

**Interim Report to the Legislature:
24 Hour Pilot Programs under
Labor Code Section 4612**

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An Interim Report to the Legislature on 24 hour care

Summary of Findings

Labor Code Section 4612, adopted in 1992 and amended in 1993, established three year pilot programs of 24 hour health care in California. These programs were set up to test the administrative efficiencies, cost control potential, and service capabilities of having a single system provide health care for occupational and nonoccupational injuries and illnesses.

Under traditional workers' compensation law, workers often have different sources of medical care, depending on whether an injury occurred at work or was not work-related. Typically, workers choose their own physician for care provided under their nonoccupational health plan (if they have health coverage). When injured on the job, employers typically determine the primary care provider. Under the pilot programs, workers have a single network of providers for both on- and off-the-job health problems. Employees signing up for the program agree to receive all medical care for on and off the job injuries from an "exclusive provider" of health care for up to one year, in contrast to the 30 day period of medical control that employers have under traditional programs. Employees have a choice as to whether to enroll or maintain their traditional system.

The pilot programs were legislated at a time when employers' costs for workers' compensation were rising rapidly, having grown from approximately \$8 billion in 1988 to \$11 billion in 1993. By 1995, when the program was getting underway statewide, overall compensation costs had dropped dramatically, back below the 1988 levels. Competitive (or "open") rating provided cost reductions just as marketing for the pilots got underway. Many employers were reluctant to attempt a conceptually interesting but largely untested program when premium discounts were already readily available. In addition, the new product combination proved to be more complex to market than separate group health and workers' compensation policies, requiring increased coordination between insurance brokers familiar with workers' compensation or nonoccupational health benefits..

Four individual pilot program designs were approved after the application period in 1994. Since their approval, one of the four has dropped its participation, and another has experienced low enrollments. The vast majority of participating employers and employees are under two related projects, emanating from the northern and southern regional offices of the state's largest health maintenance organization.

Implemented in 1994 with the participation of five employers in San Diego County, the program now includes over 65 employers in four counties. Enrollments in pilot programs have grown steadily and currently stand at nearly 8,000 employees in participating firms. Enrollments, however, are somewhat lower than originally expected. Many reasons are given for the low level of enrollments, but the most prominent is the success of controlling employers' workers' compensation costs outside the pilot program.

Those employers who entered the program are generally satisfied. Nearly all employers with experience in the program believe it is working well and would like to see it continue. Some cite the impact on their costs. Others feel that the program has led to greatly improved communication with those providing medical care to injured employees. Some like the increased period of medical control. Still others like being a part of an innovative experiment that attempts to blur the lines and treatment arrangements between the various causes of disability. While direct measurement of worker satisfaction with the program is just getting underway, at annual renewals of the individual employer programs, the number of enrollees has generally grown. While a few employees have dropped out of the program along the way, more have joined each year at open

enrollment times. Attorneys for injured workers have voiced some instances of dissatisfaction with medical care and with the process of communicating the restrictions of the programs.

A comprehensive evaluation, largely funded by external foundation grants, is now underway to test a series of questions raised by the legislation. The evaluation is being conducted by a consortium of the UCLA School of Public Health, the Rand Institute, and UC-Berkeley's Survey Research Center. The bulk of the financing comes from the Workers' Compensation Health Initiative of the Robert Wood Johnson Foundation, with other funding from the Rand Institute and from assessments on participating employers. The survey instruments and study methodology are likely to be put to use in evaluating other states' experience in 24 hour health care programs. A final report to the Legislature is due at the end of 1998, one year after the close of the pilot programs.

Introduction

Labor Code Section 4612 was enacted in 1992 and amended in 1993. This law directed the Division of Workers' Compensation to conduct a 36 month pilot project, effective January 1, 1994, commonly called the 24 Hour Health Care Pilot. The pilot project authorized participating employers to contract with a licensed health care service plan to be the exclusive provider of medical, surgical, and hospital treatment for occupational and nonoccupational injuries and illnesses incurred by its enrolling employees. The legislation requires an interim report two years into the pilot projects.

This report gives background on the 24 hour pilot program in California, describes the law and regulations developed for the program, and provides detail on the early implementation of the statute. It also describes the formal program evaluation process developed to analyze the operation and overall success of the program. A final report is due to the Legislature one year after the end of the pilot program, and will be available in late 1998.

What is 24 Hour Health Coverage

There is no single definition of 24 Hour Care.¹ At one end of the spectrum, the term implies a seamless health and disability system, providing medical care and indemnity benefits to those unable to work, whatever the cause of injury and illness. Twenty four hour care may also describe a coordinated system of health care delivery, whereby a person receives all medical care for injuries and illnesses from a single health care provider. To some, it means that claims from various benefit systems are handled by the same party or at the same location. It may also mean a system of coordinated claims settlements to eliminate duplicate claim filings involving medical, disability, accident, disease, and other forms of coverage. The National Association of Insurance Commissioners uses the working definition "any combination of traditional health insurance and workers' compensation insurance that attempts to dissolve the occupational and nonoccupational boundaries between the two coverages."²

In its various iterations, 24 hour care has potential advantages as well as obstacles to implementation. The plausible advantages include cost savings and administrative efficiencies for employers, reductions of cost shifting, maintenance or improvement in quality of care, appropriate return to work outcomes, employee ease of access and continuity of care, and reduced confusion through a single point of contact. Effective 24 hour programs can lead to the reduction of litigation by reducing the disputes inherent between group health and workers' compensation carriers over which should pay a claim. By compiling comprehensive data on the health effects of a working population, twenty-four projects could provide better understanding of the full social costs of disability and how it is financed.

Effective implementation of twenty-four hour coverage is complex. There are many obstacles to coordinating workers' compensation and group health perspectives. There are often significant costs of integration in bringing together disparate data systems. There is need for cross training of doctors, claims administrators, and brokers who often know only one system. There are regulatory and statutory constraints that govern reporting of cases and confidentiality of medical information. The traditional methods of buying and selling these two types of insurance policies also have impacts; agents and brokers usually specialize in property/casualty insurance (including workers' compensation) or in benefits (including health insurance). Typically in larger companies, health insurance buying decisions are made by a benefits or human resource manager, while workers' compensation is decided by the risk manager.

Law and Regulation

Proposals for pilot programs

Two independent efforts provided the genesis of the California legislation allowing pilot programs. One emanated from a small group of San Diego employers who had attended a “Healthy Worker/Healthy Workplace” conference sponsored by the Senate Industrial Relations committee. They sought to find a way to integrate, or at least coordinate, the medical care provided to workers and their families for both on and off the job injuries. Concurrently, Kaiser Health Plan planners were rethinking the occupational medicine programs within their facilities. The facilities were already providing much fee-for-service medical care for work-related injuries suffered by. Over time, Kaiser was also getting non-member emergencies and occupational medicine cases as walk-ins from other nearby employers, accounting for approximately 1% of their revenue.³ In an era of competition from other managed care entities, occupational medicine could be marketed to employers. The Kaiser Health Plan also wanted to see how capitation, a mainstay of the rest of their business, might exist under workers’ compensation care.

The two groups proposed legislation to allow for experimentation within the context of formally enrolling health plan members to get all of their care for work related injuries, as well, at Kaiser. Under the plan, the control of medical care for workers’ compensation cases would be managed within a state certified pilot network for up to 365 days, compared to the 30 days that most employers controlled care.

Legislative and Policy History

Assembly Health Committee chair Bruce Bronzan introduced AB 3757 in February 1992. The original proposal allowed employers to unilaterally sign up for 24 hour care programs that covered all employees for a full year. This lacked union support, but led to a compromise by which individual workers would be allowed to enroll or choose to maintain traditional coverage, and gave collective bargaining agents veto power over participation of employees under their contract. Some of the original employer support dropped out with this compromise. With lobbying by Kaiser and a bloc of San Diego employers, the legislation was enacted with no opposition.

Governor Wilson signed the bill into law in October, 1992, creating Labor Code Section 4612. The bill authorized pilot projects of up to 36 months allowing employers in 4 counties to contract with a licensed health care service plan to be the exclusive provider of medical, surgical, and hospital treatment for occupational and nonoccupational injuries and illnesses incurred by its employees. The legislation was to be implemented under regulations promulgated by the Administrative Director (AD) of the Division of Workers’ Compensation (DWC).

The original bill (as introduced February 21, 1992) contained no language relating to program evaluation. The evaluation language in the 1992 statute was added to the bill by the Assembly Ways and Means Committee. This was intended to meet the Ways and Means Committee’s longstanding commitment of assuring that pilot programs be started with a determination to evaluate their success or failure, so as to inform future legislative debates on the issues. However, the evaluation language chosen for this legislation was narrowly written and did not directly address the broad subject matter of the bill.⁴

In the 1993 session, Assembly Bill 1692 (Margolin) amended the pilot program statute. The changes broadened the scope of the pilot program to allow inclusion of multiemployer, collectively bargained employee welfare benefit plans, and bargaining agents for state employees. The amendments also specified further criteria for evaluation. Evaluation language stressed impact on price and price differentials of workers’ compensation medical care, and satisfaction of injured workers with system.

In 1995, Senate Bill 1051 (Solis) was introduced and, as amended April 18, 1995, included a provision to extend pilot program implementation from 36 months to 60 months. The bill would have permitted pilot programs to be expanded to one or more counties that were contiguous to counties already implementing the program.⁵ The sections of the bill relating to 24 hour pilot programs were dropped in the bill's May 16, 1995 version.

Key elements of Legislation on Pilot Programs

Labor Code Section 4612 (see Appendix 1) lays out the purpose of the pilot programs, the requirements for evaluation, restrictions on who can participate and what must be offered, and provisions for cancellation and nonrenewal of participants.

The programs were authorized to test the impact of having workers receive all their medical care from a single source, regardless of the causation of the injury or illness. The underlying theory was that administrative inefficiencies of having two (or more) different health care systems could be reduced, and that a combined system could offer quality medical care.

The pilot projects depend on partnerships between employers, employees, health care providers and health insurers, workers' compensation insurers, and, if under collective bargaining arrangement, agreement from bargaining agents.

The legislation mandated that the Division allow implementation in four geographically diverse counties, and that the program could include more than one health service plan.

Under the law, employers contract with a health care service plan to be the exclusive provider of medical care for both occupational and nonoccupational injuries suffered by employees. Employees who enroll waive their rights to predesignate or change to a personal treating physician outside of the exclusive provider. Beyond this, individual employees must annually be given the choice between the exclusive provider of care option and a traditional health benefit plan which allows employees to obtain workers' compensation treatment from a traditional workers' compensation medical provider. Unionized employers must secure the agreement of the collective bargaining agent before contracting for exclusive provision of care with a managed care organization.

Employers must provide treatment reasonably required to cure or relieve the effects of an occupational injury. Medical treatment for work-related injuries must be provided without coinsurance, deductibles, or premium copayment by employees. Employers participating in pilot programs must also make group health coverage available to employees' dependents, though they are not obligated to pay for that coverage.

The law further provides that the administrative director prepare a study after completion of pilot project that describes the project and reviews employer costs, employee satisfaction, and various aspects of whether and how workers' return to work after injuries take place. The amended legislation allowed the state to seek external funding for evaluation purposes.

The Regulations

Regulations proposed by the Administrative Director defined various terms in the legislation, designated pilot counties, provided detail on requirements for pilot program proposals, listed priorities for selecting participants, designated options for employee choice of the pilot versus traditional programs, and detailed requirements for record-keeping,

Terms defined in the regulations included: "employer," "exclusive provider of care option," "health care service plan," "managed care product," "principal place of business," "small employer," "traditional health benefit plan," and "traditional workers' compensation provider." The regulations were intended to allow sponsoring entities to design and test ideas of their own on how to implement 24 hour care. In addition, the regulations included minimal requirements of pilot programs. For instance, the definition of a managed care product eligible for the pilot was one that provided: 1) timely, effective and accessible medical care; 2) appropriate case management; 3)

appropriate cost control measures and systems to monitor quality deficiencies; 4) adequate methods of quality assurance; 5) expertise in providing medical reports for compensation purposes; 6) an expedited dispute resolution process; and 7) a cooperative effort to promote health and safety and return to work goals.

Section 4612 mandated that the Administrative Director choose 4 pilot counties for projects one in Northern California, one in Central California, and two in Southern California. The counties chosen for the pilots were: Santa Clara, Sacramento, Los Angeles and San Diego. Each was a large, geographically and industrially diverse area. The regulations allowed eligible firms to enroll employees who worked outside the pilot county. Regulations also allowed and encouraged a broad spectrum of applicants.

Parties eligible to apply for the program included: Employers; health care service plans licensed under the Knox-Keene Act; health, disability, or workers' compensation insurers; employers who have secured a certificate of consent to self-insure; state agencies; multi-employer, collectively bargained welfare benefit plans; employee welfare benefit plans sponsored by a union for state employees; and health insurance purchasing cooperatives authorized under state law.

The regulations also described the application and approval process for firms seeking to be pilot programs. The application required parties to describe: the structure of their organization; the potential participants and evidence of their interest; how injured workers would be informed of their rights and options; how disputes were to be resolved; and how dependents would be covered under the proposal.

Priorities for Pilot Programs

DWC Regulations gave priority in selecting participants to:

- Proposals which proposed integrating medical and indemnity benefits. These provide for coordinated administration of indemnity benefits, as well as medical benefits, including state disability insurance (SDI) benefits, workers' compensation moneys, and private disability benefits;
- Proposals targeting employers who had previously not offered group health benefits to employees;
- Joint Labor-Management Proposals;
- Proposals which include or allow comparison with control groups to assist the evaluation process; and
- Proposals that could operate in more than one pilot county

The Division of Workers' Compensation released public notices and text of proposed regulations in April, 1993 and Public Hearings were held in May, 1993 in San Francisco and Los Angeles. Fifteen sets of comments were received and responded to, and the final regulations were sent to the Office of Administrative Law in August, 1993. In April 1994, in response to the slow start up of the program, regulations proposing an extension of the final date of the program to December 1997 were proposed, and were adopted on October 11, 1994. (See Appendix 2 for copy of regulations.)

Application developed and released

Firms interested in designing 24 hour pilot programs under Labor Code Section 4612 were sent a detailed application form during the fall and winter of 1993-94 (See Appendix 3 for copy of application). Applications were due by March 31, 1994. Approximately 100 organizations requested and were sent copies of the application.

Applicants were required to describe the pilot program on several dimensions: the administrative and organizational structure of health plan, and how health care services were to be

provided; procedures under which an employee who selected the exclusive provider of care option would be permitted to change health care service plans; the method whereby employees would be informed of their rights and options under the proposal; the dispute resolution process under the exclusive provider of care option; a description of how dependents would be covered under the proposal; the enrollment and disenrollment procedures; incentives offered by the employer/applicant to employees to encourage participation; how long-term workers' compensation liability was to be handled; and a description of the employers' occupational injury and illness prevention programs.

The application required sponsors to describe and list contact persons for all of the entities expected to participate in the pilot program, including the health plan to be the exclusive provider of care, the workers' compensation carrier or third party administrator, the employers, any unions representing employees of potentially participating employers and any other parties included via contract. Signed authorization forms from all prospective participants were to be included with the application.

Applicants and all participating parties were also required to cooperate with the Division in accomplishing the program evaluation of the pilots. Applicants would provide the administrative director with information necessary to evaluate the plan, and the pilot program as a whole, and agreed to pay a proportionate share of the cost of the evaluation of the pilot projects, based on the number of participating employees, if needed. Data collection would include information concerning participating employers' recent history (three years prior to first enrollment) relating to occupational injuries and illness, workers' compensation, and non occupational health insurance coverage.

Applications Accepted and Denied

Eight proposals were received by the DWC, of which four were ultimately accepted after review, negotiation and revision. Two of the others involved state agencies and state employee unions, one of which eventually joined with another successful pilot proposal. The other was never able to work through issues between the union and employer. One of the other unsuccessful proposals was submitted by a firm that also submitted an unsuccessful proposal for an alternative dispute resolution program under Labor Code Section 3201.5. The status of the union in both proposals was questionable, and questions about the status were never adequately answered. Finally, one proposal was submitted by a private claims administration service that was seeking to expand into medical claims management. The rejected proposal did not clearly identify the employers which would be part of the program, and depended upon an unapproved medical care network. It is unclear what, if anything, deterred applications from other groups which had requested application material.

The limited number of applicants responded to some, but not all, of the DWC priorities. Of the eight proposals, one was listed as a joint labor management proposal, one targeted small employers who had not necessarily offered group health benefits to employees in the past, and one included plans to operate in two pilot counties. No proposals specifically addressed the issue of including or allowing comparison with control groups, and no proposal provided for coordinated or integrated administration of indemnity benefits such as SDI, private disability, and workers' compensation.

Analysis of successful applications

Start-up and Current Status of Kaiser South

Southern California Kaiser-Permanente presented a proposal to provide coverage to employees located in San Diego County. This application was the first 24 hour pilot program approved by the Division, and Kaiser began treating employees on June 1, 1994. Kaiser charges

employers/insurance carriers a monthly capitated rate for each participating employee, with rates developed using the employer's prior claims experience. Workers' compensation medical services are provided primarily at Kaiser's primary hospital setting in a newly organized department of occupational medicine. At its outset, the pilot included five employers and approximately 3,000 employees of: the County of San Diego, the Community College District of San Diego, Kaiser-Permanente in San Diego, and two small private sector clients insured by the State Compensation Insurance Fund (SCIF). The original goal was to have up to 20,000 employees in the program. Both Kaiser and SCIF continue to market this pilot plan. By year-end 1996, this pilot program enrolled approximately 5000 employees at sixteen employers in the county.

Start up and Current Status of Kaiser North

Northern California Kaiser-Permanente submitted a proposal to cover State employees employed in Sacramento County, with plans to expand to both private and public sector employers in Sacramento and Santa Clara counties. The plan duplicated many of the same provisions as those outlined in the Kaiser South proposal. The targeted state employees were represented by a number of unions. Kaiser and the state Department of Personnel Administration met with several state departments and their union representatives to explain the pilot program. Early expectations were that the program would cover 5-8,000 enrollees.

Enrollment in this pilot program began in January 1995 with two private sector employers, a food distributor in Santa Clara county and a automobile dealership in Sacramento. By the end of 1995, the program had grown to 15 employers, enrolling 1048 employees. This included two state agencies. By October 1996, the program had grown to 46 employers, including 3 state agencies, and enrolled approximately 2800 workers. The state agencies accounted for almost 30 percent of the total enrollment in this pilot.

Start up and Current Status of Maxicare

Maxicare Life and Health Company, a group practice model HMO, proposed using several of its independent practice associations (IPAs) to provide coverage to employees in Los Angeles County. The goal of this program was to utilize the expertise of a medical group network with experience in occupational medicine to train groups of physicians to handle worker's compensation claims. An IPA of occupational physicians was to serve as a technical resource for the nonoccupational physicians. Under this model, a patient would see the same primary care physician for all types of injuries. This contrasts with the above programs which required a patient with a workers' compensation injury to see a physician who specializes in occupational medicine. At the outset, this group projected potential enrollment of 3-5,000 workers.

The program got underway in January 1995 with enrollment of two employers, including the health plan's own employees, and some employees of another medical care provider. In 1996, two other employers, a hotel and small manufacturing firm enrolled, for a total of four employers and a few hundred employees.

Start up and Current Status of TIG/Sharp: 24 Hour Care Alliance

TIG Insurance, a workers' compensation insurance company, in conjunction with a large medical group (Sharp Rees-Steely) and an HMO (Sharp Health Plan) initially created a joint proposal for San Diego County. Unlike the Kaiser pilot programs above, this plan proposed reimbursement on a fee for service basis according to the Official Medical Fee Schedule. The plan was to be targeted to small businesses (under 50 lives). In addition, there was to be an effort to market to employers who did not have nonoccupational medical coverage for their employees. The target population was 1,000 enrollees.

The Sharp/TIG 24-Hour Care Alliance offered reduced pricing to employers for both workers' compensation and group health plans, with a 10% reduction in workers' compensation

premiums, and a 2% group health premium reduction, plus benefit upgrade equivalent to 3% for employees enrolling in the pilot.⁶

After enrolling a single employer with 13 workers, the program disbanded when TIG Insurance shut down their San Diego operation.

Pilot	Kaiser, North and South	Maxicare	Sharp/TIG
Model	Same facility provides occupational and nonoccupational services through separate units. Staff physicians who specialize in occupational medicine handle workers' compensation cases.	Nonoccupational IPA provides both nonoccupational and occupational services. The IPA is "mentored" by an workers' compensation organization which provides training and technical advice.	Sharp facility provides occupational and nonoccupational services through separate units. Sharp conforms to TIG's utilization review process.
Market Target	All	All	Small Employers
Primary Care Provider/ Primary Treating Physician	Separate doctors on occupational and nonoccupational care, injured worker may request to be treated by primary care provider	Same doctor	Separate doctors
Integration of Medical Records	Yes, all physicians have access to both occupational and nonoccupational records.	Since the patient's personal physician is also their workers' compensation treating physician, the physician has access to all records.	No. Records are kept separate.
Method of Medical Reimbursement for Workers' Compensation Cases	Insurance carriers and self-insured employers pay a monthly fee or "capitation" to Kaiser. A separate fee is calculated for workers' compensation and group health.	Official Medical Fee Schedule.	Official Medical Fee Schedule.

24 Hour NonPilot programs

Next to the state pilot programs, there are many products on the market that call themselves 24 hour health care or integrated benefit products. In addition, several large private sector employers are experimenting in integrating self-insured health and disability plans.⁷ In July, 1996, the Integrated Benefits Institute published a national review of 19 different products offered by medical providers, disability insurers, workers' compensation insurers and third party administrators.⁸ The review compiled descriptions of 19 integrated benefit products, based on the companies' self-description and highlights. Eleven of the products integrated medical care systems, six integrated disability programs, and two did both medical and disability. These and many other products are entering the market at a time of experimentation with claims processing and marketing. Unless certified by the state as an HCO (Health Care Organization) or 24 hour pilot, none of these nonpilot 24 hour plans can offer extended periods of medical care control. Firms offering nonpilot 24 hour programs are not required to have an enrollment process, and have no special reporting requirements. Many offer employers signing up for both health and workers' compensation coverage a premium discount for workers' compensation. In California, Zenith Insurance, in conjunction with UNUM long term group disability, is offering an integrated policy marketed as Singlepoint to approximately 100 employers. Blue Cross and Unicare Insurance have linked up to provide a product known as Unicare Integrated to over 3500 mostly small employers. FHP Insurance and its subsidiary Great States Insurance have coordinated services to over 100 medium size employers. CareAmerica Health Plans' "Total Care" program combines group health and workers' compensation from a single company that writes coverage on both insurance lines. As of mid-1996, the company reported over 100 participating employers.

While these marketplace products of 24 hour care offer diversity of products and raise important questions about the differing types of coordination or integration of medical and disability coverages, they will not be evaluated directly under the current evaluation. However, the surveys and evaluation tools being developed under for this project could be used by those entities to do self-evaluations.

Results and Outcomes

General Impressions

Survey of Employers

An informal survey of employers participating in the pilot was conducted during November 1996 to get general impressions of the pilot program, and solicit comments and experience on a variety of topics. The survey was administered by phone to 13 employers, whose workforce comprised nearly 60% of the participating employees. 10 of the 13 employers felt that the program had met their expectations very well, while 2 indicated it was going somewhat well, and one recently enrolled employer said it was too early to tell. On the questions of whether they would sign up again if given the chance and whether they would recommend it to other employers, 11 of 12 answered they would recommend it. The other employer was waiting for an analysis of the data before giving any recommendations. For those in insured businesses, the program seemed an unqualified success. For most, premium costs were reduced through an additional discount applied for pilot programs. Participants also described greatly improved lines of communications between themselves and the providers of occupational health care. The larger self-insured employers also commented on the improved communication, with one indicating that the difference was like night and day. Prior to the pilot, the health plan was seen as a black hole, but under the new protocols of the pilot and the newly adapted occupational medicine clinic, communication was made easy and direct, particularly though increased contact between the employer and the nurse case manager at the health plan.

Each of the regional Kaiser plans devoted some resources to convening quarterly or semi-annual employer “advisory” meetings, in which a program update and description was given, and participants had the chance to exchange information. Of surveyed employers who had attended these meetings, they were generally given positive marks. One employer in a pilot project that did not hold periodic advisory meetings thought such a practice would have been beneficial.

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 industry wide costs declining. Four employers, including two of the largest three surveyed, were not sure whether the program had produced any cost savings.

Discussions with Health Plans and Claims Administrators

Interviews with representatives of claims administrators and the health plans were also done. Pilot program sponsors all indicated that while the program was developed at a time when costs were rising and employers were seeking programs helping them to control costs, that the actual program implementation took place during a subsequent period when premium rates were rapidly falling. 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.

Enrollee and Worker Satisfaction and Outcomes

The evaluation design for the final report due in 1988 includes a substantial commitment to surveying workers as to their satisfaction and post-injury outcomes, and a true test of the program awaits that effort and analysis. As a preliminary gauge of the satisfaction and outcomes of employees who had enrolled in the program, three groups were contacted: state information and assistance personnel who handle questions and offer assistance to the public regarding compensation issues; union representatives of affected employees, and selected attorneys representing injured employees.

DWC Information and Assistance Officers in the pilot counties reported that no requests regarding the pilot program came in during program operation and that they heard no complaints or comments about the program.⁹

Union representatives for groups of represented employees were also contacted. One Sacramento-based state employee union official whose members were authorized to participate indicated that he had not heard of any complaints. He indicated that state unions that had participated had entered the program with the expectation that if there were savings generated by the program, that such savings could be reflected in other benefit gains. He was cautious about endorsing any continuation or extension of the pilot program without a better indication of what those gains might be. A representative of a social services worker union in San Diego was familiar with the program and had heard neither positive nor negative comments.

The program is not without its critics. Complaints about the program surfaced in speaking with attorneys for injured workers. One San Diego applicant attorney familiar with the program indicated that some participating workers who had been injured on the job had assumed that under the 24 hour coverage they would be able to be treated by their group health primary provider with whom they had personal rapport, rather than by occupational medicine specialists. He indicated

that at least one employer had not adequately explained to these workers that while they could be getting care under the same provider network, that did not guarantee the specific physician that they might prefer. This caused some situations where injured workers felt stuck with a provider they were not comfortable with, and some where workers felt their care had been inadequate.¹⁰ Another San Diego applicant attorney related a situation where his client entered the program with a pre-existing condition that had progressed to a point where the pre-24 hour treating physician had recommended surgery to correct a shoulder problem. After entering the 24 hour program, the client was put through another regimen of care similar to that already attempted and the client was kept from getting surgery and did not improve. Only after the person opted out of the program at the next open enrollment period was she able to get surgery. The attorney indicated that subjective complaints of the patient were not considered by the 24 hour health provider, and that it seemed that standard protocols overly influenced the judgment of the physicians in the case.¹¹

Criteria for evaluation - 13 items to review

The legislative mandate includes 13 items intended for evaluation. Many of these items will be included in the final report of the pilot programs, which is due one year after the program ends. In this section, to the extent possible, we attempt to give background and available information on each of the mandated areas.

(1) Employer costs.

Employers face many types of costs associated with the components of 24 hour care, including costs of medical care, indemnity, administration, and litigation. In looking at costs, one distinction must be made between insured and self-insured employers. Insured employers pay a premium for their workers' compensation coverage that covers all aspects of claims, while self-insureds by definition pay their own costs. Under the pilot program, most insured employers have seen market driven cost decreases of varying amounts. Self-insureds are not so sure of their cost reductions as it is too early to evaluate the effects of such a program.

Most insured employers participating in the pilots have received discounts on their workers' compensation premiums. State Compensation Insurance Fund provided a 15% discount to employers in San Diego when the first pilot began and still offers 15% reductions, seemingly irrespective of percentage enrollments.¹² Allianz Insurance Company offered a 2-6% discount, in addition to all other discounts, depending on what percentage of employees were signed up for the program.¹³ Argonaut Insurance did not specifically offer premium discounts for participation in the pilots, preferring to sell the program on its own merits rather than on cost. In addition, Kaiser on the Job employers have received discounts on Kaiser health plan premiums of up to 10%.

The issue of which employees enroll in the program can have a major impact on the cost impact to both employers and the health plans. In a capitated health system in which enrollment is not mandatory, rates negotiated prior to knowing which employees will enroll can be risky for both sides. Given a capitated rate that is actuarially sound and calculated based on the employer's overall experience, if a disproportionate number of low risk employees enroll, the employer will likely be paying more than they would have under traditional service arrangements. Conversely, if disproportionate numbers of high risk employees enroll, the health plan will provide greater numbers of services than expected. Self-insured employers have been aggressive in negotiating capitation rates with the health care service plan, and per capita rates for the larger self-insured employers have fallen during the time of the pilot.

Outside the pilot programs, under the "open rating" structure of workers' compensation today, some insurers are offering "schedule rating" discounts for non-pilot 24 hour plans. For example, in the Kaiser-SCIF Alliance product, employers receive up to a 10% premium rate reduction for participation in that quasi-24 hour plan.¹⁴ Whether insured employers have had other positive impacts that have reduced injuries and workers' compensation claims, or not, the rate decreases made the program popular among those participating.

(2) Vocational rehabilitation implications of 24-hour care pilot projects.

In the interim survey of employers, no employer noted any specific changes in vocational rehabilitation due to participation in the program. The time lag before vocational rehabilitation services occur in a case may make this difficult to measure. However, some employers indicated that the 24 hour program gave them more information from the medical care provider to design return to work opportunities for injured workers.

(3) Numbers and percentages of employees in pilot worksites that enroll in the plan.

Figures 1a and 1b show enrollment figures and numbers of employers in the pilot programs over time. At their peak, the pilot programs enrolled nearly 8000 workers at more than 65 businesses, organizations, and government agencies. For the Kaiser on the Job program, only Kaiser group health plan members were eligible for participation in the pilot; if a nonmember wished to enroll in the pilot, he or she would concurrently switch their group health coverage to Kaiser so that both occupational and nonoccupational care would be provided through the same network. Figure 2 shows the peak level of enrollment for each firm in the program. The largest participant was San Diego County, which at the peak of the program enrolled approximately 3000 workers, or about 40% of the total. Figure 3a shows the distribution of participating employers, and 3b the distribution of enrollees, among the pilot programs. Figure 4 shows the distribution of enrollment by type of employer in the following categories: self-insured private entity, self insured public entity, insured private employers and insured public employers.

(4) Incentives used by employers to encourage enrollment in the plan.

Visible incentives to encourage enrollment were rarely used in the program. One employer offered t-shirts, another entered enrollees in a raffle for an exercise machine, another offered gift certificates to a local shopping mall, and a fourth gave out earthquake survival kits at enrollment. Some employers believe that the employees' ability to access their own health care provider was also an inducement to enroll. Generally, no prizes were offered to enrollees, although it was often stated that employees were made to believe that if costs could be controlled under a pilot program, then the benefits might be shared.

(5) Extent to which dependents of pilot project employees enroll in health plans.

Surveyed employers reported no differences in dependent enrollment in health care plans due to the pilot program. Most had previously offered health care to dependents in the same manner as was offered during the pilot, at some cost to the employee.

(6) Determination of employee satisfaction with the pilot program.

Employee satisfaction with the program is a major part of the analysis being prepared by the research consultants. A patient satisfaction survey that draws on previous work by the DWC managed care unit and by other health care researchers will be administered to a sample of injured workers who got all of their medical care within the pilot and compared to a sample chosen as a control group. (See "General Impressions: Enrollee and Worker Satisfaction and Outcomes" above. See also #7.)

(7) Extent to which employees enrolling in the pilot plan continue to stay within it during the length of the pilot program.

Enrollment in the pilot grew during its first three years, starting at approximately 3000 workers at five different employers, and growing to nearly 8000 employees at over 65 employers. At the large employers that have gone through a series of re-enrollments at renewal time, the

general trend has been that while a few persons drop out of the program, many more sign up for a net gain in participants. While statistics to verify the perception are not yet available, nearly all pilot employers surveyed reported that they had seen increases in enrollment over the multi-year program.

(8) Differentials in costs of treatment between different types of pilot programs for occupational and nonoccupational injuries and illnesses.

The formal analysis plan for the final report includes a data collection effort to compare the pilots across each of these cost variables. The plan is to match each employer with a non-pilot program control group to test variations in costs and variations over time.

(9) Differentials in costs of treatment and of indemnity benefits among workplaces comparable in size, type of industry, and location, between pilot programs and non-24-hour care for occupational and nonoccupational injuries and illnesses.

See # 8.

(10) Differentials in costs of claims administration between pilot programs.

See # 8.

(11) Percentage of occupational injury claims litigated and the type of dispute giving rise to litigation.

The formal final analysis will look into the question of the scope and type of litigation in the 24 hour program, and compare that experience to outside controls.

(12) How continuing obligations for medical treatment under workers' compensation will be secured after completion of the pilot project.

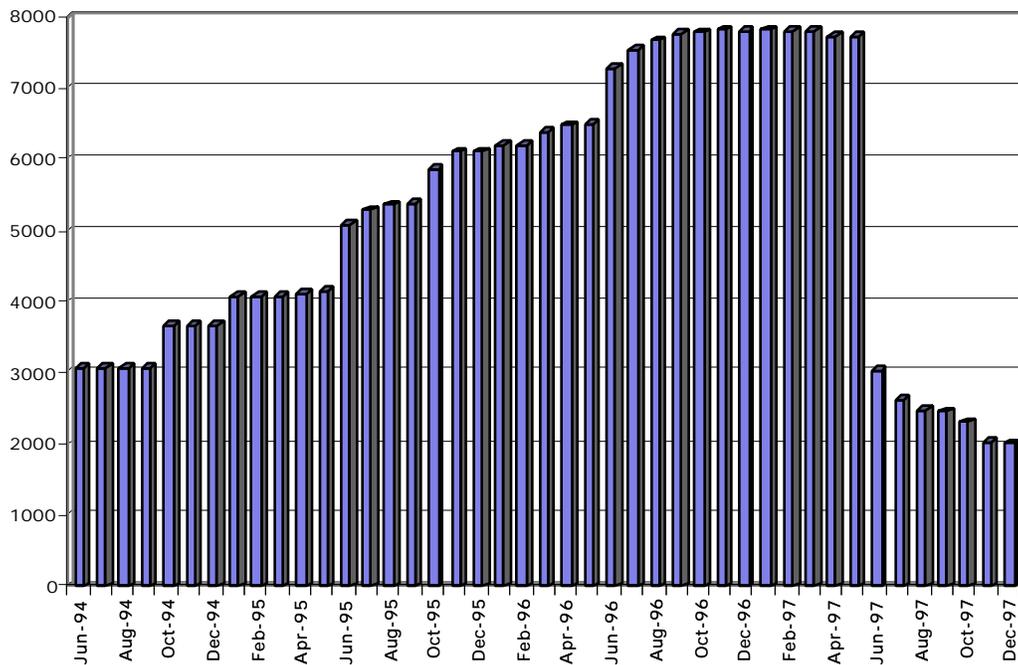
The contracts of the three arrangements included the following language pertaining to this question:

Maxicare: The liability of participating employers and of the program workers' compensation carriers to pay for workers' compensation claims incurred during the pilot program will remain as required under the Labor Code and will continue even after the pilot program terminates. The termination of the pilot program will be irrelevant with respect to the obligation to pay claims. The policies issued by the workers' compensation carriers will be the traditional occurrence-based policies. The policies will cover the periods covered by the pilot programs, thus obligating the carriers to pay for all compensable claims incurred during the policy periods. Neither Maxicare, nor the Maxicare HMO, nor Parthenia will assume any liability for the payment of worker's compensation claims.

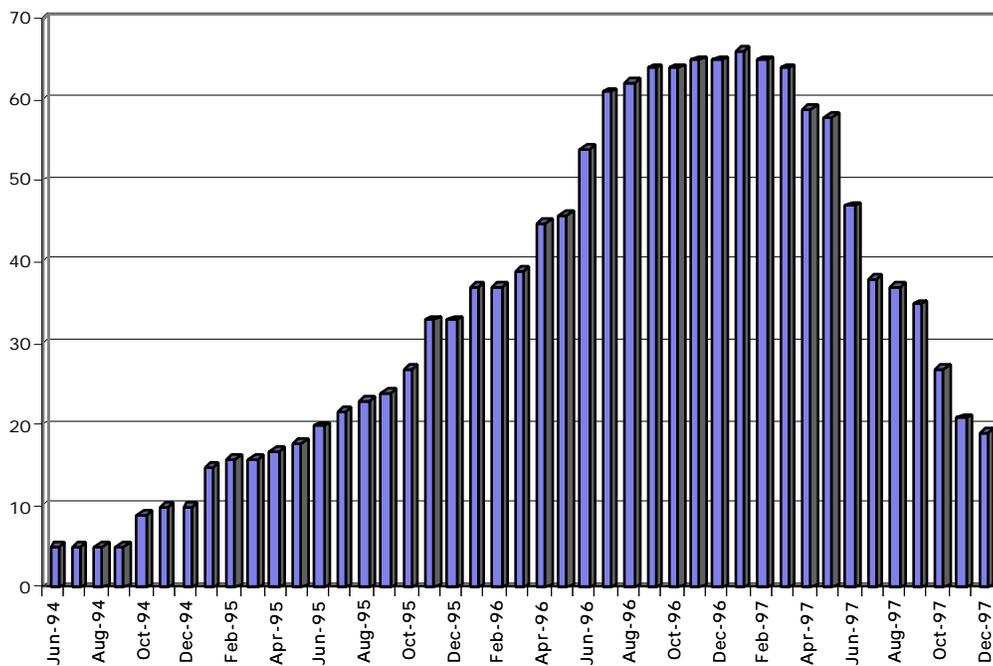
Kaiser - An enrollee who terminates participation in the pilot project but maintains his or her non-occupational Health Plan coverage may continue to receive occupational care from Kaiser Permanente in accord with the workers compensation fee schedules, however, the pilot project specific services that would have been received through KAISER ON-THE-JOB such as dental, acupuncture or chiropractic care, will not be provided. If a former KAISER ON-THE-JOB participant continues to request occupational care from Health Plan, the Employer or its compensation insurer will retain full financial responsibility for the cost of the care, as well as all other aspects of Workers' Compensation.

Sharp/TIG TIG Insurance Company agrees to provide all benefits as defined in the Labor Code (and verified as covered by standard policies) until the claim is resolved by

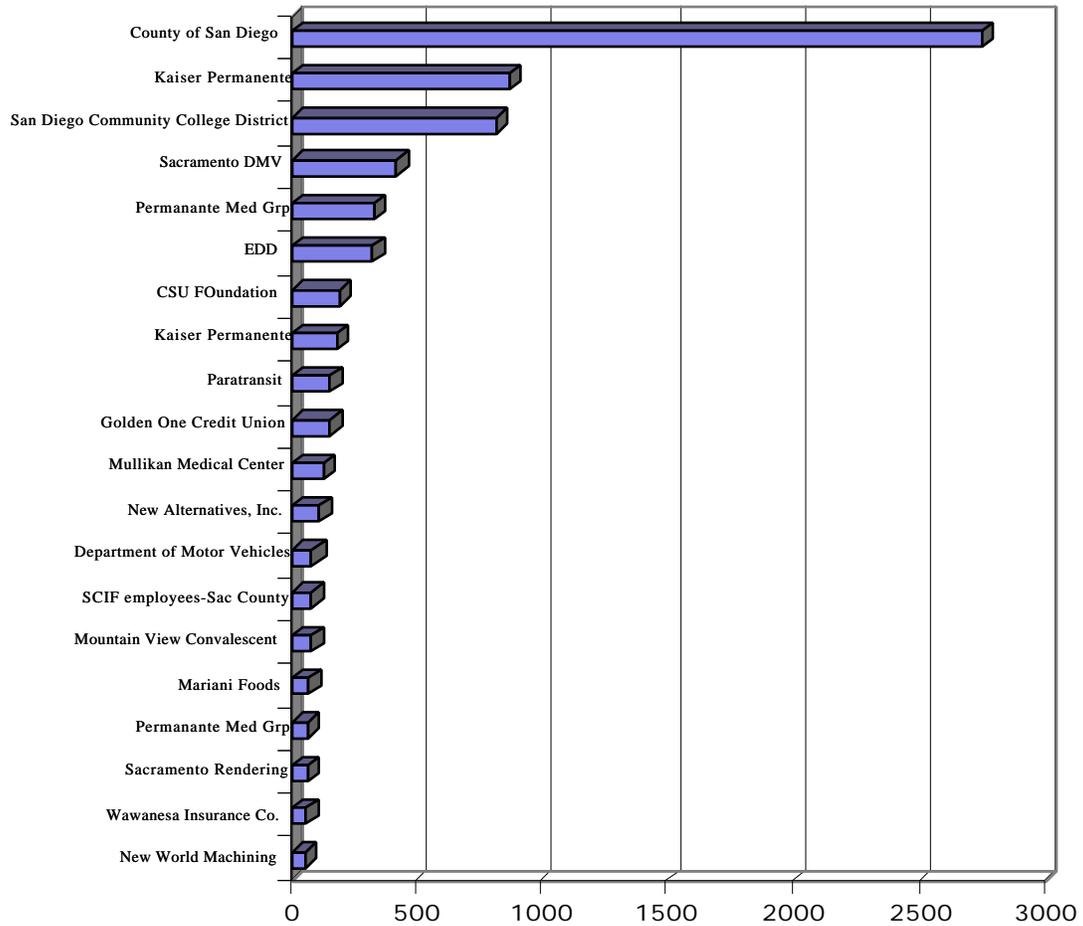
Estimated Total Enrollment in 24 Hour Pilot Programs
Under Labor Code Section 4612



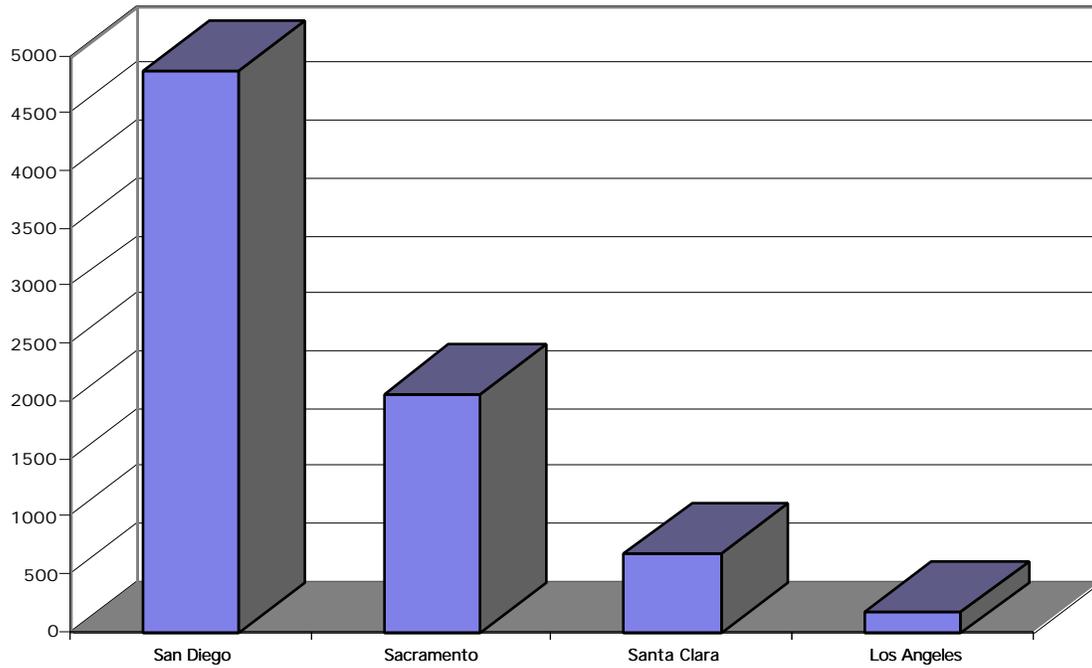
Estimated Total Companies in 24 Hour Pilot Programs
Under Labor Code Section 4612



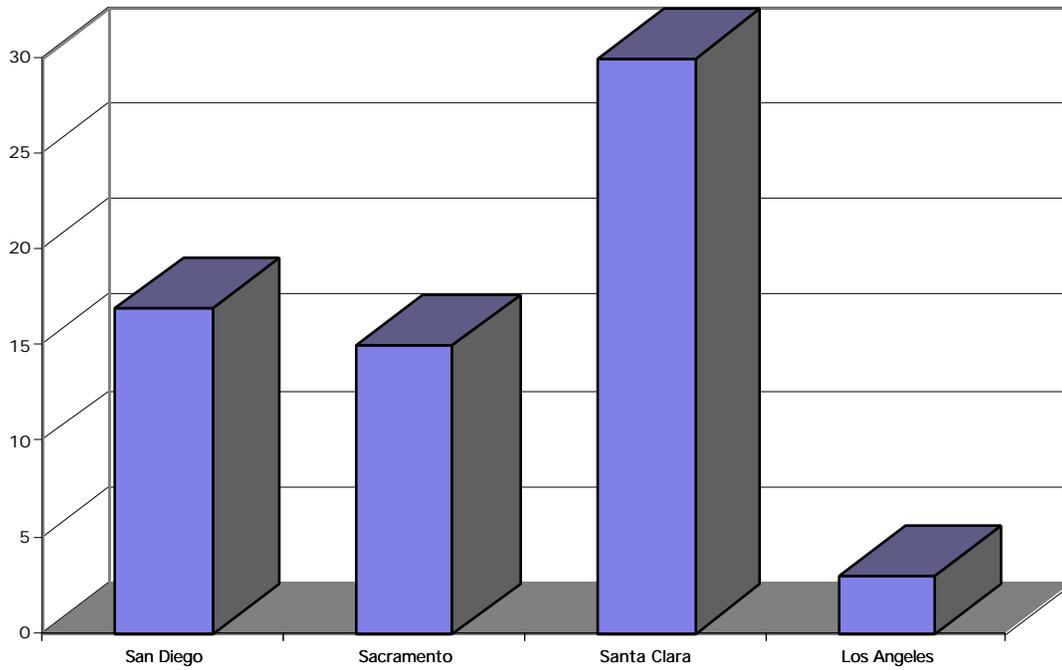
Enrollees in 20 firms with largest enrollment, November 1996



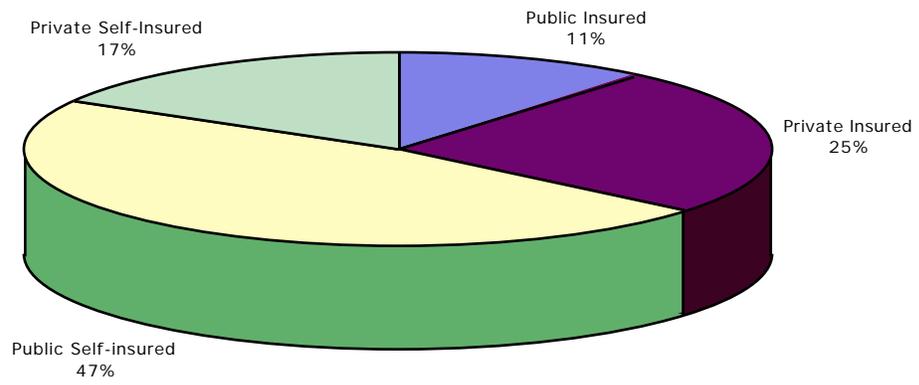
Employees Participating in Pilot Programs, November 1996



Employers Participating in Pilot Programs, November 1996



Insurance Status of Pilot Program Enrollees
as of November, 1996



compromise and release. This will occur regardless of the employer's discontinuance in the Pilot Program. The employer's discontinuance in the Pilot Program will not alleviate the medical control described in the Pilot Program to the extent the date of injury occurred within a period covered by this Pilot Program.

(13) Whether the pilot project was or could be utilized by small employers.

The number of small employers participating in the pilot indicates that the project could and was utilized by small employers.

Final Program Evaluation

Within a year of the completion of the pilot programs, the Division is required to prepare a final report to the Legislature and the Governor. With the program scheduled to end on December 31, 1997, the final report is due at the end of 1998. The purpose of this study is to evaluate the impacts of the pilot program on outcomes and costs for employees with occupational injuries or illnesses and their employers. The study has been designed to address the 13 outcome elements mandated in the legislation, and listed above.¹⁵

Because of the nature of enrollments in the pilot projects, much of the evaluation will focus on participants in a single model of "24 hour" care practiced by Kaiser On the Job pilots. Small enrollments in the other pilot programs make analysis of the process and results of those programs very difficult.

Sponsors Funding the Study

The enabling legislation specified that the evaluation of the pilot program would be financed by participants and, if available, by external sources outside of the state's General Fund. The California Division of Workers Compensation (DWC) is the initiating funding source. Participating pilot program employers pay a fee per enrollee per year to fund the evaluation, which will support the \$177,000 that DWC is providing for the study. (The assessed fee was \$5 per enrollee for 1994 and 1995.) A second funding source is the Robert Wood Johnson (RWJ) Foundation, which is providing \$459,000 from its Workers' Compensation Health Initiative to support the evaluation. This additional support has allowed the research design to include more extensive telephone surveys that will provide richer information on employee outcomes than otherwise would have been possible. The third funding source is RAND's Institute for Civil Justice, which is providing \$150,000 to support case studies of the implementation of the 24-hour pilot. These analyses will develop information on the political and administrative issues involved in this type of program, as well as other similar plans that have arisen in the California market.

Organizations Performing the Evaluation

The study is a cooperative effort by four research organizations. In addition to providing funding, the state DWC is a participant in the research with the roles of identifying and recruiting pilot and control firms to participate in the study and provision of data on employees with workers compensation claims. UCLA will perform the claims data analysis portion of the study. Under a subcontract with UCLA, RAND has the major role in designing the surveys and performing analyses of data collected by the surveys. RAND also will perform the case studies of pilot implementation. The Survey Research Center at U.C. Berkeley also has a subcontract with UCLA to conduct the telephone interviews, using questionnaires developed by RAND and reviewed by the study team, and will prepare datafiles with survey results.

Study Design

1. Enrollment analysis—a comparison of the characteristics of employees enrolled in the 24-hour pilot with those in pilot firms who did not enroll and those in control firms. The purpose of this analysis is to identify and measure differences in the characteristics of pilot employees, which will be used in interpreting the results of the outcomes portion of the evaluation. A telephone survey is being used to collect the data for this analysis.

STATUS: The survey instrument has been developed and will be tested by Berkeley SRC in the next few months. The survey is expected to begin in early 1997, after the participation of pilot and control firms has been obtained.

2. Claimant outcome analysis—an analysis of the experience of workers compensation claimants with respect to the health care they received, disability management, return to work, and satisfaction with these experiences. Experiences of those enrolled in the 24-hour pilot will be compared with those in control firms. A telephone survey will be used to collect data for this analysis, interviewing each claimant 6 months after he or she filed a claim.

STATUS: The survey instrument currently is being developed for review by the research team in the next month. The first interviews are planned to begin in early 1997, and interviews will continue over the subsequent 12 to 18 months as employees file claims, until the target number for the sample is obtained.

3. Firm-level analysis—an analysis of the impact of the 24-hour pilot on overall costs for employers, patterns of enrollment and disenrollment in the pilot, and employers perceptions and satisfaction with the pilot. Baseline and historical data are being collected this year, and data on each year's experience will be collected at the end of each subsequent policy year. A self-administered questionnaire will be mailed to each employer by the state DWC each year.

STATUS: A draft survey instrument has been completed, and is being reviewed by the research team. The instrument is being completed and data collection will begin in early 1997.

4. Analysis of costs of occupational and non-occupational conditions—a comparison of differences in costs for selected injuries or illnesses when they are of occupational versus non-occupational origin. For statistical reasons, a limited number of high volume conditions will be selected, and claims data will be analyzed for workers compensation claimants with those conditions, as well as for matched enrollees treated for those conditions under the group health plan coverage. The analysis will work with encounter and claims data obtained from pilot programs.

STATUS: Initial work is underway to ascertain the availability and quality of health plans' encounter and claims data.

5. Case studies—qualitative analyses of the processes and experiences in implementing the 24-hour pilot program and other 24-hour program options being introduced in the market. Three aspects that will be explored are what happened within the two Kaiser plans that succeeded in achieving substantial enrollments, why were the other two plans unable to develop, and what are the dynamics of the growth of other 24-hour models in the market.

STATUS: Design work for the case studies will begin in the next few months, with plans to be in the field during 1997.

Recruitment of Control Group Employers for the Study

To determine the effects of the pilot, it is necessary to match pilot firms with control groups. To make valid comparisons between pilots and nonpilots, there is an attempt to match employers based on type of work, location, company size, and, if possible, other risk factors.

Although the employers participating in the 24-hour pilot agreed to provide information for the evaluation, a number of important issues are being worked out to assure quality information at

least burden to the data providers. Significant issues include: privacy issues for the firms' employees and the administrative burden on the firms of providing requested data. It is expected that the resolution of these problems with pilot firms will help expedite recruitment of control firms.

Success in achieving a reasonable number of control firms will be critical to the ability to estimate the effects of the pilot by comparing outcomes for pilot and control firms. Substantial time and effort are being spent by UCLA, RAND, and DWC study personnel in developing relationships with firms, and finding administrative methods that respond to their concerns, to ensure that sufficient participation is achieved.

Conclusions and Recommendations

The 24 Hour Health Care Pilot Programs have been operating for about two years. Current legislative and regulatory language allows the various programs to run for three years, or until December 31, 1997, whichever comes first. At this time there is some uncertainty amongst pilot participants as to what happens when pilots end. Nearly all participants contacted for this report indicated support for the program continuing beyond its current end point, in order to allow new marketing to take place during a time of relative stability in premium rates, and to recognize that the start up period took longer than expected.

The Legislature should begin to look for ways to expand understanding of the various statutory and nonpilot approaches to the integration and coordination of health and disability systems serving injured workers. The Legislature should consider whether a next round of pilot programs would be beneficial in moving toward an integration of disability coverage as well as medical care.

Endnotes

¹ For more examples and views on this subject, see Peter Barth, Ph.D. "What is 24 Hour Coverage." Paper prepared for 24 Hour Coverage Symposium, Philadelphia, PA, September 6, 1995.

² National Association of Insurance Commissioners, "A Progress Report on the Implementation of 24 Hour Coverage," September, 1995 (Kansas City), p. 1.

³ Figure furnished by Rena David, Kaiser Permanente Occupational Medicine Project, January 3, 1997. This figure is estimate for Northern California Kaiser.

⁴ Most of the evaluation language referred to vocational rehabilitation implications. The language also included a difficult to interpret statement that "For purposes of this pilot project, a favorable comparison is defined as one in which a differential of 3 percent is noted between those participating in the pilot project and those not participating in the pilot project."

⁵ SB 1051 amended 04/18/95, proposed amending Labor Code Section 4612(b) to read: "A health care service plan that is authorized by the administrative director to participate in one or more designated counties may also, with the administrative director's authorization, implement a pilot project in a county that is geographically contiguous to the designated county or counties in which it is authorized to participate."

⁶ Sharp/TIG 24Hour Care Alliance, Seminar, San Diego, July 26, 1995.

⁷ One organization providing a forum for such experimentation in California is the Disability Management Employers' Coalition, with chapters in northern and southern California.

⁸ Integrated Benefits Institute, "Marketplace for Integrated Products Expands," July 12, 1996, San Francisco.

⁹ Interviews/discussion with I&A staffs in San Jose and San Diego. 12/30/96

¹⁰ Interview with Stan Levine, 12/30/96.

¹¹ Interview with David Dugan, 12/30/96.

¹² See State Compensation Insurance Fund rate filing to California Insurance Commissioner, #95-10233, proposed effective 1/1/96, pp. 96, 98. This meant that some companies enrolling only a few participants still got a sizable premium reduction. The filing states "There is no credible actuarial evidence for estimating the expected savings from a 24-hour care arrangement. Indeed it is the purpose of the pilot to determine if such savings do in fact exist."

¹³ See Allianz Insurance rate filing to California Insurance Commissioner, #95-10775, p. 36.

¹⁴ Under this plan, the level of discount is based on the total size of the employee group and on the level of participation by the employees in the Kaiser Health Plan. According to the filing, "this discount is 5% less than the discount offered to participants in the original 24 hour coverage program to reflect the reduced level of employer/insurer medical control in a program organized outside of the managed care possibilities granted in AB 3757." State Compensation Insurance Fund rate filing to California Insurance Commissioner, #95-10233, proposed effective 1/1/96, p. 99..

¹⁵ Labor Code Section 4612 (d).

Table of Appendices**Labor Code Section 4612****California Code of Regulations Sections 10175-10181****Application: 24-Hour Care Pilot Program****Brochures and Enrollment Information****Enrollment Material - Kaiser on the Job****Enrollment Material - Max at Work****Enrollment Material - Sharp/TIG 24 Hour Care Alliance**

Appendix 1-CALIFORNIA LABOR CODE SECTION 4612

4612. (a) A pilot project is hereby authorized, for a duration of up to 36 months, under regulations to be developed and implemented by the administrative director. The purpose of the pilot project is to authorize an employer participating in the pilot project to contract with a licensed health care service plan to be the exclusive provider of medical, surgical, and hospital treatment for occupational and nonoccupational injuries and illnesses incurred by its employees. The health care service plan shall provide all occupational-related medical treatment coverage required by this division without any payment by the employee of deductibles, copayments, or any share of the premium. Employers participating in the pilot project shall make available health plan coverage for their employees' dependents for the treatment of nonindustrial injuries and illnesses. Nothing herein shall require an employer to pay for that dependent coverage. An employer participating in the pilot project shall offer its employees a choice between the exclusive provider of care option and a traditional health benefits plan which allows employees to obtain workers' compensation treatment from a traditional workers' compensation provider. In the case of a pilot project established by a multiemployer, collectively bargained employee welfare benefit plan, or by a recognized exclusive bargaining agent for state employees that sponsors an employee welfare benefit plan for the benefit of employees, this choice may be exercised by an exclusive or certified bargaining agent that represents employees of the employer.

(b) That pilot project may be implemented in four counties as designated by the administrative director and may include more than one health care service plan. One county shall be in northern California, one in central California, and two in southern California. Multiemployer, collectively bargained employee welfare benefit plans that operate in one or more of the designated counties, or recognized bargaining agents for state employees that sponsor a welfare benefit plan, may implement a pilot project in all counties in which participants are employed and covered for nonoccupational injuries and illnesses.

(c) Notwithstanding the terms of Section 4600, 4601, or any other provision of this article, an employee employed by an employer participating in the pilot project who has elected to enroll in the pilot project shall not have the option of predesignating a personal physician, other than a physician provided by the licensed health care service plan designated by the participating employer, as his or her treating physician, nor shall an employee have the option of changing to a physician not provided by the health care service plan pursuant to Section 4601. However, this section shall not be construed to limit the requirement under Section 4600 that an employer provide treatment reasonably required to cure or relieve the effects of an injury, nor shall this section be construed to prohibit an employee from changing to another provider of health care services during any annual open enrollment period.

(d) The administrative director shall, at the completion of the second year of the pilot project, or sooner if feasible, prepare a preliminary report, and within one year after completion of the pilot project, prepare a final report to the Legislature and the Governor describing the pilot project. The report shall include a review of the following:

- (1) Employer costs.
- (2) Vocational rehabilitation implications of 24-hour care pilot projects.
- (3) Numbers and percentages of employees in pilot worksites that enroll in the plan.
- (4) Incentives used by employers to encourage enrollment in the plan.
- (5) Extent to which dependents of pilot project employees enroll in health plans.
- (6) Determination of employee satisfaction with the pilot program.

(7) Extent to which employees enrolling in the pilot plan continue to stay within it during the length of the pilot program.

(8) Differentials in costs of treatment between different types of pilot programs for occupational and nonoccupational injuries and illnesses.

(9) Differentials in costs of treatment and of indemnity benefits among workplaces comparable in size, type of industry, and location, between pilot programs and non-24-hour care for occupational and nonoccupational injuries and illnesses.

(10) Differentials in costs of claims administration between pilot programs.

(11) Percentage of occupational injury claims litigated and the type of dispute giving rise to litigation.

(12) How continuing obligations for medical treatment under workers' compensation will be secured after completion of the pilot project.

(13) Whether the pilot project was or could be utilized by small employers.

The pilot project shall be deemed a success if the administrative director can verify that the information contained in the report required by paragraphs (1) to (13), inclusive, compares favorably with that of employers and employees not included in the pilot project. In order to prepare the report, the administrative director shall prescribe information to be collected by each approved pilot program for submission to the division in a timely manner.

(e) The administrative director shall prepare an itemization of the costs to the division associated with preparation of the report described in subdivision (d). The cost of the report shall be borne by the employers participating in the pilot project, and, if available, by other external sources outside of the General Fund. Contribution by the employers shall be apportioned on a per capita basis based upon the number of employees enrolled under the pilot project.

(f) For purposes of this section, "health care service plan" includes health care service plans and disability insurers that offer a managed care product within a pilot project county, workers' compensation insurers as defined in Section 3211 of the Labor Code that offer a managed care product within a pilot project county, multiemployer collectively bargained employee welfare benefit plans that offer a managed care product within a pilot project county, and welfare benefit plans sponsored by recognized exclusive bargaining agents for state employees. Pilot projects covering state employees shall be approved by the state employer and approved pursuant to Part 5 (commencing with Section 22751) of Title 2 of the Government Code.

(g) The employer's contract with the health care service plan shall include a surcharge or other provision to cover the cost of the medical care of an injured employee which is required by this division after the employee leaves the contracting employer's employment.

(h) Enrollment or subscription in the pilot project may not be canceled or not renewed except in the following:

(1) Failure to pay the charge for that coverage if the subscriber has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

(2) Fraud or deception in the use of the services or facilities of the plan or knowingly permitting that fraud or deception by another.

(3) Any other good cause as is agreed upon in the contract between the plan and a group or the subscriber.

(i) Notwithstanding any other provision of this section, no employer that is required to bargain with an exclusive or certified bargaining agent which represents employees of the employer in accordance with state or federal employer-employee relations law for represented employees,

shall contract with a managed care organization for purposes of this section unless authorized to do so by mutual agreement between the bargaining agent and the employer.

Appendix 2-CALIFORNIA CODE OF REGULATIONS, SECTION 10175-10181

Subchapter 1.7 (commencing with Section 10175) is added to Chapter 4.5 of Division 1 of Title 8 of the California Code of Regulations to read:

§10175. Definitions .

As used in this subchapter:

(a) “Employer” means any person defined as an employer in Section 3300 of the Labor Code who has secured the payment of workers’ compensation benefits as required by Section 3700 of the Labor Code.

(b) “Exclusive provider of care option” means an option chosen by an employee under Section 10180 under which medical, surgical, and hospital treatment for both occupational and non occupational injuries and illness are provided to the employee through one health care service plan.

(c) “Health care service plan” means any of the following which offer a managed care product:

(1) A health care service plan licensed under Section 1353 of the Health and Safety Code (Knox-Keene Health Care Service Plan Act);

(2) A disability insurer authorized to transact health insurance or disability income insurance pursuant to Part 2 of Division 2 of the Insurance Code.

(3) An insurer authorized to transact workers’ compensation insurance in California, including the State Compensation Insurance Fund.

(4) The state or an employer who has secured a certificate of consent to self-insure from the Director of Industrial Relations pursuant to Labor Code Section 3700.

(5) Multi-employer collectively bargained employee welfare benefit plans or an employee welfare benefit plan sponsored by a recognized exclusive bargaining agent for State employees.

(d) “Managed care product” means a system of medical care which provides for all of the following:

(1) All medical and health care services required under Section 4600 of the Labor Code in a manner that is timely, effective, and accessible to the employee. This shall include making available to an employee, within 5 days of a request, the services of any type of physician, as defined in Section 3209.3 of the Labor Code, including a chiropractor, following an initial visit with the employee’s primary care physician, when treatment for an occupational injury or illness falls within the scope of practice of the requested type of physician.

(2) Appropriate case management, including direction of injured employees to appropriate medical service providers within a network for all non emergency services.

(3) Appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service, and mechanisms to identify and correct quality deficiencies.

(4) Adequate methods of quality assurance, peer review and service utilization review to prevent inappropriate or excessive treatment, and exclusion from participation those providers who violate treatment standards.

(5) Expertise in providing medical reports necessary for the prompt, proper administration of compensation, including those required under Sections 9785 and 10978.

(6) A procedure for resolving disputes concerning the provision of health care services under the plan, which shall be equivalent to that specified in Section 1368 of the Health and Safety Code.

(7) A program involving cooperative efforts by the employees, the employer, physicians, and other participants to promote employee wellness, workplace health and safety, and early return to work.

(8) Adequate mechanisms to assure coordinated case management goals and incentives among all providers of workers' compensation for employees with occupational injuries and diseases.

(e) "Principal place of business" means the location at which the majority of the employer's employees are employed.

(f) "Small employer" means an employer who on at least 50 percent of its working days during the calendar quarter preceding submission of the proposal under which the employer participates in the pilot project employed not more than fifty (50) employees.

(g) "Traditional health benefit plan" means a plan of medical coverage for non occupational injuries and illness provided by the employer, through a contract between the employer and a health care provider, or through a purchasing cooperative specifically authorized by state law.

(h) "Traditional workers' compensation provider" means a health care provider chosen pursuant to Labor Code Section 4600 or 4601.

Note: Authority: Labor Code Sections 133, 4612, 5307.3.

Reference: Labor Code 4612, .

§10176. Eligible Employers and Employees

(a) Employers whose principal place of business is in any of the following counties may participate in the pilot project:

- (1) Los Angeles;
- (2) San Diego;
- (3) Santa Clara;
- (4) Sacramento.

(b) Employees of employers eligible to participate in the pilot project who are employed in counties other than those enumerated in subdivision (a) are not precluded from participation in the project.

(c) Nothing in this section shall be construed to prohibit participation by employers whose principal place of business is not within one of the four counties listed in subdivision (a) above if the employer is specifically authorized to do so by statute.

Note: Authority: Labor Code Sections 133, 4612, 5307.3.

Reference: Labor Code 4612, .

§10177. Eligible Applicants

(a) Pilot project plan proposals may be submitted to the administrative director by any one or combination of the following entities or authorized agents thereof:

- (1) Employers
- (2) Health care service plans
- (3) Health insurance purchasing cooperatives specifically authorized under state law.

Note: Authority: Labor Code Sections 133, 4612, 5307.3.

Reference: Labor Code 4612, .

§10178. Pilot Project Proposal Requirements

(a) Proposals submitted to the administrative director for final approval shall include all of the following:

(1) A description of the manner in which health care services are to be provided, including the administrative and organizational structure, how each component of the managed care product will be provided, and the standards and procedures under which an employee who selects the exclusive provider of care option will be permitted to change health care service plans.

(2) The business name and tax identification number of the employer or employers, the approximate number and occupations of participating employees, the health care service plan or providers of health care services, and any other parties required in the operation of the proposal. The proposal shall include signed authorizations from all necessary parties, other than the employees, confirming their commitment to the plan. In the case of a proposal under which only small employers will participate, the proposal may specify the method by which employers will be selected to participate in lieu of identifying and obtaining commitments from participating employers and identifying the approximate number and occupations of participating employees.

(3) The method whereby employees will be informed of their rights and options under the proposal, including the right to obtain a decision from the Workers' Compensation Appeals Board in the case of disputes over compensation for injuries compensable under Division 4 (commencing with Section 3200) of the Labor Code. Materials to be used for this purpose shall be submitted with the proposal. Materials shall include a description of the dispute resolution process, a description of dependent

coverage, a description of the method and frequency of employee choice of health care provider, and a description of any other incentives offered to employees by employers to participate in the plan.

(4) The dispute resolution process under the exclusive provider of care option, including the process made available to employees to voluntarily resolve issues subject to the jurisdiction of the appeals board, as well as the process for resolving disputes which are not subject to the jurisdiction of the appeals board.

(5) A description of how dependents will be covered under the proposal, and if co-payments, premium shares, deductibles, or other charges are to be assessed against employees or dependents for non occupational injuries and illness, the amount of such charges and how these charges will be determined and segregated in a manner to assure compliance with subdivision (a) of Section 3751 of the Labor Code.

(6) The method and frequency of employee choice as to whether the employee will receive medical care under an exclusive provider of care option.

(7) A description of any incentives offered by an employer to employees to encourage participation in the exclusive provider of care option.

(8) Verification of agreement to participate executed by an authorized representative of each exclusive or certified bargaining agent which represents employees of the employer.

(9) The method by which any workers' compensation liability of the employer incurred during the pilot project will be paid after an employee's or employer's participation in the pilot project terminates.

(10) An agreement to provide the administrative director, in the form and manner prescribed by the Administrative Director, with information necessary to evaluate the plan and compliance with this subchapter.

(11) An agreement by the participating employers, or by another participating entity on the behalf of these employers, to pay a proportionate share of the cost of the evaluation of the pilot projects approved under this subchapter, based on the number of participating employees. Nothing in this paragraph shall be construed to require participating employers to pay a share of the evaluation cost if other funding sources are authorized by statute and alternative funding is obtained for this purpose.

Note: Authority: Labor Code Sections 133, 4612, 5307.3

Reference: Labor Code 4612

§10179. Selection of Proposals; Priorities

(a) Initial applications will be accepted from the date the Request for Applications is issued until March 31, 1994.

(b) The following will be given priority in selecting participants in the pilot project:

- 1) Joint labor-management proposals.
- 2) Proposals targeting employers who have previously not offered health benefits for non occupational injuries and illness to their employees.
- 3) Proposals which include appropriate control groups to assist the evaluation process.

(4) Proposals which provide for coordinated administration of indemnity benefits, as well as medical benefits, including workers' compensation temporary disability benefits, state disability insurance benefits, and private disability benefits, while retaining separate administration of the compensation required under Division 4 (commencing with Section 3200) of the Labor Code.

(5) Proposals which will operate in more than one pilot project county.

(6) Proposals which provide parity in coverage between occupational and non occupational injuries and illness.

(7) Proposals which will commence on January 1, 1994.

(c) Proposals approved for participation in the pilot project shall commence no earlier than January 1, 1994 and shall terminate no later than December 31, 1997.

Note: Authority: Labor Code Sections 133, 4612, 5307.3

Reference: Labor Code 4612

§10180. Employee Choice Of Plans

(a) An employee participating in a proposal approved by the administrative director must be offered a choice between the following:

(1) Receiving medical benefits under an exclusive provider of care option for both occupational and non occupational injuries and illness;

(2) Receiving medical benefits for non occupational injuries and illness from a traditional health benefit plan and receiving medical treatment for occupational injuries and illness from a traditional workers' compensation provider.

(b) Employees may be permitted to choose between the two options specified in subdivision (a) in the following ways:

(1) The employee selects an option only once, either (i) before the plan begins in the case of current employees, or (ii) at the time of employment in the case of persons employed after the initial selection period for current employees.

(2) After the initial election, the employee is permitted to change options annually, during an open enrollment period made available to all participating employees.

(c) Nothing in this section shall be construed to preclude an employee from changing plans at any time for good cause, as specified in the approved pilot project proposal or in the rules of the health care service plan.

Note: Authority: Labor Code Sections 133, 4612, 5307.3.

Reference: Labor Code 4612

§10181. Records, Claims Administration, Auditing, and Termination

(a) Nothing in this subchapter shall relieve any employer, health care provider, or their agents from any of the requirements or obligations contained in Division 1 (commencing with Section 1) of this Title, except for the requirements of Sections 9780.1, 9781, and 9782 to the extent an approved pilot project proposal conflicts with the requirements of these sections.

(b) Administration and accounting of the payment of workers' compensation benefits under this pilot project shall be solely for the purpose of complying with the workers' compensation laws of the State of California and shall be separate from the administration of other employee welfare benefits within the meaning of 29 U.S.C. Section 1002 (1). However, any benefit provided by a government plan, church plan, or benefits plan maintained solely for the purpose of compliance with unemployment compensation or disability insurance laws, within the meaning of 29 U.S.C. 1003, may be combined with the administration of workers' compensation under an exclusive provider of care option.

(c) Nothing in this subchapter or a pilot project plan shall be construed to relieve any person, including an employer or physician, from any reporting requirements concerning occupational injuries or illness, or to preclude or in any way inhibit the adjudication of issues involving occupational injuries, including whether an injury or illness is compensable under Division 4 (commencing with Section 3200) of the Labor Code, before the Workers' Compensation Appeals Board.

(d) An employer's participation in this pilot project shall terminate automatically, without any action by the administrative director, when an employer fails to secure the payment of workers' compensation in the manner prescribed by Section 3700 of the Labor Code.

Note: Authority: Labor Code Sections 133, 3700, 4612, 5307.3

Reference: Labor Code Sections 3700, 4612, 5300, 6409, 6409.1.

Appendix 3: Application-24-Hour Care Pilot Program Application

The California Division of Workers' Compensation seeks applications for pilot projects of up to 36 months for purposes of implementing Labor Code Section 4612. Participating employers will contract with an exclusive provider of medical care to provide all health care—both occupational and non occupational—to participating employees. Employers whose principal place of business is in the counties of Los Angeles, San Diego, Santa Clara, or Sacramento may be authorized to participate.

Who May Apply

Applications will be accepted from any of the following:

- Employers
- Health care service plans licensed under the Knox-Keene Act,
- Health, disability, or workers' compensation insurers.
- Employers who have secured a certificate of consent to self-insure.
- State agencies.
- Multi-employer, collectively bargained welfare benefit plans.
- Employee welfare benefit plans sponsored by a union for state employees.
- Health insurance purchasing cooperatives authorized under state law

Deadlines for Application

The final deadline for submitting initial applications is March 31, 1994. However, proposals will be reviewed as they are received. Pilot programs are expected to be approved and operating early in 1994.

Application Procedures

Applicants should be familiar with the applicable statute and the regulations. Copies of these statutes and regulations are attached to this application.

The information requested on the following pages about the proposed pilot project should be submitted in the order requested. Any questions concerning the application should be directed to Glenn Shor, Division of Workers' Compensation, 455 Golden Gate Ave., Fifth Floor, San Francisco, CA 94102.

A. Participants

- 1) Business name, address, telephone number, and tax identification number of the employer or employers and the approximate number and occupations of participating employees. (Note: For proposals under which only small employers will participate, the proposal may specify the method by which employers will be selected to participate in lieu of identifying and obtaining commitments from participating employers and identifying the approximate number and occupations of participating employees.)
- 2) Indicate whether the employees of any participating employer are represented by an exclusive bargaining agent or union, and if so include verification of agreement to participate executed by an authorized representative of each exclusive or certified bargaining agent which represents employees of the employer.
- 3) Business Name, address, telephone number, and Taxpayer ID number for health care service plan or providers of health care services

- 4) If insured for workers' compensation, Business Name, Address, telephone number, and Taxpayer ID of Workers' Compensation Insurer. Include the policy number and effective dates of policies over from 1989 to present.
- 5) If self-insured, attach a copy of Certificate of Self-Insurance from DIR Office of Self-Insurance Plans.
- 6) Business Name, address, telephone number, and Taxpayer ID of third-party administrator used, if any.
- 7) Business Name, address, telephone number, and Taxpayer ID of any other parties required in the operation of the proposal, and a brief description of the role of each additional party.
- 8) Attach copies of signed authorizations from all necessary parties, confirming their commitment to the plan.

B. Description of Pilot Project

- 1) Describe administrative and organizational structure of health plan, and how health care services are to be provided. Include descriptions of numbers and specialties of physicians associated with the plan, where services are provided (e.g. private doctors office, HMO owned offices, HMO owned hospital, affiliated hospitals). This description should indicate how pilot proposal meets all of the following regulatory requirements:
 - a) How the plan assures that all medical and health care services required under Section 4600 of the Labor Code are provided in a manner that is timely, effective, and accessible to the employee. Description should include method by which employee enrollee is allowed access to all types of physicians.
 - b) How the plan assures appropriate case management, including direction of injured employees to appropriate medical service providers within a network for all non emergency services.
 - c) How the pilot program will assure appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service, and mechanisms to identify and correct quality deficiencies.
 - d) How the plan will assure adequate methods of quality assurance, peer review and service utilization review to prevent inappropriate or excessive treatment, and exclusion from participation those providers who violate treatment standards.
 - e) How the plan will meet the requirement that there be expertise in providing medical reports necessary for the prompt, proper administration of compensation, including those required under Sections 9785 and 10978.
 - f) How disputes concerning the provision of health care services will be resolved under the plan.
 - g) How the plan intends to analyze recent workplace injury and illness information and implement a program involving cooperative efforts by the employees, the employer, physicians, and other participants to promote employee wellness, workplace health and safety, and early return to work.
 - h) How the plan will assure coordinated case management goals and incentives among all providers of workers' compensation for employees with occupational injuries and diseases.

- 2) Describe the proposed standards and procedures under which an employee who selects the exclusive provider of care option will be permitted to change health care service plans.
- 3) Describe the method whereby employees will be informed of their rights and options under the proposal, including the right to obtain a decision from the Workers' Compensation Appeals Board in the case of disputes over compensation for injuries compensable under Division 4 (commencing with Section 3200) of the Labor Code. Materials to be used for this purpose shall be submitted with the final proposal. Materials shall include a description of the dispute resolution process, a description of dependent coverage, a description of the method and frequency of employee choice of health care provider, and a description of any other incentives offered to employees by employers to participate in the plan.
- 4) Describe the dispute resolution process under the exclusive provider of care option. Descriptions must include the process made available to employees to voluntarily resolve issues subject to the jurisdiction of the appeals board, as well as the process for resolving disputes which are not subject to the jurisdiction of the appeals board.
- 5) Describe how dependents will be covered under the proposal. If co-payments, premium shares, deductibles, or other charges are to be assessed against employees or dependents for non-occupational injuries and illness, list the amount of such charges. Describe how these charges will be determined and segregated in a manner to assure compliance with subdivision (a) of Section 3751 of the Labor Code.
- 6) Describe the method and frequency employees enrolled in the pilot program may choose whether to receive medical care under an exclusive provider of care option. Include a copy of form to be used to enroll employee.
- 7) Describe any incentives offered by the employer/applicant to employees to encourage participation in the exclusive provider of care option.
- 8) Explain the method by which any workers' compensation liability of the employer incurred during the pilot project will be paid after an employee's or employer's participation in the pilot project terminates.
- 9) Describe ongoing injury and illness prevention programs currently in place, and include a copy of each employer's Injury and Illness Prevention Program, along with name of company official responsible for carrying out and monitoring program.

C. Evaluation

The Division is mandated to conduct a comprehensive evaluation of the pilot projects. Participants will be required to provide to DWC information to assist in the evaluation of the pilot program. (Participants *may* also be required to pay a part of the cost of the evaluation, but DWC is attempting to obtain external funds for this purpose.)

Those chosen to participate will be required to provide DWC with the following:

1) An agreement to provide the administrative director with information necessary to evaluate the plan, and the pilot program as a whole.

The final data elements and format are not yet finalized. However, claim specific data elements will likely follow the example of those used by other state workers' compensation agencies in their research on managed care and 24 hour pilots, such as those used by the Florida Department of Insurance in their evaluation of managed care pilots under workers' compensation. Information to be collected will likely include:

- Employee Information
- Employer Information
- Patient (insured subscriber) information
- Physician or Supplier Information
- Claimant Information
- Injury Information/ Diagnosis Treatment information
- Information on Amounts and Types of Medical Benefits Provided
- Indemnity Benefits
- Vocational Rehabilitation services
- Other Benefits
- Costs and policies of Claim Administration
- Return to Work Information
- Patient/Enrollee Satisfaction Information
- Information on Dependents enrolled in pilot program

Numbers and percentages of employees, by occupational grouping, enrolled in pilot program

Information on transfers out of pilot program

Information on litigation of cases treated under pilot system.

2) An agreement to pay a proportionate share of the cost of the evaluation of the pilot projects, based on the number of participating employees, if needed. As noted above, DWC is seeking external funds for this purpose.

3) Information concerning participating employers' recent history (1989-1992) relating to occupational injuries and illness, workers' compensation, and non occupational health insurance coverage:

- a) Total workers' compensation costs (premium if insured; paid losses and expenses if self-insured)
- b) Workers' compensation experience modification, if any.
- c) Lost-time cases.
- d) Total number of covered employees.
- e) Incurred losses—Total, Medical, Physician, Hospital, Indemnity, TD, PD, Rehabilitation.
- f) OSHA Form 200 Logs
- g) DLSR Form 5020s filed
- h) OSHA inspection and consultation reports.
- i) Health insurance plans offered to employees and number of employees participating in each plan.

Brochures and Enrollment Information

The promotional and enrollment materials published by Kaiser on the Job, Max at Work, and Sharp/TIG 24 Hour Care Alliance are not available in this on-line edition of the report.