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Managed Disability in Action

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Summary: Several employers discuss their experience implementing managed disability programs of different types. These employers discuss the barriers they needed to overcome to implement their approach to managed disability, and the impact of their managed programs on cost and quality of service.

Mr. Robert B. Hardin: I think the history of this particular panel discussion is interesting. It stems from a discussion that took place in Orlando about a year ago in which some of us observed that we ended up talking about disability income and what was happening in that benefit arena as if it were happening at all insurance companies. It's clear that is not the case. A significant amount of activity and work with interesting results is taking place inside the employer community largely independent of the insurance industry. And so, because I was part of those discussions, Tom Cochran suggested that I should do some recruiting. My sole claim to fame in terms of this particular session is that I've recruited really

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quite successfully. We have three panelists from three diverse employers who have done some interesting and different things. Let me tell you about them.

Among other things, Al Daniels is somebody who was willing to do this on the spur of the moment. He comes from Bristol Myers Squibb where his title is manager of health and disability programs. He will tell you about some of the things that Bristol Myers Squibb has done.

Mary Bradley is from Pitney Bowes. Mary is the manager for case management and data analysis. Mary will tell you some interesting things that Pitney Bowes has done, and it really is, in some sense, more independent of the insurance industry than any other panel members' experiences.

Janna Rogers is from FedEx. Janna is an RN and has worked with FedEx in a number of different positions, and before that she did all of the things that you would expect an RN to do, including things like hospital surgery.

Mr. Aldon Daniels: I'm on the corporate benefits staff at Bristol Myers and have been in the corporate function for about seven years. I've been with Bristol Myers for almost 14 years.

Neil Austin was supposed to be the speaker, but I will try to be competent as his replacement. When Bob invited me to come and speak to you, I went home and announced this to my spouse. I was feeling just a bit full of myself, and spouses have a way of doing reality checks on you when you are feeling a bit full of yourself. I should also tell you that my spouse works at a consulting firm, and said to me, "Hello. You're an human resource (HR) person talking to actuaries about numbers? You're in trouble, pal."

Bob has assured me that the actuaries here will indulge my lack of skills around numbers, even though I do have some numbers. Bristol Myers is very proprietary about its figures, and while I will speak to you about them, I will not distribute them.

My presentation is really in two parts. The first part is really focused on process, and this is not necessarily an area that might be of interest to you, but I found that through Bristol Myers working on the concept of managed disability, that process becomes very important, and there are a number of failings that can happen in a managed disability program for lack of good process. I want to share with you some of our findings around that concept before I share some of the numbers with you.

Bristol Myers Squibb Company, 1993 and 1994, started exploring, very vigorously, concepts of doing integrated managed disability. Integrated managed disability has many different meanings to many different people depending upon the audience that you're talking to. At Bristol Myers Squibb there is really an integration of short-term disability (STD) and long-term disability (LTD).

I want to share with you what we did, why we did it, how we did it, and some of our preliminary results. As I indicated, we started looking at the problem in 1993 and 1994 which is very early on in the paradigms of developed managed disability programs. On January 1, 1995, we implemented a managed disability program, and we're now into our third year. The first year of data wasn't necessarily credible, but the second year is getting better. Later in my presentation, I will discuss some of those preliminary results.

Just as a little bit of background, Bristol Myers is, as you may or may not know, a pharmaceutical company. We're somewhere in the neighborhood of $12–13 billion in sales each year. We're very, very familiar with the health care industry. We have thousands of sales reps who interface with the health care provider segment every day, so when we talk about managing disability we have some internal constraints just because of the nature of the business that we're in. Like most businesses, those constraints were real driving forces for us.

Back in the early 1990s we started to feel the cost of health care reform much more acutely than many other companies because when Clinton announced the health care reforms that he was talking about with his all-encompassing reform package, you could see the value of the pharmaceutical industry drop out overnight. Our stocks dropped dramatically. The cost pressures of health care reform were acute in our industry, and we started looking right away at how we could possibly review business practices. We got very involved in some productivity initiatives, and that was really the beginning and driving force for us to think about managed disability.

At the same time, from a corporate benefits perspective, we were looking at outsourcing benefits administration, and we took 20 different benefit offices across 20 different divisions and 20 different subsidiaries around the country, and we closed shop. We outsourced benefits. We were pressured internally to also look at other opportunities to outsource and, consequently, we did so with the managed disability program.

Our benefits around STD and LTD are corporate-wide benefits. We have universal benefit plans for all classes of employees for every one of our divisions. Our STD plan is essentially a salary continuation plan. It was self-insured, and it was self-administered before we started thinking about managed disability. We gained some

insights and experience as we tried to improve the self-administration of our STD plan. As for LTD, like probably most employers, we had a corporate-wide plan that was already outsourced to a third-party administrator (TPA), and we were funding it through a voluntary employees' beneficiary association trust, which we continue to do.

As I indicated, we had been doing some very active and proactive things to manage our disabilities, particularly on the STD side. Most of my comments are going to be focused on STD administration. We've been doing some fairly active things. Process can be really important in the management of disability, and as we looked at our internal processes and how we did it, we found some interesting things. I'm going to talk about the claim submission side anecdotally, and about some of the things that were happening that led us to be concerned and again start to explore the initiatives around managed disability. If we could break the process into five key steps, there was the claim submission process, claim file development, claim determination, which could lead to a denial or an approval as an outcome, ongoing administration, and, finally, return-to-work issues. I want to talk about these for just a little bit because it's my assumption that actuaries don't necessarily think about processes. I want to focus on just a couple of observations here.

The claim submission process and return-to-work issues are really HR issues. Claim file development and claim determination are the kinds of things that you're looking for from an outside vendor. Those are core competencies that are brought to the table by the insurance company or the TPA. The administration can be a conglomeration or an entanglement of your own internal processes married to the TPA. If you break this down, claim submission or the initiation of a claim or reporting of an absence and a return to work are issues that would fall outside of the outsourcing of any vendor. Most people don't think about that. Companies don't think about it, and I'm not sure we thought about it when we first started exploring managed disability. What we were looking for is core competencies and outsourcing managed disability and getting ourselves out of the managed disability business. In so doing, we only addressed two aspects of what we think are the five key processes to managed disability. If you, as actuaries, are thinking about helping one of your client companies, think about possibly outsourcing managed disability and the selection of the vendor. I dare say to you that these two are the only two key processes that you're going to influence with the outsourcing and selection of a vendor.

I tell you this anecdotal story because I'm finding that these other areas that are HR driven or administration or systems driven can actually fail your program. As an actuary, if you're consulting to client companies, and you're going outside and talking to them about the selection of a vendor, be prepared that if you aren't

talking about all of the major front-end and back-end steps and some of the systems and payroll issues, your role in helping a client outsource managed disability can lead to an abysmal failure.

Let me share with you some of the things that we found when we looked at those five processes, and these are the types of things that were instrumental in helping us make the decision to outsource. We found in the claim submission process and the absence reporting that we had very inconsistent practices among our divisions. That was largely driven by the incumbents at a particular division. We have divisions that vary in size from 12,000 employees to 300 employees to 10 employees. We had very disparate practices that led to many concerns for an ERISA corporate-wide program. It was being administered differently across 20 or 30 different locations and divisions. We also found in the claim file development that our process was largely clerical as opposed to clinical.

Let me share with you another anecdote in that area. We found that our cycle times for getting attending physician statements back were somewhere between 8 and 12 weeks. We also found that our average STD for an absence greater than five days was somewhere around eight to ten weeks long. We were, therefore, encountering a problem where we were getting the clinical evidence to make a claim determination after the employee had already returned to work. That's a real problem.

We were primarily using our occupational health groups and our benefit groups at the division level to administer or make the claim determinations. It became very clear that there was very little risk management going on. We also found that the return to work or the expected return-to-work date was being driven largely by attending physicians. We had large variability in duration for the same injury or illness, and we very infrequently were issuing denials for benefits. With that in mind we looked at claim file development, which was clerical versus clinical, and we looked at the claim determinations and recognized there was no risk management going on. That's what drove us to think about outsourcing the disability functions in our company and look at a managed disability program.

On the claim administration side, as I indicated to you, we had very inconsistent payroll practices. We had some real concerns about how we were administering our plans in those states that have statutory requirements. Although we had some level of integration, there was not good integration between our worker compensation benefits and our STD plan.

Finally, there are employment issues. We had very inconsistent return-to-work practices and employment resolution following periods of disability. At the time, it

was not so crucial, but as we come into an environment of Americans with Disabilities Act (ADA) and some of the other statutory requirements that are now issued to us as employers under Family Medical Leave Act (and because of our own family leave policies) this last key process of employment issues following periods of disability actually has become our single focus for 1997. We have addressed all these other issues without outsourcing. We have some of the techniques for employees to report disabilities, etc., but the last hurdle that we must crawl over are the employment issues that are being largely driven by the HR generalist function within our corporation. I'm focusing on process here because, for the most part, my experience with actuaries has been that they get focused on the numbers. What I'm suggesting is that there are some key processes in the managed disability arena that are largely outside of the numbers, and if they aren't done correctly, they can fail miserably.

When we began our endeavor to look at a managed disability program, we had a corporate plan that was administered by divisions, and that led to all sorts of disparate practices. Administration was driven largely by the divisions' resources, the incumbents in those jobs, and some of their HR practices. We had disability claims that were not clinically managed. I can tell you that when you go to the ERISA appeal process and, subsequently, litigation, if you don't have a claim that has been clinically managed, you're going have a very difficult time trying to convince a court that you've done things correctly by the terms of your plan. We knew that there was very limited disability risk management taking place in our STD plan that was being self-administered out of our occupational health units.

Let me share with you just a little bit of the process that we went through, and this might be instructive to you. We did a lot of work, and we collected a great deal of information. We put together some task forces, and out of our task forces we built our request for proposal (RFP) and site visit groups. We started out by realizing that we had a great deal of information. Let's try to synthesize it.

We invited some vendors in and asked them to make blue-sky predictions for us. What I mean by blue-sky predictions is inviting vendors in and asking them, if we could wipe the slate clean, what would the product look like? We asked a couple of vendors to come in. We asked them to bring their STD or their LTD product manager. We asked them to bring in their systems people. We asked them to bring in some of their business process improvement people, some of their quality assurance people, and some of their nursing staff. We also asked what the blue-sky product would look like. We had some concepts about what we thought it would be as well.

In addition, we conducted some marketplace surveys. All this, by the way, happened relatively quickly in the first part of 1994. We conducted some marketplace surveys, and we did best practices at other companies. Back in 1993–94 that was not a particularly fruitful endeavor because there weren't many companies that were really doing very much in the managed disability arena. In addition, we looked at vendors of managed disability products and tried to test our blue-sky model against some of theirs. We asked for some initial reactions. Finally, we did something that I think was a little bit unusual. We also tested our blue-sky model against a number of consultants, and we asked them to come in and talk to us about their expertise in the managed disability arena. Ultimately, that was part of our selection process in looking for a vendor to help us go through the RFP process. As I indicated, we validated the model in the marketplace. We retained a consultant, and we initiated our RFP proposal.

And let me share with you the broad parameters of our RFP model or our criteria for our RFP. We were looking for a telephonic, paperless claim submission process where there would be a single point of entry. I'll talk about that a little later in terms of our model and what we actually ended up selecting. We were looking for a clinical model. As I indicated to you, we're a company that has a number of health care professionals within our own organization. We have many doctors and nurses in our employee work force. We have research scientists who operate on developing pharmaceutical agents and pharmacological agents as their daily lives. We have thousands of pharmaceutical sales reps who interface with hospitals, HMOs, managed care vendors, and physicians every day.

In addition to it being a sound claim management process, the clinical model was going to be absolutely imperative for our environment. I don't think it's unique to Bristol Myers. I think I'm sharing with you candidly that it was part of our driving force for selecting a clinically driven model, but I think it's also important that everybody recognize that the future wave in managed disability has to be focused around a clinical model. We wanted to integrate our STD and LTD administration. We found duplicitous processes in running two programs, even though they ran sequentially with one another. We were duplicating a lot of effort.

We knew that we needed to integrate systems between Bristol Myers and whomever the managed disability vendor would be. We have an benefit information and records center to which we have outsourced all the administration of our benefits. We have an HR information system that is highly developed and talks about statuses of employees. We track those statuses very carefully for purposes of participation in all of our other benefit plans. We have a division disability coordinator, an HR generalist, who we knew needed to interface with our vendor, and we knew that we needed to do that from a system perspective. Finally,

because of our flex plans and the status of employees who are disabled within our company, we knew that we needed to integrate the vendor with our common payroll function. We pay both STD and LTD benefits out of our own payroll function.

That's mostly the overview of the process that we went through to get our managed disability program outsourced and implemented in January 1995. I'd like to share with you some of our numbers. I'll make some comments about them. Quite frankly, I think the data are much too immature for us to make many conclusions about them. The volumes in some instances are surprising, and I'm not sure what the implication is of that in the observations. Once we get through 1997 and have three years of credible data, we'll be in good stead. Prior to the implementation of this program we had virtually no data whatsoever.

One of our driving forces is that when we went back and looked at payroll to try to determine what our numbers were, the best that we could come up with is that for an employee work force of about 22,000–23,000 back in 1994, we were probably spending somewhere in the neighborhood of $17 million a year on STD benefits. Our average duration was probably somewhere in the neighborhood of nine to ten weeks.

Now let me share with you some of the information. As I indicated, some of our RFP requirements were that we would have telephonic claim submission and that claims would be initiated by employees. Our total call volume in 1995 was about 17,000 calls, and in 1996 it jumped to 18,000 calls. The average call volume is 1,400–1,500 calls a month. We had some good experience in 1995 where the average answer speed was close to nine seconds. Subsequently, in 1996, it went up. The average talk time was three minutes in almost both instances. I think the last one sort of surprised me. I thought the transactions would take much more time than that, and I'm surprised that communications with employees around these issues can, in fact, be handled in those short periods of time.

When we were going through our vendor selection process one of our two finalists did a site visit. The president of the company came to the presentation, and at the beginning of the presentation he said, "Bristol Myers, we're expecting you to take us to the next iteration of managed disability." My heart went cold. Bristol Myers is going to take us to the next iteration of managed disability? Now, I had some real problems with that because it indicated that they didn't necessarily have all the systems in place, and, as we did the site visits, it became even clearer and clearer that not all the systems were in place, and, in particular, there wasn't the telephonic capability to necessarily take the volume of phone calls that we thought might occur.

We had no idea, however, that the volume was going to be like this. On the first day that we opened the phone lines, January 2 or 3, 1995, we took 400 calls. That night I woke up in a cold sweat realizing that if I had selected the other vendor who was going to build the telephonic system that we were going to need, by the end of the month, I would have been looking for a job. So this is one of those crucial issues that may have nothing to do with the incidence rates, the lengths of duration, or anything like that, but in the selection process they become very crucial issues.

Claim frequency is something that completely surprised us. By the end of 1996, we were averaging somewhere around 185 new claims per month, and in frequency-per-thousand we've been in the 100–107 range over two years. I can tell you that when we were doing the underwriting projections back in 1994 and 1995, we expected these frequencies to be somewhere between 60 and 70. This one really surprised us. However, I can tell you that as I talk to my other colleagues in other companies that have a major managed disability initiative going on, and maybe Mary and Janet can speak to this, those numbers are also holding up for their clients as well. That's somewhat driven by waiting periods, but in our company, we essentially initiate all disability claims after five days of absence. I know that's part of what's driving that high number, but we were still very surprised by it.

We did a cliff start for closed claims. We started all new claims after January 1, 1995. We had no run out from 1994. So the 1995 figures are a bit jilted. In 1995, we had approximately 1,750 claims, and total durations of somewhere around 11,500 weeks, for an average duration of a claims greater than five days of absence of 6.62.

The 1996 numbers went up somewhat. The durations also went up, and you can see that our durations from a trend perspective are going in the wrong direction. We have some explanations for that, but, again, I want to sort of hold on to those explanations until we get more data later in 1997. We've implemented a rather aggressive return-to-work program. During the return-to-work program, we actually continue to track employees in a disability status, albeit they're back in the workplace, and that's part of what's driving this increased number in duration, but for the most part, we're a little alarmed by the increase in duration. That's not the trend factor that we're looking for.

We're breaking out our disability data into work-related and nonwork-related areas. The work-related injuries, even though they fall within our managed disability program, are paid primarily or they have a benefit factor that comes from workers' compensation for wage replacement. Those disabilities are running in longer duration than the nonwork-related disabilities. At Bristol Myers Squibb, workers' compensation is a di minimus exposure for us. We're largely a white collar/pink

collar employee population. Most of our people are marketing, research, or sales people. So we don't have a large manufacturing component that might drive up workers' compensation.

Maternity is also quite a driver from a duration point of view, and if you want me to tread into that subject, I will, but only if you invite me to. That's a tough issue from a managed disability perspective.

I thought I would also share with you some of our duration frequencies based upon length of duration both as percentage of total claims and as a percentage of total duration. I think the instructive piece that I'd like to share with you is the following. First, we have a plan that pays 100% of a benefit based on duration of service or length of service with the company. If you have ten years of service or more with our company, the STD benefit is actually 100% for the full duration of 26 weeks. As a percentage of total claims, somewhere between 60% and 70% of all claims are over with by nine weeks, and we have an eight-week, 100% pay for anybody who's been employed for more than one year. At Bristol Myers Squibb, we essentially have a 100% pay plan. Another driver for us is that we have a relatively rich benefit. So we're going to be very proactive and, I dare say, somewhat aggressive in managing our disability plans.

I suspect that the large percentage of claims that are gender driven in this instance is largely due to the number of pregnancy claims that we have which is clearly the single largest medical condition for which employees in our population have a disability. The average benefits, again, may look very large compared to other companies because we have a 100% pay benefit, and we're also a relatively highly-paid industry.

In the 25–34 age component, there are a large percentage of claims and a large dollar volume of average benefit. Again, I think that's a function of our pregnancy claims. This is the 1996 data.

I won't get into detailed diagnostic information. We've done some quite detailed analysis of that. I won't get into that, but I will share with you just a little bit of the bodily systems and so forth. The single largest reason for a disability benefit being affected by our employee population is pregnancy. I will share with you one anecdotal bit of information. Many folks have suggested to us that we just take the maternity benefit and make it a standard leave policy and not manage it—just take it out of the disability program. I will share with you that the detailed clinical information that we have shows a large number of claims coming out of that area for which there are many complications. What is somewhat surprising is the extent to which many maternity claims actually go the full 26 weeks and into LTD. If you

took the pregnancy claims out of your STD administrative process, you'd have no opportunity or you would be managing very late many of those pregnancies that have complicating factors associated with them.

In 1995, we thought we paid somewhere around $8 million in benefits for closed claims. That's a very skewed figure because, as I indicated to you, we did a cliff start in 1995. So it didn't have any of the run out of 1994 claims that ended in 1995. The 1996 figure looks much more healthy. It's what we expected. As I indicated, when we were trying to do our estimates when we were going into the program, it was our expectations that we were spending somewhere around $17 million a year in STD benefits before we went to a managed disability program.

What were our goals when we went into a managed disability program? Most companies are going to ask you, the professionals, "OK, so where's the money? What's the bottom line going to be?" At Bristol Myers, that was not particularly the driving force. We thought we had a productivity issue that we needed to address, and savings was not really the issue on the table. However, you can't talk to the finance folks without talking about numbers. Those people really want to know what you're going to deliver back to them. I'm going to share with you one of my concerns about HR people who aren't careful about presenting their thoughts about what savings might be.

At Bristol Myers, we don't talk about savings in our managed disability program. What we're really talking about are productivity gains, and what I mean is that, in our company, because of our 100% benefit, we were going to pay either STD benefits to employees, or we were going to pay them a normal wage for being actively at work. Obviously, we would prefer to pay the normal wage to have employees actively at work. The number of days that we can get employees back in the workplace, in my mind, is not a savings. I think you'd be hard-pressed to persuade a finance person that it is a savings. My fear is that there are HR people who will say this is what the savings are going to be. At the end of the year, the finance people are going to say, "OK, give me the money." You're not going to be able to give the money back because it's really a productivity gain where you paid it as normal wages as opposed to paying it as a disability benefit.

We are not particularly focused on the savings, but we are focused on the productivity gain. To that extent, we think that in the last couple of years, on a $12 million expenditure, we've exceeded a million dollars in having people back in the workplace either under full capacity or in some sort of alternative work duty program. Our alternative work duty program just kicked in recently. We were hoping for a much larger figure than that. We have structured within the terms of our plan a very innovative, temporary alternative work duty program, and in the first

four months of 1997, we have captured back 500 weeks of alternative work duty service where we have employees in the work force. So for the first couple years our alternative work duty programs were not very effective, but now we're starting to see some effectiveness.

Ms. Mary Bradley: What I'd like to share with you are the steps that Pitney Bowes has taken to integrate its health care management, and that falls basically under three programs: disease management, disability management, and demand management, but I'd like to start out by explaining a little bit about who Pitney Bowes is and what it does.

Pitney Bowes is a large multinational manufacturing and marketing operation housed in Stamford, Connecticut, with about 23,000 employees located across the U.S., a third of which reside in Fairfield County, Connecticut. We're probably best known for our mailing systems and our metered mail, but we also manufacture copier systems, fax systems, and weighing systems. One of our fastest growing business divisions is in the business service support area where we go into other companies, primarily law offices and other large corporations, and run their mail rooms. We also provide integrated software solutions for business communications.

What we've done in the benefits department is develop an aggressive total health benefit mission to optimize organizational and employee productivity. We are able to accomplish that because our benefits department houses our on-site medical clinics, our disability department, and our health care planning and administration departments. As a result, we're able to take a holistic approach at employees' health care.

Our statement of values is that our benefit package will be competitive in the marketplaces in which our businesses compete and will strive to meet the needs of our employees. We have a very diverse employee population ranging from blue collar workers in our manufacturing operations to sales, service, and administration employees throughout our field offices. There are engineers and corporate employees housed in Fairfield County. What we try to do is follow the life cycle of an employee's health care needs recognizing that those needs change throughout an employee's life events. As I've mentioned, we've developed an integrated program under disease management which is through our use of wellness, preventative, and care management programs. Our disability management program is providing resources to help our employees achieve productivity, and demand management supporting the most efficient care for our employees.

Our objectives have been to manage health care benefit costs to under 0% growth in 1996 and 1997 and to maintain future annual growth rates under medical

consumer price index. At the same time, we want to maintain our commitment to our employees to keep a constant 80/20 cost-sharing commitment. In an effort to achieve 0% growth, we're not allowed to cost-shift back to the employee segment. Our total employee out-of-pocket costs will be no greater than 20% of the total cost of the program. Another objective is to enhance the existing scope of health care benefits while providing adequate access to alternative providers, and access is very important to the director of the benefits department. We work with over 150 HMOs throughout the U.S. in delivering our managed care products as well as three regional players delivering point-of-service, indemnity, health care plans, and a catastrophic medical plan. So from the disability department's perspective, it's just a nightmare to work with so many health care plans, but one of our other objectives is to improve the overall health of the Pitney Bowes population by providing convenient and cost-effective care and to improve the functional health of our population through a return-to-work program that focuses on employees' capabilities, not their disabilities.

We believe the strategy is multidimensional and highly integrated, and we use three basic building blocks: the education of the health care consumer, the efficiency in utilization and purchasing practices, and the employer design which is providing resources to achieve these objectives. We kind of visualize it as a three-dimensional trapezoid that allows Pitney Bowes to bridge our practices from former benefit practices to a more highly integrated, efficient health care management approach.

Let me go into a little detail about our disease management programs. The education component is delivered by our on-site Pitney Bowes medical professionals, and we spent a lot of time and effort during 1995 and 1996 to provide more services to our employees and to revamp our four on-site clinics in Fairfield County in order to focus on detecting illnesses. So we've really tried to upgrade from the school nurse approach that is common at many large employers.

We deliver our programs through a health care university concept where employees enroll in the program, complete the courses, earn credits, and graduate every year. Upon graduation from the university, they receive flex dollars that they can use in the following year's enrollment. The efficiency is measured by us trying to develop an integrated and interactive database. We've partnered with the Yale School of Psychiatry in Connecticut to develop an integrated database. We gave it our health care claim data, our disability claim data, our HR appraisal data, and episode data from our clinics in order to develop a database that'll allow us to target the major risk factors in our population and eventually lay a basis for doing large case predictive studies.

The other area of efficiency is providing our employees with alternative treatment information. We've built a benefits web site page where we have a resource for our employees to look at providers in the community, look at their credentials, where they graduated from, what their specialties are, and what health care plans they operate in. This year we're also working on developing a health care village and trying to provide our employees with real-time access to the latest health care data. As I mentioned, the resources that we provide are the four on-site clinics through our care management programs.

Why do we do care management? In this day and age it's no longer typical to have employers delivering care management at the work site, but it's very simple that it's convenient and easy for our employees to access. It also gives us the ability to influence high-risk behavior because naturally we assume that improving the health of our employees will influence both cost and their productivity. Also, chronic disease management was a natural progression for us from our wellness and preventative programs.

One of the programs that we've delivered is an asthma care management program for our employees and dependents in Connecticut. The objective is to reduce health care utilization through either a self-management training program or a work-site monitoring program. What we did was send out a survey to the residents in Connecticut and identified just over 250 employees who suffered from asthma. We divided the employees into two groups. One received the self-management training program at three of our sites in Connecticut which were delivered over eight weeks in 90-minute sessions that included the typical education components of a tech management and inhalation treatment. For the other group we did work-site monitoring where they used a kiosk and measured their peak flows over the period of eight weeks. What we were trying to do there was detect conditions sooner than the employees might and deliver the appropriate intervention. The self-reported results from the program were favorable. We used both a productivity and a quality-of-life questionnaire, and we looked at the peak flow values. We're going to continue this program during 1997 through continuing education, which will be done in eight-week lunch-and-learn sessions. It will allow our employees to earn the Pitney Bowes University credits.

Another program that we're unfolding this year is diabetes care management, which will be delivered by a certified diabetic nurse educator. It will include the typical education components—meal planning and the importance of maintaining activity—but we've also added a free glucometer and glucose strips for our diabetic employees as well as waiving the copayment for annual eye exams. We also allow the employees to earn the university credits. Out of a population of 300 employees

in Connecticut whom we've identified as diabetics, we have about 60 employees signed up.

These programs are delivered through our health care university which was developed to support good health by encouraging employees to adopt more healthy lifestyle behaviors through general wellness, weight management, smoking cessations, and things like that. Last fall we delivered 1,400 flu shots to our population and 250 mammograms were done on site. Four had a negative result, and out of those four, three women said that they wouldn't have had a mammogram done that year.

We think it works. We believe that we decreased the health care costs for these participants 5% over a three-year period. The way we determined that was to look at a baseline year of 1992 and then health care costs over the next three years. We looked at the participants in any of the health care programs versus the nonparticipants. We then used many varied statistical techniques to control for age, sex, and regional price differences in the population. We also looked at items like circulatory disease, emergency room admissions, mental health diseases, and other professional services. We were one of the recipients of the 1996 Everett Koop Award for our wellness programs, and we've also been recognized by the Washington Business Group on Health for our women's wellness programs.

The education for disability management is provided by our Pitney Bowes nurse case managers on site, and a key component of education is educating the providers and communicating with the providers because they are key to balancing the needs of conservative treatment versus lost time. We tried to educate the providers on a case-by-case basis as we are managing an employee's absence. What we started to do this year was work with some of our health plans to sponsor us in their meetings that they typically have quarterly with the large individual practice groups in their communities and start having them sponsor a large employer looking at recognizing lost time. We're trying to elevate the physicians' awareness of that lost time component that typically doesn't exist unless the provider happens to practice in the workers' compensation world as well.

What we're moving to at Pitney Bowes is a vision of a 24-hour delivery integration, and ideally what we'd like to see is regional carriers throughout the country that we entrust with the totality of our employees' health. We'd like to see health care management, disability management, workers' compensation, and, in Connecticut, have a health plan staff our on-site clinics with primary care physicians. It's a vision. Unfortunately, we haven't found the administrators on a regional basis that share that vision, but that's what we're working towards.

In Connecticut we have actually developed provider networks on the nonoccupational side, and one of the objectives I shared this year with our risk manager is to develop an exclusive network in Connecticut to manage workers' compensation claims.

Our resources that we bring to disability management are the in-house disability unit where we self-administer our STD, LTD, and a workers' compensation supplement. As Al mentioned, we're a large employer that also replaces income at 100% for STD. We also supplement the state workers' compensation programs to bring those up to 100%. For the first 22 weeks of an employee's absence we're providing 100% income replacement, and therein lies the management challenge. On our LTD program, which kicks in after 22 weeks, the company provides each employee a 50% income replacement benefit, but an employee can buy up to 66.66% replacement.

Why do we manage disabilities? Very simply because the cost of lost time can be greater than medical costs, and that's especially true with mental health absences and maternity absences. We believe that the providers need to have a back-to-work orientation. We believe that returning to work should be part of the modality of care, not something that occurs once an employee has returned to 100% functionality. So, we focus on an employee's capability or functionality, and we believe disability management is also a good area in which to develop focused disease management programs. In an effort to manage disabilities what we've initiated is an employee-initiated system for managing disabilities. We have a 24-hour operation that allows an employee to call in by their fourth day out of every absence into our disability department. It's a paperless system, similar to what Al was describing at Bristol Myers. We also have another component where we allow the doctors to call in by the sixth day out and answer a series of questions, or they can indicate that they'd like us to fax them a form on which they can relay information. They can also talk to a "live" person. What we've tried to do is make it very easy for our employees to exchange information with us as we manage their disability process.

Why do we manage disabilities in-house? Again, it's a little unusual in the 1990s to have an employer use its resources towards disability and disease management because they're typically not core operations for a large employer, but what we found in the early 1990s was that we were having problems with several vendors we had used; either they were managing too aggressively or they were much too lenient.

We also didn't see any sense of integration early in the 1990s and, therefore, had a lot of duplication between short-term management and LTD management. We

didn't see many formal return-to-work plans with our outside vendors and very infrequent questioning of physicians' treatment plans. Naturally an outside vendor doesn't have as much knowledge as we do about the corporate culture and our employees. We brought the programs in-house. We hired four case managers who had, between them, over 100 years of medical case management or disability management. What they were able to do was apply their clinical and medical case management to disability management because we challenge physicians. We don't believe that an impairment is equal to a disability, and we ask the physicians simply to provide us a diagnosis, a prognosis, and a treatment plan. Then we (in the disability department) determine whether or not an employee is eligible to receive income benefits. We don't ask the physician to give us an opinion on a disability. We really think disability is a contractual definition, not a medical definition.

What we take is a total care approach to disability management where we look at whether or not the providers are appropriate and whether or not the services that are being provided are appropriate. For instance, in the behavioral health diseases, if an employee is working with a social worker or a psychologist, and they don't seem to be getting better, a psychiatrist will elevate their treatment up to a higher level. We macro manage our health plans' case management process. We found too many instances in the managed care world where an employee may be sitting home waiting for a referral to a specialist or waiting for surgery to be authorized. More time is lost if the managed care providers don't recognize that component. When we see that happening we'll contact our HMO ombudsperson and speed up that process to keep the treatment moving.

We're able to impact the workplace by achieving our employees' ability to return to work using transitional employment. We don't have a set job bank of light duty, but what we do is try to modify the employee's existing job to get them back as quickly as we can to their regular duties or place them in a temporary assignment while they continue to heal.

We link very closely with our workers' compensation management which is still done through an outside vendor by using the same protocols. Because we're paying a supplement to those programs, we're very, very closely linked with the disability management. Integrating the STD and the LTD process has allowed us to avoid duplication in those programs. If we start managing the program right from day four, we're quite comfortable that as the employees roll into LTD there's a good reason for them to be on benefits. We think this system works.

We used 1994 as a base year before we brought the programs in-house and integrated them, and over the next two years we've been able to achieve about a $3 million savings, half of which is coming from the income replacement. If we take a

look at some of the major clinical classes and look at an STD price-per-episode, you continue to see that we've been able to achieve savings over the last couple years. In total, our average price-per-episode in 1994 was just over $7,800, and by 1996 we've been able to bring that to just under $7,000, which is about an 11% savings. These STD prices-per-episode are on an annual basis, and they include both the income replacement and the medical component.

Skeptics may ask, but what about case mix? What I've tried to do is to put in an adjustment to account for the severity in the different years. What we've done is to supply our self-insured medical claim data and all our disability data to Hewitt Associates who puts the data in a database. We have an on-line system that we access. Part of Hewitt's cleanup and grouping of the data is to take the claims and group them into episode treatment groups that are International Classification of Diseases–9th Revision related and actually assign a severity weighting for these different episode treatment groups.

We took the actual price of the STD episodes and divided by the severity weighting by clinical class to try to normalize the price. We still had some rather good results over the two-year time period, and in total, the average normalized price in 1994 was about $2,600, and it dropped to $2,250 in 1996, which is about a 15% savings.

In the STD durations by some major clinical classes (in calendar year days) there has been significant savings over the past two years also. In 1994, in total, our average duration was 41.8 days, and by 1996 that had dropped to 27.8 days, which is about a 34% savings.

We took the three years of data and developed a typical expected duration for the Pitney Bowes population by clinical class. We then developed an expected duration for each of the three years and divided those by this typical expected duration to come up with a case mix adjustment. We then took the actual durations divided by the case mix adjustment and felt that we could normalize the data that way. By taking a look at our total durations using this methodology in 1994, the average duration for all clinical classes was 43.6 days, and in 1996 it had dropped to 25.7 days. That was about a 41% savings. I'd be most interested in hearing from anybody about some other ways that we could adjust our data for case mix.

A couple of the things we've done in the disability department to link with our wellness programs is to take a look at our data and see where the high incidences are. In 1995, we noticed that there was a rather high incidence of mental health claims with over half of them being depression related. We identified the need for education and earlier treatment of depression disorders and developed a program.

We worked with Pfizer to develop a pilot program in Fairfield County where we delivered 3,000 seminars to our employees. We took a random sample of 500 employees from our population and asked them a series of questions. We were trying to gauge the incidence of depressive disorders in the workplace. We found out that about 14% of employees potentially suffered from depression. We delivered these seminars to give the employees an overview of clinical depression, the signs and symptoms, what managers can do to support the clinically depressed employee, and, very importantly, a referral to the employee assistance program. We then did a second survey six months later with another random sample of 500 employees to try to see whether the program had been effective. We believe we have increased the perception of the long-term problem of depression. We've increased the awareness of the resources employees have to call on. We've increased the perception of the effectiveness of treating depression, and we've also increased the usage of our employee assistance program.

Another area we looked at is our maternity claims. We couldn't help but notice that we had a high incidence of neonatal births with a health care cost-per-day about four times higher than those of a normal baby. We also had a very high incidence of C-sections. So what we did was develop a health pregnancy program that would follow a woman through the maternity-related stages to try to achieve better outcomes. The tools we used here were two risk assessments, a clinical summary of significant conditions that's sent to the treating physician, and written educational materials.

On a monthly basis we send out educational materials to women that are appropriate for the month that their pregnancy is. We also have high-risk case management telephonic nurse consulting and what's very important is there is a strong link to the disability department. We incent the employees and spouses to enroll in the program and do two risk assessments throughout the pregnancy.

The employees are either identified as low risk or high risk, and typically if a woman is identified as low risk, the pregnancy progresses. They go out on STD and eventually return to work. What happens sometimes is that those low risks become high risks, and they kind of fall through the cracks of health care case management. When we identify that a low-risk pregnancy has become a high-risk pregnancy, we loop it back into the health care plan and make sure that the woman has the appropriate resources to help manage that pregnancy. The other thing that we did was to kind of tailor-make a tracking mechanism linked to the disability department so we can make sure that we're in step with the physicians in trying to modify the workplace or any transitional employment that the woman may need. We also modified the educational materials to include working during pregnancy, Family

Medical Leave Act material, and specific benefit information related to dependents when the final event occurs.

Just a couple quick words about our linkage with our workers' compensation program. Like any other workers' compensation program, we have a large preventative component of that. We spend a lot of time on ergonomic programs within Pitney Bowes. We also do quarterly claim reviews with our third party vendor. By taking a look at some of our high incidence over the past few years, because of our large field staff, about 20% of our claims were auto related. We developed an auto fleet safety program where we did some videos and some educational materials and sent them out to our field staff. We also do motor vehicle records checks every two years to make sure that the employees are maintaining safe auto records. We manage our workers' compensation claims from the first day out. I have a shared objective with the risk manager of the workers' compensation program, as I mentioned, to develop a workers' compensation network in the state of Connecticut.

On the demand management side, we have the large flexible benefits package that I mentioned. We use various media communications to educate our employees. On the efficiency side, we've done exclusive provider organization studies in Connecticut to try to identify the providers who use resources most efficiently. We measured the cost of inpatient and outpatient services by different diagnostic clusters, adjusted for severity and comorbid conditions. We actually came up with a ranking of the most efficient providers and then worked with our health care administrator in Connecticut to manage an exclusive network of these most efficient providers. On our employer design, it's achieved through our network management as well as coalition participation. The director of our health care planning area chairs the Southern Fairfield County Coalition group.

Let's discuss some of the critical success factors. One is partnerships that we've developed not only with our employees and our internal resources but also with our external vendors. We want them to focus on quality care as well as cost management. We believe we take a holistic approach to health care management through prevention, work site, and health care plan integration. I have some quick figures on our health care costs. We've been able to achieve about a 23% reduction in the average cost-per-employee since 1993. Now I'd like to turn the program over to Janna.

Ms. Janna L. Rogers: If you heard Dr. Hickman's opening session (Palm Desert Session 1GS) on the old age crisis, you heard about Adam Smith, who was talking about productivity as far back as 1776, and, of course, we're still talking about it. Dr. Hickman concluded that we needed to use mixed labor force strategies and that

was going to be optimized in the future. We are currently using those types of strategies. He challenged us to extend ourselves and to use those strategies.

Although we're really far from a corporate old-age crisis (the average age of the employees at Federal Express is 37), we have focused on productivity and human capital as key resources. I'll tell you a little bit about managed disability at FedEx and its impact on productivity.

I'd like to tell you a little bit about FedEx. We're headquartered in Memphis, Tennessee, which is better known, I guess, for Elvis and barbecue. FedEx is the major employer in the city of Memphis as well as the state of Tennessee. FedEx is the world's largest transportation company, and we provide fast and reliable services for more than 2.7 million items each day to 211 countries. We have over 40,000 drop-off boxes. We have over 127,000 people who operate an integrated global network of over 560 airplanes, 38,000 vehicles, and over 500,000 automated shipping systems.

About 60,000 of our employees are full-time and are eligible for both STD and LTD benefits. Our corporate philosophy at Federal Express is people-service-profit. What that means is if you take care of the people (our employees), they'll deliver the service to make us a profitable company, and, in turn, the profit is shared with the employees in terms of profit-sharing and benefits and is put back into the company through the purchase of planes and delivery of the types of service that the industry needs.

We actually began looking at disability management back in the 1980s at FedEx, and we began in workers' compensation by adding case management as early as 1983. By 1985 employee benefits had added RNs to their staff to review disability claims. Not long after that, we also began a nurse review of medical claims and we began catastrophic case management, which was an addition to the disability management. Therefore, we created a review of the total episode of care regardless of whether that was occupational injury or nonoccupational injury.

We did a modified duty program as early as 1985, and at that time that was a little bit unknown. It was a voluntary return-to-work program, and that was for employees who had some temporary restrictions and limitations from doing their jobs. We had a rehabilitated employee placement program. It wasn't your full-fledged vocational rehab that you would think you'd see in workers' compensation; it was an income replacement program for up to two years for people who were placed in jobs with permanent restrictions and limitations. It's somewhat of a bridge program.

We also looked and focused our efforts on cost containment in that period of time, and we implemented a mosaic PPO network in workers' compensation. We did that through our contractual arrangements with vendors. We also got into utilization management on the workers' compensation side by doing hospital precertification and continued stay review for work-related injuries. We also had a medical bill review program and checked out the charges. We began focusing on lost time and the loss in productivity and possible solutions to integration of occupational and nonoccupational disability. In other words, we're looking at it as a true single event, (even though the employee might have both benefits—the workers' compensation benefit and an ERISA STD or LTD benefit).

We began with a task force that was composed of vice presidents and managing directors who formally met to talk about lost time, how it's impacting human capital and productivity at the company. From the very beginning, we saw all of the departments joining in and taking ownership for this problem of lost time and the impact of disability and what it was doing to their operations and how that impacted delivery of a package on time and that type of thing.

We also began a strategic focus on outsourcing; we've insourced and we've outsourced. We've done a little bit of all of it. We're currently outsourced on our STD benefits. Those had traditionally been done in the benefits department at Federal Express, but we have moved to a vendor for that. For a number of years our LTD plans had been with an external vendor, but what we were looking for and found in a vendor was a managed disability program. It goes back to the clinical review that Al was talking about in having 100% physician review and searching for that seamless interface between STD and LTD. You don't want it to be apparent to your employees who are out on leave.

In the early 1990s, we developed a corporate productivity strategy, and again, it was a multidivisional task force. We asked people from benefits, workers' compensation, safety, personnel, and the legal departments, and even some of our vendors to participate. We came out with an entire strategy for us to move into in terms of lost time and productivity. Other changes that you saw as a result of that strategic focus is that we had added a provision to our benefit plans, the STD and LTD. That was a lump-sum payment to employees on disability plans which was the present value of their remaining disability benefits, and that's total disability from their own occupation. It was given if the employee was unable to perform his or her occupation and had reached a "maximum" medical improvement. That's a term you'll hear a lot in the workers' compensation arena. So we really began gearing our program toward that clinical definition as well.

We also implemented a program, and it was called the Human Capital Management Program. There were several features to that program. In fact, we dedicated a managing director to the program to enforce our strategy that this is a corporate-owned, multidivision-owned policy and program.

We looked at our medical leave policy because we had to structure those so that they supported a mandatory return to work if there were restrictions and limitations that were appropriate. We looked at our personnel policies and employment status, and that gets into that HR portion again that the other two panelists have talked about, that it all has to march together. You have to address their employment status and what's going on with HR as well as their benefits at the same time. We also did a massive management training program that was a one-day required training on policies and procedures with this new roll-out of human capital. We implemented a temporary return-to-work program somewhat similar to modified duty, but it was, again, for employees with temporary restrictions. We had to be very specific about the amount of time that we could put an employee into a modified or "restricted" capacity. If you'll recall, at about that time, large employers were extremely concerned with how the ADA was going to be interpreted and applied to their corporations. So we made certain that the jobs for those employees, and temporary restrictions were strict time periods. We put a cap of 90 days on the period of time that the individual could work in that.

We established a corporate human capital management committee, and that was to facilitate cross-divisional placement of employees with restrictions and limitations that were permanent. In other words, if it was a courier, and he could no longer drive a vehicle or lift the weight that was required for that particular position, this committee, if all else failed, would look at cross-divisional placement and recommend that to the directors and vice presidents. This committee also looked at requests for permanent accommodations, and, again, that's an ADA issue.

As another portion of the corporate strategy we created a position called leave-of-absence managers. They're actually becoming their manager, and they maintain a close contact with those individuals. They coordinate the return to work, in particular, if there are restrictions and limitations, and they find that the employee can return in a modified type capacity. Those individuals have a dotted-line reporting relationship to not only their operating division but also to that managing director of the human capital program.

We have identified a number of factors as predictors of lost time, and some of these have been heard before. The following were predictors of lost time: disciplinary actions in the previous year, sick time taken in the previous year, geographical location, the division that the employee worked in and their job type, (whether they

were a pilot or a courier or possibly even a computer genius who's creating our new software programs for the Internet), and finally, the gender of the individual.

In looking at the paid time lost, we find that 32% of the paid lost time is due to health-related issues. Disability is at 18.4% and sick pay is at 13.7%. We also find in terms of hours of lost time that over 40% are due to health-related issues. We've established some monthly metrics for this type of program and some corporate target goals on productivity.

We can track the effectiveness of the Human Capital Management Program. The metric for the medical leaves per 100 employees is actually the "people" portion of our measurement. For example, in April, we were just over our corporate goal of 59 days for the average duration of medical leave per 100 employees. Our corporate goal of days lost in the month is 75 per 100 employees. In April we came in over our target at 76.6 per hundred. This is the "time" portion of our measurement, and if you notice, there has been a slow decline in the average days lost.

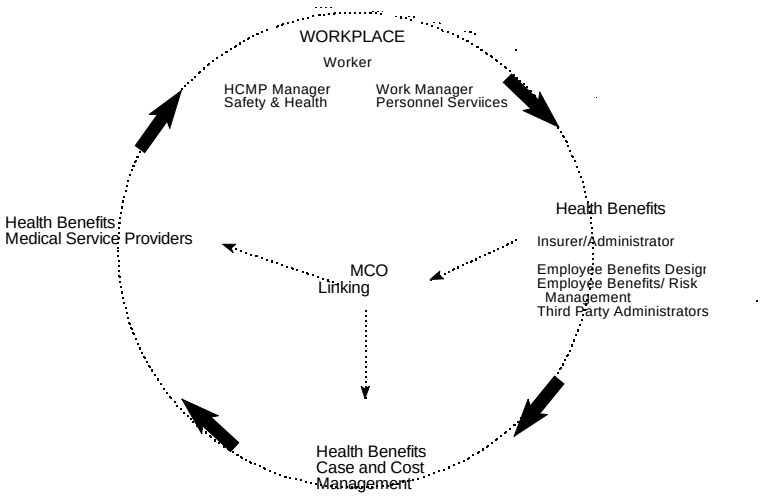
Let's discuss the temporary return-to-work component of the program. There were 16,054 days worked in a temporary return-to-work capacity in April, and that was out of a total of almost 500 leaves of absence. Temporary return to work was used in almost 36% of the lost days because of absence that month. There was a strong increase in temporary return-to-work utilization in the corporation, exceeding our target of 24% by almost 12%.

The model in Chart 1 is a really good representation. At the top is the worker in the work place. You have the human capital, the manager, your safety and health, your actual reporting manager, your personnel, and all of those policies. You have your providers that are doing all your services, your hospitals and physicians and labs. On the opposite side, you have your insurer for your fully insured products, or your TPAs, and overall the whole spectrum will make up your case and cost management program. But what links all of these programs? What is the future, and what are we looking at in terms of where we are headed now?

There are not many vendors in the market that have what we're looking for in terms of integrated products. This is your managed care organization (MCO), and that's the common link between all of these different sides. We're investigating what common ground we can reach in terms of that area as far as linking workers' compensation, disability, health, and all of that. It seems that the answer is lying with those networks and that MCO.

I'm not certain how all that will fit together. I think that's certainly the key in the future. That seems to be where the common ground is. It looks like managed care is here to stay, and I think that's probably where we may be headed or see the market headed.

CHART 1
HEALTH BENEFITS MANAGEMENT CONTINUUM



In conclusion, my advice is keep your eye on the industry. When I saw the title for this session, "Managed Disability in Action," I thought it was appropriate because it is truly moving very fast. Again, the vendor market is not where the large employer needs it to be in terms of those integrated products, but there's certainly many concepts and product opportunities out there. So we're truly in action.

Ms. Cathy M. O'Bright: All of you seem to be working for multinational or international companies, and you're doing a great deal of work as far as disability management and cost containment locally at your head offices. I wanted to know whether you have taken that concept and translated it into your benefits that you're providing for your subsidiaries outside of the U.S.?

Mr. Daniels: Well, I'll take a shot at it to begin with because the question has been raised internally in our own organization. Obviously, there are some difficulties when you have 800 lines in the U.S. We have all of our experience with the U.S. medical care system. The quick answer to your question is we haven't figured out a way that we can use our flexible benefit menu, telephone menu, and 800 line to incorporate medical episodes that occur in Italy or in Guam or some of those other places. The challenge has been put on the table for us to start to take some of these

programs and move them out internationally. I've looked at the possibilities, which are somewhat daunting because in Europe many of the benefits are statutorily driven. We're trying to look at some of our statutory benefits in this country and how we manage them, particularly along the workers' compensation side and so forth. Maybe there is an opportunity in some of those sites overseas where we have consolidated a number of our divisions into one business operating unit. We might be able to start to employ some of the managed concepts with at least those small populations. It's not a good answer, but obviously you're anticipating some of the things that we're anticipating as well.

Ms. O'Bright: I figured it would be very difficult. The benefits are very different in every country, and I just wanted to know whether you've tried to tackle that hurdle.

Ms. Rogers: Speaking for Federal Express, we're still finding it very difficult to even consider the concept of integration on domestic benefits, particularly in combining and integrating the work-related statutory requirements in each state and establishing networks. I think some of that challenge comes in at the MCO and the bigger companies trying to establish those networks. We are nowhere near it domestically to even be thinking about it internationally yet.

Mr. Jonathan M. Nemeth: Janna, you said there was a lump-sum provision in your disability plan. Why did you put it in and how is it working? Obviously you each have made many changes to your programs, and there are problems from an external perspective, such as getting the right vendors, but have you run into much internal resistance in terms of different organizations within your corporation sort of resisting any changes because of loss in responsibilities?

Ms. Rogers: I did not go into the basic design of our plans, but basically it's one plan for all. All of our full-time workers have the same plan, and it applies for a pilot to a courier or to the secretary. If you're full-time, you have a 70% STD benefit for a maximum of 26 weeks, and then you have a 60% LTD benefit for up to two years from your own occupation. After that, you go into a total from any occ period, and that is to age 65. It's quite a lucrative benefit, and it's clinically driven.

What we were finding, though, is that individuals were staying out the maximum duration (the six months) and then taking the two years of the LTD. At the end of that period they were holding up their hands and saying, "What do I do now? Where do I go to work? I can't do my job anymore."

This was a more proactive way to address the employment status of those individuals that were permanently precluded from doing their jobs. It fits in with

the human capital program of addressing that early on. It's tied into that maximum medical improvement definition.

Our goal was actually to address that as early as employees knew that they could not return to their permanent jobs. They needed to begin looking for employment in the company that fit those restrictions or possibly terminate from the company. Federal Express goes just about everywhere in the U.S., but in places where the large populations are concentrated, most of the jobs are heavy lifting. If your preclusion is lifting, you're mostly out of the boat unless you want to move somewhere or take a tremendous salary change. We allow that provision for that present value payout so that the employee, if he or she chooses to leave Federal Express, can go back to school or choose another occupation and he or she would have that remaining benefit.

By establishing that maximum medical improvement, you are verifying that they clinically meet the definition of the plan for the remainder of their own occupational benefit. So, therefore, it was their benefit. You would not find in that category of lump-sum benefits anyone that would fall under the total disability category, like those with terminal or catastrophic illnesses, etc. This is more for those with the lifting preclusions, and it seems to be quite effective. I don't have any statistics with me, but it seems to work.

Mr. Hardin: So the benefit is the present value of something like two more years worth of benefits. The remaining part of those two years.

Ms. Rogers: Yes.

Mr. Hardin: The other part of the question was, as you do these things, do your people like it?

Ms. Bradley: We didn't see much internal resistance from the loss of responsibility because so much is done in-house. However, there was a lot of internal resistance from the employees because they don't like to be challenged about returning to work. They like to take a note from their doctors and have that be acceptable for paying out benefits. We need to continue to work with our population to change those paradigms. We also found some internal resistance from our on-site clinics. The nurses there must be able to step back from the role of the caregiver and take on a role of keeping employees at work and helping to return employees to work. I believe the topic of on-site clinicians coincides with what Al was mentioning as some of the barriers.

Mr. Lewis M. Borgenicht: You mentioned on-site clinics. Is that also insourced?

Ms. Bradley: Yes.

Mr. Borgenicht: One of our clients had an on-site clinic, but we actually changed that to an outsource situation with a major carrier so we could deal at arms' length with that carrier and put that carrier at risk. It's difficult to deal at arms' length, much less to put someone at risk when you're all under the same corporate roof and under the same payroll. That's one way we did overcome that problem.

Mr. Daniels mentioned the difficulty when your heart went cold and the vendor said we want you to help bring us over this hurdle of managed disability. I couldn't agree with you more. In fact, we're working on a focus group to basically lay out the bar in terms of coordinating the ideas and desires in this area of a number of large corporations. We hope one result will be that the vendor community can respond to that and try to reach as far as possible along that path because we recognize that there's a big shortfall right now in what vendors can do. However, I'm seeing a certain amount of insourcing here. I would vote for the solution to be outsourcing and put a vendor at risk in general so you can stick with the core competencies. You reach leaders in your field, and I would think that's the long-term approach. Are any of the companies up here anticipating that they will for the long term remain insourced?

Mr. Daniels: I don't want to speak for Mary, but let me make one, quick comment here. While we have outsourced to a vendor for our managed disability program, there's a very large component that still resides within our own company, and if you look at the dynamics of an individual disability claim, there are multiple people who touch it, but nobody owns it. I think that perhaps Mary can address this better than I can, but I know that because many people touch it and nobody owns it, it becomes very difficult to manage it. I suspect that's part of why Pitney Bowes decided to insource it. Once you've insourced it and centralized it, you have so many opportunities to do many things. We had it insourced, but we had it at multiple locations, so we had no control over it. We looked very carefully at insourcing it and centralizing it versus centralizing it and outsourcing it, and both of those are very viable alternatives.

On the managed disability side, we found that occupational health nurses at particular sites found it very difficult to make disability determinations on fellow employees, irrespective of the objectivity of the evidence. In those instances where objectivity said this person's not impaired from performing the duties of their job, they were still disinclined to challenge the employee's attending physician and say this is not a payable disability under the definition of our plan. We do get resistance within our own organization.

Employees think of disability, with a lowercase d. We think of disability with an uppercase D, as it's defined under ERISA plans, where it has a specific legal definition. Employees don't think of disability that way, and we're constantly challenged with, "My doctor said I was disabled. Why am I not getting the paid benefit?" We do get a lot of resistance on that.

As I've told my boss, disability benefits are not something that employees get warm and fuzzy about, which is in opposition to the retirement benefit or the 401(k) savings plans or retirement plans. This is a tough benefit to administer because, even in the best of circumstances, employees are in an untoward medical condition.

Mr. Borgenicht: You mentioned ERISA. I mean when you do certain things in-house in this area you're a fiduciary under ERISA. There's a clear legal liability, and that's something that the corporation obviously at the most senior level needs to buy into. It only takes one or two poorly publicized situations to make some people really afraid of that in-house. Has any of that occurred as yet?

Mr. Hardin: I'd like to give Mary the last word on the in source/outsource question because she really is the in source expert up here. Tell us what Pitney Bowes is thinking.

Ms. Bradley: Pitney Bowes is thinking that it would love to have disability management in the long term under the health care management umbrella, but we haven't found the appropriate partners to work with to develop that product for us. Right now the insourcing is working in disability management, and as we can identify vendors that will take on the health care management and disability management and potentially the workers' compensation management, we would look at them.