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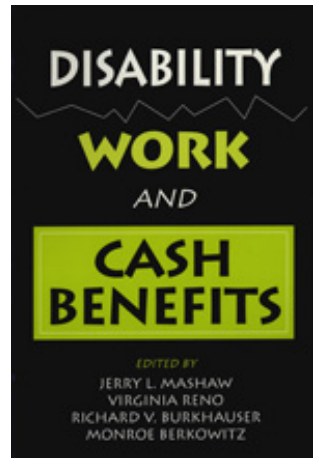
Disability and Work: Lessons from the Private Sector

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The Problem

The human and social costs of disability are well known, and increases in the number of beneficiaries and in expenditures are both causes of concern. The real economic cost of disability, namely, the lost production from individuals not at work, has been growing rapidly in recent years. Nominal, or budget, outlays have also been increasing as private and public payments for disability benefits have soared in the last 20 years. Using a nonrandom sample, a recent study estimated that employers were paying 8 percent of payroll for disability-related expenses, including both direct and indirect costs of disability (Chelius, Galvin, and Owens 1992).

At the same time, a very specific issue has arisen in the Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) programs. The return-to-work rate has declined precipitously since the 1970s. According to the Disability Policy Panel of the National Academy of Social Insurance:

The proportion of beneficiaries who leave the disabled-worker benefit rolls because of recovery has never been large. During the 1970s, it generally ranged between 1.5 and 2.5 percent of the benefit rolls. Terminations due to recovery peaked in the early 1980s, when SSA pursued an aggressive policy of reviewing the rolls and terminating benefits. In the 1990s, terminations for recovery are at

an all time low, in 1991-1993 they are below 0.5 percent (National Academy of Social Insurance 1994, p. 82).

We take this “recovery” or return-to-work issue as the impetus for our paper.¹ Are private sector actors more successful in returning persons with disabilities to work? How do they do it? Are there lessons that can be learned about return to work from the private sector that could be transferred to public sector programs? What problems would have to be overcome to translate private solutions to the public sector?

Equity and efficiency considerations are key in evaluating policy. Economic efficiency requires that we obtain the maximum amount of goods, services, and leisure time from the human and other resources in society. Thus, any human resource that is unemployed or underemployed reduces the total production available for all to consume and thereby decreases the economic well-being of all citizens. Economic equity is harder to define, but ultimately it deals with the distribution of those goods, services, and leisure time that a society can produce. Some use a standard of equity that specifies “to each according to his or her contributions”; others prefer “to each according to his or her needs.” In either event, the issue is who gets to consume what share of total production (Okun 1975).

There is also another sense of equity, and that is the equity of participation. For the last three decades or more, we as a society, have been concerned about the full and equal participation of racial minorities, females, older Americans, and persons with disabilities in the economic life of the country. We have enacted statutes attempting to promote the opportunity for such participation by outlawing discrimination against these groups. In some cases, we have even required “affirmative action” to try and involve disadvantaged groups, especially where their participation has been prevented or hindered by past discrimination. The Americans with Disabilities Act of 1990 (ADA) seeks to remove barriers to employment for persons with functional limitations by requiring employers to reasonably accommodate these individuals’ disabilities. The clear goal of ADA is to facilitate the greater participation of persons with disabilities in the world of work by removing the environmental and societal barriers to participation and integration.

However, if individuals are being encouraged to “maximize” their *disability* rather than their ability in order to receive cash or in-kind benefits, we will have a loss of both efficiency and equity. We will lose efficiency in the sense that society will produce less than it could if all resources were fully employed. We will lose equity if some individuals are not participating, thereby not contributing their share to producing the goods, services, and leisure time that we are all consuming. In this sense, equity and efficiency both mandate the optimum participation of persons with disabilities in economic life.

Reframing the Return-to-Work Issue

Traditional Approach

Before the disability management movement, attention to return-to-work or stay-at-work goals for people with functional impairments was rare in the private as well as in the public sector. A medical model of treatment and recovery was dominant, with the emphasis on benefit administration, not return to work. That is, the process moved in a linear sequence from diagnosis of impairment to independent provision of medical treatment, passive recovery at home, and claim monitoring at eligibility points by the carrier. Only when it became clear that the injured employee was failing to return to work was recourse to the vocational rehabilitation system considered.

Over the past decade, there has been growing disenchantment with the medical or clinical model of disability and with the outcomes of the traditional approach to vocational rehabilitation. Meanwhile, an ecological model of disability has gained acceptance. That is, a given individual with an impairment functions in interaction with an environment that has certain attitudinal, physical, economic, and policy characteristics, which, in large part, determine whether the consequences of an impairment will result in a work disability. Increasingly, disability has become recognized as an interactive phenomenon, not simply deriving from the medical or even the functional aspects of the impairing condition (Berkowitz 1985).

From a public policy perspective, this changing viewpoint has led to additions to the state-federal program of vocational rehabilitation, with the inclusion of such approaches as independent living services and supported employment. We have also seen the de-emphasis of the clinical model of vocational rehabilitation services in the 1992 amendments to the Rehabilitation Act (which governs the federal-state vocational rehabilitation system), particularly in regard to determination of eligibility. More fundamentally, the ecological or sociopolitical view of disability fueled the development and adoption of the ADA, explicitly changing the focus to the capabilities of persons with disabilities and requiring the larger environment to provide reasonable accommodation to allow for the participation of this "minority" group of citizens.

Further, subsequent evaluations of the modest employment outcomes achieved by the state-federal system (General Accounting Office [GAO] 1993) have recently motivated the Council of State Administrators of Vocational Rehabilitation (CSAVR 1993) to launch an initiative that calls for significant linkage with the employer community, including disability management efforts, and emphasizes employment as the desirable outcome. In summary, the service model that ignores the labor market until the end of a lengthy process has been identified by virtually all constituents as a flawed approach to employment for people with disabilities (CSAVR 1993; Stubbins 1982; Vandergoot 1994; GAO 1993).

The Disability Management Approach

During the late 1970s and early 1980s, a confluence of economic and policy factors led to heightened awareness of disability costs in the business community. Reduced profitability in the face of rapidly escalating health care and disability benefit costs led to an examination of workers' compensation and other disability programs as significant management concerns. No longer could these issues be ignored as simply a cost of doing business.

Simultaneously, many leading companies, as part of their human resource commitment, became actively involved in national and international efforts to promote the employment and full participation of people with disabilities. The Independent Living movement led to

increased leadership and expectations of the disability community in policy efforts. The field of vocational rehabilitation discovered employers as necessary partners to achieving further goals. From many directions, the economic and social forces converged to set the stage for the emergence of the disability management model. This history has been adequately summarized by other authors (e.g., Galvin 1986; Tate, Habeck, and Galvin 1986; Akabas, Gates, and Galvin 1992; Habeck et al. 1994).

In their comprehensive book on the subject, Akabas, Gates, and Galvin (1992) define disability management as

a workplace prevention and remediation strategy that seeks to prevent disability from occurring or, lacking that, to intervene early following the onset of disability, using coordinated, cost-conscious, quality rehabilitation service that reflects an organizational commitment to continued employment of those experiencing functional work limitations. *The remediation goal of disability management is successful job maintenance, or optimum timing for return-to-work...* (p.2, emphasis added).

Disability management, effectively implemented, is intended to achieve a win-win situation that addresses the reciprocal economic and humanistic needs of the true stakeholders in disability management, namely, employers and employees. Common interests that can be achieved through an effective program include reducing the risks of injury and illness, retaining productivity, effectively using human resources and health care services, improving financial security, avoiding adversarial relationships, and achieving the requirements of disability legislation.

The interest of the business community in disability management has been astounding. Since early reports of significant cost savings began to circulate a decade ago, there has been an explosion of programs. Employers by the thousands have embraced disability management techniques as a way to combat the upward spiraling of disability costs and, often, to demonstrate commitment to the well-being of their employees. Disability management conferences abound, and virtually every insurance carrier has developed a disability management product in response to this interest. In 1993, a survey of 1,050 companies revealed that more than 84 percent were actively attempting to control

their workers' compensation costs through various disability management techniques (Towers Perrin 1993).

During the last few years, a growing number of organizational case studies and empirical efforts have documented the dramatic cost reductions achieved in these initiatives. Every company is unique in the specific constellation of job risks, human resources, and business factors that must be taken into account in tailoring a disability management program to meet its needs. Nevertheless, the literature indicates several traits that successful disability management programs share. The essential components, adapted from reviews by Schwartz et al. (1989) and Habeck (1991), are as follows:

1. Companywide commitment to reduce disability costs and provide needed assistance to encourage return to work
2. Analysis and modification of related benefits and policies to support disability management objectives
3. Comprehensive assessment of corporate needs, experiences, and responses to injury and illness incidents
4. Organization of the disability management initiative across levels and locations, with clearly assigned responsibilities and accountability among all necessary people and operating units
5. Creation of an integrated, usable, and effective information system to document, analyze, manage, and evaluate relevant data about incidence, employees, costs, services, and impact
6. Educational efforts directed toward managers, supervisors, and line workers to create understanding and involvement in disability management efforts
7. Active use of safety and prevention strategies to avoid disability occurrence
8. Early intervention and ongoing monitoring for health risks and disability cases
9. Contact with the injured/ill employee and the treating physician within 24 hours of impairment onset

10. Facilitating early return to work of disabled workers through an organized process that provides modifications in assignments, hours, and/or duties
11. Systematic procedures for effective use of health care and rehabilitation services
12. Writing an individual plan of service and return to work by the responsible case manager with the participation of the employee
13. Using professional expertise to design accommodations that permit workers with disabilities to perform work in a satisfactory manner
14. Collaboration with public and private agencies to provide necessary mental health and rehabilitation services
15. Use of incentives in benefit design, cost accounting, and performance evaluation to encourage participation of employees, supervisors, and managers

One can presume that, if there is this much interest by the private sector in a specific set of techniques, there must be a substantial payoff.

Empirical Evidence on the Impact of Disability Management

Although very limited research evidence is available to document and quantify the impacts of these practices, there are a few studies that provide clear support for the significant effect of the organization's behavior on the disability experience of the company and its employees. For example, Rousmaniere (1989) and his colleagues found the most important cause of variation in disability impact among 24 hospitals in New England to be the hospital's internal system of risk management and post-injury response. Rousmaniere (1990) has further asserted that how a company responds to and manages injuries determines roughly 50 percent of the costs. Similarly, according to the National Rehabilitation Planners organization (1993), companies can reasonably expect to reduce workers' compensation costs by 25 to 30 percent after the first year of implementing a disability management

program, with nearly twice those savings realizable when long-term, inactive cases are more effectively resolved.

Lewin and Schechter surveyed 77 companies in 1989 and found that human resource policies were significantly related to disability incidence. Use of employee involvement programs, conflict resolution procedures, workforce stabilization measures, and disability management policies were each inversely associated with levels of lost work days due to occupational and nonoccupational illnesses and injuries (Lewin and Schechter 1991).

Two recent studies of disability prevention and management in Michigan demonstrate the impact of employer practices on the frequency of disability. The first study, based on a nonrandom survey of 124 firms, explored the hypothesis that a significant portion of the variability between workers' compensation experience in different companies was due to internal actions that were within the employer's control (Habeck et al. 1991). The following findings and conclusions were reached:

1. Great variability, at least tenfold differences, could be found between the workers' compensation claim rates of the firms with the highest and lowest claims within each of 29 industries studied.
2. Only part (25 percent) of this variability in claim rate could be explained by industry, size, and location of the firms.
3. Firms with high claims incidence had twice as many injuries but had four times as many workers' compensation claims, supporting conjecture that there are two distinct processes involved in disability management. The first portion involves strategies that prevent potentially disabling incidents from occurring, and the second involves managing the incident after it occurs, with each process contributing substantially to eventual outcomes.
4. Organizational characteristics, such as unionization and tenure of the workforce, are also related to the claim rate.
5. Favorable claims experience (i.e., a low claim rate) is significantly related to the managerial philosophy and the particular policies and practices adopted by the firm, including an open

managerial style, a positive human resource orientation, more rigorous pursuit of safety and preventive interventions, and specific procedures to manage disabilities. In regard to the latter, firms that had lower claims rates reported significantly more frequent use of employee assistance resources, light duty and modified work to help restricted individuals resume employment, and procedures to promote supervisors' efforts to assist in the return to work of injured employees in their departments.

The second study was conducted to quantify the impacts of specific workplace policies and practices on the incidence and outcomes of work-related disability within firms (Hunt et al. 1993). The impacts of disability prevention and management behaviors were estimated in a multivariate analysis that controlled for a wide range of organizational factors, using a random, cross-sectional survey of 220 firms in seven industries. The results demonstrate that companies engaging more frequently in behaviors defined as "Safety Diligence" and "Proactive Return-to-Work" experienced significantly fewer cases with lost workdays, fewer total lost workdays, and less frequent workers' compensation claims; in sum, they experienced less work-related disability.

Specifically, firms that reported 10 percent more frequent achievement of Safety Diligence (disability prevention) experienced 17 percent fewer lost workdays per 100 employees. Safety Diligence is interpreted as the rigorous behaviors of companies that act on their stated safety goals and put their safety measures into continuous practice. These behaviors have been accepted by managers, supervisors, and employees as an integral part of their regular functions.

Firms that reported 10 percent more frequent achievement of Proactive Return-to-Work (disability management) experienced approximately 7 percent fewer lost workdays per 100 workers. Proactive Return-to-Work is interpreted as supportive, company-based interventions for personally assisting those involved in an injury or disability, from the beginning of the incident to its positive resolution. The actions and responsibilities of individuals within the company and external providers are spelled out and related to the ultimate goal of resumption of employment.

Further, these results appear to be enabled and perhaps multiplied by the managerial commitment and corporate culture of the organization.

One observation is that firms that demonstrate their concern and commitment for injured workers receive, in turn, greater trust and cooperation from their employees. This is also manifest in the finding that "Disability Case Monitoring," defined as a reactive approach to cost containment and claims control, actually was associated with a greater incidence of lost workday cases (Hunt et al. 1993).

In addition to the survey, on-site plant visits were made to a subsample of 32 firms in order to verify the quantitative findings and to gain operational understanding of the company behaviors that contributed to low disability rates. The initiatives of successful firms are summarized as follows:

1. Extensive use of data to measure performance and identify problems
2. Analysis of problems to identify the root causes of injury and work disability and to target interventions accordingly
3. Receipt or development of the active support of top management for the goals, policies, and procedures undertaken
4. Education of labor to understand the relevance of safety and disability performance to the well-being of the company and to themselves
5. Immediate response to identified problems, which convinces labor and supervisors of the genuineness of management's concern and determination
6. Realization that their actions and performance in safety are related to their disability performance and to workers' compensation costs
7. Movement upstream in prevention through ergonomic initiatives in design
8. Development of effective working relationships with designated, knowledgeable, and responsive health care providers
9. Maintenance of an active role in case management, even when professional services are used, in order to keep the company in control of the process

10. Implementation of the return-to-work process in a systematic way throughout the organization, yet tailoring the process to meet the needs of the individual situation and maintaining a transitional perspective in accommodations made

These findings support a causal connection between the disability prevention and management policies and practices of a firm and disability performance results. The strategies of prevention and management have both been shown to be effective in reducing workplace disability in those firms that have implemented them rigorously. As expected, prevention strategies have a higher payoff, but management techniques have also been effective at reducing the total incidence and severity of work-related disability.

Case management is one of the techniques included under the broader disability management umbrella. One example of its application to Social Security claimants will be reported. An experimental design was used to test an independent case manager model with persons who had applied for Social Security disability benefits (Hester et al. 1990). Over 3,850 applicants were referred to the project. After rigorous screening for probable success, a final selection of 753 persons (20 percent) was made of those felt to be eligible for return to work.

These individuals were assigned to one of three groups. The first was an early referral group, comprised of individuals who were offered case management services to promote return to work within two weeks of their application for benefits. The second was a late referral group, in which participants were offered the same case management but not until after they had been approved for benefits. The third group was a control. Case management services included physician contact; an assessment of vocational skills, with a work evaluation if indicated; job development with former employers, if possible; referral to state vocational rehabilitation agencies for skill training; and direct placement services. Among the relevant findings were the following:

- only 6 percent in the late referral group accepted services, as opposed to 22 percent in the early referral group;
- 46 percent of those who accepted services were employed at the end of the project, as opposed to 13 percent of those in the control group; and

- 21 percent in the early referral group returned to work, as opposed to 3 percent in the late referral group.

These observations indicate that a case management approach using early intervention (even though six months or more after onset of disability) may be particularly useful before disability benefits are awarded for encouraging return to work for those still in the applicant stage. While these empirical research findings are very limited, they do strongly suggest that disability prevention and management techniques work for reducing the incidence and consequences of work-related injuries in the private sector. Some of the techniques may even work with DI claimants.

Private Sector Examples

In an attempt to determine how particular elements are implemented in private sector disability management programs, and how they might impact Social Security Administration (SSA) program concerns, we conducted a set of nine case studies. They were meant to represent a broad range of private sector experience, but not necessarily “best practice,” since much more systematic survey work would be required to determine just what best practice really is. We talked with some self-insured employers from widely divergent sectors of the economy, insurance carriers with very different books of business, and varied types of service providers. Due to the limitations of space, just three of these examples are presented here: one self-insured employer, one insurance carrier, and one service provider.² A summary of the lessons learned is provided at the end of the section.

Owens-Corning Fiberglas

Owens-Corning Fiberglas is a global manufacturer of fiberglass products. The firm has 50 U.S. plants with about 12,000 employees.

Approach to Disability Management and Return to Work

Owens-Corning characterizes its approach as an “aggressive stance” toward disability management and return to work. Owens-Corning has

taken corporate responsibility for all of its claims, including work-related and nonwork-related disabilities. The company has brought the process in-house and no longer relies solely on third parties. This approach was adopted in response to significant rises in costs in all disability areas and to anticipated changes due to national health care reform. The goal is to reduce disability costs as a means of increasing company profit, but to do so in a way that is consistent with corporate principles of (1) customer satisfaction, (2) individual dignity, and (3) shareholder value.

Specific Interventions

The major features in the administration of the Owens-Corning approach include the following:

1. A site disability case manager is used to coordinate all activities and provide case management services;
2. Case management begins on day one of the occurrence;
3. Benefit checks are cut in-house to assure prompt payment;
4. Performance standards have been tightened for third-party administrators of the company's plans;
5. The company has changed vendors for its long-term disability insurance to one that has a progressive disability management philosophy and shares the firm's vision;
6. Corporate oversight is used to address responsibility for overall disability outcomes;
7. Human resource managers and supervisors at all plants were brought in for education regarding program goals and operation; and
8. Provisions for disability management and return to work have been incorporated into contract negotiations with the company's represented groups.

Expected Outcomes

Owens-Corning stipulated the outcomes that should be accomplished by the end of the first three years of the program, which was

implemented in 1992. These outcomes included a 10 percent reduction in total disability costs, including indemnity benefits and medical costs; a 10 percent reduction in lost workdays; and a 10 percent increase in the use of modified, restricted workdays. In less than two years, each of these three goals had already been achieved. In 1992, the firm's disability cost total was estimated at \$25 million; the current goal is to reduce these costs to \$15 million by 1998 (a 40 percent reduction).

Relationship to the Social Security System

Owens-Corning sees Social Security as an added benefit. Owens-Corning recognizes that it cannot provide for all needs and that Social Security represents an important resource to the corporation. The firm provides assistance to its employees in applying for DI, including provision of information for the applicant to carry to the SSA if needed.

UNUM Insurance Company

UNUM Corporation is a specialty insurance holding company whose affiliates include UNUM Insurance Company of America, a leading provider of disability insurance and of employee benefits, long-term care, and retirement products.

Approach to Disability Management and Return to Work

Disability management and return to work at UNUM are best pictured as a continuum. The preferred disability management activity at the beginning of the continuum is disability prevention and stay at work. To that end, UNUM works with high-risk employers at an organizational level to identify trends in claim causes that suggest prevention activity, such as job restructuring, ergonomic engineering, or training in how to work more safely.³ The Long-term disability (LTD) product offers an Employee Assistance Program (EAP) for help with personal issues that can contribute to disability.

Further along the continuum, if a person does have an impairment and a functional limitation that prevents work, early intervention is important. Under short-term disability (STD) policies, that can happen much sooner than in LTD where there is a 90-to-180 day waiting period. Where UNUM provides both STD and LTD, an STD objective

is early intervention and management to prevent or minimize an LTD claim. UNUM also provides stay at work services for employees. Stay at work services include functional assessment of the person and the job, along with identifying and paying for job modifications within certain limits.

Specific Interventions

From the insurance carrier perspective, a plan design that sets waiting periods and replacement rates that provide significant incentives to return to work is an important management tool. Collection of complete impairment and work information is also key to making a fair decision regarding the person's functional ability in relationship to clearly stated job demands. These facts determine if the definition of disability is operable and if the individual is entitled to benefits.

For STD, the major tool is duration management according to guidelines that indicate how long individuals may not be able to perform the functions of their jobs or occupations, considering their age and impairment-related functional restrictions and limitations. Using these guidelines, expectations of recovery and return to work are set when the claim is approved, causing people to think of return to work from the beginning. For LTD, a case plan is set and return-to-work expectations are conveyed, but with less formal duration guides. For both STD and LTD, if expected recovery does not occur, claims managers work with treating physicians to review the medical aspects of claims and the individual's job functions, in order to facilitate return to transitional or modified employment.

Specific management protocols are developed for the more problematic impairment categories such as psychiatric, cardiac, maternity (STD primarily), and chronic back pain cases with no objective medical findings. These protocols involve specific physician questionnaires and physical/functional evaluation. Regular follow-up is used to track progress and to communicate with employee, employer, and the treating physician in pursuit of the case plan.

UNUM has developed a copyrighted return-to-work prediction scale, which claims specialists use as a guide for identifying rehabilitation candidates with return-to-work potential. For persons who have both STD and LTD eligibility, rehabilitation potential is assessed during the STD claims management for those likely to go on to long-term

disability. In some circumstances, case managers will use outside vendors for rehabilitation services, where there is likelihood that such services can return the claimant to work. A cost-benefit formula is applied based on the cost of the services, the cost of providing present and future benefits, and employer and employee motivation. For long-term disability, about 18-20 percent of new claimants are reviewed and accepted for rehabilitation.

Expected Outcomes

Success is measured by company profits as well as by customer (both employer and employee) satisfaction. Outcomes for long-term disability claimants are tracked based on the relationship between the cost of the intervention that UNUM will cover and the projected savings in future benefits that would have been paid if the person had continued on claim status (the industry calls this reserve release). By this calculation, there has been a return in the range of \$5.00 to \$7.00 for every \$1.00 expended over the last three years. Outcomes are also measured in terms of client satisfaction and recoveries, and, of course, in increased sales and renewals of insurance policies.

Relationship to the Social Security System

There is a formal Social Security referral program in the LTD claim process. Social Security is a consideration in setting up a case plan for a claimant. However, return to work is the first goal, and Social Security referrals are made based on the severity and duration of the impairment and when other efforts to achieve return to work are not successful. UNUM's benefits are in addition to those of Social Security and the LTD insurance price reflects this potential offset.

United Health Care

United Health Care (UHC) is one of the largest health maintenance organizations (HMOs) in the country, with over 2.7 million enrollees. UHC has purchased a workers' compensation preferred provider network (FOCUS) to augment integrated disability management services, starting with the medical event. The organization's disability management services are discussed from the perspective of a vendor that mar-

kets integrated disability management to insurance companies and large employers.

Approach to Disability Management and Return to Work

UHC provides a “managed care” approach, assisting clients in integrating their occupational and nonoccupational medical and disability management programs. From the onset of a claim, employees and their families have a specific primary care nurse as their contact for health care education, utilization review, and disability management services. This nurse communicates with the attending physician, the employer, and the claims payor(s) to negotiate an effective treatment plan that includes early return to appropriate transitional/modified work as part of the recovery process.

Specific Interventions

Depending on clients’ utilization of services, key features could include the following:

- centralized disability application processing for STD/LTD claims;
- early intervention by a primary care nurse (or masters-prepared social worker), who contacts the employee, employer, and provider within two business days of notification;
- health care utilization management, including preferred providers and second opinion/independent medical examination services;
- telephonic return-to-work coordination with the employer, utilizing on-site resources as needed for job accommodation, ergonomic evaluation, etc.;
- comprehensive measurement and reporting to evaluate trends, demonstrate impact, and continuously improve the efficiency and effectiveness of the program;
- employer program development support to clarify internal roles and responsibilities, identify transitional work opportunities, and influence attitudes and cultural expectations within the organization;
- rehabilitation vendor selection and management;

- specialized injury prevention programs for cumulative repetitive trauma and back conditions;
- maternity education and high-risk pregnancy programs;
- chronic disease management programs based on client-specific trends.

Expected Outcomes

Outcome indicators include the average length of disability, total wage replacement benefits paid, and total medical costs by diagnosis/procedure and by work location. In a voluntary referral program, a recent employer client report indicated that 67 percent of referred claims experienced an average 31 percent reduction in the total number of weeks of disability, as compared to the attending provider's initial plan. However, only a small percentage of the client's total claims were managed. In a mandatory referral program, 41 percent of claims were positively impacted with a 15 percent average reduction in the total weeks of disability. The program objective is a minimum five-to-one return on investment. While these results probably represent outstanding examples, it seems clear that disability outcomes are amenable to influence.

Summary

Each of these examples illustrates different aspects of the disability management continuum. Owens-Corning takes a stance typical of progressive self-insured employers that are trying to manage their disability costs aggressively. The company uses a case manager model with obvious corporate commitment to communicate among the players, solve problems, and coordinate services for a positive outcome. UNUM emphasizes prevention, early intervention, and incentives in addition to case management services for difficult categories of disability. The insurer also makes an explicit judgment about the costs and benefits of intervening in specific cases in particular ways. United Health Care uses a traditional managed care model with a strong return-to-work focus. All seem to promise substantial returns in the form of lower costs of disability, either through reduced duration, lower incidence, and/or savings from better process management.

Clearly, not all of the disability management tools developed in the private sector are completely relevant for the DI or SSI programs. For example, while prevention of disability is critically important in the private sector, it is hard to imagine how SSA could directly affect the incidence of disabling conditions. Early intervention has been shown to be crucial in private sector experience, and many believe the first 24 hours is critical to the eventual outcome. However, with a five-month waiting period, it is difficult to see how SSA could achieve early intervention in this same sense. Another consideration is that there is no private parallel to SSA concerns about children with disabilities.

In addition, in a very real sense, SSA must deal with the failures of private sector disability management treatments, i.e., the cases of those people who still have not returned to work despite private efforts. So the scope for action at SSA may be very different than in the private sector. One obvious observation is that the lessons from the private side of the economy are likely to be more relevant for the population with recent work experience. Nevertheless, there are some well-established disability management principles that might transfer to public programs, such as rationalization of incentives, a proactive return-to-work philosophy, and case management techniques.

Policy Implications

We will begin with a description of the SSA disability determination and return-to-work procedures of the past.⁴ Then, we will recount the lessons from private sector disability management efforts and examine their applicability to Social Security programs.

Critique of DI Process

For adults, the current approach to determining eligibility for DI benefits basically works to convince individuals that they belong to one of two categories. Either they have relatively few limitations and can manage on their own, or they have limitations so severe that they can never again be productive members of society on a competitive basis. Further, the system provides little support or encouragement for either

group to obtain employment. Only a select few in the second group are referred to the state/federal system of vocational rehabilitation, and this occurs only after considerable time has elapsed since their previous labor market experience. These individuals are then supposed to make an immediate reversal in their self-concepts. Suddenly, they have become potential workers, without the benefit of any intervention, other than the passage of time, to bring about this considerable change.

This approach to disability is counter to conventional wisdom and available research, which suggests that a focus on ability and early intervention is required to prevent persons from losing touch with their identification as workers. It is not surprising that only a small percentage of those referred to vocational rehabilitation are rehabilitated. The public resources available through the Social Security system are simply not designed to help adults with disabilities achieve employment. In fact, the system may actually encourage disability through factors such as excessive delays in processing claims, over-reliance on medical evidence in determining disability, and insufficient or nonexistent disability management tools.

First, the time that elapses between the onset of disability and the determination of eligibility for benefits can be months, if not years. Some of this cannot be avoided if there must be a statutory waiting period of five months, but SSA reports that the subsequent delays in processing are prodigious. According to an internal study by the SSA Office of Workforce Analysis, an initial determination of beneficiary status from SSA may take up to 155 days from first contact with the agency, with from 16 to 26 employees involved, but requires only about 13 hours of actual "task time." If the decision is negative and the individual appeals, a further 400 days may pass before a final decision is received by the claimant, of which only 32 hours is actual task time (U.S. Department of Health and Human Services, SSA, 1994, pp. 8-9). During all this time, the individual claimant is concentrating on his/her disability, rather than on the ability that could be used in an employment situation.⁵ This approach discourages motivation to return to work and minimizes personal investment in productivity-restoring activities.

Second, the primary data used to assess eligibility for benefits are medical in nature, hence input from physicians often is the deciding factor. Although medical information is certainly critical to the deci-

sion process, almost exclusive reliance on it obscures the reality that disability results from a complex array of factors. The preeminence of medical diagnostic criteria perpetuates a model that focuses on disability rather than ability. It also deflects attention from the variety of interventions or environmental changes known to be able to remove or ameliorate many of the functional limitations producing disability, as called for in more contemporary public and private policy.

Third, there is no real case management built into the system. There seems to be an assumption that the only factor to consider is the impairment that led to eligibility in the first place. If medically verifiable improvement occurs, then there is the chance for a later review of a person's condition. However, the review is only for the purposes of establishing the severity and duration of the disability and whether these remain substantial enough to warrant continued benefits. Again, the pressure is to demonstrate disability and limitations, not ability and potential participation. Nevertheless, the examples cited earlier in this paper suggest significant results are available from case management techniques alone.⁶

Although the employment incentive provisions in the 1980 disability policy reforms can support return-to-work activities, practically speaking, these are really only useful when people are ready, on their own, to make a work attempt.⁷ There is no systematic case management system to guide a person through effective utilization of these incentives, or in obtaining appropriate health care services, or in pursuing education that could qualify an individual for alternative jobs more suitable to existing limitations. There is no system to assist treating physicians in understanding the functional requirements of specific jobs for which the individual might be qualified. Finally, no one works with employers to develop appropriate accommodations that can open job opportunities by minimizing the impact of limitations, even though the employer has this obligation under the ADA. Persons receiving disability benefits are virtually left to their own devices, and to the resources of family members, to overcome the variety of limiting features that contribute to their disability.

Lessons Learned

Some of the problems that have been described are familiar to private employers and insurers. However, in recent years the private sector has improved its experience with disabled workers through prevention, early intervention, disability case management, and proactive return-to-work policies of accommodation and rehabilitation. The disability management movement in the private sector has been driven by the stimulus of unacceptably high workers' compensation and other disability costs and has produced a practical, sequential, problem-solving approach. The public programs can and must follow this same path, with the advantage of the past decade of private sector experience to draw from in redesigning a comprehensive disability policy. Let us review what we have learned from the private sector evidence presented earlier, recognizing that these lessons are most applicable to those disabled individuals who have recently been in the labor force.

Return-to-Work Focus

The first lesson is that return to work should be the ultimate goal.⁸ While it is clear that not all persons with disabilities can be expected to work, failing to adequately assist individuals with functional impairments to develop the opportunity to be employed, to participate, and to contribute is inequitable and inefficient. We must realize that disability is a continuum, and a benefit structure that maintains a bifurcated view of the world (either disabled or not) is no longer relevant. Our evidence shows that return to work is not a disconnected function that occurs at some specific point in the treatment process. Rather, it is a commitment that evolves out of early intervention and case management activities with the individual, the physician, the employer, and others. The return-to-work "treatment" does not follow medical treatment and maximum medical improvement, as has frequently been the case with the tertiary vocational rehabilitation model. It should be part of a comprehensive disability management process from day one.

From the company examples reviewed earlier, it is obvious that one key to disability management success is the immediate creation, or maintenance, of the expectation that the individual has the potential to work and will return to work. This requires personal contact and support, which must be maintained on a regular basis, either in person or

by telephone. As indicated by the SSA Disability Process Reengineering Team, current SSA procedures are far from this ideal (SSA, Plans for a New Disability Claim Process, 1994). The proposals of the SSA Reengineering Team for a more efficient and inclusive process are certainly a step in the right direction, but much more could and should be done. SSA needs to design ways to partner with private sector employers, insurance carriers, medical practitioners, and other service providers to ensure that the return-to-work goal is addressed from the beginning of an emerging disability.

Positive Incentives

It may be contentious to talk about financial incentives, but a system that encourages people with functional limitations to think of themselves as disabled is immoral. A system that effectively limits earnings to \$500 per month and then threatens to take away all supports if earnings exceed that level does not fit with an ecological model of disability. Disability is a continuum, and our support systems should mirror that reality. Partial benefits and carefully crafted implicit tax rates are needed to maintain incentives for all persons with disabilities to work as much as they can.

There are also perverse incentives for other actors in the system—employers, insurers, and service providers. Our case studies show that many private sector disability claims end with a “pass-off” to Social Security. There is no motivation for the employer or insurer to stay involved beyond that point. Further, there is no real incentive to try to prevent this outcome, since it can be regarded as a “success” from the narrow point of view. Perhaps it is time to consider experience rating of the Social Security taxes that employers pay, in order to encourage prevention of disabilities. SSA needs to consider establishing policies that encourage private sector players to serve the public interest.

We need to be sure that all incentives reinforce the social policy objective of maximizing the contribution of each individual, of achieving optimum equity and efficiency, in bringing persons with disabilities into the labor force to the extent feasible. Return to work is not appropriate for everyone, but we need to make sure that we adequately support those for whom this is a realistic goal.

Early Intervention

Early intervention is another lesson from the private sector that cannot be overemphasized. Private sector insurance carriers and third-party administrators have discovered that this is not a question of months, but of days. It would not be an exaggeration to say that the earlier the intervention begins the better for the ultimate goal of recovery or maintenance of employment. Even after six months, however, there is evidence that additional delays are harmful, particularly as compared to a system that focuses on return to work and maintains positive incentives to promote this goal.

SSA must find a way to reach forward (even into the five-month waiting period) to address the needs of individuals with functional impairments as soon as possible. Thought might be given to some innovative sort of technical assistance, consultative service, and financial incentives that could assist employers and treatment providers in preventing disability and in meeting employers' accommodation obligations under the ADA. An appropriate partnership with SSA could be made attractive to all interested parties, bearing in mind that persons with disabilities must be the major beneficiaries.

Case Management

The evidence is clear from the private sector that case management services save money for both insurance carriers and self-insured employers and reduce unnecessary disability outcomes. The marketing effort that is currently going into third-party case management services indicates that many private sector players understand this relationship. The hypothesis that the effect extends to public programs is being formally tested in the ongoing Project Network experiments for SSA clients (Rupp, Bell, and McManus 1994). Without prejudging the results of the research, it should not come as a surprise that investing time and energy in managing any process will lead to better outcomes. Evidence available from the private sector suggests that efficiency savings of from 10 to 20 percent are readily achievable through case management techniques alone. When combined with the return-to-work orientation and early intervention perspectives that we have suggested, considerably larger gains should be available.

Final Reflections

Disability management offers a critically important mechanism for stemming the tide of individuals who leave employment unnecessarily and enter disability systems, while simultaneously addressing the economic survival needs of American business and the security of the jobs it provides. In a comprehensive view of national disability policy, disability prevention and management should be seen as the keys to promoting the maximum contribution of all disabled individuals and to reducing the public burden of preventable disability.

About 10 years ago, private sector employers began to realize that nobody was going to solve the problem for them and that they had to do it themselves. It is amazing what has been accomplished in the intervening decade at "best practice" companies. Reductions of 50 percent, or more, in work-related disability incidence are possible where the company is willing to make the commitment to an integrated disability prevention and management strategy. Many of these cases have now been documented in the literature.

It is certain that public sector programs will show more limited gains, because the severity of disabilities encountered is greater, because the claimant's connection to the world of work is more tenuous, and because entitlement to public sector benefits is a matter of right (Galvin, Dean, and Kirchner 1991). However, it is our obligation to make sure that every individual has been given the opportunity and the needed support to participate. The private sector has pointed the way in developing specific disability prevention and management programs; it is up to all of us to make sure that the public sector does not ignore the lessons that are there to be learned.

NOTES

1. We specifically include stay-at-work efforts under this topic as well.

2. The full content of the interviews is available upon request from the WE Upjohn Institute for Employment Research. The subjects include Owens-Corning Fiberglas, Rohr, Digital Corporation, Union Pacific Railroad, UNUM Insurance, Wausau Insurance, United Health Care, University of Cincinnati Medical Center, and S Yangouyian & Associates.

3. While UNUM is not a workers' compensation carrier, short-term and long-term disability benefits are paid during workers' compensation waiting periods and above maximum workers' compensation benefit levels.

4 However, see the *Plan for a New Disability Claim Process* (U.S. Department of Health and Human Services, SSA 1994) Clearly, SSA has become aware of these shortcomings

5 See Bound (1989) for evidence that under 50 percent of rejected male applicants actually return to work We are not suggesting that these people are not disabled, but simply that the longer the eligibility determination process requires, the higher the proportion of individuals that will be disabled, other things equal.

6. These gains are being examined experimentally in Project Network See Rupp, Bell, and McManus (1994) for details of the design

7 See *Rethinking Disability Policy* (National Academy of Social Insurance 1994), chapter 5, for a brief history of DI and SSI policy.

8. Of course, this could be restated as securing and retaining gainful employment for those who have never held a job

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