RESEARCH UPDATE

RAMING THE ISSUES:

Twenty-Four Hour Coverage

MMARY:

Concern over the cost and availability of health care and ongoing problems with state-mandated workers' compensation programs has produced several recent proposals calling for the merger of health insurance and workers' compensation benefits into a "24-hour" health care system. At first impression, 24-hour coverage appears to hold great promise, especially if it expands coverage, but its feasibility remains untested, and the net financial impact of added benefits and anticipated savings remains purely hypothetical.

This monograph examines the issues, opportunities and unresolved problems surrounding the merger of medical and disability coverages into a single, seamless program. The paper also identifies the need for new data necessary to the analysis of various reform proposals and outlines how research undertaken by the California Workers' Compensation Institute will help policymakers evaluate alternatives.

ACKGROUND

California, like almost every other state, is burdened by the soaring outlays for health care and workers' compensation. Workers' compensation costs to California employers tripled in the last decade, approaching $11 billion in 1992. The California program is criticized as rife with fraud, driven by surging medical treatment and forensic medical expense, compensating claims having little to do with employment, and paying too little to the seriously injured worker.

In part at least, California's workers' compensation problems are a manifestation of an even bigger national problem: the lack of affordable health care. National health care costs are approaching $1 trillion annually, or 14 percent of the gross national product. Despite the huge outlays, an estimated 38 million Americans have no health coverage and millions more are underinsured. Health insurance has become both less affordable and less available. Frustration with both health coverage and workers' compensation has increased proportionally with costs and unavailability.

Because medical costs now represent 50 percent of the California workers' compensation claims dollar, legislative attention has turned to the prospect of significant savings that might be realized by combining employer-provided health care and workers' compensation into a single benefit system, an integrated program covering both occupational and non-occupational injuries and illnesses, a concept frequently labeled "24-hour coverage."

One example is a proposal developed by a task force on health care reform appointed by California Insurance Commissioner John Garamendi. In 1992 the group recommended combining medical coverages currently provided by employer-sponsored health insurance, workers' compensation and the medical components of automobile insurance. In its report, the task force estimated almost $1 billion in annual savings could be realized in workers' compensation.

Another merger proposal was placed on the November, 1992 ballot by the California Medical Association as part of its universal health care initiative. One provision of the CMA proposal would have permitted employers to combine workers' compensation and health insurance into one policy if benefits to employees were not reduced. The sponsor claimed the projected savings from a combined policy — $380 million in administrative savings and $418 million in health cost savings — would more than cover, at least for some employers, the cost of extending basic health care to all employees.

Advocates argue that merging employer-provided health insurance and employer-paid workers' compensation would:

- ▼ Eliminate duplicative administration costs and multiple insurers.
- ▼ Minimize litigation costs associated with determining if an injury or illness is work-related.
- ▼ Coordinate existing, separate total disability plans and create an effective program for compensating permanently disabled workers.
- ▼ Introduce employee cost-sharing — through deductibles, copayments and direct contributions — to medical treatment for work-related injuries and illnesses.
- ▼ Extend managed care techniques — provider contracting, employer-directed treatment, utilization management and capitation — to work injuries.

Proponents claim the anticipated savings could be dedicated to fund expansion of health care coverage and other benefits to those for whom it is currently either unaffordable or unavailable. Consequently, 24-hour coverage has become a consideration in the national and California health care debate.

Workers' Compensation vs. Health Insurance

One of the initial steps to analysis of merging or integrating health insurance and workers' compensation is recognition of the disparate, even conflicting, nature of the two coverages. These differences in turn generate a series of public policy options that must be considered in designing a merged system. Major differences include the type and amount of benefits provided, the scope and extent of coverage, the source and method of financing, and the degree of regulation.

Workers' compensation, adopted in California in 1913, is a social contract between employers and employees and provides a no-fault remedy for injuries and illnesses caused by employment. Under the legislated compromise, employees gave up the right to sue their employers in return for prompt and certain benefits. The benefits and how they are administered are specified by law. Failure to pay benefits when due can result in additional benefits and substantial penalties.

Employer-provided health insurance is a more recent innovation, originating during the World War II era of wage controls. With wage levels frozen, employers increasingly began to offer fringe benefits, including medical care, as a means to attract and retain an experienced work force.

Compulsory vs. Voluntary: Workers' compensation is a compulsory program that requires the employer to secure the payment of benefits by purchasing an insurance policy or, if financially qualified, through a self-insurance plan regulated by the state.

On the other hand, health insurance for employees is voluntary on the employer's part (unless covered by a collective bargaining agreement). The employer may purchase a policy or pay benefits directly without regulatory supervision and without regard to the employer's financial ability. At the employer's option, coverage may be purchased as a traditional indemnity contract from a commercial insurer or through a multiple employer trust, a prepaid plan such as Blue Cross or Blue Shield, a health maintenance organization, or any combination.

Scope of Coverage: In workers' compensation, coverage of employees is immediate and automatic, commencing with the first day on the job. Coverage extends to all employees — regular, temporary, full-time, part-time, even illegally-employed minors and aliens. Decisional law requires that "the employer takes the worker as he finds him," so preexisting conditions are included.

In contrast, health insurance coverage usually is subject to a waiting period, attaching only after 30 days or more beyond the date of hire. Coverage of part-time and seasonal employees may be limited or not available, and preexisting conditions generally are excluded, at least during a specified treatment-free period.

Extent of Coverage: Workers' compensation operates on an "occurrence" basis. Once a job-related injury or illness occurs, the employee is covered for its consequences, even if the worker changes jobs or retires.

Health insurance, however, is "treatment" based, paying only for treatment provided while the coverage is in effect. If the employee switches jobs or if the employer changes to a different insurer, there is no coverage.

Benefits: In the event of a job injury, the employee is entitled, under California law, to the following:

- ▼ All medical services "reasonably required to cure or relieve from the effects of the injury" — unlimited in time or amount.
- ▼ Wage-replacement payments while the employee is unable to work because of the job injury or illness.
- ▼ Additional payments, premised on an "inability to compete in an open labor market," if the injury results in permanent impairment.
- ▼ Vocational rehabilitation services to return the injured worker to productive employment if the injury prevents a return to the worker's usual occupation.
- ▼ Payments to surviving dependents in the event of death.

Medical insurance pays only for medical treatment and related services specified in the contract, subject to a maximum limit in any one year and during the employee's lifetime. Disability payments, vocational rehabilitation services and death benefits are not offered. If the employer chooses to provide disability payments, a separate policy must be purchased and payments may be restricted to instances of total disability, i.e., the worker's inability to return to any suitable employment.

Cost-Sharing: Workers' compensation costs are borne entirely by the employer. Contributions by employees are illegal.

In contrast, covered employees pay a portion of the cost of health insurance — through deductibles, copayments, coinsurance requirements and, frequently, part of the monthly premium.

Rate Regulation: Workers' compensation premium rates are regulated by the insurance commissioner and the pricing structure includes financial incentives for the safety-conscious employer. Firms employing more than 80 percent of the California work force are subject to "experience rating," and the modification — up or down from the regular rate — follows the employer even when a new insurer is involved.

Health insurance premiums generally are unregulated, and health insurers may charge what the marketplace dictates — or permits. Premium levels are "community rated," and there are no guaranteed economic incentives, i.e., discounts, if the employer (and employees) control or reduce costs.

Besides these product differences, workers' compensation has two other characteristics that distinguish it from medical insurance:

- ❑ Workers' compensation is foremost a rehabilitation system. The program's goal is to return an injured employee to work as quickly as possible with as little residual disability as medically practical. Medical treatment is only one tool used in the process of rehabilitating an employee to the workplace. As a result, workers' compensation includes a built-in quality measure: how quickly and successfully did the employee return to work?
- ❑ Although a no-fault system, litigation is endemic in California workers' compensation. More than 40 percent of disability indemnity claims are litigated. In disputed cases, 67 cents is

spent in frictional expense to deliver $1 in benefits. Work causation and the extent of residual impairment — permanent partial disability — account for the vast majority of litigated issues, controversies unknown in health insurance.

Designing A 24-Hour Coverage Program

The differences between workers' compensation and health insurance must be recognized and accommodated in developing a successful 24-hour coverage package. A forced marriage of disparate programs will not produce a healthy offspring, and faulty design may not produce savings. The following issues, among others, merit consideration.

ADMINISTRATIVE COSTS

The disparity in overhead costs between workers' compensation and health insurance frequently is cited as a potential for cost savings, but a valid comparison — apples to apples — of administrative expense in the two systems has yet to be made.

For example, the California Medical Association maintained that workers' compensation overhead amounts to 45 percent of premium, compared to less than 12 percent for health insurance. Similarly, a July 1992 Consumers Union report estimated health insurance administrative costs at 20 percent of premium.

Yet, workers' compensation insurers' pretax overhead expense for 1990, the most recent year available, amounted to 24.4 percent of premium, according to data compiled by the insurance commissioner. Of that amount, 11 points — 45 percent of the total administrative costs — was allocated to "loss adjustment expense" (litigation and other expense in resolving claims). Since there is little litigation in health insurance, a superficial comparison of overhead expense is inappropriate and casts doubt on the premise that merely integrating the two programs will produce a significant reduction in administrative expense.

⊃ ⊃ ⊃ ***Needs: Data to permit a valid comparison of administrative overhead for both health insurance and workers' compensation and measure any expected administrative savings.***

SCOPE AND IDENTITY OF BENEFITS

Twenty-four hour coverage proposals anticipate significant savings from consolidating benefit management under a single insurer and eliminating the need to determine (and sometimes litigate) the cause of the injury or illness. Workers' compensation provides "richer" medical coverage than health insurance — often for life; more generous wage-replacement benefits than State Disability Insurance; and permanent disability benefits after the employee returns to work. If work-relatedness continues to be the test for entitlement to some species of benefits but not others, separate administration and a commensurate increase in costs will be required. Therefore, potential savings under "24-hour coverage" to a large extent are contingent upon comparable benefits for injuries or illness, whether work-related or not.

Identical Medical and Disability Benefits: A merged program paying identical medical and disability benefits, regardless of causation, may result in greater savings than are available from any other design. Cost reductions can be expected from the following:

- ▼ Elimination of litigation costs in determining whether the injury is work-related.
- ▼ Consolidation of claim management and recordkeeping with one insurer.
- ▼ Elimination of "double dipping" — duplicate payments for the same condition by different insurers.
- ▼ Minimizing the length of disability through return-to-work goals — providing built-in quality standards and assuring the insurer does more than just write checks.

The unanswered question: whether the increased costs of expanded benefits would offset the projected administrative savings.

Identical Medical, No Disability: An alternative merged benefit design, espoused by the insurance commissioner's task force, would require identical medical benefits but leave disability benefits unaffected. This model cannot be expected to result in as much administrative savings for the following reasons:

- Causation still will be an issue in every lost-time case because of the potential for disability benefits for work-related injuries or illnesses.
- Two or more insurers will administer benefits. Health care providers have little experience in providing disability benefits or vocational rehabilitation. Additionally, other programs providing payments for disability — Social Security, private programs for long- and short-term disability, State Disability Insurance and workers' compensation — would continue as separate, free-standing benefit programs.
- An insurer providing only health care benefits may not have the same incentive to reduce disability and encourage return-to-work as the disability insurer. Dividing responsibility between two insurers — one for medical treatment, the other for disability management — may have unintended consequences, including cost increases on the disability side because of extended duration.

Different Medical, No Disability: Florida legislated this model and a similar proposal was part of the California Medical Association's failed ballot initiative last year. The Florida program has not been implemented because of a host of practical problems.

A design that continues different medical benefits for occupational and nonoccupational injuries incorporates all the multi-insurer coordination problems mentioned above. Additionally, a work-causation determination would be necessary even in simple cases involving only medical treatment — unless the health insurance coverage for non-occupational injuries and illnesses is identical with that provided under workers' compensation, i.e., unlimited, first dollar, no co-pay. Moreover, the proposal may create other complex problems involving risk-shifting (see Financing, Risk-Shifting Issues, p. 7).

➲ ➲ ➲ ***Needs: Although these three design models appear to have significant differences, little data is available to measure the range of potential savings (or additional costs) that may result from each merged benefit program.***

BENEFIT DELIVERY

Several general considerations, loosely related to benefit delivery, also can affect overall costs of a merged benefit program.

Permanent Partial Disability: If work causation is eliminated in an integrated benefit program, policymakers may be required to consider paying workers' compensation-style permanent partial disability benefits to all. If so, the additional cost will be substantial, particularly if disability payments are made for the effects of the non-occupational aging process.

However, if the decision is made to extend workers' compensation-type PPD benefits to nonoccupational injuries and illnesses, disputes about the extent of disability will add litigation costs. These additional costs may be avoided only if the disability payment is limited in amount and based on objective impairment measures, but the consequent reduction in what has been a workers' compensation benefit can be expected to be politically unpopular.

➲ ➲ ➲ ***Needs: More information about the relative costs of adding benefits under different system designs.***

A Small Tail on A Big Dog: National health care expenditures today approach $1 trillion annually, of which approximately $25 billion, less than 3 percent of the total, is spent for medical treatment under state workers' compensation systems. Total health care expenditures in California are not available, but the percentage of the total represented by workers' compensation (an estimated $5 billion in 1992) probably is similar. The assumption that extending health care coverage to the uninsured — in California or nationally — can be financed from "savings" attributable to integrating workers' compensation and health insurance seems misplaced.

➲ ➲ ➲ ***Needs: Data on the total costs and components of medical expenditures in California and demographic information on the uninsured population.***

California Estimates: The insurance commissioner's health care task force estimated that almost $1 billion in savings could be realized through the adoption of its 24-hour coverage proposal. Task force leader Walter Zelman acknowledged to the Institute that the savings estimate was an educated guess and was not based on hard data, underscoring a major problem in the public policy debate surrounding these issues — the lack of reliable data to quantify the effects of the various proposals.

Significantly, the estimate was based on the expected effect of managed medical care, not the anticipated administrative savings of merging medical benefits. If so, major savings may be realized simply by permitting managed-medical care and cost-sharing techniques to be used in workers' compensation.

➲ ➲ ➲ ***Needs: More data on the potential savings from managed care and cost sharing in workers' compensation, even in the absence of "24-hour coverage."***

Managed Care & Cost Sharing: To quantify the effects of managed care and cost sharing, the Institute in July 1992 asked Aetna Life and Casualty and William M. Mercer, Inc., to estimate the monthly cost for an employee's non-occupational basic medical coverage under five different options. The results of both analyses were similar. The medical package was patterned on the basic medical coverage included in the California Medical Association's ballot initiative. Table 1 contrasts Mercer's estimates of the monthly cost of the different options for a San Francisco resident.

Monthly premiums range from $259 for a first-dollar, no-copay, no-deductible coverage to $168 for an HMO-type capitated plan. The range of estimates calculated by Aetna was even more extreme, from $273 to $160.

But the health insurance package contemplated by these estimates is not as rich as medical coverage under workers' compensation, e.g. no limit on reasonably necessary chiropractic or psychiatric treatment, no maximums in time or dollar amount, no co-payments or deductible requirements.

Table 1

PLAN TYPE	MONTHLY EMPLOYEE RATE
100% Coinsur., $0 Deduct.	$259
80% Coinsur., $100 Deduct. $1000 Out of Pocket Limit	$215
90/80 PPO, $100 Deduct. $1000 Out of Pocket Limit $5 Copay.	$190
80/60 PPO, $100 Deduct. $1000 Out of Pocket Limit $5 Copay.	$172
HMO, $5 Physician Copay.	$168

Table 2 shows estimated typical costs in providing medical coverage to a sample of occupations under workers' compensation as of July, 1992. Except for the more hazardous occupations, workers' compensation medical costs are relatively less, even on an occurrence basis, than the premium for non-occupational medical coverage.

Table 2

OCCUPATION	MONTHLY MEDICAL PREMIUM
Carpentry	$197
Restaurant	$50
Retail	$45
Clerical	$9

➲ ➲ ➲ ***Needs: Data to determine comparable monthly premiums, whether occurrence- or treatment-based. Additional data on the relative cost to treat the same types of injuries under workers' compensation and health care also would assist the analysis. These data will be available upon completion of a separate research study by the Institute.***

Financing, Risk-Shifting Issues

One purpose of the Institute's analysis was to identify the financing and risk-shifting impact of merged-benefit proposals. For example, what would be the result if the merged benefit program were financed and priced on the same basis as health insurance, i.e., treatment-based? Possible outcomes:

- ▼ Coverage costs would be less, because the insurer would be liable only for treatment provided during the term of the policy, normally one year. Treatment would be furnished only for the working population — generally a younger, healthier group than those not in the workforce. Currently, under workers' compensation, liability for medical treatment can last for the entire lifetime. And the effects of the injury on other natural aging processes also can be compensable, adding still more cost to workers' compensation.

- ▼ Costs would be easier to predict, because insurers would take into account only one year's events instead of decades of uncertainty. Greater predictability means less risk and a correspondingly lower price.

- ▼ Continuation of coverage — "portability" — would not be a factor in the pricing equation. If the injured worker is no longer employed, even due to a work injury, he or she would not be eligible for medical coverage under a "treatment-based" model, as is typical with most health insurance contracts today. Under certain circumstances, workers may be allowed to pay for continued coverage, but these options are limited and expensive.

If medical coverage is contingent on continued employment, some portion of the financial burden of a work injury falls on the employee — an example of risk-shifting that may result in some 24-hour coverage models. The risk-shifting can be avoided only if design of an integrated benefit program requires employers or taxpayers to share the risk of some injuries and illnesses.

The unforeseen risk-shifting is one reason the Florida provision has yet to be implemented. Similar consequences were inherent in the California Medical Association proposal that authorized workers' compensation and health insurance to be written in the same policy. If liability for work injuries is to remain with the employer (or the employer's insurer), whenever a worker leaves employment or changes employers a determination would have to be made if the injury is work-related, diminishing possible savings and raising additional questions on how to price the coverage.

➲ ➲ ➲ ***Needs: Data to allow policymakers to quantify the financial implications entailed in any benefit integration proposal, including transfer of risk consequences.***

Simulating the Financial Consequences

To date, the public policy debate on the potential of 24-hour coverage has suffered from a lack of reliable, quantitative data that allows policymakers to evaluate the impact of proposed alternatives. The absence of comparable data distorts and limits discussion of solutions to the numerous problems confronting health care and workers' compensation systems today.

The identification of specific data needs resulted from the deliberations of the Benefit Integration Select Committee, appointed by the Institute's board of directors to develop a workable merged-benefit design. Over the past year, the select committee developed several research models for an employment-benefit program that combines medical care and disability payments, regardless of the cause of the injury or illness, and expands nonwork injury and illness coverage to all employees.

The difficulty in collecting and comparing pertinent data necessary to analyze the options stems from the complexity of the issues and the incompatibility of the information in health care and workers' compensation. Each system produces volumes of statistics, but the data generally are not available from a central source, nor are they readily comparable.

To correct this deficit, the Institute has commissioned a study to collect consistent, comparable data and improve the quality of information available to evaluate, as objectively as possible, the potential of 24-hour coverage. The study, under contract with William M. Mercer, Inc., will be completed in the fall of this year.

BUILDING THE FINANCIAL MODEL

The primary focus of the study will be the creation of an economic model to simulate changes affecting California's health benefits, disability and workers' compensation systems. Upon completion, the model can be used to quantify risk transfer, coverage expansion and financial implications to affected publics — employees, employers, taxpayers — for any changes to one or more of the current benefit systems or, as in the case of 24-hour coverage, a combination of changes.

The first major component of the Institute study will be to build an integrated employment-based benefit database covering both occupational and non-occupational benefits. The database will focus on the entire California workforce — not a sample or a series of test cases — thus encompassing all significant subgroups.

The database will be the core of a financial model of current employment-based benefit costs. The model also will include the cost of administration of the current system, divided among its major elements. Because workers' compensation includes income replacement benefits in addition to health care, the cost of disability payments — occupational and non-occupational — also will be included.

The resulting comprehensive financial picture of current benefit programs will provide a foundation for consideration of changes in the way medical and disability benefits currently are structured. The model is designed to answer the data needs identified in this monograph and, more specifically, to respond to the following issues:

- What is the financial impact of extending health and disability coverage to all California employees?
- What savings could be achieved if common health care cost-containment techniques were applied to workers' compensation medical treatment? What would be the relative economic impact on employees and employers?
- What savings could be realized if medical managed-care principles were more broadly applied, both to occupational and non-occupational treatment?
- What, if any, administrative cost savings would accrue if occupational and non-occupational health and disability coverage were combined in a single program?
- What savings might result if case management principles based on return-to-work incentives, now used in workers' compensation, were applied in all injuries resulting in disability?

***California Workers' Compensation Institute** is a private, nonprofit organization working to improve the California workers' compensation system by providing research, education and information. Members of the Institute are insurers that write 94 percent of California workers' compensation premium. The Institute's Board of Directors appointed a Benefit Integration Select Committee to conduct a study and analysis of the merged-benefit issue. Members represent national multi-line insurers, California specialty workers' compensation insurers and national insurers that write both health and property/casualty lines.*

***William M. Mercer, Incorporated**, is the world's largest human resources consulting organization, providing advice on all aspects of the employer-employee relationship. Mercer maintains offices in San Francisco, San Jose, Los Angeles, Orange and Irvine, California, among its 100 locations in 19 countries. The Mercer team responsible for the Institute-funded study includes consultants and actuaries specializing in both health care and workers' compensation.*

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