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Integrated Disability Management

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Workers' compensation carriers are moving into the so-called nonoccupational disability arena to meet their customers' demand for an integrated disability product that covers both occupational and nonoccupational disabilities. The demand is driven by the expectation that integration will produce claim and administrative savings. This panel discusses the opportunities and obstacles these carriers face integrating workers' compensation with short-term disability and long-term disability and whether integration can deliver positive results.

Mr. Charles M. Waldron: I'm with Milliman & Robertson from the Hartford office. We've taken the liberty of expanding the scope of this panel discussion on integrated workers' compensation (WC) with short-term disability (STD). The term integrated disability currently applies to a wide variety of packaged products and services, each with its own unique twist, and each claiming to deliver enhanced benefits to employers and employees. However, there hasn't been a great deal of data published yet to support or deny what might be going on.

In the marketplace today, an employer has many integrated disability models to choose from. Will one eventually succeed and predominate, or do employer and employee needs vary enough that several approaches will survive and prosper? I believe these issues will continue to be outstanding because sometimes carriers try to differentiate themselves in the marketplace by bringing new, adjusted, refined, and innovative products and services to the marketplace.

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Note: The charts referred to in the text can be found at the end of the manuscript.

As interested parties tracking the maturation process of integrated disability, we should keep in mind two fundamental questions. These questions relate to Dr. George Lundberg's* definition of quality, which is that you're trying to service needs. He went on to ask, "Whose needs are you trying to service?" My first question would be, "What is the most important benefit of integration?" Obviously, the answer depends on whose needs you're trying to service. Are you trying to reduce WC, STD, or LTD costs? Are you trying to expand the premium base of the particular carrier or reduce litigation? What are those items?

A second question might be, "What is the most important component of an integrated disability program?" Is it the early clinical intervention, a focus on the return to work, or the introduction of rehabilitation resources?

Being the moderator, I get to ask the questions, but I don't have to solve them. For that we have a panel of distinguished people. Each has prepared some remarks designed to answer some of those questions and pose more. Following me will be Joe Poplaski, vice president and group actuary for Liberty Life in Boston. He'll be providing you with some answers from the life and disability point of view. After Joe, Mike Welsh, the group insurance actuary responsible for disability and long-term care for Aetna U.S. Health Care, will present some ideas from the point of view of a medical care company. And batting cleanup is Dave Nixa, vice president and chief operating officer at Integrated Disability Resources Inc., who will provide an overview of integrated benefits and provide some data that support or refute certain widely-held beliefs.

Mr. Joseph Poplaski: I'd like to outline what we are talking about from the group benefit side. Group benefits usually will cover medical costs and lost time through group health and disability products. Typically, you'll see Health Resources (HR) running things and looking at it from a more clinical point of view because the largest cost for employers is medical.

On the other side, you have a WC carrier who has medical and what we call indemnity for lost time. The carrier tries to balance the two, but focuses more on the indemnity management than on the medical management.
Ultimately everybody's trying to get to something called 24-hour coverage where you put all the pieces together. How you go about that depends on where you're coming from. For instance, if you're a medical carrier, you may start off with a group health piece and try to expand across the WC medical piece. That's what we might be seeing now with HMOs whose core competencies are in clinical

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management and medical management. How do they expand that into the occupational arena? After they have that they may go into the WC indemnity naturally because it's coupled with the medical. WC carriers already have the occupational pieces, so they'll try to expand into the group disability next, thinking that the core competencies of managing lost time and return to work are a natural extension.

Liberty Mutual is a very large WC carrier, and we've decided to take this approach. For more than 100 years, we've done WC medical and indemnity. Five years ago, we made a decision to exit the medical market and focus on group disability coverage, so we have more of a WC carrier's approach to integrated disability management. We're going to take the core competencies we learned in WC and expand them into the group disability arena. Our focus is return-to-work versus clinical medical management, which a health carrier might take as its first approach to getting into this type of product.

We've been piloting this with a couple of different large companies for about a year now and have some results on a macro level to share with you. We've decided to bite off at this point in time the WC piece and the group disability piece. It's the STD piece that integrates with WC, so we're looking for certain types of STD plan designs from employers. We've broken them out into two different types of plans. One is what we call the "Or" plan, where STD just covers nonoccupational and WC is separate. You get either benefit but not both. This is not a preferred model for us because there's no apparent integration, just two standalone types of benefits. We're looking for what we call the "And" scenario, where the STD will offset for WC. In this case, you are truly interacting between WC and STD, and we see it as the kind of scenario we need to put an integrated product together.

Our product, like many others, is called integrated disability management. We have three goals. One, it's disability management focused; we're looking at managing the disability versus managing the medical. Our real focus is getting somebody back to work as fast and efficiently as possible and managing the lost time. On WC, the best results are achieved when you can get to that employee as quickly as possible, become the employee's advocate, and help walk him or her through the maze of regulatory paperwork and decisions he or she needs to make. It's also best to set return-to-work expectations at the beginning and try to manage them through that process. It's employer-efficient from our perspective, in the sense that we're trying to get a single point of contact working with the employer on setting up a return-to-work program and managing it through one area.

Many employers have silo effects between risk management and HR. We're depending on the benefit. If it's STD, HR controls. If it's WC, risk management

controls. We're looking for an efficient model from the employer. There's one point of contact that will manage a disability, independent of cause, to the extent possible. If you have a back claim on a WC, and the person comes back in two weeks, we'd also look for a similar nonoccupational back claim with a similar diagnosis to come back in two weeks with the same types of support mechanisms on either side of the house.

Based on our philosophy, we've created what we call a virtual office environment. Liberty Mutual believes that WC is a local phenomena, and we typically set up claims offices in every state. It's jurisdictional, and we think every jurisdiction is different. There are 50 different states and 50 sets of laws that you need to know, and local knowledge gets the best results. On the STD side, we believe you need economies of scale, so you can't have 50 offices. It's a similar program, especially if it's an ERISA plan. There's no state regulation involved. You want to combine as much as possible to get the administrative efficiencies across the spectrum.

Chart 1 is our model. It's a little complicated, but I'm going to walk you through the key points. We set up a call center for initial reporting of all claims. It's an 800 number. It can either be a vanity line or a general line, depending on the size of the employer. Regardless of whether it's a WC or an STD reporting, every claim goes into the same 800 number. At that point, we script something for our customer service representatives to determine whether it's a WC claim or a disability claim. The initial triage happens in the call center.

Remember that we're doing an "And" model. If it's just a pure STD claim, it goes immediately to the STD claims management. If it's a WC/STD claim, it'll go to the WC management in our model. The key point for us is, who controls the claim? We're only going to have one individual managing a claim. If it's an STD-only claim, it's an STD analyst. If it's a WC claim, the WC analyst will manage the claim, with the STD analysts somewhat invisible to the employee, but they'll be back there doing the STD benefits and that type of adjudication.
If the claim is determined to be a WC claim, the WC analyst will make the three points of contact. He or she will call the employer, the employee, and the medical provider to gather information. Some claims will be reported by the employer and some will be reported by the employee. That's somewhat preferential based on the employer's wishes. All the information gathered by the WC case analyst will be shared electronically with the STD analyst. The WC people are locally based, but the STD people are based in one centrally located office, depending on the employer's wishes. So, we've created a virtual office linked by technology.

All information is shared. The STD analyst has access to all the WC information. If the STD analyst needs further information, he or she will contact the WC analyst,

who will obtain it, So, it's a single point of contact throughout for all three interested parties—the employer, the employee, and the provider. This is where we bifurcate. We have an integrated call intake center. We take local knowledge on WC and jurisdictionally work with different claims offices to manage the WC piece. The STD piece is done centrally, and they share information on that.

For nurse case management, we will have protocols on both the WC and the STD pieces. If it's a combined claim, one nurse case manager will manage the case and report to interested parties on both the WC and STD side. We're using a single database and single information to have, to the extent possible, consistent decision making on claims adjudication. That's where we hope to garner administrative efficiencies. We're not doing data intake twice. We're not getting conflicting decisions. We're not getting conflicting reports from the physician. And, more than that, we're managing both the employer's and the employee's expectations consistently. If we tell somebody to return to work in two weeks, it's one decision. Both the WC and STD plans will abide by it at that point in time. So, we have integrated nurse case management.

Finally, we try to pull it all together with an integrated reporting database. All the information for both WC, STD, and LTD reside on one platform where employers have access to it. We've done some combined reporting, so they can see whether it's a WC claim or an STD claim and what has been paid out of both sides of it. They were trying to code, for instance, body parts, and map those to International Classification of Diseases-9th Revision (ICD-9s). We ask the WC claims management to fill in an STD screen as well as a WC screen, so we can gather all that information. We have the ability to do things both ways: track it by body part or by ICD-9 code. The employer can look at this from one integrated point of view. We start off integrated to recap, split out, and get the local expertise to manage a WC or an STD claim, use case management efficiently, and then pull it all back together on the reporting piece. This is how we've designed our pilot program.

In addition to the claim model, we have a dedicated account service team with a lead account service representative. Depending on the employer's preference, that will either be a WC account manager or a disability account manager. All questions will be funneled to them, and they have a support team of both disability and WC people working to resolve questions and send them in the right direction. But all report back up through a single point of contact from a service perspective for the employer. Any question, regardless of whether it's a WC or disability question, will go to the account service manager, who will use his or her expertise to get the answers.

It's an electronically integrated claims management team. All information is shared between the WC and the STD/LTD analysts. Also, as part of our product, we've integrated STD and LTD into one coverage. We have one integrated contract for both benefits. We're also integrating both pieces of disability along with the WC.

This should be a win-win situation for both employers and employees. For the employers, we're offering a consistent objective and focus, namely, that the best results will be obtained independent of cause, namely, occupational or nonoccupational. We're looking for consistent return-to-work strategies and consistent management of that throughout their organizations, independent of cause. We think we can get administrative efficiency because we only handle data once and make consistent decisions. We hope to get consolidated information through reporting. We get employee satisfaction. By getting in early, and managing the claim, employees don't have two points of contact, and we feel that's more efficient.

The goals are to reduce lost time through better management and also stop what we call the ballooning effect. If their WC is more aggressively managed, they go to STD or vice versa. This way they can't do that, so we're going to be able to control cost better in that respect. We think reducing lost time and implementing return-to-work programs have increased productivity. For employees, again, there's ease of reporting, ease of contact, and less redundancy. There's no extra paperwork, and they're going to see a proactive return-to-work process. We hope through this process that they will get back to work sooner, and that usually gives them a better mental health and income result.

What are the challenges? This is not just for Liberty. It's global. Organizationally, we tend to have silos within an employer organization that need to be overcome, typically, at the chief financial officer (CFO) level. WC and disability use different terms and understanding them both is a major barrier. WC typically charges back. We want to charge back the disability piece to the manufacturing facilities. Return-to-work policies need to be defined consistently for both sides of the equation. We are also making sure that there are no turf issues. We sometimes see fragmented programs on medical, STD, paid time off, salary continuation, and pension, especially in different states and municipalities. There'll be retirement benefits involved. We have to deal with multiple vendors. On the medical side, that's a challenge for Liberty because we don't have a health plan.

WC is highly regulated by the Americans with Disabilities Act (ADA), the Families and Medical Leave Act (FMLA), and, on the financial side, by *FAS No.112*. How do you price this? How do you get baseline data? How do you combine it? How are you going to handle all these new disabilities coming out in a subjective nature,

such as what the physician's role is and dealing with different subsets of physicians. WC typically deals with a very small group of physicians. Now that we have to expand that to the whole gamut of physicians on the nonoccupational side, how do we educate them into the kind of return-to-work policies that have worked successfully with occupational physicians?

We have a large employer in the financial services industry that wanted to proactively manage STD, LTD, WC, and FMLA. It wanted to implement formal return-to-work programs and reduce and realign internal staffing. The company hired a consulting firm for external expertise and assistance on this. The consultants evaluated and revised the plan designs. They were looking to streamline the administrative process. Part of the goal was to outsource some HR functions. We worked with them for about six to eight months and developed a model to do this. This was a large customer of ours that wasn't a disability customer at the time, and the disability business came to us.

The financial service company completely overhauled its plan designs, especially on the nonoccupational side. It got rid of its sick banks, put in an STD plan, and revised its LTD plans. Overall, it did return-to-work policies, guidelines, and contacts and gave it all to one vendor. In this case it was us. Results after a year are somewhat sketchy, but what I've been able to pull together is an internal staff reduction of six employees. As part of the arrangement, some of the employees became return-to-work coordinators instead of losing their jobs, but there was a net savings of six employees by outsourcing. We reduced administrative expenses 6% in the first year. We've reduced the reporting lag, partly because of the telephonic process and partly because employees don't report to both sides at once. This way they didn't have to. Especially on the STD side, we were able to reduce the reporting lag by the electronic notification.

Overall, we've seen a decrease in frequencies of 10–20% on the STD/LTD program. WC, surprisingly, has gone up slightly, and that was due to the fact it was miscoded internally. STD was paying, especially with sick banks, much larger benefits, so people tended to go over on the STD side instead of reporting it as a WC claim. Now we have correct coding of WC claims. And, overall, when we add up total WC, STD, and LTD, to date, there has been a 10–15% savings on the claims costs.

What do you need to make this work? You need high-level, organizational support typically at the CFO level of an organization to get through the silos of risk and HR. You need to be able to educate the whole organization and get both risk and HR working together across the different units. This was a multisite location. You need to have the return-to-work philosophy that's shown on the WC side brought over to the nonoccupational side, and align the plans. We asked for very detailed

functional job descriptions, which is typically what you'll see only on the WC side. We expanded the light duty and modified job availability across the board so we could get earlier return to work. We made sure charge-back mechanisms were across both coverages. There were high incentives across the organization. We reduced the total cost of the plan through a good process for reporting evaluation and quantifying results. And, finally, the real key is a well-structured, well-thought-out implementation. This has to go right from the beginning to get people's buy-in and satisfaction.

Mr. Michael Welsh: The premise of my discussion, the basic theme, is that disabilities are health events, and every disability is accompanied by some kind of a medical event that results in a diagnosis or a treatment. So, there's a direct tie-in on the medical side of the house.

I'm going to start with Chart 2, which is very similar to the one that Joe showed you. What Joe described was really that bottom horizontal line that ties in STD, LTD, and WC. I'm going to talk about the vertical line, tying in group health, STD, and LTD. There's been a lot of activity in integration on a lot of different fronts. HMOs have gotten into the WC business. Some of them have lost money and pulled out. Some of them pulled out because of all the regulatory issues. WC has incorporated some managed care techniques into managing medical claims, and there's been a lot of attempts at 24-hour models. I haven't heard the term "24-hour" used recently. I think that's been dropped because some of the complications of trying to pull all this together. But in looking at this from a more global perspective, if we work toward trying to integrate all these different components, the bottom-line goal is to improve total health and productivity, and that may take many years to accomplish, but we can integrate and tie all these pieces together.

In Chart 3, the vertical line shows the health and productivity, and the horizontal line shows the pre-onset/onset of a disability all the way through recovery. Generally, most managed care and innovative products focus on the bottom two circles, but the real opportunity exists before the onset of disability and during the early stages of onset of disability to get more effective intervention and faster recovery. It starts with prevention and early detection. Referral to the right providers for the right diagnosis and treatment result in faster recovery and return-to-work. You have to measure all this and look at the final outcome. Is the patient healthier?

To accommodate this, it requires a paradigm shift both on the medical and health side. Right now you have a stovepipe approach. We're really looking at benefits as a cost as opposed to an investment in productivity. Increasingly, our large life and medical customers are focusing on productivity—what we can do to help them on

the medical side and disability side to help increase their productivity. We also look at things from a product view rather than having a member-focused approach. We look at medical cost focus, as opposed to prevention and improvement of health and function. Medical professionals are not prepared to assess function. The incentives are not consistent between the medical side and the disability side of the house. In fact, some of those incentives are in direct conflict with one another.

Very often the return-to-work actions are very passive and disjointed. We need to move to something that's more managed and controlled. Very often there are multiple case management points, where you have a case manager on the health side, a case manager on the disability side, and maybe even on the WC side, all giving different messages and conflicting signals to the providers and to the patients. We need to work toward that single-care coordinator. We're very involved in inspection and control. We try to inspect and control the providers, the patients, and the disableds. We're adhering more to a collaborative approach, where we bind together the providers, the patients, and the employer to speed up their return to work. And, last, all the information is stored in different silos and is not directly accessible to one source or the other, so there's a lot of leverage that has been gained by combining claims-encounter, pharmacy, and disability data to get better detection and a measurement of the outcomes of various return-to-work efforts.

The key components of an integrated disability program are disease management, provider networks, and case management, but I don't want to underestimate the impact of a good disability claim management system. It's very important that the other aspects of disability management are there. For example, examining a contractual issue, Social Security offsets, fraud, and their types of activities are critical to the process. These are things we're talking about adding on as part of the integrated process.

A lot of health plans have started developing disease management programs around asthma, diabetes, congestive heart failure, lower back pain, and depression. It's really a data-driven approach where you stratify the data, look at trends, and identify high-risk individuals. It's critical in managing those medical conditions and return to work. By being able to identify high-risk individuals, we can target intervention through mailings, reminders, calls from nurses, and follow-ups to make sure that the right care is being delivered and patients are following through on the care that's been prescribed for them. And, last, we have to measure the quality of that care across a continuum of all medical and disability.

Here's an example of a disease management program that U.S. Health Care has developed for diabetes. We analyzed all of our data and identified 40,000 of our members who were diabetic. One of the complications with diabetes is blindness,

so we targeted 24,000 people who had not had an eye exam to identify a deteriorating eye condition. We stratified data into five different risk categories, targeted about 2,600 high-risk people, and sent reminders to them, as well as the providers, that they should get an eye exam soon. As a result, 48 people took the eye exam, had the proper laser treatment to correct the eye situation, and saved their eyesight. If disease management is used appropriately and data is used to identify those high-risk individuals, it can be very powerful in preventing and delaying the onset of disability.

Provider networks are a very critical component. Providers manage expectations to a large degree, so it's very important to have them as part of the system and the process. The key feature of a return to work network or a subnetwork of a health care plan is to focus on providers who represent the key diagnostic categories. Optimally, you'd like to have all your providers focused on return-to-work and educated on assessing function and so on. But the reality is that's never going to happen in my lifetime, so we need to focus on key diagnostic categories such as musculoskeletal and heart disease, focus on those as a specialist, and have special features around them to give individuals an incentive to go to those providers within that network. We offer them either an incentive of enhanced disability benefits or a cash payment if they follow through with the treatment regimen prescribed by the doctor.

Other components of that would be flexible office hours and appointment scheduling similar to some of the things done in the WC networks. Apply the best practice treatment and disease management guidelines, assess function, and work in a collaborative effort in the return-to-work process, so that providers become partners, rather than obstacles in the process. It's important for the health plan to provide education and support. We're targeting physicians and specialists who in key diagnostic categories first and then expanding as we go along. The nurse case manager is a key person here. He or she can coordinate with the work site, understand the job requirements, recommend modified duty, and work very closely with the provider, the patient, and the work site.

Many doctors are not equipped to do functional assessments. Developing this capability for them with the help of the nurse case manager or an expert panel is critical, as is having online disability protocols and guidelines that the doctor can use directly in the office. Probably the most important thing here is incentives. Nobody is going to do anything without an incentive. Many health plans, in addition to their fee-for-service reimbursement or capitation, have additional incentive payments, and those should be adjusted to reflect return-to-work outcomes and collaborative effort on return-to-work processes. There's also feedback from provider report cards that is based on the outcomes of disability,

return to work, disability management, and feedback from patients. We can adjust and enhance capitations if these providers are part of the subnetwork. Also, we could pay them additional fees or a special bonus fee, such as $500 or $100 whatever if they follow through on return-to-work efforts with these individuals.

The last component is case management. This is really the glue that keeps things pasted together. It's the clinical resource for the provider and for the employee. It supports the functional assessment and coordinates all that return-to-work planning, and it is very involved with the employer and the supervisor in matching job requirements and work site accommodations. It also coordinates all of the other programs an employer might have, such as employee assistance programs, ergonomics, and disease management programs. Case management provides continuity of care by being involved with that individual right from the start of the disability or the health event. And having one case manager eliminates the confusion and inefficiency that can result from having multiple case managers.

Integration offers opportunities for doing more enhanced disease management. Disease management costs our society somewhere in the neighborhood of $36 billion in treatment and lost productivity. Fewer than one in three cases are diagnosed appropriately, and very often the treatment is not followed through with the patients. So, the effectiveness of dealing with depression management and mental and nervous disorders is very spotty. There are many opportunities for effective disease management, which would result in better return to work and fewer people being disabled.

A significant cost on the disability is musculoskeletal conditions, which constitute about $149 billion in medical care and wage losses. The treatment for these conditions is not consistent. Some studies have shown that some of the treatment being administered is unnecessary and detrimental. So, there's a lot of opportunity to develop effective disease management programs and incorporate them into health plan disability programs.

This is a future view of the integration of disability and medical, and it raises a lot of key questions. Will medical costs go up because of this? Maybe yes, maybe no. I have a basic philosophy that people who are back to work are less likely to make doctor appointments and get medical care. Will absence costs decrease? It's very likely they will. Will administrative costs decrease? I definitely think they will because fewer people will touch that patient. What is the incremental value of coordinating the occupational/nonoccupational? That remains to be determined.

Another issue in trying to coordinate health and disability is the fact that most employers will have multiple health plans. They'll have multiple HMOs in one

location. If they have multiple locations, they have multiple carriers. Generally, they have one disability carrier, though, so there is not a one-to-one relationship between disability and medical, which is going to be very complicated for an employer to roll out. However, some of the employers we've talked to are willing to accept different disability programs for different segments of their employee base. There are opportunities to try to piece this together, but it's going to be a long road to travel to accomplish total integration get total health and productivity across the whole employee base.

Mr. David A. Nixa: I'd like to give you some perspective on integration of benefits. A lot is going on in the industry today. I'd like to present some of the possible alternatives, some of the current responses in the marketplace in terms of products and services being sold, and a bit of real data or perspective on what seems to be working and not working quite so well.

I will take a look at where the market seems to be going both in terms of product and service providers. I've been doing this for quite some time. I managed a product with my former employer, and I've managed several different products, both as a consultant and in my current role. Most important, I'd like to stimulate you to think about integration and make sure that you challenge what might be considered conventional wisdom—or at least have questions in your mind about what needs to be answered by your employer. Or, in your situation, I want to make sure that you're meeting the needs of the market or the customer.

First, I'm going to cover some basic real and theoretical integration models to try to give you sense of what I think they're trying to accomplish. I've collected quite a bit of data and tried to keep this as current as possible. I'd also like to make a few observations about what is happening with each of the models and then stimulate some discussion.

Table 1 should look familiar to you. My colleagues have both presented it. There are multiple combinations of this. In addition to the obvious ones that we'll go through, you can add various and sundry additional coverages, including stop-loss, catastrophic, automobile, or any kind of liability coverage. As Mike said, most alternatives look at the medical event as being the focus, so that's probably one thing that's consistent. If you look at integration as not just being what you think of as the occupational/nonoccupational medical indemnity combinations, but also in terms of any medical event where there's some liability involved, what's the effect of that going to be?

TABLE 1
INTEGRATION ALTERNATIVES

	Medical	Indemnity
	I	III
Non-Occupational	Insured Self-funded (includes stop loss and catastropic)	Insured Self-funded (includes sick pay, salary continuation, STD/LTD, includeing stat. DI)
	II	IV
Occupational/Work	Insured Self-Funded WC, AEC, Excess	Insured Self-funded WC, AEC, Excess

What are the advantages or disadvantages of integration? I try to look at it from both a market point of view, meaning the customer, and from a product point of view, meaning the insurer or the service provider. Obviously, there's a perception on the market side that benefit plan cost will be reduced, that the claims will get paid in the right place by the right person using the appropriate networks. Employers would like to achieve a healthy work force, simplify their benefit program administration, and have satisfied, happy, and productive employees. For the most part, what we have out there today is just intuitively appealing. Most employers look at this and say it just makes sense.

On the product side, insurers and service providers are looking to achieve a competitive advantage and internal efficiency. You've already seen the single point of claims and integrated case management systems and data. Most of the firms are attempting to capitalize on their core competencies. A lot of the combinations you see are partnerships that are not delivered by the same firm. They also want to reduce internal cost and customer costs and maximize the utilization of the various networks on the medical, disability side, and WC side. They want to reduce price and add value, whatever that means right now. Joe and Mike addressed improving the employer and employee's satisfaction by looking at patient-centered or client-centered satisfaction. Everybody's doing that. All the providers have something in the works to make sure that they don't lose market share, and they're ready to go. But frequently I also hear, "Why should I do this? I haven't lost a customer to it yet." Yet, on the employer side, it is intuitively appealing.

What are the critical success factors for an integrated benefits program? It should save money. It should increase satisfaction and productivity. You can fit most of the outcomes into these categories.

The first alternative is a combination of medical and WC. Some of you may be familiar with the Kaiser plan that was introduced a few years ago when 24-hour was

all the rage. There are very few companies pursing medical and WC only. Unfortunately, there isn't much current data available.

Another fairly obvious combination of benefits is STD/LTD, and virtually all of the disability carriers are pursuing this alternative. My colleagues are looking at it and, so far, acknowledge that it's too soon to tell. Available is company data, largely from marketing materials that have been internally generated by their own actuaries, and objective data, which I view as third-party and/or true results that companies have published. In this case, there isn't much subjective or objective data out there, but just about everybody is doing this.

The next combination is medical and disability, as Mike talked about. This is a fairly new combination, so there are lots of prospects in terms of what it might accomplish. Essentially, little significant effort or progress has been made to date because most of these programs are in development. But this is a combination that you'll see a lot of medical carriers and HMOs begin to pursue, based on the belief that disability begins with a medical event. Largely, the medical carriers control the benefit dollars and many of the benefit decisions. You can expect to see more of this type of combinations because of successful efforts like Aetna's.

Integrated disability is the most popular combination. There's a lot more data available, although not much of it objective. This does not include the medical part of WC, but the integrated disability part, and most of the firms or service companies that are pursuing this alternative, walked down this path after health care reform collapsed a few years back. You may recall the attempts by our politicians to put medical and WC together legislatively. Once that collapsed, there was no reason to do it, particularly because medical was so diffused around the country. It was difficult to have a single carrier for WC and medical on the medical side, so this became the popular alternative, and most of the results data that we're beginning to see are on the integrated disability side.

The next combination adds the medical component, and the results are sketchy. The true results that we tend to be seeing right now are those associated with service providers. That means TPAs who are getting risk through either self-funded programs or multiple insurers. Some of the insurers are beginning to publish results in their marketing material, and we are beginning to see some of the carriers produce or sponsor studies by independent third parties that are generating some results as well. But, again, there isn't big body of data here, and I sometimes struggle with whether or not the integrated disability and integrated WC has to be LTD data—or, in fact, the same data—because you can talk to employees in the same company or read results in the same report and find that they are integrating

networks, for example. So, you don't really know the product if you compare the marketing material to the results.

The ultimate form of benefits integration integrates everything from medical, WC, disability, and, theoretically, at some point, other medical-based event indemnity coverages. There's a little bit more data on this from studies that have been conducted on behalf of one major carrier and several major TPAs and industry research groups. It's real employer data that shows they've achieved some fairly impressive savings. But I'm not sure there's yet enough information for us to determine whether or not this is still anything more than intuitive.

This model is now being pursued fairly aggressively by some of the larger service providers and TPAs. Essentially, what is occurring is a form of the prior model, which is to put together some or all of the benefits coverages in a form that doesn't really care who's providing the risk. The company assuming the risk may be any insurer or HMO, but the important piece is the service. Much of what you heard discussed today, in fact, is about combining service. There wasn't a lot of discussion of how risk plays a role in this.

Although most of the major insurers have a vested interest in putting their own capabilities together, there are options and opportunities for insurers to partner with other firms if they don't have this type of service as a competency already. It's my expectation that you're going to see such partnerships; otherwise the TPAs are going to go out of business. They won't be able to compete with the economic clout of the major insurers and the underlying service infrastructures that they're now beginning to build to serve the market that seems to be looking to buy this product at some future point.

A lot of people are selling this stuff to a lot of different client bases. In gathering data, I started with insurer marketing collateral because I wanted to see what they said they were selling or what they said they could benefit from. I got a lot of information from industry news, employer-sponsored research, and some employer-sponsored case studies.

Hopefully, my comments have caused you to think about what are the kinds of questions that you, as actuaries, need to have answered in order to be convinced that your firms should invest in, pursue, or modify their strategies with integration of benefits.

Mr. Ronald James Williams: One of the items that always comes up when you start integrating STD, LTD, and WC—and your STD is offsetting for WC—is that you get into situations where a claimant qualifies for WC but not for STD because of the

involvement of the physician more heavily on the WC side. Are we trying to manage the expectations of the individual insureds or are we starting to see some STD plans that are relying more heavily on WC and potentially increasing cost? When everything is packaged together, do you get some offsetting?

Mr. Poplaski: On the lost-time piece what we're recommending to define STD is "own job, same job, and same employer." It ties much better with the WC piece in terms of returning to their own job. That's why I went through the "And" and "Or" scenarios. We're looking for one plan where, if you get WC, you will get STD and vice versa. The plan designs we're looking get those kinds of economies; otherwise it's a very fragmented approach. But also realize, even with integration, a large percentage of it is going to be, for instance, med-only on WC, without ever using STD. Maternity claims on STD never see WC, we hope. So, even within the integrated system, a large piece is independent. The real integration only the combined claims, but you still want to pull that data together to see. For instance, you'll want to determine durations by diagnosis on the WC versus the STD side for similar claims. Are they running the same? That's what you want to show to the employer. Ultimately, if you're going to do integration, you must get the same results.

Mr. Nixa: I'd like to add to that. It's possible to make sure, as your primary goal, that the employee gets paid and still see where you can get the greatest value. Joe has combined his STD/LTD. I don't know if I heard anything about combining pricing, but there are certain advantages to making sure that a claim gets put in the right bucket. In fact, there is a philosophy in one self-funded firm of putting as many claims into STD as possible. This is a major auto manufacturer that operates with the assumption that every claim is an STD claim, period, until it's demonstrated to be otherwise. Obviously, as Joe said, some claims fall into that category very quickly, but when I looked at the incidence rates and determination rates after they started this program the results were dramatic. There are other implications, such as reduced litigation costs and all of that if you can get a claim paid as STD, because most people just want to get paid.

Mr. Gregory S. Benesh: Joe, in your virtual office environment, where are the nurses located?

Mr. Poplaski: The nurses are centrally located in their own case management unit. If you get a dedicated team, you'll get a dedicated nurse if you're large enough, but otherwise they swap off with other employers. We tend to keep them all in one unit, for instance, based in large claim offices. If we have a very large customer, we'll have a couple of nurses there and a separate set for the smaller customers, especially on the WC side.

Mr. Michael J. Francescone: I have a question for Joe Poplaski. You mentioned that, if you have a claim that is both WC and STD, that the WC claims management directs the claim. What do you do if the claim comes in and it is known at that time that it will also be an LTD claim? Do you immediately transfer it or wait?

Mr. Poplaski: The WC analyst will still control the claim. The STD analyst is still involved, but the WC analyst is what we call a day-one analyst. He or she would manage the claim from the LTD point of view as well, but STD analysts are invisible to the employee. Anything they wanted to get done or accomplished would go through the WC analyst via e-mail.

Mr. Francescone: The WC analyst would manage it for the duration of the claim?

Mr. Poplaski: Yes.

Mr. Francescone: Is it in a handoff to the LTD analyst?

Mr. Poplaski: Yes, especially if we're doing a settlement on the WC side. We get the offset and can manage the settlement a little easier in terms of offsetting on the LTD, but that's when the transition would occur.

CHART 1
INTEGRATED DISABILITY MANAGEMENT

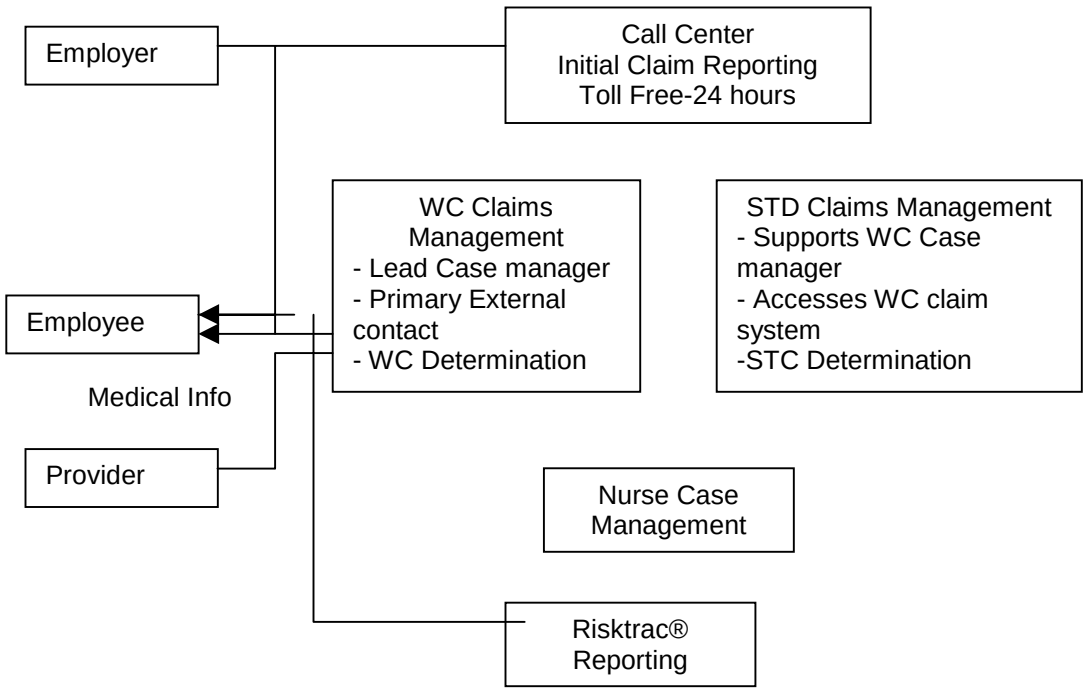


CHART 2
THE INTEGRATION MARKETPLACE

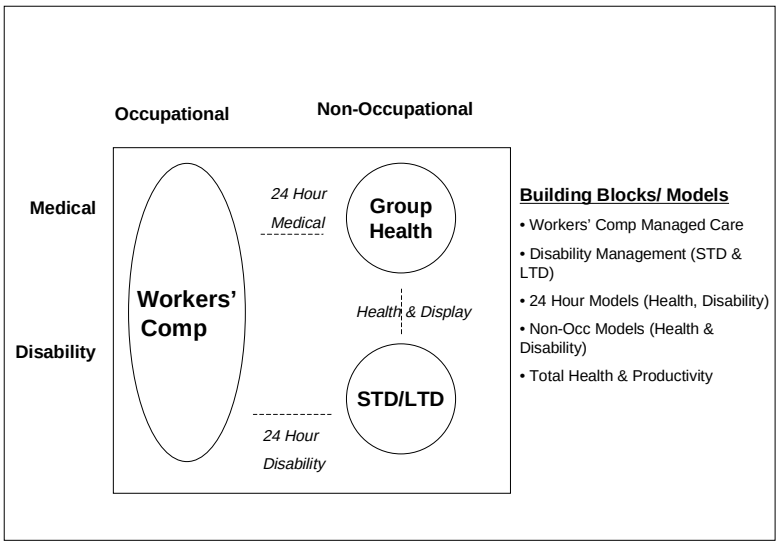
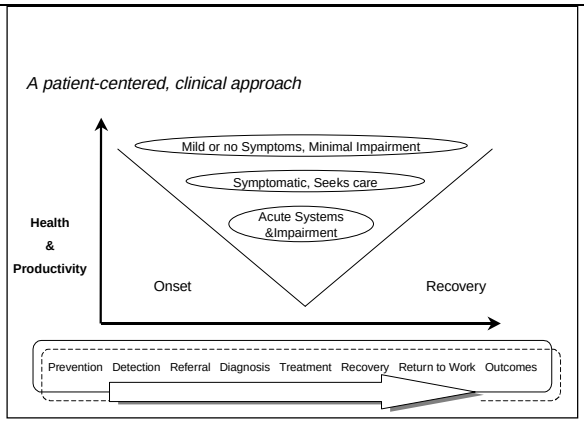


CHART 3
INTEGRATED HEALTH AND DISABILITY



IHD- Requires Paradigm Shifts

A different way of looking at benefits...

Stove-Piped Approach	Integrated Approach
• Views benefits as costs	• Investment in productivity
• Product view	• Member/popular view
• Medical cost focus	• Prevention, health & function
• Medical professional not prepared to asses function	• Professionals trained to ffff assess function
• Passive, disjoined RTW	•Managed RTW
• Multi case management points	•Single care coordinator
• "Inspect & Control"	•Collaborative approach
• Information stored in separate silos	•Comprehensive information for better detection and outcome measurement