Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	To Chris Jennings from Carol Rasco re: Hubert Mayes (1 page)	05/18/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Carol Rasco (Meetings, Trips, Events)
OA/Box Number: 4592

FOLDER TITLE:
Hubert Mayes 5-19-93 4:30 pm

rw157

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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WORKERS COMPENSATION
AND
NATIONAL HEALTH CARE REFORM

Background

Workers Compensation medical is different:

- Costs are roughly split 80% doctor, 20% hospital
- Predominately trauma-related medicine
- Provides for full medical coverage -- no deductibles, no co-payments, and no maximum limitation
- 100% employer sponsored
- Does not reach health care and cost issues of the very young or the aged
- Outcome goal transcends wellness -- return to work

Each of these differences affect public policy choices or political choices or both.

WORKERS COMPENSATION
AND
NATIONAL HEALTH CARE REFORM

Recommendation

We believe that Workers Compensation medical needs reform. But to merge its financing and delivery into the national health care program would be a mistake. We believe that the best alternative from a public policy perspective would be to mandate that Workers Compensation service providers must triage occupational injuries using precertified Workers Compensation health care networks authorized and established within the framework of national health care reform.

WORKERS COMPENSATION
AND
NATIONAL HEALTH CARE REFORM

Rationale

Our systems of Workers Compensation contain a number of public policy objectives:

- Workplace Safety Incentives -- Allocates the cost of occupational injury to those industries and businesses that created them.

- Medical and Disability Management Integration -- Separate financing and delivery recognizes the important connection between medical case management and disability case management.

- Exclusive remedy -- Promises fixed benefits in exchange for tort immunity. It is essentially a no-fault system.

- Outcome focused -- return to work.

We believe that merging the financing and delivery of Workers Compensation medical into the National Health Care Program would threaten these Workers Compensation public policy objectives.

We believe the best alternative is to mandate that Workers Compensation service providers (insurers, State Funds, TPAs, and self-insurers) must triage occupational injuries using precertified Workers Compensation health care networks, authorized and established within the framework of national health care reform.

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TO: Rosalyn Kelly FAX NO.: 202-456-2878

ATTN: _____ DEPT.: _____

FROM: S. Hubert Mayes, Jr. PHONE: _____

RE: _____ NO. PAGES: 2
(Including Cover Page)

DATE: 5-18-93

NOTE: IF YOU DO NOT RECEIVE THE NUMBER OF PAGES LISTED ABOVE, PLEASE CONTACT THE SENDER AT (501) 376-2981.

REMARKS

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May 18, 1993

VIA FAX # 202-456-2878

Ms. Rosalyn Kelly
Office of Domesetic Policy
White House West Wing
Washington, D.C. 20500

Dear Rosalyn:

Here are the names and birth dates of the persons who will be meeting with Ms. Rasco at 4:30 on 5/19/93:

S. Hubert Mayes, Jr. - Little Rock, AR - DOB: P6/b(6)
Gary L. Countryman - Boston, MA - DOB: P6/b(6)
Rodger Lawson - Schaumburg, IL - DOB:
David Rolwing - Sandy Spring, MD - DOB: P6/b(6)

P6/b(6)

Waived

Thanks for your help. See you tomorrow.

Yours very truly,

S. Hubert Mayes, Jr.

SHMjr/bg

4679H

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May 14, 1993

VIA FEDERAL EXPRESS

Ms. Carol Rasco
Assistant to the President,
Domestic Policy
The White House - West Wing
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Carol:

Chris Jennings suggested I send this to you for distribution so it wouldn't get lost in the shuffle. Please give the original to Hillary and a copy to Chris. Thanks.

Yours very truly,

S. Hubert Mayes, Jr.

SHMjr/bg
Enclosures

4661H

S. HUBERT MAYES, JR.
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May 14, 1993

VIA FEDERAL EXPRESS

Ms. Hillary Rodham Clinton
The White House - West Wing
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mrs. Clinton:

Thank you for the opportunity to express the views of the Alliance of American Insurers about the integration of workers compensation and the medical portions of automobile insurance into the delivery mechanisms expected to emerge under the managed competition structure to be recommended by the Task Force on National Health Care Reform. The Alliance is a trade association which represents approximately 200 property/ casualty insurers including a number of the largest private insurers of workers compensation and two state workers compensation funds.

The Alliance agrees that the Task Force report should address the appropriate relationship between the provision of medical care under existing programs and the new mechanisms to be proposed by the Task Force. We believe a failure to address the appropriate relationship and to leave workers compensation and automobile medical totally outside these delivery systems would result in substantial cost shifting to the medical portions of these lines.

There are a number of ways that the relationship could be established. The Alliance believes that an optimal approach will draw on the strengths of both healthcare reform and the existing workers compensation system so as to maximize the

synergism between the two. The Western democracies that have both universal health care systems and workers compensation systems usually maintain the financial integrity of the two systems (and frequently that of the automobile reparations systems as well). The medical treatment of workers compensation injuries utilizes the health care delivery vehicles of the national health insurance programs, but the workers compensation systems retain in varying fashions and degree, involvement in the medical care treatment decisions. The relationship that has evolved reflects public policy decisions that injured worker benefits more fully approximate those that would be available from the liability system and that employers should bear the cost of workplace injury which costs are then reflected in the cost of products and services. At the same time, these designs likely reflect the political realities that existed when the systems were established, especially when the workers compensation system predated the establishment of the health system, since it is unlikely that workers' representatives would be willing to settle for scaled back benefits or to pay for a portion of benefits previously paid entirely by the employer.

The Alliance believes that this model adapted to our particular health care reform and our historical environment is the most appropriate way to bring the two programs together. It is our recommendation that the essential integrity of the workers compensation system be maintained, but that workers compensation medical treatment utilize the delivery systems contemplated by national health care reform. Because these delivery systems will be evolving over at least the coming decade, it is important that within broad parameters the relationship between the systems be allowed to evolve as well.

Workers compensation is essentially a system designed to compensate and manage disability resulting from work-related injuries and diseases. The most successful way to manage disability is to prevent the injuries and illnesses producing disabilities from ever happening. Disability itself is a complex set of interactions that result in loss of earning capacity. These include physical limitation, emotional health, socioeconomic status, economic conditions, etc. All of these must be addressed together. Medical treatment is only one component of disability. The goal of disability management is to minimize loss of earning capacity and to restore the injured worker to productive employment as soon as possible. If this goal is to be achieved, the ability to manage disability must continue. Under the present workers compensation system, the employer is financially at risk for the cost of medical

treatment and disability payments. This encourages the employer to minimize the total cost of these items by adopting strategies designed to achieve this end. Thus, providing a more intensive level of medical care may reduce disability payments, resulting in a net savings. When working as intended, both employee and employer benefit.

Placing the full responsibility for the cost of workers compensation on the employer, both encourages safety and prevents cross-subsidies among employers. As was explained to the insurance reform work group, insurance industry pricing places employers into different classifications depending on the hazards of the industry involved. In typical states, there is a 200 times, or more, difference in the rate between the least hazardous and most hazardous classes. For those employers large enough to be experience rated, there typically is nearly a threefold difference within a class between employers in the same business with the best and worst safety records.

The Alliance believes that we ought to bring the best aspects of the workers compensation and reformed health care systems together. Financing of both workers compensation medical and disability should remain with the workers compensation system, but medical care should be delivered through the mechanisms of health care reform. In order to maintain the ability to manage disability, the employer should be able to triage injured employees to those providers with appropriate occupational medicine experience either within the AHP or without the AHP, as needed. Over three-quarters of workers compensation medical cases involve medical only claims. Frequently, these are treated by in-plant first aid or sent to the nearest emergency medical center. Even under managed competition, this is unlikely to change. In most of these minor injury cases, injuries not treated by first aid or emergency care are likely to be treated by the primary care physicians of AHP selected by the injured employee for treatment of his other health needs. However, the Alliance believes that the reformed health system ought to allow employers and their insurers to triage those cases requiring special care to quality medical providers within the network, experienced in occupational medicine and who utilize appropriate treatment protocols if available, or to centers of excellence or other networks in situations in which this is advisable.

In the case of catastrophic injuries such as brain damage, serious burn cases or cases involving spinal cord injuries,

immediate referral may be required. In others, the need may be only for a more activist treatment protocol or referral to a specialist. A number of state workers compensation laws presently allow the employee to select the physician of his choice. Often injured employees do not exercise the choice because emergency care is involved or because they do not have a personal physician. Where it is exercised, the medical provider may be unfamiliar with the treatment of work related injuries and the employer's only tool for obtaining the cooperation of the medical provider is to withhold payment, which is counter productive to establishing rapport with both the injured employee and the medical provider. The Alliance believes our triage approach using the delivery systems of the health care system meets the needs of both employee and employer while bringing workers compensation medical within the ambit of the cost containment mechanisms of health care reform. The cost of this medical care would continue to be borne entirely by the employers. Casualty insurers would negotiate appropriate financial arrangements with AHPs and centers of excellence. The arrangement would depend on the particular plan and AHP involved the volume of work injuries in the geographic area, the nature of the services required, etc. In some cases, an all payor fee schedule might be needed.

The advantages of this approach are:

* The relationship between medical and disability management is maintained, as is the relationship between risk and responsibility.

* The full cost of workers compensation medical care remains with the employer and is incorporated into the cost of products and services.

* Safety incentives and protection against cross-industry subsidy continue.

* Injured employees retain the right to a broader medical care benefit care package than that available to the general population without having to create two classes of entitlement within the health care system.

* The employer retains a significant role in the medical decisionmaking process.

* Employee would have a greater role in the medical selection process than they presently do in many states.

* Small employers (those within the HIPC system) and large employers (those outside the HIPC system) would be treated equally in the case of work-related injuries.

* The states would retain control of both medical and disability aspects of workers compensation within a single agency.

* New bureaucracies would not be created and significant state public policy decisions would not be overturned.

* The approach would not have a significant negative impact on the interests of either business or labor, although both might want to change some of the details.

Obviously, there are other alternatives that the Task Force has considered. However, these tend to create more disruptions of existing systems, increase the complexity of the design decisions faced by the Task Force, overturn important state level policy decisions, and increase the level of potential opposition to health care reform.

For example, the health reform system could simply absorb workers compensation medical, pulling it out of the state program entirely. Employees would, for the first time, have to pay part of the cost of medical care for work-related injuries through their portion of premium or payroll tax, through payment of deductibles and coinsurance, and through premium payments or service payments for medical care not covered by the basic package. Lines also would have to be drawn between medical care and other services required to minimize disability. For example, is work hardening medical or vocational rehabilitation?

However, employers would not be winners either. State legislatures and courts are likely to react to this shift of cost to the employee by holding that the essential bargain of workers compensation exclusive remedy no longer exists because the worker is not sufficiently compensated. Therefore, tort suits against employers will again be allowed. Small employers would be particularly hard hit because many would not have the resources to properly insure against such liability. Also, the splitting of medical and disability is likely to lead to an increase in the cost of disability which may offset any employer savings from shifting medical costs to employees. Thus, workers would be concerned about such an approach, but employers, who appear to benefit, also have reason to be concerned.

The other approach which has been suggested is to shift workers compensation medical to the health care system, provide an enriched medical benefit package similar to workers compensation, require the employer to pay through the health system rather than workers compensation, the full cost of work-related medical care (including employers not presently subject to workers compensation) take away any employer say so in medical care decisions, eliminate any role for the employer or the state workers compensation agency in determining causal relationship, and create a duplicate bureaucracy to somehow experience rate costs among employers.

There is nothing in this approach that will generate support from the employer community, large or small.

This approach would:

* Increase employer cost

* Create incentives for declaring conditions work-related and eliminate any ability to object

* Cut the employer out of the decisionmaking process

* Requires a much more complex system

* Hurt small employers worse than large employers since large employers would continue to have a say so in the selection of AHPs.

* Require a HIPC bureaucracy essentially duplicative of the functions presently performed by insurers and rating organizations

* Require all sorts of complex decisions to be made by federal statute and regulatory agencies

* Increase the costs of the disability portion of workers compensation

* Undermine the state workers compensation system

The approach suggested by the Alliance does the least violence to existing systems and relationships, provides a fair balancing of employee and employer interests, and requires the fewest policy decisions. We therefore urge serious consideration be given to this approach.

We are less certain about the rationale and options being considered regarding the first and third party medical coverage portions of automobile insurance policies. The Alliance was advised there would be a specific work group meeting on this issue, and we requested and were advised we would have an opportunity to discuss the issue with the Task Force work group, but this never occurred. We continue to believe that the financing of automobile medical should remain in the automobile reparations system, although the medical care should be delivered through the reformed health system. Morever, the Alliance believes state law needs to be changed if double recovery is to be avoided.

Absorbing the cost of medical treatment for automobile injuries in the health care system involves two significant policy decisions. One is to shift most of the automobile medical care costs in liability states from a third party to a first party basis. Given our experience with automobile no-fault laws, it will be difficult to convince people to accept the notion that the wrong doer will no longer be paying for the cost of medical care. Second, employers will be upset when they learn that they will be paying a significant portion of bodily injury coverage previously paid for by the individual automobile owner. The Alliance continues to be willing to discuss these issues in more detail.

The Alliance supports your efforts to seek a positive relationship between workers compensation and automobile medical and proposed health care reform, but we do not believe that a carte blanche stripping of these medical delivery systems would help achieve the economic or health care goals we are all seeking. We appreciate the opportunity to explain the Alliance views on these subjects. If we can amplify any of our comments, furnish additional information, or meet with you or Task Force officials, please let us know.

Kindest personal regards to you and the President.

Yours very truly,

S. Hubert Mayes, Jr.

SHMjr/bg

cc: Ms. Carol Rasco
Assistant to the President,
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1600 Pennsylvania Avenue, N.W.
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(Via Federal Express)

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