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**MANAGED WORKERS' COMPENSATION/24-HOUR HEALTH CARE**

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- Current activities
- Legal considerations
- Casualty actuary perspective
- Potential role of utilization review (UR) organizations

MR. DAVID B. TRINDLE: I am with QED Consulting Group in Philadelphia. According to a recent survey of employers conducted by the publication *Risk and Insurance*, the number one priority of corporate risk managers is the spiraling cost of workers' compensation benefits, exceeding even the concern with the health cost spiral generally. This has brought increased pressure to look for ways of controlling costs, including so-called 24-hour coverage programs that promise to eliminate duplication, reduce administrative costs and bring managed care savings to the workers' compensation system. Yet while there are many advantages to 24-hour coverage, there are also significant barriers – especially regulatory barriers – that must be overcome. We are very privileged to have a knowledgeable group of experts on our panel to discuss all these issues. We have Ruth Estrich-Baldwin from CNA, Keith Bateman from the Alliance of American Insurers, Cecily Gallagher from Tillinghast, and Jim Francis from IOA Reinsurance. As we get further into the program, I am going to introduce each person in more detail.

We're going to try to cover a lot of ground, including the pros and cons of 24-hour coverage, regulatory issues, the casualty industry perspective, sources of data and other actuarial issues, what can be done (and what is being done) in the market today, and, of course, the all important question of a national health care policy.

Let's start by defining exactly what we mean by 24-hour coverage, or at least how we will be using the term in this discussion. Twenty-four-hour coverage in our discussion is going to mean any program of coverage that attempts to coordinate occupational and nonoccupational health or disability benefits. The most sophisticated or most complex version of that might be a fully integrated, fully insured program

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under one policy form issued by one carrier. As far as I know, none of these actually exists yet. The least sophisticated version of 24-hour coverage might be just a simple administrative arrangement to eliminate duplication of coverage between the health plan and the workers' compensation plan. Most of the actual plans end up somewhere between these two extremes. In our discussion, we're going to address the issue of 24-hour coverage in its broadest sense.

Before moving on to our panelists, let's review the workers' compensation program for those health actuaries in the audience who, like me, may have forgotten a few details since we studied them on the exams. The workers' compensation system is the oldest social insurance program in the U.S., originating in the early 1900s. There are now 56 separate programs including all the states, territories, and other federal programs. At this point, about half the benefits are funded through private insurance, with the remainder split between state/federal funds and self-insured programs. Premiums to employers generally average about 2.5% of payroll, but this varies widely by state and by occupation.

I have a breakout of what I believe are 1991 costs split by the type of payer. A little over half of the benefits were provided by commercial carriers. State and federal funds (which I believe are active and competitive in about 13 states) and the remainder are self-insured programs.

Typical workers' compensation benefit plans pay 100% of charges on the medical side without any deductibles, copayments, maximums, or other controls. For disability, a typical benefit is two-thirds of salary up to a weekly cap of around \$500. (All this by the way varies by state somewhat). There are also survivor benefits, representing a continuation of the disability benefit upon the death of a worker, or a lump-sum benefit.

In terms of the total pie of workers' compensation payments, medical represents about 40% of the total, and disability represents a little bit over half with a small remainder being the survivor benefits.

In 1992, the total benefits paid under the workers' compensation system are estimated to be about \$50 billion, and about 103 million workers are covered under the program. Finally, unlike most group health insurance, premium rates are heavily regulated within the workers' compensation system involving state-by-state policy filings. Compare the 1991 premiums for the workers' compensation system versus health coverage generally. There is about a 10 to 1 ratio of about \$70 billion in premiums under the workers' compensation program versus \$800 billion in premium under various health insurance programs. This gives you an idea of what the relative dollars are. Obviously a 1% savings on the health insurance side is equivalent to about 10% savings on the workers' compensation side.

Our first panelist is Ruth Estrich-Baldwin, assistant vice president of group benefit support at CNA in Chicago. Ruth is responsible for systems, product development, cost containment, advertising and sales support for the group benefit lines of business at CNA. She is very active in the health insurance industry. She serves as chair of the Health Insurance Association of America (HIAA) Data and Policy Management Committee and is a member of the Insurance Accounting and Statistical Association

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(IASA) Group Committee as well as chair of the HIAA task force on 24-hour coverage. Ruth will outline the advantages of 24-hour coverage. She will also discuss some of the things that are being done in the market today, and bring us up-to-date on the activities at the HIAA and the NAIC working group.

MS. RUTH ESTRICH-BALDWIN: I'm from the CNA Insurance Companies in Chicago. CNA is a multiline carrier, and we have a sizable book of business both in employee benefits and in workers' compensation. We have spent a lot of time looking at 24-hour coverage, and as Dave just told you, I am also the chair of the HIAA's task force on 24-hour coverage. I am going to spend a few minutes telling you where the HIAA is and what it is doing in response to 24-hour activities.

There are many definitions of 24-hour coverage or 24-hour health care, ranging from a coordination of services across two distinct policies on one end of the continuum, to a single policy addressing both medical and salary replacement on the other end. There are many out there who have put a lot of effort into looking into the obstacles to true single-policy 24-hour coverage, and what's interesting is that they did not have to look very far. In general, the barriers come in three different flavors: legal, institutional and regulatory. I am not going to spend too much time on the barriers because that's not supposed to be my part of the discussion. I'm supposed to tell you what we can do and why we should be doing it.

The one barrier I want to spend some time on is the institutional barrier, because I think we can do something about that. That obstacle is really ours. Property/casualty companies write workers' compensation, life/health companies write employee benefits programs, and even multiline companies like mine have historically operated very independently of each other with little communication, let alone coordination, between the lines of business. As a matter of fact, until about two years ago, I didn't even know who my peers were in the casualty part of CNA even though we are housed in the same building. We have all built separate systems; we have separate means of distribution; and as you know, we have separate actuarial departments. In many instances, the purchasers are separate as well. Companies that are large enough have a risk manager who purchases workers' compensation insurance, among other things, and an employee benefits manager who worries about group health and disability. So we clearly have a lot of institutional barriers that we need to deal with.

So with all these kinds of barriers, why bother? The answer I think is simple: it makes sense. If we could somehow manage to eliminate all of the obstacles and provide a single integrated 24-hour policy, we could provide consolidated administration, reducing processing costs and overhead. We could provide one managed-care structure and process improving the continuity and quality of care for the patients. Ultimately, if we can better control the rapid escalation in the cost of health care, we should be able to increase the affordability of insurance and therefore improve the accessibility of medical care coverage and services. That, of course, is a very tall order, with legislative and regulatory changes required to achieve all of these advantages. I'm sure you'll hear more about some of the problems as we go along in our panel.

But what I am supposed to talk to you about is that there are a lot of things that we can do today. If we define our overall objective as managing the cost of health care, the place that I think all of our industry should be looking to is the life/health companies. We have been in the managed-care business for about a decade now, and we've learned many things. Before I outline the specific lessons that I think our years of program design have taught us, I want to quickly review some underlying managed-care theories.

The first is what I call the balloon-in-the-box theory. The health-care dilemma can be compared to a large balloon: as the health insurance industry pushed on one side of the balloon through cost-containment programs, all we accomplished was the creation of a bigger bulge on the other side. As we controlled the cost of inpatient care, outpatient care skyrocketed. As we controlled medical care, mental health costs went crazy. On a broader basis, as the employee benefits or group medical costs were managed, workers' compensation medical costs grew. It would seem that the solution is to stop poking at the balloon. We need to put it in a box of our own design and creation. An important step in that design is predicated on my next theory, which I call the right-minded-doc hypothesis. Simply put, this theory says that health-care costs can be appropriately managed if you can get patients to the right doctors, right being defined as knowledgeable and cost effective. An underlying hypothesis of this hypothesis is the "you don't get what you pay for" or "the good health care is not expensive" hypothesis. Health care that generates a positive result or outcome is not necessarily expensive. On the contrary, unnecessary surgeries and unneeded hospitalizations often lead to infections, complications and an increase in cost.

With these theories or hypotheses in mind, the health insurance arena evolved to its managed-care programs of today. While there are a number of different models out there, if you look at our best managed care programs, you'll find that they share four key features. They are integrated, including all diagnoses from medical to mental health. They are all inclusive, covering all services, including surgical and nonsurgical, in all settings, inpatient and outpatient, acute and nonacute, and they are designed to allow for early intervention. Care management begins as early as possible, ideally prior to the actual service delivery through precertification or a gatekeeper or through an employee assistance program (EAP). Finally, managed-care programs provide significant consumer incentives to redirect patients into the managed-care system.

If we step away from our own carrier and perspective and look at the business needs of our customers through their eyes, I think you will see some interesting things. From the employer perspective, more money is being spent on insurance programs for employees. Whether traditionally insured or self-funded, employee health, disability and workers' compensation programs are cutting more into the employer's profits. The health-care pie is growing with the increase in the two medical pieces outstripping the disability or indemnity pieces. The numbers that Dave described on workers' compensation are a little different from where we are right now at CNA. We used to be at a split between the medical and indemnity where the medical was about 40%, the indemnity was 60%. That is no longer the case. At best, our medical is at least 50% of our experience these days.

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There are many reasons why the medical is growing, including escalating health-care costs, the age of the working population, the growing use of controlled substances, the lifting of the stigma in mental health problems and treatment, the litigation-happy society we live in, the lack of meaningful tort reform and lots of statutory issues. The study of these causes, while worthy, does not provide the employer with obvious and immediate answers. However, managed care does.

The key components of effective group-medical, managed-care programs provide the blueprint for what I call the consumer solution. If the keys are integration, all inclusiveness, early intervention and incentive, then the employer's answer, if created from scratch and ignoring all of our historical distinctions, would be a program that would manage all four pieces of the pie to include all medical costs, both group benefits and workers' compensation, and all disability costs, including short-term disability (STD), LTD and workers' compensation. All the care management would be integrated, eliminating the operational or processing distinctions between lines of business, and would be triggered at the earliest possible point.

In this kind of program, the key separation of those activities would be between care management and claim processing as opposed to between group benefits and workers' compensation. Line of business distinctions would only be important from a backroom perspective and from an accounting perspective, of where to put the dollars that you're paying out. From the employer's perspective, whether the employee breaks his back on the job or off, both the employer and employee benefit from the most appropriate cost effective medical care and the earliest recovery and return to work. Separating the care-management process from the claim-management process allows immediate management of the situation without regard to cause or the delay of determining which insurance carrier is liable. Additionally, eliminating the historical distinctions between medical and disability management allows for better coordination of treatment on the group benefits side, and a seamless progression along what I call the managed-care continuum, from determining the necessity of care, to the location, to length of stay, to getting the patient home, and then back to work.

The type of 24-hour program that I have just broadly sketched is not limited by the current legal or regulatory environment. The only barrier is us. If we can break down the distinctions between our companies, we can structure 24-hour managed-care services that are not limited by artificial boundaries, and we can start to meet the real needs of our customers. As chair of the HIAA task force on 24-hour coverage, I have experienced the challenge of finding common ground between the life/health and property/casualty industries, which is no small task. Reaching consensus has been a very lengthy process, and it continues to this day.

We currently have a draft paper that is being reviewed by the HIAA member companies and is therefore subject to modification. What I'm telling you is preliminary at best. As of right now, the task force is endorsing true single policy 24-hour programs, but only if they include the following 11 key principles: (1) Regulation should be efficient, meaning the avoidance of dual regulation. We should be simplifying things, not making them more complicated and more expensive. (2) Twenty-four-hour programs should be considered employee welfare benefit plans and therefore subject to ERISA. (3) Principle of exclusive remedy should be retained. (4) Programs

should incorporate managed care, specifically including preferred providers, explicit standards for provider selection, formal programs for quality assurance and utilization review, and incentives for members to use the managed care providers and procedures. (5) There should be economic incentives for consumers to make cost-conscious choices. (6) The programs should be offered to all full-time employees, optionally to part-time employees in lieu of a traditional workers' compensation program, and with dependents covered for nonoccupational medical services only. (7) There should be no waiting period. (8) Terminal liability should be consistent with current group health practices, inclusive of COBRA and statutory continuation and conversion privileges. (9) Benefit specifications should be detailed as in the group benefits world. (10) Disputed adjudication should be pursuant to the provisions of ERISA. (11) Policies should be sold by or through carriers or broker agents who are either life/health or property/casualty licensed.

In summary, the rising costs of health care is one of the country's most critical issues. Controlling the cost of employee insurance to include workers' compensation and group benefits is at the top of many employers' "to do" lists, let alone the federal government's. And obviously our health and disability costs are impacting U.S. workers directly in terms of their ability to compete and to continue to be employed. Designing 24-hour health care programs is one solution that we should be pursuing.

MR. TRINDLE: Our next speaker is Keith Bateman, vice president of policy development in the commercial lines division of the Alliance of American Insurers, which is the casualty industry trade association. Keith is the coauthor of the Alliance paper, "24-Hour Coverage, an Analysis and Report About Current Developments" (which, incidentally, I recommend to anybody who wants to get up-to-speed with this topic quickly; it is very well-done and comprehensive). He has written numerous other articles on workers' compensation. He is on the advisory board of John Burton's *Workers' Compensation Monitor*, and he is on the editorial board of the *Journal of Workers' Compensation*. Keith is active with the NAIC, the Michigan Workers' Compensation Board, the Michigan legislature and its committees. Keith will discuss the casualty industry perspective, regulatory barriers and the very important public policy aspects of the 24-hour coverage issue. He will also outline some of the initiatives underway at the state level.

MR. KEITH BATEMAN: I wish I could cover all that in this time period, but I cannot so I am going to have to be a little more focused than that. The property/casualty industry hasn't been very profitable lately. I cannot give you all the fancy overheads.

First of all, there are several trade associations that represent the property/casualty insurance industry. When you asked for the property/casualty perspective, it reminded me of what Will Rogers said about being a Democrat: that he didn't belong to any organized political party. So when I say that I am here representing the property/casualty industry, I am going to make it clear that I am representing members of the Alliance of American Insureds as far as I have authorization to do so.

I think it is obvious that I would not be here for the trade association saying that we would certainly favor forms of 24-hour coverage that would put us out of business. I certainly would not have a paycheck for very long, but that does not mean that we necessarily oppose all forms of 24-hour coverage. In fact, we are willing to have

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states experiment in those areas where forms of 24-hour coverage allow us to compete. A number of the states have been moving in the direction of allowing an alternative means of meeting the workers' compensation obligation. We certainly do not have any problem with that.

We do have some suggestions on how states ought to proceed. One, we suggest they use a pilot project approach and take things slowly. Two, right now a lot of the states have been moving in the direction of having 24-hour medical only, and having the disability side of the compensation equation handled in the traditional manner on a work-related test. We think that is a mistake. We really do not think you can separate medical and disability. Disability is a very complex concept that involves medical and economic conditions, psychological factors, and a whole variety of other factors. It is somewhat clear that in the marketplace the professional corporation (PC) industry and those selling disability insurance, in theory on how we manage, have come closer and closer together over the years.

One of our concerns is that frequently there is no clear objective stated on a pilot project; we believe that it is important that, if a state is going to go down that line, it understands what it's trying to accomplish. Another point we want to make to the states is, do not design the policy yourselves. Let the marketplace design the policy, and you will have much more innovation. Let us design the policy because there are practical problems that have to be dealt with, and the marketplace is better at handling them.

Second, there are social obligations that insurers have, residual markets, guarantee funds, data reporting and all sorts of things. Try to keep a level playing field in that area, particularly since you're talking about pilot people who may have to be moving back and forth between the systems. Then, by all means, if you make policy decisions that have implications, the state has to be willing to face up and deal with those implications. It cannot simply say to private industry, alright, now the system has gone this direction and there are problems, but go ahead and do something. Another thing that we feel is important is that there be a very meaningful evaluation process.

I am not going to talk about the barriers in the traditional sense. We talk about some of those in our booklet, and if you want to know about state activity, I'll keep my commercial going. I have done an article for the January/February 1993 issue of *John Burton's Workers' Compensation Monitor* that uses current December 1992 information, which means it's now outdated as to what's going on at that state level. You were told earlier that 24-hour coverage is a generic term. That is one of the problems with talking about the barriers because they are not the same for different forms of 24-hour coverage.

Another thing that disturbs me greatly is when we talk about pros and cons of 24-hour coverage. Twenty-four-hour coverage is not an end; it is a means to an end, and when people think of it in terms of an end, that means they are not thinking through the process. After looking and talking from a public policy point of view, I would say the single greatest barrier to 24-hour coverage is a lack of thought on the part of those who are putting forth the proposal for 24 hours. They say that this is a silver bullet, that it sounds great, and they leap without deciding all those things I

mentioned earlier about what they want. They don't clearly define their objective, and that makes a difference. I can design any form of 24-hour coverage that anybody wants. I can give you a 24-hour coverage program that covers all injuries, all diseases, and provides unlimited medical benefits, but you may not be able to afford it. You simply have to draw some parameters around what you want to do.

Then another thing people have to do is understand that, when they start making decisions about this, consequences flow from those decisions, and they have to deal with them, not avoid them. You do not start making decisions going down a decision tree, and then avoid the implications that flow from it.

Another thing you have to do once you have articulated where you want to go is say, is 24-hour the way to go, do I have to make major changes? Or as Ruth was saying, you can take the present system and administratively accomplish many of the things that you might want to accomplish while talking about going to a form of 24-hour that involves a combined coverage. I'm going to relate these points to both what I see happening at the state level and what's happening at the federal level.

At the state level, the states have been moving in a direction of permissible legislation allowing 24-hour medical alternatives as a means of meeting the workers' compensation obligation, i.e., they are trying to keep it within the current workers' compensation system. We are going to hear some discussions about how you do it in a system that's outside those boundaries a little later, but all those decisions mean something. You do not have to have the same carrier providing the medical and the indemnity portion, and the employer has to pay the entire cost of the 24-hour medical coverage under most of these programs. Most coverages permit deductibles, copayments and managed care, but not all of them.

One of them, a Florida law enacted in 1990, is on a nonpilot basis. There are pilot legislations in Maine, Massachusetts, Georgia and California on the books. In Oregon, there will either be legislation or an administrative leave policy this year. Iowa is likely to experiment with a form of 24-hour coverage for government employees because by focusing on government employees, it avoids ERISA problems.

Why did the states go for this particular version of 24-hour coverage? The shocking point is in most cases they really are not clear on why they decided to do it. One state did it, so the rest followed the same approach. Obviously one of the factors is somewhere they feel that they are going to save on medical cost, but they really have not thought through and analyzed where they are going to save medical cost and why they want to save medical cost.

In other cases, there's a secondary motive in that they hope that there is a way that they can get employers to extend health insurance coverage where they do not have it through the mechanism of the 24-hour coverage. Of course, anyone knowing anything about the relative cost of workers' compensation medical and health-care coverage knows that would be a somewhat sad trade-off for an employer. In many cases, the states leave a lot of unanswered questions when they talk about doing that, for example, whether they're going to deal with any sort of requirement that they make an offer anyway to dependents, or whether cost can be shifted to the employee in the guise of dependents' coverage.



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Obviously, another reason why states are talking 24-hour medical probably is there is a lot more health insurance coverage out there than there is disability insurance coverage, and it is a lot less scary to most people because they are familiar with health insurance. Another idea they have is that this type of legislation is going to reduce litigation, but the medical only aspect of compensation is not what drives the litigation. It is driven by the indemnity cases and in most cases, you are still going to have the same issues. The issue in most compensation litigation is not whether it is work related or not, it is the nature and extent of disability that is the issue.

Now what are some of the consequences of the decisions that the states have made? First, obviously one decision that they made is that 24-hour coverage is going to be a state program, which means, to the extent that there are some overriding federal interests, the state can be preempted out of the business. Second, the states have made the decision that it is to be an employer-based system, basically because they were looking at it in most cases as an alternative to workers' compensation, but it does not have to be. If you look at Insurance Commissioner John Garamendi's proposal in California, it's an employer-financed system in the form of payroll tax, but it is not a mandated benefit program. But as soon as you make it an employer-based system, then you face the ERISA problems that the states have faced. They are still not able to figure out how to get around the fact that they're going to be preempted as soon as they have a product that combines workers' compensation and nonwork coverage.

Another problem that flows out of the decision to make it an employer-based system is that it raises questions of what happens when someone loses his or her employment status and, consequently, benefits. Also, how do you move out of that system, the tail-coverage aspect, when you move from a system that has been basically a current-based system to one that has paid claims on a different basis? All of these programs also include the decision that it is to be done through private insurers. But as Ruth has pointed out, there are historical and cultural differences in the health insurers and the work property/casualty insurers, that even in the same company pose major problems.

Another thing that people have to decide is, if we are going to combine these, can we save money and pay the same level of benefits that the present workers' compensation system provides for medical? In other words, in most cases this means a group health benefit that would have to be higher than most traditional group health benefits. You are talking unlimited first-dollar coverage with possibly some change in the first dollar if it is a state that allows for deductibles and coinsurance. The general reaction is, it is not possible, and that compensation benefits must be somehow brought down closer in line with the health benefits. There is also the disability medical split and all the coordination issues that it entails. Again, we will hear it makes a difference whether you do this within the statutory scheme of compensation or outside.

I will move quickly to the federal level and tell you what's going on there to the best we understand it. One, it is basically clear to us based on a number of discussions we have had with the Clinton health-care task force that it is seriously, very seriously, likely to propose the combining of workers' compensation medical and all medical into the national health system, both in terms of financing and health-care delivery.

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Second, it appears that labor has made its way around the toll gate process and is higher up into the process and has received a commitment that in the case of workplace injuries, the benefits to be provided will be as rich as the benefits in workers' compensation, even if this means enriching somehow the basic benefit package and providing a supplemental premium assessment against the employer to fund those benefits. In addition, the one thing that is not clear is whether labor has a commitment for no deductibles and copayments. It thinks it does. My impression is that the Clinton people are waffling on whether they have, in fact, made that sort of commitment.

Even though the idea is to move to this community-rated system with the use of Health Plan Purchasing Cooperative (HPPC) or alternately Health Insurance Purchasing Cooperative (HIPC) and the individual choosing his health-care provider, labor seriously wants the workers' compensation medical cost to still be experience-rated back to the employer.

What are the consequences of these sorts of decisions? One, in splitting the medical from the disability management, you have to see what that does and what sort of incentives are created. You have a health system that will have incentives for controlling health care, but no incentives for controlling disability. You have people who are employed who are not protected by the workers' compensation system, so the task force has to make a decision on how people will get these enriched benefits since the benefits are not the same in both cases. To the extent the administration is talking about self-declared work relatedness or where there's an enriched benefit package that may produce additional revenue for health-care providers, it's creating perverse incentives for people to declare cases work-related.

Now obviously we currently face the problem of people who don't have health insurance coming in on Monday morning and saying they hurt their back in the 20 minutes on the job and not playing football with their kids, but at least the employer and the property/casualty carrier are in the position now to try and look into that and see whether that's in fact the case. That protection will not be there under that system.

The experience-rating aspect mixes all sorts of apples and oranges together in trying to reach a way of dealing with this. You are talking incurred pay-as-you-go-type medical. You are talking community rating and employer responsibility. You are talking situations where you have medical for preexisting claims that compensation is paying for presently. You have claims arising during a given year, all sorts of issues are coming up, and you can see these folks going more to changing a HPPC from being a relatively unstructured, very limited thing, to a bureaucracy duplicating the services presently provided by insurers and their rating bureaus.

This gives you some idea of what I mean about how the decisions affect what flows from them. I think the state and federal examples are precise examples of the wrong way to do things. I have been saying this now for 2.5-3 years, and they still do not particularly care to listen to me, but it is a problem. It certainly is not fair to leave it up to private enterprise and those government officials who are charged with implementation to straighten out all these problems.

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Also, as you know, there has been a lot going on in the marketplace that I have not touched on that others on this panel have touched on, and we may want to talk at some point, if the Clinton plan actually should get passed, what implications it would have to those programs.

MR. TRINDLE: Our next speaker is Cecily Gallagher. Cecily is a principal with Tillinghast Towers Perrin, in San Antonio. She is a Fellow of the Casualty Actuarial Society and is the practice leader for the 24-hour coverage program at Tillinghast. Cecily is the President of the Southwest Actuarial Forum, and she chairs the Casualty Society's Committee on Risk Classification. She has been in consulting for 14 years and has been heavily involved in workers' compensation. Cecily will discuss some of the experimentation that is now underway in Texas. She will also address some of the issues that actuaries face in designing and pricing 24-hour plans, including some suggestions on sources of data that actuaries can use.

MS. CECILY A. GALLAGHER: You are getting a lot of different perspectives on 24-hour coverage and a lot of different attitudes here, and now you are going to hear the casualty actuary's attitude. As an actuary who lives in Texas, I'd like to give you a little background on some very different things going on there. Some of the things may not totally agree with some of the other things that have been said; in particular, we do have 24-hour coverage in Texas. Now there are some restrictions, and it may be for a limited time only depending on what happens with our legislature, but I think it is fairly safe to say, as any political projection is, that it is going to be around for at least a couple more years.

In Texas, employers have the right to opt out of workers' compensation. They can just say they do not want to be in the system at all. When they do that, they revert to the tort system, and an employee's only legal recourse, unless the employer has promised protection of some kind either under ERISA or some other form, is to sue the employer to get compensation for injuries. All the rules are off, totally unregulated and the employer does not have to offer anything. I guess the exciting thing from my standpoint is that this is an unregulated trial.

Everybody has a lot of preconceived ideas of what should be done about the pilot programs that we are talking about. In Texas, the employers are deciding what they want to do under the little threat of a potentially large lawsuit. They have that hanging over their head, but it still is their game, those that decide to unsubscribe, and we are seeing some very interesting experimentation.

I'm working with Texas A&M on a study right now to estimate how many nonsubscribers there are and how many employees are employed by nonsubscribing employers. The rough numbers are something like one in five employees are employed by nonsubscribers and it is about 40% of the employers, so it is a lot of the small- to medium-size employers, but there are quite a few large ones as well. In the ones that we worked with (because we do work with several), the new programs in lieu of workers' compensation are extremely interesting. The ones that we are working with are very well-designed and offer generally good benefits.

In particular, many of them are offering first-dollar medical benefits, they are offering wage benefits that are as good or a little bit more generous than workers'

compensation for just wage. What they do not provide is what I call pain-and-suffering-type benefits that you get under compensation. There is some accidental death and dismemberment. And there are some programs that have deductibles, but I would say the majority do have first dollar medical coverage. And, at least for the larger employers, they are promising unlimited medical. So despite the unregulated nature of it, they are just experimenting with a lot of different things, and it does not necessarily mean that the occupational program looks just like the nonoccupational.

So the 24-hour coverage products that are coming to meet this demand that the employers are designing basically is really paying a subset of the two. It is not a product that pays 100% of what was paid under compensation, and it is not a product that pays what was under the nonoccupational. They are just kind of carving out a piece and paying 100% of whatever is in that circle, whether it's occupational or nonoccupational.

Some of the more common products are the excise medical for example. Excise medical coverage is where it does not matter whether the injury is due to occupational injury or nonoccupational. It pays for the catastrophic medical. So there are 24-hour products out there, and they are just not as all encompassing as you might first imagine and that may be what evolves later on.

So given that there is a market and there is some experimentation going on, now I will talk to you as a casualty actuary. The challenges in helping companies develop these products are fundamental coverage differences. As Ruth has alluded to, there are some fundamental differences between property and casualty and life companies that we still have to overcome, partly by just talking to each other. There are differences in actuarial techniques, and this was really interesting and kind of fun for me because just as Ruth had met her counterparts on the property/casualty side, I never met any of the health actuaries in our firm, and we had an opportunity to actually talk and work on a project and the problems are the same, I don't care what anyone says.

Your techniques are a little bit different, and the terminology is different, which is usually the first barrier. For example, what you call disability, we call indemnity, and you use indemnity a lot of different ways. So, you have to get to the language problem first, and once you do, we are really not approaching the problems that differently. Probably the biggest pain, which is always our biggest pain, is data problems. As bad as your data seem to you, wait till you look at workers' compensation data, it is terrible and I will talk about a few of those there. But I think as far as developing very good, well-priced products, this is where we are going to have a problem, just like we do on almost any actuarial problem.

To get a little more specific on the types of issues you have to cover when you are getting into this area, the first one is the exposure base. Your side uses a per employee, our side uses per \$100 of payroll, and there are, as far as we can tell, no really nice industrywide sources that you can go to give you a nice conversion between these two. You can get some rough census data to give you a feel by occupation, but it varies dramatically from one occupation to another, and this is one that adds a lot of uncertainty to whatever estimation you do. However, you convert from this to this. The data sources are not there to give you a nice clean answer.

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Some of the products that are being sold in the Texas market for occupational programs are on a service-provided basis. The workers' compensation product is generally occurrence basis, date of injury. The insurer that is on the policy when the injury occurs is responsible for all the medical benefits until the individual is healed, essentially lifetime benefits.

Some of the products that are being sold in the Texas market are occurrence basis, but they usually have a cap, a time limit. There are a number of products that are being sold, particularly to the smaller employers, that are on a service-provided basis, and that is a major difference. We can measure some of those differences. We have data that are a fairly good surrogate for estimating that impact.

Up until just a few years ago, compensation did not have any deductibles. Now we are just getting into where we are introducing about one deductible per injury. It still extends for the lifetime of the injured employee but it is one deductible per injury. You have an annual deductible. That is a tough one to handle when you are talking about data that are summarized on an occurrence basis. You can see some of the problems we face here.

We do not have any coinsurance. It is somewhat similar to the deductible issue. I am assuming coordination of benefits is solved since you are coordinating with our benefits. We do not have any coordination of benefits, but I figure that you were going to solve that one for us.

As far as classification variables, the only variable we have in compensation is occupation, that is it. Occupation and payroll are the only details you get. On your side, yours is more like our auto insurance where you have geographic location, age, gender, a lot of different variables. In our defense, we have not needed anything other than occupation and payroll it is for the majority of the risk because the majority of the premium, not majority of the risk, that comes from large employers that are retrospectively rated or experience rated. You don't need a lot of detail to figure out what their costs are going to be because, within fairly large parameters, it is fairly stable and you do not need it. When we are trying to integrate a single product, it is a real problem, even though we do know the studies that we had done show that geographic locations have a significant effect on workers' compensation costs as well.

Just talk a little more broadly about impediments to 24-hour coverage. When we talk about 24-hour coverage, we really talk about it in two pieces, integrating the systems and processes that can be done now, which has a lot of the structural impediments, and then integrating the coverage and the benefits. I'll break those up.

As far as the systems and processes, I have divided the major impediments as I see it as the employer traditions, which is the fact that workers' compensation has been handled by the risk managers who are normally in finance, and the human resources department, which handles the employee benefits, and then the insurance industry structure. In my opinion, the second one is a far greater impediment than the employer.

When you consider the employer's risk-management department may have three to five people, there are definitely turf battles that are going on and we see them. There

is a lot of pressure there, but I have problems believing that solving those turf battles are anywhere near the problem that a CEO has to face when he has to close down a division or lay people off. It is a matter of admitting or deciding that there really are cost benefits to the integration process, or even if there are not cost benefits, that their employees are being taken care of better. A lot of the employers that we're talking to are really good nonsubscribers. They're as interested in taking care of their employees properly as they are in the cost savings. I just do not think that is a huge, insurmountable step. It has to be done, and there is going to be some tension and problems; but once people believe that is the way to go, it is going to be fast.

In industry, that is a lot tougher because I think the structure is much more ingrained. I am not sure on the aspect of integration of coverage of benefits because I think it is more than just a regulatory or legal situation. From what we are seeing in Texas – a wholly unregulated situation – employers are offering different medical benefits. Just talk about the simple one, which is medical benefits. Employers are offering unlimited first-dollar benefits for injuries even though they do not have to. In talking to the employers we are working with, it goes back to the idea that they feel a greater duty to the injury and the employees who are injured on the job than they do for the nonoccupational benefits. And until we figure out how to handle that philosophical difference, it may just be a mechanism where the employer picks up the deductible for occupationally related injuries or something like that, but there is a philosophical difference that has to be addressed as well as many of the other issues that I have brought up.

Is it coming? No one else has ventured a guess on this one, but I will take a stab. I think the system and the process is coming, most definitely and very soon. We did a study a couple of years ago just asking risk managers what managed-care procedures and tools they were using on the workers' compensation side. And this was 1991 and just mentioning things that you take for granted like the use of networks to the extent you can, precertification, provider profiling, a lot of things you just do on almost a normal basis from what I understand.

On our side of the house, 20-30% of the risk managers indicated they were using those tools at that time. Two years later, we are doing a follow-up study. The early indications are that number has increased over 150%. It is now closer to 50% of the people are saying they are using those tools. During that 1991 study, we asked about all these different tools employers used, and one of the things we asked them was about coordinating the occupational and nonoccupational. About 17% of the risk managers or whoever was responsible for workers' compensation at the time indicated that they were doing some type of coordinating between the two, but it was one of our lowest numbers. But of those that are using it, 87% said it was at least somewhat effective in helping control cost. It got the highest rating in terms of effectiveness, and we did not ask them what they were getting out of it but they were convinced that this was one of the areas, and this is what broke us up to spend a lot more time looking at 24-hour coverage.

I do not know where the integration of the coverage of benefits is going. I am not as worried about that. With everything that's going on in Washington, I think it is a little more productive to spend time where we know that there are some or at least there

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is very good evidence that there are some gains to be made and let Washington and the states worry about that.

MR. TRINDLE: Our final speaker is Jim Francis, senior vice president of IOA Reinsurance, a reinsurance underwriting management company in Philadelphia. Jim is in charge of IOA's special risk division. He is a certified property casualty underwriter and a certified financial planner. His career spans 35 years in a wide variety of reinsurance activities. Jim will discuss the reinsurance perspective, review some of the markets that exist out there today, and address the future of 24-hour coverage.

MR. JAMES B. FRANCIS, JR.: Reinsurance always seems to come at the end. We are kind of the behind-the-scenes people. We are not in the forefront of the 24-hour movement, but the life and A&H reinsurance markets are ready for this. We are particularly ready for it on the medical side where this is where we feel it is going to come. Of four of the larger accident and health reinsurers who had been active both in the workers' compensation side and in the major medical side of the business for a number of years, three of those are underwriting pool-management-type companies. Northwestern National Life underwrites for its own account.

For possibly a little more than 15 years, these reinsurers and others have provided excess major medical reinsurance. Basically, it has been done with the employer retaining each year a certain amount of medical expenses incurred for each employee and each dependent. These retentions can vary, anywhere from as low as \$10,000 for a small employer to as much as \$250,000 for a very large employer, each year in incurred expenses. It is an annual recurring retention, which means that in an ongoing illness claim or a very tough nonoccupational trauma claim the employer will come back on that claim and retain in the second year whatever his retention is. The reinsurers also offer an aggregate stop loss, which protects the retentions that the employer is keeping, and those attachment points are basically at 125% of expected claims.

Going back maybe nine years or so, these same reinsurers have been providing workers' compensation excess of loss reinsurance on a different basis, basically per occurrence, with a maximum limit per person that is well up into the \$1-2 million dollar range or even higher. These life and A&H companies, because they are life and A&H companies and not casualty companies, exclude employers' liability. Part of it is an A&H-type cover and part of it is a casualty cover. These companies basically from day one have excluded employers' liability and occupational disease for obvious reasons, and I will get into that in a little bit.

The retentions per occurrence generally have been a million dollars or higher. Property and casualty reinsurers generally still are picking up what we call the buffer layer between, say, an employer's retention of \$250,000 and \$1 million, a little different basis. There is one retention; it is not the key as it is in major medical.

Where are the gaps? Obviously, there are gaps in disability. Looking at the 24-hour concept from the reinsurance point of view, there are companies like CNA, Cigna and others who have been writing long-term-disability reinsurance for years. I do not think if we get into the 24-hour concept for both medical and disability that solving the reinsurance problem on the disability side will be a problem. And obviously from the

life and A&H side, employer's liability is a gap because those reinsurers have to exclude it. Employees' loss varied by state. There generally has to be in most states gross negligence, but that does vary by state. As I mentioned previously, life and A&H reinsurance carriers are unable to reinsure the employer's liability. There are casualty reinsurers, including some syndicates in Lloyd's who will entertain stand-alone employer's liability but, again, not necessarily in every state. The typical workers' compensation policy, for those of you who are unfamiliar, provides employers' liability limits up to a maximum of anywhere generally from \$500,000 to \$1 million. Above that, employers can get protection under their umbrella covers for claims above a million dollars.

Here is a real gap as far as the reinsurers are concerned: occupational disease. The ability to accumulate claimants as part of one occurrence gets us all fit. We are talking here about things like toxic substances, dust. Computer radiology today is not that much of a problem. Lead-base paint is something that people are talking about now. Chemicals in carpets could be the latest thing that is going to give us problems. Asbestos has been a problem for years. And then again there are goodness knows what other unknown causations that could cause future problems. This is a real hang-up for us as reinsurers. Obviously, we could be liable for huge claims if there are problems in some of these areas, in chemical plants and things like that. Plant closings are a problem. Every time a company closes a plant, a certain number of people will allege stress, back problems, headaches, all the things that they can, and obviously those can probably be accumulated and called one occurrence. With the recent bombing of the World Trade Center complex, we are waiting to see what happens out of that occurrence as far as stress is concerned. There are a lot of people who do not want to go back to work in the I and II World Trade Center buildings right now, and whether those situations are going to be filed as workers' compensation claims we will have to wait and see. I think there will be some, and how they are aggregated in one occurrence and how that affects the reinsurance market, we are probably a year or two away from really knowing; it could be a problem.

Let us just take a few moments and look at what is causing all the problems in the medical side and what we are doing. A lot of these were brought out in an article that was in *Business Week* not too long ago when many of you probably read it. Nurses' and doctors' wages are growing faster than other wages. We all know about waste, fraud and abuse. They are the normal things you see whenever there is a problem. It is always waste, fraud and abuse and believe me, they exist in the medical and workers' compensation areas.

Regarding demographics we all know the population is aging. We all know that our life expectancies are increasing. We are a wealthy country, the wealthiest country in the world, and the wealthiest country in the world is going to demand more health care. So that is one of the reasons. Probably the biggest reason is technology, and the article pointed out that 2,000 MRI scans result from one tumor. That is a total cost of about \$2 million to determine one tumor. So you can see the effect that technology has had on the problems of health care.

The President's been bashing the drug companies, probably for symbolism or intimidation. But drugs only account for about 7% of overall health care, and if you cut the



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drug companies' profits in half, that's total health-care expenditures by 1%, so obviously that is not the answer. If we cut physicians' wages 20%, total health-care expenditures are estimated to fall by only 2%. Now here is one that all of us, as we get older, look forward to, \$30 billion spent by Medicare persons in the last six months of their life, and as the population ages, you can see what is going to happen to that number, and it is why the Medicare system is in big trouble.

As we look at the concept of 24-hour coverage, the savings and the elimination of administrative waste, the ability to manage patients and cut down on low benefit medical procedures and the concept of buying cooperatives, which I am certain will come out in the Hillary Clinton task force, will introduce this idea of managed competition, and somehow we have to find a way to ration high tech services. That is a difficult thing to do, but if you are going to cut health care costs, you have to do that.

We are going to see 24-hour coverage on the medical side. I am not so sure we will see the complete combination of medical and disability. I do not think we will initially, and I kind of agree with Keith that it is going to be a problem. But I do not think it is going to come down that way.

Will workers' compensation be included in the Hillary Clinton task force? My feeling is, yes, it will be addressed. What the Congress will do with it, I do not know, but I think her task force, from all I'm reading and hearing, is definitely going to address combining workers' compensation, automobile and health in the medical side, not on the disability side.

I think you'll see small deductibles and copayments. The unions, of course, are going to press for none, and they are a tough constituency for the Clintons to look past. Likewise, our legislature is completely Democratic, but I still think that the task force is going to come up with ways for insureds to pay some of the cost; employers are not going to pay it all. Now whether this takes the form of deductibles and copayments or whether it takes the form of the insureds paying part of the premium themselves, that will happen, I think. There will be a maximum limit, which again goes against workers' compensation which is unlimited lifetime. We are going to see maximum limits of either lifetime or per disability or a combination of both in the core package that the Clinton people recommend.

We spoke with a physical therapist the other day in New York City who was very worried about whether physical and occupational therapy will be part of the core package. I do not know about that one. I would suspect it would be, but there again it might not be. Outpatient mental and nervous coverage is a very expensive benefit and is generally limited in most health policies today. Will it be part of the Clinton recommendation? I am not so sure. It is a very costly add-on. Likewise, prescription drugs are a costly add-on, but I think there will be something there as far as prescription drug coverage in the combination. I do not think nursing home care will be part of the core package. I see the wage loss as still covered under workers' compensation statutes.

Again, we are going to have a separation I think of medical and disability. Whether that is good or bad, I do not know. We could see physical and occupational

rehabilitation. If it is not part of the core package that is recommended and passed by the legislature, it will be part of the state workers' compensation laws. They are obviously going to have to change the laws if the Congress passes any kind of a health reform that includes workers' compensation. If the task force does not include workers' compensation, you are going to see a terrible cost shift. There is already a terrible cost shift going on now that the workers' compensation industry has had to face. What they are going to face if it is not included is going to be astronomical in my opinion. Therefore, the states are going to have to address it. If Hillary Clinton brings it from the back burner to the front burner, this thing is going to move. If she does not, it is going to take a lot longer, but I still think it is going to happen. It was interesting in the last couple of weeks, both Florida and the state of Washington have passed health reform packages, and neither one of them included workers' compensation to the best of my knowledge. Is that correct, does anybody know?

MR. BATEMAN: I have not read the bill, but there is a provision in the Washington package to study and make recommendations by 1995.

MR. FRANCIS: I have not seen or read that it really was addressed in any concrete form. It was basically a health provision.

MR. BATEMAN: In Florida while it's not in the bill, they just have some sort of health-care agency set up that will be looking at the subject.

MR. FRANCIS: The governors of both of those states said that they thought that their bill would be the model that Hillary Clinton would use. I am not so sure. I thought this was very interesting. This was in the *Business Week* article, for those of you who did not see it. Health care is currently 14% of our gross domestic product, and most economists think it will be 18% by the year 2000. If you look at productivity, from 1950-73, it averaged 2.5% a year. In the last 19 or 20 years, it has only averaged 1% a year; it is starting to come back.

As corporations restructure and trim their work forces, productivity figures that I have seen in the last couple of months are back up to the 2.5% range. If for the last 10 years productivity had averaged 2.5%, the gross domestic product would be a lot higher and medical health-care cost would be a lot lower percentage of it. We might not even be talking about any of this as a problem.

Maybe the problem is the fact that we have just been a very nonproductive society for quite a long time now, and we are just getting around to recognizing it and doing something about it. And if you look at it in that form, I do not think the health-care costs are that big a problem. It is an interesting angle.

MR. TRINDLE: We have heard several different perspectives. We have heard from the carriers, the casualty industry, the actuarial side, and the reinsurance perspective.

MR. WILLIAM C. CUTLIP: I think it is always refreshing to have nonlife actuaries on a panel. It is sort of like the person who is 50 miles from home because then you end up looking like an expert, so it is really great. The two questions I really want to bring up are two pieces that I do not see how they would be covered through the 24-hour coverage. First is in a group situation where you have a family plan. What

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happens with the dependents on that family plan, especially if you have a working spouse, and would that working spouse have the 24-hour coverage and would it be through the spouse's employer or would it be through the employer on the family plan and then who has the dependent children? And the second question is, what do you do for individually insured people, self-employed people? This is, of course, of particular interest to us because we are part of the Wisconsin farm bureau, so we look at farmers. In fact in our medical plan, we do not go so far as to cover workers' compensation entirely, but we do provide medical coverage for disease or accidents that happen that are work related so that would take care of our farmers. But what do you do for 24-hour coverage for people who are self-employed?

MS. GALLAGHER: I guess from my standpoint, again I make the distinction between the coverages integrating the coverages and integrating the processes, and I do not know if I have an answer for a fully integrated, cover-all-the-bases benefit structure because at this stage, I think we are well away from that, we are not there yet. For self-employed, if the market is there, I don't know whether it is a financially viable market as a whole because agricultural workers in general are not covered by compensation as it is in many states. So that is a group that is not addressed in the system as it stands now. I do not see why they could not be considered as a 24-hour coverage market. Somebody could go after it, and it may be more reasonable to go after farmers as a 24-hour market than trying to split between occupational and nonoccupational, but I do not think I have an answer for you at this stage.

MR. BATEMAN: The Clinton administration does have an answer to the extent that you are covered under that plan. You have the 24-hour medical and to answer your other question, obviously I'm not a spokesman for the Clinton administration, but my understanding of the way it is dealing with the other issue you asked about where you have two working spouses and which comes first may be something as simple as who has the earlier birth date.

MR. WALTER WESLEY WELLER: I have a question for Cecily. To what extent have employers in Texas relied on HMOs for 24-hour health coverage? And more generally, what do you see as the role of HMOs, and particular difficulties that they might have perhaps with respect to the lock-in that you have with an HMO and the lack of freedom?

MS. GALLAGHER: As far as nonsubscribers, they are using HMOs. They are using all forms of the networks, and in fact, there are some basically aggressive HMO providers working in Texas. The lock-in, I think that is going to be a problem on our side just as it is on your side, the same limitations you are going to apply. I do not think that is going to make any difference, so really the way it is working in Texas is we are generally adapting what you have already developed, and now you do need different specialties. It is not the same doctors providing your nonoccupational and your occupational. It is different doctors, and whether it is the same network or a subset of the network or two distinct networks, from the employee's standpoint, he has coverage 24 hours a day and the back room may be handled a little differently.

MS. ESTRICH-BALDWIN: I have seen published statistics that are very similar. So looking at things like that, it is clear at least to us that the management of the care that we are doing on the benefits side is having some effect, either because as you

said the sentinel or because the doctors are cost shifting to where there is no management and overservicing over there. So again, it is our intuitive assumption that, if you take the managed-care policies that we have been using for years on the group side and apply them on the certificate of need (CON), you will see their numbers start to come down. That's what I was talking about with the balloon in the box. We've been pushing on the one side, on the employee benefits side, and it has been bulging out on the CON. What we need to do is design a managed-care system that supports both. The Clintons I think are probably going to try to do that. I hope we will all still be employed at the end of it.

MS. GALLAGHER: I can give you some anecdotes from Texas, and again it's not specifically an HMO, but it is managed care with all of the different definitions that that entails, but working with some of the nonsubscribers. One of the problems on compensation is for so long the situation that your industry had, about 10 or 15 years ago, when there was no management of it. And for a lot of employers, they're still now just catching up to actually trying to manage the cost, and I have two very good nonsubscribers who had fairly good workers' compensation costs before they went nonsubscription. But with the threat of a lawsuit, they spent some extra money in safety and developing networks and really paying attention to actually communicating workers' compensation as a benefit, which is a very novel idea on our side of the house, but it is extremely well-received by employees. Their costs have been reduced by 60%, and I'm setting the numbers on it; I'm trying to be conservative. They don't pay everything that compensation pays, but they're paying all of the medical and 90% of wage. I mean it is not everything, but it is a very reasonable package, and their costs are down by 60%, and there's a good chance that those numbers are high. Now they may have the one multimillion dollar lawsuit, but I do not think so because they are approaching it in a very nonadversarial way. It is a very different attitude towards compensating injured employees.

MR. J. MARTIN DICKLER: I have learned a lot about workers' compensation that I did not know an awful lot about, but it seems to me in listening to all of this, there is another component that really has not been touched on. I am not an attorney, but would employees paying deductibles and coinsurance close off any right they would have to sue in a small claims court for injuries? And second, as I understand it, the segment of the legal profession has made a lot of good money handling workers' compensation over the many years. Would you comment on where they stand on all of this?

MR. BATEMAN: One of the reasons that the Florida statute, passed in 1990, hasn't been implemented is precisely because there is employer concern that if you go to deductibles and coinsurance, the courts will then say that the exclusive remedy provision of workers' compensation is unconstitutional, and there are two things to keep in mind there. You have a federal constitutional issue and a state constitutional issue. There are a number of states that have their own constitutional provisions on access to the courts, but they are much more liberal than the provisions of the federal constitution, and provide a basis for courts that want to overrule exclusiveness or remedy an opportunity to do it. We really don't sit down and talk with the attorneys, but I can assure you that they are concerned about their income level as much as anybody else in this whole situation.

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MR. TRINDLE: Attorneys are the "gatekeepers" of the workers' compensation system.

MS. ESTRICH-BALDWIN: In terms of the deductible and coinsurance issue that comes up a lot on the group benefits side, where a lot of us have come to is, we're really providing first-dollar coverage often if you stay within the system. The consumer incentive that we're building into a lot of our programs is, if you go through the network, if you go through the utilization review, if you go into the managed-care system, you get 100% coverage, no deductible, with a disincentive, if you will, for going out of network. So I think that there are ways that we can play that on the compensation side without getting into a problem on the exclusive remedy situation.

MS. GALLAGHER: Again with the nonsubscribers, I hear from them that they're providing first dollar. They're not saving a ton from charging an employee \$5 to go see an orthopedic surgeon. The types of care they're getting within workers' compensation is very different from the nonoccupational. The abuse comes in staying off work too long, the malingering, and they are more concerned about getting them in, getting them healed quickly, they are not worried about that front end deductible for the ones I am working with. I cannot talk for all of them, but the focus is getting employees back to work because you heal them, get them back to work, you have cut your lost time indemnity or disability benefit as well as your medical.

MR. BATEMAN: It is weaning them off the excessive medical treatment that is the problem, not the initial walk through the door. It is after they get through the door where the problem comes about.

