



# Spotlight Report

## Revisiting 24-Hour Health Care Coverage and Its Integration With the California Workers' Compensation System

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### Introduction

Efforts by the Trump Administration and Congress to “repeal and replace” the Patient Protection and Affordable Care Act (ACA) have prompted renewed debate over health care reform. Last year in California, Senators Ricardo Lara (D-Bell Gardens) and Toni Atkins (D-San Diego) co-authored Senate Bill 562, modeled after federal legislation authored by Senator Bernie Sanders (I-Vt.), calling for the adoption of a single-payer, “Medicare-for-All” health care system. While these proposals have captured recent headlines, the issues surrounding health care reform and the payment of medical benefits under California’s workers’ compensation system are not new. In this monograph, we revisit CWCI’s 1993-1995 three-part series that examined the issues, opportunities, and unresolved problems surrounding the integration of workers’ compensation into a 24-hour coverage system, and consider the many changes that have occurred in both the occupational and non-occupational health care delivery systems since that report series was published. As was the case almost 25 years ago, important questions need to be asked – and answered – by lawmakers before embarking upon any type of merger of these two systems.

### Background

The debate over health care reform involves many concepts that have different meanings – and implications – for treatment under the workers’ compensation system. The idea of 24-hour coverage is that medical treatment would be available regardless of the causation of the illness or injury. Under most proposals, this implies an integration of occupational and non-occupational medical care. The California Workers’ Compensation Institute (CWCI) first explored the issues of 24-hour coverage beginning in 1993 with “Framing the Issues: Twenty-Four Hour Coverage,” the first of a three-part report series.<sup>1</sup>

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<sup>1</sup> California Workers’ Compensation Institute and William M. Mercer, Inc. Part 1: “Framing the Issues: 24 Hour Coverage” (1993); Part 2: “Mandating Medical Coverage for California Employees” (1994); Part 3: “Evaluating Potential Sources of Costs and Savings” (1995).

Relative to all California health care costs, the California workers' compensation system makes up approximately 2 percent of the overall health care economy. While workers' compensation represents a small slice of the general health care pie, there are significant differences in patient needs and associated treatment when compared to group health and federal health care programs. Workers' compensation injuries are largely orthopedic in nature (*i.e.*, sprains, strains, and fractures of the back and upper and lower extremities), but also include repetitive motion injuries, burns, mental health related injuries, and other conditions. In contrast, the most common types of care covered by group health are maternity, pediatric and geriatric conditions, cardiac conditions, and preventive medicine. These differences require distinct specialties and professional experience within each system. For example, workers' compensation medical treatment providers often need to evaluate the degree of permanent impairment and return-to-work options for the injured worker.

This report revisits and updates the challenges in merging the workers' compensation and group health systems. For context, the Appendix of this report provides a summary and review of health care reforms and enacted and proposed legislation promoting 24-hour coverage or managed care principles in California workers' compensation over the past 25 years.

### 24-Hour Coverage Models

There are two basic models for 24-hour coverage:

#### *Single-Payer*

A single-payer concept has been presented in a number of proposals over the years in California, including Proposition 186, a 1994 ballot initiative that was rejected by California voters by nearly a 3-to-1 margin, and 2008 legislation, Senate Bill 840 (Kuehl), that was vetoed by then-Governor Arnold Schwarzenegger.<sup>2</sup>

California Senate Bill 562, the 2017 legislation introduced by Senators Atkins and Lara, is also a single-payer proposal. SB 562 calls for the creation of the Healthy California program, which would be required to provide comprehensive, universal single-payer health care coverage for all California residents. The sole reference to workers' compensation in this legislation is that the Healthy California Board "...shall develop a proposal for HC coverage of health care services currently covered under the workers' compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating."

The basic premise behind single-payer is to replace the private health insurance market with a single, government-sponsored program that is funded by a combination of premiums and public funds. The goal of single-payer proposals, including "Medicare for All," is to provide universal coverage for all eligible residents.

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<sup>2</sup> California Health Care Foundation (CHCF) (2017), "Timeline: California Health Reform Policy Proposals Before the ACA."

### ***“Pay-or-Play” (Employer/Individual Mandate)***

Another concept that has been advanced over the years is the “pay-or-play” proposal that requires employers either to secure health insurance for their employees or to pay a fee to fund a health insurance pool providing health care for all workers and their dependents. This concept was most recently put forth at the state level in the “Health Insurance Act of 2003,” (Senate Bill 2, Burton), signed 15 years ago by Governor Gray Davis. Shortly thereafter, however, opponents gathered sufficient signatures to challenge the new law in a 2004 voter referendum (Proposition 72), and the proposal was ultimately defeated by a very narrow margin. A “pay-or-play” program would not displace the private health insurance marketplace. The program envisioned in SB 2 is similar to the local “Healthy San Francisco” program developed in 2008 that requires employers to pay to fund a “public option” health access program if they do not offer qualifying health care coverage. The “pay-or-play” concept is also at the core of the shared responsibility requirements for both individuals and small businesses that were originally included in the ACA.

The early efforts to integrate workers' compensation and group health coverage through legislative activity and market-based experimentation failed to find a broad audience. Pilot programs in 24-hour coverage were unsuccessful primarily due to low levels of employer participation and the degree of difficulty in reconciling and integrating fundamentally different systems with distinct laws and regulations. Though there were lessons learned, significant hurdles remain, which can be summarized in four categories:

- System Structure
- Managed Care and Health Care Delivery
- Administrative Expenses
- Other Matters

### **System Structure**

Any effort to merge workers' compensation and general health must account for and resolve some significant challenges. Those challenges, detailed below, include: (a) the fact that workers' compensation is a complete system of benefits that in some cases must account for wage loss, permanent disability, and life-time medical care; (b) removing those benefits likely would re-engage a worker's right to sue his or her employer in tort, thus increasing system costs significantly; and (c) in California, as in other states, the workers' compensation system is enshrined in the Constitution, requiring a significant legislative effort to approve and implement any alteration in benefits.

- *Workers' Compensation Is a Complete System.* Workers' compensation benefits include medical treatment, wage replacement (temporary disability), and permanent disability payments. Thus far, the debate over health care reform has focused only on the medical benefits provided to injured workers. But to the extent that a separate disability system would need to be maintained for occupational injuries and illnesses, the scope of savings would be diminished -- especially given the highly litigious nature of determining permanent disability in California's workers' compensation.

- *Access to Medical Data.* Frictional costs, particularly new requirements to integrate the health care and disability systems, can be anticipated in a 24-hour system as disability insurers would want prompt access to medical records when administering lost-time claims. All aspects of the system integration would need to ensure privacy and security compliance with the federal Health Insurance Portability and Accountability Act.

*Preservation of Exclusive Remedy.* Regardless of the nature of the proposal for providing medical benefits, health care reform recommendations to date have kept the basic workers' compensation bargain intact. The right to sue an employer would still be protected by exclusive remedy, and indemnity benefits would still be the liability of the employer; but the party liable for medical treatment could vary, depending on the nature of the health care reform.

In some proposals, health care would be financed without regard to the occupational nature of the injury or illness through a range of taxes, fees, and potentially, premium. In others, there would be a single payer for health care that would either literally or practically be the sole provider of occupational medical services, which would remain the liability of the employer.

The 24-hour coverage concept would preserve an injured worker's right to receive medical and indemnity benefits, but the rights of way – or more appropriately the rights to sue – at the intersection of exclusive remedy, the preemption of state actions under the Employee Retirement Income Security Act of 1974 (ERISA), and a universal coverage health care plan have not yet been engineered. Nevertheless, any 24-hour system proposal will need to incorporate the limitation on civil actions against employers for injuries and illnesses arising out of and in the course of employment, as that is a fundamental element of the workers' compensation grand bargain.

- *Litigation.* California has a high rate of attorney involvement with almost half of all indemnity claims associated with litigation.<sup>3</sup> How might the litigation rate change in a merged medical system? In a 24-hour system, the workers' compensation payer would inherit the medical treatment decisions of the medical benefit provider and then have to reconcile the treatment plan with the remaining associated issues of disability rating (restrictions), permanent and stationary status, and return-to-work determinations.

Resolving such disputes might increase administrative costs and the likelihood of litigation from the payer side. Coordinating external medical care decisions with disability rating issues would also require revisiting and redefining the role and jurisdiction of the Workers' Compensation Appeals Board (WCAB).

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<sup>3</sup> CWCI Industry Research Information System V19A, 2018.

## Managed Care and Health Care Delivery

Research shows that medical utilization and treatment costs for comparable injuries are significantly different in workers' compensation than in group health.<sup>4</sup> Some of the differences have been mitigated in recent years through the integration of managed care principles common in group and federal health programs (*e.g.*, expanded fee schedules, physician and hospital networks, inpatient and outpatient utilization reviews, and pharmaceutical formularies) into workers' compensation. Details of these efforts can be found in the Appendix.

There have been limits to innovation, however, including the lack of risk-sharing for both providers and patients. Other differences between occupational and non-occupational medical care include dispute resolution, duration of treatment, coordination of care, and access to physicians with expertise in workers' compensation injuries and disability management. Any chance of achieving a true 24-hour medical delivery system would require reconciling these fundamental differences in medical care delivery and shared risk.

- *Shared Risk.* One of the biggest differences in the financing of health care and workers' compensation medical treatment is the cost sharing expected of employees for non-occupational health care. This takes several forms, including premium payments, deductibles and co-pays, contractual limits on certain services, and waiting periods. These group health shared risk elements serve to balance supply and demand for medical services and curb excessive cost and/or unproven utilization of certain medical procedures. Barring a constitutional amendment, an injured worker could not be required to contribute to the cost of medical treatment necessary to cure or relieve the effects of an occupational illness or injury, and their eligibility for benefits must begin immediately upon employment. To the extent that any health care delivery system -- whether a single payer, employer mandate, or 24-hour coverage -- must administratively identify whether there is an employee contribution required for the payment of services, there would be a reduction in administrative savings. The current workers' compensation system offers a superior benefit to injured workers than they are afforded through general health, as workers' compensation has no deductibles, co-pays, lifetime limits, etc. Duplicating this benefit approach for general medical care would be markedly more expensive than the existing health system, as there would be little counter balance on consumption.
- *Dispute Resolution.* While utilization review disputes are now resolved through independent medical review in both systems, in workers' compensation disability determinations remain the domain of the WCAB. In addition, all aspects of a workers' compensation claim are subject to settlement between the employer and the injured worker. If a health care system were to require that one insurer provides all medical treatment while another insurer adjusts the indemnity part of the claim, how would an employer settle its obligations under the workers' compensation system -- assuming that the employer at injury remains liable for ongoing medical treatment?

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<sup>4</sup> Victor, R., Fomenko, O. "Comparing Workers' Compensation and Group Health Hospital Outpatient Payments" (WCRI) June 2013; Robertson, R., Corro, D. "Workers' Compensation vs. Group Health, A Comparison of Utilization" (NCCI) November 2016.

- *Treatment Duration.* Unlike most group health claims, treatment duration for a workers' compensation injury or illness often continues for several years (with 24 percent of workers' compensation medical payments made 10 years after the inception of the claim).<sup>5</sup> Under an integrated system, the group health plan administrators would need to mesh such differences.
- *Coordination of Care.* Coordinating an employee's occupational and non-occupational care through the same provider or provider organization should improve the quality of care and produce savings through reductions in medication interactions and duplicate testing and the elimination of "double dipping" -- duplicate payments by different insurers for the same condition.
- *Access to Care.* The mix and expertise of medical providers is different in workers' compensation than in group health, not only due to the types of injuries that are most prevalent within each system, but also due to the fact that workers' compensation providers must also factor disability management and return-to-work issues into their treatment decisions.

### Administrative Expenses

- *Reduction of Administrative Expenses.* Critics of California's current workers' compensation system often cite its high loss adjustment expenses (LAE), as the ratio of allocated LAE to benefits is 26.9 percent -- by far the highest of any state workers' compensation system and 2.6 times higher than the median level noted for all state programs (Arizona's 10.5 percent).<sup>6</sup>

Comparisons of California workers' compensation administrative costs to those in other states and general health care delivery systems further underscore the issue. For example, administrative costs represent about 2 percent of all expenses for Medicare; 18 percent for private health care; and 22 percent for the median workers' compensation state. In contrast, allocated and unallocated administrative costs in California workers' compensation account for 53 percent of all expenses.<sup>7</sup>

Weighing workers' compensation administrative costs against those found in group health is somewhat of an apples-to-oranges comparison due to the role that litigation over disability benefits plays in the workers' compensation calculation.

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<sup>5</sup> WCIRB 2017 Pure Premium Rate Filing.

<sup>6</sup> NCCI 2016.

<sup>7</sup> WCIRB "State of the System" 2017.

## Other Matters of Consideration

- *Impact of Reduced Insurance Premiums.* While public policy and the competitive marketplace encourage reduced insurance premiums through greater efficiency and competition, the establishment of a single-payer system that would include workers' compensation medical treatment creates potential unintended consequences. The General Fund would lose tax revenues from health insurers regulated by the Department of Insurance and health plans regulated by the Department of Managed Health Care. Also, since workers' compensation insurers would be limited to adjusting the indemnity portion of claims, total workers' compensation premium would decline, providing a smaller assessment base for the California Insurance Guarantee Association and for premium-based assessments that help to fund the Division of Workers' Compensation (DWC), Cal-OSHA, the Subsequent Injuries Fund, and other programs within the Department of Industrial Relations (DIR). These revenues would need to be replaced.
- *Definition of Pre-Existing Condition.* Depending on the type of health care reform enacted, and most specifically if a single-payer structure were created, there is the question of what would constitute a pre-existing condition and how that would be funded. Currently, medical costs for open claims are funded through reserves maintained by insurers and self-insured employers, and through the periodic adjustment of premiums and collateral or loss reimbursements for employers who purchased a retrospectively rated insurance policy or a policy with a deductible endorsement. These obligations can continue many years after the end of a policy term as the at-injury employer is obligated to pay benefits for as long as the claim requires. This leaves the question of whether a single-payer plan would assume all the outstanding liabilities for medical treatment of open claims -- and if so, how it would be funded.
- *Solvency.* It is unclear from reviewed proposals who would be the functional regulator of a single-payer system and under what solvency guidelines it would operate. Solvency regulation might remain the purview of either the Department of Insurance or the Department of Managed Health Care, or an alternative regulatory agency might be required for a public or quasi-public single payer.
- *Uninsured Workers.* As noted by the California Health Care Foundation, there are nearly 2 million uninsured workers in California.<sup>8</sup> A system that merges occupational and non-occupational medical treatment would need to have some ability to deliver medical treatment to workers injured on the job who are uninsured for health care.
- *Reciprocity.* If medical treatment is separated from indemnity benefits, as would be the case in a single-payer system, California workers injured in other states would still likely receive all necessary treatment, but simply from two payers. The more difficult question,

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<sup>8</sup> California Healthcare Foundation (CHCF) California Healthcare Almanac, December 2016, updated November 2017. "California's Uninsured: As Coverage Grows, Millions Go Uninsured."

however, is what would happen to a worker who is not a California resident who is injured in California?

Under a single-payer structure, medical benefits would not be available to a non-resident. Furthermore, one version of a single-payer proposal, SB 562, expressly limits coverage to “an individual whose primary place of abode is in the state, without regard to the individual’s immigration status.” The solution might be as simple as permitting workers who reside in another state who are injured in California to have their claims resolved under the law of the state of residence. Without a reexamination of this issue, however, the question of what benefits an out-of-state worker is entitled to in California would most certainly be litigated.

- *Claim Frequency and Workplace Safety.* Eliminating the medical component within workers’ compensation might compromise the national trend of decreasing claim frequency as individual employers would no longer be rewarded on a differentiated basis for promoting a culture of safety. In 2016, almost 80 percent of Colorado voters rejected the creation of a single-payer system, ColoradoCare (also known as Amendment 69). Pinnacol Assurance, the Colorado state compensation insurance fund and largest insurer of workers’ compensation obligations in that state, noted that the measure would have significantly reduced the ability of insurers to “...work with employers to keep workers safe and minimize the potential for injury, and work with providers to help injured workers get back to work in a timely and safe way. So we expect that time off from work would increase, productivity would decrease and wage replacement costs would rise.” On the other hand, while the overall premium would be lower due to the elimination of medical costs and associated expenses, there would still be sufficient data to experience rate based on indemnity claims. This is tacitly acknowledged in SB 562 regarding workers’ compensation: “The board shall develop a proposal for HC coverage of health care services currently covered under the workers’ compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.”<sup>9</sup>
- *Market Issues.* Depending on the structure, there also are market barriers to fully coordinating occupational and non-occupational health care delivery. In a 24-hour coverage model, there would need to be premium-based financial incentives to encourage employers to make the long-term commitment to remain in the program. This could be complicated in years of aggressive price competition in the workers’ compensation insurance marketplace where significant discounting is already taking place. It would also depend on the criteria used to establish health insurance rates – especially for small and mid-sized employers. And the “long tail” of workers’ compensation would make it challenging to provide a competitively priced product that delivers occupational and non-occupational medicine through a coordinated program.

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<sup>9</sup> SB 562, proposing to amend Govt. C. §100612(i)(3). <https://leginfo.legislature.ca.gov/faces/billNavClient>



## Conclusion

The debate over health care and workers' compensation reform has changed considerably since CWCI's first analysis of 24-hour coverage issues in 1993.

Since the 1990s, California lawmakers have enacted multiple legislative reforms that have integrated managed care tools into workers' compensation medical delivery. These tools include utilization review, employer-directed care through medical provider networks, and independent medical review. In addition, employers and injured workers alike have benefitted from the creation of evidence-based treatment guidelines in the Medical Treatment Utilization Schedule (MTUS), which as of January 1, 2018 includes a prescription drug formulary, reducing the opportunities for unnecessary and potentially harmful medical treatment and fraud. Lawmakers and regulators have also established fee schedules that have helped contain costs while making compensation for medical providers more consistent with other payers. And, as we have seen from the most recent legislative efforts -- including Senate Bill 1160 (Mendoza), Assembly Bill 1244 (Gray), and Assembly Bill 1422 (Insurance Committee) -- the effort to combat provider fraud is now receiving unprecedented attention.

The health care delivery system as set out in the ACA and augmented by the State of California drives much of the discussion over health care reform. There is uncertainty over the fate of the ACA and the known and unknown consequences of large-scale actions by President Trump and Congress to further tinker with or fully dismantle the status quo.

While many are attracted by the curb appeal and promise of 24-hour coverage, after some 25 years of pilot projects and evaluation California has yet to find an accepted path to integrating medical treatment for occupational and non-occupational injuries and illnesses. This has not been for lack of effort. Differences in statutes and regulations, coupled with additional costs, create a muddled picture. Public policy change, especially on such a large scale, can only be accomplished through transparency and candid presentation of the details. Future proposals are best served by confronting the challenges outlined above.

## Appendix A: 25 Years of Health Care Reform and 24-Hour Integration Efforts

### Health Care Reform in California 1992-2017

Over the past 25 years, California lawmakers have undertaken efforts at reforming non-occupational health care with regularity. More than a dozen proposals – both major and minor – have come before the Legislature and voters in an effort to make health care more accessible and affordable.<sup>10</sup>

Efforts to enact comprehensive health care were particularly intense between 1992 and 1994, both in Sacramento and Washington, D.C. In California, this involved several legislative efforts, including one spearheaded in 1992 by then-Insurance Commissioner John Garamendi and authored in the Senate by Art Torres (Senate Bill 6) and in the Assembly by Burt Margolin (Assembly Bill 502). Neither of these bills, nor Senate Bill 248 (Maddy and Brown) – the major effort to negotiate legislative reform – got to Governor Pete Wilson's desk. The "Garamendi Plan" called for a merger of occupational and non-occupational health care, as did the unsuccessful Proposition 166 – a proposed employer mandate that received only 30 percent approval by the voters.

On the national level, President Clinton offered the Health Security Act to Congress in 1993, which promptly triggered a public relations/grassroots campaign by opponents that brought an end to health care reform in Washington, D.C. for more than a decade and a half.

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 represented a major step toward the goal of increasing accessible health care. For Californians, the implementation of the ACA included the expansion of the state's Medi-Cal (Medicaid) program with the chaptering of Assembly Bill 1 (Pérez) of the 2013-14 First Extraordinary Session in 2013. This measure extended Medi-Cal eligibility under the ACA to families and individuals whose income is at or below 138 percent of the federal poverty level.

In addition, the ACA created a Health Insurance Marketplace, also known as an exchange, where individuals and small businesses can shop among competing insurance plans offering required essential health benefits. In California, the state-operated health insurance exchange is known as Covered California. Under Covered California there are a variety of premium assistance plans for individuals and families with earnings up to 400 percent of the federal poverty level. The Covered California exchange currently has 11 participating insurers in the individual market.<sup>11</sup>

Covered California also offers small business insurance plans for employers with 100 or fewer employees. If a qualified employer contributes at least 50 percent to the cost of insurance it may be eligible for a tax credit. The maximum available tax credit is 50 percent of insurance

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<sup>10</sup> California Research Bureau, "Ninety Years of Health Insurance Reform Efforts in California" (2007). California Agencies. Paper 316; California Health Care Foundation, "Health Reform Before the ACA: A Timeline of Policy Proposals for California" (2017). None of the major efforts at comprehensive reform were signed into law or approved by the voters.

<sup>11</sup> <http://www.coveredca.com/>

premium expenses and is available for a total of two consecutive years.<sup>12</sup> There are currently six insurers offering small business plans through Covered California.

The ACA does not mandate that employers provide coverage. If an Applicable Large Employer (ALE), defined as having at least 50 full-time employees, does not provide qualifying coverage then it must make a “shared responsibility” payment to the federal government.<sup>13</sup>

With these changes, there remains the persistent problem of the uninsured, and in particular, uninsured employees. Per the California Health Care Foundation’s report, “California's Uninsured: As Coverage Grows, Millions Go Without,”<sup>14</sup> of the 1.8 million uninsured workers in the state, 44 percent worked in firms with fewer than 50 employees.

### 24-Hour Care and Workers' Compensation Reform in California: 1992-2017

- **Legislation Promoting 24-Hour Care – Enacted and Proposed**

*AB 3757 - 24-Hour Pilot.* In 1992, when many efforts were underway to reform health care in California, Assembly Bill 3757 (Broznan) was signed into law by Governor Pete Wilson. This legislation authorized the DWC to undertake a 36-month pilot project to test the use of 24-hour coverage programs in which employers could contract with a health service plan to act as the exclusive provider of medical care for occupational and non-occupational injuries and illnesses.

There were four pilots approved, and marketing for the first plan began in June 1994, with the remainder starting in 1995. Enrollment peaked at about 65 employers and 8,000 covered lives before the pilot ended in December 1997. The pilots did not have enough enrollment and were not active long enough to provide adequate data for evaluation. In an interim report to the Legislature, the DIR Research Unit interviewed representatives of claims administrators and the health plans and noted:

Even though the programs offered many insured employers a reduction on compensation premiums, employers also needed to go through an enrollment process, and explaining the program required marketing and explanation. The 24 hour product was more complex than a traditional health or workers' compensation policy, and awareness of the concept took some time to be disseminated. Because of open rating, the newness and unfamiliarity of the product, the difficulty of establishing fair and competitive capitation rates, the enrollment process, and the absence of initial data to show the program's efficacy, the marketing of the plans fell below initial expectations.<sup>15</sup>

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<sup>12</sup> <http://www.coveredca.com/forsmallbusiness/taxcredit/>

<sup>13</sup> Kaiser Family Foundation, “Employer Responsibility Under the Affordable Care Act” <https://www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/>

<sup>14</sup> California Health Care Foundation (CHCF) (2016; updated 2017) “California's Uninsured: As Coverage Grows, Millions Go Without.”

<sup>15</sup> “Interim Report to the Legislature: 24 Hour Pilot Programs under Labor Code Section 4612” March 1997, Research and Evaluation Unit of the California Division of Workers' Compensation.

***AB 3625 - Provision of Workers' Compensation Coverage by Health Insurers.*** In 1994, Assembly Bill 3625 (Campbell) amended several producer licensing sections in the Insurance Code and added Section 1749.02. This insurance producer licensing legislation defined 24-hour coverage as “the joint issuance of a workers’ compensation policy with a disability insurance policy, health care service plan contract, or other medical insurance coverage for non-occupational injuries and illnesses. This product shall not include a life insurance policy.”

In the Assembly Floor analysis of AB 3625, it was noted:

The sponsor is Blue Cross of California, which is one of many health insurers who have begun to market managed care workers’ compensation coverage to employers. Until recently, treatment of injured workers under the workers’ compensation system was done almost exclusively on a “fee-for-service” basis. It is generally believed that the cost of workers’ compensation coverage could be reduced substantially if managed care principles such as selective contracting with providers of care, which have been increasingly used by health insurers over the past decade, were to be used in the workers’ compensation system. Applying managed care to workers’ compensation is generally referred to as “24-hour care,” since it seeks to have workers use the same managed care system for industrial injuries as they do for all other health care needs.<sup>16</sup>

While most of the vestiges of this effort were removed from the Insurance Code in 2010 when Assembly Bill 2782 (Insurance Committee) deleted references to 24-hour coverage in producer licensing statutes, the 24-hour coverage definition in Insurance Code §1749.02 stands as a remnant of a public policy innovation that never materialized in the marketplace.

***AB 110 – HCOs & the Minniear Decision.*** In 1993, Assembly Bill 110 (Peace and Brulte) added Health Care Organizations (HCOs) in Labor Code §4600.3 and §4600.5 to deliver medical treatment through an employer-controlled network. At that time, per Labor Code §4600, an employer could only direct medical treatment for a work-related injury for the first 30 days after the injury. The law encouraged 24-hour coverage by giving extended control of medical treatment to the employer if they demonstrated that the injured worker was also receiving, or was eligible to receive, health care benefits from the employer.

In addition, as noted in the Institute’s earlier publication, one of the intended benefits cited by advocates of 24-hour coverage was the extension of managed care concepts to workers’ compensation.<sup>17</sup> This was in part addressed by AB 110’s creation of HCOs, which attempted to bring capitated payments into the reimbursement structure for occupational medicine while creating an opportunity for employer-directed treatment.

The mechanics of the HCO are important to note for purposes of this discussion. First, the employer had to offer two HCOs and the employee was required to elect which one would

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<sup>16</sup> Senate Floor Analysis of Sen. Bill No. 3625 (1993-1994 Reg. Sess.).

<sup>17</sup> California Workers’ Compensation Institute and William M. Mercer, Inc. Part 1: “Framing the Issues: 24 Hour Coverage” (1993).

provide treatment for industrial injuries or illnesses. There would also be an annual open enrollment period, as is the case with health insurance coverage. One of the two HCOs offered by the employer was required to compensate its providers on a fee-for-service basis, an acknowledgment that capitated payments were considered an option at that time. The duration of the employer's medical control depended on the health care coverage provided to the injured worker. If the employee was not insured or not eligible for insurance, then the HCO would provide 90 days of care before the injured worker could see a provider of his or her own choice. If the employee was receiving or eligible to receive health coverage, that period of medical control was extended to 180 days. Finally, if the HCO network contained an employee's personal physician or chiropractor, medical care could be provided through the HCO for 365 days.

In addition to allowing the creation of HCOs, however, AB 110 also added the following:

In cases where an additional comprehensive medical evaluation is obtained under Section 4061 or 4062, the findings of the treating physician are presumed to be correct. This presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of impairment. However, this presumption shall not apply where both parties select qualified medical examiners.

The physician presumption in AB 110 was greatly expanded by the 1996 *Minniear* decision,<sup>18</sup> a 1996 en banc ruling by the WCAB that gave the primary treating physician the presumption of correctness in regard to all medical issues, including the use of any given medical treatment. The practical effect of the *Minniear* decision was to limit a payer's ability to challenge medical treatment choices unless it could be proven that the provider's recommendation was not supported by the medical literature. This standard was rarely overcome in the appeals process. Gardner (2002) and Johnson (2002) found that the immediate escalation of medical costs was associated with the expansion of the physician's presumption of correctness rather than a change in the mix of injuries inherent in the system.<sup>19, 20</sup> Likewise, CWCI found a four-fold increase in average medical costs following the passage of AB 110 and the subsequent expansion of the presumption under *Minniear*.<sup>21</sup> By 2003 – a decade after AB 110 was enacted – the Legislature was forced to confront this new workers' compensation crisis.

By the end of the 1990s, the aspirations of the 1993 reforms relating to coordinated coverage and 24-hour care had failed to materialize. HCOs remain in use today, but the initial complexities in its requirements, combined with the turbulent insurance marketplace of the late 1990s, prevented this early effort at managed care from having a measurable impact on

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<sup>18</sup> *Minniear v. Mt. San Antonio Community College District*. Workers' Compensation Appeals Board (en banc) 61 Cal. Comp. Cases 1055, 1996 Cal. Wrk. Comp. LEXIS 3570.

<sup>19</sup> Gardner L, Swedlow A. California Workers' Compensation Medical Payments, Litigation and Claim Duration - A Post-Reform Report Card. *Research Note*. CWCI. May 2002.

<sup>20</sup> Johnson, T. The Effect of California's PTP Legislation on the Utilization of Healthcare, California Workers' Compensation Institute, Dec 2002.

<sup>21</sup> Gardner L, Swedlow A. California Workers' Compensation Medical Payments, Litigation and Claim Duration - A Post-Reform Report Card. *Research Note*. CWCI. May 2002.

the delivery of medical benefits and HCOs contributed nothing toward the creation of an environment in which occupational and non-occupational medical care could be coordinated.

***SB 723 and AB 550 - Allow State Fund to Offer Health Insurance.*** In 2008, Senator Leland Yee amended Senate Bill 723 to authorize State Fund to engage with health care service plans to provide 24-hour coverage in a six-year pilot project, but the proposal did not pass the Legislature. Assembly Bill 550 (Ma) that would have allowed State Fund to underwrite health insurance was also proposed and did not pass. Per the legislative analysis of AB 550, the sponsors of the bill (the State Building and Construction Trades Council, AFL-CIO) felt that if an employer or individual mandate were to be enacted, a non-profit alternative in the market would be needed that could enhance competition and help keep costs down.<sup>22</sup> Given the status of the debate over health care reform at the time, AB 550 demonstrated that the sponsors were already contemplating a “public option” to help force health insurers and plans to compete on price. The analysis further noted, “(t)he author suggests that health insurance rates continue to rise because of the lack of competition and argues that allowing State Fund to sell health insurance as a new nonprofit competitor will increase competition and potentially lower rates.”<sup>23</sup>

- **Legislation Promoting Managed Care in Workers' Compensation**

***SB 228 - UR and MTUS.*** In 2003, Senate Bill 228 (Alarcón) established a utilization review (UR) structure within workers' compensation and created the Medical Treatment Utilization Schedule to provide a guide for presumptively correct medical treatment. SB 228, however, did not change the law as it related to employer-directed medical care, nor did it remove the jurisdiction of the WCAB over medical treatment disputes. The UR provisions of SB 228 were derived almost verbatim from the UR requirements applicable to health care service plans governed by the Knox-Keene Health Care Service Plan Act of 1975.<sup>24</sup> In other words, at least initially, UR was technically supposed to be the same process that providers were already using for health care requests under group health plans.

***SB 899 - MTUS and MPNs.*** In 2003-04, California lawmakers continued their efforts to incorporate additional managed care concepts into workers' compensation, and on April 19, 2004, Governor Schwarzenegger signed Senate Bill 899 (Poochigian), which enhanced the strength of the MTUS and created Medical Provider Networks (MPNs). As originally codified, this legislation required the DWC to approve an employer's plan to deliver all reasonably necessary and medically appropriate treatment through a physician network that, among other requirements, would provide prompt access to primary and specialist care. Medical treatment under an MPN continues for the lifetime of the claim. Use of physician networks in workers' compensation grew rapidly after SB 899 became law, with utilization of network providers increasing from approximately 39 percent of all treatment prior to the passage of SB 899 to more than 80 percent by 2016.<sup>25</sup>

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<sup>22</sup> Assem. Com. on Insurance, Analysis of Assem. Bill No. 550 (2007-2008 Reg. Sess.), p. 1.

<sup>23</sup> *Id.* at p. 2.

<sup>24</sup> Health & Safety Code Sec. 1367.01.

<sup>25</sup> Ireland, J., Swedlow, A. Analysis of California Workers' Compensation Reforms Part 3: MPNs and Medical Benefit Delivery—Preliminary Results Research Update, CWCI, June 2007; Ireland, J., Hayes, S., Swedlow, A. PPO to MPN: Impact of Physician Networks in the California Workers' Compensation System. Research Note, CWCI, June 2015.

**SB 863 - IMR.** In 2012 Senate Bill 863 (De León) created independent medical review (IMR). Again, as had been the case with the adoption of mandatory UR, the IMR requirements mandated for California workers' compensation closely aligned with the existing requirements for IMR for health insurers and plans – and divested the WCAB of jurisdiction over medical treatment disputes. The adoption of IMR eliminated the costly system of resolving medical disputes by having dueling forensic doctors each present testimony in an attempt to persuade or dissuade an administrative law judge in regard to the necessity of a requested medical procedure. There was an unanticipated consequence, however, as attorneys and physicians filed a high volume of IMR challenges, leading to more than 165,000 IMR determinations per year between 2015 and June 2017.<sup>26</sup>

- **24-Hour Studies and Reports**

Researchers have been looking at the 24-hour coverage issue ever since the first pilot projects were authorized in 1992. In 1997, the DWC issued an “Interim Report to the Legislature: 24 Hour Pilot Programs under Labor Code Section 4612.” The preliminary report noted, “The employers were asked whether they perceived that the pilot program had saved them money. Five employers said yes, all of whom were insured for workers' compensation and had been given direct incentives through a modest discount on rates. One indicated that a previous bad injury year had sent his premiums rising, even with industrywide costs declining. Four employers were not sure whether the program had produced any cost savings.” The pilots ended in 1994.

Over the 6-year period ending in 2008, the Commission on Health and Safety and Workers' Compensation (CHSWC) sponsored various studies and hosted stakeholder discussions on 24-hour coverage. A 2004 study undertaken by RAND included an assessment of 24-hour care options which concluded that, “it is premature for the state of California to embark on statewide introduction of 24-hour care.” RAND further noted:

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 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.<sup>27</sup>

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<sup>26</sup> David, R., Bullis, R. IMR Outcomes: January 2014 Through June 2017. Spotlight Report. CWCI. September 2017.

<sup>27</sup> Farley, D., Greenberg, M., Nelson, C., Seabury, S. “Assessment of 24-hour Care Options for California” RAND 2004.

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## California Workers' Compensation Institute

The California Workers' Compensation Institute, incorporated in 1964, is a private, nonprofit organization of insurers and self-insured employers conducting and communicating research and analyses to improve the California workers' compensation system. Institute members include insurers that collectively write 83 percent of California workers' compensation direct written premium, as well as many of the largest public and private self-insured employers in the state. Additional information about CWCI research and activities is available on the Institute's website ([www.cwci.org](http://www.cwci.org)).

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