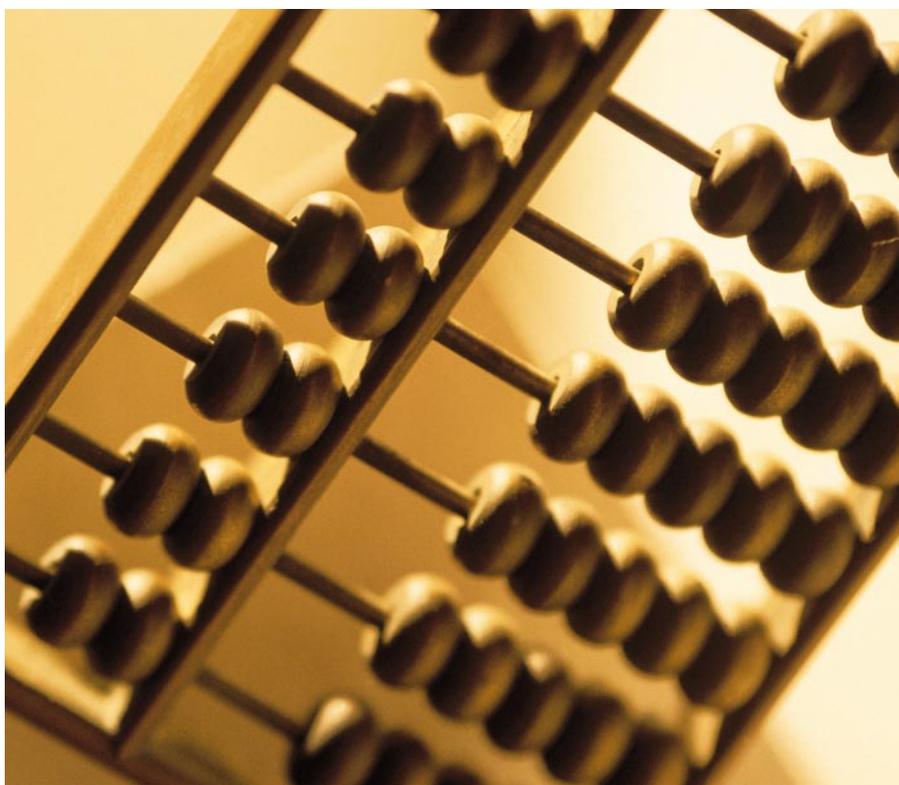


The Impact of Integrating Health and Disability Data

An IBI Research Summary



**Research by the
Integrated Benefits Institute**

August 2006



Overview

This research analyzes the link between medical care, disability and lost productivity from a database of 15,600 disability claims and 52,800 associated medical episodes. CIGNA Corporation, an IBI Board of Directors member, provided this integrated database for cases involving disability to IBI researchers for this analysis.

The report explores the complexity of medical episodes influencing disability cases, analyzes the impact of the “Pareto group” on medical and disability costs and evaluates the importance of absence-based lost productivity for the disability claims studied.

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Integrated Benefits Institute

The **Integrated Benefits Institute** is a national, nonprofit organization directed and supported by its members, including employers, consultants, insurers, healthcare providers, disease management firms, third-party administrators, pharmaceutical companies, behavioral health providers and others having an interest in integrating health and productivity. To best serve the needs of employers and employees, IBI identifies and analyzes health and productivity issues as they cut across traditional health-related benefits programs. IBI provides research, an integrated health and productivity educational forum, and benefits-measurement and benchmarking tools to monitor benefits down and across programs and up to business impacts.

CIGNA Group Insurance is one of the nation’s largest providers in disability management and insurance with solutions that focus on helping employees return to work as quickly and as safely as possible. Also offering healthcare, behavioral health, disease management and pharmacy programs, CIGNA Corporation provides integrated health and disability services that help employers reduce costs and improve health outcomes and productivity. CIGNA Group Insurance is also one of the five largest providers of group term life and group universal life and is the second-leading provider of group accident insurance, including voluntary accident and business travel accident insurance.

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Key Findings

- **Medical care represents the overwhelming share of total medical and disability costs for disability cases analyzed.** In a database of integrated medical and disability claims data for 14,321 employees filing disability claims, medical care represents 80 cents of each claims dollar and disability accounts for 20 cents. The sample comprised 15,600 disability claims and 52,800 associated medical episodes for 183 employers during an 18-month study period.
- **Multiple medical conditions are associated with each disability claim.** On average, each disability case involves care for 3.4 different medical conditions. Only 20% of the disability claims are associated with a single medical episode, and 25% involve five or more. At the same time, each claimant filed an average of only 1.1 disability claims.
- **Just 10% of the disability cases account for more than half of all medical and disability costs.** Claimants filing more disability claims per person, being treated for more medical episodes, suffering more-severe medical conditions and having higher-cost disability claims characterize this “Pareto group” among disability claimants.
- **Lost-productivity costs associated with disability absence alone are greater than the combined costs of medical and disability payments and vary substantially by disabling condition.** Lost productivity associated with disability absence averages \$22,800 per disability claim compared with \$13,600 in medical costs and \$3,800 in disability costs in the subset of cases studied for lost-productivity impacts. Disabling musculo-skeletal conditions are the biggest driver of lost productivity for these cases.

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Background

Steeply rising healthcare costs are forcing employers to demonstrate the business value of workforce health and to measure the impact of health interventions. This pressure compels employers to look beyond the group-health program: Nearly nine in 10 participants in IBI's survey of employers' medical cost-control strategies¹ report plans to bring health and business-relevant outcomes—such as absence and lost productivity—together. Linking medical care and disability data is an important step in this direction.

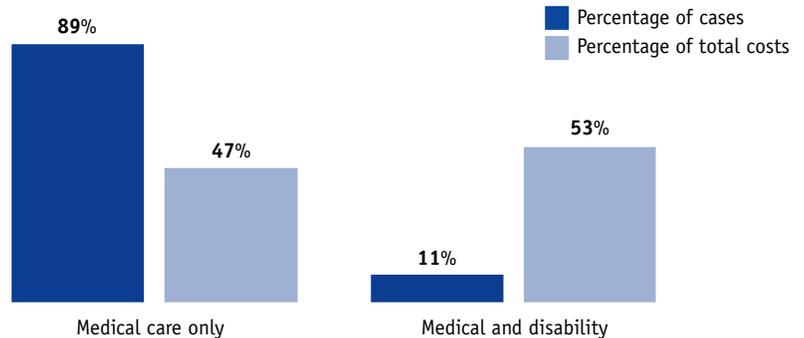
IBI research² in 2001 on this topic emphasized the cost impact of this link. Analysis of three years of integrated non-occupational medical care and disability data in conjunction with Medstat and CORE, Inc., for a 60,000-life manufacturing company showed the effect of cases that involve both medical care and disability. For this company, nearly 90% of the cases involved medical treatment without an associated disability claim. The 11% of cases that did include both medical care and disability benefits, however, were responsible for more than half of the total medical and disability costs. For this employer, managing all health-related costs meant explicitly recognizing the link between the two benefits programs.

To go beyond data from a single employer, IBI worked with CIGNA Corporation, a member of IBI's Board of Directors, to examine integrated medical, pharmacy and disability data³ for cases involving disability from 183 CIGNA client employers. The database includes more than 15,600 disability cases and 52,800 medical episodes⁴; the study spanned a period beginning in April 2001 and ending in December 2002. CIGNA provided the integrated database to IBI; IBI researchers undertook the analysis described in this report.

Episode-of-care Definition

The episode of medical care is a widely used measure of utilization in health services

The Importance of Disability



research and is used to represent the totality of medical services provided to treat a particular medical condition (such as diabetes, bronchitis or depression) for an individual. Applied to health claims data, the episode of care is composed of one or more outpatient procedures/visits or inpatient procedures/admissions and related pharmacy information occurring over an explicit time period. It is built by linking all medical claim information for a specific medical condition for a particular individual during a specified time period. CIGNA used the Episode Treatment Group (ETG) methodology developed by Symmetry Health Data Systems to construct episodes of medical care for this database.

Disability Episode Definition

The disability episode typically represents an uninterrupted period in which an employee is out of work due to a disabling health condition. Data from short- and long-term disability claims files are used

For one large employer, 11% of the cases that did include both medical care and disability benefits were responsible for more than half of the total medical and disability costs.

¹ *Beyond Cost Containment to Health and Productivity: A Shift in Employers' Healthcare Focus*, Integrated Benefits Institute, May 2005, p. 6. <www.ibiweb.org/publications/research/45>

² *Considering a New Employer Healthcare Strategy: Linking Medical Care to Productivity*, Integrated Benefits Institute, February 2001. <www.ibiweb.org/publications/research/15>

³ Unlike workers' compensation, which integrates medical and disability delivery and payment as part of the way the program is constructed, linking non-occupational medical care and disability data is usually undertaken "after the fact" and thus requires an explicit linking methodology. Readers interested in methodological issues and the impact of different linking criteria should see the appendix.

⁴ See the appendix for a discussion of the methodology used to link medical and disability claims data.

to represent the disability episode for this research. The process of linking medical episodes and disability involves assigning each disability episode to one or more medical episodes that occur during a specified time period. For this research, medical episodes are linked to disability based on the start date of the medical episode and the start date of the disability. The rule for matching was defined as a medical episode with a start date 100 days before and up to 100 days after the disability start date.⁵

Questions Addressed

The resulting integrated health and disability database allows us to explore several key questions:

- How can we more clearly understand the link between medical care and disability for disability cases?
- How varied are the medical conditions associated with disability cases, and what are the implications for disability and disease management?
- How important are lost-productivity costs for disability cases compared with medical care expenditures and disability payments?
- How important is the way medical episodes are defined?

Important Caveat

We use this database and provide these analyses to be illustrative rather than definitive. Because results of integrated health and disability data analysis will be influenced by population characteristics, underlying health conditions, plan design and the methodology used to link medical care and disability, we caution the reader against generalizing from this analysis. Exploring these questions, however, can lead to a fuller understanding of the true costs of health, promote solutions that cut across traditional benefits lines and serve the interests of both employers and employees.

⁵ The impact of this linking time-period window is substantial. See the appendix for the effect of using different linking patterns on number of episodes, average medical costs and average durations of care.

Understanding Total Medical and Disability Costs

Medical care represents an overwhelming share of total medical and disability costs for the 183 employers in the database that served as the basis for this research. Of total expenditures for these disability cases, medical care accounts for 80 cents of each dollar, while short- and long-term disability make up only 20 cents. Indeed, the average medical costs for each medical episode is about \$12,400, while disability costs are just under \$3,000 per case.

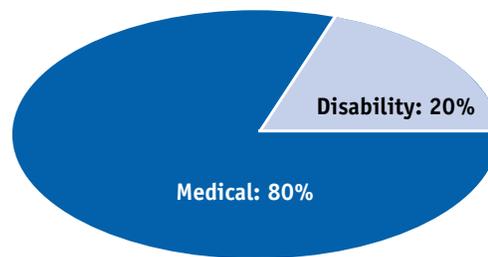
The composition of the cases studied shows why there is this significant cost differential. During the 18 months of the study period, claimants filed an average of only 1.1 disability claims (in fact, more than 91% of the claimants filed only one disability claim).

Thus at first blush it would seem that focusing on individual medical conditions alone would be the most logical approach to a medical cost-control strategy, assuming that a single medical condition is associated with the disability event. That solution, however, may be misleading. The reason for the great disparity in medical and disability costs lies in the number of medical episodes associated in time with the disability event. On average, each disability case is temporally associated with 3.4 medical episodes. In fact, only 21% of the disability cases involve a single medical episode with the disability case. A quarter of the disability cases have five or more medical episodes being treated around the disability event, and nearly 60% involve three or more episodes.

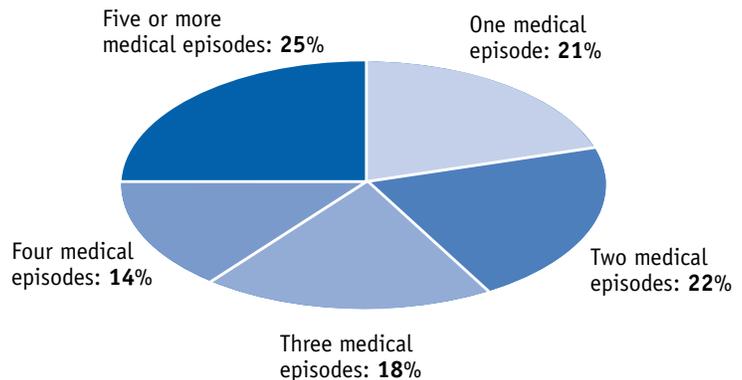
When restricting the analysis to the “simplest cases”—that is, the 21% of cases that involve a single disability case tied to a single medical episode of care—we garner a different perspective on costs. For these cases, average medical expenditures drop to 60% of the total, while disability wage replacement payments increase to 40%.

In fact, only 21% of the disability cases involve a single medical episode; a quarter of them have five or more medical episodes being treated, and nearly 60% involve three or more.

Medical Versus Disability Costs



Medical Episodes Linked to Disability



The exhibit to the right shows the average medical and disability costs based on the number of medical episodes associated with the disability claim. Interestingly, when we analyze the 79% of disability cases with multiple medical episodes, we find that *per-medical-episode* costs average about \$3,600 (compared with \$4,233 for disability cases with a single medical episode), whereas disability costs per disability case average about \$3,200 (up from \$2,586 for disability cases with a single medical episode). It appears from these data that when multiple medical episodes are involved, they may be less severe individually but, acting together, may serve to increase disability costs.

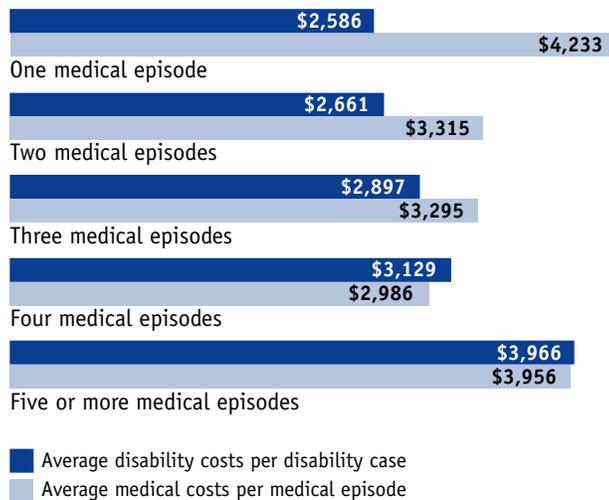
We also found a statistical relationship between the number of medical episodes and disability costs: As the number of medical episodes increases, so do disability costs. This implies that the complexity of the claimant’s overall medical condition—not just the disability diagnosis—is a key driver of disability case costs. We also found a statistical association between longer disability durations and higher medical costs. Whether disability duration drives medical costs or vice versa cannot be gleaned from the data. These two findings have important implications for both disability management and disease management approaches and impacts.

Employers often desire to get the greatest return for their benefits management investment by focusing on a small group of claimants that drives a disproportionately large share of costs. This “Pareto effect” is strongly evident in this group of claimants. For the 183 employers, 10% of the employees filing disability claims account for more than half of the total medical and disability costs.

As we might expect, this Pareto group (the 10% of cases driving half the costs) is quite different from the other disability

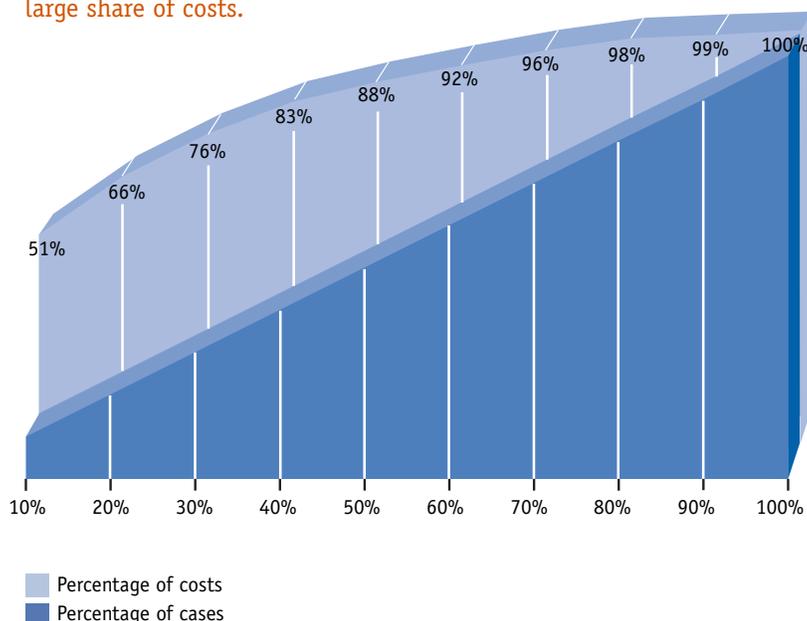
Costs by Number of Medical Episodes

Disability cases with:



The Pareto Effect

A small group of claimants drives a disproportionately large share of costs.



claimants in this sample on several dimensions and is well worth the effort to identify through integrating data across programs and, thus, to manage. What factors make them high-cost claimants?

Employees in this group:

- File 13% more disability claims per person (1.22 versus 1.08 on average). Surprisingly, however, 81% of the Pareto group filed only a single disability claim over the 18-month research period, while 92% of the rest of the claimants filed just one disability claim during the study period.
- Are treated for more medical conditions around the disability event (6.32 medical episodes per person in the Pareto group versus 3.4 medical episodes for other disability claimants). Because of the greater number of medical episodes per person in the Pareto group and the higher costs per episode (per-episode medical costs are six times higher in the Pareto group), medical costs average \$75,700 per person in the Pareto group versus \$6,500 for the other claimants. Because of the more-diverse medical conditions involved, the types of diagnoses between the two groups differ as well. Employees in the Pareto group are treated more often for medical conditions involving blood and blood-forming organs, the circulatory system, neoplasms, the nervous system and sense organs.
- Have worse disability claims experiences (average cost of \$9,280 per person in the Pareto group versus \$2,620 for other claimants). On a per-disability claims basis, the cost differential is three to one.
- Typically are older, male and work longer for their employers before the disability claim is filed compared with employees in the other group.

By focusing on a relatively small number of employees making up this Pareto group, employers would be able to attack the greatest share of both medical and disability costs. The complexity of the cases, however, raises important issues for approaches to disease management and how to deal with co-morbid medical conditions in the context of a single disability case.

One must use caution, however, in focusing only on the Pareto group in a given year. In his research on benefits costs, Dr. Dee Edington of the University of Michigan points out that the composition of the Pareto group of individuals changes from year to year (that is, the individuals in the Pareto group in one year may not be in the group in another year). Thus, perhaps the most important endeavor is to anticipate through predictive modeling who is at risk for *becoming* part of the Pareto group and take steps to minimize that risk.

In addition, employees *not* in the Pareto group—either because they haven't filed claims or because they are in the low-cost claims category—are the primary drivers of health-related productivity for the company. Thus, it is critical to maintain the health status of these employees as drivers of business results. Rather than planning to manage ill-health events, preventing them from occurring is a good business strategy.

One must use caution, however, in focusing only on the Pareto group, as its composition changes from year to year. Using predictive modeling to identify those likely to become part of that group and taking steps to minimize that risk is a good business strategy.

Implications for Disease Management

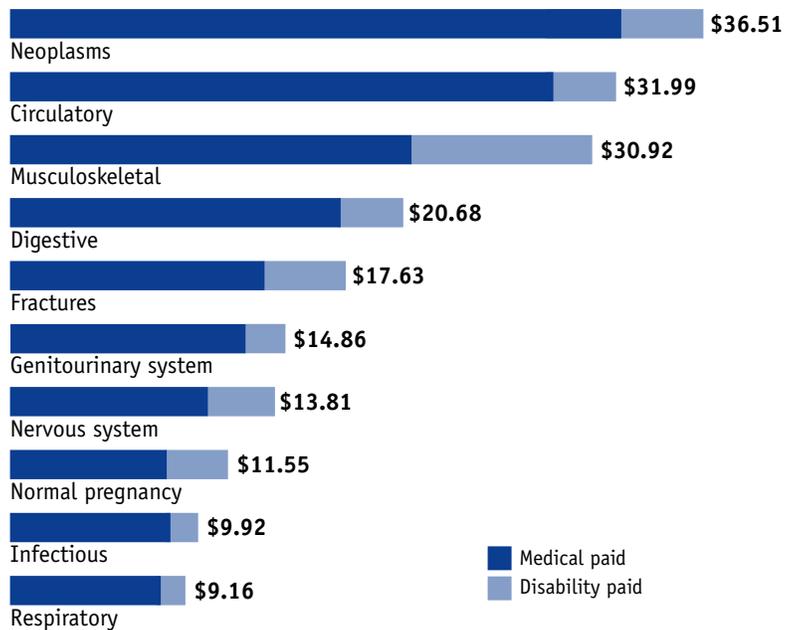
Disease management has become increasingly important to employers as they explore ways to control burgeoning medical costs. Historically, disease management has had a singular goal: reduce medical costs by focusing on proper medical care and related care compliance. What does this sample tell us about the disability conditions driving both medical and disability costs and the relative importance of disability for each of these conditions?

The exhibit to the right shows the major diagnostic category (MDC) for the disability cases in the sample and, for each, the total medical and disability expenditures. At first glance, disability doesn't loom large as a cost driver for any major condition. Musculoskeletal has the largest proportion of disability costs of any single condition, but disability represents only 30% of the total expenditures for this diagnosis. For the remaining disability diagnoses, disability costs average less than 20% of the total. These results might lead employers to discount the importance of disability management and focus solely on disease management for the most prevalent and costly medical conditions.

The *number* of medical episodes associated with disability cases greatly influences the pattern of costs. Although, on average, 3.4 medical episodes are linked to each disability case, the mean number of medical episodes associated with disability cases varies substantially by disability MDC. For example, disabilities involving circulatory conditions

Total Payments by Disability Diagnosis

In \$ millions



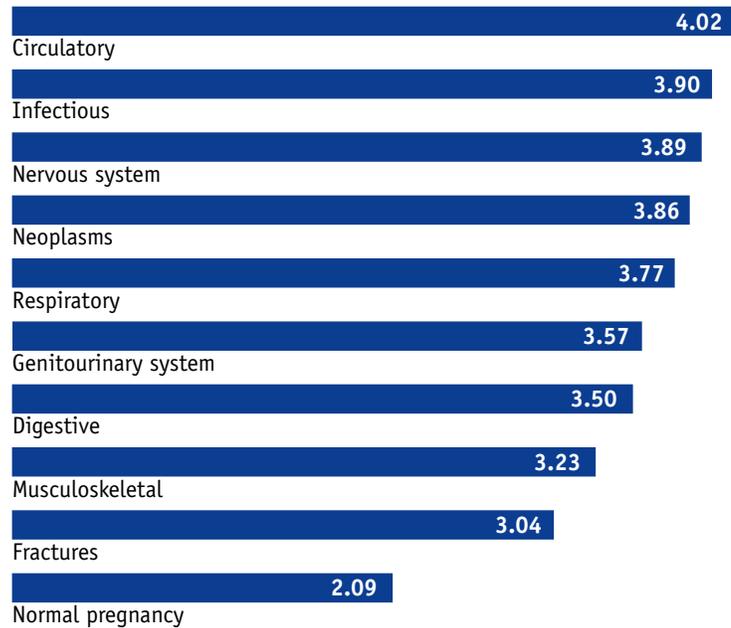
are associated temporally with an average of four different medical episodes, while normal pregnancies are associated with just two. A vast majority of this group of claimants may have multiple chronic conditions that occur during the time of the disability case, presenting significant challenges for disability or disease management.

For disability cases associated with a *single medical episode*, we get a different view of what medical conditions are important and the influence of disability on total costs.

For these cases, half the total costs are associated with three medical conditions: normal pregnancy, musculoskeletal and neoplasms. At the same time, for this subset of cases, disability looms larger as a cost driver, making up 35% of all costs compared with just 18% for cases involving multiple episodes. With particular conditions—mental disorders, nervous system conditions and musculoskeletal conditions—disability comprises more than 40% of total costs for single-episode claims.

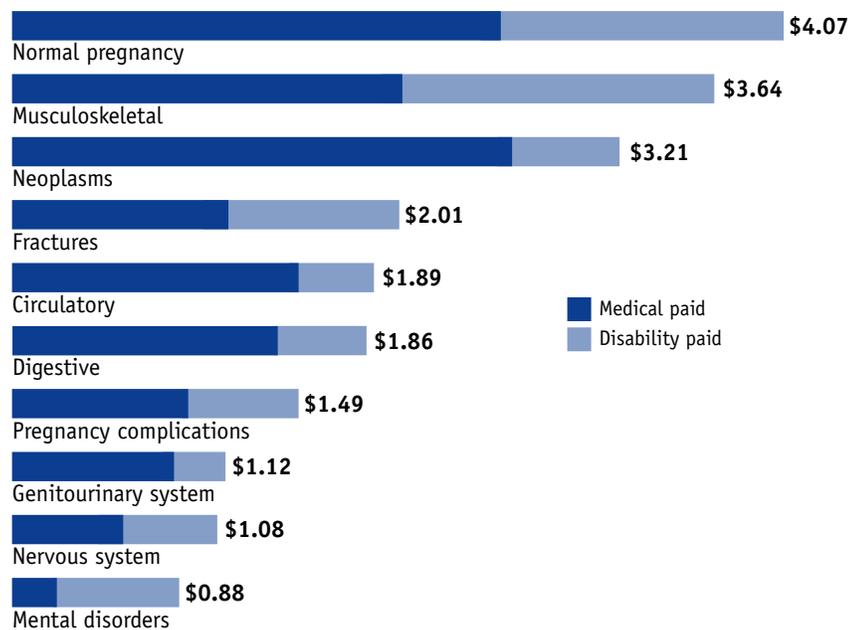
Because disability claimants typically are being treated for a number of different medical conditions, this research tells us that disability management may be a way to gain the broadest view of medical care for disabling health conditions. This approach may provide a way of dealing explicitly with medical co-morbidities by using the disability outcome (measured as costs or lost days) as one way to examine the impact of a comprehensive approach to multiple-condition disease management. These results imply that one approach to disease management may be appropriate for cases involving one medical episode and one disability and a different approach for cases involving multiple medical episodes and a single disability.

Average Number of Medical Episodes by Disability Diagnosis



Total Payments by Disability Diagnosis: Single Medical Episode; Single Disability

In \$ millions



The Impact of Disability-based Lost Productivity

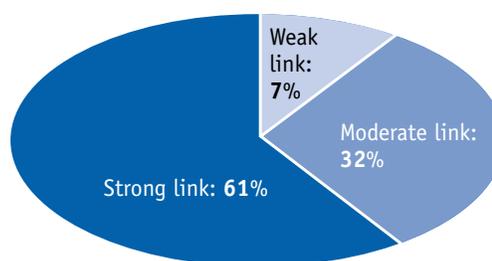
Senior financial executives understand that the health of their workforce is more than just a driver of medical expense. IBI's 2002 survey of CFOs⁶ demonstrates that a large majority of respondents understand that workforce health has a strong link to workforce productivity and, in turn, to the company's financial success. The challenge to employers has been how to quantify health-related lost productivity, particularly in the non-manufacturing setting.

IBI quantifies health-related lost productivity as the employer's "opportunity cost" of employees' not coming to work. These opportunity costs can be measured straightforwardly based on the costs the employer bears in its response to absent employees. For example, some employers rely on overtime to take up the slack, others hire temporary workers or have larger staffs, while still others don't replace absent employees and may miss deadlines and lose revenue and client goodwill because they provide fewer services or produce less product. Although for most employers these absence costs are not tracked, they can represent a significant financial impact on the employer. A 2004 IBI study of 87 employers with 3.3 million covered lives shows that these lost-productivity costs range from a low of \$2,929 per FTE to a high of \$19,433 per FTE, depending on the employer's absence-response strategy.⁷

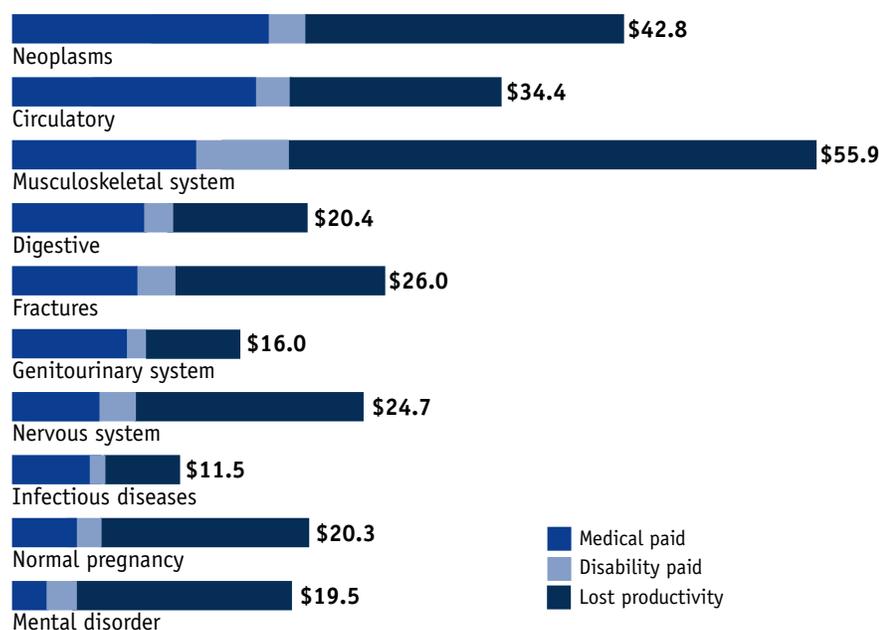
For the analysis presented here, we use a midrange lost-productivity estimate calculated as the value of disabled employees' lost contributions from not being at work. This lost-productivity value is calculated as absent workers' wages, an additional benefits load of 30% of earnings and a multiplier of 1.4 to represent the "flow-through" effect of absent employees on the work of their colleagues.⁸

Adding these health-related lost-productivity costs to medical and disability expense for this sample⁹ more than doubles total case costs. In this exhibit, disability conditions

Linking Health, Productivity and the Bottom Line



The Impact of Lost Productivity In \$ millions



⁶ *On the Brink of Change: How CFOs View Investments in Health and Productivity*, Integrated Benefits Institute, December 2002. <www.ibiweb.org/publications/research/33>

⁷ *The Business Case for Managing Health and Productivity: Results from IBI's Full-cost Benchmarking Program*, Integrated Benefits Institute, June 2004. <www.ibiweb.org/publications/research/42>

⁸ The "flow-through" multiplier was developed by Dr. Sean Nicholson of Cornell University in his seminal research on absence-based lost productivity. See Sean Nicholson, et al., "Measuring the Effects of Workloss on Productivity with Team Production," *Health Economics* 15: 111-123 (2006).

⁹ This analysis is limited to the 8,144 cases in the sample for which we had complete wage and lost-time information.

are ordered by medical expenditures associated with the case. One can easily see the impact on total case costs of adding the lost-productivity component.

Several things are apparent. First, lost productivity represents a significant share of total case costs. Lost-productivity costs range from a low of 44% of total costs for circulatory and genitourinary diagnoses to a high of 75% of total costs for mental disorders. Second, adding lost productivity also changes the order of condition importance based on full costs: Musculoskeletal becomes the most costly condition, while fractures, nervous system conditions, normal pregnancy and mental disorder move up in

importance. These five conditions represent 54% of total medical, disability and lost-productivity costs for the sub-sample. When examining medical costs alone, the five conditions represented just 37% of all medical expenditures.

Including lost productivity in the analysis of the costs of medical care and disability provides a framework for employers to identify which conditions drive the largest share of total costs and to evaluate the impacts of health interventions—on both costs and business results. Thus, such a framework supports health as an investment as opposed to viewing medical care only as a cost center.

Including lost productivity in the analysis of the costs of medical care and disability provides a framework for employers to identify which conditions drive the largest share of total costs.

Conclusion: Why Integrate Data?

Analyses of these data show the value of linking medical care and disability claims data.

- Data integration allows the employer to understand related medical and disability costs. Employers and their vendors typically bifurcate medical and disability events in their databases. In reality, these events are meaningfully related and have an important impact on employees and employers alike.
- Data integration provides the basis for understanding the complexity of medical events and encourages broader approaches that explicitly recognize medical co-morbidities in identifying, quantifying and managing elevated medical costs, diseases, disability events and their lost-time consequences.
- Data integration offers a means to connect outcomes for health, medical care, disability and health-related lost productivity. This is a key step in permitting employers to identify the true high-cost health conditions and use pragmatic outcomes measures for judging the value of health interventions.

Employers are in transition from a benefits-centric model that emphasizes out-of-pocket expense control to an employee-centric model that emphasizes the value of a healthy workforce. Linking medical care and disability data will be an important step in that transition as employers seek to understand the relationship between workforce health and business-relevant outcomes.

Linking medical care and disability data will be an important step in the transition from a benefits-centric model emphasizing out-of-pocket cost control to an employee-centric one emphasizing the value of a healthy workforce.

How Important Is the Methodology to Link Medical Care and Disability?

As employers seek to better understand the relationship between medical care and disability, they must determine the method they will use to link data from the two programs. On the medical side, we typically have transactions data, where each data point represents a single medical procedure. For disability cases, a data point represents either a single transaction such as a disability payment or the aggregation of all disability transactions. All disability transactions, however, are related to a single disability case that unfolds over time as opposed to individual transactions in the medical arena that are not necessarily related to treatment of a single condition over time. We provide an overview of methodological issues around linking the two types of data.

Components

The two basic pieces of the puzzle that must be matched are *episodes of medical care* and *disability episodes*.

Episodes of Medical Care

The episode of care is a widely used measure of utilization in health services research. Applied to health claims data, the episode of care is composed of one or more outpatient encounters/visits or inpatient procedures/admissions that occur over an explicit time period. It is built by linking all claims for services provided during a specific time period.

Development of disease-specific episode groupers has advanced the usefulness of health claims data in the areas of risk assessment, severity rating and disease management. Several are in use today. For example:

- Episode Treatment Group (ETG) methodology, developed by Symmetry Health Data Systems and used in this study, is a claims-based illness classification methodology that combines related services into a medically relevant unit describing a complete patient episode.
- Medstat Episode Grouper (MEG) classifies disease-specific episodes of care based on organ system, etiology and severity of illness.
- Adjusted Clinical Groups (ACGs), a risk-adjustment system developed by Johns Hopkins University, are used by managed-care plans and provider groups to assess the illness burden of patients for actuarial, payment, profiling and quality purposes.

Disability Episodes

For lost time, episode constructs have been applied to disability claims data for the purpose of capturing measurable units of utilization. The disability episode generally represents an uninterrupted period of time that an employee is not at work due to a disabling condition.

Linking Medical and Disability Episodes

The key elements of linking health and disability episodes are (1) the driver episode, (2) unique person identifiers and (3) the time-period window. Once matched, algorithms can also be developed to classify the link records as (clinically) related or unrelated to the episode driver or to the unit of measure that is being created from the linking process.

Driver episode defines the unit of measure or anchor episode to which all other services, events or episodes (health or disability) are attached (based on predetermined matching criteria).

The Driver Episode

Two approaches are taken to define the driver episode:

1. **Disability episode as driver.** When using disability as the driver episode, all medical services occurring between the start and the end of the disability episode are linked. In this example, a disability claimant is the driver, and the person and date-matched medical episodes linked to the disability time period can be summarized by occurrences, types and payments.
2. **Medical episode as driver.** When using the medical episode as the driver, all absences and disability episodes associated with a specific medical episode (inpatient admission, surgery, disease group) are linked. Medical episodes vary widely: severity, chronic versus acute, brief versus extensive, and condition and illness etiology. Additional—and possibly extensive—episodic development may be necessary.

Unique Person Identifiers (Patient or Employee)

To link medical care to disability, regardless of the driver approach, each individual must be uniquely identified so that data can be integrated for the same individual. Common unique person identifiers are Social Security number (SSN) and employee ID. Employee or patient names are not useful person identifiers. For privacy reasons, data suppliers often scramble SSNs and other employee IDs, but the same unique scrambled ID is assigned to the same individual, allowing data integration while supporting patient confidentiality. Such is the case for this research.

The Time-period Window

A window of time between the medical event and the disability event must be defined explicitly for matching purposes. The time-period window defines the link of a longitudinal series of events, services, diseases and treatments during and around a key medical or disability event. The key questions are: *When does the episode driver as a unit of measure start and end?* and *What events are driven by the episode driver and for how long?* It is important to define the window based on a specific set of processes such as clinical practice, disease states, risk models, benefit or financial practice.

For this research, medical episodes are linked to the disability based on the start date of the medical episode and the start date of the disability episode. The time-period window rule used for the match of medical episodes and disability for this research is a medical episode with a start date 100 days before and up to 100 days after the disability start. Only employees with disability claims are included in this analysis.

The time-period window selected can have a significant effect on both the incidence of a condition and its cost. To illustrate the importance of the definition of the time-period window, we examined six mutually exclusive patterns of linking criteria that fall within the original time rule used for our analysis:

Patterns:

- 1 The medical episode begins and ends 30 days before the disability starts.
- 2 The medical episode begins 30 days before the disability starts but ends up to 30 days before or any time after the disability starts.
- 3 The medical episode starts within seven to 30 days before the disability starts.
- 4 The medical episode starts within a period between seven days before and seven days after the disability starts.
- 5 The medical episode starts eight days or more after the disability starts and less than 30 days before the disability ends.
- 6 The medical episode starts 30 days or more after the disability ends.

The table below shows the number of medical episodes, average medical cost and average duration for each of the six distinct and mutually exclusive patterns within the time-period window used to link the data for our analysis.

Pattern	Number of Medical Episodes	Average Medical Cost	Average Days of Medical Episode
1	8,305 (14.7%)	\$454	3.4
2	6,528 (11.6%)	\$6,436	133.8
3	6,618 (11.7%)	\$3,939	55.3
4	15,949 (28.4%)	\$4,899	46.7
5	15,469 (27.4%)	\$1,849	38.8
6	3,505 (6.2%)	\$1,157	38.1
Total	56,374¹⁰	\$3,240	48.7

¹⁰ The final analytic dataset used for this research includes 52,800 medical episodes for the core analysis presented in this paper.

Clearly, the strategy chosen to define the link between medical and disability is highly sensitive to the start and stop dates selected. The pattern selected by a user should be consistent with the user’s needs, the kinds of analyses undertaken and the types of medical conditions and disabilities that need to be linked.

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For membership information, please contact us through one of the channels below. IBI can provide you with invaluable information, work with you to benchmark your benefits programs and offer communication opportunities to keep you in tune with the latest changes in this rapidly evolving arena.

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