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# Assessment of 24-Hour Care Options for California

Donna O. Farley, Michael Greenberg,
Christopher Nelson, Seth Seabury

Prepared for the
California Commission on Health and Safety and Workers' Compensation


INSTITUTE FOR CIVIL JUSTICE

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Robert T. Reville, Director
RAND Institute for Civil Justice
1776 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138
Phone: (310) 393-0411 x6786; Fax: (310) 451-6979
E-mail: Robert_Reville@rand.org
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# Preface

In October 2003, California State Senator Richard Alarcón formally requested that the Commission on Health and Safety and Workers' Compensation (CHSWC) perform an in-depth study of 24-hour care, a health care benefits model that would integrate work-related health care benefits and traditional group health benefits, so that services are delivered by the same group of providers under a coordinated insurance package. In his request to the CHSWC, Senator Alarcón observed that proponents of 24-hour care believe that a system that combines health care coverage for work-related injuries or illnesses and coverage for other health care needs could yield substantial savings. At the same time, however, he noted that such a system could also raise concerns about the quality of health care delivered to workers.

In December 2003, CHSWC contracted with the RAND Institute for Civil Justice to conduct a study of 24-hour care to address these issues. This monograph is the product of that study. We present the results of our assessment of the value of 24-hour care as a mechanism for reducing workers' compensation costs, while maintaining or improving the quality of care. This monograph is intended to help California policymakers determine whether 24-hour care should be adopted, and if so, in what form. We also sought to clarify some of the key legal and organizational challenges for 24-hour care and to identify ways to surmount those challenges.

This study was sponsored by the California Commission on Health and Safety and Workers' Compensation and was conducted within the RAND Institute for Civil Justice.

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# Summary

## Background

The California workers' compensation system provides insurance coverage for both medical care and (partial) wage replacement for work-related injuries or other health conditions, as well as disability benefits for workers whose injuries prevent them from returning to work for extended periods. This system, which is governed by state statutes, operates separately from the traditional group health care insurance under which employees and their families obtain coverage for their personal health care, and it operates separately from other disability insurance plans.

The term *24-hour care* refers to the consolidation of health care benefits and, possibly, disability benefits for both work-related and non-work-related claims, so that services are delivered by the same group of providers under a coordinated insurance package. A 24-hour care program could be designed and implemented in various ways. At one extreme, a 24-hour care program could be framed to coordinate only health care providers and services while maintaining separate insurance coverage for work-related and other health care services. At the other extreme, a 24-hour care program could involve merging traditional group-health and workers' compensation plans into integrated insurance products.

An integrated 24-hour care benefits program offers the potential to improve efficiency in claims administration, reduce overuse of workers' compensation–based health services through care management, and reduce related health care costs. These benefits, however, are not yet proven in practice. Further, the kinds of benefits that an integrated system of care might provide are likely to vary, depending on the form of 24-hour care implemented.

## Research Questions and Methods

Recognizing the complexity of assessing 24-hour care, we defined five research questions designed to guide a decisionmaking process:

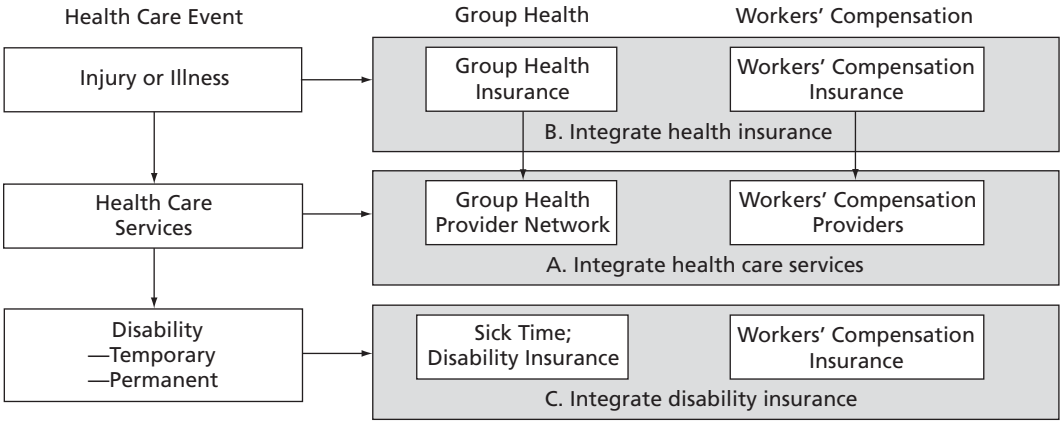
1. What are the problems with the current workers' compensation system that have motivated stakeholders to consider 24-hour care as an option to improve the system?
2. What evidence is there that 24-hour care can address these problems effectively, and how would it need to be designed to do so?
3. What does 24-hour care offer that would make managing health care and costs in this way more effective, compared with reforms now being made (or that could be made) to the existing workers' compensation system?
4. How feasible would it be to implement a 24-hour care system across California within the current employer-based health insurance environment in which employers can offer multiple health plan options?
5. How would the feasibility of implementing 24-hour care change if it were introduced in other group health insurance environments?

In conducting this study, we reviewed existing and pending legislation, published papers, and various documents on 24-hour care systems and relevant program components. We also discussed issues related to 24-hour care with individuals who had experience with these programs. In addition, we researched a series of legal issues that pose constraints for 24-hour care in California, focusing on issues that are of greatest importance to the implementation of 24-hour care. Finally, we conducted eight focus groups that included representatives from the key stakeholder groups concerned with the issue of 24-hour care: public employers, private employers (two groups), labor unions, workers' compensation health care providers, workers' compensation insurers, state regulators, and workers' compensation claimant attorneys. By meeting with these groups of stakeholders, we sought to find out their views on the potential value of 24-hour care, the issues that are of most concern to them, and the incentives that would motivate them to accept and participate in a 24-hour care system.

## Options for 24-Hour Care Program Design

The numerous design options for 24-hour care can be quickly reduced to a few basic prototypes, and the design details of each may vary widely. As shown in Figure S.1, the differences in design derive from whether the medical services or insurance coverage are fully integrated for occupational and nonoccupational injuries or disabilities. The boxes on the left side of Figure S.1 show the generic process through which an individual experiences an injury or illness, obtains care for the health problem, and, possibly, experiences some temporary or permanent disability as a result of the health problem. The boxes on the right side of the figure represent the insurance entities

**Figure S.1**
**Comparison of Integration Options Under 24-Hour Care**




NOTE: We placed Box B above Box A because workers first must have insurance before filing a claim and receiving care following an injury.

that cover the costs of health care or disability and the providers who deliver the health care services. As shown, both insurance coverage and health care services are separate for work-related or nonoccupational injuries or illnesses.

The shading around the boxes on the right indicates options for integrating the separate benefit components for the two types of injuries or illnesses (those covered by group health or workers' compensation). Box A represents integration of the health care services, such that all health care for an individual would be provided by the same providers. Box B represents the integration of insurance for health care benefits, and Box C represents similar integration of insurance for disability benefits. The 24-hour care options that we considered differ in the extent to which they integrate these components. The least-integrated package would integrate only the medical care services (Box A), the next level would integrate medical services and health insurance benefits (Boxes A and B), and the highest level would integrate medical services and both health and disability benefits (Boxes A, B, and C).

In assessing the feasibility and value of these alternative models for 24-hour care, we took into account how the health insurance environment in which they would be implemented might affect their viability. We considered the following health insurance environments: (1) the current employer-based group health insurance system in which employers may offer multiple plan options; (2) the employer-based "Pay or Play" health insurance framework established by California Senate Bill

(SB) 2;[1] (3) a universal health coverage scheme (e.g., such as proposed in California SB921); and (4) a "carve-out" from traditional workers' compensation rules in which employers and insurers implement the 24-hour care model on a more limited scale.

## Lessons Learned

This study focuses solely on integration of the medical care side of workers' compensation (and excludes integration of disability benefits). As stated in the previous section, the 24-hour care options that we considered differ in the extent to which they integrate Components A, B, and C in Figure S.1. We first examine two basic options—consolidating only medical care services and consolidating both services and health insurance. Myriad specific design options exist within each basic option. Some of those specific options would be the purview of the state, and others would be decided upon by employers and insurers as they implement 24-hour care plans. In this section, we summarize the key findings from our assessment and present them as answers to the following research questions, which guided our work.

**What are the problems with the current workers' compensation system that have motivated stakeholders to consider 24-hour care as an option to improve the system?**

The main problem that has motivated policymakers to search for options to the current California workers' compensation benefits system is the cost of the system, which has both the highest and the fastest-growing insurance premium costs in the country. These costs are driven by the growth in medical care expenditures in workers' compensation cases and issues with appropriateness of care. Furthermore, few stakeholders feel that the California system adequately meets the needs of employers or injured workers, which may partially account for the relatively high litigation rates associated with California workers' compensation claims.

**What evidence is there that 24-hour care can address these problems effectively, and how would it need to be designed to do so?**

A 24-hour care system offers the potential to reduce both administrative costs and medical care costs. However, despite a substantial amount of published material on the concept of 24-hour care, there have been few systematic attempts to estimate the potential benefits of 24-hour care and almost no attempts to assess the likely benefits of a fully scaled program. Perhaps most troubling, a number of states attempted to introduce 24-hour care pilot programs, but almost all of them failed to

[1] With Pay or Play, employers either offer health insurance coverage to their employees or pay a tax for the cost of coverage provided by the state.

come to fruition because of lack of interest or legal constraints. Some never were implemented and others were not able to attract employers or workers to participate in them.

We found only one empirical evaluation of 24-hour care pilot programs, which was the evaluation performed of a recent 24-hour care pilot program in California, one of the few such programs that has survived (Kominski et al., 2001). In this pilot program, workers' compensation medical costs were higher than they would have been under the existing system, but costs for permanent and partial disability claims did not change significantly. The effects of the pilot program on costs for non-work-related medical care were not analyzed, which makes it difficult to interpret overall effects. No differences were found in patient satisfaction or in self-reported emotional or functional outcomes.

**What does 24-hour care offer that would make managing health care and costs in this way more effective, compared with reforms now being made (or that could be made) to the existing workers' compensation system?**

Much of the improvement in care and cost savings that 24-hour care might achieve could be derived within the existing workers' compensation system. Twenty-four hour care might add value by establishing a consolidated structure for delivering health care, which would result in the unified medical care culture needed to create effective processes for improved care management and for controlling costs. However, almost all of those processes could be implemented in the current workers' compensation system, and, in fact, many are being adopted as of this writing under the terms of recent California legislation (SB 228 and SB 899). What is not known is whether the added organizational structure provided by a 24-hour care system could help to consolidate and preserve improved practices, or whether in the absence of such a unified structure, practices introduced by workers' compensation reforms might be weakened over time by political pressures.

A 24-hour care model that integrates only health care for workers' compensation and group health could achieve improvements in health care services and costs, but it would not help to reduce many of the administrative costs of insurance claims processing. To achieve administrative cost savings, a 24-hour care model would be needed that also integrates workers' compensation and group health insurance packages. Integrating insurance coverage also could reduce the need to determine work causality[2] for many of the less-severe work-related injuries. As long as workers' compensation and group health insurance are separate, determination of work causality would be required to determine whether workers' compensation or group health insurance should pay the medical care claims.

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[2] *Work causality* refers to injury or illness caused by workplace factors and therefore is subject to workers' compensation provisions.

**How feasible would it be to implement a 24-hour care system across California within the current employer-based health insurance environment in which employers can offer multiple health plan options?**

Our assessment reveals a dilemma: A more fully integrated 24-hour care system offers greater potential for health benefits and cost savings than the current insurance system/insurance environment, but at the same time, it would be less feasible to implement than the proposed changes to the workers' compensation system. The federal Employee Retirement Income Security Act (ERISA) creates this dilemma because it limits the range of 24-hour care designs that are legally permissible in an employer-based health insurance environment. Although we did not perform a formal legal analysis, our review of ERISA suggests that the only 24-hour care options that would be feasible under ERISA are a model that integrates medical care services only (see Box A in Figure S.1) and a model voluntarily implemented by employers that integrates both medical care services and health insurance (see Boxes A and B in Figure S.1).

In addition, our analysis revealed that employers and insurers face operational barriers that would influence their willingness to participate in a voluntary program, such as the time and costs required for employers to negotiate consolidation of coverage with multiple health plans and insurers.

**How would the feasibility of implementing 24-hour care change if it were introduced in other group health insurance environments?**

To answer this question, we considered two alternative health insurance environments: the Pay or Play system enacted in California SB 2 that expanded employer-based health insurance to smaller employers, and a statewide universal health insurance program.

The Pay or Play system of SB 2 gives small employers the option to introduce group health insurance coverage, which would increase the number of workers who have health insurance. Therefore, a 24-hour care program implemented within the Pay or Play system could cover a larger number of workers than the number it would cover under the current system. Because small employers are likely to offer only a single health care plan, they might be able to implement 24-hour care more easily than larger employers because they would have to convert only one group health plan to the 24-hour integrated model. However, small employers may be the least willing or able to incur the implementation costs of 24-hour care, even if those costs are less than those for large employers.

A 24-hour care system would be much more feasible under universal health insurance than under any employer-based health insurance system because the ERISA constraints would not apply. Universal health insurance also would eliminate some implementation issues because all workers would be covered by the same health insurance program. Therefore, many insurance issues that apply to 24-hour care would

be reduced or eliminated within a universal insurance system because workers would continue to have the same health insurance coverage even when they change jobs.

## Recommendations Regarding 24-Hour Care in California

Given the implications of ERISA in the current employer-based health insurance environment, as well as substantial conflicting factors that would affect the design and execution of a 24-hour care program, we believe that it is premature for the state of California to embark on statewide introduction of 24-hour care. First, the alternative approaches to designing a program that effectively addresses the numerous legal and operational issues surrounding 24-hour care, which are identified in this report, should be tested. This testing can best be done by interested employers and insurers who would work in cooperation with the relevant state agencies to develop small-scale 24-hour care pilot programs.

**Recommendation**: The state should establish the following guidelines that support the voluntary development of small-scale 24-hour care pilots by employers and insurers:

- Undertake pilots that can test both the 24-hour care model that integrates medical care services only and models that integrate both medical services and health insurance.
- Include the requirement that an evaluation is to be performed as an integral part of every pilot program.
- Allow pilots to operate for at least five years before making final judgments on the feasibility and scalability of 24-hour care, which also would allow sufficient time for learning by experience and for adjusting program design as needed.

**Recommendation:** The implementation of any carve-out 24-hour care pilot program should be accompanied by a high-quality evaluation capable of generating actionable recommendations on program design and program scale-up. In particular, we recommend that any evaluation plan be designed to

- guide in the selection of sites that are likely to yield data that can be generalized across programs to assess both program quality and a program's potential for scale-up and transportability to other sites
- provide detailed information about implementation
- provide valid information about the program's impact on a range of outcome indicators.

## Suggestions for Initiating 24-Hour Care Pilot Programs

To ensure that the pilot programs will yield rich information on various approaches to 24-hour care, we encourage the state of California to establish a process that encourages participation by employers, unions, and insurers in the pilot programs and that supports creative approaches to designing those programs. To ensure that workers' rights and welfare are protected, the state should establish a set of performance goals for the pilots with respect to getting injured workers the treatment they need and informing them of their rights and options during the treatment process. The processing of proposals for pilots would be handled by the state, as described in the Carve-Out Manual prepared by CHSWC (2004). Other details of the pilot design should be driven by the participating stakeholders so that the pilots are most appropriate to stakeholders' specific needs and preferences.

The following criteria should be used to identify employers for possible participation in pilots. Desirable candidates would be employers that

- are government entities (not subject to ERISA rules)
- are self-insured for both group health and workers' compensation insurance or obtain both types of insurance coverage from the same insurance company
- offer group health insurance for all their full-time employees
- structure their group health insurance so that definable populations of workers (e.g., workers in one union) are served by one health plan
- have sufficient rates of work-related injuries or illnesses among their workers to ensure that there will be observable use of health benefits for work-related events during the pilot.

Selection of pilot candidates also should provide for variation in employer characteristics with respect to the probability of achieving a successful pilot and variation in the type of job functions, work environment, and injury risk for the employee groups involved. Variation in these characteristics would yield useful information for evaluating the pilot programs.

The state should assume that it would need to take the initiative in identifying candidate employers and approaching them to request their participation in a pilot. The recruitment process would also serve to build working relationships with employers and permit the state to obtain employers' views on how a 24-hour care pilot might be designed. It would be useful for the state to establish an advisory task force composed of employer, union, and insurer representatives to help guide the preparatory work and to provide feedback on issues as they arise. The individuals selected for this task force should be respected leaders in their stakeholder groups and should support testing of 24-hour care.

After an employer is committed to participating in a 24-hour care pilot, the next step of negotiating the design of the pilot are in the hands of the employer, the union(s) represented at the employer's workplace, and, if the employer is not self-insured, the insurers underwriting the employer's group health and workers' compensation insurance. The state should provide technical support for these negotiations to ensure that they comply with any state requirements and to help the parties involved to succeed in designing a workable program plan.

## Stakeholder Issues to Be Addressed in Pilot Programs

As the design stage of the pilot progresses, the participants in the design negotiations must address the issues and concerns of each 24-hour care stakeholder group. Success in establishing a program plan and operating an effective pilot will depend to a large extent on how well the stakeholders' concerns are managed in the design and implementation process. The following are some key issues regarding 24-hour care plans that we identified in our discussions with members of stakeholder groups.

### Issues for Employers (Public and Private)

- Many employers offer their employees multiple health plan options, and those employers will have to determine which of those plans are candidates for becoming 24-hour care plan(s).
- Employers will need to decide which employee group(s) should be the population served by a 24-hour-care plan.
- The terms of the written contract for a 24-hour-care plan will have to be drafted carefully to ensure that all the intended functions of the plan are specified and fulfilled by the insurer and provider network.
- Many employers will have to adjust their departmental functions to manage any 24-hour care plan that is established because their workers' compensation and group health benefits currently are managed by separate departments.

### Issues for Employees

- Employees want to have access to initial care as soon as possible after an event occurs (work-related or not), which is a feature that an effective 24-hour-care plan should be able to provide.
- An effective 24-hour-care plan would be expected to reduce employees' access to some follow-up treatments as part of reducing overuse of services. This expectation would run counter to employees' desire for easy access to follow-up treatments and ready approval of services they believe are medically necessary.

- Employees probably would respond negatively to the introduction of cost sharing for work-related health care services, because it would increase their out-of-pocket costs.

### Issues for Insurers

- Insurers may be reluctant to participate in a plan that integrates medical care services only, because the plan would require them to coordinate insurance products and provider networks with another insurer.
- The primary concern of insurers regarding a plan that integrates both medical services and insurance will be how to handle the underwriting of risk for the "tail" of employer liability for medical care for work-related injuries.[3]

### Issues for State Regulators

- The introduction of 24-hour care, even as a pilot, will require the relevant state agencies to establish an infrastructure and regulations to guide the pilot. Such an infrastructure probably would require staff from multiple agencies to work together because the 24-hour care model cuts across workers' compensation and group health authorities.
- For the 24-hour care model that integrates services and insurance, the separate state regulatory functions in various departments will need to be combined into one authority or otherwise coordinated closely to ensure consistent guidance is provided to the people in the field trying to work with the new model.

## Recommendations for Workers' Compensation

Several issues and concepts directly related to the existing workers' compensation system emerged from our assessment of options for 24-hour-care programs. Addressing these issues would strengthen the existing system and also would better position the state to implement 24-hour-care pilot programs. We offer the following recommendations for actions by the state to address these issues:

- The requirement for separate medical and fiscal decisionmaking that currently applies to both workers' compensation and group health managed-care plans should be adopted for the new provider networks specified by California SB 899.

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[3] The tail of liability refers to liability for covering future health care for a work-related injury covered by workers' compensation insurance but not covered under a group health insurance model that covers only claims made during the policy year.

- Reforms should be undertaken to address the problems and inefficiencies in the workers' compensation appeals process, with the goal of reducing delays in processing disputes and improving the evidence base for making determinations on the appeals.
- The state should consider adding Independent Medical Review (IMR) to the workers' compensation appeals process to provide a mechanism for review of medical care grievances that precedes taking the appeal to the Workers' Compensation Appeals Board (WCAB).

## Summary

Despite continuing interest by California policymakers in 24-hour care as a possible solution to escalating workers' compensation costs, designing and implementing a viable and effective 24-hour care program presents some formidable challenges. Past experience shows that many states failed to get 24-hour-care pilots started, and other states that achieved operating pilots had limited success in achieving cost savings or improvements in care. ERISA is an obvious barrier that affected some of these past efforts, but if our analysis is correct, some 24-hour care models can be developed that would be less affected by ERISA than others. We encourage policymakers to use small-scale pilots to test 24-hour-care models and to move forward carefully as they do so, placing an emphasis on effective design, implementation, and evaluation of the models being tested.

# Acknowledgments

We gratefully acknowledge the participation of numerous people in the focus groups we conducted with various stakeholders involved in or affected by workers' compensation issues. Their willingness to participate and thoughtful participation in the group discussions offered insights into issues related to 24-hour care and their concerns regarding its introduction in California. The information obtained from these discussions was a critical component of our assessment of implementation issues, which we present in this report.

Our project officer, Christine Baker, was instrumental in setting the direction for our study and providing feedback throughout the analytic process. Similarly, through his collaborative involvement in this assessment, Frank Neuhauser enriched the work by participating in the focus group discussions, providing the results of analyses he had performed on 24-hour care and related issues, and discussing issues and options for 24-hour care programs. We offer our thanks to David Studdert and our RAND colleague Barbara Wynn for their thoughtful and constructive review of an earlier version of this report, and to Jolene Galegher for her contributions to strengthening the report's discussions. Any errors of fact or interpretation are, of course, the responsibility of the authors.

## Acronyms and Abbreviations

| | |
|---|---|
| AB | Assembly Bill |
| A.L.R. Fed | American Law Reports, Federal |
| ACOEM | American College of Occupational and Environmental Medicine |
| Cal. App. 3d | California Appeals Court Reports, third series |
| Cal. Bus. & Prof. | California Business and Professions (Code) |
| Cal. Code of Regs. | California Code of Regulations |
| Cal. Welf. & Inst. | California Welfare and Institutions (Code) |
| CFR | Code of Federal Regulations |
| CHSWC | Commission on Health and Safety and Workers' Compensation (California) |
| DCBS | Department of Consumer and Business Services (Oregon) |
| DIR | Department of Industrial Relations (California) |
| DMHC | Department of Managed Health Care |
| EBP | employee benefit plan |
| ERISA | Employee Retirement Income Security Act of 1974 |
| F.2d | Federal Reporter, second series |
| HCO | health care organization |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| IMR | independent medical review |
| IPA | Independent Practice Associations |
| KOJ | Kaiser on the Job |

| | |
|---|---|
| LC | Labor Code |
| MCP | Managed Care Pilot (program) |
| P.2d | Pacific Reporter, second series |
| Pub. L. | Public Law |
| SB | Senate Bill |
| S.Ct. | Supreme Court Reporter |
| Stat. | Statutes at Large |
| Tit. | Title |
| TPA | third-party administrator |
| U.S. | United States Reports |
| U.S.C. | U.S. Code |
| WCAB | Workers' Compensation Appeals Board |
| WCIRB | Workers' Compensation Insurance Review Board |
| WCRI | Workers' Compensation Research Institute |

CHAPTER ONE

# Introduction

In October 2003, California State Senator Richard Alarcón formally requested that the Commission on Health and Safety and Workers' Compensation (CHSWC) perform an in-depth study of *24-hour care,* a heath-care benefits model that would integrate work-related health care benefits and traditional group-health benefits. With a 24-hour care plan, health care benefits and, possibly, disability benefits for both work-related and non-work-related claims are consolidated.[1] Senator Alarcón noted several recent state legislative enactments designed to expand workers' access to employer-sponsored health benefits and to reform the workers' compensation system to reduce costs.[2] He concluded that a possible next step in reforming workers' compensation benefits might involve creating a 24-hour care program.

The senator observed that proponents of 24-hour care believe that a health care system that combines health care coverage for work-related injuries or illnesses and coverage for other health care needs could yield substantial savings. At the same time, he noted that such a system might also raise concerns about the quality of health care delivered to workers. Based on these considerations, Senator Alarcón directed that CHSWC examine the following areas relating to the design and implementation of 24-hour care:

- distinctions between the current level of care provided in managed care versus the level of care provided in the workers' compensation arena
- the difference between the legal "cure and relieve" standard in workers' compensation and the "medical necessity" standard in managed care

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[1] The name "24-hour care" derives from the premise that a single health benefit mechanism can be designed to cover health care needs regardless of when they occur during the day, either at work or at home.

[2] These legislative enactments include California Senate Bill (SB) 228, which enacted managed care and other reforms in the workers' compensation system, and California SB 2, which expanded employer-based health insurance for employees of small firms.

- implementation challenges for 24-hour care, both inside and outside the framework of a universal health care initiative, including
  - problems associated with portability of health benefits for work-related injuries following termination of employment
  - issues surrounding health care copayments for workers
  - issues regarding provider payment
  - restrictions on litigation about benefits coverage in current managed care and workers' compensation settings.
- a review of the evidence on existing 24-hour programs within "carve-out"[3] settings and on any other such programs based in California or elsewhere.

In December 2003, CHSWC contracted with the RAND Institute for Civil Justice to conduct a study of 24-hour care to address these issues. This report is the product of that study. In this report, we assess the value of 24-hour care as a mechanism for reducing workers' compensation costs while maintaining or improving the quality of care. This report is intended to help California policymakers decide whether to adopt 24-hour care, and if so, in what form. It also seeks to clarify some of the key legal and organizational challenges for 24-hour care and to identify ways in which those challenges might be surmounted.

## Background on 24-Hour Care

The California workers' compensation system provides insurance coverage for both medical care and (partial) wage replacement for work-related injuries or other health conditions, as well as disability benefits for workers with injuries that prevent them from returning to work for extended periods. This system operates completely separate from both traditional health care insurance under which employees and their families obtain coverage for their personal health care needs and from other disability insurance plans.

The workers' compensation system is governed by state statutes, under which the state government has established rules and procedures regarding insurance coverage for benefits. When a worker has a work-related injury or illness, the employer refers the worker to a workers' compensation physician for treatment. After 30 days, injured workers can switch to a treating physician of their choice. State statutes also created a specialized administrative judicial system in which the Workers' Compensation Appeals Board (WCAB) has exclusive jurisdiction in resolving claims and disputes related to workers' compensation benefits.

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[3] As described further in Chapter Seven, a "carve-out" is a negotiated agreement between unions and employers that essentially replaces the workers' compensation system.

A 24-hour care program might be designed and implemented in various ways. At one extreme, 24-hour care could be defined as a program for coordinating health care providers and services while maintaining separate insurance coverage for work-related and other health care services. Under this model, 24-hour care could operate without requiring many changes in legislative or regulatory guidelines or in government oversight for workers' compensation and group health care.

At the other extreme, 24-hour care could involve merging traditional health care and workers' compensation plans into integrated insurance products. This model would require combining regulatory guidelines and oversight into a single, unified framework, which would, in turn, involve substantial changes in existing workers' compensation mechanisms for health insurance, the determination of whether illnesses or injuries are work-related, delivery of health care services, and dispute resolution. Many of these changes would require extensive revisions in current laws governing workers' compensation and group health care.

An integrated 24-hour care benefits program offers a number of potential advantages over the current workers' compensation system, including greater efficiency in the administration of claims, care management to reduce the overuse of workers' compensation-based health services, and more effective containment of related costs.[4] However, given the variety of forms that 24-hour care might take and the limited availability of empirical evidence from previous pilot programs, whether such programs do in fact offer these benefits is as yet largely a matter of speculation.

As is well known among program evaluators, the proof of any new concept depends on how well its design becomes reality during implementation. Any 24-hour care program that integrates workers' compensation and group health insurance benefits would have to be well organized and operated effectively to achieve its purported benefits. Even though 24-hour care might help to solve existing problems with health coverage under the current workers' compensation system, it would introduce its own set of operational and regulatory challenges. In particular, the process of aligning two very different insurance designs involves an array of challenges, which we examine later in this report.

Some versions of 24-hour care could face significant implementation barriers in the form of current laws and regulations, organizational challenges, and insurance issues. Moreover, some plan features that likely would be included in any 24-hour care model, such as evidence-based medical practices, utilization management, employee cost-sharing for workers' compensation health services, or improved dispute resolution mechanisms, are not inherently tied to 24-hour care. These features might be introduced just as readily in the existing workers' compensation system, and many

[4] See, for example, the discussion in Baker and Kreuger (1993).

of them already have been included in recent workers' compensation reform legislation (California SB 899).

## Research Questions

In the analysis that follows, we endeavor to systematically address the issues presented in the previous section. We describe their logical implications and summarize relevant findings from other studies whenever possible. Although it is impractical to address every possible variant of 24-hour care, we hope that our analysis will help policymakers to understand the trade-offs involved in the various 24-hour care models.

In recognizing the complexity of issues involved in assessing 24-hour care, we designed the following five research questions to guide the decisionmaking process. Our findings from this study are framed in the form of answers to these questions:

1. What are the problems with the current workers' compensation system that have motivated stakeholders to consider 24-hour care as an option to improve the system?
2. What evidence is there that 24-hour care can address these problems effectively, and how would it need to be designed to do so?
3. What does 24-hour care offer that would make managing health care and costs in this way more effective, compared with reforms now being made (or that could be made) to the existing workers' compensation system?
4. How feasible would it be to implement a 24-hour care system across California within the current employer-based health insurance environment in which employers can offer multiple health plan options?
5. How would the feasibility of implementing 24-hour care change if it were introduced in other group health insurance environments?

## Study Methods and Activities

Evaluations of policy options must consider not only the range of possible designs for a proposed program but also how the designs are likely to operate in particular contexts. The prospects for 24-hour care, for instance, must be assessed within the context of a number of legal requirements that influence whether workers' compensation and group health insurance can be successfully integrated. Policies regarding 24-hour care must also be evaluated in terms of how realistic policymakers' assumptions are about the behavior of those who will implement 24-hour care plans and be affected by them. Indeed, the designs of most policy benefits are influenced by both their target populations and implementers (Whitaker, 1979; Schneider and Ingram, 1997).

In conducting this study, we collected information from various sources. At the outset, we reviewed existing and pending legislation, published papers, and other documentation on 24-hour care systems and relevant program components. We complemented this work by discussing these issues directly with individuals possessing real-world experience with 24-hour care programs, and with workers' compensation and health care coverage programs more generally, to obtain further details on system design and lessons learned from implementation of these programs.

As a second study activity, we researched a series of legal issues that pose obstacles for 24-hour care in California. We began with a review of relevant laws and regulations followed by a search for secondary analyses and cases in the published law literature, which was supplemented by consultation with CHSWC legal counsel. We focused our attention on legal issues that we identified early in the study as being of the greatest importance in the implementation of 24-hour care, and we balanced depth of analysis with the desire to address a broad base of issues.

To ensure that we understood the implications of 24-hour care for stakeholders who would be participants in such a program, we conducted eight focus groups with representatives from the key stakeholder groups: public employers, private employers (two groups), labor unions, workers' compensation health care providers, workers' compensation insurers, state regulators, and workers' compensation claimant attorneys.

Through these focus groups, we sought to learn stakeholders' views about the potential value of 24-hour care, the issues of most concern to them, and the incentives that would motivate them to accept and participate in a 24-hour care system. The information generated from the focus groups guided our consideration of the feasibility of 24-hour care in general and identified potential barriers to its successful implementation.

After integrating the information obtained from these various sources, we devised several models for 24-hour care in California, based on a series of alternative assumptions about the health insurance environment within which they might exist. Our models include versions of 24-hour care as they might be designed within the follow environments: (1) within the context of the current employer-based health insurance system; (2) within the employer-based "Pay or Play"[5] health insurance framework established by California Senate Bill (SB) 2; (3) within a universal health coverage scheme (e.g., such as proposed in SB 921); and (4) within a "carve-out"[6] from traditional workers' compensation rules in which interested parties implement the 24-hour care model on a more limited scale. Each of our models defines the key

[5] With Pay or Play, employers either offer health insurance coverage to their employees or pay a tax for the cost of coverage provided by the state.

[6] A carve-out is a negotiated agreement between unions and employers that essentially replaces workers' compensation. See Chapter Seven for more details.

elements of a complete 24-hour care system and reflects lessons learned from our research about relevant legal, insurance, operational, and data issues.

As another component of our model-building effort, we assessed the implications of each model for stakeholder behavior in an effort to anticipate stakeholders' responses to changes in the current group health and workers' compensation systems. We considered the possible effects of stakeholders' responses on health care quality and on costs associated with the delivery of services under a 24-hour care model.

## Organization of This Report

In Chapter Two, we identify problems with the current workers' compensation system that might be mitigated by introducing a 24-hour care system. In Chapter Three, we describe alternative designs for 24-hour care programs and discuss the potential for 24-hour care to address cost and performance issues with the current workers' compensation system. In Chapter Four, we summarize the results and implications of previous evaluations of 24-hour care programs. Chapter Five examines the legal barriers to 24-hour care in California and their implications for program design and implementation. In Chapter Six, we discuss the operational issues involved in establishing and implementing a 24-hour care benefit in California within the framework of the existing group health benefits system. We also discuss the likely effects on health care quality and the costs of 24-hour care, and we delineate implications for policymakers to consider in their analyses of such programs. Chapter Seven presents our assessment of the likely performance of 24-hour care if it is implemented in the context of alternative group health benefits. Finally, in Chapter Eight, we synthesize our findings and recommendations. We recommend a strategy for 24-hour care that we believe would be most feasible given the legal constraints and current status of the California workers' compensation system. We also suggest a set of key factors that must be addressed for successful implementation of a 24-hour care model, and we present a suggested design for evaluation, which we recommend be made a part of any attempt to test or implement 24-hour care models.

CHAPTER TWO

# Medical Treatment and Workers' Compensation in California

For the past several years, the California workers' compensation system has been the subject of enormous controversy. The main source of this controversy has been the cost of the system. Table 2.1 compares Oregon Department of Consumer and Business Services (DCBS) estimates of premium rates in California with premium rates of other states from 1996–2002. In 1996, insured employers in California paid $4.11 per $100 of payroll in workers' compensation insurance premiums, just 16 percent higher than the median (ranking 13th overall). By 2002, the premiums had risen to $5.23 per $100 of payroll, the highest in the nation and 121 percent higher than the median rate.[1]

Even though costs are so high, few feel that the California workers' compensation system adequately meets the needs of employers or injured workers. Historically,

**Table 2.1**
**California Workers' Compensation Premium Rates Compared with the Median Rate of Other States, Weighted by Oregon Industrial Mix, 1996–2002**

| Year | California Premium Rate ($) | Median Premium Rate ($) | Percentage Difference | California National Ranking |
|---|---|---|---|---|
| 1996 | 4.11 | 3.54 | 16 | 13 |
| 1998 | 4.86 | 2.69 | 81 | 1 |
| 2000 | 3.34 | 2.26 | 48 | 3 |
| 2002 | 5.23 | 2.37 | 121 | 1 |

SOURCE: Ferrin-Myers (1996, 1999), Drost (2000), and Reinke and Manley (2003).

NOTE: Premium rates represent premium dollars per $100 of payroll. Rates are weighted to represent the Oregon industrial mix. National rankings include the 50 states and the District of Columbia. The median premium rate is the estimated rate for the 26th-ranked state. For more information see Ferrin-Myers (1996, 1999), Drost (2000), and Reinke and Manley (2003).

[1] The cost per $100 of payroll overstates the cost by a substantial amount (about 20 percent) because the payroll estimate excludes any additional costs over the base rate, such as overtime, shift differentials, bonuses, and other factors.

workers' compensation in California has faced far more disputes and much more litigation than other workers' comp programs on average across the country (Berkowitz and Burton, 1987). The California workers' compensation courts are unable to handle their huge caseloads or to resolve disputes in a timely manner, leading to long delays and drawn-out cases that increase the length of time before injured workers are compensated (Pace et al., 2003). And even though California's benefits for permanent partial disability are relatively generous compared with those of other states, permanently disabled workers in California often face substantial uncompensated losses in long-term earnings (Peterson, et al., 1998; Reville, et al., 2001; and Biddle, Boden, and Reville, forthcoming). All of these facts are troubling given that the goal of the workers' compensation system is to provide adequate benefits to workers in a timely and efficient manner, while minimizing disputes.

The list of factors that contribute to the high cost and inefficiency of the California system is long. Pace et al. (2003) argued that many problems in the workers' compensation court system in California stem from understaffing, lack of training for new judges, and inconsistent standards for legal procedures throughout the state. The California permanent disability rating schedule is often claimed to be a source of dispute and a cost driver, because the use of subjective factors in disability evaluation allows substantially more workers to be classified as disabled than would be the case if decisions were guided by more tightly defined and objective factors (Berkowitz and Burton, 1987). Another common complaint is that the system encourages fraud, or, at least, that it does not do enough to deter it. All of these issues have been targeted in some kind of reform effort in recent years.

Our report, however, focuses on another potential cost driver for workers' compensation in California: the growth in expenditures on medical care in workers' compensation cases and issues regarding appropriateness of care. Specifically, we examine the ways in which 24-hour care might lower the costs, and the growth in costs, of treating injuries and illnesses in the workers' compensation system. In the remainder of this chapter, we describe recent trends in medical expenditures for workers' compensation in California and discuss why medical expenditures are so high. We then review some recent reform efforts intended to slow the growth in medical costs.

## Why Is Medical Care for Work-Related Injuries So Expensive?

Expenditures for medical care have been the single fastest-growing component of workers' compensation costs in California, rising from $2.6 billion in 1995 to $5.3 billion in 2002 (CHSWC, 2003b). California has been outpacing the national average in this regard, with the total medical benefits per 100,000 workers moving from 114.2 percent of the national average in 1996 to 169.2 percent in 1999. This

increase raised California from 14th to fourth nationally in medical expenditures for workers' compensation in just three years (Blum and Burton, 2003).

Concern over rising medical costs is not unique to the California workers' compensation system. For the past 20 years, the cost of health care has consistently risen above the rate of inflation, drawing much attention from policymakers and researchers. However, the evidence suggests that treatment for injuries covered by workers' compensation is considerably more expensive than treatment for injuries covered outside the workers' compensation system, particularly in California.

Zaidman (1990), Baker and Krueger (1995), Durbin et al. (1996), and Johnson et al. (1996) all showed that injuries covered by workers' compensation typically result in significantly higher medical expenditures than similar injuries covered by group health insurance plans. The size of the cost differential varies according to a number of factors, most notably the type of injury or illness. In general, these studies suggest that the cost of treating injuries under workers' compensation is about twice as high as treating the same injuries under a group health plan. Neuhauser (2003) argues that this differential is likely conservative for the case of California, particularly in recent years. While it is generally accepted that medical expenditures are higher under workers' compensation than under group health plans, there is less agreement on the drivers behind those expenditure differences. The studies discussed above hold the observable severity of injuries constant, leaving only two potential culprits to explain higher expenditures: higher prices or greater utilization of services for a given injury.

Differences in price can arise from different fee schedules for services in the two systems or from differences in utilization rates, which may, in turn, arise from the application of different utilization review standards and the lack of cost-sharing mechanisms (such as copays and deductibles). The studies by Zaidman (1990) and Baker and Krueger (1995) focused on data from Minnesota and found that the expenditure difference was solely due to differences in pricing. In a later study, however, Durbin et al. (1996) reanalyzed the Minnesota data using a more comprehensive data set and found that most of the differential was due to utilization. A multistate study by Johnson et al. (1996) suggests that the relative influence of price and utilization on costs is linked to state policy. Specifically, price is a more important driver of cost differentials in states that have generous fee schedules, while utilization is a more important cost-differential driver in states whose standards of coverage are less clear.

It seems likely that, at least in recent years, California has suffered from both overutilization and overpricing in workers' compensation medical care. Utilization of services definitely appears to be higher in California than elsewhere. In a comparison of utilization rates in California to those in 12 other states, the Workers' Compensation Research Institute (WCRI) (Eccleston et al., 2002) found that workers' compensation claims have an average of 49 percent more physician visits per claim than the

12-state median. The California physician fee schedule, on the other hand, is one of the lowest in the nation. Neuhauser (2003) attempted to decompose the California differential into price and quantity effects, and found that roughly 20 percent of the differential is attributable to price and 80 percent to utilization.

## Recent Reform Efforts

A number of recent reform efforts have been dedicated to reducing the costs of workers' compensation in California. One recent reform, SB 228, introduced extensive modifications to the workers' compensation system that were aimed at reducing the cost of medical treatment. Enacted in October 2003, SB 228 contained, among other things, provisions designed to lower both the price and utilization of medical care. Another major reform bill passed in 2003 was California Assembly Bill (AB) 227, which, among other things, increased the penalties for fraud, required CHSWC to examine the feasibility of the reinstitution of insurance-rate regulation, and repealed vocational rehabilitation benefits. In April 2004, SB 899 was passed, bringing more sweeping reforms to the California workers' compensation system.

Two central components of SB 228 addressed the utilization of care. The first was a provision requiring the CHSWC to survey existing medical utilization standards and recommend a set of utilization schedules. SB 228 deemed that the American College of Occupational and Environmental Medicine (ACOEM) *Occupational Medical Practice Guidelines* would be used as being presumptively correct until CHSWC recommended a new schedule. The purpose of a utilization schedule is to provide the courts with a method of evaluating the appropriateness of a given treatment plan for a given injury, thereby discouraging inappropriate or extraneous treatment.

The second key part of SB 228 that addressed utilization set a cap on chiropractic and physical therapy visits. Data from the WCRI (2002) showed that the average number of physical therapy visits stemming from a workers' comp claim in California was 39 percent higher than the average number of visits for a comparison group of 12 states (17.0 compared with 12.2), whereas the average number of chiropractic visits stemming from a workers' comp claim was 105 percent higher in California (34.1 compared with 16.6). Thus, reducing the apparent overuse of these services was seen as an important cost-containment measure. Toward this end, SB 228 capped the number of chiropractic and physical therapy visits at 24 visits for the life of the claim, unless the insurance company specifically authorizes additional visits, for injuries occurring on or after January 1, 2004.

SB 228 contained two other key components aimed at reducing the price paid for medical treatment in workers' compensation claims. The first provision reinforced previous legislation (AB 749) requiring greater use of generic drugs when such

drugs are available. Generic drugs are generally much cheaper than their brand-name counterparts, so increasing the use of generics could substantially reduce treatment costs. The second provision required that the fee schedules used to pay providers for treatment services in workers' compensation claims be updated. The fee schedule that determines reimbursement for inpatient hospital care had been set at 120 percent of the Medicare rate, but had not been updated since it was established. In addition, a new fee schedule was established for hospital outpatient and ambulatory surgery center services, with fees set at 120 percent of the Medicare hospital outpatient department fee, and reimbursement for pharmaceuticals was set at 100 percent of the Medi-Cal schedule. All of these changes, except the updates to the hospital inpatient fee schedule, represented substantial reductions from the previous fee schedules.

While it is impossible to determine at this point what the long-term impact of SB 228 and AB 227 will be, these bills introduced substantial reform measures and have the potential to significantly reduce the growth of workers' compensation costs in California. The Workers' Compensation Insurance Review Board (WCIRB) estimated $17.9 billion for the statewide cost of workers' compensation benefits for 2004, down $7 billion from previous estimates. The WCIRB attributed $4 billion of the decline to the impact of SB 228 and AB 227, $2 billion to changes in the estimated size of the self-insured market, and $1 billion to changes in estimates of benefits growth trends for workers and claims (Workers' Compensation Insurance Review Board, 2004).

Despite the significant changes brought about by SB 228 and AB 227, the consensus among policymakers was that further reform was needed. In April 2004, the state legislature passed SB 899, another sweeping reform bill that included major overhauls to many aspects of the system. Much of SB 899 focuses on elements of the workers' compensation system other than medical care, in particular permanent disability. However, the bill does include some important provisions regarding the medical care of injured workers in California.

The most noteworthy provisions in SB 899 with respect to health care are the restrictions placed on the physicians to whom injured workers may have access.[2] Specifically, the bill allows employers or insurers to "establish or modify a medical provider network for the provision of medical treatment to injured employees" (Labor Code [LC] 4616 (a) (1)). Injured workers then must select a physician in the employer network from whom to obtain treatment. The administrative director of the California Department of Industrial Relations (DIR) must approve all networks.

The statute requires the DIR administrative director to "encourage the integration of occupational and nonoccupational providers," stating a goal that 25 percent

[2] Note that in addition to changes in physician access, SB 899 also refined the provisions with respect to utilization schedules and added an additional cap on "occupational therapy" visits at 24. In general, these changes may be seen as clean-up legislation for SB 228; they are not as sweeping as the provisions regarding network providers.

of physicians in a provider network should be primarily engaged in the treatment of nonoccupational injuries (LC 4616 (a) (1)). These provisions have the potential to achieve substantial integration between occupational and nonoccupational care. If such integration does occur, there will be less need for a 24-hour care option to achieve service integration.

SB 899 also places a high priority on enabling a worker to get care quickly. Although the employer's liability is limited to $10,000, the employer is required to authorize care within one day after a worker files a claim form. The bill also creates an incentive for prompt payment by the employer by imposing a 25 percent penalty on delayed payments, up to $10,000.

Nevertheless, a great deal of interest remains in a 24-hour care program that would integrate workers' compensation medical care with the care provided by group health insurance. Supporters see 24-hour care as a mechanism that can enhance efforts to reduce workers' compensation health care costs. We now turn our attention to 24-hour care itself, and discuss the potential benefits, costs, and challenges of its implementation.

CHAPTER THREE

# 24-Hour Care Models and Mechanisms

One of the challenges in discussing 24-hour care is defining exactly what such a program would entail, and California has a history of varying definitions of 24-hour care. In the early 1990s, some universal health care plans, including one proposed by California Insurance Commissioner John Garamendi, called for the three-way integration of health insurance with insurance for medical treatment for workers' compensation and insurance for medical treatment for automobile injuries (Baker and Krueger, 1993). In fact, the idea of this kind of program led to the term "24-hour care" (or "24-hour coverage") because, in principle, individuals would be covered for medical care by the same plan 24 hours a day. Over time, proponents of 24-hour care have focused more on workers' compensation and less on automobile insurance. In addition, 24-hour care plans are often proposed outside of the realm of universal health insurance. The term *24-hour care* now is applied generally to almost any form of integration of workers' compensation benefits with nonoccupational health or disability benefits (Burton, 1997).

In this chapter, we present an overview of the possible options for the design of 24-hour care, and we review the potential benefits that are expected to arise from designs with various features. The chapter focuses on providing a factual framework for the evaluation of alternative models of 24-hour care by defining the dimensions of 24-hour care and how the models vary according to those dimensions. This information provides a point of departure for the analyses of legal issues in Chapter Five and operational issues in Chapter Six.

## Options for the Design of 24-Hour Care

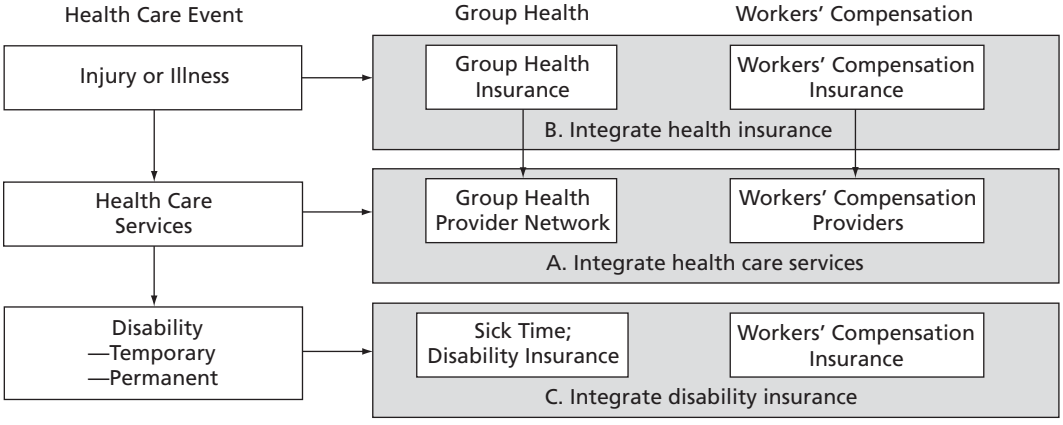
Although there appear to be numerous specific design options for 24-hour care, they can quickly be reduced to just a few basic prototypes, the design details of which may vary widely. As shown in Figure 3.1, the differences in designs derive from whether the medical services or insurance coverage are fully integrated for occupational and nonoccupational injuries or disabilities.

The boxes on the left side of Figure 3.1 show the generic process through which an individual experiences an injury or illness, obtains care for the health problem, and, potentially, experiences some temporary or permanent disability as a result of the health problem. The boxes on the right side of the figure represent the type of insurance coverage that underwrites the risk of health care or disability and the providers who deliver the health care services. As shown, both insurance coverage and health care services are separate for work-related or nonoccupational injuries or illnesses.

The shading around the boxes on the right represents options for integration of these separate benefit components for the two types of injuries or illnesses (those covered by group health or workers' comp). By *integration,* we mean the formal organization of services or insurance, such that individuals are served within a unified system. Box A represents integration of health care services, such that an individual would receive all medical care from the same set of providers, e.g., through a provider network designated by an employer. Box B represents the integration of insurance for health care benefits, and Box C represents similar integration of insurance for disability benefits.

The 24-hour care options we considered differ in the extent to which they integrate these components. The least-integrated package would integrate only the medical care services (Box A), the next level would integrate medical services and health insurance benefits (Boxes A and B), and the highest level would integrate medical services and both health and disability benefits (Boxes A, B, and C).

**Figure 3.1**
**Comparison of Integration Options Under 24-Hour Care**

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NOTE: We placed Box B above Box A because workers first must have insurance before filing a claim and receiving care following an injury.

## Potential Benefits of 24-Hour Care

Generally, 24-hour care has been considered as a method to cut the costs of workers' compensation. Thus, when we assess the potential benefits of 24-hour care, most of the discussion will be focused on reviewing some of the savings that might be derived from such programs. However, 24-hour care may also improve the quality of care received by injured workers and reduce disputes between injured workers and their employers; thus, we also discuss these possibilities.[1] However, because there have been only limited attempts nationally to actually install a 24-hour care program, the empirical evidence regarding its actual effectiveness is weak. Nonetheless, in the next chapter we discuss past experiences with 24-hour care and the evidence, such as it is, on the effectiveness of 24-hour care.

Many who have argued for a 24-hour care model in California see it as a way to extend the standards of coverage and management practices used in group health insurance into treatment of work-related injuries. While we agree there is merit to this argument, our approach to this assessment has been, first, to identify the problems that exist in workers' compensation health care and, second, to examine how an integrated system might reduce or eliminate those problems and which standards or practices the system needs to adopt to achieve these ends.

### Potential Cost Savings

Generally speaking, the potential cost savings from 24-hour care can be divided into two types: administrative cost savings and medical cost savings. We discuss each of these in turn.

**Administrative Cost Savings.** Under the current system of workers' compensation, employers who offer group health insurance are essentially forced to provide two separate insurance systems for their injured workers. Group health insurance provides coverage for medical costs due to nonoccupational illnesses or injuries, while workers' compensation insurance provides coverage for both medical care and (partial) wage replacement for work-related injuries or other health conditions. The administrative burden of both systems can be large. Each insurance system has numerous filing requirements for patients and health professionals in order to obtain compensation, and these requirements are particularly burdensome under workers' compensation. Moreover, the employer, the insurance company, or the employer's third-party administrator (TPA) must maintain and review this paperwork. If there are fixed administrative costs in setting up two separate insurance systems, or, more

[1] The literature on 24-hour care models is voluminous. For general discussions of various 24-hour care models, see Baker and Krueger (1993); Burton (1997); Skeba et al. (1993), Murray (1986); and Hughey (1997).

generally, if there are economies of scale in administration, a 24-hour care system could lead to some cost savings for employers.[2]

The potential administrative savings would depend largely on the extent to which the two insurance systems are actually integrated. For example, suppose that a 24-hour care program integrated both medical care services and insurance coverage for workers' compensation and group health into one insurance package (see Boxes A and B in Figure 3.1). Such a program might reduce administrative costs if its centralized insurance administration had economies of scale and if the combined insurance plan could become more efficient by eliminating separate benefits packages and simplifying claims processing. If the disability insurance plans also were integrated, additional administrative efficiencies might be achieved for disability claims processing. Furthermore, integration of disability insurance could reduce medical administrative costs by reducing the need to make determinations as to whether a disability is causally related to the workplace.

The determination of work causality[3] involves some medical costs (particularly if it requires additional medical tests or procedures), and it also involves administrative costs because the determination involves additional filing of medical reports. If we construe administrative costs broadly to include the legal costs associated with workers' compensation, the determination of work causality could be a substantial driver of administrative costs. This may be particularly true under SB 899.

Prior to SB 899, employment needed to be only a contributing factor to a workplace injury for a worker to receive full workers' compensation benefits. Under SB 899, however, the law was changed to read "the employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment" (LC 4664 (A)). Given that the portion of disability that arises out of employment is a judgment made by physicians, it seems very possible that this reform will generate additional litigation. Under 24-hour care, however, a physician would have access to all of a patient's health care records and so would be in a better position to judge the share of disability attributable to employment, which could reduce costs related to disputes and litigation.

At least some of these additional disability insurance administrative costs could be eliminated under a system that integrated both medical and indemnity insurance for occupational and nonoccupational injuries or illnesses. If an individual received the same medical coverage and income replacement for occupational and nonoccupational injuries, there would be no reason to determine whether the medical problem is causally related to work. Thus, employers and insurers could realize the full ad-

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[2] There has been some evidence of economies of scale in administering insurance programs, e.g., see Chelius and Smith (1987), Ghilarducci and Terry (1999), and Guiffrida et al. (2000).

[3] *Work causality* refers to injury or illness caused by workplace factors and therefore is subject to workers' compensation provisions.

ministrative cost savings from eliminating that step from the process.[4] In addition, reduction in temporary disability claims has been found to reduce subsequent claims for permanent disability, so eliminating the determination of work causality also could reduce disability costs.

Integrating occupational and nonoccupational indemnity benefits would require that the wage replacement benefits be equal in the two systems. In general, there is no real analog to the permanent disability benefits provided under workers' compensation for nonoccupational conditions, and we are unaware of any proposals that seek to integrate permanent disability under a 24-hour care system. Thus, it seems unlikely that administrative services would ever be completely integrated, and therefore potential administrative cost savings would never be fully realized.

The lowest level of integration—that of combining only the medical care services for occupational and nonoccupational ailments (Box A in Figure 3.1)—would not be expected to achieve the same level of administrative savings as would integrating the insurance coverage into one package. Most of the administrative efficiencies derive from combining the insurance claims processing, which could be done only under integrated insurance coverage. Nonetheless, as discussed in Chapters Five and Six, there are legal and operational implications for 24-hour care that may make it desirable to leave the two insurance products separate. Although this model may be least likely to achieve administrative savings, it does offer the potential for medical cost savings.

**Medical Cost Savings.** As discussed in Chapter Two, California employers and policymakers are concerned, in general, that medical care for workers' compensation cases is too expensive and that the increasing medical care cost comes from both higher prices and excessive utilization of care. In principle, 24-hour care could help alleviate both problems. Three standard techniques have been applied to group health insurance to control growth in health care costs: (1) control of provider payments, (2) proactive care management to reduce inappropriate care, and (3) cost-sharing to reduce patient demand for services. We examine each of these approaches here as they apply to workers' compensation health care. To set the stage for this discussion, we first identify some of the financial incentives inherent in the workers' compensation system that have contributed to the escalating cost of medical care. The most obvious incentive is the fee-for-service payment that was based on usual and customary charges, the result of which are higher fees than those paid in the group health sector (SB 228 created a standard fee schedule to replace this system). In theory, this payment method encourages providers to both raise their prices per

[4] We note one exception to this logic—the "tail" of liability that an employer has for covering future health care for a work-related injury covered by workers' compensation insurance but not covered under a group health insurance model that covers only claims made during the policy year. (See Chapter Six for further discussion of this issue.)

encounter and increase the number of encounters. Another provider incentive is the lack of review and control to ensure appropriate use of high-cost procedures, which can be extremely profitable for physicians. An incentive for workers is the absence of cost sharing, which increases their demand for care (because they do not have to pay for any of it). If workers had to pay part of the costs, they would likely visit physicians less frequently.

Baker and Krueger (1993) argue that one of the principal benefits of 24-hour care in workers' compensation would be a reduction in *price discrimination* (setting differential prices for health care) for workers' compensation medical services, stating:

> The financial incentives in workers' compensation tend to lower the elasticity of demand for medical care. It appears that health care providers know that workers' compensation recipients are not sensitive to the price of medical services and therefore can be charged more. In spite of regulation to outlaw such overt price discrimination, it does in fact occur. Moreover, to avoid overt price discrimination, providers may engage in procedure upgrading . . . to increase the amount of the bill.

The ability of providers to set differential prices for workers' compensation health care and for care provided under group health (or other) insurance plans could be reduced by establishing consistent payment rates for all medical care. A 24-hour care model that integrated both health care services and insurance would be able to establish consistent rates readily, and a model that integrated only medical care services also might be able to do this if the two insurers could agree on a common fee schedule or capitation rate.

Baker and Krueger likely focused on price discrimination, at least in part, because their data showed that the additional cost of workers' compensation medical care was almost entirely driven by higher prices rather than higher utilization (Baker and Krueger, 1995). However, this finding does not seem to hold for California, where utilization is a strong cost driver (Neuhauser, 2003). Moreover, the SB 228 reforms that reduced physician fees by 5 percent, expanded fee schedules, and mandated a new physician fee schedule by 2006 should decrease the potential for price discrimination by providers for workers' compensation services. To the extent that providers try to compensate for declining revenues due to price reductions by increasing their service volumes, reductions in fees may come at the price of increased utilization. Risk of price discrimination and related effects on utilization could be alleviated by 24-hour care, which would establish consistent fees for all health services, regardless of causality.

Changing the financial incentives of both medical providers and patients is the primary mechanism through which 24-hour care could reduce overuse of medical services. Under a 24-hour care system, service providers could face either the capitated fee schedules typical in managed care or a lower negotiated fee schedule. In ad-

dition, other mechanisms could be used to control costs, including payment for performance (giving higher payment for higher quality), profiling of provider performance, or other payment incentives. These mechanisms would likely lead physicians to be more vigilant in managing the care that patients receive so that the cost of services more accurately reflects the marginal cost of the service.[5]

Unlike the group health system, almost no cost-sharing is required of patients in the workers' compensation system. The RAND Health Insurance Experiment (Newhouse, 1993) demonstrated that cost-sharing mechanisms are crucial to preventing the overuse of care by patients. Under a truly integrated medical system, in which workers with occupational injuries were treated identically to those with nonoccupational injuries, we would expect some cost sharing to be included. Depending on how much of the cost workers were expected to bear, we would expect that introducing these measures would reduce some of the overuse of care in the workers' compensation system.

The recent reform efforts directed toward the California workers' compensation system already have set in motion rule changes that will curb workers' compensation medical costs, which reduces the potential for 24-hour care programs to generate additional cost savings. The SB 228 provisions will bring about some of the price reductions that 24-hour care otherwise might achieve, and both SB 228 and SB 899 are likely to bring about utilization reductions that 24-hour care otherwise might achieve. The use of utilization schedules, if effective, could affect the utilization of medical services in California significantly. Moreover, to the extent that the network contracts establish lower payment rates for participating physicians and create incentives for them to reduce overutilization, the SB 899 provision for employer-selected networks should reduce costs for injured workers who obtain treatment within these networks.

### Quality of Care and Other Benefits from 24-Hour Care

The overall quality of medical care provided to injured workers might be improved under 24-hour care. The current financial incentives in workers' compensation push physicians to recommend extra procedures, some of which may be not only superfluous, but also harmful. For example, certain types of back surgeries have questionable medical merit, but they involve lucrative rewards to the physicians. If well-established evidence-based practices and stricter utilization review were used to discourage such procedures under group health networks, injured workers' could be better off in a 24-hour care system.

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[5] We note here, and discuss in more detail later in this report, that many of the actions that could be taken under 24-hour care also could be pursued in the current system. In evaluating 24-hour care, what must be judged is the added value it offers that cannot be achieved by the existing system.

A similar issue could arise from physicians' determinations as to whether an individual is fit to return to work. Under the current workers' compensation system that pays physicians for each health care visit, with no limit on the number of visits, physicians have a financial incentive to extend the number of visits for reviewing a patient's readiness to return to work. This incentive, together with delays in determining whether the illness or injury is work related, can delay the point at which physicians declare an individual fit to return to work beyond the time when the individual was, indeed, ready to work again. To the extent that care was managed appropriately under the integrated system and physicians had financial incentives to comply with the system, fully integrating medical care could reduce the incentives to provide more care, or more visits to assess readiness to work, than needed.

An additional benefit of 24-hour care might be to increase patient satisfaction with the medical care they receive. Under the current system, workers sometimes face delays in treatment due to disputes over whether medical problems are work related. If a 24-hour care system allowed workers to receive immediate medical care from a physician they knew and trusted, they likely would be more satisfied with the experience. On the other hand, care management is likely to reduce workers' free access to services, which could make them less satisfied (see Chapter Four for studies that have found reduced satisfaction with 24-hour care).

Patient satisfaction could yield an additional benefit of reducing the number of disputes between injured workers and their employers. Delays in treatment likely contribute to decisions by workers' compensation claimants to hire an attorney, and, given the attorney fee structure in California, attorneys have a strong incentive to encourage injured workers to file for permanent disability. Thus, incentives that delay treatment or increase the likelihood of permanent disability claims could lead to both higher costs for employers and worse long-term employment outcomes for injured workers (if it strained the relationship between a worker and his or her employer). Of course, the potential benefits we have identified are entirely theoretical at this stage, and, without empirical information from small-scale tests, we cannot predict the extent to which they would be realized in 24-hour care.

## Why 24-Hour Care?

When discussing a 24-hour care program, it is important to consider not only what can be accomplished by 24-hour care but also what can *only* be accomplished with 24-hour care. Many of the potential benefits we have discussed so far could be accomplished individually by other kinds of reforms. In fact, as we noted above, many of the recent reforms in California have dealt specifically with some of the same issues that would be addressed by a 24-hour care program.

As discussed below, 24-hour care might not be necessary to obtain much of the savings in medical care costs, but it is necessary to achieve the administrative savings. These savings would be obtained only if the separate workers' compensation and group health insurance plans were integrated into one plan, which would reduce the separate processing of claims and paperwork for different insurance plans into one claims process.

If medical services for occupational and nonoccupational illness were integrated in 24-hour care, negotiated fees for physicians and cost-sharing mechanisms for workers (e.g., deductibles, copays) could be used to reduce the price and utilization of medical services in workers' compensation. All of these measures, however, also could be established directly in the current workers' compensation system. Some of these measures (e.g., cost-sharing for workers) would require changes to state statutes. The fee schedule adopted in SB 228 is an example of an attempt to reduce price discrimination, and any overuse that may result from it, through regulating lower prices. Thus, moving all the way to a 24-hour care approach to achieve cost savings through such techniques would be unnecessary.

Provisions for cost-sharing for workers have been implemented only rarely. Florida is currently the only state to use cost sharing for injured workers in workers' compensation, and it requires a $10 copay after maximum medical improvement has been achieved.[6] Baker and Krueger (1993) note that one benefit of 24-hour care could be that it makes the use of cost-sharing in workers' compensation more feasible politically.

Any decision to introduce 24-hour care must address two medical care issues that are central to the debate over the potential value of 24-hour care—(1) the standards of coverage for health care services and (2) the determination of readiness to return to work. There is substantial disagreement among stakeholders about whether the same medical standards should apply for each of these issues. Standards for medical care encompass both standards for coverage of health care benefits and standards for the care provided in treating a covered injury or illness. For example, should the same medical care benefits be provided for a specific type of injury if it occurs at work as opposed to at home? Should the physician be treating this injury using the best practices based on scientific evidence? Similarly, should a physician's judgment regarding the patient's readiness to return to work differ, depending on whether the injury occurred at work or at home? We believe the answer to all of these questions

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[6] For more on state workers' compensation policies, see the U.S. Department of Labor website at http://www.dol.gov/esa/regs/statutes/owcp/stwclaw/stwclaw.htm (last accessed August 30, 2004).

should be "yes," and that one of the goals of a 24-hour care system should be to achieve these consistent standards of coverage, care, and return to work.[7]

The differences in standards between workers' compensation and other health insurance relate to the very origin of workers' compensation. The state workers' compensation systems were the result of a "bargain" that established health care and disability benefits for workers who have work-related injuries or illnesses, while removing these benefits from the jurisdiction of the state tort system. The norms and expectations built into this system for medical care and return to work have differed historically from those for other personal health care needs.

The differences in these norms for medical care and return to work must be addressed in considering 24-hour care options. Ideally, a 24-hour care program could help to achieve consistency in medical standards, which might not be as achievable without integrating workers' compensation and group health medical services. The policy issue to be addressed, however, is how important it is to achieve this consistency. We discuss these issues in some detail in Chapter Six, which addresses operational issues of implementing a 24-hour care program.

Ultimately, the chief value of a 24-hour care program could be its ability to create a unified system of medical care benefits with a consistent package of cost-savings reforms. Medical treatment should be driven by the goal of improving patient outcomes, up to the point that the marginal benefit of additional treatment is exceeded by the treatment's marginal cost. An advantage of a 24-hour care program is that it seems to create the infrastructure to ensure that the medical care given to workers' compensation claimants is the same, or at least more similar to, the care given to other patients outside the workers' compensation system. In the absence of such a system, each of the two systems will continue moving along their respective trajectories and, over time, workers' compensation will be vulnerable to losing any cost savings obtained from the reforms. Unfortunately, despite its intuitive appeal, there are substantial obstacles to successful implementation of 24-hour care, which are discussed further in Chapters Four through Six.

## 24-Hour Care in California

We summarize this chapter with a brief discussion of what shape we would expect a 24-hour care program to take in California. As discussed, the gains that can be expected from 24-hour care depend largely on the extent to which benefits are integrated. As presented in Figure 3.1 above, the three models we identified would inte-

[7] The term *return to work* encompasses many aspects of post-injury employment, including the amount of time from injury until the next reported day of work, whether the next reported day of work is at the same employer, and whether the post-injury employment is sustained (Reville et al. [2001]).

grate (1) only medical services provided under (still separate) workers' compensation and group health insurance, (2) both medical services and health insurance coverage for the two sectors (keeping disability coverage separate), or (3) medical service provision plus all insurance coverage for both health care and disability. We summarize in Table 3.1 the relationship between expected benefits and the specific policy design.

The columns of Table 3.1 represent different levels of what we call the "breadth" of integration. Here, we specifically refer to whether a 24-hour care plan would integrate only the medical portion of workers' compensation with nonoccupational health care, or whether it would integrate both health care and disability benefits (in Figure 3.1, either Box A and B, or all three boxes A, B, and C). The rows of Table 3.1 represent what we call the "depth" of integration, distinguishing between whether a system integrates just the treatment portion, or both the treatment and insurance products (either Box A alone, or both Box A and B in Figure 3.1).

Note that treatment in the form of service delivery applies to the health care benefits but not to indemnity (disability) benefits, so we have marked "not applicable" in the Medical Treatment Only cell under Medical and Indemnity. Also note that we only focus on a substantive integration of insurance products. It is possible that an insurer could offer a "coordinated" policy to an employer that covers both workers' compensation and other benefits, but does so using separate insurance underwriting and premiums for each benefit package.

In the cells of the table, we summarize the expected benefits of a 24-hour care program for each combination of depth and breadth of integration. In general, administrative and medical cost savings increase with both the depth and breadth of integration. To the extent that patient satisfaction will be influenced by 24-hour care, satisfaction would be expected to come largely from integrating the two health systems, so this benefit is present in all combinations of integration.

To better focus the discussion, we limit our analysis to the integration of occupational and nonoccupational medical care in California. Given that the obstacles to integrating medical coverage are large in and of themselves, we feel that it is appropriate to address this issue as a first step toward the consideration of a broader integration of benefits. As discussed above, it would be extremely difficult to integrate medical and indemnity insurance products, although California has some advantage over most states because it has a substantial nonoccupational disability benefit. Thus, a full review of all the potential implementation challenges for a comprehensive 24-hour care program are beyond the scope of this report. Note that we do explicitly consider the depth of integration in our analyses, because we have found that it is very relevant to the barriers to integrating medical care for the two systems.

**Table 3.1**
**Potential Benefits of Various Models of 24-Hour Care**

| "Depth" of Integration | "Breadth" of Integration | |
|---|---|---|
| | Medical Portion Only | Medical and Indemnity |
| Medical Treatment Only | Some reduction in overuse of care; potentially higher patient satisfaction; few administrative savings | Not applicable |
| Treatment and Insurance | Some administrative savings; reduced overuse of care; potentially higher patient satisfaction | Potentially large administrative savings; reduced overuse of care; potentially higher patient satisfaction; possibly fewer permanent disability claims |

NOTE: The expected benefits of each type of 24-hour care program are listed in each cell. Here, we hold the policy context constant at the status quo, meaning that other potential reforms that might impact the potential benefits or costs of a 24-hour care program, such as universal health care, are ignored.

CHAPTER FOUR

# Lessons from Previous Work with 24-Hour Care

Since the late 1980s, a great deal has been written in the academic and trade literatures on 24-hour care. As might be expected, much of the early literature was largely conceptual and speculative, with some commentators extolling the potential benefits of the concept and others pointing out its potential pitfalls. However, there have been very few systematic attempts to estimate the potential benefits of 24-hour care and almost no attempts to assess the likely benefits of a fully scaled 24-hour care program.

The dearth of empirical evidence on 24-hour care does not reflect a failure to try it in practice. Indeed, a number of states passed legislation calling for 24-hour care pilots, fully intending to produce systematic evaluations. A pilot implementation in Oregon, for instance, was successfully initiated. However, a planned evaluation of the Oregon pilot program was cancelled when it became clear that the program would not attract enough participants to make the evaluation worthwhile (Robert Wood Johnson Foundation, 1997). Similarly, 24-hour care pilots and evaluations in Florida and Maine were cancelled due to lack of employer interest. In addition, Florida was unable to get any insurance providers to submit proposals to run 24-hour care programs, and the Maine program was the object of threatened litigation by labor unions (CHSWC, 2003). A similar pilot in Minnesota was cancelled due to lack of employer interest. However, that state later implemented an integrated-care pilot.

In all, we were able to locate only two rigorous studies of 24-hour care's costs and benefits, both from the state of California. These two studies—one an empirical evaluation, the other a simulation study—are the primary focus of this chapter.

## California's 24-Hour Care Pilot Demonstrations

The only *empirical* evaluation of a 24-hour care pilot we were able to locate examined a 24-hour care pilot program in California (Kominski et al., 2001). In 1993, the California legislature established provisions for four countywide (in Sacramento, Santa Clara, Los Angeles, and San Diego counties) pilot implementations of 24-hour care in the state. As with the current debate over workers' compensation, the impetus

for the pilot programs was rapid increases in workers' compensation costs for employers. By 1995, however, workers' compensation costs had dropped dramatically due to reforms designed to introduce competitive bidding into the market for workers' compensation insurance. Because cost savings had become available through traditional fee-for-service workers' compensation insurance programs, interest and participation in the four pilot programs were lower than expected. In 1997, the program included just 8,000 workers employed by 65 employers in the four counties.

The pilot program involved integration of medical benefits only, even though the evaluation examined cost impacts on both medical and indemnity costs. Two plans were offered. One, Kaiser on the Job (KOJ), offered by Kaiser Permanente, was used primarily in Southern California, whereas the other plan, Maxicare, was more prevalent in Northern California.

Injured workers enrolled in KOJ received most of their treatment for workers' compensation-related injuries from physicians specializing in occupational medicine; however, they could also request treatment by a primary care provider for these injuries. All physicians had access to patients' occupational and nonoccupational medical records. Employers paid a monthly capitation fee that was separate from group health fees. With Maxicare, nonoccupational Independent Practice Associations (IPA) provided both occupational and nonoccupational medical services. However, each IPA received training and technical assistance from an organization with extensive experience in occupational medicine and workers' compensation.

As with other 24-hour care pilots, participation in the program was voluntary.[1] Thus, the evaluation sought to both estimate the cost of participation in the program and assess any selection bias in the treatment group. To estimate the counterfactual (what would have happened in the absence of the intervention), claims costs in the treatment group were compared with two sets of groups not exposed to the intervention: (1) injured employees in pilot firms not enrolled in 24-hour care and (2) injured employees in a matched set of nonpilot firms. Statistical models were used to account for observable differences between the treatment and control groups.

On the medical side, the 24-hour care pilot was associated with increased claims costs. Indeed, the average medical claim was 20–34 percent higher than similar claims in comparison-group firms—a statistically significant difference.[2] By contrast, pilot firms paid slightly less in permanent and partial disability claims, but the differences were not statistically significant. Overall, pilot firms paid 47.5 percent more in premiums than firms in the comparison group (again, a statistically significant difference) (Kominski et al., 2001).

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[1] As discussed in Chapter Five, the requirement that participation be voluntary is a consequence of a number of legal hurdles that are likely to affect any future attempts to design and implement a 24-hour care system in California and elsewhere.

[2] The variation in estimates reflects differences in how the researchers handled data on open claims.

As noted above, because participation in the program was voluntary, the extent to which pilot firms and their workers are representative of the larger population is uncertain. The study found that enrollees in the pilot program tended to be older, more satisfied with their pay, and more likely to have a chronic medical condition than those in the comparison groups. Moreover, minorities and those who perceived their jobs as being risky were less likely to participate. The study's authors interpret the risk issue as being associated with trust. To be willing to give up their choice of provider and access to specialized workers' compensation services, workers have to trust their employers. [3]

A companion study sought to assess some of the noneconomic outcomes of California's 24-hour care pilot (Rudolph et al., 2000). The authors found no statistically discernible differences in patient satisfaction or in self-reported emotional or functional outcomes. Thus, while some observers have feared that the introduction of managed-care principles into workers' compensation might lead to greater worker dissatisfaction, this did not appear to be the case in the California 24-hour care pilot program.

## A Simulation Study of 24-Hour Care

The finding that 24-hour care is associated with higher overall claims costs is consistent with an earlier simulation study conducted by Mercer, Inc. for the California Workers' Compensation Institute (Skeba et al., 1993). This study sought to provide prospective estimates of the cost implications of two 24-hour care designs: (1) integration of medical benefits only and (2) integration of medical and indemnity benefits. The study, released in 1993, used data on the current workers' compensation and group health insurance systems at the time to project the effect of the two types of 24-hour care systems. Using a database constructed for the project, the authors estimated both the aggregate effect and the differential effects on 24-hour care in various types of firms.

The study is somewhat dated, and, like all simulation studies, its findings are sensitive to the accuracy of the assumptions it used. But, given the dearth of empirical evaluations of 24-hour care, the study is worth considering. We place more emphasis on the medical-only model than on the medical-plus-indemnity model because that is the focus of our assessment.

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[3] Non-equivalence of the pilot program and comparison groups can also bias the direction and magnitude of program-effect estimates. The authors found that pilot firms, as a group, had a substantial insurance cost advantage before the start of the program, but that insurance costs for these firms had been declining more slowly prior to the pilot program. Thus, the two groups of firms were not well matched on pre-intervention levels and trends in claims costs.

The Mercer, Inc. team assumed that the group health insurance component (for which expenditures were some seven to nine times higher than workers' compensation expenditures at the time) would be the basis for any integrated design (Skeba et al., 1993, p. 44). For instance, the authors assumed that the prices used for group health insurance would be applied to pay providers for treatment of occupational injuries. Using this price structure, integrating health service payments for occupational and nonoccupational injuries would yield considerable cost savings because the group health insurance prices were lower.[4] Similarly, the authors assumed that additional cost savings could be obtained by eliminating duplicate payments and other administrative functions. However, the authors also expected some overall cost increases associated with designs that failed to integrate both medical and indemnity benefits. This increase, they argue, would occur because integrating health and disability benefits—whether in the traditional workers' compensation system or in a 24-hour care system—provides incentives to return workers to the job in a timely manner. Unfortunately, the Mercer, Inc. analyses assumed that previously uninsured workers would be included in the integrated program, which makes it impossible to assess the effects on costs for already insured workers, which is what we need to know to be able to assess possible cost effects of 24-hour care. Unlike group health insurance, where coverage is discretionary, workers' compensation covers all workers. Thus, the authors assume that implementation of a 24-hour care design would extend coverage to formerly uninsured employees (although not to all previously uninsured citizens). For a medical-only 24-hour care design, the Mercer team estimated cost increases ranging from 24–27 percent, with the need to extend coverage to previously uninsured workers being a major cost driver in the simulation.

## Evaluations of Other Cost-Saving Reforms for Workers' Compensation

As noted in the previous chapter, 24-hour care is not unique in seeking to subject medical care under workers' compensation to some of the cost-control methods more typically found in managed care. Several states, including Oregon, New York, Maine, and Florida, have implemented such policies (Cheadle et al., 1999). Thus, a pertinent question for a prospective evaluation of 24-hour care involves the extent to which some of the putative benefits of the design might be realized by other means. Previous literature on the use of managed-care cost controls in workers' compensation suggests that while the reforms are often associated with lower levels of patient

[4] The authors note, however, that some of the savings could be realized through the introduction of managed-care principles short of a full-blown 24-hour care system. This point is addressed in some detail in Skeba et al. (1993).

satisfaction (Dembe, 1998), they are often effective in reducing both medical and indemnity costs (Workers Compensation Research Institute, 1997).

Experience from a Washington State pilot program provides evidence about the efficacy of less-ambitious attempts to integrate occupational and non-occupational medical care. In 1993, as part of a larger health care reform effort, the state of Washington initiated a pilot project to evaluate the effects of treating injured workers through managed-care arrangements. The program, known as the Managed Care Pilot (MCP), was extended in 1995 by the state legislature. The pilot involved two principal deviations from traditional fee-for-service workers' compensation health care. First, the method of payment involved capitation rates based on previous health care experience. Second, instead of allowing workers to see any willing and authorized physician, injured workers selected a physician from a limited network of physicians, many of whom were trained in occupational medicine. Use of occupational medicine medical directors, case managers, and treatment protocols sought to both control costs and encourage coordination of occupational and nonoccupational care. A formal bidding process yielded two health plans, one by Providence Health Plan and another by the Kaiser Foundation (Cheadle et al., 1999).

Researchers at the University of Washington evaluated the MCP during 1995 and 1996, focusing on self-reported medical outcomes, patient satisfaction, and cost. The evaluation used a matched comparison group, with firms selected on the basis of county, risk class, retrospective rating status, firm size, and premium levels. Data on costs were obtained through administrative records, while a sample of workers were interviewed by telephone to assess medical outcomes and satisfaction.

The study's authors found that medical claims costs were some 21 percent lower for patients in the pilot program compared with costs for patients with injuries in the comparison group, with most of the savings coming in outpatient surgery and ancillary outpatient services. Hospitalization rates were actually higher for the pilot group, but these higher rates were offset by lower rates of utilization of outpatient services. Disability payments and lost workdays were also significantly lower in the pilot group (Kyes et al., 1999). The researchers found no discernible differences between the pilot and comparison groups in self-reported health outcomes, but workers in the pilot group were less satisfied than those in the comparison groups—particularly with access to care. Thus, the authors concluded that the pilot ". . . promoted efficient resource consumption, but at a price of diminished satisfaction" (Kyes et al., 1999, p. 992).

## Implications for the Current Debate over 24-Hour Care

Perhaps the most striking finding in our review of the evaluation literature on 24-hour care is how little of it there is. While there is a considerable literature speculat-

ing about the costs and benefits of the design of 24-hour care plans, few pilot implementations have gone to scale, leaving few opportunities to assess the programs empirically. Indeed, 24-hour care pilot projects and evaluations in a number of states have been canceled due to lack of interest and concern over legal issues. These and other implementation barriers are discussed later in this report.

The two studies we were able to locate—one empirical, the other computational—do not provide reasons for optimism about the impact of 24-hour care designs. Both suggest that 24-hour plans might actually cost more than traditional compensation systems.

These findings, however, are of limited utility in seeking to estimate the costs and benefits of a fully scaled 24-hour care program. Findings from the Mercer, Inc. study, as noted above, were based on a computational model whose assumptions and design parameters are based on data that are more than a decade old. In addition, there are likely to be interactions and other complexities in the real-world operation of 24-hour care plans that are not well captured by such models. Similarly, findings from the empirical study by Kominski et al. (2001) are based on a small, self-selected sample of firms and workers. It is certainly possible that a fully scaled 24-hour care program would perform differently, given changes in participation patterns, workforce composition, and other contextual conditions.

CHAPTER FIVE

# Legal Considerations for 24-Hour Care

In the course of this study, we identified several legal issues as being pertinent to 24-hour care, either because they involve legislative or regulatory changes needed for 24-hour care to be implemented effectively or because they restrict the 24-hour care options that might be implemented. Workers' compensation and group health insurance entities are regulated in California under completely separate legal frameworks and governmental jurisdictions. Furthermore, on the group health side, managed care plans (called "health care service plans" in the words of California law) are regulated under rules that are separate from those regulating other health insurers offering fee-for-service health insurance coverage. In this chapter, we assess the following legal issues, and we offer suggestions regarding how they might be addressed when implementing 24-hour care:

- Federal regulation through the Employee Retirement Income Security Act of 1974
- Standards of medical care
- Differences in dispute resolution procedures
- Medical decisions by health plans
- Privacy protection under the Health Insurance Portability and Accountability Act of 1996.

The issue of greatest concern for implementing 24-hour care is the federal Employee Retirement Income Security Act of 1974 (ERISA), which limits the feasibility of some 24-hour care options. We assess possible ERISA constraints for four alternative 24-hour care models, and we consider implications for implementation.

Four other legal issues are examined in this chapter—standards of coverage, medical decisions by health plans, differences in dispute resolution procedures, and privacy protection regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These issues must be addressed in any 24-hour care program, but they do not appear to represent absolute barriers to putting such a program into place.

The following discussion of legal issues pertaining to 24-hour care is not comprehensive, and it is *not* offered as legal advice.[1] Instead, we examined these issues as an essential part of the environment that would influence the ability to implement 24-hour care models effectively, which needed to be considered in our analysis of alternative policy models for 24-hour care in California. The legal issues are relevant primarily as design considerations in the development of a 24-hour care program and as possible barriers to implementation. Wherever legal constraints appear to favor some possible versions of 24-hour care over others, we have endeavored to make this clear in our analysis.

## Federal Regulation Through ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal statute that regulates employee benefit plans (EBPs), which include health insurance plans, pension plans, and other types of benefits plans that employers may offer their employees. The ERISA statute has a provision, however, that exempts from ERISA requirements all workers' compensation benefits plans that are ". . . maintained *solely* for the purpose of complying with applicable workmen's compensation laws [emphasis added]."[2]

Because ERISA shifts regulatory authority for employer-based benefit plans away from the states to the federal government, it is an important factor that constrains the options available for establishment of a 24-hour care model. Although ERISA protects the states' jurisdiction over traditional workers' compensation benefits plans, any 24-hour care model that creates employer-based plans that combine group health and workers' compensation health care benefits potentially could become subject to ERISA, with the state losing regulatory jurisdiction over the plans.

Concerns about ERISA preemption reportedly have impeded several previous pilot programs for 24-hour care in Oklahoma, Hawaii, and Maine (CCHWC, 2003, p.3). Our review of the provisions of ERISA indicates that potential effects of ERISA on implementation of an integrated 24-hour care benefit in California will differ, depending on the form of 24-hour package that is contemplated.

An important part of the ERISA statute is a complicated set of preemption rules that operate to prevent state governments from regulating EBPs, while preserving the

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[1] The discussion in this chapter is intended to give a general view of some aspects of state and federal laws pertaining to 24-hour care options. It is provided with the understanding that the authors are not rendering legal advice or other legal services. If legal advice or other expert assistance is required, the services of a legal professional should be sought. The authors and the RAND Corporation specifically disclaim any personal liability, loss, or risk incurred as a consequence of the use or application, either directly or indirectly, of any information presented in this document.

[2] ERISA §4, 29 U.S. Code (U.S.C.), §1003(b)(3) (2003).

states' regulatory authority over their own insurance industries.[3] These preemption rules have several nonintuitive effects on the regulation of health insurance and health benefit plans. First, in interpreting ERISA, the U.S. Supreme Court has distinguished between health benefit plans that are purchased through traditional insurers and those that are self-funded by employers. ERISA generally preempts state oversight over the self-funded plans, while the health insurance coverage purchased from insurers may be regulated through state laws that apply to insurers.[4] Second, where ERISA preemption applies, the states have been strictly limited in their ability to regulate health benefit plans, [5] particularly concerning mandated benefits and disputes over determinations of the medical necessity of treatment, denials of benefits, and so on, which ultimately must be resolved under federal ERISA provisions rather than under state tort law.[6] ERISA preemption of state authority over health benefit plans has been controversial because, compared with state law, ERISA imposes only very limited substantive standards on those plans.[7]

We have identified four distinct 24-hour care scenarios; for each, ERISA appears to have different implications. The first scenario (number 1 in the following list) addresses the 24-hour care model that combines only the health care services, leaving separate the two health insurance policies. The other three scenarios (2a through 2c) address the alternative versions of the 24-hour care model that combine health insurance benefits. These scenarios differ in whether they are voluntary or mandatory and in whether they are employer-based or would be implemented within a universal health insurance environment.

1. **Integration of employer-based medical care but not insurance coverage** (see Box A in Figure 3.1, Chapter Three). This model would integrate the medical care processes provided under workers' compensation and group health coverage, while leaving the two insurance packages separate. Because the workers' compensation insurance plans would remain separate from the group health plans, we believe this model would retain the state's authority over workers' compensation benefits under the ERISA exemption for workers' compensation plans.
2. **Integration of medical care and insurance coverage** (see Box B in Figure 3.1).

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[3] For a general discussion of ERISA's preemption rules, see Korobkin, 2003.

[4] *Metropolitan Life Insurance Co. v. Massachusetts,* 471 U.S. 724 (1985). See more generally Butler, 2004.

[5] But *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645 (1995) limits the scope of ERISA preemption concerning state laws that "relate to" EBPs.

[6] With regard to ERISA preemption of state-mandated health benefits, see *Mullenix v. Aetna Life and Casualty Ins. Co.,* 912 F.2d 1406 (1990) and *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985). With regard to ERISA preemption of state tort law in connection with disputes over denial of benefits, see *Aetna Health Inc. v. Davilla,* 124 S.Ct. 2488 (2004). See also Butler and Polzer, 2002, pp. 51–52.

[7] See discussion in Rosenblatt et al. (1997), pp. 160–161. See also Butler and Polzer, 2002, pp. 5–8.

a. *Voluntary integration of employer-based coverage.* This model would permit—but not require—employers in the state to integrate their separate workers' compensation and group health benefits packages into a combined insurance coverage. The ERISA implications are least clear for this model. Because an employer-based, integrated health benefits plan would not be dedicated "solely" to workers' compensation, it appears that its work-related health care benefits would no longer be exempt from ERISA provisions. Such a plan would be subject to ERISA oversight, which means that the state would likely lose its regulatory jurisdiction over work-related health care covered by the integrated plan.[8]

   Case law under ERISA suggests, however, that the state can compel employers to choose between providing workers' compensation benefits through a traditional workers' compensation plan or offering equivalent coverage under an integrated plan that is subject to ERISA. Furthermore, the state can establish standards and criteria that define equivalent coverage under the integrated plan option.[9] Thus, even where a voluntary, integrated 24-hour care plan would fall under ERISA jurisdiction, the state might be able to impose mandates for the design of workers' compensation benefits that are part of that voluntary plan.

   Even if the state could require employers who offer voluntary 24-hour care plans to meet state standards in designing their plans, the ERISA preemption might prohibit the state from using its workers' compensation laws and dispute-resolution mechanism to resolve grievances arising during the operation of such plans. Both the U.S. Supreme Court and the U.S. Department of Labor have taken the position that states' independent medical review programs are not inconsistent with (or necessarily preempted by) ERISA.[10] However, independent medical review is a different mechanism from the administrative-judicial process currently used for workers' compensation disputes in California, through which disputes are resolved regarding medical coverage issues, other procedural issues, and state law liability claims for workers' compensation disability benefits.

b. *Mandatory integration of employer-based coverage.* This model would require all employers across the state to integrate their separate workers' compensation

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[8] See the discussion and citations in Bezdichek (1996), which describe cases in which EBPs were found *not* to be maintained solely for workers' compensation, with resulting ERISA preemption of state regulatory authority.

[9] See discussion of *Shaw v. Delta Airlines, Inc.,* 463 U.S. 85 (1983) in National Association of Insurance Commissioners (1999), p. 6.

[10] See *Rush Prudential HMO Inc. v. Moran,* 536 U.S. 355 (2002), upholding an Illinois independent medical review statute against a federal ERISA preemption challenge. With regard to the Department of Labor's perspective on state-mandated independent medical review, see Butler and Polzer (2002), pp. 51–52.

and group health benefits packages into combined insurance coverage for their employees. ERISA case law has established that states are generally barred from mandating that employers give health insurance as a benefit to their workers, and we believe this standard would apply to such a mandatory integrated model. [11]

c. *Mandatory integration of coverage in a statewide universal health insurance program.* Because this model would not be employer-based, it would not be subject to ERISA and so would fall completely within state jurisdiction. [12]

ERISA has quite distinct implications for integration of disability insurance benefits in a 24-hour plan. As described in Chapter Three, the most comprehensive 24-hour care model integrates both workers' compensation and group health care benefits, and the two disability benefits. The statutory language of the ERISA exemption protecting state authority over workers' compensation *also* appears to protect state authority over benefit plans "maintained solely for the purpose of complying with . . . disability insurance laws."[13] Interestingly, if formal legal analysis confirms this observation, it may be possible to integrate disability benefits without the state losing authority to ERISA for regulation of the integrated disability plans. This discussion highlights the importance of ERISA as a constraint on the choices available to policymakers for design and operation of a 24-hour care plan in an employer-based health insurance environment. The provisions and application of ERISA tend to be ambiguous and subject to substantial interpretation, so it will be important for the state to obtain an authoritative legal review of this issue as it considers the various models for 24-hour care.

The only option that the state might be able implement in the current employer-based health insurance environment without risk of loss of some jurisdiction is the model that retains separate insurance benefits while integrating the operational aspects of health care delivery. It appears that the state would be prohibited from mandating employer-based 24-hour care that integrates workers' compensation and group health benefits, because ERISA has been interpreted to prohibit state mandates for universal employer-based health coverage.[14] The state could pursue a voluntary

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[11] *Standard Oil Co. of California v. Agsalud,* 633 F.2d 760 (1980), aff'd 454 U.S. 801 (1981).

[12] An example of such a model is the universal health care system proposed by California SB 921 (2003).

[13] See ERISA §4, 29 U.S.C. §1003(b)(3) (2003). Despite this statutory exception from ERISA coverage for benefit plans maintained "solely for purposes of . . . complying with . . . disability insurance laws," there have been several Supreme Court cases dealing with more general ERISA preemption issues in the context of disability benefit plans. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *UNUM Life Ins. Co. of America v. Ward,* 526 U.S. 358 (1999). Although we did not analyze these cases in detail, it is clear that they illustrate the complexity of ERISA preemption in connection with disability insurance, and the fact that the statutory exception from ERISA may, in fact, *not* apply to all disability insurance plans.

[14] See *Standard Oil Co. of California v. Agsalud,* 633 F.2d 760 (1980), aff'd 454 U.S. 801 (1981).

24-hour care program, but if it did so, it would risk loss of some regulatory jurisdiction over the workers' compensation component of those benefits; it is not fully clear what the extent of that loss might be.

## Standards of Coverage

One of the key legal distinctions between workers' compensation and group health insurance coverage involves the ultimate legal standard that defines the extent of benefits to which covered individuals are entitled. In group health insurance, coverage determinations are typically made based on a standard of "medical necessity." For example, in the California Medicaid program, medical necessity is defined as a service that is "reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain."[15] Such judgments are made partly based on the standards and review procedures of health insurance entities. California law specifically requires that managed care plans operating in the state establish formal grievance systems, as well as written policies that specify processes for utilization review and guidelines for determining medical necessity.[16] The medical necessity guidelines must be (1) developed with involvement from practicing medical providers, (2) consistent with sound clinical principles and processes, and (3) evaluated and updated at least annually.[17]

Physicians make medical necessity judgments routinely in their medical practices. In particular, California law contemplates that physicians will advocate for "medically appropriate" care for their patients (in the context of coverage denials by payers) and that physicians cannot be penalized for doing so.[18] However, California law also expressly allows payers to enforce reasonable peer-review and utilization-review protocols in determining whether to pay for particular medical treatments or services.[19] These provisions imply that group health insurers in California have some latitude in determining which services are medically necessary in particular cases, and therefore are covered by insurance, and they are authorized to apply various health care review and management procedures in making those determinations.

California workers' compensation coverage determinations are based on a separately defined legal standard. Under the California state constitution, the state legislature is empowered to create and enforce a workers' compensation system that

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[15]This is California's statutory definition of "medical necessity" for purposes of the California Medicaid program. See Cal. Welf. & Inst. Code §14059.5 (2003).

[16] See Cal. Health & Safety Code §1367.01, §1368 (2003).

[17] See Cal. Health & Safety Code §1363.5 (2003).

[18] See Cal. Bus. & Prof. Code §2056 (2003).

[19] See Cal. Bus. & Prof. Code §2056 (2003).

includes ". . . full provision for such medical . . . remedial treatment as is requisite to *cure and relieve* the effects of (work-related) injury [emphasis added]."[20] In addition, state statutes specify that employers are obligated to provide "treatment . . . that is reasonably required to *cure and relieve* [an] injured worker from the effects of his injury [emphasis added]."[21] We were not able to locate any California case law that defines the constitutional meaning of "cure and relieve," but some observers have noted that the language in the constitution implies a strong obligation by employers to correct the effects of occupational injury.[22] Many believe that this obligation goes beyond the "reasonable and necessary" standard used for group health coverage, and some have argued that the obligation was made more demanding in return for employees' concession of civil remedies through the tort system. In addition, we note that several older California precedents generally hold that workers' compensation statutes must be liberally construed in favor of compensating injured employees.[23]

Consistent with the language of the California Constitution, California workers' compensation statutes define a broad range of health care services that employers must provide that are reasonably needed to "cure and relieve" injury.[24] California statutes also forbid employers or medical providers from seeking financial contributions from employees to share in the costs of health care services provided under their workers' compensation benefits to "cure and relieve" the effects of an injury.[25]

Any discrepancies between the work-related and group health standards of coverage would make it difficult to implement any form of 24-hour care, which, by definition, is intended to provide seamless care under an integrated clinical care process. Therefore, to move toward adoption of a 24-hour care model, the California legislature would need to establish consistent medical necessity standards that apply to both work-related and group health care benefits. Furthermore, this step would be advisable, even if 24-hour care were not adopted, to clarify a lingering source of confusion regarding the clinical standards for workers' compensation health care. It is simply not clear whether (or how) the existing standards of coverage for workers' compensation and group health differ from one another as applied to particular clinical cases. Any future legal analysis should include a detailed comparison of the two independent bodies of case law.

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[20] California Constitution, Article XIV, Labor Relations, §4.

[21] California Labor Code, §4600 (2004). SB 899 modified this provision from "cure or relieve" to "cure and relieve."

[22] See, for example, Raven (2001).

[23] For example, *Smyers v. Workers' Compensation Appeals Bd.,* 157 Cal. App. 3d 36 (1984); *Henson v. Workmen's Compensation Appeals Bd.,* 27 Cal. App. 3d 452 (1972); *Subsequent Injuries Fund v. Industrial Acc. Commission,* 59 Cal. 2d 842 (1963).

[24] Cal. Labor Code §4600 (2003).

[25] Cal. Labor Code §3751 (2003).

Even with consistent legislative language regarding standards of coverage, these standards need to be interpreted daily in the delivery of care. For workers' compensation health care, the recent SB 899 reforms call for formal utilization schedules as instruments to define standards for the delivery of care.[26] The comparable instruments for regular health care services are evidence-based practices, as defined in practice guidelines. Although such guidelines may make some standards more explicit, there still will be areas in which case-by-case judgments will have to be made regarding eligibility for medical benefits. In addition, to the extent that the workers' compensation utilization schedules differ from other relevant clinical practice guidelines, there is opportunity for differing interpretation of the standard of care defined by various guidelines. Such differences could, in turn, increase the probability of litigation.

## Medical Decisions by Health Plans

The issue addressed in this section is protection of the integrity of medical decisionmaking in managed care plans, which are plan options under both workers' compensation and group health care benefits. Current regulatory requirements in the workers' compensation and group health sectors appear to have similar aims regarding this issue—namely, to ensure that medical decisionmaking by managed care plans is not unduly influenced by financial considerations. We note that these managed care plans are not the only models used in health benefits plans, which also include preferred provider organizations, discounted fee-for-service, and other models that give patients an open choice of providers. However, only the capitated managed care plans are the subject of these regulations.

Managed care plans in the group health sector are organized to enroll members and manage the delivery of health care to those members through defined networks of health care providers. The employers contracting with these plans pay them a fixed amount per enrollee (capitation) for providing these services. (These plans differ from traditional health insurers that simply underwrite health care risk and reimburse providers on a fee-for-service basis for services rendered to insured employees.) Under the California Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), most managed care plans in the state (called "health care service plans" in the Act) must be licensed by the Department of Managed Health Care (DMHC), and they are subject to regulation by the DMHC.[27]

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[26] SB 899, §23 (2004).

[27] Knox-Keene Act, §1345 and §1349 (1975).

Pursuant to the Knox-Keene Act, California regulations require that health care service plans be organized to establish ". . . separation of medical services from fiscal and administrative management sufficient to assure the [DMHC] Director that medical decisions will not be unduly influenced by fiscal and administrative management."[28] This regulatory provision is clearly intended to establish some independence between clinical decisionmaking processes and financial management in health care service plans. At the same time, the director of DMHC is given interpretive discretion regarding the rule. It is not clear what specific procedures or plan structures the rule actually requires to adequately separate medical decisionmaking from fiscal management.

California workers' compensation regulations impose a similar requirement on certified health care organizations (HCOs) that contract with employers for providing workers' compensation health benefits: "The HCO shall be able to demonstrate to the Division that medical decisions are rendered by qualified providers unhindered by fiscal and administrative management, and that such decisions adhere to professionally recognized standards of care . . . "[29] This rule also leaves interpretive discretion in the hands of an administrative authority, in this case the Division of Workers' Compensation within the California Department of Industrial Relations.

Because the Knox-Keene Act and workers' compensation requirements for separation of medical and fiscal decisionmaking by managed care plans are so similar, these provisions do not appear to present a major barrier to implementation of an integrated 24-hour care model. Under the current legal framework, some 24-hour care plans probably would be managed care entities licensed as health care service plans and subject to the Knox-Keene regulation.

## Differences in Dispute Resolution Procedures

The operation of both health insurance and workers' compensation insurance is sometimes characterized by disputes between claimants and their insurance plans. California has separate systems in place for resolving such disputes under group health and workers' compensation health benefits plans. One of the potential challenges in implementing a 24-hour care program would be to reconcile these separate dispute resolution mechanisms in the integration of benefits. We note that the provisions discussed here apply only to health insurance plans, managed care plans, or workers' compensation insurance plans. They do not apply to self-insured group

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[28] Cal. Code of Regs. Tit. 28, §1300.67.3(a)(1) (2003).

[29] Cal. Code of Regs. Tit. 8, §9772(7) (2003).

health plans, for which the employer is the risk-bearing entity that makes determinations on health benefits disputes or appeals.

On the group health side, disputes often involve adverse pre-approval determinations in which a health plan denies requests for health care services based on medical necessity criteria. Claimants may challenge such adverse determinations through internal or external review procedures mandated by California law. Additional grievance-review mechanisms are available to consumers for other types of disputes (e.g., regarding contractual coverage limitations) that arise over health plans.[30] Neither of these review mechanisms involves a formal administrative judicial process.

California statutes have established two separate—but very similar—mechanisms for independent medical review (IMR) of disputes regarding group health care benefits, one for managed care plans under DMHC jurisdiction and the other for health insurance products under the jurisdiction of the Department of Insurance. The statutes provide that consumers can use the IMR process to challenge denials of health services made by health plans based (in whole or in part) on medical necessity criteria. To dispute a denial of health care services, a consumer in a managed care plan would file a complaint with the DMHC, and a consumer in another health insurance plan would file with the Department of Insurance.[31] Before being allowed to file such a complaint, the consumer first must participate in his or her health plan's internal grievance processes for at least 30 days.[32] If the IMR overturns a plan's denial of services, the reviewer's opinion is binding on the plan.[33] For the consumer, however, the IMR is not an exclusive substitute for access to the civil justice system; the consumer may appeal to the courts an IMR decision that upholds a health plan's denial of service.[34]

Disputes under workers' compensation are addressed through a specialized administrative judicial system established by California statutes.[35] This system invests the WCAB with exclusive jurisdiction over claims related to workers' compensation benefits,[36] and it further grants the WCAB the power to establish procedures for the resolution of workers' compensation disputes (both at the administrative trial court level and through appeals to the WCAB itself).[37]

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[30] Cal. Health & Safety Code §1368 (2003).

[31] Cal. Health & Safety Code §1374.30 (2003).

[32] Cal. Health & Safety Code §1374.30(j)(3) (2003).

[33] Cal. Health & Safety Code §1374.34 (2003).

[34] Cal. Health & Safety Code §1374.30(h) (2003) and Cal. Labor Code §§3600-3605 (2003).

[35] Cal. Labor Code §5300 et. seq. (2003).

[36] Cal. Labor Code §§5300–5303 (2003). Note that rulings and orders of the WCAB can ultimately be appealed to an appellate-level California court. See Cal. Lab. Code §5950 (2003).

[37] Cal. Labor Code §5307 (2003).

The complex procedural framework and requirements for dispute resolution in the WCAB system are defined partly by statute[38] and partly by regulation.[39] Some important features of the WCAB system deserve particular mention. First, the dispute resolution system is adversarial, and claimants are entitled to seek representation by attorneys. Second, the range of disputes within WCAB's jurisdiction includes conflicts over all aspects of workers' compensation benefits, including work causality, medical care benefits, disability benefits, and permanent disability status. Thus, many of the conflicts dealt with by the WCAB system involve substantive legal issues unrelated to the health care benefits. Third, as an adjunct to the WCAB system, California law includes a series of mandates for the conduct of medical-legal evaluations, which is a formal process for generating medical evidence pertaining to workers' compensation disputes.[40]

The WCAB system does not include an analog of the California group health IMR processes. If applied to workers' compensation, IMR would be a mechanism to resolve disputes internally, and those that could not be resolved would be taken to the WCAB process.

When establishing a 24-hour care plan, decisions would need to be made on which of the multiple dispute resolution systems would be used to handle disputes. Under the most basic form of 24-hour care, which would integrate medical care services but not insurance policies, the current dispute resolution systems may be satisfactory. As long as claims administration under 24-hour care continues to identify which health care claims are work related, disputes regarding the work-related claims could be processed through the WCAB system, while other claims would be processed through the relevant IMR procedures. A drawback to this approach is that fundamentally similar claims for medical services could be subject to very different dispute resolution procedures and determinations, depending on whether they were work-related or not. Another drawback to this approach is that it does not attempt to address any of the shortcomings or inefficiencies in the current workers' compensation dispute resolution procedures, which could impair the effectiveness of the 24-hour care approach.

By contrast, implementing a 24-hour care model that integrated insurance products and relevant state regulatory oversight would require integrating or reconciling the currently separate dispute resolution systems for workers' compensation plans and group health plans. We discussed above the importance of reconciling the "cure and relieve" and "medical necessity" standards of coverage. In addition, relevant laws would need to be revised to clarify where, and how, disputes regarding cov-

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[38] See Cal. Labor Code §§5400–6002 (2003), inclusive.

[39] See Cal. Code of Regs. Tit. 8, §§10300–10999 (2003).

[40] See Cal. Labor Code §4628. For general background, see Industrial Medical Council (2001).

erage of medical treatment would get resolved. To the extent that medical disputes can be addressed under 24-hour care without regard to work causality, it might make sense to channel all of the disputes through the IMR process. At the same time, some version of the current WCAB system would still be needed to deal with other workers' compensation disputes, including work causality, disability benefits, and permanent disability status.

Somewhat less clear is how an integrated dispute resolution system for medical care benefits would deal with consumers who are dissatisfied with results of their IMRs. Currently, health insurance claimants who are unhappy with IMR can go to the courts for relief, but workers' compensation claimants are obligated to pursue an "exclusive remedy" appeals process through the WCAB. One way to resolve this discrepancy would be to establish a single appeals process for all medical treatment disputes, which potentially could increase the burden on WCAB or on an equivalent authority to process the disputes. Alternatively, medical disputes could be channeled into separate appeals mechanisms for work-related and other disputes, which would require the administrative tracking of workplace involvement.

Ultimately, any restructuring of current dispute resolution mechanisms for a 24-hour care model that fully integrates health insurance would have to accommodate the reality that workers' compensation disputes are not limited to coverage of health care benefits, but also involve disability benefits. Restructuring also would be affected by the fact that the current WCAB system has significant operational and procedural problems, which are described in Pace et al. (2003). Based on the findings of previous RAND research (Pace et al., 2003), it appears unlikely that the problems associated with the current WCAB system can be addressed simply by combining it with the IMR process.

## Privacy Protection Under HIPAA

Privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[41] restrict the disclosure of protected health information by health care providers, plans, and clearinghouses.[42] HIPAA regulations apply broadly to medical doctors and allied clinical personnel, regardless of whether the services they perform are compensated by health insurance or workers' compensation insurance. Group health plans also are directly regulated by the HIPAA privacy rules. Traditional

[41] Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 42 U.S.C.).

[42] 45 CFR §164.502 (2003).

workers' compensation insurance plans, by contrast, are *not* covered entities under HIPAA, and are not directly subject to the HIPAA privacy regulations.[43]

HIPAA has a "treatment, payment, and operations" safe harbor that permits use of and communication about protected health information under specified circumstances. Under this provision, communications between providers and health plans related to treatment and payments are generally permitted,[44] as is the use of protected information in quality-assessment and quality-improvement activities (subject to some limitations).[45] Disclosure of protected health information for purposes of government oversight by a "health oversight agency" also is expressly permitted.[46] Finally, HIPAA permits disclosures of protected health information as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation or other similar programs.[47]

One significant legal effect of establishing 24-hour care plans might be the extension of HIPAA rules to health care services for work-related injuries provided by the 24-hour care plans, where these services otherwise would have been free from HIPAA regulation under workers' compensation. In organizing the 24-hour care plans, some additional administrative costs might be incurred to achieve initial HIPAA compliance for the workers' compensation side of the new plans. Once the plans were established, however, the HIPAA privacy rules should have little additional operational effect on the delivery of care, or on quality monitoring and evaluation efforts. To the extent that 24-hour care would require use of protected information that was not covered by any of the HIPAA safe-harbor provisions,[48] such use might still be made HIPAA-compliant by obtaining written authorization from the insured.[49]

The broader application of HIPAA to 24-hour care plans would not introduce privacy protections into a context in which such regulation was previously unknown. Existing California statutes already impose confidentiality rules on the Division of Workers' Compensation with regard to identifiable information in workers' compensation claims files, as well as on employers with regard to medical information con-

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[43] 45 CFR §160.103 (2003); see also Office of Civil Rights (2003).

[44] 45 CFR §§164.502, 164.506 (2003).

[45] 45 CFR §164.501 (2003).

[46] 45 CFR §164.512(d) (2003).

[47] 45 CFR §164.512(l) (2003).

[48] For example, in connection with workers' compensation insurance "indexing" processes, whereby insurers disclose identifiable claims information to a central database to facilitate the validation of subsequent claims against that database. See, however, 45 CFR §164.508(b)(4) (2003) with regard to HIPAA authorizations for purposes of determining insurance eligibility.

[49] 45 CFR §64.508 (2003).

cerning their employees.[50] Although the California laws are not identical to HIPAA, they do illustrate that medical information in the workers' compensation system already receives some legal privacy protections.

In summary, the HIPAA issues that are relevant to implementing 24-hour care plans appear to be readily manageable. Although HIPAA compliance probably would be required of 24-hour plans, and ambiguity remains in several aspects of the HIPAA privacy rules, the rules include ample safe-harbor provisions that appear to be sufficient to cover all aspects of the provision of health care for work-related injuries or illnesses.

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[50] California Labor Code §138.7 (2003) and California Civil Code §56.20 (2003), respectively.

CHAPTER SIX

# Operational Issues for Implementation of 24-Hour Care

The previous chapter presented a number of legal issues that bear on the implementation of a 24-hour care system in California. In this chapter, we present the results of our analysis of operational issues relevant to implementation of 24-hour care within the current employer-based group health environment, in which consumers obtain their health care benefits through their employers. Insurers and managed care plans currently offer employers a multitude of health benefit options. Some employers offer their employees one or more of these purchased options, other employers are self-insured, and yet others do not offer health insurance as an employee benefit. We examine the feasibility of 24-hour care models in this employer-based, multiple-plan environment, taking into consideration the incentives, capacities, and resources of key stakeholders and participants.

In Chapter Seven, we then consider how the effects of these issues might change if 24-hour care were implemented in two alternative environments. The first alternative is under the expanded employer-based health insurance mandated by recent legislation (SB 2), and the second is under state-level universal health insurance.

As discussed in Chapter Three, California policymakers are considering 24-hour care because it offers the potential to reduce costs and increase quality of workers' compensation health care benefits. The following mechanisms have been identified as possible sources of savings:

- Relying on the same providers for both care related to work-related injuries and other health care to achieve appropriate care, as defined by evidence-based standards of care
- Reducing overutilization for treatment of work-related injuries by applying the well-established incentives and care management techniques used by group health plans to both work-related and other health care
- Reducing or eliminating price discrimination in medical treatment provided under workers' compensation as compared with group health insurance

- Reducing or eliminating the need to ascertain work causality before health care is provided, which would improve timely access to care for work-related injuries and reduce the probability of litigation and related costs
- Making the health care system easier for workers to understand and use, which should increase patient satisfaction and reduce the frequency of litigation regarding health care benefits.

Our review of previous experiences with 24-hour care pilots and feedback from stakeholders suggests that the effects of operational issues will differ depending on the extent to which the workers' compensation and group health benefits are integrated. Implementing a 24-hour care model that integrated only medical care services for work-related and other health care needs is expected to pose fewer operational challenges than implementing a model that fully combined workers' compensation and group health benefits into integrated insurance products. On the other hand, it is not clear that integrating only medical care services would create sufficient efficiencies to achieve the desired improvements and cost savings for work-related health care. With this tradeoff in mind, in this chapter we present our specific findings for each of the relevant issues we identified.

Like most strategies for change, successful implementation of 24-hour care will require alignment of the incentives and behaviors of key participants and stakeholders such that they are willing to participate in the new system (see, for example, Ingram and Schneider, 1997). For each stakeholder group, the following conditions are required for a successful 24-hour care program:

- Health care providers that previously have not provided much health care for work-related injuries or illness are willing to do so under 24-hour care, and they have the requisite skill to carry out the other workers' compensation functions required of a treating physician (e.g., determination of work causality and disability status). Alternatively, a mechanism may be provided so that these providers do not have to perform these functions.
- Employers are willing to establish 24-hour care plans for their employees, and they have the capacity to implement the needed structural and operational changes within their organizations to achieve an integrated system.
- Employees are willing to participate in a 24-hour care plan, and they are able to successfully navigate its procedural requirements for health care services and the related claims processes.
- Insurers are willing and able to underwrite risk for integrated health insurance products that cover health care services for both work-related injuries and other health care needs.

- State regulators have the capacity to make the structural and operational changes needed to establish the regulatory infrastructure for an integrated 24-hour care system, and they can effectively regulate the system.

When considering how stakeholders might respond to the introduction of a 24-hour care model for integrating workers' compensation and group health benefits, it is important to recognize that "willingness" to participate is relevant to both voluntary and mandatory approaches. In a voluntary 24-hour care program, employers and insurers obviously would have the freedom to choose whether to participate in the new program or remain in existing benefits systems. Thus, the more attractive 24-hour care is to stakeholders, the more participation the program would have.

For a mandatory 24-hour care program, employers and insurers that did not like the program would still have choices, although the choices would involve difficult tradeoffs. Both employers and insurers could challenge the new program through legal channels or the political process, which could slow or derail its implementation. Ultimately, employers could decide to close their businesses or move their businesses out of California. Insurers could decide to stop offering insurance for workers' compensation or group health and convert to serving only a claims administration role, or they could discontinue all insurance business in California. These responses would have obvious negative economic implications for California.

Although employers and insurers would drive decisionmaking on whether or not to use a 24-hour care program, employees are not without a voice in this matter. The extent of employee satisfaction with such a program potentially would be expressed in the rate of disputes or litigation over employee health care benefits under the program. Thus, if employees are unhappy with the system, and more likely to have disputes with it, the savings that would have been gained through reduced litigation are less likely to be achieved. Information for the following discussion came largely from the focus groups we conducted with groups of stakeholders (described in Chapter One).

## Provider Roles and Responsibilities

Central to 24-hour care is designing the program such that workers obtain all their health care from the same set of providers, whether the health care needed is work related or not. The goals of this approach are to simplify workers' access to care for work-related injuries and to achieve consistency in delivering appropriate care for all health needs, whether work related or not. These goals would be achieved by applying the evidence-based standards and care management practices that already are in general use in the health care system.

Many physicians and other clinical practitioners who previously had little experience with workers' compensation health care would be taking on new roles for treating work-related injuries and illness in 24-hour care. In addition, these clinicians would have all the other responsibilities that treating physicians have under workers' compensation—determination of work causality, treatment plans for back-to-work, judgments on temporary disability benefits, and ultimately, determination of permanent disability status.

The relevant stakeholders seem to agree that integrating care under the same group of physicians and other clinical practitioners offers the potential to achieve better care for workers and cost savings for the system. However, focus groups members expressed concerns about several issues that could have negative consequences for workers or employers:

- Reduction of workers' access to all the care needed to "cure and relieve" a work-related injury, because the group health standards of coverage provide for less-rich benefits than those for workers' compensation
- Inability of physicians with little workers' compensation experience to perform effectively the other roles expected of treating physicians for determining other workers' compensation benefits
- Weakening of physicians' emphasis on getting workers back to work in a timely manner and provision of medical guidance on work limitations.

### Workers' Access to Health Care

As discussed in Chapter Five, debates about differences in standards of coverage for workers' compensation and group health benefits reflect the ambiguities in the definitions of these standards in the state constitution and statutes. From a clinical perspective, it could be argued that "medical necessity" should be the same regardless of the source of the health problem being treated. A counter-argument to this logic is that injured workers currently have access to a number of services (e.g., palliative care or pain relief) that are not normally covered under group health insurance, and, if those benefits were lost under an integrated health care benefit, the workers' access to care would be diminished.

This debate highlights the need to establish a single definition of medical necessity that applies to both workers' compensation and group health care, which we believe will be critically important to implementing a 24-hour care program successfully. Furthermore, the need for a standard definition exists even if 24-hour care is not implemented. The "cure and relieve" standard for workers' compensation appears to be contributing to the documented overuse of services for work-related injuries.

Establishing a consistent standard of coverage should reduce the inappropriate use of some health care services. As this reduction of use occurs, some injured work-

ers likely would express concerns about loss of access to care, and if these concerns are not addressed effectively, they could ultimately be expressed in grievances or litigation. Because workers would obtain all services from their personal physicians under a 24-hour care program, the trust that already exists between physicians and patients should mitigate workers' concerns. However, during implementation of a 24-hour care program, it would be important to communicate openly with workers and educate them about how to work with their physicians to achieve appropriate care for work-related injuries.

A related issue is workers' perception that treatment supplied by employers for work-related injuries is less than optimal. These concerns could increase in response to the recent reforms in SB 899, which offer employers the option of directing all care. This concern could be mitigated under 24-hour care, where the worker's usual health care provider provides all of the worker's care, and the worker chooses the provider from a provider network. If a worker chooses a health care provider for the 95 percent of care that is nonoccupational, this choice probably reflects the worker's preference for medical delivery under a broader definition than just occupational health care.

#### Physicians' Experience with Care Under Workers' Compensation

Virtually every stakeholder group has raised questions about the extent to which workers' personal physicians would be able to perform the specific workers' compensation functions required of a treating physician. Physicians who now work with workers' compensation cases are knowledgeable about these roles, and even they have been criticized for not providing effective documentation for determinations of work causality and disability status. Many of the stakeholders we interviewed believe that these performance issues would be even more serious for physicians who were new to the system. For example, stakeholders' expressed concerns about the average physician's ability to make determinations of the work relatedness of health conditions or to properly document the required information in formal reports. Many stakeholders also felt that physicians with little workers' compensation experience would be ill-equipped to make the determinations needed for allocation of permanent disability benefits.

From the physician's perspective, the additional workers' compensation functions translate into providing clinical judgments and completing formal reports for determination of workers' compensation benefits. Physicians would have to invest some time initially in being trained on reporting requirements, and they would continue to invest some time on a regular basis in completing reports for their patients. Ultimately, physicians could be involved in adversarial relationships with some patients over workers' compensation disability claims, which could impair both patient trust and quality of care. These requirements could discourage physicians from par-

ticipating in a 24-hour care program unless some support were provided to ease their burden and allow them to focus on clinical care.

One approach to addressing the procedural requirements would be to separate the treating physician from direct involvement in the workers' compensation process for determination of disability benefits by placing those functions in a separate entity. For example, physicians with workers' compensation expertise could be designated to serve as formal reviewers of disability eligibility, working with the clinical information provided by the treating physicians. These clinicians also could serve as expert resources for the treating physicians. Possible structures for this review mechanism would need to be explored, including assessment of options for setting up the mechanism as an insurer function or as a function of the state. Any 24-hour care design would have to include provisions for ensuring a sufficient supply of physicians with workers' compensation skills, which would entail careful definition of the treating physicians' roles, along with provision of training on performing the necessary functions. This training probably should extend to existing workers' compensation physicians, in addition to newly involved physicians.

#### Maintaining Effective Back-to-Work Practices

One of the aims of workers' compensation health care is to achieve timely return to work for injured workers. There is a general sense in the workers' compensation field that workers' compensation physicians get injured workers back to work more quickly than do physicians working under group health insurance. However, there is little empirical evidence that this is occurring for California workers' compensation cases. Some stakeholders are concerned that the group health standard would dominate under an integrated 24-hour care program, which could lead to slower returns to work that would increase costs for both employers and workers.

In considering this issue, it is important to start with the clinical standards of care, which, in principle, should be consistent regardless of the source of an injury or illness. A physician should render the same treatment to any worker with, for instance, a compound fracture and should provide the same direction regarding return to work, regardless of the reason for the fracture. However, workers' compensation physicians probably are more attuned than other physicians to making explicit decisions to ensure timely return to work, simply because it is an explicit part of their responsibility.

If we view this issue from the worker's perspective, an injured worker has an incentive to return to work if he or she is losing wages due to any injury or illness. To the extent that temporary disability benefits under workers' compensation were richer than sick pay or other temporary disability benefits, a worker would have less incentive to return to work following a work-related injury than he or she would have following the same injury that was not work related. Applying the same standard of care to treating the injury could mitigate the effects of these worker incen-

tives on clinical decisions regarding return to work and any related work limitations. Thus, it appears that, to maintain effective back-to-work practices under 24-hour care, physicians would need to apply the relevant standards of care consistently to all cases, regardless of place of origin of an injury or illness. Physicians' actions on return to work might play out differently for a 24-hour care model that integrated only medical care services than for one that integrated both medical services and health insurance. If only the medical services were integrated, all of the workers' compensation insurance and related procedures would remain intact, including the physicians' roles in determining work causality, temporary disability, return to work, and permanent disability status. As a result, physicians treating work-related injuries or illnesses in this model would be aware of the need to address return-to-work effectively, even if they previously had not done much workers' compensation care. This awareness might be diluted, however, under a 24-hour care model that integrated the health insurance packages, to the extent that delivery of health care services was separated from the other aspects of workers' compensation.

## Potential Value of 24-Hour Care for Employees

From an employee's point of view, a potential advantage of 24-hour care would be its relative simplicity. Workers would be able to use their personal physicians for all their health care needs, including any work-related injuries or illnesses. In addition, administrative requirements for determining work causality should be reduced, as should the frequent delays that workers are reported to experience in gaining access to care as work causality is determined.

Some aspects of 24-hour care design, however, might be unattractive to employees. One of these is the perceived differences in standards of coverage between workers' compensation and group health insurance, which are described in Chapter Five and in this chapter. Although the existing standard of coverage for workers' compensation generally is perceived to allow for more health care services to be provided than the standard for group health insurance, some of the extra services being provided may in fact amount to overuse of services. Whatever the reason for the extra services, workers who expect to have access to more services could be unhappy with a new system that leads to a perceived decline in service levels.

As stated in Chapter Three, to achieve the goals of appropriate care and cost efficiencies, a 24-hour care plan must include proactive management of the health care services provided, as well as alignment of incentives toward this end. The use of employee cost-sharing in the form of copayments and deductibles creates a financial incentive for employees to consider whether to seek health care services more carefully, which has been proven to reduce excess service use (Newhouse and the Insurance Experiment Group, 1993). As reported in Chapter Five, current workers' compensa-

tion statutes prohibit worker cost-sharing. Legal issues notwithstanding, we can anticipate that workers would view any extra out-of-pocket costs unfavorably.

## Policy and Administrative Changes for Employers

As noted in Chapter Four, 24-hour care pilots in other states have foundered on lack of employer interest. In many cases, flagging interest was apparently driven by reductions in insurance premiums, which in turn reduced the extent to which employers were willing to incur the costs of adopting a new set of insurance and health care practices. Thus, we might expect employers' willingness to participate in 24-hour care policies to vary with the cycle of fluctuating rates of insurance premium increases. However, the designers of a 24-hour care model would need to address a number of other more persistent operational issues. Our analysis presented in Chapter Five led us to identify two 24-care options that are most likely to be feasible under ERISA requirements: (1) a model that integrates health care services and some operational processes but retains separate workers' compensation and group health insurance products and (2) a voluntary model that offers employers the choice of establishing integrated health care benefits that combine workers' compensation and group health insurance into one insurance package. These two models have different implications for employers.

In the model that brings together only clinical and operational processes, employers would seek changes that improve health care and reduce operational efficiencies. To integrate health care services, the employer would have to establish networks of health care providers who would provide all the health care for their employees, while still identifying separately which cases are payable under the workers' compensation insurance or under group health insurance. It is not clear where operational savings might be derived from this model because all the health care claims still would be processed through separate insurance policies.

Implementation of the model that integrates workers' compensation and group health insurance would pose a number of challenges for employers, and many of these challenges would be driven by the scope and structure of their existing group health benefits. Workers' compensation benefits accrue to all employees, whereas group health insurance is offered at the employer's discretion. Moreover, unlike workers' compensation, group health benefits are often extended to employees' dependents.

When introducing a 24-hour care plan, an employer would have to either limit the integrated insurance coverage to employees already covered by group health or extend group health coverage to all employees. Extension of coverage to all employees would increase the employer's health benefits costs, which could reduce or eliminate any potential cost savings derived from integrating the health benefits. Keeping

some employees out of the 24-hour care program would require the employer to maintain separate workers' compensation health care insurance for those employees.

Another issue for employers is the fact that many of them—especially the large ones—offer their employees multiple group-health-plan options; thus, a separate 24-hour care plan would have to be negotiated for each health plan. Employers in our focus groups reported that they would not want to undertake 24-hour care unless they could do it for all their group-health-plan options. The larger the number of group health options an employer currently offers, however, the more difficult and burdensome it would be to negotiate agreements with insurers on all its health plans.

Employers report that they would face some significant organizational and administrative challenges in implementing an integrated 24-hour care insurance package. Typically, separate departments within each employer organization are responsible for the two benefit programs, with workers' compensation benefits handled by risk management, finance, or another department and group health benefits handled by human resources. Employers would have to either combine these functions under one department or define rules and procedures to coordinate those functions' activities. Employers in our focus groups reported that the integration process could be time consuming because of its complexity and because of probable resistance to the change from staff who are in both of the separate insurance functions.

## Reconciling Two Types of Insurance Coverage

Insurance may be structured within either of two basic types of coverage, which differ in the reference period (the period of liability) for an insured event. The first type is "claims made" coverage that applies to any health care encounter that occurred during the period the policy was in effect, regardless of when the underlying injury or illness started. The second type is "occurrence" coverage that applies to damage or injury that accrues during a policy period, even if a claim for health care services is filed after the policy period. Group health insurance and workers' compensation insurance differ in their basic structures, posing a significant problem for an integrated 24-hour care insurance package. Most forms of health insurance are "claims made" policies. When the consumer ceases to be enrolled in a plan (i.e., when the consumer or his or her employer ceases to pay premiums), then the consumer is no longer entitled to benefits under that plan. Workers' compensation insurance policies have "occurrence" coverage, which is defined to be compensation for treatment of injuries that arise from a particular workplace.[1]

If a worker has a work-related injury or illness while working for an employer, the employer remains liable for all related health care, and valid workers' compensa-

[1] See Cal. Labor Code §3600 (2003).

tion claims for medical services can sometimes occur long after a worker stops working for an employer. California currently imposes a one-year statute of limitations on workers' compensation claims from the date of an occupational injury.[2] However, a series of cases has established that the limitation does not begin to run until ". . . an employee's condition culminates in incapacity to work, and the employee knows, or in exercise of ordinary care should have known, that he was suffering from disease or injury, and that such disease or injury was caused by his employment."[3]

This "tail" of employer liability for claims for work-related medical treatment is factored into the actuarial basis for workers' compensation insurance premiums. By contrast, premiums for the claims-made structure of group health insurance represent only the actuarial risk of services provided during the term of the insurance contract.

The tail of occupational liability for work-related health care needs is a significant challenge to structuring an acceptable insurance policy that covers services for both work-related and other health care needs. Insurers would have to estimate and price the expected risks, possibly as a separate, identifiable premium component. Insurers in our focus groups were not optimistic about the feasibility of such an underwriting task. Administratively, the insurance claims mechanism would have to support work-related filings by persons no longer eligible for general health care benefits.

Insurers' willingness to participate in 24-hour care programs with integrated insurance coverage will depend on how effectively the coverage is designed to address their concerns regarding integration of risk underwriting, premium setting, and claims adjustments. Indeed, as mentioned in Chapter Four, a 24-hour care pilot program in Florida was canceled, in part, because no insurers submitted plans for coverage.

Creation of integrated workers' compensation and group health coverage also would affect workers' compensation insurance claims adjusters. Several participants in our stakeholder interviews reported a number of problems with the performance of adjusters, which have resulted in frequent delays in processing workers' compensation claims and determinations of work causality for injured workers. It was reported that adjusters typically do not have adequate clinical credentials, are not trained sufficiently to perform the variety of functions they are expected to perform, and they are not well compensated relative to their level of responsibility. As a result, there is an inadequate supply of adjusters, and those who serve in this capacity carry larger workloads than they can handle in a timely manner.

The introduction of a 24-hour care program could be designed to reduce the need to determine work causality, by allowing injured workers to obtain health care services from their personal physicians just as they would other health care services.

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[2] See Cal. Labor Code §5405 (2003).

[3] *Pacific Indem. Co. v. Industrial Acc. Commission,* 34 Cal.2d 726, 214 P.2d 530 (1950). See also, e.g., *Fruehauf v. Workmen's Compensation Appeals Bd.*, 68 Cal. Rptr. 164, 68 Cal.2d 569, 440 P.2d 236 (1968).

Insurance adjusters could then determine work causality while health care is being provided, and such determinations would not be necessary for many acute conditions that do not result in disability. The result could be smaller workloads for the insurance adjusters. In addition, if, as described above, formal physician-review mechanisms were established to support treating physicians, these mechanisms should reduce the case-processing demand on adjusters.

## Administrative Effects for State Regulators

Establishing 24-hour care would create some administrative challenges for the state agencies that oversee these functions. At least three different agencies have regulatory responsibility for some aspect of the health insurance involved in either workers' compensation or group health coverage. The Division of Workers' Compensation has responsibility for regulating all workers' compensation activities; the Department of Insurance regulates insurance companies; and the DMHC regulates managed care organizations. A 24-hour care system would require, at a minimum, administrative mechanisms for coordinating these functions, and possibly, consolidation of the functions within a single agency.

It would be more important to restructure the state regulatory functions for the 24-hour care model that integrated workers' compensation and group health insurance coverage into one insurance package. It should be possible for the existing agencies to regulate a 24-hour care model that leaves the insurance coverage separate because each agency would still have clear authority over an identifiable type of insurance. Jurisdiction would become less clear, however, for an integrated 24-hour care insurance model.

A complicating factor in determining how to structure state regulation for integrated 24-hour care insurance is the separate regulatory jurisdiction for managed care plans and traditional health insurers (the DMHC and Department of Insurance, respectively). In practice, some integrated packages would combine workers' compensation coverage with a managed care plan, and other packages would combine workers' compensation coverage with a traditional health insurance policy. To ensure that insurers can establish coverage successfully, the state must provide timely and consistent regulatory guidance for both types of combined coverage.

Given the goal for 24-hour care programs of achieving consistent delivery of health care according to evidence-based standards of care, it could be argued that a 24-hour care model that integrates insurance coverage should be regulated by one state department. This approach would ensure that performance standards and other regulatory control are consistent for any plan established under the 24-hour care program. This function probably would be better placed in either the Department of Insurance or the DMHC than in the Division of Workers' Compensation, because

consolidation of benefits merges health care for work-related injuries into the larger group-health benefit structure. However, the Division of Workers' Compensation should have an advisory role, at a minimum, to ensure that the functions of the 24-hour care program are appropriately coordinated with the remainder of the workers' compensation benefits and relevant state policy and procedural requirements.

History offers ample evidence that any reorganization of governmental functions has the potential to generate confusion and uncertainty—in this case, it could generate disagreements about the new structure and the roles within it, resistance to change by agency staff, difficulties in merging separate organizational cultures, and a host of possible operational challenges. To the extent that these challenges would occur in implementing a new 24-hour care program, they would contribute to delays in implementing the reorganization, which in turn would lead to delays in providing the regulatory infrastructure that employers and insurers would need to establish their 24-hour care benefits.

Once again, we observe a tradeoff in the effects of implementing 24-hour care, depending on the levels of benefit consolidation. A 24-hour care model that left the insurance coverage separate would be easier to implement from the perspective of the state regulator. Therefore, this model likely would become operational more readily than a fully integrated model. On the other hand, the non-consolidated model might be less effective in achieving appropriate levels of care than a consolidated insurance model, because the separate insurance coverage and administrative processes might be difficult to coordinate.

The non-consolidated model might be able to achieve more appropriate levels of care; however, if standards of coverage were made consistent, and if employers and insurers worked together to create one care management mechanism to apply to all health care. One way to create such a mechanism would be to have one insurer write coverage for both of the separate workers' compensation and group health benefits and to administer the two policies together.

## Implications for 24-Hour Care

The analyses of operational and legal issues, reported in this chapter and Chapter Five, respectively, reveal some clear boundaries on the 24-hour care models that could be established by California in the current employer-based health care environment. The analyses also highlight a number of issues that need to be addressed to implement any one of these models successfully.

If our interpretation of the law is correct, implementation of mandatory 24-hour care would not be allowed because ERISA prohibits states from mandating employers to provide health insurance. Therefore, the only options that appear to remain are those that have been discussed in this chapter—a model that integrates only

the clinical and operational aspects of health care benefits, and an alternative model that also integrates workers' compensation and group health insurance into one insurance package. To comply with ERISA, it appears that the consolidated insurance model must be voluntary for employers.

The stakeholder issues discussed in this chapter have differing implications under each of the 24-hour care models. Issues regarding providers' roles and responsibilities and the potential value of 24-hour care to workers are equally relevant to both models because the delivery of health care would be integrated under both models, whereas other stakeholder issues—including changes required for employers, reconciling two types of insurance into one package, and administrative disruptions for state regulators—are more important to the model that integrates both service delivery and insurance coverage. In particular, reconciling workers' compensation and group health insurance coverage is an issue relevant only to the second model.

CHAPTER SEVEN

# Alternative Models of 24-Hour Care

The nature of any 24-hour care program will depend on the nature of the health insurance system in which it is implemented. In the previous chapters, our analysis focused largely on the implementation of a 24-hour care program within the current employer-based health insurance environment in California, in which employers have a wide variety of approaches to offering health insurance options for their workers, and in which some employers offer no health insurance at all. This insurance environment limits the size of the worker population that could be covered by a 24-hour care program because 24-hour care would not be implemented for workers who do not have group health insurance, such as part-time workers and workers at small firms that do not offer health insurance benefits.

In this chapter, we examine how a 24-hour care program might operate in three alternative health insurance environments. One of these alternatives is the subject of recent California health insurance reform—the Pay or Play system enacted through SB 2. The second is a proposed universal health care system that has not been enacted. The third alternative is a test environment offered by the workers' compensation "carve out" provisions for agreements between labor and management. As in the previous chapters, we focus our attention on the integration of health care services and insurance, and we do not address the issue of integrating disability benefits.

The potential effects on health care and the obstacles involved in implementation of 24-hour care in all three environments are summarized in Table 7.1 and discussed further in this chapter. For each policy context (the existing employer-based group health insurance system, Pay or Play, and universal health insurance), implications are considered for the two levels of integration under 24-hour care—medical care services only or both medical care and health insurance.

**Table 7.1**
**Assessment of 24-Hour Care Within Various Health Insurance Environments**

| "Depth" of Integration | Health Insurance Context | | |
|---|---|---|---|
| | Existing Employer-Based Insurance | Employer-Based Pay or Play (SB 2) | Universal Health Care |
| Medical care services only | Some potential benefits for stakeholders; some obstacles to implementation of 24-hour care | More workers with health care will be eligible for 24-hour care coverage; should lead to greater effects on cost and performance | Identical treatment for all workers; full effect on health care costs and performance |
| Medical care services and insurance | More potential benefits and more obstacles to implementation than with medical-care-services-only option | Potentially more benefits for stakeholders than with medical-care-services-only option; there may be fewer obstacles to implementation if small firms have a single insurer | Many fewer obstacles to implementation than in other contexts |

NOTE: The expected benefits of 24-hour care in each policy environment are shown in each cell. We hold the "breadth" of integration constant, and consider only the potential benefits of integrating medical care services or insurance and ignore the possible integration of disability benefits.

## 24-Hour Care Under Pay or Play Health Coverage

California SB 2 extends health insurance coverage to workers at small employers by (1) requiring "covered" employers to pay into a fund for purchasing health insurance for their workers and (2) providing a credit for this payment to employers that provide the health insurance themselves. As of January 1, 2006, family coverage will be offered to workers at firms employing 200 or more workers. As of January 1, 2007, worker-only coverage will be offered to workers at firms employing 20 to 199 workers. Employers with fewer than 20 workers are exempt. Workers must be employed for at least 100 hours per month for at least three months to qualify to be covered by SB 2.

The primary effect of SB 2 on a 24-hour care program would be to increase the number of workers that could be covered by such a program because more workers will have health insurance coverage. However, because their health insurance still will be tied to employment, the issues involved with integrating workers' compensation and group health medical care services or insurance coverage under the current system also would apply for the expanded coverage. Furthermore, because a 24-hour care program probably would be voluntary (due to ERISA), any increase in use of

24-hour care under SB 2 could be limited. Many of the small employers with new health insurance coverage per SB 2 might choose not to participate in a 24-hour care program because they cannot afford to incur its startup costs. On the other hand, small employers are likely to offer only one health care plan, so they might find it easier and less costly to implement 24-hour care than large employers that offer their workers multiple health insurance options.

The approach taken in SB 2 to structure the Pay or Play insurance program could be a useful model for implementing a voluntary 24-hour care program. The Pay or Play system was designed to avoid becoming subject to the ERISA preemptions by retaining a voluntary component to employer-based health benefit coverage. The insurance system introduced by SB2 could be expanded to cover all work-related and other illnesses and injuries, and employers could either pay into a fund or provide such coverage themselves. However, legislative challenges to SB 2 are under way as of this writing, and SB 2 may end up being challenged legally on ERISA provisions, so it still is far from clear how viable this model might be.

## 24-Hour Care Under Universal Health Insurance

A system of universal health insurance coverage could provide an effective foundation for establishment of a 24-hour care program. Under universal health insurance, the same insurance coverage is provided to all individuals regardless of their work status or where they work. Therefore, universal health insurance would eliminate ERISA issues. It also could mitigate the underwriting issue concerning the liability "tail" for work-related injuries, because insurance would cover an individual at any place of employment, as long as the individual remained in California. For workers who move out of state (or out of the country, if the hypothetical universal health care were nationwide), this liability could be compensated through some state-level fund, which would be easier to implement than employer-based premium adjustments.

Implementation of 24-hour coverage under universal health insurance also would be straightforward because two state insurance systems would be integrated, in contrast to the multiplicity of group health plans now offered by individual employers in the current system. Even if multiple health plan options were offered as part of the universal coverage, coverage for work-related health conditions could be included as part of the benefits provided by all the plans. In fact, there would be no real reason to continue identifying work-relatedness of injuries or illnesses, except for those cases that involve disability that would be covered separately by workers' compensation and personal disability plans.

Not all of the operational problems involved with implementing 24-hour care would be eliminated under universal health insurance. Challenges that would remain include reconciling the distinction between "cure and relieve" and "medically neces-

sary" standards of coverage in state law, as well as determining whether there should be cost sharing for medical care for injured workers. Still, it does appear that implementation of 24-hour care would be simplified under a universal health insurance system.

The potential benefits of universal health insurance, as well as the substantial hurdles to its passage and implementation, dwarf those associated with 24-hour care. Thus, the prospect of any potential gains from the implementation of 24-hour care being simpler than that of a universal plan is unlikely to provide a strong argument in favor of universal health insurance.

## 24-Hour Care as a Carve-Out of the Workers' Compensation System

Another policy context that could make 24-hour care easier to implement is the carve-out system in workers' compensation. A "carve-out" is a negotiated agreement between unions and employers that essentially replaces the workers' compensation system. Any number of facets of workers' compensation may be negotiated, including medical treatment and medical legal evaluation. As reported in Levine et al. (2002), the carve-out system was implemented in California in 1993 as a method to control the rising costs associated with workers' compensation.

One of the ways in which carve-outs were expected to generate savings was through a reduction in medical costs. It was assumed that employers would use carve-outs to negotiate a substantial amount of medical control, thereby eliminating the "high-cost" physicians from the system. An advantage to allowing strong medical control in the carve-out system is that unions could protect the interests of employees, and renegotiate the carve-out arrangement if physicians appeared to be withholding necessary medical treatments to restrain costs.

Levine et al. (2002) argue that the carve-out system did not lead to the expected savings in workers' compensation, a position that was offered at least some circumstantial support by the recent controversy over the system's high costs. One of the reasons they offer for the failure to reduce costs was that the carve-outs failed to take advantage of the potential to implement some form of 24-hour care.

The framework of a union-employer negotiated carve-out agreement is potentially attractive for the establishment of a 24-hour care program. Given that the carve-out legislation is already in place in California, 24-hour care programs could be implemented as carve-outs with little or no additional legislative action by the state. Because carve-outs are voluntary arrangements, the ERISA preemptions do not apply to them. Employers and unions can negotiate the definition of "medically necessary," an appropriate dispute-resolution format, and introduction of cost-sharing mechanisms.

In addressing carve-outs as an option for 24-hour care, a natural question that should be considered is why unions and employers have not implemented 24-hour care already by taking advantage of the existing law. A possible explanation is that the uncertainty involved in pursuing this option may be viewed as being too large, given the general lack of evidence regarding the effectiveness of 24-hour care. Until a positive effect of 24-hour care has been demonstrated and quantified, employers and unions probably will continue to have concerns about potentially significant short-term costs and uncertain long-term benefits.

Given the uncertainties about the potential performance of 24-hour care, a pilot program in the context of a carve-out program seems to be the most prudent and sensible strategy. One of the key goals of any pilot program should be to quantify both the costs and benefits of the program. A detailed study of the challenges that arise in the pilot program would facilitate the design of a better program that is larger in scope, if such a program were thought to be a good investment. Additionally, quantifying the potential impact of 24-hour care on medical costs, disputes, and patient satisfaction would allow for a much more informed debate on the merits of a larger program.

Because past pilot programs have had only limited success, there is some question as to whether or not a new program is merited. We have identified four important conditions that need to be met to ensure that a pilot program has the greatest chance of success. First, the pilot should be undertaken by an employer for whom integrating the two systems would be relatively easy, such as an employer that self-insures both its group health and workers' compensation coverage. Second, both the employer and the union(s) involved in the pilot must actively commit to making the program work and have a willingness to experiment with various options and learn from their experience. Third, the pilot must be well designed so that it meets the needs and priorities of both the employer and the union(s). Fourth, both the employer and the union(s) should make a long-term commitment to the pilot to allow time for learning, for adjustments to be made during the pilot's implementation phase, and for evaluation of the pilot's effects. While much of the implementation cost for a 24-hour care program is incurred relatively early, it is reasonable to anticipate that some of the program's benefits would accrue over a longer period of time.

CHAPTER EIGHT

# Synthesis of Findings and Recommendations

Historically, the debate over 24-hour care has foundered repeatedly over the conflicting views and experiences of stakeholders. There continues to be, at once, optimism about how 24-hour care might achieve more appropriate and affordable workers' compensation medical care, confusion over what 24-hour care is exactly, conflicting opinions on how best to design an effective 24-hour care program, and pessimism regarding 24-hour care's actual viability given that various pilot efforts have failed or have yielded few of their intended effects. This muddled situation is not surprising. Twenty-four-hour care is more complex than it appears to be on the surface, and stakeholders tend to bring to the debate differing assumptions about what it constitutes.

One of our goals in this study was to establish a common foundation for defining options for the design of 24-hour care and assessing the feasibility of those options. Our work included parsing out how the options may differ and assessing constraints created by statute or by the health care environment under which a program option would be implemented. Another goal was to assess which 24-hour care options appear to be the most viable, taking into account the constraints and the practical considerations for effectively implementing a 24-hour care plan. Among these considerations are the perspectives and needs of key stakeholders whose participation would be essential to the success of any 24-hour care program.

## Lessons Learned

Workers' compensation encompasses both medical care and disability (indemnity) benefits that are covered by one insurance policy provided by an employer. A 24-hour care plan would integrate one or more of these benefits with the parallel benefits for non-work-related health events. We defined three basic levels of integration: (1) consolidation of medical care services only, (2) consolidation of both medical care services and health insurance, and (3) consolidation of medical care services plus both health insurance and disability insurance. Our analysis focused on only the medical-care side of workers' compensation, and we examined the first two basic options of

consolidating only medical care services or consolidating both services and health insurance. Of course, within each basic option there exist myriad specific design options for which decisions must be made. Some of these decisions are the purview of the state, and others would be in the hands of employers and insurers as they implement 24-hour care plans.

In this section, we summarize the key findings from our assessment, organized as answers to the research questions that guided our work (which are also listed in Chapter One).

**What are the problems with the current workers' compensation system that have motivated stakeholders to consider 24-hour care as an option to improve the system?**

The main problem that has motivated stakeholders to search for alternatives to the traditional California workers' compensation system is the cost of the system, which has the highest and fastest-growing premium costs in the country. An important driver of these costs has been the growth in medical care expenditures in workers' compensation cases and concerns about appropriateness of care. Furthermore, few stakeholders feel that the California system adequately meets the needs of employers or injured workers, which is reflected in part in high litigation rates.

**What evidence is there that 24-hour care can address these problems effectively, and how would it need to be designed to do so?**

In general, a 24-hour care system potentially could achieve savings in administrative costs and medical care costs. However, despite a substantial amount of published material on the concept of 24-hour care, there have been few systematic attempts to estimate the potential benefits of 24-hour care and almost no attempts to assess the likely benefits of a fully scaled program. Perhaps most troubling, a number of states attempted to introduce 24-hour care pilot programs, but almost none of them have come to fruition because of lack of interest or legal constraints. Some never were implemented and others were not able to attract employers or workers to participate in them.

We found only one empirical evaluation of 24-hour care pilot programs, which was an evaluation of a 24-hour care pilot in California, one of the few surviving pilots (Kominski et al., 2001). This pilot was found to have higher workers' compensation medical costs than those of the existing system but no significant change in costs for permanent and partial disability claims. The evaluation did not analyze effects on costs for non-work-related medical care, which makes it difficult to interpret overall effects. No differences were found in patient satisfaction or in self-reported emotional or functional outcomes.

**What does 24-hour care offer that would make managing health care and costs in this way more effective, compared with reforms now being made (or that could be made) to the existing workers' compensation system?**

Much of the improvement in care and cost savings that 24-hour care might achieve could be derived within the existing workers' compensation system. The added value of 24-hour care might be its establishment of a consolidated structure for delivering health care, which would result in the unified medical care culture needed to create effective processes for improved care management and for controlling costs. However, almost all of these processes could be implemented in the current workers' compensation system, and, in fact, many are being adopted, as of this writing, under the terms of recent California legislation. Without a 24-hour care system, each of the two health insurance systems—group health insurance and workers' compensation—will continue to operate independently and, over time, workers' compensation reforms, and any cost savings initially obtained from them, may be eroded.

Integration of medical care processes and the resulting improvements could be achieved with a 24-hour care model that integrates only medical care services. Integration of workers' compensation and group health insurance packages could achieve savings in administrative costs. Integration also could reduce the need to determine work causality for many of the less severe work-related injuries, which ultimately could contribute to reductions in permanent disability claims. As long as workers' compensation and group health insurance are separate, however, determination of work causality would be required to determine which of the two insurance plans should pay the medical care claims.

**How feasible would it be to implement a 24-hour care system across California within the current employer-based health insurance environment in which employers can offer multiple health plan options?**

Our assessment revealed that a more fully integrated 24-hour care system offers greater potential for more appropriate health benefits and cost savings than the current workers' compensation system, but at the same time, it would be less feasible to implement than the proposed changes to the workers' compensation system. This situation is created by the federal ERISA, because it limits the range of 24-hour care designs that are legally permissible in an employer-based health insurance environment. Although we did not perform a formal legal analysis, our review of ERISA suggests that the only 24-hour care options that would be feasible under ERISA are a model that integrates only medical care services and a model voluntarily implemented by employers that integrates both medical care services and health insurance. Our analysis suggests that a mandatory, statewide 24-hour care program that integrates the two types of insurance would be prohibited under ERISA. In addition, we identified operational barriers that would influence employers' and insurers' willingness to participate in a voluntary program.

**How would the feasibility of implementing 24-hour care change if it were introduced in other group health insurance environments?**

To answer this question, we considered two alternative health insurance environments: (1)the Pay or Play system enacted in California SB 2 that expands employer-based health insurance to smaller employers and (2) a statewide universal health insurance program, which has been proposed in California but has not been enacted.

The Pay or Play system under SB 2 gives small employers the option to introduce group health insurance coverage, which would increase the number of workers who have health insurance. Therefore, a 24-hour care program implemented within the Pay or Play system could cover a larger number of workers than the number under the current health insurance system. Because small employers are likely to offer only a single health care plan, and therefore would have to convert only one group health plan to the 24-hour integrated model, they might be able to implement 24-hour care more easily than larger employers. However, small employers may be the least willing or able to incur the implementation costs of 24-hour care, even if those costs are less than those for large employers.

A 24-hour care system would be much more feasible under universal health insurance than under an employer-based health insurance system because the ERISA constraints would not apply to the former. Universal health insurance also would eliminate some implementation issues, in particular the issue of the insurance "tail" for work-related injuries, because workers would be covered by 24-hour care regardless of work status or job changes.

## Recommendation for 24-Hour Care in California

Given the implications of ERISA in the current employer-based health insurance environment, as well as substantial conflicting factors that would affect the design and execution of a 24-hour care program, we believe that it would be premature for the state of California to embark on statewide introduction of 24-hour care. Rather, we believe the first step should be to conduct one or more pilot programs to test alternative approaches to a program design that effectively manages the numerous legal and operational issues identified in this report. This can best be done by interested employers and insurers who would work in cooperation with the relevant state agencies to develop and carry out small-scale 24-hour care pilots.

## Suggested Approach for Designing a 24-Hour Care Pilot

In this section, we offer some suggestions for steps the state can take to stimulate and guide the development of one or more 24-hour care pilots under the workers' compensation carve-out provisions. The state should establish guidance and technical support, as follows, to encourage voluntary development of small-scale 24-hour care pilots by employers and insurers:

- Pilots should be undertaken that can test both a 24-hour care model that integrates only medical care services and a model that integrates both medical services and health insurance.
- Every 24-hour care pilot should be required to include an evaluation that documents and assesses issues in designing and implementing a 24-hour care plan and that assesses the plan's effects on costs, worker satisfaction, and other outcomes.
- Pilots should be allowed to operate for at least five years before a final judgment is made on the feasibility and scalability of 24-hour care, which will also allow sufficient time for learning through experience and for adjusting program design as needed.

In the spirit of using pilots to test and learn from various approaches to 24-hour care, we recommend that the state establish a process that encourages participation by employers, unions, and insurers and that supports creative approaches on the part of these stakeholders in designing 24-hour care pilots. To ensure that workers' rights and welfare are protected, the state should establish a set of performance goals for the pilots with respect to getting treatment for injured workers and informing injured workers of their rights and options during the treatment process. The processing of proposals for pilots would be handled by the state, as described in the CHSWC *Carve-Out Manual* (California Commission on Health and Safety and Workers' Compensation, 2004).

### Select Pilot Participants Based on a Defined Set of Criteria

After the performance standards and application process are in place, participating stakeholders should drive most of the other details of a pilot's design so that the pilots are most responsive to stakeholders' individual needs and preferences. This approach is consistent with the intent of SB 899, which allows employers and unions to use carve-outs to explore alternative ways to handle both workers' compensation and group health benefits.

The following criteria may be used to guide identification of employers for possible participation in pilots. Desirable candidates would be employers that

- are government entities (not subject to ERISA rules)
- are self-insured for both group health and workers' compensation insurance, or that obtain both types of insurance coverage from the same insurance company
- offer group health insurance for all their full-time employees
- structure their group health insurance so that definable populations of workers (e.g., workers in a single union) are served by one health plan
- have sufficient rates of work-related injuries or illnesses among their workers so that there will be an observable use of health benefits for work-related events during the pilot.

In addition to these criteria, possible participants should also provide a variety of employer characteristics with respect to (1) the probability of achieving a successful pilot and (2) the type of job functions, the work environment, and the risk of injury to employees. Variation in these characteristics will provide useful information for evaluating the experiences and outcomes of the pilots. For example, having at least one site with a good chance of implementing a successful 24-hour care pilot would provide "proof of concept" evidence about the effectiveness of a 24-hour care system in reducing costs and improving health care delivery. That site also would generate information on which conditions are the most important for achieving success. At the same time, including other sites with a lower probability of success would further test the conditions for success and would offer insights into the amount of retooling and time required to achieve a viable and stable program design. The lessons learned from the initial pilots could then be shared with others to increase the probability of successful implementation of subsequent pilots.

Variation in the job functions and work environment across pilots would generate information on the effects of various workplace factors on the feasibility of 24-hour care and what is required to make 24-hour care work under different circumstances. For instance, one site might have a high risk of injuries with long "tails" of coverage, while another site might generate fewer such injuries.

#### Invite Employers to Participate in Pilot Programs

Although a few employers may take the initiative to pursue a 24-hour care pilot, it is reasonable for the state to assume that it will have to take the lead in identifying candidate employers and inviting them to develop a 24-hour care pilot. This recruitment process also would serve to build working relationships with employers and obtain their views on how a 24-hour care pilot might be designed.

The first step in the recruitment process would be to identify a list of candidate employers that appear to fulfill the selection criteria listed above and to rank the candidates in order of how well they match the criteria. The employer candidates should then be contacted by the state to explore their interests and concerns regarding 24-hour care. In advance of these discussions, information sheets should be prepared

that list the key features of a 24-hour care plan and that answer questions that employers would be expected to ask about such a plan.

Establishing an advisory task force of employer, union, and insurer representatives would be useful to help guide the preparatory work and to provide feedback to the state on issues as they arise. The individuals selected for this task force should be respected leaders in their respective stakeholder groups and should support testing of 24-hour care.

After an employer is committed to participating in a 24-hour care pilot, the next steps are managed by the employer, the union(s) represented at the employer's workplace, and, if the employer is not self-insured, the insurers that are underwriting the employer's group health and workers' compensation insurance. At this point, these stakeholders should begin to negotiate the details of the pilot design. They will need to determine which employee group(s) should be involved in the pilot and whether to integrate only medical care or both medical care and insurance. The state can and should provide technical support for the negotiation process to ensure that stakeholders comply with applicable state requirements and to help stakeholders succeed in establishing a workable plan.

### Address Stakeholders' Issues and Concerns

During the course of designing the pilot program, the stakeholders should address the issues and concerns voiced by each member of the design team. Each stakeholder group has its own specific concerns regarding 24-hour care plans. To a large extent, the degree of success in establishing and operating a plan will depend on how well these concerns are addressed during the design and implementation process. The following are some key issues that we identified in our discussions with members of stakeholder groups.

### Issues for Employers (Public and Private)

- Many employers offer their employees multiple health plan options, and they will have to determine which of those options are candidates for 24-hour care plan(s).
- Employers will need to decide which employee group(s) should be the population served by a 24-hour care plan.
- The terms of a written contract for a 24-hour care plan will have to be drafted carefully to ensure that all the functions the plan is intended to perform are specified and fulfilled by the insurer and provider network.
- To manage any 24-hour care plan that is established, many employers will have to make adjustments to their departmental functions, because their workers' compensation and group health benefits currently are managed by separate departments.

### Issues for Employees

- Employees want to have access to initial care as soon as possible after an event occurs (work-related or not), which is a feature that an effective 24-hour-care plan should be able to provide.
- An effective 24-hour care plan would be expected to reduce employees' access to some follow-up treatments as part of its reducing overuse of services. This expectation would run counter to employees' desire for easy access to follow-up treatments and ready approval of services they believe are medically necessary.
- Employees probably would respond negatively to the introduction of cost-sharing for work-related health care services because it would increase their out-of-pocket costs.

### Issues for Insurers

- Insurers may be reluctant to participate in a plan that integrates only medical care services because the plan would require them to coordinate insurance products and provider networks with another insurer.
- The primary concern of insurers regarding a plan that integrates both medical services and insurance will be how to handle the underwriting of risk for the "tail" of employer liability for medical care for work-related injuries.

### Issues for State Regulators

- The introduction of 24-hour care, even as a pilot, will require the relevant state agencies to establish an infrastructure and regulations to guide the pilot. Such an infrastructure probably would require staff from multiple agencies to work together because the 24-hour care model cuts across workers' compensation and group health authorities.
- For the 24-hour care model that integrates services and insurance, the separate state regulatory functions in various departments will need to be combined into one authority or otherwise coordinated closely to ensure that consistent guidance is provided to the people in the field who are trying to work with the new model.

## Implementing a Successful 24-Hour Care Plan

Establishing a 24-hour care design that is acceptable to key stakeholders is a critical first step toward conducting a pilot program. The next step is to bring that design to life in an operational 24-hour care plan. In this section, we identify the action steps for successful implementation of a 24-hour care pilot. These steps are listed in Table 8.1, along with the steps' suggested implementers. These steps emerged from our re-

view of legal and operational issues concerning 24-hour care; the results of that review are reported in Chapters Five and Six.

For implementation of a 24-hour care plan that integrates only the medical care services for work-related and non-work-related health conditions, steps 1 through 13 in Table 8.1 should be taken. The first three steps, which are to be taken by the state government, establish policies on a standard of coverage, a standard of clinical care, and worker cost-sharing. The next two steps, which are to be handled by the state in consultation with participating employers and unions, establish an expert clinical resource in workers' compensation and an internal medical review process. Steps 6 through 13 are to be carried out by employers, unions, and insurers as part of their negotiation of a 24-hour care pilot under a carve-out. In most cases, the employer would be the lead implementer, and the unions and insurers would be actively involved to ensure that their concerns and opinions are reflected in the program's design and operation.

For implementation of a 24-hour care plan that integrates both the medical care services and insurance coverage, all of the steps in Table 8.1 should be undertaken. These include all the steps for a plan that integrates only medical services and the additional two steps listed at the bottom of the table. The additional steps address establishment of a dispute-resolution mechanism and methods to insure the tail of workers' compensation liability.

## Recommendations for Workers' Compensation

Several issues directly related to the existing workers' compensation system emerged from our assessment of options for 24-hour care models. Addressing these issues would strengthen the existing workers' compensation system and would better position the state to implement 24-hour care pilots. The following recommended actions might be taken by the state to address these issues:

- The workers' compensation appeals process has been shown to have a number of problems and inefficiencies that have been contributing to rising workers' compensation costs. Reforms should be undertaken to address these problems, with the goal of reducing delays in processing workers' compensation disputes and improving the evidence base for making determinations on any appeals of decisions.
- Although IMR is an integral part of the grievance process for group health insurance, it is not currently part of the workers' compensation process. The state should consider adding IMR to the workers' compensation appeals process to provide a mechanism for review of medical care grievances that precedes taking appeals to the WCAB.

- The new provider networks specified by SB 899 do not appear to be subject to the requirements for separation of medical and fiscal decisionmaking that apply to both workers' compensation and group health managed care plans. New regulations should be established that would make this requirement apply to the new provider networks.

**Table 8.1**
**Suggested Action Steps for Implementing a 24-Hour Care Plan**

| Action Step | Implementer |
|---|---|
| **For Integrated Medical Services in 24-Hour Care** | |
| 1. Establish a *consistent standard of coverage* that defines the scope of medical care covered by workers' compensation and group health insurance plans. | State government |
| 2. Establish a *consistent standard of care* for delivery of medical care services that is based on scientific evidence for best practices. | State government |
| 3. Establish *employee cost sharing* for medical care services for work-related conditions as an authorized design feature of 24-hour care plans. | State government |
| 4. Create an *expert resource in occupational health and workers' compensation* that can support treating physicians in their workers' compensation roles. | State, employer, insurer |
| 5. Establish an *internal medical review process* to hear grievances about denial of medical services. | State, employer, insurer |
| 6. Define the *covered employee group(s)* for a plan to assure that all members of a group are covered by the plan and to avoid enrollment selection. | Employer, union, insurer |
| 7. Contract with a *network of providers* to deliver medical care for all injuries or illnesses, whether or not the injury is work related. | Employer, union, insurer |
| 8. Implement *provider payment methods* that align their financial incentives with providing appropriate care and reducing overutilization of services. | Employer, union, insurer |
| 9. Develop a *care management function* to track and manage complex or costly cases. | Employer, union, insurer |
| 10. Provide *treating physicians with regular training* on the administrative and reporting requirements involved in treating work-related cases. | Employer, union, insurer |
| 11. Provide *education to employees* on their 24-hour care plan, the expected benefits and changes from the plan, and how to use the plan's services. | Employer, union, insurer |
| 12. Provide employees with *ready access to needed care* by establishing a mechanism to determine work causality while care is being provided. | Employer, union, insurer |
| 13. Routinely *monitor the timeliness of return to work* for all patients, with a special focus on those with work-related conditions. | Employer, union, insurer |
| **For Integrated Services and Insurance in 24-Hour Care (in addition to steps 1 through 13)** | |
| 14. Establish a *dispute resolution mechanism* that can be used to appeal medical care disputes after the plan's IMR process is exhausted. | State government |
| 15. Develop actuarial methods to *insure the "tail" of coverage* for work-related health care after employees leave the liable employer. | Insurer |

## Evaluating a 24-Hour Care Pilot Study

The value to decisionmakers of a carve-out 24-hour care pilot program will depend on the inclusion of a high-quality evaluation capable of generating actionable recommendations on program design and scale-up. In particular, we recommend that an evaluation plan be designed to provide

- detailed information on the implementation process and experiences of participating stakeholders
- valid analyses of the effects of the program on a range of outcomes.

### Learning from the Implementation Process

Given the importance of the legal and operational issues identified in Chapters Five and Six, implementation of any 24-hour care pilot must be carefully documented in a process evaluation. Whether or not the evaluation ultimately shows the pilot to be successful, it is nevertheless critical to gaining a clear understanding of the drivers of and barriers to a successful 24-hour care program. A process evaluation might seek to answer the following questions:

- To what extent are physicians able to effectively integrate traditional occupational and non-occupational care practices into a common set of best practices?
- To what extent are insurance firms' claims departments able to develop processes for integrating the management of occupational and non-occupational claims?
- Is worker access to treatment expeditious?
- Are physicians able to make effective and timely work causality determinations?
- Can insurers find viable ways to underwrite risk from "tail" coverage?

### Assessment of a Program's Impact

The biggest challenge in any impact assessment is to determine the counterfactual outcomes—i.e., what would have happened in the absence of the intervention? In previous evaluations of 24-hour care, researchers have compared costs and outcomes for the 24-hour care pilots with two alternative comparison groups: (1) non-participating workers in firms with 24-hour care pilot programs and (2) workers in firms with no pilot programs. In firms with carve-out pilots, participation presumably would be universal among the firms' workers or within groups of the firms' workers who are in one or more unions. Therefore, the comparison group probably would be limited to firms that do not have pilots.

Using workers from non-participating firms as a comparison group should help to avoid possible cross-contamination, i.e., individuals in the comparison group inadvertently learning about the 24-hour care program and placing pressure on the

employer to allow them to participate.[1] However, using workers from non-participating firms as a comparison group also introduces additional sources of non-equivalence between participating and comparison groups. Thus, any pilot evaluation should include a careful examination of whether workers in participating firms are observably different from those in comparison firms in age, previous disability, or other factors that could be linked to injury frequency, severity, or cost of care.

After a reasonable comparison group is constructed, the pilot evaluation should be designed to measure differences between the two groups over a full range of outcomes and costs. Even though the pilot would not be integrating disability benefits, the evaluation of the pilot should also include an assessment of its impact on disability costs to determine whether incorporating common standards of medical practice reduces lost workdays and, ultimately, disability costs. Moreover, an attempt should be made to construct a database of costs that would enable program evaluators to determine whether any changes in overall health care costs are related to changes in price versus changes in utilization levels.

Finally, the evaluation should seek to measure a broad range of outcomes. Ideally, the evaluation would assess long-term medical outcomes. Given the practical difficulties associated with such an assessment, another strategy might be to rely on self-reported outcomes obtained through surveys (see, e.g., Kyes et al., 1999). Surveys could also be used to seek information on patient satisfaction with various aspects of care and claims processes. In past studies, one justification for studying satisfaction is that patient dissatisfaction may be an indicator of a propensity to litigate, and litigation tends to drive up workers' compensation costs. Researchers might also seek to study rates of litigation more directly by tracking changes in the probability of litigation over time and across pilot and non-pilot firms.

## Summary

Despite California policymakers' continuing interest in 24-hour care as a possible solution to escalating workers' compensation costs, designing and implementing a viable 24-hour care program presents formidable challenges. Many states have failed in the past to get 24-hour care pilots started, and others have had limited success in achieving cost savings or improvements in care with their pilots. ERISA is an obvious barrier that impeded some of these past efforts, but if our analysis is correct, some 24-hour care models can be developed that would be less affected by ERISA than others. We encourage policymakers to use small-scale pilots to test 24-hour care models, moving forward carefully as they do so, while emphasizing effective design, high-quality implementation, and careful evaluation of the models being tested.

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[1] This, in turn, tends to lead to underestimates of program effects.

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