

Proposal to Reimburse Occupational Medicine Disease and Injury Claims Through Third Party Health Insurance

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The current system of compensation for the medical costs of occupational illnesses and injuries, a component of health insurance coverage for most workers in the United States, has recently come under scrutiny in the national health care reform debate. The cost of treatment of these conditions is significant, and there exist numerous disincentives for physicians and patients to use the workers' compensation system. Physicians who treat workers with occupationally related diseases may find compensation for a condition is disputed at the same time that it is excluded from payment by third party insurance coverage, leaving the patient selectively uninsured for at least some medical care services. In addition, most workers' compensation programs have been designed in a way that discourages efficient resource use by providers and claimants.

We propose allowing health care providers to bill third party health insurers for all care, including work-related diseases and injuries. Insurers, in turn, would bill workers' compensation programs for associated treatment costs. The potential advantages of such a system include reductions in inefficiency and unfair burdens placed on providers and patients, in reporting bias, and in administrative costs balanced against the risks of insurers excluding workers in high risk occupations from obtaining low cost health insurance and shifting away from employers the administrative burden for workers' compensation. © 1994 Wiley-Liss, Inc.

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INTRODUCTION

The workers' compensation system for occupational disease and injury, a component of the health insurance coverage for nearly 91.3 million workers in the United States, has recently come under discussion in the national health care debate as a target for reform. Treatment of work-related injury and illness consumed over \$11.5 billion in health care resources in the United States in 1988 and is expected to cost more than \$16 billion in 1993 [Nelson, 1993]. Despite the magnitude of expenditure, workers' compensation is regarded by many as inefficient and inequitable, and fre-

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quently is seen as a barrier rather than an aid to the delivery of necessary medical care to affected individuals [Baker and Krueger, 1993; Burger, 1989; Nelson, 1993].

Several proposals for "24-hr coverage" have been offered as a remedy for the perceived shortcomings in workers' compensation, both at the state and national level. Twenty-four-hour coverage schemes offer a variety of approaches to assure continuous medical coverage for all conditions, whether or not they are work related. Some integrate workers' compensation and private health insurance coverage into a single insurance plan that would cover all illnesses or injuries, regardless of cause. Georgia, Florida, California, and Maine have passed 24-hr coverage laws, a pilot program is underway in Massachusetts, and several other states are considering various versions of this idea. The Health Security Act of the Clinton Administration also identifies integrating workers' compensation into its national health plan.

This article presents an alternative to most proposals offered to date: one that would provide the benefits of 24-hr coverage, yet retain the essential structure and incentives of the current workers' compensation system. We will examine the current system of claims compensation, including some previously unmentioned problems with the system, and the effects of the proposed change on those problems. We will also discuss the potential strengths and limitations of our proposal.

The reform proposal outlined here is designed to be flexible, working within the existing health care delivery system, or within the framework of the managed competition plan proposed by the Clinton Administration. As will be discussed, the current dichotomized system of paying for work-related vs. other conditions creates barriers to obtaining diagnosis and treatment, and thus is of particular importance when considering any health reform proposal which aims to increase access to medical care [American College of Physicians, 1992].

DEFINING THE PROBLEM

Barriers to Access

Currently, a physician who diagnoses and treats an occupationally related illness or injury is generally responsible for filing a claim for reimbursement with a state, federal, or private workers' compensation agency. Workers' compensation, which in the United States began on a state-wide basis in the early 20th century, is a no-fault insurance system designed to cover costs of medical and rehabilitative care, wage replacement, and provide awards for permanent disability for conditions deemed work-related [Barth and Hunt, 1980].

The main criterion for compensation, that the condition is work-related, is met in most jurisdictions only if there is a "more probable than not," or greater than 50% likelihood, that the condition resulted from or was aggravated by a workplace exposure or factor. Several barriers discourage patients and physicians from filing workers' compensation claims. First, patients may be reluctant to file claims if they feel it will result in an adversarial relation with their employer. If companies do not self-insure, their workers' compensation premiums are often experience rated. In either case, employers are interested in minimizing the number of claims incurred. Employers challenge about 10% of occupational injury claims (a greater number of low back injuries) and about 60% of chronic disease claims [Barth and Hunt, 1980]. The frequency of disputes stems from employers' desire to minimize insurance costs combined with uncertainties in assigning responsibility for many occupational dis-

eases. Several barriers exist to establishing the work relatedness of many diseases, including: 1) long latencies between exposure and disease; 2) uncertainties about exposure as a cause of illness; 3) the multifactorial nature of many occupational diseases; and 4) similarities of clinical and pathologic expression of occupational and nonoccupational disease. As a result, employees often feel that their jobs could be threatened if they file a workers' compensation claim for an illness where the etiology is uncertain or will otherwise be challenged.

Physicians also face several difficulties when filing a workers' compensation claim. The paperwork burden is usually much greater for workers' compensation than for third party insurance claims [Institute of Medicine, 1988]. Reimbursement for services can be significantly delayed, particularly if a claim is contested. In most states, payment is withheld until the dispute is resolved; payment delays of 1–3 years may be encountered for chronic disease claims that are eventually accepted. In addition, the time involved in submitting evidence while a claim is reviewed and particularly if it is contested can place substantial burdens on physicians and their staff. At the same time, third party insurance plans will likely exclude coverage for treatment of a potentially work-related condition during the period of dispute. As a result, the physician finds the patient is selectively uninsured for some medical services.

The level of compensation for medical claims varies widely from state to state and among workers' compensation programs. Many states pay "usual and reasonable" charges for medical care in workers' compensation cases, but rising health care costs and state budget crises have created stringent cost control measures and substandard fee schedules. As a result, a substantial difference in the "rate of return" for filing occupational disease claims exists among states, and may artificially vary reporting differences among them. In addition, fee schedule differences may influence diagnosis and treatment strategies for patients, thus creating adverse outcomes as a consequence of suboptimal or excess care.

Because of the difficulties in identifying and obtaining reimbursement for occupational diseases, analysts estimate that only 5–10% of justifiable claims for disabling occupational diseases are remunerated through workers' compensation [Brandt-Rauf and Brandt-Rauf, 1988; Rosenstock et al., 1991]. Although filing claims through health insurers would not completely resolve this problem, it would have several beneficial effects on reporting and treatment.

Higher Costs

Costs of care in workers' compensation have been reported to be higher than costs in other health insurance plans for similar illnesses and injuries [Baker and Krueger, 1993]. This cost difference, which has been estimated at \$6 billion, can be explained, at least in part, by price discrimination and disincentives to search for low cost services under workers' compensation. Price discrimination refers to the notion that health care providers charge more for the same service under workers' compensation than they do for other insurance claims, typically by upgrading procedures to codes that pay more generously (since charging different prices for the same service is outlawed). Since under workers' compensation, medical costs are covered without copayments or deductibles, there are no incentives for seeking low cost providers, or to limit utilization of services. This phenomenon, termed "moral hazard" by economists, has been theoretically and empirically proven to exist for traditional health

insurance plans, and would apply to workers' compensation as well [Pauly, 1968; Manning, et al., 1987].

HOW THE NEW SYSTEM WOULD WORK

In the new reimbursement plan we propose, physicians diagnosing a work-related injury or illness would need to complete two forms: 1) a simplified notification form to the workers' compensation agency, indicating the nature of the condition and the length and severity of disability expected to result, and 2) a claim for medical services used to diagnose and treat the condition to the patient's health insurer. Insurance forms would have standardized sections to indicate that the disease or injury is occupationally related, and which tests and procedures were applied for that condition. Thereafter, services for continued treatment would be marked as such on the health insurer's claim form. Health insurers would be required to apply the same fee schedule for reimbursing services used to diagnose and treat both occupational and nonoccupational conditions.

Health insurers would bill the workers' compensation agency for those services designated "in treatment of occupational disease or injury" by the physician on the health insurance claim form. In cases where claims are contested, insurers would be prohibited from denying coverage for medical services during adjudication. Claims for a disputed condition that are ultimately determined to be work related would be reimbursed from the workers' compensation fund to the insurance agency, with interest added for the time value of money lost during the contestation period. Claims that are denied coverage through workers' compensation would be considered as any other nonoccupational illness, and therefore covered by the individual's health care plan.

In some cases, should health care reform (as now proposed by the Clinton Administration) not be implemented, workers who lose their job and health insurance benefits as a result of the occupational illness or injury could be ineligible for other forms of health insurance, including government funded assistance. The occupational illness claims in these instances would be filed directly to the workers' compensation agency, after coverage by the third party insurer is lost. Individuals qualifying for Medicare, Medicaid, or Social Security Disability would have claims filed through those agencies. If an individual with an occupationally related medical condition transfers to another health insurance plan, he or she would be required to provide the new insurer with the name and address of the agency handling the workers' compensation claim. Thereafter, claims would be filed through the new insurer from the patient's physician. This process should obviate the current practice of excluding individuals from acquiring new insurance coverage for at least those preexisting conditions which are identified as work related.

ADVANTAGES OF HEALTH INSURER REIMBURSEMENT

Patients suffering from work-related illnesses and injuries will benefit under this system. It will lessen uncertainties about coverage, thus reducing incentives to delay early evaluation and treatment. Prompt diagnosis may prevent progression of the condition, and obviate the need for more expensive care in the future. Furthermore, timely diagnosis would allow physicians to employ secondary preventive measures to

reduce the effects of future injurious exposures. Finally, if patients know that their health care needs will be covered through health insurance, regardless of cause, they may be more willing to comply with treatment regimens over time.

Beyond the requirement to initially file two simplified forms for work-related conditions (to the workers' compensation agency and the traditional insurance system), this proposal should eliminate additional paperwork burdens and payment delays, thus reducing disincentives to classify illnesses as work related. As a result, improved reporting would enhance tracking and classification of trends in industrially related diseases. Patients may well also receive better medical care and preventive services if the correct identification of the work relatedness of their illness is now documented in their medical records. Finally, improved occupational disease reporting and a lessening of the externalization of costs by industry for these conditions should strengthen incentives to enhance prevention at the work place.

Currently, administrative costs consume nearly \$12 billion of the premiums paid by employers to workers' compensation agencies. Overhead expenses could be reduced, however, if health insurers filed claims to workers' compensation. The savings would stem from the expertise and economies of scale in claims processing that health insurance firms enjoy compared to physicians' office practices. One should note, however, that while overhead costs per claim may fall, total administrative costs might rise if the number of occupational disease claims rises substantially.

Additional cost savings would be achieved through reductions in price discrimination and moral hazard. Since providers would bill only one insurer, price discrimination between workers' compensation claims and traditional health insurance could be eliminated. The new system could introduce copayments and deductibles for workers' compensation claims that exist for third party insurance, and hence introduce incentives to find low cost providers and eliminate excessive use of services. Copayments and deductibles, however, are not a necessary component of the proposed system.

Finally, if advances in identification and treatment of occupational diseases represent a "social good," then public welfare will be enhanced if improved reporting leads to the discovery of new etiologies for occupational diseases and injuries. Physicians who are spared the administrative hassle and expected payment delays in reporting a disease that could stem from the work place might report "questionable" cases that turn out to be unique diseases. Improved reporting, if coupled with surveillance and other data analysis requirements, may also elucidate new patterns of exposure and disease that were heretofore unnoticed. Fellow workers who are similarly affected or at risk are more likely to be identified in improved case tracking surveillance systems.

DISADVANTAGES TO CHANGING THE STATUS QUO

Changing to a system of billing health insurers for the care of individuals with occupationally related conditions is not without potential problems. Many concerns would be raised loudly by the health insurance industry itself, and not without some justification. The paperwork costs and monetary losses from payment delays in filing workers' compensation claims, which are essentially a "tax" on providers or patients or both, would shift to insurers. Indeed, insurers may find dealings with state work-

ers' compensation bureaucracies so distasteful that they would create administrative barriers to filing workers' compensation claims that are similar to those physicians face today. Furthermore, when the nonallocatable portion of administrative expenses associated with workers' compensation is spread among all individuals with health insurance, workers in low risk occupations will end up subsidizing health insurance customers who work in high risk jobs. Thus, this measure of the expenditures for administering workers' compensation will not be internalized to employers, theoretically creating incentives to underfund safety programs in high risk work environments and overprovide safety in low risk occupations. The degree to which the actuarial base of most workers' compensation programs does, in fact, result in prevention activities is unproved and highly debated.

Changing the reimbursement system to bill health insurers for occupational conditions creates a danger of compounding the adverse selection that currently exists in the health insurance market. If third party insurers are allowed to design policies that select employees from low risk jobs, those workers in high risk occupations such as logging and fishing, for example, might find themselves facing exorbitant health insurance premiums compared to clerical workers of the same age and health status. Again, the disincentives to insurers are in the inefficiencies and delays in the workers' compensation system that they must bear when claims are filed, assuming workers' compensation reimburses medical costs fairly. Substandard reimbursement rates would only exacerbate the incentives for adverse selection.

Insurance companies could complain that they will bear the brunt of a huge influx of workers' compensation claims that would not have appeared but for the new regulations. If administrative costs associated with processing the additional claims cannot be passed on to workers' compensation agencies, and if health insurers are reimbursed from substandard workers' compensation fee schedules, then health insurers will suffer real losses. However, the degree of the loss will be mitigated by more accurate reporting. Many bills that health insurers pay today certainly include work-related diseases that are assigned other etiologies to avoid dealing with the burdensome workers' compensation program. If claims are more accurately recorded under the new system, this "hidden tax" on health insurers might shift to workers' compensation programs.

Finally, health insurers might argue that the new payment system will force them to pay medical costs in the present for treating diseases that will not be ascribed as work-related until some future date. If improved reporting "artificially" shifts the knowledge base towards the present, there would be a one-time cost associated with the increased burden of reporting. One might argue, however, that advances in knowledge will identify conditions wrongly considered nonoccupational (and hence covered by health insurance) as truly work-related, thus shifting the payment burden to workers' compensation programs. In this scenario, total claims costs to health insurers would actually fall over time.

MODELS AND EMPIRICAL EVIDENCE

Although several authors have proposed 24-hr coverage health insurance systems, there has been comparatively little study quantifying the effects and savings of such a program. Perhaps the most vocal supporter of reform has been the California Insurance Commissioner, John Garammendi, who estimates that 24-hr would save

the state \$1 billion through savings in administration, legal costs, fraud, and patient incentives [Garamendi, 1992]. As has been mentioned, Baker and Krueger [1993] predict \$6 billion in savings nationally from reduced price discrimination as a result of 24-hr coverage. The monetary and nonmonetary benefits of improved access have not been quantified, probably due to the inherent difficulties in making such calculations.

As for reporting of disease, one study examined the notion that health maintenance organizations (HMOs) overdiagnose work-related injuries and illnesses to increase their income [Zwerling et al., 1991]. HMOs are presumed to have an additional incentive to report disease relative to fee-for-service plans, since they operate under a fixed budget and workers' compensation payments would increase their net income. Although others [Ducatman, 1986] have argued that HMOs can allocate inappropriate costs to workers' compensation programs, evidence of cost-shifting was not found in this study. This suggests that insurers would not file excessive workers' compensation claims if they became the payer of first resort for occupational illnesses and injuries.

OPTIONS FOR INCREMENTAL REFORM

In light of the uncertainty surrounding the effects of these reforms on workers and insurers, a limited implementation program may smooth the transition and limit transaction costs. For example, one alternative would have health insurers reimburse the medical costs for contested claims initially, while noncontested claims would continue to be paid directly through workers' compensation. This would minimize the initial claims burden on third party insurers. However, it would almost certainly create an incentive to contest more claims if health insurers' reimbursement rates exceeded those of the workers' compensation system.

Another possibility would involve implementing the entire program immediately, while providing health insurers with an additional payment per workers' compensation claim to cover transition expenses. This transition allowance would be phased out over the time period that insurers would be expected to need to adjust their capacity to accommodate the additional claims. This approach would have the advantage of minimizing third party insurers' resistance to the reform on financial grounds. Determining the level of reimbursement, however, would be somewhat arbitrary, and subject to intense political and economic pressures brought to bear by the insurance industry.

CONCLUSIONS

The current system of compensation for the medical costs of occupational conditions imposes inefficient and unfair burdens on patients and health care providers. Streamlining all illness and injury claims to third party insurers, regardless of etiology, would likely reduce reporting bias, moral hazard, and administrative costs, and could improve the identification and treatment of occupational disease. The detrimental effects of insurers excluding workers in high risk occupations from obtaining low cost health insurance, and the net effect of shifting the administrative burden for workers' compensation away from employers would have to be determined. An experiment in implementing such a program, with careful measurement of

the costs and benefits—even on a limited basis to deal with the most problematic of claims, namely, disease—seems well worth the effort.

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