

**managed
care matters**

A LASER, NOT A SPOTLIGHT: FOCUSED, INTEGRATED APPROACH MAY HELP CONTAIN RISING BENEFITS COSTS

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A tragic accident, upward trends in health-care and indemnity costs, and a compelling Pareto group¹ all helped to shape one North American employer's move toward a more integrated management approach to employee benefits — specifically, a return-to-work program structured to manage both occupational and nonoccupational absences through specialized resources embedded within its operations nationally. Grounded in a philosophy of human capital management — optimizing workforce performance in order to maximize earnings — the approach uses strategic, employee-centric case management that focuses on those employees who demonstrate the highest risk for protracted absence as well

as for excessive utilization of the health-care system. Based on sophisticated data-mining and analysis, the employer identified the primary driver to be a small percentage of high-benefit utilizers within the employee population.

Initiated in 2003, the still-evolving program appears to have made an impact already, leveling the trend toward escalating workers compensation lost-time claims and lost workdays. The ultimate goal is to manage all health benefits — workers compensation, group health, short- and long-term disability, and behavioral health — with an integrated, employee-centric view that maximizes health and productivity.

REDUCING INJURIES AND IMPEDIMENTS TO RETURN TO WORK

A reportable incident rate above 20 percent prompted Waste Management to revamp its health and safety programs. In 2001 the company launched “Mission to Zero” (M2Z), an aggressive safety program built to reduce injuries utilizing tools typical to the transportation industry, including extensive training. By reducing accidents, the employer anticipated a reduction in workers compensation costs and lost time, as well as a reduction in the property damage claims associated with motor vehicle accidents. The initiative was successful in that it helped focus a companywide effort to achieve a zero-reportable injury rate. However, the employer did not attain the expected reductions in workers compensation costs. In fact, both workers compensation costs and lost workdays continued to rise.

Organizations often look to return-to-work programs to reduce lost workdays. Reducing lost workdays can reduce both direct expenditures, including indemnity payments in workers compensation claims and the cost of temporary labor, and indirect costs, such as reduced productivity. Historically, return-to-work programs have been limited to addressing lost time due to occupational injuries or illness, but this limitation may have the effect of driving some employees with work-related injuries to the group health and disability systems if they do not want to be managed on the path to return to work.

PHYSICIAN-BASED MODEL REQUIRES INFRASTRUCTURE AT INDIVIDUAL SITES

Some return-to-work programs are built on a physician-driven model and are based on the assumption that if injured employees receive optimal care, they will return to work in a timely manner. However, although this assumption may make sense in theory, it does not always occur in practice. Not all workers go back to work when they are able. Not all line managers know how to bring employees who cannot perform their job at full capac-

ity back to work. Not all physicians know how to help employers solve these issues.

The Integrated Benefits Institute surveyed the return-to-work practices of more than 300 physicians who treat both occupational and nonoccupational injuries and illnesses.² It found that although physicians may support return to work — and 95 percent said that they would release a patient to transitional work when asked by an employer to do so — they do not always take the initiative. Physicians were more likely to make contact with an employer if they were experienced with conducting functional capacity assessments, had previously worked with a case manager or employer on return to work, and felt they were adequately trained in disability management. With that in mind, it makes sense that directing care to physicians who were experienced and knowledgeable in workers compensation managed care would reduce lost workdays.

The physician-based model, in which injured employees are managed by a third-party occupational health clinic, works best when an organization has the human resources infrastructure necessary to manage the return-to-work component at the site level. Sites often are resistant to transitional duty; in industries that involve heavy labor, many managers believe that unless individuals can do the whole job, they shouldn't be working. The ability to hire temporary replacement labor makes supporting transitional duty even less attractive. Although Waste Management appreciated the value of the physician to the return-to-work process, it did not have a dedicated human resources infrastructure at the site level and, with 1,500 sites across North America, hiring the personnel necessary to create one would have been overly cumbersome and beyond the company's core competencies. The organization sought a partner who could provide a layered structure of embedded personnel with regional support by case managers.

ASLEEP-AT-THE-WHEEL ACCIDENT IS A WAKE-UP CALL

The company selected a new vendor for group health and was considering consolidating benefits vendors when a fatal accident occurred. A driver fell asleep at the wheel and killed someone. A look at the driver's records over his years of employment with the company revealed that the driver had lost significant time under both the group disability and workers compensation wage replacement plans, presumably for medical conditions that may have contributed to his accident risk. Several of the company's third party administrators and case managers had previous contact with the driver — often simultaneously — but had never shared their information with each other.

Effectively reducing injuries required more than just training and risk management. It required a reevaluation of the benefits structure to ensure that the most effective and immediate assessment of such employee risk and intervention occurred.

MOVING TOWARD A NEW PARADIGM

Faced with a finite budget for benefits, a company must determine how to allocate resources most effectively without creating a negative environment. This requires an understanding of how the various benefits interrelate. For example, when group health costs increase, companies traditionally elect to reduce benefits, increase health-care spending, or pass more costs on to the employee. Most companies take a combination of those three steps, with the ultimate result being that treatments and medication are more costly to employees. For a transportation company, however, erecting barriers to treatment for a condition such as sleep apnea could have disastrous consequences. Reducing benefits and increasing co-pays must be done strategically.

Ideally, decisions should be driven by data. Waste Management contracted with an information services provider to build an integrated database with data inputs from human resources, payroll, group disability, workers compensation, property and casualty claims (including both auto claims and other property claims), group health, and managed behavioral health. The database includes more than 9.6 million records.

INTEGRATED DATABASE REVEALS INTERESTING PATTERNS

Vilfredo Pareto, an early 20th-century Italian economist, observed that 20 percent of the people in his country controlled 80 percent of the wealth. Later called the Pareto principle, his 80/20 rule has since been extrapolated to many situations, including sales and quality management. Integrated analysis of the Waste Management database produced person-specific risk information used by an integrated management team, led by the corporate medical director and supported by senior management, the health and safety department, the benefits and human resources department, as well as the return-to-work taskforce. The risk analysis not only validated the Pareto principle, but also revealed an even more dramatic maldistribution of health benefit costs.

The key finding was that 10.3 percent of employees used 80 percent of health benefits. The average cost for employees in this Pareto group was 35 times greater than the average cost for the vast majority of employees. Similarly, in a 2004 study of data from 156 companies, CIGNA found that

20 percent of employees were responsible for 91 percent of employee medical costs and that although employees on short-term disability represented only 5 percent of the population, they were responsible for 35 percent of employee medical costs.³

The return-to-work team used the Pareto risk information in a number of ways. It looked at integrated health benefits — health insurance, workers compensation medical and indemnity, short- and long-term disability, and sick leave — for more than 58,000 individual employees, not including dependents. It broke the results into quintiles, i.e., each group represented 20 percent of the total cost. In the first quintile, encompassing 91.7 percent of the population, the average cost per employee was \$436. In contrast, the fifth quintile contained only 0.2 percent of the population, with an average cost of more than \$183,000 per employee. Ninety-nine percent of the population cost very little. The fourth and fifth quintiles — totaling 0.9 percent of the population — were responsible for the most health-care spending. In some cases, the costs within those quintiles were driven by catastrophic injury or illness, but further analysis revealed other factors.

The company tracked employees who repeatedly had motor vehicle claims and transportation rules violations. Further analysis revealed that half of the repeat offenders were also in the fourth and fifth quintiles. A more in-depth analysis of this high-risk population's health-care spending over one year showed a trend of utilizing both occupational and nonoccupational benefits sequentially and simultaneously. Analysis of pharmacy data showed that many of these employees received multiple pharmaceuticals in the same classes and/or pharmaceuticals that interact with each other — an indicator of fragmented care.

When auto accident costs were incorporated into the risk report, cost increases followed the same pattern as the rest of the integrated health benefit spending, with dramatic increases in the fourth and fifth quintiles. Less than 2 percent of the population was driving the total increase in health benefit spending, although the entire population was paying for it — if not in higher co-pays or reduced access to benefits, then in reduced compensation. The key to successfully addressing the dilemma would appear to lie in precise intervention to target risks and reduce costs.

Focusing on high-risk groups requires a paradigm shift on the part of both employers and managed care vendors. Applying case management to the vast majority of medical and lost-time claims that follow normal distribution does not have the same impact as a more surgical approach to the employee population. A robust database provides a tremendous amount of risk information about specific individuals and specific populations. For

example, a 32-year-old male without children in the Bay Area of California falls into a high-risk category based on the risk analysis. The database enables accurate, data-driven decisions about which cases to manage for the greatest impact.

PHASE I: FOCUSING ON WORKERS COMPENSATION AND WORK-RELATED DISABILITY

Built on top of the Mission to Zero initiative, the “Transition to Recovery” (T2R) program initially addressed occupational injuries and illness. The program was ultimately expanded to incorporate all disability-driven absences — regardless of their cause. The challenge was to shift the company’s focus toward getting good medical care for injured employees and getting sites and employees accustomed to the idea of transitional duty. In order to facilitate the return-to-work process, Waste Management embedded 17 contract “occupational health counselors” at various sites throughout North America, based on claims volume and geographic distribution of employees. Clinical group case managers were located in a central call center to support the occupational health counselors.

To overcome supervisory resistance to returning disabled employees to work if they couldn’t perform at full function, the T2R team communicated to management a sense of urgency about high costs and low productivity. The company formed a workers compensation coalition consisting of a cross section of employees from field and corporate departments including operations, health and safety, human resources, and legal to help the T2R team vet its decisions. The team also developed a disability management infrastructure that included not only the placement of occupational health counselors, but also policies and procedures, communications to employees and health-care providers, and a database of work alternatives. In some cases, the transitional work was crafted from tasks, such as washing trucks and mowing lawns, that were often outsourced to contract labor. Districts that successfully developed lists of transitional duty options were encouraged to share their best practices with other districts.

TRANSFERRING BOTTOM-LINE RESPONSIBILITY

Models that charge workers compensation costs back to sites on a per-capita basis do not encourage individual sites to take responsibility for the problem of lost time. In this case, the company developed a new budget allocation model that better reflected actual costs. Under the new model, sites are charged per incident, at one rate for medical-only claims and another, significantly higher, rate for lost-time claims. In addition, the sites

are charged a per diem for paid lost days (due to total temporary disability) in each fiscal year regardless of when the injury occurred. Sites incur a significant one-time charge for any employee fatality. This approach is a powerful incentive to keep employees safe and to get injured employees back to work in transitional duty jobs, which the company mandates are not to exceed 90 days.

The occupational health counselors facilitate return to work and carefully monitor the injured employee's progression to full duty. This is particularly important in an organization without a dedicated human resources professional at the local level. The occupational health counselors direct the injured employee toward quality medical care. When the occupational health counselor receives the clinic's recommendation, he or she can assess the employee's physical capabilities, develop a transitional duty plan, and coordinate communications among the injured employee, the medical provider, and the supervisor to assure timely return to work and compliance with the transitional duty plan. The occupational health counselors also work together to build and expand the transitional duty database.

As part of the strategy for targeted management of the high-risk groups, the occupational health counselors direct the overall disability management process and play an important role as a liaison with front-line supervisors to overcome barriers to return to work. They also establish realistic expectations with employees and look for any psychosocial issues that might impede an employee's timely recovery or return to work. To this end, occupational health counselors and supervisors establish a dialog with claimants regarding their approach to the work environment that could lead to continuing or recurring lost-time patterns.

PUTTING THE PROGRAM TO WORK

When a mechanic injured his back at home and sought care, his physician put him on a no lifting, bending, or twisting restriction. The occupational health counselor at the site shared a list of transitional work options with the treating physician and then reviewed appropriate possibilities with the injured employee. The supervisor also presented the employee with a form that states, "Our goal is to keep you healthy and to follow your doctor's return-to-work restrictions. All supervisors will do everything needed to support you. Do not feel that you need to do anything to increase productivity if it challenges your restrictions. Your health is the most important factor right now."

The mechanic immediately went back to work in a transitional capacity. As his back continued to improve, his weight-lifting restrictions were

reduced, and the employee received a full work release within 90 days after the injury. He never needed to apply for short-term disability. He was able to stay at work because of the opportunity to work in a capacity that did not exceed what his physician recommended.

In the first year after the program was initiated, the company experienced a 45 percent reduction in lost-time claims, a 40 percent reduction in lost workdays, and a \$49.3 million reduction in allocation costs. The total number of claims continues to trend down, although severity does not. Still, the number of inappropriate claims is down. This may be due to the “sentinel” effect of the T2R program — individuals are less likely to try to take advantage of a benefit if they feel they are under scrutiny.

THE NEXT STEPS TOWARD INTEGRATION

With the focus aimed on managing occupational injuries and illness, it is to be expected that risk would migrate to the nonoccupational side and that the employer would experience an increase in claims for short-term disability with an associated increase in group health expenses. So far, that does not appear to have happened proportionately to the reduction in occupational claims. Nevertheless, although group health and short-term disability costs have not escalated to as high a level as was expected, this remains an undesirable possibility. In a holistic health expense model, occupational and nonoccupational health must be managed alike. The first steps on that path are to consolidate management of workers compensation, short- and long-term disability, medical, and behavioral health benefits with one care management and return-to-work vendor. A 2004 CIGNA study found that most of the top cost drivers are the same for disability and medical claims. The study also found that the short-term disability durations were 12 percent shorter for employees with coordinated health and disability care management and that return-to-work rates were 6 percent higher than for companies that did not coordinate health and disability.⁴

Ideally, a single care management unit should handle group health/behavior health, group disability, and workers compensation disability programs. The same infrastructure and staff can be used to handle both work- and non-work-related disability management and return to work, with a common intake for both group and workers compensation disability. The foundation should also allow for streamlined Family and Medical Leave Act (FMLA) administration, which accounts for disability and incidental absences.

When all of the above components are in place, the brass ring an employer is really after is human capital management — a comprehensive, information-driven approach to managing employer investments in employee health

and productivity. By reducing unnecessary health- and disability-related spending, a company can shift its financial resources back to the training and technology necessary to enhance productivity. Reducing absenteeism and contingent labor expenses, employee turnover, and inappropriate allocation of benefits not only helps improve profitability, but it strengthens employee relations. Human capital management requires the realization that program design and administration drive behaviors and, therefore, costs. Whether the goals of human capital management are ultimately attainable will depend on benefit design, compensation structures, corporate culture, and other influences.

SUMMARY

The Pareto principle, or the 80/20 rule, appears to be at least as valid in the benefits utilization arena as it is in other environments. A few sequential and simultaneous users drive costs — and cost increases — for an organization, and the entire population pays the price. It stands to reason that targeted management of high-risk individuals and populations, with a focus on quality medical care and timely return to work, would help contain escalating costs. The building blocks necessary to support such targeted interventions include a robust database, an integrated management team, a comprehensive return-to-work infrastructure, and facilitators to manage the process. In the organization described here, initial results indicate that the approach is working. Expansion of the holistic, employee-centered approach is anticipated to provide further benefits.

ENDNOTES

1. A “Pareto group” is the subset of an overall population that overuses a given type of resources.
2. Integrated Benefits Institute, *Physicians Managing Disability: Identifying Opportunities and Constraints* (San Francisco: Integrated Benefits Institute, 2002).
3. CIGNA Group Insurance, *How Strong Is the Link? The Disability HealthCare Connection* (2004), available at <http://www.cigna.com/general/healthconnect.pdf>.
4. *Id.*

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