TESTIMONY OF THE TEXAS AFL-CIO
SENATE COMMITTEE ON STATE AFFAIRS

TEXAS NON-SUBSCRIBERS: AN ANALYSIS OF NON-SUBSCRIPTION IN TEXAS THROUGH THE LENS OF THE WALMART TEXAS INJURY CARE BENEFIT PLAN

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TO CHAIRMAN DUNCAN AND THE HONORABLE MEMBERS OF THE SENATE STATE AFFAIRS COMMITTEE:

My name is Richard Levy and I am submitting this testimony on behalf of the Texas AFL-CIO. As many of you know, the Texas AFL-CIO is federation of labor unions consisting of approximately six hundred fifty (650) local unions with over two hundred twenty-five thousand (250,000) dues paying members. The Texas AFL-CIO is the principal statewide labor federation in Texas existing for the purpose of promoting the interests of Texas wage earners, union and non-union, in legislative, judicial, and other public forms and activities. We have affiliate membership in every major sector in the economy as well as a presence in every geographic region of the state. It is from this base that we bring our comments to you today.

This committee has been tasked with looking into the dispute resolution process and benefits available from employers that do not subscribe to workers compensation in Texas. At the outset, it is important to remember that many non-subscribers don't have any plan at all and provide no benefits, and the workers at these companies are left entirely to their own devices to attempt to get medical treatment or replacement wages. Unfortunately, in many such instances, particularly in the construction industry, the employer simply goes out of business and leaves the worker without anything, without the reserves of the insurance company or certified self insured to back any claim. While these situations are tragic, there is no secret as to what is going on – the employer has chosen to risk going bare and the worker pays the price. This is one clear situation that we feel the legislature should act by requiring that employers in the dangerous construction industry carry workers compensation insurance.

The focus of this testimony is on those who purport to provide a true alternative to workers compensation. Non-subscribers come to the legislature touting the virtues of how they can serve the needs of the workers in a more cost effective and streamlined manner. You will probably hear much of that today. The real story is, however, that workers and the communities in which they live pay a steep price when they are not covered by workers compensation.[1] A cursory review of provisions typical in non-subscriber plans shows how that is the case: Benefits are egregiously restricted, medical care is under the total control of the employer, and the adjudication process is tilted dramatically towards the employer. Workers who even seek to avail themselves of benefits under these plans are subject not only to denial directly by their employer, but also to termination, as the Texas Supreme Court has ruled that employees of non-subscribers have no legal right to be free from retaliation for attempting to access benefits.

Significantly, though non-subscribers maintain that workers are treated fairly under these systems, they vigorously resist any attempt to verify these claims. They have opposed every effort to have accountability and oversight of these private systems. If the story is such a glorious one, it would seem that there would not be so much resistance to having it objectively evaluated.

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[1] This is not at all to say that all non-subscribers have set out to swindle their workers. Some employers I am sure do a very good job in treating and assisting injured workers in getting back to work. But this body doesn't generally make the laws for those who do the right thing, and the structural inequities and potential for abuse in the non-subscriber community is the focus of my testimony and hopefully will be the focus of the committee's legislative efforts.

Opposition has been expressed in terms of not wanting to increase costs through regulation, that any government involvement would cripple the program. This argument has lost some force given recent developments in Oklahoma. There, lawmakers are considering enacting legislation that would for the first time allow for non-subscription in that state. In contrast to the law here, however, that legislation has clear mandates as to minimum levels of benefits that must be provided, reserves that must be maintained, due process that must be respected, etc. (A copy of the proposed legislation is provided along with this testimony.) And many of the same companies that fight any regulation here in Texas are supportive of the effort there, including the very architect of many non-subscription plans here in Texas. If standards and oversight are good enough for the workers of the state of Oklahoma, surely they are good enough for workers and employers in Texas.

As research from the Texas Division of Workers Compensation has demonstrated, non-subscription rates have been increasing among large employers in this state. Most recently, Walmart, one of the largest, if not the largest employer in this state, made the decision to leave the workers compensation system and set up their own private plan. What follows is an analysis of some of the key provisions of this plan, most of which are common to virtually all non-subscription plans in use today. After looking at what they really provide for employees, it is our hope that you will recommend that this legislature impose standards and oversight over a system that is a permanent feature in the lives of millions of working Texans.

THE WALMART STORES, INC. TEXAS INJURY CARE BENEFIT PLAN (EFFECTIVE MARCH 1, 2012)

Article I: DEFINITIONS

1.3 **"Appeals Committee"** means the individuals or entity **appointed by the Company** to make Determinations on appeal of benefits claims on behalf of the Company and all other Employers. (p. 1)

Analysis: Many non-subscribers, including Walmart here, appoint themselves prosecutor, judge and jury in handling workers claims. No verifiable statistics are made available to workers, nor to policy makers about outcomes. Nowhere in the administrative process does the employee ever have their claim evaluated by anyone not specifically appointed by and directly accountable to the employer.

1.12(a) **First and Continuing Treatment.**

(1) The first Covered Charge must be received from an Approved Physician and incurred within 14 days following the date of the Injury (unless the Claims Administrator determines that good cause exists); and

(2) No further amount shall be considered a Covered Charge if the Participant does not receive medical treatment from an Approved Physician or Approved Facility…for a period of more than 60 days…(p. 4-5).

Analysis: No such requirements exist in the Texas Workers Compensation System. Workers are able to receive treatment for their injuries without the imposition of random time limits by their employer.

1.12(b) **Approved Provider and Pre-Authorization Requirements.** The cost of a service or supply shall be a Covered Charge only if:

> (1) treatment is furnished by or under the direction of an Approved Physician or Approved Facility, acting within the scope of the Approved Physician's or Approved Facility's license, and pre-approved in accordance with Section 4.2(d) by the Claims Administrator (except when the Claims Administrator determines that prior approval was impossible under the circumstances). Such pre-approval may include authorization for multiple visits to an Approved Physician or Approved Facility, and must be in writing, or by electronic notice (except as otherwise specified below or in Article VI herein) (p. 5).

Analysis: Here Walmart reserves for itself the right to select the doctor (except in emergency situations), and places upon the worker the obligation to have the provider pre-approved. There are no standards for adequacy of care, for quality of care, or for economic independence from the employer. Walmart maintains complete control of the entirety of the medical process. This is in stark contrast to the balanced safeguards that exist in the workers compensation system that this legislature labored so diligently to establish.

> 1.12(d)(17) **Non-Covered Medical.** Acupuncture, behavior modification, pain management programs, hypnosis, biofeedback, other forms of self-care or self-help training or any related diagnostic testing, or any service or supply ancillary to any of these treatments;
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> (18) Chiropractic or spinal manipulation services (p. 9).

Analysis: Acupuncture, all pain management, all chiropractic and spinal manipulation services are summarily excluded from coverage regardless of the medical needs of the patient.

1.26(c) **Non-Covered Injury Circumstances.** Furthermore, no benefits shall be payable under the Plan if: ...

> (5) the Injury occurred while the Participant was employed in violation of any law; ...
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> (13) the Injury arose out of the Participant's participation in: ...
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> (E) a felony or an assault, except an assault committed in defense of an Employer's business or property; or ...
>
> (14) 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 (pp. 13-15).

Analysis: Note that the policy summarily excludes underage employees, undocumented immigrants, and others from coverage, even if Walmart violated the law in hiring them. In addition, if an employee is injured by assault while at work, the injury is not covered unless the employee was engaged in the defense of the employer's business or property. Merely being the victim is not sufficient. Finally, asbestos and nuclear and biological contaminants are excluded.

1.27 "Maximum Benefit Limit" means the total amount of all benefits payable to, or with respect to, any Participant under the Plan with respect to an Injury. Payments made for each form of benefit shall be counted towards the Maximum Benefits Limit amount. The Maximum Benefit Limit for this plan is $300,000; provided, however, that the aggregate amount of the Maximum Benefit Limits with respect to claims of all Participants arising out of a single Accident, or related series of Accidents, or Occupational Disease or Cumulative Trauma exposure, shall not exceed $1,000,000. Such aggregate amount may proportionally reduce the Maximum Benefit Limit applicable to each Participant involved in such Accident, related series of Accidents, or exposure, in such manner as the Claims Administrator or Appeals Committee may determine (p. 15).

Analysis: These maximum benefits limits are one of the most striking differences between these plans and Texas Workers Compensation provisions. For workers who are covered by workers' compensation, there are no benefit limits as employees are entitled to lifetime medical care in addition to whatever income benefits that they qualify for. Here there is a $300,000 per claim limit. This covers all types of benefits, medical and indemnity, including death benefits. Note also the $1,000,000 aggregate limit, so that, for example, if four workers are injured in the same or related series of accidents, each worker is limited to only $250,000.

3.1(d) **When Wage Replacement Benefits Cease:** Wage Replacement Benefits shall continue until the earliest of:

(1) the expiration of 120 weeks from the date of the Injury. This 120-week maximum period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether or not the Participant qualifies as Disabled at all time during such period or received Wage Replacement Benefits continuously throughout such period; ...

(4) termination of both the Participant's status as a Covered Associate <u>and</u> all other employment of the Participant with an Employer; provided, however, that this paragraph (4) shall not apply if termination of employment is solely due to -

(A) application of a duration limit in the Employer's leave of absence policy, or

(B) elimination of the Participant's employment position (pp. 22-23).

Analysis: Another restrictive provision that undermines worker protection. Under Labor Code Section 408.083, workers are entitled to a maximum of 401 weeks of benefits. Here, the maximum is only 120 weeks. Note also that if the employee quits and moves on to another job, or is fired for a good reason, a bad reason, or no reason at all, they immediately lose any right to benefits, including medical benefits. In the workers compensation system, leaving your job does not affect your right to lifetime medical benefits.

It is also important to note that there are no provisions for supplemental income benefits, or impairment income benefits under this plan, further limiting the recovery available to workers.

3.2 Death Benefits. In the event that a Participant dies as the direct and sole result of, and within 365 days of, an injury, then the Plan shall pay such Participant's Beneficiary a Death Benefit equal to $250,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Maximum Benefit Limit. The Death Benefit shall be paid to the Participant's Beneficiary as follows: (i) 20% of the Death Benefit shall be paid in a lump sum cash payment as soon as administratively possible following the death of the Participant and the determination of the proper Beneficiary; and (ii) the remainder of the Death Benefit shall be paid in 35 equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment. Death Benefits payable under this Plan shall be in addition to Medical Benefits, Wage Replacement Benefits, and Dismemberment Benefits payable to, or with respect to, the Participant; provided, however, that no interest in future Dismemberment Benefits survives after a Participant's death which results in the payment of benefits under this Section 3.2. In addition to the Death Benefits set forth above, the Plan shall reimburse reasonable burial expenses to any person who incurs liability therefore, up to $12,000. Reimbursed reasonable burial expenses are not subject to the Maximum Benefit Limit (p. 23).

Analysis: Death benefits are a maximum of $250,000, minus, of course, any medical expenses incurred by the deceased. This will often leave very little for the surviving spouse. For employees covered by workers compensation, by contrast, the surviving beneficiary is entitled to lifetime benefits in addition to whatever medical expenses are incurred.

3.4 Medical Benefits. Subject to the medical management and other provisions of this Plan, the Plan shall pay Medical Benefits to, or with respect to, a Participant for an injury in an amount equal to all Covered Charges; provided, however, that Medical Benefits shall cease upon the earliest of:

(a) the expiration of 120 weeks from the date of an injury;

(b) reaching the Maximum benefit limit;

(c) involuntary termination of employment of the Participant with an Employer for Gross Misconduct;

(d) the Participant not receiving medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days; or

(e) as otherwise provided under Section 4.3 (p. 25).

Analysis: Again, this is in stark contrast to the lifetime medical benefits available to covered employees.

4.1(a) (1) N**otice of Injury.** For Injury due to an Accident, or for a known exposure to an Occupational Disease, verbal notice must be provided within 24 hours of the time of the injury.

(2) For an actual Injury due to Occupational Disease or Cumulative Trauma, verbal notice must be provided within 24 hours after being medically diagnosed with a work-related injury, or within 30 days after the Participant should have known of the work-related injury, whichever is earlier (pp. 25-26).

Analysis: This is a critical provision that operates to deprive many workers of any benefits at all. Under Texas law, covered employees have at least thirty days to report an injury, and in many cases, up to a year. Here, the worker has to notify the employer within 24 hours, even if the injury occurs on a Friday. Some employers have even more restrictive requirements, including that the injury must be reported in writing prior to the end of the shift on which they were injured. Obviously, these provisions exclude many viable claims which under state workers compensation law would be covered.

(b) **Providing Required Information:** An injured Participant (or the Participant's Representative) must complete the incident report form and medical authorization form within 24 hours after the injury is reported. These forms must be submitted to the Participant's supervisor (or such other person as the Claims Administrator may specify). The Participant must provide verbal, written, or recorded statements, and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm suffered by the Participant, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may from time-to-time direct. No benefits will be payable under the Plan if all information is not provided as required above, unless the Claims Administrator determines that good cause exists for failure to provide such information in a complete and timely manner. (p. 26)

*Analysis: Note the requirement that the employee submit a complete **written** report within 24 hours, without access to counsel, without access to medical records, and quite probably while still dealing with the initial impact of the injury. Needless to say, no such requirement exists under state law.*

4.3 Suspension or Termination of Benefits. The Claims Administrator may deny a claim for, or suspend or terminate the payment of, Plan benefits otherwise due a Participant if: ...

(b) the Participant does not received prior approval for all medical care other than Emergency Care;

(c) the Participant utilizes a non-approved physician or facility other than for Emergency Care; ...

(g) the Participant fails to provide accurate information to, or fails to follow the directions of, a treating Approved Physician. Following the directions of a treating Approved Physician includes, but is not limited to, any recommended treatment, therapy, course of action, abstinence, or rehabilitation program;

(h) the Participant fails or refuses to allow an authorized representative of the Plan to accompany the Participant to an appointment with a health care provider;

(i) the Participant fails to keep, or is late for, a scheduled appointment with a health care provider. Except in extraordinary circumstances as determined by the Claims Administrator, a first missed appointment shall result in a warning and/or suspension of benefits and a second missed appointment shall result in a termination of benefits; ...

(k) the Participant does not actively participate in activities that increase the likelihood of the Participant's return to work or pre-injury status, including, but not limited to, reporting Participant's work status or expected recovery time after each appointment or as directed during the course of the claim (pp. 29-30).

Analysis: A laundry list of gotchas for the Walmart appointed Claims Administrator to cut off benefits.

5.1(b) **Administrative Authority:** Subject to the Plan claims procedures, the Claims Administrator and Appeals Committee shall have discretionary and final authority to interpret and implement the provisions of the Plan, including, but not limited to, making all factual and legal determinations, correcting any defect, reconciling any inconsistency and supplying any omission, and making any and all determinations that may impact a claim for benefits hereunder (p. 32).

Analysis: The Walmart-appointed Claims Administrator and the Walmart-appointed Appeals Committee are given free rein to administer this program, and are given final authority over who gets benefits, what benefits are provided, etc. This is as opposed to the public system which is conducted according to clear statutory and administrative rules that guarantee due process to participants.

<u>Appendix A</u>

The employer hereby adopts a mandatory company policy requiring that certain claims or disputes must be submitted to final and binding arbitration under this arbitration requirement ("Policy"). (App. p.1)

Arbitration Process

(b) **Arbitration Filing Fees:** The associate shall pay a nonrefundable arbitration filing fee equal to the standard associate filing fee specified under then-current JWA Arbitration Procedures. The associate's filing fee must be paid when he or she submits a request for arbitration (or, if this process is challenged by an associate, when arbitration is compelled by court order). The Employer shall pay a nonrefundable arbitration filing fee equal to the standard employer filing fee specified under then-current JWA Arbitration Procedures. The Employer will also pay the arbitrator's entire fee and any other JWA administrative expenses; provided, however, that an associate may elect to also pay up to one-half of these fees and expenses. The arbitrator shall state his or her hourly rate in writing prior to the time that the arbitrator is selected. The arbitrator's rate shall not change during the pendency of a case. If the arbitrator must travel, the time spent in travel and reasonable travel expenses shall be paid as specified above.

(1) If the arbitrator finds completely in favor of the associate on all claims, the Employer will reimburse the associate for his or her share of the filing fee.

(2) If the Employer initiates the arbitration (by means other than a motion in court to compel arbitration), the associate will pay no portion of the JWA or arbitrator filing fees (p. 3).

(h)(4) **Attorney Fees:** Each party shall be responsible for their own attorney's fees, if any. However, if any party prevails on a statutory claim which allows the prevailing party to be awarded attorney's fees, or if there is a written agreement providing for such fees, the arbitrator may award reasonable attorney's fees to the prevailing party (p. 5).

Analysis: Mandatory arbitration. Walmart, like virtually all other non-subscribers with alternative plans, has set up their own private arbitration system, where the verdicts are private, the claimants must pay to play, and the entire system is tilted to employers. The arbitration company that they use is one that was specifically set up by and for non-subscribers. It is unclear what role Walmart specifically played in setting up this company.

CONCLUSION

Workers who are covered by workers compensation insurance have a clear right to critical measures to assist in the difficult transition from injury back to work. While clearly not perfect by any means, workers get various levels of replacement income benefits, lifetime medical benefits, and the guarantee of impartial due process in the adjudication of their claims. There is public accountability in this system.

For workers who are not covered by workers compensation, the same cannot be said. As Walmart's plan makes clear, the deck is stacked against injured workers in a way that I don't think we as a state should tolerate in any adjudicative process. Other than the potentially self serving claims of those who benefit from the system, we have no objective data or information as to what actually happens to those who are caught in this system, but it is easy to surmise that the costs of injury and care all to often fall back on the injured workers themselves through reduced

access to benefits, and on the taxpayers in the communities in which they live through increased uncompensated care.

As the Walmart plan shows, employers in this state have the freedom to employ whatever means that they desire, with no minimum standards and no oversight from the state, in the way that they treat injured workers. Almost two million workers come to work every day without the protection workers compensation offers. The time has come for this committee to assert control over this growing sector of employers and recommend to the full senate that oversight and fairness demand that a set of minimum standards be set for those who choose to not be part of the workers compensation system

We thank you for your consideration of our views.