Mental HealthWorks

FIRST & SECOND QUARTERS 2009

PUBLISHED BY THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE AMERICAN PSYCHIATRIC FOUNDATION

Mental HealthWorks

Mental HealthWorks is published quarterly by the Office of Healthcare Systems and Financing of the American Psychiatric Association and the American Psychiatric Foundation.

Mental HealthWorks is distributed free of charge to APA members and the business community and is available online at: www.workplacementalhealth.org.

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Dear Reader,

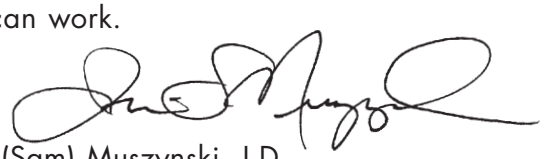
The passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was the result of years of collaboration and careful negotiation among employers, insurers, health plans, mental health advocates, and professional organizations. It does not escape the Partnership for Workplace Mental Health and the American Psychiatric Association that the majority of employers now face the challenge of redesigning their mental health benefits to comply with the law. We hope you find this issue of *Mental HealthWorks* helpful as you make your plans to do so.

In our conversations with employers, we try to emphasize the following three points.

Parity is affordable. Mental health treatment is an incredibly good bargain, especially when compared to treatment for other chronic illnesses. It yields a relatively quick return on investment and significant productivity gains. We encourage you to think of mental health in the context of value-based benefit design (see research by Pitney Bowes on page 5) and/or benefit and services integration (see approach by IBM on page 6).

Treatment works. Studies show that treatment for mental illness is effective. Unfortunately, two-thirds of people with a mental illness receive no treatment at all, and these individuals contribute disproportionately to productivity losses. Treatment remains the single, best solution.

You're not alone. Starting on page 7, you will find stories about employers who have already implemented parity and have found little or no increase in costs. Parity can work.



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Straight Answers to Employer Questions About Mental Health Parity

On October 3, 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was signed into law. This new mental health parity law does not mandate coverage of mental health and/or substance use disorders. It simply says that when mental health and/or substance use disorders benefits are offered, they must be offered on par with medical/surgical benefits.

Parity Basics. The new law applies to group health plans with 50 or more employees that provide both medical and surgical benefits and mental health and/or substance use benefits. These plans must ensure that financial requirements and treatment limitations applicable to mental health/substance use disorders benefits are no more restrictive than those requirements and limitations placed on medical/surgical benefits. This means that deductibles, copayments, coinsurance, out-of-pocket expenses, frequency of treatment, number of visits, days of inpatient coverage and other cost-sharing mechanisms must be no more restrictive for mental health and/or substance use disorders benefits (assuming they are offered) than they are for medical/surgical benefits.

Essentially, the new law picks up where the 1996 law on mental health parity left off. Plus, the new law includes substance use disorders.

The parity bill that passed received broad support from the business and insurance community, including the U.S. Chamber of Commerce, National Retail Federation, American Benefits Council, and America's Health Insurance Plans. The Chamber issued this statement in www.uschamber.com upon the bill's passage: "The U.S. Chamber of Commerce supports this carefully crafted mental health parity provision because it is a balanced and reasoned approach for addressing mental health insurance coverage."

Effective Date. For most employers, the law takes effect January 1, 2010. (That date may be different for collectively bargained health plans, depending on when their current agreements expire.) The law directs the U.S. Secretaries of Labor, Health and Human Services, and Treasury to publish "guidance and information" on the Act by October 3, 2009. However, if the federal government fails to meet its deadline, employers must still be in compliance with their deadline.

There are several other important provisions in the 2008 parity law.

- If a group health plan experiences an increase in actual total costs with respect to medical/surgical and mental health/substance use benefits of 1% (2% in the first plan year that the law is applicable), the plan can be exempted from the law. Plans may only opt out for one year, and may be under audit by the Department of Health and Human Services, the Department of Labor, and actuarial analysis to assure transparency.

- The parity law is extremely protective of state law. Only a state law that "prevents the application" of the law will be preempted, which means that stronger state parity and other consumer protection laws remain in place.

Corporate Reaction. Some companies see the new legislation as an opportunity to take a second look at their entire healthcare package. Hyong Un, M.D., National Medical Director for Behavioral Health at Aetna, said, "We believe that employers will benefit from an evaluation of their total healthcare package to optimize the integration of mental health on a parity basis. We know that improved access to quality mental health treatment leads to better health outcomes and that better outcomes are linked to increased productivity. These all contribute positively to the bottom line."

Below is a summary of frequently asked questions about the law and key points from conversations with employers.

Q. These are tough times for us. We've had layoffs. Isn't this the wrong time to be talking about revising our approach to mental health?

A. No. It's precisely the right time. To preserve a company's ability to adapt to challenges, Nancy Spangler, a prevention and health management

The American Psychiatric Association sent letters to President Obama and the Secretaries of Labor, Health and Human Services, and Treasury urging them to expedite guidance on the parity law.

See page 7 in this newsletter to read about employers who have already successfully established mental health parity in their organizations.

The full text of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 can be accessed at http://tinyurl.com/qpqw78 See pages 310-344.

Twenty percent of Americans experience a mental health disorder in any given year, but only one-third of those seek care. –*Mental Health: A Report of the Surgeon General,* US Dept. of Health and Human Services.

The Partnership on Workplace Mental Health recently surveyed employers about what impact the new parity law will have on their benefit offerings. Most employers (74%) said they would not drop their mental health coverage, and 77% said they have no plans to discontinue their substance use disorders coverage. As a result of the new law, 38% plan to increase promotion and use of EAP services. To learn more, go to www.workplacementalhealth.org.

consultant, reminds employers that the mental health of their workforce is vital to the company's health. "During difficult economic times, especially when there are large reductions in the workforce, is not the time to abandon the mental health of your workforce," Spangler said. "Instead, it's precisely the time to revise benefits to get optimal value from preventive care and to provide quality behavioral treatment."

For example, J. Brent Pawlecki, M.D., Corporate Medical Director at Pitney Bowes, pointed to his company's decision this year to make a financial advisor available to all employees. Paul Heck, Manager, Global EAP at DuPont, emphasized focusing on resilience-based training. He explained, "We know that employees who have a mental illness can have a negative impact on business. Conversely, we know that business announcements bearing bad news can have a negative impact on employees. To break this cycle and optimize the well-being and performance of our employees, we must be proactive in training managers to recognize the symptoms of mental illness." Neither of these two approaches is particularly costly to implement, but the payoff can be substantial.

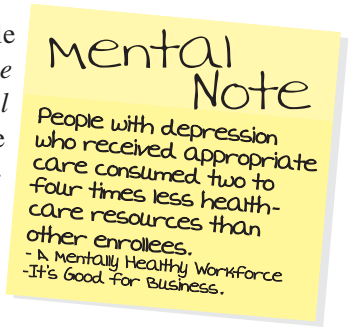
Q. ***Couldn't we just drop our mental health/substance abuse coverage altogether and come out ahead?***

A. ***You can, but you'll end up paying for it anyway … and then some.*** Mark Attridge, Ph.D., a researcher and consultant with expertise in designing outcome studies for workplace health services, told *Mental HealthWorks* that employers have a choice. "Employers can pay for mental illness/substance use disorders up front," he said, "where they have some control over the process and can intervene before the problems get worse or they can pay for them down the line in increased medical and disability costs, increased absenteeism, and increased presenteeism. Either way, they are going to pay."

Many studies have demonstrated the link between poor quality mental health treatment and increased medical costs. For example, the Partnership for Workplace Mental Health notes the following in its publication *A Mentally Healthy Workforce—It's Good for Business:* "Aggressive efforts to contain mental healthcare costs at one large corporation resulted in a decline of mental health services use and costs by more than one-third, but triggered a 37% increase in medical care use and sick leave."

Last year researchers writing in *Psychiatric Clinics of America* showed that untreated or ineffectively treated patients who had mental health/substance use disorders were high users of general medical health services.

Editor's Note: *All sources cited in this article are included in a reference list posted at the Partnership's Web site, www.workplacementalhealth.org/mhparity.aspx. Look for "Reference List: Straight Answers to Employer Questions About Mental Health Parity."*



Conversely, an article in the *Journal of the American Medical Association* made the link between appropriate treatment and increased productivity. Researchers found that employees diagnosed with depression who received "enhanced treatment" showed nearly a three-hour improvement in their work performance *each week*. Job retention also improved significantly.

Q. ***Will parity cost us more?***

A. ***Not necessarily.*** The Congressional Budget Office estimates that the new parity law will increase premiums by an average of about two-tenths of one percent. That amounts to pennies per employee per month. When productivity is also taken into account, the business case is even stronger. And there are real-life examples from organizations that already have a history of success with parity of mental health and substance abuse coverage.

For eight years, the Federal Employee Health Benefits Program has offered mental health parity benefits to 8.5 million federal employees and members of Congress **without a significant increase in costs**. Researchers reported their findings in the *New England Journal of Medicine*.

Parity cost data also exist from the states—most of which have already enacted some form of parity.

- New Hampshire implemented parity in 1994. They surveyed 11 of the state's insurance carriers and health plans and found that none of them attributed any change in premiums due to parity.

- North Carolina instituted parity for state employees in 1992, and mental health payments as a portion of total health payments decreased from 6.4% to 3.4% for the fiscal year ending in 1996.

Rhonda Robinson Beale, M.D., Chief Medical Officer at OptumHealth Behavioral Solutions (formerly United Behavioral Health), recently led a retrospective analysis of Optum clients who operate in states that have already enacted mental health parity laws. She reports that during the first year some employers experienced increases in the use of services and cost, but by the second year costs began to return to normal.

Q. *Can we still manage care?*

A. *Yes.* The law's intent is for health plans to retain their ability to manage benefits. Health plans are permitted to continue use of medical necessity criteria, utilization management, and other care management techniques.

A word of caution when implementing managed care tools: Researchers writing in the *Medical Clinics of North America* called attention to the experience of one company that reduced behavioral healthcare benefits, which simply shifted costs from mental health to physical/surgery medicine. At the same time, the company experienced a 22% increase in absenteeism among users of behavioral health services. The conclusion was inescapable: The company ended up paying more for an inferior product that also increased its disability costs.

Q. *Can managed mental health plans provide quality health services?*

A. *Yes, by offering value-based benefits that focus on positive outcomes as well as cost.* Pitney Bowes recently studied the effects of value-based benefit design on improving medication compliance. John J. Mahoney, M.D., M.P.H., a consultant for Pitney Bowes, wrote in the *Journal of Managed Care Pharmacy* that the total-value approach of using disease management and promoting preventive care translated into significant savings for Pitney. He concluded that employers cannot just cut costs or copayments to achieve compliance; such action must be taken as part of a concerted program.

The concepts of maximizing the "value" of employer-provided healthcare benefits and measuring the return on investment (ROI) have gained considerable currency among employers and their broker/consultants and vendors. As pioneered by Pitney Bowes in the early part of this decade, the concepts seek to eliminate plan design barriers and incentivize employees to seek the best, high-value, evidence-based care.

A group of Kansas City employers affiliated with the Mid-America Coalition on Health Care is currently pursuing this approach, and an initial analysis of their baseline data identified mental health needs as one of the four key health risks among their workforce.

"Our employers understand the impact depression has on the workplace," says William L. Bruning, president of the Coalition. "The concepts of presenteeism and depression's impact on productivity resonate intuitively with employers. However, employers are distrustful of many of the ROI figures appearing in the business press. What they want to see demonstrated is a return that is slightly better than break-even on their mental health investment. They know that an additional, but difficult to measure, return will be in the areas of productivity and absence management."

Employee Benefit News covered a study by CIGNA Behavioral Health that looked at clients who had been hospitalized for a psychiatric illness. CIGNA compared those clients discharged to "usual" outpatient care with those discharged to "enhanced" outpatient care and found that those in the enhanced care group had 53% less recidivism while those in the usual care group had an increase of 11% in readmissions.

Beale, too, advises employers to focus on ways to achieve the greatest possible value by offering new or improved behavioral health services and/or initiating treatment earlier. As employers make benefit changes, Beale suggests they analyze cost drivers, review the history of complex

"The primary concern has been that the existence of parity would result in large increases in the use of mental health and substance abuse services and spending on these services. With respect to the seven FEHB [Federal Employee Health Benefits] plans we studied, these fears were unfounded."
–Behavioral Health Insurance Parity for Federal Employers, H. H. Goldman, et al., *New England Journal of Medicine,* March 30, 2006, pp. 1378-1386.

"Enhanced" care in the CIGNA study referred to an intensive outpatient care management program.

"Enhanced" treatment in the JAMA article noted on page 4 included a telephonic outreach and care management program that encouraged workers to enter outpatient treatment, monitored treatment quality continuity, and attempted to improve treatment by giving recommendations to clinicians.

cases, and identify gaps in coverage and networks. Optum uses informational and coaching models effectively to promote earlier treatment.

The informational model used by Optum involves reaching out to members with print or Web-based materials about specific mental conditions, appropriate treatment, available resources, and benefits. The company's coaching model includes regular outbound phone calls and personal support for behavior change and adherence to treatment plans.

Researchers who analyzed the Federal Employee Health Benefits Program also looked at the quality of the mental healthcare delivered. Even though care in all seven plans was managed, the quality of mental health services did not decline. In fact, quality improved slightly in three of the plans.

Q. *Does the law require us to cover all psychiatric diagnoses? If not, couldn't we save money by picking and choosing diagnoses?*

A. *No and no.* The bill that passed does not require employers to cover all the diagnoses listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. However, selecting which diagnoses to cover from the *DSM* is not recommended.

DSM, published by the American Psychiatric Association, lists psychiatric disorders. Each disorder is accompanied by a set of diagnostic criteria that require clinically significant distress or impairment. Medical and other insurance companies use these criteria for audits and medical records.

The most important issue here is not the specific diagnoses, but the severity of symptoms, the impairment in function, and the specific type of treatment that is required. "It makes more sense," according to Irvin I. (Sam) Muszynski, J.D., Director of the American Psychiatric Association's Office of Healthcare Systems & Financing, "to focus on 'medical necessity.' Are the patient's symptoms severe enough and the patient's functionality impaired enough to warrant treatment? If the answer is yes, that patient should be treated."

The American Medical Association defines "medical necessity" as healthcare services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is 1) in accordance with generally accepted standards of medical practice; 2) clinically appropriate in terms of type, frequency, extent, site, and duration; and 3) not primarily for the convenience of the patient, physician or other healthcare provider.

Q. *We're concerned about increased costs. Does parity extend to out-of-network coverage?*

A. *Yes.* Parity for out-of-network coverage, however, does not need to increase costs. Researchers writing in *Health Affairs* said,

> "If parity for out-of-network benefits is required, estimates from Stephen Melek [at Milliman] and colleagues are that 20% of professional services nationally would be provided out of network, associated with an aggregate 0.6% cost increase if unmanaged and virtually no increase if managed. These data combined with the data from our study indicate that ensuring access to an out-of-network benefit could be essential to facilitating access to mental healthcare, given the large amount of out-of-network use."

Q. *In addition to value-based benefits, are there other cost-saving measures we can make at this time?*

A. *Yes. Integrating benefits and services can lower costs and improve outcomes.* Juan Prieto at IBM told *Mental HealthWorks* in 2004 that IBM's Care Advocacy Model, which integrated mental health, other medical illnesses, pharmacy, disability, disease management, as well as its employee assistance program, saved IBM $500,000 in outpatient costs in one year. Earlier this year Prieto told *Mental HealthWorks* that IBM will be expanding the philosophy of its Care Advocacy Model into an overall healthcare delivery model, focusing on behavior change.

Researchers at Milliman lend support to IBM's move toward more integration. They wrote recently in a Milliman document, "Those that can achieve and document measurable savings through integrated medical-behavioral care management may gain a market advantage through lower healthcare costs, lower employer costs, and improved clinical outcomes."

Aetna's Chairman Ronald Williams spoke to the benefit of integration and parity coalescing and predicted in *Managed Healthcare Executive* that parity is likely to improve health outcomes "through integrated medical and behavioral benefits and services."

Q. *So, mental health parity will be a win/win/win for employers, employees, and the entire healthcare system?*

A. *Yes.* Mental health parity will work for the long haul—it's sustainable. IBM's Juan Prieto summed it up best: "Everyone can benefit from having a healthcare system that offers the same level of care for mental health and medical care." ◆

Sources: The sources cited in this article are included in a complete reference list posted at the Partnership's Web site, www.workplacementalhealth.org/mhparity.aspx. Look for "Reference List: Straight Answers to Employer Questions About Mental Health Parity."

If you have questions about the parity law, send an e-mail to Mary Claire Leftwich at the Partnership for Workplace Mental Health, mleftwich@psych.org.

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When Parity Means "Business as Usual"

By Nancy Spangler, M.S., OTR/L

Adapting to changes in mental health parity legislation may be a challenge for some employers, but to others, parity is not terribly new. In fact, a number of U.S. workplaces have been offering mental health benefits on par with their medical plans, or very close to it, for many years. In some cases, their mental health coverage is even better than their medical coverage (i.e., co-payments or cost-sharing are lower for mental health than for medical/surgical treatment).

The Partnership for Workplace Mental Health talked with several employers to learn more about their experiences with offering strong mental health benefits and the impact that this has had on their organizations. (Read about these employers and others in the Partnership's database, *Employer Innovations Online* at www.workplacementalhealth.org/search.aspx.)

Weingarten Realty Investors In the Houston area, a number of employers began a move toward parity in 2002 through the leadership and encouragement of Stanford Alexander, Chairman of Weingarten Realty Investors. Weingarten is a self-insured Fortune 500 firm with more than 400 employees in 23 states. Alexander's family was touched by mental illness, and when he learned that a number of his employees who had mental conditions were not seeking the professional help they needed due to limitations of medical coverage, he was determined to do something about it.

Weingarten's plan includes coverage for alcohol and substance abuse and for treatment of family/marital problems. There are no caps on mental health treatment, and deductibles are the same as they are for general medical treatments. Mickey Townsell, Vice President of the company's Human Resources, says that Weingarten budgets about $10,000 per employee per year for benefits. Mental health represents approximately 1.5% of annual benefit costs.

"Every company is obviously looking for ways to reduce costs, but with all the demands we have to deal with in this day and age, you have to see what you can do to help employees," says Townsell. Assisting the company's employees, which Weingarten considers its "key assets," adds value long term. Here is just one example of how this program paid off for Weingarten.

An employee, who had been with the company for 15 years, was struggling with a mental health issue and took a leave of absence. Access to professional care helped this employee work things through, and he was able to return to work. "You don't want to lose those long-standing employees or their family members if you can help them," Townsell stated. "Getting them the care they need may help the employee's overall ability to be at work."

Weingarten assesses the results in a number of ways. "Yes, you can look at turnover—and our turnover is about half of the industry standard—that's a meaningful measure. But peace of mind is immeasurable. Employees being more productive, more thankful to the organization: Those are meaningful outcomes that are not easy to quantify."

Townsell says that Alexander treats employees like family. Parity was another step toward giving people the help they need. Alexander values and develops good leaders. Senior managers have grown up together, many for 20 years or more. That gives the leadership team comfort with each other. "Employees here want to do a good job for these leaders; they have a sense of pride in this organization," says Townsell. "People work hard, they know what they need to do—but at the same time family is highly valued. If I need to leave early to get to my son's game, I know that's all right."

Alexander has served on several hospital boards and will contact the hospital himself to use his

Mental Health America and Mental Health America of Greater Houston provided a portion of the information included in the descriptions of Weingarten Realty Investors, the *Houston Chronicle*, and the Houston Texans. Additional information about parity is included on the Mental Health America of Greater Houston Web site, www.mhahouston.org.

influence on behalf of an employee or family member if needed. Employees know that they can count on him to help in many ways. They all call Weingarten a family-owned, publicly traded company.

Houston Chronicle After Weingarten Realty Investors set the stage for mental health parity, a number of other Houston employers joined in, including the *Houston Chronic*le and the Houston Texans (featured in *Mental HealthWorks*, 4th Quarter, 2008).

The *Chronicle* employees 1,400 people in the Houston area and is led by Jack Sweeney, President and Publisher. Their organization is self-insured. In 2002, the *Chronicle* implemented mental health parity and increased promotion of their EAP, which provided 24-hour access to mental health support and three in-person visits at no cost.

The *Chronicle's* total healthcare costs remained flat, and Sweeney reports they experienced a number of additional benefits. The parity effort and increased attention on mental health has helped improve worker performance, enhanced communication between managers and employees, and reduced the stigma of accessing treatment. “It’s a win-win for the company and the employees,” he said. “People seek help earlier and get back to health and to work quicker if you show respect for their issues.”

Just implementing parity is not enough, though. Sweeney suggests leaders need to set examples and address emotional issues right along with exercise and other physical health issues. He also encourages employers to think of the work performance side, not simply direct costs, when evaluating parity. “Emotional problems drive up health costs on the primary care side if you do not deal with them. Companies need to push for high quality, well coordinated care, and get their vendors to work together to address costs and cost drivers,” says Sweeney.

Houston Texans To implement mental health parity, the Texans sought an insurance carrier to work with them hand-in-hand designing a plan with co-pays and deductibles equal across behavioral and medical/surgical areas. To their surprise, carriers predicted their healthcare costs would increase 20%-25% if they offered such generous coverage in behavioral health.

In 2002, the first year of operations for the Texans, parity was instituted. Cigna agreed to equalize the plans and charged 2% more than expected costs without parity with the understanding that additional charges would be added at the end of the year based on increased costs. Employees did use the mental health benefits, but total costs did *not* increase. The base rate and premiums stayed the same.

JPMorgan Chase With headquarters in New York and Chicago, the JPMorgan Chase benefits crew is evaluating adjustments needed for parity for their many different medical and behavioral health plans across the country. The behavioral health plans covering their 140,000 U.S.-based employees are strong, and although most plans already meet parity requirements, all must be reviewed to ensure agreement with the measure. The complexity of plan designs makes the revision challenging for large employers with many locations.

Daniel J. Conti, Ph.D., Managing Director of EAP & Work-Life for JPMorgan Chase, says, "Really, the message of parity is old news to us—we’ve known for a long time that good mental health coverage is critical to businesses. What employers should know is that psychiatric illness has a profound impact on work. This is not speculation. There is strong research showing that psychiatric illnesses drive more disability and longer periods of disability ... so it would only make sense that a corporate-sponsored health plan would pay close attention to mental health."

Pitney Bowes J. Brent Pawlecki, M.D., Corporate Medical Director of Pitney Bowes, told *Mental HealthWorks* that Pitney Bowes has

had parity for many years, and "we don't expect to have to make many changes" to comply with the new law. He noted that Pitney Bowes has worked hard over the years to create a "culture of health," which is tied to mental health. "We don't separate mental health from physical health," he said.

Pawlecki emphasized that while some companies may look at each of their programs as a way to contain costs, Pitney Bowes tends to look at the entire culture of health and see quality health benefits as an investment in their employees.

The cornerstone of Pitney Bowes' approach to healthcare is the integration of value-based benefits and services. Even with good health benefits, though, Pitney Bowes' annual costs are rising at a substantially lower rate than the other companies it benchmarks against. "We believe these results are testimony to the return-on-investment of our integrated approach to health and wellness," Pawlecki said.

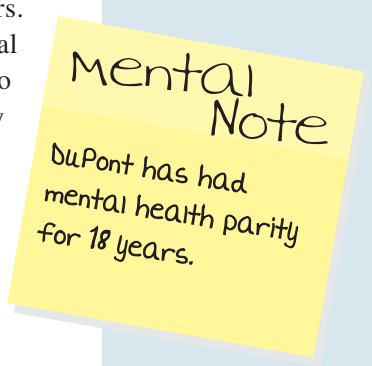
To keep tabs on employee morale, Pitney Bowes uses an employee engagement measuring tool, which asks questions about how engaged employees are, how effective the leadership is, which benefits they value, and so on.

The leadership at Pitney Bowes believes that investment in the health of its employees has proven important for the overall success of the corporation, providing value for both its employees and shareholders.

DuPont Paul Heck, EAP Director, shares that DuPont has had mental health parity since 1991. "In the U.S., DuPont pays 90% for any mental health treatment, up to $1.5 million per year, with no deductible as long as care is accessed through the EAP. This is *better* coverage than our medical/surgical plans, though the difference would depend upon which plan is chosen by the employee."

EAP referrals are required for all in-network treatment, from intensive outpatient therapy to certified alcohol/substance abuse counseling to inpatient care. EAP is not just a benefit but also a hands-on manager of quality of care. With an emphasis on improving quality of care, not just cost, DuPont developed a grid to guide EAP referrals to the right level of care, matching need to level of intervention.

In the 1990s when others were seeing 9%-12% increases in overall healthcare costs, DuPont's increases were 0%-3%. Recidivism from treatment was also lower than other employers. "We're still offering a robust EAP/behavioral health program because we've been able to justify that better management and quality of mental healthcare reduces total costs," Heck said. "This is very important to self-insured companies."



Integrating behavioral health also extends to disability management. DuPont's EAP coordinates psychiatric disability management, and the EAP is often involved as a consultant to the employee and the manager as workers go out on leave and as they return. "Our whole philosophy is that if a person is too sick to work, it is a personal crisis. Our model is based on managing disability, getting people back to work, and helping them return to better health. People self-actualize through positive work experiences."

Heck made the following recommendations. As employers implement mental health parity, they should think beyond simply improving mental health coverage—the effort has to be value-driven. Workplaces need to reduce financial barriers and stigma. People with mental health conditions that are unaddressed will often act out in the workplace in ways that employers don't consider, e.g., by excessive emotionality and confrontation that leads to work team disruptions, presenteeism, lawsuits, loss of intellectual property, increased turnover rates, etc.

State of Ohio The State of Ohio has had a joint labor management group for many years with equal representation from bargaining units,

management, and union employees. The union drove the effort to equalize mental health and substance abuse benefits with their medical plans. In 1990, a behavioral health carve-out plan was initiated in one of the state's 17 health plans. Ohio was among the first states, and perhaps the very first, to include parity of substance abuse.

In 1990, behavioral health care expenditures for the 23,000 covered lives included in this plan dropped from $11 million in 1989 to $7 million.

Mental Note

Ohio was one of the first states to have substance abuse parity.

Benefit manager Gary Hall was hired in 1990 to manage the transition to the new behavioral health vendor. At the time of his hire, Hall was working as a psychiatric nurse. He was able to use his clinical and health system skills when talking with employees who were concerned about having to switch from a current clinician to a clinician within the behavioral health network. To smooth the transition and to ensure proper coverage as the regional networks were developed, the vendor worked with employees on a case-by-case basis. In some cases, the vendor allowed employees 12 additional visits with their current clinician, and patients were allowed the right to nominate their clinicians for inclusion in the vendor's network, upon review of credentials. Hall also has a business degree and a background in human resources.

Hall says that before parity, coverage in some cases was too restrictive, but in other cases was overly generous and without accountability. Through the new plan, the state finally had some kind of handle on what their dollars were covering. Anecdotally, Hall feels the quality of behavioral healthcare improved as well through the concerted effort and attention. He says "Mental health parity is still saving us money."

In 1995, all mental health and substance abuse coverage came under one behavioral health plan managed by the vendor now operating as OptumHealth Behavioral Solutions. Coverage increased from 23,000 lives to 134,000 lives, yet costs only increased from $7.1 million in 1995 to $10.6 million in 1996. This is still less than what the state paid for 23,000 lives in 1989. Next year, the state will be moving to a self-insured plan.

Polk County, Florida Before 2008, Polk County's carve-out plan for mental health and substance abuse treatment limited the number of hospital days or outpatient visits allowed. As the County analyzed chronic conditions among its employees and their dependents, they discovered that mental health problems were affecting people's ability to improve physically, and work abilities were declining. The County began implementing disease management programs, primarily for diabetes and hypertension, in 2005. They found tremendous value in the case management approach and in treating the whole person, not just a part of the problem. In addition, they determined that most mental health treatment is now being delivered in outpatient formats, and they felt their risk was low in moving to full parity for mental health coverage.

Risk Management Director Mike Kushner said that in January 2008 the County began working with Aetna for its EAP and behavioral health treatment. Aetna also became the third-party administrator for the County's self-funded general medical/surgical plan. There is now no distinction between mental health and medical visits. Although there are some elements of utilization management, such as focusing on outpatient care, there are no limits on hospital days or the number of psychological or psychiatric outpatient visits. The plan does cover treatment in residential facilities for drug addiction and withdrawal, but the incidence of these cases has been greatly reduced.

The County's disease management approach removes several barriers to treating chronic conditions. For people with diabetes, for example, easier access to pharmacy services is provided by a clinical pharmacist onsite in their health clinic. To reduce financial barriers, all co-pays for treatment are waived, as long as participants routinely complete their hemoglobin A1C

checks, eye examinations, and foot checks. All medications are covered at a 100% level, including those for common co-morbidities, such as depression, bipolar disorder, and hypertension.

Screening for depression is included in both the diabetes and hypertension management programs. Participants are referred to mental health professionals for psychotherapy as needed. Aetna has a "gap-in-care" approach that allows them to determine through claims analysis when adherence with treatment has dropped. Letters are then sent to the individual and to his or her physician to alert physicians to potential problems in discontinuing treatment.

In terms of costs, the County had expected to see mental healthcare utilization rise in the first year after parity, and it did increase slightly. Total healthcare costs, however, have not increased.

Common Themes. Several themes recur among the examples of employers who are leaders in the move toward parity in mental health benefits.

- Equalizing benefits is a good fit with the company's workplace culture and/or company leadership values. Leaders visibly support mental healthcare.
- Features of enhanced health management are frequently implemented concurrently with parity. These include cost control (case management), quality improvement (integrated benefits, coordinated care), and/or enhanced consumer involvement (early identification, enhanced communication with employees and family members about benefits, and enhanced support for mental health conditions).
- Those who have offered strong mental health benefits tend to provide them in the context of a range of proactive health and wellness programs or other employee-centered programs, such as work/life balance initiatives or safety programs.
- Employers assess a wide variety of outcome measures, including total healthcare costs, employee engagement and satisfaction, attendance, and work performance. ◆

Ms. Spangler, president of Spangler Associates, Inc. and consultant to the Partnership for Workplace Mental Health, is a prevention and health management specialist in Kansas City.

Everybody Wins When Employers Help Employees In Financial Distress

The current financial crisis is taking a toll on people's mental health, not just their pocketbooks, according to *Research Works*, a new series of issue briefs published by the Partnership for Workplace Mental Health. "Our goal with this new series of issue briefs," says the Partnership's Director Clare I. Miller, "is to translate research into action for employers. Each issue will include a review of the literature, action steps, and employer case examples."

The first issue brief, "Employee Personal Financial Distress and How Employers Can Help" covers research about the impact financial education and counseling can have on improving employee health, work performance, and attendance. It recommends steps for employers to take to alleviate employee distress about finances. For instance, employers can offer employees personal financial education and ensure access to mental health counseling. The brief also includes case examples from companies such as IBM, Pepsi Bottling Group, The Home Depot, and USAA.

"Today's troubling economy makes a focus on mental health all the more important," said Alan A. Axelson, M.D., Co-Chair of the Partnership's Advisory Council and Medical Director of InterCare Psychiatric Services in Pittsburgh, PA. "Job retention concerns often translate to people not taking care of their health, especially their mental health."

William L. Bruning, J.D., M.B.A., Co-Chair of the Partnership's Advisory Council and President and CEO of the Mid-America Coalition on Health Care in Kansas City, Missouri, notes, "As the economy worsens and employers streamline their workforces, it is critical to maximize employee productivity. We hope employers take advantage of this exciting new resource." ◆

Research Works is distributed online and posted on the Partnership's Web site at www.workplacementalhealth.org. To be included on the distribution list, e-mail mleftwich@psych.org. Include "mailing list" in the subject line and contact information in the body of the e-mail.

Upcoming issues of *Research Works* will cover employee engagement and the new federal parity law. Issues will be available for free download at www.workplacemental-health.org.

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Mental HealthWorks

FIRST & SECOND QUARTERS 2009

PUBLISHED BY THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE AMERICAN PSYCHIATRIC FOUNDATION

Conference Focuses on Productivity Amid Economic Decline

The Disability Management Employer Coalition's 14th Annual International Disability and Absence Management Conference, "Expanding Our Horizons: Cost Savings through Collaboration & Innovation in Workforce Management," takes place July 19-22, 2009, at the Doubletree Hotel-Lloyd Center in Portland, Oregon.

This year's conference focuses on innovative, cost-saving disability and absence management strategies for a new economy. The conference includes 44 sessions covering a broad range of topics, e.g., managing workforce productivity during economic decline, meeting the new FMLA and ADAAA challenges, and understanding Hispanic claimants in the disability world. More than 70 companies will share their stories, including Harley-Davidson, Boeing, Puget Sound Energy, and Owens Corning.

To view the complete program, visit www.dmec.org. Published conference registration fees start at $599. Members of the American Psychiatric Association are eligible to receive a $100 discount; simply register online at www.dmec.org and use promotional code APA2008.

For more information about the DMEC Annual Conference, go to info@dmec.org or call 800-789-3632.