument against the integration of workers' compensation into a universal health care system is that the experience rating under workers' compensation provides a strong safety incentive to employers. Research provides conflicting information on this issue. It has been reported that workers' compensation prevents fatalities;³¹ however, a more recent study concludes that nearly 80 percent of workplace related illness are paid by government or private health plan, reducing the actual costs for workers' injuries and subsequently reducing the incentive to provide a safe workplace.³² Other authors agree that whether workers' compensation, by itself, acts as an incentive to provide safe workplaces is questionable.³³ Although the experience rating of workers' compensation may not provide much safety incentive, various premium discounts for safety measures taken by employers may be more effective.

ERISA

Some of the insurers voiced concern that ERISA would pre-empt any integration of the health care portion of workers compensation into Green Mountain Care. The Employee Retirement Income Security Act (ERISA) is a federal statute that regulates private-sector employer-sponsored benefit plans, including health care coverage, for self-insured plans and plans offered through an insurance product.³⁴ ERISA's protections "supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."³⁵ This is commonly known as ERISA's "preemption clause," which was established to encourage employers to provide benefit plans to their employees across state lines, independent of dissimilar state laws. Workers' compensation, however, is an exception to the preemption clause, meaning that states have the right to regulate workers' compensation. The exact language of the exception includes plans "maintained solely for the purpose of complying with workman's [sic] compensation laws."³⁶

One possible argument against integrating workers' compensation into Green Mountain Care is that once the health benefits of workers' compensation are integrated, they are no longer considered "solely" for the purpose of workers' compensation laws and will be preempted by ERISA as health care benefit plans. Although some cases have touched on this argument, none of them have directly addressed integration of workers' compensation health care benefits into a public system. In one case examining disability benefits, which are also an exception to

³¹ Michael J. Moore and W. Kip Viscusi, "Promoting Safety Through Workers' Compensation: The Efficacy and Net Wage Costs of Injury Insurance," *The RAND Journal of Economics*, Vol. 20, No. 4 (Winter, 1989), pp. 499-515, available at: <http://www.jstor.org/stable/2555730>

³² Paul J. Leigh, "Workers' Compensation Benefits and Shifting Costs for Occupational Injury and Illness," *The Journal of Occupational and Environmental Medicine*, 54(4), 445-450, April 2012.

³³ Geoffrey C. Beckwith, "The Myth of Incentives in Workers' Compensation Insurance, *New Solutions*," Winter 1992.

³⁴ 29 U.S.C. 1002(1)

³⁵ 29 U.S.C. 1144(a)

³⁶ 29 U.S.C. 1003(b)(3)

preemption, it was determined that a state may not require integration of disability benefits into a health plan, but it may require an employer to choose between providing disability benefits in a separately administered plan or in an ERISA plan.³⁷ This precedent regarding state disability benefits laws has been applied to cases involving state workers' compensation programs. For example, the Court of Appeals for the Second Circuit held that ERISA did not preempt a state law requiring employers to provide certain health benefits to employees eligible for workers' compensation.³⁸ On the other hand, state laws that would directly affect ERISA plans, such as laws requiring the employer to coordinate health care plans with workers' compensation plans, are preempted.³⁹ The preemption was premised on the fact that integration would affect the ERISA health insurance plan, not workers' compensation. Accordingly, ERISA should pose no preemption obstacle to the state integrating workers' compensation into a fully publicly financed and administered health coverage program because under the workers' compensation exception of ERISA, the state retains authority to regulate workers' compensation programs. Arguably, the state also could require such employers to contribute to and participate in a publicly administered workers' compensation system, if necessary, though the case law has not addressed legislation that fails to give employers a choice of how to structure their workers' compensation plans to meet state standards.

Administrative Savings

Despite costs increasing under California's 24-hour pilot plans, some scholars argue that there are significant savings to be had by integrating workers' compensation into the health care system. In his article, "Comparing the costs of delivering medical benefits under group health and workers' compensation-- Could integration pay for covering the working uninsured?", Frank Neuhauser argues that integrating workers' compensation into a universal health care system would reduce workers' compensation premiums by 37 to 48 percent and the subsequent savings could fund health insurance for the working uninsured.⁴⁰ He achieved his numbers by assigning the total administrative costs as a fraction of the benefit paid out. So, if administrative costs are \$100 and 65% percent of medical benefits are paid out with 35% indemnity benefits paid out, the administrative cost is \$65 for medical benefits and \$35 for indemnity benefits. Neuhauser also notes that there will be greater savings in the first couple of years because during those years, all employees with ongoing injuries will remain covered by the workers' compensation plan, so that the only costs to be paid out will be new injuries. Neuhauser

³⁷ *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983)

³⁸ *R.R. Donnelley & Sons Co. v. Prevost*, 915 F. 2d 787 (2d Cir. 1990), *cert. den.* 499 U.S. 947

³⁹ See *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) (holding that ERISA preempted a D. C. ordinance requiring workers' compensation plans to coordinate with any employer-sponsored health coverage because the law was "premised on the existence of an ERISA plan" and used an ERISA plan as a standard to comply with the state workers' compensation law); *Kapuscinski v. Plan Administrator*, 658 F. 2d 427 (6th Cir. 1981) (holding that laws prohibiting a pension or health plan from setting workers' compensation payments against an ERISA plan's benefits, are preempted);

⁴⁰ Neuhauser, Frank. "Comparing the costs of delivering medical benefits under group health and workers' compensation-- Could integration pay for covering the working uninsured?" available at:

http://www.dir.ca.gov/chswc/Reports/2009/Medical_Overhead_Cost_Comparison_2009.pdf.

addresses the issue of workers paying copayments and deductibles for treatment of work-related injuries by noting that employer savings should reduce the downward pressure of health costs on wages and control workers' coinsurance payments. On the employer end, Neuhauser argues that the savings from integrating workers' compensation will virtually mitigate the increased cost of universal coverage.

The American Academy of Actuaries, as requested by the U.S. Commission on Health and Safety and Workers' Compensation, responded to Dr. Neuhauser's findings regarding administrative savings through the integration of workers' compensation into a universal health care system.⁴¹ It was reported that administrative savings may be possible through a group health model, but that the savings may not be as great as reported because the paper did not sufficiently account for: premium discounts; increased indemnity costs due to the elimination of return-to-work goal; and the continued cost of disputes arising out of the claim management process. In addition, the American Academy of Actuaries questions Neuhauser's direct comparison of savings from workers' compensation, a long-term, event-based system of insurance to health insurance, a pay-as-you go system.

From the literature, administrative savings may be possible through the integration of workers' compensation into a universal health care system, although the amount of savings remains in dispute. One assumption underlying Neuhauser's estimated savings that may inhibit Vermont's integration is universal coverage. Universal coverage is necessary for the successful integration of workers' compensation into health care because if a worker leaves or loses her employment, she will not be covered for her occupational injury.⁴² Since Vermont will have universal coverage, but the rest of the nation will not, there would have to be some mechanism to ensure that injured workers who leave the state receive coverage for their occupational injury.

Possible Models for Workers' Compensation and Green Mountain Care

Integrating workers' compensation into Green Mountain Care would necessarily occur at the state level. Only three countries provide workers' compensation at the sub-national level: the U.S., Canada, and Australia. In examining these countries and Vermont's own goals, three models emerged: full integration, partial integration, or administrative reform.

Exclusive Public Insurer: Publicly-Funded Workers' Compensation and Health Care

Public funding of workers' compensation with Green Mountain Care would look like Canada's workers' compensation system, which takes the exclusive public insurer approach. Each

⁴¹ Brian Clancy, Chair, Workers' Compensation Subcommittee, American Academy of Actuaries, Letter to Christine Baker, Executive Officer, Commission on Health and Safety and Workers' Compensation, Feb. 12, 2010, available at: http://www.actuary.org/files/chswc_feb10.4.pdf/chswc_feb10.4.pdf.

⁴² Neuhauser, Frank. "Comparing the costs of delivering medical benefits under group health and workers' compensation-- Could integration pay for covering the working uninsured?" available at: http://www.dir.ca.gov/chswc/Reports/2009/Medical_Overhead_Cost_Comparison_2009.pdf.

province controls its own workers' compensation funds and requires employers to purchase coverage from the public funds.⁴³ Such a model is possible in the U.S. because North Dakota, Ohio, Washington, and Wyoming operate monopolistic state funds where private insurers do not compete.⁴⁴ Out of these states, North Dakota is the only state that runs a purely monopolistic system in that it is the exclusive provider of compulsory workers' compensation insurance for the entire state. Wyoming is only monopolistic for certain hazardous industries, and Ohio and Washington allow employers to self-insure. Twenty-one states,⁴⁵ have state funds for workers' compensation in addition to its private market that are typically used to cover businesses that are high-risk or cannot find coverage in the private market.⁴⁶ Vermont's workers' compensation is exclusively funded by private insurers.

At first glance, an exclusive public insurer approach holds some potential advantages for Vermont. A monopolistic state fund may yield administrative savings through better coordination between not only Green Mountain Care, but other state agencies. A recent study by an insurance industry think tank found that public workers' compensation providers tend to have higher losses than the workers' compensation insurance industry as a whole, but those losses are offset with lower expenses, higher investment returns, and better injury prevention efforts.

Instituting a monopolistic state fund in Vermont, while potentially holding some long term advantages, would require a seismic shift from exclusive private funding of workers' compensation to exclusive public funding. This shift, without the intermediary step of expanding an existing high-risk state-funded program, would come at a high administrative cost to the state and an immediate loss of an entire insurance product. Making such changes contemporaneously with the implementation of Green Mountain Care would create a great amount of market disturbance.

In addition, aligning the workers compensation system with Green Mountain Care would be more appropriately done after Green Mountain Care is fully implemented and the administrative changes in the health care system are in place. At that point, the state will be better positioned to do an in-depth, Vermont-specific analysis of the effects of integration on stakeholder interests and any potential savings.

Publicly-Funded Health Benefits, Privately-Funded Indemnity Benefits

⁴³ H. Allen Hunt, The Upjohn Institute, "Three Systems of Workers' Compensation," Vol. 5, No. 2, 1998, available at: http://research.upjohn.org/cgi/viewcontent.cgi?article=1051&context=empl_research.

⁴⁴ National Association of Insurance Commissioners, "Workers Compensation Insurance," last updated Sept. 17, 2012, available at: http://www.naic.org/cipr_topics/topic_workers_comp.htm.

⁴⁵ Arizona, California, Colorado, Hawaii, Idaho, Kentucky, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Utah, and West Virginia.

⁴⁶ Anne Steinberg, Conning Research and Consulting press release on a study performed by Mark Jablonowski, "Workers' Compensation State Funds: Evolution of a Competitive Force," Oct. 5, 2009, press release available at: <http://www.insurancejournal.com/news/nationa/2009/10/21/104665.htm>

Another option explored was providing the health benefits of workers' compensation through Green Mountain Care while indemnity benefits, such as lost wages, would be provided through a private insurance product. There are no other comparable workers' compensation systems that use this model. The closest model is found in Australia, which has three states with public-private mixed models of workers' compensation made up of publicly funded workers' compensation programs that contract certain functions, such as marketing, claims management, or premium collection to private entities.⁴⁷ At its basis, though, this model still requires public funding of workers' compensation. The mixed model examined here would require a whole new insurance product to cover solely the cost of indemnity. Private insurers operating in Vermont have indicated that they are not interested in offering such a product. Offering indemnity without any sort of oversight over the health benefits creates a disconnect and subsequent risk that would be potentially difficult for private insurers to manage. Even if insurance companies were interested in offering indemnity-only coverage, the problem of ensuring that workers receive first-dollar coverage or equivalent benefits through the health care system would still exist. As a result, a mixed-model is not a solution at this time.

Administrative Alignment

Administrative alignment of the workers' compensation system to what is currently done with health insurance would maintain the current structure of the workers' compensation market while providing greater efficiency and safety incentive. The current structure could include mandates or incentives for companies to meet certain performance benchmarks. These benchmarks would not need to be created from whole cloth, as there is considerable precedent for imposing efficiency standards on health insurers and for collecting performance data from workers' compensation insurers. The department of financial regulation (DFR) is already responsible for evaluating bids submitted by insurers for the chance to be designated as an insurer in the residual workers' compensation market. Every employer is required to carry workers' compensation insurance but, for a variety of reasons, not every employer is able to secure the necessary coverage in the voluntary market. Insurers in the residual market offer coverage to these employers. Every three years DFR accepts, and insurers submit, applications to be designated as a member company in the residual market. As part of the Department's evaluation of these applications, DFR and NCCI evaluate the companies' performance record based on twenty measurements in four categories. The four categories for which data is submitted are underwriting, premium audit, claims performance, and loss prevention. Applicants whose data reflects high standards of claims management and low loss costs are permitted to write insurance in the residual market. The data in question is compiled from company data extracts and plan administrator databases.

Health insurance reform may provide an appropriate model for improved administration of workers' compensation. Minimum loss cost ratios are imposed on health insurers at both the state and federal level. In Vermont, Regulation 80-1 long has imposed ratio standards on health plans. In more recent years, the Affordable Care Act has imposed even more stringent loss

⁴⁷ H. Allen Hunt, The Upjohn Institute, "Three Systems of Workers' Compensation," Vol. 5, No. 2, 1998, available at: http://research.upjohn.org/cgi/viewcontent.cgi?article=1051&context=empl_research.

ratio requirements on health insurers. Currently, workers' compensation plans are not generally subject to these loss ratio restrictions. In Vermont, the workers' compensation insurance marketplace is deemed to be competitive. Participants in this market compete and prices are moderated based upon free-market economic forces. A modified approach to the status quo might include requirements that all workers' compensation insurers report the sort of data submitted to DFR as part of the residual market request for proposal (RFP). As the data is drawn from data-sets already maintained by the insurer, there is minimal interference with the insurer's operations. Currently, DFR collects this data voluntarily, on a triennial basis, and only by those insurers seeking to write in the residual market. This system might be modified to remove the voluntariness of the submissions, and could be expanded to include all workers' compensation insurers who wished to write in the primary or the residual market. These filing requirements might be coupled with cost reduction measures similar to those imposed by Vermont Regulation 80-1 and the Affordable Care Act. The status quo might also be modified by the imposition of standards for the aforementioned twenty measurements. A combination of any of these modifications may succeed in capturing systemic savings without entirely reimagining workers' compensation and the guaranty that it provides to workers and employers.

Recommendation

Vermont should pursue greater administrative alignment of the workers' compensation system with cost-reduction measures posed under the Vermont's health care reform efforts and the Affordable Care Act. The research on the amount of potential savings through integration is conflicting, so integration should be considered only after a thorough analysis that is Vermont-specific. Furthermore, integration would require Vermont to develop a monopolistic publicly funded workers' compensation system, which it is not well-positioned to do at this time. Consideration of alignment is more appropriate after the new system is in place. In the meantime, administrative reform will preserve workers' rights and the current workers' compensation insurance market while potentially increasing savings for employers.

Appendix – Public Comments



VERMONT INSURANCE AGENTS ASSOCIATION, SM

April 6, 2012

Deputy Commissioner Susan Donegan
Commissioner of Insurance
State of Vermont
Department of Banking, Insurance, Securities, and Health Care Administration
89 Main Street
Montpelier, VT 05620-3101

Re: Integration of Workers' Compensation System with Green Mountain Care

Dear Commissioner Donegan:

My name is Jon Jamieson, owner of Jamieson Insurance, in Waitsfield. I am here today representing myself and the Vermont Insurance Agents Association where I serve on the Board of Directors.

The Vermont Insurance Agents Association (VIAA), a professional association, represents approximately 800 licensed insurance agents, brokers, consultants and employee benefits specialists throughout Vermont. The members of VIAA service workers' compensation policies for thousands of Vermont businesses and work on a daily basis to help employers of all sizes purchase and administer workers' compensation coverage along with claim management for injured workers.

VIAA and our members oppose integrating or aligning Vermont's workers' compensation with Green Mountain Care (GMC) for the following reasons:

1. As you know workers compensation covers medical expenses and indemnity (lost wages) for injured workers. GMC has been designed as a medical only system. Our experience in this market leads us to believe that cost savings will be diminished if the coverage were separate. Removing the carrier from managing the medical case would increase the costs related to indemnity claims substantially. Additionally, the insurer will no longer be able to facilitate the transition for an employee to return to work.
2. The employers' premium is directly tied to their claims experience. Having the workers' compensation coverage wrapped into GMC would remove one of the major incentives for maintaining a safe workplace. Furthermore there is a high probability that VOSHA non-compliance measures would increase along with administrative costs. Vermont's workers' compensation marketplace is working

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efficiently. The State of Vermont has seen an overall workers' compensation rate reduction in the assigned risk market each year from 2006-2011 and each year in the voluntary market from 2007-2011 in comparison to double digit rates increases in health care policies. In the current system there are ample checks and balances, which provide incentives to employers, injured workers and carriers to keep both medical and indemnity costs low. This reinforces the need for a business owner to create the safest workplace possible.

3. The role of independent property and casualty insurance agents and brokers has been overlooked in evaluating the feasibility of the proposed integration of workers' compensation insurance into Green Mountain Care.
 - a. We are the primary advisors for classification of workers which ensures premiums remain adequate to support the system.
 - b. We assist the client and company during claims administration. The agent plays a key role in the communication process between the injured employee, carrier and employer. Additionally, we help our client base with the entire life cycle of the claim, from first report to accident investigation, assisting with return to work and light duty accommodations and eventually getting the claim closed out as expeditiously as possible.
 - c. We advise our clients with proactive loss control services and safety program implementation. We also provide the expertise employers need to comply with state and federal regulation such as OSHA.

Our work with Vermont business owners goes far beyond the sale. Independent property and casualty insurance agents and brokers are licensed and highly regulated and play a key role in facilitating continuous improvement in the workers' compensation system that protects the health and safety of Vermont workers. It is difficult to project the financial costs or opportunity costs of replacing agents in this system.

Although we cannot speak for carriers, whether multi-line or mono-line, we fear they would leave the state if forced to write indemnity only policies because they would not be able to control costs. At the very least we predict that premiums would become inflated eroding any savings GMC might offer. Additionally, some carriers are prohibited by their corporate charter to write indemnity only policies.

In evaluating the direct impact on local independent agent insurance businesses we anticipate significant layoffs at agencies throughout the state. We project a 35% reduction in workforce if the medical portion of workers' compensation is rolled into Green Mountain Care. As a small business owner I employ 11 people at my agency. I would be forced to reduce hours for four skilled and experienced staff or lay them off. That is significant in Vermont's small town economies.

We are further concerned that the cost of workers' compensation insurance could be passed on to an employee. If GMC is being paid for by broad based taxes and the employer has less "skin in the game"

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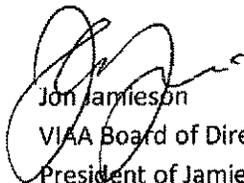


to keep the workplace safe the employee is going to end up paying the consequences of unsafe workplaces.

The business community in Vermont needs licensed, trained and independent professionals to help employers meet the statutory requirement for workers' compensation with or without Act 48. It is an extremely complex coverage and provides an incentive for employers to create and maintain safe workplaces for their employees. Integrating workers' compensation into Green Mountain Care limits choices for consumers and would likely force carriers to leave the state. Insurers that choose to provide indemnity only policies will certainly do so at significantly higher cost that will discourage economic recovery and development in Vermont which is sorely needed in a post-Irene economy.

VIAA sincerely appreciates the opportunity to provide you with information about independent agents and brokers. We look forward to working with you and the Governor's Administration on helping Act 48 succeed as we have done with the establishment of the Health Care Exchange. If you have any questions or need additional information, please do not hesitate to contact me at 802.496.2080 or VIAA's Executive Director, Mary Eversole, at 802.229.5884.

Sincerely,



Jon Jamieson
VIAA Board of Directors
President of Jamieson Insurance

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ACT 48: VERMONT HEALTH REFORM LAW OF 2011

The Property Casualty Insurers Association of America's response to the Vermont Department of Banking, Insurance, Securities & Health Care Administration's request for comments on the feasibility of integrating or aligning the Vermont workers compensation system with Green Mountain Care.

Submitted April 2012 by:
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Property Casualty Insurers
Association of America

Shaping the Future of American Insurance

PCI Comments on the Feasibility of Integrating or Aligning the Vermont Workers Compensation System with Green Mountain Care

INTRODUCTION

Vermont is creating a new paradigm for medical coverage, which is truly a daunting task. The Property Casualty Insurers Association of America (PCI) shares the concern about the ever escalating cost of medical care which increases the cost of doing business for our member companies, their policyholders and ultimately impacts all citizens of Vermont. PCI appreciates the opportunity to comment on the feasibility of integrating or aligning Vermont's workers compensation system with Green Mountain Care.

PCI is composed of more than 1,000 member companies, representing the broadest cross-section of insurers of any national trade association. PCI members write over \$180 billion in annual premium, 38.3 percent of the nation's property casualty insurance. Member companies write 44.3 percent of the U.S. automobile insurance market, 31.6 percent of the homeowners market, 36.3 percent of the commercial property and liability market, and 42.6 percent of the private workers compensation market.

Before integrating or aligning workers compensation medical benefits with Green Mountain Care, one must clearly understand the goals of workers compensation system:

The over-arching goals are returning injured workers to productive employment and providing lifetime benefits for the totally disabled.

Medical treatment under workers compensation services has an occupational focus, with the explicit goal of returning people to their jobs. Costs belong exclusively to employers and carriers; there is no cost-shifting onto injured workers.

The goal of health insurance is to take care of people, regardless of the employment implications. In the conventional health system, any occupational focus would be subordinate to the goals of the consumer.

PCI believes that the primacy of workers compensation coverage should be maintained by any health care law so that workers compensation insurers can offer to their policyholders the coverages required to meet the obligations created by the Vermont's Workers Compensation Act. Workers compensation insurers have worked with their policyholders and others to prevent occupational injuries and diseases, to understand the causes of these injuries and diseases, to develop innovative ways of treating industrial injuries in order to reduce the time lost from work and improve the medical outcome, to improve the quality of prostheses, and to retrain workers for new employment when their injuries prevent them from returning to their prior employment.

Workers compensation insurers have long played the major role in providing the specialized services that are essential to the proper functioning of workers compensation systems. Workers compensation insurers are skilled at managing occupational medicine cases to achieve optimal return-to-work outcomes by identifying the best providers and ensuring that care is given in the most effective way possible. Case management and loss prevention services provided by insurers minimize the human toll resulting from workplace injury while keeping the cost to employers as low as possible.

Vermont's workers compensation program places the obligation on the employer/insurer to provide injured employees with quality medical care including a range of services designed to reduce disability and return the injured employee to work as quickly as possible. This obligation can only be successfully carried out if the employer/insurer is given authority to assure quality care commensurate with its responsibility and can coordinate medical and nonmedical services focused on returning injured workers to employment.

WORKERS COMPENSATION IS MORE THAN A MEDICAL PLAN

Workers compensation is not just a system for financing medical care. It is a system that compensates for work-related disability and attempts to manage disability so as to minimize its effect on the injured worker. The general health care system focuses on the prevention of what can be prevented and the treatment of that which can be treated, up to limits of coverage defined in specific health plans. The general health system provides defined services to individuals and families. Virtually any illness or injury is covered. The overall goal is to preserve the life and health of individuals and families and restore functionality even if it is not related to employment. This system provides treatment from conception up to the moment of death.

The workers compensation system has a much narrower focus: workers compensation provides treatment only to workers who are in the course and scope of employment. Workers compensation treats work-related injury and illness, with the specific goal of returning injured/ill workers to productive employment. Workers compensation will provide expensive medical treatment if it is likely to accelerate recovery and return to work.

In general healthcare, the premiums for coverage are paid by individuals and their employers. Depending upon the plan, individuals and their family members assume at least some of the cost of treatment, through premiums, co-pays and deductibles.

In workers compensation, employees never pay workers compensation premiums and are never charged co-pays or deductibles. Injured workers are covered from the first dollar. Thus, only the employer self-insured or the insurer has the incentive to control costs. No such incentive exists for injured workers.

WORKERS ARE BUSINESS ASSETS

As the United States has entered into this new millennium, employers are recognizing that skilled employees are their most valuable asset. Workers compensation through loss control and disability management is designed to protect and restore the functioning of this asset. When an employee is unable to work because of injury, the employer's financial loss is more than the direct costs of medical and compensation. The employer faces a loss of productivity and the added expense of using a replacement worker.

DISABILITY IS MORE THAN A MEDICAL CONDITION

Disability is a complex set of interactions that, in the workers compensation context, involves the loss of earning capacity. There is extensive literature relating to workers compensation and other programs that shows that disability is the result of the interaction of functional limitations (physical), emotional health, socioeconomic status, economic conditions, etc. All these components need to be addressed together. Treating the medical aspect in isolation will not reduce overall costs of disability. It is likely to increase them. Workers compensation provides intensive medical services often entailing many medical procedures per treatment and a high frequency of treatment. Again, the workers compensation goal is get the worker back to work whereas the duration of care is longer under ordinary medical care coverage. Under an integrated system, workers compensation indemnity costs and lost time from work will likely increase.

WORKERS COMPENSATION IS AN INTEGRATED DISABILITY AND HEALTH CARE PROGRAM

In this complex relationship, the effects of medical treatment and disability management flow both ways. The timeliness, appropriateness, quality, and intensity of medical treatment may reduce the extent of disability, not only by relieving the physical effects of injury, but the psychological effects as well. Similarly, a program that encourages early return to work may reduce the demand for medical treatment. The busy person does not have time to dwell on his/her aches and pains, so he/she is less likely to seek unnecessary treatment or to develop post-traumatic emotional problems requiring medical treatment.

WORKERS COMPENSATION MANAGES DISABILITY INCLUDING MEDICAL

Workers compensation insurers, self-insurers, and state funds recognized decades ago that a large proportion of medical costs and compensation were generated by relatively few serious cases. Therefore, many of them have long used case managers (usually rehabilitation nurses) who work with medical providers and the injured worker to develop the most effective medical treatment plan for that worker. In addition, these case managers work with the employee, family members, employers, and vocational rehabilitation specialists to resolve family concerns and to develop a plan to restore the injured worker as quickly as possible to gainful employment, preferably with his former employer. If this is not possible, efforts are made to get the injured worker employed elsewhere. As it became evident that medical costs were rapidly rising for those cases not warranting such intensive resources, insurers have followed the example of health insurers and moved to utilize devices such as bill reviews and the

development, where economically feasible, of managed care networks. At the same time, they have intensified efforts to convince employers, medical providers, and employees of the economic and psychological benefits of early return to work, whether to regular employment or a light duty job.

To lose control of the medical aspects of a workers compensation case is to lose the ability to minimize disability.

WORKERS COMPENSATION MEDICAL IS BROADER THAN TRADITIONAL HEALTH INSURANCE

Workers compensation medical, in keeping with the need of disability management, covers a much broader range of services than do most health insurance policies. One policy provides first dollar, unlimited coverage with no employee contribution for all the care covered by a health insurance policy, but in addition, it provides dental work, prescription and nonprescription drugs and appliances, prosthetic devices, life-time long-term care and at-home care, non-traditional care, unlimited mental health coverage including institutionalization, experimental treatments, home and vehicle modification, work-hardening and vocational rehabilitation, etc. There are no limits for pre-existing conditions, and workers compensation assumes full responsibility for the medical treatment if the workplace causes, aggravates, or accelerates the onset of disability. In many states, the workplace contribution to the injury or disease need not be more than one percent in order to trigger the obligation to provide benefits. In addition, unlike health insurance, eligibility for treatment is triggered only by a compensable event.

SAFETY INCENTIVES UNDERMINED

The rating system used in most states develops premiums that reflect the hazards of the industry involved. For employers large enough to be experience rated, the employer's accident experience is compared to that of others in the same industry, and those with a poor safety record pay more. This internalizes cost and provides an incentive for safety. Including the workers compensation medical component into a single payer system, workers compensation will lose all relationship to employment and eliminate workers compensation's internalization of the medical cost portion. To the extent that insurance costs would cease to be based on an employer's actual experience, safe employers would no longer benefit from their loss control efforts, and unsafe employers would enjoy lower costs. The result would be a reduction in workplace safety efforts.

EXCLUSIVE REMEDY LOST?

One of the workers compensation trade-offs is that workers gave up the right to sue in tort for a certain, but limited, benefit. If that benefit becomes more limited, will courts overturn that bargain and allow tort suits against employers? As a result of an integrated plan, Vermont workers might seek recovery for costs that are currently financed by workers compensation but not covered by the integrated plan through tort actions against their employers. We need to be aware that employers could potentially lose this protection in addition to workers compensation insurers being able to manage medical decision making, these issues will impact overall medical and indemnity costs. Whether the exclusive remedy doctrine in Vermont could withstand such a legal assault remains to be seen.

MERGING WORKERS COMPENSATION INTO VERMONT'S SINGLE PAYER SYSTEM

May Create Jurisdictional Conflict

- If workers compensation medical is absorbed into the state's Green Mountain Care, injured workers, employers, and insurers will be forced to deal with two levels of jurisdiction, with all the problems that could entail. Administrative costs for employers and the state will increase. Also, an injured worker may be required to provide medical reports to the workers compensation insurer or to the WC regulatory agency.

May Shift Costs to Injured Workers

- Absorbing workers compensation medical into Vermont's single payer system will shift part of workers compensation medical to all employees that have to pay a portion of the cost of health insurance coverage. Furthermore, even more of the cost will be shifted to injured workers in the form of deductibles and co-payments.

May Increase Administrative Costs

- Combining workers compensation into general health care will not produce administrative savings. Employers may save the administrative expense and commission dollars associated with the medical portion of workers compensation insurance. However, this is likely to be offset by increased expense for the state agency and insurer having to deal with two jurisdictions. Moreover, the major claims expense has been driven by the disability aspect of workers compensation.

Eligibility and Treatment Are Radically Different

- The general health system provides defined services to individuals and families. Virtually any illness or injury is covered. Workers compensation covers only what occurs during work and is proven to be work-related.
- Medical treatment under workers compensation is provided by occupational specialists, who bring a unique "return-to-work" focus to the treatment plan. These occupational specialists are involved with employers at times in seeking workplace modification to return injured workers to productive employment. These specialists specify the restrictions so that employers can design appropriate modified duty job. In the health care system, primary care physicians may lack occupational expertise, return to work may become secondary.
- The medical benefits delivered via workers compensation are tied to indemnity benefits. Medical decision-making in workers compensation cases is often accelerated in comparison to health insurance. For example, for a knee injury, if the clinical picture is suggestive of a meniscus tear, an MRI may be ordered in a workers compensation case up front to focus treatment, provide the best possible outcome, and to drive the overall cost of delivering benefits on the claim down, as a quicker surgery, if indicated, equals a better result and a more timely recovery, thus impacting disability benefits. Decision making in workers compensation is "managed" with

jurisdictional rules and utilization review protocols to be as efficient as possible. In a health insurance situation (non-occupational), the protocol may be anti-inflammatories and watch-- followed by potentially physical therapy and watch -- ultimately followed by an MRI and surgery.

- If Vermont should include workers compensation medical as part of Green Mountain Care, the potential exists that all medical bills will be paid the same way including workers compensation. Employers may have little input into the choice of doctors or specific treatment plans. The role of occupational doctors as previously indicated is critical to the successful treatment of work related injuries. Without this perspective, there is a risk of substantial increases in indemnity costs.

Increase in Litigation Costs

- Litigation costs may increase due to questions regarding the degree of disability and return to work status for claims associated with both medical and indemnity costs.
- Workers compensation medical coverage is a legally established right that is entitled to due process when the right is challenged. Group health has historically been contractual with some statutory mandates but not subject to the amount of due process associated with workers compensation. If workers compensation is combined with other programs, it is likely to increase the probability that Green Mountain Care will be treated more like workers compensation than group health. Consequently, administrative costs will be greater than those of group health.

Cross-Jurisdictional Issues

- When workers compensation statutes were first enacted, the primary focus was on relationships between employers and employees located in the same state. The most mobile workers at that time probably were railroad workers and seamen, and federal programs were established that applied to them. While there have always been some cross-jurisdictional movement of employees, the volume has picked up with our increasingly mobile workforce within the borders of the U.S. and across national borders. From a workers compensation perspective, there are a number of issues with integrating workers compensation medical into Green Mountain Care for employers located in Vermont and outside of the state.
- From a policyholder/employer perspective, conflicting state requirements create a potential for an uninsured compensation liability within the current structure of today's system. Unharmonized workers compensation laws and regulations have created a web of complexity for employers doing business in multiple states. This issue could become more complex for Vermont employers with employees working in other states on both short-term and long-term projects. In addition, employers located in other states sending their employees on short-term or long-term projects to Vermont would have parallel problems if workers compensation medical is integrated into Green Mountain Care.

- Will other states recognize that the health insurance benefits from Green Mountain Care with the workers compensation indemnity policy meet the requirements of a workers compensation policy for cross-jurisdictional purposes?

May Conflict with the Employment Retirement Income Security Act (ERISA)

- ERISA preempts states from regulation of employee benefit plans but grants exceptions solely for the purpose of meeting state workers compensation statutes. If the medical component of workers compensation is integrated into Green Mountain, the benefit plan could be deemed too broad to fit under ERISA's exemption clause. If this would occur, Vermont would have to cede to the federal government the right to regulate the medical component of workers compensation. PCI is not aware if the single payer system including workers compensation medical has been tested in the court system. This issue needs to be thoroughly vetted out.

OTHER FEDERAL AND STATE ACTIONS

Neither the federal government nor any other individual state has successfully enacted or implemented a single payer system, which included the medical component of workers compensation.

The most recent federal attempt was in September 2009; Senator Rockefeller introduced in the Senate Finance Committee an amendment during the mark-up of the federal health care legislation mandating "24-hour health coverage." The amendment proposed to merge the medical components of workers compensation and auto insurance with health insurance. The amendment was not adopted. Attachment A includes a Joint Trade Letter to Senator Max Baucus outlining the problems with this concept.

A number of states have attempted to implement pilots on various 24 hour coverage proposals; however, due to a number of barriers none were fully activated.

- California implemented a pilot program in 1994 involving mostly governmental entities and some private employer. By 1996, only 65 employers with a total of 6500 employees were enrolled in 24 hour programs statewide. By 1998, California found that the system was too expensive to administer efficiently and consequently employers were not attracted to the system and group health carriers were withdrawing from the system. California's second pilot program in 2007 for state employees and employers paying for 80% or higher of health care costs was not endorsed by Governor's task force. In addition, there was strong opposition from the California State Chamber of Commerce in 2007 since it would water down medical utilization controls of the 2004 workers compensation reforms. Also, it was opposed by other employer groups, medical providers, consumer groups, and most group health care providers.
- Oregon was the first state to create a pilot program in 1993. It was abandoned in 1996 as a result of administrative difficulties in combining workers compensation with group health coverage and due to low enrollment as a result of the higher costs. Ten programs were approved by the state but only four of the programs were successful in enrolling any employers, covering only 14 employers statewide. By the time that the pilot program was disbanded, only

461 employees with two employers were covered by 24 hour coverage. The program ended June 30, 1998 due to lack of interest.

- Maine passed rules in 1995 to promote 24-hour coverage plans. By 2003, there were no 24-hour project filings on file with the Maine Bureau of Insurance. The only insurance plan on file that remotely resembled a 24-hour coverage plan had no policies issued under that plan. The agency has cited many reasons for the lack of interest on the part of both carriers and employers including (1) the difficulty in coordinating three lines of insurance, (2) employer inability to direct medical care, and (3) ERISA preemption issues. There was also concern over an increase in litigation. The State of Maine is quoted as saying that the more the insurance programs are integrated, the more legal conflicts are created.
- Florida began looking at 24-hour coverage beginning in 1993 and never implemented any pilot plans due to statutory barriers, price barriers for employers and underwriters, state regulatory issues, and lack of interest on the part of employers. The statutes were repealed in 2003.
- Georgia passed legislation that would allow for pilot 24-hour coverage plans. Five “alternate coverage” plans were filed which were not true 24-hour coverage plans. In 1997, the Insurance Department solicited the amendment of these “alternate coverage” plans into true 24-hour coverage plans with seamless integration of health coverage for both occupational and non-occupational health care. Only one plan was submitted and was later withdrawn.
- Hawaii in 1995 looked into 24-hour coverage since it already required mandatory workers compensation and auto insurance and since most employers were required to provide health insurance coverage. No statute was ever passed because the state could not obtain an ERISA exemption for such plans.
- Iowa looked at 24-hour coverage in 1992-93 and eventually refused to pass any legislation to enable 24-hour coverage because of (1) potential negative impact on workplace safety (2) potential negative impact on return to work outcomes (3) difficulties in merging workers compensation 100% pay health benefits with cost-sharing health benefits and (4) fear that there would be increased litigation as a result of the financial motivation to make all illnesses work related.
- Kentucky took two legislative sessions (1994 and 1996) in order to pass legislation that would allow 24-hour coverage plans. Since then, there has been little interest in the plans due to cost and ERISA preemption.
- Louisiana has had legislation for pilot programs in place since 1993 but could not implement any plans because of the conflict in how to resolve disputes and how to assess premiums when workers compensation premiums cannot be charged back to the employee.

- Massachusetts passed legislation in 1991 allowing for 24-hour coverage plans for employers and employees with collective bargaining agreements. There were no such plans ever filed with the state and the legislation was repealed through the sunset process.
- Minnesota enacted legislation in 1995 allowing for 24-hour coverage, but no true 24-hour plan has been filed with the state due to concerns with ERISA. A modified pilot project is in effect through The Minnesota Health Partnership.
- Oklahoma has had legislation in place since 1995 that would allow for coordinated medical services through separate workers compensation and health insurance policies. There are no known pilot projects under this legislation. Pilot projects were opposed by employers because of cost and opposed by labor because of the risk of copayments and deductibles.
- Wisconsin did not adopt legislation for a 24-hour pilot program because of opposition by both labor and employers and the recommendation of their state Advisory Council

For additional information on 24-Hour Coverage, refer to Attachment B, which includes the National Association of Insurance Commissioners, 1999 Progress Report on the Implementation of 24-Hour Coverage.

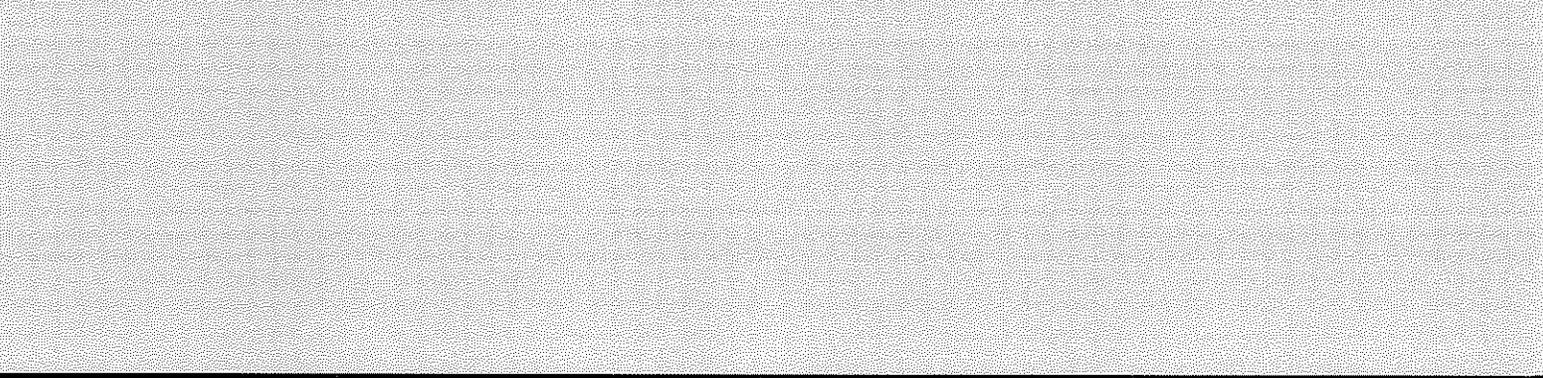
CONCLUDING COMMENTS

As previously indicated, one of the key reasons for not integrating the medical component of workers compensation into Green Mountain Care is that employers/insurers will lose control of the medical aspects of a workers compensation case meaning that they will lose the ability to minimize disability. In addition, there are other substantive and administrative reasons for not integrating the medical component of workers compensation into Green Mountain Care including the following:

- Potentially higher over-all costs to employer;
- Increased administrative burdens for all stakeholders;
- Potential regulatory conflicts with federal law (ERISA and HIPAA) and state laws;
- Due process of law issues over which agency will resolve disputes and under which regulatory standards; and
- Coverage issues created by conflicts between WC insurance which provides lifetime medical based on date of injury and health insurance which only provides coverage during the policy period.

PCI urges the Vermont Department of Banking, Insurance, Securities & Health Care Administration to make a recommendation against integration or alignment of the workers compensation medical component into Green Mountain Care. Vermont's Green Mountain Care Board is currently addressing a number of critical health care system reform initiatives including the implementation of the health benefit exchange required by the Patient Protection and Affordable Care Act. Workers compensation medical represents only a few percentage points of the total health care dollar. Considering all of the complex issues that must be addressed in establishing Green Mountain Care, it would seem unwise to attempt to integrate work compensation medical with all of its troublesome issues.

To overlay the workers compensation medical component into these initiatives could adversely impact the overall medical treatment and recovery period of injured workers and employers could be subject to substantial increases in indemnity costs. The Vermont workers compensation is stable at this time and stability during these economic times is critical for business development including the creation of jobs.



Attachment A

**Joint Trade Letter to Senator Max Baucus Senator
Rockefeller's 24-Hour Health Care Coverage**



September 24, 2009

Senator Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20010

Dear Mr. Chairman:

We are writing to express our strong opposition to Senator Rockefeller's amendment mandating "24-hour health coverage" as filed for consideration in the Senate Finance Committee's on-going markup of health care legislation. This amendment proposes to merge the medical components of workers' compensation and auto insurance with health insurance. As a result, the amendment would upend the systems now in place to protect injured workers, drivers and passengers.

Health insurance reform is already a major legislative undertaking. Integration of the medical components of workers' compensation and auto insurance is a very complex issue in its own right. This matter has not been the subject of hearings in the Finance Committee or any Congressional committee. In light of the serious damage it would do to our nation's workers' compensation and auto insurance systems, we respectfully urge the Finance Committee not to add the Rockefeller Amendment to the pending bill. The following is a list of reasons not to do so:

- The concept of "24-hour coverage" was looked at in the 1970's and again in the early 1990's and not pursued. Among other factors, implementation would be extremely difficult. In addition, several states experimented with pilot projects (California, Kentucky, and Oregon) that were not successful.
- Workers' compensation and traditional health insurance are very different. Workers' compensation health coverage is part of a package of benefits for injured workers that most states require employers to purchase. Workers' compensation health benefits are administered with these other benefits in a coordinated manner. As a result, the health portion cannot simply be taken out of

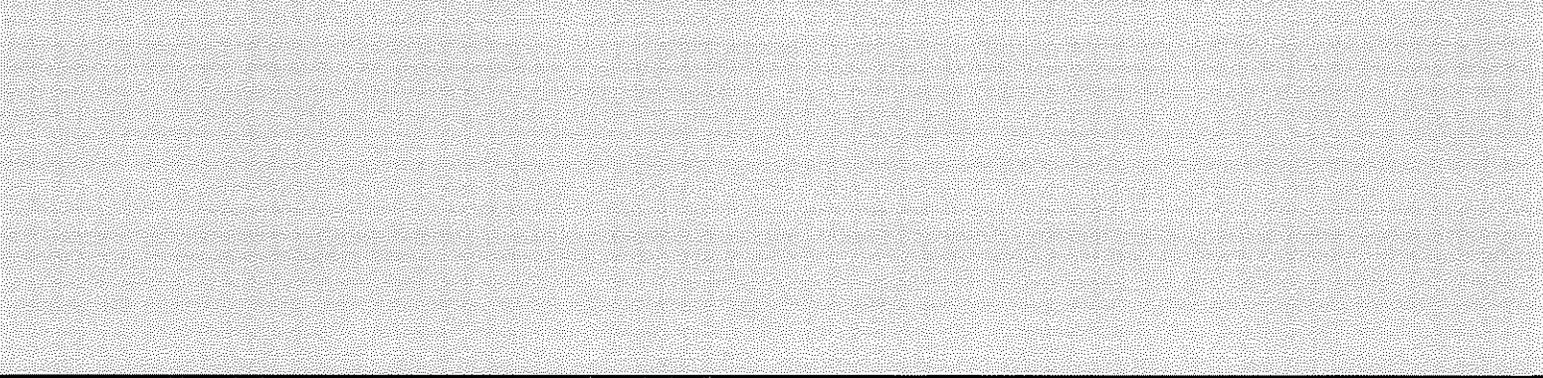
the workers' compensation systems as the Rockefeller Amendment proposed without examining its broader implications.

- Workers' compensation coverage is by its very nature exclusively no fault. By contrast, traditional health insurance is not. Integration or merger of these completely different systems would cause serious impacts on both sides. The litigation questions alone are reason enough not to pursue the amendment on the pending health care bill.
- Workplace safety is a serious issue. Workers' compensation premiums are determined by the particular track record of each employer. Workers' compensation insurers have special expertise in workplace safety and work closely with employers. If the existing experience rating of premiums is not incorporated in any merger, employers would lose existing incentives to promote safety. This would also harm companies that have engaged in best safety practices while potentially rewarding those that do not.
- "24-hour coverage" would destroy the healthy and competitive auto insurance marketplace. The premiums charged for this coverage are highly risk based, meaning that the pricing creates a very strong financial incentive to avoid engaging in dangerous behavior such as drunk driving and violating safety laws, so the auto insurance system works to prevent accidents, deaths, injuries and their related economic losses, including health care costs.
- Adding auto insurance medical coverage to the traditional health insurance system would not solve the many challenges already facing that system, including the need to reduce costs. In addition, auto insurers have developed and implemented sophisticated anti-fraud programs that effectively prevent fraudulent payments under auto insurance coverages. These very successful anti-fraud measures would be lost if auto insurance medical benefits are integrated into health insurance.

In sum, we have not heard of any compelling reasons to expand the number of issues being addressed in the pending legislation by completely overturning the existing medical benefits provided through workers' compensation and auto insurance. This is particularly so when the full ramifications of such a major step have not been fully explored. As a result, we urge you to vote NO if the Rockefeller 24-Hour Care Amendment comes up for consideration.

Sincerely,

American Insurance Association
The Council of Insurance Agents and Brokers
Independent Insurance Agents and Brokers of America
National Association of Health Underwriters
National Association of Mutual Insurance Companies
Property Casualty Insurers of America



Attachment B

NAIC's Progress Report (1999) on the Implementation of 24-Hour Coverage

A PROGRESS REPORT ON THE IMPLEMENTATION OF 24-HOUR COVERAGE

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INTRODUCTION

What is 24-hour coverage? 24-hour coverage can be loosely defined as any combination of traditional health insurance and workers' compensation insurance that attempts to dissolve the occupational and non-occupational boundaries between the two coverages. In fact, some proponents would also include coverage for personal injuries suffered in auto accidents as well. There are six variants of 24-hour coverage that combine, in one way or another, traditional health and accident insurance with workers' compensation insurance.

24-HOUR COVERAGE VARIANTS

24-hour coverage marketing package offers integrated management of an employer's workers' compensation and group health insurance claims. This product is the claims settlement process so that duplicate claims under a workers' compensation policy and a health insurance policy are discovered and the duplication eliminated. In some states the integration process will allow the insurer to utilize the discounted provider rates secured under the health plan for workers' compensation claims. The insurer will continue to provide separate contracts to the employer. This product also appears in the self-insured market where self-insurers of both health and workers' compensation are urged to secure both their administrative services and their excess cover from a single source to allow for effective coordination of the delivery of benefits.

24-hour medical coverage provides, in a single policy, medical benefits for all of an employee's injuries and diseases whether work-related or not, while disability benefits are provided only for work-related injuries and diseases. This form is one that has generated significant interest across the land. One major drawback of this type is that there is still a need to determine if a claim is work-related when indemnity benefits are to be paid.

24-hour disability coverage provides disability benefits for all of an employee's injuries and diseases, but medical benefits are provided for work-related injuries and diseases only. This form of 24-hour coverage has not generated much interest as many feel that the greatest potential for savings is in the medical area. Further, often employers do not offer disability income coverage to their employees that would equate with the indemnity portion of the workers' compensation contract.

24-hour coverage of accidents provides medical and disability benefits for all injuries, but only work-related diseases are covered. This variation has not drawn much interest, as there is concern over the defined boundaries between injury and disease. Interestingly, the New Zealand Accident Compensation Scheme utilizes this approach.

24-hour coverage of diseases provides medical and disability benefits for all diseases, but only covers work-related injuries. This type of 24-hour coverage has received some attention. It is seen as a way to reduce the considerable litigation that arises over the causation of a given disease.

24-hour medical and disability coverage is an all-inclusive approach that provides medical and disability benefits for all diseases and injuries. Sometimes known as Universal 24-Hour Coverage, this is the approach envisioned by most people when they think of 24-hour coverage.

ADVANTAGES OF 24-HOUR COVERAGE

Proponents of 24-hour coverage point out several advantages of the concept. On the forefront are economic factors, such as the potential to control the rapid escalation in the cost of medical and hospital services that has occurred recently. Some also see the potential for administrative savings that might be gained from combining the systems. In concept there are structural efficiencies that might be realized from better integration of the systems for providing health services. There are currently myriads of social and insurance programs that deliver certain elements of health care in this country. This complicated delivery system can lead to coverage gaps and overlaps that might be more efficiently handled by a system that integrates and monitors the coverage provided. Avoiding duplicate payments for the same elements of loss could lead to some savings.

The topic of 24-hour coverage has become increasingly prominent with the difficulties that have arisen in the health insurance and workers' compensation markets. Proponents of the concept point to the possibility of administrative savings and the ability to avoid coverage gaps and duplications. Since employers provide the majority of health insurance benefits delivered in this country, it seems logical to investigate methods to accomplish this result in the most efficient manner possible.

BARRIERS TO IMPLEMENTATION OF 24-HOUR COVERAGE

This portion of the report discusses barriers to implementation of 24-hour coverage. It was undertaken by the Workers' Compensation (C) Task Force to aid the NAIC membership in their deliberations concerning the combination of traditional health insurance with workers' compensation insurance.

The task force has identified a number of barriers to implementation of 24-hour coverage. While not every impediment applies in each jurisdiction, for those interested in the viability of the concept this report should serve as a guide to analyzing the roadblocks that may be encountered.

The information presented in this part of the report was obtained from published sources; written responses to an NAIC questionnaire completed by the NAIC membership; and input from members of the NAIC 24-Hour Coverage Working Group.

BARRIERS

Barriers to establishment of 24-hour coverage programs may be categorized as legal, institutional or regulatory in nature. Barriers are classified as legal if a law change would be needed to implement 24-hour coverage. Institutional barriers are characterized by disruption of a process or entity that is currently operating to provide one of the components that will be provided by 24-hour coverage. Regulatory barriers are characterized by the conflict or jurisdictional struggle that may develop when 24-hour coverage is implemented. There is often overlap between the various classifications.

LEGAL BARRIERS

The first legal barrier that is of concern to employers is the exclusive remedy provision in the workers' compensation acts. Protection of the exclusive remedy provisions is an overriding concern to employers and insurers as it is the cornerstone of the workers' compensation system. Workers' compensation is a no-fault system that developed in the early 1900s to address injuries occurring in the workplace. The workers' compensation concept provides a basic give-and-take situation for addressing work-related injuries and disease. The employee must give up the right to sue the employer in exchange for a specified and guaranteed set of benefits. Thus workers' compensation becomes the employees "exclusive remedy" for addressing work-related injuries.

The employee is not alone in giving up certain rights. The employer must agree to fund this liability for the injuries that occur. The benefits are delivered to the injured employee regardless of fault. Thus the employer gives up the right to certain defenses that would be available in tort. In exchange for this, the employer gains immunity from suit except in certain circumstances. Employers may continue to be sued for injuries that are not covered by workers' compensation; intentional injuries; under a dual capacity theory, and if the employer has failed to properly secure its obligation to provide workers' compensation insurance.

Any 24-hour coverage proposal must be analyzed to see that the exclusive remedy provision remains intact for work-related injuries and disease. A comparable problem does not seem to develop for the health insurance portion as the employer is typically not obligated to provide health benefits and may not be sued for injuries and disease that are not work related. Any language drafted to implement 24-hour coverage should either specifically mention and continue the exclusive remedy provisions or reference the exclusive remedy provisions contained in the workers' compensation statutes.

Another major legal hurdle to implementation of 24-hour coverage appears to be the interaction of a state-administered workers' compensation law with the Employee Retirement Income Security Act of 1974, as amended (ERISA). It appears that ERISA provides an exemption from state regulation including an exemption from regulation under state insurance laws. If steps are not taken to address the ERISA implications when establishing a 24-hour coverage program, a state may find that it has given up the right to regulate the health insurance component of traditional workers' compensation coverage.

When evaluating the effect of ERISA, the first step necessary is to determine if benefits being provided are subject to ERISA. 29 U.S.C. §1002(1) defines an employee welfare benefit plan as "any plan, fund or program which was heretofore or is hereafter established or maintained by an employer,..., to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits in the event of sickness, accident, disability..."

If the benefits being provided meet the first criteria set forth in 29 U.S.C. §1002(1), then one must evaluate whether or not the exemption to ERISA applies. The exemption is set forth in 29 U.S.C. §1003(b)(3) which provides that ERISA does not apply to a plan which "is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws." The term "solely" appears to provide the greatest cause for concern with respect to 24-hour coverage. If the "medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability..." are not "maintained solely for the purpose of complying with applicable workmen's compensation laws", then it appears the exemption from ERISA would be inoperable. In its deliberations concerning 24-hour coverage, a state must be prepared to deal with the possibility that the state insurance regulators may lose regulatory controls if the enabling statutes fail to address this very real possibility.

There is some case law that should be considered in evaluating the enabling language for 24-hour coverage. Information and insight into the operation of ERISA can be gleaned from reviewing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). Other cases that may be of interest are *Employee Benefits Committee v. Pascoe*, 679 F.2d 1319 (9th Cir. 1982), *PPG Industries Pension Plan A (CIO) v. Crews*, 902 F.2d 1148 (4th Cir. 1990), *Stone & Webster Engineering Corp. v. Isley*, 690 F.2d 323 (2d Cir. 1982), *Gibbs v. Service Lloyds Insurance Co.*, 711 F. Supp. 874 (E.D. Tex. 1989), and *Foust v. City Insurance Co.*, 704 F. Supp. 752 (W.D. Tex. 1989).

The following language is an excerpt taken from a letter of Nov. 25, 1992, from the U.S. Department of Labor. It was addressed to California Insurance Commissioner John Garamendi and the California Director of Industrial Relations, Lloyd W. Aubry.

“In *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), the Supreme Court considered the effect of the exemption established by Section 4(b)(3) on the scope of preemption under Section 514 with respect to a state disability law. Although the Court held that the state disability law was preempted to the extent that it related to a “multi-benefit” plan that provided disability benefits among others, rather than to a plan that “solely” satisfied state disability requirements, *see id.* at 107-08, the Court further held that a state is not therefore rendered powerless to enforce its state disability laws against employers providing such plans. *Id.* at 108. The Court described the role preserved for state laws enumerated in Section 4(b)(3) as follows:

Congress surely did not intend, at the same time it preserved the role of state disability laws, to make enforcement of those laws impossible. A state may require an employer to maintain a disability plan complying with state law as a separate administrative unit. Such a plan would be exempt under § 4(b)(3). The fact that state law permits employers to meet their state-law obligations by including disability insurance benefits in a multi-benefit ERISA plan...does not make the state law wholly un(en)forceable as to employers who choose that option.

In other words, while the state may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan. If the state is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply. *Id.*, at 108.

Although *Shaw* involved a state disability insurance law, the Court’s reasoning applies equally to the other types of state laws enumerated in Section 4(b)(3) of ERISA.

Based on the reasoning in *Shaw*, it is clear that a state may require employers to provide purpose. A state could also permit employers to satisfy state workers’ compensation requirements through a plan that is covered by ERISA. In addition, if a state permits an employer to provide required benefits through an ERISA-covered plan, the state may determine, in a given case, whether workers’ compensation benefits through a separate plan maintained solely for that its requirements have been met, and may, as a remedy for any failure, require that the employer comply with state law, while permitting the employer to choose whether to do so within or outside the ERISA-covered plan.”

On Dec. 14, 1992, the United States Supreme Court ruled on the case known as *The District of Columbia and Sharon Pratt Kelly, Mayor Petitioners v. The Greater Washington Board of Trade*, 1992 WI.362797 (U.S. Dist. Col.). This case evolved around a requirement in the District of Columbia that obligated employers to provide health coverage to its employees who were receiving workers’ compensation benefits. The Court found that such requirement is preempted by ERISA.

In April 1994, the U.S. Court of Appeals for the Ninth Circuit ruled that ERISA does not preempt California’s Workers’ Compensation Act in a case known as *Employee Staffing Services Inc. v. Aubry*, CA 9, No. 93-15482, 4/5/94. A request for a declaratory judgment was rejected by Judge Andrew J.

Kleinfeld. Thus the earlier ruling of the U.S. District Court in California in the STAFCOR case was affirmed. The U.S. Court of Appeals for the Ninth Circuit reviewed the case de novo. They found that ERISA's coverage provisions exclude workers' compensation from ERISA's scope. California could not regulate STAFCOR's ERISA based plan; however, California could require STAFCOR to establish another separately administered plan for workers' compensation.

The U.S. Court of Appeals for the Ninth Circuit reviewed the case De Novo, assuming for purposes of the decision that STAFCOR's claim that its plan was an ERISA plan, was valid. This case arose when STAFCOR, a unit of Employee Staffing Services, Inc. of Dallas, maintained that it offered workers' compensation benefits through a self-insured benefit plan. They argued that ERISA preempts state regulation of that plan. In 1992, the California Department of Industrial Relations ordered STAFCOR to secure workers' compensation insurance or cease its operations in California. This action precipitated the court case. California argued that allowing benefit plans to be used as STAFCOR wishes would fundamentally undermine the state's authority to regulate workers' compensation insurance.

In a filing on March 17, 1993, the Court concluded that the federal statute did not preempt the state law. The decision held that the imposition of the requirements of the California workers' compensation law on STAFCOR was a traditional and proper exercise of State power. It further stated that the Court could not read into ERISA, any intent or effort to invalidate the California workers' compensation law. The First Circuit reached the same conclusion on similar facts in Combined Management, Inc., v. Atchinson.

There are other aspects of ERISA that are in need of investigation because "exemption" or "no exemption" is not the only issue. Different scenarios may involve both state and federal regulation. It appears that plans involving municipalities or other governmental entities are not subject to ERISA and are clearly subject to state regulation. If a single employer offers a plan that combines a self-insured portion with excess stop-loss coverage by an authorized carrier, the department of insurance regulates the excess carrier. Fully or partially insured plans that do not qualify as ERISA plans are subject to state regulation.

Furthermore, as a simple rule of thumb, only when one has a truly single employer that maintains a qualified ERISA welfare benefit plan that is 100% self-insured is a state preempted from regulating the plan. To the extent this simple rule is deviated from such as two or more employers maintaining or participating in the benefit plan and/or to the extent the plan is not 100% self-insured, then state regulatory authority is present either in full force or to a lesser degree.

It may be possible to implement limited pilot projects testing 24-hour coverage without determining if these barriers to global implementation may prohibit the concept. Implementing pilot projects might allow appropriate testing to determine the viability of the product.

An additional barrier that may arise is whether employers will, at least initially, have to offer their employees multiple options for vendors for coverage. There is a provision in Federal law called the "dual choice" provision (Section 1310 (b) 42 U.S.C. 300e-9b) that says that if an employer with 25 or more employees offers health insurance to its employees and there is a qualified HMO in that geographic area that requests it, the employer must offer its employees HMO coverage as well and allow the employee to choose. The employer is responsible for offering one group model HMO and one staff model HMO if both types have approached the employer. Further investigation is necessary to determine if the "dual choice" provision would apply to 24-hour coverage. Initial analysis leads one to conclude that it does since it includes the health insurance portion, especially if we are discussing a health policy with the workers' compensation exclusion removed.

INSTITUTIONAL BARRIERS

The delivery system for health care and disability income benefits involves many entities. Work related benefits are provided by insurers, state workers' compensation funds and both individual and group self-insurance mechanisms. Non-occupational benefits are provided by insurers, HMOs, MEWAs, ERISA based plans and statutorily enabled state health benefits plans such as Blue Cross/Blue Shield. It should be noted that the insurers who provide workers' compensation are not usually the same insurers that provide health and disability benefits. Each might be expected to have a desire to guard its own turf when the topic of 24-hour coverage is being considered. If any of the entities feels threatened by the 24-hour coverage proposal being espoused, one can expect them to oppose the 24-hour coverage proposal. There will be great interest from any of the entities that perceive the particular 24-hour coverage proposal being discussed will allow them to expand their markets or decrease expenses of delivery.

Another institutional barrier is the fact that the actual benefits provided under the systems operating today are different. Medical benefits provided under the workers' compensation system are typically unlimited and rarely require the injured employee to participate in the claim expenses by using deductibles or copayments. Non-occupational medical benefits typically have a maximum amount payable and usually require participation from the individual in the form of deductibles and copayments. Resolution of the issue of employee participation to the satisfaction of all parties involved may be a sticky issue. Labor unions and employees can be expected to resist any proposals that require the employee to contribute additional funds or receive diminished benefits. Employers can be expected to balk if they perceive they will be required to provide additional benefits. There are similar differences in the disability income benefits provided by workers' compensation and non-occupational disability income policies.

The issue of how to deal with the separate guaranty funds must be addressed. Any proposal for 24-hour coverage must come to grips with the issue of different guarantee funds. Further complicating the issue is the fact that some of the delivery mechanisms delivering either occupational or non-occupational benefits are not subject to any guarantee funds. Second injury funds and other state-specific workers' compensation funds such as silicosis and dust disease funds also will be impacted by a 24-hour coverage proposal.

Currently, employers who are unable to secure workers' compensation coverage from voluntary market insurers are able to purchase the coverage through residual market mechanisms available in most states. If these mechanisms are to continue operating under a 24-hour coverage proposal, a determination must be made whether to expand their operation to provision of the full benefit package set forth in the 24-hour coverage proposal. Analysis must be completed of the residual market mechanisms to determine if expanded residual markets will develop.

An additional institutional barrier that must be addressed is the subject of conversion privileges upon termination of employment or coverage under the 24-hour coverage proposal. What type of conversion privileges would an employee have who resigns, retires, or is terminated? Also what happens to coverage if a policy is terminated for nonpayment of premium? If coverage is implemented on a pilot project basis, what happens at the end of the pilot project? There would need to be provisions in the pilot project proposal to include an automatic conversion to traditional coverage at the end of the pilot project as well as provisions addressing these other areas. On the health portion, the issues of pre-existing condition exclusions and waiting periods must be considered.

Another issue to be examined is in regard to traveling employees when the employer has another state's endorsement on its workers' compensation policy. If an employee is traveling in the course and scope of his or her employment and is injured in another state, the employee may file for benefits under the benefit structure for the state which employs him or her or the benefit structure for the state in which the employee was injured. The impact this would have on 24-hour coverage should be addressed.

Safety in the workplace is, of course, an important issue. If these policies are not experience rated, what will the incentive be for the employer to provide a safe work environment? Requiring or providing an incentive for a safe work environment is an important consideration that is based in sound public policy. This should be addressed prior to implementation of 24-hour coverage.

REGULATORY BARRIERS

The system of regulation that is established for workers' compensation insurance often divides responsibility between two agencies. Insurance departments are usually charged with responsibility for regulating the contractual language contained in the insurance policies and the rating systems applied by insurers. Industrial accident boards or commissions are typically responsible for the delivery of benefits to the injured employee. They usually serve as the referee in resolving disputes between the injured employee and the entity charged with providing the benefits. Often the industrial accident boards or commissions are charged with collecting data with respect to occupational injuries and disease. For a 24-hour coverage proposal to function effectively, these responsibilities must be addressed.

One of the potential savings espoused for the 24-hour coverage concept is the reduced litigation expenses that will result from not having to determine if a particular injury or disease is work related. A state must determine if it no longer will require information on that basis.

Another area that will need to be addressed under a 24-hour coverage proposal will be the dispute resolution process. Often there is a jurisdictional split with the industrial accident board or commission charged with determination of the amount and type of benefits that will be received by the injured employees. The insurance department may be required to resolve disputes among employers and insurers regarding rating issues or coverage matters. The interrelationship between these governmental entities can be of concern.

STATE ACTIVITIES

This section of the report provides an update on the status of the various proposals to provide 24-hour coverage that are being considered in the states.

Before delving into specific state activities with respect to 24-hour coverage, it is important to note that employers in two states already have the option to opt out of the workers' compensation system. The workers' compensation laws in the states of New Jersey and Texas are elective for most employers. In these states, an employer may choose not to purchase workers' compensation insurance, however, in New Jersey an employer must either purchase workers' compensation insurance or employer's liability insurance. As a result, only Texas has a significant number of employers and employees who are operating under the voluntary election to not obtain workers' compensation coverage. A survey revealed that approximately 40% of Texas employers have elected not to participate in the workers' compensation system. This effects approximately 20% of the employees in Texas. Recent improvements to the Texas workers' compensation marketplace have reduced the number of nonsubscribers.

In Texas, the employer may choose to fund its liabilities for workplace injuries by voluntarily purchasing a workers' compensation policy, by retaining the exposure or by purchasing another product, such as a policy providing some form of 24-hour coverage. It is noteworthy that the choice to "opt out" of the workers' compensation system is not without peril to the employer. It appears that the employer exercising this choice would forego the exclusive remedy provisions of the workers' compensation act. The employer would then face the real possibility of dealing with torts brought by the injured employees seeking damages for work-related injuries and diseases.

In New Jersey, there is a statutory presumption that every employer is subject to the Workers' Compensation Act (§34:15-9). This statutory presumption has been in place since July 4, 1911. The election to not be covered under Article 2 (statutory benefits) but instead opting for Article 1 (common law) of the Act requires an express written statement between the employer and the employee prior to an accident. The written statement must be contained in the contract of hire or a separate written statement. Further, if the employer elects not to be covered under Article 2, it is not free from statutory obligation to provide coverage. If the employer elects not to be covered under Article 2 of the Act, it must purchase insurance in accordance with Article 5 of the Act to cover injuries to workers' through the negligence of the employer. Thus, the worker must prove that the employer was negligent, however, the damages are not limited to those outlined in Article 2. No employer in New Jersey has elected to not be covered under Article 2 of the Act. Lack of election of Article 1 is undoubtedly due to the fact that the cost of providing the required insurance under Article 1 would be determined to be at least equal to and most likely more than the cost of coverage under Article 2.

There are eighteen states where the workers' compensation statutes allow the use of alternative products or programs for employers to meet their statutory obligation to provide benefits under the workers' compensation act. These alternatives do not necessarily provide any of the 24-hour coverage products that have been discussed in this document. These alternative products typically require that the benefits be greater than or equal to those required under the workers' compensation act. They also often require approval of the workers' compensation administrator and/or the insurance department prior to issuing the contracts. The states of Alabama, Colorado, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Missouri, Oklahoma, Rhode Island, West Virginia and Wisconsin allow various forms of alternative coverage.

The remainder of this section of the report provides discussion of specific steps various states have taken towards providing 24-hour coverage within their borders. This includes states that have implemented pilot programs, or considered legislation that would authorize some form of 24-hour coverage.

CALIFORNIA

Effective Jan. 1, 1993, the California Legislature authorized the Director of the Division of Workers' Compensation to engage in pilot projects testing 24-hour coverage. Assembly Bill 3757 added Section 4612 to the Labor Code allowing a pilot project of up to 36 months duration. The pilot projects are limited to four designated counties where the employer contracts with a licensed health care service plan to serve as the exclusive provider of medical, surgical and hospital benefits to the employees for all injuries and illnesses.

Under the California pilot project, the employer is required to pay the entire premium for the occupational medical benefits and the employees cannot be assessed deductible amounts or copayments. Coverage for dependents must be made available; however, the employer is not required to pay for

dependent coverage. The employer, through the health care service plan, can direct the employee to a participating physician, provided adequate care is provided.

The Director is subject to various reporting requirements following the completion of the pilot project. The costs of the report will be borne by the employers participating in the pilot project and may be supplemented by external funding sources. Specific standards appear in the Act to measure the success of the pilots relative to other coverage.

The Research and Evaluation Unit of the Division of Workers' Compensation is charged with administering the pilot projects. On March 15, 1993, regulations and an evaluation plan were distributed for comments from interested parties. Two hearings were held in May 1993 to receive comments. The comments were reviewed by staff of the Division of Workers' Compensation. Final regulations were sent to the State Office of Administrative Law.

A Sept. 7, 1993, Bulletin (93-9) from the Division of Workers' Compensation provides an announcement of the regulations that have been adopted. It also emphasizes that priority will be given to small employers who have not previously offered health insurance to employees; to proposals submitted jointly by labor and management; to proposals providing parity in coverage between occupational and non occupational care; and to projects seeking to provide 24-hour income protection as well as medical care.

Assembly Bill 1692 was introduced by Assemblyman Burt Margolin. This bill was passed in late 1993, amending the pilot project enabling legislation. Highlights of the proposal are amendments to the evaluation specifications; allowance for the Division of Workers' Compensation to seek outside grant moneys to fund the evaluation aspects of the pilot project; liberalization of the timing of the reporting requirements for final evaluation of the project; and exemption from compliance with California's minimum rate law for workers' compensation rates, subject to approval of the Insurance Department.

A collateral issue that has developed concerns the application of the minimum rate law to the pilot projects. The 1993 adopted amendments exempted the pilot projects from application of the minimum rate law. The minimum rate law was repealed for all workers' compensation carriers in 1995.

Applications were distributed in September 1993 and accepted until March 1994. Eight proposals were received, some of which were consolidated. The Division of Workers' Compensation granted approval to four proposals.

The first approved program began June 1, 1994, in San Diego County. In this pilot, submitted by Kaiser Permanente, sixteen (16) San Diego-based employers are currently participating with marketing continuing for other employers to join in. Included are public sector employers and private businesses. The public sector employers are the County of San Diego, Padre Dam Municipal Water District and San Diego Community College District. Some of the private sector employers are insured by the State Compensation Insurance Fund, while the others had received approval to self-insure the workers' compensation risk. The pilot project will run for three years.

In January 1995, the California Department of Industrial Relations' Division of Workers' Compensation announced that three more pilot projects had been approved for operation in San Diego, Los Angeles, Sacramento and Santa Clara Counties. The three pilot projects approved by the Department were:

- ◆ Kaiser Permanente's Northern California region. This pilot covers both public and private sector employees in Sacramento and Santa Clara Counties. Currently there are over 30 employers, including the State of California, enrolling employees in this pilot.
- ◆ Maxicare Life and Health Insurance Company. Maxicare has established a network of doctors and medical groups in Los Angeles County. These networks and medical groups are trained in both occupational and non-occupational medicine, thus allowing patients to visit the same primary care physician for all types of injuries. This characteristic is unique to the Maxicare pilot. In other pilots, an employee may be required to see a physician who specializes in occupational medicine for work-related injuries. Maxicare is marketing to both large and small private sector employers in Los Angeles County. Currently four employers have enrolled in the program.
- ◆ An alliance between Sharp HealthCare and TIG Insurance Company which, together, have developed a 24-hour care product sold primarily to small employers in San Diego. Marketed under the name "The 24-Hour Care Alliance," this pilot used the Sharp Rees-Stealy Medical Group's dedicated occupational medicine approach to managing the medical and disability costs of the pilot. This program never achieved significant enrollment.

The termination date of the pilot has been extended by regulation until Dec. 31, 1997, to provide for a longer testing period and allow a three-year pilot for programs commencing in January 1995.

The legislation requires an interim and final report evaluating the implementation and outcomes of the pilot projects, with focus on employer costs and savings, and on injured worker satisfaction with the projects. In February 1996, the Robert Wood Johnson Foundation awarded the first evaluation grant in its Workers' Compensation Health Initiative to the UCLA Center for Health Policy Studies and the Rand Corporation to study and report on the California 24-hour pilot programs, and to create a template for evaluating other ongoing programs. Participants in the pilot projects are also responsible for funding a portion of the evaluation costs.

As of December 1996, there were approximately 65 employers participating in the pilot programs in the four counties, with a total of over 8,000 employees signed up for coverage.

An interim report to the legislature on the project was released in April 1997. The summary and text are available on the Internet at http://www.dir.ca.gov/dwc/dwc_newslines/Newsline_97-9.html and a downloadable version is found at http://www.dir.ca.gov/dwc/dwc_newslines/24intrpt.pdf. Legislation to extend the pilot project was introduced as Senate Bill 410, but was not enacted however; the project was extended by regulation. The pilot program ended on December 31, 1997. The division is currently evaluating the project. The final report is in process.

For further information on the California pilot project you may contact Glenn Shor, Ph.D., Research and Evaluation Unit, Division of Workers' Compensation, 455 Golden Gate Avenue, 9th Floor, San Francisco, California 94102. Dr. Shor's telephone number is (415) 703-4600; fax (415) 703-4718; e-mail address gshor@hq.dir.ca.gov.

FLORIDA

Florida has a very extensive enabling statute for providing 24-hour health insurance coverage pilot projects, which would allow employers to purchase an integrated policy providing medical and indemnity coverage. During a special legislative session in November 1993, the Florida Legislature

amended §440.135, F.S., to authorize the establishment of one or more pilot programs to provide 24-hour health insurance coverage. The term "24-hour coverage" is used to describe insurance coverage, which combines traditional health, workers' compensation and employers' liability coverage under a single policy. The intent of the legislature was to determine whether the total cost to an employer that provides a policy or plan of health insurance and a separate policy or plan of workers' compensation for its employees can be reduced by combining the coverages under a policy or plan that provides 24-hour health insurance coverage.

The Department was charged with evaluating the feasibility of initiating one or more pilot programs under which employers would provide a 24-hour health insurance policy to their employees under a single insurance policy or self-insured plan. The statute provided that the plan must provide medical benefits for at least occupational injuries and illnesses comparable to those required by the workers' compensation law and may use deductibles and coinsurance provisions that require the employee to pay a portion of the actual medical care received by the employee. The statute also requires that the employer pay the entire premium for the 24-hour health insurance policy, other than the portion of the premium which relates to dependent coverage.

The Department spent several years in discussion with companies interested in participating in the program and studied the experiences of other states attempting to develop similar programs, and has concluded that the current statutory requirements and practices in Florida do not permit the implementation of a proposal that would provide sufficient incentives for both buyers and sellers. An initial request for participation resulted in five joint venture applications from which the Department selected two potential participants. The Department then encountered operational considerations that could not be resolved, a lack of coordination between venture partners, and changing enthusiasm for the projects.

The request for application was reissued and generated three respondents, two of which eventually withdrew. Given the statutory requirements, the third potential participant was unable to design a plan which would generate the sale of sufficient policies necessary to have a pilot project large enough to accomplish a serious study of the viability of 24-hour coverage.

The Department has concluded that additional statutory changes are a prerequisite to the 24-hour pilot project moving forward in any meaningful way. Employers are reluctant to consider purchasing a policy that requires payment of the entire group premium for their employees since employee cost participation through co-payments and deductibles would not offset or ameliorate this concern. Fundamental differences in the benefit structures makes it difficult to implement one policy, but the usefulness of conducting a pilot project to measure the effectiveness of administering two separate policies is in doubt since no statutory changes were originally needed to administer two separate policies. Also there were issues surrounding whether the new product was a life and health product or a property and casualty product and what licensure would be required to market the product. Finally, stabilization of the workers' compensation market has reduced the interest and enthusiasm in the industry for creating a "new" workers' compensation product. At present there is no activity on these projects and none is anticipated in the near future.

The contact person for the Florida Department of Insurance is Robbie S. Simpson. She may be reached at (850) 413-5250. The address for the Department is 200 East Gaines Street, Tallahassee, Florida 32399-0326.

GEORGIA

Authorization to establish 24-hour coverage pilot projects was granted by the Georgia Legislature in § 34-9-122.1. This section requires the Commissioner to “adopt rules to enable employers and employees to enter into agreements to provide the employees with workers’ compensation medical payment benefits through comprehensive health insurance that covers workplace injury and illness.” The Commissioner has the authority to review all pilot project proposals. To be acceptable, a proposal must provide medical benefits substantially similar to those provided by the Georgia Workers’ Compensation Act. It authorizes the use of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to deliver the medical benefits. Premiums must be paid entirely by the employer. The pilot program may apply deductibles, coinsurance and copayments to the employees. These are capped at \$5 per office visit with a \$50 maximum per occurrence. Each November, a report is required of the Commissioner on the status of any pilot projects that have been approved.

The insurance department staff reports that there are five entities currently providing coverage under § 34-9-14, which authorizes “alternative coverages.” Three of these entities have also sought and received approval to provide coverage under § 34-9-122.1. Pilots have been approved for affiliates of Firemen’s Fund, Travelers and Zurich-American. In addition, Liberty Mutual and Guarantee Mutual Life are providing coverage under the alternative coverage law. It should be noted that none of these products provide a true 24-hour coverage. They provide for occupational injuries and illness only. Department staff believes that alternative coverage status was sought principally to avoid participation in the residual market mechanism. Approval as a 24-hour pilot project also allowed insurers to apply the deductible amounts discussed above. All filings proposing alternative coverages or 24-hour pilot status are being reviewed by the Property & Casualty Section of the insurance department. The department staff reports that they are currently performing in depth investigation into the alternative coverage products. This includes market conduct examinations to ascertain that the alternatives are delivering the required benefits. A recent law change that requires alternative coverage products to participate in the Georgia residual market mechanism has diminished the enthusiasm for these products. In addition, the Georgia residual market mechanism has become self-supporting.

In the September 1997 report, the insurance department was reviewing the application for an alternative product seeking status as a 24-hour pilot. That proposal provided for a single policy using coverage parts to assemble the coverage selected by the employer. Seamless coverage was proposed for both occupational and non-occupational injury and illness as well as disability income benefits which were consistent with the workers’ compensation indemnity benefits. Dental benefits were also offered as an option in this integrated 24-hour coverage product. The program sought to insure businesses in the 50+-employee range. The proposal indicated a fully insured program and was to be written in conjunction with a self-insured ERISA health plan. However, late in the fall, the company submitting the proposal withdrew their submission.

Information on the alternative coverage products and 24-hour pilots may be obtained from Steve Manders at (404) 656-2022. The address of the Georgia Department of Insurance is 2 Martin Luther King, Jr. Dr., Floyd Memorial Building, 704 West Tower, Atlanta, Georgia 30334.

HAWAII

Hawaii currently requires most employers to provide group health insurance benefits to all employees in addition to traditional workers’ compensation benefits. Also, registered owners of motor vehicles are

required to maintain motor vehicle coverage, which includes personal injury protection benefits. Thus, it seems only natural that Hawaii would be interested in 24-hour coverage.

During the 1995 legislative session, several bills were introduced that proposed various forms of 24-hour coverage. However, Hawaii's ability to obtain approval of an ERISA exemption to any amendments of Hawaii's Prepaid Health Care Law, Chapter 393, Hawaii Revised Statutes, is the major barrier to any legislation on 24-hour coverage.

The Hawaii Department of Labor and Industrial Relations has allowed certain self-insured employers to impose components of managed care subject to agreement by the employees. And, Senate Bill 2386, SD2, HD2, CD1, passed by the 1998 Legislature and enacted July 14, 1998, permits employers to select two registered coordinated care organizations to provide coverage for the medical and rehabilitative benefits in the policy. However, the employee shall have the choice of selecting one, or need not select any. Thus, Hawaii remains an employee choice state for selection of medical care providers.

For further information on 24-hour coverage activities in Hawaii, please contact Shelley Santo at (808) 586-2809. The mailing address for the Hawaii Insurance Division is Insurance Division, Department of Commerce and Consumer Affairs, State of Hawaii, P.O. Box 3614, Honolulu, Hawaii 96811-3614.

IOWA

Based on interest expressed by consumer, business and labor groups in 1992, former Commissioner David Lyons established an open roundtable to study the feasibility of implementing a 24-hour coverage pilot project. Participants included representatives from the insurance industry as well as various business and labor groups.

The group focused on the legal and regulatory impediments involved, including ERISA issues and necessary changes that would be required for an authorized insurer to write a policy with both property/casualty and health components.

The roundtable made the following recommendations:

1. Legislation must be passed which grants authority to establish pilot projects.
2. Initial pilot projects will be conducted with governmental entities until questions regarding ERISA are clarified.
3. Recommendations and legislation for the authority to offer a policy providing 24-hour coverage on the open market will be made after the pilot project has been tested for one or two years.

In January 1993, a written report on the topic was produced by the roundtable members and presented to the Legislature for consideration. It contains a number of recommendations to the Legislature for consideration.

The Workers' Compensation Subcommittee of the Iowa Health Reform Council recommended that 24-hour coverage not be made mandatory. Instead, the subcommittee recommended that health benefits and the medical component of workers' compensation be coordinated rather than combined, though 24-hour coverage should be made available as a permissive option. Primary reasons were the desire to retain workers' compensation experience rating as an incentive for workplace safety; appropriate motivations

for rapid return to work; and fundamental problems in requiring the merger of health benefits subject to cost-sharing with workers' compensation. Concern was also expressed that stress not be made a compensable workplace injury. Similarly, the subcommittee expressed support to retain employer-choice of doctor in workers' compensation as a key to cost-containment and fraud prevention.

Subsequent action by the Iowa General Assembly, the Governor and the Division of Insurance on health care reform is consistent with these recommendations.

As of this writing, no legislation has been passed in Iowa granting authority to establish pilot projects.

For further information on the 24-hour coverage situation in Iowa, contact Angela Burke Boston at (515) 281-4119.

KENTUCKY

With the passing of HB928 in 1994, the Kentucky General Assembly allowed the development of a pilot project to study the effects of linking occupational and non-occupational medical benefits to create a 24-hour medical plan. This plan would encompass all current workers' compensation laws and regulations, including employer's liability. Since this plan would include the non-occupational medical benefits, HB250, the major Health Care Reform bill, also included statutory language to allow this type of project to be conducted in our state.

The 1996 Kentucky General Assembly returned to clean up some of its health care reform efforts in 1994 by passing SB343, which continued the concept of 24-hour pilot projects. The only changes made were to eliminate the need for the plans to be presented before the Health Policy Board, which was abolished in the legislation. The power once held by the board now rest with the Department of Insurance and the Department of Worker's Claims. Both agencies must review the proposed plans for compliance. New Administrative regulations have been issued by the Department of Insurance. The applications and filing instructions for all potential applicants are the same.

Although two plans were approved in January 1996, no employer groups ever enrolled in the pilot project. The Kentucky General Assembly moved into a Special Session on Workers' Compensation on December 2, 1996. Included in the Governor's reform bill, was language to repeal the pilot language and allow the development of 24-hour coverage in Kentucky. HB1, a complete Workers' Compensation reform package now allows 24-hour plans to be established without pilot participation.

The workers' compensation market is fluid once again in Kentucky. More carriers in the market give employers a great deal of choice. The Competitive Fund, Kentucky Employers Mutual, provides more than adequate coverage for employers locked out of the competitive market because of size or income. With these dynamics in place, employers are now looking to try new innovative approaches to their workers' compensation. We have had several inquiries from consulting firms and companies. The standardized benefit levels of the health portion prevents carriers from taking a serious look at Kentucky.

For further information, contact Mona Carter of the Kentucky Department of Insurance, 215 West Main St., P.O. Box 517, Frankfort, Kentucky, 40602. (502) 564-6026.

LOUISIANA

Current state law authorizes the Department of Insurance in Louisiana to establish pilot programs for providing comprehensive health benefits to employees which includes medical care for work related injuries. Following passage of the authorizing legislation in 1993, the Department began developing a model to implement the pilot program.

To date, the Department has been unable to implement a pilot because of various problems. Legislation (SB 1055) submitted in the 1997 Regular Session of the Louisiana Legislature and awaiting final passage on the house floor as of May 29, 1997, addresses the problems as follows:

Current law requires the employer to pay 100% of health premiums. SB 1055 eliminates the requirement for the employer to pay 100% of all premiums and the employer's 100% liability is being retained for the cost of providing work related injury coverage.

Current law establishes each pilot program for a two-year period. SB 1055 extends the pilot period to five years because of the start-up time and maintenance of employee choice of providers for work related injuries.

Current law limits the number of employers in each pilot to one. SB 1055 allows employer groups and associations to participate in the pilot.

Current law does not address what recourse employees will have to resolve disputes involving work-related injuries. SB 1055 proposes to establish the Workers' Compensation statute as the exclusive remedy for settling disputes.

The contact person for the Louisiana Department of Insurance is Denise Cassano, Executive Director of the Louisiana Health Care Commission. Her address is 950 North 5th Street, P.O. Box 94214, Baton Rouge, Louisiana 70804-9214. Ms. Cassano's phone number is (225) 342-0819.

MAINE

The state of Maine enacted enabling legislation for a pilot project in 1991. 39-A M.R.S.A. §403(2). In 1992, the Maine Bureau of Insurance held a public hearing to receive comments on a proposed implementing rule; however, no rule was enacted at that time. Originally scheduled to sunset in 1996, the pilot project legislation has been extended to 2001, and the Bureau of Insurance adopted Rule 690 on March 1, 1995.

Legislation was adopted in 1995 that allows the consideration of 24-hour coverage plans providing both medical and disability benefits. The Bureau then amended Rule 690 to provide criteria for approval of alternative indemnity benefit structures, and the amended Rule was upheld by the Maine Law Court on December 3, 1998.

The Maine Bureau of Insurance obtained a grant from the Robert Wood Johnson Foundation to aid in the implementation and evaluation of pilot projects, and the Maine Employers Mutual Insurance Company has filed a wrap-around indemnity policy which may be used by employers participating in 24-hour medical pilot projects. Although the interest in 24-hour coverage has lessened in the last few years due to reduced workers' compensation rates in the State of Maine, the Bureau of Insurance continues to solicit proposals for pilot projects.

The Maine law allows considerable flexibility in designing innovative coverage structures, subject to approval by the Bureau of Insurance in consultation with the Workers' Compensation Board. Concepts that have been presented to Bureau staff include: a 24-hour HMO with a single network and uniform co-payment structure, coordinating with an indemnity-only policy whose carrier reinsures the medical tail; a single excess policy to cover occupational and non-occupational medical care for self-insureds; a capitated arrangement for occupational and non-occupational medical coverage, and a coordinated product with a single entry point for occupational and non-occupational medical care.

For further details, please contact Glenn Griswold of the Maine Bureau of Insurance at 34 State House Station, Augusta, Maine 04333. The Bureau's telephone number is (207) 624-8475.

MASSACHUSETTS

Enabling legislation (Chapter 152:10C) was enacted in Massachusetts in 1991 that allows employers and employees, through collective bargaining agreements, to adopt 24-hour health care coverage plans. In another section (Chapter 398:101A) the Insurance Commissioner was authorized to initiate up to 10 pilot programs where the employer could meet the requirements of the Workers' Compensation Act to provide medical coverage through a health insurance policy or a self-funded health plan.

The pilots were originally scheduled to begin July 1, 1992, with a three-year sunset. The Division of Insurance was required to provide status reports on the pilot programs every six months, including any recommended legislative changes. The effective date of the pilots was moved back to July 1, 1993, when no pilots were filed until that time. The Division of Insurance made a mass mailing to health insurers and workers' compensation insurers to identify those interested in participating in the pilot programs. There was little interest in the concept as the law in Massachusetts did not allow for any employee participation through use of deductibles or co-payments. The provision for pilot projects has reached its sunset and is, therefore, no longer effective.

Massachusetts has approved in 1996 and 1997 a request for a downward rate deviation from a workers' compensation insurer that gave bigger discounts to employers that also purchased long-term disability policies paying similar wage loss benefits.

For further information, contact the Massachusetts Division of Insurance. You may call Walter Horn at (617) 521-7335. The mailing address is Division of Insurance, Commonwealth of Massachusetts, One South Station, Massachusetts 02110.

MINNESOTA

In April 1992, Minnesota enacted many significant changes to its workers' compensation law. Included in those changes (CH. 510, Article 4, Sec. 24) was a mandate for the Commissioner of Commerce and the Commissioner of Labor and Industry to study 24-hour coverage. They were to report their findings, including specific recommendations to the legislature by Feb. 1, 1993. The report was released the last week of February 1993. John Gross and Hollice Allen of the Minnesota Department of Commerce and Lisa Thornquist, former Director of the Legal and Legislative Affairs Division of the Department of Labor and Industry, collected the necessary information and compiled the report.

In 1994, the Minnesota Legislature passed an Act known as the 1994 MinnesotaCare Legislation. Section 7 of Article 5 of the Act requires the Department of Health and the Department of Labor and Industry to report to the Minnesota Legislature their recommendations for necessary legislative changes

to implement a 24-hour coverage plan, incorporating and coordinating the health component of workers' compensation with the health care coverage to be offered by an integrated service network. The report was submitted to the legislature on Jan. 12, 1996. No action was taken regarding 24-hour coverage in the 1996 legislative session.

In early 1997, The Minnesota Health Partnership, a local coalition, comprised of a diverse group representing employers, health care provider organizations, insurers and state government agencies, received a grant from the Robert Wood Johnson Foundation to pilot a coordinated health care delivery model that blends traditional employee health care and workers' compensation medical coverage. The Minnesota Department of Commerce is continuing to monitor the progress of this coalition.

The Minnesota Department of Commerce remains concerned about the interaction of 24-hour coverage with ERISA.

Questions regarding the 1993 report may be directed to John Gross at (651) 297-2319. Other questions regarding 24-hour coverage or the 1996 Report to the Legislature may be directed to Tammy Lohmann at (651) 296-2327. The mailing address is Department of Commerce, State of Minnesota, 133 East 7th Street, St. Paul, Minnesota 55101.

MONTANA

House Joint Resolution 33, a joint resolution requesting an interim study, passed the Montana Senate and was concurred in the House on April 24, 1993. This resolution calls for a study of 24-hour coverage and other alternatives to the workers' compensation system. The study was compiled by the Montana Legislative Council and was published in November 1994. It concluded that Montana was not in a position to pursue 24-hour coverage at this time. It did, however, recommend that Montana monitor its recent workers' compensation reforms and the activities of other states with regard to innovative health care reform. For information on the study, contact Susan Byorth Fox at (406) 444-3064 or Nancy Butler at (406) 444-6500. For workers' compensation issues, please contact Eddy McClure at 406-444-3064 or fax 406-444-3036.

NORTH CAROLINA

North Carolina initially took an interest in 24-hour coverage. A task force was established which looked at such items as permissive legislation, pilot projects, and related issues. However, there is currently no activity and none is anticipated in the future.

Commissioner Long has designated Charles Swindell, Deputy Commissioner, as the contact person. The mailing address is: North Carolina Department of Insurance, P.O. Box 26387, Raleigh, North Carolina 27611. Mr. Swindell may be reached by calling (919) 733-3368.

OKLAHOMA

The Oklahoma Integrated Claims Management Pilot Program, in compliance with 85 O.S. Supp. 1995, § 14.1, is an integrated claims management approach to the handling of medical and/or disability claims of Oklahoma employees covered under standard (to include employers liability) or equivalent workers' compensation policies and under group medical policies. Only carriers licensed in Oklahoma for casualty and/or life and health may participate after approval from the Commissioner. Managed care

workers' compensation medical coverage can be provided by a Certified Workplace Medical Plan [85 O.S. Supp. 1995, § 3 (16)] which may apply up to 10% schedule rating credit.

Separate policies for the workers' compensation and group medical coverages must apply, as a combined policy integrating workers' compensation and group medical coverages has not been allowed in Oklahoma. Carriers may handle claims processing either singularly or in combination with other carriers in the same pilot project. The approval of each pilot will be for a three-year period, with renewal of the pilot subject to approval by the Commissioner.

For further information on the Oklahoma Integrated Claims Management Pilot Program, contact Mike Armstrong, Property & Casualty Division, at (405) 521-3681. The mailing address for the Oklahoma Insurance Department is 3814 N. Santa Fe, Oklahoma City, Oklahoma 73118.

OREGON

Oregon became the first state to submit a proposal to the Robert Wood Johnson Foundation (RWJF) for funding of a pilot program. This proposal was submitted on March 6, 1992, by former Governor Barbara Roberts and former Director Gary K. Weeks. The proposal identified three entities that had expressed an interest in the pilot projects—a large private corporation, a major city and a state agency. Oregon suggested to RWJF that all three entities be considered for pilot projects so that results may be meaningfully compared.

The Oregon proposal was divided into two phases. First, a year-long planning phase identified the models to be tested, analyzed costs and benefits associated with chosen models, identified any barriers to successful implementation, and designed a management control and reporting system. The second stage was the implementation phase of the project. Necessary legal documents and legislation were prepared, final participants were chosen and barriers removed. The pilots were implemented with appropriate monitoring. Analysis of results occurred during the following months.

On Feb. 4, 1993, Oregon was awarded a \$336,658 grant from the RWJF to fund an 18-month pilot project testing the combination of workers' compensation with health insurance. The grant paid for set-up costs and supervision of the pilot projects. On March 26, 1993, the Department of Consumer and Business Services formally solicited employers to participate in the pilot project. On May 11, 1993, Ed Nieuburt was hired to coordinate the 24-hour coverage pilot project.

On Aug. 3, 1993, enabling legislation (HB 2285) was passed that provided for implementation of pilot projects. Administrative rules were adopted on Dec. 29, 1993. The rules provide various definitions: a provision on the maintenance of exclusive remedy; information on the type and structure of the pilots and the type of sponsors; details about the application process; details about the approval process; a process for revocation of pilots under certain circumstances; an oversight committee; a dispute resolution process; details on provider networks and managed care; a description of the coverage that must be provided; details on coverage after the pilot project has been completed; details on claims administration; evaluation criteria; reporting requirements of participants; approval of rates and forms; residual market effects; premium tax and guarantee association assessment details; and duties of agents, adjusters and Third Party Administrators (TPAs).

The initial pilot plan became operational in January 1994. The initial plan provided a coordinated product consisting of a joint venture between a Blue-Cross/Blue Shield HMO and the State Accident Insurance Fund (SAIF—which is Oregon's workers' compensation competitive state fund). This plan

wrote a variety of employers. It was the largest pilot plan. As of Jan 1, 1996, it provided services to nine employers with a total of 2,235 covered employees. In a coordinated plan, the employer receives two separate contracts; however, the insurer and the health plan use the same managed care network and physician payment rates, thus providing seamless delivery to the employees.

A second pilot plan was approved in April 1994. This plan was a partnership between the Kaiser Permanente HMO and employers that are self-insured for workers' compensation. Plan members received all medical care (work-related and non-work-related) via the HMO and the HMO accepted capitated payment for all services. As of Sept. 1, 1996, two self-insured employers participated with a total of 928 covered employees.

Six other pilot plans were approved for operation. Four of the plans were HMO-based and two were PPO-based. Two of the HMO plans used capitated provider payments for all medical services; the other plans used some form of negotiated fee schedule. Two of the pilot plans subsequently withdrew, leaving a total of six pilot plans in effect. As of Sept. 1, 1996, four of the six pilot plans actively provided coverage to fourteen different employers with 3,624 employees enrolled.

Because the pilot plans attained only modest enrollment levels, the Department phased-out the pilot program. RWJF funding expired on May 1, 1996, and additional funding for statistical analysis of the program was not sought. A report summarizing the experience of the program was provided to RWJF on June 24, 1996. Copies of the report are available from RWJF or the Department. Statistical analysis of pilot plans that operated after RWJF funding expired was not pursued because of insufficient enrollment levels. The legislation that implemented the 24-hour coverage pilot program expired July 1, 1998, so the pilot program is no longer operating.

Further information on the pilot plans may be obtained from Nancy Ellison at 503-947-7980. The address for the Oregon Department of Consumer and Business Services is 350 Winter Street N.E., Salem, Oregon 97310.

WASHINGTON

The Washington Health Services Act of 1993 contained legislation requiring a study about the provision of medical benefits for injured workers under a consolidated health care system (RCW 43.72.850). Known as the Consolidation Study, the research effort was broader in scope than just 24-hour coverage. State legislators envisioned blending health care delivery for occupational and non-occupational injury and illness as part of Washington's transition to a universal coverage health care system.

The statute provided that any consolidation would not take effect until at least 97 percent of state residents had access to a uniform health care benefit package. The legislature expected universal coverage would be reached through the implementation of the 1993 health care reform package. During the 1995 legislative session, however, the Health Services Act was scaled back. Washington's legislature repealed universal insurance coverage due to stakeholder concerns about the costs of such a plan. This made the Consolidation Study difficult to complete, since there was no longer a future universal health insurance system with which to consolidate workers' compensation health care delivery.

Washington's Health Care Policy Board, the lead agency for the Consolidation Study, agreed to wait for results from the State's Workers' Compensation Managed Care Pilot Project before proceeding with further recommendations on consolidation. After obtaining information from the pilot project Interim

Report, the Health Care Policy Board issued a report in December 1996. Their report concluded that consolidation of the State's general health insurance system with the medical benefits portion of the workers' compensation insurance was not feasible.

Washington's Workers' Compensation Managed Care Pilot study continued, despite repeal of the Health Services Act. The Department of Labor and Industries, which runs the State's workers' compensation program, contracted with two managed care organizations (MCOs) for the pilot: Kaiser Permanente and Providence Health Plans. They also contracted with the University of Washington Health Services Department for a scientific evaluation of the pilot. The Department of Labor and Industries enrolled 7,000 workers in the managed care group and the University of Washington established a matched control group of 12,000 workers who received medical care through the Department of Labor and Industries' traditional fee-for-service system. The two MCOs employed features, such as: capitation based on industry risk class, primary care physicians trained in occupational medicine, case management, and quality oversight by medical directors trained in occupational medicine. The University of Washington's evaluation, just published in April 1997, demonstrated that capitated managed care systems with occupational medicine programs reduced medical costs by 27% and had no adverse effect on quality. The study also showed managed care increased employer satisfaction while decreasing worker satisfaction. Contact: Roy Plaeger-Brockway, Manager, Health Services Analysis, Washington State Department of Labor and Industries, (360) 902-5052 or plae235@Ini.wa.gov.

NAIC ACTIVITIES

The 24-Hour Coverage Working Group of the Workers' Compensation (C) Task Force was actively involved in consideration of 24-hour coverage. Since its inception in 1991, the working group served as a forum for all parties to discuss the myriad of issues related to implementation of 24-hour coverage. It was also responsible for publication of this quarterly progress report.

The working group exposed a draft of the Twenty-Four-Hour Coverage Pilot Project Model Act on Feb. 9, 1992. The exposure draft was discussed and refined through analysis of written comments received from interested parties, analysis of oral testimony and the input of a dedicated team of regulators. Lenita Blasingame (Ark.); Don Switzer (Ark.); Barbara Yondorf (Colo.); Kenney Shipley (Fla.); Robbie Simpson (Fla.); Jim Watford (Fla.); George Renaudin (La.); Rich Piazza (La.); Steve D'Amato (Mass.); Walter Horn (Mass.); Bob Card (Okla.); Larry Donovan (Okla.); Ed Nieubuurt (Ore.); and Shawn W. Bryan (Vt.) dedicated countless hours to the drafting process, providing their expertise to develop the current model law. The working group participated in a number of conference calls to work out the details of the proposed model. The working group released the extensively revised draft at the NAIC meeting in Denver on March 9, 1993. A comment period was provided. The working group addressed the comments received on the draft and made several technical amendments to the draft. The draft was adopted by the working group at its meeting in Baltimore on June 13, 1994.

After the working group adopted the Twenty-Four-Hour Coverage Pilot Project Model Act, it was forwarded to the NAIC's Workers' Compensation (C) Task Force. The task force adopted the model act at its meeting on June 14, 1994. The model act was forwarded to its parent committee for consideration and adoption. The NAIC's Commercial Lines—Property and Casualty Insurance (C) Committee adopted the Twenty-Four-Hour Coverage Pilot Project Model Act at its meeting on June 15, 1994. The model act was considered at the NAIC Plenary by the entire NAIC membership. The Twenty-Four-Hour Coverage Pilot Project Model Act was adopted at the Fall National Meeting on Sept. 18, 1994, in Minneapolis, Minn. Copies of the model act are available from the NAIC Publications Department—(816) 374-7259.

The 24-Hour Coverage Working Group was discharged at the December 1994 NAIC National Meeting after completing its assigned charges. Responsibility for the publication of this quarterly report now rests with the Workers' Compensation (C) Task Force. Due to inactivity in the 24-Hour Coverage arena, Colorado has asked to be deleted as a contributor to this quarterly progress report effective June 1, 1998. Any comments or suggestions on the content of this report should be directed to the task force. For questions concerning the information contained in this report, contact Bob Card, Senior Regulatory Specialist, NAIC, 120 West 12th Street, Suite 1100, Kansas City, Missouri 64105-1925. His phone number is (816) 374-7248 and fax number is (816) 460-7513.

NCSL ACTIVITIES

The National Conference of State Legislatures (NCSL) is working with the pilot project states with respect to evaluation of the pilot project results. A meeting was held in December 1994, at the NCSL offices to discuss application of common methodologies for collection and analysis of pilot project results. The pilot project states are hopeful that common evaluation criteria can be agreed upon to facilitate the cross-comparison of state results. At that meeting, the state representatives representing the pilot project states began assembling data elements that they agreed would be useful to collect.

A second meeting was held in the offices of the California Division of Workers' Compensation in late January 1995. Further progress was made on evaluation criteria and initial plans for a symposium on 24-hour coverage were discussed. This symposium was intended to allow participants to learn about trends and innovations related to 24-hour coverage. It offered opportunities for participation in roundtable discussions of issues related to 24-hour coverage. Participants learned about the current pilot projects and how they will be evaluated. They also learned about the current legislative and regulatory environment that surrounds 24-hour coverage.

In 1997, NCSL, in conjunction with the NAIC and IAIABC, will establish an Educational Outreach Program on Workers' Compensation Health Care Issues, including managed care and 24-hour coverage issues. The program is holding a series of focus groups, workshops and seminars to provide information in this rapidly developing area. The first was held in San Francisco on April 4. A second is scheduled in Chicago on June 6. As a result of the focus group meetings, the NAIC, NCSL and IAIABC co-sponsored a workshop in Newport, RI on Workers' Compensation Managed Care Data Collection issues. In January 1998, another focus group meeting was held in Washington, D.C. to further define and discuss issues concerning 24-hour coverage. The topic is of major interest to members of all three organizations.

In 1999, the focus for the project will be data collection in the health care area.

Brenda A. Trolin (NCSL) is coordinating NCSL activities in this area. She may be reached at (303) 830-2200.

24-HOUR COVERAGE SYMPOSIUM RESULTS

The symposium was held preceding the Fall NAIC National Meeting in Philadelphia on Sept. 6 and 7, 1995. It was jointly hosted by the NCSL and the NAIC, with assistance provided by the International Association of Industrial Accident Boards and Commissions (IAIABC) and the Council of Governors' Policy Advisors. In this section, some of the symposium outcomes are discussed.

In recent years, state workers' compensation programs and health care programs have been criticized for excessive costs and lack of access. In response to these problems in both systems, sporadic attempts to create new systems to replace the old ones have been tried. However, lack of information, misinformation and restrictive state and federal laws and regulations have thwarted innovations in this area.

The principal objectives of the symposium were to:

- Explain the concept of 24-Hour Coverage to policymakers and private sector interest groups.
- Summarize trends and innovations related to 24-Hour Coverage that has been identified in the marketplace.
- Discuss how current 24-Hour pilot projects are proceeding and learn how to evaluate these pilots.
- Provide a presentation on the current legislative and regulatory environment so that participants are aware of legal impediments which may have to be overcome to implement programs.
- Discuss the variations on the 24-Hour concept so that participants who wish to design programs will understand the complexities of each variant, particularly the ones that contemplate a medical and disability program which is all-inclusive, providing medical and disability benefits for all diseases and injuries.
- Bring legislators, insurance commissioners, state workers' compensation administrators and governors together so a working relationship based on a clear understanding of conceptual and practical issues could be initiated.

The symposium objectives were achieved in several ways.

First, there were 150 participants from both the public and private sector in attendance. There were representatives from the public sector from the following constituencies: governors, legislators, insurance commissioners and state workers' compensation administrators. They all actively participated in the discussions.

Second the agenda for the symposium provided all the information outlined in the objectives. The speakers have national reputations as experts in their respective fields and clearly and concisely addressed the issues.

Third, ample time was provided for the participants to discuss the presentations, ask questions and make comments. Based on the quality of the questions and comments from the participants, it was clear that participants were not only learning about the issues, but planned to initiate projects in their states.

The post-symposium plans by the sponsoring organizations include:

- A joint meeting of the groups involved to best determine how the associations can better coordinate activities to facilitate experimentation designed to resolve issues related to workers' compensation and health care.
- Continued dissemination of information on the topic and state activities involving 24-hour coverage. This includes the NAIC's quarterly publication on 24-hour coverage.
- Assistance to states in designing and implementing 24-hour coverage pilot projects.
- Distribution of the work papers and tapes of the symposium. These are available from the IAIABC, the NAIC or the NCSL offices.

THE ROBERT WOOD JOHNSON FOUNDATION

In 1995, the Robert Wood Johnson Foundation established the Workers' Compensation Health Initiative, a grant program supporting innovations in the delivery and financing of workers' compensation medical care. Since its inception in 1995, the initiative has made 21 grants totaling approximately \$6 million.

On November 1, 1999 three new grants totaling \$698,844 intended to improve the quality of medical care provided to persons with occupational injuries and illnesses was announced. Two of the new grants support the development of model state-agency based resource centers for the improvement of workers' compensation medical care in Rhode Island and California. The third grant is for a planning and feasibility study to facilitate the eventual creation of a national interstate research database for workers' compensation medical care. The 1999 grant recipients are:

- The State of Rhode Island Department of Labor and Training. Project Name: Development of a Model State Technical Resources Center for the Improvement of Workers' Compensation Medical Care. Grant Period: 10/1/99—9/30/01. Grant Amount: \$267,500
- The California Public Health Institute. Project Name: Planning and Development of the 'California Work Injury Resource Center for the Improvement of Workers' Compensation Medical Care. Grant Period: 10/1/99—9/30/00. Grant Amount: \$81,079.
- The University of Texas—Houston School of Public Health. Project Name: Development and Testing of a Standardized Method for Creating an Interstate Database for the Study of Workers' Compensation Medical Care. Grant Period: 11/1/99—10/30/01. Grant Amount: \$350,265.

Information about the initiative can be found on its Internet web page at <http://www.ummed.edu/dept/f+cm/rwj/rwj.htm>. For further information, contact:

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CONCLUSION

The interest in 24-hour coverage has subsided somewhat the last few years due, in part, to the renewed interest of private insurance companies to write workers' compensation coverage. It is, however, continuing to be discussed by insurers, regulators, legislators, governors, employers and employees as a way to curb the rising cost of providing medical coverage and workers' compensation. As this report reveals, the NAIC members have only begun to scratch the surface in analyzing the effect of implementing 24-hour coverage. The subject of 24-hour coverage deserves careful review and analysis by all stakeholders.

The pilots serve well as a testing ground for the 24-hour coverage concept and should allow the opportunity to evaluate the intricacies of 24-hour coverage in a practical fashion without creating chaos in the marketplace. The Workers' Compensation (C) Task Force intends to continue playing an active role in monitoring and reporting developments that impact 24-hour coverage.

TESTIMONY OF
THE AMERICAN INSURANCE ASSOCIATION

Bruce C. Wood
Associate General Counsel &
Director, Workers' Compensation

Department of Financial Regulation
State of Vermont

April 6, 2012

INTEGRATION OF WORKERS' COMPENSATION MEDICAL TREATMENT
WITH GREEN MOUNTAIN CARE

Vermont is evaluating the merit of integrating the medical component of workers' compensation into a single payer health care system pursuant to legislation (H.202) enacted last year. H.202 was enacted in response to requirements of the Patient Protection and Affordable Care Act (PPACA) that states create health care exchanges by PPACA's effective date, 2014. Vermont went a step further and established a framework for a single payer health care system, while leaving to a five-member governing board of the exchange – Green Mountain Care – how and if such a plan could be implemented. Separately, the legislation required the Department of Labor to report by January 2012 on the feasibility of incorporating workers' compensation into a single payer framework.

AIA believes that folding workers' compensation medical treatment into a single payer healthcare system to be inadvisable, unworkable, and unachievable. Integrating non-occupational healthcare with workers' compensation has superficial appeal, but, on closer examination the complexities of combining the two systems reveal the implausibility of the premise and conclusion. Workers' compensation is not a medical program; it is not group health. It is a disability program with a medical component, and therein lays a critical difference. The objective of workers' compensation is not merely providing "healthcare," it is in providing medical treatment of the nature and intensity necessary for returning the injured employee to work – the essence of disability management. Treatment delivered under group health does not focus on managing disability and does not evaluate return-to-work capabilities.

Integrated coverage was examined initially by the National Commission on State Workmen's Compensation Laws in its seminal 1972 report on the status of state workers' compensation systems. The Commission made no formal recommendation. Integrated coverage was debated in the context of the Clinton Healthcare plan. Then-First Lady Hillary Rodham Clinton publically stated the Administration's interest in

integration of the two systems, a major objective of which was to attract small business support for the Administration's overall healthcare proposal. The proposed language released by the Administration in November 1993 did not propose merger outright but did call for partial integration to be followed by a proposed Commission on Integration of Health Benefits to resolve difficult implementation issues. There was broad opposition to integration, both the partial proposed and the presumed full integration following the Commission's work. The Clinton healthcare legislation eventually proposed a benefit coordination approach that was flawed in eroding the ability to effectively manage disability, through directed care and employer/insurer involvement in claims management, among other shortcomings. The Commission proposed to study the feasibility of transferring financial responsibility to the national healthcare system was viewed as nothing more than a forum for blessing this course of action.

Predating the Clinton healthcare discussions, integrated coverage, dubbed "24-hour care," debuted in the states in the early to mid-1990s, as a "new idea" for how employers could save on escalating medical costs. Florida enacted comprehensive reform legislation in 1990 authorizing 24-hour coverage. That was followed in 1992 by then-California Insurance Commissioner John Garamendi's plan for "universal health care," providing for integrating workers' compensation in this single payer plan, with assumed savings from integration identified as a major source of funding for universal coverage. The Garamendi plan came to naught following the Governor's veto of legislation providing for a study of the Garamendi proposal, followed by the voters' rejection of an initiative authorizing any carrier to provide combined health insurance and workers' compensation medical coverage in a single policy.

Other states adopted "pilots," though none was able to figure out how to combine the medical component of workers' compensation and group health into a single policy. California, Oregon, and Maine were among those states adopting pilot programs.

The National Association of Insurance Commissioners was avidly interested, as well, and the NAIC promulgated a model "24-hour" pilot statute states could adopt to test the concept. AIA and others in the insurance world were equally critical of the NAIC initiative; we told the NAIC it was an unworkable concept and, to the extent a state implemented even a pilot program, injured workers would lose important protections because, with the preemptory authority of the Employee Retirement Income Security Act ("ERISA"), the state would be unable to enforce its laws protecting workers. Our predictions proved correct. Although a handful of states adopted pilot programs, none was successfully implemented, no state adopted the NAIC model, and even the NAIC ceased periodic "24-hour progress reports" in 1999.

The idea persisted among a few adherents in California in the years since, but now it apparently has died out there as well. Nowhere but Vermont is integrated coverage now under consideration, or even being seriously discussed.

No serious study has ever endorsed the merits of integrated coverage or shown how such a program could be implemented. Indeed, the literature is as extensive as it is unanimous in holding the opposite.

The case against integrated coverage is summed up as follows:

Integrated coverage will NOT reduce occupational and non-occupational health care costs

- Every serious study of the issue for the past 20 years, including the National Association of Insurance Commissioners (NAIC) has concluded that the objectives of "24-hour coverage" are not practical and/or can be accomplished through existing systems.

Workers' compensation is NOT a medical program. It is a DISABILITY PROGRAM with a medical component.

- The purpose of workers' compensation medical treatment is broader than under the health care system, in which the objective is to expedite return to work, requiring coordination between the nature and intensity of medical treatment with the employer's obligation to pay benefits for lost wages.
- Ripping workers' compensation medical treatment from its indemnity component would disconnect the responsibility for managing medical issues from disability claim costs. This was the same flaw in the 1993 Clinton health care plan which also envisioned integrated coverage. The result will be a *loss* in "coordinated care" that now exists under workers' compensation, coordinating medical treatment with payment of wage loss benefits.

Integrated coverage will NOT eliminate the need for determining work causation OR lower administrative expenses.

- Causation would still need to be determined for payment of indemnity benefits.
- The medical benefit paid under workers' compensation differs from that under health insurance. Workers' compensation medical treatment is first-dollar coverage, paid without co-payments, deductibles, and dollar or duration limitations. Grossing up all benefits to workers' compensation-level benefits would make integrated coverage even more expensive than the trillion dollar price tag already estimated.
- Cutting medical coverage for work-related injuries effectively rations medical treatment for injured workers, diluting the promise employers have made to their workers under the workers' compensation system and creating hardship for

workers who need more intensive – and expensive – medical treatment to expedite return to work.

Reducing medical benefits payable under integrated coverage WILL lead to INCREASED LITIGATION against employers, as injured workers seek to recover medical expenses previously paid on a first-dollar basis.

- “24-hour coverage” will jeopardize workers’ compensation’s exclusive remedy, in which the employer promises to pay statutory benefits for medical treatment and lost wages, in exchange for the employee relinquishing his right to sue the employer in tort. Diluting the promise to pay first-dollar medical treatment will weaken the exclusive remedy and destabilize the workers’ compensation system, our nation’s oldest social insurance system.
- There is relatively little dispute and consequent litigation over causation in workers’ comp related claims; and much of the dispute and litigation would remain even with under integrated coverage, as disputes over coordinating treatment between an integrated health system and return-to-work programs.

Integrated coverage will jeopardize worker safety by eroding the predictive value of workers’ compensation experience rating and thereby shift costs to safer employers away from less safe employers.

- Safer employers would subsidize less safe employers; and the result would be work places that are less safe for all workers.
- Experience rating includes both frequency and severity (cost) components to equitably allocate expected losses among individual employers.
- Experience rating is a key component of workers’ compensation insurance rating, and without the medical treatment cost component, its actuarial credibility will be compromised.

Canada’s Experience

It is instructive that even in the Canadian healthcare system, which some single payer advocates point to as a model, workers’ compensation is not integrated. Workers’ compensation is a “parallel” system – workers’ compensation boards (“WCBs”) are “parallel payers” – that have drawn upon the provincial health insurance plans. Workers’ compensation in Canada, like that in the United States, is a no-fault system paying medical and indemnity benefits, along with vocational rehabilitation benefits, to promote return to work. Like the United States, medical costs in the Canadian workers’ compensation system are a fraction of total healthcare spending – 1.5% of total provincial healthcare spending in 2003. WCBs provide workers direct access to their own healthcare facilities and through contractual arrangements with

public and private providers. A 2008 Canadian report on healthcare detailed the efforts WCBs have undertaken over the past two decades to expedite care for injured workers – underscoring the critical link of medical treatment and indemnity benefits that is the essence of sound disability management that exists in the Canadian system and which would be lost in a Vermont single payer system that included workers’ compensation. According to the report, in the late 1980s and accelerating after the mid-1990s, WCBs became more aggressive in exploring alternatives to promote access to healthcare services:

Rising healthcare costs and increasing evidence of unnecessary, inappropriate or ineffective services spurred WCBs to better manage their purchasing and provision of services During the 1990s the combination of three factors – service delays in the provincial systems, new evidence of the link between workplace absence and long-term disability, and unfunded disability costs – pushed WCBs to develop new arrangements to expedite care for workers

Wait times for care mushroomed, especially in areas vital to WCBs such as orthopedic surgery and diagnostic imaging. These delays impose large financial costs on WCBs because every day of delayed care was another day that a WCB had to pay a worker’s wage replacement Research showed that, other things being equal, the longer a worker was off work, the greater the chance he or she would never return to work

The implication for WCBs was clear: by stressing early return to work and maintaining a worker’s link to his or her workplace during an episode of disability, the WCB could reduce the likelihood that a short-term disability would turn into a chronic disability and a lifetime WCB pension.¹

WCBs took focused steps to improve access to medical treatment: New service delivery arrangements with providers and financial incentives for providers to treat injured workers more quickly than other patients. These steps came at a time when WCBs had begun to rely more heavily on “community-based delivery,” rather than so-called “direct-care” facilities through which they had traditionally provided care. One WCB hired in-house medical services; others hired nurse “pathway” managers to assist workers with their claim, to ensure they received timely treatment and appropriate care. Other strategies included a “visiting clinic” program, contracting with a WCB facility on a seasonal basis; contracting with private, for-profit surgical or imaging clinics; contracting for “excess capacity” in the provincial system; and establishing specialty clinics within publicly funded hospitals.

The initiatives to expedite care save substantial costs for a WCB. The WCB in British Columbia, for instance, estimated that the combination of

¹HeathcarePapers; New Models for the New Healthcare; Unequal Access; Invited Essay: Parallel Payers and Preferred Access: How Canada’s Workers’ Compensation Boards Expedite Care for Injured and Ill Workers (Hurley, et al.); New Models for the New Healthcare, Vol. 8, No. 3, 2008, pp 9-10.

its specialist visiting clinic program for assessments and contracts with private clinics for surgery reduced the treatment time from six to nine months through the provincial plan to less than six weeks, saving the WCB an estimated \$50,000 per client in wage-replacement costs alone.²

The Canadian experience – and its lessons in disability management -- is instructive for those promoting integration of workers' compensation medical into a single payer healthcare system in the United States. The evidence in that single payer system, a system that does not encompass workers' compensation, in any event, illustrates the particular challenges Canadian workers' compensation authorities have had in promoting access to timely and high-quality medical treatment in order to promote more expeditious return to work.

The Canadian experience mimics ours, reflecting research conducted in the mid-1990s when interest in integrated coverage was at its zenith. The California Workers' Compensation Institute (CWCI) published research on the costs and implications of integrated coverage in California. One study – “Medical Benefit Delivery – Group Medical Versus Workers' Compensation in California” – measured the effects of non-occupational managed care techniques on workers' compensation medical disability costs. CWCI reported:

Work injuries and illnesses involve more frequent treatment and more intensive care than non-occupational injuries and illnesses, so medical payments for treating similar conditions average 21 percent more in workers' compensation than in group medical. On the other hand, group medical treatments extend 78 percent longer than workers' compensation treatments – and apparent tradeoff between time and intensity of care. These results raise the issue of whether introducing traditional group medical managed care techniques into workers' compensation would extend duration of medical care, as well as disability payments.³

So, one illusion of integration proponents is that “medical treatment is medical treatment.” The reality is far different.

Will Integrated Coverage Eliminate the Need to Determine Causation?

Another illusion is the premise that integrated coverage will – and should – eliminate the need to ascertain work causation, the premise being that compensability disputes are a major cost-driver in the workers' compensation system. The premise is incorrect; in fact, compensability disputes are relatively infrequent. Most system costs stem from determinations of the existence and degree of disability which is why the permanent partial disability component is the most costly element of a workers' compensation system. Furthermore, the need for determining causation would still be

²HealthcarePapers, pp 10-11.

³“Twenty-four Hour Coverage: Managed Medical Care in Workers' Compensation; Evaluating Potential Sources of Costs and Savings”; California Workers' Compensation Institute, June 28, 1995, p. 2-3.

necessary to ascertain eligibility for indemnity benefits under what would remain of the workers' compensation system; and state and federal occupational safety and health mandates would still require some determination of work-relatedness.

Would an Integrated System Reduce Costs?

Eliminating any distinction assumes identical benefits for work-related and non-occupational injuries. Costs would rise significantly if the first-dollar medical treatment construct were extended to medical treatment under a single payer system. Of course, that is not likely and, indeed, if anything, there will be enormous pressure to reduce costs to float a universal mandate. The result will be less generous medical benefits for injured workers – importation of demand-side controls, such as co-payments, deductibles and duration limitations on treatment – as well as other government-imposed utilization mandates, all of which will dilute the intensity of medical treatment required to expedite return to work. With elimination of actuarially credible experience rating, employer incentives to maintain a safe workplace are also diluted, with some consequently higher costs stemming from more unsafe workplaces.⁴ So, there might be some reduction in direct medical costs, but at the price of high-quality and cost-free medical treatment for injured workers and with offsetting higher costs bred of delayed return to work.

Would an Integrated System Reduce Litigation?

Another premise of combined medical coverage is it would reduce litigation. Would it? No, because much of the dispute and consequent litigation in workers' compensation pertains to aspects that are unrelated to medical treatment. These include:

- Prompt payment requirements that are too short to allow full investigation of more complicated cases, forcing denial of an otherwise legitimate claim still under review in order to preserve legal rights;
- Permanent total disability definitions that encompass work of some kind and therefore incent larger settlements for permanent partial disability;
- Tests for permanent partial disability that are based on subjective determinations, such as “lost earning power,” or “lost wage earning capacity”;
- Termination of temporary total disability, either because the worker has reached maximum medical improvement (MMI) or the statutory maximum number of weeks has been paid drives dispute, to contest MMI and release to

⁴ “To the extent that insurance costs would cease to be based on an employer’s actual experience, safe employers no longer would benefit from their efforts, and unsafe employers would enjoy lower costs. According to a recent study conducted by Milliman & Robertson for the American Insurance Association, these changes would increase lost work time due to injury by approximately 11.5%”. [Cited as note 25, “Impact of National Health Care Reform on Workers’ Compensation” by Debra T. Ballen, Cornell Law Review Symposium, Legal Issues in National Health Care reform, March 4, 1994; [“Ballen”]. At the time, Ms. Ballen was AIA’s Senior Vice President, Policy Development.

- return to work or to obtain an extension to TTD if permitted under the state's system;
- States with attorney fee rules requiring the insurer to reimburse claimant attorney fees means there is no disincentive to litigating.

Are Workers' Compensation Expenses Higher?

Yes and no. Advocates of combined medical systems often cite administrative savings as an argument for integration. However, this assertion ignores that the two coverages are not comparable. Expense factors in rates reflect the totality of managing disability, of coordinating medical treatment with indemnity, of assessments to support the workers' compensation agency, finance second injury funds, assessments for guaranty fund obligations, taxes, safety and loss control engineering (sometimes mandated by statute), and litigation costs. In fact, workers' compensation expenses might be less than group health if elements unique to workers' compensation are excluded. This was the result of an analysis by CWCI 20 years ago, as the integrated coverage debate intensified. CWCI reported that the expense load in California's workers' compensation system at 24.4% of premium. But, when elements unique to workers' compensation were excluded, the expense ratio fell to 13.4% compared to about 20% for group health.⁵

Workers' compensation's overall cost also is a function of an extensive regulatory fabric designed to ensure financial security, for injured workers and their employers' insurers. This reflects workers' compensation's "long-tail" exposure, where benefit obligations can extend for decades. Indeed, this long-tail exposure accounts for how workers' compensation is priced, on an occurrence basis, unlike group health which is priced on a claims-made basis. In workers' compensation, actuarially projected loss – and the cost of covering that exposure – is based on the relative cost of carrying that risk, effectively forever. The employer's insurance policy will respond, even if a loss occurs years later that is traced to the policy year. With group health, a claims-made policy covers only losses for that year, the year the policy is in effect.

The workers' compensation "promise" is far broader than that of group health. The scope of coverage is virtually universal, with exemptions narrow and no employer precluded from electing coverage even if statutorily excluded from mandatory coverage. Medical treatment is provided on a first-dollar basis, without co-pays, deductibles or duration limits; and the employer is required to provide under all state laws all treatment "reasonable and necessary" for healing the injury and returning the employee to work. Workers' compensation generally covers all injuries and all diseases (exceptions are narrow and relatively few). It includes psychiatric treatment and long-term care, coverage of which in a non-occupational setting is uneven and very expensive, with significant costs assumed by a patient, if available at all.

⁵ William P. Molmen, General Counsel, California Workers' Compensation Institute, letter dated September 11, 1992; cited as note 21, "Ballen."

So, in comparing system costs, looking narrowly only at medical treatment under group health and comparing that to workers' compensation is a false comparison, apples and kumquats. The scope of benefits and the financial guarantees workers' compensation provides, along with the expense inherent in managing disability, must be part of an overall calculation of relative cost.

Impact on Exclusive Remedy

An integrated system also jeopardizes the bedrock of workers' compensation – the exclusive remedy, whereby injured workers forsake their right to sue their employer in exchange for the promise of statutorily promised benefits, delivered without fault. Whatever medical benefits are delivered through a single payer system will be less generous than what is now provided through workers' compensation, and the budgetary pressure to hold down system costs will militate against more intensive medical treatment for injured workers, promoting return to work. It is questionable whether what remains of the workers' compensation "promise" would be sufficient to withstand an exclusive remedy attack. Will a hollowed out workers' compensation system still afford workers with a right broadly symmetrical with that relinquished? It is difficult to imagine this question not being litigated and employers' financial security jeopardized should a challenge succeed. Aside from an exclusive remedy attack, the loss of a critical element in the employee's "bargain" might generate a constitutional challenge.

ERISA's Preemptive Impact

ERISA's role cannot be overstated. Indeed, even if there were a sound basis for integrating workers' compensation and non-occupational medical treatment, ERISA effectively forecloses this approach absent amendment of ERISA itself. ERISA preempts state laws "relating to an employee benefit plan." An "employee benefit plan" includes any health and welfare benefit plan, including disability insurance programs. However, ERISA exempts from preemption state laws designed "solely" to comply with "workers' compensation plans." Because any plan integrating group health and workers' compensation would not be "solely" for the purpose of complying with a state's workers' compensation law, that plan would violate ERISA. Although ERISA has been interpreted to allow states to mandate certain types of benefits under a health insurance policy, such mandates cannot be enforced against self-funded benefit plans.

The practical implication is a state could lose its authority to regulate an integrated coverage plan, including a single payer health plan. Indeed, this is the reason why no state was able to successfully implement even a 24-hour coverage pilot program and why the NAIC's model 24-hour pilot law came to naught. So, aside from whatever merit Vermont policymakers may see in folding in the medical component of workers' compensation into a single payer healthcare system, is Vermont prepared to make the case to Congress and the Administration for an exemption from ERISA? What national policy implications for employee benefit plans – and the broad federal preemption policy that undergirds ERISA – would a single state's argument for exemption raise?

Conclusion

The case against integrated medical treatment is as extensive as it is unanimous. There is no serious study over the past 20-plus years that has concluded it is achievable and would not severely compromise the quality of care and the ability to more promptly return injured workers to work, nor result in administrative savings that adherents have predicted. Vermont's single payer legislation already incorporates language excluding workers' compensation "and other similar insurance coverage where benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act." Permitting the health benefit exchange to offer medical treatment for work injuries, apart from the Workers' Compensation Act, is inconsistent with this exclusion and would violate ERISA if implemented.

Insurers are mindful of the costs of the workers' compensation system to Vermont's employers, as well as to frustrations physicians and other providers might experience in treating work injuries. The focus and energy should be in addressing these problems through the workers' compensation system, not in ripping from its roots the social bargain Vermont made with employers and employees that has greatly benefitted both principals for much of the last century.

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Re: Responses to questions posed by the administration

Name: Peg Franzen

E-mail: peg@workerscenter.org

Organization: Vermont Workers' Center

Worker's compensation is a trade-off; the employee receives health care coverage and wages for work-related injuries in exchange for giving up her right to sue her employer. How do you think integration of workers' compensation health benefits into Green Mountain Care would affect this trade-off?

The integration of workers' compensation health benefits into Green Mountain Care (GMC) would strengthen the core elements of the original trade-off by enabling better access to care for injured and ill workers.

In the decades since the workers' compensation system was created, the nature of the original bargain has been degraded in practice. In an effort to maximize cost containment, private insurance carriers and employers contest injured/ill workers' claims in a way that results in legitimate claims being denied or delayed or in benefits getting discontinued. The claims resolution process can take months and even years. Doctors often refuse workers' compensation claimants due to the adversarial environment the system creates. Workers are also often intimidated into not filing claims at all. In fact, the highly charged, hostile nature of the system is largely why only about 50% of workers injured or made ill on the job file for workers' compensation¹.

In Vermont and throughout the United States, lack of access to timely medical care for workers' compensation claimants is a significant problem.² One of the root causes for this is that the workers' compensation system perpetuates a separate health care system where access is based on causation (proving that the worker's condition is work-related). The difficulty of establishing causation results in legitimate claims being denied or delayed. Proving causation is especially difficult in the case of illnesses, in particular those with long latency periods.³ It has been estimated that only 1 of every 20 occupational disease victims receive workers' compensation health benefits. For occupational cancer it is less than 1 in 100.⁴ All of this upends the original bargain: workers are unable to sue their employer *and* they are unable to access needed care. In effect, this violates two of the most basic rights.

The foremost consideration at this stage should be improving access to health care for injured and ill workers. Integration would achieve this by eliminating the problem of determining cause in order to provide health care.

The integration model the national AFL-CIO proposed during the national health care reform effort in the 1990s as well as the alignment models practiced in Canada demonstrate how this would work in practice. Within an integration/alignment model, workers would continue to receive wage replacement for work related injuries from their employers. Employers would continue to be liable for costs associated with medical treatment for occupational injuries and illnesses. They could, for example, pay premiums or taxes for workers' compensation medical coverage directly to the GMC financing system and these premiums/taxes could be "community rated" and adjusted periodically based on group experience.

¹ Biddle et al, What percentage of workers with work related illnesses receive workers' compensation benefits? 40 Journal of Occupational and Environmental Medicine, pg. 325; See also in this context, Emily A. Spieler & John F Burton, The Distressing Lack of Correspondence between Work-related Disability and the Receipt of Workers' Compensation Benefits, forthcoming article in the American Journal of Industrial Medicine, February 2012, ps24-25

² Interviews with injured workers and claimant attorneys; Emily A. Spieler & John F Burton, The Distressing Lack of Correspondence between Work-related Disability and the Receipt of Workers' Compensation Benefits, forthcoming article in the American Journal of Industrial Medicine, February 2012, ps 9-10, 25-32; Workers' Compensation Reform, Policy Number 20097, American Public Health Association, 11/10/2009; Michael Lax and Frederica Maneti, Access to Medical Care for Individuals with Workers' Compensation Claims, 11 New Solutions, 2001; James Ellenberger, Current Problems in the Workers' Compensation System, pgs 4-6, http://nycosh.org/uploads/injured_on_job/on_workers_comp/Current%20Problems%20in%20Workers%20Comp%20System%20paper.pdf

³ Workers' Compensation Reform, Policy Number 20097, American Public Health Association, 11/10/2009.

⁴ J. LaDou, Occupational Medicine in the United States: A Proposal to Abolish Workers' Compensation and Reestablish the Public Health Model, 12 International Journal of Occupational and Environmental Health, 2006, pgs. 154-168.

Workers' compensation is often described as an incentive for employers to create safe working conditions. Do you think it actually works as a safety incentive? If you answered yes to the above question, do you think integration of workers' compensation health benefits into Green Mountain Care would weaken workers' compensation as a safety incentive, making workplaces less safe?

The key mechanism within workers' compensation that could potentially act as a safety incentive for employers is experience rating. Workers' compensation benefits are funded by employers largely through insurance premiums. Insurance companies employ a mechanism called experience rating to calibrate the standard insurance premium rate based on safety records. Thus the assessment rate for firms with better than average safety records is reduced, and the rates of firms with worse than average safety records are increased. In theory, therefore, experience rating ought to encourage employers to promote safety in the workplace since fewer injuries result in lower insurance premiums.

However, experience rating is not universally available to all employers. Where it is available, it does not tend to work well as a safety incentive⁵. In fact, many authorities in the field of workers' compensation have argued that the impact of experience rating is minimal to nil.⁶ Even worse, research indicates that experience rating can undermine workers' access to health care. This is the case when employers, instead of promoting safe workplaces, try and contain costs by a wide range of adversarial tactics that lead to under-reporting and claims denials.

Experience rating can lead to employers and insurance companies contesting claims more aggressively, intimidating workers into not filing claims and retaliating against workers who do so. It can also motivate employers and insurers to pressure occupational health practitioners to provide insufficient medical treatment to hide or play down work-related injuries or illnesses. Also it is significant that a recent report by the US Government Accountability Office (GAO) found that OSHA data reported by employers failed to include up to two-thirds of all workplace injuries and illnesses.⁷

When experience rating does positively impact practices promoting safe workplaces, it is usually in the case of large employers. Usually the smaller the employer is, the less they respond to experience rating as a safety incentive. This means experience rating might play a lesser incentivizing role in Vermont, where the majority of employers are small businesses.

Nevertheless, since there is some literature that suggests that experience rating may help promote safer workplaces in certain cases,⁸ and since the need for improving workplace safety is paramount, we would suggest incorporating some method of experience rating within an integration/alignment model. Because of the potential negative effects of experience rating, outlined above, this should include a parallel track monitoring system that helps curb unintended effects. Incorporating a method of experience rating is certainly feasible as demonstrated by the integration model the national AFL-CIO proposed during the national health care reform effort in the 1990s as well as the alignment models practiced in Canada.

⁶ Joe LaDou, Rethinking Workers' Compensation: The Public Health Model, Working Paper, 2010; interview with Emily Spieler (2011); interview with Katherine Lippel (2011); Tompa, Systematic review of the prevention incentives of insurance and regulatory mechanisms for occupational health and safety, 2007; The Myth of Incentives in Workers' Compensation Insurance, New Solutions, 1992; Les Boden, Workers' compensation in the United States: high costs, low benefits, 1995; Ison, Administrative law--the operational realities, 2009; Rey & Bousquet, Compensation for occupational injuries and diseases: its effect upon prevention at the workplace, 1995.

⁷ Joe LaDou, Rethinking Workers' Compensation: The Public Health Model, Working Paper, 2010, p. 20; Interview with Emily Spieler and Katherine Lippel, 2011.

⁸ Asfaw & Pana-Cryan, The impact of self-insuring for workers' compensation on the incidence rates of worker injury and illness, 2009; Victor, The Future of Workers' Compensation: Opportunities and Challenges, 2004.

Another aspect to consider is that in any integration/alignment model it is important to ensure an efficient system of data collection as regards occupational injuries and illnesses, as well as the reporting of that data to government agencies responsible for the enforcement of health and safety laws and those overseeing the operation of the workers' compensation system. This would allow appropriate agencies to work with companies that have poor safety records towards implementing improvements.

In Vermont, the administration already works with companies with poor safety records to improve their practices. Integration of workers' compensation may open up further targeted and strategic opportunities to strengthen inter-agency cooperation to improve and strengthen health and safety protections that would effectively advance workers' human right to a safe and healthy workplace environment.

Currently, workers' compensation does not require the employee to pay premiums, co-pays, or deductibles in order to receive health benefits. Green Mountain Care will likely require some kind of contribution from most individuals. What do you think about this?

Act 48 does not require Green Mountain Care (GMC) to charge user fees of any kind; on the contrary, it stipulates that "systemic barriers, such as cost, must not prevent people from accessing necessary health care." There is a large body of research evidence that shows that all forms of user fees or "cost-sharing" harm people's health. User fees, even at very low levels, discourage people from seeking necessary care and filling their prescriptions, thus causing them to become sicker (and increasing the costs to the system down the road). There is also a discriminatory effect of user fees, as they shift the burden of financing the health care system on people in poor health.

Regarding the financing of the health care system as a whole, Act 48 requires that GMC be publicly and equitably financed, which points to contributions through the tax system, and specifically individual and corporate income taxes, as the main founding source. Thus, as residents of Vermont, workers will already contribute to the system, via taxation, and must not be charged again at the point of accessing needed services.

Additionally, workers injured on the job require special protection from financial burdens, as they have already relinquished the right to sue their employer in exchange for full coverage of their medical treatment and wage replacement. Even in the current market-based health care system, an integration of the health aspect of workers' compensation would be possible without "cost-sharing". For example, if the AFL-CIO model is considered, any "cost-sharing" assessed on patients would, in the case of injured/ill workers, be covered by GMC and then recovered from the employer. In the case of occupational injuries and illnesses that cannot be assessed against a specific employer, the community rating system for all similarly situated employers could be adjusted.

However, this is not the health system model mandated by Act 48. In a publicly and equitably financed universal system, there is no justification for charging user fees for accessing medically necessary care.

Do you find that employees have to wait longer to receive care through workers' compensation as compared to health insurance?

Yes. In our experience and according to testimonies from different stakeholders, including calls we receive from injured/ill workers on our workers' center hotline, denial of care, delays to care and provision of inadequate care are prevalent in Vermont's worker's compensation system. It is often the difficulty of establishing causation that results in legitimate claims being denied or delayed. It is an unfortunate reality that many claimants within the workers' compensation system in Vermont, especially those with illnesses or serious injuries leading to long term disability, face unconscionable delays in accessing needed health care, with devastating effects on their health and well-being. Original medical conditions can worsen, or secondary injuries can develop, due to delays in receiving necessary medical treatment.

When the claims process runs smoothly, in certain cases, people injured or made ill at work, particularly those with traumatic injuries, seem to be able to see the correct specialist sooner than in the current health insurance system. This can partly be traced to workers' concerns about costs and income, as they may put off surgery when injured outside work due to the lack of sick leave and wage replacement. Also, because worker's compensation insurers or

self-insured employers have to pay indemnity, there is an incentive for them to push for quicker and more aggressive treatment for those injured or made ill on the job. However, aggressive medicine does not necessarily lead to good health outcomes for workers, and in fact can harm their long-term health. It is important to consider that the motivation for prompt and aggressive treatment is not necessarily workers' health but cost containment. The goal of any health system must be timely access to appropriate care, but care received under current workers' compensation has not always proved appropriate.

Under workers' compensation, the goal is to get the employee back to work. What are your health care goals for employees?

Workers' health considerations rather than cost containment should be the primary factor that determines when a worker is ready to return to work after an occupational injury or illness. The goal of integration is to ensure that workers' health receives higher priority than it does now.

The goal of any good return to work program within workers' compensation is the safe and timely return of employees to transitional or regular employment. That is achievable only if employees do not return to work before they have fully recovered from their injury or illness. In the current system there are reports that to keep insurance costs down employers require injured/ill workers to work when they need to be at home healing. It has also been documented that some employers and insurance companies pressure occupational health practitioners to provide insufficient medical treatment to hide or play down work-related injuries or illnesses which may compel workers to return to work before they are fully recovered.

Integration would address these problems by designing return to work programs, especially vocational rehabilitation, as part of an overarching focus on worker's health as well as their right to work. It would also facilitate a move to free choice of physicians for workers, so that the workers' own physician would determine when the worker is fit to return to work. We believe that integration will lead to the best health outcomes for workers and advance the human right to health care, which mandates patient-oriented, appropriate care.

Other comments:

A core element of the human right to healthcare is universal access, namely that access to health care must be guaranteed for all on an equitable basis and provided in a timely manner. A human right to healthcare requires that all individuals, including all workers who have become injured or ill from work-related causes must have access to patient-oriented, quality and timely healthcare and treatment. There must be no delayed, partial or second class system of healthcare for injured and ill workers. The need to prove the work-relatedness of a medical condition must be delinked from access to needed health care.

Section 1 (a) (1) of Act 48 states that the state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. In order to conform to the statute, Vermont must devise a method of integrating its workers' compensation into this new system. To conform to Act 48's requirement that all Vermonters are to be provided with healthcare as a public good, a system must be established that does not exclude workers that have become injured or ill from work-related causes.

Important Elements of an Integrated Workers' Compensation System:

Regardless of how integration or alignment is achieved, the following include certain critical elements of any system for providing health care to injured or ill workers.

- Immediate access to healthcare for any injured or ill workers, regardless of cause of illness or injury, and without cost burden on the injured or sick worker.
- Worker choice in the selection of medical providers.
- The incorporation of mechanisms that act as preventive tools towards strengthening health and safety at the workplace [for example some form of experience rating or other strategic features. Upon request, we can provide more information on different types of options available while structuring such mechanisms.]

- Data collection as regards occupational injuries and illnesses and the reporting of that data to government agencies responsible for the enforcement of health and safety laws and those overseeing the operation of the workers' compensation system.
- Timely access to information that will enable injured and ill workers to navigate the complex workers' compensation system and make informed decisions. This could be achieved, for example, through the Office of Healthcare Ombudsman, Vermont Legal Aid.
- Guaranteed appropriate medical treatment and the provision of medical services that may be unique to occupational injuries and illnesses – for example, expertise in the area of repetitive motion disorders.⁹

This is an incredible opportunity in Vermont to pioneer a policy model within the United States whereby injured and ill workers can, regardless of the cause of their injury, access appropriate health care in a timely manner through a unified publicly financed health care system.

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⁹ See in this context: The Integration of Workers' Compensation Medical Services within National Health Care Reform, AFL-CIO-1993.

MEMO

To: Devon Green
From: David Mickenberg
Re: Worker's Compensation Incorporation
Date: January 14, 2013

Thank you for meeting with us to discuss the potential incorporation of Worker's Compensation medical benefits into a single payer health care system. Both organized labor and the worker's compensation bar look forward to continuing this discussion and to reading your report.

Below is a summary of some of the points that were made at the meeting as a way of highlighting our discussion. As we stated at the meeting, many of the issues we raised should be considered questions and observations, not necessarily firm positions on the overall concept of incorporation.

- 1) **Safety**: Workers are concerned that by incorporating worker's comp. medical benefits into single payer system employers will have less of an incentive to focus on safe workplaces. Given that worker's comp. rates are mostly driven by experience mods and that medical benefits constitute the majority of workers comp. claims, employers will have less incentive to foster safe work environments if they no longer are factoring in medical benefits. Workplace safety is already an issue and incorporation could increase the prospect of more numerous and severe injuries, a deep concern for workers.
- 2) **Costs to Claimants**: Right now workers are held harmless in terms of out of pocket expenses for worker's compensation. It remains unclear how this would work in an incorporation model and it would be fundamentally unfair to workers if they were required to absorb new costs.
- 3) **Settlement of claims**: Settlement of worker's compensation claims are complicated and often technical, in particular when looking at future medial benefits. It is unclear how such settlements would work under an incorporation model.

Furthermore, given that medical benefits are a large part of settlements currently it may be difficult for claimants to get full value for their claims and will likely reduce the legal representation available.

- 4) **Level of Benefit**: Often time worker's comp. claimants are entitled to benefits that they may not be entitled to through their health insurance. The right to such reasonable and necessary benefits was part of the grand bargain that claimants made when they gave up their right to sue their

employers. There is a serious concern that incorporation would diminish claimants right to these benefits.

It is also unclear how a claimant would adjudicate denial of benefits which is now adjudicated through the Department of Labor and the Court system. For instance will there be mechanisms in place to appeal denials to court; how would costs for appeals be dealt with; would claimants have the right to representation at hearings; how would the body of law concerning work injuries be viewed etc.?