IAIABC FOREWARD : *UNDERSTANDING THE OPT-OUT ALTERNATIVE*

For the past several years, state policymakers have been introduced to a new idea in workers' compensation, known as "opt-out," the "option," or an "employer alternative." "Opt out" gives employers a choice to purchase a traditional workers' compensation policy or to develop an employer benefit plan to cover occupational injuries and illnesses.

Workers' compensation coverage is compulsory for the vast majority of employers in all states except Texas. Therefore, the introduction of an alternative coverage system, in the form of employer designed benefit plans, represents a significant development for US workers' compensation systems. Implementation of these plans has the potential to impact thousands of employers and their employees. A desire to understand the consequences of opt-out on both employers and injured workers motivated the IAIABC to study the issue.

Employee benefit plans for occupational injuries and illnesses were first implemented in the early 1990s in Texas, as employers were voluntarily leaving the workers' compensation system (called "non-subscription") but desired coverage for their employees. Texas is unique in the nation; employers are not required to carry workers' compensation coverage but can be sued for negligence. The business model flourished and opt-out proponents cite significant cost savings, improvement in safety, and higher return to work for these Texas employers. Few independent research studies validate all of these claims.

In 2012, Oklahoma enacted a sweeping array of changes to its workers' compensation system, which included an unprecedented alternative option for compensation of work related injuries. Two significant differences distinguish Oklahoma, and proposals in South Carolina and Tennessee, from Texas non-subscription. First, employee benefit plans must provide equal to or better benefits than workers' compensation. Second, employers with an approved plan cannot be sued for negligence related to work injuries. The IAIABC believes these differences will materially influence the development of opt-out and thus chose to exclude Texas from this analysis.

Given the significant public policy implications, the IAIABC Board of Directors commissioned an analysis of the treatment of occupational injuries and illnesses under state workers' compensation systems and opt-out programs adopted in Oklahoma and proposed in South Carolina and Tennessee. The analysis seeks to inform important public policy questions of opt-out, including:

- What part of workers' compensation law is the employer renouncing by opting out?
- What are the conditions, or regulatory requirements, that the state places on opt-out employers?
- What regulatory monitoring and enforcement system should govern opt-out benefit plan compliance?

One of the key assertions for proponents of "opt-out" is that employer benefit plans offer benefits that are equal or better to workers' compensation. The analysis provides no clear answer to this question; in fact, its strongest conclusion is it really depends on the specific circumstances of the plan in question.

This lack of uniformity and consistency has drawn sharp criticism from the workers' compensation community because equity in benefits and the treatment of employees, irrespective of employer, is a core value in workers' compensation.

Wage Replacement Benefits

With respect to indemnity benefits, many of the plans studied mirrored the benefits offered by Oklahoma workers' compensation, some were even more generous. However there are some differences of note.

- In opt-out plans, very short term claims (four to seven days) can be more favorable for an injured worker. Most opt-out plans eliminate the waiting period, which is currently three days for Oklahoma workers' compensation.

- In opt-out plans, the longer or more severe claims are generally more unfavorable to an injured worker. This is because opt-out benefits appear to be subject to income tax.

	Oklahoma Workers' Compensation	**Oklahoma Opt-Out Plans**
Benefits	Statutorily defined; % of statewide average weekly wage (SAWW)	Minimum and maximum defined by employer; generally mirrors structure of work comp statute
Taxes	Tax free	Taxable
Waiting Period	Three days before benefits begin	Generally no waiting period
Settlements	Must be approved by an administrative law judge, with a clear understanding of future medical issues	Offered by claim administrator; can be offered within days of an open claim. Refusal of settlement can result in permanent claim closure (and possible dispute by the claimant)

Workers' compensation goes well beyond the payment of wage replacement benefits; it creates highly structured rights and responsibilities for employers and their employees. Workers' compensation emphasizes access to similar rights for medical treatment and due process for system stakeholders. Many states have rules about selection of medical provider, rules that govern medical treatment disputes, and access to an impartial dispute resolution process. Opt-out plans give employers much greater control and decision-making authority in all of these areas. For example, plan language often states that employers may deny a claim if an injured worker misses an appointment, fails to comply with medical treatment, or follow the claims process.

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Causation Threshold

Another area of consideration in evaluating the equality of the two systems is to compare the causation threshold for compensable claims.

	Oklahoma Workers' Compensation	Oklahoma Opt-Out Plans
Causation	Threshold is defined in statute, but is heavily influenced by case law.	Causation is defined by the employer and plans typically have a long list of excluded conditions. For example, many plans exclude conditions resulting from exposure to asbestos, silica, or mold.
Covered injuries/illnesses	Injuries/illnesses arising out of employment are very broadly construed by the courts, e.g. occurring while traveling on business, during work breaks, or degenerative conditions aggravated by work are generally covered; determinations are made according to well established precedent.	Injuries/illnesses occurring in parking lots, during work breaks, or degenerative conditions can be specifically excluded by the employer.

An area that has gotten significant attention is what are viewed as strict, and in many cases unreasonably short, accident reporting requirements in opt-out plans. Some plans require end of shift or 24-hour reporting requirements or the claim can be denied. There is much evidence that early reporting improves claim outcomes and is highly desirable in both workers' compensation and opt-out. However, the ability of workers to meet these reporting requirements is impractical or unrealistic for many types of injuries and circumstances.

Opt-out proponents argue these requirements enhance employee responsibility and improve outcomes. In addition, they say claims administrators have discretion in applying "good cause" exceptions. Short of systematic interviews with claim administrators, employers, and injured employees, there is no way to validate how stringently these requirements are carried out. The only obligation is that determinations be consistent with language in the written plan. If the plan gives the administrator sole and complete discretion to make claim determinations, this will place a heavy burden on any employee disputing a benefit denial.

Dispute Resolution

Another issue addressed in the analysis is significant differences in the dispute resolution process. Workers' compensation is intended as a self-executing system where fairness and impartiality are highly valued. The process and procedures for resolving disputes apply to all employers, employees, and other system stakeholders. Achieving fairness, impartiality, and equity may come with drawbacks; many criticize the dispute resolution system as complex and overly burdensome. The high cost of disputes was a primary driver in the 2012 Oklahoma reform efforts.

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	Oklahoma Workers' Compensation	Oklahoma Opt-Out Plans
Dispute resolution process	Dispute resolution process is defined by statute and administrative procedure.	First (possibly second) level of dispute resolution is defined by the employer; subject to general requirements of ERISA.
Hearings	Disputes are heard by an administrative law judge of the Oklahoma Workers' Compensation Commission.	After internal appeals are exhausted, disputes are heard by an administrative law judge in the Oklahoma Workers' Compensation Commission.
Determination	Determinations are made based on the facts of the case; parties can present evidence. In the case of medical disputes, the judge can order an opinion of a state selected expert.	Determinations are based solely on the claim and internal appeal records. Parties can not present new evidence, etc.

APPLICATION OF ERISA

In lieu of state regulatory oversight, opt-out plans are developed as employee benefit plans federally regulated by the Employee Retirement Income Social Security ACT (ERISA). ERISA does not mandate benefits but sets standards for the development and execution of plans to protect both employees and employers. This paper discusses the application of ERISA to opt-out plans in Oklahoma; an issue which has not been clearly defined by the US Department of Labor and federal courts.

The paper outlines the following three schools of thought on the application of ERISA in Oklahoma:

	Impact
ERISA does not apply	ERISA is referenced only once in the Oklahoma statute. If ERISA does not apply, there is no state or federal law governing the application of these employee benefit plans.
ERISA is concurrent with OK state law	Mandate of "equivalent" benefits can be enforced. If a qualified employer failed to comply with state pre-requisites for opting out, the qualified employer status would be withdrawn, putting them back into the traditional workers' compensation system.
ERISA pre-empts state law	Pre-emption would negate any state mandate requiring specific benefit provisions or security against default of payment by the employer. Employers would have complete discretion in developing plan requirements.

Proponents are convinced ERISA is concurrent with Oklahoma state law, other legal experts argue the connection to ERISA is an open question.

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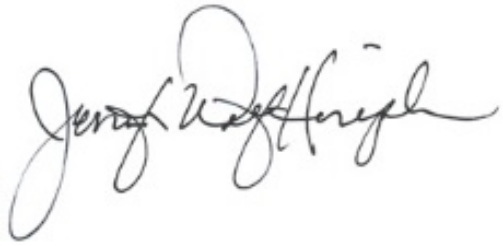
UNCERTAIN FUTURE

Approximately sixty employers have chosen to opt-out in Oklahoma. Many employers who have employee benefit plans in Texas have purchased traditional workers' compensation policies in Oklahoma, citing uncertainty in the face of court challenges.

A March ruling by the Oklahoma Workers' Compensation Commission ruled that two major sections of the opt-out law were unconstitutional, finding the law created two separate classes of workers, one under workers' compensation and one under opt-out plans. An April Oklahoma Supreme Court ruling upheld the Commission's authority to rule on matters of constitutionality. The outcomes of these, and other pending cases, is that opt-out in Oklahoma may need to be substantially modified.

It is likely the landscape for opt-out legislation will continue to evolve in the coming years. Determining whether it is evolution or destruction of the grand bargain is in the eye of the beholder. However, this analysis provides a framework and facts to guide the public policy debate.



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UNDERSTANDING THE OPT-OUT ALTERNATIVE

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ABOUT THE IAIABC

Founded in 1914, the International Association of Industrial Accident Boards and Commissions is a not-for-profit association representing most of the government agencies charged with the administration of workers' compensation systems throughout the United States, Canada, and other nations and territories, as well as other workers' compensation professionals in the private sector. Its mission is to advance the efficiency and effectiveness of workers' compensation systems throughout the world. It is governed by a Board of Directors made up of jurisdictional agency leaders, and maintains a staff headquarters in Madison, Wisconsin, USA. Learn more at www.iaiabc.org.

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TABLE OF CONTENTS

SECTION 1: INTRODUCTION 4
SECTION 2: COMPARISON OF LEGISLATION 8
SECTION 3: COMPARABILITY OF BENEFITS AND COVERAGE 16
SECTION 4: PROCESS IN DISPUTED CLAIMS 29
SECTION 5: COMPARISON: ERISA TO WORKERS' COMPENSATION 33
SECTION 6: REGULATION OF OPT-OUT EMPLOYERS 52
SECTION 7: OTHER ISSUES 58
SECTION 8: OVERALL CONCLUSIONS 66
REFERENCES 69

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SECTION 1: INTRODUCTION

Workers' compensation is 105 years old, the "grand dame" of US Social Insurance. The system of state regulation of workers' compensation has weathered some big changes during this span. But, the current drive to allow any employer to freely opt-out of the system is one of the most unusual policy developments to have shaken traditional workers' compensation.[1] Historically, an election to be in or out of the workers' compensation system was an option in the original statutes of several states. The number of opt-out states dwindled until Texas became the last to allow employers in general to "unsubscribe" from the workers' compensation system.[2] This embrace of universal coverage[3] seems to vindicate the merit of the so-called "grand bargain," which traded off the employee's right to sue their employer for negligence against the offsetting promise of prompt delivery of statutory benefits without any consideration of fault. For both employers and employees, the "grand bargain" was seen by most as a superior alternative to the tort remedy for job injuries.

Opt-out has many faces. It has a different look in every state in which it has been proposed (i.e., Oklahoma, Tennessee, and South Carolina; the proposal was passed into law in OK, effective 2014). Illustrations of the variations include the proposal in Tennessee allows tort actions against opt-out employers; Oklahoma establishes rules for an internal and external appeal process; and the proposal in South Carolina establishes the equivalency of benefits to workers' compensation in greater detail than the other states. Notwithstanding these differences, this paper identifies segments of the legislation that are identical in two or all three states.

The descriptions of opt-out contained here are based on the three recent manifestations of the concept drafted as statutes. To underscore the fluid nature of opt-out, the Oklahoma statute was substantially revised after its 2012 failure to pass and made into the current version. Substantial amendments were proposed for the Tennessee bill, and more amendments are likely if it is reintroduced in 2017. Amendments are rumored for the South Carolina bill. There are three high-level design questions that legislators ought to address in framing opt-out legislation.

[1] Peter Rousmaniere has compared "union carve-out" plans pioneered in Massachusetts with opt-out. While carve-out plans can share features of an opt-out plan, one critical difference between carve-out and opt-out is that the former are always negotiated plans between organized labor and the employer. Another difference is that the parties in Massachusetts and elsewhere could not negotiate away certain statutory benefits found in workers' compensation law.

[2] It should be noted that the Texas system is quite unlike the opt-out system in Oklahoma. In Texas, there are no benefit obligations placed on "non-subscribing" employers and also such employers face the possibility of tort suits from injured employees.[3] All state systems allow narrow classes of workers or businesses to opt-out of the workers' compensation system (corporate officers, some independent contractors), and for non-covered employers (independent contractors and farm businesses) to opt-into the system. Some states allow local governments to opt-out. Such situations cover only a small share of the workforce.

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All three state versions of opt-out come up with different answers to these questions:

- What part of workers' compensation law is the employer renouncing by opting out?
- What are the conditions, or regulatory requirements, that the state places on opt-out employers?
- What regulatory monitoring and enforcement system should govern opt-out benefit plan compliance?

Complicating conclusions about opt-out is the shifting nature of opt-out legislation. Some parts of the law have already been declared unconstitutional in Oklahoma (further Oklahoma Supreme Court involvement is likely). The Tennessee bill is a moving target: a large number of amendments were incorporated in March 2015; more amendments were rumored for early 2016, but instead, the bill was withdrawn by the sponsor. The proposed bill in South Carolina is still under consideration. Legislators might be awaiting resolution of legal issues in Oklahoma (discussed in Section 7) before moving opt-out legislation in other states. Naturally, the proponents of opt-out will modify their approach pending future court decisions. Finally, much of the actual or proposed laws are not tested in actual practice. The administration of opt-out in Oklahoma, including administrative rules, is still new. In the other states administrative rules would need to be written after the possible passage of an opt-out law, and these rules might change the nature and attraction of opt-out. The paradigm for opt-out legislation will change as courts and important lobbies react to recent controversies surrounding the performance of opt-out benefit plans in Oklahoma.

The novelty and promise of the “Oklahoma Option” touched off interest in opt-out in other states. What’s behind the enactment of the “Oklahoma Option?” The first version of Oklahoma opt-out (introduced in 2012) came at a time of extreme business angst over the high cost of workers' compensation.[4] Oklahoma had one of the highest workers' compensation insurance average rates in the nation, and there was employer disdain for the way the Workers' Compensation Court was handling disputed cases. The first bill in 2012 was clearly motivated by business interests trying to cost control. High on the list of things that many employers said needed fixing were compensable claims that were not truly related to work, protracted periods of temporary disability, high medical costs, and excessive and protracted litigation.

To address these employer complaints, the Oklahoma legislature enacted a number of benefit and process reforms within the traditional workers' compensation system. For example, the “excessively long” periods of disability were countered by lowering the cap on the number of days of temporary total disability (TTD) payment for a given injury. The conditions on compensability were substantially tightened with provisions such as: 1) requiring that work had to be shown as the “major cause” of an injury by the preponderance of evidence and 2) conditions for compensability of cumulative trauma injury, mental injury, and heart attack were

[4] Oklahoma had the 6th highest cost in the nation according to the *2012 Premium Rate Ranking Summary* produced by the State of Oregon. Critics of this ranking system contend that it can unfairly portray the relative position of a state, yet it stands as the single most influential metric for comparing state systems.

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tightened. In the same bill that created these major cost reductions in workers' compensation, the legislature instituted the Oklahoma Employee Injury Benefit Act (commonly called the Oklahoma Option). The package of reforms in Oklahoma's workers' compensation system has had a dramatic effect on lowering the losses financed by employers and their insurers. In September 2015, the National Council on Compensation Insurance (NCCI) filed a 14.8% drop in insurance loss costs (claims cost per $100 in payroll). The cumulative drop in loss costs form the three most recent years is an astonishing 37.2%.

As effective as the reforms were in reducing workers' compensation claims cost in Oklahoma, it seems that the opt-out movement is not blunted by lower insurance costs for traditional workers' compensation. Greater employer control of claims is an important consideration. As an indication that more than cost is involved, neither Tennessee nor South Carolina, where opt-out is being actively sought, has particularly high average insurance costs. Even though Tennessee has enjoyed loss cost reductions since its 2012 reforms, opt-out proponents found enough legislative support to make a serious go at passing opt-out immediately after these reforms became effective.

While proponents declare big cost savings, they also emphasize the benefit to employees from improvements in the claims management process. This is said to stem from better control of medical care, timely return to work, and prompt closure of claims. In the three opt-out frameworks considered in this paper, there is clearly great freedom in designing a benefit plan to define covered injuries, reporting and medical obligations, treatment options, and internal appeals to benefit decisions. We will leave it to readers to draw their own judgments on whether this flexibility is well used-- and of the same merit to workers and employers.

ORGANIZATION OF THE PAPER

Opt-out is a multivalent subject, with many different aspects to explore. The plan for this paper is as follows. In SECTION 2 we compare the different versions of opt-out in legislation introduced in Oklahoma, Tennessee, and South Carolina. The similarities and dissimilarities of the statutes are summarized; also omissions in the laws for issues routinely covered in workers' compensation law are listed.

SECTION 3 makes a comparison of benefits and coverage offered by the two systems implemented in Oklahoma. We address the major similarities and differences between workers compensation benefits and opt-out plans. As opt-out proponents claim, with considerable justification, the nominal benefits in opt-out plans are as good as or better than workers' compensation. But, this can be misleading. The conditions for receipt of benefits and the possible taxable nature of indemnity benefits are big disadvantages to some of those covered by opt-out plans. This section examines limitations and exclusions of workplace injuries covered. This is taken from a sample of benefit plans of qualified employers in Oklahoma. Also covered are the differences in the claims administration process, which can have a substantial effect on claims acceptance and costs.

SECTION 4 looks at the rights of plan participants in matters of disputed claims, again as in Oklahoma. In this respect, the details of the benefit plan define much of the process. The Employee Retirement Income Security Act (ERISA) (we see in Section 5 that the way in which

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ERISA applies is uncertain) adds some regulatory requirements, which are reviewed in this section. The Oklahoma statute overlays on benefit plans a detailed appeal process that seems to ignore the ERISA preemption. We compare the dispute process within an opt-out benefit plan with the requirements found in the traditional Oklahoma workers' compensation system.

SECTION 5 is a general discussion of the range of protections offered by ERISA to beneficiaries of employer plans covered by that law. It offers summary information about requirements for communication with beneficiaries, claim processing, and internal appeals. It does not cover regulations aimed at protecting plan assets and financial integrity, which are the biggest share of enforcement actions under ERISA.

SECTION 6 discusses the state regulatory process. It reviews the duty of the Oklahoma insurance commissioner to qualify employers into opt-out and monitor their compliance with the requirements for opt-out employers. The three states in this study also establish guaranty funds to step in if an insurer or self-insured employer defaults on benefits payable to employees of an opt-out employer. The different guaranty techniques will be reviewed, including limitations on the benefits covered. As we shall show, opt-out employers and their agents face fewer regulatory mandates compared to workers' compensation. Disentanglement from the “huge bureaucracy in the name of protecting workers’ rights” is one of the selling points for opt-out.

Finally, SECTION 7 comments on miscellaneous differences in opt-out versus traditional insurance: the potential impact on employers that remain in traditional insurance, the effect on workplace safety, HIPAA, the relative difficulty of measuring performance in opt-out programs, and potential constitutional challenges.

Recognizing that the above topics may have varying degrees of interest to the reader, we provide summaries at the end of each section that highlight key findings.

As the last introductory comment, this paper will not provide any conclusion about the desirability of opt-out, nor recommendations on a model opt-out law. Our interest here is only to provide objective information to highlight and discuss the major differences between the three state opt-out versions, and these against traditional workers' compensation.

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SECTION 2: COMPARISON OF LEGISLATION

This section compares three versions of systems to allow employers to opt-out of the state workers' compensation system—one enacted into law and two other legislative proposals. It is organized as follows. First, is a summary comparison of the enacted law in Oklahoma, and legislative proposals in South Carolina and Tennessee (the Tennessee bill was recently withdrawn), shown in Table 2.1. Second, is a summary discussion of these differences and similarities across states. Third, is a list of features common in workers' compensation laws but absent in the three state statutes reviewed here. One purpose of this statutory review is to illustrate the variations in proposed opt-out systems. Another is to show the novel provisions that are unlike workers' compensation (e.g., settlement procedure and dispute resolution).

Table 2.1. Important Provisions in Oklahoma Law Compared with Bills in South Carolina and Tennessee

	Oklahoma	**South Carolina**	**Tennessee***
Employers eligible	"Any employer" that can successfully pass the application process	Any employer >5 employees and some construction firms, provided they pass application process	Any employer, provided they pass application process
Review process	Oklahoma Insurance Commission has rules on review process; main review points are financial condition, insurance used, and prior claims cost.	South Carolina Insurance Commission has authority to review benefit plans for compliance, and to broadly control financial security for payment (deposits or excess insurance); related employers under the same application must have the same benefits and claims administrator.	Very similar to South Carolina; biggest difference is the aggregate $500,000 Self-Insured Retention per occurrence to trigger "safe harbor" for insured plans (retention limit dropped in March amendments)
Ongoing monitoring	Duty of Insurance Commission to monitor compliance with law; can require ongoing reports on total claims in past three years, and benefit plans to determine compliance	May require ongoing reports on plan design Security level may not be monitored regularly for changes in insurance, financial condition, or claims.	Same as South Carolina

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	Oklahoma	South Carolina	Tennessee*
Security requirement	Employer can insure or self-insure. Insurance Commission sets bond/letter of credit (LOC) for self-insured employers within guidelines.	Complex formula for gauging security by the degree of risk retention; great discretion for Director to waive or reduce requirements	Similar to South Carolina; exempts employers with <$25K loss retention from security requirement; great discretion for the Insurance Commissioner
Guaranty fund	Two segregated state funds administered by the Oklahoma P&C Guaranty Association: 1. Oklahoma Option Insured Guaranty Fund 2. Oklahoma Option Self-Insured Guaranty Fund Both funds subject to assessments by the Insurance Commissioner	The existing guaranty funds for P&C and Life & Health insurers will respond to defaults of insurers covering qualified employers. No provision for guaranty fund for self-funded employers.	One fund for self-insured and another for insured qualified employers: For insured plans: Life and Health Insurance Guaranty Association or the Tennessee Insurance Guaranty Association to respond to insolvencies depending on which insurance company is writing the coverage for the qualified employer.
Notifications to employees	Notification of employer's intention to opt-out and benefit plan description; Insurance Commission rules govern the notice.	Similar to Oklahoma Statute does not require plan must be given to all beneficiaries; however summary of plan required by ERISA.	Similar to Oklahoma Statute does not require plan must be given to all beneficiaries; however summary of plan required by ERISA.

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	Oklahoma	South Carolina	Tennessee*
Benefit mandates	Indemnity and medical must be at least comparable to workers' compensation in amounts, limits, and durations; methods for determining wage, death beneficiaries and disability same as workers' compensation. Considerable debate as to the degree to which the workers' compensation statutory benefits must be followed in benefit plans	Very specific enumeration of South Carolina benefits; covers many small details and requires that claims adjusters perform as they would in workers' compensation.	Medical benefits shall be at least 156 weeks with a $500,000 cap Temporary disability minimums like workers' compensation law; minimum death benefits; TPD, PPD, PT, and death and benefits added in March amendments (sometimes less than workers' compensation). The benefit plan may have a combined single limit for all benefits payable due to an occupational injury, up to $1M per employee.
Medical claims	Very broad freedom to control/manage delivery of medical care. Almost no mention of issues related to medical care or physicians.	No mention of limitations on handling of medical care	No mention of limitations on handling managing medical care
Settlements	Employer has broad discretion to quantify and pay lump sum equivalent to all future benefits ("actuarially equivalent"); a "fair" settlement can be involuntary, (i.e. the claimant must accept it or face denial of future benefits). Voluntary settlement agreements must contain disclosures to the worker, require medical evaluation, and be 10 or more days after report of injury	Very similar to Oklahoma	Very similar to Oklahoma
Internal appeal process	Appeal committee as defined in plan; Oklahoma statute sets requirements for review.	No mention	No mention

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	Oklahoma	South Carolina	Tennessee*
External appeal	Workers' Compensation Commission, after all internal appeals exhausted; statute sets standards for review.	No mention	No mention
Specification of covered accidents	"Occupational injury" means an injury, including death, or occupational illness, causing internal or external harm to the body, which arises out of and in the course of employment. However, see below on limitations and exclusions.	Definition of occupational injury is more expansive than Oklahoma; seems to broaden stress coverage caused by violent crime.	Definition of occupational injury is slightly more expansive than Oklahoma; seems to have a more liberal causation standard than workers' compensation law (2013 reforms)
Exclusions and conditions permitted	Broad discretion to limit covered events and limit benefits; not bound by workers' compensation law except where expressly required in statute.	Plan is free to limit coverage or make exclusions; not bound by what is customary in workers' compensation.	Goes a bit further than South Carolina in stressing that workers' compensation rules do not apply, except as provided in this bill.
Settlements	Allows plan to force lump-sum close out of claims based on actuarially fair present value of future obligations, as determined by the administrator. Allows "voluntary" settlements at any amount (subject to having at least one medical report, general disclosure, and a short waiting period).	Same as Oklahoma	Same as Oklahoma
Exclusive remedy	No tort remedy (except as noted below); declares benefits to be paid on a "no-fault" basis. For "intentional torts," damage payments are capped and offset by benefits paid by the plan.	Strong no-fault declaration; no mention of tort.	Tort against employer allowed; March amendments: per occurrence limit on economic damages in a tort claim is $1M per employee and a $5M cap on the sum of all damages recoverable in a tort claim (added in March amendments)

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	Oklahoma	South Carolina	Tennessee*
ERISA	No explicit mention of ERISA; §85A-210 (compliance with federal law) states: "A qualified employer or its insurers or other payment sources shall be responsible for compliance with any applicable federal law regarding the administration of the plan and claims for benefits under such plan."	Language was included to say that the plan was "not maintained solely to comply with the WC law"; this is for the purpose of justifying ERISA control. - Plan must comply with reporting and disclosure, fiduciary responsibility, claims administration, enforcement, and other applicable provisions of ERISA; benefits within the meaning of 29 U.S.C. Section 1191b(C)	Identical to South Carolina
Severability	Standard clause preserving parts of the law that were not deemed unconstitutional; provides for a grace period for insuring employers if opt-out is declared unconstitutional.	No mention	Like Oklahoma on partial invalidity; covers the obligations of employers if their status changes due to opt-out invalidity; adds alternative appeal procedure if primary procedure is declared unconstitutional.
Out of state employees	Not covered as part of qualified plan	Not covered in plans	Not covered in plans
Taxation of benefits	No mention	Declares benefits to be exempt from federal and state income tax	Like South Carolina; yet allows for "normal payroll deductions" for disability benefits, which seems to imply taxable
Medical records	No mention of medical records, though there is a broad record access specified within the workers' compensation title. The question arises as to whether the benefit plans are exempt from HIPAA (see Section 7).	No mention	No mention

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	Oklahoma	South Carolina	Tennessee*
Confidentiality	With minor exceptions, the information supplied by employers in connection with qualified employer status is confidential (see Sec 6).	Has a confidentiality protection for employer information	No mention

* March amendments refer to amendments made in March 2015.

SUMMARY OF SIMILARITIES AND DIFFERENCES IN LAW

The three state approaches share many common concepts and procedures; blocks of text are identical in two or all three laws. Broadly speaking they all allow a fairly easy application process, with few barriers to employer opt-out. The process of qualifying an employer to participate in the opt-out system is regulated by each state's insurance commission. In Section 6 we discuss the regulatory rules, procedures, and performance of the Oklahoma Insurance Department. Obviously, since the bills in South Carolina and Tennessee do not have the force of law, there are no rules and procedures for these states.

The laws share the following characteristics:

- They require benefit plans to specify that they will include payment for the basic workers' compensation benefit types, although the enumeration of specific benefits (e.g., temporary total disability, permanent partial disability, permanent total, death, and vocational) is much different across the three states.
- Apart from the benefit mandates, the laws contain very few specific interpretations and definitions of benefit delivery contained in workers' compensation statutes, rules, and case law.
- The covered injury events are similarly described in a general way similar to workers' compensation law, but all three allow employers to write into their plans conditions and rules on the acceptance of claims and what types of events are covered.
- The lump sum settlement procedure is identical in all three versions; all three seem to allow the plan to impose a lump-sum payment to close out a claim.
- All three make provisions for insured and self-insured benefit plans.
- All three establish guaranty funds to pay the claims of opt-out employers that default on benefit obligations (South Carolina does not have a guaranty fund for self-funded risk).
- ERISA regulations are explicitly cited in Tennessee and South Carolina and implicitly referred to in Oklahoma law.

As noted, many of the important features of the Tennessee and South Carolina bills are worded identically.

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Some of the greatest differences:

- South Carolina and Tennessee expressly require compliance will all ERISA requirements for the benefit plan; Oklahoma is more circumspect and says that the statute does not conflict with established federal law regarding benefit plans, but it does cite the ERISA section on courts for reviewing appeals.
- Only South Carolina and Tennessee declare that benefits are exempt from federal and state tax; Oklahoma is silent on this.
- Oklahoma alone specifies how internal plan reviews of appeals on benefit denial should be handled; it further declares that after the internal appeal, the outside appeal should be heard by the Oklahoma Workers' Compensation Commission.
- Tennessee expressly allows employee tort actions against the employer (though with caps on recovery); at the same time Tennessee declares that benefits must be paid on a no-fault basis.
- Oklahoma and South Carolina establish the confidentiality of most information filed with the Insurance Department in connection with approving or maintaining qualified employer status; Tennessee and South Carolina both require reports to the legislature on the effectiveness of the opt-out system.
- Formulae for establishing financial security for self-insurers vary considerably; but in all give commissioners broad discretion to wave or modify the formula amount.
- South Carolina does not have a guaranty fund for self-funded qualified employers.

Common features of workers' compensation statutes in many states are absent in the three approaches to opt-out discussed here (note that some of these are requirements of ERISA plans):

- responsibility of prime contractor for workers' compensation obligation of subcontractors
- time standards for promptness of payment of indemnity
- necessity of providing medical records to payer without release by patient, and scope of records that may be demanded
- reporting lapses/changes in insurance coverage to state compliance agent
- requirement to provide claim process information to claimant
- language assistance for non-English speakers
- prohibition of balance billing of non-covered medical treatment charges
- rules on employee choice of provider and referrals
- baring tort actions against fellow employees
- protection from discharge for filing a claim

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Of course, the benefit plans can address these areas as the plan owner deems appropriate.

In addition to the above, the whole corpus of case law governing the interpretations of compensability of events and the claims process are not binding to opt-out benefit plans.[5] Thus, plan administrators will be making their own standards (for their agents, and medical providers in their panel) on how to interpret the requirements of the plan in various situations (e.g., when a particular accident is covered, when an injury is due to a pre-existing condition, or when a medical treatment is necessary). As indicated in the introduction, this sweeping flexibility is probably a major attraction to opt-out, but critics regard this as unequal treatment across a state's workforce.[6]

[5] The proposed South Carolina statute contains a unique provision that adjusters should process claims as if they were under workers' compensation. Even with this there seems to be a considerable amount of discretion in interpreting the case law.

[6] Plans are substantially different. It seems likely that the claims administration will differ as well across employers. There are several lawsuits in Oklahoma and other states asserting unequal treatment under the law. But if you consider—as proponents do-- these occupational injury benefits as just another ERISA welfare plan, then why is inequality surprising. Benefits and administration are radically different across employers on ERISA retirement and health plans. For a review of equal protection constitutional challenges in workers' compensation see the excellent summary by Judge David Langham, WorkCompCentral, March 8, 2016, found at https://www.workcompcentral.com/columns/show/id/34fd7485eea691eeef6bc3b37cdd1f177e4002cf

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SECTION 3: COMPARABILITY OF BENEFITS AND COVERAGE

Prominent leaders in the opt-out movement often assert that benefits are at least as great if not greater than Oklahoma traditional workers' compensation. It is worth quoting the statute on this contentious issue:

> The benefit plan shall provide for payment of the same forms of benefits included in the Administrative Workers' Compensation Act for temporary total disability, temporary partial disability, permanent partial disability, vocational rehabilitation, permanent total disability, disfigurement, amputation or permanent total loss of use of a scheduled member, death and medical benefits as a result of an occupational injury… with dollar, percentage, and duration limits that are at least equal to or greater than the dollar, percentage, and duration limits contained in [relevant sections of Admin. Act]. (Sec 203(B))

Proponents and opponents read the law differently. It is not too much of a simplification to characterize proponents as taking a narrow view that it covers the formula for computing benefits like temporary total disability (TTD), permanent partial disability (PPD), etc. Opponents take a broader reading and say that equivalency must include the terms of coverage, including such things as reporting requirements or status of benefits upon termination of employment. How is a thoughtful, open minded person to react to these dissonant readings of the law?

Supporting data for either of these arguments is lacking. This section will focus in on comparative differences for types of benefits claimed, durations of disability, and wage of the injured worker. Complicating the comparison is a wide range of benefits defined in different plans. There is no easy generalization. We contend that a large share of injured workers would end up with about the same net of tax wage replacement in either system. Some workers will clearly be worse off in an opt-out benefit plan because their claim was denied or their net after tax indemnity was lower. However, some plans (relatively few) are considerably more generous in benefits than the typical plan. For example, the most generous plans pay 100% of the wage loss from the first day with no cap on the weekly benefit, which is very advantageous for workers with short durations of injury and/or high wages. Below we show that the correct answer to “which system has the better benefits?” is “it depends.”

MEDICAL BENEFITS

Employers face the same essential obligations in either opt-out or traditional workers' compensation: pay the full cost for all reasonable and necessary medical treatment necessary to cure and relieve the effects of the injury to the worker, with no co-payment or deductible.[7]

[7] “The employer shall promptly provide for an injured employee such medical, surgical or other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus as may be necessary after the injur.”(85 O.S. §14A1). The Oklahoma court has interpreted the statute as follows: The medical care required by law: “…is such as will reasonably and seasonably tend to relieve and cure the injured employee from the effects of the injury," and to rehabilitate the worker "in order that he may return to the ranks of productive labor with normal capacity when possible, and when impossible to restore normal capacity the to the highest degree attainable… together with temporary relief." *McMurtry Bros. v. Angelo*, 139 Okl. 236, 281 P. 964, 965 (1929).

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Opt-out proponents claim significant medical cost savings from their greater ability to manage medical care so as to provide the most effective and streamlined treatment. Of course, the truth of this depends on how skilled the plan owner and administrator are in managing medical care.

Medical costs in workers' compensation have been rising rapidly for the past 20 years, and studies have identified significant patterns of relatively high cost in some states for certain medical treatments. One example is the relatively high rate of low back surgery in Oklahoma. Without careful study it is impossible to know what causes the anomalous rate of surgery, but it would appear that Oklahoma surgeons have been allowed to expose workers to surgery in situations that would not be allowed in other states. Unnecessary opioid use is another frequently cited problem in Oklahoma and elsewhere. Some of the causes in this treatment variation are poor decisions by treating physicians, fee schedules that provide incentives for some treatments, and excessive numbers of second and third opinions about medical issues. “Dueling doctors” disagreeing about treatments or the degree of impairment delay decisions and increase cost.

To address these problems, traditional workers' compensation systems have deployed many tools to contain costs and improve the quality of medical delivery. Examples include managed care networks, treatment guidelines, and fee schedules. Opt-out proponents assert that they can go beyond the tools available in traditional workers' compensation. For example, many opt-out plans use the Official Disability Guides (ODG), also officially adopted for Oklahoma workers' compensation. But proponents claim that the plans use the guidelines more effectively. Similarly, plans can come up with their own drug and medical treatment payment schedules.

The equivalency of medical care for opt-out turns on many issues, chiefly the following:

- Do employers provide the full range of services and durations of treatment that would be generally recognized as prudent within the field of occupational medicine?

- Is the fee payment for panel doctors sufficient to attract high quality providers?

- Are injured workers satisfied with access to care and quality of delivery?

Quality of care depends on the skills of the claims adjuster and his/her medical advisors along with the skill of the party selecting and managing the provider network. Comparing a progressive Oklahoma Option employer with an average insured employer is not appropriate. A fair comparison would be how well the top rated self-insured employers or insurers deliver medical care versus the top rated Oklahoma Option employers. There is no practical way to answer these questions given the absence of good data to compare objectively the performance of workers' compensation with opt-out. Anecdotal evidence and selective statistics may be interesting but are not dispositive.

Plan designs use some rather narrow definitions and conditions for determining the necessity of treatment. They place strict requirements on injured workers to attend medical appointments and follow treatment plans, subject to denial of future benefits. This seems to be what opt-out proponents describe as “encouraging employee initiative.” A survey of plan language did not uncover many provisions which seemed to unreasonably eliminate treatment options for the sake of cost cutting. There were isolated limitations that would not be allowed in workers' compensation (e.g., setting fixed limits on home health visits and chiropractic care, and

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disallowing payment for a replacement of a prosthetic device). Clearly, at least some plans were designed to replicate workers' compensation coverage. For example, the AEI, Inc. (draft) benefit plan stated: “No provision of this Plan shall operate to exclude a benefit that would otherwise be payable under the Administrative Workers’ Compensation Act.”

Proponents of opt-out see a day and night difference between opt-out and workers' compensation. This sharp distinction is puzzling. Good occupational medicine can be enjoyed within the traditional workers' compensation system by contracting with a high performing Certified Workplace Medical Plan (CWMP)[8], as allowed by Oklahoma law. If the employer has contracted with a CWMP, the employer is entitled to choose the treating physician from physicians that are part of the network of the CWMP. The process for a worker to change his or her physician is to apply through the dispute resolution process set out in the CWMP. Some traditionally insured employers may forsake the careful use of CWMPs to improve the delivery of medical care, but the system seems to allow all employers (opt-out or traditionally insured) to take a hands on approach to managing care. Two CWMPs claim substantial reductions in medical cost, though we cannot verify the basis for such claims. Yet, like the rest of occupational medical care delivery in Oklahoma, evidence on what works well is shrouded by lack of objective evidence.

Even if we agree that option plan administrators are professionally skilled, we cannot escape the fact that they have an inherent conflict of interest in making judgments about the necessity of medical treatment. All else equal, the lower the treatment cost for the block of claims handled, the better the third party administrator’s (TPA’s) track record looks for marketing to other clients. This is also true in traditional workers' compensation, but in that system the claims decision maker can be challenged by a medical provider of the claimant’s choice and have the right to an appeal before an impartial judge. Thus, there is a difference in how the judgments of the plan administrator might be tempered by the dispute resolution process. As a generalization, the option plan administrators are ruled by the terms of the plan, while the workers' compensation adjuster minds adherence with the law as the standard for claims decisions.

INDEMNITY BENEFITS

TEMPORARY TOTAL DISABILITY (TTD)

Comparing benefits on TTD will necessarily cover the largest number of wage loss claims. For TTD, the replacement of lost wages varies by the length of disability. For example, assume three days of lost time at $100/day gross wage and $70 net after federal and state income tax. Oklahoma pays 70% of the average weekly wage (AWW), up to the state-wide average weekly wage (SAWW); there is a 3 day waiting period for disability benefits to begin on 4th day.

- For workers' compensation, the worker loses $210 after tax for the three days in the waiting period.
- For opt-out, the worker gets $49/day indemnity (70% of $100 less tax withholding). Total compensation for three days is $147.

[8] Such networks must be approved by the Oklahoma Health Department.

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The opt-out advantage goes down slightly with each successive day of disability because the gain from paying benefits without a waiting period gets washed out by the average compensation for the entire disability period. Because of the tax free nature of workers' compensation tends to provide a higher net wage replacement, but this depends on the duration of TTD and terms of the benefit plan. The income tax free nature of workers' compensation gives that system an inherent advantage over taxable benefit plans.

Out of the 51 plans reviewed,[9] all but the following exceptions tried to conform their plans to the Oklahoma workers' compensation benefit for TTD. The exceptions were that 10 of the 51 paid TTD at greater than 70% of lost wage (ranging from 85 to 100 percent) and of these 10 there was no limit on wage shown. As for the duration of TTD, 4 out of 51 paid for more than the workers' compensation limit of 104 weeks (120, 110, 126, and 110 weeks).

In order to show that comparing benefits in the two systems is very much a mixed bag the following table picks out just two of the many variables that affect the comparative benefits—for TTD of varying durations. The first two columns deal with the marginal income tax bracket of the claimant; the next two deal with the plan's percentage of wage replacement. The superiority or inferiority of opt-out benefits depends on many factors not shown here, so the qualitative color codes should only be regarded as approximate judgments.

[9] The plans that were available came from a request to the Oklahoma Insurance Department made before the law was changed to make the plans confidential. Thus, they were plans on file as of late 2014.

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Table 3.1. Illustrative Comparison of Relative Benefit Levels: Oklahoma Opt-out Versus Workers' Compensation

Days of lost time	20% tax rate; plan pays 70% of wage	30% tax rate; plan pays 70% of wage	30% tax rate plan pays 90% of wage up to SAWW	30% tax rate plan pays 90% of wage without cap; wage well over SAWW
3				
4				
7				
30				
100				

Note: this assumes opt-out TTD benefits are taxable; and that the plan pays TTD on first day of disability (which is typical).
Legend: the color codes show the likely relative ratio of opt-out over WC. Dark green=highly favorable; light green=moderately favorable; light yellow=moderately unfavorable; and dark yellow=highly unfavorable. Uncolored cell indicates the difference is too ambiguous to call.

We emphasize again that possible benefit outcomes are driven by many factors. The outcome is an interaction of many variables, including weekly wage, replacement rate, max weekly benefit, waiting periods, and tax treatment. Thus, a global better or worse description for individual claims is not meaningful.

PERMANENT INJURY

We could find no plan deviations from statutory benefit levels for permanent partial disability (PPD) and permanent total disability (PTD) benefits. Scheduled injury compensation is exactly at the statutory levels in all reviewed plans. The rating of the extent of permanent injury is based on the latest edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*. The biggest factor controlling PPD for non-scheduled injuries is the skill and orientation of the physician rater. The plan picks the doctor to do the rating, and controls the claimant's right to a second opinion on the rating. Though doctor selection is not a difference in the formula for PPD benefits, it is a significant deviation in practice from traditional workers' compensation. Most plans sampled paid PPD for the same maximum period and with the same

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weekly maximum as in traditional workers' compensation. These benefits do not appear to be taxable[10], so there would be no difference with workers' compensation based on this factor.

DEATH BENEFITS

This too was shown in plans exactly as dictated within the workers' compensation statute. Again, this benefit is not taxable and hence the same net benefit in both systems.

DISFIGUREMENT

Plans follow the brief statutory parameters. But unstated in the statute is how the benefit amount will be set for applicable injuries (i.e., how much is a three inch scar on the cheek worth?). The Dillard's plan says that "…the Claims Administrator may consider specific guidelines and measures for an award for disfigurement, such as a percentage of the body affected and part of the body affected."

BENEFITS CONDITIONED ON EMPLOYMENT

A potentially significant aspect of benefit comparison is that some plans may end or modify benefits when the employment relationship ends. This can include both voluntary and involuntary termination of employment. Thus, if you quit your job the with plan owner, you might forfeit any remaining TTD, PPD, or medical benefits. The termination or modification of benefits based on employment varies tremendously from plan to plan. One plan pays out remaining weeks of PPD in a lump sum upon voluntary termination of employment. Another plan continues medical care for a terminated employee under covered treatments (provided the claim was valid). The majority of plans appear to continue TTD (up to the 104 week limit) if the employee cannot return to work because of disability, even if the employment relationship has ended. It is misleading to say that benefits are strictly tied to employment with the plan owner.

What of work injuries or disease conditions unknown at the time employment ends? Insured opt-out plans appear to pay for covered occupational disease claims if the last exposure was with the insured employer and the claim was made as soon as the injury or disease was known. Recall that some plans have exclusions on the diseases that are covered (e.g., bacterial infections and dust related pulmonary conditions may be excluded). Because of the variability of plans and insuring agreements, the response to a late manifestation of occupational disease is may be different from case to case.

COVERAGE LIMITATIONS

Another issue that must be considered is the lower range of injuries covered by some opt-out plans versus traditional workers' compensation. Before making this comparison, it should be noted that Oklahoma workers' compensation law has a number of relatively stringent restrictions

[10] It is beyond the scope of this paper to confidently describe the tax status of Oklahoma Option indemnity benefits.

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on the compensability of claims. Most, though not all, benefit plans copy the statutory restrictions. For example, not allowing claims for repetitive motion if the claimant has not worked for the employer for at least 180 days is a typical restriction; 22 of 28 plans examined had this 180-day restriction.[11] There are other examples of compensability restrictions in the Oklahoma statute that appear in most benefit plans, including:[12]

- any injury occurring in a parking lot or other common area adjacent to an employer's place of business before the employee clocks in or otherwise begins work for the employer or after the employee clocks out or otherwise stops work for the employer;

- any injury occurring while an employee is on a work break, unless the injury occurs while the employee is on a work break inside the employer's facility and the work break is authorized by the employee's supervisor;

- any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure or other body part resulting from the natural results of aging, osteoarthritis, arthritis, or degenerative process; and

- injury where the accident was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician's orders.

The particular fact situation and a given state's case law will shape how judges interpret such limitations in workers' compensation. For example, if the employer owned the parking lot and made it available for employees use this would typically allow for compensability of a slip and fall even if the worker had 'clocked out.' But, no common body of precedent applies to opt-out.

Many plans contain identical language for some exclusions. The most common set of identical exclusions includes cumulative trauma with less than 180 days working at employer; employee working in violation of law[13]; exposure to asbestos, silica, or mold; and injury caused by alcohol or illegal drugs. Other exclusions that have identical language involve benefits, for example a cap on the number of chiropractic treatments or home health care visits, regardless of the case for "medical necessity." Following are other repeated exclusions:

- assault injury from member of the public at the workplace, unless defending the employer;

- bacterial infection except by cut; and

- injuries on break outside the designated break room.

[11] On March 4, 2016 the Oklahoma Supreme Court ruled this limitation to be an unconstitutional violation of equal protection of the law.

[12] Many states have language defining parking lot injuries, preexisting conditions, and alcohol/drug related injury exclusions; we would contend that the Oklahoma exclusions are somewhat more restrictive than seen in other states.

[13] This has been interpreted by some to include undocumented workers.

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Using Dillard's filed plan as an example, following is a sample of limitations or exclusions that appear to be relatively strict compared to many workers' compensation laws:

- any damage or harm arising out of the use of or caused by: A) asbestos, asbestos fibers or asbestos products; or (B) the hazardous properties of nuclear material or biological contaminants;
- an injury that arose out of a participant's participation in an off-duty recreational, social or athletic activity not constituting part of the participant's work-related duties except where these recreational activities are not covered unless expressly required (more than an invitation or request to participate or attend);
- an Injury that arose out of an act of God, unless the participant's employment by an employer exposes such participant to a greater risk of Injury from an act of God than ordinarily applies to the general public;
- injury that occurred while the participant was employed in violation of any law [interpreted by some to mean that undocumented immigrants are not covered];
- no coverage for any preexisting condition, except to the limited extent (if any) /that an approved physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a preexisting condition;
- no coverage for physician's diagnostic labels which imply generalized musculoskeletal aches and pains in the absence of any demonstrable primary pathophysiology, such as Fibrositis, Fibromyalgia, Myofascial Pain Syndrome, Myositis, or Chronic Fatigue Syndrome;
- hernia must be caused solely as the result of an accident in the course and scope of employment;
- injury from "a felony or an assault, except an assault committed in defense of an employer's business or property"; and
- only if a participant dies as the direct and sole result of an injury will the Plan pay Occupational Death Benefits.

There are a few exclusions that seem so out of place in these plans that they are almost comical:[14]

- flying in any aircraft that is rocket propelled;
- riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; and
- the participant's long-term cell phone use.

[14] These odd exclusions are probably due to generic language insistent on by an insurer or reinsurer.

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Some plans contain other rather peculiar and employer specific exclusions (e.g., pollen and mold exposure working for a nursery). We did not find explicit examples of the coverage being expanded beyond statutory workers' compensation, although many plans have a small non-occupational death benefit.[15]

Also, a claim can be denied if it is not timely reported (typically "end of shift or within 24 hours of injury) or the written accident report is not submitted timely. It is not clear how strictly this is interpreted by claims administrators. How often do adjusters accept extenuating circumstances (which the plans term "good cause")?

For the worker whose injury falls outside the plan coverage the above exclusions amount to a complete wage loss; some of these putatively work related injuries would be compensated in workers' compensation. These exclusions over and above worker's compensation would probably affect only a very small percentage of claims, but they might include some serious disability situations. To the extent the opt-out employer uses extra stringent exclusions, or interprets standard workers' compensation exclusions in a strict way, the opt-out employer may be offering less benefits paid than through the traditional system. However, there is virtually no objective data to measure the rate of claim denials and the basis of the denials.

On the other side of the spectrum, some plans are liberal on covered claims. AEI, Inc. (a drilling company) for example, treats occupational injury claims and non-occupational medical conditions for all employees through the same health benefit plan. They offer the usual health protections for occupational injuries (e.g., COBRA coverage and mental health benefits). As noted above, a few plans pay a much higher wage replacement than required by law. Employees with work injuries are fortunate to work for these employers. Workers' compensation, on the other hand, has much more uniformity across injured workers.

As discussed earlier, the claim of comparability of benefits is partly true for covered injuries of short duration, or for longer durations if wages are above average, because Option plans do not cap benefits at the SAWW. It is not true for most other types of claims, primarily because most plans examined in this study pay 70% of lost wages (as in workers' compensation) but the benefit is probably taxable.

[15] A $1,000 non-occupational death benefit has been added to the majority of plans, presumably to better support ERISA regulation of the plan. The gambit here is that this benefit shows the plan provides more than workers' compensation benefits.

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Thus, it is impossible to make broad, general statements about the comparability of opt-out benefit plans to workers' compensation applicable to all plans and all claimants. The following generalizations, however, seem safe:

- For perhaps the majority of plans, claimants with short durations of lost time (roughly 3-5 days) will receive higher indemnity payments than they would under workers' compensation (because there is generally no waiting period).

- For all plans, the average wage replacement ratio of benefit plan to workers' compensation shrinks with each day of disability (because the waiting period loss in workers' compensation is spread over more days).

- For roughly a quarter of the plans examined, claimants with wages substantially greater than the SAWW may be better off under opt-out regardless of the length of disability.

It is worth noting that the Oklahoma Workers' Compensation Commission did not judge benefits to be equivalent in opt-out plans overall. They concluded:

> Although at first blush it appears that the Opt-Out Act requires that injured workers under an authorized benefit plan must be afforded benefits equal to or better to those under the administrative Workers' Compensation Act, this is decidedly not so. A closer look at the statutorily authorized plan requirements reveals that the benefit plans permitted to be used to opt-out establish a dual system under which injured workers are not treated equally.[16]

As we have shown above that there is no simple generalization about the equivalency of benefits and coverage. The construction of the benefit plan coverage (exclusions, limitations, and conditions), level of wage replacement offered and the claimant's wages and duration of disability can all dramatically alter the relative benefits of the two compensation systems.

MAKING BENEFIT DECISIONS

We have previously discussed the written benefit plans in Oklahoma. By statute, the benefits are to be equivalent in the written plans. But the processes of receiving claim reports, investigating them, managing medical care, and determining the indemnity payable are in the control of the claims adjuster, and these steps control what benefits the injured worker receives. The same steps are the responsibility of the claims adjuster in the traditional workers' compensation system. We consider here the qualifications, direction, and control of adjusters in opt-out plans versus workers' compensation.

[16] Oklahoma Workers' Compensation Commission decision in *Vasquez v. Dillard's*, February 26, 2016. Much earlier, ProPublica/NPR analyzed benefit plans and concluded that 80 percent provided lower benefits than Oklahoma workers' compensation. See: Howard Berkes, "Opt-out Plans," October 15, 2015, found at: http://www.npr.org/2015/10/14/448544926/texas-oklahoma-permit-companies-to-dump-worker-compensation-plans

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To illustrate the degree of discretion given by the plan we could start with the definition of an accident. The Dillard's plan, and many others drafted by the same hand, defines it as follows:

> An "accident" means an event involving factors external to the employee that:
> (1) was unintended, unanticipated, unforeseen, unplanned and unexpected,
> (2) occurred at a specifically identifiable time and place,
> (3) occurred by chance or from unknown causes, and
> (4) was independent of sickness, mental incapacity, bodily infirmity or any other cause.

This is taken verbatim from the 2013 Oklahoma statute (s. 85A-2(9)) governing traditional workers' compensation. By comparison with other state laws, this definition is fairly restrictive (i.e., gives justification for ruling out an accident that would be covered in other states). However, for our purpose it shows that the nominal standard for accepting an accident as compensable is the same as workers' compensation in Oklahoma.[17] Other statutory language is echoed in benefit plans, but in some plans the definitions are unique to the particular plan. This again illustrates the latitude of plan owners to write plans that suit their preferences.

The benefit plans vary in length and detail, but the typical plan is more than 50 pages long and laden with specifics about coverages and requirements. Backing up the wording of the plan itself are the tools and guides adopted by the plan owners for use by the adjuster. These include such things as treatment guidelines, disability duration estimates, drug formularies, fee schedules, and guides for impairment and disfigurement rating. Many of these supporting tools are identical to those used in Oklahoma workers' compensation (AMA impairment guide and ODG treatment guide), but some may be quite different (fee schedule and drug formularies). While benefit plans may be difficult for the average worker to comprehend, it is also true that workers' compensation law and processes are also very difficult to understand. Both present communication challenges.

The qualifications of TPAs in opt-out plans would be much like TPAs used by self-insurers in the workers' compensation system. Commonly, TPAs that service the workers' compensation market are also involved in opt-out plan administration.

When a TPA handles an Oklahoma Option claim what guidance do they have, and how does this compare to their orientation and techniques in traditional workers' compensation? The first difference seems to be that the plan, not any prior knowledge of workers' compensation or statutory requirements is the basis for their actions. The plan controls.

For typical occupational injuries, the TPAs should be operating as they would in traditional workers' compensation. There is probably scant difference in the decision process for a timely reported and credible minor injury (e.g., small cut, minor bump to the head, or mild tendonitis). Any differences would begin to emerge on the more serious injuries, particularly with respect to the extent of treatment and timing of return to work. For these more complicated injuries, good occupational medicine can make a huge difference in the claim outcome. As a common example, a low back sprain or strain could be treated quite differently by the physician, and the return to work timing could be quite different between the two systems. A physician savvy to

[17] If Dillard's were operating under opt-out in another, more liberal, state, would it conform its definition to that state's statute? At present, Oklahoma is the only test of equality of treatment.

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occupational medicine treating a garden variety low back strain might rule out any diagnostic imaging (at least initially), suggest two days of sedentary activity before return to work on light duty, and prescribe only over the counter medicine for the pain. Other physicians might cause this claim to magnify by early use of opioids and enabling a lengthy time away from work. Populating a provider networks with good occupational medicine providers is to the benefit or both employers and injured workers. Proponents of opt-out say that they make more effective use of occupational medicine than workers' compensation, but there is no compelling reason in law that workers' compensation could not employ the same techniques to equal effect.

Finally, we close this discussion of decision making by claims administrators with a legal requirement often raised by Bill Minick the president of PartnerSource. He contends that under ERISA, claims administrators are plan fiduciaries, and as such they must act in the beneficiaries' best interests.[18] He adds that they are personally liable for breaches of their duty. Their fiduciary duty, he says, is strongly instilled in claims administrators he is familiar with. ERISA and plan language may recognize the fiduciary duty of the claims administrator, but is this a practical control or check on the conduct of the plan? How likely is it that a plan administrator would be disciplined by ERISA or a court for breaches of its duty? In this regard, it is worth noting the language in the Great American Security Insurance plan template:

> Except as otherwise provided under ERISA, neither the Employer, the directors, officers, partners, managers, or supervisors of the Employer, the Plan Administrator, the Claims Administrator or the Appeals Committee nor any person designated to carry out fiduciary responsibilities pursuant to this Plan shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.[19]

We cannot say how often bad faith claims are lodged against ERISA claims administrators for individual benefit denials. The defenses of the plan administrators, given the discretion claimed in the plan (shown in Section 4, Summary of Process Differences), seem formidable.

NOTICE REQUIREMENTS

Here we call special attention to an aspect of benefit plans that has drawn a good deal of negative comment. A very important difference between the two systems is in the timeliness of injury reporting. Insurers and TPAs in workers' compensation know well that timely reports of injury allow them to act immediately on a claim and manage the treatment and return to work.[20] On the other extreme, late-reported claims are often very problematic and associated with

[18] A PartnerSource information brochure references "the plan administrator's fiduciary obligation to administer the program in the best interests of employees." See "Frequently Asked Question on the Oklahoma Option," found at: http://www.partnersource.com/media/23221/faqonoklahomaoption14-1215.pdf
This same assertion of fiduciary obligation is given by Texas attorney Gary Thornton, "Texas Work Comp: Rising Above Critics," March 24, 2016, found at: http://insurancethoughtleadership.com/tag/gary-thornton/

[19] "Oklahoma Employee Injury Benefit Plan, Official Plan Document," copyrighted by Great American Security Insurance Company, January 15, 2015.

[20] PartnerSource lists good justifications for 24 hour reporting: 1. More immediate medical care, with, 2. An early determination of the extent of injury, leading to, 3. More effective medical management, and 4. Better medical outcomes… More immediate notice of injury also supports: 5. Timely investigation of the claim, prior to changes to the accident scene and with better availability of witnesses, 6. Drug and alcohol testing, with valid results that support important legal defenses, and 7. Correction of any unsafe condition that jeopardizes the safety of other workers. These are found at: http://www.partnersource.com/oklahoma-oklahoma-option-challenge-rejected-by-supreme-court/

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higher claims cost. Thus, the strict requirements in opt-out plans for verbal reporting by the end of a work shift and complete written accident reports within 24 hours may be welcomed by adjusters, but a source of concern to workers.[21]

The problem with immediate reporting is that a great many work injuries are not known recognized immediately after they occur. A common claim report goes something like this: "I was doing [some task in the job] at work when I felt a pop in my back. I didn't think much of it. I thought the minor ache would go away. But, the next day I could not get out of bed because of the pain." After some time—which could be days-- the worker cannot stand the pain so they see a doctor and are diagnosed with a work injury. Such a delayed medical confirmation of injury is common.[22]

Some plans require immediate injury reporting, no matter how minor; some even demand accident reports, even if there was no injury of any sort. In some work environments it would be completely impractical for employees to report any potential injury immediately, as some plans require.[23] On construction sites, workers bang, twist, and nick themselves routinely in the day with no disabling harm. On a construction site, it would be chaotic to have workers stop what they are doing to report to their supervisor an event that has a very small chance of requiring any medical attention. This reporting requirement is another example of unreasonably strict language that may need to be softened by allowances by the claims administrators. Plan consultants appear to be working with employers to come up with more reasonable plan language (e.g., job injury should be reported as soon as practically possible after a reasonable person should have known that an injury might have occurred on the job).

The above statements are not intended to dismiss the importance of early reporting and investigation of accidents. On the contrary, early reporting to the employer is extremely important to communicating expectations to the injury worker and managing early medical interventions. Early reporting of accidents and injuries has been demonstrably proven to improve claims outcomes.[24] The practical issue involved is how to impose prompt reporting rules that recognize legitimate delays. One plan seems to set a reasonable standard not terribly removed from traditional workers' compensation: "report an injury or illness to your supervisor within 48 hours of occurrence or awareness." The reporting standards in most plans seem harsh on their face, but may be administered with tolerance for extenuating circumstances. We simply cannot describe how systematic the practices are.

[21] The "immediate" reporting standard has been challenged by the US Department of Labor. The agency is suing a U.S. Steel-Delaware on the grounds that its "immediate reporting policy" is both undefined and discriminates against an employee for reporting a work-related fatality, injury or illness, arguably prohibited by 29 C.F.R. § 1904.36. See: http://compblog.com/wp-content/uploads/2016/03/DOL-v-US-Steel-Delaware.pdf

[22] According to the NCCI, only 20% of lost time claims are reported on the day of injury. See: NCCI Research Brief, "The Relationship Between Accident Report Lag and Claim Cost in Workers Compensation Insurance" (January 2015) (Exhibit 2). Surely defenders of immediate reporting would say that this statistic only shows that injured workers in workers' compensation lack the motivation and direction to report injuries timely, and that late reporting is a characteristic of injuries with a dubious connection to work.

[23] The *DOL v U.S. Steel Delaware* case (in earlier note) turns on just such an excusable late report of a head injury.

[24] See for example, Besen, Elyssa, Harrell, Mason III, Pransky, Glenn, "Lag Times in Reporting Injuries," *Journal of Occupational & Environmental Medicine*, January 2016, 58(1), pp 53–60.

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SECTION 4: PROCESS IN DISPUTED CLAIMS

This section discusses the duties of the opt-out employer and rights of employee in the event that a claim for benefits is denied. It seeks to show the balance of control—employer, claimant or neutral—when comparing the dispute process in Oklahoma's traditional workers' compensation system and opt-out. The dispute process is broadly defined to include dispute resolution steps, such as providing early information to claimants and alternative dispute resolution. In making this comparison, there will be gaps (empty cells) in Table 4.1 for the Oklahoma Option. This is because many of the steps in the process are undefined by law, and can only be discovered through individual plan language and internal procedures.

Since it comes up frequently in the context of alternative workers' compensation systems, the term "due process" deserves further discussion. It has been defined as:

> A fundamental, constitutional guarantee that all legal proceedings will be fair and that one will be given notice of the proceedings and an opportunity to be heard before the government acts to take away one's life, liberty, or property. Also, a constitutional guarantee that a law shall not be unreasonable, arbitrary or capricious. (Free Dictionary by Farlex, at: http://legal-dictionary.thefreedictionary.com/due+process+of+law)

Due process is one of the original constitutional issues that blocked the earliest workers' compensation laws. Some state courts found that the early attempts to institute workers' compensation deprived employers of their due process of law in defending themselves against the payment of statutory benefits without any showing of fault on the part of the employer. The present Oklahoma context potentially involves a far different due process complaint, namely, the right of the worker to have a due process remedy for an injury alleged to be from work. Constitutional due process issues are treated in Section 7. Here we restrict our attention to the legal proceedings to determine if a benefit denial was fair and according to defined procedure and rules.

"Fairness" of a hearing on a benefit denial has both subjective and objective elements. In one sense, fairness is subjective, a personal determination of the parties to the dispute. Public policy and courts define many objective requirements for fairness. One very commonly held standard of fairness is that the jurist/arbitrator should be impartial both in terms of conflicts of interest and conduct before the parties to the dispute. It is also widely held that compensation by, or financial interests with, one of the parties taints the impartiality of the decision maker. ERISA clearly recognizes these objective standards of fairness and impartiality. But, we have no way of knowing how opt-out beneficiaries would subjectively rate fairness of the dispute process.

The complexity, duration, and costs of the dispute process are a frequent source of complaint in many workers' compensation systems. However, a speedy, streamlined dispute resolution may conflict with fairness. From some litigants' point of view the due process under the workers' compensation system may seem horribly inefficient. They might complain that there are too many notifications, delays, evidentiary restrictions, dueling doctors, high court costs, high attorney costs, etc. The complex dispute resolution process of many workers' compensation systems can often lead to long delays, exactly what the expedited process in opt-out plans is obviously intended to avoid. The low frequency of appeals and the streamlined appeal process have been hailed by advocates as major advantages of opt-out. But the reasons for low

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litigation costs are not well understood by those outside of plan administration. The fairness of the internal review is still a matter of debate.[25]

One measure of the efficiency, though not necessarily the fairness, of the internal appeal process is the frequency with which they are appealed. As of this writing, Oklahoma Option plans have generated three appeal cases for the Oklahoma Workers' Compensation Commission. This seems to indicate that during this early experience with the opt-out plans, claimants do not often find it in their best interest to appeal the internal review decision to the Commission. This may be from a combination of factors, such as a low number of internal appeals, claimant unfamiliarity with the right to appeal, or the low chance of prevailing against the adverse benefit decision. The Commission can only reverse the benefit decision if the internal appeal record shows that the plan administrator or appeal committee acted outside the terms of the plan in an arbitrary fashion.

Table 4.1 below offers a summary description of the elements of due process in Oklahoma under the two systems for providing occupational injury benefits.

Table 4.1. Due Process and Communication Requirements

	Oklahoma Option	Workers' Compensation	Comments
Providing written information to parties to avoid unnecessary dispute	Under ERISA the benefit plan, at least in summary, must be given to every employee; plans must always describe, at least in general terms, the claim denial and appeal process.	"Guide to injured workers" distributed by the Workers' Compensation Commission. "Understanding the Claims Process" from the Counselor Division. The above are available in English and Spanish.	PartnerSource asserts that opt-out plans are very proactive in explaining the claims process, in writing and orally.

Summary of Process Differences

The dispute process under a given state's workers' compensation system is clearly more uniform across covered employers than under varying opt-out benefit plans. Injured workers throughout the state can expect the same process, and educational materials that explain the process are available. Educational brochures, like "Facts of Injured Workers,"[26] apply to every employee in the workers' compensation system. The workers' compensation system in

[25] Judge David Torrey (Pennsylvania) has pointed out that a significant body of administrative law literature exists on the specific issue of "what kind of hearing" is necessary in US legal systems to constitute due process. He recommends a classic law review article on this topic, Henry Friendly, "Some Kind of Hearing," Owen J. Roberts Memorial Lecture, at the University of Pennsylvania Law School, April 3, 1975, found at: http://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=5317&context=penn_law_review.

[26] See: https://www.ok.gov/wcc/documents/10_5_15%20Guide%20for%20Injured%20Workers%20%20FINAL.pdf

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Oklahoma appears to exert more effort to counsel and assist claimants with questions than is common in other states, and it would appear that this additional effort is designed to prevent disputes. For example, providing credible and understandable advice from the Oklahoma Workers' Compensation Counselors Division early in the process can forestall formal disputes. The mediation process offers an easily accessible opportunity for resolving some disputes outside of a formal appeal. If these informal processes are insufficient to resolve the issue, and a formal dispute is filed with the Workers' Compensation Commission, the hearing before a workers' compensation administrative law judge (ALJ) is, by design, free of conflict of interest and is conducted with a *de novo* hearing (the ALJ takes testimony from both sides and can order new medical evidence from an impartial provider). ALJs are allowed to hold pre-hearing conferences in which they can advise unrepresented workers on the process and try to facilitate settlement discussion. The problem in making comparisons is that we know quite a bit about the practices in Oklahoma workers' compensation, but very little about the specific practices in opt-out employer plans.

Opt-out plans have considerably more flexibility in designing and administering their claims process and dispute resolution. Using the Dillard's Oklahoma plan as an example:

> Every interpretation, choice, determination or other exercise by the Claims Administrator or Appeals Committee of any power or discretion given either expressly or by implication to it shall be given the maximum deference provided by law and shall be conclusive and binding upon all parties having or claiming to have an interest under the Plan (or otherwise directly or indirectly affected by such action) without restriction, however, on the right of the Claims Administrator or Appeals Committee to reconsider and redetermine such action. There shall be no *de novo* review by any arbitrator or court of any decision rendered by the Appeals Committee 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 AEI plan, written by a different consultant, claims:

> The Plan Administrator shall have sole, full and final discretionary authority to determine eligibility for benefits and to construe the terms of the Plan. This includes but is not limited to the full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents;[27] to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participants' rights; and to determine all questions of fact and law arising under the Plan.

These are breathtaking assertions of discretion for the claims administrator and the appeals committee, which would be unthinkable in any state workers' compensation system. However, such discretion is quite consistent with the way ERISA benefit plans are written and administered for non-workers' compensation benefits. The plan's description of discretion given

[27] We insert this note to point out that some courts have interpreted ambiguity or lack of clarity in favor of the plan beneficiary, on the principle of adhesion. As an example, attorney Michael Quiat cites *Cosey v. Prudential, 2013 WL 5977151, 4th Circuit (2013*). Here the Fourth Circuit found that ERISA plan language stating that benefits will be paid to a claimant who "…submit(s) proof of continuing disability satisfactory to Prudential…" was ambiguous and therefore failed to grant the necessary discretionary power to the administrator.

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to the plan administrator is the standard of discretion accepted by a court reviewing the decision on appeal.

ERISA lays out some process requirements (e.g., time to make a claim decision and time allowed for internal appeal of benefit denial). But ERISA gives the employer wide latitude to define a process and supporting administrative resources. In benefit plans reviewed for this study, the internal appeal process seems to be streamlined. It appears that many employers contract with specialty providers of review panels. If denials are rendered within the express intent of the plan and in harmony with internal guides and tools, the benefit denials are likely to be sustained by the internal review and in a court appeal. The dispute resolution process may be more efficient (speed and cost to employer), but the employer's control over the medical evidence through selection of providers and the selection and compensation of the appeal tribunal would seem to fall short of the common standards for fairness provided in state workers' compensation systems.[28]

The only practical check on the primary claims adjuster's handling of the claim would be the internal appeal process. Court review, after the internal appeal process is exhausted, is very limited in scope, basically to determine if the claim decision was not "arbitrary and capricious." The way opt-out is implemented by employers varies by employer and ultimate application is likely to take many different paths, and these variant paths may eventually be constrained by administrative regulations or the courts. For example, an employer plan can specify how intoxication at time of injury shall be determined or how "intentional injury" is to be shown. Such plan provisions likely vary among employers, and whether they are upheld, and if common aspects are determined to be lawful or not, will be determined after formal review. Finally, under ERISA, the plan owner has complete freedom to change the benefit plan details at will, with notice to plan beneficiaries as to the effective date of the changes.

[28] Critics of opt-out charge that the evidentiary record kept by the claims administrator may not be complete and unbiased. This is extremely hard to verify and generalize about.

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SECTION 5: COMPARISON: ERISA TO WORKERS' COMPENSATION

To date, the public policy debate over opt-out has centered on the equivalency of benefits under opt-out compared to traditional Oklahoma workers' compensation. But, the applicable mechanism to assure fair administration of benefits deserves attention. Here we address the question: "Does ERISA apply to opt-out plans?" This is a very complicated issue that will ultimately need definitive rulings by the US Department of Labor (US DOL) and the courts. Second, we provide a summary of ERISA protections juxtaposed to workers' compensation.

DOES ERISA GOVERN?

Experts wrangle over how ERISA may govern opt-out benefit plans. The schools of thought are:

1. ERISA does not govern the plans because they are exempt as workers' compensation plans;
2. ERISA governs concurrent with state mandates on the plans;
3. ERISA governs and pre-empts any state intrusion into the plans.

We discuss each in turn.

1. ERISA does not apply. One school of thought is that ERISA probably does not govern the Oklahoma Option plans. The rationale for this is that ERISA exempts workers' compensation laws and opt-out is simply an alternative form of workers' compensation. This theory is in the distinct minority. It was articulated publically by Daryl Davis (an insurance consultant who has become involved with Oklahoma Option employers) in March 2016:[29]

> In 2012, the Oklahoma legislature did not pass HB 2155—a bill co-authored by Minick and clearly drafted with the intent to have ERISA as a guiding force. In fact, HB 2155 was littered with the "ERISA" acronym, creating easy fodder for opponents, who used epithets such as "Obamacomp" to strike fear into a very Republican electorate. A year later, the attitude on the Oklahoma option had consolidated: no ERISA. SB 1062 passed with flying colors without one usage of the acronym for the federal law. That cake (SB 1062) baked by the legislature in 2013 was free of any ERISA ingredients…[30]

In December 2015 Davis wrote:

> Nevertheless, ERISA's applicability to the OKO [Oklahoma Option] has always been questioned by those in the know. After all, there was never any intent in the Oklahoma legislation to have ERISA govern the OKO, and the term "ERISA" never appears—not once!—in the language of the Oklahoma law. Even more importantly, two and a half years after passage, there is zero case law to support any assertion that ERISA applies.

[29] Daryl Davis, "Oklahoma Workers' Compensation Commission: Push Them on ERISA and They Will Push Back," WorkCompCentral, March 3, 2016, found at: https://www.workcompcentral.com/columns/show/id/9d396b45e32e8d14e828d3741a8acbd79714ee98

[30] This section refers to ERISA as follows: "The administrative law judge and Commission shall act as the court of competent jurisdiction under 29 U.S.C.A. Section 1132(e)(1)…"

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As far as we know, Davis is the lone public advocate for this position. Justifications for his position on ERISA seem to be founded on: 1) the statute and administrative rules never mention ERISA; 2) the exclusive remedy is extended to these plans; and 3) there are several plan mandates that would not be allowed if they were governed by ERISA. Other versions of opt-out do not conform to these arguments. For example, Tennessee allows tort actions by injured workers, thus eliminating the exclusive remedy. Both South Carolina and Tennessee explicitly mention that opt-out plans must conform to ERISA and other federal laws.

2. ERISA is concurrent. A second line of reasoning is that ERISA applies, but the state mandates on benefit plans are also valid. The AEI, Inc. plan, discussed earlier, illustrates this stance:

> This is a self-funded benefit plan within the purview of and governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is governed by Oklahoma law to the extent it is not pre-empted by federal law. The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Concurrent authority[31] is a seemingly novel theory that cuts against a body of federal court cases establishing pre-emption of state intrusion into benefit plans. But upon closer examination, there might be a basis for indirect state involvement in the plans. This theory holds that the state mandates are not on the plans themselves, but are preconditions for opting-out of the traditional workers' compensation system. If a qualified employer failed to comply with the state prerequisites for opting-out, the qualified employer status would be withdrawn.[32]

Two federal trial judges appear to have accepted this concurrent governance by remanding appeals of benefit denials to the Oklahoma Workers Compensation Commission, in accordance with the Oklahoma statute. This statute established, *inter alia*, that an internal appeal must conform to certain processes and that appeals, after completion of the internal review, must go to the Workers' Compensation Commission.

3. ERISA pre-emption. The third school of thought is that ERISA applies and preempts any involvement of the state in benefit plans. If this is the case, several parts of the Oklahoma statute would be invalid. The three biggest areas: 1) internal appeal provisions, 2) mandate to conform benefits to workers' compensation statute, and 3) guaranty fund and mandatory assessments for self-insured qualified employers. Arguably, even requiring reports may be pre-empted.[33] Similar preemption problems may apply to the mandates in the South Carolina and Tennessee bills. Apparently, policy makers in South Carolina and Tennessee contemplated some ERISA control by inserting in the formal plan: "… the plan is intended to conform to the requirements for an employee welfare plan under the Employee Retirement Income Security Act of 1974." But, they appeared to believe that the pre-conditions on the plans would be permitted.

[31] ERISA does allow some concurrent state regulation of insurers of ERISA plan benefits (such as health insurers), but state regulation of self-insured plans seems to be preempted.

[32] This sort of state involvement has gotten support from DOL, PWBA Office of Regulations and Interpretations, in advisory opinion 96-22a to officials in the State of California, November 25, 1992; of course DOL make take a different view today.

[33] In *Gobeille v. Liberty Mutual*, (No. 14-181, March 1, 2016) the Supreme Court held that ERISA pre-empts a Vermont law that requires certain entities with ERISA benefit plans from mandating reports of payments relating to health care claims and services to a state agency for compilation in an all-inclusive health care database. A major concern of the Court was inconsistent state mandates that increased the cost of benefit plans.

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Secretary Perez of the US Department of Labor (US DOL), in an interview with NPR on March 25, 2016, offered an unflattering assessment of opt-out: "What opt-out programs really are all about is enabling employers to reduce benefits…[opt-out plans] create really a pathway to poverty for people who get injured on the job." The US DOL has not publicly weighed in on the scope of its authority to regulate opt-out benefit plans without state conditions on the nature of the plans. Secretary Perez did indicate that a study of opt-out plans in Texas and Oklahoma was being conducted by the US DOL.[34]

ERISA law is exceedingly complex and has become a specialty law practice. The following is only a superficial overview of ERISA as it may apply to opt-out plans. It is beyond the scope of this paper to make legal judgments on how the ERISA authority over the Oklahoma Option, or other state opt-out plans, will be exercised.

What's at stake is how the plans will be regulated for benefit design, claims payment and appeals of benefit denials. If theory 1 holds (a longshot), ERISA has no role and the only regulation of the plans is what is stated in the Oklahoma statute for the Oklahoma Option plans. Thus, most of the benefit design and claims handling are a blank slate on which the plan can write its own rules, not prohibited by or inconsistent with Oklahoma law. If theory 2 holds, the ERISA regulations reviewed below would apply alongside the Oklahoma statutory mandates. The Tennessee and South Carolina bills are also counting on the compatibility and mutual application of state mandates and ERISA. If theory 3 holds, the ERISA regulations apply exclusively. In all three cases, the body of Oklahoma rules and case law interpreting workers'' compensation benefits and claims would not apply; for example, there is a considerable amount of case law defining such things as the necessity of treatment, the duty to provide prosthetics and attendant care, the payment for continuing medical maintenance, and many other nuances of the claims process.

[34] See C. Bronson, Insurance Business America, March 28, 2016 found at: http://www.ibamag.com/news/workers-comp/us-labor-secretary-slams-workers-comp-opt-out-plans-as-pathway-to-poverty-29940.aspx See also: ProPublica/NPR report on the DOL, March 26, 2015, announcement found at: http://www.npr.org/sections/thetwo-way/2016/03/25/471849458/labor-secretary-calls-workers-comp-opt-out-plans-a-pathway-to-poverty?utm_source=twitter.com&utm_campaign=npr&utm_medium=social&utm_term=nprnews

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ERISA PROTECTIONS

Knowledgeable proponents of the Oklahoma Option say that ERISA will amply protect the rights of those covered by the benefit plans of qualified employers. They claim:

- ERISA's primary function is to provide a well-established system of employee protections. ERISA does this by imposing disclosure, fiduciary and dispute resolution requirements on employers.
- "ERISA ...benefits must be administered in the best interests of employees."[35]
- ERISA has a formal claims procedure that requires a full and fair review.
- "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 and the dispute resolution process. This certainty enables employers to plan for the efficient deployment of an Option program."[36]

Given such claims, it is important to understand, at least in a very general way, how employee benefit plans governed by ERISA protect the rights of plan claimants by regulating plan administration pertaining to such things as procedures for adjudicating claims, communicating benefit decisions to the employee, and conducting full and fair appeals to benefit denials. For the purpose of studying opt-out, we compare a selection of ERISA protections to regulations in Oklahoma's traditional workers' compensation system. Of course, other states that may enact opt-out would present a different backdrop to compare with ERISA.

It is also important to consider the duties of benefit plan owners as they pertain to the day-to-day administration of the plan. For instance, how easy will it be for participating employees to know and understand the claim process? Over the years ERISA has added many requirements that make benefit processing more transparent and timely and the appeal process "fair" and has emphasized the fiduciary responsibility of plan administrators. This noted, ERISA allows much latitude for benefit plan design and how claims are adjudicated.

As originally conceived, ERISA protected primarily pension plan participants from: 1) improper use of plan assets or 2) breach of fiduciary responsibility. Pension, health and disability benefits are considered voluntary offerings by the employer and, hence, ERISA makes few attempts to regulate the eligibility, level, value, or duration of these benefits. Rather, the spirit of the law is to say: 'Deliver the benefits you promise with reasonable speed and transparency.' Since its inception in 1974, the US DOL rules for plan administration have been expanded, to include such things as guarantying beneficiaries' access to plan documents, processing claims timely, and giving a full written explanation of a benefit denial.

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[35] Statement by Bill Minick as quoted by Howard Berkes, "Federal Workplace Law Fails to Protect Employees Left Out of Workers' Comp," NPR, January 21, 2016, found at: http://www.npr.org/2016/01/21/460257932/federal-workplace-law-fails-to-protect-employees-left-out-of-workers-compensation

[36] This is an ARAWC summary of findings of the report by Peter Rousmaniere and Jack Roberts, "Workers' Compensation Opt-Out: Can Privatization Work?" New Street Group, 2012, found at ARATPA website: http://arawc.org/resources/

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A good example of the scope of plan discretion is the timing of claim notice to the plan administrator. While ERISA does not include specific rules governing the period of time for claimants to file claims, the US DOL's ERISA website says: "a plan's claim procedure nonetheless must be reasonable and not contain any provision, or be administered in any way, that unduly inhibits or hampers the initiation or processing of claims…." Yet, as noted in Section 3, some benefit plans filed with the Oklahoma Insurance Department require "end of shift" notification of a claim, which has been cited in lawsuits and media stories as unreasonably rigid given the delayed confirmation of some injuries. Another example is a plan requirement that allows claim denial if a full written report is not filed with the plan administrator within a short period of the injury.

Because it is crucial to the purpose of this paper, it is worth repeating that that ERISA generally preempts state laws regulating benefit plans that fall under the protection of ERISA. But the concurrent governance theory discussed above has plausibility. Given the novelty and importance of the opt-out concept, it seems inevitable that there will be relevant interpretations by the US DOL and federal courts.

Below are select protections of ERISA compared to traditional workers' compensation laws and regulations. Again, these are a selection of particularly relevant regulations to the claims process.

Table 5.1. Basic Protections Required by ERISA Disability Benefit Plans Contrasted with Workers' Compensation Law

Regulation Category	Summary of ERISA Regulatory Requirements*	Workers' compensation protections**
Plan Design and Rules	Plan design information must be provided to all participants; every participant must be given a Summary Plan Document (SPD) that tells participants what the plan provides and how it operates, including: 1) detailed explanations of what is covered under the plan and what is not; 2) directions on how to file a claim if the employee becomes disabled; and 3) an outline of the appeal process if a claim is denied. Other documents must be provided periodically or upon request.	In Oklahoma, Form CC-Form-1A Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees must be posted; contains many details about both employer duties and employee rights. (Available in English and Spanish). Other states generally require a similar posting of rights and procedures.
Employer changes in plan design	Complete discretion to modify or eliminate a plan; notice requirements to explain modifications to employees	No discretion to pay benefits below the statutory levels; an employer is not prohibited from paying more than the statute demands; formal changes to benefits would require legislative action
Equality of benefits^	Prohibitions against unfair discrimination among eligible beneficiaries	Benefits apply equally to all employees

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Regulation Category	Summary of ERISA Regulatory Requirements*	Workers' compensation protections**
Level of benefits^	Complete discretion by employer, unless subject of collective bargaining; however, the Affordable Care Act may apply to certain health benefits.	Benefit levels are defined in detail by statute and regulations; a huge body of case law has been developed to govern the application of the statute.
Benefit eligibility^	Complete employer discretion on conditions triggering benefits	Some explicit statutory exclusions (such as parking lot injuries or intoxication), amplified by case law
Filing a claim	The SPD or claims procedure booklet must include information on where to file, what to file, and whom to contact with questions about the plan.	In Oklahoma, the injured worker must file a claim for benefits with the Workers' Compensation Commission (WCC) on a prescribed form; must be filed within one year of the injury. Note that claim filing pertains to more formal WCC procedures; in practice most claims are processed directly by the claims adjuster without involvement of the WCC.
Timing of claim filing	ERISA does not contain any specific rules governing the period of time that must be given to claimants to file their claims. However, a plan's claim procedure nonetheless must be reasonable and not contain any provision, or be administered in any way, that unduly inhibits or hampers the initiation or processing of claims for benefits. Adoption of a period of time for filing claims that serves to unduly limit claimants' reasonable, good faith efforts to make claims for and obtain benefits under the plan would violate this requirement. See 29 CFR § 2560.503-1(b)(3).	In Oklahoma, notice of injury must be given by injured worker to employer; if notice is more than 30 days after the date of injury a rebuttable presumption of non-compensability is established. If a worker wants to reserve the right to dispute a claim denial, he/she must file a claim with the Commission within a year of the injury.
Timing of claim decision	Disability claims must be decided within a reasonable period of time, but not later than 45 days after the plan has received the claim (can be extended for cause). Health claims have generally shorter time requirements, depending on the degree of urgency.	In Oklahoma, the employer is required to file with the Commission a form declaring their acceptance or intention to contest a claim within 15 days after the report of injury to the employer. Some states have provisions that if not denied within a certain time after notice or payment, compensability of an injury is deemed established.

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Regulation Category	Summary of ERISA Regulatory Requirements*	Workers' compensation protections**
Adjudication process	The US DOL's ERISA rules anticipate that claimants who request this disclosure will be provided with what the plan actually used, in the case of the specific claim denial, to satisfy this requirement. The plan could, for example, provide the specific plan rules or guidelines governing the application of specific protocols, criteria, rate tables, fee schedules, etc., to claims like the claim at issue, or the specific checklist or cross-checking document that served to affirm that the plan rules or guidelines were appropriately applied to the claimant's claim.	Workers' compensation claims are almost always handled by trained professionals that are taught to follow well established procedures that are compliant with law or run the risk of a reversal after a hearing.
Consistency of decision making	The US DOL did not intend to mandate any particular process or safeguard to ensure and verify consistent decision making by plans. Rather, DOL intended "to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with the prudent administration of a plan." Consistency in the benefit claims determinations might be ensured by applying protocols, guidelines, criteria, etc. Consistent decision making might be ensured and verified by periodic examinations, reviews, or audits of benefit claims to determine whether the appropriate protocols, guidelines, criteria, rate tables, fee schedules, etc. were applied in the claims determination process.	We have no information on whether the Insurance Commission's Market Conduct examinations may look at the consistency of claims policy and its compliance with law. . Many states have enforcement programs for chronic non-compliance. State-hosted conferences provide continuing education to adjusters on application of state rules and regulations.

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Regulation Category	Summary of ERISA Regulatory Requirements*	Workers' compensation protections**
Payment of benefits	Benefits must be paid "within a reasonable time after a claim is approved."	In Oklahoma, the first installment of TTD is due on the 15th day after the employer has notice of the injury, unless employer files notice of controverted claim. In most states there is a standard for prompt payment, usually around 14 days of report of injury to the employer or insurer.
Benefit denial process	Notification requirements to employee with a detailed explanation of why your claim was denied and a description of the appeal process; 45 days is allowed to accept or deny a disability claim (extensions are permitted for cause such as the need for more information). Also, the plan must include the plan rules, guidelines, or exclusions (such as medical necessity or experimental treatment exclusions) used in the decision, or give instructions on how to obtain free copies. On request, the plan must identify any medical or vocational expert whose advice was obtained by the plan.	In Oklahoma, if a claim is controverted by employer, written notice must be given to the Commission. The statute sets forth a specific set of reasons for terminating TTD benefits.

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Regulation Category	Summary of ERISA Regulatory Requirements*	Workers' compensation protections**
Employee counseling/ assistance	Not required	In Oklahoma, the claimant is mailed a notice of available assistance from the WCC's "Counselor program," (if not represented by an attorney); workers' compensation state ombudsmen programs are relatively common.
Internal appeal^	Health and disability plans must have internal appeal that is "full and fair," with strict conditions on the process and on the selection of the review panel; minimum of 180 days must be allowed to file an appeal and administrator must give appealing party free access to documents used in the decision-making process. On appeal, the claim must be reviewed by someone new who looks at all of the information submitted and consults with qualified medical professionals if a medical judgment is involved. This reviewer cannot be a subordinate of the person who made the initial decision and must give no consideration to that decision. It is of the utmost importance to the employee making an appeal to get as much supportive information into the appeal record as possible. Any court review of an appeal denial will be based strictly on the appeal record.	Claimants can informally appeal to the claims adjuster. In Oklahoma a counselor or claimant's attorney might contact the claims handler to see if the issue can be voluntarily resolved. Mediation session can be required, though the parties are not compelled to settle the dispute.
Mediation	Permitted but not required	Oklahoma has established procedures for mediation; parties can be compelled to attend, but not required to settle the dispute; mediators must be certified and meet rigorous qualifications; there is a list of about 60 certified mediators.
Binding arbitration	There is nothing in the regulation that would preclude a plan from using binding arbitration or any other method of dispute resolution. See § 2560.503-1(c)(3). Also see 65 FR at 70253.	Oklahoma allows binding arbitration, under specific statutory requirements. Involuntary binding arbitration is seldom allowed in state workers' compensation programs.

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Regulation Category	Summary of ERISA Regulatory Requirements*	Workers' compensation protections**
Settlements	No specific requirements.	In Oklahoma, settlements must be approved by the Commission, an ALJ, or a Benefit Review Officer; settlement is rejected if patently unfair or based on a material misrepresentation or if no medical report is entered for permanent injury cases. State workers' compensation programs typically review benefit settlements, and apply a standard of review that protects the interest of the party giving up rights, typically the injured worker. Some states do not allow a "full release of rights."
Appeal to courts^	After exhausting all internal appeals, an employee may file a federal suit. Most courts usually give great deference to the plan administrator, and limit the scope of appeal to "abuse of discretion;" the judge's ability to review and overturn or reject the decision being challenged is limited to the process followed, not the underlying facts of the case. When reviewing ERISA benefits claims, the court is supposed to limit review to the administrative record of the claim and appeal; no new information can be entered.	In Oklahoma, the first external appeal is to the WCC which assigns an ALJ; the ALJ decision can be appealed to the Commission. The statue calls for a "trial de novo," but later says that "The Commission shall rely on the record established by the internal appeal process and use an objective standard of review that is not arbitrary or capricious." (s. 211(b)(6))
Pre-dispute arbitration agreements	Employers have wide discretion in establishing mandatory requirements to arbitrate certain disputes (with possible limitations by state law on arbitration).	In Oklahoma, employers are allowed to implement an Alternative Dispute Resolution (ADR) program, with appeal to the WCC.
Administrator qualifications	Sets minimum requirements on qualifications of plan administrator.	In Oklahoma, independent & staff claims adjusters, whether working for a third-party claims handling firm or on staff with an insurer or self-insured employer, are licensed by Insurance Department.

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Regulation Category	Summary of ERISA Regulatory Requirements*	Workers' compensation protections**
Participant attorney representation	Attorney fees are not recoverable at the internal appeal stage; on appeal, the court has discretion to award attorney fees for the employee's civil appeal if the Court decides that the plaintiff attorney has had "success on the merits" of the claim on behalf of the client. As a practical matter, attorneys would likely be reluctant to take on benefit appeals unless there was a clear case of abuse of discretion by the plan owner; attorneys are more likely to prosecute class action appeals rather than individual benefit denials.	In Oklahoma, attorney representation is allowed, but claimants can file applications for hearing without counsel. Fees are regulated.
Notice requirements to employees	Notice must be given to eligible employees of plan benefits and rules via the SPD.	Employers must post a workers' compensation statement of rights.

Notes to table:

* copied mainly from DOL website and from the Legal Information Institute, Cornel Law School, ERISA rule on claims processing, titled § 2560.503-1 Claims procedure, found at: https://www.law.cornell.edu/cfr/text/29/2560.503-1

** Where relevant the OK law that comes closest to matching the ERISA regulation is cited; the general practice in other states may be added for perspective on the OK law.

^ The ERISA requirements governing internal claims appeals and external review are found in 45 CFR § 147.136. Oklahoma law specifies plan mandates that are required for "qualified employer" benefit plans. As previously discussed the authority of the state to control an ERISA plan's internal review may be challenged in court, but state law affecting external review is permitted under some conditions. The authority of the Oklahoma statute to regulate claim appeals and will presumably be settled by rulings from the DOL or in federal courts.

It cannot be over emphasized that comparing ERISA with state workers' compensation systems is akin to comparing apples to oranges. ERISA was not conceived to perform the same regulatory functions that have traditionally been assigned to state workers' compensation agencies. Unlike workers' compensation, it was not enacted with the mandate to monitor and enforce compliance with very specific statutory benefit payments and administrative requirements. ERISA is unlike workers' compensation in its strong focus on the protection of plan assets and enforcement of fiduciary responsibilities of plan owners.

Additionally, there are many fundamental differences between the benefit review decision in an ERISA plan and the same benefit issues addressed in the traditional workers' compensation system. We elaborate next on major differences in the rights and duties of claimants to secure benefits and to appeal benefit denials. We caution that workers' compensation statutes and case law differ across states and court systems. Thus, one must be careful about applying the general norms discussed below.

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UNDERSTANDING THE CLAIM PROCESS

As a general principle, before workers can exercise their rights they must know what they are. Communicating rights is a challenge for both ERISA benefit plans and workers' compensation because they can be confusing to the injured worker. In many respects workers' compensation may be more difficult to comprehend in its entirety because there is such a large body of regulation and case law. Countervailing the volume of workers' compensation law is its uniformity of application throughout a state. Thus, all attorneys, injured workers and their representatives can learn to operate under one set of rules. The various forms for reporting and processing a claim may be standardized along with instructions on how to obtain assistance. Communication of an opt-out benefit plan's terms and requirements is more individualistic across employers.

Another factor in navigating the claim process is the availability of assistance in understanding rights and duties for both employers and employees. ERISA requires that all beneficiaries of a plan must receive at least a "Summary Plan Document" (SPD) containing a review of the plan benefits and the process for claiming benefits. Other documents relevant to the beneficiary must be provided on request. These documents vary in detail from plan to plan. Language assistance with forms and documents is not required unless the population of a particular non-English speaking group exceeds a trigger percentage. Of course, and individual plan owner can exceed the ERISA minimums for communication.

State workers' compensation agencies assist in educating employers and workers about the law with brochures and other written materials designed specifically for employers and injured workers.[37] In addition, workers' compensation agencies generally have staff designated to receive calls from workers and assist them with information or assistance in contacting the adjuster to resolve problems. For example, the Oklahoma employee report of injury form, used in every claim, contains the following statement, "NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-5308 or In-State Toll Free (855) 291-3612." In Oklahoma workers' compensation, within 10 days of the employer's filing of a claim, the Oklahoma Commission's Counselor Division sends notice to the injured worker about the Counselor Program and mediation to help resolve any claim dispute. Also, the mediation service provides skilled, Commission-certified attorneys to assist the parties in mediating a dispute (the mediator is paid by the insurer or employer). Because many mediators are actively engaged in representing workers or employers in litigation, the mediator may not always be free of conflicts of interest or bias.

Characterizing traditional workers' compensation generally, the employees of the workers' compensation agency who handle public inquiries are intended to be impartial experts. Many states have a separate office for an ombudsman to assist injured workers in understanding the claim process. The mission and values of most ombudsman offices motives them to provide very proactive assistance with questions or complaints.

Most states provide forms and information brochures in Spanish and other languages as well as English and provide oral translation services for any person that needs language assistance.

[37] Bill Minick has often stated that the Oklahoma Option plans that he works with are extremely proactive in informing workers of the plan operation and their rights and responsibilities. However, the quality of such communications among opt-out employers generally has not been independently verified.

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The US DOL monitors compliance with federal standards on assisting non-English speakers with government mandated benefits.

Of course, opt-out plan owners may be just as proactive in reaching out to employees covered by the plans. Consultants to opt-out plans represent that plans they work with are extremely proactive in communicating the steps of the claims process, especially the importance of prompt reporting of claims and the process for seeking medical treatment. Reportedly, the claims process is explained at time of hire, and is reviewed with the claimant as soon as the claim is known to the claims administrator.

DISCRETIONARY CLAIMS HANDLING

Many of the Oklahoma benefit plans reviewed by the author contain numerous references to the plan administrator's sole or complete discretion to make benefit determinations. If a benefit is denied and the participant in the plan disputes the denial in federal court, most federal courts will apply an "abuse of discretion standard." Under this standard, the decision of the administrator must be within the discretionary bounds written into the benefit plan and must avoid the appearance of being arbitrary or capricious. ERISA section 2560.503-1 gives a long list of minimum requirements for employee benefit plan procedures pertaining to claims for health benefits. Examples include preauthorization for medical treatment, reasonable time for processing authorizations, and waivers of authorizations in emergency situations. Also, if a provider network is used, the plan must make names and locations of the providers known to participants. These health benefit requirements may not apply directly to occupational injury treatment.

Thus, an ERISA plan could be highly restrictive in how it applies a benefit as long as it acts within the authority expressly included in the plan. For example, a claims administrator may have total discretion in deciding whether there should be a second opinion on the need for a medical treatment or an impairment rating, provided the adjuster follows all internal plan guidance and procedure in making this judgment. The extremely broad discretion claimed in two plans was cited in Section 4: Summary of Process Differences.

However, some federal courts modify or set aside this "deferential standard" if the ERISA plan administrator has a conflict of interest. The conflict of interest arises if the administrator making benefit decisions has a financial stake in the amount of losses paid out by the plan. This conflict is often associated with an health insurance company underwriting the ERISA benefits, since it gains financially from benefit payments denied, whether justified or not.

DEFERENCE TO TREATING PHYSICIAN

Medical judgments drive the claim's process. The plan administrator's complete control of the availability of treating physicians and referrals to specialists is a prized employer right in the Oklahoma Option. Some employers are attracted to opt-out because they feel they can provide better medical care than in traditional workers' compensation. On the other hand, worker advocates assert that this strong control of the medical deliver process is biased toward minimizing treatment and speedily cutting off disability benefits.

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ERISA plaintiffs' attorneys have had little success in persuading circuit courts to apply something akin to the Social Security Administration standard, which gives deference to the treating physician. In *Black and Decker*[38], the Supreme Court found that a benefits plan administrator was not required under ERISA to give preference to the opinion of the treating physician (the "treating physician rule") for the purpose of a disability determination under an employee benefits plan under ERISA. It seems that under ERISA, there are two issues related to the credence of a doctor's opinion: 1) on what is the doctor's opinion based (usually a physical examination; an ongoing treating relationship with the patient strengthens credibility); and 2) whether the doctor's direct or indirect compensation is affected by the opinions rendered.

By comparison, in workers' compensation the treating doctor is generally given deference, but this is colored by how the physician was selected. The party selecting the physician is thought to exert influence on the treating physician's decisions. In more than half the states, employers have a say in the selection of the panel of doctors that initially treat injured workers, and thus, it is thought, exert indirect control of medical practices. However, regardless of who chooses the treating physician, in a dispute before an ALJ in workers' compensation, most states the weight of credibility for the treating physician versus the "examining physician" is determined by the quality of their medical reports and, perhaps, their credentials.

How much deference should the treating physician get in an opt-out plan? The ERISA plan owner has complete control over the selection of the doctor(s) that could be used to diagnose and treat the injured worker (they can of course offer a panel of doctors for the employee). Thus, you would assume that they would have little reason to dispute the treating physician with another medical opinion, yet under plan terms reviewed for this paper they could obtain additional medical opinions and chose the one they found most credible. Proponents say that plans readily allow second opinions requested by the claimant. Some plans in the internal appeal of a benefit denial may refuse to recognize medical evidence supplied by physicians chosen by the employee from outside of the plan network. (In fact, one plan said that seeing a physician outside the network would be grounds for claim denial). Regardless of the liberality with which individual plans authorize or allow medical evidence, critics say that the lack of uniformity in allowing medical evidence favorable to the claimant's position defeats the fairness of the appeal process.

APPEAL PROCESS

Appealing a benefit denial is quite a bit different under ERISA compared to workers' compensation. ERISA requires a "fair and full" appeal of a denial. Sec 2560.503.1(c)(3) requires:

> The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to

[38] *Black & Decker Disability Plan V. Nord (*02-469) 538 U.S. 822 (2003)

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> representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process…

Under ERISA, there can be up to two successive internal appeals required, with time limits on decisions for each appeal. The selection of the appeal committee is in the control of the plan owner. Reportedly, the typical appeal committee is composed of qualified employees of the plan owner, such as the safety director or human resource director.

As shown in Section 4: Summary of Process Differences, plans can claim extraordinary discretion for the appeal committee in making decisions. Claimants disputing their benefit denial are compelled to get all the information supporting their claim into the appeal record because the next level of appeal to a federal court will typically only consider information in the internal appeal record. Appeals to federal court are expensive, and attorneys may resist taking such cases unless there is clear evidence of error or bias by the plan administrator or internal appeal tribunal.

Workers' compensation, by contrast, allows for appeals of benefit decisions to be immediately filed with the workers' compensation agency. In Oklahoma, as in all but two other states, the claimant is entitled to an administrative law hearing of the dispute. Before the hearing, Oklahoma and many other states promote mediation or some form of alternative dispute resolution. Oklahoma and other states allow *pro se* petitions for hearing and judges normally advise claimants representing themselves on how the process must operate, e.g., a judge would advise a claimant on the type of medical report that is needed before the hearing can proceed.

A major difference between the state hearing and the internal review of the benefit plan is that the judge employed by the state is free of any conflict of interest or association with the parties to a dispute or their counselors.[39] ERISA does contain provisions for the impartiality of plan appeals. One such standard is:

> …the issuer [referring the insurer of the plan] must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits (Sec. 147.136(b)(2)(ii)(D)).

The above standard offers no less explicit protection to claimants than one might find in the state governance of workers' compensation self-insurance, specifically standards for the hire of a TPA for claims adjudication. The above standard applies to "health insurers;" it is unclear if such a standard would apply to plans covering occupational injury.

Notwithstanding ERISA requirements for a "full and fair" internal appeal, we have gotten dramatically different renditions of the process, some painting quite a liberal process and others

[39] Fraternization between an ALJ and a member of the workers' compensation bar is frowned on.

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portraying a process very much in the control of the plan. Commenting on the rigor with which these requirements are enforced is beyond the scope of this paper.

FIDUCIARY DUTY

ERISA, from its origins, was designed to impose strict duties for plan fiduciaries and apply sanctions for mishandling of plan assets. Section 409 states as follows:

> ERISA § 409 "Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary ..."

Proponents of opt-out contend that a sense of a "fiduciary duty" is instilled into claims administrators for opt-out plans, and they cite the personal liability of the claims administrator for breaches of this duty.[40]

The majority of problems investigated and enforcement actions taken by the Employee Benefits Security Administration (EBSA, the enforcement arm of ERISA) have to do with the assets or funding of retirement plans. While EBSA does receive about 200,000 inquiries per year, there are no statistics published on how many of these were from benefit denials on health and disability. Arguably, the claims administrator could be held personally liable in a law suit for errors in the claims process. But is this effective protection? Given the high cost of litigation, personal liability seems to be an unlikely exposure to administrators, unless they engage in obviously tortious conduct that involves a denial of substantial benefits. Also, if a mistake is uncovered during the internal appeal or appeal to a court, presumably the benefit will be paid, and thereby remove a possible cause of action in court.

Would opt-out shift a material dispute docket from state to federal courts? The Oklahoma statute requires that after all internal dispute appeals have been exhausted, the next appeal is to the Workers' Compensation Commission (this is how two federal judges have construed the law). Bills proposed in South Carolina and Tennessee are silent on court appeals. Thus, presumably, the federal courts would be the typical venue for benefit denial appeals in those two states. By way of perspective, as of February 2016 the Oklahoma Workers' Compensation Commission had heard only two appeals covering nearly two years of experience since the first employers were qualified for the Oklahoma Option, with 14 cases pending further qualification for a hearing.
We can find no statistics measuring the frequency of federal court appeals under ERISA.

[40] Personal communication with Bill Minick, April 4, 2016.

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ENFORCEMENT

How are these rules enforced? As well conceived as ERISA protections might be, experience with law enforcement teaches that there will be lax compliance if the rules are not enforced.

Part 5 of Title I of ERISA confers on the US DOL's considerable authority to bring a civil action to correct violations of the law; provides investigative authority to determine whether any person has violated Title I; and further sets criminal penalties for willful violations of any provision of Part 1 of Title I. The US DOL enforcement of these regulatory requirements is mainly vested in EBSA, the enforcement arm of ERISA. The scope of EBSA oversight is vast, covering nearly 681,000 retirement plans, approximately 2.3 million health plans, and a similar number of other welfare benefit plans, such as those providing life or disability insurance. As of October 2015, the above plans covered about 143 million workers and their dependents and held assets of more than $ 8.7 trillion (all EBSA statistics).

Summary data taken from EBSA shows the scope of its enforcement activities. The agency closes more than 200,000 inquiries from the public each year. In FY 2015, EBSA's 125 Benefits Advisors "recovered" $402.9 million in benefits for plan participants, up from $356 million in the previous year. In 2015, 583 investigations were opened by EBSA based upon public inquiries to the agency. Non-specific complaints (e.g., indefinite, general in nature, grounded in rumor or conjecture, or alleged activity that does not constitute a violation of law) are not investigated. While these statistics appear to compliment EBSA, it should be noted that most of this formal enforcement effort did not deal with individual benefit denials. A review of the investigations concluded with an enforcement action in 2015, which found that none involved individual employee benefit denials. Instead, the vast majority dealt with of plan assets or breaches in fiduciary duties. As another illustration of the minimal points of contact from an individual in an ERISA plan that served opt-out employers, we are told by National Public Radio (NPR)[41] that EBSA reported that no public inquiries were received from alternative workers' compensation benefit plans in Texas or Oklahoma. Perhaps this is because of high level compliance with plans and beneficiary satisfaction, but also it suggests that there is very little EBSA interaction with benefit decisions for opt-out plans in these states.

EBSA has a highly developed set of rules on conducting investigations and levying penalties. The law allows for a progression of penalties. "First level" penalties are 5% of the amount involved in the complaint. "Second tier" penalties may be 100% of the amount involved, and may be assessed in addition to the first level penalty if the prohibited transaction is not corrected within 90 days after a final agency order is issued. As noted above, most concluded actions announced by EBSA appear to involve plan assets or fiduciary breaches on asset management.

There are compliance audits done by the US DOL that cover the regulatory requirements enumerated above. The US DOL 'laundry list' of audit points: investments, contributions, benefit payments, participant data, plan obligations, prohibited transactions, tax status, commitments/contingencies, administrative expenses, subsequent events, and plan representations.

[41] Personal communication with Howard Berkes, National Public Radio, February 2016.

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No statistics are published on the number of audits, violations found, or the corrective actions taken. The US DOL seems to place a good deal of trust in voluntary compliance by plan owners. The adverse consequences to the plan owner from improperly "cutting corners" in the administration of benefits seem small, unless a class of injured claimants can be certified. For example, suppose a plan administrator denied a benefit but gave only the most cursory explanation to the plan participant and withheld the medical report on which the decision was made even after it was requested by the participant (two rather flagrant breaches of ERISA procedure). While this is clearly in violation of the regulations, the worst consequence of this might be that this particular denial would be reversed on internal appeal or appeal to court. The plan would unlikely face any fines or penalties for an isolated violation.

The high degree of flexibility and employer discretion in ERISA plans is a big attraction of the Oklahoma Option. Nothing in this writing should be interpreted to mean that any fraction of Oklahoma Option employers offer improper or unfair benefit determinations under the rules of ERISA. Some employers may take great pains to instill good advice to claimants and fair determinations in the administration of plans. There is simply no data to compare the claims performance on any objective standard for Oklahoma Option employers, as a whole, contrasted to traditional workers' compensation claims adjusters.

Opt-out is an entirely new concept that the US DOL has not officially reacted to or interpreted under ERISA enforcement regulations. But, as mentioned in Section 5, the US DOL has instituted a study of opt-out plans in Texas and Oklahoma. Given Secretary Perez's expressed criticisms of opt-out,[42] one might expect regulatory guidance will be forthcoming from the US DOL in the near future.

[42] The Department of Labor has also been quite critical of aspects of the traditional workers' compensation system. See OSHA, "Adding Inequality to Injury: The Costs of Failing to Protect Workers on the Job" June 2015, found at: http://www.dol.gov/osha/report/20150304-inequality.pdf

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SUMMARY

The dispute process under workers' compensation is clearly more uniform within a given state than under opt-out benefit plans. Injured workers in the workers' compensation system throughout a state can expect the same process for filing and adjudicating claims, and this uniformity makes it easier to educate claimants and interested parties about how the system should operate. The workers' compensation system in Oklahoma and elsewhere appears to use considerable effort to counsel and assist claimants with questions. Providing credible and understandable advice early in the process can forestall formal disputes. The mediation process offers a quick and relatively low cost opportunity for resolving some disputes outside of a formal appeal. If all else fails and a formal dispute is filed with the Oklahoma Workers' Compensation Commission, the hearing before a workers' compensation ALJ is free of any hint of conflict of interest and is conducted with a *de novo* hearing (the ALJ takes testimony from both sides and can order new medical evidence from a provider *selected by the judge*). ALJs are allowed to hold pre-hearing conferences in which they can advise unrepresented workers on the process and try to facilitate settlement discussion.

It is impossible to generalize about the quality of communication, claims handling, and dispute resolution offered by opt-out employers.[43] All we have is anecdotal evidence amidst a diversity of plans. Opt-out plans have considerable flexibility in designing and administering their claims process and dispute resolution. ERISA lays out only general process requirements, e.g., time to make a claim decision and time allowed for internal appeal of benefit denial. The key task for the ERISA plan owner is to clearly define the benefits and claims process.

The internal appeal process seems to be extraordinarily efficient in terms of its speed and low cost to the employer. If denials are within the express intent of the plan and in harmony with internal guides and tools, the benefit denials are likely to be sustained in a court appeal. Despite the efficiency of the dispute resolution process the employer's control over the medical evidence through selection of providers and the selection allows for the possibility that internal appeals will fall short of the common standards for impartiality found in most state workers' compensation systems.

In evaluating legislation to authorize opt-out, lawmakers might want to set standards for the fairness and efficiency of dispute resolution and weigh the importance of uniformity of process across all workers within a state.

[43] Bill Minick has extolled the clarity of information given to plan participants, and given in "a language they can understand." ERISA only requires that a summary plan be given to beneficiaries and that language assistance be given if the plan includes a minimum threshold of non-English speakers.

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SECTION 6: REGULATION OF OPT-OUT EMPLOYERS

This section discusses a variety of regulatory issues involving the security of payment and compliance with statutory mandates that qualify employers for opt-out. All three states considered here vest the state insurance commissioner with the sole responsibility of qualifying an applicant for the right to opt-out of the traditional workers' compensation system. All three require annual renewal applications.

The steps taken to comply with these regulatory responsibilities in the statute can only be described for Oklahoma, since it is the only state with a functioning regulatory cadre and administrative rules. However, some lessons will be drawn about the challenges and costs of regulation by other states.

COMPLIANCE WITH MANDATES

The Oklahoma Insurance Department (Department) has the sole responsibility for qualifying employers for opt-out. Assigning this function to the insurance regulator seemingly requires that agency to build up expertise and regulatory staff in an area that is already regulated by the Oklahoma Workers' Compensation Commission (WCC). The WCC has the responsibility to qualify employers for self-insurance. In this capacity, the WCC has a detailed application process that is comparable to many other states in its sophistication. There are a considerable number of skills that are required in the evaluation and monitoring process, which the WCC staff presumably have experience with (e.g., understanding the intricacies of calling surety bonds or letters of credit and evaluating claims exposures from loss reports). The process used by the Insurance Department is not transparent. The Department's administrative rules are clear enough, but the actual process of reviewing applications and monitoring compliance has not been made available to inquiring parties. The Department does not supply statistics on its regulatory activities, nor any other reports that would shed light on the review process.

It was apparently the intent of the legislature that any Oklahoma employer can apply for opt-out, regardless of size and financial track record. But, there is a downside in allowing small or financial challenged employers to opt-out. Small or financially weak firms have a greater risk of bankruptcy and inability to pay benefit obligations. This may be a manageable problem for fully insured employers, because the insurer and not the employer is the entity that pays benefits. Self-insured employers, on the other hand, present a threat of default on benefit payment if they are financially impaired. Their net worth is what ultimately funds benefits. To relieve this threat of default self-insured employers are almost always required to post security with the state to cover benefits in the event of payment default. Another means of securing payment is for the state to only qualify financially solid firms (established firms, high net worth, strong earnings, clean CPA opinion, etc.). Another option in guarding against default, which is discussed in greater detail below, is the use of a guaranty fund that can step in when other risk-protection measures are insufficient to cover losses. Finally, in the traditional workers' compensation system, firms with a poor claims history are often disqualified from self-insurance. As mentioned, the Oklahoma Insurance Department screening process for opt-out employers is not

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published or otherwise available to the author. It may or may not be as rigorously conducted as the screening that self-insurers in the workers' compensation system undergo.[44]

The Oklahoma Insurance Commissioner has broad discretion to define the application form and materials to evaluate an employer's capacity to be certified as a qualified employer. The application form posted to the Insurance Department web site is relatively less detailed than the application for self-insurance. We do not know how rigorously the Insurance Department reviews these applications.

The Commissioner is authorized to require a notice to employees of the insurance status of the employer in the form and manner it determines:

> 85A-202(H): A qualified employer shall notify each of its employees in the manner provided in this section that it is a qualified employer, that it does not carry workers' compensation insurance coverage and that such coverage has terminated or been cancelled

As covered in Table 5.1, if the plan is considered to be regulated by ERISA, there is also a notification requirement for all employees covered by the plan. This includes at least a summary of plan features and the method for reporting claims.

SECURITY OF PAYMENT

Assuring payment of benefits incurred from work injuries has been one of the strongest features of workers' compensation. If an insurer was to become insolvent, each state has a "guaranty fund" set up by statute to pay all claim obligations under the insuring agreement. This mechanism has worked extraordinarily well even in the face of large, concurrent insurance company insolvencies. In a similar way, self-insured employers in the workers' compensation system are responsible for securing benefits through their net worth, bonds or letters of credit mandated by the state, or in a worse case by the self-insurance guaranty fund. A self-insured guaranty fund pays for defaults by the licensed self-insured employer, not an insurer.

All three states considered here have similar mechanisms to secure payment of benefit obligations. Quite sensibly the legislative drafters modelled the security systems after the security for self-insurance in traditional workers' compensation. As noted, workers' compensation claimants are typically guaranteed full payment of statutory benefits via an insured or self-insured guaranty funds. To ease the burden of paying for defaults on the self-insured guaranty fund, regulators try to screen out financially weak employers and those with inordinate claim losses. The state agency, usually the workers' compensation commission or equivalent, requires appropriate surety bonds or letters of credit matched to the size of the exposure to benefit obligations. All licensed, self-insured employers are ultimately responsible for funding the defaults of their fellow self-insured employers, initially paid by the guaranty fund. Self-insured employers have quite naturally lobbied for very rigorous reviews of the

[44] The Insurance Department has not supplied the details of their review process, including how many firms are disqualified or how many have their surety bonds increased.

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qualifications of self-insured employers and the adequacy of their security deposits. We comment further on this below in connection with the Oklahoma process.

All covered employers for workers' compensation in any state system must secure the payment of their benefit obligations. Likewise, opt-out employers must secure payment of benefits with one of three techniques: 1) fully insuring the benefit obligations; 2) posting financial security with the state in an amount determined by formula based on the size and financial condition of the employer; or 3) any other method determined by the Commissioner (such as a "parental guaranty"). In Oklahoma, there is a grey area of "semi-insured," that is a situation in which the employer buys insurance with a very large deductible and administers claims through their own choice of TPA. By Oklahoma rules, the level of security appears to be related to the previous three years' claims experience, but the formula for translating this into a bond requirement is not obvious. The Insurance Commissioner has great discretion in setting security requirements. We have no way of knowing if the Commissioner exercises discretion in easing the security (to facilitate opt-out) or tightening the bond amount (to be cautious in funding unusually high benefit obligations).

A good illustration of the security process in Oklahoma is the following rule:

> Employers with less than 100 employees or less than $1,000,000 in net assets, deposit with the Oklahoma Insurance Department securities, an irrevocable letter of credit or surety bond payable to the state in an amount equal to the Employer's average yearly claims history for the last three (3) years or as determined by the Commissioner.

These size and net worth tests are not conservative. A firm that falls beneath either of these minimums would have a difficult time being qualified for self-insurance in most states. Most regulators would be skeptical of their ability to fund unexpectedly high losses through their own financial resources (essentially their net worth). The Oklahoma Insurance Department's remedy of securing benefit payment seems to be a bond or letter of credit at least equal to three years' incurred loss experience. This provides basic protection. However, it would be inadequate for a catastrophic claim. Even for a firm with a 100 employees, the worst case (such as a truck overturning with three employees in it) could be ten times or more the average annual claims experience. Losses over the basic security level incurred by a qualified employer that goes into bankruptcy would be absorbed by the self-insurance guaranty fund. The Insurance Department retains the discretion to adjust the security amount up or down from any formula amount.

The Oklahoma Insurance Department is provisionally allowing a "safe harbor" for all employers who choose a "Self-Insurance Retention" (SIR) no greater than $25,000. This means that any employer in the state who wants to take advantage of the Oklahoma Option--even if that employer is in a weak financial condition--is able to carry up to a $25,000 loss retention without providing any security that this loss retention can be met. Depending on the insuring agreement, the insurer may be responsible for an employer that cannot pay its loss retention amount. Presumably, this safe harbor is to ease the burdens of estimating and creating security deposits, letters of credit or bonds.

Another security issue that seems to be undefined regarding guaranty fund coverage for opt-out employers is whether claims filed after the employees were discharged by a firm at or before bankruptcy are covered. Benefit plans have different rules for paying benefits once an employee leaves the employment of the plan owner. In most cases no new claims discovered after employment has ended are allowed. In workers' compensation by contrast, some "late" claims

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are nevertheless allowed (e.g., claims that are timely reported after a disease is first diagnosed within any statute of limitations) would be covered by the guaranty fund as policy claim. Would the rules of the special opt-out funds similarly respond to claims after employment had ended?

All three states create an assessment obligation to fund the respective guaranty funds. This is like the method for funding guaranty funds for traditional workers' compensation. Yet, for the state to levy a tax on a self-insured ERISA plan would seemingly be an unprecedented tax on a federally regulated plan. The enforceability of this requirement has been called into question by two insurance trade associations.[45] It seems ripe for a court challenge.

DISCLOSURE

The only publicly available information about individual qualified employers is governed by 85A-202(C):

> The Commissioner shall maintain a list on its official website accessible by the public of all qualified employers and the date and time such exemption became effective.

The Oklahoma statute prohibits the disclosure of information received from qualified employers. 85A-203(F) requires:

> Information submitted to the Commissioner as part of the application for approval as a qualified employer, to confirm eligibility for continuing status as a qualified employer, or as otherwise required by the Oklahoma Employee Injury Benefit Act may not be made public by the Commissioner or by an agent or employee of the Commissioner 'without the written consent of the applicant, except… [naming two narrow exceptions].

Confidentiality of financial information on applications to self-insure is common. But, researchers, potential claimants and their representatives have an interest in basic facts about the qualified employer.[46] For example, it seems useful to publish on the web the date of initial application, date of renewal, and date that qualified employer status ended, name of administrator and contact information, and name of insurer (if any). Public disclosure of the above information seems benign to the employers and helpful to some parties. Going further, the Commission could aggregate data to protect confidentiality and report on the regulatory process and the growth and impact of the Oklahoma Option. For example, it would be of great interest to the public and lawmakers to know how many employees were covered and in what industries. The framers of the South Carolina bill seemed to appreciate the need for public policy analysis; the bill requires the Insurance Commission to report annually to lawmakers on the effectiveness of the law. The Texas Insurance Commission regularly reports on the growth of "non-subscribers" in that state.

[45] At the 2016 WCRI annual meeting (and elsewhere) speakers from the American Insurance Association and Property Casualty Insurance Association have expressed doubts that self-insurance guaranty funds for opt-out employers would be permissible under ERISA.

[46] The details of benefit plans contained in this paper could not have been written without National Public Radio's success in obtaining about 51 benefit plans from the Oklahoma Insurance Department, and making them freely available. This was before the law was changed in November 2015 to make everything submitted by employers in connection with opting-out to be confidential. Benefit plans are no longer available to the public.

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Oklahoma's traditional workers' compensation system, allows the relatively unusual right of employers to inquire about compensation claims. The statute says:

> A. Except as otherwise provided by state or federal law and subject to the provisions of this section, an employer may inquire about previous workers' compensation claims paid to an employee while the employee was employed by a previous employer. If the employee fails to answer truthfully about any previous permanent partial disability awards made pursuant to workers' compensation claims, the employee shall be subject to discharge by the employer." (§85A-120(A))

It is unclear whether this requirement extends to qualified employers to give and seek disclosure of claims.

Finally, there is no publicly available evidence on whether the Oklahoma Insurance Department has challenged written plans that do not appear to be offering equivalent or better benefits as those required for Oklahoma workers' compensation. For example, some of the exclusions in coverage in plans reviewed by the author appear to go beyond coverage conditions for workers' compensation (e.g., peremptorily excluding claims from silica, pollen, and bacteria even if medically related to work). Another example is denial of coverage for a host of failures to follow process, such as immediate reporting of injuries, missing a doctor's appointment, seeing your own doctor, or quitting the company (which can end the right to benefits). One possible explanation of this tacit acceptance of all submitted plans may be explained by a lack of authority. "It's my opinion that the insurance department does not have the statutory authority to disapprove or deny based on the content of the benefit plan," reportedly said by Gordon Amini, General Counsel of the Insurance Department.[47] If this is accurate, what is the merit in collecting written plans each year from qualified employers? And how is the statutory requirement of equivalent benefits to workers' compensation enforced? Apparently concerned about the regulatory gap, the Insurance Department has proposed legislation to strengthen its authority.

SUMMARY OF REGULATION

The regulatory responsibilities for the state insurance commissioners are similar in all three states. The insurance commissioners are given discretion to require ongoing reporting to monitor compliance with the conditions of opting-out. They also have discretion in setting security levels to protect against insolvency.

We cannot report much on the methods used by the Oklahoma Insurance Department, for want of statistical data or descriptive reports on the process. We do not know how thoroughly applications are reviewed, whether corrections to plans are ever demanded, or the rigor of review of claims history for setting security requirements. Answers to these questions would be of great importance to policymakers, and to other opt-out employers subject to assessments.

[47] Howard Berkes, "Opt-Out Plans Let Companies Work Without Workers' Comp," NPR, October 15, 2015, found at: http://www.npr.org/2015/10/14/448544926/texas-oklahoma-permit-companies-to-dump-worker-compensation-plans

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There do not appear to have been any insolvencies among opt-out employers in Oklahoma. However, the program remains relatively new, and the set of qualified employers has yet to weather a severe recession, which would be a more rigorous test of employer screening and the adequacy of security.

Some issues worth considering by other states interested in regulating the opt-out system would be to:

- Obtain clear legal basis for regulating against insolvencies in the face of federal ERISA preemption;
- Require reporting each year on the number of covered employees, the number of accepted and denied claims, and the average medical and indemnity benefits paid;
- Establish rigorous criteria for setting financial security that considers the magnitude and potential variability of ultimate claims obligations of an employer; review and update these requirements at least annually for each qualified employer;
- Report on the insolvencies of opt-out employers and how successfully benefit payments were maintained; and
- Publish performance data on opt-out employers that can be used to evaluate the effectiveness of this option relative to workers' compensation.

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SECTION 7: OTHER ISSUES

This section reviews other assorted issues that help in our understanding of opt-out.

INSURANCE[48]

Opt-out employers would almost always purchase insurance for at least some degree of protection. The opt-out employer faces the risk of claims against the plan which may be much bigger than expected based on recent loss history. The insurance protection could be very broad and cover almost all of their claims, or it could be only for excess losses over a large self-insured retention level.[49] The insurance protection they choose would be a function of their willingness to fund different levels of risk[50] exposures, the cost of the insurance protection, and the security requirements (bonds or letters of credit) imposed by the regulator as a condition of opt-out.

There are several notable features of opt-out that should make insurance for opt-out less expensive than traditional insurance for the same level of self-insured retention:

- The claim cost is probably lower than if the employer was covered by traditional workers' compensation (see claims of savings in *Performance Measures* section below).
- Claim defense costs should be less than traditional workers compensation, due to internal appeal mechanisms, which should avoid some defense attorney involvement.
- Medical costs per claim might be somewhat reduced because of a variety of cost containment tools, such as fee schedules below the workers' compensation schedule, much tighter selection of providers, and fewer second opinions or medical review fees.

Notwithstanding these differences with workers' compensation, establishing an insurance agreement and rating the exposure is easily enough done, as evidenced by the rapid appearance of insurers to serve the Oklahoma Option market. The cost of the insurance would vary with the form of the written plan, self-insured retention (SIR), the maximum payment limits on an individual or aggregate claim, and the technique selected for administering claims. Also, the insurance rates would be affected by the risk profile of the employer, including the history of claims.

A particularly interesting feature of opt-out insurance is that the insuring agreement is founded on the benefit plan, as opposed to traditional workers' compensation which simply conforms the

[48] Thanks to Jerry Murphy for sharing his expertise on opt-out insurance; he may not necessarily agree with statements here.
[49] Retention in Oklahoma opt-out is almost always stated on a per occurrence basis (all claims cost from a single incident even if more than one worker is injured. Oklahoma retentions range from $25 thousand to $1 million or more.
[50] As used here, "risk" is the variability of possible losses in a given year. Opt-out employers may be somewhat more able to control risk through plan design, e.g., by denying late reported claims and benefits for injury discovered after an employee has terminated employment. Yet, the biggest risks come from catastrophic injuries, which would be a common exposure for similar type firms in either system.

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coverage to all benefits legally required. Insurers have their own plan templates which the insurer can modify to suit their needs. The cost of the insurance depends on the “richness” of benefits selected by the employer. For example, one employer might elect to pay TTD on the first day of disability and replace 85% of lost wages, while another employer might stick as closely as possible to the statutory minimums.

The insurers for opt-out enjoy two small advantages not shared by traditional workers' compensation insurers: 1) there is no administrative assessment to pay for the cost of the regulatory agency or special funds, and 2) there is a reduced volume of reports to the regulator on claims (first reports of injury, medical reports, closed claim reports, etc.). In workers' compensation, even large deductible insurance or self-insurance must typically report basic claims data to the state workers' compensation agency; they also report to a workers' compensation statistical agent (NCCI). Because opt-out claims are not reported to the state, either directly or indirectly through a statistical agent, the statistical record on loss experience for opt-out versus traditional workers' compensation is unavailable. This gap in loss data makes it difficult to conduct a fair comparison of the two systems.

The administrator for claims handling will depend on the size of the policy and the insurer. Most commonly, an employer selects a third party administrator (TPA) to administer benefits, with approval from the insurer. The TPA reports loss payments to the insurer and the insurer reimburses the employer for payments made over the retention levels. The insurer would typically take over claims administration for large losses that were likely to exceed the employer’s loss retention. Insurers might engage the TPA directly for policies with less than around a $50,000 SIR.

Employers are given latitude on how much risk of loss they wish to retain within the Oklahoma Option. Allowing the employer to self-fund even catastrophic losses exposes the plan beneficiaries to default if the employer becomes financially impaired and unable to fund the benefits. Good risk management practice suggests that self-funding levels should be set by an interaction of claims managers (who can identify the variability of losses and potential for very large claims) and financial experts (who determine how much exposure can be funded easily).

The risk of unfunded losses is considerably greater for most self-insured employers, than for insured employers, which is why regulators need to be very careful in setting security amounts. In traditional workers’ compensation, most states require the insurer to be “first dollar” payers should the policyholder default on the SIR. There seems to be potential for an unfunded benefit liability if the Insurance Department is not very careful to monitor SIR levels and demand a conservative amount of security for the exposure. The $25,000 SIR “safe harbor” means that employers with SIRs less than the safe harbor cut off are not required to post any security, which creates a small guaranty fund exposure. Finally, we could not tell if insurers of opt-out plans are required to notify the Insurance Department if the policy retentions have changed or a notice of non-renewal was served on the policyholder. The Insurance Department should get advance notice of coverage changes so that it can: 1) respond to changes in the SIR by modifying the security requirement, and 2) get assurance of continued coverage with another insurer after a policy is terminated.

As a final observation on insuring opt-out plans, the Insurance Department accepts coverage from any insurer with an AM Best Rating of B+ or better. This includes admitted insurers and surplus lines insurers. Surplus lines insurers, however, are not covered by the guaranty fund in

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Oklahoma (and probably most other states), so their policyholders would not have protection should such an insurer become insolvent.

In summary, there is a robust insurance market for opt-out plans. A large fraction of employers "fully" insure their plan liabilities (availing themselves of the $25,000 SIR safe harbor). The Insurance Department should be requiring adequate security for plans with SIRs larger than the safe harbor limit and monitoring changes in loss exposure. The guaranty funds set up for opt-out employers provide an additional line of protection against financial impairment of either a self-insured or insured employer.

WORKPLACE SAFETY

Daryl Davis, a consultant to employers interested in the Oklahoma Option, has made the claim that opt-out gives employers new powers to improve workplace safety:

> … you have the legal freedom to craft your own workplace safety program, outside of WC [part of a rhetorical question]. You can customize it so that it fits your particular workforce—and likely save money in the process, even if you choose to offer employees bigger benefits.

There is no substantive mention of workplace safety in the Oklahoma statute pertaining to traditional workers' compensation or opt-out. It is hard to see how an employer is in any way constrained by workers' compensation law or insurance in providing customized safety programs to fit its particular workforce. Large employers, both insured and self-insured, typically have strong and effective safety programs. Small insured employers are typically weaker on safety, not because of workers' compensation requirements but because they are small businesses without the internal resources or budget to implement state of the art safety programs.

Economics says that positive or negative incentives modify behavior. A possibly negative effect of the Oklahoma Option on some employers might be to refocus their loss control away from events that are not covered by their plans and protected from law suit by the exclusive remedy[51] (e.g., parking lot injuries, recreational events, employee travel for work in personal cars, or assaults by outsiders at the workplace). However, it seems doubtful that risk-managers would be so strategic in how they address safety of employees.

[51] The leveraging effect of mandatory workers' compensation on promoting safety has been studied and well-documented. Upjohn, *Essays in Honor of Terry Thomason,* Upjohn Institute, 2005, found at: http://research.upjohn.org/up_press/155/

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EFFECTS OF OPT-OUT ON INSURED EMPLOYERS

Following are some of the early trends in the types of employers choosing to opt-out in Oklahoma:

- Construction companies and utilities are so far not opting-out in Oklahoma. They make up a larger portion of self-insured employers, which demonstrates their willingness to manage claims or retain risk.
- National retail establishments probably employ the largest single block of employees covered by opt-out plans.
- Health care providers, especially nursing homes, are heavily represented in opt-out relative to their share of self-insurance.
- Public entities and religious organizations represent one of the largest classes of employers in self-insurance but are completely absent from opt-out.

Opt-out is a new system in Oklahoma. The current mix of employers choosing opt-out may change as the legal status and performance of opt-out becomes clearer.

Some writers contend that opt-out will hurt businesses remaining in the traditional system. True, when an employer drops from the risk pool of insureds in a state, class rates can be changed if the employer is large and has an unusually high or low loss rate. But this happens when large companies move from being insured to self-insurance. Large employers that opt-out of workers' compensation should have about the same effect on insurance markets as employers shifting from fully insured to self-insurance. Interestingly, research done on a sample of "non-subscribers" in Texas, finds that as large Texas employers elected to non-subscribe workers' compensation costs dropped.[52] This is a surprising finding since large employers tend to have lower frequency and severity of injury and hence their removal from the Texas workers' compensation system should increase the average loss cost for the remaining segment of employers.

PERFORMANCE MEASURES

Very positive claims are made about the benefits of opt-out for workers, employers, and the state's economy. An extraordinary claim comes from the Association for Responsible Alternatives to Workers' Compensation (ARAWC):[53]

> Initial data shows claims costs for employers have also decreased by over 50% under the Oklahoma Option [they add that this over and above the 37.2% drop in loss costs since the 2013 reforms were passed]

[52] This finding is provisional since the paper is labeled "Work in Progress Not Yet Submitted for Publication." Alison Morantz, "Rejecting the Grand Bargain: What Happens When Large Companies Opt Out of Workers' Compensation?" March 18, 2016, found at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2750134
[53] ARAWC website at: http://arawc.org/option/oklahoma/

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> What's happened is the vast majority of workers covered by injury benefit plans are eligible for higher levels of wage replacement benefits than they would receive in workers' compensation.

More recently, PartnerSource has described a study of 10 of its Oklahoma Opt-Out clients. The findings:

> The Oklahoma employers surveyed realized an average 73 percent savings on their claims expense, even after adjusting historic workers' compensation losses for reductions expected under the new Oklahoma Administrative Workers' Compensation Act."[54]

These savings claims are really "the only game in town." No one has advanced counter arguments to rebut them. They may be true, but they cry out for confirmation by neutral parties. The confirmation should be not just for the gross savings, but on the claim factors that brought about the savings.

The Oklahoma system is not collecting data to measure the performance of opt-out objectively. However, the Insurance Department could obtain and analyze claims data from qualified employers and produce performance indicators that would test compliance with law and performance improvements. A report by the Insurance Department, state university researchers, or the Casualty Actuarial Society would have more credibility in evaluating performance than trade group statements, such as the ones quoted above. Of course, comparable data would need to be collected for both traditional workers' compensation and the Oklahoma Option. Some of the important metrics for evaluating the success of the Oklahoma Option would include:

- share of state workers covered by opt-out plans;
- number of claims/100 workers accepted and denied;
- average medical and indemnity claims cost for opt-out against a comparable mix of employers in workers' compensation;
- percentage of claims paid or given a denial within the 15 day window provided by statute for workers' compensation (sec 211(A));
- the speed with which injured workers return to their pre-injury jobs;
- The number of workers with permanent injuries;
- Percentage of claims that are appealed internally in the plan and the percentage of these that are decided within the 45 day window provided in the statute (sec. 211(B));
- Number of benefit denials properly (after all internal appeals are exhausted) appealed to the Commission; and
- Employer cost for defense of claim denials.

[54] "Oklahoma Option: First Results," February 16, 2016, found at: https://www.partnersource.com/oklahoma-option-first-results/

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Even if all of these were well developed it would be only a partial picture in evaluating opt-out from the employee's perspective. To get at whether workers are better off within the opt-out system you would need to survey of employees of firms in both systems. The survey would ideally cover such things as:

- How would you rate the claims reporting process?
- Was your claims adjuster fair and helpful in processing your claim?
- Was your wage indemnity payment prompt?
- Did you think your choice of medical provider was adequate for your needs?
- Do you think you needed more treatment than the adjuster would allow?
- Did you get proper referrals to specialists as needed?
- Were you given a settlement and was it voluntary?
- If you had an appeal of your[55]claim denial, was the process fair?

Absent direct evidence from opinion surveys, focus groups, or other systematic methods of gathering opinions of a sample of workers, any generalized statements about worker likes and dislikes are anecdotal and speculative.

The above type of performance evaluation is a tall order. But, absent good research the debate about opt-out will continue to generate more heat than light.

HIPAA

Does the Health Insurance Portability and Accountability Act (HIPAA) apply to opt-out plans? Among other objectives, this law provides data privacy and security provisions for safeguarding medical information. The HIPAA Privacy Rule does not apply to "entities that are either workers' compensation insurers, workers' compensation administrative agencies, or employers, except to the extent they may otherwise be covered entities."

[55] It should be noted that the bills for both South Carolina and Tennessee commendably require the insurance department to report to the legislature on the effectiveness of opt-out. The Texas Department of Insurance does an admirable job of periodically reporting on non-subscription, including detailed information about the types of employers opting-out, reasons for opting-out, and benefits offered by non-subscribing employers (see bibliography).

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Few plans reviewed by the author mentioned HIPAA. AEI is one of the minority of Oklahoma Option plans that provides medical treatment for injuries as part of the normal operation of its health insurance ERISA benefit (except for elimination of the cost sharing). AEI's written plan (labelled draft) clearly says that it will comply with HIPAA:

> The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:
>
> 1. The Plan's disclosures and uses of PHI;
>
> 2. The Participant's privacy rights with respect to his/her PHI;
>
> 3. The Plan's duties with respect to his/her PHI;
>
> 4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
>
> 5. The person or office to contact for further information about the Plan's privacy practices.

It is only speculative to think that a court, any time soon, might find that opt-out plans are not workers' compensation, and not qualified for the exception from HIPAA. But if they are not workers' compensation, as proponents strongly assert, then would not HIPAA apply to opt-out plans generally? This would impose new, significant duties on the administration of the medical benefits.

CONSTITUTIONAL ISSUES

David Langham (Florida Deputy Chief Judge) has noted that constitutional challenges to workers' compensation statutes have risen sharply over the past five years. He explains that the constitutional issues primarily fall into the following categories: the preemption doctrine, separation of powers, due process, equal protection, access to courts, and compensation for labor.[56]

The Oklahoma reforms signed into law May 2013 (SB 1062) have generated a good share these constitutional challenges. First to be decided was a challenge on constitutionally prohibited multipurpose legislation. In *Coates v Fallon*,[57] the Court ruled that the legislature did not act "outside its constitutional authority by enacting a bill containing multiple subjects." After this, litigation has surrounded the benefits defined for traditional workers' compensation. On March 4, 2016 the Oklahoma Supreme Court ruled unconstitutional a statute that denied consideration of repetitive motion claims if the claimant had not worked for the employer for at least 180 days. They said that this did not provide equal protection of law for all workers covered by the workers' compensation system.[58]

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[56] David Langham, "Constitutional Challenge Recap and Overview," WorkCompCentral, March 8, 2016, found at: https://www.workcompcentral.com/columns/show/id/34fd7485eea691eeef6bc3b37cdd1f177e4002cf

[57] *Coates v. Fallin*, 316 P.3d 924 (Okla. 2013).

[58] *Torres v. Seaboard Foods,* Supreme Court No. 113,649.

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The Workers' Compensation Commission created a stir in the workers' compensation world by ruling that sections 203 and 209 of the 2013 law governing Oklahoma Option plans were unconstitutional.[59] That decision will almost certainly be appealed on either the constitutional argument itself, the authority of the Commission to rule on constitutional issues, or likely both. Other constitutional challenges of an assorted nature await decisions by the Oklahoma Supreme Court.[60]

It would not be surprising if constitutional tests regarding equal protection or due process were to appear in other states enacting opt-out. The success of challenges will depend on each state's constitution, makeup of the state's Supreme Court, previous court decisions, and the way in which opt-out is framed. For example, if opt-out were coupled with a realistic right to a tort remedy for injured workers employed by opt-out firms (as in a version of the Tennessee bill); it arguably would be more likely that equal protection and due process challenges could be met. The constitutional issues are too complex and too state specific to offer a prediction how this will develop.

[59] *Vasquez v Dillard's*, Oklahoma Workers' Compensation Commission, File CM-2014-1106OL, Decided February 26, 2016.

[60] The following are a sample of pending cases before the Oklahoma Supreme Court, all of which are on specific benefit issues, not the constitutionality of the Oklahoma Option per se. *Mullendore v. Mercy Hospital Ardmore,* Supreme Court No. 113,560; *Robinson v. Fairview Fellowship Home,* Supreme Court No. 113,735; *Brown v. Claims Management Resources,* Supreme Court No. 113,609; and *Nowlin v. Medicalodges, Inc.,* Supreme Court No. 113,607 (all four challenge "special law" giving a class of worker disparate treatment); *Harrison v. Landair Logistics, Inc.,* Supreme Court No. 113,656 (challenges limitation on TTD duration); *Pilkington v. Doak,* Supreme Court No. 113,662 (Sup. Ct. denied hearing until claimant exhausts internal review); *Smith v. Baze Corp Investments,* Supreme Court No. 113,811 ("special law" pertaining to AMA Guides).

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SECTION 8: OVERALL CONCLUSIONS

Oklahoma, in 2012, inaugurated a vigorous discussion of a new form of compensation for work injuries. Employers could opt-out of the workers' compensation system, and substitute an employer controlled benefit plan, subject to minimum requirements. Oklahoma passed its version of opt-out in 2013, which was put into practice in February 2014. Similar bills were introduced in Tennessee followed by South Carolina. Legislators in other states have expressed interest in the concept. Along with this strong legislative interest came charges and counter charges about the merits of opt-out. The debate has often been in sharp terms, with little consensus or common ground. Below is a summary of the elements of the debate.

Opponents of opt-out contend:

- Cost savings are gained by a combination of reduced benefits and limited eligibility.
- Cuts in benefits and denial of coverage are borne by the injured worker and social welfare programs such as Medicare and Social Security.
- There is a lack of monitoring for compliance in these programs by regulators.
- There is a lack of data supporting the claims that injured workers get better medical outcomes and that alternative plans can provide better benefits to workers at lower costs.
- There is a fundamental lack of fairness and impartiality in the resolution of disputed claims.

Proponents of opt-out say:

- By control of medical networks and treatment protocols, employers can ensure that injured workers receive the best-possible care.
- Reducing the use of attorneys and legal maneuvering cuts cost without harm to workers.
- A significant amount of the savings is from elimination of the bureaucracy that increases workers' compensation costs.
- The TPAs and insurers servicing opt-out plans are applying the same best-practice techniques for handing claims, and acting as fiduciaries of the best interests of plan participants.
- ERISA offers plan participants many protections against unfair claims handling and dispute resolution.

The debate has almost all been at the conceptual and logical level. High level principles, like the "grand bargain," "innovation," and "market competitiveness" are used without a clear explanation of their meaning. The gaps and shortcomings in opposing arguments are picked apart. After all the debate, there are few uncontested facts about the operation of the opt-out system.

Finding common ground is hampered by the fact that Oklahoma Option plans vary a good deal. Review of sample plans revealed that it is relatively easy to find a plan to support a particular position. In some plans, employers pay very generous benefits and/or have avoided

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unreasonable restrictions on coverage. In other plans, employers pay the minimum statutory benefits and are laden with restrictions and exclusions far more stringent than workers' compensation. Thus, one can rightly paint some opt-out employers as being very protective of their employees' interests, but other plans seem to contain many conditions and exclusions as part of their cost containment strategy. The Oklahoma system allows both scenarios.

Criticism of opt-out plans is stoked by some rather harsh wording in most benefit plans. The plain language of some plans gives the plan administrator every opportunity to exercise discretion in denying a claim or limiting the duration of benefits. It is possible to imagine that the plan allows the administrator to use hand-picked medical opinion to declare an injured worker healed and terminating further medical care and TTD. Against this proponents-- with considerable passion-- describe the claims process in much more benign terms. They say that claims administrators are fiduciaries and operate in the best interest of the claimant. Administrators often give "good cause" allowance for innocent breaches of the ostensibly tough plan language. This is one of the maddening aspects of opt-out—one cannot tell for sure what is going on across the spectrum of opt-out plans and claim situations.

The diversity of opt-out plans and their administration creates unequal treatment of employees, both across opt-out plans and compared to traditional workers' compensation. Who could object if an employer voluntarily provided relatively generous benefits and truly administered the plan in the "best interests" of the workers? Yet, the freedom of opt-out also affords the darker possibility of minimal statutory benefits, stringent claims determinations, and a dispute process that seems unfair to the claimants. There seems to be enough agreement on system objectives and the rights of employers and employees that it might be possible to frame a set of standards[61] that could guide opt-out legislation.

Apart from the constitutional questions, there are loose ends in the Oklahoma opt-out law that merit further consideration. These open questions are shared to an extent by the bills proposed in South Carolina and Tennessee:

- Should equivalency of benefits be defined beyond the formula amounts and limits? Should it include equivalency in the detailed process for determining such things as the causes for cutting off TTD, necessity of medical treatment, and level of impairment?
- Can a state mandate benefits and other procedural requirements, like internal appeals, be sustained against ERISA preemption?
- Is there sufficient compliance monitoring and enforcement authority for the state insurance department in regulating qualified employers, including careful review of the benefits offered in their plans and the security levels prudently required to guard against default on payment?
- Would the exclusive remedy be maintained by courts if in an opt-out plan the scope or conditions of coverage were narrowed a great deal relative to workers' compensation?

[61] Property Casualty Insurance Association of America has offered some principles for establishing a "responsible alternative to workers' compensation." Of course, their principles may not quite match those of other interest groups.

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- Could guaranty fund coverage and assessments for self-insured employers survive ERISA preemption?
- Is there an iron-clad guaranty coverage for all the scenarios involved in insured and self-insured defaults on benefit payments?

Even if the above legal and regulatory issues could be resolved satisfactorily, there would remain four propositions about opt-out that have not been objectively analyzed in detail:

- Workers with injuries get the same or better indemnity benefits than in traditional workers' compensation.
- Injured workers have better medical outcomes.
- Injured workers are at least as well satisfied with opt-out as traditional workers' compensation.
- Employer costs per claim are lower because they can be better at claims management, medical care delivery and injury prevention.

We have quoted in this paper some of the strong claims for cost savings (Section 6: Performance). They are indeed impressive. But prudent employers and policy makers need more details on the objectivity of sources and methods used to produce these savings estimates. The other assertions of "better outcomes" need similar supporting detail. Public policy of this gravity deserves independent research, transparent accountability of regulatory agencies, and reporting by the state on the performance of opt-out.

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REFERENCES

Duff, M. (2016, January). Worse than pirates or Prussian chancellors: A state's authority to opt-out of the quid pro quo," *17 Marq. Ben. & Soc. Wel. L. Rev (*Summer 2016, forthcoming*).* Retrieved from: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2713180

Grabell, M. and Berkes, H. (2015, October 15). Inside corporate America's campaign to ditch workers' comp." *ProPublica/NPR*. Retrieved from: https://www.propublica.org/article/inside-corporate-americas-plan-to-ditch-workers-comp

Grover, N. (2015). Workers' compensation opt-out: Who's next? *Workers' Compensation 2015 Issues Report.* NCCI*.* Boca Raton, FL.

Morantz, A. (2016, March 18). Rejecting the grand bargain: What happens when large companies opt out of workers' compensation? (labeled "work in progress"). Retrieved from: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2750134

Morantz, A. (2011). Opting out of workers' compensation in Texas: A survey of large, multistate nonsubscribers. *Regulation vs. Litigation: Perspectives from Economics and Law, ed. Daniel Kessler*, pp. 197-238. University of Chicago Press.

PartnerSource. (2016, February 11). Oklahoma Option: First meaningful results, February 11, 2016, Retrieved from: http://www.partnersource.com/oklahoma-option-first-results/

PartnerSource. (Undated) Oklahoma Option (general information. Retrieved from: http://www.partnersource.com/oklahoma-option/

Texas Department of Insurance. (2014). Employer participation in the Texas workers' compensation System: 2014 estimates. Retrieved from: www.tdi.texas.gov/reports/wcreg/documents/nonsub.pdf

Texas Department of Insurance. (2008). Employer participation in the Texas workers' compensation system: 2008 estimates. Retrieved from: www.tdi.state.tx.us/reports

©IAIABC 2016

Torrey, D. (2015, November 20). The opt-out of workers' compensation legislation in the southern states. *MCLE New England*. Boston, MA.

ERISA RESOURCES

Copy of recent ERISA rule on claims processing, titled § 2560.503-1 Claims procedure. Retrieved from: https://www.law.cornell.edu/cfr/text/29/2560.503-1

EBSA enforcement statistics. Retrieved from: http://www.dol.gov/ebsa/newsroom/fsFYagencyresults.html

National Academy for State Public Health Policy. (2009, March 30). ERISA preemption primer. Retrieved from: http://www.nashp.org/sites/default/files/ERISA_Primer.pdf

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