

Health and productivity connections:

An employer's guide to managing lost time

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What is the Big Deal about lost time?

The fact is, lost time costs. Unscheduled absences disrupt productivity and have a financial impact on both employers and employees. The average absenteeism rate is reported to be 2.3% of the workforce— at the cost of \$660 per employee per year.¹ The average healthcare premium cost per employee is \$7,009.² Lost time and healthcare costs are connected³ and are on the rise. But in the end, the issue is time lost on the job and the subsequent productivity impact due to an injury or illness.

The complexity of administering lost time benefits is not just in the accurate and timely processing of the claim but managing the post injury or illness return to work expectations of the employee, the supervisor/manager and the physician. The eventual impact of an injury or illness on the employee's productivity also extends beyond medical care and recovery but lies within the work expectations created by various corporate policies, practices, as well as benefit and entitlement programs.

A unique employee / employer relationship was created by the enactment of the Family Medical Leave Act (FML) in 1993. The FML Act requires the employer to protect the job of the employee during a maximum of 12 weeks per year of unpaid leave. While there are many options and configurations of the protected 12 weeks, the leave can be used for any combination of personal and family health reasons or part of the adjustment process for adoptive or birth parents. The movement individuals make from FML claims to other benefit programs, such as short-term disability, is unexplored. By understanding the transitions and movement from within and between benefit programs the employer is able to offer both support and resources to protect the productivity of the employee.

This guide to managing lost time invites employers, healthcare providers and insurance professionals to partner in:

- protecting employee productivity
- managing the impact of lost time
- influencing the utilization and cost of health care

Data for this publication, unless otherwise referenced, was generated using UnumProvident's disability database, the leading private disability database in the nation.

It's about time

Figure 1 illustrates the crucial points where employers and their lost time management partners can:

- continue productivity;
- offer a timely return to work; or
- promote an extended absence.

At each of these decision points, employers and employees make critical decisions that forge the health and productivity patterns of the organization. Each work and benefit decision represents an opportunity for timely action. Managing each step effectively has shown to be a cornerstone of maintaining a safe and productive workplace.⁴

Managing lost time is complex, but achievable. Knowing who and what drives lost time within an organization is essential. The way an organization manages lost time represents a set of behaviors of the employee and the employer. Each can be modified, reinforced by a set of corporate beliefs and data that illustrate the relative impact on the organization.

Lost time is influenced by a complex set of factors that include:

- **timing** – the onset of medical problems in the context of an employee's work and family life
- **incentives** – economic incentives that support productivity during temporary medical and functional capacity problems
- **corporate culture and commitment** – resources available and attitudes in the corporate culture related to solving health and productivity issues
- **medical advice** – patterns in the physician's practice that either encourage or discourage continued productivity
- **legislation** – how federal and state laws define the eligibility and use of benefit programs within the context of an employee's work and family life

Impact and myth Determining the impact of various types of lost time benefit programs is the first step in managing lost time. One of the more common lost time myths is that work-related injuries (i.e., workers' compensation benefits) are more expensive and have a greater impact on productivity than non-work-related lost time events.

Fig. 1 – Lost time progression

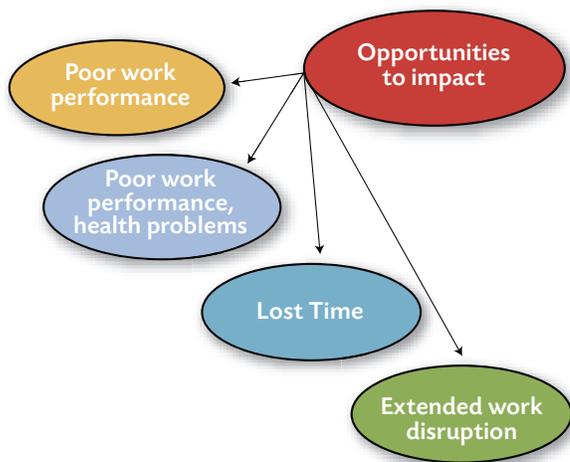
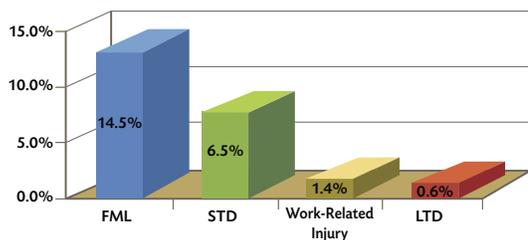


Fig. 2 – Incidences of benefit types



FML Source: Employment Policy Foundation Analysis of EPF FMLA Survey.

STD and LTD Source: JHA 2004 U.S. Group Disability Rate Study & Risk Management Survey, 2005.

Work-Related Injury Source: “Workplace Injuries and Illnesses in 2004”, Bureau of Labor Statistics, U.S. Department of Labor.

Fig. 3 – Annual Health Costs
(as a percentage of payrolls)

Medical Costs	2002	2004
Direct Costs		
Medical	10.0 %	10.0 %
Sick Leave	1.0 %	1.9 %
Worker’s Compensation	1.1 %	1.2 %
Short Term Disability	1.0 %	1.0 %
Long Term Disability	.5 %	.5 %
Health Improvement Programs	N/A	1.0 %
Indirect Costs		
Overtime	3.0 %	3.4 %
Work Site Modifications	1.0 %	1.0 %
Replacement Workers	3.0 %	2.0%
Total	20.5 %	22.0 %

Source: Watson Wyatt Staying @ Work 2005

Figures 2 and 3 show reference points for understanding the relative impact of various types of lost time.

Family Medical Leave is the leading lost time benefit used, with STD and LTD claims much more common in incidence than work-related injury claims.

Non-work related lost time makes up a greater percentage of direct and indirect payroll costs than work-related lost time. This encourages employers to re-examine a commonly-held risk management myth; that work-related injuries and illness have more impact on costs and productivity than non-work related injuries or illness.

The first health and productivity connection is for employers to balance their lost time management strategy between work-related and non-work-related events.

Motivation for continued productivity Understanding employees’ motivation to work during and following a medical problem is another key step in lost time management.

Too often, employers question an employee’s work motivation when there seems to be an unexpected delay in returning to work. When this happens, the lost-time behavior is explained by a combination of medical events that reduce the potential for a return to work or to the other extreme, as a character flaw on the employee’s part.

Work motivation is not a simple “yes I am” or “no I am not” coming back to work. It’s an interplay between (Figure 4):

- the value a person places on being at work;
- his or her perceived ability to successfully continue to work; and
- the costs of returning or not returning to work.

Fig. 4 – Work motivation

$$\text{Motivation} = f \left(\frac{V \times \text{Pos}}{C} \right)$$

V = Value of task
 Pos = Perceived Success of Achieving a Positive Outcome
 C = Cost of tasks

Understanding where an employee is within these three areas provides practical intervention points for employers and human resource managers to change lost time behavior. If the value of work for the employee is low, increasing job satisfaction may lead to decreased lost time. Creating incentives to stay at work and improving the employee’s sense of ability to work can improve work capacity. Current research supports the notion that an untimely or delayed resumption of work is based on a myriad of interpersonal and employee relations.^{5,6,7}

Drivers of lost time

Fig. 5 – Presenteeism: patterns of productivity disruption

Condition	Prevalence	Average productivity loss	Aggregate annual loss
Migraine	12.0%	4.9%	\$434,385
Arthritis	19.7	5.9	865,530
Chronic lower-back pain (without leg pain)	21.3	5.5	858,825
Allergies or sinus trouble	59.8	4.1	1,809,945
Asthma	6.8	5.2	259,740
GERD (acid reflux disease)	15.2	5.2	82,660
Dermatitis or other skin condition	16.1	5.2	610,740
Flu in the past two weeks	17.5	4.7	607,005
Depression	13.9	7.6	786,600

Prevalence = % of ee's reporting condition

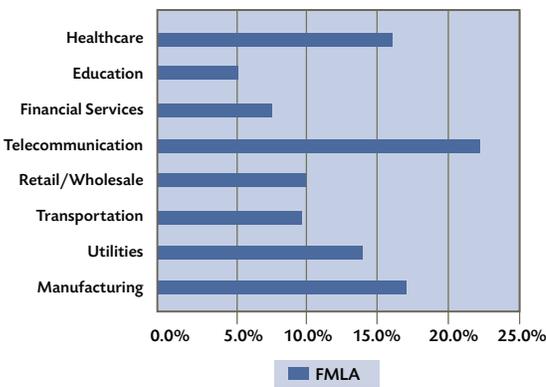
Ambiguous Impairments

High Scores

Source: D. Lerner, W.H. Rogers, and H. Chang, Tufts-New England Medical Center, 2004.

Lockheed Martin Study – Harvard Business Review, October 2004.

Fig. 6 – Percentage of employees who took FMLA by industry



Source: Employment Policy Foundation Analysis of EPF FMLA Survey, 2004.

There are numerous testimonials, some legendary, about employees who returned to work in near-miraculous time following catastrophic health events. Yet, for each of these successes, there are other reports of employees with minor health problems who are unable to resume any work activities. This leaves the medical provider, employer and insurance partners often bewildered.

Research suggests that all lost time is connected— lost time doesn't occur in a vacuum or in isolated benefit silos. Lost time is influenced by combinations of organizational and personal factors. Likewise, the availability of benefits and the nature, scope and context of the injury or illness play a part.

Paradoxically, returning to work starts before going off work. A lost time event is not the beginning or the end, but a point in time. When the employee's work is disrupted due to a chronic emotional or physical condition (e.g., depression, back pain), the onset of the symptoms has often presented over time as an emerging personal health, family or employee relations problem. This is referred to as presenteeism.

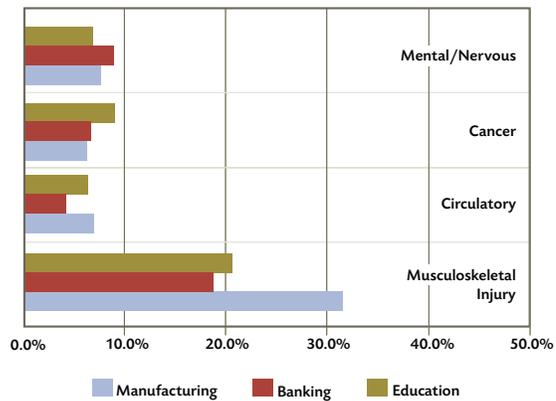
The prevalence of work-disrupting, but not medically-disabling conditions, presented in Figure 5 highlights the common starting points of many disability claims.

Debra Lerner's study provides a snapshot of the range of health problems that erode daily productivity.⁸ Most important is how impairment patterns begin as an FML claim and progress to STD/LTD or workers' compensation (WC) claims.

While the acute onset of an injury or illness may not always be predictable, characteristics like job satisfaction, benefit plans and worksite accommodations are key influencers on the rate and pace of a return to full productivity.^{9, 10 11, 12, 13}

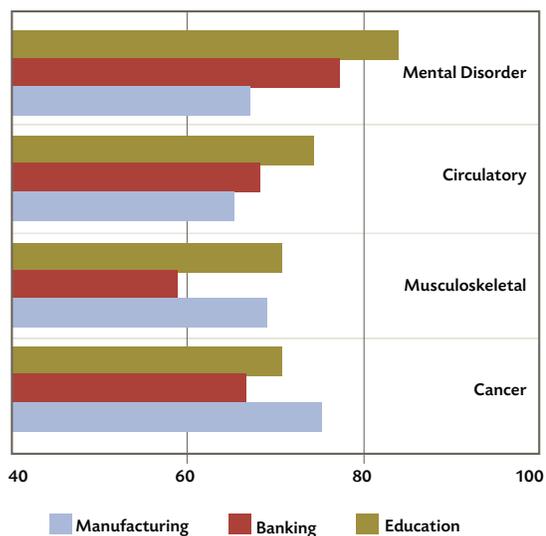
Figure 6 illustrates the reported use of the FMLA benefit by industry. Different industries have different lost time patterns. It's important that business leaders in these industries understand how the work, organization and workforce invite different levels of benefit utilization. Telecommunications leads FMLA benefit usage with healthcare and manufacturing a distant second and third, respectively.

Fig. 7 – Variation of STD claim frequency by industry



Source: UnumProvident Disability Claims Database, 2005.

Fig. 8 – Short term disability duration of impairment



Source: UnumProvident Disability Claims Database, 2005.

Figures 7 and 8 illustrate the variation of STD claim frequency and duration by selected industries. In manufacturing, the leading cause of lost time is musculoskeletal-related problems. Banking and education see a similar pattern with cancer and mental/nervous disorders. But, the length of time off work for mental disorders varies significantly by industry. Again, what drives the variations in lost time?

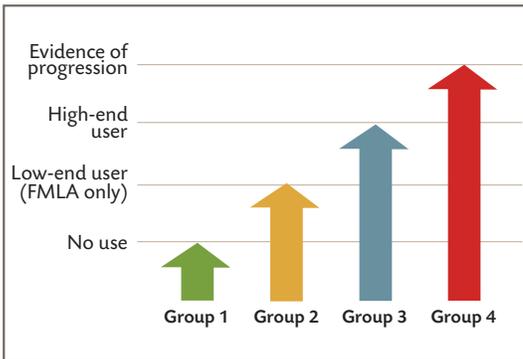
To understand the drivers, it's important that employers define the unique patterns of lost time events in their respective workforce. It is also valuable to understand what extends a lost time event beyond expectations or what drives the claim beyond its FML starting point.

Summary of lost time drivers

- **Body Mass Index (BMI)** contributes to lost-time related to chronic disease and work-related injuries. Excessive weight is connected to increased levels of chronic disease, increased musculoskeletal disorders and reduced work capacity related to endurance, strength and flexibility.¹⁴
- **The older worker** has a lower incidence of work-related injury and a lower rate of short-term disability. But older workers experiences a longer length of time off when they do go off work. The older worker demonstrates a lower level of depression and fewer overall behavioral health impairments.¹⁵
- **Job satisfaction** is a critical factor in lost time and benefit use. The employee's prediction of "if" and "when" they will return to work has been demonstrated to be the best indicator of success.¹⁶
- **Corporate policies**, worksite flexibility and physician practices interact to invite either a timely return to work, or unnecessary extended lost time. Corporate policies that emphasize a timely return to work for individuals with work-related injuries at the expense of individuals with non-work-related injuries/illness will have greater lost time. Likewise, employers who do not support transitions out or back to work create a greater impact on productivity.^{17, 18}
- **Economic incentives** and entitlements appear to push lost time beyond what is expected for healing and for work transitions. The watershed level of incentives appears to be at 70% wage replacement. That is, wage replacement over 70% increases lost time and below 70% reduces lost time. The key factor here is the number of individuals with lower wage replacement coming back to work prematurely.¹⁹

The FML to STD connection: an empirical study

Fig. 9 – FML study groups



Source: UnumProvident Disability Claims Database, 2005.

Fig. 10 – FML/disability claim by group and year

Year	Group 1	Group 2	Group 3	Group 4	Total
2001	5,335	84	112	230	5,761
2002	21,301	798	129	1,699	23,927
2003	50,639	1,845	354	4,437	57,275
2004	51,172	1,907	371	4,047	57,497
Total	128,447	4,634	966	10,413	144,460
	89%	3%	.6%	7%	100%

Group 1: No Disability or Leaves

Group 2: Just FML – No Disability

Group 3: High FML – With Disability Progression

Group 4: Low FML With Disability Progression

Source: UnumProvident Disability Claims Database, 2005.

Fig. 11 – Approved claims by year and type

Year	FMLA	STD	LTD	WC Indemnity
2001	343	306	29	48
2002	3,061	1,937	48	141
2003	7,740	5,278	240	260
2004	7,625	4,784	68	189
Total	18,769	12,305	385	638

Source: UnumProvident Disability Claims Database, 2005.

While much is written about Family and Medical Leave (FML) administration and compliance, little is known regarding the use of this leave and its relationship to other lost time benefit programs.

Because little has been documented on FML and its relationship to other benefit programs, UnumProvident has analyzed the progression of lost time from intermittent FML through short and long term disability benefits. The results show a link between claim type, claimant demographics and the progression of an FML claim to a short term disability, workers' compensation or long term disability claim.

Study population

Lost-time data from six UnumProvident integrated disability management clients was matched with a control group for employer size, industry and benefit plans:

- 144,460 lives
- six employers (three manufacturers, one call center, one healthcare organization, one financial institution)

Methodology

- **Time Frame:** 2002-2004. Employees were included in the database once for each year they were eligible, and for which data were available.
- **Definition:** FML leaves were considered to have progressed if the employee had a subsequent disability claim within six months of the FML claim.

Four employee groups were studied:

- Group 1- employees with no lost time
- Group 2- employees with < two FML claims and no STD or WC claims
- Group 3- employees with two or more FML claims and progression on to STD or WC
- Group 4- employees with < two FML claims and a progression on to STD or WC
- **Analysis:** A logistic regression analysis was used to determine which factors influenced the likelihood of an employee filing:
 - an intermittent FML leave;
 - FML leave, and
 - an FML claim that progressed to a STD, LTD, or WC claim.
- The research pool of 144,460 employees generated 32,097 lost-time claims (4.5/1000 employees):
 - 18,769 FML claims (59%)
 - 12,305 STD claims (38%)
 - 305 LTD claims (1%)
 - 638 WC claims (2%)
- 89% of the participating individuals did not file a lost-time event during the study period

Fig. 12 – Approved FML leaves by year and type

Reason	2001	2002	2003	2004	Total - %
Child health	3	97	347	303	750 - 4%
Employee health	221	2,040	5,224	4,982	12,467- 66%
Maternity	101	688	1,411	1,057	3,042 - 16%
Parent health	8	117	337	358	820 - 4%
Parent in law	0	0	0	0	0 - 0%
Pregnancy related	0	0	6	588	594 - 4%
Spouse health	7	102	333	268	720 - 4%

Employee Health	66%
Maternity/Paternity/Pregnancy	20%
Child/Elder Care	12%
Mother-in-Law care	0%

Source: UnumProvident Disability Claims Database, 2005.

Fig. 13 – Medical diagnostic descriptions by group

MDC Description	Group 3		Group 4	
	#	%	#	%
Complications of pregnancy and childbirth	112	17%	2,470	20%
Diseases of musculoskeletal and injury	145	23%	3,024	24%
Diseases of respiratory system	36	6%	774	6%
Malignant neoplasm	21	3%	579	5%
Behavioral health/mental disorder	99	15%	1,095	9%
Ill-defined medical and health conditions	55	8%	727	6%

• Complications of pregnancy and childbirth – 17% and 20% of lost time
• Musculoskeletal and injury – 23% and 24% of lost time
• Behavioral health impairments – 15% and 9% of lost time

Source: UnumProvident Disability Claims Database, 2005.

Fig. 14 – Predictors of disability following FML (family)

Issued claims	Number	Percentage
FMLA claims	13,456	
Family FMLA claims	2,302	17%
Family FMLA claims followed by STD or WC	213	9%



Source: UnumProvident Disability Claims Database, 2005.

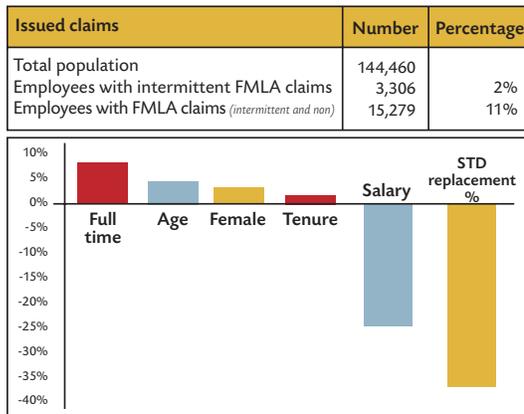
Principle findings

- Lost time was impacted by:
 - Benefit replacement ratio—Duration averages were at least 20% higher than normal when there was 100% income replacement.
 - Age and STD replacement—Increases in the employee’s age and the initial STD replacement percent were associated with increased disability indemnity costs.
- Family-related FML leave utilization and progression to STD claim
 - 17% of all FML leaves were family related
 - 9% of family leaves were followed by either an STD or WC leave in six months
 - being older or female increased the likelihood of a family-related FMLA leave progression
 - increases in salary and STD elimination periods decreased the likelihood of a family-related FML leave progressing
- Intermittent FML leave utilization and progression
 - 2% of the employee study group (144,480 employees) used intermittent FML
 - 19% of all FML leaves were intermittent leaves
 - 28% of those intermittent leaves progressed to other types of claims
- STD plan policies and intermittent FML leave
 - increases in full-time status and age, and being female increased the likelihood of an employee taking an intermittent FML leave
 - increases in initial STD replacement percent and salary decreased the likelihood of an employee taking an intermittent FML leave

Recommendations for effective administration:

- Take a close look at your benefit program mix and your policies relating to PTO, STD, stay-at-work, return to work and workers’ compensation. You may be unintentionally reinforcing lost time.
- Develop consistent tracking and reporting, especially for unscheduled time off. Defining weekly and monthly patterns by department, supervisors, employee age, gender and types of health conditions provides a set of data to support the application of various resources to interested employees
- Allow for only a limited time and use for employee sickness (e.g., five working days) before formal review and certification is required.
- Consider instituting a process where PTO days are used and not replenished for incidental time off.
- Performance manage patterns of lost time that may indicate emerging productivity problems, possibly including the use of unprotected unscheduled time off.
- Develop connections between employee assistance programs, work-life balance services and FML processes that focus on the impact of emerging stress and fatigue related to care of sick family member.

Fig. 15 – FML intermittent use



Source: UnumProvident disability claims database, 2005.

Fig. 16 – Return on investment of FML and STD integration

Metrics	Customers with FML services integrated with STD/LTD administration	Customers with STD/LTD services only	Difference	
			Value	%
Average (Mean) work days per STD claim	32.9	42.3	-9.4	-22%
Median work days per STD claim	28.0	31.0	-3.0	-10%
FML Claims per 1000 employees	133	N/A	N/A	
STD Claims per 1000 employees	83	73	10	+13%
Percent Repeat STD Claimants	12.2%	19.1%	6.9%	-36%
STC Claim Reporting Lag	2.9 days	7.8 days	4.9 days	-62%

1. All values include pregnancy claims.
 2. STD durations values were calculated using survival modeling techniques to adjust for the ratio of open to closed claims.
 3. LTD duration was not reported due to claim maturity issues.
 4. Values based on 2004 experience.

The Progression of Family and Medical Leave to STD and LTD, UnumProvident database 2002-2004

Source: UnumProvident Corporation Lost Time Progression Study, 2005.

Recommendations for return to work planning:

- Develop return-to-work plans for individuals who are off work for periods of time determined to be an extended disruption of productivity. Common thresholds are 30-45 lost work days, with many 60-90 day leaves requiring a return-to-work plan.
- Implement a well-developed, planned process of work reengagement for impairments like heart attack, stroke, cancer and depression.

Your primary return-to-work strategy should be developing a safe, timely transition to full productivity. A full, optimal transition can occur between 30 to 45 days. Transitions should be in concert with the manager and attending physician, and be tailored to the employee and the job.

Return on investment (ROI): outcomes of the FML to STD research suggest a number of opportunities to improve the ROI of lost time management initiatives.

Best practices that pay off both for the employer and employee:

- Develop a benefit plan that connects the management of Family and Medical Leave with short term disability to reduce the delay in claims submission and to identify individuals with a high risk for repeat claims.
- Create worksite flexibility that allows for timely adjustments to the temporary disruption of changed work capacities.
- Implement employee assistance and disease management programs that may help reduce intermittent lost time and work disruptions related to behavioral health, family problems and cancer-related impairments.
- Use a focused lost time management program to reduce the number of STD claims that move to LTD. While reducing lost work days is an excellent barometer of success, an STD and LTD focus better meets employers' and employees' need to return to full productivity. The outcomes of managing FML and STD in a coordinated and integrated fashion are highlighted in Figure 16. The integrated FML/STD /LTD customers' lost time measures are different than those of a similar sample of UnumProvident customers who have a combined STD/LTD product.
- Initially, the average number of lost days per claim is different. The integrated FML/STD/LTD group shows 22% and 10% reductions in the mean and median number of lost days per STD claim. This represents a measurable reduction in lost time and increased productivity. Correspondingly, we see an increase in STD claims incidence in the integrated group. This suggests a timely transition to STD from the FML status. The study shows a well-defined pattern of increased movement to STD from FML based on income replacement levels. With the limits on managing a FML claim, the timely progression to STD offers the employer and lost time management partners to provide resources that will ultimately reduce the impact of the absence.
- The integration group showed reductions in repeat STD claims, as well as reduced claim reporting lag time. Both of these measures reinforce the notion that the ability to influence the claim to a positive outcome is based on timeliness and access. The STD management process allows the employer to be better prepared to support continued productivity during time of a health or family predicament. Each of the lost time metrics can be converted to actual dollars based on the employers' costs per day and FTE (full time equivalent position).

The health and productivity solution

Managing the lost time benefit connection starts with asking the right questions at the right time. When an employer asks, “When is my employee coming back to work?” It’s too late.

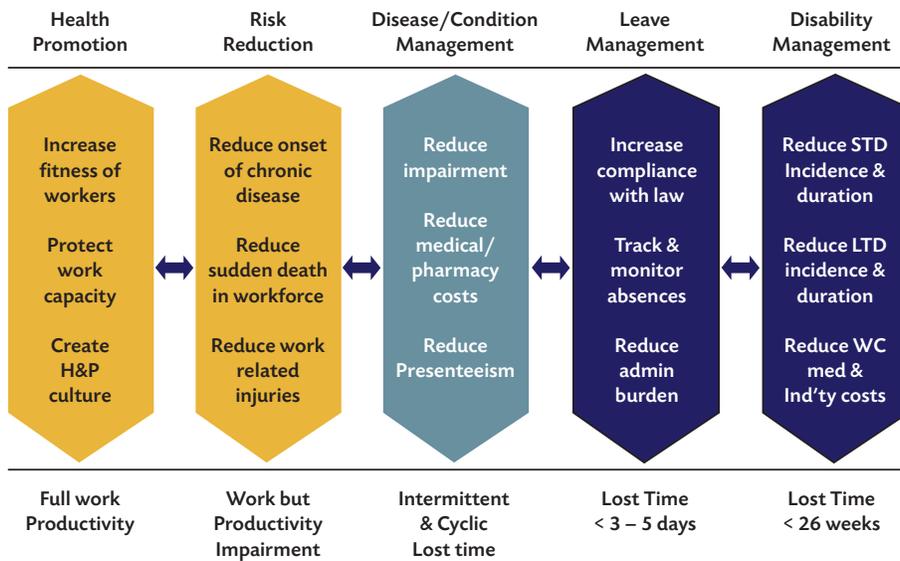
More relevant questions are:

- How can I keep my employee productive?
- How can my employee return to full productivity?

The “how” defines the “when.” The “how” produces the health and productivity solution.

Developing a health and productivity solution requires the employer to decide how and when resources should be used to support continued productivity.^{20, 21, 22} Figure 17 illustrates a health and productivity continuum that outlines the timely application of resources for both an employer and its partners— it’s up to the participating group to develop programs that fit workforce needs and corporate resources.

Fig. 17 – H&P Service Connections



Health promotion: Promoting healthy lifestyles is intuitive and practical. Recent reports point to the positive impact that health promotion has on lost time management. Likewise, investigations into healthcare costs have identified emerging issues such as:

- Who is responsible for the employee's health?
- What role should the employer play?

Clearly, employees bear responsibility for protecting their own health and well-being, while the employer is responsible for promoting a healthy, safe workplace. In most cases, the employer can be the catalyst that makes the difference.

The following health promotion features should be considered as part of any health and productivity program:

- **Identify health risks:** The advent of health risk assessments has created a timely, effective method of defining employee risk. The combination of self reporting and medical reviews offers a foundation for the employer and employee to make sound health decisions.
- **Employee education:** Using the Internet as a health education vehicle has revolutionized health education strategy. An employee can secure accurate, up-to-date information on medical conditions, outcomes of medical interventions, drug information, and other health and productivity connections.
- **Economic incentives and accessibility:** The cost and accessibility of healthcare are at the core of managing lost time. Current practices of offering financial incentives to participate in health risk assessments linked with onsite healthcare programs invites greater participation and improved outcomes.
- **Work capacity and job demands:** Physical work capacities include maintaining strength, flexibility and endurance to engage in productive work. The employer's ability to create a suitable match creates a safer workplace that can reduce symptoms and long-term work implications.

Risk reduction: Risk reduction pays. The employer can identify employees with health risks and help reduce that risk. The result is a clear health and productivity dividend. The following are key program features:

- **Avoid smoke and mirrors:** While many programs can have attractive brochures, outcome data is the only valid method to measure the value of a risk reduction program. It's critical to determine what health and lifestyle behaviors have changed and how those changes have affected health metrics (e.g., weight loss, lowered cholesterol and blood sugars).
- **Incentives and reinforcement:** Create clear incentives to start and reinforce risk reduction. These may be economic, through counseling with a therapist, or by worksite recognition.
- **Feedback:** Behavior changes are achieved through timely, clear feedback. Employees participating in a risk reduction program may benefit from appropriate measurement and recognition of success.

Disease/condition management: Reducing the impact of chronic disease is critical to controlling lost time and healthcare costs. Disease management programs in the following areas have reported positive financial outcomes:

- asthma
- depression
- cancer
- diabetes
- chronic pain

For disease management programs that focus on these areas, the primary impact has been a decrease in inpatient care and drug costs. While the industry has not yet defined the ROI for investing in these programs, 1.5 to 2.5 ROI's have been reported.

The cost of healthcare is intertwined with lost time. Figure 18 illustrates the current drivers of healthcare cost increases. This suggest discrete targets employers can address within their health plan and lost time management programs.

Fig. 18 – Healthcare Cost Pressures*

<ul style="list-style-type: none"> • Demographics – An aging population/work force with greater longevity 	(+ 1% annually)
<ul style="list-style-type: none"> • Emerging Technologies – New diagnostics and treatment, new devices, new medications 	(+ 2% annually)
<ul style="list-style-type: none"> • Change in Status of Drugs – Generic and OTC applications 	(- 0.5% annually)
<ul style="list-style-type: none"> • Mandated Benefits – Legislation affecting medical costs (e.g.. Colorado move from no fault auto insurance to tort system = +2.0% 	(+0.5% annually)
<ul style="list-style-type: none"> • Medical Price Inflation – 2.5% general inflation plus Medical inflation @ 3.5% 	(+ 6.0% annually)
<ul style="list-style-type: none"> • Baseline Utilization – Changes in patient behavior – Changes in provider behavior 	(+2.0% annually)
<ul style="list-style-type: none"> • Benefit Plan Changes – Risk and cost transfer to patient 	(- 2% annually)

* Reported by the American Academy of Actuaries, 2005 Rising Healthcare Cost Briefing

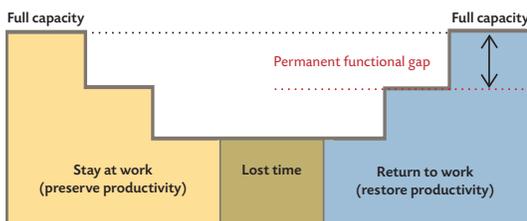
Leave management: Effective management and administration of Family Medical Leaves creates a sentinel effect at the start of any lost time event.

Likewise, the reported results of UnumProvident research suggests that coordinating a leave management program with short- and long-term disability management can result in measurable benefits for the employer.

Employee eligibility for FML:

- worked for employer for at least 12 months
- worked at least 1,250 hours during the prior 12 months (approximately 24 hours per week)
- worked at a location that employed at least 50 employees within a 75 mile radius

Fig. 19 – Transition in and out of work



Source: UnumProvident Corporation Lost time Progression Study, 2005 data.

Appropriate use of FMLA benefits:

- birth of a child, or placement of a child for adoption or foster care
- to care for the employee's parent, spouse or child who has a serious health condition
- for medical leave, if the employee is unable to work because of a serious health condition

Top five employer mistakes:

- granting FMLA leave for a serious health condition without first evaluating whether the employee/family member is incapacitated by it
- failing to ask employees enough detail about absences to determine if the absence is FMLA-covered
- failing to give written FMLA notice
- not keeping complete, accurate records of when FMLA time is used. As a consequence, employers may not legally discipline or terminate an employee for using FMLA time

Disability management: To influence the outcomes of short- and long-term disability claims:

- understand the impact of the impairment on employees' current and future work options
- pay special attention to employees' psychological adjustment and other influences on the return-to-work effort
- isolate corporate policies and practices that support or hinder a timely reengagement of full productivity
- create a defined plan for how the employee will resume work, including a transition through increased levels of work demands
- make sure the plan is an agreed-upon effort between the employer, employee and attending physician

Designing the health and productivity benefit plan—A health and productivity benefit should have the following features:

- health insurance benefits that are portable if employment status changes
- health insurance benefits as part of full or partial employment
- employee mobility within jobs or careers to meet changing needs and skills
- reduced or eliminated disenfranchisement of the worker or premature disengagement from the workplace by the employee
- employer avoids promoting the disenable worker syndrome

Measuring the health and productivity ROI

- **Baseline** - The employer must create a reference point or baseline to determine both the relative impact but the direction health and productivity metrics are moving. The baseline can be made up of a number of groups or constellations of data that illustrate practical applications. The constellations can be:

1. demographic profiles,
2. lost time patterns,
3. healthcare utilization and
4. interactions of the various patterns.

- **Qualitative** – Qualitative ROI illustrates the changes in process and efficiencies, customer satisfaction along with user benefits

- **Quantitative** – Quantitative ROI highlights the define ratio between resources investment in change and the measurable changes incurred through the changes

Fig. 20 – Cost and benefit of outsourcing leave management services

Sample company has 10,000 employees and an annual payroll of \$500 million. Incidental absence/sick days equal approximately 2%¹ of payroll or \$10 million.

	<i>Reduction in productivity costs associated with unscheduled absence</i>		
	3%	5%	7%
<i>Productivity savings</i> ²	\$ 300,000	\$ 500,000	\$ 700,000
<i>HR staff savings</i> ³	+ \$ 120,000	+ \$ 120,000	+ \$ 120,000
<i>Legal review savings</i> ⁴	+ \$ 24,100	+ \$ 24,100	+ \$ 24,100
<i>Litigation cost savings</i> ⁵	+ \$ 150,000	+ \$ 150,000	+ \$ 150,000
<i>Cost to outsource FMLA/Leave administration</i> ⁶	- \$ 180,000	- \$ 180,000	- \$ 180,000
Potential Savings	\$ 414,100	\$ 614,100	\$ 814,100

Cost/benefit illustration demonstrating some of the potential financial benefits an employer may experience by outsourcing the management of FMLA and state leaves.

¹ Based on internal UnumProvident employer studies. Includes incidental absence/sick days only - no STD, salary continuation or workers' compensation, 2005.

² Amounts reflect 3%, 5% or 7% reduction in overall payroll costs associated with unscheduled absence.

³ Cost of two full-time HR professionals based on Society for Human Resources Management, Family and Medical Leave Act, 2003.

⁴ \$2.40 per employee per year based on UnumProvident in-house legal counsel, 2003.

⁵ Estimated litigation cost of one FMLA related case (i.e. wrongful termination, etc.) based on UnumProvident internal costs, 2003

⁶ Based on UnumProvident's FMLA/Leave Management Service fees for a sample company with 10,000 employees, 2003.

Additional Resources

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Health and lost time information used for this publication was generated, unless otherwise referenced, from UnumProvident's disability database – The largest private disability data base in the nation. UnumProvident regularly applies the information within this database, which tracks 21 million lives and an estimated 90,000 employer policyholders, as an absence management tool.

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