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Workers' Compensation Opt-Out: **Can Privatization Work?**



The
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Workers' Compensation Opt-Out: Can Privatization Work?

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The idea for the analysis of the Texas non-subscription market and the movement towards privatization of the state-based workers' compensation system belongs to workers' compensation columnist and consultant Peter Rousmaniere. Mr. Rousmaniere joined with his former *Risk & Insurance* editor, Jack Roberts, for this report.

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This report in whole and by individual chapters is available without charge as pdf downloads at New Street Group (www.newstreetgroup.net). Bound copies may be purchased on Amazon, with the title *Workers' Compensation Opt-Out: Can Privatization Work?* For further information, contact New Street Group.

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Chapter 1:



Introduction

For more than a century, the work-injury compensation system, mandated and regulated by individual states, has been the reality in the United States. For all this time, the fundamental system has remained about the same.

At the heart of the traditional state-based workers' compensation system is something of a "grand bargain." Workers receive medical treatment and wage replacement benefits if they are injured on the job, regardless of whether or not they or their employers are at fault for the injury. In return, employers receive statutory protection against liability lawsuits filed by employees for on-the-job injuries. This no-fault tradeoff is known as the "exclusive remedy."

For the variety of reasons mentioned in this report, employers and workers' compensation professionals have sought reforms to the traditional system — even replacements. Indeed, the modern opt-out alternative to the statutory, state-controlled workers' compensation system has been gaining increasing interest throughout the United States.

The Texas Model

In almost all states, employers must be a part of the traditional, state-regulated workers' compensation system, but in Texas, employers have a unique alternative: a legally authorized privatization of the workers' compensation system. In fact, Texas employers have three choices:

- Join the traditional workers' compensation system and abide by its large body of laws, rules and regulations, and oversight by the Texas Department of Insurance.
- Opt-out of the statutory system and create their own "non-subscription" work-injury compensation program, gaining freedom and its advantages but losing exclusive remedy protection.
- Opt-out and offer no workers' compensation benefits or protection at all and risk catastrophic legal liability.

This report focuses on the privatized employer option — commonly called the modern opt-out or non-subscriber alternative. Non-subscribing employers in Texas have extremely broad discretion on how they use the opportunity to privatize work-injury benefits; they do not have to adhere to a single strategy for addressing these problems. Nonetheless, the more prominent non-subscribers in Texas tend to share a common strategy. One crucial shared aspect is the adoption of federal standards under the Employee Retirement Income Security Act of 1974 (ERISA) for administering work-injury benefits. This is the same federal law that governs employers' long-term disability, retirement, healthcare and other employee benefit plans

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Stripped to their essentials, modern, opt-out work-injury programs share another trait: They eliminate, truncate or drastically reset four classic elements of the statutory state workers' compensation system:

- Statutorily defined benefits to injured workers for medical costs and wage replacement.
- State measures to ensure that employers will pay these benefits. Most states impose laws and regulations, including mandatory insurance requirements and state guaranty funds, to make sure that all workers' compensation benefits will be paid, even if employers file for bankruptcy or insurers become insolvent.
- Use of state administrative or civil courts to resolve disputes.
- Exclusive remedy.

Since the late 1980s, employers nationwide have increasingly taken control of the management of their workers' compensation programs, rather than relying on the traditional insurance system with a standard workers' compensation insurance policy, often without any deductible. Especially among large employers, a self-insurance or a high-deductible program for workers' compensation has become much more common, mirroring the increasing role and expertise of corporate risk management. Many employers have seen significant cost savings and reductions in both the frequency and severity of on-the-job injuries under a self-insurance plan. The share of workers' compensation losses retained by employers has at least doubled since 1980, from about 17 percent to about 38 percent.

The above strategies operate inside the statutory workers' compensation system, however. They serve as precedent to non-subscription, yet they do not offer the same unique freedoms or creativity in work-injury benefit plans. While employer interest in the opt-out system in Texas, Oklahoma, Tennessee and elsewhere is to a degree a reflection of political distaste for government regulation of economic activity, it is also grounded in a careful critique of persistent problems in statutory workers' compensation systems, which state legislative reforms usually appear unable to resolve. The opt-out concept arises from employers' belief that statutory workers' compensation systems are inherently and excessively costly and burdened with fraud and abuse.

By and large, six specific problems appear to be controlled or even eliminated through non-subscription plans in Texas:

- **Lack of control over medical provider selection.** Non-subscribers enjoy complete discretion over the selection of providers, which can dramatically reduce medical costs, significantly improve the quality of medical treatment and dramatically speed the recovery of injured workers so they can return to work.
- **Weak enforcements of evidence-based medicine practices.** Non-subscribers can strictly refuse to approve any treatment not consistent with what they construe as evidence-based best practices, thereby avoiding questionable treatment.

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- **Pharmaceutical management and excessive opioid use.** Opioid problems are virtually non-existent among non-subscription claims in Texas. Opioid abuse has been the fastest growing expense in the treatment of workers' compensation injuries throughout the United States.
- **Complexities in terminating temporary disability.** Non-subscribers can easily terminate temporary disability benefits when recovery is satisfactory or the injured worker has not complied with benefit guidelines. In statutory programs, these benefits are mandated by law with complex rules for termination.
- **Pervasive permanent partial disability awards.** Non-subscribers typically don't offer these benefits, eliminating a controversial and expensive element in statutory systems.
- **Cumbersome and expensive dispute resolution.** Non-subscribers use vastly simplified ways to resolve benefit disputes, such as ERISA appeals protocols. Negligence liability can be contained by mandatory arbitration.

An Exportable Model?

In April 2012, the Oklahoma Senate passed legislation to allow employers to opt-out of the Oklahoma system. It would allow employers to forgo workers' compensation coverage if those employers agreed to a set of minimum benefits similar to many in the existing Oklahoma workers' compensation law. The differences with the Texas non-subscriber system include a requirement that non-subscribers in Oklahoma operate under federal ERISA rules and regulations. The final bill, however, failed to gain the approval of the Oklahoma House of Representatives. It is expected that the legislation will be revived in the 2013 legislative session.

For individuals of all perspectives in Oklahoma and across the other 48 states without a non-subscription option, a question needs to be carefully considered: Has federal law, employment practices and jurisprudence since the 1960s created a framework for work-injury risk management that is more effective, efficient and trustworthy than the workers' compensation design created some 100 years ago? In the past half-century, American employers have absorbed employee benefit program standards (ERISA), equal opportunity standards (EEOC), worksite safety standards (OSHA), worker disability protections (the Americans With Disabilities Act) and alternative dispute resolution. Two generations of managers, advisors, underwriters and attorneys have grown up with this new alphabet soup mix of risks and opportunities.

Also, the insurance industry has developed new products to cover employment risks. In fact in Texas, a mature market for insurance products has emerged to transfer a portion of financial risk in non-subscriber programs.

It stands to reason that within the opt-out concept and applying these modern tools and standards, there may be a formulation that can appeal to all parties engaged in work-injury benefits, including employers, employees, state regulators and insurers. We encourage readers to consider how such a formulation might work in their state.

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Chapter 2:



Executive Summary

This report is the first thorough, documented and impartial study and analysis of the most radical idea in workers' compensation in a hundred years: that states permit employers to opt-out of the statutory system and create and administer their own work-injury benefit programs.

The opt-out concept is appealing to many who believe that statutory systems are hopelessly complicated, burdensome to both employers and their injured employees, and out of touch. Comparatively, privatized programs can better integrate into the mainstream of modern employee benefits and protections.

Only Texas allows employers to stop subscribing to its statutory workers' compensation system and instead establish their own programs, similar to the state of affairs before 20th century workers' compensation reforms. The Texas non-subscription laws are not entirely pre-1910s; lawmakers have removed some disadvantages to injured employees in negligence suits. Otherwise, Texas non-subscribers are subject to virtually no state oversight.

This report details Texas' experience with opt-out, as well as Oklahoma's consideration in 2012 of a similar system. They provide the nation with a unique window into how the non-subscription concept might be replicated in other states. In addition, this report will stimulate discussion about the desirable and undesirable features of statutory workers' compensation systems today, and whether reforms are capable of fixing traditional state-based workers' compensation.

Leading non-subscribing employers in Texas, their advisers/consultants and their insurers have devised innovative ways to manage work-injury risk. They have adopted the modern standards and practices in employee relations that have emerged during the past 40 years. They use federal employee benefit standards under the Employee Retirement Income Security Act (ERISA) to structure work-injury benefit plans. Many of these employers are experienced in ERISA through their other employee benefit programs such as health and disability benefits.

Non-subscribers are free to define their own threshold of eligibility for work-injury benefits, and many set a very high bar that work must be the sole cause of, not just the major contributor to, injury. They can elect which if any widely accepted and published treatment guidelines to apply. They are also free to establish their own restricted networks of providers.

Under Texas law for non-subscription, employers with opt-out programs do not enjoy exclusive remedy, the traditional workers' compensation tradeoff that protects employers from negligence lawsuits by injured workers. Non-subscribing employers often require employees to sign arbitration agreements, which re-direct injured employee complaints over the work safety practices from civil courts into arbitration. These ERISA and arbitration strategies are designed in part to severely limit state regulatory interference, the use of civil courts and involvement of plaintiff attorneys.

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The unique combination of freedoms and exposures experienced by Texas non-subscribing employers has led to the development of a completely new claims management strategy and culture, which emphasize initiative, critical thinking and close attention to steering a claim through a well-thought-out plan for recovery. This chosen style of claims management also attempts to minimize the risk of negligence suits. Thus, a separate opt-out claims culture has emerged in Texas, supported by advisors, professional associations and dedicated claims staffs.

Almost all non-subscribers report that their work-injury claims costs are much lower than what they would be under the statutory system — by at least 20 percent lower to as much as 90 percent. At the same time, they assert, most of their injured employees enjoy work-injury benefits equivalent to or even better than those that the statutory system provides. Some employers design their work-injury benefits to effectively coordinate with other non-occupational benefits, specifically group health insurance.

This report considers the opt-out program of Costco, which is representative of the basic design of many other programs. Non-subscription encourages and essentially requires that injury response and loss prevention be more proactive than in conventional workers' compensation. The program has eliminated the drivers of high claims costs. Overall, the program ensures that work-injury risk is easier for Costco to manage and if it were allowed, the warehouse retailer would opt-out of workers' compensation systems in other states. Because Costco operates throughout the United States, it has the ability to compare results in Texas with the results in other states. Both the loss costs and the administrative costs are substantially lower for the Texas operations.

One such possible other state could be Oklahoma. Advocates for an Oklahoma opt-out law submitted proposals during the 2012 legislative session. The bill ultimately failed in the state House; however, advocates expect to resubmit legislation in 2013. In contrast with Texas' law, Oklahoma's bill specifies many requirements for and rights of opt-out employers, including the requirement that opt-out employers adopt an ERISA plan and offer work-injury benefits similar to some contained in the statutory system. In return, employers would still enjoy exclusive remedy. Thus, the Oklahoma opt-out proposal both differs from the statutory system but preserves certain key provisions.

Despite the innovation inherent in the Texas and potentially the Oklahoma opt-out systems, opposition exists. Workers' concerns about an opt-out system are substantial. They include the limitations of their control and choice if their employers opt-out, restrictions on medical and wage replacement benefits, and the loss of permanent disability benefits, among many others.

Yet the question remains whether employees receive better treatment in a statutory workers' compensation system fraught with concern about fraud and inefficiencies. This report addresses the answer head on, and details how even substantial reforms of traditional state-based workers' compensation may not provide as adequate a solution either.

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Chapter 3:



Historical Overview: Non-Subscriber Research

Between 1911 and 1920, 44 states enacted workers' compensation laws. In 1948, enactment of a law in Mississippi resulted in every state having a workers' compensation system. For the large majority of these states, workers' compensation is a mandatory benefit for all employment not expressly excluded (e.g., very small employers and agricultural employers).

The National Commission on State Workmen's Compensation Laws, created during the Nixon administration, reviewed state workers' compensation laws and in 1972 issued a report calling for reforms, including the expansion of mandatory coverage. Most likely thanks to this commission's report, mandatory coverage has significantly increased since (see Table 1) in primarily two ways: the elimination of opt-out provisions and the reduction of excluded workforces.

A number of states had originally authorized employers to exit the workers' compensation system. Between 1970 and 1975, 21 states removed the legal option to exit the workers' compensation system. Eventually, all of the states that had allowed opting-out ceased to do so, except Texas and New Jersey.¹ In New Jersey, the option is for all practical purposes moot, as no employer has opted-out due to the restrictive nature of the statute.²

States have also gradually removed statutory exclusions from the workers' compensation system. In recent years, for example, numerous states have significantly limited the ability of employers not to cover workers on the basis that they are independent contractors.

While states gradually adhered more to the concept of universal, mandatory workers' compensation, innovations in corporate risk management and public policy encouraged more flexible self-management of work-injury risk, spurred in large measure by a crisis in workers' compensation that affected many states in the late 1980s. By the end of that decade, workers' compensation insurance costs as a percentage of payroll had increased by nearly 40 percent. The private-sector markets for workers' compensation insurance nearly collapsed in some states.

The crisis provoked four broad kinds of changes: smarter employer injury management practices; statutes that made it more difficult to obtain benefits; managed care, both statutory and voluntary; and risk-transfer innovations.

¹ Shields, Joseph and D.C. Campbell. A study of Nonsubscription to the Texas Workers' Compensation System: 2001 estimates. Texas Department of Insurance, Division of Workers Compensation. 2002.

² Morantz, Alison. "Opting Out of Workers' Compensation in Texas: A Survey of Large, Multistate Non-subscribers." In Kessler, Daniel. Regulation vs. Litigation: Perspectives from Economics and Law. (Cambridge, MA: National Bureau of Economic Research, 2010).

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Employers learned better techniques to manage injuries, shifting from a largely passive to a more proactive response. They began to stay in closer touch with their convalescing employees, and they introduced temporary modified duty programs to speed up return-to-work. One simple-sounding statistic shows how vigorously employers acted: Between 1986 and 1994, the incidence of alternative work assignments for injured workers rose by greater than 300 percent.

Meanwhile, many states tightened their eligibility criteria for workers' compensation benefits, for instance, by narrowing the scope of coverage for occupational diseases. Some states experimented with ways to speed up dispute resolution and to discourage litigation that many employers saw as excessive.

Managed-care practices also spread rapidly in the 1990s, abetted by new state laws and employer initiatives. The practices included formal and informal medical provider networks, utilization review, reference to evidence-based medical practices and more sophisticated bill review.

Employers also applied more proactive risk-transfer practices in workers' compensation, which drove a large increase in retentions, to the point where many insureds retained upward of 90 percent of their expected losses and many employers turned to self-insurance.

The increased corporate retention of risk demonstrates how employers are willing and able to mitigate their work-injury risk through innovative approaches. Labor-management agreements are another example.

Corporate Retention of Risk

Self-insurance is technically a risk-transfer decision that meets the workers' compensation mandates. Employers often believe it to also be a path toward greater flexibility in managing work-injury risks. The use of large deductibles is another risk-transfer decision, though it provides less flexibility in managing work-injury risks within the mandatory framework.

The percentage of paid workers' compensation benefits absorbed by self-insuring employers has been rising, as has the share of benefits covered by deductibles, while the national share of wages covered by workers' compensation has increased (see Table 1).

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Table 1³

Year	% of wages covered by WC	Self-insured % of total benefits	Self-insured and deductibles %
1950	77.2%	13.8%	NA
1960	80.9%	12.4%	NA
1970	80.4%	14.3%	NA
1980	82.8%	16.6%	NA
1990	89%	19%	19%
2000	NA	22%	35%
2010	97.3% ⁴	23.3%	37.5%

Labor-Management Agreements

Responding to complaints about the burden and expense of the mandatory system, particularly in the construction industry, some states have created a limited opportunity to self-manage work-injury risk.

Labor-management “carve-out” laws authorize employers and employees represented by collective bargaining to negotiate variances, within limits, to a jurisdiction’s workers’ compensation law. The principle innovations within labor-management agreements are improvement in benefits, restrictions on treatment within a provider network and mandatory alternative dispute resolution.

This strategy was used first in the early 1990s and has received spotty support. Massachusetts (1992), California (1993), Florida (1993), Maine (1993), Kentucky (1994), Hawaii (1995), Minnesota (1995), New York (1995), Pennsylvania (1996) and Maryland (1997) enacted laws enabling these labor-management agreements. Its most recent manifestation was included in the multifaceted workers’ compensation reform law passed in Illinois in 2011. To date, more carve-outs exist in California than in any other state.⁵

Both of the above strategies, risk retention and labor-management agreements, operate inside the statutory workers’ compensation system, however. They serve as a prelude to employers’ efforts in opt-out.

³ Years prior to 1990, from <http://eh.net/encyclopedia/article/fishback.workers.compensation>, Table 2. From 1990 through 2009, National Academy of Social Insurance, *Workers’ Compensation: Benefits, Coverage and Cost*, 2009. No data available on deductibles prior to 1990.

⁴ National Academy of Social Insurance. *Workers’ Compensation: Benefits, Coverage and Costs*, 2010. 2012. Col 1 page 8. Col 2 Table 6 page 20 Col 3. Table 6 page 20.

⁵ <http://tinyurl.com/9nqn timer>

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Texas Non-Subscriber Program

Since the introduction of workers' compensation in the state in 1913, Texas has allowed employers to elect to stay out of the conventional workers' compensation system. Employers that opt-out are referred to as "non-subscribers."

State Law

Statutes on the non-subscriber program are located in the state's Labor Code, though they are parsimonious.⁶ Two important passages can be found in Title 5, Subtitle A, Chapter 406 (Workers' Compensation Insurance Coverage), subchapter A (Coverage Election; Security Procedures). The first:

Section 406.002. COVERAGE GENERALLY ELECTIVE. (a) Except for public employers and as otherwise provided by law, an employer may elect to obtain workers' compensation insurance coverage.

Sec. 406.004. EMPLOYER NOTICE TO DIVISION. (a) An employer who does not obtain workers' compensation insurance coverage shall notify the division in writing, in the time and as prescribed by commissioner rule, that the employer elects not to obtain coverage.

The convoluted wording of these sections above means, "If you elect to participate in (that is, subscribe to) the statutory system, simply buy workers' compensation insurance. No other action is needed. If you elect not to participate, notify the state." Whether one participates or not, insurance and self-insurance are options. (Thus, not buying insurance does not by itself imply non-subscribing, but buying a workers' compensation policy does indicate participation.)

Section 406 goes on to describe the state's authority to mandate reporting requirements. Section 406.005 requires disclosure to employees of coverage or noncoverage.

The second important passage, Section 406.033: Common Law Defenses; Burden of Proof, qualifies employer defenses by removing three key defenses used throughout the United States prior to the introduction of reform laws in the 1910s:

- The employee was guilty of contributory negligence.
- The employee assumed the risk of injury or death.
- The injury or death was caused by the negligence of a fellow employee.

⁶ A fact sheet for employers is located at: <http://www.tdi.texas.gov/pubs/factsheets/noncoveremp.pdf>

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Texas courts have interpreted the removal of the contributory negligence defense to mean that employers must prove that employees are solely responsible for their injury to escape liability.

One major change to these laws in the past 20 years is the addition in 2001 to Section 406.033 of a provision to prohibit pre-injury waivers of liability:

A cause of action described in Subsection (a) may not be waived by an employee before the employee's injury or death. Any agreement by an employee to waive a cause of action or any right described in Subsection (a) before the employee's injury or death is void and unenforceable.

The legislature added another provision that permits post-injury waivers only when 10 days have passed after an injury, after a medical examination and with other employee protection provisions.

State oversight of non-subscribers is light and until recently has not been aggressively enforced. The Division of Workers' Compensation within the Texas Department of Insurance is the regulatory agency. Non-subscribing employers are required to file an annual notice of non-subscription (DWC-5), report injuries (DWC-7) and post notices for employees. DWC-5 enforcement has been weak, resulting in a Department of Insurance count of 8,360 non-subscribers as of Apr. 18, 2012, in contrast to an estimate of "approximately 114,000 employers" by the Texas Association of Responsible Non-subscribers. The division estimates that only 10 percent of non-subscribers report, based on a 2008 biennial survey of Texas employers.

In July 2012, the Department of Insurance revised its DWC-5 reporting requirements and indicated a commitment to more vigorous enforcement. It intends to coordinate enforcement with other employer-related agencies, an authority that it has had in the past though not applied.

State-Run Surveys

The Texas Department of Insurance began to survey non-subscribing employers in 1993. At that time, it estimated that 44 percent of employers were non-subscribing and that one-fifth of workers were employed by them. Its survey in 2008 reported that 33 percent of employers were non-subscribing, employing one-quarter of the workforce, reflecting a shift in participation in non-subscribing towards larger employers. It appears that between the early 1990s and today, the most important change in the distribution of non-subscribing employers is the entrance of large, multistate firms. The effect of this on stimulating nationwide interest in the opt-out concept should not be underestimated.

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Since the early 1990s, employer awareness of the non-subscriber option increased significantly. In a 1996 survey, 23 percent of insured employers said that they purchased workers' compensation insurance because they were not aware of the non-subscriber option. In a 2001 survey, only 7 percent cited ignorance of the option as a reason for staying in the workers' compensation system.⁷

Academic Studies

Only two academic studies of this opt-out system exist. In 1996, Richard Butler of Brigham Young University attempted to uncover patterns in lost injury days for non-subscribing and subscribing employers. Butler did not find a particularly strong difference. He wrote:⁸

In industries of roughly comparable levels of safety, the legal and indemnity costs of injuries appear to be about the same for subscriber and non-subscriber firms. (pg 430)

However, he also noted:

As hypothesized, the observed frequency of injury is slightly higher for non-subscribing firms, while the observed duration of lost work days is slightly longer for subscribing firms. (pg 423)

In the second study, Alison Morantz of Stanford Law School surveyed 54 large, multistate non-subscriber firms, reporting her results in a chapter in a book about litigation versus regulation.⁹ She found that "overall, the occupational injury plans that non-subscribers offered in lieu of workers' compensation were remarkably homogenous." This homogeneity may be a reflection of many responding firms using the same broker/consultant, Dallas-based PartnerSource, which helps to design ERISA plans.

"Unlike workers' compensation," Morantz writes, "most plans did not impose any maximum weekly dollar amount or waiting period on the receipt of wage-replacement benefits. Moreover, the maximum duration of wage-replacement benefits for temporary total disabilities typically exceeded the statutory cap. On the other hand, most non-subscription plans imposed end-of-shift or 24-hour reporting deadlines; did not cover partial total or permanent total disabilities; limited medical benefits to about two years; capped death and dismemberment benefits; and imposed per-person and/or per-event caps on total benefits. The vast majority of respondents also directed employees' medical care."

7 Shields and Campbell, A study of non-subscription, 2001 estimates. pg xii.

8 Butler, Richard. Lost Injury Days: Moral Hazard Differences between Tort and Workers Compensation. *Journal of Risk and Insurance*. 1996. (63) 3: 405-433.

9 Morantz, Alison. "Opting Out of Workers' Compensation in Texas: A Survey of Large, Multistate Non-subscribers." In Kessler, Daniel. *Regulation vs. Litigation: Perspectives from Economics and Law*. (Cambridge, MA: National Bureau of Economic Research, 2010).

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Morantz goes on to state that 94 percent of responding firms “judged these programs to be a success. Not only did virtually all (98 percent) of companies report cost savings, but most were pleasantly surprised by the magnitude of these savings, which reportedly exceeded 50 percent (on average) across all industries. Other commonly cited benefits of non-subscription were greater control over medical providers; greater control over program benefits; improved quality of medical care; faster return-to-work; and access to better doctors.”

Half of the responding firms said that their assumption of negligence liability risk was a “drawback.” About 85 percent of non-subscriber plans channeled disputes to mandatory arbitration. About a fifth of respondents reported that non-subscription affected safety practices outside of Texas, and a quarter spontaneously expressed a desire to spread non-subscription to other states.

In summary, state and academic studies lead to a profile of a community of non-subscribers increasingly tilted toward large employers that are happy with the choice to opt-out.

Two Systems in One

It is useful to characterize Texas non-subscription as, in effect, dual informal systems: one largely unchanged from pre-1913 with the exception of certain employer defenses, the other an adaptation of modern employer benefit management tools. In Texas, the original system is referred to as “bare,” as in without insurance, an ERISA plan and mandatory arbitration. A rough estimate could be that nine out of 10 non-subscribing employers are still part of this original system.

The modern system, used by most large employers, applies insurance, ERISA and mandatory arbitration. States looking to introduce an opt-out system should focus on the modern system as a model.

In 2011, a coalition of employers in Oklahoma drafted a proposal to introduce a voluntary opt-out system for that state. It drew upon the experience of neighboring Texas in developing its modern system of non-subscription.

The tools of the modern system are addressed in depth in other chapters of this report.¹⁰

¹⁰ Two matters uniquely affect non-subscribing companies that employ transportation workers. First, the Federal Arbitration Act, employed by many non-subscribers, does not apply to employment contracts of interstate commerce workers. Therefore, mandatory arbitration agreements, discussed in Chapter 6, are problematic for these workforces. Second, Texas Transportation Code Section 643.106 requires non-subscribing “motor carriers” to carry “accidental” insurance for its employees, at prescribed amounts. We do not explore these matters further in this report. Our thanks to Dennis Gibson, Esq., Bridgemark Arbitration and Nonsubscriber Consultants, LLC, for bringing them to our attention.

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Chapter 4:



The Critical Workers' Compensation Issues: Opt-Out vs. Statutory

Any proposal to create an opt-out system in workers' compensation contains an express or implicit critique by the employer community of the conventional system. The proponents are attempting to create an environment in which perceived problems of the conventional system are, in effect, eliminated or greatly reduced.

Some critics argue that opt-out proponents' energy might better be directed at correcting the problems within the conventional system. Those improvements would apply to all employers rather than only the non-subscribers.

However, the non-subscription supporters counter that the entrenched political nature of legislative and regulatory change makes such an effort problematic in the traditional workers' comp system, and they can cite numerous examples to support their case.

Employers and workers' compensation professionals identify two critical issues with the current, state-based statutory systems: costs and persistent fraud and abuse. At the time of this report, workers' compensation insurance premiums, after declining for more than five years, have started to rise — in some cases rather significantly — while coverage options are narrowing as carriers exit the market.

In addition, when the economy improves, frequency and severity of injuries should also increase to reflect greater employment.

No doubt, the cost of workers' compensation, both losses and premiums, continues to be an economic issue of varying degrees among the different states' systems. It is clear that rising costs, fueled by increasing medical costs, will in the next few years be a feature of the statutory system.

As for fraud and abuse, while no reliable figures of incidence and cost exist, the broadly held perception is that most injuries, and most medical treatment, are legitimate. However, there is also the perception that the degree and duration of disability are inflated because of the positive reinforcement of a disability mindset — injured workers' preoccupation with vindicating their status as permanently impaired at the expense of focusing on timely and maximum recovery of productivity and wage earning, perhaps with the acquiescence of medical providers and the claimant bar.

The evidence from Texas is that non-subscription's response to these and other problems cuts claims costs by roughly two-thirds.

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A Study in Contrasts

It is worthwhile to identify the perceived problems of the statutory workers' compensation system, and then consider the probabilities of their resolution through the cycles of reform, long and uncertain as these cycles may be.

We have followed two paths to arrive at a list of the perceived problems. One path is to listen to and read the arguments of opt-out advocates against the statutory system, and then examine the actual ways in which non-subscribing employer practices (most clearly documented in their ERISA plans) sharply depart from the statutory system in Texas. The point is not to find out what would constitute a perfect conventional system. Rather, it is to identify a few signature problems that, if resolved to the satisfaction of the employer community, could render the case for an opt-out system redundant.

The second path, which can be found at the end of this section, is to examine the impact of current reforms to Texas' statutory workers' compensation system. Did the reforms satisfy the opt-out advocates?

Excessive complexity in terminating temporary disability

The Workers Compensation Research Institute (WCRI) recently explored the issue of the termination of temporary disability benefits. WCRI conducted extensive interviews of workers' compensation experts in two states and published the results in the report *Factors Influencing Return to Work for Injured Workers: Lessons From Pennsylvania and Wisconsin* (2011).

Wisconsin enjoys a long-standing reputation as a statutory system that encourages early return-to-work and can be viewed as a best-in-breed system for terminating temporary disability. Pennsylvania, on the other hand, represents states that tend not to incent parties to terminate temporary disability. The WCRI captures the issue thusly: "Workers have a greater financial incentive to return to work when the employer or insurer can unilaterally terminate TD (temporary disability) benefits, but if the worker returns to work too soon, this return may not be sustainable. The more difficult it is for the employer or insurer to terminate benefits, the greater the likelihood that some workers will perceive a smaller financial incentive to return to work, and thus return to work may be delayed."

The authors note that Wisconsin permits the unilateral reduction or termination of temporary disability benefits by employers or insurers without a prior hearing based on specific statutorily defined end-points. System experts in Wisconsin see the system as encouraging workers to

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focus on their recovery and return-to-work rather than on the continuation of their benefits. In contrast, the authors noted that Pennsylvania has a system that allows workers more readily to disagree with a proposed change in benefit status. Employers and insurers continue to pay ongoing benefits pending a judge's decision. Workers do not typically return to work during the litigation process.

In the Texas workers' compensation system, a bone fide job offer letter has to be mailed to injured workers, citing a written work release (Texas form DWC 73) by a treating physician. A verbal conversation is not sufficient. Workers can claim they did not receive the letter. They can wait seven days to respond and can ask the treating physician to change the work release. And they can retain an attorney to contest a termination of benefits.

Non-subscribing employers in Texas, in contrast, are free to establish their own protocol for terminating temporary disability. In effect, employers can tell employees to return to work the next day, and if workers fail to return to work, benefits will cease immediately. In this case, the financial incentive for workers to return to work is clear.

A permanent partial disability award process that reinforces a disability mindset among injured workers

At a time when athletes with lower limb amputations excel in foot racing using prostheses, it is understandable that many employers perceive permanent partial disability (PPD) as at best a distraction from injured workers recovering to their full earning capacity, and at worst a systemic adverse incentive. Nationwide, about 38 percent of workers' compensation claims are classified as permanent partial injuries; they consume 72 percent of total lost-time claims dollars. (Total permanent claims are a mere 0.3 percent of injuries and account for 9 percent of claims costs.)¹

Most PPD awards appear based on permanent impairment ratings of a low range, for instance, a 1 to 10 percent impairment according to the American Medical Association's 6th edition.² Many workers with ratings of this level can return to work at their pre-injury level of compensation, with modest or no work accommodations. Critics of permanent partial awards say that these awards are largely unrelated to return-to-work.

Windham Group of Manchester, N.H., has performed several thousand return-to-work consultations for workers with permanent impairments. Virtually all of these workers received

1 National Academy of Social Insurance. *Workers' Compensation: Benefits, Coverage and Costs*, 2010. Figure 3, page 12.

2 American Medical Association, *Guides to the Evaluation of Permanent Impairment, Sixth Edition*. (Chicago, IL: American Medical Association, 2007).

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or will receive a permanent partial disability award at the time of reintegration into the workplace. Yet the large majority of these workers returned to work at their prior employer at substantially full duty and with their prior wage compensation intact, and with the employer incurring little or no expense at making accommodations.

A Texas non-subscriber can completely ignore permanent impairments in its injury benefit plan. It can also settle claims unilaterally, both wage replacement and medical treatment costs. The proposed Oklahoma law would have imposed on participating employers a simplified version of a permanent award, and would have allowed voluntary settlement of claims, both wage replacement and medical.

Cumbersome dispute resolution process, leading to gaming

The statutory no-fault system of work-injury benefits is supposed to have a quick, self-executing process of resolving disputes. However, workers' compensation courts are filled with litigated matters. Even just the initiation of a court case does not bode well for employers hoping to get employees back to work.

As the WCRI notes in its comparative study of Wisconsin and Pennsylvania, "The vast majority of system participants agreed that to the extent that litigation could be avoided or the process to resolve could be faster or more efficient, the likelihood or speed of return to work could be increased. When a worker's claim is in litigation — particularly in a dispute related to earning capacity — there is little or no incentive for the worker to return to work."

Wisconsin is again held up as a model for encouraging timely and non-litigious resolution of disputes. According to the WCRI, "Wisconsin's system is characterized by multiple features that help minimize or resolve disputes without the need for formal litigation. . . . In contrast, the Pennsylvania system has multiple friction points that have the potential to lead to greater attorney involvement and litigation. The Bureau of Workers' Compensation plays a greater role in the dispute resolution process rather than in actively preventing disputes."

In the Texas statutory workers' compensation system, there are several levels of hearings, including a "contested case hearing." If not resolved at that level, the disputing party appeals to the Department of Workers Compensation, where a panel of attorneys reviews the case. Beyond that, appeals go to civil court.

A Texas non-subscriber who elects to deliver benefits through an ERISA plan, on the other hand, relies on an internal appeals process prescribed by ERISA, with appeal to a federal court only when the internal appeals process is exhausted. Federal court appeals are reported to be very infrequent. This overall scheme of dispute resolution meets the desired goal of a no-fault system's resolution of disputes as short and summary.

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Suboptimal medical care that could be corrected if employers were allowed to select providers

As of 2011, 28 states authorized employers to limit the choice of initial medical provider. Forty states impose some restrictions on employees wishing to change their treating provider. A few states allow for employer control over providers for the lifetime of a claim. States typically circumscribe employer control by requiring larger-than-needed panels of specialists, leading to lack of effective full control of choice.

Published studies have accumulated in recent years that analyze the impact of employer-driven provider networks, reporting that these networks reduce the duration of disability for injured workers and lower medical costs. None of these studies relied on provider reimbursement discounts for the reduction in medical costs. They calculated the impact of shorter duration because employees have returned to work. Other studies have examined the treatment practices of large populations of treating physicians. These studies showed that a very small number of physicians are extreme outliers in prescribing large amounts of opioids or in high medical utilization and high duration of disability. These latter studies inferred that careful selection of providers will enable employers to avoid these outliers. Indeed, there is also the inference that, besides ineffective treatment, there may be fraud issues involved with these medical providers.

Texas and California amended their workers' compensation statutes in the 2000s to allow for employer choice of providers, conditioned upon state approval of provider networks. While the employer community has applauded these changes, they have drawn criticism for the regulatory burdens associated with designing and managing these networks.

Texas employers may create healthcare networks (HCNs), approved by the state, and into which all care must be directed. Network management is a burden. For example, HCNs must go to great lengths to document workers' geographic access to care, even for rarely used catastrophic care services. It is harder for employers to demonstrate that providers should not be in their network than that they should be.

One major problem regarding provider selection is the adverse effect of conventional workers' compensation regulations in turning away many physicians from treating injured workers.

Contrast that with Texas non-subscription. Employers can approach providers with a promise to eliminate much of the hassle, such as forms preparation and complex utilization review procedures. Claims administrators report that removing these burdens results in a dramatic realignment of their provider networks because specialists who otherwise refuse to do workers' compensation cases are willing to treat non-subscription cases. Higher compensation for care, above the state workers' compensation fee schedule, also helps with specialist recruitment.

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Texas non-subscribers have the freedom to create provider networking using their own network design and their own rules on injured worker rights and responsibilities. As examples of this complete breadth of discretion, employers can elect to exclude types of providers such as chiropractors, set their own standards on supply of providers and instruct workers on how to access care. For example, Costco identified the use of chiropractors as the major cost driver in its Texas workers' compensation program and prohibited their use in its non-subscriber plan. (See Chapter 5 for a detailed look at Costco's work-injury benefit program.)

Excessive opioid use

Roughly half of injured workers receive pain medication prescriptions at their initial medical encounter post-injury. Some of these injured workers go on to take prescribed opioids for the long term. No evidence exists that long-term use of opioids by injured workers is effective in reducing pain perceptions and improving function. Rather, long-term use increases risk of dependency, addiction and death, and can add several hundred thousand dollars to claims cost.

In the Texas non-subscriber community, employers and claims executives report that long-term use of opioids is virtually non-existent. Opt-out employers have eliminated this problem by a number of measures, including disallowing pain management as a form of treatment, active utilization review and avoidance of opioid high prescribers in provider networks.

Evidence-based medicine guidelines often ignored

One of the most noteworthy developments in medical care for injured workers in the past decade has been the emergence of evidence-based medical practice guidelines. Prescribed in 23 states, with the expansion of formal utilization review into 29 states, these guidelines hold out the promise of a high level of provider adherence to evidence-based medicine.³

The reality is quite different. According to Joseph Noel, a physical therapist and vice president of clinical services at TechHealth, "the guidelines for physical rehabilitation issued by the Official Disability Guidelines and the American College of Occupational and Environmental Medicine are highly credible evidence-based medicine guides to appropriate type and volume of treatment for physical rehab."

Yet there remain, says Noel, systemic fault lines between the treatment expectations of physical therapists and these guidelines even where mandated. Evidence-based guidelines have found their way into the physical therapy educational system and will continue to do so, but "clinicians are creatures of habit."

³ Workers Compensation Research Institute. Workers' Compensation Cost Containment: A National Inventory, 2011. 2011.

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"We simply do what we have always known to work and often times in the face of literature that directs a better course of action, following treating patterns and frequencies that are antiquated and in need of change," he says.

According to Noel, the majority of treatment plans, for lumbar or back strain, for example, are submitted with substantially more visits than what ODG recommends, which is 10 visits over an eight-week period.

A well-run peer review or UR program will probably approve only about 20 percent of these non-compliant initial treatment plans. However, Noel notes, claims adjusters are inclined to approve non-adherent treatment plans, out of deference to the physician who wrote the plan and to the claimant, and possibly out of concern that denying treatment would ignite a contentious dispute.

In Texas, providers' treatment plans are required to go through a pre-certification process to ensure payment. The state officially endorses ODG guidelines. However, per Noel, providers frequently appeal based on non-agreement of the reviewer's rationale for denial, and win on appeal often.

Texas non-subscribers, in contrast, are free to select medical providers who treat in greater adherence to guidelines. If they employ an ERISA plan, employers are confident that their point of view about best medical practices will prevail in their plan's internal dispute resolution process.

Can Statutory System Reforms Remove These Problems?

Opt-out advocates are quick to point out problems in statutory systems. Legislative reforms of these systems could conceivably weaken the case for non-subscription. The example of Texas suggests that reforms enacted in 2005 (HB 7) may not have lessened the attractiveness of non-subscription in that state, although the reforms appear to have had a favorable impact on losses and premiums. This favorable impact has only been evident recently, years after the enactment of reforms. Some parties in Texas point to an estimated decline in the number of non-subscribers as a sign that the 2005 reforms have induced many employers to return to the workers' compensation system.

Did the 2005 reforms make non-subscription less attractive? The Department of Insurance has issued a biennial report on non-subscribers since 1993, most recently in October 2010.⁴ From a high of 44 percent of all Texas employers in non-subscription in 1994, the participation rate declined to 38 percent in 2004 and 32 percent in 2010. That same year, the department issued

⁴ Texas Department of Insurance. Employer Participation in the Texas Workers' Compensation System: 2010 Estimates. 2010.

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an analysis of statutory system trends in premiums, timeliness of initial medical care and return-to-work rates from the late 1990s through the late 2000s.⁵ All of these trends turned favorable before the 2005 reforms and continued in favorable directions after the reforms. While conditions clearly improved in the 2000s, it is not clear from the survey data that the 2005 reforms had any direct effect on employer decisions.

The Insurance Council of Texas summarizes the “landmark” reforms as “providing for the use of healthcare networks, strengthening medical treatment guidelines, placing a greater emphasis on return-to-work and restructuring the workers’ compensation agency.”⁶

On Oct. 17, 2012, the council reported that, per Department of Insurance figures, “premiums for workers’ compensation policies have seen a 49 percent decline in rates since House Bill 7 was passed. The average premium was \$1.38 per \$100 dollars of payroll in 2010 as compared to \$2.70 per \$100 of payroll in 2004.”

It also cited the just published 2012 state ranking report of the Oregon Department of Consumer and Business Services. In 2006, Texas was ranked 17th highest, with premiums 116 percent of the national median (the ranking used Jan. 1, 2006, data, which was likely weakly affected by the reforms of the prior year). In 2012, Texas was ranked 38th highest and was 85 percent of the national median. During this period, the national median premium declined by 24 percent.⁷

Steven Bent, executive director of the Texas Association of Responsible Nonsubscribers, observes that very few large non-subscribers have returned to the statutory system, but many small to midsize employers have. The reasons they cite include more favorable workers’ compensation insurance terms, the relative simplicity to some of workers’ compensation, and growing demand by prime contractors and customers that their suppliers have workers’ compensation insurance.

We consider key aspects of the 2005 reforms for their impact upon the statutory workers’ compensation system.

Medical treatment guidelines

Non-subscribers are free to use any medical treatment guidelines. HB 7 authorized the state to adopt medical treatment guidelines for the statutory system, and on May 1, 2007, use of the Official Disability Guidelines became required for treatment of injured workers not covered by a certified HCN.

5 Texas Department of Insurance. *An Analysis of the Impact of the 2005 Legislative Reforms on the Texas Workers’ Compensation System, 2010 Results*. 2010.

6 Insurance Council of Texas. *Texas Employers See 49% Drop in Work Comp Premiums*. October 17, 2012.

7 Oregon Department of Consumer and Business Services, *Oregon Workers’ Compensation Premium Rate Ranking Summaries, for 2006 and 2012*.

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The Workers Compensation Research Institute analyzed if medical care changed after the effective date of the guidelines for non-HCN care. It found a decrease in the amount of services for low-back injury, mixed results for upper-back and shoulder injuries, and inconclusive impact on knee injuries.⁸ The authors of the report noted that prior to HB 7, claims-payers had been employing some managed-care strategies and that utilization of certain services had already declined prior to HB 7. The WCRI authors were guarded about the effect of the treatment guidelines, writing only that “in certain situations” medical treatment guidelines might help to “monitor” medical care, and that “some evidence” suggests that treatment guidelines change the mix of treatments.

Reduction in duration of disability

Non-subscribers estimate that duration of disability declines with non-subscription, though they have not released data to support that claim.

The Workers Compensation Research and Evaluation Group within the Texas Department of Insurance analyzed changes in duration of disability in the statutory system from 2005 through 2009 (the most recent year covered at the time of release of its report in 2011).

The median days away from work for lost-time compensable injuries decreased from 24 days in injury year 2005 to 21 days in 2009. Re-employment within six months of the injury date increased from 75 percent in 2005 to 81 percent in 2009. Re-employment within two years of the date of injury rose from 88 percent in 2005 to 94 percent in 2008 (the most recent year covered). The authors refrained from commenting on the contribution, if any, of the 2005 reforms to these trends.

Use of opioids

Non-subscribers can, and do, prohibit the long-term use of opioids.

HB 7 mandated the creation of a closed formulary for drugs — that is, a list of approved drugs. It took until September 2011 for the first step in the formulary phase-in to occur. Insurers had to approve use of non-formulary drugs. In a matter of several months, it became clear that the formulary was having an effect on prescribing. According to Coventry, a managed-care firm, 64 percent fewer non-formulary drugs were prescribed. It recorded “even larger decreases” for controlled substances such as opioids that were excluded from the formulary, such as Soma, Xanax and OxyContin.

8 Workers Compensation Research Institute. Impact of Treatment Guidelines in Texas. 2012.

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For injuries occurring within six months after the formulary's implementation, Coventry reports, 71 percent fewer injured workers received such excluded controlled drugs.⁹

A mid-summer 2012 report issued by the Texas Department of Insurance also showed that utilization of drugs had changed but cited a smaller reduction in opioid prescriptions.¹⁰ In October 2012, the department reported that the number of claims for which non-formulary drugs (those requiring special insurer approval) were used dropped by 60 percent and the total number of non-formulary drug prescriptions dropped by 81 percent.¹¹

These changes in medical care and duration of disability are good news for employers in the statutory workers' compensation, and obviously, HB 7 caused at least some of these changes.

However, it is not clear if these changes affected employer attitudes about opt-out. By extension, it is not clear if reforms of Texas' magnitude would weaken the resolve of opt-out advocates elsewhere.

Summary

Nationwide, employers perceive that persistent problems afflict the statutory workers' compensation system, resulting in excessive claims costs and abetting fraud and abuse. Opt-out systems can remove or mitigate these problems. As demonstrated in the case of Texas, statutory system reforms can also positively address these problems, but that may not be enough to satisfy advocates of the opt-out option

9 Coventry Workers' Comp Services: The Texas Formulary: A Look at History, Current Impact, and Future Expectations. August 2012.

10 Texas Department of Insurance, Fewer Texas Workers' Compensation Claims Include Opioids and Not-Recommended Prescriptions, July 2012.

11 Texas Department of Insurance. Impact of the Texas Pharmacy Closed Formulary A Preliminary Report, 2012.

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Chapter 5:



Costco: **A Case Study of a Non-Subscriber Employer**

When Costco Wholesale Corp. became a non-subscriber to the Texas statutory workers' compensation system on Sept. 1, 2007, the international warehouse retailer expected it would enjoy lower administrative and loss costs. It anticipated fewer legal disputes between management and its employees, and it saw an opportunity to create a more agile and less cumbersome system for effectively treating on-the-job worker injuries and returning employees to work.

But as Costco's Director of Workers' Compensation Katrina Zitnik warns, instituting an effective alternative to the statutory workers' compensation system requires different systems to handle worker injuries, strong coordination between employee benefit programs such as group healthcare and being prepared for both employees and management to develop different attitudes towards work injuries.

"The Texas non-subscriber program allows Costco to customize an injury program that is consistent with all of our core values," Zitnik says.

Growth in Texas

The responsibility for both statutory workers' compensation programs in other states and for the Texas non-subscriber program is housed within the benefits and risk management department at Costco headquarters in Issaquah, Wash. Zitnick reports to the assistant vice president for benefits, Jay Tihinen, who reports to the senior vice president of human resources and risk management, John Matthews. Risk management handles insurance issues, including excess coverage, and manages the company's workers' compensation captive insurance company.

Zitnick's tenure at Costco dates back to before the company opted-out of the Texas workers' compensation system. (She had worked earlier for Crawford, the third-party administrator, in liability and workers' compensation claims.) Since 2000, Costco has grown its operations in Texas from a small footprint to the 15 large warehouses it has today. From 2001 through 2007, its Texas payroll grew from about \$22 million to about \$87 million. Its Texas-based workforce grew to about 4,000 employees. Costco's annual workers' compensation losses (both medical and indemnity) more than doubled from about \$250,000 in 2001 to about \$600,000 in 2007.

Texas Issues

As Costco saw its workers' compensation costs in Texas grow, it became apparent that Texas losses were higher than the average costs that Costco incurred in other states.

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The company identified the most problematic cost-drivers in Texas. Those included:

1. High participation of chiropractors in medical treatment (in fact, researchers report that Texas claims are almost three times as likely to involve a chiropractor compared with other states).
2. Long duration of temporary total disability benefits.
3. High frequency of permanent partial disability awards.

These drivers, the company found, led to a large number of small-dollar, \$5,000-level settlements. The main driver of these settlements was the Texas claimant bar. Legal representation of injured workers tends to foster such a low-severity, high-frequency pattern of settlements. Claims tend to settle even when an employer believes that they should be denied because it can appear to be more cost-effective to settle small claims rather than incur the probably prolonged legal costs. Costco was particularly concerned that most of these settled claims involved injuries that did not appear to diminish work capacity; employees usually returned to work with the ability to perform their pre-injury job. Costco observed the same pattern in other states where many, if not most, permanent partial disability awards were made to workers who had not suffered any real loss of function or experienced a decline in their earnings due to their injury.

In Texas, however, the company could do something about it by choosing to opt-out of the statutory system and become a non-subscriber.

Planning and Implementation

Costco's interest in non-subscription dates to 2005. Initial conversations within the risk management and benefits department centered on concerns regarding liability risks and the absence of the exclusive remedy protection against lawsuits afforded by the Texas statutory system. Without much discussion with Costco's insurance brokers, Zitnik began to study the option seriously in early 2007. She talked with Safeway and Target, large retailers that were already non-subscribers. These firms counseled Zitnik that non-subscription was a "legitimate approach" to address work-injury risk.

In May 2007, Zitnik asked for and received a green light from her management to elect the non-subscription option. Zitnik's direct superior Tihinen, who was versed in the use of ERISA for employee benefits, signed on, as did the risk management department. The senior vice president for human resources and risk management, Matthews, approved the plan.

Costco hired an influential expert on non-subscription with numerous national firms already as clients to prepare for the four-month transition — PartnerSource of Dallas, a division of Arthur J. Gallagher Risk Management Services, Inc. It drafted Costco's ERISA plan, after which Costco

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had its own outside ERISA counsel (retained for the company's other benefit plans) review the PartnerSource plan. Among many changes from the statutory system, the plan included a mandatory arbitration provision, eliminated permanent partial disability awards and paid wage-replacement benefits from the day of the injury.

PartnerSource also advised the company on how to manage claims in light of the forthcoming ERISA plan and a mandatory arbitration agreement for disputes about employer safety negligence. (ERISA plans and arbitration agreements are addressed in depth in other chapters). This firm continues to advise Costco on administration of the ERISA plan. It comments on every planned action by Costco to deny (technically, "adversely respond to") requests for ERISA plan benefits, for instance.

Costco also hired non-subscription consultants to design and implement a medical provider network. Corporate Remedies, Inc., a Dallas-based medical provider network manager that works exclusively with non-subscription clients, undertook to create a network of initial care, physical therapy and diagnostic services providers.

Melissa Tonn, M.D., president and chief medical officer of OccMD Group, another Dallas-area firm specializing in non-subscription work, created a network of specialist physicians.

Costco retained its pre-existing third-party administrator, Sedgwick, which had established a dedicated non-subscription claims office in Richardson, Texas.

On Sept. 1, 2007, the company formally withdrew from the workers' compensation system by filing the required DWC-5 notice with the Texas Department of Insurance.

Communicating the details of its ERISA program and its differences with the previous statutory program became a high priority. It assigned this task to Towers Watson, which managed Costco's overall employee benefits communications. Costco also began to ask employees to sign acknowledgement of both the ERISA plan and the mandatory arbitration provision. When Costco introduced a revised ERISA plan in early 2012, Zitnik's workers' compensation department handled the communications itself as it felt comfortable with conducting the process.

Results

Costco's workers' compensation losses, both medical and indemnity, dropped dramatically after non-subscription. For the six years prior to its decision to opt-out of the Texas system, the company incurred 97 cents in losses per \$100 of payroll. In the four years after it became a non-subscriber, losses were 46 cents per \$100 of payroll. Losses fell by more than 52 percent.

The program has essentially eliminated the drivers of high claims costs. The work-injury benefit plan does not cover chiropractic care or pay permanent partial disability awards.

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Work-injury risk in Texas is now much easier to manage, Zitnik explains. She reports that Costco's partners — Sedgwick, PartnerSource, OccMD and Corporate Remedies — work closely together to anticipate and resolve problems in administering the ERISA-based work-injury benefit plan. Medical claims management and treatment, she says, are easier and more effective in Texas with the freedom from the state's statutory medical management regulations.

The relative simplicity of the non-subscription system, which allows Costco to make timely claims and medical decisions in accordance with its own ERISA plan, is reflected in the low level of disputes compared to the conventional workers' compensation system. Costco employees have the option to appeal a claims denial to federal courts if the denial relates to plan provisions and if an internal appeals process failed to resolve the dispute. Since the plan's launch in September 2007, no such appeals to a federal court have occurred. Two negligence disputes have been settled prior to the plan's required mandatory arbitration process, and a third one is being negotiated. Zitnik says that the two settlements, which occurred in the same year, modestly increased total claims costs.

Temporary disability from work injury has plummeted, in part due to a financial incentive policy that Costco introduced into Texas with the start of the ERISA plan. Normally, the company charges warehouse budgets a fixed-dollar allocation for each lost-time work injury. The company waives the charge in Texas if workers return to work within seven days. This has not resulted in a decline in the number of lost-time injuries, but the number that exceeded seven days sharply dropped. Zitnick estimates that roughly a quarter of the total reduction in losses was due to this incentive. Costco credits its warehouse managers and its medical provider network for making better use of temporary, modified-work assignments. The program has worked so well that it will soon be rolled out across the country.

Insurance

Costco obtains insurance cover for Texas through PartnerSource. North American Capacity Insurance Co. underwrites a "Comprehensive Employers Indemnity" policy, which provides ERISA benefit coverage and employers' liability coverage above the policy's self-insured retention. Owned by Swiss Re, North American is an "A" rated insurance carrier by A.M. Best.

For Costco's current policy, the combined retained amount (self-insured retention or SIR) for the ERISA benefits and employers' liability coverage is \$1 million per claim. Any combination of, one, benefit payments under the ERISA plan and, two, liability payments toward defense costs, a settlement, judgment or arbitration award with respect to a non-subscriber negligence liability claim will erode the SIR.

Benefit Design

In sum, Costco, like many other non-subscribers, has taken advantage of its freedom to craft a completely privatized claims-adjusting and medical management program.

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Costco's ERISA plan includes a provision on injury causality that allows it to deny claims not solely caused by a work-related injury. This very high threshold of compensability contrasts with the statutory system in Texas, in which the conditions include work only needing to be a "major contributing factor" in the injury or the injury not having taken place "but for" work.

Under Costco's plan, all treatment must be done by network providers and approved in advance (except for emergency care). In another contrast with conventional workers' compensation, its pre-approval protocol need not adhere to the state regulation for workers' compensation utilization review. For instance, state-mandated utilization review determines only if the treatment is reasonable and necessary, not whether the treatment is related to the injury.

To implement the program, the company has retained vendors that are specialists in non-subscription, as do many other non-subscribers. Its aforementioned third-party administrator, Sedgwick, likes to hire adjusters who do not have a workers' compensation background for its Richardson office dedicated to non-subscription.

"We have found that a workers' compensation adjuster with three or more years of experience has a difficult time transitioning to non-subscription claims," says Kim Corcoran, the vice president for operations to whom the dedicated unit in the Dallas suburbs reports. "This is a fast-paced job. Adjusters need to think on their feet. Liability examiners do not mesh well in non-sub because they don't have the hand-holding skills in working with the employee and with the doctors. Some 85 percent to 90 percent of our non-sub adjusters have started with no experience in managing either workers' compensation or liability claims."

Besides developing Costco's specialist provider network, as previously mentioned, OccMD provides physician-directed medical management and performs utilization review in a highly customized manner. Costco gives OccMD latitude to negotiate reimbursement with specialists, sometimes at billed charges. This approach to working with medical specialists has meant that Costco has access to some physicians with strong clinical reputations who decline to treat injured workers in the statutory system due to paperwork issues and low compensation. Costco and its partners find these physicians often provide higher quality care, resulting in earlier recovery and faster return-to-work.

Claims Management

Costco denies benefits (that is, makes an adverse benefit determination) about 50 times a year, most commonly to deny further medical treatment or wage compensation related to work injury. To put this into context, it incurred 341 compensable injuries in Texas in fiscal year 2011.

One example of an adverse benefit determination occurred when an employee decided to go to her personal physician initially and stay at home convalescing after reporting the injury to her supervisor. Sedgwick had asked the employee to go to a network-designated physician. The employee expected wage replacement from the first day; however, Sedgwick paid wage replacement only from the day of the first network physician encounter.

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Another example, involving denial of the entire claim, happened when a worker sustained a strained back while lifting. A clinician ordered an MRI, which revealed degenerative changes not caused by the injury, but no acute findings that would be caused by the injury. A peer reviewer of the case advised Costco and Sedgwick that the worker's back condition was not solely caused by the event at work. The claim for any work-unrelated MRI findings was denied. In the statutory system, a judge might have drawn upon a lower threshold for compensability and ordered that the claim be accepted.

Sedgwick and Costco can help employees cope with denial of a claim or treatment by offering out-of-plan arrangements for medical care conditioned upon a settlement of the claim. For instance, the employer might agree to fund treatment for a number of months and up to a dollar cap, provided that the employee uses network providers.

"This goes a long way to prevent litigation" because employees see their healthcare needs addressed, says Chance Fleming, Sedgwick claims manager at the Richardson office.

Sedgwick account managers consult with PartnerSource on individual claims regarding possible denial, as well, to ensure that its adverse determinations are defensible. Zitnick at Costco pays close attention to prospective adverse benefit determinations and reviews them with Sedgwick. This process has been refined over many claims in the space of five years.

The Costco approach is to listen to PartnerSource's interpretation about application of the provisions of the ERISA plan. Zitnick refers to this collaboration with PartnerSource as "healthy tension" that balances the company's tendency to stretch the provisions of the ERISA plan with PartnerSource's more strict interpretations.

Zitnick explains that Costco's ERISA plan removes much of what she calls the "looseness" in the workers' compensation system that, among other weaknesses, virtually invites employees to shift personal healthcare treatment onto work-injury benefits. For instance, according to Zitnick, the statutory workers' compensation system would allow new employees with only five days' tenure to file a claim for carpal tunnel, a condition that typically takes months or years to arise from work. The Costco plan honors such claims only after employment of at least six months. It also limits its benefits to returning workers to their pre-injury baseline of personal health. Pre-existing personal conditions are not covered for treatment. Costco refers workers to their health insurance plan, including the company's group health benefits. It is the employees' responsibility to obtain group health benefits.

Dispute Resolution

On average, employees turn to the plan-specified internal appeals process only about once a year (that is, for one out of every 50 benefit denials). To do so, employees can send a letter simply stating their wish to appeal a claims decision. At times, employees provide the needed information to show exactly why the desired benefit should be covered under the plan.

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Once Costco receives an appeal, it sends it to Sedgwick for review. At that point, Partner-Source prepares a detailed outline of the claim, which it forwards to Costco's three-member appeals panel. The panel reviews the appeal, a detailed outline of the claim and any additional information it might request, and it determines if the denial of benefits should be upheld or overturned. One specific requirement of the ERISA plan is that the members of the appeals panel must have had no part in the original decision and be unbiased. The injured employee typically does not have direct contact with the appeals committee. The timeframe for appeals and their review are consistent with ERISA regulations for appeals.

Costco experiences appeals where the original denial is based on late reporting and other appeals where the denial is based on medical opinion. In the latter case, the appeals panel will request another opinion from a new physician, as stated in the ERISA plan.

Three injured employees have filed complaints of alleged negligence by the company. Costco has a mandatory arbitration agreement in force exclusively for complaints of alleged safety negligence. Two of these cases were settled before arbitration proceedings began; the third case is now after in pre-arbitration mediation.

Coordination of Benefits

Zitnik takes pains to note that benefit restrictions in the non-subscription plan were drafted with expectation that another employee benefit could respond and provide the employee coverage for benefits denied by the ERISA plan. One example is the plan's requirement that injuries must be reported within 24 hours, which at times results in employees with legitimate work injuries being denied benefits in the non-subscription plan. Employees may have access to medical care, however, through the company's health plan and non-occupational disability programs. Employees sometimes use claim denial letters to justify their receiving treatment under the company health plan.

Innovative Accident Prevention and Investigation

Looking back over five years' experience with non-subscription, Zitnik concludes that non-subscription encourages, and in fact virtually requires, injury response and loss prevention that are more proactive than she finds in the conventional workers' compensation system.

In her view, claims adjusters for non-subscription are not influenced by the more relaxed climate in workers' compensation in which questionable behaviors by injured workers and medical providers are more tolerated. This is due, she says, to relatively worker-friendly regulations and the more accepting predispositions of many workers' compensation judges. Because of these factors, workers' compensation adjusters are inclined to be rather perfunctory in claims investigations. In contrast, non-subscription adjusters need to apply more critical thinking and effort, asking deeper and more intensive questions about the injury, an approach that Zitnik believes to be closer to liability claims management.

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"An employee might report that her or his back was injured while lifting a toilet onto a customer's truck," she explains. "An adjuster in workers' compensation might simply ask the employee to describe the injury. In contrast, an adjuster for the non-subscription program would ask, 'Who was the customer? Who else was with you? How high did you lift the toilet?'"

"The adjuster thereby builds the strongest possible limits to subsequent misinterpretations of the incident," she says.

Those kinds of questions are needed to ascertain that the injury was work-related and whether there may be liability exposures.

Costco's loss-prevention efforts are more intense in Texas than in other states, though the types of workers and their injury risk are similar — customer-facing workers doing a lot of lifting, stockers exposed to strains and sprains, meat-cutters working with knives and forklift operators.

"The liability aspect of non-sub makes you think about member [i.e., customer] injuries," Zitnik says. "I don't know what to say other than that you have to be more vigilant. You insist that the worker puts her safety glasses on. You make the warning sign bigger."

Overall Assessment

The Costco non-subscription program is much less expensive and much easier to administer, with tighter boundaries on benefits and employee discretion, no regulatory burden, and a simpler and faster dispute resolution process.

The result: Losses are less than half than what was incurred under the statutory system.

Costco's employees, according to Zitnick, are treated well. The company's other fringe benefits are positioned as a backstop to the non-subscription plan to ensure that healthcare needs are addressed.

Zitnik would "absolutely" opt-out in other states were the opportunity to exist.

"This," she says, "is a plan that makes so much sense."

Still, she advises caution and coordination.

"If we didn't have a good benefit program, I would have a hard time implementing our non-sub program," she says. "I am moving people into a non-occupational program, with a safety net of health benefits, STD and LTD. You need a way to absorb injuries and treatment which do not qualify as work-related."

"Compare that with the workers' comp system, where everything is loaded into workers' compensation," she says.

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Chapter 6:



Managing Negligence Risk

When workers' compensation professionals consider the opt-out concept, usually they focus immediately on the loss of the exclusive remedy protections against negligence liability lawsuits. Employers believe the financial consequences on such risk exposure can be huge.

An opt-out system need not involve the complete removal of exclusive remedy however. The proposed opt-out system for Oklahoma, which the state legislature eventually rejected in 2012, would have preserved the protection. Advocates of opt-out systems in other states are likely to view the removal of this protection as a major impediment to gaining widespread employer support.

Texas non-subscribers do not enjoy exclusive remedy protection. Nonetheless, many non-subscribers have learned how to minimize negligence risk through more exacting work safety programs, aggressive claims management and the use of mandatory arbitration agreements, which can remove the risk of "runaway" jury awards. Employers also transfer the risk to insurers.

To establish negligence, injured workers must produce evidence that their employers had a duty to provide for worker safety, breached that duty and that the breach was the proximate cause of the injury. The generally recognized common defenses for employers are that, first, the employee was solely responsible for her or his injury and, second, the employer itself was reasonably not aware of the contributing hazard and therefore could not be held responsible for failure to mitigate or remove it.

Background

Exclusive remedy, a cornerstone of the workers' compensation system, was a pre-eminent feature in the innovative tort reforms of the 1910s that ushered in the modern U.S. workers' compensation system. It was at the heart of a trade-off. At that time, reform legislation matched the injured workers' rights to workers' compensation benefits, regardless of fault, with employer immunity to common-law negligence liability suits by workers. The outgrowth was today's no-fault system of workers' compensation benefits.

Except for narrow and very atypical exceptions, exclusive remedy has remained intact for a century. According to *Larson's Workers' Compensation, 2010 Desk Edition*, exclusiveness clauses have been consistently found constitutional under the equal protection and due process clauses at both the federal and state levels.

Even when a state legislature has barred compensation for specifically named work injuries or illnesses, the exclusivity doctrine extends to these named conditions. Thus, employer exposure to liability suits has not grown at all over the past few decades. The rare relaxation in the exclusive remedy doctrine has involved intent by employers to inflict an injury upon workers.

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The Risk in Texas

Texas non-subscribers can be subject to negligence liability suits because they are not covered by exclusive remedy. Workers can file suits in either county or district courts. The substance of a suit would be that the employer failed to reasonably make the worksite safe for its workers. Nothing in state law or case law particularly discourages these claims. The truth is quite the opposite. In the Texas labor code, Section 406.033, the state legislature removed three classic common-law employer defenses that were used before the no-fault system: employees' assumption of risk in taking a particular job, contributory negligence and negligence of fellow employees. The contributory negligence doctrine holds that the employees have no right to damages if they are in any way partly at fault. Once the employees have proven negligence, they are entitled to recover for economic as well as non-economic damages regardless of their own contributory negligence, the negligence of fellow employees or their assumption of the risk.

The Texas labor code, Section 411.103, "Duty of Employer to Provide Safe Workplace," affirms the obligation of employers to maintain a safe workplace, including taking "actions reasonably necessary to make the employment and place of employment safe." Texas non-subscribers commonly refer to this provision as governing in their negligence risks. However, their exposure really arises from common law.¹

This "reasonableness" threshold is similar to liability exposures of retail establishments with respect to customers. It is no wonder then that plaintiff and defense personal injury lawyers who may not practice workers' compensation law comprise the bar for non-subscriber liability claims. Barry Moscovitz, an attorney at Thompson, Coe, Cousins & Irons, L.L.P., in Dallas, explains that the threshold is applied to retailers' exposure by asking two questions about a hazard on its premises. First, was the retailer actually aware of the hazard prior to it contributing to a customer accident? Second, did the retailer have constructive knowledge of the hazard before the accident; in other words, should it have known?

According to Moscovitz, "a reasonably safe workplace inherently means that some accidents are going to happen." In applying the threshold to employers, the questions become: Did the employer have an appropriate work safety program, such as a preventative maintenance program for making appropriate repairs to its facilities, and did it provide appropriate safety instruction?

He warns, however, that a jury may use a much different standard no matter how well employers can document that their safety program meets professional standards. The jury can decide simply that if an employer asked an employee to do a certain job and the employee was injured, then the employer is strictly liable.

"In front of a jury, a non-sub case can be dangerous [to the employer]," he says.

¹ Smith, Peyton and David Johnson. The first step in non-subscriber employer suits is defining the scope of the employer's duty – it affects everything. *Baylor Law Review*. Spring, 2007: 101-133.

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Anatomy of a Negligence Suit

The great majority of non-subscription claims for damages based on safety negligence are, according to both the defense and claimant bar, resolved by settlement. Very few go to jury trial in Texas. As a result, it is difficult to assess the frequency, nature and outcomes of these negligence claims beyond anecdotal reports from cases that go to trial.

By reviewing two jury verdicts that went against the employers, it is possible to better understand how these plaintiff assertions and employer defenses play out before juries. In both these cases, neither company had a mandatory arbitration provision. In the Ben E. Keith, Inc. case, according to its risk manager, the company had an ERISA plan. Employer defenses in the two cases failed.²

Brookshire Brothers v. Lewis

Carl Dean Lewis sued his employer, the supermarket chain Brookshire Brothers, Inc. (a non-subscriber), for injuries he sustained while working in the meat department of one of Brookshire's grocery stores. Lewis was the head meat-cutter and retail meat market manager of Brookshire Brothers, when on July 9, 1990, he injured his back by lifting a sausage case. He later suffered a second and third injury. All three injuries led to surgeries. After the third injury, Lewis sued his former employer for damages, asserting that the company breached its duty to provide a safe workplace and that the breach proximately caused damages. The jury awarded Lewis \$300,000, including an unspecified amount for mental anguish.

Brookshire appealed on several grounds. It contended Lewis' initial injury was not foreseeable because sufficient help was available, yet Lewis proceeded to do the work without asking for assistance from co-workers and supervisors. It additionally argued that it cannot be held liable for Lewis' injuries because Lewis was the manager of the meat department and held the responsibility of staffing and scheduling. At trial, Lewis had alleged Brookshire did not have sufficient staffing in the meat department — an inadequacy which, Lewis claimed, was a cause of his injury and which made the injury foreseeable.

Brookshire also argued the injury was not foreseeable because Lewis "was performing functions and activities specifically within his job description and as a part of the normal duties of his position at the time of his injury." The employer cited a prior court decision that it does not constitute negligence to require an employee to perform customary work for a grocery store that the employee was accustomed to doing without injury.

² For an analysis of employer defenses, see Smith, Peyton and David Johnson. The first step in non-subscriber employer suits is defining the scope of the employer's duty – it affects everything. *Baylor Law Review*. Spring, 2007: 101-133.

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The employer further asserted that Lewis' injury was not foreseeable because Brookshire had provided training to its employees, including proper instructions on lifting techniques, and had maintained a system of safety meetings to discuss safety issues and implement safety measures.

Yet a witness testified that the safety films did not have instructions or safety requirements for lifting a lug of meat and putting it into the grinder, and that the employer did not have written safety rules specifically regarding lifting meat.

Result: The jury in this case from the 1990s decided that a food retailer should have foreseen the hazards incurred by one of its meat-department employees on a busy, short-staffed day. The employer appealed, and the Court of Appeals in Beaumont decided in August 1999 against the employer on all 10 matters raised by the employer.

The appeals court concluded, "The following evidence supports an inference that a possible injury was reasonably foreseeable: the department was inadequately staffed; there was a sale on ground beef making the department extremely busy on the particular day of Lewis' injury; Lewis was never given specific instructions pertaining to lifting activities involved with the meat department; and the equipment Lewis used to perform his duties was not reasonably safe, specifically the lug weight and grinder height."

It found the evidence "legally and factually sufficient to support proximate causation."

Brookshire had also asserted that the jury should have applied the concept of comparative negligence and apportioned fault between itself and Lewis, thus lowering its burden of the award. The appeals court, however, stated, "The employer's only defense may be that it was not negligent in causing the injury or that its employee was the sole proximate cause of the injury."

Defense attorney Gary Thornton of Jackson Walker LLP in Austin observes that this appellate court is known for its liberal rulings. For this reason, the *Brookshire* decision may be viewed as a relatively aggressive pro-worker interpretation of law.³

Montoya v. Ben E. Keith

On June 23, 2009, Larence Rene Montoya, 42, a truck driver newly employed by Ben E. Keith, a food and beverage distributor and non-subscriber, was on his first day behind the wheel. At the advice of his trainer, he went underneath his trailer to use a ballpoint pen to repair a stuck air-brake valve. While he was doing so, the air brake disengaged, and Montoya was dragged 16 feet.

³ A copy for the verdict can be found at: <http://caselaw.findlaw.com/tx-court-of-appeals/1163235.html>.

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He sustained third-degree burns to his face, underarm and chest; broken ribs; a broken left scapula; and a collapsed lung. He underwent outpatient and inpatient treatment including plastic surgery. He sustained significant, permanent scarring to his face and torso. At the time of his trial in June 2012, Montoya was under no physician restrictions other than keeping his scar tissue out of sunlight, but he said he still experienced daily physical pain and recurring nightmares about the incident and had developed a claustrophobic disorder.

Montoya sued his employer for negligently allowing and instructing its drivers to climb under trailers and perform brake maintenance in violation of Federal Motor Carrier regulations. According to Montoya, on the morning of the accident, a supervisor had shown him how to repair a stuck brake valve with a ballpoint pen. Montoya claimed that other supervisors and company mechanics had instructed this supervisor on the technique to save the company time and money, that this technique was a common practice and that the company allowed it.

Furthermore, the employee argued that the company was aware of the sticking brake valve on this particular trailer and had failed to fix it or perform preventive maintenance for more than 500 days. A day or two before the incident, another driver had purportedly complained about this trailer's sticking brake valve.

Ben E. Keith did not have a written policy prohibiting drivers from performing brake maintenance under tractor trailers, the plaintiff's counsel noted.

Montoya alleged ordinary and gross negligence, as well as negligent training.

Ben E. Keith denied the allegations. According to the defense, the valve issue is common in the trucking industry, and the procedure to correct it is not complex and does not violate Federal Motor Carrier Safety Regulations. The defense argued that Montoya was shown the steps to correct the issue, but that Montoya negligently failed to set his tractor brakes before performing the correction, which was the sole proximate cause of the accident.

The court instructed the jury to consider what was the sole proximate cause of the injury in rendering its verdict.

Result: In June 2012, the jury decided that the employer should have known that working beneath a rig to fix a problem exposes the driver to hazards, which the jury concluded it had failed to adequately address.

The jury found that the employer's negligence alone was the proximate cause of the occurrence and that Montoya's damages were \$8.59 million. The jury awarded Montoya \$90,000 to reimburse his employer for past medical care, \$2,500,000 for past physical impairment, \$2,500,000 for past pain and suffering, \$1,000,000 for future pain and suffering, \$1,500,000 for past disfigurement and \$1,000,000 for future disfigurement.

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The case was settled in October 2012, without an appeal. Settlement terms were not disclosed.⁴

Non-Subscriber Risk Mitigation

The non-subscribing community of employers and advisors has tried various methods to reduce risk of negligence liability suits. One method has been to induce employees to agree upon hire to make work-injury benefits conditional upon waiving their rights to common-law negligence claims.

In the 1990s, some employers included a negligence-claim waiver in their work-injury ERISA plans, making the plan the exclusive remedy for the employee. In a setback to employers, a federal court in 1994 ruled these waivers not subject to ERISA pre-emption,⁵ reasoning that employers cannot expect to use ERISA as a pre-emption for exposures not directly related to ERISA plan benefits.

In 2001, the Texas Supreme Court ruled that pre-injury waivers were constitutional.⁶

In swift response to this Supreme Court decision, the state legislature abolished pre-injury waivers in 2001. Then in 2005, the legislature went on to restrict the use of, but not abolish, post-injury waivers. But, as described below, non-subscribers can effectively introduce a form of pre-injury waiver through the use of mandatory arbitration agreements.

Defense Strategies

Many employers are satisfied with non-subscription and appear to find negligence liability risk to be manageable. However, the risk exposure puts pressure on employers to be very thorough in their safety and post-accident practices.

Jackson Walker attorney Thornton advises his clients to avoid two gaps to protect themselves against non-subscription negligence suits: failure to address a safety hazard in the company's safety literature, and failure to assuredly communicate the written safety procedures through all the layers of management down to workers. Plaintiff attorneys in the two aforementioned cases focused on these kinds of gaps.

4 Information about this case obtained at: <http://www.verdictsearch.com/index.jsp?do=news&rep=recent&art=207657>.

5 *Hook v. Morrison Milling Company*, 1994.

6 *Lawrence v. CDB Services, Inc*, 2001, preceded by appeals court decision, *Lambert v. Affiliated Foods*, 1999.

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Non-subscribing employers can also limit negligence liability exposure by undertaking intensive investigations of work injuries. These investigations carefully identify the nature of the injury, analyze causes, and document what the company has done in prevention and employee training to minimize injury risk.

Mandatory Arbitration

To avoid jury trials, the dominant strategy of choice today is for non-subscribers to make employment (or work-injury benefits) conditional upon signing a mandatory arbitration agreement to cover negligence liability complaints. Employers usually make these agreements governed by the Federal Arbitration Act (FAA). Texas courts have supported the practice, ruling that state laws prohibiting or circumscribing waivers of right to sue are pre-empted by arbitration agreements governed by the FAA.⁷ Mandatory arbitration agreements effectively provide an end run around the state's probation of pre-injury waivers.

Arbitration is rarely used within the statutory workers' compensation systems. Mandatory arbitration provisions exist only in collective-bargaining agreements between labor and management that are authorized by state "carve out" statutes that permit binding alternative dispute resolution systems, such as California's Labor Code section 3201.5 and 3201.7. California is one of a handful of states that authorizes organized labor and management to create carve-outs and embed alternative dispute provisions within them under certain conditions. Examples of California carve-outs include the use of ombudsmen, mediation and arbitration, triggered between five and 60 days after one party makes a request depending on the exact language.

Mandatory arbitration of workplace disputes was rarely used at all in the United States until the U.S. Supreme Court ruled in its 1991 decision in *Gilmer v. Interstate/Johnson Lane Corp.* that mandatory arbitration over a right asserted in employment law can be made a condition of employment. The employer community realized that this decision allowed them to use mandatory arbitration to cover disputes such as discrimination and sexual harassment. Adoption in non-union workplaces rose sharply in the 1990s. The Supreme Court and other courts have since reaffirmed the use of mandatory arbitration provisions so long as they are not egregiously one sided to the employer's benefit.

Non-subscribers perceive that mandatory arbitration speeds up dispute resolution, minimizes the expense of discovery, reduces legal costs, ensures the preservation of confidentiality and avoids the possibility of runaway jury verdicts.

⁷ Ohana, Jason. Texas Elective Workers' Compensation: A Model for Innovation? *William & Mary Business Law Review* 2011 2: 323-344.

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Mandatory arbitration has drawbacks, including the fact, borne out by non-subscribing employers' experience, that arbitration expenses, such as the arbitrator's charges, can be substantial. Additionally, the arbitrator is free to disregard, mix and create rules of evidence and procedure, and the arbitrator's decision cannot be appealed to a court. According to Richard A. Bales, a faculty member at the Salmon P. Chase College of Law of Northern Kentucky University and an expert on arbitration, arbitrators are disinclined to make a summary judgment out of concern that a court will find the summary judgment to be arbitrary. Bales noted in an interview that mandatory arbitration agreements can grant the arbitrator the option of summary judgment.

Common Provisions in Arbitration Agreements

The employer may include the arbitration agreement in the same document with its ERISA plan or keep it separate. It has each employee acknowledge the plan in writing. The agreement may warn the employee that were she or he to pursue a claim for liabilities covered in the plan through other channels, such as civil court, the employee would be financially liable for the employer's legal expenses in voiding that claim.

What the arbitration policy covers. The language of coverage is typically broad, covering, for example, any claim for any form of physical or psychological damage, harm or death which relates to an accident, occupational disease or cumulative trauma, emotional distress, retaliatory discharge, or violation of an other non-criminal federal, state or other governmental common law, statute, regulation or ordinance in connection with a job-related injury.

What the policy does not cover. Any claim relating to ERISA.

Who is covered? Employees and their family, parents and beneficiaries.

How the arbitration process works. The employee is to notify an arbitration firm pre-selected by the employer. The American Arbitration Association is just one of several sources in Texas. The arbitration firm provides a short list of candidates, typically attorneys and judges with experience in personal injury law. The agreement states how a final selection of one arbitrator is made. The employer typically pays for the cost of the arbitrator, which can be considerable.

Which arbitration law (state or federal) governs? Employers commonly select the Federal Arbitration Act. Employer-employee binding arbitration agreements usually refer to the federal act because the employer community perceives it as more immune to court reversals than state arbitration acts, according to Bales.

How a decision is arrived at. The arbitrator submits a written decision within specified days after the hearing. The decision is confidential and does not serve as a precedent. The arbitration

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may award economic and non-economic damages, and attorney fees. In setting a framework for permissible awards, the agreement might state that awards must be consistent with the remedies available under the state or federal statute, common law, code or regulation that is the subject of the claim.

In sum, employers can strongly influence the arbitration process, from selecting the vendor which provides arbitrators to framing the scope of the decision.

Other Examples of Employer Exposure to Suit

In two ways, the exclusive remedy doctrine fails to protect American employers from employee work-injury suits. Employees covered by the Federal Employers' Liability Act (FELA) can sue their employers for negligence. And persons who assert they have been harmed by a work injury sustained by another person can sue for liability. These exposures in theory might be useful benchmarks for employers to imagine life without exclusive remedy. In reality, they are too remote from the opt-out experience, actual or hypothetical, and therefore are not instructive. We review them here very briefly, to round out our overview of employer negligence liability for work injuries and to dispel expectations that experience at the edges can be useful to opt-out program designers.

FELA

In 1908, Congress enacted the Federal Employers' Liability Act, which regulates worker-injury benefits for the interstate railroad business. The act, which preceded the wave of state workers' compensation reforms in the 1910s, preserved the tort system of dispute resolution, which state statutory systems later largely eliminated. FELA removed some of the common employer defenses, such as the fellow servant rule and contributory negligence.

The 1980s saw a steep rise in FELA claims costs. Amtrak's total FELA losses, for instance, more than doubled between 1982 and 1988 even though the number of closed claims slightly declined.⁸ The rise in claims costs, according to James Wolfarth, senior vice president of Marsh's Global Rail Practice, occurred because of an increasingly sophisticated plaintiff bar, which developed expertise in areas such as cumulative trauma, chemical exposures and hearing loss.

Railroads responded in several ways. They attempted without success to reform FELA. They shifted some labor to outsourcing vendors covered by state statutory systems. And they dedicated more attention to safety.

⁸ Baker, Thomas. Why Congress Should Repeal the Federal Employers' Liability Act of 1908. *Harvard Journal of Legislation* 1992 (29): 79-121.

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"The mantra I have been aware of in the past 20 to 30 years," Wolfarth says, "is to put a tremendous effort into training and thoroughly document the training."

Between 1980 and 1995, the frequency of worker injuries under FELA dropped by over 65 percent and has since declined annually.

It is difficult to draw lessons about negligence liability from FELA because the culture of claims management in FELA is much more litigious than an opt-out system. An opt-out system, as in place in Texas or proposed in Oklahoma, makes extensive use of ERISA plans and mandatory arbitration. ERISA work-injury benefit plans do not exist under FELA. No railroad has induced its unions to accept arbitration as a dispute resolution process. Federal judges who hear FELA cases often require opposing parties to try mediation or arbitration before trial. But given the presence of unions and vocal support among union members of the current system, it is unlikely that a railroad will be able to use arbitration as a normal process in settling disputes.

FELA also departs sharply from the Texas non-subscription system because it adheres to the comparative negligence doctrine, while non-subscription does not. According to this doctrine, the courts can apportion fault between the injured worker and the employer as a step in awarding damages. For instance, an injury could be 70 percent the fault of the employer.

Employers' Liability

Workers' compensation statutes and insurance policies that cover statutory benefits do not cover every work-injury exposure for employers. For instance, exclusive remedy does not apply to a spouse who may suffer from loss of consortium, nor does it block a suit by an equipment manufacturer that, when sued by an injured employee for insufficient safety protections on an item of equipment, decides to sue the employer for disabling some protections the manufacturer had designed. Numerous other conceivable scenarios can lead to a suit by a third party against employers. The employers' liability insurance policy is the most practical way for employers to transfer this risk.¹⁰

However, employers' liability risk is not a feasible learning tool for employers considering opting-out. First, the frequency of these types of suits is so low that most employers and even insurance brokers have had no direct experience with one. Second, the exposures covered by employers' liability insurance are sometimes those for which employers have no viable means to mitigate, such as a spouse's lack of consortium.

¹⁰ Boggs, Christopher. *The Insurance Professional's Practical Guide to Workers' Compensation* (San Diego, CA: Wells Publishing, 2nd edition 2001) pages 71 - 87.

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Chapter 7:



The ERISA-Designed Program

The employer community in Texas began in the 1980s to look to ERISA, the federal Employee Retirement Income Security Act of 1974, as a strategic asset in managing work-injury risk outside the conventional workers' compensation system. While many non-subscribers do not structure their work-injury benefit program as an ERISA plan, its use has become standard best practice because it offers a variety of advantages compared with the only other practical options, which are to develop a plan without any state or federal statutory guidance or to have no plan at all.

The pertinence of ERISA for a workers' compensation opt-out system should not be a surprise. ERISA has served for close to 40 years as the American employer's accepted approach to delivering privatized employee fringe benefits, including long-term disability benefits.

Background

The Employee Retirement Income Security Act of 1974 is a federal law that sets minimum standards for retirement, health and other employee benefit plans at private-sector employers. Congress intended the law to encourage the growth of private-sector, employer-sponsored benefit plans that are financially sound and attractive to both employers and to their workers. And importantly, ERISA pre-empts any state regulation.

Since 1974, employers have elected to create ERISA plans on their own, without needing federal or state certification. Meanwhile, further legislation — such as HIPAA, or the Health Insurance Portability and Accountability Act of 1996 — has added to the regulation of ERISA-based plans without changing the original intent of ERISA.

Outside Texas, the workers' compensation community is largely unaware of the details of ERISA for a simple reason: Workers' compensation is expressly exempted from its provisions out of deference to state workers' compensation systems. Even if employers created an ERISA plan to manage their workers' compensation benefits, state compensation laws would prevail in all matters, including benefit design and dispute resolution, so there would be no point in having the plan. State workers' compensation laws, which have their origins 60 years before the passage of ERISA, are silent about the act, as they are also silent about HIPAA and other federal employee benefit statutes.

On the other hand, ERISA plans to cover work injuries are legally recognized for employers not subject to state workers' compensation laws, such as non-subscribing employers in Texas.

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A federal court ruled in 2002 that a benefit plan to cover the work injuries of non-subscribing employers can be subject to ERISA (*Hernandez v. Jobe Concrete Products*, 2002). ERISA includes exemptions for a plan that “is maintained solely for the purpose of complying with applicable workmen’s compensation laws or unemployment compensation or disability insurance laws” (29 USC §1003 (b)(3)). Federal courts have held that a Texas non-subscriber’s ERISA plan is not “solely” to comply with state workers’ compensation laws and therefore can stand as an ERISA plan with its immunity from state interference.

An ERISA work-injury plan that includes medical benefits and wage replacement falls within the scope of ERISA, which covers:

any plan, fund or program of benefits established or maintained by an employer that provides for its participants or their beneficiaries, through insurance or otherwise, medical, surgical or hospital care or benefits in the event of sickness, accident, disability, death or unemployment. (29 U.S.C. §1002(1))

ERISA plans for non-subscription may sometimes be called “health plans” or the more general “employee welfare benefit plans.”

A federal court ruled that a non-subscriber’s ERISA plan does not pre-empt employees’ common law right to sue their employer in state court on the basis of the employer’s obligation to its employees, independent of the injury benefit plan, to maintain a safe workplace (*Hook v. Morrison Milling Co.*, 1994). Employers who opt-out of the statutory workers’ compensation system in Texas can control liability risk by using a mandatory arbitration provision, which may be included in the same document in which the ERISA plan is placed. Insurers provide insurance for ERISA plans and the employers’ liability exposure.

Non-subscriber ERISA plan benefits are delivered on a no-fault basis with limited exceptions noted in the plan, such as injuries arising out of horseplay or intoxication. However, there is nothing inherent in ERISA that would prevent employers from denying benefits more broadly on the basis of fault — for example, if it found that employees were solely responsible for injury.

Non-subscribing employers are free to offer other ERISA plans to cover other benefits for employees and their dependents. This freedom and flexibility offer employers the opportunity to better integrate their management of work-injury risks with the management of other employee benefits.

ERISA Benefits for Employers

An ERISA-based work-injury plan delivers all of the advantages and responsibilities for employers that typically come with ERISA.

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The major advantages include practically unlimited employer discretion in benefit design; internal dispute resolution that is difficult for employees to transfer to a court, state or federal; pre-emption from state interference; and a high degree of predictability due to ERISA's accumulated experience. Furthermore, insurance policies are available to cover the employer exposure to ERISA injury benefits.

Benefit design discretion. Employers can restrict benefits to injuries that meet a special threshold of causality. For example, the Costco non-subscription plan accepts only conditions that “directly and solely result from” the course and scope of employment. This threshold is considerably higher than the common threshold in statutory workers' compensation systems — namely, that work be the major contributor to the injury. The involvement of the pre-existing condition means that the injury was not caused solely in the course of and arising out of employment. The higher Costco threshold effectively rules out coverage for this and potentially many other injuries, or portions of their treatment, that state workers' compensation courts might otherwise rule compensable.

Another example of design discretion is compensating the injured worker on disability at 90 percent of pre-injury payroll, or even 100 percent of payroll (full wage continuation), without a weekly cap, effective the first day of disability. Workers' compensation statutory benefits throughout the country are almost always in the range of 66.67 percent to 70 percent of pre-injury payroll and almost always include a waiting period and a maximum weekly indemnity benefit linked to the state's average weekly wage. ERISA plan wage replacement is taxable, contrasted with workers' compensation benefits, which are not. The net financial differences between the two are not easily comparable, but the ERISA plan's removal of a waiting period makes the work-injury benefit plan more consistent with sick leave and short-term disability benefits in the view of the employees.

Internal dispute resolution. ERISA prescribes a protocol for administrative review of disputes — for instance, over denied benefits — through an appeals process within employers. Employees dissatisfied with a decision by an appeals committee may file a suit in federal court; however, federal court review of a benefit denial is very constrained and focused on if the denial was arbitrary or capricious. Punitive damages are not available. Federal courts also cannot question the adequacy or equity of a plan's benefits. ERISA suits filed in state courts are routinely removed to federal district courts.

Pre-emption from state interference. ERISA has a very broad federal pre-emption over state law, regulation and courts. To skirt constitutional challenges, the law's drafters provided for states to continue to regulate insurance, but the benefit plans themselves are immune from state interference. Thus, states do not even possess the power to require employers to file their ERISA plans with them. The Texas legislature cannot require ERISA plans for non-subscribing employers to, for example, include chiropractors in its panel of approved medical providers. Annual ERISA plan reports (but not the ERISA plans themselves) must be filed with the federal Department of Labor, though they are not subject to review and approval by DOL.

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Predictability of ERISA plans. ERISA is a complicated law and can be daunting for the workers' compensation professional. But labor relations attorneys and consultants can bring expertise to make the best of the law. Decades of employer experience with ERISA for medical, accident and disability benefits and ERISA regulation by the Employee Benefits Security Administration within the Department of Labor have brought about a high level of predictability with compliance requirements, the dispute resolution process and the strength of the federal pre-emption. This certainty enables employers, with counsel, to plan for the efficient deployment of an opt-out program and insurers to design insurance products and underwrite with confidence.

A note of caution: The high level of predictability in the Texas non-subscriber program derives in key respects from case law developed over decades by the federal district and appeals courts in the Fifth Circuit, which covers Texas. Other federal courts may rule differently.

Against these benefits, employers should weigh the fiduciary responsibility of becoming the plan administrator. ERISA assigns to the sponsor of a plan (employers, for example) a fiduciary role, whose principle function is to provide benefits to participants. The fiduciary shall discharge its duties "with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." (29 USC 1104 (a) (1) (B))

The plan administrator is also required under risk of federal penalties to make plan descriptions available to employees and provide annual reports upon employee request. An annual report to the federal government is also required.

Employers with an existing ERISA plan for health or other fringe benefits are accustomed to how these plans work and most likely already have ERISA advisors. Employers without experience can retain consultants to develop a plan or be provided a plan template from an insurer.

Liability for the Claims Tail

Employers have the right to change or terminate an ERISA plan entirely at their choosing. Unless employers expressly commit to honoring future benefits to injured workers who have not yet recovered, they have no legal obligation to pay these obligations if they terminate their plan. ERISA does not impose any obligation to provide for funding of future payments through the plan administrator's fiduciary responsibility. This is one of the more important, yet misunderstood, aspects of ERISA plan use.

Because this freedom from the claims tail is foreign to workers' compensation professionals, it is worth exploring the subject at some depth.

Antoinette Pilzner, a member of the advisory firm McDonald Hopkins PLC in Bloomfield Hills, Mich., and an experienced ERISA advisor, explains that ERISA does not mandate that non-retirement benefits be funded, which means that employer promises to provide welfare benefits, such as

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long-term disability benefits, do not have to be backed by assets irrevocably set aside to fund those promises. This is consistent with the ERISA position that welfare benefits are generally not “vested” unless employers clearly indicate their intent to vest those benefits. But even if the employers elect to vest welfare benefits, they are not obligated under ERISA to pre-fund those benefits.

Long-term disability benefits subject to ERISA can be fully insured long-term benefits such as for long-term disability and work injuries. When they are fully insured, the insurance carrier assumes the liability to continue funding benefits for disabilities that occur while that particular insurance policy is in effect, even if the employers change insurers in the future or the employers cease to exist. Many employers insure their long-term disability benefit plans precisely to transfer this tail liability to underwriters.

Arguably, state law could not generally obligate employers to fully insure long-term benefits such as for long-term disability and work injuries. Such a state law would “relate to” an ERISA employee benefit plan and would be pre-empted by ERISA.

Some employers, however, self-insure their long-term disability benefit plans. Again, these employers are not obligated under ERISA to set aside funds for those benefits. Some employers use tax-exempt trusts (VEBAs) to fund these benefits, nevertheless, because employers can then get a tax-deduction at the time they contribute assets to the trust instead of when the benefits are actually paid. Even in those situations, employers are generally not legally obligated to fund the VEBA so that all future benefit payments are supported. Beneficiaries of ERISA benefit plans sponsored by employers that enter bankruptcy are unsecured creditors of the employers.

Again, state law does not come into play. ERISA self-funded benefit plans are exempt from state laws regulating insurance; thus, state insurance laws cannot be applied to require employers to fund their self-funded long-term disability benefit plans.

Key ERISA Provisions in Opt-Out Programs

Costco's revised ERISA plan, introduced in April 2012, exemplifies how an opt-out program is deeply influenced by ERISA provisions. Important aspects include:

Plan administrator. Costco's “Benefit Committee” is the plan administrator.

Written plan document. Costco issued an amended Summary Plan Description of its Texas Injury Benefit Plan, effective April 1, 2012. The language in the document is largely free of technical terms and written to be understood by the average Costco employee. Costco is required by federal law to distribute the plan to its employees. The document says that Costco can amend or terminate the plan at its discretion, provided that it will honor claims awarded prior to such change.

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Covered conditions and treatment. The document describes at some length the covered injuries; non-covered injuries (degenerative conditions and work stress, for instance); non-covered injury circumstances (e.g., "your long-term cell phone use, or secondhand smoke was a proximate cause of the injury"); and non-covered treatment (such as chiropractic).

Description of benefits. The plan document describes the medical and wage-replacement benefits, including benefit limitations of time and money. These benefits are entirely at the discretion of Costco to design and revise at any time. The Costco provisions differ from the statutory system in numerous ways. For instance, Costco provides no permanent disability benefits.

Employee obligations. The document specifies what employees must do to obtain benefits. Consistent with ERISA provisions, the Costco plan has different protocols for obtaining urgent and non-urgent medical care. One employee obligation is submitting an injury incident report by the end of the business day after the day of injury, and submitting an incident report within 24 hours of the injury report. (Other ERISA plans stipulate the report must be made at the time of injury, but not later than the end of the shift.) The plan provides some leeway for reporting injuries requiring emergency care and for cumulative-trauma injuries. Benefits can be denied for failure to comply with some obligations. Non-subscribers view their employee obligations as a key component to preventing fraud.

Dispute resolution. Tracking closely to ERISA's detailed, explicit requirements for dispute resolution, the document describes how adverse benefit determinations are made and the protocol for appeal, including timeframes for appeals and decisions. The document also cites the employees' right to seek a reversal of an adverse benefit determination in federal district court.

Coordination of benefits, COBRA. To comply with ERISA and other statutes, the document includes a rule for coordination of benefits and COBRA, or the Consolidated Omnibus Budget Reconciliation Act of 1985 as later amended.

Exclusion of HIPAA's privacy rules. The Health Insurance Portability and Accountability Act's privacy standards for personally identifiable health information exempt workers' compensation but apply to other benefit plans. Costco's document states that HIPAA does not apply to its work-injury plan, though it does not expressly explain the logic that allows ERISA non-subscriber plans to be exempt from HIPAA. An ERISA work-injury plan enjoys a HIPAA exemption for "workers' compensation and *similar* programs" (italics added). The law permits the disclosure of protected health information "[a]s authorized and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault." (45 C.F.R. § 164.512(l))

A recent development in Texas privacy law may, however, extend HIPAA-like standards to non-subscribers and their agents. HB 300, enacted in 2011 and effective on September 1, 2012, may subject non-subscribers to privacy rules equal to or more demanding than HIPAA.

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Mandatory arbitration. Costco elected not to include a mandatory arbitration provision within its plan document; other employers present the provision with their ERISA plan.

Discretionary clause. The plan says:

The Plan Administrator has sole, exclusive and final discretionary authority to interpret and implement the provisions of the Plan. ... The Plan Administrator's exercise of discretion and determinations in all matters shall be entitled to the highest deference permitted by law. There shall be no de novo review by any arbitrator or court of any decision rendered by the Plan Administrator and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Plan Administrator may adopt any rules and procedures it considers necessary or appropriate for the administration of the Plan. The Plan Administrator may deny a claim for or suspend the payment of Plan benefits otherwise payable to you if you do not comply with any provision of the Plan or the rules and procedures adopted by the Plan Administrator.

ERISA rights statement. The document includes a description of employee rights under ERISA, including the right to sue in federal court over denial of benefits.

Employee acknowledgement. The employee is to sign the document, including a safety pledge.

A Revolution in Accountability

After looking at the ERISA provisions as a whole and listening to experienced claims professionals and employers about how they apply them, the observer of non-subscription comes to the conclusion that these ERISA work-injury plans represent nothing less than a revolutionary realignment of accountability. Here is why:

We expect you to come back to work.

An ERISA plan that extends wage replacement for up to two years, and no more, communicates to workers that very few injuries should lead to workers not returning back to productive work. Among lost-time compensable workers in Texas' statutory system, about 80 percent return to work within six months and 95 percent within two years.¹ Of the 5 percent still out of work two years post injury, most of them are likely to be classifiable as permanent partially impaired, according to conventions in most states' workers' compensation systems. The two-year cap on wage replacement implies that these partially impaired individuals should be able to return to work before, and perhaps well before, 102 weeks have expired.

¹ Texas Department of Insurance. Return-to-Work Outcomes for Texas Injured Employees, December 2011 Results. 2011.

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Our injury plan is not your health plan.

ERISA plans aggressively carve away employers' financial responsibility for the personal, non-occupational health conditions of employees who report injuries. Statutory systems often absorb, sometimes by judicial order, health conditions loosely related to the occupational injury.

The sole-cause provision (such as found in Costco's plan) allows employers to deny coverage to injuries that arise even only partly from non-occupational health factors, such as natural, age-related joint deterioration. It also enables employers not to pay for medical care loosely related to the occupational injury. The implication is that an employee health plan covers these non-occupational conditions.

We asked a number of experts to estimate the impact of these carve-away policies. There is a consensus among experts polled for this study that the wisdom of Solomon is needed to render consistently defensible decisions on whether a particular personal health condition should or should not be covered and if a medical treatment should be paid for. About one out of every five lost-time, compensable claims involve a personal health condition that may complicate recovery from a work injury, according to the estimate of surveyed experts. They also tended to agree that about 5 percent of lost-time claims involve personal health conditions that must be taken care for the injured worker to achieve recovery potential. The bottom line is that a strictly enforced carve-away policy within an ERISA plan works only if employees have access to health benefits through a company's group health plan, through an individual health insurance policy or through coverage under a spouse's health insurance group policy.

You are accountable for your personal behavior.

ERISA plans demand more aggressively than statutory systems that injured workers be responsible for their own health behaviors.

For example, Costco's ERISA plan tells employees that benefits can be suspended if the employees are "nonresponsive," including (in the language of the Costco plan) "nonresponsiveness due to the need for participant behavioral modification recommended by the treating approved physician."

This provision could remove a major barrier to injury recovery, as perceived by claims professionals. Workers' compensation judges are generally reluctant to suspend benefits to injured workers who fail to quit smoking, attend gym exercises or lose weight in accordance with physician orders. Another plan provision requires that workers attend all medical appointments. Workers' compensation judges, on the other hand, are reluctant to suspend benefits for missing appointments unless the employees' behavior is egregious.

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ERISA's Influence on Losses

Francis Fey, president of the Austin, Texas-based third-party administrator JI Specialty Services, compares the loss experience among the firm's non-subscriber clients with the loss experience of workers' compensation clients to reveal a universal downward trend. Employers moving to non-subscription might see a reduction in losses of 25 to 50 percent over its statutory workers' compensation experience, with a select number seeing as much as an 80 percent reduction.

Yet the mere use of an ERISA plan to deliver work-injury benefits does not ensure claims will be fewer, losses lower, risk of fraud and abuse curtailed, or worker recovery from injury faster and more complete.

To deter fraudulent claims or an abuse of awarded benefits, knowledgeable claims professionals and employers tend to cite three common ERISA plan provisions as essential tools: the requirement that all injuries be reported instantly, the requirement that workers show up at all medical appointments and the difficulty for workers to challenge a treating doctor's work release.

The key to unlock ERISA's loss-reduction potential, however, is really the broad discretion it affords employers to define and enforce benefit rules, provided that benefit delivery and rule enforcement are neither arbitrary nor capricious. Even when employees allege employer misconduct, their sole recourse is through an internal appeals process and, exhausting that avenue, suit in a federal court that cannot award damages.

The "discretionary clause" in an ERISA plan magnifies employer rights. As previously cited as an example, the Costco ERISA plan includes a "discretionary clause" that allows Costco wide latitude to interpret the plan, minimizing the risk that a federal court would decide that Costco was arbitrary or capricious in its plan administration.

What is most noteworthy is not the exact wording of individual plan provisions documents, therefore, but the fact that all of their key loss-reduction drivers are enabled by employers' broad discretion under an ERISA plan.

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Chapter 8:



The Oklahoma Opt-Out Proposal

For years, employers and business leaders in Oklahoma have targeted the cost of workers' compensation for complaint and criticism. According to the 2010 Oregon Workers' Compensation Premium Ranking Study, Oklahoma had the fourth highest workers' compensation premiums in the United States. The state advisory forum reports from the National Council on Compensation Insurance show that Oklahoma has one of the highest loss-cost ratios as a percentage of payroll in the United States.¹

In part to tackle these issues, the governor and state legislature passed a sweeping package of reforms in May 2011. For some in Oklahoma, however, more was needed to be done.

Advocates for an Oklahoma opt-out law submitted proposals during the 2012 legislative session. In the spring, the bill failed in the House of Representatives after Senate approval. However, advocates expect to resubmit legislation in 2013, which will likely depart from the 2012 version to improve chances of passage.

Their proposal offers a fresh look at how an opt-out program can be structured. In contrast with Texas' law, Oklahoma's bill specifies many requirements for and rights of opt-out employers. Oklahoma opt-out employers would be required to adopt an ERISA plan and offer work-injury benefits similar to some contained in the statutory system. They would also continue to enjoy exclusive remedy, through a package of incentives that might be called "play and gain." Thus, the Oklahoma opt-out proposal both differs from the statutory system but preserves certain key provisions.

Background

On Feb. 8, 2011, SB 878 was introduced into the Oklahoma Senate to reform the state's workers' compensation system. This reform package, however, was not the opt-out legislation. On May 24, Governor Mary Fallin, who had campaigned on a platform of workers' compensation reform, signed the reform bill into law after the Senate had passed it unanimously and the House by a vote of 88 to 8 had passed the 220-page package.

Among many changes to the workers' compensation code, SB 878 shortened the maximum duration of total temporary disability from 500 to 208 weeks; changed the method for calculating permanent disability benefits; introduced the Official Disability Guidelines as the standard for medical care; lowered the medical reimbursement fee schedule; strengthened the claims-payer's ability to use second opinions; and made appointments to the Workers' Compensation

¹ National Council for Compensation Insurance West Virginia Advisory Forum, August 22, 2012, page 32, places Oklahoma as fourth most expensive when using West Virginia's payroll distribution.

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Court subject to Senate approval. Oklahoma had already allowed, and continues to allow, legal settlement agreements for both indemnity and medical expenses, an ability sought after by employers in other states.

Some Oklahoma employers, unsatisfied with the scope and pace of reform, wanted to promote the concept of an alternative to statutory workers' compensation. A number of these proponents have operations in Texas, where they are non-subscribers. In March 2011, Oklahoma employers organized the Oklahoma Injury Benefit Coalition (OIBC) to promote a voluntary alternative to the mandatory statutory workers' compensation system. They used the 2011 legislative session to raise awareness of the opt-out concept. Toward the close of 2011, IOBC secured the support of Speaker of the House Kris Steele and Senate President Pro Tempore Brian Bingman as sponsors of the opt-out bill.

The Oklahoma Employee Injury Benefit Act

The Oklahoma Employee Injury Benefit Act was introduced in January 2012, with identical bills filed in the House (HB 2155) and in the Senate (HB 1378). The stated purpose of the legislation was "a fair and balanced alternative" to the statutory system that provides indemnity and medical benefits to workers, helps employers control costs, and assists the state in "attraction and retention of new employers."

The major difference between the opt-out bill and the reforms passed in 2011 is the freedom afforded opt-out employers to use an ERISA plan to control care and return-to-work and resolve disputes over benefits. Employers would have virtually complete discretion over the administration of benefits and still enjoy exclusive remedy (with a key exception that an ERISA plan would have to include at a minimum a set of prescribed benefits).

In the bill's preamble, the authors wrote: "The Legislature has determined that the inability on the part of those employers to effectively and efficiently manage [workers' compensation] claims has contributed to the increased costs associated with such claims and has resulted in reduced efficiency in the treatment of injured employees. In an effort to provide more efficient management of such claims, to help provide employees with better managed medical care and to assist this state in the attraction and retention of new employers, the Legislature hereby adopts this act."

IOBC and the Oklahoma Chamber of Commerce vigorously promoted the legislation throughout the 2012 legislative session. OIBC referred to its members' success in managing their Texas non-subscription plans. Calling it an "Oklahoma injury benefit option," the coalition asserted that the alternative work-injury system would improve outcomes for both employees and employers, reduce costs to employers and provide the state a key tool in promoting economic development.²

² Oklahoma Injury Benefit Coalition, Questions and Answers: The Oklahoma Employee Injury Benefit Act. No date.

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The coalition highlighted that the opt-out system would result in “immediate injury reporting,” a sore subject in Oklahoma because even under the 2011 reform law, employees have 30 days to file a claim and two years to initiate litigation. HB 2155 would not prescribe reporting deadlines, leaving that to the discretion of non-subscribing employers.

The coalition also predicted that medical care would improve through the use of “the best medical providers,” presumably by granting employers complete discretion and control on the selection of providers. The coalition said that HB 2155 would bring about “increased employee accountability to follow prescribed medical treatment plan.” The legislation again left it to employers to set the conditions in the ERISA plan under which medical care would be provided.

Another item on the coalition’s summary list of benefits was “more efficient resolution of injury disputes.” The coalition had in mind ERISA dispute resolution protocols, which by cutting lawyers out of the process can quickly resolve disputes.

As for cost savings, the coalition reported that “18 Texas companies saved an average of 76 percent in total claim costs in their first year as a non-subscriber after leaving the Texas Workers’ Compensation System.” It spotlighted the cost of a knee injury — how Oklahoma employers paid an average of \$27,374 for knee injuries compared with the \$1,888 paid by Texas non-subscribers.

Delving into the details of the proposed legislation, OIBC stressed four important differences of HB 2155 with the Texas non-subscriber program: higher benefit protections for injured workers as no opt-out employers would be allowed to “go bare” without insurance cover; mandatory benefit levels that are similar to the statutory system’s benefits; continuation of exclusive remedy legal protections with an exception for intentional tort; and more state regulatory oversight than Texas, where oversight of non-subscribers is nominal and weakly enforced.

The HB 2155 advocates asserted that employee benefit levels would be actually higher than those in the statutory system in certain respects. The dollar, duration and percentage limitations on benefits were the “same or higher,” they claimed — for example, no waiting period rather than a seven-day waiting period for disability benefits. The inclusion of a benefit package justified to the advocates the preservation of exclusive remedy for employers.

The bill would require non-subscriber employers to adopt an ERISA plan, which in the perspective of the OIBC was a “proven system of employee protections.” Benefits would be awarded without regard to fault, according to OIBC, and ERISA provides “extensive, mandatory claim rules to ensure a full and fair review of injury claims.” The plan administrator would have to pay or deny claims within specified time frames, and explain the basis for claims decisions and provide open access to records for denied claims. Employees would have the right to an internal appeal and the right to submit additional information in support of the claim.

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The bill spelled out the protocol for employers to review appeals from injured employees, adding some steps to ERISA's prescribed protocol. For example, the appeal body would have to bring "in a new medical provider to advise on matters of medical judgment." The bill went on to confirm employees' right of access to federal courts after the appeal process is exhausted.

As for negligence claims, the OIBC noted that "intentional tort claims can be filed in Oklahoma courts; or an employer may (but is not required to) adopt a requirement for arbitration of any intentional tort claim (arbitration must satisfy statutory and case law requirements on fairness)."

"The employer's normal human resource and risk management policies and procedures on drug/alcohol testing, return-to-work, leaves of absence, etc. continue to apply; along with other laws protecting employee rights, like the ADA, FMLA, OSHA, etc.," added OIBC about further employee protections. The advocates thereby made explicit reference to federal laws enacted since 1970 intended to protect workers.

The House approved the legislation by a vote of 70 to 22 on March 13. The Senate, after amending the legislation, voted its approval by a vote of 28 to 17 on April 18. The House voted down the amended version by a vote of 42 to 50 on April 25, however. In the waning days of the legislative session, House members tried to revive the bill, but the effort failed.

Mike Seney, senior vice president, policy analysis and strategic planning, for the State Chamber of Oklahoma, cites legislators' two major objections to the bill: concern that the act would lead to a rise in premiums within the statutory system, and concerns about worker protections.

Some opponents, including the opposition group Oklahomaworks.org, also asserted that the reforms of 2011 had not had a chance to show their effect.

The state's AFL-CIO said that HB 2155 compromised worker protections, particularly by giving employers the power to determine which work injuries and illnesses were to be covered.

An insurers' association opposed the bill as well. As reported by the trade media, Joe Woods, the Austin, Texas-based vice president of state government relations for the Property Casualty Insurers Association of America, said that the bill would lessen worker benefits.

"I suspect that if this passes in Oklahoma, there will be businesses pushing it in lots of other states," he is quoted as saying.³

For the bill's advocates, the defeat was a sudden, difficult end to a year of planning, drafting and advocacy. Just days before the final vote, the legislation's most ardent supporter, the

³ <http://tinyurl.com/9sy6gyo>

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Oklahoma Injury Benefit Coalition, issued a press release celebrating Senate passage, referring to the bill as “a bold and proven approach to the chronic problems associated with the current [workers’ compensation] system.”

“The bill will provide the state a game-changing tool in its quest to create and retain jobs while protecting injured workers,” OIBC states in the premature press release.

Selected Provisions of the Proposed Law

Employers subject to the Oklahoma Workers’ Compensation Code would be able to elect to be exempt from the statutory system (and become “qualified” employers) only if they had a workers’ compensation experience modifier greater than 1.00. OIBC did not publicly explain the rationale for this provision, which would have left out the majority of employers, whose premiums are too low to be experience rated. The provision appears to be designed to prevent the statutory system from being depopulated by employers with low modification rates. The legislation would also require employers to have incurred at least \$50,000 in annual incurred claims in one of the preceding three years. This provision, which also would have excluded the majority of employers from the exemption, was removed near the end of the legislation session because the provision appeared to violate a state constitutional prohibition about creating special classes of entities. The bill retained an annual filing fee of \$1,500, which would have further discouraged small employers from exempting themselves. In Texas in comparison, any employer can exempt itself without a filing fee.

The Oklahoma proposal would also have required employers to file a notice of exemption annually with the Oklahoma Insurance Commissioner (along with the above-noted filing fee). The law would have required other state agencies that regulate employment, such as the Oklahoma Employment Security Commission, to cooperate to ensure that the Insurance Department had a complete list of employers in and out of the workers’ compensation system.

All employers electing to exempt themselves would have to adopt a written work-injury benefit plan to “provide for payment of medical, disability, permanent bodily impairment, death and dismemberment benefits as a result of an occupational injury.”

The bill would mandate a minimum level of medical, disability, permanent bodily impairment, death and dismemberment benefits, comparable to benefits in the Oklahoma workers’ compensation code. In some instances, the benefits would be more generous. For instance, qualified employers would be required to provide wage replace at a level of at least 80 percent of pay (taxable) from the first day of disability, for up to 156 weeks. The workers’ compensation code provides for 70 percent (untaxable) of pay, with a seven-day waiting period (covered retroactively on the 21st day of disability), for 156 weeks, which a court can extend by another 52 weeks.

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In designing its plan, however, employers would be provided wide latitude:

The benefit plan may specify conditions and limitations on benefits, including but not limited to additional criteria for covered and non-covered injuries and medical charges, and continuation, suspension and termination of benefits; provided, however, the benefit plan shall pay benefits without regard to whether the covered employee, the qualified employer or a third party caused the occupational injury. . . . None of the provisions of the Workers' Compensation Code shall define, restrict, expand or otherwise apply to a benefit plan. [Section 5 C]

A Permissible ERISA Strategy?

The drafters of HB 2155 pursued a creative strategy of mandating minimum benefits and insurance cover, while immunizing the qualified employers from state interference by shielding the benefit plan within an ERISA plan. This strategy attempted, in effect, to do what would appear to be impermissible by federal court decisions — that is, to have state law tell employers what to put into their ERISA plans.

The drafters wanted to present the qualified-employer status as a choice to be freely made. Employers could choose to opt-out on the condition that they adopt an ERISA plan with minimum benefits. Or they could remain in the statutory system.

Federal courts have ruled against state efforts to legislate mandatory benefits for ERISA plans. In an important 2007 case, *Retail Industry Leaders Association v. Fielde*, a federal appeals court said that “a state law has impermissible ‘connection with’ an ERISA plan if it directly regulates or effectively mandates some element of the structure or administration of employers’ ERISA plans. On the other hand, a state law that creates only indirect economic incentives that affect but do not bind the choices of employer or their ERISA plans is generally not preempted.”

The Oklahoma drafters wrote the bill to, in effect, meet this test.

The bill includes two significant references to ERISA. In the first passage, the authors wrote, “Qualified employer status is optional for eligible employers, and no benefit plan shall be considered to be maintained solely for the purpose of complying with the workers’ compensation laws of this state, provided that the benefit plan is otherwise subject to the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).”

The intent here was to protect the act from constitutional challenge. The employers are not merely and solely replacing the workers’ compensation system, which might make the ERISA plan vulnerable to a suit claiming that the plan is nothing more than a workers’ compensation substitute and therefore exempt from ERISA protection. The employers’ election of qualified status and an ERISA plan is 100 percent optional.

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And the employers are free to return to the statutory workers' compensation system. A memorandum on ERISA prepared for the bill's advocates by the Oklahoma City law firm of McAfee & Taft states, "If it turns out that it is not a good idea to provide benefits for on-the-job injuries through ERISA plans, Oklahoma employers can simply return to the workers' compensation system and/or amend or even terminate their ERISA plans."

Exclusive Remedy Retained

In the second significant passage, the bill expressly linked ERISA status of the plan with another important benefit for qualified employers: exclusive remedy protection:

"The benefit plan shall comply with and shall be subject to the employee benefit plan requirements of ERISA. Such compliance is required in order for a qualified employer to be protected by both ERISA and the exclusive remedy protection contained in subsection A of Section 6 of this act."

In Section 6, the exclusive remedy provision is described as such: "The exclusive remedy protections provided by this subsection shall be as broad as the exclusive remedy protections of Section 302 of Title 85 of the Oklahoma Statutes, and thus preclude a covered employee's claim against a qualified employer for negligence or other causes of action."

Exclusive remedy would only be pierced by an intentional tort, which the bill defined as of willful, deliberate, specific intent of qualified employers to cause injury.

The bill's advocates justified the extension of exclusive remedy by the minimum prescribed benefits being similar to those of the statutory system. One might call this a "play and gain" proposition.

The bill affirmed that all disputes over occupational injury benefits are to be resolved in accordance with the terms of the qualified employers' benefit plan and ERISA. All intentional tort or other employers' liability claims are to be resolved through the appropriate state or federal courts, mediation, arbitration, or any other form of alternative dispute resolution or settlement process available by law.

A Model for Other States?

The Oklahoma proposal attempted to create an opt-out program in which the ERISA plan and minimum benefits were required. Its approach would formalize some important elements in the purely voluntary ERISA plans used by Texas non-subscribers, while also attempting to preserve exclusive remedy, virtually untouched.

Critics of HB 2155 believe, however, that had the bill been passed by the House, Governor Mary Fallin would have vetoed it. And even if not and the bill became law, the state Supreme Court would have struck out the exclusive remedy provision, if not rule the entire act unconstitutional.

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Opponents would have argued before the court that the state constitution requires that persons have the right to their day in court. As the Oklahoma constitution states:

The courts of justice of the State shall be open to every person, and speedy and certain remedy afforded for every wrong and for every injury to person, property or reputation; and right shall be administered without sale, denial, delay or prejudice. [Oklahoma Constitution, Article 2, Section 6]

Still, for other states considering an opt-out program, this initiative deserves close study.

Table 2

This table compares selected portions of Oklahoma HB 2155 with provisions in the state's statutory workers' compensation system.

Benefit	HB 2155 (with sections cited)	Workers' compensation law
Time limit on filing from date of injury	Set by employer	30 days; two years to litigate.
Threshold of compensability	Set by employer	Work must be the major cause of injury (determined by state statute and Workers Compensation Court)
Temporary total disability	5 B: 80% of pay, max is 100% of (SAWW), for 156 weeks. No waiting period. Taxable.	70% of pay for 156 weeks (can be extended 52 weeks by court); seven-day (21-day retro).
Medical benefits	100% with no maximum. Medical necessity must be directly related to the occupational injury and confirmed by objective medical evidence.	100% of medical expenses
Choice of medical provider	100% employer choice	Employer choice, with qualifications

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Benefit	HB 2155 (with sections cited)	Workers' compensation law
Medical treatment guidelines	At employer discretion	Official Disability Guidelines
Vocational rehab	5 B 3: maximum 52 weeks	52 weeks (can be extended to 102 weeks)
Permanent partial disability	5 B 4: 80% of pay for five weeks per one impairment point, using 4th AMA edition of impairment guide	70% of pay, with a low maximum amount, and generally up to 520 weeks
Permanent total disability	5 B: 80% of pay until employee reaches age for 100% Social Security benefits or 15 years, whichever is longer	70% of pay until employee reaches age for 100% Social Security benefits or 15 years. Mandatory review every three years.
Disfigurement	5 B 4: maximum \$50,000	Maximum \$50,000
Security for the payment of benefits in the event of employer insolvency	5 H A: bond, letter of credit, excess insurance or insurance, as prescribed by Commissioner of Insurance	Must be insured or self insured with state's approval
Lump-sum settlements	5.C: must be voluntary by both parties and actuarially equivalent to expected future payments	Can settle all claims, with Workers Compensation Court's approval
ERISA plan	5 D.: The benefit plan shall comply with and shall be subject to the employee benefit plan requirements of ERISA. Such compliance is required in order for a qualified employer to be protected by both ERISA and the exclusive remedy protection contained in the act.	Not applicable

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Benefit	HB 2155 (with sections cited)	Workers' compensation law
Other benefits	<p>5 I: The ERISA benefit plan shall provide some level of benefits for sickness, injury or death not due to an occupational injury</p>	<p>Not applicable</p>
Exclusive remedy	<p>6 A: The exclusive remedy protections provided by this subsection shall be as broad as the exclusive remedy protections in the workers' compensation statute. and thus preclude a covered employee's claim against a qualified employer for negligence or other causes of action. (Exception: 6 B: intentional tort.)</p>	<p>Exclusive remedy applies</p>
Dispute resolution	<p>8 A: Covered employee and a qualified employer shall resolve:</p> <ol style="list-style-type: none"> 1. All occupational injury benefit disputes in accordance with the terms of the benefit plan and ERISA; and 2. All intentional tort or other employers' liability claims through the appropriate state or federal courts, mediation, arbitration, or any other form of alternative dispute resolution or settlement process available by law. Mandatory arbitration agreements permitted. 	<p>Workers Compensation Court</p>

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Chapter 9:



Non-Subscriber Insurance and Financial Risk-Transfer Issues

A mature insurance market for the non-subscriber workers' compensation market in Texas has developed over the past 20 years. A number of brokers cater to opt-out employers. They offer specifically designed coverage and services, and some operate specialized third-party claims administration operations. A number of the TPAs have specialized units designed to serve the non-subscriber market. Wholesale brokers also exist in the space. More than two dozen admitted and non-admitted carriers offer coverage. However, a significant number of large commercial insurers active in the statutory market do not participate in the non-subscriber market, or participate only to a limited degree. The major impediment to carriers offering coverage to non-subscribers is the lack of exclusive remedy provisions, which protect employers in the statutory program from negligence lawsuits by injured workers.

Brokers and carriers experienced with the non-subscriber market report that these employers must be far more involved in their work-injury program. Non-subscriber employers must implement significant changes to their policies and processes for occupational injuries in order to qualify for insurance coverage.

"It is easy to stay in the statutory market. With traditional workers' compensation, especially with guaranteed-cost coverage, the employer hands over the workers' compensation program to the insurer," says one broker source.

"Management must buy into the non-subscriber process and the administration of that process," explains another broker who specializes in non-subscription, particularly for small and midsize employers.

A broker who focuses on large employers that have opted-out adds, "To be successful, the non-subscriber must work with brokers and consultants who can coordinate the different service providers effectively, including claims, medical management, benefits, liability and legal management, and insurance coverage. This is not an option that can be easily cobbled together or implemented without substantial experience in the market."

Significant differences exist with insurance coverage in non-subscriber programs. In almost all cases, carriers will only write coverage for employers that can document and commit to three important changes. Employers must have an ERISA plan that specifies benefits for occupational injuries, separate mandatory arbitration provisions, as well as an effective safety and loss-prevention program aimed at mitigating negligence liability risk. These commitments affect insurance underwriting and coverage options.

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Another non-subscriber broker explains, "We have a checklist for employers that want to consider a non-subscriber program. If the employer will not agree to those requirements, then we will not be able to provide insurance coverage or agree to take them on as a client."

Overall, brokers report that the opt-out option probably works best for employers with 1,000 or more employees. For small employers, brokers offer a turn-key solution that requires small businesses to use qualified third-party claims administrators and agree to a series of other provisions requiring them to be more actively involved in claims management and loss prevention than they would in a statutory program. The turn-key solution includes an ERISA benefit plan and mandatory arbitration provisions.

Because of the lower level of benefits offered by non-subscriber employers and their typically much lower losses, premiums for non-subscribers are typically less than those for companies in statutory plans. With the dramatic drop in premium costs for statutory programs during the soft insurance market of the past eight years — current pricing for Texas workers' compensation is near historic lows—the difference in rates for statutory versus non-subscriber coverage has significantly narrowed. For many employers there is little reason to opt-out. If pricing in the statutory market begins to increase, employer interest in the non-subscriber market may increase, brokers speculate.

Demand for the opt-out option may not increase for some classes of employers. The lack of exclusive remedy protection from negligence lawsuits dissuades brokers and carriers from offering coverage to employers whose workforces consist of occupations with potential for high-severity, on-the-job injuries. In Texas, this means that fewer employers in the oil and gas, refinery, chemical, construction and heavy-industry manufacturing sectors choose to opt-out. Also, by law, state and municipal governments and organizations cannot opt-out. The state's public colleges and universities, for instance, must stay in the statutory system.

For employers that can and do opt-out in Texas, they do not need to disclose whether any insurance coverage is in place. Non-subscribing employers are supposed to file a notice with the Texas Department of Insurance and notify employees that the workplace isn't covered by the Texas workers' compensation system. Generally, brokers or claims administrators handle the filings for non-subscriber employers, including the notification of opt-out status and the reporting of claims to the department as required by law. There are penalties for not filing appropriate forms, and insurance coverage can be denied if proof of filing is not provided. But both the Texas Department of Insurance and insurance groups estimate a large percentage — probably as many as 90 percent of employers who have opted-out of the Texas system — have not filed the documentation required under state regulations. A very large percentage of employers that have not filed with state regulators are small, family-owned or single-employee operations, brokers report.

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With recently announced increased enforcement and imposition of penalties for non-filing, more non-subscribing employers may submit the proper documentation.

Policy and Coverage Options: Statutory Texas System

Regardless of state jurisdiction, most employers in a statutory system purchase two types of workers' compensation coverage. The first covers employers' statutory liabilities from on-the-job employee injuries as specified by a state's workers' compensation laws. The second covers liability that doesn't fall under the state's workers' compensation laws.

In Texas, employers may choose to remain in the state-regulated, statutory workers' compensation system and buy the traditional workers' compensation/employers' liability policy. Benefits, including wage replacement and medical treatment, are provided according to a specified state schedule of benefits. Traditional insurance coverage — including first-dollar, guaranteed-cost, and excess for self-insured retentions and self-insurance/self-administration — is available.

Underwriting a statutory risk involves three basic criteria — size of payroll, employee occupations and the employers' record of losses (per an experience modification rating).

Risk-Transfer Options: Non-subscription

Insurers, conservative by nature, are frequently reluctant to offer coverage to employers that opt-out of the traditional system. One very large carrier that writes statutory coverage but generally does not write non-subscription coverage states: "We believe that all employers should remain in the traditional workers' compensation system. Workers' compensation provides a more comprehensive coverage than any product for non-subscribers. Employers who do not purchase a workers' compensation policy lose certain tort defenses, which put a higher legal burden on them. Furthermore, employees appreciate the higher benefits that a workers' compensation policy provides."

Some employers may choose to opt-out of workers' compensation and not purchase any workers' compensation insurance coverage.

To cover work-injury benefits, some non-subscribers choose minimal, and inexpensive, coverage by purchasing a group accidental death and dismemberment policy (commonly called accident insurance) for its workers. This is not a workers' compensation policy. It typically pays both occupational and non-occupational benefits, which are generally restricted to lump-sum payments in the event of death or loss of a limb. These policies generally do not: cover medical treatment, provide wage replacement benefits or offer protection against tort actions.

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Non-subscribers may also purchase special insurance policies designed for the Texas opt-out market. This includes employers' excess indemnity insurance to cover negligence suits. In conjunction, non-subscribers can purchase occupational accident insurance to cover work-injury benefits delivered through an ERISA plan. The benefits are similar to those from a workers' compensation policy but may have specific safety and loss prevention requirements for employers to qualify for coverage. Both employers' excess indemnity insurance and occupational accident insurance policies are usually purchased together as a so-called combined employers' liability policy.

These non-subscriber policies may also include lump-sum accidental death and dismemberment benefits. Insurers also offer first-dollar coverage for non-subscriber policies for a limited number of non-hazardous occupations.

In general, no guaranteed-cost coverage is available. Most policies require retention of \$1,000 or more per claim. Coverage in excess of a self-insured retention (SIR) is also available in the market for non-subscriber policies with aggregate limits as high as \$25 million. Depending upon the employer, retentions of up to \$1 million per claim, combining both ERISA and negligence related losses and expenses, are offered.

"It's important that if an employer chooses non-subscription, they need to have skin in the game and have at least a \$1,000 per claim retention," says a broker who works with non-subscribers.

The portion of non-subscriber policies covering work-injury benefits are generally underwritten based on the same three factors as subscriber policies — payroll size, worker occupations and loss experience. It's not unusual for insurers to require specific safety and loss-prevention programs in the policies. Generally, premiums will be adjusted to reflect when ERISA plans eliminate certain benefits that are included in the statutory system. For example, most ERISA plans do not include permanent partial disability benefits. In effect, non-subscribers have custom work-injury benefit plans, and underwriting is adjusted to reflect those differences through discounts or credits to the premium. The most significant underwriting adjustment often occurs because of the substantially lower level of claims and losses experienced by non-subscribers. For most employers, too, there are few long-tail claims. Potential long-tail claims are typically settled. The result is that collateral requirements by insurers can also be lower, reducing a very significant cost for large employers, brokers report.

"In my more than 20 years in the non-subscriber market, I have never seen a long-tail claim comparable to what we have experienced in the statutory market. Where there might be a potential for a long-tail claim, we work out a negotiated settlement with the injured worker," says one source.

Employers with multistate locations need to purchase a separate policy for their Texas operations and include in that operation provisions for an ERISA benefit plan, mandatory arbitration, and more extensive safety and loss prevention. National employers typically use a third-party administrator with a staff experienced in the non-subscriber market.

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Chapter 10:



Claims and Medical Management Issues

Traditional workers' compensation claims management consists of investigation; compensability determination; benefit payments; legal defense in a claims dispute; coordination of the return-to-work program and process; and management of settlement, recoveries and other related tasks.

In the past few decades, as medical claims costs have escalated, much of the claims management process has focused on management of medical benefits. Almost every claims and medical management decision is governed, complicated and restrained by rules, regulations and precedent. It can be a very cumbersome process that consumes time and dollars.

The Texas non-subscriber system gives employers broad discretion to administer its employee work-injury benefit program. One obvious advantage is that the non-subscribing employer, in effect, has adopted a program designed expressly for its workplace.

An ERISA plan is both a schedule of benefits and a guide for claims administration, and the non-subscription experience in Texas shows that the combination of benefit design and administrative discretion effectively eliminates major problems that employers typically cite in managing workers' compensation claims. The differences in practices between non-subscription and the Texas statutory system are so sharp that adjusters for each system are recruited differently and come from differing backgrounds and training.

One example of many contrasts is that disability benefits can be extended much longer and, for severely impaired workers, for life in the statutory system. The typical ERISA benefit plan has medical and wage replacement benefits terminating after two years. Employers believe this time limitation reflects the normal course of recovery for the vast majority of injuries and serves to motivate workers to recover. This hard time cap not only influences the expectations and behaviors of injured workers but of claims personnel too.

Another major departure from statutory systems is the virtual absence of the claimant bar from the resolution of non-subscriber claims.

For this project, the Combined Group, JI Companies, Providence Risk & Insurance Services, and Sedgwick — all of whom have dedicated non-subscription claims departments — shared their observations of claims and medical management in non-subscription. We also interviewed medical managers and other claims specialists, such as claims consultancy Risk Navigation, who know the Texas non-subscription system and statutory systems nationwide.

What they told us is that managing work injuries in an opt-out environment requires not only special knowledge not found within traditional workers' compensation systems but also a

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special style of professional problem-solving. Texas employers, their advisors and their insurers have had years to cultivate these resources. An association of non-subscribers, the Texas Association of Responsible Nonsubscribers (TXANS), and PartnerSource, a broker and consultant, host conferences on non-subscription topics — one way to develop and share expertise.

A state that is contemplating a new opt-out system needs to consider how this infrastructure of expertise will arise.

Unique Staffing Requirements

Non-subscription claims and medical management involve the application of a privatized schedule of benefits and procedural guidelines for injured workers and employers. Employers are required, under ERISA standards, not to administer a plan arbitrarily or capriciously, but this gives employers extraordinary discretion.

The benefits, as one non-subscriber observed, may be “more Chevy than Cadillac.”

Written by employers (almost always with the advice of a broker, consultant, third-party administrator or insurer), guidelines are refined by building on the experience of other employers. They are clear and straightforward.

To service these non-subscription programs, claims organizations tend to create dedicated claims units and to engage medical management professionals with specialized knowledge of non-subscription. Kim Corcoran, vice president of operations at Sedgwick, reports, for example, that she prefers to employ claims adjusters who have neither a workers' compensation claims background nor a background in liability claims management. A typical workers' compensation background might have suppressed adjusters' initiative and placed their focus on legal compliance.

A liability claims background often encourages a more adversarial relationship between adjusters and claimants.

“Liability examiners do not mesh well in non-sub because they don't have the hand-holding skills needed for working with employees and with doctors often in a tense, charged environment,” she says.

Work on non-subscription claims, on the other hand, is a “fast-based job [with] lots of time management demands.”

“Adjusters must think on one's feet,” she says.

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Incident Investigation

Many non-subscribers, and perhaps the large majority of ERISA work-injury benefit plans, require injury reports within 24 hours of acute injuries with varying deadlines for occupational diseases and cumulative trauma cases. One TPA reports 98 percent compliance with acute injury reporting within 24 hours. Contrast that with its experience in the statutory Texas workers' compensation system, in which 75 percent of claims were reported within the first week post injury. The employer ERISA plan may also require employees to submit a separate incident report within 24 hours, to aid incident investigation. The plan can make the payment of benefits conditional on compliance with these requirements.

The claims department investigation of an injury report is designed to both determine compensability and gather the needed information to analyze potential exposure to a negligence liability suit.

Reducing Negligence Liability From the Beginning

Such liability exposure accompanies a non-subscription plan because of the absence of statutory exclusive remedy protections. (For a full discussion of negligence, see Chapter 6.)

A full investigation into potential exposure to a negligence liability suit sometimes even takes place for "incident only" claims, where there is neither a medical expense nor disability payment but simply the filing of an incident notice. Employees may later declare that such an incident precipitated a health condition, such as a mild brain injury. The non-subscriber claims adjuster might analyze an incident in much the same way employers might investigate an incident involving a third party, such as a customer or visiting supplier. The objective is to demonstrate that the employer was diligent in making the workplace safe, documenting hazards, training employees on safe work practices and ensuring a reasonable level of safety supervision of the employee prior to the incident.

Due to the exclusive remedy doctrine, workers' compensation claims adjusters lack strong incentive to investigate liability exposures that can be plausibly linked to an incident, such as defects in equipment, slippery walking surfaces, overlooked safety instruction and poor safety-related signage.

Compensability

ERISA plans often require as a condition of compensability that the injury arise "solely" from work. This is a very high threshold. It's much higher than thresholds cited in the Texas and other state statutory systems. Typically, these conventional thresholds require that work need only be the major contributing factor to the injury. Some states have an even lower threshold — an injury is compensable if it would not have occurred "but for" the employees' presence at work.

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Some ERISA plans do not use the term “solely” in their compensability threshold, but the message is typically the same; namely, that a covered injury is one that was incurred as a direct result of a job.

Claims adjusters can refer to a medical specialist to obtain a clinical opinion about the involvement of non-occupational conditions in an injury. In the statutory system, these opinions help weigh whether the non-occupational conditions were the major contributing factor. In the non-subscription system, the opinion need only determine whether they were a factor at all.

For example, say an employee was standing at a cash register awaiting customers. The employee has a seizure from pre-existing, diagnosed epilepsy. She falls to the floor and hits her head on the register. Under most ERISA plans, this claim would be fully denied because a contributing cause of the event was the epilepsy; the injury did not arise solely from the course and scope of employment. The location of the seizure, at the workplace, would be deemed incidental. It could have just as easily happened at home. A loss-prevention specialist's report on the employee's workstation might rule out the presence of a work hazard. But the denial would be driven by a medical expert's opinion that the worker's epilepsy contributed to the injury, regardless of work hazards.

Under the state's statutory system, however, the injury to the head might be covered because the employee hit her head on the register while falling. The claim would normally not cover the care of the epilepsy, unless the treating physician states that the pre-existing condition of epilepsy was aggravated or accelerated by the fall. In that case, the employer could become financially responsible for some epilepsy treatment.

Under the non-subscriber plan, the best course of action for the employee would be to have the injury covered by the company's group health policy. Typically, a denial of ERISA work-injury coverage would be enough to allow the incident to be covered by the non-occupational group health policy.

The high threshold for awarding ERISA benefits justifies a very thorough incident investigation, to document the proximate cause of injury through witness statements, the worker's recollection, the medical provider's initial report and inspection of the injury site.

Nothing, including ERISA, prevents non-subscribing employers from applying a standard of fault for determining eligibility for work-injury benefits. Companies could, for example, deny or qualify benefits if they decided on their own that an injury arose from an accident due to employee fault. Employers, however, adopt this approach at their peril. A denial of benefits based on fault might invite employees to sue for negligence. By state law, employers could defend themselves only by convincing a jury that employees were solely responsible for the injury. As case studies of employee negligence suits in Chapter 6 show, a jury can decide that employers are at fault even when the facts might appear to suggest that the proximate cause of the accident was employee behavior.

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Medical Utilization Management

Medical care, including decisions to treat, is far easier to control in a non-subscription context compared with the statutory system.

Just as a non-subscriber plan may state that benefits are required only if the injury is “solely” due to a workplace injury, it can strictly limit medical care to the work injury alone and not to pre-existing conditions. While this narrow reading of employers’ financial responsibility may by law be recognized in statutory systems, in practice a workers’ compensation court might decide and workers’ compensation claims adjusters are inclined to allow other underlying conditions to creep into the medical treatment plan.

Workers injured in non-subscription often have pre-existing medical conditions. Diana Craft, CEO of Providence Risk & Insurance Services, estimates that 60 percent of non-subscription claimants have diabetes, hypertension or other co-morbidity factors. Therefore, the potential of non-occupational conditions creeping into the care plan is high.

All the claims executives interviewed for this project testified to the fact that their staffs informally apply evidence-based treatment guidelines, in particular those published by the Official Disability Guidelines. Clinicians and managed-care professionals use these extensively documented directories of published medical research to assess what is appropriate medical care for a patient. However, plans can and do inject their own standards, which may go beyond or even conflict with recognized treatment guidelines. ERISA plans may refuse, for example, to cover chiropractic care, perceived as a traditional workers’ compensation cost-driver in Texas.

Or ERISA plans might more tightly control pain management treatments, some of which are controversial throughout the country and frequently associated with prolonged disability. One common practice among non-subscribers is to have claims adjusters use utilization review to cut off long-term use of opioid medications, which reflects research that suggests long-term use of opioids for musculoskeletal conditions offers no proven benefits and rather may be deleterious. In Michigan, claims involving long-term prescription of long-acting opioids are close to four times more likely than claims without any prescription to exceed \$100,000.¹

In the Texas statutory system, the prescribing of narcotics (until the state’s drug formulary was introduced in September 2011) has been relatively pervasive. The Workers Compensation Research Institute drew from statutory system claims data to uncover in 2011 that Texas physicians were most likely to prescribe narcotics to injured workers — and prescribe the highest dosages — among a sample of 17 states. Moreover, Texas injured workers were the most likely to receive narcotics on a long-term basis.²

1 White, Jeffrey Austin, Xuguang Tao, Milan Talreja, Tower, and Edward Bernacki, The Effect of Opioid use on Workers’ Compensation Claim Cost in the State of Michigan. *Journal of Occupational and Environmental Medicine* 2012 (54) 8: 948-953.

2 Workers Compensation Research Institute. Interstate Variations in Use of Narcotics. 2011. Table 4.10.

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Non-subscribers do not experience the cost inflation caused by physician-dispensed prescription drugs, an increasingly worrisome problem in workers' compensation nationally. Texas, among very few states, prohibits this practice by law. Were physician dispensing allowed in Texas, non-subscribers most likely would include a prohibition in their ERISA plans.

Medical Provider Networks

Claims executives have seen a radically new alignment of medical providers who treat non-subscriber injuries in Texas. Many sought-after specialists who refuse to treat workers' compensation cases are willing to treat non-subscriber cases. All claims executives we talked with stated that these specialists prefer non-subscription cases because of higher reimbursement (often at billed charges), less paperwork and a simpler appeals process. Providence and Sedgwick report that as much as half of specialist care for their non-subscription patients is performed by specialists who refuse cases in the statutory workers' compensation system.

The provider community for non-subscribers thus tends to be less inured to the high utilization culture of traditional workers' compensation treatment, which could be the ultimate reason why long-term opioid treatment and controversial spinal fusion surgery occur much less in non-subscription than in workers' compensation. The more forceful application of utilization review and peer review in non-subscription is certainly a contributor as well.

Similar to workers' compensation provider networks, though, non-subscriber provider networks tend to favor occupational medicine clinics for initial care. Concentra is the largest chain of occupational medicine clinics in Texas and has a perspective on the difference in medical care due its large work-injury treatment business. Douglas R. McAndrew, vice president of operations at Concentra, observes, "The biggest benefit for non-subscribers is the ability to direct care to a specific provider, define preauthorization requirements and control referrals."

Concentra, however, finds that non-subscribers on balance are slower to reimburse for care. They often "will send claims [Concentra's invoices] out to be [examined], which also adds to the delay in processing." The speed of treatment pre-authorization is dependent on specific employer policies; no standard timeframe exists for when an authorization request must be responded to. Concentra's experience extends throughout all of the approximately 100,000 non-subscribing employers in Texas, but it does not include specialist services such as orthopedics. Therefore, its experience can differ from that of specialists who have been wooed to participate. The point is that slow, complicated medical reimbursement practices, one of the chronic problems in workers' compensation, are not foreign to non-subscription.

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Control Over Care and Recovery

Injured workers may have few options for medical choices under a non-subscription ERISA plan. Costco's ERISA plan states that "medical treatment or rehabilitation . . . remains the sole prerogative and responsibility of the attending approved physician [selected by Costco] and other healthcare providers based on their independent judgment for the provision of healthcare."

The ERISA plan guideline may also provide the injured worker limited options to dispute the findings of the treating doctor. Costco's plan, for instance, allows employees to ask for a second medical opinion, but it caps the risk of "dueling doctors" by its right to retain a third physician whose opinion on diagnosis and treatment will be "controlling."

Costco's ERISA plan dictates that for medical benefits to continue, employees must "provide accurate information to, and follow the directions of, a treating approved physician. Following the directions . . . includes, but is not limited to, any recommended treatment, therapy, course of action, abstinence or rehabilitation program."

Medical benefits can cease when employees become "nonresponsive" to treatments. On the day that the approved treating physician determines that employees are no longer "disabled," and employers have offered a full or transitional job, indemnity benefits stop — regardless of whether workers have returned to regular or transitional duty.

The Costco plan further stipulates that injured employees are required to report to their supervisor "periodically as directed" until they are able to return to work. Mandated check-ins include informing the supervisor of expected recovery time after each appointment with the approved treating physician and immediate supervisor notification after the approved physician provides a release to return to full or transitional duty.

Resolution of Benefit Disputes

One of ERISA's singular attributes is that it prescribes a dispute resolution process that is non-litigious and almost always contained within the employer. As described in Chapter 7, ERISA prescribes a protocol for employers to receive a complaint over, for example, the amount of authorized physical therapy before a worker returns to work, including how to process the complaint through an internal appeals committee within a set timeframe. Workers can take their complaints a step further by appealing to federal court, which will primarily address the complaint by deciding if employers acted arbitrarily or capriciously with respect to their ERISA plan provisions. The judge cannot rewrite the provisions, can order a reversal of the appeal committee's decision without the power to award damages, and has the discretion to award attorney fees for workers' legal representation.

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Non-subscribing employers with an ERISA plan can virtually lock out the claimant bar from the dispute resolution process. Injured workers' attorneys have no right to appear before the internal appeals committee. Attorneys can represent the workers in federal court, but the odds of winning a case are poor.

Managing Liability Litigation

In the non-subscription system, injured employees have the right to sue their employers for negligence in contributing to injury. The statute of limitations in Texas for negligence suits (including non-subscriber cases) is generally two years.

Assigning defense of a negligence complaint can take several directions, but it usually follows an approach agreed upon by the employers and those managing their claims.

According to Sedgwick, its clients typically react to a negligence complaint in a handful of ways. Clients may keep their ERISA-plan claims adjuster in charge, assign the case to a liability specialist or turn the case over to a defense attorney.

Non-subscribing employers can elect to require employees to sign a mandatory arbitration agreement for complaints that would otherwise be litigated in civil court.

Whether or not they do, there is often first an attempt at mediation. In Texas, most state and federal court judges require mediation prior to trial. In arbitration, the arbitrator usually allows parties to decide whether they want to mediate before formal arbitration. Many parties agree to settle before formal arbitration begins.

(Chapter 6 addresses negligence liability in detail.)

Other Departures From Statutory System Claims Management

Independent medical examinations (IMEs) are frequently performed in conventional workers' compensation systems. In a statutory system, claims-payers often order IMEs when they disagree with a treating physician over diagnosis, causality, treatment plan, recovery prognosis or expected restrictions on return-to-work. States heavily regulate how IME reports are ordered and performed because either claims-payers or attorneys for injured workers can submit them as evidence in contested cases. The scope of IMEs can be considerably broader than peer reviews, which typically focus on diagnosis and treatment.

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In non-subscription, IMEs are used to a much lesser extent due to the absence of the contending force of the claimant bar. Still, Providence's Craft reports that her firm uses them, as well as peer reviews. For instance, if a worker was not recovering within normal recovery times, Providence might order a peer review or an IME to clarify the issues impeding recovery. This would be a fact-finding assignment, however, not one designed to build an argument before a judge.

Likewise, permanent impairment ratings, a staple of statutory systems, are rarely developed in non-subscription. These ratings are frequently done in statutory systems in response to the high volume of permanent disability awards, the vast majority of which are for partial disability. ERISA plans rarely include any reference to or benefits for permanent disability.

"Unless coverage of permanency is written in the ERISA plan, impairment ratings are not used or requested in non-subscriber claims," Craft says. "There are times that we might estimate a permanent partial disability to help position the file for an 'out-of-plan settlement.' "

Summary

Claims and medical management in non-subscription depart sharply from practices in Texas' statutory system and for that matter in other states' workers' compensation systems, not only in substance but also in style. Non-subscribers are free to define their own threshold of eligibility for benefits, and many set a very high bar that work must be the sole cause of, not just the major contributor to, injury. They are free to set their own rules for appropriate treatment. While claims staffs typically refer to widely accepted published treatment guidelines, employers in an opt-out work-injury program can disregard these guidelines. They are free to establish their own restricted networks of providers.

Non-subscribers, however, can be subject to employee suits contesting that employer safety negligence contributed to employee injury. This exposure can drive employers to more assiduously analyze and document the cause of injury. More non-subscriber policies and practices on minimizing this risk and responding to employee complaints about safety can be found in Chapter 6.

This combination of freedoms and exposures has led non-subscribers to develop a unique style of decision-making on claims, emphasizing initiative, critical thinking and close attention to steering a claim through a well-thought-out plan for recovery. This chosen style of claims management also attempts to minimize the risk of negligence suits. Thus, a separate opt-out claims culture has emerged in Texas, supported by advisors, professional associations and dedicated claims staffs.

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Chapter 11:



Worker/Employee Concerns

Workers' concerns about opt-out work-injury systems focus on the loss of statutory workers' compensation benefits protections. To address these issues, we look at the Texas non-subscriber system and the proposed Oklahoma system, the only current available examples where it is possible to benchmark worker protections.

The Texas experience comes in two strikingly different versions. In the "old" version, employers can decide not to provide any formal work-injury benefit plan. Typically, employers forgo liability insurance coverage and mandatory arbitration provisions in this case, exposing employers to the full force of lawsuits from employees when injuries occur. The "modern" version is centered on an ERISA plan, which can provide formal coverage, including medical treatment and wage replacement, to injured employees. A mandatory arbitration dispute resolution process is usually also included to address and manage negligence disputes.

How do workers fare in either of these versions? Since the early 1990s, Texas has not surveyed employees working for non-subscription companies, and no other published analysis of potential and actual employee problems does exist.

We have completed interviews with attorneys in Texas and Oklahoma and worker organizations — including the Texas AFL-CIO, the Austin-based Workers Defense Project and the Houston-based Interfaith Worker Justice Center — and they have identified several recurrent employee issues, which pertain in varying degrees to the old and the modern non-subscription systems.

In this discussion, we frame employee concerns as "Frequently Asked Questions," after which is a brief explanation of how the old and modern Texas opt-out systems address each. The questions are not meant to address every concern that workers might have about opt-out.

Question: Do I have a choice if my employer elects to opt-out?

Answer: In Texas and hypothetically in Oklahoma, the decision to opt-out is entirely the employer's. The discretion is the employer's under both the old and modern Texas system. Texas requires employers to notify their employees if they elect to opt-out, as well as if they change from non-subscription back to subscription and re-enter the workers' compensation system. But other than a requirement to file a notification form (DWC-5) with the Texas Department of Insurance, there is no filing fee or other requirement on employers at the time of electing non-subscription. Providing that employers file the required DWC-5, companies facing financial difficulties can in effect let their workers' compensation policy lapse without cost or fear of penalty for non-coverage.

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Most non-subscribing employers fail to notify the Department of Insurance — the department estimates that only about a tenth of non-subscribing employers file the needed form — and the department does not enforce authorized penalties of up to \$25,000 per day to induce compliance. This lack of enforcement suggests that many Texas employees may not be informed by their employers that use the opt-out system.

Question: I have an open workers' compensation claim. What happens to that claim if my employer elects to non-subscribe?

Answer: In both Texas and Oklahoma, any claims from the statutory workers' compensation program remaining open at the time of non-subscription election are not adversely affected.

Question: Will my non-subscribing employer pay for my medical treatment and wage replacement if I am injured on the job?

Answer: In Texas, opt-out employers may refuse to pay for medical care and wage replacement or may choose to create a comprehensive work-injury benefit plan. That plan may or may not be an ERISA plan. Typically, ERISA plans in Texas will cover 100 percent of medical care. However, many ERISA plans have a dollar cap on total benefits per claim, such as \$250,000.

In the Oklahoma proposal, opt-out employers would be required to set up an ERISA plan for work-injury benefits and pay for 100 percent of injury-related medical expenses. Similar to non-subscribing employers in Texas, those opting-out in Oklahoma control the decisions on what medical care will and won't be covered.

A special situation arises when non-subscribing employers with employee health plans deny medical benefits for treatment of conditions that they assert are unrelated to the work injury — but that the employee believes is work-related. For employers with a group medical plan, in most cases the group medical plan will cover the treatment if the injured worker has a statement in writing that the work-injury plan denied treatment. This is the case in Texas and presumably would be in Oklahoma as well.

If non-subscribing employers routinely shift work-injury medical care to any group, individual and spouse medical plan or a government program such as Medicaid that expressly does not cover work injuries, the employers may be committing insurance fraud.

Question: Can I choose my own doctor?

Answer: In most cases in non-subscription programs, employees cannot select their own medical providers. That is generally at the discretion of employers, who can disapprove any treatment by certain kinds of medical providers, such as chiropractors. ERISA plans in Texas can also disallow benefits if injured employees see unapproved providers, even at their own expense.

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It is unlikely that opt-out legislation drafters in any state would agree to limit the employer authority over provider selection because this authority is perceived to be one of the major factors that reduce claims costs and generally improve treatment.

Employers have not been successful in inducing state legislators to grant them choice of provider in the statutory system. Only in a few states (especially Connecticut, Florida, Georgia, Indiana and New Jersey, and under certain circumstances California and Texas) may employers direct treatment to specific providers under certain conditions throughout the course of care.

Question: If my employer sets a dollar cap on injury benefits, what happens when my medical bills exceed the cap? What if my duration of disability exceeds a time limit in my employer's work-injury benefit plan?

Answer: When an work-injury benefit plan contains an aggregate dollar cap for claims — for example, \$250,000 — there is a risk of exceeding it. In most cases, that risk is low if the cap is set high enough. Only about 6 percent of lost-time compensable work injuries in the United States incur medical expenses of \$100,000 or more.¹

An opt-out plan can also impose a cap on duration of wage replacement — for instance, two years. In the Texas statutory system, about 5 percent of lost-time compensable injuries incur disability durations of greater than two years.²

For claims that exceed a monetary or duration of disability cap, the employer can agree to make a special accommodation to the worker. If the employer is unwilling to waive the cap, Texas employees can escalate the issue by filing, or threatening to file, a suit for negligence against their employer, including a demand for payment of medical expenses. Texas non-subscribers sometimes pay the full cost of medical care in part to deter a lawsuit if the cap is exceeded.

Question: If I incur a permanent impairment from the injury, am I eligible for a permanent disability benefit?

Answer: Most modern opt-out plans contain no provision for permanent partial or total disability payments. Non-subscription ERISA plans typically place two-year limits on all post-injury wage replacement and/or disability benefits.

Nationally, most workers with permanent partial impairments are able to return to work at their pre-injury position or a similar job within the two years after injury, as reported by the Windham Group in Manchester, N.H., a managed-care firm that has advised insurers on more than 5,000 return-to-work placements. Sometimes, employers might have to modify the job or reassign tasks.

1 National Council on Compensation Insurance. Research Brief, Medical Services by Size of Claim. 2009. Table 1, page 2.

2 Texas Department of Insurance. Return-to-Work Outcomes for Texas Injured Employees, December 2011 Results. 2011. Page 4.

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The Americans with Disabilities Act effectively requires employers to make a good faith effort to accommodate the permanently impaired worker. If the employer fails to make a good faith effort to return the worker to employment, it may be exposed to a suit based on ADA requirements.

Question: Do my benefits end if my non-subscribing employer elects to terminate or change its work-injury benefit plans, even if I am disabled and receiving medical care?

Answer: Unless stated otherwise in the work-injury benefit plan, the benefits are terminated and the “tail” is not covered. ERISA imposes no requirement that plans ensure continued benefits after plan termination or change. When employers go bankrupt, the enforceability of commitments to pay long-tail liabilities can be challenged by other creditors.

Legislation drafters in any state ought to consider requiring non-subscription work-injury plans to include a commitment to pay for open claims upon plan termination and to arrange for their funding.

Question: If I fail to report my injury according to the directives of my employer, can I be denied benefits?

Answer: Yes, failure to follow reporting (and other) plan requirements allows employers to nullify benefits. This applies to Texas and to the Oklahoma proposal. Most ERISA work-injury plans in Texas require that employees report a claim within 24 hours of injury occurrence, with qualified exceptions for occupational diseases and cumulative trauma.

Question: Can my employer fire me for reporting an injury? Can the employer then not be sued or disciplined by the state?

Answer: In Texas, yes, employers can fire employees for reporting work injuries. Texas law does not prohibit retaliatory discrimination by non-subscribing employers against injured employees.³

Question: ERISA's dispute resolution process is stacked against me, is it not?

Answer: An ERISA plan always, per federal law, must include an appeal protocol, including an appeal committee consisting of other employees. Appeals tend to focus on denial of benefits. If not satisfied with the committee's decision, injured workers can file suit in a federal court, which can award benefits consistent with plan prescriptions if it finds the denial to have been arbitrary or capricious.

ERISA plans follow a well-tested dispute resolution process, one that employers may have broad experience with in group health, long-term disability and other employee fringe benefits. The “discretionary clause” in the ERISA plan can provide the employer wide latitude in interpreting the ERISA plan provisions. Employers often retain outside expert advisors to help interpret their plan, communicate their decisions to employees, and explain the reasoning behind denials of benefits.

³ *Texas Mexican Railway Co. v. Bouchet*, Supreme Court of Texas, 1998.

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Question: What if my employer cannot afford to pay for my medical care and wage replacements?

Answer: Texas does not require non-subscribing employers to ensure funding of work-injury benefits. The Oklahoma proposal would require employers to post bonds and carry insurance.

Question: Can I sue my employer for negligently contributing to my injury?

Answer: In Texas, yes, employees can sue their employers for negligence. Exclusive remedy does not protect non-subscribing employers, unlike in statutory workers' compensation systems. In addition, Texas law eliminates some traditional defenses for employers. There is no limit in Texas on the nature and size of damages and penalties that may result from these suits, except as may exist in a state for personal injury suits in general.

However, employers in an opt-out scenario have the right to demand as a condition of employment or of receiving work-injury benefits that employees agree to a mandatory arbitration provision covering negligence disputes. Employers select the firm that arranges for arbitration and can include arbitration guidelines that restrict the discretion of arbitrators.

The right to sue in non-subscription systems is meant not to just secure damages arising out of unsafe work conditions, but as a cudgel to induce employers to pay for injury-related medical expenses and wage replacement. Thus, the threat of suit is likely to be exercised much more than the act of suing.

Still, this right is meaningless without the credible threat of plaintiff attorney involvement, which is hardly guaranteed. Attorneys will not take on a case where little prospect exists that the employer can afford to pay a settlement or jury-directed award worth the attorney's efforts. Most non-subscribing employers in Texas are small and are estimated to have neither insurance nor sufficient net worth to fund a court judgment or pre-trial settlement. The state of Texas imposes no requirements that non-subscribers make any provisions for paying for work-injury benefits, through insurance, reserves, bonds or other mechanisms. Therefore, for many injured workers of non-subscribers, the right to sue is a hollow one.

Question: Can my employer force me to waive my rights to demand benefits?

Answer: Pre-injury waivers of the employee's right to sue for negligence are not permitted. Texas prohibited it in 2001. The state subsequently imposed some limited legal restrictions on post-injury waivers. But, as noted above, Texas employers do have the right to require employees to sign mandatory arbitration agreements.

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Chapter 12:



Recommendations

In this report we do not take a summary position regarding the merits of the workers' compensation opt-out concept for a particular employer or, from a public policy standpoint, for a state as a whole. Nor do we take a summary position regarding the actual or proposed design of opt-out systems in Texas and Oklahoma.

A Few Observations

There is an opportunity, using the "modern," privatized Texas opt-out experience, to reduce loss costs and greatly reduce employer concerns about fraud and abuse. The results from the employer point of view can be dramatic. In a matter of months, employers that elect such an option enjoy improvements that state legislatures debate for decades.

Injured workers, however, may receive fewer work-injury benefits under an opt-out option. Even if employees received benefits equal to (or greater than) what the statutory workers' compensation system provides, their discretion is very limited compared with the statutory system. The potential for liability damages from employer negligence may induce employers to be more diligent in safety. Workers are considerably more dependent on the goodwill and skills of their employers than if they were under the statutory system.

Negligence risk can be managed. Employers can ensure that workers receive fair benefits for actual injuries, use arbitration and act more assiduously toward workplace safety. If they offer other fringe benefits such as health insurance and short- and long-disability benefits, they help protect workers from being left out in the cold due to the narrowed work-injury benefit package.

One opt-out alternative, such as appeared in the Oklahoma proposal, is to employ ERISA to design the benefit plan.

An opt-out program without defined benefits isn't privatization. It is simply the elimination of workers' compensation.

The entire opt-out exposure to work-injury benefits and negligence risks is very insurable. A state that permits opt-out will not lack for expert advice and insurers from day one.

Clearly, it is questionable whether the opt-out alternative is appropriate for small employers. Any opt-out regime should set a minimum size for employers to be able to privatize, defined by the number of employees, payroll size or other criteria.

Overall, state oversight of an opt-out system can be lean and effective.

Any provision for an opt-out program must also include the ability to opt-in — that is, to remain in the existing statutory system.

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An Agenda for Change

Advocates of an opt-out option for their state should carefully design their strategy to sell the concept to others.

An opt-out concept is similar in key respects to other privatization proposals in the United States. Scholar Brian Glenn has summarized how advocates of privatization in the United States should achieve their goals, be it for workers' compensation or, say, for school choice:

First, establish the government as the guarantor of services, but not the direct provider. (The Oklahoma proposal would have done this.)

Second, divert demand into the private sector by offering recipients more rather than less, and choice rather than command. (The Oklahoma bill in 2012 had elements of this.)

Third, detach key elements of the doubters, possibly through side payments (or instead of payments, exemptions and incentives).

Fourth, create a "mirror coalition" that would fight for private provision to offset those who argue for public (such as the Oklahoma Injury Benefit Coalition).

Finally, move incrementally, in part to learn from early mistakes or to avoid making huge ones, and also to not frighten the population, which almost always finds any change worrisome. (The all-or-nothing flavor of opt-out legislation makes this hard to do.)

Further Research

Those stakeholders interested in exploring workers' compensation opt-out further may wish to access the following resources:

Employers interested in Texas non-subscription

Insurance brokers, third-party administrators and insurers that participate in the non-subscription market are prepared to advise and service employers.

Policymakers

Public policy researchers can draw upon the limited published research noted in the bibliography. Sources of analysis, pro and con, include the Texas Association of Responsible Nonsubscribers (TXANS), the Oklahoma Injury Benefit Coalition, Oklahomaworks.com and the Texas AFL-CIO. Co-author Peter Rousmaniere monitors developments in policy on his website, www.peterrousmaniere.com.

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