Depression: A Lot Bigger Than You Think

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Depression: A Lot Bigger Than You Think
The absenteeism- and presenteeism-related costs of depression outweigh the medical and pharmaceutical costs and make a strong case for EAP intervention against this condition.

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For any benefits or employee assistance professional seeking financial support for program expansion, the question likely to be asked by senior management is, "What return are we getting for our benefits investment?"

Like it or not, those senior managers are doing their job, driving corporate success the best way they know how. To those in the trenches, however, such questions sound short-sighted in not recognizing the value of an investment in the employer's most important asset: a healthy workforce.

The tension between viewing health care as a cost versus health as an investment is more noticeable when economic times get tough and all programs are forced to justify their business value. As noted by Westbay and Sarfaty (2009) in a recent Journal of Employee Assistance article, "In uncertain and difficult times, such as the economic meltdown we are currently experiencing, personal resilience and resources are needed. EAPs are a resource that can make an important difference in employees' lives and, therefore, employers' bottom lines."

Given these competing tensions, what will happen as EA professionals seek approval to expand their EAP resources to meet this increased need? Because employers have come to view EAPs as commodity benefits rather than workforce productivity tools, employee assistance professionals must dig more deeply to present the value of their programs in a way that recognizes the real costs of doing nothing and also expands the definition of "value of investment" beyond medical cost savings.

Advocates for health interventions can come to welcome the "value of investment" question if, instead of focusing only on paid benefits, they also demonstrate the business costs of health-related lost time and lost productivity in making their business case. The Integrated Benefits Institute (IBI) can assist by providing research and measurement tools to help both benefits/EAP managers and senior management demonstrate the full business value of health.

Why a Focus on Paid Benefits?
Unfortunately, when the discussion turns to costs, the focus is on paid benefits because that's the only kind of data most employers, senior managers and program administrators typically have available to them. Some employers can't even get condition-specific medical claims information from their insurers or program administrators, much less condition-specific absence or disability data. And when such medical information is available, it only exists when treatment is rendered.

Worse, few employers can track incidental absences associated with a health condition since payroll information usually isn't linked to human resources databases. Even short-term disability (STD) wage-replacement payments are likely to be associated with multiple health conditions, most of which comprise no part of the diagnosis for the disability in the claim file of an insurer or third-party administrator.

A resulting focus only on paid costs, often limited just to medical costs, dramatically underestimates the workforce impact of various medical conditions. Research co-authored by IBI and published this year in the Journal of Occupational and Environment Medicine (JOEM) reports on the full costs of medical and pharmaceutical claims combined with employee-reported lost time. For every $1 of medical and pharmacy costs, there are $2.3 dollars of health-related lost productivity costs from presenteeism (being at work but under-performing due to a health condition) and absence. For some conditions, the ratio of lost productivity to medical/drug costs can be as high as 20:1. As a result, seeking increased resources for health intervention using only paid claims data puts the health advocate behind a significant 8-ball, in that only a portion of existing costs (and potential savings) can be shown.

The Challenge of Depression
Recent research by IBI (Gifford, Parry and Jinnett 2009) demonstrates the daunting challenge that workforce depression presents to employers. This article draws on examples from that research to demonstrate how misleading a paid-benefit view of depression's effects can be and to present baseline information on the impact

of depression—information that EA professionals can use to make the business case for more resources to prevent, identify and manage depression.

In IBI's experience, employers are most likely to single out depression costs for attention when those costs are associated with a claim for STD. This may result because medical treatment costs for depression—absent any disability or significant lost time—typically haven't been near the top of the cost-driver list. Disability payments for depression cases are where the money seems to be. After all, according to a recent RAND Research Brief (RAND Health 2008), depression is the second-leading cause of disability worldwide.

A focus only on depression-diagnosis STD claims, however, severely underestimates depression's workplace impact. The JOEM research referenced previously identifies depression as the leading driver of the combined costs of health-related lost productivity, medical care and pharmacy benefits. Beyond disability claims, the broader issue is not just the lost productivity and medical costs associated with depression-related STD absences, but also how depression acts as an aggravating, potentially undetected condition that undermines health and productivity more generally.

IBI's research draws on two databases—one claims-based and the other self-reported by employees—to suggest several surprising results that should cause employers to take a closer look at managing depression in their workforce.

Short-term Disability and Depression
Employers aren't wrong in pointing to the adverse effects of depression on disability—after all, significant additional costs do occur when depression accompanies an STD claim. Most employers, however, simply don't go far enough in recognizing these effects and investing in the resources to manage them.

For example, when IBI analyzed a sample of 45,171 employees with STD claims (using claims data supplied by Ingenix), we found that STD claims with depression had significantly more lost time than STD claims without depression. (IBI used regression models throughout the STD analysis to control for age, gender, chronic health conditions, injuries, company, lost time under other programs, and pre-STD health care spending.) But there is an additional cost component to STD claims that has a significant impact on employers—the lost productivity associated with disability.

IBI estimates the dollar value of disability-related lost productivity based on research by Nicholson et. al (2006). Their work with 800 employers quantifies the opportunity costs of an employee's absence as a function of the ease with which the employer can replace workers, the degree to which employees work in teams, and the time value of output (i.e., whether the employer can sell all of its good or services as soon as they are available). The methodology IBI used to convert lost STD days to lost productivity is spelled out in IBI's depression research report (Gifford, Parry and Jinnett 2009).

When we add these lost productivity costs to STD medical and pharmaceutical costs, we get a far different view of total employer costs related to disability than if we looked only at medical and drug costs. To demonstrate this difference, we compare in Figure 1 the full-cost results from two samples of STD cases from the Ingenix database. Both groups consist of STD cases where no depression treatment occurs prior to the onset of STD within the study period.

The control group is composed of STD claims with no medical treatment for depression after the onset of STD. The co-morbid group comprises STD claims for a diagnosis other than depression with treatment for depression after the STD claim. Thus, the only difference between the two STD claims samples is the presence of diagnosed depression that arose after the onset of short-term disability.

Two results stand out. First is the presence in both groups of significant lost productivity costs resulting from lost days. These lost productivity costs exceed the medical/pharmacy costs in each group. Thus, when employers ignore lost productivity and focus only on medical/pharmacy drug costs, they ignore a major cost component associated with STD claims.

The costs associated with lost productivity make depression management even more important to an employer's bottom line and enhance the return on investment for a management intervention if some or most of these excess costs can be minimized. It is important to remember that these lost productivity costs can't be avoided by shifting them to others when disability occurs. That is, lost productivity costs remain with the employer as additional operating costs regardless of who bears the direct expense of disability benefits or medical/ pharmacy costs. Cost-shifting containment measures such as increasing co-pays for employees or dropping STD insurance for the workforce will not affect this major cost burden, which will continue to be borne by the employer.

Second, the two samples are similar, with the only difference being the presence of medical treatment for depression after an STD claim occurs. Depression-related medical treatment costs total only $605, compared to $7,752 in additional total costs spread across all five classes of full-cost expense, including medical costs for treating other conditions that are co-morbid with depression.

We can't go so far as to say that the depression caused these additional costs or that the more serious nature of the illness resulted in an added depression condition. What we can say is that the existence of depression-related medical treatment after an STD claim occurs is a marker for the need for corporate management to minimize the additional costs likely to be associated with depression treatment. What better place to initiate such minimization than in an EAP?

Lost Productivity Transcends STD

The costs of depression-related STD, however, are only a small part of the story for employers. IBI's research also relied on an analysis of employee responses to questions about their health-related lost time.

These questions are included in the Health and Work Performance Questionnaire (HPQ) database. IBI manages the database and the next-generation survey, HPQ-Select, in partnership with Dr. Ronald Kessler of Harvard Medical School, who developed the original HPQ with the World Health Organization. The database includes information on 27 self-reported chronic health conditions, including depression, together with data on prevalence, treatment by a health care professional, and related lost time from absence and presenteeism.

IBI's analysis shows that 28 percent of employees report depression, but 70 percent of these currently receive no professional depression treatment. IBI's HPQ analysis also shows that depressed employees have higher rates of sick-day absences and presenteeism than employees without depression. This is due, in part, to their high rate of co-morbid chronic conditions: 97 percent of employees who report depression report at least one co-morbid medical condition, with an average of seven co-morbidities.

Combining our regression results with information obtained from the HPQ paints a more complete picture (see Figure 2) of the sources of health-related lost productivity for depressed employees. Based on the combined analysis, STD claims result in only 19 percent of lost days for depressed employees; more than 80 percent of the lost time comes from sick-day absence and presenteeism. Given the large share of employees with untreated depression, it is not surprising that presenteeism is so significant, at 63 percent of total lost work time.

These results should drive home the need for employers to view this leading driver of health-related lost productivity, treatment and pharmacy costs more broadly than as a driver of medical claim costs or even disability results.

Managing Depression: What's Next?

Although employers recognize that depression presents a problem, too often they view it as a disability issue or a medical/pharmacy problem. Instead, IBI's research demonstrates the huge bottom-line effect resulting from workers suffering from depression.

EAPs have an important role to play in preventing, identifying, and managing depression. The very existence of depression represents a marker to help prioritize services to eliminate the excess medical, pharmaceutical, lost-time and lost-productivity costs that often accompany a depression diagnosis.

Active, supportive communication by an EAP is an important step in de-stigmatizing this crippling condition. EA professionals also have a role to play in educating supervisors to discern when what appears to be a performance problem actually reflects the need for help. The EAP can work with disability administrators to screen for signs of co-morbid psychiatric issues and depression, regardless of what the insurer thinks the disability diagnosis might be. Finally, senior management needs to know where best to invest valuable resources to improve human capital assets. IBI's research and measurement tools can help point the full-cost way for that investment.

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