From John Burton's Workers' Compensation Resources

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In This Issue:

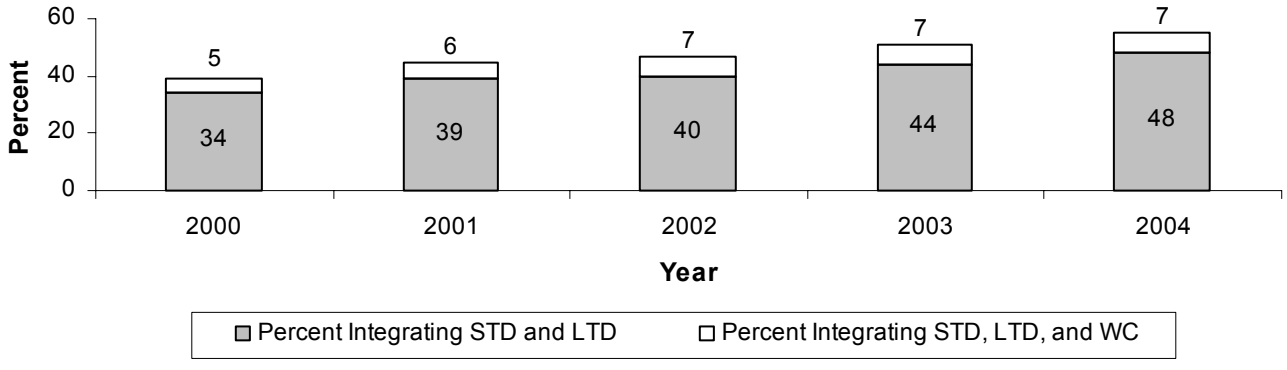
Featured Topics

Summary of the Contents

Expenditures on medical benefits in workers' compensation programs have been increasing rapidly in recent years. Barry Llewellyn and Jim Stevens discuss a major source of increasing costs, namely expenditures on prescription drugs. From 1997 to 2002, the share of total medical costs due to expenditures on drugs increased from 10.1 percent to 12.1 percent. In part, the increased expenditures were due to higher prices for the drugs, but a more important factor for the increasing costs over the six years was greater utilization of drugs. Llewellyn and Stevens also discuss the efficacy of several policies designed to moderate the increasing costs of prescription drugs, including fee schedules and the use of Pharmacy Benefit Managers.

Annmarie Geddes Lipold examines the integration of workers' compensation with employee benefits during recent decades. She carefully delineates the various approaches to benefits integration. One variant, sometimes referred to as 24-Hour Coverage, involves the elimination of distinctions between the medical benefits (and in some proposals, cash benefits) for occupational and non-occupational disability. After a number of starts in this direction in the early 1990s, the proposals for unitary benefit schemes have largely been abandoned. Another variant of integration involves the combined administration of workers' compensation, short-term disability, and long-term disability programs. As shown in Figure A, integration of this type has rapidly increased in recent years, with over half of all surveyed employers now integrating at least two disability programs.

Figure A
Mercer/Marsh Survey of Employers' Time Off and Disability Programs, 2000-2004



Source: Faulkner and Craig (2005).
STD is short-term disability, LTD is long-term disability, WC is workers' compensation.

Workers' Compensation Prescription Drug Study

by Barry Llewellyn and Jim Stevens

Background

The National Council on Compensation Insurance's (NCCI's) 2003 study, "Prescription Drugs: Comparison of Drug Costs and Patterns of Use in Workers Compensation and Group Health Plans," examined the cost and use of prescription drugs in workers' compensation. That study showed that prescription drugs' share of total medical costs increased substantially from 1997 to 2001; that utilization had a greater impact on workers' compensation drug costs than price; and that, since workers' compensation was already doing a good job prescribing generic equivalents when available, there was little opportunity for savings from increasing the use of generic equivalents. The complete study is available on ncci.com. This 2004 update looks at the effects of more mature data on these issues and examines the nature of the states' efforts to control prescription drug reimbursement levels in workers' compensation.

Prescription Drug Study 2004 Update – Key Findings

The 2004 update yields several key findings for injuries through 2002. First, payment patterns by accident year[1] show continued growth in prescription drugs' share of total workers' compensation medical costs. The estimated share of ultimate medical benefits rose from 10.1 percent in 1997 to 12.1 percent in 2002. Second, drug price increases had a slightly greater impact on workers' compensation drug costs than utilization increases for 2002 over 2001. Third, 28 states were identified as having prescription drug fee schedules, and all use average wholesale price (AWP) as a mechanism for reimbursement. Finally, although creating Pharmacy Benefit Managers (PBMs)[2] initially looks promising as a cost containment strategy, other factors also will need to be assessed and addressed.

Prescription Drugs' Share of Medical Costs

As expected, prescription drugs' share of total workers' compensation medical costs by accident year continues to grow. As shown in Table 1, this share is estimated to be 12 percent at ultimate development for accident year 2002 compared with approximately 10 percent for accident year 1997. This 20 percent growth in the prescription drug share is noteworthy because it occurred over a period during which total medical costs for workers compensation have risen substantially.

Drug Costs Breakdown

For the first time in several years, we see the impact of drug pricing slightly outpacing the utilization[3] impact in drug costs from 2001 to 2002. Notwithstanding this recent result, most knowledgeable observers agree that utilization is the more important driver of medical costs. Any successes achieved from efforts to control costs through price reduction alone will be diluted or eliminated if utilization is not effectively controlled. One of the factors contributing to this year's cost change may be that companies are focusing more attention on drug utilization due to continued reports of the rise in prescription drugs' share of total medical costs. It will be interesting to see if this change is just a one-time occurrence or the beginning of a new trend.

Although prescription drugs' share of total medical costs continued to grow, as shown in Table 2, the overall rate of growth of drug costs slowed in 2002 compared to the three previous years.

Prescribing Patterns

The percentage of times a generic drug prescription was written when a generic drug was available rose from 79 percent in 2001 to 86 percent in 2002. Consistent with that increase, the remaining potential for savings from generic drugs decreased from 8 percent of total workers' compensation prescription drug costs in 2001 to 7 percent in 2002. A total of 53 percent of the 2002 workers' compensation prescription drug costs were associated with drugs that have no generic equivalent, compared to 56 percent in 2001.

The update also showed that the top three types of prescription drugs by total paid in workers' compensation remained the same with only slight changes in percentages of total paid, as shown in Table 3. Painkillers are by far the largest category, accounting for 54 percent of total prescriptions paid. Muscle relaxants are the second largest category of prescription drugs at 18 percent of total

Table 1
Accident Year Drug Costs/Total Medical Costs
(Estimated at Ultimate)

Injury Year	Accident Year % Rx
1997	10.1%
1998	10.6%
1999	11.1%
2000	11.5%
2001	11.8%
2002	12.1%

prescriptions paid. The third largest category of prescription drugs is antidepressants, making up fifteen percent of total prescriptions paid.

The top 10 drugs in the 2004 update, shown in Table 4, represented almost 43 percent of total prescription drugs paid. There was little change in rank by total paid from the 2003 study. The muscle relaxant Soma® dropped from the list, moving from ninth in the original study to fifteenth in the update, and was replaced by anti-inflammatory Naproxen at tenth. Five of the top 10 drugs had no generic equivalent available in 2002.

Drugs Showing Rising Rankings in Workers Compensation. Several drugs showed significant increase in rank by total paid from the initial 2003 study (1997–2001 data) to the 2004 update (1997–2002 data).

Bextra® is a painkiller used to relieve joint pain, inflammation, and stiffness associated with osteoarthritis and adult rheumatoid arthritis. It moved from a ranking of 1,852 to a ranking of 19 in the update. Bextra® was not approved by the Food and Drug Administration (FDA) until November 2001.

Ultracet® is a painkiller used to help relieve the pain (for a short period of time—usually 5 days or fewer) from acute conditions such as sprains, strains, joint pain flares, and postoperative pain. It received FDA approval in August 2001 and moved from a ranking of 212 in last year's study to a ranking of 31 in the update.

Actiq® is an opioid analgesic (painkiller) used only for the management of breakthrough cancer pain (a flare of severe cancer pain that breaks through the medication that is being administered at regular intervals for persistent cancer pain). Although Actiq® received FDA approval in 1998, it moved in rank from 224 in the 1997–2001 data to 47 in the 1997–2002 data.

Tizanidine HCL and Tramadol HCL are generic forms of the muscle relaxant (Zanaflex®) and painkiller (Ultram®), respectively, and they re-

Table 2
Factors Affecting Change in Workers' Compensation Drug Costs

Years	Drug Price Impact	Utilization Impact	Total Impact
1997–1998	1.07	1.06	1.13
1998–1999	1.12	1.21	1.35
1999–2000	1.07	1.16	1.25
2000–2001	1.08	1.22	1.31
2001–2002	1.08	1.07	1.15

Table 3
Top Three Types of Workers' Compensation Prescription Drugs as a Percentage of Total Paid Prescriptions (1997–2002 Data)

Drug Group	Percent of Total Rx Paid
Painkillers	54
Muscle relaxants	18
Antidepressants	15

Table 4
Top 10 Prescribed Drugs by Total Paid in Workers' Compensation (1997–2002)

Prescribed Drug	Percent of Total Rx Paid	Brand vs. Generic
Celebrex® (anti-inflammatory)	7.6%	Brand (generic not available)
Oxycontin® (painkiller)	6.6%	Brand (generic not available)*
Vioxx® (anti-inflammatory)***	5.6%	Brand (generic not available)
Hydrocodone (painkiller)	5.4%	Generic
Neurontin® (painkiller)	4.9%	Brand (generic not available)**
Carisoprodol (muscle relaxant)	3.2%	Generic
Ultram® (painkiller)	2.9%	Brand (generic available 6/02)
Cyclobenzaprine (muscle relaxant)	2.4%	Generic
Ambien® (sedative)	2.1%	Brand (generic not available)
Naproxen®(anti-inflammatory)	2.1%	Generic

Notes:
* Generic versions of OxyContin® (oxycodone hydrochloride extended-release tablets) received FDA approval in 3/04.
** Generic for Neurontin® received FDA approval in 9/03.
*** Withdrawn from market 9/30/04.

ceived FDA approval in mid-2002. Tizanidine HCL ranked at 34 and Tramadol HCL ranked at 39 in this year's update. Intuitively, we would expect to see a decrease in the share of total prescription drug costs that a brand represents when generics are introduced into the market for that particular drug (i.e., the substitution effect). That theory held true for one of these two particular drugs. The share of total prescriptions paid that Ultram® represents decreased from 4.49 percent in the 2003 study to 2.92 percent in the update. However, the share of total prescriptions paid that Zanaflex® represents increased from 0.87 percent in last year's study to 0.89 percent in the update.

Current Events and Cost Containment

As prescription drug costs continue to rise and represent an increasingly larger share of medical cost in workers' compensation, states continue to search for ways to control these costs. This section examines several new developments in the area of prescription drug cost containment.

Prescription Drug Fee Schedules. There are currently 28 states that have some type of workers' compensation prescription drug reimbursement schedule (see Appendix). The following is a summary of the key components of these fee schedules:[4]

All 28 states use average wholesale price (AWP)[5] as a mechanism for prescription drug reimbursement.

Eleven states differentiate in some way (the majority have higher dispensing fee for generics) between generic and brand for reimbursement. The other 17 states use the same formula in calculating brand and generic reimbursements.

Nine states reimburse up to a level ***above*** AWP (range 4 percent to 40 percent), 11 states reimburse ***up to*** AWP, and eight states reimburse up to a level that is ***below*** AWP (range –5 percent to –15 percent).

As discussed in our previous study, fee schedules can be part of an effective cost containment strategy. Many states that don't already have prescription drug fee schedules are considering establishing them, and some of those states that do have prescription drug fee schedules are reviewing them to determine the appropriateness of the current levels of reimbursement.

California 2003 Reform. California is an example of a state that has reviewed its pharmacy fee schedule and made some changes. The 2003 California workers' compensation reform included mandatory generic substitution and changed the California pharmacy fee schedule to 100 percent of Medi-Cal (California Medicaid) pharmacy payments (AB 227 and SB 228). The previous California workers' compensation prescription drug fee schedule was:

Brand name drugs: 1.1 x AWP x Quantity + $4.00 dispensing fee

Generic drugs: 1.4 x AWP x Quantity + $7.50 dispensing fee

The Medi-Cal pharmacy schedule (California Department of Industrial Relations 2004) (effective for CA workers' compensation 1/1/04) pays 95 percent of the lesser of: (AWP – 10% + $3.55), or (MAC + $3.55), or usual and customary fee. (MAC is the Maximum Allowable Cost.[6])

The Workers' Compensation Insurance Rating Bureau (WCIRB) in California estimates pharmaceutical cost savings from the provisions of AB 227 and SB 228 to be 1.7 percent of medical costs or 1 percent of total workers' compensation costs (a savings of $249 million based on a $24.9 billion estimate of the total cost of statewide benefits) (WCIRB 2003).

It should be noted that, as with any change to the workers' compensation system, there is always concern for the effect of changes on access to care for injured workers. Lawmakers face a constant struggle to strike a balance between lowering costs as much as possible while maintaining adequate access to care. For example, although its recommendations were not incorporated in the final bill, a Department of Industrial Relations, Division of Workers' Compensation study (California Department of Industrial Relations 2004) included a survey of pharmacies and commercial insurers in the state on the change in the pharmacy fee schedule. Pharmacies clearly indicated that there is a potential for loss of pharmacy access for workers' compensation clients. To mitigate the negative effects of implementing the new payment program (i.e., restricting access to care), the study recommended modifying the program, either by phasing it in more slowly (such as increasing the payment rate from 95 percent to 100 percent), or by providing some protections for the independent pharmacies (since they will have less ability than chain pharmacies to shift losses to others and to re-negotiate new rates). The study also suggested that "combining this type of fee schedule with other cost containment policies through the use of the negotiating power of pharmacy benefits managers (PBMs) should achieve the kind of necessary cost containment in the pharmaceutical benefit sector of workers' compensation, without disrupting access to drugs for workers compensation patients."

AccessRx Act of 2004. The Council of the District of Columbia (DC) approved the AccessRx Act of 2004 on March 2, 2004. The Act creates a new program intended to reduce prescription drug prices for low-income, elderly, and uninsured city residents.

Title II of the Act, entitled, "Transparent business practices among pharmacy benefits managers," has caused some controversy. This section of the Act focuses on establishing "transparent business practices" between PBMs and the covered entity. Some of the requirements set forth in Title II are that PBMs must:

Show the quantity and net cost of drugs purchased by the entity,

including rebates, discounts, and other similar payments (on a drug-by-drug basis if requested);

Disclose all financial terms and arrangements for remuneration of any kind that apply between the PBM and any prescription drug manufacturer or labeler, including formulary management and drug substitution programs, educational support, claims processing, and data sales fees; and

Transfer in full to the covered entity any benefit or payment received as a result of a prescription drug substitution.

Critics of PBMs say that companies sometimes keep payments from drug companies in return for promoting certain drugs, often the new, brand-name drugs in place of lower-priced generic versions (*The Common Denominator* 2004).

The Pharmaceutical Care Management Association (PCMA) filed suit to block enforcement of Title II of the AccessRx Act of 2004. PCMA is a national association that represents pharmacy benefits managers whose membership includes three of the nation's largest PBMs. The PCMA contends that Title II will result in higher prescription drug costs for DC residents and is unconstitutional (*Washington Business Journal* 2004). Pharmacy benefit managers say they need the confidentiality in their transactions to increase competition and obtain lower prices for drugs (*The Common Denominator* 2004). A study prepared for PCMA by PricewaterhouseCoopers (PricewaterhouseCoopers 2004) estimates that drug costs for individuals in PBM-managed plans would rise by 5.2 percent ($8.2 billion) in 2005 and 7 percent ($225 billion) over the 2005–2014 period.

Non-profit PBMs. Legislators from the nine-state National Legislative Association on Prescription Drug Prices (NLARx) are developing a non-profit group to manage prescription drug costs and limit drug manufacturers' ability to sell states their most expensive drugs. The goal of the program is to cut out the middle-man (for-profit PBMs), which many states use to negotiate prices and manage pharmacy benefits for Medicaid recipients and state employees, to ensure that payments and rebates from drug companies benefit the states. The group would also develop a preferred drug list based on effectiveness and cost and obtain rebates from companies whose drugs are included on the list (National Conference of State Legislatures 2004).

Comments on Cost Containment Strategies

Pharmacy Benefits Management—Discounts from Sticker Price, or Long-Term Cost Reduction? As the workers' compensation industry continues to search for strategies and techniques to control prescription drug costs, interest has increased in the potential use of PBMs for workers' compensation. Many studies and articles have highlighted the savings achieved through the use of PBMs. Few question the bargaining power of these large companies and their ability to secure discounts from full-billed prices. In fact, prices paid by cash paying customers and even Medicaid programs in many states are higher than PBMs would typically pay (University of Wisconsin School of Pharmacy 2000). The apparent conclusion may be that PBMs are the answer to curbing the continually increasing prescription drug costs in workers' compensation.

However, obtaining a discount on a prescription's AWP, or sticker price, does not necessarily translate into a reduction in costs for the workers' compensation system. Utilization plays a major role in driving workers' compensation costs, and AWP can be a moving target when used as a benchmark for calculating discounts. Although the expanded use of PBMs in workers' compensation could result in an initial drop in overall prescription drug prices, the year-to-year and long-term effects on reducing medical costs in the workers' compensation system are not certain.

Theoretically, the techniques used by PBMs should work, and some successes have been documented. However, prescription drug expenditures continue to rise. This suggests that this specific cost containment mechanism is not singularly sufficient to contain costs and that there are other factors driving cost increases that need to be assessed and addressed. The following are some possible examples (University of Wisconsin School of Pharmacy 2000).

Generic substitution policies have increased the use of generics when available, but the use of higher priced new drugs has diluted the impact of generic drugs on overall costs.

Use of low-cost prescription drug providers (e.g., mail service pharmacies) has decreased emphasis on assessing appropriate (cost-effective) drug selection and sound, well-informed drug use by consumers.

Since rebates are typically provided for new, brand-name drugs, the potential use of older, low-cost generics as effective alternatives may not be getting the necessary attention.

The NCCI will continue to monitor and report on prescription drugs and other important issues that affect the workers' compensation industry.

ENDNOTES

1. Workers' compensation looks at costs by accident year (the year of injury) because insurance coverage continues (potentially for many years) following the date of injury in workers' compensation. This "long-tail" feature of workers' compensation is distinct from most other lines of insurance coverage, for which costs are normally confined to the 12-month calendar year (or service year) for which premium is charged. As a result, other types of insurance coverage are much more sensitive to short-term increases in costs, while workers' compensation is subject to substantial uncertainties concerning long-term cost pressures.

The "long tail" nature of workers' compensation is critical and underscores the need for further research. Substantial quantities of medical service are routinely delivered for many years following the occurrence of a workers' compensation claim. As a result, estimates of the annual costs and reserves on serious claims must fully account for the compounding effect of medical inflation. For example, if the annual cost of a fixed regimen of medical treatment is $10,000 in the first year following a claim and annual medical cost inflation is at 10 percent, the cost for these services in the eighth year following the claim will be nearly double the first year's cost.

2. Pharmacy Benefits Managers (PBMs) are companies that provide a service to covered entities that facilitates the provision of prescription drug benefits to covered individuals, including negotiating pricing and other terms with drug manufacturers and retail pharmacies. "Pharmacy benefits management" may include any or all of the following:

1) Claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to covered individuals;
2) Clinical formulary development and management services;
3) Rebate contracting and administration;
4) Certain patient compliance, therapeutic intervention, and generic substitution programs;
5) Disease management programs.

3. Utilization includes movement toward new or more powerful drugs and an increase in the number of prescriptions. Price impact represents the unit price change for a fixed-market basket of prescriptions.

4. Most states also include a dispensing fee as part of prescription drug reimbursement.

5. Average wholesale price (AWP) is the most commonly used price benchmark for ingredient cost. The total price of a prescription is: Ingredient Cost (which includes the costs of R&D, marketing and profit) + Dispensing Fee + Tax. AWPs are reported by drug manufacturers to organizations that publish the data in compendia (e.g., Red Book), which are used by Medicare and other third parties to calculate prescription reimbursement. The AWP is not the acquisition cost paid by suppliers and physicians, as it does not reflect rebates and discounts. AWP is not defined by law or regulation.

6. Maximum Allowable Cost (MAC) is an overriding fixed price used in lieu of the AWP basis. The MAC is the highest price that will be paid for a drug or its equivalent.

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About the Authors

Barry Llewellyn has been active in the property casualty insurance regulatory arena for over three decades, with a particular concentration in matters involving workers' compensation insurance, actuarial, regulatory and legislative issues. Through his employment with NCCI, he has served as Vice President and Actuary-Law Evaluations, Senior Vice President and Actuary and currently as Senior Divisional Executive-Regulatory Services. He was previously employed by Cigna Property and Casualty Group as Assistant Vice President and Actuary and by NCCI as Assistant Vice President and Regional Actuary. Barry received a Bachelor of Arts degree from Susquehanna University and he is an Associate of the Casualty Actuarial Society and a Member of the American Academy of Actuaries. He is a member of the National Academy of Social Insurance and served as a U.S. delegate to the Tri-National Conference on Workplace Violence.

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Appendix: Prescription Drug Fee Schedules (as of 07/13/04)

State	Maximum Prescription Drug Reimbursement
Alabama	BRAND: AWP + 5% +$6.88 GENERIC: AWP + 5% + $8.94
Arizona	DRUGS AND SUPPLIES (only those dispensed by a doctor): (AWP x QT) +15%
Arkansas	AWP + $5.13 DISPENSING FEE; OR PROVIDER'S USUAL CHARGE
California	The max reasonable fee is 100% of the fee prescribed in the relevant Medi-Cal Payment system. Currently, 95% of the lesser of: (AWP – 10% + $3.55) , or (MAC + $3.55), or (usual and customary fee). (As of 3/24/04)
Colorado	ALL DRUGS: (AWP X QT) + $6.00 All prescriptions shall be filled with bio-equivalent generic drugs unless, DAW. COMPOUNDING PHARMACIES REIMBURSEMENT: the cost of the materials plus 20%, $50.00 per hour for the pharmacist's documented time, and actual cost of any mailing & handling.
Florida	AWP + $4.18; OR the contracted amount arranged between provider and carrier, WHICHEVER IS LESS.
Georgia	BRAND & GENERIC: (AWP) X 1.2 + $4.00 dispensing fee.
Hawaii	PRESCRIPTIVE DRUGS: AWP (American Druggist Red Book) + 40 % (of the AWP when sold by a physician, hospital, pharmacy, or provider of service other than a physician).
Kansas	BRAND: AWP - 10% + $4.00 dispensing fee GENERIC: AWP - 10% + $5.00 dispensing fee
Kentucky	DISPENSED BY PHARMACIST: Reimbursed in the amount of the equivalent drug product AWP of the lowest priced therapeutically equivalent drug the dispensing pharmacist has in stock, at the time of dispensing, plus a $5 dispensing fee plus assessment: AWP + $5. If an employee's prescription is marked DAW, the dispensing pharmacist shall be entitled to reimbursement in an amount equal to the brand name drug wholesale price, at the time of dispensing, plus a $5 dollar dispensing fee plus any applicable federal or state tax or assessment: AWP + $5 + TAX. If an injured worker prefers a brand-name drug, the worker is responsible for payment of the difference between the equivalent drug product wholesale price of the lowest priced therapeutically equivalent drug the dispensing pharmacist has in stock and the brand name drug wholesale price at the time of dispensing: BRAND AWP – GENERIC AWP.
Louisiana	BRAND: the provider's usual charge; a provider/insurer contracted charge; OR AWP + 10% + dispensing fee (equal to the Medicaid dispensing fee set by the State of Louisiana, Department of Health and Hospitals); WHICHEVER IS LESS. GENERIC: the provider's usual charge; a provider/insurer contracted charge; OR AWP + 40% + dispensing fee (equal to the Medicaid dispensing fee set by the State of Louisiana, Department of Health and Hospitals); WHICHEVER IS LESS. (The AWPs for brand-name and generic pharmaceuticals will be the AWP listed in the most recent monthly update of the Annual Pharmacists' Reference Red Book).
Massachusetts	LESSER OF: Federal upper limit of the drug + $3.00 dispensing fee; MA upper limit of the drug + $3.00 dispensing fee; Red Book AWP X 84.8% + $3.00 dispensing fee; OR usual and customary.

State	Maximum Prescription Drug Reimbursement
Michigan	PRESCRIPTION MEDS: AWP + $4.00 dispense fee as determined by the Red Book. OTCs: dispensed by a provider other than a pharmacy, shall be dispensed in 10-day quantities and shall be reimbursed at the AWP, as determined by the Red Book, OR $2.50, WHICHEVER IS GREATER. MEDICAL EQUIPMENT& SUPPLIES (including pre-fabricated splints): AWP + not more than 50%; OR the provider's usual and customary charge, which-ever is less.
Minnesota	SMALL HOSPITAL: paid at 100% of the usual and customary charge OUTPATIENT: AWP + $5.14 dispensing fee INPATIENT: LARGE HOSPITAL: limited to 85% of the usual and customary charge.
Montana	Insurers are liable only for the purchase of GENERIC-NAME DRUGS (unless un-available); home health care is paid in terms of usual and customary fees. DRUGS: (AWP X QT) + $5.50 dispensing fee SUPPLIES: $30.00 OR (AWP X QT) + 30% WHICHEVER IS LESS If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the reimbursement rate between the brand-name drug and the generic-name product. BRAND AWP – GENERIC AWP.
Nevada	DRUGS: (AWP X QT) + $6.00; usual and customary price; OR contracted amount between the provider of health care and insurer; WHICHEVER IS LESS, except those provided to an injured employee occupying a bed in the hospital. A physician or advanced practitioner of nursing shall prescribe a GENERIC DRUG in lieu of a drug with a brand-name, except when the generic drug is higher in cost OR it is not beneficial to the health of employee.
New Mexico	BRAND: AWP x 1.04 + $6.50 GENERIC: AWP X 1.04 + $8.06
North Dakota	BRAND: AWP - 10% + $4.00 dispensing fee GENERIC: AWP - 10% + $5.00 dispensing fee workers' compensation shall pay in full any charges submitted that are less than or equal to the maximum allowable fee DAW: If the injured worker does not accept the generic equivalent at a lower price, the injured worker is responsible for the cost difference between the generic and brand-name medication: BRAND AWP – GENERIC AWP.
Ohio	The maximum allowable charge for drugs shall be the lesser of: The provider's usual and customary charge; BRAND DRUGS (AWP* – 9%) + $3.50 dispensing fee; GENERIC DRUGS: (AWP* – 9%) + $3.50 dispensing fee, (HCFA Federal Upper Limit – 9%) + $3.50. DAW: If the injured worker does not accept the generic equivalent at a lower price, the injured worker is responsible for the cost difference between the generic and brand-name medication: BRAND AWP – GENERIC AWP. * Blue Book AWP
Oklahoma	AWP x QT + $6.00 dispensing fee
Oregon	BRAND & GENERIC LESSER OF: usual and customary OR 95% of AWP + $6.70 dispensing fee (except in-patient hospital charges.)
Pennsylvania	DRUGS & PHARMACEUTICAL SERVICES REIMBURSEMENT: limited to 110% x AWP
Rhode Island	PHARMACEUTICALS REIMBURSEMENT: 120% of AWP; cost-to-charge ratio is applied to hospitals. Generics should be used as a first choice.

State	Maximum Prescription Drug Reimbursement
Texas	The maximum allowable charge for drugs shall be the LESSER OF: The provider's usual and customary charge for the same or similar service GENERIC DRUGS: ((AWP per unit) x (number of units) x 1.38) + $7.50 dispensing fee BRAND-NAME DRUGS: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee
Vermont	DRUG REIMBURSEMENT shall be the LESSER OF: The charge for the drug OR AWP + $3.15 dispensing fee (as determined by the Red Book manual or its equivalent).
Washington	GENERICS: The lesser of BLP or AWP less 10% + $4.50 BRAND-NAME WITH GENERIC EQUIVALENTS (Substitution Allowed): The lesser of BLP or AWP less 10% + $3.00 BRAND-NAME WITH GENERIC EQUIVALENTS (DAW): The lesser of BLP or AWP less 10% + $4.50 SINGLE- OR MULTI-SOURCE BRAND-NAME DRUGS: AWP less 10% + $4.50. OTC = priced on 40% margin
West Virginia	BRAND: AWP - 15% + $2.00 GENERIC: AWP - 15% + $2.50; DAW - the injured worker is responsible for the cost difference between the generic and brand name medication: BRAND AWP – GENERIC AWP.
Wyoming	"Red Book" AWP + $5.00 professional fee

Key :

Average Wholesale Price = AWP
Maximum Allowable Cost = MAC
Baseline Price = BLP—derived by calculating the mean average for all NDC's (National Drug Code) in a specific product group, determining the standard deviation, and calculating a new mean average using all prices within one standard deviation of the original mean average. "Baseline price" is a drug pricing mechanism developed and updated by First Data Bank.
Quantity = QT
Over-the-Counter = OTC
Dispense as Written = DAW—a generic brand of therapeutic equivalence must be dispensed unless physician orders "DAW," by which the generic drug cannot substitute for a brand-name drug.

Note:
This list includes all states for which we could obtain information on prescription drug fee schedules. There may be other states that currently have prescription drug fee schedules and/or other regulatory language governing the payment of prescription drugs. This chart is intended to give a general idea of the main components of each fee schedule and does not contain all information pertaining to prescription drug reimbursement in a particular state.

The Evolution of Integrated Benefits Delivery in the United States

by Annmarie Geddes Lipold

Overview and Summary

Over the past 15 years, the idea of combining voluntary employee benefits and social insurance programs to improve employee health and disability outcomes has moved from the legislative arena to employer-sponsored initiatives. What was once best characterized as a governmental drive toward universal 24-Hour Coverage of healthcare has become an employer-based strategy aimed at improving employee health and productivity by integrating benefits.

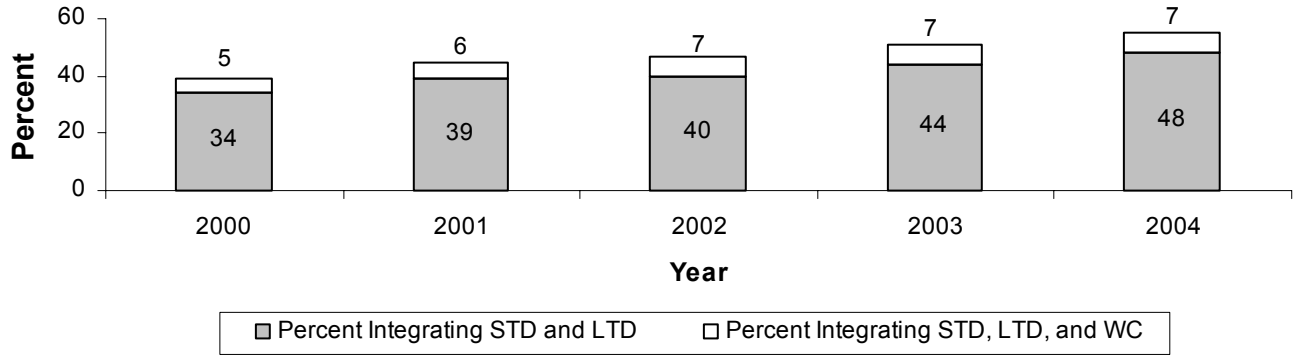
For purposes of this article, benefits integration is a generic term used to describe various forms of coordinating and combining employee benefit programs that can include healthcare, disease management, income replacement benefits, rehabilitation, and return-to-work programs for workers and their families. Some fruits of integration include improved employee health and productivity, reduced employer costs, greater treatment consistency, and enhanced administrative efficiency.

There are several variations of benefit integration. Integrated Disability Management (IDM), for example, often uses case management and transitional return-to-work programs to help employees return to the job, no matter how the injury or illness occurred. Thus the management of short- and long-term disability and workers' compensation claims is combined. Absence Management involves managing all lost work time, including absences due to injuries and diseases, leave under the Family and Medical Leave Act, and incidental sick time. Health and Productivity Management is a broader concept that includes private and public disability programs and various healthcare programs such as medical coverage, wellness, risk reduction, nurse case management, employee assistance programs, consumer education, and disease management.

Benefits integration programs have developed from a novelty concept to a bottom line-enhancing pursuit for employers. Far from a passing fancy or the unique project of a few employers, integration of disability programs is increasing, according to Mercer, which has been charting employer activity for the past five years. Over one half of surveyed employers have implemented benefits integration in some form. As shown in Figure A, according to the 2004 "Mercer/Marsh Survey of Employers' Time off and Disability Programs," 55 percent of employers said they have already integrated short-term and long-term disability with one carrier. Included in that group are 7 percent of the employers surveyed who have also combined workers' compensation with short-term and long-term disability. Another 10 percent are considering combining STD and LTD with one carrier or third-party administrator (TPA), and 4 percent are planning to do so (Faulkner and Craig 2005). In some form, this approach is changing the way employers view and practice benefits delivery.

The growing popularity of benefits integration means workers' compensation can no longer be viewed as just a stand-alone, state-mandated, no-fault social insurance program. Rather, workers' compensation is increasingly seen as an important part of a broader strategy to enhance worker health and productivity. Ultimately, proponents believe that comprehensively combining benefits delivery, including workers' compensation, will boost employer competitiveness.

Figure A
Mercer/Marsh Survey of Employers' Time Off and Disability Programs, 2000-2004



Source: Faulkner and Craig (2005).
STD is short-term disability, LTD is long-term disability, WC is workers' compensation.

Although differences in healthcare delivery systems have yet to be resolved, the combination of short- and long-term disability has shown promise for comprehensively integrating the administration and delivery of benefits programs. Even though the market has yet to produce the elusive and adaptable "off the shelf" program, some observers predict benefits integration will be adopted by most employers in the future.

One Body, Many Parts

At different times throughout the history of social insurance in the United States, specific employee needs gave rise to distinct benefits programs. Starting with workers' compensation nearly a century ago and following with group healthcare, life insurance, and disability, these programs evolved separately to provide employees and their dependents medical, rehabilitation, and wage replacement benefits needed because of accidental injury, disease, or death. Federal and state governments also enacted benefits programs, including unemployment compensation, Social Security disability insurance (SSDI), and temporary disability insurance (TDI).

These benefit and social insurance programs were developed, sold, and managed in isolation, leading to problems including coverage gaps, litigation over claim work-relatedness, and overlapping programs that resulted in "double dipping." Medical case managers and claim examiners were trained to view injuries within the boundaries of a particular benefit or policy limitation, while employers often perceived benefits like short-term disability as an employee entitlement. Such tunnel vision hindered recovery and return to work.

The human body makes no distinction whether an injury or disease occurs on the job, but benefit delivery systems do, leading to inconsistent outcomes for the same health issues. This is especially true in complex cases, where various physical, emotional, intellectual, and psychological factors affect return to work.

The multiple benefits approach, proponents of integration argue, costs employers millions of dollars annually in direct and hidden expenses while denying employees the opportunity to lead happier and more productive lives. The average combined cost of sick leave, disability, and workers' compensation for employers is 4.0 percent of payroll, according to figures from the 2004 Mercer/Marsh survey (Faulkner and Craig 2005). But factoring in the indirect costs of replacing absent employees or the loss of their productivity can double or triple these costs. Active employee healthcare coverage costs employers 13.1 percent of payroll, according to the *2003 Mercer National Survey of Employer-Sponsored Health Care Plans* (Bos 2003:6), so the full cost of lost time is nearly as significant as medical costs to employers.

Cost Crisis Stokes Interest in Unification

While benefits and social insurance programs have developed separately, the idea of merging them dates back to the Truman Administration, said Roger Thompson, a workers' compensation specialist who handled workers' compensation issues for Travelers Insurance for more than 30 years. Some time later, in 1972, *The Report of the National Commission on State Workmen's Compensation Laws* (National Commission 1972:120-121) mentioned the possibility of combining workers' compensation with other benefits systems. The report, an outgrowth of the Occupational Safety and Health Act of 1970, did not perceive cause for combination at the time.

In the early 1980s, Thompson wrote the first known document to contemplate and envision a combination of employer benefits and social insurance programs. "Circle of Protection" describes merged programs to form unified coverage for employees and uses the term "twenty-four hour coverage" (Thompson:2). "We started with the premise that we had a patchwork of economic security programs, but envisioned creating one out of a whole cloth—seamless economic security for the whole person," Thompson recalled. By the early 1990s, Casey Young and Phillip Polakoff, MD, documented their visions for 24-Hour Coverage after the steady acceleration in workers' compensation and healthcare costs ignited cries of crisis (Young and Polakoff 1990).

Historical data show that general medical inflation in the 1980s averaged 8.3 percent annually, almost 50 percent more than the general increase in the consumer price index (CPI) of 5.6 percent a year (*Economic Report of the President* 2004:358). Similar data on increases in the price of medical care in workers' compensation during this period are not available. There are, however, useful comparable data on employer expenditures on healthcare that reflect both changes in the price per unit of medical care and changes in the quantity of healthcare provided to patients. From 1980 through 1989, employer expenditures on general healthcare benefits for employees--healthcare not related to workplace injuries and diseases--increased 11.7 percent per year, as shown in Table 1. Meanwhile, employer expenditures on the healthcare component of workers' compensation increased by an average of 14.2 percent per year in the 1980s. Ohio, for example, which has the largest exclusive state workers' compensation fund in the country, reported workers' compensation medical costs rising 14 percent annually during the early 1990s. Over the course of the 1980s, the average medical cost per injury for private employers in Ohio rose more than 300 percent-- from $1,671 in 1980 to $7,368 in 1990 (Geddes 1992).

Cash or indemnity benefits have traditionally been the largest workers' compensation expenditure, but workers' compensation medical benefits were going up so quickly that medical benefits rivaled cash benefits, as shown in Table 2. In 1980,

Table 1
Employers' Expenditures on Medical Benefits, 1980-2002

Year	Group Health Insurance (Billions) (1)	Group Health Annual Rate of Increase (Percent) (2)	Workers' Compensation Medical (3)	Workers' Compensation Annual Rate of Increase (Percent) (4)
1979	52.575	--	3.520	--
1980	61.016	16.1%	3.947	12.1%
1981	71.681	17.5%	4.431	12.3%
1982	82.616	15.3%	5.058	14.2%
1983	91.459	10.7%	5.681	12.3%
1984	100.287	9.7%	6.424	13.1%
1985	109.999	9.7%	7.498	16.7%
1986	117.409	6.7%	8.642	15.3%
1987	126.198	7.5%	9.912	14.7%
1988	142.277	12.7%	11.519	16.2%
1989	158.619	11.5%	13.299	15.5%
1980s Averages	101.285	11.7%	7.266	14.2%
1990	176.889	11.5%	15.067	13.3%
1991	192.848	9.0%	16.715	10.9%
1992	215.741	11.9%	18.130	8.5%
1993	234.302	8.6%	17.409	-4.0%
1994	245.978	5.0%	17.084	-1.9%
1995	242.810	-1.3%	16.631	-2.7%
1996	242.859	0.0%	16.460	-1.0%
1997	246.126	1.3%	17.178	4.4%
1998	267.633	8.7%	17.912	4.3%
1999	294.125	9.9%	19.156	6.9%
1990s Average	235.931	6.5%	17.174	3.9%
2000	331.416	12.7%	20.555	7.3%
2001	353.291	6.6%	22.050	7.3%
2002	388.750	10.0%	24.220	9.8%

Sources: Column (1): Private Group Health Insurance, National Income and Product Accounts Table 7.8 Supplements to Wages and Salaries by Type, Bureau of Economic Activity, Department of Commerce, downloaded August 31, 2004 from www.bea.doc.gov/bea/dn/nipaweb/TableView.asp.
Column (3): Williams, Reno, and Burton (2004, Table 7).
Columns (2) and (4): calculated from data in columns (1) and (3).

medical benefits made up about $0.28 per $100 of payroll compared to $0.68 for cash benefits. In 1988, medical benefits reached $0.50 and then leaped to $0.57 in 1989. By 1992, medical benefits reached an all-time high of $0.69 per $100 of payroll.

Meanwhile, the cost of workers' compensation to employers had risen dramatically both in total dollars and as a percentage of payroll. Between 1970 and 1991, workers' compensation costs had risen from 1.11 percent to 2.16 percent of employer payroll, (Column (1), Table 2). In 1991, an estimated $55.2 billion was paid in workers' compensation costs (Williams, Reno, and Burton 2004:Table 12), up from $22.3 billion in 1980 (Nelson 1992:Table 7).

Rising claim costs compounded with inadequate insurance rates led to a crisis in the insurance market beginning in the late 1980s, Thompson said. In fact, he added, insurance companies were losing so much money they actually quit offering coverage in certain states.

Harnessing the Silver Bullet

Rising group medical expenses were also causing concern, said Rick Service, who covered healthcare as a journalist for more than 20 years and served as editor of *Business & Health* magazine. Medical costs had been on the rise for several reasons, including technology, which provided newer, more expensive, and oftentimes better care. Huge advances in diagnostic imagery and laparoscopy to replace more invasive surgical techniques are two examples. Routine monitoring of fetuses became standard practice as did therapies for heart attack victims. These were great innovations, Service said, but they came at a cost. On top of that, healthcare utilization was on the rise.

Those bearing the brunt of rising medical costs began looking for silver bullets to contain rising medical costs, Service said. The business community felt that intelligent and efficient business practices could be applied to healthcare on a for-profit basis to improve the healthcare delivery machine, he added. The result was managed care, the genesis of which stemmed from the traditional Kaiser HMO model of directing patients to the appropriate medical care.

Managed care was appealing for many reasons--people could choose from within a network of physicians, while carriers could establish fee schedules, capitation and other strategies to stabilize medical costs. Managed care also appeared to be the answer because it purported to emphasize administrative efficiency and

preventive maintenance, and it guided people through the healing process.

Consumers saw managed care as interference with their access to necessary care, said William Molmen, general counsel of the Integrated Benefits Institute (IBI), a research organization that monitors integrated benefits practices, policies, and programs. Fee schedules caused doctors to over-utilize medical services to gain back lost income, and capitation delayed effective treatment as healthcare providers substituted the "poultice of time" for active diagnostics and restorative treatment, Molmen added.

Regardless, since managed care was showing impressive results on the group health side, the approach was soon applied to workers' compensation wherever possible. In fact, from 1990 to 1994, states held regular and "special" sessions to address workers' compensation problems, Thompson said. Reform efforts included managed care, anti-fraud programs, applying American Medical Association guidelines for measuring impairment, and carve-outs. New state funds, which were sometimes the market of last resort, were started by legislators so employers could still obtain workers' compensation insurance. Hawaii, Kentucky, Louisiana, Maine, Missouri, New Mexico, Rhode Island, and Texas all created new funds in the 1990s (Thomason, Schmidle, and Burton, 2001, Table A.8).

For its part, managed care did help contain rising medical costs but could only go so far in workers' compensation. Elements of managed care--physician networks, contracts, and fee schedules--could only be applied on a limited, state-dependent basis. More significantly, workers' compensation would remain first dollar coverage, so insurers and employers would continue to carry the financial burden for medical care. Additionally, caps on medical expenses were not permitted in workers' compensation and employee choice of physician varied by state, Molmen said.

Managed care was much easier to implement than 24-Hour Coverage, a concept also introduced to some state legislators at that time, Thompson said. However, managed care had its limits in controlling rising workers' compensation medical costs and was useless in helping to solve ever-vexing problems that continue to plague the healthcare system in the United States, problems like ineffective healthcare delivery, an ever-growing uninsured public, healthcare quality, and coverage affordability. Initiatives to provide 24-Hour Coverage were aimed at addressing those problems along with rising group health and workers' compensation costs.

Table 2
Workers' Compensation Benefits and Costs As Percent of Payroll, 1980-2002

Year	Costs/$100 Payroll (1)	Benefits/$100 Payroll (2)	Medical Share of Benefits (3)	Medical Benefits/$100 Payroll (4)	Cash Benefits/$100 Payroll (5)
1980	1.76	0.96	29.0	0.28	0.68
1981	1.67	0.97	29.4	0.29	0.69
1982	1.58	1.04	30.8	0.32	0.72
1983	1.50	1.05	32.3	0.34	0.71
1984	1.49	1.09	32.6	0.36	0.73
1985	1.64	1.17	33.7	0.39	0.78
1986	1.79	1.23	35.1	0.43	0.80
1987	1.86	1.29	36.3	0.47	0.82
1988	1.94	1.34	37.5	0.50	0.84
1989	2.04	1.46	39.1	0.57	0.89
1980s Averages	1.73	1.16	33.6	0.40	0.77
1990	2.18	1.57	39.7	0.62	0.94
1991	2.16	1.65	39.9	0.66	0.99
1992	2.12	1.68	40.9	0.69	1.00
1993	2.16	1.61	40.8	0.66	0.95
1994	2.05	1.51	38.6	0.58	0.93
1995	1.82	1.38	38.6	0.53	0.85
1996	1.66	1.26	39.6	0.50	0.76
1997	1.49	1.18	40.9	0.48	0.70
1998	1.38	1.11	41.3	0.47	0.65
1999	1.34	1.09	42.1	0.47	0.63
1990s Averages	1.84	1.40	40.2	0.57	0.84
2000	1.33	1.06	42.9	0.46	0.60
2001	1.40	1.08	44.6	0.48	0.60
2002	1.58	1.16	45.4	0.53	0.63

Sources:

Columns (1) and (2): 1989-2002 from Williams, Reno, and Burton (2004, Table 13); 1980-1988 from Social Security Administration (2003, Table 9.B1) multiplied by 0.9 based on Burton adjustment explained in Appendix A.
Column (3): 1980-2002 from Williams, Reno, and Burton (2004, Table 7).
Columns (4) and (5): 1989-2002 from Williams, Reno, and Burton (2004, Table 13); 1980-1988 calculated by multiplying columns (1) and (2) by column (3).

Legislating 24-Hour Coverage

Getting 24-Hour Coverage off the ground meant getting the nod from lawmakers. In 1989, the Florida legislature was the first to pass legislation supporting 24-Hour Coverage (Baker and Krueger 1993). Florida permitted employers to meet the medical portion of their workers' compensation obligations by providing medical coverage under a 24-Hour healthcare plan. The coverage required that, with the exception of permitted co-payments and deductibles, employers meet the standards set in the existing workers' compensation law (Baker and Krueger 1993).

In fact, between 1989, when Florida enacted the first pilot program for integrating medical benefits, and 1994, when Kentucky enacted legislation enabling 24-Hour coverage, 11 states passed some form of enabling legislation, according to Thompson, as shown in Table 3. Other states, including Colorado, Hawaii, Iowa, Kansas, Montana, North Carolina and Utah, deliberated the issue and established study commissions and working groups to examine the obstacles to the concept, Thompson said. By 1995, interest in 24-Hour Coverage was at an "all time high" (BNA 1995a:49).

In retrospect, none of the pilot programs or study commissions resulted in a viable 24-Hour Coverage program because creating 24-Hour Coverage through the legislative process was fraught with obstacles, Thompson said. The duration of entitlement to benefits was a major obstacle because workers' compensation carriers are responsible for all medical and wage replacement benefits resulting from injuries occurring during the policy period. Some of the payments may continue for decades, while health insurance carriers are only responsible for the medical care provided during the policy period.

In some instances, Thompson said, regulators insisted that the healthcare benefits had to be provided without deductibles or co-payments for both the occupational and non-occupational claims. In other instances, he said, "onerous reporting requirements were imposed, allegedly to measure incurred savings, but actually would have served to increase administration costs."

Finally, little flexibility was granted for program participants to be creative in tackling the perceived integration obstacles, Thompson said. Legislators enacting "24-Hour" pilot programs, Molmen said, were understandably hesitant to erode medical benefits to which workers injured on the job were entitled. "They did little to encourage or compensate marketing across traditional insurance lines," he added.

The Garamendi Plan

While other states tinkered with 24-Hour Coverage, John Garamendi, California's insurance commissioner in the early 1990s, boldly pushed for the most comprehensive plan ever attempted. California's workers' compensation costs alone (adjusted manual rates) represented 3.0 percent of payroll in 1986, roughly 1.6 times the national average of 1.9 percent of payroll. By 1991, those California costs were 4.2 percent of payroll, roughly 1.5 times the national average of 2.8 percent of payroll. California costs peaked at 4.9 percent of payroll in 1993, the year that national costs also peaked at 3.2 percent of payroll, which meant that California was still about 1.5 times the national average (Thomason, Schmidle, and Burton 2001: Tables C17 and C18.)

Besides high workers' compensation costs, California had serious healthcare issues. In Garamendi's vision for 24-Hour Coverage, he cited "failings" of the healthcare system, including: millions of uninsured, a

Table 3
24-Hour Coverage in Individual States

Florida	1989	Integrated medical pilot
Maine	1991	Pilot programs permitted; deductibles limited to $50 per injury or illness
Massachusetts	1991	Collective bargaining agreements permitted to adopt 24-Hour coverage plans
California	1992	Three-year integrated medical pilot
Georgia	1992	WC medical benefits permitted through health insurance plans
Minnesota	1992	24-Hour coverage to be studied. In 1994,department of labor charged with developing coordinated healthcare plan
Louisiana	1993	Five employer pilot projects authorized
Oklahoma	1993	Pilot program permitted for integrated management of WC and group health claims
Oregon	1993	Pilot program (18 months) to test the combination of WC with health insurance.
Washington	1993	A form of universal health insurance,available to all state residents, to be phased in over five years beginning in 1995 (SB 5304).
Kentucky	1994	Legislation enabling 24-Hour coverage

Compiled by Roger Thompson

"regressive" financing system that often takes the most from those with least, and severe access problems and unaffordable costs for small businesses. Two of the most cited cost concerns were the increasing amounts of the state's gross national product (GNP) being consumed by healthcare costs and premium increases that were outpacing inflation (Garamendi 1992:8).

To Garamendi, 24-Hour Coverage was the cure for the ailing healthcare system in California. He envisioned 24-Hour Coverage for individuals all the time––on and off the job. By taking a comprehensive approach, many workers' compensation and healthcare woes could be solved simultaneously. Just the idea of eliminating causation issues was compelling in and of itself. Multiple benefits systems were confusing for consumers, and untold millions of dollars had been lost annually to causation questions, administrative duplication, cost-shifting, and legal costs.

In 1992, Garamendi proposed universal coverage as a means of controlling healthcare costs within the state's borders. His plan was the forerunner of the integration aspect of the Clinton healthcare plan, which put 24-Hour Coverage in the national spotlight.

On its face, the Garamendi plan would appeal to consumers because it simplified access to coverage provided by group health, workers' compensation, or auto insurance (Himmelstein and Rest 1994:2). To Garamendi, combining the healthcare portion of these three unrelated insurance lines would make healthcare financially accessible to more people. Savings would accrue from less duplication, fewer liability disputes, and greater administrative efficiency. "These savings could then be used to help finance universal healthcare coverage while improving disability benefits and rationalizing the entire system," according to one publication. The plan would save the California workers' compensation system $1 billion in healthcare costs, according to a news release announcing the plan. Rolling in medical/auto would reduce auto insurance premiums by 15 percent (California Department of Insurance 1992:2).

The system would be funded through an "equitable and affordable" financing structure that charged all California employers and employees premiums based on ability to pay (Garamendi 1992:30). According to the plan, employers would see "substantial savings" —about 20 percent—in their workers' compensation premiums, and the employer healthcare premium of 6.75 percent of payroll would cover higher healthcare system costs (Garamendi 1992:4). When the proposal was put on the table, employers were paying an average of 8 percent of payroll for health insurance and additional premiums for the healthcare portion of workers' compensation (Garamendi 1992:30).

Health plans would be required to accept any individual regardless of age, gender, or pre-existing condition. There would be no waiting periods. Health plans could not avoid high risk individuals (Garamendi 1992:5). Employees would contribute pay premiums averaging 1 percent of their wages and salaries (Garamendi 1992:31).

Consumer advocates might have seen the benefits of a new system worth the employee contribution, but getting organized labor to agree to employee contributions for workers' compensation was politically naïve. An overall healthcare budget would keep costs from rising any faster than wages unless premium rates were increased by the state (Garamendi 1992:3). This element added a political incentive to hold the line on healthcare costs (Garamendi 1992:19), but I wonder what would have happened to the quality of medical care and employee health, as healthcare affordability would have driven utilization up and strained a delivery system that might not have been ready to handle such an increase.

When it came to assumptions about what merging medical coverage would mean for workers' compensation, the Garamendi plan and the report it was based on "got it wrong," Molmen asserted. For example, the report said 24-Hour Coverage would eliminate workers' compensation litigation, completely ignoring the fact that most litigation and medical-legal expenses in California involved the existence and extent of permanent partial disability (PPD), which would be unaffected by 24-Hour Medical Coverage, he added.

Dealing with PPD in any type of 24-Hour Coverage model, Molmen said, was an "unresolved quandary," specifically noted by both the National Commission (1972) and by Young and Polakoff (1990) as needing further study. "The Garamendi report simply ignored the issue, evincing no awareness that PPD, based as it is on the loss of future earning capacity and not the ability to return to the pre-injury job, was even an issue," Molmen said. Litigation might be reduced based on workers getting immediate access to medical treatment, but it is unclear how much different that would be than the timing of treatment under "siloed" medical delivery, Molmen said. "Since 24-Hour Coverage as proposed by Garamendi included only medical coverage and not disability, delays and worker frustration could still exist," he added.

Many states had made tentative forays into 24-Hour Coverage pilot programs, Thompson said, but there was no real substance to the change until Garamendi introduced his 24-Hour Coverage plan. "While it certainly had 'holes,' the proposal offered a new approach that addressed health coverage across the board," Thompson said. Having a strong proponent like Garamendi and coming from a state like California, the concept drew a great deal of attention and served to move the discussion to a higher level, he added. Ultimately, the Garamendi proposal died in the California legislature (Himmelstein 1994:2), eclipsed, Molmen said, by the Clinton plan.

The Clinton Plan

In 1993, with some of the authors of the original Garamendi plan now appointed to the Clinton Task Force on Health Care Reform, 24-Hour Coverage became part of President Bill Clinton's commitment to improving healthcare in America (Himmelstein 1994:2).

Speaking at a National Federal of Independent Business meeting in 1993, President Clinton reportedly said his administration was trying to "fold the health care costs part of workers' comp into this health care program, which would dramatically cut the cost of workers' comp" (BNA 1993).

Title X of the Clinton Health Security Act, as written, would have coordinated medical care by requiring each health plan to be offered through a health alliance that would provide workers' compensation medical services to its enrollees. The employer, through the workers' compensation carrier, would then reimburse the health plan (Himmelstein 1994:8). Medical and disability would continue according to state law. Workers would choose a health plan for general medical care and receive workers' compensation medical care through the same plan (Himmelstein 1994:8).

According to an analysis of the bill by the American Alliance of Insurers, the plan retained the effect of state workers' compensation law for work-related injuries and illnesses and provided that disputes be resolved under existing state laws. States would continue to define medical care for work-related injuries and illnesses (Alliance of American Insurers 1993:2).

"It appears the Administration's ultimate goal is the integration of all forms of health care delivery into a single system," the report said, citing the creation of the Commission of Health Benefit and Integration. The commission, which was to be operated by the departments of Labor and Health and Human Services, was to study the "feasibility and appropriateness" of transferring financial responsibility for medical costs—including those covered under workers' compensation and automobile insurance—to the new health system. If it were to recommend integration, the commission would develop the administration's plan (Alliance of American Insurers 1993:1).

Organized labor supported the Clinton proposal. "It is essential that national health care reform include the medical portion of workers' comp to achieve the goals of effectiveness, cost containment, quality, and confidence in the system," James Ellenberger of the AFL-CIO said at the time. "Maintaining a separate medical delivery system for workers' comp, as we do now, will simply encourage medical providers, insurers, employers, claimants, and attorneys to continue behavior that will exacerbate current problems" (Himmelstein 1994:8).

Some employers, such as those in the auto industry, supported the proposal, said George Faulkner, a consultant with Mercer Human Resource Consulting. However, much of the business community rallied against it. Paul Mattera, vice president of public relations for Liberty Mutual Insurance Company at the time, reportedly said merging healthcare and workers' compensation would erode financial incentives to employers for maintaining a safe workplace and interrupt the critical connection between medical case management and disability case management. "There is simply no incentive for a health plan to be aggressive in its medical treatment in order to maximize medical improvement, reduce duration of disability and hasten return to work," he said. Liberty estimated that any promised medical savings would be dwarfed by estimated increases of about $10 million in disability costs (BNA 1993:329).

Employers and insurers also wanted to maintain provider choice and medical case management to contain costs. "Workers, on the other hand, believe that their control of provider choice will enhance their quality of care and inject more fairness into the system," one report said (Himmelstein 1994:8).

The Clinton plan was aimed at improving healthcare delivery and assumed workers' compensation could, with a few allowances, join up for the ride. To Molmen, the Clinton plan really had little to do with true 24-hour Coverage and just ignored workers' compensation issues altogether except to put it all off to a commission to review.

The Clinton approach also failed to appreciate that each insurance line had developed its own infrastructure of brokers, actuaries, advocacy organizations and other support that would also need to be streamlined into the new approach. Even the nomenclature differed between insurance lines. Group health insurers consider indemnity to mean what the insurer covers for a policyholder. In workers' compensation, however, indemnity means wage replacement.

But more importantly, by not considering the crucial relationship between healthcare and disability outcomes, the Clinton and Garamendi proposals, I believe, would have introduced new structural impediments into benefit delivery systems. "The purpose of benefit delivery should not be to suboptimize individual program costs, but to serve overall needs such as workforce health and productivity and worker quality of life issues," Molmen said. Ultimately, the Clinton Administration did not generate the support needed from Congress to transform the vision to law.

Regardless, the mere fact that the Clinton plan merited serious discussion scared players in the healthcare system, Service recalled. Nobody in the healthcare system—insurers, providers, or even consumer groups—was going to surrender turf. "It was too big of an idea that took away too many people's rice bowls," he added.

Further, the country was not ready for that level of change, Service said. "We had not yet experienced enough pain in terms of affordability." In fact, consumer groups back then, like today, pushed for more affordable and obtainable benefits while rarely mentioning consumer responsibility to make healthier lifestyle decisions that would make healthcare more affordable for everyone, he added.

The concept of integrating healthcare did not fail on its merits, Thompson said, "but rather through the self-interest of those fearful of change and those who stood to gain by maintaining the status-quo." When it comes to healthcare, the average individual today is no better off than fifteen years ago, he said. "A healthcare crisis continues in this country and will continue until we find some way of providing universal coverage where the cost is shared by all - not just those paying for coverage through insurance," he added.

To Thompson, public policymakers like Garamendi and Clinton did not have all of the answers, but they were at least facing in the right direction. To Thomas Parry, president of IBI, the approach to federalizing medical care was an ill-conceived idea, but "it generated a lot of discussion." Such discussion would lead to other forms of benefits integration in the future.

Medical Care Affected by Insurance Type

While public policymakers were sorting out the viability of integration, surfacing evidence revealed that in addition to benefit structural differences between workers' compensation and group health, treatments and procedures for the same incidents were handled differently. Johnson, Baldwin, and Burton (1996), for example, examined the differences between the charges for medical care in workers' compensation and health insurance in California and Minnesota and found significant differences in treatment costs.

The average total charges for treating workers' compensation in California were four times the average charges for treating similar non-work-related injuries. Workers' compensation average total charges––quantity of healthcare services times the average charge per unit of healthcare services––were more than twice the average charge for similar non-occupational injuries in Minnesota.

The differences in total charges varied among four types of injuries: back injuries; sprains, strains, and dislocations; inflammations, lacerations, and contusions; and fractures. Back injuries showed the greatest difference––with average total charges in workers' compensation being 4.8 times the average total charges for non-occupational injuries in California. The comparable ratio in Minnesota was 2.5. Fractures had the smallest differentials: average total charges were 2.1 times higher in workers' compensation than for non-work-related injuries in California and 1.3 times higher in Minnesota.

The sources of differentials varied between states. In California, unit charges for workers' compensation cases were lower than for health insurance. However, workers' compensation patients received much larger quantities of medical services than health insurance patients with similar injuries. In Minnesota, workers' compensation patients received somewhat larger quantities of medical services than healthcare patients with similar injuries, but the major source of the higher total charges was the higher charges per unit of healthcare services.

Research published by the California Workers' Compensation Institute (CWCI) in 1994 showed that although workers' compensation medical treatment per episode for all injuries in the sample data was 21 percent more expensive than in group health, it was more aggressive and was 44 percent shorter in treatment duration (Parry 1994:6). Follow-up CWCI research, published in 1996, confirmed that treatment costs for back injuries were 43 percent higher, while treatment duration was 52 percent shorter compared to group health (CWCI 1996). Parry and Molmen, who conducted the CWCI research and analysis while they were employees there, opined that this might mean that so-called sports medicine may result in shorter disability duration and less lost time—saving employers in overall costs.

Later, a 1996 IBI study showed that in a workers' compensation setting, disability can be affected by differences in both the amounts of medical treatment and the timing or intensity of treatment. Employer focus on returning injured workers to the job also can produce savings and superior results apart from the effects of medical treatment, IBI concluded. Workers' compensation payers had a built-in incentive to get employees better sooner to save on disability costs and the disruption caused by workers' absences. Therefore, IBI concluded, workers' compensation cases were much more likely to have a more aggressive "sports medicine" approach to treatment (Parry and Molmen 1996).

Changing Markets Shape Future

The CWCI research on medical costs was an important factor motivating Parry and Molmen to launch IBI near the end of 1995. In an article announcing the new organization, Molmen said as many as 45 million workers were expected to receive workers' compensation and integrated health programs or 24-Hour insurance policies by the end of the century. As a result, there needs to be more information available on public policy implications of this approach, Molmen said (BNA 1995b:471-472).

But just as IBI was getting started, the tide of rising medical costs that had spurred discussion of 24-Hour Coverage began to subside. Workers' compensation began experiencing double-digit rate and loss cost decreases, fostering affordable coverage (Lipold 1996a:21). Healthcare was also becoming more afford-

able. As a result, employers' once heady interest in 24-Hour Coverage began to dissipate. Such was the reason given for the declining interest in Oregon's 24-Hour Coverage pilot project, which was one of the first of its kind (BNA 1996:292).

In fact, by the end of 1995 many policymakers were losing their appetites for a concept that no longer seemed necessary when the initial cost-cutting success of managed care and a booming economy were ushering in better times. Public policy changes were not necessary to experiment with 24-Hour Coverage anyway, Eric Oxfeld, then a lobbyist with the American Insurance Association, said at the time. "Market forces, not legislation, will determine whether 24-Hour coverage is viable," Oxfeld added (AIA:1).

With or without legislation, there were signs that employers were at least interested in benefits integration. Almost three quarters of 240 large California employers said their preference would be to adopt an integrated healthcare approach because the benefits outweighed the risks, according to a 1995 Price Waterhouse survey. Cost reduction was the single most important benefit of integration, the survey said (Price Waterhouse 1995:1,2).

"Although true benefit integration has regulatory hurdles to overcome, this is the first time we've seen such strong support for combining administrative functions," Michael B. Sirkin of Price Waterhouse said in a news release (Price Waterhouse 1995:1,2). Meanwhile, some 46 percent of those surveyed by the American Insurance Group said they expected 24-Hour Coverage to be the "wave of the future (Samson 1995:284)."

Parry, Molmen, Thompson and other visionaries saw there were reasons beyond cost savings to pursue integration, even as the workers' compensation and health insurance markets were softening. Some pioneering employers, vendors, and consultants also recognized that benefits integration could ultimately lead to a healthier and more productive workforce.

Vendors assembled and introduced integrated benefits products into the marketplace. These products varied from a healthcare based model to a form of integration that combined disability programs. "SinglePoint" developed by Zenith and Unum, for example, combined workers' compensation, healthcare, and disability coverage (Molmen 1996:20). The Hartford also merged disability for early and consistent return to work for occupational and non-occupational injuries and illnesses (Molmen 1996:13).

By mid-1996, IBI identified 19 integrated programs, which took several approaches to the concept. There were six integrated disability programs, 11 merged workers' compensation and group medical programs, and two programs connected workers' compensation, group disability, and group medical coverages. By the end of 1996, IBI published descriptions of 36 private programs, thus showing benefits integration was making inroads in the marketplace (Molmen 1996:1).

Experimentation in integration and market forces set the tone for future programs and approaches. Cecily Gallagher, a Towers Perrin consultant who evaluated Oregon's 24-Hour Coverage pilot project, concluded that there were limited places for occupational and non-occupational healthcare to merge. Instead, it made more sense to apply workers' compensation return-to-work strategies to non-occupational injuries (BNA 1996:292).

At that time, managing disability benefits in tandem was viewed as the easiest place to begin integration. Disability programs operate in silos, Molmen said, but benefit delivery differences were easier to negotiate. Combining disability management and return-to-work programs for both occupational and non-occupational disabilities was also the most immediately rewarding, since the goals and means were the same across occupational and non-occupational boundaries and both could rely heavily on nurse case managers, who were often viewed and positioned as worker advocates, he added.

In reality, combining group healthcare delivery with workers' compensation was simply a lot harder than people thought. The reasons why workers' compensation and group health are difficult to combine mirror reasons why managed care had limited application in workers' compensation. Workers' compensation has unlimited coverage without co-pays or deductibles and choice of physician issues interfered with merging medical care, Parry said.

Meanwhile, insurers, third-party administrators and insurance distribution systems were "siloed," while employers too had benefit silos in their organizations, Molmen said. As a result, various marketing channels had poorly structured compensation programs for agents, brokers or other intermediaries who could "influence" their clients' choices, he added.

From 24-Hour Coverage To Integrated Disability Management

As vendors and consultants worked to develop competitive products, the term "24-Hour Coverage" was still being used even though it did not accurately describe what was happening in the marketplace. Terms like "benefits integration" and "merged care" sprang up to describe various marketplace initiatives. There was no clear way to know by the terms being used, however, how one program might differ from another.

When the term, "benefits integration" was first introduced, it was intended to apply to the integration of various existing forms of protection––i.e., short and long term disability, group health insurance, workers' compensation, Social Security disability, etc.—in a seamless form of

economic security available to workers who sustained an occupational or non-occupational injury or illness, Thompson said. "Over time, due to the difficulty and complexity of achieving its original intent, the term has migrated toward the coordination of the administrative features of those existing forms of protection in an effort to realize certain efficiencies including improved worker health, greater worker productivity and overall administrative efficiency," he added.

Even today, the industry itself resists clearly defined nomenclature. Terms like integrated disability management, absence management, total health and productivity management, and human capital management can include the same or different benefits and programs. Such lack of consistency generates confusion, inhibits marketing to employers, fuels skepticism of the benefits integration movement, and muddies the waters when the subject undergoes critical discussion.

In fact, what was meant by "24-Hour Coverage" or "benefits integration" was one of many unanswered issues that fueled skepticism among workers' compensation experts in the mid 1990s. Such skepticism was expressed in 1996 when Richard Victor, president of the Workers Compensation Research Institute, observed that 24-Hour Coverage was being discussed more by consultants and at conferences than anywhere else (Lipold 1996b:313).

By 1997, 24-Hour Coverage had completely shifted from a state-based healthcare model to an employer-based disability management model geared toward directing medical care, reducing lost-time days, and boosting employee productivity. Market offerings continued to grow. IBI reported 52 vendor-sponsored programs and 14 consulting/facilitative services in 1997. Twenty-seven additional programs were in the planning stages (Molmen 1997).

That sounded good to employers, who, by the end of the decade, were increasingly interested in at least the idea of benefits integration. Eight out of 10 employers in a 1999 Risk and Insurance Management Society survey saw a "high probability" that group health, disability, and workers' compensation would be combined (BNA 1999a:221). An IBI survey that year of 800 employers—the largest survey of its kind—revealed that 45 percent of employers were already integrating benefits or discussing integration, and nearly 30 percent of those were currently integrating in some form (Chajewski, Parry, and Molmen 1999:3). Meanwhile, two-thirds of employers surveyed by Liberty Mutual Insurance said integrated disability management would be an important part of their company's future (BNA 1999b:485).

Employer-based Efforts Before 2000

Despite market wares, most real-world benefits integration programs were initiated by employers. These employers did not just dive into benefit combinations. The ground for integration in the employer environment was softened by, ironically, the workers' compensation and healthcare crises of the late 1980s and 1990s. Rising benefit costs motivated employers to expand their roles in their group health and workers' compensation programs from merely buyers of coverage to active players in the process. Employers invested more effort in prevention, such as employee safety and wellness, and in process and productivity, including case management, managed care and return to work.

From these efforts, employers reaped other fruit, including better employee morale and less litigation. And, after seeing success from returning employees injured on the job back to work as soon as medically possible, it became obvious that the same case management efforts should be made for non-occupational injuries as well. As early as 1994, employers like Hughes Electronics Corporation and Pitney Bowes began ground-breaking programs that combined management of their workers' compensation and short-term disability claims to bring workers back to the job as soon as medically feasible.

"In order to decrease medical costs, the entire process needed to be fixed," said Pamela Hymel, the architect of the Hughes program. After getting workers' compensation under control, Hughes began integrating disability management. Short- and long-term disability combined were costing Hughes more than workers' compensation costs. Disability benefits there were "totally abused," she recalled. Occupational safety and wellness program staff worked together to improve employee health and safety on and off the job. In 1996, a health enhancement program was implemented. In 1998, a disease management program was embedded in the company's Preferred Provider Organization to help employees identify and better manage chronic diseases. Hymel fastened together as many benefit and program pieces as she could, but never did tackle the challenge of integrating medical with disability.

Other notable employers include the County of San Bernardino and Steelcase, which began its program in 1997. Steelcase's well-publicized program showed significant savings in disability and workers' compensation costs, a reduction in litigated claims and significant improvement in the morale of employees involved with the program (Lipold 2000).

By the end of the decade, scores of articles and research papers documented the success of integrated benefits programs. Employers integrating benefits reported financial savings, safer workplaces, fewer lost workdays, improved employee morale, reduced litigation and enhanced productivity.

Prelude to the 21st Century

As employers expressed interest and experimented with benefits integration, other trends were taking

place in the late 1990s that would affect its evolution into the next century. For starters, the much-hailed tool for controlling medical costs—managed care—was losing its grip. This was bound to happen, Rick Service of *Business Health* magazine said, because managed care had built its success on blocking access to care in order to reduce utilization and reimbursement. "To be sure, much of the care blocked was and still is unnecessary. Still, there are limits to how much care you can deny," he said.

Besides enraging consumers, managed care soon exhausted its ability to cut away all the obvious fat in the system, propelling costs into another steady ascent. And, Service said, even though managed care did make some progress in establishing best practice guidelines, it was always fundamentally a financial control system and not a medical care system. By primarily focusing on containing costs, Parry said, managed care was an "absolute failure" from a health and productivity standpoint. Managed care limited access to healthcare, which interfered with timely treatment and hampered early return to work, he added.

While managed care was running out of steam, economic conditions in the global economy were beginning to put pressure on employers to look more at improving productivity, Parry said. Margins were growing paper thin, so CEOs were turning to their benefit and risk managers and asking them what bottom line value they could bring to the business. Without demonstrating value, these professionals would be "part of the outsourcing phase," he added.

Improving productivity by reducing absences became a higher priority, so human resources professionals had to work more to that end to show their own value, Parry said. But to demonstrate value, measures needed to be established that went beyond direct costs and also included lost productivity, Faulkner of Mercer said. In fact, the interest level of benefits integration led to the inception of Mercer's annual benefit design survey, which has consistently been polling employers about their benefits interests and activities. The first survey, issued in 2000, showed that 34 percent of large employers were integrating short-term and long-term disability, and that five percent had added workers' compensation to the mix, as shown previously in Figure A.

Integrating Into the 21st Century

Interest in integration continued into the beginning of the 21st century for reasons differing from the initial motivation of 24-Hour Coverage, which was to save on medical costs and improve medical care for the general population. Instead, integrated benefits plans transcended merely saving on employer medical and disability costs, becoming a far-reaching strategy for keeping a valuable workforce healthier and on the job. A more highly-trained but cut back workforce and declining employee health status, Parry said, put pressure on organizations to take a more holistic approach to benefits.

"In 2000, there was a low unemployment rate, so the pressure to retain employees was very significant and the economy was doing well, but there was not the pressure on benefit costs," Parry said. As a result, employers were willing to absorb rising costs to attract and maintain their workforce. At the same time, integrating workers' compensation, short-term disability and long-term disability was becoming more commonplace. These employers were also discovering that it was logical to tack on Family Medical Leave Act administration to ensure leave time was being used appropriately. IBI had profiled several employers that had successfully done so.

The vision, however, grew to more actively evaluate the reasons for absence and to use benefit programs to ensure healthy employees were at work. This vision went beyond merely integrating benefits to forming a comprehensive approach to total health and productivity. Pioneers like Pitney Bowes and Nationwide Insurance were already looking at ways to use absence reporting and integrated benefits to ensure workers were on the job. Most employers interested in integration, however, were more focused on integrating disability programs.

By 2001, there were so many vendor-provided programs and services—at least 100—offering such a bewildering array of benefit combinations that IBI quit keeping track in an annual compilation, Molmen said. A strong U.S. economy was also beginning to weaken. But by 2002, the economic downturn, the 9/11 terrorist attacks, the threat of future terrorist attacks, and already-rising workers' compensation and medical costs were threatening jobs and adding to employers' benefit burden.

Once again, workers' compensation and group health costs have begun to steadily escalate. According to Mercer's latest *National Survey of Employer-Sponsored Health Plans*, the average total cost of health benefits for active employees rose to $6,215 per employee in 2003. This 10.1 percent increase from the prior year was the smallest increase since 1997 but was still five times higher than general inflation, Mercer reported (Bos 2003:6).

Workers' compensation figures, which are not as up-to-date, do show that after workers' compensation costs dramatically dipped in the mid and late 1990s, costs began to increase in the beginning of the millennium. Costs increased from $1.33 per $100 of payroll in 2000 to $1.58 in 2002, according to the latest information shown in Table 2. The steady rise of underlying claim costs coupled with rising insurance premiums will show costs continuing to rise into the first decade of this century.

Despite rising costs, awareness of benefit delivery issues is more focused than ever, Parry said, because employers are paying more attention to employee access and use of benefits. The concept of integrating benefits too is

more widely accepted by employers, Dr. Dennis Richling, president of the MidWest Business Group on Health, said. "I don't think employers have lost interest. More are recognizing they need to take a long-term strategic perspective in managing long-term health overall," he added.

However, increasing medical costs are distracting employers from making the long-term investment necessary to improve employee health and productivity, Richling warned. "There is urgency for action to control costs," he added. Some employers are tempted by strategies like consumer driven health plans—an approach that reduces employer involvement with employee healthcare choices. While it is possible consumer driven health plans can save actual dollars, they could adversely affect employee health, and in turn, productivity (Lipold 2003:63).

Parry is confident that, ultimately, most stakeholders realize that there is no silver bullet that will lower healthcare costs. "I think what the midmarket and larger employers realize is if we don't provide health care to our employees, then the fundamental and important issue to every employer—attracting and retaining employees—becomes problematic," Parry said.

Only the Motivated Need Apply

Even with its far-reaching promises and potential, benefits integration programs continue to be pursued by "true believers," employers willing to hire multiple vendors and upset their current structure in hopes of enjoying the fruits of integration—healthier and more productive employees.

As it stands now, Faulkner said, employers that want to integrate benefits still need to "build their own" program by coordinating vendors. There was hope at the beginning of the decade that IDM would be available, but it never got off the ground, Faulkner said. Also, comprehensive programs that integrate disability with national health coverage networks have not been readily available. Some carriers who offer both health and disability coverage, like Aetna and CIGNA, are beginning to refine and re-launch integrated products. The absence of such products has been a big disappointment to employers, who are generally willing to hand over the task when the data shows it is worth it, Faulkner said. "If they could consolidate and outsource disability management with best-in-class health benefit delivery, they would," he added.

Ironically, vendors came closest to providing comprehensive off-the-shelf products in the mid-1990s, when the private sector began experimenting with benefits integration products. Some vendors at the time could offer connected and comprehensive services because their companies already offered them on a benefit-by-benefit basis, Parry said. Unfortunately, employers' motivation to try integration was curbed in the mid-1990s when workers' compensation and medical costs were looking manageable again. By the late 1990s, Parry said, insurance companies had sold off different functions and currently, not one company can offer a program that offers group health, workers' compensation, and disability without partnering with other vendors.

During the first decade of benefit integration, there has been a focus on looking at benefit plans and identifying the linkages that could be made between benefits, as opposed to total integration with one vendor or system, Faulkner said. Stakeholders are still identifying those linkage points, he said, and they are beginning to share claim data, seek clinical management consistency, and better record and document the full cost impact of absence.

Relationships between vendors that have joined forces to offer integrated benefit products are growing in numbers but have not been successful, Leo D. Tinkham, Jr., head of product development and management of Aetna, Inc., said. This might be occurring because partners view themselves as having the marketing role instead of truly viewing themselves as partners providing benefits. Aetna's Integrated Health and Disability program, considered one of the more comprehensive integrated products and available in 49 states, can include short- and long-term disability, healthcare, pharmacy, behavioral health, and long-term care benefits. The product is specifically aimed at identifying employees who are most likely to suffer a disability to prevent the disability from occurring.

Employers are building their own programs or at least taking baby steps by aligning policy and plan provisions to make them more consistent, Faulkner said. "Some of our consultants have already had a lot of success helping employers look at various plan provisions," he said. They are realizing there are a lot of inconsistencies with medical plans compared to disability plans, like mental health, for example," he added.

So much experimentation means that the hybrids of benefit integration can be as individual as the employer. Of 85 employers with programs that integrate two or more of group health, workers' compensation, short-term disability, long-term disability, incidental absence, and Family Medical Leave Act administration, there are an astonishing 50 different combinations of benefits involved in their integrated programs, according to forthcoming survey results from 620 employers conducted by IBI and LRP Publications in 2004.

"Today, employers are doing all sorts of things that have little to do with traditional integrated programs," Molmen said. "The need to track family and medical leave exposure causes employers to focus new resources on integrated, cross-program databases. Managing medical treatment to minimize disability and unnecessary absence is bringing health plans and disease management companies into new relationships with disability managers within employers and their suppliers," he

added. In addition to transitional return-to-work accommodation, employers report to IBI that they are frequently using the same program for workers' compensation and non-occupational benefits for disease management, health-risk appraisals, and wellness.

Lessons Learned and Predictions

The idea of combining benefits to improve their delivery and help employees and their families has traveled from a vision combining private and social insurance to countless benefit combinations on a per-employer basis. Pieces of experimentation—from state-sponsored pilot projects to employer programs and insurance products—have shown that much more experimentation is needed.

Some lessons have been learned. Managing occupational and non-occupational disability together reaps immediate productivity results. However, the inescapable reality is that even with the best return-to-work programs, the best results cannot be realized without including health and healthcare programs. Managed care saved money in the short-term, but did not address flaws in the health care system that still remain.

While many experiments showed exciting possibilities for benefits integration, the reality is that many of the same challenges that plagued the approach continue to do so. Benefits integration has been in the marketplace for about a decade, but the industry has yet to define itself. In the name of allowing for experimentation, its own ambiguity has hampered success.

Without defining and classifying programs, the concept remains misunderstood and ill-appreciated. Employers—the primary customers of integrated products—are marketed programs that sound similar but, in reality, can be very different. Marketing integration continues to be a struggle, Molmen said, because brokers, agents, and insurers have not effectively reached across benefit lines to sell their products.

A lack of common nomenclature makes clear communication and understanding nearly impossible. Media coverage of benefits integration, which stands to provide the largest marketing boost, tends to be spotty and shallow. The media are siloed by different audiences and editors and, with a few exceptions, either do not fully understand integration or do not consider it realistically viable.

Without common nomenclature and perfecting measures of program effectiveness, making the business case for benefits integration will continue to be a struggle for employers. This is especially important because employers still need to appreciate the total value of the benefits integration investment, Tinkham said. Metrics for measuring productivity and showing the value of the integration investment have improved greatly, from IBI's benchmarks to those developed by Ron Kessler of Harvard University. However, Richling said, "Because these tools of measurement have not been readily available, there is not a way to use these tools to make a business decision about how to take an integrated approach to managing health."

Employers are also slow to change their infrastructures to accommodate integration. Most employers still have different departments handling various benefits and lack an effective structure to integrate, Molmen said. The "real opportunity" for integration is through common intake that starts benefits and directs people to a physician immediately and uses nurse case management to communicate with the worker/physician/supervisor about appropriate medical treatment, he said.

Employers Control Destiny

Just as it was up to employers to pursue benefits integration on an individual program basis to move the idea forward, employers continue to control its destiny. Yes, employers in the United States are slow to adopt benefits integration principles, but they are still going in that direction. Employers will be propelled further, despite barriers yet to be overcome, by economic forces from the rest of the world, experts agree.

The reason is simple. To be competitive globally, employers will have to do more to maintain the health and productivity of a highly-skilled workplace that is harder to replace, Parry said. "That will really mandate the highest productivity out of our workers," Richling said. "It is very firmly my belief that the issue of health status is not just about feeling good but about competing internationally in a global marketplace."

In short, employers will more actively promote health because it is good business to do so, Parry said. They will more actively provide incentives to reward healthy behaviors, such as reductions in healthcare premiums and first-dollar coverage for preventative services, he added.

Helping employees manage their health will become more critical, especially because risk factors like obesity continue to grow in the United States, Parry said. In short, the best way to address rising medical costs is to help people be healthier so they will not need the system as much. Proponents of benefits integration believe that is its most compelling feature. "I see the integrated system of health management as the way to get your arms around true costs of health to an organization," Richling said. Richling sees disease management as a key way to address the risk factors for employee diseases and disabilities (Lipold 2002). Employee assistance programs, psychological benefits, and wellness programs are other possible additions to the mix.

Technological advances in data mining and predictive modeling can help vendors learn who is more likely to have a disability. Using this information, more preventive steps, such as medication compliance, can be

encouraged to reduce the likelihood of disability, Tinkham said. Additionally, since co-morbidities inevitably accompany most medical conditions, such as cancer patients suffering from depression, care can be better coordinated to address all of the patient's needs.

The potential to prevent obese employees from becoming disabled is even greater because obesity is a co-morbidity for so many disabling ailments. The healthcare carrier is in a better position to help employees because the co-morbidity is known before the disability. A workers' compensation carrier, on the other hand, does not know the worker is obese until the claim is filed, Tinkham said. In fact, observers like Tinkham believe that integrating health and disability has more future promise for integration than combining workers' compensation with disability. Health and non-occupational disability costs are rising faster than workers' compensation costs, he said, which provides carriers the incentive for vendors on the non-occupational side of the benefits equation to look for solutions.

Additionally, many employers will want to simplify all the benefits so they don't have to spend so much time managing them, Faulkner said. Employers will increasingly realize that the true cost to the employer is much bigger than wage replacement payments. Vendors too will finally be able to offer products in response to employer demand.

Employers, driven to be more competitive, will need to be willing to work with vendors and invest in measuring the value of the investment in employee health and productivity, Parry said. Integrated disability management programs will be more prevalent than currently, Richling said. Vendors will also come to the table to combine new programs, such as providing disease and disability management. On the healthcare side, employers want to better integrate basic healthcare with state-of-the-art disease management.

Conclusion

Those committed to the benefits integration concept remain hopeful that even long-held obstacles will be overcome. Employers will be forced financially to recognize that employee health is a greater determinant of competitiveness than ever before. Boosting competitive advantage with healthy employees will motivate employers to design benefit programs that comprehensively encourage health. How this will affect workers' compensation programs remains to be seen. Some employers will adopt comprehensive programs that include workers' compensation coverage, but traditional workers' compensation coverage is far from becoming extinct because employers have different needs.

"The integration of administrative features... will ultimately lead to meaningful discussions on the potential for a truly integrated benefits program."

The focus of integration will return to the 24-Hour Coverage vision of improving personal health by boosting access to care. In the future, however, this focus will be through a different lens—that of using data technology to identify and more effectively address underlying health conditions (such as obesity, diabetes, and heart disease) and merging disease management, wellness programs, psychological treatment, and other benefits with group healthcare to improve employee health status.

Improving employee health "provides far greater dividends than just controlling the rise in medical plan premiums," Faulkner said, including workers' compensation costs, disability and incidental absence costs, and the cost of lost productivity or the extra staffing needed to maintain a set level of productivity. Workers' compensation claims costs could decrease if workers are safer and healthier, and employers could reap the productivity benefits of a strong workforce.

The merging of benefits programs, coupled with scientific breakthroughs and future developments, further begs the need to address ethical issues already haunting the medical, insurer, and employer communities, including the potential for breeches of employee health privacy and for genetic discrimination. It is my sincere hope that innovative ways to boost the nation's overall health will be found and that industry will responsibly balance civil rights with individual health status.

To Thompson, once the marketplace develops and perfects benefits integration, its best practices could then be legislated for the common good. "Despite what occurred during the late 1980s and into the 1990s, the concept of 24-Hour coverage remains evolutionary rather than revolutionary," Thompson said.

The integration of administrative features, followed by some "blending" of the medical coverage, will ultimately lead to meaningful discussions on the potential for a truly integrated benefits program. Once a potential concept for benefits integration is designed in the marketplace, Thompson said, stakeholders will return to the legislative process for approval with a minimum of regulatory oversight.

Others are not so sanguine about legislative intervention. IBI's Molmen wonders whether evolutionary improvements would survive official sanction. "Early legislative attempts to pilot merged medical coverage failed miserably due to legislated limitations. Had it been done correctly, would employers have gone on to experiment with integrated disability and absence management or to the current focus on integrating workforce health and productivity?"

Marketplace experimentation will continue, Molmen said, and is likely to pause for legislative intervention only when employers and their workers identify intractable structural impediments to further advances.

About the Author

Annmarie Geddes Lipold is president of Lipold Communications, LLC, an Arlington, Va.-based public relations firm specializing in the insurance and employee benefits industries. Annmarie started writing about workers' compensation nearly 15 years ago when she began working at the Ohio Bureau of Workers' Compensation. There she wrote occupational safety and health and workers' compensation articles and speeches and brochures for OBWC while also freelance writing business articles for *Business First*, central Ohio's weekly business publication.

Later in Cleveland, she was a reporter for *Small Business News* and host of a live-call-in radio program. Her expertise in workers' compensation landed her the lead reporting position at *BNA's Workers' Compensation Report*. Upon leaving BNA, she became a contributing editor for *Business & Health* magazine and also wrote for *Workforce Magazine*, *HR Magazine* and authored special reports and clinical newsletters.

Annmarie, who earned a B.S. in Journalism from Ohio University, has served as the communications director for actuarial firms and is committed to improving communication and understanding in the workers' compensation, integrated benefits, and insurance industries.

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Annmarie Geddes Lipold

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Appendix A
The Methodology for Estimating Costs and Benefits as a Percentage of Payroll, 1980-1988

by John F. Burton, Jr.

This appendix explains the methodology used to prepare the entries for 1980 to 1988 in Table 2 of the article by Annmarie Geddes Lipold. Adjustments for some of the 1980 to 1988 data published in Table 9.B1 of the 2003 Edition of the *Annual Statistical Bulletin to the Social Security Bulletin* (Social Security Administration 2004) are necessary because of changes in the estimated proportions of the workforce and of total payroll covered by the workers' compensation program.

The primary source of national data on workers' compensation coverage, benefits, and costs for many years was the Social Security Administration (SSA). The SSA estimated that the payroll covered by the workers' compensation was about 82 percent of all civilian wage and salary disbursements in 1993 (Schmulowitz 1995), which was similar to the SSA coverage estimates for prior years. The 1993 estimates were the last prepared by the SSA because of permanent staff limitations.

The National Academy of Social Insurance (NASI) assumed responsibility for publishing the national data on workers' compensation effective with the 1994 data. The first volume published by NASI was written by Jack Schmulowitz, who had been the author of the last article published by the SSA. The NASI volume contained data for 1994-95 and was published in 1997 (Schmulowitz 1997). Schmulowitz revised the procedure used to estimate the numbers of workers and the amounts of payroll covered by the workers' compensation program and substantially increased the estimated coverage of the program. Appendix Table A.1 is based on Table 9 in Schmulowitz (1997). The ratio of the average number of workers covered under the old procedure to the average number of workers covered under the new procedure is 0.90. This ratio of payroll under the old procedure to the payroll under the new procedure is also 0.90.

The revised procedure for estimating coverage of workers and payroll did not affect the total dollar amounts of benefits and costs. However, because the benefits and costs are divided by a larger payroll, the benefits and costs as a percent of payroll are affected. For example, costs were $2.27 per $100 of payroll in 1989 using the older payroll estimates but are $2.04 per $100 of payroll using the new payroll estimates (Schmulowitz 1997, Table 11). The new estimate of $2.04 per $100 of payroll is the old estimate of $2.27 times 0.90, the ratio of payroll under the old procedure to the payroll under the new procedure.

The Schmulowitz revisions in coverage of wages and payroll only went back to 1989. However, the proportion of the workers and payroll probably did not change much during the earlier portions of the 1980s. Subsequent to the publication of *The Report of the National Commission on State Workmen's Compensation Laws* in 1972, a number of states revised their laws to cover more workers. However, most of the statutory changes were completed by the end of the 1970s.

Table A.2 provides the currently published data on costs and benefits as a percent of payroll for 1980 to 1988 in columns (1) and (2). However, these data are not comparable to the data beginning in 1989 that are shown

Appendix Table A.1
Number of Workers Covered under Workers' Compensation Programs and Total Wages: Current and Former Estimates, 1989-95

	Current Estimates		Former Estimates	
Year	Number of Workers (in millions) (1)	Total Wages (in billions) (2)	Number of Workers (in millions) (3)	Total Wages (in billions) (4)
1989	103.9	2,347.3	93.7	2,112.6
1990	105.5	2,442.1	95.1	2,251.0
1991	103.7	2,552.9	93.6	2,300.7
1992	104.3	2,699.6	94.6	2,402.3
1993	106.2	2,802.1	96.1	2,492.6
1994	109.4	2,948.7	99.0	2,626.1
1995	112.8	3,122.6	102.1	2,781.0
Total	**745.8**	**18,915.3**	**674.2**	**16,966.3**
Ratios of Former to Current	**0.90**	**0.90**		

Source: Data in Columns (1) - (4) from Schmulowitz (1997), Table 9. Ratios calculated by John Burton.

in Table 2 of the Lipold article. In order to make the data comparable, I have multiplied the 1980 to 1988 data in columns (1) and (2) of Table A.2 by 0.9, which is the ratio of unrevised to revised employment and wages for 1989 to 1995 shown in Appendix Table A.1. The adjusted data for costs and benefits as a percent of payroll in 1980 to 1988 are shown in columns (3) and (4) of Appendix Table A.2. For example, the published data indicate that workers' compensation costs were 1.96 percent of payroll in 1980 (Table A.2, column (1)), and 0.9 times 1.96 percent is 1.76 percent of payroll (Table A.2, column (3)). The adjusted data on costs and benefits shown in columns (3) and (4) of Table A.2 are used as the 1980 to 1988 entries in columns (1) and (2) of Table 2 in the Lipold article. Any reader who has carefully followed this explanation is eligible for a certificate suitable for framing designating the reader as a bona fide data grubber.

Appendix Table A.2
Workers' Compensation Costs and Benefits as Percentage of Covered Payroll, 1980-1988

Year	Published Data		Adjusted Data	
	Costs (1)	Benefits (2)	Costs (3)	Benefits (4)
1980	1.96	1.07	1.76	0.96
1981	1.85	1.08	1.67	0.97
1982	1.75	1.16	1.58	1.04
1983	1.67	1.17	1.50	1.05
1984	1.66	1.21	1.49	1.09
1985	1.82	1.30	1.64	1.17
1986	1.99	1.37	1.79	1.23
1987	2.07	1.43	1.86	1.29
1988	2.16	1.49	1.94	1.34

Source: Data in Columns (1) and (2) from Social Security Bulletin Annual Statistical Supplement, 2003, Table 9.B1.

Data in Column (3) are Column (1) data times 0.9; Data in Column (4) are Column (2) data times 0.9.

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