WORKING ON REFORM

How Workers' Compensation Medical Care is Affected by Health Care Reform

SYNOPSIS

THE MEDICAL COMPONENT of workers' compensation programs—now costing over $24 billion annually—and the rest of the nation's medical care system are linked. They share the same patients and providers. They provide similar benefits and services. And they struggle over who should pay for what. Clearly, health care reform and restructuring will have a major impact on the operation and expenditures of the workers' compensation system.

For a brief period, during the 1994 national health care reform debate, these two systems were part of the same federal policy development and legislative process. With comprehensive health care reform no longer on the horizon, states now are tackling both workers' compensation and medical system reforms on their own.

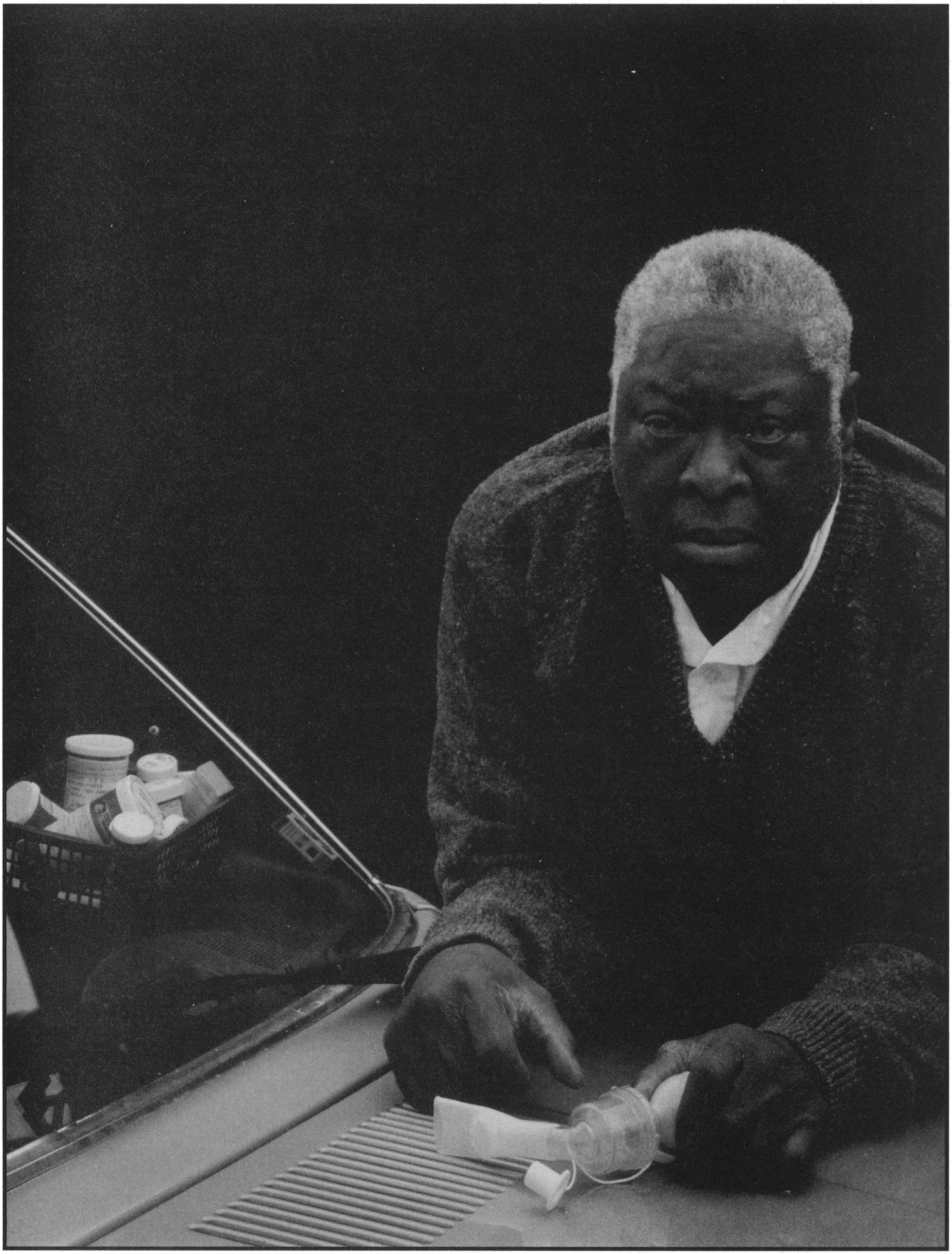
This paper reviews the major issues federal and state policy makers face as they consider reforms affecting the relationship between workers' compensation and traditional health insurance. What is the relationship of the workers' compensation cost crisis to that in general health care? What strategies are being considered by states involved in reforming the medical component of workers' compensation? What are the major policy implications of these strategies?

Jay Himmelstein, MD, MPH ■ *Kathleen Rest, PhD, MPA*
Photographs by Bill Ravanesi, MA, MPH

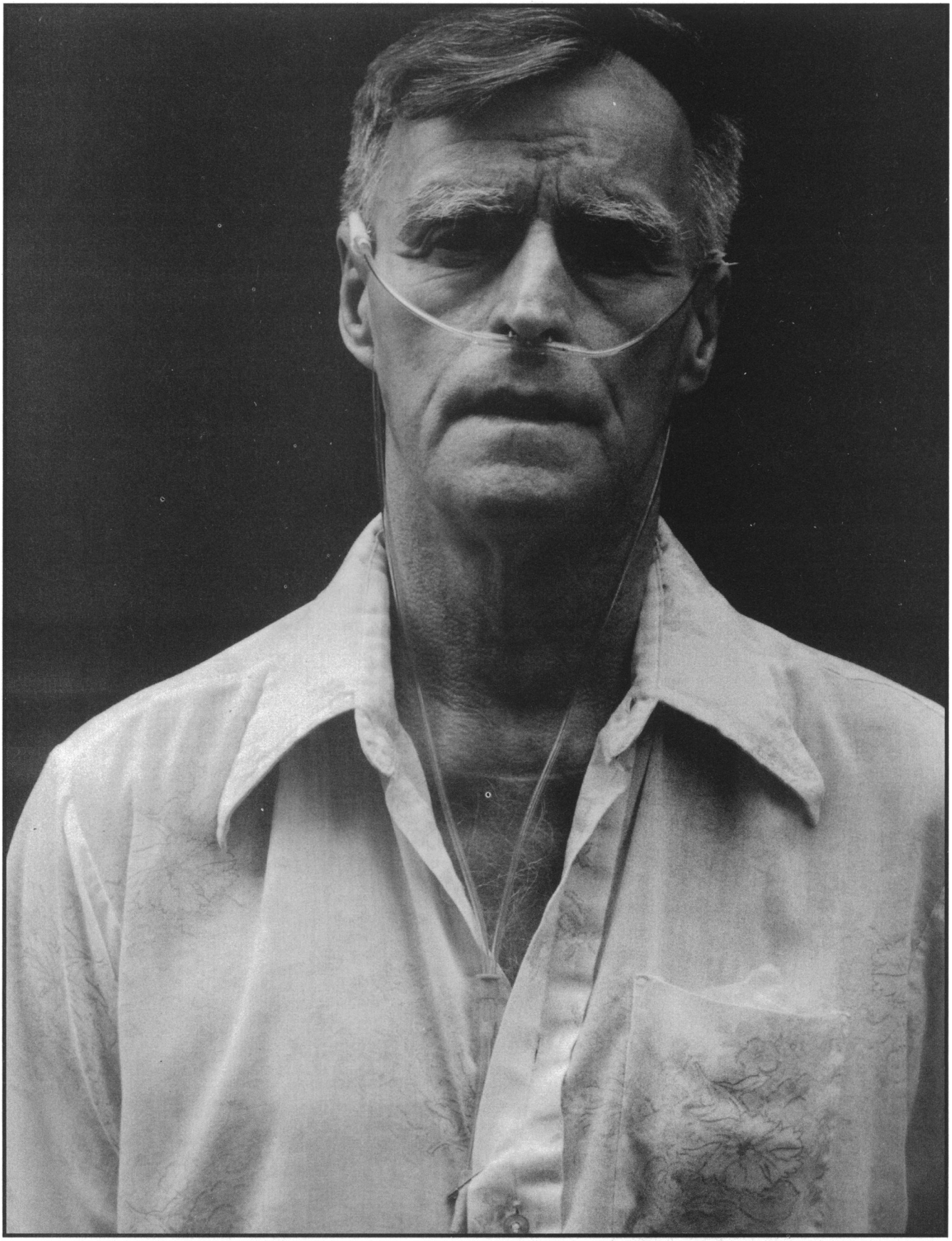
In 1992, California Insurance Commissioner John Garamendi caught the attention of the health policy world by proposing a state managed competition plan for controlling health care costs while providing universal coverage. His plan would have merged the medical component of workers' compensation and automobile insurance with traditional group health benefits. Garamendi's plan was the first comprehensive proposal to suggest that linking reform of these two systems could lead to cost savings that would pay for universal coverage and improved benefits.

The policy arguments seemed compelling enough: it made little sense for a person injured as a result of a work or auto accident to receive medical care different from someone suffering the same injury at home. Eliminating this unnecessary distinction, proponents argued, would generate significant savings through reduced service duplication, fewer liability disputes, and increased administrative efficiency. Savings could then be used to help finance universal health care coverage while improving disability benefits and rationalizing the entire system.

The Garamendi proposal died in the California legislature, but the idea of coordinating or integrating all health benefit plans into a single package was given new life by the Clinton Task Force on Health Care Reform, some of whose members had helped craft the original Garamendi plan. Political motivation pushed the idea of integrating workers' compensation medical care into a new health system. The primary source of new money needed to finance universal coverage would come from mandated employer contributions,



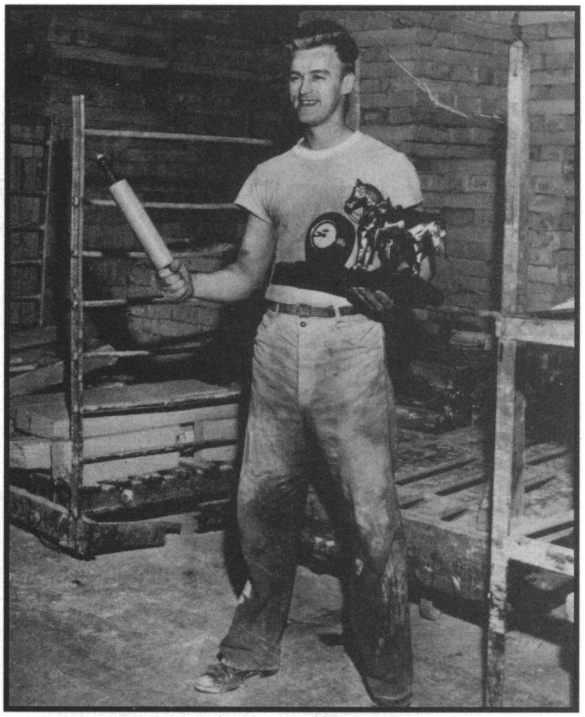
Paris Jenkins is a former shipyard worker at the Charleston, SC, Naval Shipyard, disabled with asbestosis. (1989)



Joe Darabant cut asbestos shingles and made asbestos block and pipe-covering materials for Johns-Manville for more than 30 years. He was forced to retire at age 50 with many ailments and was subsequently diagnosed with asbestosis. (1989)

and the Task Force recognized that this employer mandate would meet stiff resistance from the employer community. At the same time, employers across the country were facing a workers' compensation cost crisis of historic proportions fueled by workers' compensation medical costs that were growing, on average, more than 15% per year. If the Clinton health care plan could "fix" the workers' compensation medical cost crisis, the Administration hoped that employers would be more willing to accept the overall health plan, mandates and all.

The great health care reform debate of 1994 revealed that the policy and political barriers that make national health reform difficult present similar obstacles to federally-driven reform of workers' compensation systems. Historically, workers' compensation (WC) has been a state prerogative, and states are unwilling to relinquish the responsibility of regulating workers' compensation insurance. Recently reported successes in controlling the growth of workers' compensation costs have bolstered states' confidence. States are also concerned that federal intervention would impede their ability to create attractive business climates. Some employers, citing their own success in controlling costs, are not interested in help from state or federal government. Commercial insurers that sell workers' compensation policies are concerned about separating the responsibility for medical management from the financial responsibility for cash benefits. They are also worried about losing control over the medical portion of the workers' compensation premium—41% of the overall premium, or approximately 24 billion dollars a year. And organized labor, a possible beneficiary of national standards for workers' compensation and health care, is resistant to reforms that might erode benefits or limit worker's choice of medical provider.



Joe Darabant at the JM plant in 1947, covered in asbestos dust and holding wedding gifts from fellow employees.

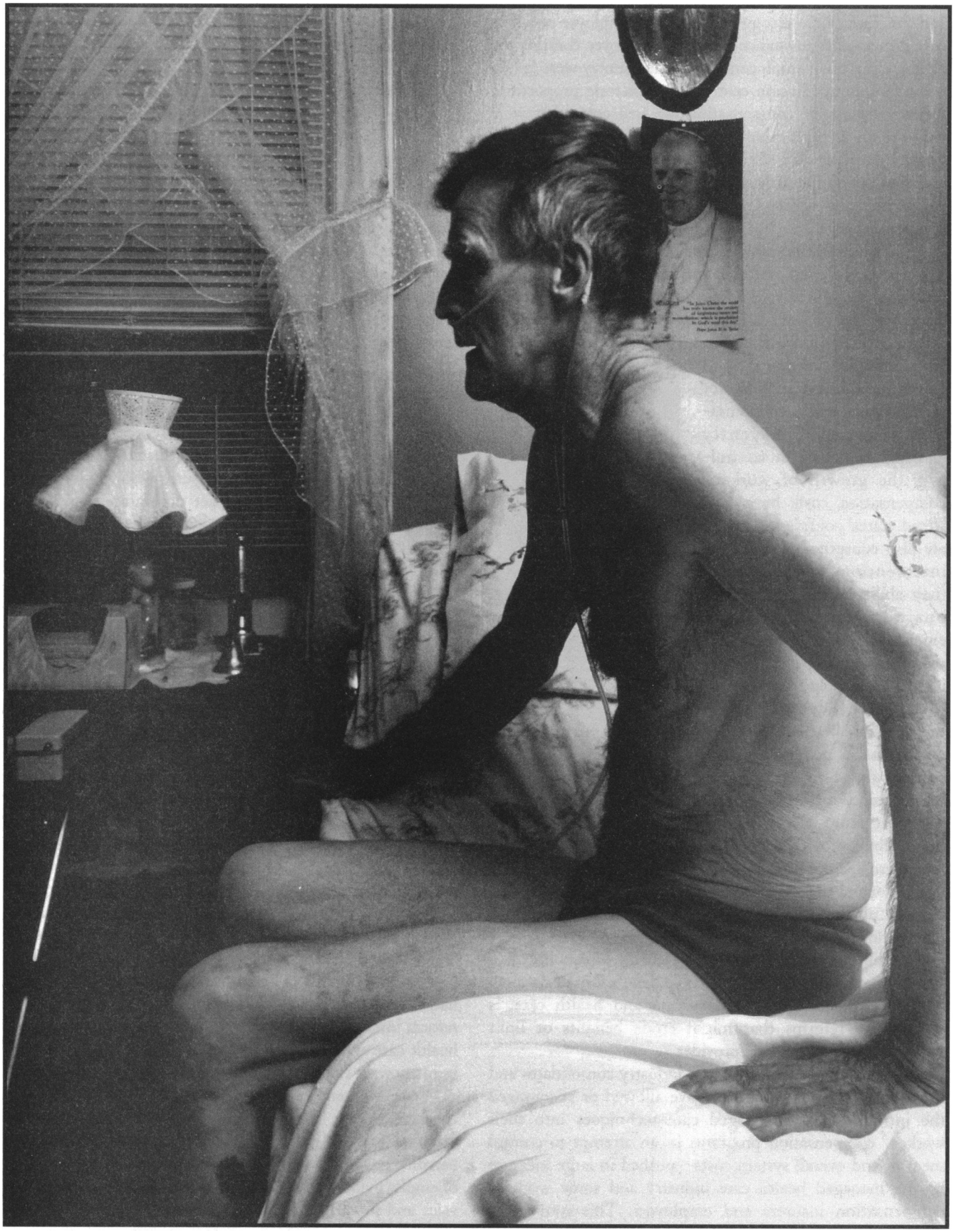
Meanwhile, as the health care industry consolidates and restructures itself, many states have allowed or encouraged the introduction of managed care techniques into their workers' compensation programs in an attempt to control medical and overall system costs—pushed in large measure by the managed health care industry and some workers' compensation insurers and employers. This movement toward managed care has been viewed with suspicion by many employers and with outright disdain by worker representatives.

Workers' Compensation Systems: The First Wave of Reform

In the early 20th century, industrial activity was extremely dangerous, and disabling workplace injuries were common. Limited financial support and legal remedies meant that injured workers found it difficult to receive compensation. Their only options were to seek charitable assistance or to attempt to recover in court. Litigation was difficult and uncertain, because workers had to prove employer negligence, and employers used several defenses successfully. Defenses included (*a*) contributory negligence; (*b*) the fellow-servant doctrine (the injury was the result of negligence on the part of the worker's fellow employee[s]); and (*c*) assumption of risk (the worker could not recover if the injury was due to an inherent hazard of the job which the worker had known or should have known about in advance). The tort system also created uncertainty for employers, who could neither predict nor insure against jury awards to successful claimants.

By 1910, the deficiencies of the tort system for compensating injured workers were well known, and states began to enact workers' compensation statutes as an alternative. Indeed, these state laws were the first major social insurance programs in the United States. Many early reformers felt that workers' compensation insurance would be the first step towards a comprehensive social insurance system which would protect families from the poverty that might accompany illness and injury, work-related or not. By 1920, all but 6 of the 48 states had enacted workers' compensation laws, but support for and interest in a national health insurance program had waned. From the mid 1920's until recently, debates and reform initiatives in the workers' compensation and general health care systems have been pursued separately, although in many ways the systems are clearly linked.

State workers' compensation programs vary widely in coverage, benefit levels, and costs, but they share a common set of historic principles and goals. All state programs provide benefits to workers whose injuries arise out of or in the course of employment. These include medical and rehabilitation services and wage replacement (indemnity) benefits. Workers' compensation is meant to protect workers and employers alike. Workers are insured against lost income and medical expenses relating to a workplace injury; employers are relieved



This photograph of Joe Darabant was taken three months after the one on page 14. He was unable to feed himself and required constant care. He died at age 66 seven months after this was taken. (1989)

of the uncertainty of tort proceedings and, to a degree, are able to pool their risks to insure against losses. All state laws assume employer liability for workplace injury and illness, and all serve as injured workers' exclusive remedy for compensation. These principles reflect the historic trade-off between management and labor. Employers assumed "no-fault" liability for compensating injured workers, and workers gave up their right to sue in court. Because employers bear the costs of workplace illness and injury, workers' compensation programs—at least in theory—provide an economic incentive to prevent accidents and reduce hazardous exposures. Today's experience-rated workers' compensation premium, in which the premium is adjusted to reflect the past claims experience of the policy holder, reinforces this goal.

The Second Wave: The 1972 Workers' Compensation Commission

By the 1960s, criticism about the inadequacies, inequities, and inefficiencies of the state-based workers' compensation system was widespread. Benefit levels, largely inadequate, varied tremendously across states. Many workers lacked coverage. The system was bureaucratic and rehabilitation was seldom emphasized. In 1970, Congress not only revisited the health care needs of the poor and elderly but also heeded calls for change in the workplace by passing the Occupational Safety and Health Act. While doing so, Congress noted serious questions relating to workers' compensation and established the National Commission on State Workmen's Compensation Laws to determine if these laws were providing an "adequate, prompt, and equitable system of compensation"[1a].

The Commission defined five objectives for a modern workers' compensation system: broad coverage of employees and of work-related injuries and diseases; substantial protection against interruption of income; provision of sufficient medical care and rehabilitation services; encouragement of safety; and an effective system for delivery of the benefits and services[1b].

The Commission noted that Medicare and the Veterans Administration provided medical benefits to injured workers when statutory limitations or settlement agreements created gaps in coverage. The Commission rejected the assumption of medical costs for work-related injury by other programs, noting it "would be inconsistent with the central tenet of workmen's compensation—that the cost of work-related injuries and diseases should be allocated to the responsible source"[1c].

The Commission made several additional recommendations relating to the provision of medical care and rehabilitation services.

- Workers should be permitted the initial selection of the treating physician, either from among all licensed physicians in the state or from a panel of physicians selected or approved by the state compensation agency.
- There should be no statutory limits on the length of time or dollar amount for medical care or physical rehabilitation service for any work-related impairment.
- The workers' compensation agency should have discretion to determine the appropriate medical and rehabilitation services in each case, and there should be no arbitrary limits by regulation or statute on the types of medical service or licensed health care facilities which can be authorized by the agency.
- Each workers' compensation agency should establish a medical-rehabilitation division, with authority to supervise medical care and rehabilitation services.
- Every employer or carrier acting as an employer's agent should be required to cooperate with the medical-rehabilitation division when an employee needs rehabilitation services[1d].

Between 1972 and 1990, many states expanded their workers' compensation programs to address inadequacies in both medical and wage-loss benefits. Arbitrary limits on the level and duration of medical treatment were often eliminated, and fee-for-service evolved as the normal mode of payment for medical services. Many of the commission's recommendations, however, have not been fully implemented, and wide disparities in coverage and benefits persist across states. Indeed, some states have recently begun to reduce benefit levels in an effort to control rapidly rising expenditures. Currently, only seven states provide workers with an unrestricted right to select their initial health care provider and change providers at any time.

> Workers who lack other disability or health insurance may want to attribute an injury or illness to the workplace in order to obtain needed care and avoid wage loss.

Despite recent moderation in the cost growth of workers compensation premiums, employers still believe they are paying too much and often receiving too little from a system that is riddled by employee, provider, and legal fraud. Workers are frustrated by lengthy delays, claim denials, and by what they see as inadequate care and inequitable benefits. Providers are sometimes reluctant to participate in a system they see as overly bureaucratic and adversarial and that, in some cases, pays inadequate rates. Other critics decry the system for its inadequate recognition and compensation of even known occupational diseases.

Two Health Care Systems: Two Worlds Apart?

What currently happens when workers seek medical care for work-related injuries? In some states, employees see the physician or other health care provider of their choice.

In others, employers may direct workers to specific providers: "company doctors" or members of a preferred provider network with whom the employer or insurance carrier has contracted for service. Most work-related injuries are minor, are clearly "work-related" (for example, a finger cut while operating machinery on the shop floor), require only routine medical care, and result in little lost time. In these situations, the workers' compensation system generally works well; it pays for the necessary medical care that facilitates a rapid return to productive work.

In other situations, where the relationship to work is less clear (for example, low back pain) or where extensive time may be lost from work, employers and insurers often contest compensability, extent of disability, and return-to-work issues. A number of factors affect whether workers (now patients) and providers choose to attribute an injury or illness to the workplace. Workers who lack other disability or health insurance may want to attribute an injury or illness to the workplace in order to obtain needed care and avoid wage loss. Workers who may not recognize that a particular condition or disease is related to work or who may fear a confrontation with, or reprisals from, their employers will seek care from the general health care system. Providers may shift a case onto the workers' compensation system if they will receive better reimbursement or be subject to fewer limitations or less oversight of the patient's care. Conversely, providers—because of ignorance, a desire to avoid the administrative hassles of the workers' compensation system, or a sense of loyalty to an employer/insurer—may shift a case into the general health care system by refusing to recognize its relationship to work.

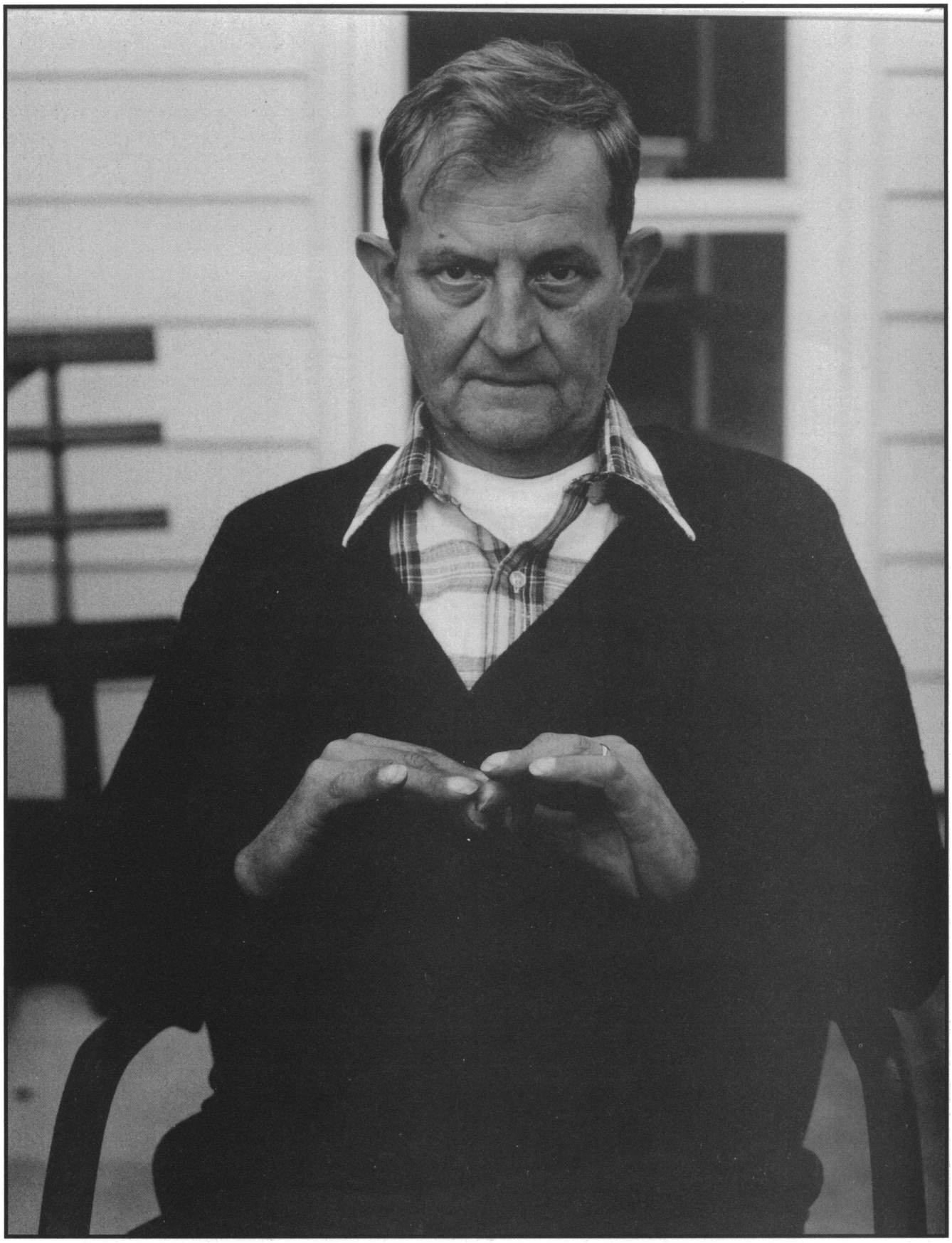
The clubbed fingers of Clementine Szukis indicate impaired oxygenation from advanced lung scarring. She was a beauty salon operator who was exposed to the asbestos on her clients' bodies. (1988)

Insurance-induced limbo constitutes a serious problem for those patients whose workers' compensation claims are denied. Most, if not all, group health plans specifically exclude payment for medical expenses related to workplace injuries and illnesses, and workers' compensation insurers will cover only those injuries and illnesses they believe are truly work-related. Thus, patients whose cause of injury or illness is in question may find their claim rejected by both the workers' compensation insurer and their own health plan, leaving them at least temporarily without access to appropriate care. This impasse may signal the entry of lawyers and the beginning of "doctor-shopping" and "dueling doctors" as workers and employers seek support from the medical and legal communities either to obtain needed benefits or to limit their liability. Despite the overlap of providers in worker's compensation medical care and the group health delivery systems, it is easy to see how the separate financing and benefit structures create confusion, tension, case-shifting, and legal confrontation.

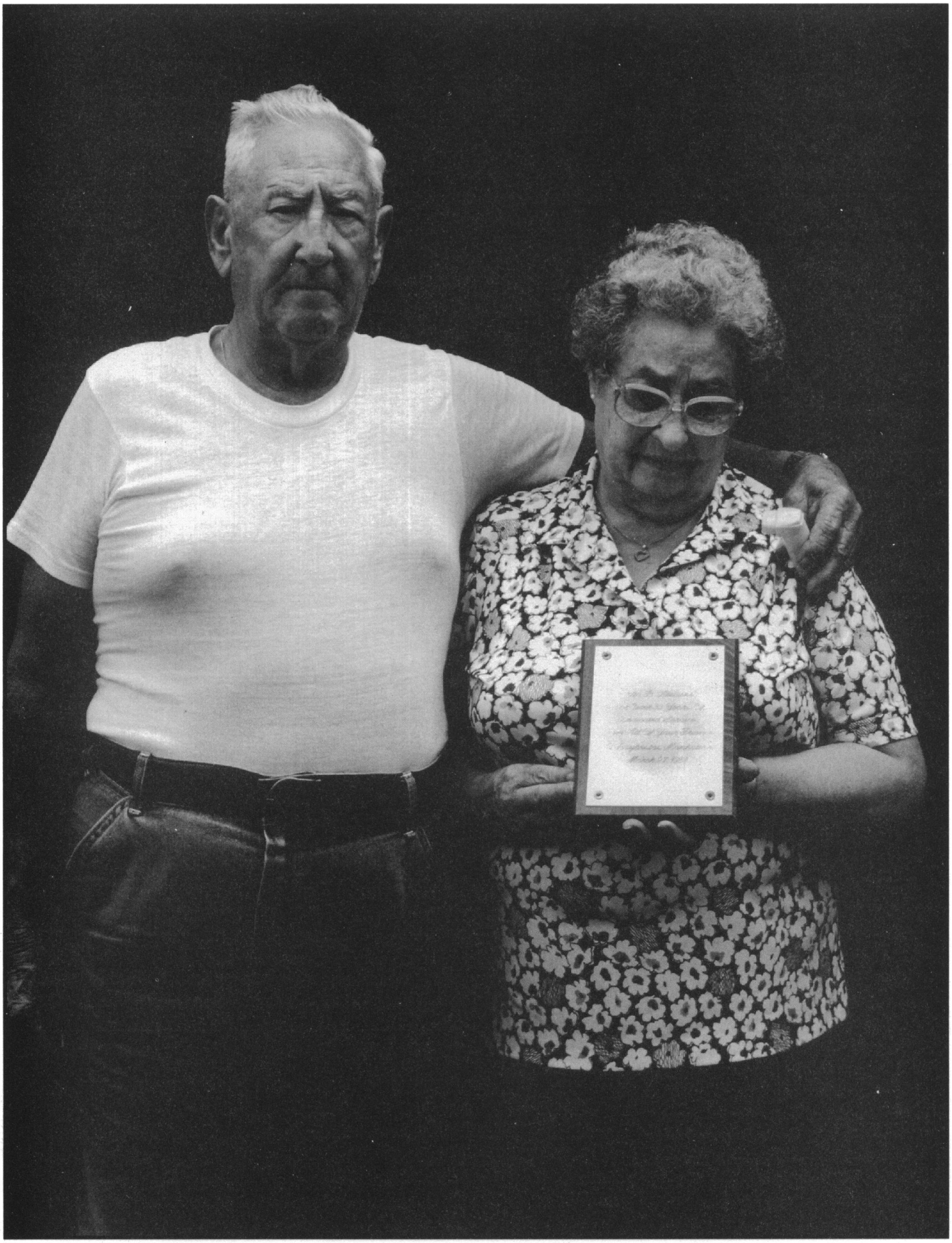
The Cost Crisis Drives Options for Reform

As in the group health care system, cost has been the primary force driving workers' compensation reform. Nationally, workers' compensation costs have grown from $2.1 billion in 1960 to an estimated $60 billion in 1992. Medical benefits now comprise 41% of all benefits, compared to 33% in 1965[2]. Since 1972, growth of workers' compensation medical expenditures has exceeded cost growth in the group health care system. From 1985 to 1990, national health care expenditures increased 9.8% per year while workers' compensation medical care expenditures increased 15.2% annually[2]. Several factors have contributed to the rapid growth in workers' compensation medical care expenditures, including price discrimination (charging a higher price for a service delivered within the system than for the same service delivered outside the system), over utilization, cost-shifting, and litigation. Recent studies suggest that the need to determine eligibility, impairment, disability, and work-relatedness results in a substantial portion of expenditures devoted, not to treatment, but to medico-legal determinations[3]. Although the spiraling inflation of workers' compensation medical care costs has slowed in the last few years, the growth in medical costs still exceeds that in wage loss benefits. Thus, medical care consumes an ever larger portion of benefits that could be going to injured workers in the form of wage replacement and/or rehabilitation.

This has lead to an ever-growing number of state



Tom Bowlby worked for Johns-Manville for more than three decades as a maintenance supervisor. He was "awarded" disability and retired because of asbestosis at age 54. He died one year after this photo was taken. (1985)



Ella Alewine holds a plaque commemorating the 33 years of service rendered by her and her husband, Buddy, to Raybestos-Manhattan in Charleston, SC. They are both disabled by asbestosis. (1988)

reforms—many of which focus on controlling medical care costs through managed care or the coordination of worker's compensation medical care with group health care benefits. The logic behind these initiatives can be summarized as follows: Workers' compensation costs have risen rapidly due largely to escalating medical costs. Cost containment efforts applied to the non-workers' compensation medical market have increasingly constrained that sector and worsened the cost problem in workers' compensation through price discrimination and cost-shifting. In an effort to prevent further increases in workers' compensation medical care expenditures, state policy makers have been lured by the promise of managed care and intrigued by the concept of coordinating or integrating services.

Current Reform Efforts

Improvement of the workers' compensation system at the state level remains a priority despite the failure of legislated national health reform. Changes in workers' compensation medical care are being sharply influenced by the restructuring in the group health marketplace, an anti-regulatory environment characterized by profound mistrust in all levels of government, and the perceived weakness of organized labor. Two very different models are being developed and tested for delivering worker's compensation medical care: 1) The use of managed care organizations and techniques for delivery of WC medical services, and 2) the use of a common benefit and delivery system for both work and non-work related health problems—so-called "24-hour coverage."

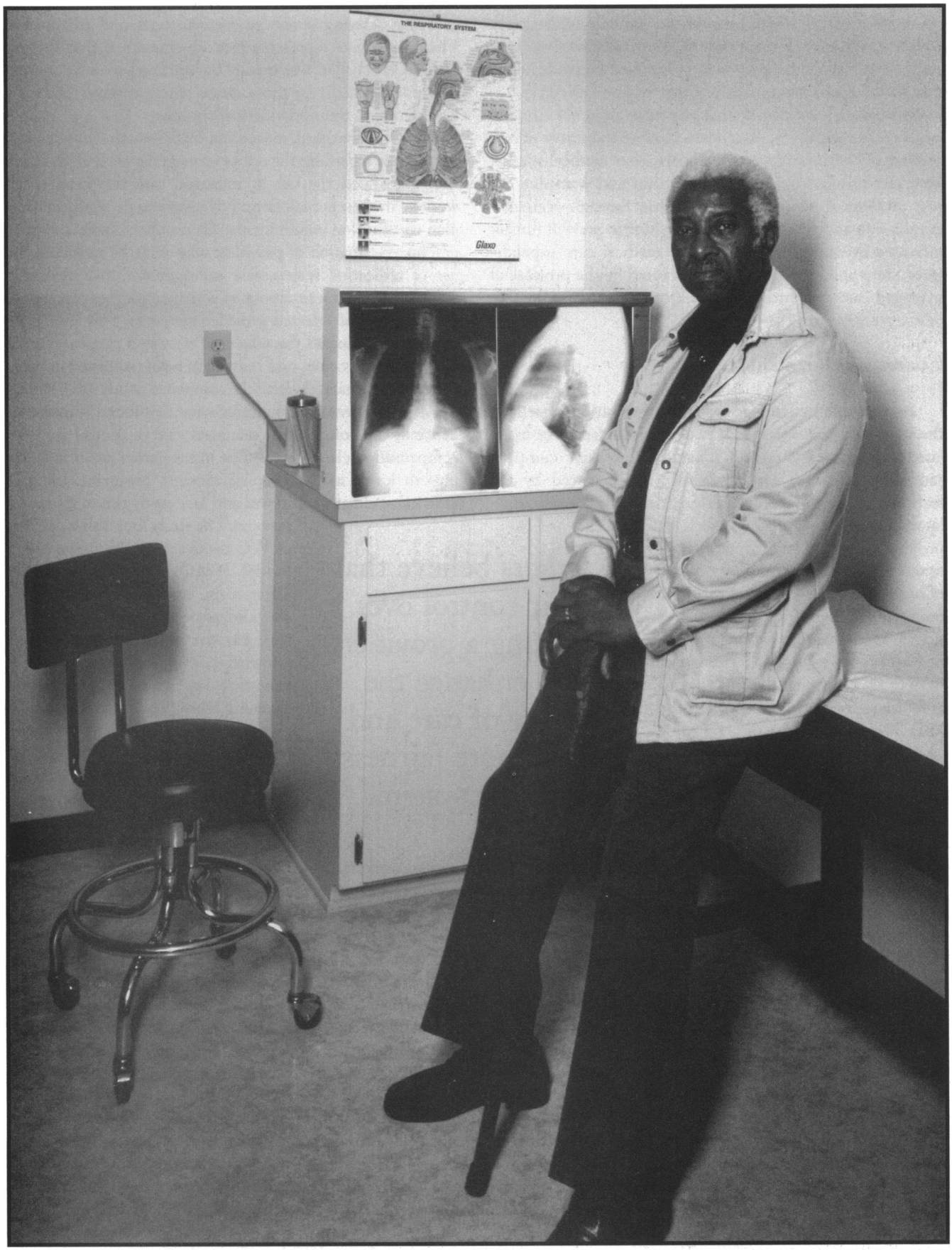
> Workers believe that their control over selecting a provider will enhance the quality of care and inject more fairness into the system.

The managed care model for workers' compensation is similar to managed care models developed for traditional group health insurance. A contract for the delivery of WC medical services is made between a self-insured employer, employer group, or WC insurance carrier and a managed care organization which uses managed care techniques and a selected provider network to control costs and utilization of health services. The managed care organization (MCO) may be established solely for the delivery of workers' compensation services or may be part of an existing health maintenance organization.

The use of a managed care model in WC raises several significant concerns. It continues to require the determination of work-relatedness, and, depending on the method of payment—capitated vs fee-for-service—there is concern that an MCO might have incentives to refuse or encourage the labeling of particular injuries and illnesses as work-related. The so-called "medical-indemnity" connection raises another concern: traditional managed care approaches to controlling medical costs may actually increase wage-loss costs by delaying access to medical tests and treatments. Finally, workers' representatives are concerned that the use of MCOs may decrease quality by limiting access for injured workers, especially in those states where workers currently have access to their providers of choice.

As of this writing, more than half the states have passed regulations regarding the use of managed care, and six states have mandated the use of managed care for some or all workers in their jurisdictions. State statutes generally address plan certification requirements; the numbers, types and geographic distribution of providers who must be included; the use of utilization review, case management, and treatment guidelines; and the situations in which employees can choose and 'opt-out' of selected provider networks. Few investigations have evaluated the effects of managed care in WC on quality and outcomes and none have been published in peer-reviewed journals. A recently-completed study of Florida's workers' compensation managed care pilot found "strong evidence of the potential for managed care to control workers' compensation claim costs." The investigators attributed savings to lower use of hospital services, lower incidence of indemnity claims, and fewer and less costly use of physician services. The study found that delivery of WC medical care through a group model HMO plan was especially effective in controlling costs, but it was also associated with significantly less patient satisfaction[4]. To our knowledge, this is the only study to date that has attempted to evaluate anything other than direct cost data in comparing alternative delivery systems for WC medical care. Although the data on costs is promising, these findings support concerns that targeting costs alone may compromise satisfaction and long-term outcomes in injured workers.

Coordinated or merged models for the delivery of medical services—24-hour care—deemphasize the distinction between work and non-work-related conditions, at least for the purposes of medical care delivery. The coordinated model, similar to that envisioned in the Clinton Health Security Act, would require that injured or ill workers obtain all their medical care from the same health care organization regardless of cause of injury—although the financing mechanisms might remain separate. Proponents argue that this model facilitates continuity of care while decreasing litigation and duplication of services. Opponents argue that the model may actually increase WC costs by making it easier for HMOs to shift costs onto workers' compensation, and by decreasing the amount of control that employers and insurers have over workers compensation medical care. Labor unions are concerned that the use of 24-hour models may result in reducing WC benefits to the level commonly available under group health, including limitations on care and the



Clarence Chisolm sits next to an X-ray of his lungs afflicted with asbestosis from work at the Charleston, SC, Naval Shipyard. (1987)

use of co-payments and deductibles, cost control methods which have not heretofore been used in WC systems.

The workers' compensation task force of the National Association of Insurance Commissioners (NAIC) has issued a series of reports over the past year that describe the legal, institutional and regulatory barriers to implementation of 24-hour coverage[5]. Legal barriers include concern about the impact of 24-hour plans on the exclusive remedy provisions in workers' compensation acts and the relationship of state administered workers' compensation law with the Employee Retirement Incomes Security Act of 1974 (ERISA). Institutional and regulatory barriers arise because of the different entities involved in the delivery system for work and non-work related benefits and the regulation of workers' compensation insurance. Insurance departments are usually charged with the responsibility of regulating the contractual language contained in the insurance policies and the rating systems applied by insurers. Industrial accident boards or commissions, on the other hand, are typically responsible for regulating delivery of benefits to the injured employee.

To address these barriers, the NAIC task force drafted a Model 24-hour Act to assist states in establishing pilot programs to test the feasibility of 24-hour care. As of this writing, California and Oregon have ongoing 24-hour pilot programs, and planning is underway in at least 16 additional states. No data are yet available to evaluate the performance or success of these 24-hour pilot projects.

Legal and political barriers may inhibit efforts to use managed care and 24-hour care models in workers' compensation. Generally, insurers and employers can pursue the use of managed care techniques such as utilization review, medical fee schedules, hospital payment regulation, and bill review in workers' compensation if state laws do not expressly forbid it. However, state law may expressly permit workers to choose a provider, thus limiting insurers' and employers' authority to direct the care of injured workers to a preferred provider, health maintenance, or managed care organization. Even if state law allows some degree of employer control, worker representatives may strongly resist further attempts to expand employer control over injured workers' medical care. Indeed, the issue of control underlies much of the debate around managed care and merged systems. Both employers and insurers fear losing control of the system, believing that their control over provider choice and medical case-management is critical for containing costs, especially indemnity costs. Workers, on the other hand, believe that their control over selecting a provider will enhance the quality of care and inject more fairness into the system.

Public Policy Considerations

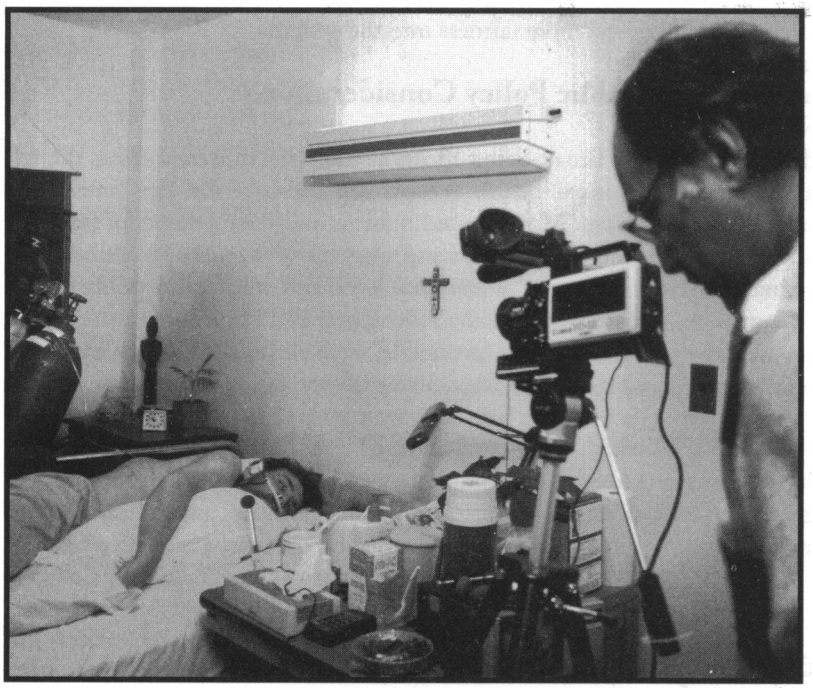
Broad-based efforts at achieving universal access though national health reform are unlikely for the foreseeable future. More limited reforms and restructuring of both the group health care and workers' compensation systems will likely occur at the state level, and will require public policy experts to consider several new and challenging issues.

Will it be preferable, or even possible, to maintain the status quo in the delivery of workers' compensation medical care in the face of a restructured health care marketplace which relies on managed care technologies and selected provider networks to control the price and volume of services? By comparison to most existing group health plans, workers' compensation medical coverage is a relatively generous package, characterized by first dollar coverage for all services and medications with no co-payments and deductibles. Without the application of some cost containment measures, the medical care component of WC is likely to continue to consume a growing proportion of WC benefits.

> The policy arguments seemed compelling enough: it made little sense for a person injured as a result of a work or auto accident to receive medical care different from someone suffering the same injury at home.

If managed care becomes the dominant form of medical delivery, how can the historical and unique attributes of the workers' compensation system be addressed? Proponents suggest that the use of managed care in workers' compensation will enhance quality and control costs through a more effective and efficient use of medical resources. Advocates hope that rapid and complete resolution of medical problems will reduce payments for lost wages. But the use of managed care may also erode freedom to chose a provider and thus adversely affect results for patients who feel 'locked in" to a particular system. In workers' compensation, providers do more than diagnose and treat. They usually determine whether or not a specific injury is compensable and make crucial decisions about when and under what conditions or restrictions an injured employee can resume work. Policy makers should be fully aware of the potential pitfalls of managed care in the context of workers' compensation and should maintain appropriate oversight so that the basic goals and principles of workers' compensation systems are preserved.

Should states set criteria for certification of managed care organizations offering WC medical care or coordinated benefits? Traditionally, state insurance divisions and departments of public health have been involved in licensing, certifying, and evaluating insurance and health plans offered to residents of the state. Regulating organizations that seek to



Father Richard Pankowski died of pleural mesothelioma at age 36, five months after this photo was taken. He probably contracted it from his father who worked for Johns-Manville for 30 years.

offer managed WC medical care will raise issues and concerns new to these agencies—such as determining eligibility for a different health and disability benefit package, dealing with second injuries and uninsured employers. Guidelines for certifying these new MCOs will need to be developed to address issues such as the geographic and specialty distributions of providers in the network, time and distance access standards, quality parameters (e.g. the availability of expertise in occupational medicine), and conditions under which an injured worker can 'opt-out' of the managed care system to obtain a second opinion or to seek care unavailable within the MCO. Additional standards that monitor the outcomes achieved by MCOs will need to be developed.

To what extent should reform of the workers' compensation medical system be done in concert with reform of the traditional health care system? The initial hopes for a reformed and coordinated system were that the savings achieved would be re-cycled to help finance the costs of universal access. Now that universal access is off the table, are there sufficient reasons to coordinate benefits so that it is no longer necessary to make the distinction between work-related and non-work-related conditions for the purposes of medical treatment? This will require careful consideration of the benefits that should be offered under a merged system. A truly merged system will require either increasing the benefits offered by group health plans or decreasing the benefits currently available to injured workers.

Change often presents opportunities for improvement, and the restructuring of the health care system may provide new opportunities for controlling costs in the WC system while improving the quality of services received by injured workers. To be successful in the broadest sense, however, reforms must be driven by the key stakeholders in the workers' compensation system—the workers and their employers—not by the economic interests of insurers, lawyers and doctors. These reforms should emphasize the most effective and non-controversial means for controlling costs: prevention of workplace illness and injury. If managed care is to be the model for medical care delivery, then states should require that the participation of MCOs in injury and disease surveillance efforts be linked to educational, consultative, or compliance activities with employers and employees. Through economic and other incentives, MCOs could be encouraged to work closely with government agencies and insurance loss prevention departments to help employers enhance workplace safety and injury prevention. If restructuring of the WC medical care system can help align the incentives of those involved—workers, employers, health care providers, and insurers—towards preventing work-related injury and illness, then state reform efforts may succeed in ways that federal efforts have failed.

Drs. Himmelstein and Rest are with the Occupational Health Program, University of Massachusetts Medical Center, Worcester MA. Ravanesi is President of the Center for Visual Arts in the Public Interest and a doctoral student in environmental health at Boston University School of Public Health.

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Tearsheet requests to Dr. Himmelstein, Occupational Health Program, Department of Family and Community Medicine, University of Massachusetts, Medical Center, 55 Lake Avenue North, Worcester MA 01655-0309; tel. 508-856-2734; fax 508-856-1680; e-mail <jhimmels@umassmed.ummed.edu>.

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