

**RECORD OF SOCIETY OF ACTUARIES
1992 VOL. 18 NO. 4A**

TWENTY-FOUR-HOUR HEALTH COVERAGE

Moderator: JAMES E. DRENNAN
Panelists: ERIC C. NORDMAN*
GODFREY PERROTT
Recorder: JAMES E. DRENNAN

Traditional health insurance plans have been nonoccupational, coordinating around workers' compensation coverage for on-the-job accidents and illnesses. Combining health coverage into a single 24-hour plan is receiving considerable attention. Discussions will center around issues related to:

- Regulatory constraints and the role the NAIC is playing to help facilitate 24-hour programs
- Plan design issues
- The use of managed care
- Coverage as part of a workers' compensation plan versus coverage of health care outside of the workers' compensation system

MR. JAMES E. DRENNAN: The subject of 24-hour coverage is one of those that, using an overused term, is at the cutting edge. Twenty-four-hour coverage is moving so fast that we feel many people do not really understand it. We are going to try to explain some of the issues, some of the problems, some of the concerns, and why you should consider even knowing more and maybe getting into this business, or why you should not. It is a very individual company and state-by-state decision.

Why are we even interested in this subject? One is the increasing trend of claims. We have seen them in the medical area already, but the workers' compensation area seems to have even higher trends, and they seem to be escalating with no end in sight. There is no cost sharing in most workers' compensation plans, with first-dollar coverage, no maximums, no inside limits, and everything paid. Typically plans have no managed care, no networks, no direction – no controls. It sounds like the medical industry years ago, when we were going full stream, and paying everything that came in the house.

Cost shifting is a very significant aspect. It is hard to identify exactly how much, but there is a feeling that every time we push down on employer health insurance, claim increases pop up on the workers' compensation side. In other words, a physician may be treating both sides, and he can actually charge full fees on the workers' compensation. So, we feel there is a significant cost shifting effect to the workers' compensation. We have seen this before, as hospital costs were pushed down, the inpatient costs increased.

The economic downturn being debated clearly has an effect. Workers' compensation is probably more affected because persons can, instead of potentially being laid off,

- * Mr. Nordman, not a member of the Society, is Senior Regulatory Specialist of National Association of Insurance Commissioners in Kansas City, Missouri.

file under workers' compensation, if they can convince their employer, or their lawyer can convince their insurer, that they are disabled. They can continue to get workers' compensation as opposed to other coverages that might come from their lack of employment.

The litigation impact of workers' compensation is probably the biggest difference between that area and typical group health insurance. Almost every claim was litigated for years. The system has changed to try to eliminate some of that by saying that someone in the workers' compensation system waives the right to sue. They have to take the benefits that are provided by the state mandate. However, there are a lot of exceptions, and there still are a significant number of suits. Lawyer's fees are frequently a large part of the cost in workers' compensation. Basically, all of these reasons lead to high costs, which is the bottom line on workers' compensation.

We need to be clear on terminology. This may clear it up or may muddy it up, but you will find that when talking to a workers' compensation actuary, terms will be used differently. For instance, health insurance is used to mean group health insurance that we have typically sold for years through insurance companies and Blue Cross plans. Workers' compensation benefits will typically be called medical and disability. That is the terminology I will use, and I think most of us will use. The real problem is using the term "medical," because it is also very commonly used in any health insurance plan. Workers' compensation has both medical coverage and disability coverage. Disability coverage has many subparts to it, total and permanent, partial permanent, and temporary.

Another term that we have often used is indemnity insurance. We have typically called our traditional insured medical plans indemnity, as opposed to an HMO, or as opposed to a managed-care plan. In workers' compensation, indemnity means the disability portion of the workers' compensation as opposed to the medical. So that term "indemnity" could really confuse the issue. I think you have to be very careful. This is an item that Eric pointed out he had seen misused.

Incurred dates have significant differences. The service date is what I would call a typical group health plan incurred date definition, also called claims made. In workers' compensation, the incurred date is more of an accident date or the original diagnosis. What effect does that have? It can have the effect of a nine-year lag versus a one-year lag. There can be significant differences in lag patterns in workers' compensation. So, any time you are talking about incurred claims for workers' compensation, very little of the claims have come in during the first year. I will get into some figures a little bit about how that differs from health insurance.

Some other differences are data issues. The data that are collected in typical health insurance are by provider, by Current Procedural Terminology (CPT-4) or Internal Classification of Diseases-9th Revision (ICD-9) codes, or others that are coming into play. We typically gather data per insured, and typically keep the data by age and sex, and if we can get it, for the dependents also. We also keep it by Standard Industrial Codes (SIC). It is not at all the same on workers' compensation. The data are collected by body part. That typically sounds a little gruesome, but they will tell you how many eye injuries, how many back injuries, how many hand injuries, how

TWENTY-FOUR-HOUR HEALTH COVERAGE

many feet injuries, and how many of different parts. But they cannot tell you, typically, where those services took place, if patients went to a physician or they went to the hospital. It is very hard to get data by provider. So if you want to make an estimate of claims in your network, a workers' compensation actuary will usually not have the data. The data are not kept in the same manner as health insurance.

Data are also kept per \$100 of payroll. To find the cost per member you have to take the payroll of each type of job and convert it. We have done some of this, and it requires several approximations. You have to take, typically, a whole state's data. Data are collected quite frequently by state regulatory bodies from which you can get a lot of data per \$100 of payroll, and by different occupations. The next item is occupation. Occupation is not the same as industry. There is not a one-to-one correlation, and it is a very difficult correlation to make. An example, in an insurance company you may have an actuary and a lawyer and an accountant, and if you were priced for health insurance, you would have rated the group as an insurance industry, most likely. Workers' compensation would look at each separate occupation as a different rating class. For workers' compensation, those three occupations would be very much the same rate, as opposed to a mail boy, or a driver, which would have a very high rate. In fact, if you recall most of your SIC codes, assuming you do industry adjustments on medical, you might have a 1.25 as your highest factor and a 0.9 or a 0.8 as your lowest. In workers' compensation it could be as much as 100 times from low to high, a wide variation. It is phenomenal how much the occupation ratings vary.

What are some of the levels of coverage that you, as a health insurer, might want to investigate? Eric will give you a little different cut on this, since you can analyze it in different ways. As a start, you can just rent your network out. Let us suppose you have a good network in a city, and you have an employer who has problems with workers' compensation, you could just rent your network with no changes. That is not very effective, but it can be done, and it is being done. It is probably the easiest thing to do.

You can try to manage the occupational claims. In this case you would want to modify your network. You would want to get different providers in, and then try to get some occupational specialists, such as some RNs who are specializing in occupation coverage. Rehabilitation is the key thing.

Claims administration is another level; you could use your claim system and pay workers' compensation claims. It will probably have difficulties immediately. Your system would not be able to handle the data unless you already have workers' compensation on another side of your company, and you can combine the two.

At a more involved level, you could actually underwrite the risk of the occupational side. In other words, you really may still be keeping the coverage separately, but you could underwrite workers' compensation. You could have it in a network, you could have managed care on the workers' compensation, and you could take the underwriting risk.

And then, the full-blown, 24-hour coverage is basically having one policy covering workers' compensation medical portion and health insurance. That is the true

RECORD, VOLUME 18

24-hour coverage in my definition. Typically, the disability portion is left out, although it can be brought in. But, the pattern I typically see is a self-insured employer who wants to bring all his coverage for medical health insurance into one policy, one carrier, one claim system, and one managed-care network to eliminate all the duplications and get the savings. That is 24-hour coverage.

You will find more at the first stage of this scale than the latter, because you have to have the perfect situation for 24-hour coverage. Typically, it has to be a state that allows the workers' compensation opt-out, and you do not have to have the mandated benefits. You really need a self-insured employer who is very knowledgeable and is willing to try this on an experimental basis. There are quite a few experiments going on.

If you have all these problems, why get in this? What is the reason? Why are we discussing this? There are several very good reasons. One, the covered population is the same, in most cases. Let me expand on that, because it does not sound that exciting, but if you have an employer that your insurance company is covering for health insurance, and if you can also cover their workers' compensation insurance, you can tie them to you as a complete insurer. Alternatively, someone else may come in and write their workers' compensation and try to add the health insurance also. So you can protect your base, and you can expand your market. You can go after employers you do not have, and can provide full service. It is a significant selling point. Marketing people love this, but administration is difficult. Legal issues are difficult.

The second reason is utilization review. Most insurance companies, most Blue Cross plans, and most HMOs, have strong utilization review that can be used for workers' compensation. Why should you have a separate set developed for workers' compensation? Why not use what we have with some modifications? That makes sense, and I think that is one of the strong points. The catastrophic case management is useful, because there are a lot of large workers' compensation long-term claims. Case management does seem to work well in this arena. Provider networks are already set up. They should be modified, of course, but most companies have networks that are very strong.

Claims administration is another reason to combine for efficiency and expense savings. That is a lesser reason, but it does make some sense. There are a lot of duplicate claims that are filed. A person will file a workers' compensation claim and file a health insurance claim, with maybe 2-5% duplicate claims, but if you could eliminate that, you could cut a lot of fat out.

If you were to evaluate your company getting into the workers' compensation market, it could be at the stage where you are doing the network only, or you could be providing full coverage. Some of the things you would have to evaluate are your network modifications – capacity and configuration. For example, I saw a Request for Proposal (RFP) on a state workers' compensation pool, and they asked how many primary care physicians are in your network of these three types: family practitioners, internists, and chiropractors? How many of you have chiropractors as a primary care physician in your network? You would almost have to, in order to get into this

TWENTY-FOUR-HOUR HEALTH COVERAGE

business. You would have to have chiropractors if you are going to be serious in this business.

In the design of the network, the rehabilitation aspect is a real key, so you really have to design your network differently. You have to put a lot of different providers in. Standards and protocols would have to be reviewed. With regard to payment methods, you may not want to do a capitation, and you may want to use some modified approaches.

The network approach would be different if you are just doing the first or second phase, where you are just renting your network. If you are going to do claims processing, you have systems issues. What are you going to do about coding body parts, and what are you going to do about incurred dates? You have to have different sets of rules for your claims people. Suppose you want to combine the two coverages. If you go to a full 24-hour integrated coverage, you possibly could use one coding scheme. But if you are just assuming the workers' compensation claims, and they are in a state where you have to keep the data, then you will have to change your complete system. You may have to go out and buy another system or do some major modifications. Do you want to integrate it with your health-care claims? It depends on the coverage and to what level you are integrating coverage and contracts.

The coding issues were discussed previously. For example, do you want to capture ICD-9 codes, do you want to capture hospital data by inpatient, by outpatient, or do you want to capture it by body parts, or both? Can you imagine the complexity if you did both types, capture everything on both sides, which you may want to do. And the fraud and abuse is very significant on workers' compensation. I think it is even more significant than on health insurance coverage, and you definitely want to have some very strong controls. With respect to your data management, how do you report to an account? Are they used to different reporting for workers' compensation? The savings documentation, and the data requirements all are going to be very significant. It would be to your advantage if you could combine this in one report. That is the ultimate that you want to do. But only if you get to full integration.

Utilization management has been touched on, but you definitely want to integrate the medical and the disability, if you could. The disability portion of workers' compensation is the bigger portion. It is approximately 60%, versus the medical portion of approximately 40% on a national average, and that varies a lot by state. But you would want to try to integrate the two. Your occupational review criterion is the key to get people back to work quickly. For example, carpal tunnel syndrome is one of the key new things. Most of our utilization review people would not be very familiar with that as a major item. And then, how do you report your utilization review?

The real adjustment comes in underwriting, if you are going to take some risk. Do your underwriters even know how to underwrite a workers' compensation case? Would you have to hire new underwriters? Typically, I would say either hire new ones, or retrain some, due to the terminology differences and the data differences. What would you ask for as underwriting criteria if you were looking at a new case? How much credibility would you give? What experience would you ask for? In other

words, if you have a case that was only two years old, you would not have very much of an incurred claim trend on that case. So you would have to really change your criteria and what you would ask for.

Joint ventures seem to be one of the popular ways of avoiding a lot of these problems. Some companies have subsidiaries that do property and casualty, they have underwriters, and they have actuaries. A common goal is to merge the two or to find a partner. A lot of the Blue Cross plans are looking for someone who has some expertise for a joint venture.

Now, if you are the actuary, how would you price for this if you are taking the risk? Or even if it is a self-insured carrier and they want you to give them an estimate of their claims cost, what would you do? Your data source is a real key. It would be, typically, by workers' compensation plan year, which means all claims go back to the earliest diagnosis. So you would have to decide if you want to modify that to try to adjust to more of a service-date approach, and per \$100 of payroll. And then you need to try to convert the data if you want to merge the two.

For example, under a workers' compensation coding system, a typical claims runout will have 36% of the claims incurred and paid in the first year. The second year after incurral would be roughly another 29%, for a total of 65% after two years, and you still have 35% to estimate. Even after nine years, you still have 12% left to come in, on average, on the medical portion of workers' compensation. Disability may be a little longer than that, so conversion of data for pricing is very difficult.

Area and industry factors are issues. We have talked a little bit about industry. Area is typically not a factor in the workers' compensation pricing, except that each state is basically kept independent. Most states gather data through a rating bureau, and you can get good data from them on a state basis. Within the state, there is very little area rating. The real question is, if you were to area rate by using typical medical area ratings, would you be duplicating the industry factors? Are the areas different only because of different industries?

The first-dollar benefits are a problem. In some states where you opt out, you can actually put in typical deductibles and co-insurance. That is where we think the real trend is going, and some states are passing laws to allow you to do that. The deductibles are typically per employer, more like stop-loss coverage, where it is not per employee. It is an issue to overcome and decide how you do your plan benefits.

Claims lag on and transfers can be a problem. Suppose you have an employer who comes out of the workers' compensation system. He opts out, and he comes into your medical plan. You will not have claims for almost the first year, as far as any new incurred claims. There are also very few the second year. So, you have a real long period of low claims. How do you price for that? Then on the other end, if the employer leaves your health plan and goes into workers' compensation again, you have a gap in coverage where no one wants to pay the claim. If you have a claim that was an original diagnosis while he was under the health plan, but then he goes back to work, the health plan says his claim is completed. He then goes to a new workers' compensation carrier, and now he has a reoccurrence or a follow-up visit. The workers' compensation carrier will not pay, because that is back to the original

TWENTY-FOUR-HOUR HEALTH COVERAGE

occurrence, back where he had other coverage. The health insurance does not cover it because it is after the contract terminated. So you have some real questions about gaps, both ways, going and coming.

Multistate coordination is difficult. My recommendation, really, is to start with single-state employers. If you have a multistate plan, suppose the carrier is in Texas where he can opt out of the workers' compensation plan, and in another state where he cannot. You have an employee who travels from his Texas location to the employer's site in another state, and then has a claim at work. He can file under either state's benefit pattern. How do you price that? How do you handle the claims payments? Some real issues occur, if an employer is in multiple states where the laws are different. Reinsurance is gradually becoming available, but it is still fairly hard to find for true 24-hour type coverage, where you are covering all medical benefits under one plan. There are a few carriers who are starting to price this.

Claims issues have been discussed, but the disability claims have been ignored. If you are giving full coverage to an employer, you want to provide somehow for the disability claims. You may want to tell him to just get another insurer for that. And that is possible, because you can buy just disability coverage only, on an insured basis, in some areas.

The ability to channel to providers is a real problem. There are some states that say you cannot force an employee to go to a certain provider for workers' compensation. Now, the employer can always suggest that employees go to listed providers. But in some states, you cannot force them, and you cannot vary the benefits. You cannot have a true PPO in some states. So, you need to look at each state separately.

Legal issues are the last and probably the biggest issue of the workers' compensation 24-hour coverage. I am going to hit the highlights, and Eric will expand on this quite a bit as to some of the legal issues. The right to sue is basically waived when you are in the workers' compensation system. The employee effectively gives up some of his rights to sue. Once you opt out, you have negated that, and therefore you will be more likely to have suits. Stipulated benefits are, in most states, required. There is a certain benefit level, and if you are in the states, you have to follow those.

Rate regulation is quite common, much more than our health insurance products. Most of the time that you file workers' compensation rates, you file experience for the company and you get slightly less than what you file. The rate regulatory bodies are always under pressure to keep rates down. Multistate employers, as I said, are a real problem because of the different state regulations. Coverage gaps could occur when leaving or coming in, and you need to make sure that your legal department or the employer's legal department really look at all those issues. You do not want to get a suit because you did not inform an employee or employer of some gaps in coverage.

Different covered workers is another issue. Quite often a different population is found of those who are under the workers' compensation and under the health insurance program. If you try to cover them both under the same contract, you have problems dealing with the outlyers. Some people are not under the health insurance program, maybe part-time workers, maybe they are in a different location than the union, and

vice versa, there may be some going the other way. So you do not have exact population matches within a single employer.

The legal climate is extremely litigious. In the workers' compensation area, lawyers advertise. Any time you see that, you should know that there is a real risk to getting in this area.

The ERISA preemption versus state regulation is an issue. Now, I am not an authority on this, but if you opt out of the workers' compensation system and become a self-insured employer, you are typically subject to ERISA. But then the states may have some real concerns about that. So I think we have to look at that on a state-by-state basis.

One last item is taxation. Typically, the workers' compensation disability claims are not taxed, whereas our short-term disability claims are taxed. So you could have an argument that you are cutting benefits in some sense by making them taxable if combined under a health policy.

I think the overall result is that you cannot generalize, you have to look at it state by state and company by company. Eric is going to give you a little bit more information about state-by-state issues. And then Godfrey is going to tell you about other countries, how they have solved these issues or not solved them, and the problems they have.

MR. ERIC C. NORDMAN: What is 24-hour coverage? Twenty-four-hour coverage can be loosely defined as any combination of traditional health insurance and workers' compensation insurance that attempts to dissolve the occupational and nonoccupational boundaries between the two coverages. In fact, some proponents would also include coverage for personal injuries suffered in auto accidents as well. We won't go into great detail today with respect to the auto insurance variable. We will, however, attempt to look at six variants of 24-hour coverage that combine, in one way or another, traditional health and accident insurance with workers' compensation insurance.

Twenty-four-hour coverage marketing package offers integrated management of an employer's workers' compensation and group health insurance claims. This product is actually being marketed today by some multiline insurers. The insurer typically agrees to coordinate 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.

The 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

TWENTY-FOUR-HOUR HEALTH COVERAGE

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.

The 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 believe 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.

Twenty-four-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 definitional boundaries between injury and disease. Interestingly, the New Zealand Accident Compensation Scheme utilizes this approach.

The 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.

The 24-hour medical and disability coverage is an all-inclusive approach which provides medical and disability benefits for all diseases and injuries. This is the approach envisioned by most people when they think 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 a myriad of social and insurance programs that deliver some 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.

What are the barriers to implementation of 24-hour coverage? There are various ways of categorizing the barriers to implementation of 24-hour coverage. 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 the 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. 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 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 state insurance department regulates the excess carrier. Fully or partially insured plans that do not qualify as ERISA plans are subject to state regulation.

TWENTY-FOUR-HOUR HEALTH COVERAGE

Furthermore, as a simplified 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 simplified 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.

An additional barrier that may arise is whether employers will, at least initially, have to offer their employees multiple options for vendors of coverage. There is a provision in federal law called the "dual choice" provision 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. 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.

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.

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. Nonoccupational benefits are provided by insurers, HMOs, Multiple Employer Welfare Association (MEWAs), ERISA-based plans and statutorily enabled state plans such as Blue Cross/Blue Shield. It should be noted that the insurers who provide workers' compensation are not the same insurers that provide health and disability benefits. Each might be expected to have a desire to guard their 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 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.

Nonoccupational 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

RECORD, VOLUME 18

disability income benefits provided by workers' compensation and nonoccupational disability income policy.

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 different guarantee funds issue. Further complicating that is the fact that some of the delivery mechanisms delivering either occupational or nonoccupational 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 will also 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 every state. 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.

Another institutional barrier that must be addressed is the subject of termination of coverage and related conversion privileges. 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 something in the pilot project proposal which includes an automatic conversion to traditional coverage at the end of the pilot project as well as addresses these other areas.

Another issue to be examined is in regard to traveling employees if the employer has another state's endorsement. If an employee is traveling in the course and scope of his or her employment and gets 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 would have to 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 global 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. 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

TWENTY-FOUR-HOUR HEALTH COVERAGE

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 whether a particular injury or disease is work related. Each state must determine if it no longer will require information on that basis.

Another area that will need to be addressed under 24-hour coverage will be the dispute resolution process. Often there is a jurisdictional split where the industrial accident board or commission is 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.

What are the states doing to implement 24-hour coverage? Currently very few states have enabling legislation which would allow the implementation of most forms of 24-hour coverage. In a recent NAIC survey on the topic of 24-hour coverage, Florida, Kentucky, Maine, Massachusetts, Nebraska, Tennessee, and Texas indicated that their laws allowed for some form of 24-hour coverage as an alternative to traditional workers' compensation insurance. A number of states have taken an interest in the concept. California, Colorado, Florida, Georgia, Kentucky, Maine, Massachusetts, Minnesota, and Oregon are actively investigating 24-hour coverage alternatives. While there is not enough time for us to address the activities in each state, I would like the opportunity to address specific proposals that have been touted in Oregon and California.

On March 6, 1992, Oregon became the first state to request funding from the Robert Wood Johnson (RWJ) Foundation for a pilot project implementing 24-hour coverage. The Oregon proposal is divided into two phases. First, a planning phase of a year would identify the models to be tested, analyze costs and benefits associated with chosen models, identify any barriers to successful implementation, and design a management control and reporting system. The second stage would be the implementation phase of the project. Necessary legal documents and legislation would be prepared, final participants chosen, and barriers removed. The pilots would be implemented with appropriate monitoring and analysis of results. Recommendations for future direction of the 24-hour coverage concept would be made based on the results of the pilots. Director Gary Weeks has indicated that Oregon is very close to receiving approval of the funding grant.

In California, Commissioner John Garamendi is proposing a program that would combine the health-care components of all insurance policies into a single, unified health-care system. This would include a consolidation of the health-care components of workers' compensation insurance and auto insurance with traditional health insurance. All California residents would receive health services through one health-care system. A Health Insurance Purchasing Corporation (HIPC) would serve as a clearing house to certify private health plans. The private health plans would then compete for enrollees on the basis of price and service. The plan would be funded by both employers and employees who would contribute to a fund on an equitable basis.

Consumers would have a choice of the types of certified-benefit plans. The plans must take all comers with no preexisting condition exclusions or waiting periods. Consumers would have access to the no-frills package of state-mandated benefits. For additional premium, plans could offer added benefits and flexibility.

The proposed system has a number of espoused cost-control measures. Savings are pointed out in the areas of increased consumer choice, increased competition among insurers, reduction of administrative waste, reduction or elimination of agent commissions, and reduced frictional costs such as litigation to determine "work-related injury" and auto torts. The projected savings from the workers' compensation system would be used to fund additional work-related disability benefit payments.

The benefits to be provided under the system would be equivalent to those now provided by HMOs. Preventive care would be provided with no copayments or deductibles applied. Consumers would benefit by not having to adjust coverage when switching jobs or by becoming unemployed.

A legislative bill was developed to establish a commission to draft the Garamendi proposal. This bill was eventually passed by the California Legislature and sent to the Governor. Governor Pete Wilson vetoed that bill in early October, indicating that the plan would have been too costly for businesses in California.

What is the NAIC doing with respect to 24-hour coverage? At the present time, the NAIC does not have a model law for 24-hour coverage nor has it taken a position for or against any of the various possible 24-hour coverage types that have been described. The NAIC recognizes that states vary widely in terms of the circumstances they face with respect to the costs of both their workers' compensation system and the cost of medical and hospital services.

The 24-Hour Coverage Working Group of the Workers' Compensation (D) Task Force is evaluating the feasibility of the concept and related issues. The working group is chaired by Commissioner Joanne Hill of Colorado. Other members of the working group are Commissioner Lee Douglass of Arkansas, Commissioner Tom Gallagher of Florida, Commissioner James H. Brown of Louisiana, Commissioner Katherine Doughty of Massachusetts, Commissioner Catherine Weatherford of Oklahoma, and Board Chair Claire Koriath of Texas. The working group will be involved in monitoring pilot projects implementing various forms of 24-hour coverage. They are also instrumental in researching issues related to 24-hour coverage. At the December meeting of the NAIC, this working group will present reports to the Workers' Compensation (D) Task Force identifying Barriers to Implementation of 24-Hour Coverage and status updates on state activities.

CONCLUSION

As you can see, there is a great deal of interest in the topic of 24-hour coverage. There is also a long way to go before a truly integrated 24-hour program can be established either as a pilot program or a true alternative to the products being marketed.

MR. GODFREY PERROTT: I have attempted to gather some information on the approach that other countries take to 24-hour Health and Disability coverage. I will be

TWENTY-FOUR-HOUR HEALTH COVERAGE

discussing Canada very briefly, and then Germany, New Zealand, and the United Kingdom. Finally, I will discuss some U.S. statistics to place the issue in perspective.

CANADA

The Canadian health system is effectively 24-hour medical coverage, and the benefits, place of service, and reimbursement mechanisms are identical whether the system is used for sickness or accident, and whether the sickness or accident is occupational, caused by automobiles or other.

Unfortunately, I was not able to get information on the Canadian disability system. Possibly, there is someone in the audience who might like to comment on that after our presentation.

GERMANY

I will describe the health care delivery system first, and then discuss health coverage and disability coverage.

Health Care Delivery System

Germany can roughly be described as consisting of several large HMOs, which negotiate as a body with the provider organizations to set fees. All private-sector employees earning less than 75% of BBG must belong to gesetzliche Krankenversicherung (gK) which is the social security health insurance system. (BBG is the maximum social security wage base.) At the present time 75% of BBG is approximately 61,000 DM or \$40,000 U.S. or \$48,000 Canadian.

Private sector employees earning above 75% of BBG may either stay in gK, join other HMOs, or be uninsured.

GK premium is approximately 12% of salary capped at 75% of BBK and does not vary by age or family status. Half the premium is paid by the employee and half by the employer.

Health Insurance

Health insurance is, in effect, 24-hour coverage where the benefits are identical, but there are two different funding vehicles. If the sickness or injury is occupational or is incurred traveling to or from the workplace, it is funded through gesetzliche Unfallversicherung (gU) which collects premiums from employers and the government. Any other illness is funded by gK, other HMOs, or direct payment for people who are uninsured. The individual I talked to in Germany had the opinion that most workers' didn't even realize that different intermediaries were funding the care.

Disability

The structure is very similar to health. The disability payments are funded by different sources but the benefits are identical and the employee cannot collect additional benefits from the employer. The benefit structure is as follows: up to week 6, salary continuation paid by employer; week 6 until disability is 80% of latest wage less judged permanent employees share of health insurance premiums (latest wage is capped at 75% of BBG), permanent to age 65 Social Security Disability Benefit, 65 on Social Security Retirement Benefit.

Disabilities are presumed permanent after the individual has been disabled for 1.5 years.

NEW ZEALAND SYSTEM

Health Care Delivery System

New Zealand has three delivery systems – the public sector, the private sector, and the voluntary sector.

The public sector provides free health care at hospitals for all medical problems both chronic and acute. This includes general practitioners (primary care physicians practicing out of hospital clinics).

The private sector consists primarily of doctors, dentists, pharmacists, etc., and some private hospitals. Approximately 45% of the population has private insurance to cover these additional costs. The purpose for carrying private insurance is quicker access and avoiding any waiting lists.

The Accident Compensation Corporation (ACC) covers all accidents (whether work related, auto, or nonoccupational) for both disability and medical. It is funded by levies on employers, employees, automobile owners, and automobile drivers. The ACC will not pay private doctors and hospitals. Thus, it is really a transfer payment within the government accounts.

There are other minor contributors of the total health care budget: 77% is paid by the government and funded through taxes; 14.5% is paid out of pocket by private individual; 4.2% is paid by the ACC; 3.5% is paid by private insurance; and 0.8% is paid by other sources.

Health Insurance

Again, like Germany, the medical care provided is not differentiated between occupational and nonoccupational accident and sickness, although the payor is different under different circumstances.

Disability

Disability benefits in New Zealand are quite different than most other countries. The benefit depends on whether the disability is caused by accident or sickness, rather than by occupational or nonoccupational.

The ACC pays disability payments for all accidents (occupational, automobile, non-occupational). The benefit is 80% of most recent wages with a cap of \$65,000 NZ (\$35,000 U.S. or \$41,000 Canadian). New Zealand has a problem with the trend in its ACC. Over the last five years the trend has been 25%! This is primarily caused by disability claims.

Disability caused by sickness comes under social security which pays 60% of the average wage of all workers. This is a flat amount which is independent of the individual workers' salary or wages.

Private insurance is available to supplement either one of these.

TWENTY-FOUR-HOUR HEALTH COVERAGE

UNITED KINGDOM

Health Care Delivery System

The National Health Service in the U.K. provides a complete health care delivery system, including medical, surgical, hospitalization, drugs, etc. Since it is part of the national budget, there is considerable political pressure to contain costs. This has resulted in poorly maintained facilities and significant waiting lists (as much as three or four years) for noncritical surgery. The most quoted waiting lists are for hip replacements which can be several years in some areas.

Health Insurance

A private insurance industry has grown up to supplement the National Health Service by providing payment for private care by physicians and care in private hospitals. Physicians may work both for the National Health Service and take private patients; hospitals are fully differentiated. There is no differentiation in medical care between accident or sickness and occupational or nonoccupational. The primary differentiation is between critical and noncritical care.

Disability

The U.K. disability system contains three components.

Social Security pays a limited amount for both accident and sickness disability. All accidents are handled by the Industrial Injuries Board. The benefit is small and not wage-related.

Occupational Accident and Sickness is covered by an employer's liability, which is a mandatory coverage very similar to workers' compensation in the U.S. However, there are two notable differences.

- Coverage is provided only if the employer is at fault. As a practical matter to reduce litigation costs, the insurers will tend to pay a benefit unless the employer can demonstrate clearly that he was not at fault. However, legally it is a fault system rather than a no-fault system as in the U.S.
- There are no tribunals or other state bodies to determine benefits. The benefits are ultimately determined by the courts although the system operates with relatively little litigation.

It is usual and customary to pay lump-sum benefits which have rough connection to the lost wages. The maximum benefit is typically 6-7 years of wages for total disability. It is not integrated with any other disability benefits. Private insurance is used to supplement social insurance and employer liability. It traditionally does not integrate with employer liability, although one would expect that to change.

SUMMARY

At first glance, the German looks very similar to the U.S. system, but the key difference is that the German system delivers identical benefits through different funding vehicles, whereas the U.S. system delivers different benefits through different funding vehicles.

This time the U.S. looks closest to the U.K., although the key difference is that employer's liability is a fault coverage whereas workers' compensation is no fault.

U.S. HEALTH AND DISABILITY EXPENDITURES

I thought it would be constructive to get together in one place the total expenditures on disability and health care based on the different sources. This is difficult to do because different statistical sources have different bases of counting. I have tried to eliminate double counting and to include all self insured and other alternative financing mechanisms. This is almost certainly not perfect.

The most important area to focus on in terms of 24-hour health coverage is the relationship of workers' compensation to private insurance. Workers' compensation is only 7% of the total. At first glance, this suggests that there is little merit in 24-hour health. The sources for savings are limited:

- Avoidance of paying claims twice; once through compensation, once through health
- Simplification of administration (although this has pitfalls)
- Extension of vendor discounts to workers' compensation
- Possible savings in subrogation and litigation costs between carriers

If you could save 30% of the cost of workers' compensation, you are only saving 2% overall; this is not likely to be enough to overcome the inertia of the system.

The important thing to recognize is while group health premiums are relatively narrow with, at most, a 5-to-1 range, workers' compensation premiums are much wider and have a range of over 100-to-1. Workers' compensation premiums are determined as percentage of payroll with no cap. Office and clerical workers have premiums for disability and medical of less than 1%, whereas extremely hazardous occupations have premiums of over 100%. Thus, there may well be a niche market for 24-hour health in the hazardous occupations, whereas there would be little interest in the nonhazardous occupations.

It's also worth considering how 24-hour health might affect groups of different sizes. The most interesting is the small group market (groups with less than 25 employees). The health premiums for this market are rapidly getting compressed into much narrower ranges than 5-to-1. If 24-hour coverage became common, one might expect a similar premium compression. This would mean that it would be very attractive to high-hazard occupations (some of their insurance costs would be shifted either to low-hazard occupations in the small group market or possibly into all occupations in the medium group market). This would depend on what kind of small group reform we end up with.

In the medium group market (25-500 employees), health and workers' compensation are probably insured plans with a degree of experience rating; there has not been the same agitation toward rate compression. It seems that 24-hour health would have little effect except in the hazardous occupations. If the health portion of the workers' compensation premium is sufficiently large, then the economies of scale of 24-hour health should be attractive.

TWENTY-FOUR-HOUR HEALTH COVERAGE

In the large group market it is likely that both health and workers' compensation are self-insured and the effects would be limited.

MR. W. KEITH SLOAN: I don't have questions so much as I want to add some comments, because I've been involved in this thing for more than a decade. Particularly, in one of the states which Mr. Nordman mentioned as allowing it, actually the law does not but a court decision does. The state insurance department's interest has been to try to get away from it. But they haven't been able to do so.

I have some suggestions, primarily on data. You can get data from the National Council of Compensation Insurers, and it's fairly reasonable. But you do have to look very closely at what it is. The easy way is to go to your state insurance department and look at their filings, and see if you can translate them. You have the problem that was mentioned, of it all being on payroll. You can do that, because they do show average salary, and they do show average people covered. But averages and averages and averages don't always give you real results. Also, you need to know if they have data comparable to your prospective insured. They frequently do not get data from self-insureds or from pools. I have seen some absolutely wild guesswork, such as the assumption that everyone who is disabled is male, 50 years old, and so is his spouse.

Another suggestion. Occupational Safety and Health Act (OSHA) has some required reporting, and it frequently generates better data than are obtainable from the National Council of Compensation Insurers (NCCI). Data published in the reports of the Casualty Actuarial Society (CAS) is another source. They're excellent. They'll confuse you, but you can get through them. There's a good reason for collecting things by body parts. Some states, for example, will give you temporary permanent disability of, say, six weeks for that joint, two weeks for that joint. So you have to keep track, in those states especially by very small body parts, so you have to get the compensation law and find out what you have to keep track of.

On total and permanent disability, you can use your regular NAIC valuation tables for valuation, it works quite well. One of the problems, and this is one of the areas in which you have nonoverlapping populations, is that people who are covered as spouses elsewhere still have to be covered as primary insureds for the occupational coverage.

A suggestion on the safety requirement is that you can go to some of the large property and casualty carriers who have consulting engineering operations, and they can give you safety evaluations.

MR. DRENNAN: I agree with what he said about getting data from the NCCI, and gathering that. That is good data. You can get actual claims tapes from a large block of data. We have tried to convert that and develop actual continuance tables for the workers' compensation, adjusting it for the difference in incurred coding and the accident year versus service date. We have been successful in trying to get actual data, but it creates quite a bit of work.

MR. RICHARD J. ESTELL: Texas has allowed you to opt out. Our own particular company opted out about one-and-one-half years ago for all of our employees. Those

RECORD, VOLUME 18

of us who have been writing small-group or self-employed people have been covering workers' compensation for a long time. I mean, that's just a part of it. They don't have workers' compensation in a lot of states, or they don't have to, if they're self-employed. Our own experience has been, and partly relating to what you said, without the litigation and without the fraud, our claims are running less than 10% of what they did under workers' compensation. And I know in Texas, Wendy's has pulled out, McDonald's has pulled out. As many as 55-60% of the employers have gotten out of the system because once you get out of the system, you'll find that your costs go down drastically, primarily because of litigation issues. I think it's an excellent idea. I wish more states would pass it.

MR. DRENNAN: To clarify what you said, they have not gone down by 10%, they have been 10% of what they were before.

MR. ESTELL: They are 10% of what they were before.

MR. DRENNAN: That is significant. And I agree with what Dick is saying. We feel like, if you recall back to when managed care was first put in on medical coverage health insurance, we all heard these big numbers from our marketing people as to what this is going to save. It turned out, in most of what I have seen, it did not accomplish quite that much over a long period of time. It looks like workers' compensation managed care will accomplish what we thought would have happened, under group health, as far as cost control and reduction in claims, and more! At least, early indications like Dick's are predicting that.