27 Government Programs: Medicaid, CHIP, FEHB, TRICARE, and Workers’ Compensation

Objectives

After completing this module, you will be able to:

- describe the main federal health coverage programs for low-income people (Medicaid and CHIP),
- explain the role of health plans in Medicaid and CHIP,
- describe the Federal Employees Health Benefits (FEHB) Program and the TRICARE program for the uniformed services and explain the role of health plans in them, and
- describe state-mandated workers’ compensation coverage and the role of health plans in it.

In the preceding module we discussed a federal program, Medicare, that provides health benefits to the elderly and some disabled persons. In this module we will look at the other major government health benefit programs.

- Medicaid is a federal-state program that pays for healthcare for low-income people who meet certain criteria. Currently most recipients are children, pregnant women, and elderly and disabled persons, but under healthcare reform all people with income below a certain level will qualify.

- The Children’s Health Insurance Program (CHIP) is also a federal-state program. It provides health coverage for children whose families are not poor enough to qualify for Medicaid but too poor to buy private-sector health insurance.

- Under the Federal Employees Health Benefits (FEHB) Program, the federal government, as an employer, sponsors health coverage for its employees and their dependents.

- TRICARE is the health plan of the Department of Defense for members of the uniformed services, retirees, and their dependents.

- Under workers’ compensation laws, states require employers to purchase or provide coverage that pays employees benefits for healthcare costs and lost earnings if they suffer a work-related injury or illness.

Medicaid

Medicaid is a government program that pays for healthcare received by some poor people. Medicaid is a major component of the nation’s healthcare financing system—in 2008 it served more than 58 million people and spent almost $320 billion. And
healthcare reform will substantially increase these numbers, adding an expected 16 million new recipients.

Medicaid is a federal-state program. The federal government establishes broad guidelines for its operation, but each state administers its own program and determines, within these guidelines, eligibility criteria; the type, amount, and duration of services its program pays for; and rates of payment for services. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the benefits provided in one state may not be provided in another. Also, state Medicaid programs may change from year to year in response to changing needs or emerging problems.

The federal government pays a percentage of each state’s Medicaid expenditures, and the state covers the rest. The federal percentage is higher for poor states and lower for rich states, but it is at least 50 percent.

**Eligibility**

Medicaid is for the poor, but not all poor people are eligible. Some people are considered **categorically needy**, that is, they qualify for Medicaid because they fall into certain categories. The federal government has established a number of **mandatory categories**—all state Medicaid programs must provide benefits to people in these categories in order to receive federal funding. The most important mandatory categories include:

- children ages six through 18 whose family’s income is at or below the federal poverty level (FPL) and children under six whose family’s income is at or below 133 percent of the FPL;
- pregnant women with family income at or below 133 percent of the FPL;
- elderly and disabled persons with very little or no income who qualify for Supplemental Security Income (SSI) payments; and
- a few parents and other family members (such as grandparents) who take care of children younger than 18, have extremely low income, and meet certain restrictive conditions.

There are also **optional categories**—states may provide Medicaid coverage to members of these categories but are not required to do so. The optional categories generally cover the same populations (children, pregnant women, the elderly, and the disabled) as the mandatory categories, but income standards and other criteria are slightly less restrictive. For example, a state may cover children six through 18 with family income up to 133 of the FPL or elderly and disabled persons who do not qualify for SSI but have incomes below the FPL.

Some states also extend Medicaid eligibility to the **medically needy**—those who do not qualify as members of one of the above categories but who have depleted their income and assets to pay for healthcare or long-term care. These states allow non-poor individuals to **spend down**—that is, they can qualify for Medicaid benefits by spending their money on care until their income and assets are reduced to very low levels established by the state. Many middle-income people faced with the enormous costs of
an indefinite period of nursing home care or home healthcare spend down until they have almost nothing left, at which point Medicaid begins covering costs.

As mentioned, under PPACA eligibility for Medicaid will be substantially expanded. As of January 2014, states will be required to cover all persons with income at or below 133 percent of the FPL. The greatest change: Low-income adults, who currently qualify only if they fall into a certain category (pregnant, elderly, or disabled persons and a few parents), will be eligible. This means that millions of non-disabled adults under age 65, who have not been eligible in the past even though they have very low incomes, will be enrolled in Medicaid. Also, children six and older, who currently must have income at or below the FPL (although some states have somewhat higher limits), will qualify with income up to 133 percent of the FPL. The federal government will pay nearly all of the cost of providing Medicaid to these additional people: 100 percent until 2016, decreasing gradually to 90 percent in 2020.

**Coverage**

The healthcare and long-term care services covered by Medicaid vary somewhat from state to state, but in all states they are extensive. The federal government requires all state programs to provide benefits for these services:

- inpatient and outpatient hospital services,
- physician services,
- laboratory and X-ray services,
- medical and surgical dental services,
- nursing facility services for individuals age 21 or older,
- home healthcare for persons who are **nursing home eligible** (those who, according to criteria established by Medicaid, would need nursing home care if they did not receive home care), and
- various other services.

Many states also provide benefits for dental services, optometrist services and eyeglasses, prosthetic devices, and prescription drugs. Medicaid recipients may be charged small deductibles and copayments for some services. Only a few states charge premiums, and the amounts are very small.

In the area of long-term care, as noted above, all states are required to pay for nursing home care and home healthcare for the nursing home eligible. And although federal guidelines do not require it, some states also pay benefits for home and community-based long-term care services for certain other Medicaid recipients. Finally, some states pay for long-term care services received in an assisted living residence.

**Medicare and Medicaid Overlap**

Some elderly people with very limited assets and incomes are **dual eligibles**—they receive benefits from both Medicare and Medicaid. If a service is covered by both programs, Medicare pays. Medicaid pays for services not covered by Medicare but covered by Medicaid (such as nursing facility care beyond Medicare’s 100-day limit,
eyeglasses, and hearing aids). Medicaid also pays for Medicare premiums and
deductibles, coinsurance, and copayments for certain very poor Medicare beneficiaries.

Children’s Health Insurance Program (CHIP)

The Children’s Health Insurance Program (CHIP) is a federal-state program that pays
for healthcare for children from families not poor enough to qualify for Medicaid but too
poor to afford private-sector health coverage. As with Medicaid, the federal government
sets broad guidelines, and within those guidelines each state administers its own
program, establishes eligibility rules, and provides coverage. Also like Medicaid, CHIP is
jointly funded by the federal government and the states, but the federal government pays
a higher percentage of costs than for Medicaid.

While nowhere near as large as Medicare or Medicaid, CHIP provides coverage to large
numbers of children who otherwise would have been uninsured. In 2008 CHIP covered
7.4 million people. Under PPACA, CHIP will not be substantially changed, but some
CHIP children will be shifted to Medicaid, and federal funding for CHIP will increase.

Eligibility

Eligible for CHIP are children who:

- are 18 or younger,
- are not covered by health insurance,
- are ineligible for Medicaid, and
- have family income below a certain level.

States set their own income eligibility limits for CHIP. However, full federal funding is
provided only for children with family income at or below 300 percent of the federal
poverty level (FPL). A state may provide coverage to children with higher family income,
but federal funding is lower. Most states have income limits from 200 to 300 percent of
the FPL, but a few have limits above or below this range.

States have the option of offering CHIP coverage to pregnant women without health
insurance, and about a quarter of the states do. A few states also cover parents of low-
income children, but this is being phased out. Some states offer families eligible for
CHIP the alternative of financial assistance to pay for private health insurance.

Coverage

A state’s CHIP can be part of its Medicaid program, a separate program, or both. Under
a Medicaid expansion, a state must provide CHIP eligibles the same coverage it
provides other Medicaid recipients. In creating a coverage package under a separate
CHIP, a state may choose from these three options:

- **Benchmark coverage.** The state provides the same coverage as the standard
  Blue Cross/Blue Shield plan offered to federal employees, the health plan offered
to state employees, or the health maintenance organization (HMO) with the
largest number of non-Medicaid enrollees in the state.
- **Benchmark-equivalent coverage.** The state provides basic coverage (physician and surgical services, inpatient and outpatient hospital care, well baby/well child care including immunizations, and laboratory and x-ray services). The state also provides coverage for additional services (prescription drugs, vision and hearing care) that is at least 75 percent of the actuarial equivalent of the benchmark plan.

- **Secretary-approved coverage.** The state proposes an alternative plan and receives approval from the Secretary of HHS.

Under both Medicaid expansions and separate CHIPs, premiums and copayments may be charged. But there are limits for families with incomes at or below 150 percent of the FPL, and for all families the total amount of premiums and cost-sharing cannot exceed 5 percent of family income.

**Medicaid, CHIP, and Health Plans**

**The Growth of Medicaid Managed Care**

In the early years of Medicaid, most states made healthcare available to recipients exclusively through fee-for-service arrangements with participating medical providers. But as the program and the number of recipients grew, states began using managed care to control and predict costs and provide access to healthcare in areas where Medicaid providers were limited. States also hoped to reduce reliance on emergency rooms as a source of primary care.

However, the shift to managed care was initially slowed by federal rules that allowed enrollment in health plans only on a voluntary basis (with the agreement of the recipient). A state could require individuals to participate in managed care, but only by obtaining a waiver (an exemption from federal guidelines) from the federal Centers for Medicare and Medicaid Services (CMS). Two waivers were used for this purpose: The 1915(b) waiver allowed states to require enrollment in managed care and to mandate managed care in only parts of the state (waiving the rule that the same coverage must be provided statewide). The 1115 waiver provided for even more flexibility in state Medicaid programs’ benefit packages and service delivery models and allowed states to require managed care statewide.

These waivers enabled states to increase the use of managed care, and large numbers of Medicaid recipients were enrolled in health plans. But the process of obtaining a waiver is burdensome and lengthy, often taking a year or more, and renewal is required every five years. The Balanced Budget Act (BBA) of 1997 addressed this problem by allowing states, without a waiver, to mandate managed care for all Medicaid enrollees except Medicare-Medicaid dual eligibles (elderly and disabled persons), American Indians, and certain children with special needs. Under the BBA, a state need only obtain approval of a state plan amendment (SPA), which can take as little as 30 days.

The BBA resulted in substantial growth in Medicaid managed care. When the Act was passed in 1997, slightly less than half of Medicaid enrollees were in managed care, but by 2009 over 70 percent were. By that year, in nearly all states a majority of the Medicaid population was in managed care, and in 21 states more than 80 percent was. Only two states (Alaska and Wyoming) had no Medicaid managed care.
Medicaid Health Plans

Under Medicaid managed care, recipients choose or are assigned to a “medical home” (a health plan) and a primary care provider (PCP). State Medicaid programs must contract with at least two managed care entities or with a single entity that offers at least two health plans, so that recipients have at least two options to choose from. There are two broad categories of service delivery: primary care case management (PCCM) and risk-based care.

- **Primary care case management (PCCM).** In this approach, PCPs provide basic healthcare and serve as case managers in making referrals for specialty care. PCPs are compensated for primary care on a fee-for-service basis and for case management by means of a small monthly capitation payment. Specialty care may be delivered by a fee-for-service provider or in some cases by another managed care provider such as a prepaid health plan (see below). PCCM programs have become particularly prevalent in rural areas where there are few health plans.

- **Risk-based care.** Health plans in this category provide care to enrollees for a monthly capitated fee. A plan may provide either comprehensive or limited healthcare services. Risk-based care plans include the following types:
  
  - A **health insuring organization (HIO)** is county-based and covers healthcare through payments to or arrangements with providers. HIOs are exempt from the rule requiring recipients to have a choice of at least two health plans.
  
  - A **prepaid inpatient health plan (PIHP)** does not have a comprehensive risk contract with Medicaid. It provides or arranges for the provision of inpatient hospital care or institutional services.
  
  - A **prepaid ambulatory health plan (PAHP)**, like a PIHP, does not have a comprehensive risk contract. A PAHP provides or arranges for the provision of services other than inpatient hospital care or institutional services (such as dental care or mental healthcare).
  
  - A **managed care organization (MCO)** is either a federally qualified health maintenance organization (HMO) or another public or private entity that provides comprehensive healthcare services comparable to those available to other Medicaid enrollees in the area.

The BBA, in addition to allowing mandatory enrollment in managed care, eliminated the so-called 75/25 rule. This rule was designed to maintain quality by preventing an MCO from serving only Medicaid recipients—specifically, an MCO participating in Medicaid had to have at least 25 percent of its members enrolled through the private sector. The abolition of this rule resulted in the birth of so-called **Medicaid MCOs**, which are established specifically to serve Medicaid recipients and now play a major role in the managed care arena.

Many Medicaid MCOs are operated by safety-net hospitals or clinics that have traditionally served low-income populations, but others are run by private corporations.
that have chosen to specialize in the Medicaid market. A few states now rely solely on Medicaid MCOs, but most use Medicaid MCOs, other MCOs, and other health plans. The choices offered by states vary widely and are often tied to geographic, political, and market considerations. And a recipient may be enrolled in more than one health plan, with different services provided by each.

**Quality Standards**

Another change made by the BBA was the establishment of quality standards and recipient protections for Medicaid health plans. These require plans to:

- demonstrate adequate capacity and services,
- meet certain quality assurance standards,
- assure coverage of emergency services,
- have a grievance process in place, and
- ensure that mechanisms are in place to assess the quality and appropriateness of care to enrollees with special healthcare needs.

States may use their own review process to ensure compliance with these standards, or they may use information obtained from a Medicare or private accreditation review.

**Challenges in Serving the Medicaid Population**

Medicaid recipients often have special needs, and health plans participating in Medicaid are required by law to take certain steps to address these needs.

- Medicaid recipients have low incomes, and many low-income people have limited access to transportation. Plans must take into account the means of transportation ordinarily used by potential enrollees when developing their networks and considering the location of providers.

- The Medicaid population is more culturally diverse than the general populace. A plan must make available enrollment materials in non-English languages prevalent in its service area, and it must make oral interpretation services available free-of-charge. Enrollees must be given information about plan providers who speak non-English languages.

- Medicaid recipients often have more complex health and social needs than is typical of the commercial market.

Another challenge to health plans participating in Medicaid relates to the periodic redetermination of a person’s Medicaid eligibility. A recipient must be reevaluated at least annually, and in some states this is done more frequently. Individuals must complete a form and submit documentation of certain eligibility factors, and many people lose their eligibility not because they no longer meet the criteria but because they fail to comply with administrative requirements. Some people let their eligibility lapse if they do not currently need medical care and reapply when they do. The result is “churning”—
people moving in and out of Medicaid and in and out of their health plan, resulting in interruptions in the continuity of care and added administrative work.

The Elderly and Disabled

The elderly and disabled are only a small percentage of the Medicaid managed care population. This reflects the fact that they represent only about a quarter of the overall Medicaid population (most recipients are children). But another reason is the problems states have encountered establishing contracts with health plans to cover these categories, as plans entering into such contracts must manage the complex medical conditions inherent to older and disabled persons and meet their needs for specialty medical care and in some cases long-term care (nursing home care and home healthcare). As a result, some state Medicaid programs still have no managed care for the elderly and disabled, and the rest vary significantly in the plans available to these people.

But while the elderly and disabled are only a minority of Medicaid recipients, because of their greater needs they account for over two-thirds of expenditures. So states seek to rein in spending for these categories and better manage their care, and in doing so they continue to experiment with new health plan concepts.

The most successful model to date has been PACE (Program of All-Inclusive Care for the Elderly). First established in San Francisco in the early 1970s, PACE is now offered in 27 states. It provides community-based long-term care at a capitated rate to frail persons age 55 and older who would otherwise need nursing home care. While some services are available in an individual's home, most are provided at an adult day center. However, although PACE is a widely praised model, total enrollment is extremely small (less than 16,000 nationwide, half of this in only five states.)

Managed Care in CHIP

As in Medicaid, in the Children’s Health Insurance Program managed care has become increasingly important, and most participants are enrolled in health plans. As with Medicaid, states may offer a PCCM plan, a risk-based care plan, or a combination. States have the option of offering CHIP enrollees a more restrictive benefit package than that provided to Medicaid recipients, provided it meets the standards described above.

A significant difference between Medicaid and CHIP has to do with when coverage begins. A Medicaid recipient is covered as of the date of her application for Medicaid (or sometimes even a few months before), and her care is covered on a fee-for-service basis until her enrollment in a health plan is completed. In CHIP, on the other hand, coverage does not begin until the applicant has enrolled in a health plan, which may take a month or two after her CHIP application is approved.

Premium Assistance in Medicaid and CHIP

Instead of providing Medicaid and CHIP recipients with health coverage (either fee-for-service or managed care), a state has another option—premium assistance. Persons who qualify for Medicaid or CHIP but who also have access to employer-sponsored health insurance enroll in the employer plan, and the state pays the premium. (Often the premium for family members not eligible for Medicaid or CHIP is also paid.) The state
pays cost-sharing (deductibles, coinsurance, and copayments) for Medicaid-eligibles; CHIP-eligibles may have to pay some cost-sharing themselves, depending on their income. Finally, the state provides wrap coverage to pay expenses covered by Medicaid or CHIP but not by the private insurance.

Premium assistance enables a state to ensure that a person has health coverage while spending considerably less than it would to provide coverage directly. Medicaid recipients may generally choose between premium assistance and Medicaid coverage; in some states premium assistance is mandatory for CHIP-eligibles. Premium assistance is commonly used and is often mandatory for Medicaid waiver populations (people who are not eligible for Medicaid under normal rules but to whom a state extends eligibility under a waiver, most commonly childless adults).

**Federal Employees Health Benefits (FEHB) Program**

The **Federal Employees Health Benefits (FEHB) Program** provides health coverage for full-time employees of the United States government, qualified retirees, and their spouses, dependents, and survivors. Under FEHB a large number of insurance companies and employee associations (including labor unions) offer health plans, and employees choose one. FEHB is operated by the federal Office of Personnel Management (OPM), and it is the largest employer-based group health insurance program in the world, providing coverage to more than 8 million people.  

Federal employees can select from a large number of health plans offering a variety of coverage types, benefit packages, and premiums amounts. In recent years more than 250 plans have participated in FEHB, although the number available to each employee varies depending on where she lives. (While some plans operate nationally, others are regional.) Plans include traditional fee-for-service insurance policies, PPOs, HMOs, HMOs with a point-of-service (POS) feature, and high-deductible health plans.

While benefit packages vary significantly, all FEHB plans must provide a minimal level of coverage that includes hospital care, surgical care, in-patient and out-patient care, obstetrical care, mental health and substance abuse care, and prescription drugs. All plans must also meet FEHB standards related to access to care, benefit design, and patient safety. Premiums vary according to plan type and benefit package. The federal government pays a portion (usually 72 or 75 percent), and the employee pays the rest.

When a person is hired by the federal government, he chooses a plan from those available in his locality. A plan may not refuse to enroll him based on preexisting conditions, other health factors, age, or similar factors, and it may not impose a waiting period before coverage begins. Each year there is an open enrollment period during which federal workers can change plans if they wish.

**TRICARE**

**TRICARE** is the U.S. Department of Defense healthcare plan, serving members of the military and other uniformed services of the U.S. government, retirees, and their spouses and dependents. TRICARE uses a worldwide system of military hospitals and clinics as its main healthcare delivery system, but this is augmented by a network of civilian providers and facilities. TRICARE provides coverage to nearly 10 million people.
Congress funds TRICARE through the annual Department of Defense appropriation, and it can make changes to TRICARE benefits. The Assistant Secretary of Defense for Health Affairs (ASD/Ha) and the TRICARE Management Authority (TMA) translate the annual appropriation and changes into policy. Contracted third-party administrators (three regional U.S. contractors and one international contractor) execute the policies to serve beneficiaries. The contractors also develop and maintain the network of civilian providers and facilities.

Eligibility

To qualify for TRICARE, a person must be associated with one of the seven uniformed services of the U.S. government: the four branches of the military (the Army, the Navy, the Air Force, and the Marine Corps) plus the Coast Guard, the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA), and the Commissioned Corps of the Public Health Service. Those eligible include the following:

- active duty members of the services and activated members of the National Guard and the Reserves;
- retirees of the services (honorably discharged after 20 or more years of service); and
- the spouses and dependent children of the above.

Service members honorably discharged after less than 20 years are not eligible for TRICARE, but they can receive care through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Coverage

TRICARE covers a broad range of healthcare services from both military and civilian providers. Participants choose from numerous plans based on their needs; the major options are summarized below:

- **TRICARE Standard and Extra**—traditional fee-for-service health insurance with annual deductibles and two levels of cost-sharing. A member can receive care from an authorized non-network provider (the Standard option), but she pays higher cost-sharing than if she uses a TRICARE network provider (the Extra option).

- **TRICARE Prime**—a traditional gatekeeper HMO with a point-of-service (POS) option. The beneficiary's primary care provider (called a “primary care manager”) must work in a military facility or be a network provider. TRICARE Prime is required for active duty service members and activated reservists; it is an option for beneficiaries living in a “Prime Service Area” who are not eligible for Medicare.

- **US Family Health Plan**—a version of TRICARE Prime. Beneficiaries do not receive care from military facilities, TRICARE network providers, or Medicare providers, but rather one of the six former Public Health Service healthcare providers.
Government Programs: Other Programs

- **TRICARE Reserve Select**—a premium-based health plan for certain members of the Reserves and their families who are not eligible for FEHB.

- **TRICARE for Life**—Medicare wrap-around coverage for individuals enrolled in Medicare Parts A and B.

- **TRICARE Dental Program**—a voluntary traditional, premium-based dental insurance plan. It is free-of-charge for active duty service members and activated reservists.

- **TRICARE Pharmacy Program**—tiered formulary prescription drug coverage provided through military facilities, network and non-network retail pharmacies, and mail-order pharmacies.

TRICARE is always the payor of last resort. When a dependent or military retiree has health insurance from an employer or some other coverage, TRICARE pays benefits on the remaining balance only after the other insurance has paid.

**Premiums**

Active duty service members and activated reservists do not pay a premium for TRICARE, although they may be charged copayments for some benefits (such as prescription drugs). Most other TRICARE beneficiaries pay premiums. Premiums vary based on a person’s status (retiree or dependent) and the benefit package she chooses, and they range from nominal amounts to rates typical of the private-sector market. Retirees generally pay very low premiums; rate increases for them have been discussed many times over the past several years, but most in Congress are reluctant to take action that might be viewed as burdening veterans.

**Health Plan Features**

TRICARE has adopted health plan features such as referrals, authorization systems, and case management. In some locations military treatment facility (MTF) staff conduct medical management activities, while in others private-sector health plans are contracted to perform them. TRICARE medical management programs include preventive care, utilization management, disease management, case management, and care coordination. TRICARE has undertaken a variety of quality initiatives using performance measures, and it seeks appropriate accreditation for facilities. All health plan contractors are required to follow TRICARE quality management and utilization management procedures.

**The Effect of War**

Armed conflict has important affects on TRICARE:

- Active duty physicians, nurses, and other medical providers are routinely deployed overseas. Since their military facility positions are then vacant, network providers are more heavily relied on to maintain the same access to care.

- When reservists are called to active service, they and their families are added as TRICARE beneficiaries before, during, and for a period after deployment.
- Significant care, both physical and emotional, is needed for those injured in war. The full impact of post-traumatic stress disorder (PTSD) is only now starting to be recognized.

- The effect on families should not be ignored either—being separated from a family member in harm’s way for a prolonged period takes a severe mental and physical toll on spouses and children, increasing their need for medical services.

Workers' Compensation

**Workers’ compensation** is a state-mandated insurance program that provides benefits to cover healthcare costs and lost earnings for employees who suffer a work-related injury or illness.

Every state has a workers' compensation law, and all states except Texas require employers to provide workers' compensation benefits. Most employers meet this requirement by purchasing workers’ compensation insurance from an insurer. But some larger employers obtain permission from the state to self-insure or purchase high-deductible policies under which the employer retains much of the risk. Self-insured employers often hire a third-party administrator to manage their program.

Workers’ compensation provides the same types of medical benefits as regular group health insurance, but there are some significant differences:

- Workers’ compensation benefits are paid only if an injury or illness is work-related.

- Workers’ compensation laws prohibit deductibles and copayments, and they do not specify an annual or lifetime dollar maximum on medical benefits.

- While group health plans typically limit coverage to employees who meet eligibility requirements (for instance, excluding part-time workers), workers’ compensation laws in nearly every state mandate coverage for all employees.

- In many states employers are prohibited from limiting provider choice.

While in general group health plans provide benefits whether an injury or illness is work-related or non-work-related, an injury or illness that is covered by workers’ compensation is typically excluded from health plan coverage. But health plans differ greatly in the extent to which they enforce this provision. Many plans make little or no effort to determine if a medical bill should have been covered by workers’ compensation, while a few are quite aggressive. If there is evidence the condition is occupational, plans often pay a submitted bill but then seek reimbursement from a workers' compensation insurer.

In addition to medical benefits, workers' compensation also provides disability income benefits, which replace most (typically two-thirds) of the earnings an employee loses while she is unable to work because of a work-related injury or illness. These DI benefits, known as **workers' compensation indemnity benefits**, account for about half of all workers’ compensation expenses, with medical benefits making up the other half. All states provide for temporary DI benefits during a recovery period, and in all there is
some form of benefits for permanent disabilities, although the nature of these permanent benefits varies greatly by state.

Workers’ compensation is a “no fault” system. It is not required that an employer be at fault for an employee to be eligible for benefits—if an employee suffers from an illness or injury arising out of her employment, she is eligible. However, under state laws, workers’ compensation is an employee’s exclusive remedy—if an employer is at fault, the employee receives workers’ compensation, but she cannot obtain damages in a civil lawsuit against the employer.

**Managed Workers’ Compensation**

Although total workers’ compensation costs have been trending downward for the last 10 to 15 years, workers’ compensation medical benefits have been increasing. In response to this, employers and insurers have applied managed care principles to workers’ compensation, including case management, selective networks, and utilization review. Some of these projects have reduced costs substantially.

In general, the same approaches that help control health insurance costs also work in workers’ compensation. A potential problem arises in states that (as mentioned above) prohibit employers from limiting an employee’s choice of providers. But in these states many employers find that if they suggest a provider, employees will usually give her a try and continue with her if they are satisfied with the care and service they receive.

To help employers and health plans comply with state laws designed to ensure quality care, accreditation standards have been developed for workers’ compensation PPOs and workers’ compensation utilization review organizations (UROs) by the American Accreditation HealthCare Commission/URAC.

**Notes**

5 Ibid.
6 Ibid.