

The California Commission on Health and Safety and Workers' Compensation



Summary of Occupational and Non-Occupational Integrated Care Roundtables

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Summary of Integrated Occupational and Non-Occupational Care Roundtables

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Background

Group health care costs have been rising much more quickly than inflation and wages. Costs have been rising even more quickly for treatment of occupational injuries in the California workers' compensation system. This creates major financial challenges for employers, especially those in industries with already high workers' compensation costs. Furthermore, group health care and workers' compensation medical care are typically delivered through separate provider systems, resulting in unnecessary, duplicative, and contraindicated treatment, and inefficient administration. (See Attachment A.)

Occupational and Non-Occupational Integrated Care Pilot Project

The California HealthCare Foundation (CHCF) awarded a planning grant to the Commission on Health and Safety and Workers' Compensation (CHSWC) to evaluate the potential savings to both occupational and non-occupational health costs from integrating all care under a single provider.

The project seeks to demonstrate that delivering both occupational and non-occupational care within an integrated provider network will reduce overall costs. The project team is collaborating in a pilot project with union and employer representatives to integrate occupational and non-occupational medical services for janitorial workers and to evaluate cost savings and improvements in health care delivery.

The pilot integration of care project is between the employer, DMS Facility Services, and the Service Employees International Union (SEIU) Local 1877, which have negotiated, created, and entered into a labor-management carve-out agreement (authorized by California workers' compensation law) to allow medical services to be delivered with fewer constraints, delays, and disputes than in the state workers' compensation system. The carve-out agreement includes an alternative dispute resolution (ADR) system to the state system involving formal legal proceedings before a workers' compensation judge.

The goal of the pilot, which uses Kaiser Permanente for delivery of workers' compensation medical care and group health, is to identify areas of administrative savings and how to eliminate litigation, as well as better ways to deliver care. The pilot is being conducted by CHSWC and the University of California (UC), Berkeley with

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support from CHCF. Also collaborating on the project are Kaiser Permanente and the California Workers' Compensation Institute (CWCI).

Savings in the pilot are expected in medical utilization, indemnity costs, and administration. Medical services are expected to be delivered with fewer delays and disputes, enabling injured employees to recover more fully and return to work sooner.

The pilot agreement is completed, and integrated care is presently available for the janitorial workers of DMS Facility Services. A report on the evaluation of the pilot will be conducted.

Occupational and Non-Occupational Integrated Care Roundtables

The Occupational and Non-Occupational Integrated Care (ONIC) Project is conducting a series of roundtable discussions with employers, unions, and providers. The objectives of the roundtables are to present information about the DMS/SEIU pilot program in integration of occupational and non-occupational medical care and to explore challenges and key strategies for implementing integration of care.

The basic concept of integrated care is having the same physician or medical group treat all conditions – both occupational and non-occupational – regardless of the cause of injury or illness. There are many ways to accomplish integration. Key benefits of integration are that it: eliminates duplicate tests and treatment, as well as inconsistent care by different providers; and it allows for better coordinated care and concurrent care for all conditions. Integration of care helps control costs by avoiding disputes about causation and by reducing administration of two separate systems.

Description of Roundtables

Roundtables have been held for key stakeholders in the workers' compensation system to assess integration of occupational and non-occupational care.

The Department of Industrial Relations (DIR), the California Manufacturers & Technology Association (CMTA), and CHSWC held a roundtable for private sector employers on June 13, 2008. The roundtable included 17 stakeholders in the workers' compensation system representing insured and self-insured employers, insurance carriers, and medical providers.

Roundtable discussion addressed issues relating to integrating workers' compensation medical care and group health. The purpose of the discussion was to assist employers in evaluating their potential for integrating care and undertaking steps toward that goal. Discussion covered such topics as: the pros and cons of integrating care; different models of integration; specific steps toward integrating care; and potential barriers and how to address them.

ONIC Roundtables

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A key outcome of the first roundtable was the recommendation that the public sector would be the ideal setting for a pilot. The next steps would be to develop a feasibility study of integration in the public sector, using public sector data. Preliminary meetings have been held with some parties who have indicated they would cooperate.

A second roundtable was held by the American Federation of Labor (AFL-CIO) and CHSWC on September 9, 2008. The roundtable included over 40 stakeholders representing labor. Key discussion points are summarized below. Next steps from the labor roundtable would be to work with unions on providing specific details and resources on carve-outs and integration of occupational and non-occupational medical care. In addition, a panel of experienced carve-out participants in which union and employer representatives can share their experiences with unions and employers considering carve-outs would be helpful.

A third roundtable was held for six representatives of the California Applicants' Attorneys Association (CAAA) on October 21, 2008. Additional roundtables were held for members of the Executive Branch and CalPERS and for members of group health insurers and employer purchasing coalitions.

Summary of Presentations for Occupational and Non-Occupational Integrated Care Roundtables

I. Presentation on Integration of Care Pilot Frank Neuhauser, UC Berkeley

- Integration of care is a way to reduce costs, improve quality of care, and improve access.
- A pilot project is underway with DMS Facility Services and SEIU Local 1877 custodial workers.
- Integration of care involves having the same physician or medical group treat all conditions, both occupational and non-occupational.
- The benefits of integration are:
 - Eliminates inconsistent care and duplicate tests and treatment.
 - Allows for better coordinated and concurrent care.
 - Reduces disputes about causation and administration of two separate systems.
- The nature of work injuries has changed from a majority of traumatic injuries to non-traumatic injuries; currently: traumatic injuries (33%); and non-traumatic injuries (67%).
- Workers' compensation does a good job with injuries caused by negligence but not with the chronic injuries occurring today.
- California employers' costs in 2006 were \$35 billion for group health insurance payments for single employees; the costs are \$14 billion for the medical portion of workers' compensation, which is about 25% of the total cost of medical care.
- Only a fraction, less than 2% per year, of the \$14 billion for workers' compensation medical treatment costs goes to health care providers.

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- The costs to deliver \$1 of medical benefits are: \$1.25 in group health; \$2.65 in workers' compensation (1984-2006); and \$4.25 in workers' compensation (post reform, 2004-2006). In workers' compensation, over 75% of the monies that employers are spending to cover medical treatment costs, or \$3.25, goes to pay for administrative costs.
- Since the reforms of 2004, a lot less medical treatment care is being paid for in workers' compensation (as noted by Kaiser's experience). More care is being denied through utilization review exacerbating the ratio of administrative costs to the medical treatment care being paid for.
- There are different levels of integration: basic integration, greater integration, and full integration.
- Basic integration:
 - The group health provider is the same as the workers' compensation medical provider.
 - Fee-for-service and two different billing systems remain.
 - Benefits are improved quality of care and limited cost savings.
- Greater integration:
 - A single insurer handles group health and workers' compensation medical.
 - There is a single insurance product and a single payment method for provider(s).
 - There is a single pricing structure and set of incentives for the medical provider.
 - There is a single administrative structure and therefore much less fee-for-service billing and more of capitated payment.
 - Benefits include further improved quality of care and substantial cost savings.
- Full integration:
 - There is no distinction based on cause of injury or illness.
 - Financial responsibility is based on the date of treatment, not on the employer at the time of treatment.
 - Benefits include that quality of care is maximized and cost savings are maximized.
 - Requirements are that health insurance is broadly available, and workers and employers may need to share costs of all care (same as cost-sharing in group health).
- Cost savings in California to cover all workers:
 - Savings from integrating care would help cover the cost of universal care.
 - Savings could be \$8 billion a year from the current system from the administrative side, not from medical treatment.
 - Two-thirds of costs for both insured and self-insured employers that is being paid in medical costs and is going to administrative costs and overhead could be saved.
- Some of the lessons learned from the pilot and getting to the first step of integration include:
 - A strong advocate for integration is needed on the employer and union sides.

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- A sufficient number of employers or employees are needed for insurers to offer an integrated care product.
- Regulatory and statutory changes are needed to streamline the process to get to full integration.

II. Presentation on Legislative Proposal for Integrated Care in Workers' Compensation Brent Barnhart, Kaiser Permanente, and Juliann Sum, UC Berkeley

- In 2007, there were different proposals for a 24-hour care pilot program.
- The Governor, as part of his overall health care reform proposal, outlined a demonstration project involving state and local government agencies through CalPERS. Private employers could elect to participate.
- Two bills were introduced in 2007 using the State Compensation Insurance Fund (SCIF) to establish 24-hour care pilots: Senate Bill (SB) 721 (Yee); and Assembly Bill (AB) 550 (Ma).
- The pilot would measure whether:
 - Integration would reduce duplication of medical services and associated disability/costs.
 - Injured workers experience better medical outcomes and higher patient satisfaction.
 - Better return-to-work averages, dispute resolution/rates of litigation, lower indemnity costs and administrative efficiencies for employers, insurance carriers, medical providers and workers are achieved.
- A CWCI study of SCIF policyholders from 1996 through January 2005 who participated in a SCIF-Kaiser Permanente Alliance indicated that integrated managed health care and workers' compensation saved more than \$395 million in total workers' compensation claims:
 - 32% lower medical treatment costs.
 - 25% lower disability costs.
 - 30% lower attorney involvement rate (friction costs are greatly minimized).
 - 24% lower average total costs.
- Workers' compensation requires identification of causation if the injury or illness is occupational.
- The right to submit issues through the Workers' Compensation Appeals Board (WCAB), if not resolved through the health care service plan mechanisms, would be maintained under integration.
- Significant practical and conceptual changes to achieve integration include:
 - Appropriate medical treatment for injured workers.

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- Recoding and communication of information concerning work-related injuries and illnesses for employers, injured workers, insurers, attorneys, and the Division of Workers' Compensation (DWC).
- Required injury and illness reports submitted to Cal/OSHA would still be required.
- Reports needed for determination of industrial causation and liability, temporary and permanent disability compensation, and need for future medical care would be provided.
- Challenges include:
 - Administration of co-payments, deductibles and other out-of-pocket devices, which may be imposed for non-occupational care, cannot be imposed for workers' compensation-related care.
- Current status:
 - Employer representatives and labor representatives urged an approach designed to apply to private as well as public employers.
 - Private parties were encouraged to get together to see if they could develop a consensus bill.
 - After meetings in June 2007, representatives of employers, labor and health plans submitted a product to the Governor's office in early August.
 - Administration representatives asked for a series of changes and urged the group to begin discussion with the Legislature.
- Legal issues at the national as well as the state level need reconsideration.
- Dispute resolution:
 - Existing rules under the Knox-Keane Act for the majority of health care providers require relatively quick dispute resolution within the health plan.
 - In a 24-hour care system, injured workers would retain the right to dispute resolution within the health plan, and then if that does not work, it could go to the WCAB.

Summary of CMTA, DIR, CHSWC June 13, 2008 Occupational and Non-Occupational Integrated Care Roundtable

The roundtable included 17 stakeholders in the workers' compensation system representing insured and self-insured employers, insurance carriers, and medical providers. (See *Attachment B* for the roundtable Agenda and *Attachment C* for a List of Participants.)

Discussion centered on identifying the current issues and challenges with respect to 24-hour care in California:

- Lessons learned from the integrated medical care pilot.
- Challenges to implementing integrated medical care.
- Recommendations and objectives when moving toward integrated medical care.

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Introduction

Jack Stewart, President of California Manufacturers and Technology Association (CMTA), welcomed the roundtable participants and thanked them for taking the time to discuss the issues. He stated that CMTA has been interested in combining health care and workers' compensation for a long time and is interested in hearing about current integrated care efforts.

Christine Baker, Executive Officer, CHSWC, thanked CHCF for funding and support of the pilot, as well as Kaiser and others who are working on identifying all the areas that can provide administrative cost savings to employers and better medical care delivery to injured workers.

John Duncan, Director, Department of Industrial Relations (DIR), stated that he was pleased that there would be discussion of innovation in this area and that despite problems in the past, it is important to find a way to integrate the two competing medical care delivery systems. Looking at a pilot format will help identify what works and what does not. He stressed that employers will be critical to integration.

Carrie Nevans, Administrative Director, Division of Workers' Compensation (DWC), stated that a number of people present at the roundtable were involved in Governor Arnold Schwarzenegger's efforts on changing health care.

Christine Baker stated that the pilot under discussion between DMS Facilities Services, a unionized employer with employees throughout the state of California, and SEIU 1877 is under a carve-out and uses Kaiser for delivery of workers' compensation medical care and group health. The pilot is a model which will help to identify areas of administrative savings and how to eliminate litigation. Going through this process should reveal better ways to deliver care and how to move toward that goal.

Key Issues from Roundtable Participants

- Understanding and controlling the component pieces of the \$3.25 of administrative costs of workers' compensation per \$1 of medical benefits, which include utilization review and bill review:
 - Billing by doctors not at fee schedule, which leads to reviews.
 - Risk of increasing the administrative costs on the group health side as a result of integration of care. Some administrative costs will remain, though they can be reduced.
 - Reducing administrative costs by reducing paperwork for most claims which are medical-only. The medical record will always be there, as this is required by law, and the medical provider will always have medical records.
 - Advantages of coordinated care and concurrent care can be achieved without costs decreasing if administrative costs are not streamlined.
- Less time lost and better, more efficient and less costly medical care when provided by an occupational physician rather than by a group health physician.
- Whether integration of care assumes an employer mandate for health care coverage.
- What happens when employees are no longer employed and the employer has made payment in advance based on anticipated risk.

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- Legislation has mandated an evidence-based system for determining impairment ratings by using the American Medical Association (AMA) *Guides*.
- Taking the leap to full integration may be more convincing than doing partial integration levels.
- Workers' compensation system picks up a lot of group health costs because of approximately 60% of cumulative, or chronic, disease.
- CalPERS may be the most appropriate for a test case of integration of care:
 - Longevity of employment is more typical at a state agency.
 - The economics works better for employers with this type of population and longevity at the same employer.
 - Exclusive PPOs were resistant as there might not be the needed level of providers, primarily because the level of paperwork is not attractive. Attracting providers will have to address paperwork, as well as low reimbursement rates.
- How insurance coverage for temporary disability and permanent disability will be covered under the level of greater integration; whether there will need to be separate coverage for permanent disability.
- Information about the way that reserves are handled by self-insureds:
 - Though not generally publicly disclosed, self-insured reserves are secured money which earn interest and are available; the amount reserved may be more than what the actuarial projection is.
- How legal barriers can be overcome.
- Importance of case law that states that the Legislature can place limits on medical care.
- Recognition of different agendas of different constituents, including: organized labor and its policy goal of universal health care; injured worker advocates; and applicants' attorneys.
- Small business needs should be considered. Interest in integration exists in the small business community, even though small businesses could find it difficult to participate in a pilot.
- How to eliminate defense and applicants' attorneys and the expense that they add to the system. Attorneys build a case for indemnity benefits through the medical treatment record.
- Consideration of the role of medical provider networks (MPNs) as a centralized source for providing medical care and independent medical review (IMR). MPNs and IMR could be a building block for integration.
- Whether SCIF would provide only indemnity insurance or the integrated care insurance if there is integration; currently, SCIF insures medical and indemnity.
- Fraud in the workers' compensation system due to lack of group health coverage is an issue.
- Perception of the employer community that the move toward 24-hour care is on hold; questions will have to be addressed before there will be substantive involvement.
- Need to address all questions on integration. Questions on earlier models of integration prior to SB 899 and before the establishment of MPNs were not addressed in the past.
- Whether full coverage can be funded by the State. Employers would want cost-containment. Small businesses do not yet see the relationship between integration and mandated health care coverage.

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- Whether workers' compensation carriers would be comfortable about turning over medical coverage to group health, since they would not be able to control and contain the medical record; then their liability will be exceptionally high.
- Whether the employer community will be ready to give up some of the control it has achieved over medical care and return to work (RTW) with the implementation of MPNs.
- What the impact of the duration of State Disability Insurance (SDI) is on workers' compensation claims after 52 weeks of temporary disability.
- What the ongoing relationship of the Fair Employment and Housing Act (FEHA) requirements and process to RTW and the workers' compensation system will be and whether workers' compensation carriers could take this on.
- Whether one type of RTW process could be created, at least to remove the adversarial part of the system:
 - Currently, employers may be more willing to bring back employees who have non-occupational injuries and illnesses than those who have occupational injuries and illnesses.
 - Turnover is an expensive process for employers.
 - The incentive for employees on non-occupational medical is much less than for occupational medical.
- What the first steps of the State's move to universal health coverage would be.
- The need to prove that there are savings from integration and the need for peer-reviewed studies of what the savings would be:
 - The California Department of Insurance (CDI) publishes on an annual basis the medical overhead of group plans, though the areas of medical that it covers need to be defined.
 - The California Workers' Compensation Insurance Rating Bureau (WCIRB) has data on the administrative costs.
- Barriers for employer associations exist, as they lack permission by law to provide health care.
- What the requirement of incident reporting for OSHA requirements would be.
- Whether utilization review could be reduced.
- Whether MPNs could operate more efficiently.
- Whether a carve-out is the best way to make changes required to implement integration.
- How the State's industrial disability program (IDL) benefits would relate to benefits under integration -- it pays two-thirds of salary for up to a year and then the person goes to temporary disability. Currently, 92 to 94% of temporary disability cases are under the SDI and the state program; some employers that self-insure for disability pay for six months.
- Whether temporary disability should be handled the same regardless of whether it is occupational or non-occupational and whether a pilot should include integration of disability in addition to medical care.
- The need for understanding costs for medical-only cases vs. indemnity cases; the majority of cases are medical-only, but the majority of the costs are indemnity cases.
- Assessment of the effect of RTW in an integrated care pilot.

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Roundtable Recommendations and Next Steps

John Duncan stated that there seems to be consensus among roundtable participants that the next step to be taken from an employer perspective is to implement integration and see proven outcomes and that CalPERS would be the right type of population for a pilot. Participants emphasized that the next steps should be to:

- Implement a pilot program in the public sector; CalPERS is probably the most appropriate area for a test case of integration of care. Local government and employers cannot afford the financial risk, but pilot participation could be open to larger employers as well as other employers if interested. Consider issues such as:
 - What can be addressed and what is attainable currently and months later on.
 - What the major barriers are and what are ways to overcome those barriers.
 - What the ramifications would be over 12 months, 16 months and 18 months.
 - Whether cities, counties, special districts and Joint Powers Authorities (JPAs) can be involved in drafting the pilot prior to implementation.
 - Analysis of how it translates from the long-term state employee to the employee who moves to different employers.
 - How the workers' compensation carrier role will change.
 - How the issues of the pilot relate to other employers across industries.
 - What the effect is on 4850 claims.
 - How CalPERS would negotiate rates.
 - Whether other departments, such as the Department of Personnel Administration (DPA), could be involved and what resources would need to be available.
- Support and control for injury and illness prevention.
- Address questions about all levels of integration.
- Conduct a roundtable with labor to encourage labor to support and push for integration (see discussion of labor roundtable below).
- Conduct three pilots each with a large enough number of participants: one with medical integration only; one with indemnity integration only; and one with medical and indemnity integration.
- Conduct a feasibility study of the costs of implementing all levels of integration, as well as of cost control, medical control and cost savings under all levels of integration.

Christine Baker stated that the Commission will review comments and recommendations from the roundtable and look to DIR and DWC to help carry out more roundtables. She thanked participants for their time and interest and urged everyone to provide feedback on an ongoing basis.

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Summary of September 9, 2008 CHSWC and California Labor Federation (AFL-CIO) and Labor Representatives Occupational and Non-Occupational Integrated Care Roundtable

Introduction

Angie Wei, of the California Labor Federation (AFL-CIO) and 2008 Chair of the Commission on Health and Safety and Workers' Compensation (CHSWC), welcomed participants. She stated that the Commission helps fund important research to improve the workers' compensation system, and as a labor-management Commission, it brings together the two principals in the workers' compensation system to develop policy objectives to improve the lives of working people. She then acknowledged Tom Rankin who helped create the Commission through statute.

The roundtable is part of the effort to improve the workers' compensation system to improve medical care for injured workers, as well as achieve efficiencies in administrative costs. (See Attachment D.) Proposals for 24-hour care have been developed over the past two years, but there needs to be an effort for labor and management to come together to develop alternative dispute resolution programs and the integration of medical treatment.

Following participant introductions, Angie Wei acknowledged the Commission for all the work done on behalf of improvements. (See Attachment E.)

Art Pulaski thanked the participants for their interest in the roundtable and then thanked the Commission and Tom Rankin for their efforts on behalf of labor. He stated that the most critical area of the current workers' compensation system is the reduction of benefits for permanent disability, or those most seriously injured. Given the current state of the workers' compensation system, a crucial next step for labor is carve-outs. The building trades have been using carve-outs to reduce disputes, get injured workers the care they need, and get people back to work as soon as possible. Current legislation permits carve-outs under collective bargaining agreements and also permits 24-hour care.

Under 24-hour care, there is no separation between occupational and non-occupational injury and illness; there is a single provider for health care and that should create much greater efficiency. Currently, many injured workers are choosing not to file workers' compensation claims and are going directly to their group health provider. This creates a cost shift and results in a bigger burden on health care providers. At the same time, injured workers end up having to pay deductibles and out-of-pocket fees under group health, which they would not have to pay under workers' compensation. In addition, under this informal shifting, there is no accountability on the part of employers with unsafe workplaces about their experience rating and their workers' compensation insurance costs; as a result, the incentive to provide safety in the workplace is reduced. Currently, worker's compensation insurance companies have been making greater profit than in any other period of time. Moving to carve-outs will make a significant positive change in the kind of care, the efficiency of care, and the cost of care that injured workers will get. By bringing together a number of unions at this roundtable, it is possible to get questions asked and resources identified.

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Christine Baker, CHSWC, stated that the Commission does independent research to present information to policymakers to move issues along, and it needs the feedback from constituents. She encouraged roundtable participants to bring questions and concerns to the roundtable discussion and to the Commission on an ongoing basis. Although it is important to think about the opportunities that carve-outs offer to improve medical care, it is also important to think beyond carve-outs to 24-hour care to identify the benefits of integration of care, specifically the different levels of savings and delivery of medical benefits that would be available under different levels of integration. It is important to think strategically and try to move toward long-term objectives. A key goal is to reduce areas of the current overhead cost of the workers' compensation system, that is, those areas that make money off the system. If those areas can be removed, it will be a two-way system, directly between labor and management. Christine Baker thanked CHCF for its support of the integration of care pilot and for making it possible to have public meetings, such as this roundtable, to bring discussion on integration of care to key constituents.

John Duncan, Director, DIR, expressed his support for CHSWC's important efforts to bring together labor and management and to evaluate the health and safety and workers' compensation system and suggest improvements. He stated that he was at the signing ceremony for the DMS/SEIU Local 1877 integration of care pilot and that a lot of innovation is going on regarding the benefits of potentially integrated care. Any long-term solution to rising health care costs and administrative redundancies will come from labor and management coming together to serve injured workers, keep costs down, and introduce efficiencies. The role of the Department is to support employers and employees on a daily basis and as they work together on a long-term solution to rising health care costs, one of the most exciting areas of workers' compensation reforms. As part of moving forward, it will be important to show that integration of care can work in different sectors. Collectively bargained solutions are often the best way of achieving consensus and cooperation.

Discussion on Carve-outs

- Carve-outs:
 - Control of the carve-out process is in the hands of the union; the union has to initiate the process.
 - The Labor Code in 1993 was changed to allow unions and employers in the building trades to create carve-outs as an alternative to the State's workers' compensation system. In 2002, all industries were allowed to create a carve-out.
 - Across the State, there might be around 55 ongoing carve-outs; most have been in the private sector. Carve-outs in the public sector include:
 - City of Long Beach safety officers have negotiated a limited carve-out to deal with specific problems of Labor Code 4650.
 - Some public school districts are looking at carve-outs.
 - The public sector has been self-insured and there is no big fluctuation in rates.
 - Costs are higher in the public sector, which is more unionized.

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- In 2004, there was legislation to allow integration of care within a carve-out.
 - Full integration would require some changes in federal law (including ERISA) and the State Constitution.
 - A detailed legal analysis is being done by CHSWC.
- Everything is bargainable:
 - Cost savings should be known and be part of the bargaining process.
 - Choice of doctors to be included in the network under the carve-out would be decided by the bargaining process. Those gaming the system could be excluded.
- Alternative dispute resolution is handled by the ombudsperson, mediator and arbitrator:
 - Appeals of an arbitrator's decision can go through the WCAB.
- Anything guaranteed by the state workers' compensation system (including use of attorneys and appeal to WCAB) cannot be eliminated.
- Resources on carve-outs are available:
 - Guidebook on how to create a carve-out is available from CHSWC.
 - Pilot project (SEIU Local 1877 and DMS Facility Services) documentation can provide language to create a carve-out.
 - CHSWC is ready to work with labor to move forward on establishing carve-outs or integration of care models.

Key Issues from Roundtable Participants

- Expense of utilization review in the current system:
 - Insurers in California are paying 14 cents on every dollar on utilization review and bill review.
 - Medical provider networks (MPNs) – allow employers to choose the doctors, but if the employers do not like the opinions of network doctors, the employer can send the claim out for utilization review.
 - More care is now being denied by utilization review.
 - Under integration, there would not be utilization review and bill review.
- Intrusion of insurance companies in medical care:
 - Whether physicians would become company doctors, i.e., tell the employer or insurance company something different from what they tell the injured worker.
 - In capitated care, the doctor is answerable to the group health system rather than the workers' compensation system. Would this exist with an integrated system?
 - The choice and control of doctors could be negotiated in a carve-out.
- Selection of provider within a carve-out with treatment of prior injuries:
 - Exceptions could be negotiated for past conditions.
 - Carve-out cannot bring in prior injuries; an MPN can.
- Choice of networks for general health care under integration:

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- Choice of group health provider could be maintained.
- Range of benefits of carve-outs:
 - Carve-outs can determine what the level of benefits would be.
- Report writing and other requirements inherent to workers' compensation claims:
 - Example: occupational clinics within Kaiser would write the reports.
- Medical-only (92% of claims) and disability claims:
 - Easy to integrate the disability side.
- Value for provider to be motivated to get full integration:
 - Will not have to go outside workers' compensation insurer – eliminates paperwork issues.
 - Occupational doctors who are not surgeons get paid lower than Medicare – middlemen are taking a cut of money before the occupational doctor does.
 - In full integration under the group health model, administrative costs are 17 cents in group health instead of \$1.65 or \$3.25.
- Coverage when a worker leaves employment:
 - Need for universal health care; full integration possible with universal health care.
- Interest from employer groups:
 - More interest now but a lot less before rates started to go up.
 - Employers would like to see a large pilot project, with about 100,000 workers, to be undertaken by the State, so that they could see the benefits.
- Statutory benefits:
 - Have to be maintained in an integrated model.
- Motivation for employer:
 - Cost savings will only be evident after three years when the experience modification factor (Ex-Mod) is modified and costs come down.
- Concerns about employer motivation to provide a safe workplace:
 - Potential for less motivation by employers to provide a safe workplace under integrated care.
 - Group health programs are experience-rated; employers will still see the impact of safety in group health costs; emphasis could be on incentives for cost-savings in group health.
 - Safety needs to be made more of an incentive in the pricing of health care and workers' compensation costs.
- Cost-shifting (cost sharing) to employees:
 - Employer might see health care costs rising and want to have employees share the increase in cost.
 - Increases at the bargaining table might seem to be related to workers' compensation rate increases.
 - Would hope to eliminate co-pays in both group health and occupational health under full integration.

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- Moving the cost of overhead on the workers' compensation side should be an incentive for employers.
- Right to predesignate or the right to see the doctor of your choice:
 - Will sunset next year.
 - SB 1338 (Migden), sponsored by California Labor Federation, AFL-CIO, is proposing to eliminate the sunset date. Legislation must be passed by next year or the right to predesignate will be lost.
 - The California Labor Federation, AFL-CIO, has a sample letter and forms on its website.
- Quality of publicly available data on safety practices:
 - A lot of data driven by insurance carriers.
 - Under-reporting exists.
 - All the usual reporting requirements would still exist including OSHA 200 Logs, doctor's first report (DFR), etc.
 - With full integration, there would be no distinction between occupational and non-occupational medical; that does call into question reporting requirements.
 - There could be oversight by the carve-out agreement of employers and ombudsmen, mediators and arbitrators.
 - Employers should be held accountable.
 - Programs would involve collecting data on the group health and the workers' compensation side.
- Invisibility of injured worker:
 - There are different rates of industrial injury in different industries.
 - Often the injured worker is no longer in the workplace, and the only consciousness raised about injuries and illnesses is raised by the union.
 - Workers' compensation law should be adjusted; the State should require that any injury in dispute should be treated within 30 days. This would take injured workers off State Disability Insurance.
- Self-insured employers put aside large amounts of money. Integration would help reduce large reserves.
- Whether there is a way to move toward universal health care along with the move toward individual carve-outs with integration of care.
- Leadership is needed on both the employer and the employee sides to establish a carve-out.
- Confidentiality of electronic records needs to be ensured:
 - Choosing the medical provider and discussing occupational and non-occupational health jointly should allow discussion about this issue.
 - This should be a topic for bargaining for a carve-out.
 - Currently, there are restrictions in workers' compensation for access by employers to the medical records.

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- New bills just went in to the Legislature to tighten up security of electronic medical records beyond HIPAA by establishing an enforcement entity and greater fines.
- Bill for SCIF to do a pilot was halted last year and could be re-introduced with interest and support from partners. This could be a good trial project.
- RTW:
 - There are a lot of employers who have programs to keep workers off the job.
 - With integration, there should be less incentive to keep workers off the job.
 - CHSWC has a comprehensive study on RTW in process with RAND which should provide good data within the next year.

Roundtable Recommendations and Next Steps

- The Carpenters Union could consider a pilot program with a small industrial unit with one provider.
 - There could be a presentation for Trust Funds on how to create a program.
 - CHSWC has a model and is ready to work with interested labor groups.
 - Data could be included and directed to an independent party (e.g., the University, RAND, etc.).
 - Pilot would have to be large enough to interest an insurer (about 10,000 participants).
- Provide answers to questions asked at the roundtable and more detail about integration of care to be able to address issues on medical records, co-pays, sequestration of costs, etc.:
 - Another factor to consider would be the ability that the average health plan may have to handle integration of care.
 - Develop a document “Ten things to think about and answer before integrating occupational and non-occupational medical care.”
- CHSWC is ready to share information from the pilot project underway.
- Tie discussion of integration of care with the debate on universal care.
- Assess how integration would work with workers’ compensation costs for public sector employees in school systems, or a JPA.
- Present a panel of unions and employers in successful carve-outs: discussion on the key steps and the lessons learned.
- Develop a checklist (included in the Commission’s carve-out guide).

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Summary of October 21, 2008 CHSWC and California Applicants' Attorneys Association Occupational and Non-Occupational Integrated Care Roundtable

Introduction

The roundtable included six applicants' attorneys from the California Applicants' Attorneys Association (CAAA). (See Attachment F for the Roundtable Agenda and Attachment G for a listing of the participants.)

Frank Neuhauser welcomed participants and participants introduced themselves. He acknowledged CHCF for providing support for the project and then provided background information on the project and a presentation on levels of integrated care (described above).

Key Issues from Roundtable Participants

- Whether there would be an equal or greater burden on the group health side to streamline operations and whether that can be valued.
- Whether insurance company profits would be reduced as utilization and bill review processes would be eliminated.
- How to deal with treatment guidelines under integration:
 - Determination of appropriate medical care would happen on the group health side. There would be a uniform standard of medical necessity. Kaiser currently does not use guidelines but rather medical necessity. They do litigate disputes.
 - Under a carve-out, an ombudsperson will facilitate this process.
- With basic or greater integration, how there would be coverage if you leave the employer for another employer or you leave employment. There would have to be umbrella group health coverage. This would not be a problem with universal health care coverage.
- What would happen to co-pays and deductibles, whether they would be the same as under group health and whether that would require a legislative/constitutional change.
- Whether integration of care would shift liability from the employer to the worker, which is labor's major concern.
- Whether an assumption that employers want to expand health care coverage is realistic.
- Whether required record-keeping would still have to be maintained even under full integration.
- Whether there would be occupational medical specialists.
- Whether doctors would understand the full complexity of occupational injuries and illnesses.
- Whether there are integration of care models in other states.
- Whether group health insurers would have an incentive to develop an integrated care product, given the complexity of issues in the occupational injuries and illnesses arena, and whether workers' compensation insurers would be willing to give up the profits they make from workers' compensation claims:
 - Model in British Columbia, Canada, is based on universal health care, but occupational medical treatment is dealt with separately – the same providers but different payor. This structure exists mostly because it developed before universal health care. Almost all employers are experience-rated for group health. Only about 10% of medical claims are paid in the current year, thereby saving about \$8 billion.

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- The difficulty of separating occupational from non-occupational health issues and costs.
- How situations when an injured worker is not happy with the treating physician would be dealt with.
- What the standard for group health would be to ensure equal treatment in group health as in workers' compensation.
- Whether any legislation on universal health care coverage is in process.
- Whether those without employment would have coverage (currently, 70 million people are covered by employer-based insurance).
- Whether anything prevents a carve-out from doing an integrated product.
- What the impact on individual rights would be under an integrated care system; integration appears to take away the right of the injured workers to workers' compensation benefits and the right to contest the benefits received and instead appears to put control in the hands of the insurance companies and the employers.
- Whether there would be an increase in group health cost under integration of care:
 - Currently, group health cost for employers is much costlier than workers' compensation cost.
 - The majority of small employers in high-risk industries that do not offer group health and have workers' compensation costs that are very high will have an opportunity to reduce costs.
 - Currently, medical treatment costs for the same condition are less expensive in group health than in workers' compensation.
- What the impact on Medicare and Social Security costs would be:
 - Currently, cost shifting from workers' compensation costs exists but constitutes a small portion of these other social insurance costs.
- What the process would be for employers with multiple insurers.
- Whether the role of insurers in creating the high costs of workers' compensation costs would be addressed:
 - Currently, employers are not demanding that premiums come down and that injured workers get care.
- Whether the emphasis by employers on effective treatment to return workers back to work and the attempt to avoid paying disability costs would be addressed.
- Whether there would be an emphasis on injured workers taking a proactive role in their recovery.
- What the process for permanent disability would be and how the costs would be borne:
 - Currently, there is no permanent partial disability product, so causation and apportionment are not addressed.

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Summary of CHSWC and Public Sector Working Group Executive Branch Participants November, 10, 2008 Occupational and Non-Occupational Integrated Care Roundtable

Introduction

The public sector working group discussion included selected executive branch participants from the Office of the Governor, DIR, DWC, the Department of Personnel Administration (DPA), and the State and Consumer Services Agency. (See Attachment H for the working group Agenda and Attachment I for a List of Participants).

The discussion centered on the opportunities and challenges of integrating occupational medical and group health care for the public sector in California. The specific objectives of the meeting were to:

- Provide an overview of the lessons learned from an integrated care pilot.
- Explain the opportunities for savings for employers, in particular public sector employers.
- Obtain feedback on the barriers to getting to integration.
- Obtain recommendations on feasible solutions for an integrated care project in the public sector.

Christine Baker, Executive Officer, CHSWC, welcomed everyone to the meeting. She stated that the Commission is holding a number of stakeholder meetings to explore challenges and key strategies for implementing integration of care in California. She further commented that this is an important project that can help to streamline costs for employers, and she asked for feedback from the participants on integration of care and any barriers to its implementation.

Key Issues from Roundtable Participants

- According to a key participant, there was an attempt to develop a CalPERS pilot, but it did not go through. They felt that the obstacles were not administrative but political. It was determined at that time that the CalPERS pilot could not be attempted without legislative language authorizing CalPERS to integrate care for state employees.
- There was interest in considering non-legislative solutions for an integrated care pilot (see the section below on legislative and non-legislative solutions).
- The suggestion was made to make the project a demonstration project.
- A number of reasons were identified for the failure of the previous pilot in the early 90s, among which were that it was too short in duration and was not mandatory (the employee could choose whether to participate or not).
- It was suggested that pressure might come from workers' compensation insurers and applicants' attorneys. It was suggested that another avenue for integration might be through a carve-out with CalPERS. In a carve-out, it is possible to negotiate any aspect of medical delivery as long as it is not less than what is currently authorized in statute by the workers' compensation system. Therefore, it would be possible to grant more within a carve-out arrangement if group health has a more flexible standard of medical necessity. This would still require a statutory amendment.

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Discussion

- CalPERS contracts with health plans like Kaiser and Blue Shield. Their PPO plans are self-insured. They contract with Blue Cross for third-party administrator (TPA) services and provider networks for those plans. CalPERS has a business relationship with the group health plans. Each state agency pays through the State Controller Office to the health care providers. With an MPN, the system seems to be less contentious. The vast majority of treatment for state employees that is requested through the MPN gets approved.
- If a state employee has CalPERS PPO, the dispute resolution is through the CalPERS program; part of the dispute resolution is handled by Blue Cross and part through CalPERS. For cases that require an independent medical review, CalPERS contracts with physicians.
- The group health side has a better defined set of rules within which to work: medical policy is published; and doctors know what Blue Cross is likely to approve or not approve in any particular circumstance.
- The dispute resolution process in group health care is much more appropriate: doctors are making medical decisions vs. judges; and the dispute resolution can fall under the health insurer which would require a law change.
- The Department of Managed Health Care (DMHC) conducts 1,100 dispute resolutions each year. Most of the reason that DMHC has more disputes with workers' compensation claims is that on the group health care side, doctors have similar incentives to those of the patient and the employer, and are less likely to recommend something that is then denied.
- To get an advantage on dispute resolution, it is necessary to set up contracts for workers' compensation medical that are more like the group health side.
- To get to greater integration, most savings are not possible unless there is an integration of the insurance product. Having capitation in which the health plan is the risk-bearer would significantly control costs.
- Injured workers who pre-designate (most are public sector employees) their physician, go under DMHC and the IMR dispute resolution process, in theory. However, there is no evidence that people are interpreting the statute this way. It would be important to see if injured workers who pre-designate are using the group health plan's dispute resolution process versus the workers' compensation process.
- For integrated care, group health carriers have to reorganize themselves and reorganize their contracting arrangement with their medical groups. They have to get a large mass of participants for it to be economically feasible to do integrated care.
- 90% of workers' compensation claims close within a short period of time; 10% of cases that have attorney involvement make up the majority of the costs in the workers' compensation system which will generate medical reports.
- Case files still have to be set up even if there is a very minor injury; notices have to be sent out with regard to injury.
- 90% of cases do not go through permanent disability determination, but there is still a cost for opening up case files, including bill review and utilization review on those cases.
- It is important to try to get rid of dispute resolution in the first part of the process. The later in the process that litigation is initiated, if at all, the better, so that the worker can go

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straight through the system. What brings the client to an attorney is that the employee delayed over a medical issue.

- Efficiencies on the front end can be very useful; this will lead to a more expeditious system and get people back in the workplace without going through legal disputes.
- Reforms have controlled workers' compensation costs, but have driven up the State of California's administration costs dramatically.
- For private insurers, the medical cost containment expenses in workers' compensation (11% of medical costs) equal all the administrative costs for group health insurers, because in group health, the majority of the care is capitated.

Potential Obstacles and Solutions to Integrated Care Pilot

- It may be more difficult to integrate care in Blue Cross than in Kaiser. Blue Cross has to arrange its contracts with its participating physicians and hospitals to get to greater integration.
- Even if the medical coverage is combined, there are still other elements of the workers' compensation system to consider:
 - Have to make liability decisions within 90 days and determine when benefits are due.
 - It would take a significant change to waive the co-pays.
 - Have to consider that co-pays are a significant source of revenue for the doctor; almost all provider contracts where there is some form of cost sharing for the patient prohibit the providers from waiving the member share because if care is for free, then utilization goes up. Insurers would be concerned that co-pays were not waived any more than what was absolutely necessary since that will drive utilization.
 - Timely and accurate medical reporting of occupational injuries; from a benefits point of view, reports are very important. If the health care plan no longer had financial interests in getting those reports out, there could be delays in provision of benefits. Now there are reporting requirements and financial incentives so reports are submitted promptly. Some solutions to this barrier include:
 - Allow the Administrative Director (AD) of DWC the discretion to decide when and where the reporting requirements could be relaxed instead of writing them all into the law.
 - Requirements for reporting at initiation of treatment and notification potentially could be side-stepped until benefits decisions have to be made.
 - With integrated care, incentives for reporting would change. It has been important for the employer to have current knowledge of the occupational injury; previously, the medical provider had different incentives from the employer, especially if it was a worker-selected doctor. If integrated care was in place, perhaps those incentives would not be there, and the complexity at the initiation of the case would be eliminated.
 - Some of the items above might require a legislative change. Since most cases will be medical-only, there could be solutions so that not every case will have to go through the same formalities as a life pension case. In the 2007 reforms, some of

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the solutions included: no employer's report form requirement if there is no lost time; and no 90 days within which to make a determination. With these solutions, there is risk that the costlier cases would not have been monitored from the beginning.

- The group health care provider might not want to take workers' compensation cases due to additional reporting requirements and forms.
- Not every state employee obtains health care through the State.
- Not all of state employees' group health is capitated; all PPO plans are fee-for-service.
- The workers' compensation agency would need more information on an occupational claim than non-industrial disability insurance:
 - This difference in information requirements has more to do with the occupational injury oversight rather than medical treatment or controlling the duration of disability.

Legislative and Non-Legislative Solutions

- State agency carve-out. It is possible that the unions might be more agreeable to go forward with a carve-out.
- Universal change in the law for integrated medical care. This would apply to everyone including the State. This would not be negotiated. However, there might be political barriers.
- Implementing integrated care without legislation: use a phased-in approach that would allow group health to act as the MPN; create dispute resolution in that MPN would now be under group health; and conduct an evaluation in two or three years.
 - Potential barrier is that health carriers would have to segment a portion of their business to administer one set of employees one way and another set of employees another way. Blue Shield or Blue Cross would have to reorganize itself.
 - It was argued that the State already has homogeneity between group health care and MPN; the State currently uses Kaiser and Blue Shield as MPN. However, it was pointed out that these are still two separate insurers for workers' compensation and group health care.
- Implementing integrated care through a carve-out agreement; an integrated pilot through a collective bargaining agreement with municipalities.

Savings from the Integration of Care Pilot

- The biggest savings result if health care providers deliver workers' compensation like it is group health. This is leading into integrating the insurance products; currently there are two separate insurers.
- Insurers/health care providers might structure and behave differently if the revenue stream was the same.
- Under a capitated plan, bill review and utilization review costs can be eliminated.
- Litigation will be reduced. This will lead to further savings.

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- When DWC was estimating savings from previous pilots, the biggest savings were in a decrease in permanent disability and a decrease in length of temporary disability, because medical disputes and the utilization review process are shorter.
- No duplication of care.
- Dispute resolutions are much quicker in group health than in the workers' compensation system.
- Medical management is shifted from the workers' compensation claims administrator back to the medical facility.

Summary of Considerations for Integrated Care Pilot

- Need to work with the business and labor communities to overcome political barriers.
- The project should not focus on small pilots by individual industry.
- Need to look for potential ways that an integrated care pilot can be done without legislation on a large scale.
- Need to have a large enough number of participants (i.e. CalPERS pilot) to show the cost-benefit impact on the system; this is important for obtaining buy-in of private employers.
- If considering doing a carve-out with CalPERS, getting a large enough mass would mean having to get all the unions to buy in. For non-union employees, it would not be an option unless they pre-designate or go through SCIF.
- Will have to take into account employees who are not receiving health care through the State of California, including retirees and employees who are receiving care through a spouse.
- If as a result of integration of care, changes were done that would affect the bargaining agreement, then the Department of Personnel Administration (DPA) would come into the process.
- It is better to set up the project as a demonstration rather than as a pilot.
- Definition of what is medically necessary falls under two sections of the Government Codes and those might have to be coordinated.
- Would have to take into account that there will be a dual system (if an employee doesn't get care through the State; he/she can get care through MPN):
 - Need to consider what it would cost to administer the program if the State had to administer the old program as well. It would not be as expensive if the State used SCIF's MPN. It would be necessary to make sure that if the State had part of the old system, then the State would be allowed to use SCIF's MPN so that the administrative costs would not increase.
- Consider allowing the AD the discretion to decide when and where the reporting requirements could be relaxed instead of writing them all into the law.
- Would need some model that will work also in a fee-for-service environment; capitation is declining, and if fee-for-service is not considered, the project could be constrained only to highly urbanized areas with the largest medical groups.
- Aligning of interests is important. There needs to be an incentive/benefit for the doctor to get the employee back to work; performance guarantees could be part of the contract. If

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incentives are included for the doctors to return patients back to work in the contracts, one would have to be careful about the political implications.

- Would need to consider those who are enrolled in the program vs. those who are not and whether the pilot would apply to cases already in existence and also to cases going forward.
- Would need to consider how to cover employees when:
 - Employee leaves the company.
 - Terms of the insurance product end.
 - Changing insurance providers or obtaining a new insurance policy occurs.
- Different terms of insurance for workers' compensation and group health.
- Need to consider what to do with employees who are enrolled in the health plan vs. those who are not.
- The tail of the case.

Roundtable Recommendations and Next Steps

- Provide a cost/benefit analysis of alternatives. The analysis of alternatives should include:
 - Pros and cons of each scenario.
 - What would happen to people who are enrolled in the program vs. what would happen to everyone else.
 - Documentation that would overcome the identified obstacles.
- Once alternatives are developed, they will be provided to the participants of the working group for feedback.
- People to talk to at the early stage of the demonstration project development include: SEIU, Keith Mentzer, Julie Chapman, Head of DPA Labor Relations Department, and Greg Franklin of CalPERS.
- Look at what already has been drafted by the Governor's Office and other parties on this issue. Need to make sure that everything about the previous process has been learned.
- DPA to provide figures on what the State of California is paying for group health.

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Summary of November 12, 2008 CHSWC, University of California, Berkeley, and Group Health Insurer and Employer Purchasing Coalition Occupational and Non-Occupational Integrated Care Roundtable

Introduction

Marian Mulkey, California HealthCare Foundation (CHCF), welcomed participants. She stated that CHCF is motivated, like other parties, to look at integration of care as a way to reduce costs. She thanked Christine Baker, Frank Neuhauser, Rena David and Juliann Sum for the work they have done on this project. (See Appendix J.)

Christine Baker stated that there is a lot of interest in the integration of care project. There have been meetings with the California Manufacturers Technology Association (CMTA), labor, the State of California, which is interested although there are a number of barriers to address, and some public entities. Everyone sees an opportunity to reduce administrative costs and is interested in discussing how to do so. She stated that participants at these discussions thought that the State of California, cities, counties and municipalities would be best able to undertake integration of care because there is less job turnover and less movement in and out of health care providers. The State is interested at a political level in moving this concept forward.

Participants introduced themselves. (See Appendix K.) Frank Neuhauser then discussed the integration of care pilot project (see discussion above) and its objectives of reducing cost and improving medical care.

Key Issues from Roundtable Participants

- Whether improving functionality (shortening durations of disability), which could reduce costs, is also an objective of integrated care. It is a key concern for employers and could be part of an RTW study.
- Whether information would still have to be captured on the medical condition for the indemnity side even if much of the need to establish causation for indemnity payments could be eliminated. Cases that involve permanent disability indemnity payments would always be handled as a separate function.
- What has been learned from the integrated care pilot such as: the size of the pool (e.g., 50,000) to have insurers be willing to design a new insurance project; whether there is significant cost savings; whether there has been any quality-of-care improvement because of a single provider; and whether small employers would see cost savings.
- What a comparison looks like of the process to send disputes through the group health side vs. the workers' compensation side.
- What the process with the Department of Managed Health Care (DMHC) involves and what the ERISA requirements are.
- What the quality control guidelines for medical care would be. Whether each plan would have a set of clinical guidelines. The workers' compensation system has just come up with medical guidelines to use as a baseline.
- Who would be controlling the decision-making process: workers' compensation is an adversarial system; group health is not.

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- How workers' compensation cases could be absorbed into the group health system; whether the independent medical review (IMR) process could be adapted.
- Whether there would be a different level of disputes on the workers' compensation side when there is a different way of delivering medical care.
- Whether members would still be able to be participatory in the decision-making process in group health as they are currently.
- How co-pays and deductibles, which have never been part of workers' compensation but are part of group health, would be handled. Whether there would be two different plans and how that would affect administrative costs.
- How all the reporting that is part of workers' compensation would be handled and whether the legislative requirements would need to be changed.
- How PPO plans would be affected and how benefit design would have to be modified.
- What type of agreement there would be to control costs which vary among providers.
- Whether the IMR process would provide the opportunity for labor and management to work together to eliminate friction costs and whether there would be a problem bringing the workers' compensation process to the IMR process.
- Whether predesignation, which is allowed in workers' compensation, would be part of integrated care and whether the statute about predesignation is being implemented or ignored.
- Whether there would be a different definition of medical necessity between workers' compensation and group health.
- Whether the definition of medical necessity would change.
- Whether certain frequently disputed conditions in workers' compensation, such as spinal surgery, would be better handled by group health and whether there are different guidelines for medical necessity in place that account for that.
- Whether pricing would be based on the policy of what is allowed universally in workers' compensation.
- How the determination of appropriate medical care would be controlled and whether non-physicians would be making medical determinations.
- Whether integrated care could move the focus on due process in the workers' compensation system to a focus on patient health.
- How to relieve the paperwork burden in workers' compensation.
- How to find ways to have treating doctors take responsibility for disability management and focus on getting injured workers back to transitional work or to their job prior to injury.
- Whether an electronic medical record system could be an effective element of integrated care.
- How to let medical necessity be decided by group health and let the health plan's limitations of benefits govern.
- How to interest group health providers to take on occupational health cases and how to address the paperwork issues and the more cumbersome and uncertain payment schedule issues.
- Whether the perception that funds would be transferred from workers' compensation to group health could be managed so that group health would not perceive that it would be funding occupational health; this is a concern of both group health providers and workers.

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- Whether there are ways to develop objective standards for disability cases, which are expensive because they involve more medical treatment than medical-only cases.
- What the impact is of an organization having several administrators.
- How a triage system might work and whether certain health conditions could be coded for potential indemnity.

Roundtable Recommendations and Next Steps

- Meet with CalPERS to look at possible pilot solutions. Include a clinician and someone who deals with the legal issues of the workers' compensation side.
- Identify interest on the part of the State.
- Provide more information on the integrated pilot, when available.
- Find a large self-insured employer, such as Safeway, to consider integrated care.

Christine Baker stated that some unions and municipalities that have large groups that are looking for ways to streamline their costs have been approaching the Commission to explore establishing integrated care. She thanked everyone for their interest and participation.

Information Resources on Integrated Occupational and Non-Occupational Medical Care

California Department of Managed Health Care. "Potential Benefits and Obstacles to the Integration of Workers' Compensation Insurance with Employer Purchased Health Benefits," August 2005.

California HealthCare Foundation (CHCF). "Snapshot, California's Uninsured 2006"
<http://www.chcf.org/documents/insurance/CAUninsured06.pdf>

Carve-Outs in Workers' Comp: Analysis of Experience in the California Construction Industry, September 1999

<http://www.dir.ca.gov/CHSWC/CarveOutReport/Carveoutcover.html>

Carve-Outs: A Guidebook for Unions and Employers in Workers' Compensation, April 2004

<http://www.dir.ca.gov/CHSWC/CARVEOUTSGuidebook2004.doc>

CHSWC Annual Report, 2005

<http://www.dir.ca.gov/CHSWC/Reports/AnnualReport2005.pdf>

CHSWC Annual Report, 2007

<http://www.dir.ca.gov/CHSWC/Reports/AnnualReport2007.pdf>

Commission on Health and Safety and Workers' Compensation "CHSWC Background Paper: Twenty-four Hour Care," December 2003.

http://www.dir.ca.gov/CHSWC/CHSWC_24hCare.pdf

How to Create a Workers' Compensation Carve-Out in California: Practical Advice for Unions and Employers, 2006

<http://www.dir.ca.gov/CHSWC/carve-out1.pdf>

Integrated Benefits Institute (IBI) research publications

www.ibiweb.org/publications/research

RAND. "Assessment of 24-Hour Care Options for California," 2004.

<http://www.dir.ca.gov/CHSWC/Reports/24HourCare.pdf>

or <http://www.rand.org/pubs/monographs/MG280/index.html>

Attachment B

**California Manufacturers & Technology Association (CMTA)
Department of Industrial Relations (DIR)
Commission on Health and Safety and Workers' Compensation (CHSWC)**

**Integrated Occupational and Non-Occupational
Medical Care Roundtable**

Agenda

California Manufacturers & Technology Association
1115 – 11th Street
Sacramento, California
Friday, June 13, 2008
10 a.m. – 2 p.m.

- Welcome and Introductions 10:00 a.m.
 - Jack Stewart, President, CMTA
 - John C. Duncan, Director, DIR
 - Christine Baker, Executive Officer, CHSWC

- Presentation 10:15 a.m.
 - Frank Neuhauser, UC Berkeley

- Legislative Considerations 10:45 a.m.
 - Brent Barnhart, Kaiser
 - Juliann Sum, UC Berkeley

- Discussion 11:15 a.m.

- Lunch will be provided 12:00 p.m.

- Next Steps 1:00 p.m.

- Closing 1:50 p.m.

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Attachment C

**CMTA, DIR and CHSWC Integrated Occupational and
Non-Occupational Medical Care Roundtable
Participants**

Brent Barnhart
Kaiser Foundation Health Plan, Inc.

Phil Milhollon
California Self-Insured Association

Doug Benner
Kaiser Permanente

Robin Nagel
Kaiser Permanente

Jim Burque
Intel

Carrie Nevans
Division of Workers' Compensation

Jeanne Cain
California Chamber of Commerce

Dave Perbix
Kaiser Permanente

Joe Carresi
Southern California Edison

Jason Schmelzer
California Chamber of Commerce

John Duncan
Department of Industrial Relations

Jack Stewart
California Manufacturers & Technology
Association

Scott Hauge
Small Business California

Kathleen Webb
Governor's Office of the Insurance Advisor

Lori Kammerer
Kammerer and Company

Project Staff

Cynthia Leon
California Manufacturers & Technology
Association

Frank Neuhauser, UC Berkeley
Christine Baker, CHSWC
Rena David, CA HealthCare Foundation
Juliann Sum, UC Berkeley
Selma Meyerowitz, CHSWC

Scott Lipton
California Workers' Compensation Coalition

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Attachment D

California Labor Federation, AFL-CIO and CHSWC

Integrated Occupational and Non-Occupational Medical Care Roundtable

Agenda

September 9, 2008
Elihu Harris State Building
1515 Clay Street, 13th Floor, Room 1304
Oakland, CA
10:00 a.m. – 2:00 p.m.

- Welcome and Introductions 10:00 a.m.
 - Art Pulaski, Executive Secretary-Treasurer, California Labor Fed
 - Angie Wei, Legislative Director, California Labor Fed
 - Sean McNally, Commissioner, CHSWC (Employer)
 - Christine Baker, Executive Officer, CHSWC

- Presentation 10:15 a.m.
 - Frank Neuhauser, UC Berkeley

- Legislative Considerations 10:45 a.m.
 - Brent Barnhart, Kaiser
 - Juliann Sum, UC Berkeley
 - Lachlan Taylor, CHSWC

- Discussion 11:15 a.m.

- Lunch will be provided 12:00 p.m.

- Next Steps 1:00 p.m.

- Closing 1:50 p.m.

**California Federation of Labor, AFL-CIO and CHSWC
Integrated Occupational and Non-Occupational Medical Care Roundtable
Participants**

Martha Guzman Aceves
California Rural Legal Association

Bill Feyling
46 No. California Counties Conference Board

Thomas Aja
Operating Engineers Local 3

Deanna Furman
California Nurses Association (CNA)

Bob Alvarado
Northern California Carpenters

Richard Gannon
Ombudsman

Brent Barnhart
Kaiser Foundation Health Plan, Inc.

Linda Gregory
AFSCME Council 57

Doug Benner
Kaiser Permanente

Susie Griffith
AFSCME Council 57

Christy Bouma
California Professional Firefighters

Kelly Gschwend
OPEIU 29

Emily Clayton
California Labor Federation, AFL-CIO

Jay Hansen
CA Building Trades

Lisa Dickerson
Operating Engineers Local 3 District 20

Monadel Herzollah
California Schools Employees Assoc. (CSEA)

Paul Doolittle
IBEW 302

Norma Harrison
Peace & Freedom Party

John Duncan
Department of Industrial Relations

George Landers
UFCW Western States Council

Mike Egan
California Teachers Association

Suzanne Murphy
WORKSAFE!

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Vickey Nickel
United Steelworkers Local 7600

Fred Pecker
ILWU Local 6

Gene Price
Carpenters Funds Administrative Office

Art Pulaski
California Labor Federation, AFL-CIO

Gregory Ramirez
AFSME District Council 57

Tom Rankin
WORKSAFE!

Alice Robinson
OPEIU Local 29/Kaiser

Rebecca Rosas
Bakers Local 125

Libby Sanchez
Broad and Gusman, LLP

Margaret Shelleda
California Federation of Teachers

Joey Smith
Black Women Organized for Political Action

Maria Solano
United Steelworkers Local 7600

Loretta Springer
ATU Local 265

Karen Summers
SEIU Local 521

Richard Thomason
SEIU-UHW

Daniel Villao
LA City Coalition of Unions
Building Trades Council

Michael Vlaming
Scarth-Lyons & Associates

Charlie Warren
Operating Engineers Local 3

Angie Wei
California Labor Federation, AFL-CIO

Jocelyn Won
AFSCME

Amy Young
AFSCME 829

Project Staff

Frank Neuhauser, UC Berkeley

Christine Baker, CHSWC

Lachlan Taylor, CHSWC

Rena David, California HealthCare Foundation

Juliann Sum, UC Berkeley

Irina Nemirovsky, CHSWC

Selma Meyerowitz, CHSWC

CHSWC and California Applicants' Attorneys Association

**Integrated Occupational and Non-Occupational
Medical Care Roundtable**

Agenda

October 21, 2008
Elihu Harris State Building
1515 Clay Street, 13th Floor, Room 1304
Oakland, CA
11:00 a.m. – 1:00 p.m.

- Welcome and Introductions 11:00 a.m.
 - Christine Baker, Executive Officer, CHSWC
 - Lachlan Taylor, Workers' Compensation Judge, CHSWC
- Presentation 11:15 a.m.
 - Frank Neuhauser, UC Berkeley
- Discussion 11:45 a.m.
- Closing 1:00 p.m.

Attachment G

**California Applicants Attorneys' Association and CHSWC
Integrated Occupational and Non-Occupational Medical Care Roundtable
Participants**

Linda Atcherley
Past President, CAAA

Todd McFarren
President, CAAA

Sue Borg
Past President, CAAA

Brad Shaw
Chapter President, CAAA

Adam Domchick
Gordon, Edelstein
Chair, CAAA

Project Staff

Doug Kim
Assistant Legislative Advocate, CAAA

Frank Neuhauser, UC Berkeley
Christine Baker, CHSWC
Lachlan Taylor, CHSWC
Juliann Sum, UC Berkeley
Irina Nemirovsky, CHSWC
Selma Meyerowitz, CHSWC

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Attachment H

Commission on Health and Safety and Workers' Compensation (CHSWC)

Integrated Occupational and Non-Occupational Medical Care Discussion

Public Sector Working Group Executive

November 10, 2008
801 K Street, Suite 2100
North Conference Room
Sacramento, CA
10:00 a.m. – 2:00 p.m.

AGENDA

- Welcome and Introductions 10:00 a.m.
 - John Duncan, DIR Director
 - Sean McNally, CHSWC Commissioner
 - Christine Baker, Executive Officer, CHSWC

- Presentation 10:30 a.m.
 - Frank Neuhauser, UC Berkeley

- Legislative Considerations 12:00 p.m.
 - Brent Barnhart, Kaiser
 - Juliann Sum, UC Berkeley
 - Lachlan Taylor, CHSWC

- Lunch will be provided 12:30 p.m.

- Discussion 1:10 p.m.

- Next Steps and Closing 1:50 p.m.

Public Sector Working Group Executive Branch Participants

Catherine Aguilar
Gitter and Associates

Sara Oliver
Grimmway Farms

Ralph Cobb
Department of Personnel Administration

Manolo P. Platin
State & Consumer Services Agency

John Duncan
Department of Industrial Relations

Herb Schultz
Office of the Governor

Sean McNally
Grimmway Farms

Project Staff

Frank Neuhauser, UC Berkeley

Christine Baker, CHSWC

Lachlan Taylor, CHSWC

Brent Barnhart, Kaiser

Juliann Sum, UC Berkeley

Rena David, Consultant

Irina Nemirovsky, CHSWC

Keith Mentzer
Department of Personnel Administration

Carrie Nevans
Division of Workers' Compensation

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Attachment J

Commission on Health and Safety and Workers' Compensation (CHSWC), University of California, Berkeley, and Group Health Insurer and Employer Purchasing Coalition

Integrated Occupational and Non-occupational Medical Care Roundtable

November 12, 2008
1438 Webster Street, Suite 400, Oakland, CA
10:00 a.m. – 2:00 p.m.

AGENDA

- Welcome and Introductions 10:00 a.m.
 - Marian Mulkey, Senior Program Officer, CHCF
 - Christine Baker, Executive Officer, CHSWC

- Presentation 10:15 a.m.
 - Frank Neuhauser, UC Berkeley

- Legislative Considerations 11:00 a.m.
 - Brent Barnhart, Kaiser
 - Juliann Sum, UC Berkeley
 - Lachlan Taylor, CHSWC

- Discussion 11:30 a.m.

- Lunch will be provided 12:15 p.m.

- Next Steps 1:00 p.m.

- Closing 1:50 p.m.

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Attachment K

Commission on Health and Safety and Workers' Compensation (CHSWC),
University of California, Berkeley, and
Group Health Insurer and Employer Purchasing Coalition

Integrated Occupational and Non-occupational Medical Care Roundtable

List of Participants

Connie Chiulli
Kaiser Permanente

Maral Farsi
California Association of Health Plans

Angelica Gonzalez
Anthem Blue Cross

Rob Honaker
Anthem Blue Cross

Timothy Hoops
WellPoint, Inc.

Charles Larsen
Blue Shield of CA

Lisa Lee
Aetna Workers' Comp Access

Marian Mulkey
California HealthCare Foundation

Chris Ohman
California Health Plan

Dave Perbix
Kaiser Permanente

Dave Riverside
Kaiser Permanente

Project Staff

Frank Neuhauser, UC Berkeley
Christine Baker, CHSWC
Lachlan Taylor, CHSWC
Brent Barnhart, Kaiser
Rena David, Consultant
Juliann Sum, UC Berkeley
Irina Nemirovsky, CHSWC

Factsheet

Integrating Group Health and Workers' Compensation Medical Care



What Is Integrated Health Care?

Traditionally, employers and their employees have been required to deal with two separate systems to obtain employee medical care. Non-occupational medical conditions have been treated through group health plans, while occupational injuries and illnesses have been treated through the workers' compensation system.

With integrated health care, the same individual physician or medical group sees the employee for both occupational and non-occupational conditions. Starting with this simple concept, integration can be implemented in many ways, as described below.

Why Integrate Care?

Rising premiums for group health plans and the high costs of workers' compensation continue to threaten employers' profitability. The same factors can also limit employees' access to group health coverage as the availability of affordable coverage declines.

Integrating care in the two systems can reduce costs by eliminating duplicative treatment and reducing the costly administration of workers' compensation medical care. Integration can also improve quality of care through better coordination of care and broader access to treatment. The form and extent of integration determine the degree of improvement in quality of care and level of cost savings.

This factsheet describes findings from a pilot project conducted in 2006-08 to integrate medical care for unionized janitorial workers in California. The principal participants were the workers' union, Service Employees International Union (SEIU) Local 1877, and a major janitorial employer, DMS Facility Services. Collaborating organizations included Kaiser Permanente, workers' compensation insurers, and workers' compensation brokers. The project was managed by the California Commission on Health and Safety and Workers' Compensation and the University of California, Berkeley's Survey Research Center and Institute for Research on Labor and Employment. Partial support was provided by a grant from the California HealthCare Foundation.

Achieving Integration

The important changes involved in integrating insurance as well as medical treatment will face resistance from entrenched interests. Our experience is that to be successful, implementing integration beyond simply using the same provider requires several conditions:

- ▶ Rising workers' compensation premium rates to motivate employers.
- ▶ Commitment within an employer's organization from both the group health and workers' compensation administrators.

—continued—

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Achieving Integration —continued—

- ▶ A large enough pool of covered workers to motivate insurers to offer new, innovative products. This may involve a very large employer or an association of employers.
- ▶ A strong advocate at the highest level of the employer's organization or employer association to drive the change despite the resistance of many established interests.

Group health and workers' compensation are controlled by two different, complex, and often mismatched legal systems. Employers and employees can move integration forward despite these incompatibilities. However, legislative and regulatory changes would facilitate integration, reduce costs, and increase benefits. These changes could include:

- ▶ Aligning the definitions of necessary medical treatment in the two systems.
- ▶ Reducing and/or eliminating many reporting requirements that exist under workers' compensation but are unnecessary under integration.
- ▶ Placing medical treatment dispute resolution under a single process for both occupational and non-occupational conditions.

Levels of Integration

The extent of integration is an important factor in cost and quality of care.

Basic Integration

At its most basic level, integrating care means that the same individual physician or medical group sees the employee for both occupational and non-occupational medical conditions.

What are the benefits of basic integration?

Basic integration can reduce costs by avoiding duplicative care. It can also improve the quality of care through better coordination of medical tests and treatment, as well as avoiding unnecessary or inconsistent care.

How can care be integrated at this level?

The employer and workers' compensation claims administrator can integrate care at this level by selecting and offering to employees the same provider for both group health and workers' compensation medical care, and by requiring the provider to fully coordinate all tests and treatment, including pharmaceuticals.

Cost of Delivering Treatment Through Group Health and Workers' Compensation

In California from 1994-2006, the average total cost of delivering \$1 of medical treatment through group health plans (A) was much lower than the cost of delivering it through workers' compensation (B). The cost through workers' compensation was even higher in 2004-06 (C) after changes were made in the system. (Data derived from Workers' Compensation Insurance Rating Bureau publications, 2007, and Center for Policy and Research publications, 2005.)



Summary of Integrated Occupational and Non-Occupational Care Roundtables

Greater Integration

Care can be further integrated under a single medical provider or medical group by combining the insurance premiums for both occupational and non-occupational medical treatment in a single insurance product.

What are the benefits of this type of integration?

In addition to the costs saved with basic integration, this type of integration offers the potential to save significant administrative costs. The main driver of workers' compensation medical care costs is the administrative expense to review and approve treatment recommendations and pay providers. This can be 8 to 15 times higher than in group health, and it consumes two-thirds or more of premium dollars related to medical benefits.

How can care be integrated at this level?

Combining insurance means paying a single premium to the group health insurer to cover occupational and non-occupational treatment. Usually this is a single premium per worker per month (the capitated rate commonly used by health insurers). This approach eliminates many of the administrative processes (e.g., utilization review, bill review, bill payment, etc.) that drive high administrative costs in workers' compensation.

Full Integration

Full integration means that the employee receives the same medical benefits regardless of whether his or her condition is work-related. No distinctions are needed regarding causation to determine whether the employee may receive care, whether the employee may see his or her regular physician, or whether deductibles or co-payments are required.

What are the benefits of full integration?

Full integration completely eliminates the expensive administration and overhead that characterize workers' compensation medical treatment. It eliminates disputes and delays in medical treatment related to identifying the source of payment, and eliminates the inefficient overlap between workers' compensation and group health.

How can care be integrated at this level?

Full integration requires health insurance coverage for the entire working-age population. It may require that workers share in some of the costs of care. If these structural changes can be made, workers will have greater access to care and total costs will be substantially reduced.

Benefits of Integrating Care

This chart ranks the benefits of integrating care at different levels, with A+ indicating the best outcome and F indicating the worst.

	No Integration	Basic Integration	Greater Integration	Full Integration
Quality of Care	C	B	B+	A
Access and Timeliness of Care	D	C	A	A
Disputes and Resolution	F	D	B	A
Administrative Streamlining	F	C-	B	A+
Cost Savings	F	C-	B+	A+

Summary of Integrated Occupational and Non-Occupational Care Roundtables

Authors

Frank Neuhauser, M.P.P., Survey Research Center,
University of California at Berkeley

Juliann Sum, J.D., Sc.M., Institute for Research on
Labor and Employment, University of California at
Berkeley

Christine Baker, M.A., California Commission on
Health and Safety and Workers' Compensation

Rena David, M.B.A., M.P.H., Consultant

Contact Information

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