

Improving Health and Productivity Through Benefits Integration

Joint Forum on Health, Productivity &
Absence Management



Panelists

- Joseph Doyle, MD, Medical Director, Aetna Disability and Absence Management – Moderator
- William G. Johnson, PhD, Professor & Director, Center for Health Information and Research, Arizona State University
- Charles Cutler, MD, Chief Medical Director, Aetna
- Mike Farrell, Director, Benefits & Services, Benjamin Moore & Co.
- Hyong Un, MD, National Medical Director, Aetna Behavioral Health



Agenda

- Dr. Johnson
 - A non-traditional disability model
 - The potential for cost reductions
 - Patient profiles: targets for intervention
- Dr. Cutler
 - Managing claims through spectrum of care
 - Aetna's integration model (IHS)
 - Case study
- Mike Farrell
 - Benjamin Moore: an employer case study
- Dr. Un
 - Integrating behavioral health to positively impact claims



Challenging the Traditional Disability Model

- Design for multiple recurring episodes of disability rather than the traditional single episode model
- Ontario Study of 12,000 workers shows that over a five year period:
 - Out of every 100 workers:
 - ***25 returned to work and remained***
 - ***27 never returned***
 - ***25 returned and left the workforce after one spell of employment***
 - ***23 had continuing spells of work disability***
- Demonstrates that completion of apparently successful health care does not eliminate the probability of work disability



The Benefits of Disability Management in an Integrated Model

The Marriott Model

- **Marriott International employs nurses to manage cases with disability/WC claims**
 - guidelines stress early communications with employees, health care providers and the employees work units
 - emphasis is on return to work and possible modified work
- **The Arizona State University Healthy Back Study (37 states, 5 employers)**
- **Early nursing contacts with workers with back pain (all else equal)**
 - increased workers satisfaction with how they were treated by the firm
 - no change in back problems
 - doubled the odds of remaining on the job

Butler, R.J., Johnson, W.G., & Gray, B. (November 2007). Timing makes a difference: Early nurse intervention and low back pain. *Professional Case Management*.

Potential Cost Reductions

- Focus on minimizing *all* health-related costs
 - Health care costs *plus* administrative costs *plus* disability benefit payments *plus* losses from presenteeism and work absences
- Understanding Savings: Who pays? Who Saves?
 - Identify parties that share in costs
 - Identify the related potential savings for each party

Johnson, W. (1999). *An integrated approach to employee health*. Dallas: Institute for Health and Productivity.

Allocation of Costs and Savings

Payor	Health Care Costs	Admin Costs	Disability Benefit Payments	Work Absences (indirect) (wage loss)
Insurer	X	X	X	
Employer	Self Insured	X	Self Insured	X
Worker	X			X

Patient Profiles: Targets for Interventions

- **Recurring episodes of disability rather than the single episode model**
- **Separate patient profiles into**
 - Group 1: Patients with conditions that can be identified and measured by objective criteria
 - Group 2: Patients with conditions whose diagnosis depends primarily on self-reported symptoms
 - Group 3: Patients with behavioral disorders, depression
- **Separate patient profiles by the sum of health care costs and disability benefit payments into:**
 - High Cost
 - Low or Medium Cost

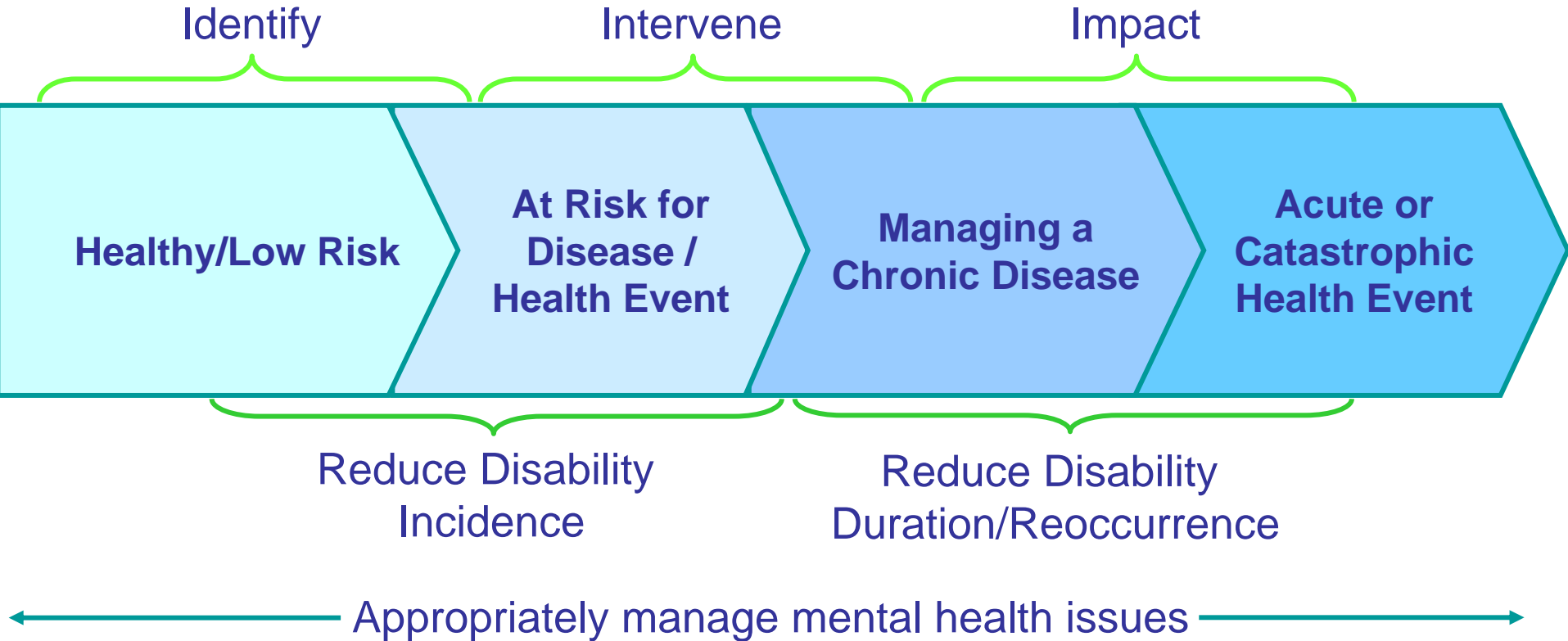


Targets for Integrated Strategies

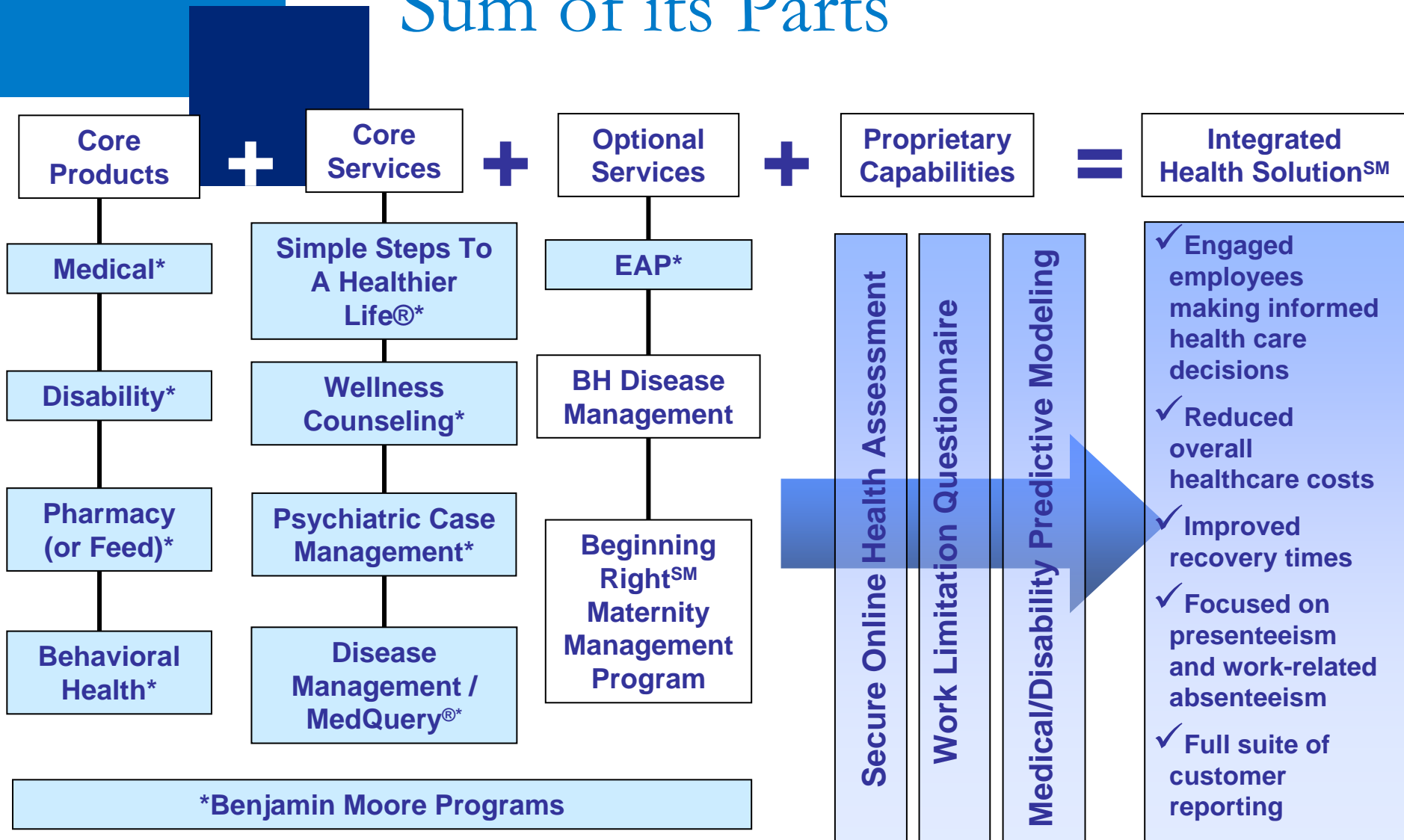
- Individual's compliance with the regimen of health care
- Individual's responses to the limiting effects of the conditions (compliance, expectations of recovery)
- Employer's response to an individual filing a claim, being absent from work (adversarial, accommodating, supportive)
- Worker's perception of the employer's response

The greater the influence of perceptions and behaviors (arthritis, back pain, depression) the greater potential savings from the integration of health care and disability management.

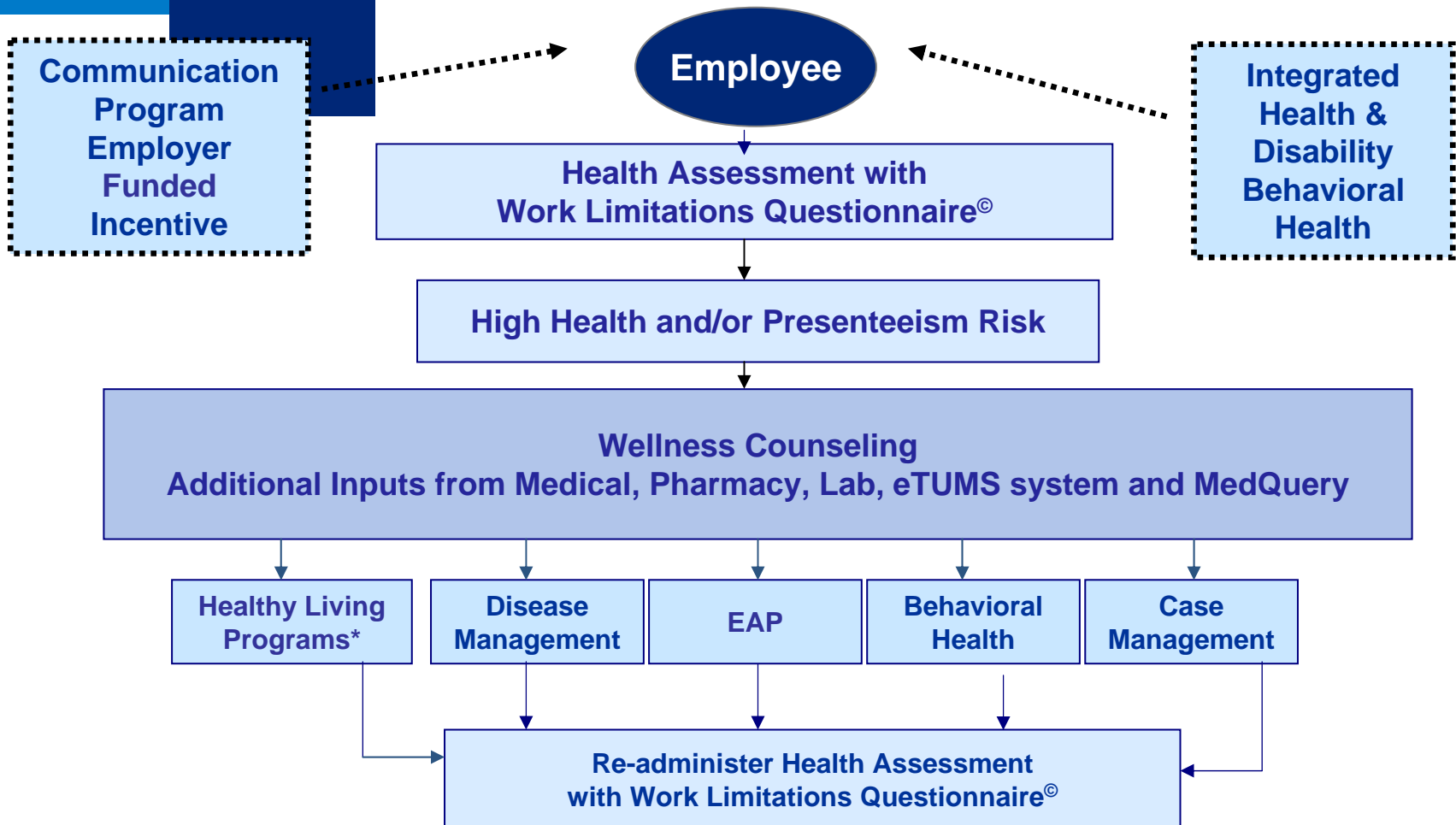
Managing Claims Throughout Entire Spectrum of Care



The Whole is Greater than the Sum of its Parts

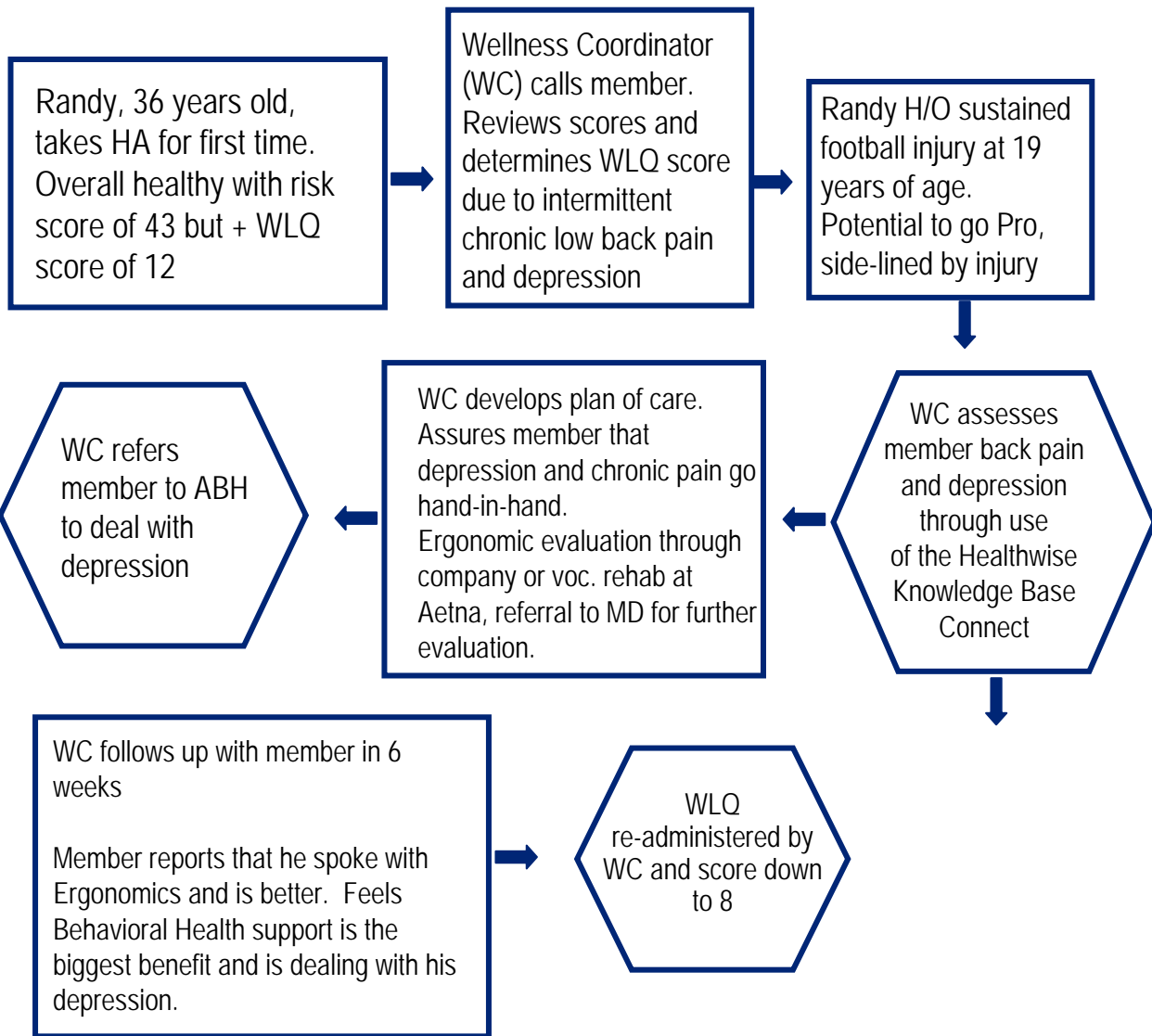


Making the Connection



*Including programs on diet, weight loss, exercise, aging, heart and stress relief.

Meet Randy



Benjamin Moore: Who We Are

- Develop highest-quality paints and finishes in the industry
 - Owned by Berkshire Hathaway since 2000
- Active in US and Canada
- Seven manufacturing plants, 22 distribution facilities
- 2283 employees
- Total STD spend:
 - 2004: \$637,666
 - 2005: \$591,166
 - 2006: \$1,031,483

Medical and Rx spend*:

2006: \$19.5 million

First half 2007: \$10.5 million

*Includes total membership (employees + dependents) for both Benjamin Moore and Indecor. Claim costs includes Aetna, BC/BS and Caremark.



Benjamin Moore: Where We Started

- Provide fitness incentives to motivate employees to address physical health
 - Improve food choices in cafeteria and vending machines
 - Build fitness facilities on location and provide reimbursement for private gym memberships
 - On-site fitness classes
 - On-site lunch & learn courses
 - On-site health and wellness tests and counseling

Benjamin Moore: What We're Doing Now

- Integrate benefits package to help
 - Reduce number of health and welfare vendors overall
 - Reduce administrative oversight at Benjamin Moore
 - Earlier identification of individual issues and population trends
- Provide incentives to encourage participation in Health Assessment
 - Year 1: \$25 gift card, Year 2: \$25 gift card ... Plus
 - Prizes including \$100 gift cards, flat screen TV, elliptical trainer
 - Additional incentive for completing a “Healthy Living” program (waiver one month of medical premium for 2008)

Benjamin Moore: Results of Integration

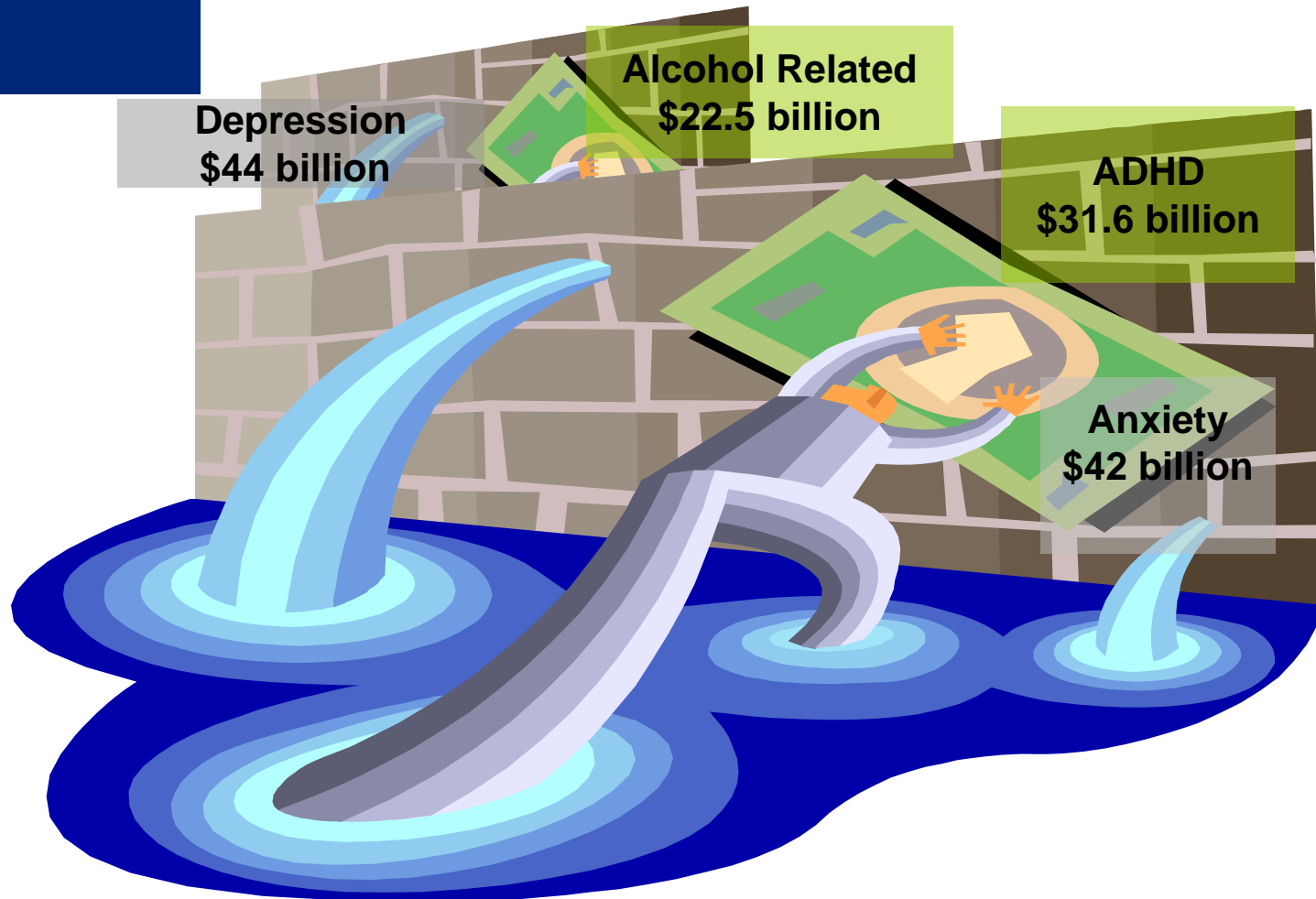
Condition	Risk Factor Status / HRA		Annual Medical Cost Based on Risk Status	
	<i>Risk Not Identified by Member on HA</i>	<i>Risk Identified by Member on HA</i>	<i>Risk Not Identified by Member on HA</i>	<i>Risk Identified by Member on HA</i>
<i>High Blood Pressure</i>	207	24	\$2,267	\$4,987
<i>High Cholesterol</i>	150	58	\$2,298	\$3,323

Benjamin Moore: Results of Integration

- IHD saved an average of 15 days per claim compared to industry benchmark
 - \$409,500 estimated dollars saved (based on avg salary benchmark of \$39,000/yr)
 - 168 closed STD claims in prior 12 months
- Disability outcome review: claim duration analysis (closed STD)

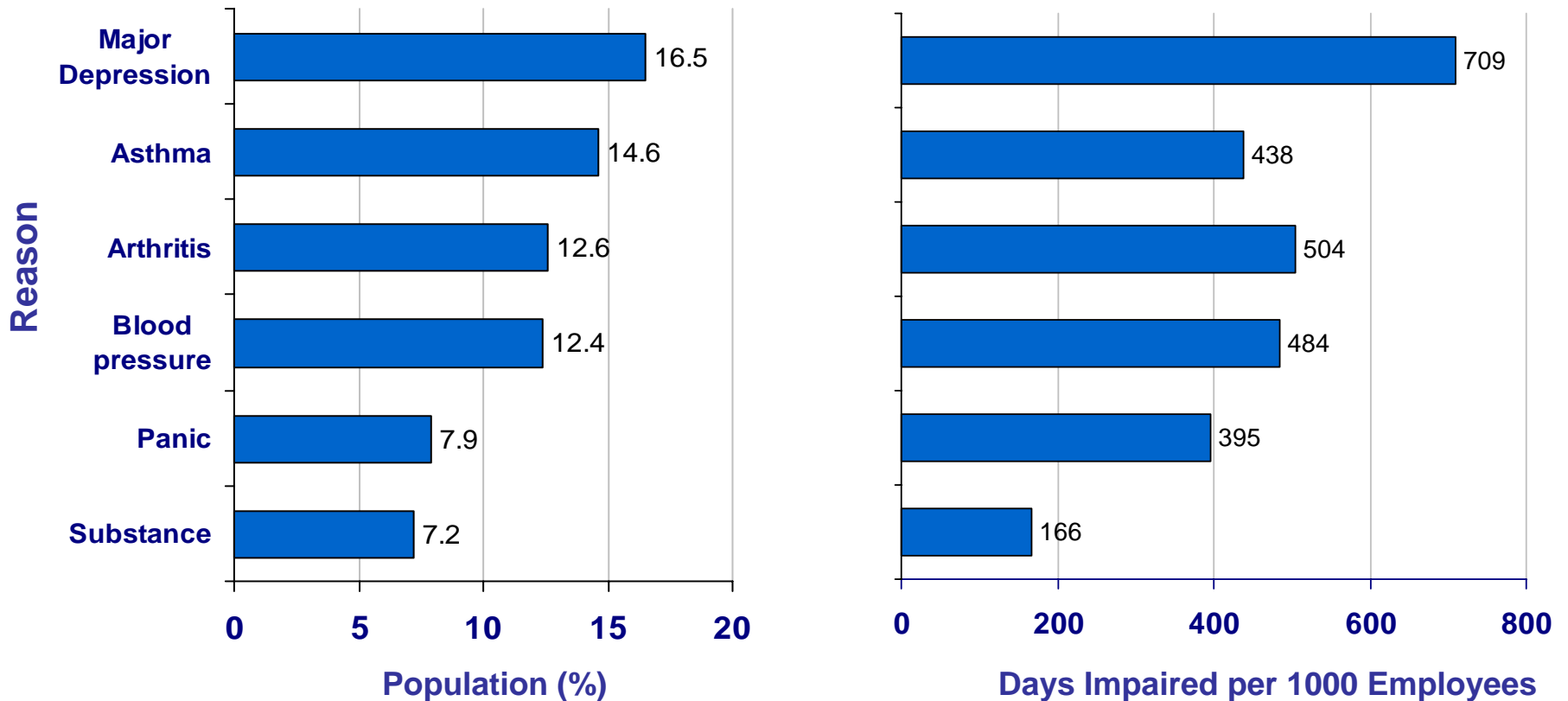
Dx Category	% of Total Claims	Avg Duration	Benchmark	Avg Days Saved
Musculoskeletal	21%	42	72	30
Injury/poisoning	17%	42	62	20
Digestive System	12%	23	43	20

Cost Burden of Behavioral Health Conditions



Depression Prevalence and Impact

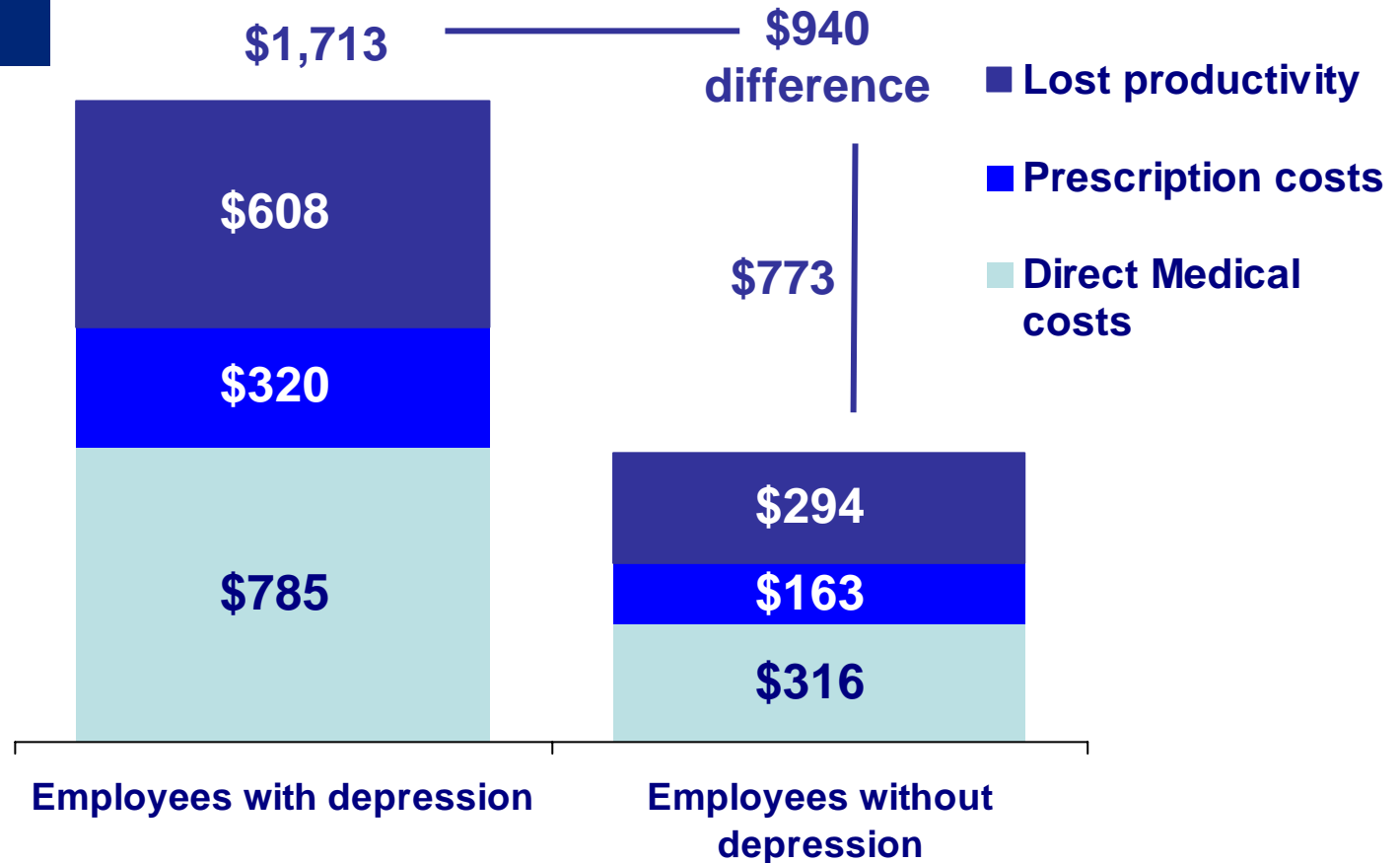
Work Impairment Because of Illness



Kessler RC, et al. *J Occup Environ Med.* 2001;43:218-225.

Example of Average Employer Cost

Impact of depression on lost productivity, prescription costs and direct medical costs





Medical Psychiatric Care Management Program

Program Description:

- Focused on members with co-occurring chronic medical disorder (e.g., CHF, Diabetes) and depressive disorder
- Depression screening and referral process for all members in Aetna's medical case and disease management programs
- Use of pharmacy and predictive model to identify potential enrollees
- Collaboration between medical and behavioral health case managers
- Coordinate medical and behavioral care and enhance adherence
- Minimum monthly member outreach by behavioral health care managers
- Facilitated access to BH specialists with expertise in Medical/ Psychiatric issues

Medical Psychiatric Care Management Program: Clinical Results

Changes in SF12 scores:

- Comparison between admission and discharge scores
- Self report of physical and mental health functioning
- Days absent from work or school

Med/Psych SF 12 (N=1571)

8.9%	Physical Health Improvement
44.9%	Mental Health Improvement
3.95	Average work days gained per month
11.2%	Improvement in work performance

Integrated Medical/Behavioral Health: Clinical Outcomes

SF12 Mental Health

Condition	Intake	Discharge	Outcome
Depression	79%	44%	35% drop in depression
Energy Level	49%	75%	26% increase in energy
Work Limitations	63%	29%	34% drop in work limitations
Social Limitations	71%	41%	30% drop in social limitations

SF12 Physical Health

Condition	Intake	Discharge	Outcome
Depression	79%	44%	35% drop in depression
Energy Level	49%	75%	26% increase in energy
Work Limitations	63%	29%	34% drop in work limitations
Social Limitations	71%	41%	30% drop in social limitations

Medical Psychiatric Case Management Program: Medical Cost Offset Results

For enrollees of the program:

- \$175 to \$222 pmpm reduction in total medical cost
- \$129 to \$170 pmpm reduction in inpatient pmpm cost
- \$21 to \$40 pmpm increase in Rx cost
 - Portion of Rx increase was due \$8 to \$11 pmpm increase in antidepressant cost
- \$136 to \$201 pmpm net cost saving
- ROI approximately 3:1



Panel Discussion

- Questions