# Improved Mental Health Benefits.
# Improved Productivity.
# Healthy Employees.

Making the right choices for
your organization.

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New York Business Group on Health would like to thank our partners and contributors to *Improved Mental Health Benefits. Improved Productivity. Healthy Employees*. For their insight and expertise, special appreciation goes to Noah Morgan of Merrill Lynch, Yahayra Gonzalez and Michelle Martin of CBS, Kathleen Mahieu of Hewitt Associates, Denise Podeschi of Mercer Health and Benefits, and Claire Miller of the Partnership for Workplace Mental Health. We would also like to extend a special thanks to Pfizer for funding this important initiative.


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# INTRODUCTION

## FOCUS ON MENTAL HEALTH BENEFITS

As a purchaser of healthcare benefits, you know the importance of mental health benefits. You are probably also aware of the array of options available and the complexity of making the best choices for your organization. To help in this effort, New York Business Group on Health (NYBGH) has created *Improved Mental Health Benefits. Improved Productivity. Healthy Employees*. This resource will serve as a roadmap for employers to navigate both mental health benefits and related internal programs.

# EXECUTIVE SUMMARY

Despite large expenditures for mental health services, employees are not receiving high-quality care and do not have access to services. This is particularly important for purchasers to manage because mental health disorders are common, serious, and expensive.[1] Unlike most other medical conditions, the indirect costs related to absenteeism and productivity loss meet or exceed direct treatment costs.[2,3] NYBGH has produced this publication to briefly explain the issues related to mental health and to provide employers with the necessary information to create the best-suited benefits for employees.

This guide presents step-by-step information for employers and other healthcare purchasers on how to evaluate current needs and compare them to the benefits they provide. Future strategies for benefit design and contracting needs are also included. For example, the federal mental health parity legislation enacted at the beginning of 2010 has given employers a new set of benefit-related considerations to address. This resource will assist employers in achieving compliance with those regulations.

Over $100 billion is spent on the delivery of mental health and substance abuse treatment.[3]

Comprehensive mental health benefits information and tips throughout this guide may help you

- **Meet the unique mental health benefit needs and goals of employees in your organization—**Developing an appropriate strategy requires working with current vendors to create benefit offerings that encourage appropriate, effective, high-quality, and efficient treatment. As an employer, you have the financial clout to negotiate with health plans. Working closely with your plans will allow effective implementation of targeted initiatives that will assist in realizing your organization's goals

- **Understand the distinct advantages and disadvantages of carving-in versus carving-out to a specialty vendor, as a way to administer mental health and substance abuse (MH/SA) benefits—**Carving out mental health benefits is a different approach for providing access to services. Carve-outs are most often used in large companies. A Deloitte & Touche study found that only 31% of employers with fewer than 1,000 employees carve out part of their medical plans to specialty vendors, which compares to 78% of employers with 19,000 or more employees[4]

- **Learn what employers are doing with respect to mental health—**If your organization offers an employee assistance program (EAP), information is available on the projected value from the agreement since costs can vary dramatically based on the package of elected benefits. You will also find strategies for communicating EAP and other mental health benefits to your employees

- **Sell your plan to the C-Suite—**Even in tough economic times, a business case can be made for comprehensive mental health benefits. Stress and depression are intertwined with factors in an employee's work and home life, which then impact effectiveness and productivity. Quantifying the impact of depression and related comorbidities early on will help you make an effective business case to the C-Suite, and this guide provides the tools to assist in this endeavor

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# The Impact of Mental Health Issues in the Workplace


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# THE BROAD REACH OF MENTAL ILLNESS

Mental illness takes many forms. It can be found in the offices of CEOs, in the cubicles of analysts, on the field with star football players, at your accountant's desk, and in your subway conductor's car. Mental illness is an equal opportunity medical disease. It does not discriminate. Mental illness affects men and women, young and old, rich and poor, and people of all races and cultures.

### Of workers employed full-time[3]

- More than 8% were diagnosed with a mental illness
- 10.5% were diagnosed with a substance abuse disorder

## Did you know?

Major depressive disorder is the leading cause of disability in the United States for people ages 15-44, with the median age of onset at 32 years.[5] In other words, people are affected in their prime working years. It is therefore not surprising that most of these people are covered by a commercial payer.[6] In the depressed population, the presence of other psychiatric conditions (comorbidities) is common; 27.7% of patients have two or more of these comorbidities.[7]

Despite these alarming figures, the workplace traditionally has been more supportive of employees with diabetes or heart disease than it has been of employees with posttraumatic stress disorder or depression.[8]

# WHAT DO EXECUTIVES SAY ABOUT THEIR OWN BATTLES WITH MENTAL ILLNESS?

> “A CEO is expected to be a strong, stable, dynamic leader. I didn’t want to provide a bullet that could be used against me.”[9]

**Tom Johnson,**
former chairman of CNN News Group, explaining why he did not seek treatment for depression. Johnson finally found relief after a psychiatrist prescribed one of the newer antidepressants in the early 1990s, and he went public with his struggle in January 2002.

—Attributed to the Wall Street Journal Online, June 26, 2002.

> “…there’s nothing, repeat, nothing to be ashamed of when you’re going through a depression. If you get help, the chances of your licking it are really good. But, you have to get yourself onto a safe path.”[10]

**Mike Wallace,**
co-editor of 60 Minutes, on his personal journey through depression.

—Attributed to an interview with CBS Cares.

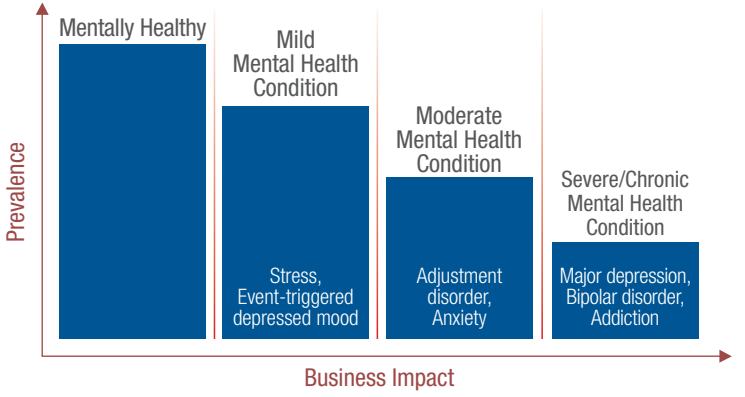
> “I knew I wasn’t well.”[11]
>
> **Jane Pauley,**
> as she recounts her behavioral impulses during her battle with bipolar disorder.
> —Attributed to her autobiography, *Skywriting:A Life Out of the Blue.*

> “My embarrassment of the stigma of mental illness kept me from getting it properly treated.”[9]
>
> **Larry Gellerstedt,**
> on his silent struggle with depression. He managed to hide his illness while still participating in notable projects such as the construction of the Olympic Stadium in Atlanta.
> —Attributed to the Wall Street Journal Online, June 26, 2002.

And then, of course, there are legions of not-so-famous employees who “struggle along” daily with their depression or anxiety or alcoholism or all three while they are at work. A Harris Poll found that 22% feared that mental health therapy would go “on their record,” and 19% were afraid that family and friends would find out. (Men expressed concern more often than women.)[12] In fact, many prefer to pay for treatment out-of-pocket to avoid the diagnosis of depression appearing on their medical records.

# THE IMPACT ON EMPLOYEES AND THE BOTTOM LINE

**Impact of Mental Health Conditions[13]**




It is important for healthcare purchasers to manage costs and services because mental health disorders are common, serious, and costly. Unlike most other medical conditions, the indirect costs related to absenteeism and presenteeism meet or exceed direct treatment costs. In fact, mental illness and substance abuse cause a loss of approximately 217 million work days annually and cost employers an estimated $17 billion per year.[3]

## Did you know?

$104 billion was spent on the delivery of mental health services in 2001.[14] Despite this immense outlay, employees were not receiving access to high-quality services.[3]

Contrary to popular belief, most people with mental health illnesses or substance abuse disorders work. Within the working population (aged 18-54), 8.2% of full-time employed adults experienced a mental illness and 10.5% experienced a substance abuse or substance dependence disorder.[3]

Additionally, disability costs related to psychiatric disorders are high and continue to rise. According to the World Health Organization (WHO), depression was the fourth leading contributor to the global disease burden in 2000, and by 2020 depression is projected to be the second leading contributor to the global burden.[15] Further, behavioral health issues are the third leading cause of long-term disability for employers in the United States.[16]

## GOOD NEWS ON THE HORIZON

Research has shown that programs—such as those suggested here—that address prevention and early intervention may help improve productivity levels and reduce absenteeism and disability claims associated with mental health disorders. Employers can assist employees with mental illness by providing robust resources that address

- Prevention
- Treatment
- Management of mental health and substance use conditions (eg, offering EAPs and comprehensive mental health benefits)

Another way employers can help their employees is to focus on the quality of these mental health benefits and to promote their use. Today it is more common for patients with depression to be treated by their primary care physician than by a specialist.[3] In order for patients to get the proper treatment, the collaborative care model is a systematic approach that helps primary care physicians provide treatment in conformity with evidence-based guidelines. Research shows that patients with depression respond well to pharmacotherapy and supportive care in the primary care setting when collaborative care is practiced.[17] Another effective depression treatment is exercise. A study demonstrated that the efficacy of exercise was generally comparable with patients receiving antidepressant medication for major depression.[18] In sum, treatments are available that can save lives and improve the daily functioning and quality of life of employees.

# The Impact of Mental Health Issues at the Workplace

People may be affected by depression during their prime working years.

In the United States, mental illness and substance abuse cause[3]:

- An approximate loss of 217 million work days annually
- An estimated cost of $17 billion to employers per year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# Identify Your Organization's Needs


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# FIRST AND FOREMOST: EVALUATE

If you are reading this, then you probably are wondering about the effectiveness of the mental health benefits that your organization offers and how to evaluate them. Collier Case, Sprint's Corporate Benefit Manager, who helped roll out the company's depression workplace initiative in 2005, identified evaluation as a very important first step. This section presents a step-by-step guide to evaluating your organization's needs and how best to meet them.

## Step 1: Assess the prevalence of mental health conditions

**How prevalent are mental health conditions in your workforce, and within your employees' families?**

Your health plan and disability vendors can assist you in collecting the necessary data to take this first step. Another possibility is to use online calculators such as the *Alcohol cost calculator* and the *Depression calculator*. These resources can help measure the costs your organization incurs from alcohol abuse or depression. Refer to page 66 for links to the online calculators.

A health risk appraisal (HRA) can also provide prevalence information if it includes questions that screen for depression. Use the data to answer the following questions:

- What mental health conditions are most prevalent?
- How are mental health conditions affecting absence and disability rates?
- Is your population utilizing antidepressant medications, and if so, are members compliant with their treatment?
- Which medical conditions are prevalent in your population, and is there evidence of depression comorbidities?

## Step 2: Assess the impact these mental health conditions have on your business

**How are both direct and indirect costs affecting the performance of your business?**

Again, the source of this information will reside with the vendors with whom you contract, and you can use the calculators on page 66 to get statistics with your company's profile in mind. Of course, some of the indirect cost data will be information collected internally within your organization. Some areas to consider include

- Program cost and utilization data for EAP, Work/Life, and mental health/substance abuse (MH/SA) programs
- Frequency, duration, and cost associated with absence and disability related to mental health conditions
- Prevalence and cost of conditions with medical and mental comorbidities
- Business performance metrics, such as productivity measures and employee engagement

This information can be used to convince the C-Suite to invest in mental health.

## Step 3: Determine your compliance with the new mental health parity legislation

**Is my organization compliant with the Mental Health Parity and Addiction Equity Act?**

On October 3, 2008, President Bush signed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) into law.[19] Under this federal law, any group health plan that offers mental health and substance use disorder benefits is required to provide coverage at parity to medical and surgical benefits.[20]

# MAJOR PROVISIONS OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT[21]

The MHPAEA applies to employers with 50 or more workers whose group health plan chooses to offer mental health or substance use disorder benefits.[20] Specifically, the MHPAEA includes:

**Permanence of original 1996 law—**The MHPAEA makes permanent the 1996 law providing that a healthcare plan or policy may not provide a separate lower annual or lifetime dollar maximum on mental health benefits compared to medical benefits.

**Substance use disorders—**The MHPAEA extends its requirements to benefits for substance use disorders, not just mental health disorders.

**Financial coverage—**The MHPAEA mandates that the financial coverage for mental health and substance use disorder benefits cannot be more restrictive than the predominant (ie, the most common or frequent) financial requirements applied for substantially all medical and surgical benefits under the plan. Financial requirements include deductibles, cost-sharing, out-of-pocket limits, and annual and lifetime dollar limits.

**Treatment limitations—**The MHPAEA requires that the treatment limitations for mental health benefits cannot be more restrictive than the predominant treatment limitations applied for substantially all medical and surgical inpatient and outpatient benefits under the plan. Treatment limitations include the number of covered office visits, days of inpatient coverage, and other similar limits on duration or scope.

**Out-of-network coverage—**Group health plans must provide out-of-network benefits for mental health and substance use disorders in a manner consistent with parity requirements if out-of-network benefits are provided for medical and surgical services.[21]

**Definition of "mental health conditions" and "substance use disorders"—**Under the MHPAEA, the terms "mental health conditions" and "substance use disorders" are to be defined by the group health plan, in accordance with any applicable federal and state laws.[20]

**Effect of state laws—**The MHPAEA provides that states may impose additional requirements and consumer remedies relating to coverage of mental health conditions and substance use disorders. Any additional state law requirements, however, will apply to fully insured plans. The Employee Retirement Income Security Act (ERISA) continues to preempt such laws for self-insured plans.[21]

**Disclosure of medical necessity criteria—**The MHPAEA requires employer healthcare plans to disclose to current and potential plan participants and providers the plan's criteria for determining medical necessity.[21]

**Cost exemption—**A group health plan can obtain an exemption from the requirements of the MHPAEA if the plan can establish that application of the MHPAEA will result in a cost increase of 2% in the first year and 1% in each subsequent plan year.[20]

The Congressional Budget Office estimates employer premiums will increase 0.4% as a result of parity.[22]

## Limiting access to mental healthcare services does not lead to savings for employers

One study showed that any savings obtained from reduced employer-sponsored mental health specialty services were offset by utilization of nonmental health benefits.[23] The retrospective analysis was conducted on employee claims data at a time when the employer introduced several cost-containment measures, for both mental and nonmental health benefits. This included

- Plans that had lower premiums, but higher deductibles
- Prior authorization requirements on inpatient care and utilization review for inpatient and outpatient care

Definitions of mental versus nonmental health benefits were based on International Classification of Diseases, Ninth Revision (ICD-9) codes.

During the 3 years of analysis, results showed a decrease of 37.7% in total costs of mental health services per user. However, savings in mental health services were fully offset by an increased use of other services, mainly outpatient nonmental health services.

Further, reduced utilization of mental health services substantially increased the number of sick days taken by employees with mental health problems. The study concluded that savings attributed to limiting mental health services had negative outcomes on the health status of patients, with no savings to the payer.[23]

# Identify Your Organization's Needs

### To evaluate needs

1. Assess prevalence
2. Assess impact
3. Determine compliance with the MHPAEA

Once you understand your organization's needs, you can develop a strategy and sell it to the C-Suite (next 2 sections).

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# Develop a Strategy

# DETERMINE EXPECTED OUTCOMES. IMPLEMENT TARGETED INITIATIVES.

Based on the data collected, you will be well positioned to determine the direction for your strategy and identify specific focus points such as EAP use and pharmaceutical utilization that will be targeted to achieve the maximum value. With these focus points, you can then determine your expected outcomes. For instance, if antidepressant utilization is high, but EAP and MH/SA benefits utilization is low, you might consider a joint initiative that improves awareness of EAP services and at the same time addresses appropriate antidepressant use and compliance.

## Did you know?

As a result of these initiatives, your organization may develop a set of expected outcomes such as an increase in EAP utilization of 3% to 5% and an increase in compliance with antidepressant medication of 80%.

A specific example is a large New York City employer that has an in-house clinic and an EAP that allows for an unlimited number of visits and referrals for therapy. Within the next year, the company plans to analyze data by linking claims, benefits, and EAP records with productivity and in-house clinic data as well as with information collected from outside clinics. It is important that employers develop and implement a metric to evaluate their data in order to improve the health outcomes of their employee population and increase productivity.

While doing this exercise, the quality of the health plan offerings should also be taken into account. To aid employers in evaluating various plans, the National Business Coalition on Health developed the eValue8 survey tool that allows purchasers to compare plans and decide which offers the highest-quality healthcare to their employees. Included in eValue8's assessment of a plan's overall competence is a section on depression and substance abuse disorders. Questions are asked about how the plan impacts members who need these services, and the physicians and other professionals who provide the services. To learn more about eValue8, which is increasingly being used by purchasers, visit www.nbch.org/eValue8.

# DESIGN BENEFIT PROVISIONS THAT ENCOURAGE APPROPRIATE, QUALITY TREATMENT

As mentioned previously, the newly enacted federal parity legislation requires parity between medical/surgical and MH/SA benefits with regard to treatment limitations and financial requirements. However, employers should look at the entire package, including the

- EAP model available to members
- Structure of disability program
- Availability of pharmacy benefits
- Benefit provisions that encourage both pharmaceutical and mental health therapy when appropriate

# ASK THE RIGHT QUESTIONS

Ask your health plan or mental health vendor questions. Mental health clinicians listed the following questions as important ones for employers to ask vendors.

## Access to Information

Do your employees have ready access to: mental health information through employee educational and referral programs, the Internet, or other self-screening tools? A toll-free number? A well-trained clinician at the earliest point of contact?

## Accurate Assessment

Once employees contact your program or plan, do they receive a diagnosis from a clinician adequately trained in the following areas: Screening for depression and anxiety disorders? Core personal, family, or work issues? Substance abuse? Medical illnesses? An accurate initial diagnosis facilitates quality treatment and successful clinical outcomes.

## Best Treatment Options

After an accurate diagnosis is made, will the employee be referred to a clinician who can effectively manage a psychiatric disorder with the appropriate balance of medication and psychotherapy? Medication and psychotherapy enhance, but do not replace, one another.

## Screening for Depression

Does your health plan encourage its primary care practitioners (PCPs) to routinely screen for depression? Find out more about the importance of this testing and how NYBGH is working to encourage physicians to perform it at www.nybgh.org.

Does the vendor have a program that provides PCPs with the appropriate support and guidance, including information about when to refer patients to mental health specialists? Let your health plan know this is important to you and/or join NYBGH's Mental Health Task Force.

## Geographic Access

How will mental healthcare be provided if clinicians are not readily available in the employee's location? Employers should place special emphasis on specialty providers, such as child therapists.





Asking the right questions of your health plan or mental health benefits vendor will help you understand what your organization needs.

eValue8 is a survey tool that allows purchasers to compare plans and decide which offers the highest-quality healthcare to their employees.

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# Sell Your Plan to the C-Suite

# PRESENTING THE BUSINESS CASE FOR MENTAL HEALTH BENEFITS[12]

Even in tough economic times, a business case can be made for comprehensive mental health benefits. Stress and depression are intertwined with factors in an employee's work and home life, which then impact effectiveness and productivity. The bottom-line investment return should be emphasized to the C-Suite up front; this should occur prior to enumerating benefits for employees.

So, how do you sell your recommendations to the decision makers at your organization? Catherine Baase, MD, Global Director of Health Services for The Dow Chemical Company, made the following suggestions during an interview with Mental Health Works.[12]

1. Add up your direct costs and estimate your indirect costs, such as absenteeism, presenteeism, and job satisfaction. Additionally, you can try employee satisfaction surveys.
2. Figure out what kind of performance outcomes you want (eg, employees who are creative, show initiative, are innovative).
3. Emphasize this is an investment. Write a report for management emphasizing the total economic impact on the company and the outcomes the company can expect from "the spend." Rather than asking management for more money, seek to spend what you have more wisely by eliminating duplication, and implementing better practices.
4. Start with a quick success—the low-hanging fruit, so to speak—so that you can build on early successes.

# Sell Your Plan to the C-Suite

Addressing mental health conditions by providing necessary resources and benefits is a critical investment in population health and productivity.

Kathleen Mahieu,
Hewitt Consulting

In addition to Catherine Baase's recommendations, use the following 2 insights to strengthen your business case when presenting to the C-Suite:

**Emphasize that in the vast majority of cases, effective treatment for mental illness will have a net positive impact on employees and the bottom line, even when you factor in the cost of treatment.**

- Nearly 86% of employees who were treated for depression with antidepressant medications reported that their work performance improved
- A Harris Poll found that 80% of those treated for mental illness reported "high levels of efficacy and satisfaction"
- Abbott achieved a 1.7:1 return on investment by conducting a depression screening program

**Ignoring mental illness is costly.**

- People with untreated mental illness cost more; 50% of visits to PCPs result from patient symptoms unexplained by a physical illness but often associated with depression or an anxiety disorder—such as fatigue, sleep disorders, chronic pain, chest pain, dizziness, and abdominal discomfort—which often lead to unnecessary and expensive testing
- The number of outpatient visits to nonpsychiatric providers was about 50% higher for patients with undiagnosed, untreated, or undertreated psychiatric conditions than for those diagnosed and treated
- Depressed individuals not receiving treatment consume 2 to 4 times the healthcare resources of other enrollees

A number of company-specific variables need to be considered when developing the business case for management, making it difficult to set forth a one-size-fits-all template. There are, however, useful tools and resources that already exist. Particularly helpful are the previously mentioned depression and alcohol cost calculators, and additional resources found in the "Resources" section on page 64.

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# Benefit Design Considerations


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## VALUE-BASED BENEFIT DESIGN

Value-based benefit design (VBBD) is a strategy that can help employers be more effective purchasers of mental health benefits while improving the health of their employees. Currently adopted by some self-insured employers, VBBD provides healthcare services for the management and prevention of chronic diseases or other illnesses at little or no charge to employees. The goal of removing cost barriers is to increase access, improve compliance, and provide better health outcomes to maximize the value of overall healthcare spend. VBBD has the potential to provide a return on investment (ROI) even in the short term because it targets underutilized, high-value medications and procedures for these expensive conditions.[24]

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Value-based benefit design has shown promising results and ROI for chronic diseases such as diabetes and asthma.[24]

Positive ROI for chronic diseases has been achieved by moving medications used to stabilize the condition to the lowest tier (no cost to the employee). The same principles can also be applied to mental health treatment. Reducing the financial barriers to pharmacological treatments and/or talk therapy can help facilitate uptake of necessary mental health treatment by employees and place them on the road to recovery.

To begin to include and implement a form of VBBD for mental health benefits, NYBGH has listed a series of questions to ask each vendor. Of course, even if your organization does not adopt VBBD, it is still valuable to find the answers to these questions. The answers to these questions will help you learn what might work for your organization.

# CARVE-IN VERSUS CARVE-OUT

According to Mercer's 2007 Survey of Health, Productivity and Absence Management Programs, more than 95% of employers offer MH/SA benefits, including employers with fewer than 1000 employees. Most employers administer their MH/SA benefits through their medical plans. Only 17% of all employers "carve-out" MH/SA benefits with a specialty vendor. However, about one quarter of employers with 10,000 or more employees do carve-out MH/SA benefit administration. It is important to evaluate which approach is most appropriate for your organization.[25]

To determine if a carve-in or carve-out approach to MH/SA benefits is right for your organization, consider

- The current health plans and what level of mental health expertise and programming they bring (eg, staff expertise, utilization protocols, reports, network access)
- The current financial and clinical outcomes under the current plan (MH/SA costs, utilization, readmission rates, cross referral rates, etc)
- Whether better outcomes can be achieved through better contracting and performance guarantees
- Other health programs that are carved out (ie, disease management, care management)
- The overall strategy specific to management of high-cost/high-risk populations

## Carve-in[26]

| Advantages | Disadvantages |
|---|---|
| Simplicity—there is one less vendor to manage, unless MH/SA benefit administration is integrated with EAP | Primary account representatives from the health plan may not be trained to understand MH/SA programs and the interfaces required for an integrated model |
| Ease of implementation—when medical and pharmacy programs share a database, MH/SA initiatives are more easily integrated. However, implementation oversight, reporting requirements, and performance guarantees are still recommended to achieve optimal integration, even when MH/SA benefits are carved into the medical plan | The best medical plan may not have the best MH/SA program |
| Unified data capture and reporting—all medical and mental health claims may be centralized, although this could be achieved through a data-warehouse with a carve-out. There are usually additional fees for data feeds | Some medical plans do not have robust MH/SA specialty programs, particularly in the areas of mental health–specific reporting, utilization management, and network discounts |
| Ease of combining and administering deductibles for CDHP/HSA plans | |
| Ease of meeting state-specific benefit mandates for fully insured plans | |
| Lower administrative costs | |

## Carve-out[26]

| Advantages | Disadvantages |
|---|---|
| More robust mental health–specific clinical solutions | More administrative time required to implement integration initiatives with one or more plans |
| More focus on mental health network discounts | One more data feed and it can be difficult to administer shared accumulators (deductibles, out-of-pocket expenses) |
| More comprehensive mental health–specific reporting | |
| More opportunities for custom solutions | |
| More mental health expertise at all levels that results in better cost control and improved outcomes | |
| Mental health–specific performance guarantees and fees at risk | |

Regardless of whether the MH/SA benefits are carve-in or carve-out, consider adding MH/SA-specific contract requirements in the areas of network access, utilization management, screening, and cross referral of high-risk medical populations. This may help achieve better results from your medical plan contract.

# HEALTH RISK APPRAISALS

Increasingly, many employers offer health risk appraisals (HRAs) to their employees. Although not a benefit per se, these tools provide useful information to both employees and employers. Typically, HRAs are self-administered surveys that query employees about health behaviors, risk factors, current health status, and weight as well as other health-and-wellness-related issues. An HRA can be used by employers and other healthcare purchasers to determine the prevalence of certain conditions in their population. They can be provided by health plans or other vendors and completed online, in a written format, via telephone, or in person. In addition, a summary of the results is provided for the employees to take to their physicians.

Regardless of the form of the HRA—or who provides it—it is imperative that it contain questions about mental health. One way of doing this is to ask the questions contained in the widely used depression screener, the Patient Health Questionnaire-2 (PHQ-2). The PHQ-2 uses questions like this in looking for signs of depression:

> Over the past 2 weeks, have you been bothered by
> - Little interest or pleasure in doing things?
> - Feeling down, depressed, or hopeless?

As a part of the planning to offer HRAs to employees, employers should review all federal and state regulations that have been established to guide the use of HRAs and any incentives to complete HRAs. The Genetic Information Nondiscrimination Act (GINA) of 2008 includes provisions that generally prohibit group health plans and health insurance issuers from discriminating against individuals based on genetic information.[27] GINA prohibits a group health plan from collecting genetic information (including family medical history) from an individual prior to, or in connection with, their enrollment in the plan, or at any time for underwriting purposes. Further, GINA prohibits plans and insurers from offering rewards in return for the provision of genetic information, including family medical history information, collected as part of an HRA.[27]

# CARE COORDINATION

Employers should seek to implement the collaborative care model widely in the primary care setting. To that end

- Employers should set specifications for disease management (DM) programs in their DM vendor RFPs and contracts. Specifications should include providing tailored mental health services within DM programs to individuals with comorbid physical and mental health conditions
- Individuals with high-cost medical diseases (eg, diabetes) should be enrolled in a DM program that formally includes a mental health component
- Employers should pay for case management services for major depression and anxiety disorders. This can be accomplished in several ways, including the use of clinical Current Procedural Terminology (CPT)* codes that allow reimbursement for
  - Non–face-to-face clinical activities
  - Administrative payments (such as a case rate) for the management of care by specialty vendors or DM companies
- Consultation between the case manager, the primary care provider, and a consulting psychiatrist should occur in a way so that the psychiatrist advises the primary care treatment team about their caseload of patients with depression. This is intended to maximize the cost-effectiveness of collaborative care by ensuring that patients are receiving the appropriate level of treatment for their condition

*A CPT code, used for billing purposes, is any one of a set of codes that describes services and procedures provided by a physician or other healthcare provider.

More than 10 large trials, in a wide range of settings, have demonstrated the feasibility of improving depression treatment and outcomes relative to usual care administered.[28,29] Collaborative care benefits include higher rates of evidence-based depression treatment (ie, antidepressant medication and/or psychotherapy), improved medication adherence/compliance, a reduction in depression symptoms and earlier recovery, improved quality of life, higher satisfaction with care received, improved physical functioning, and increased labor supply.

Collaborative care has typically been found to increase direct healthcare costs slightly, relative to usual care, mainly by increasing the use of evidence-based depression treatment.[3] However, this investment yields substantial improvements in patients' health status and functioning, so collaborative care is more cost-effective than usual care for depression and has very favorable cost-effectiveness compared with other accepted medical interventions.[30]

There is strong evidence to support the use of "collaborative care" for depression and anxiety disorders in primary care practice settings.

## Benefit Design Considerations

There are distinct advantages and disadvantages to carving-in, or carving-out to a specialty vendor, to administer MH/SA benefits.

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# Components of Mental Health and Substance Abuse Benefits

# EMPLOYEE ASSISTANCE PROGRAM

In recent years, an increasing number of employers have begun offering an EAP. In Mercer's Survey of Health, Productivity, and Absence Management Programs, 93% of respondents offered an EAP. Furthermore, the prevalence of EAPs is similar across small and larger employer groups. In all, 86% of employers with 100-999 employees have an EAP compared to 93% of workplaces with more than 10,000 employees.[25]

Key EAP design elements include the number and type of counseling visits offered to employees and their dependents without additional charge, the array of services offered, and who is eligible for the program. Table 1 provides more detail on the frequency of EAP and Work/Life design elements based on Mercer's 2007 Survey of Health, Productivity, and Absence Management programs. The most common EAP contract is for an externally administered benefit that includes 5 or 6 counseling visits plus Critical Incident Stress Management (CISM) and Work/Life services.

## Table 1. EAP Design Elements[25]

| Employers Offering EAP<br>Basic EAP Program Design Elements* | All employers | >10,000 employees |
|---|---|---|
| EAP | 93% | 93% |
| Face-to-face counseling visits | 89% | 89% |
| Median number of in-person visits | 5 | 5 |
| Critical Incident Stress Management (CISM) | 60% | 69% |
| On-site counselors | 28% | 37% |
| Behavior change/wellness seminars | 45% | 48% |
| WHO'S COVERED | | |
| Part-time employees | 76% | N/A |
| Retirees | 13% | N/A |

*Mercer Survey of Health, Productivity, and Absence Management Programs, 2007. Based on companies with >100 employees.

## PRICING AND UTILIZATION

Most EAPs are priced on a per employee per month (PEPM) basis, with the cost of in-person counseling included in the PEPM. As a result, pricing is largely dependent on utilization of the in-person counseling benefit. The in-person counseling utilization is driven by 3 factors[26]:

- The number of individuals who call the EAP line. As a percentage of eligible employees, this can vary from less than 2% to more than 10%; the average is 5% to 6%
- The percentage of EAP callers referred to the in-person counseling benefit. This can vary from less than 50% to over 90%
- The number of in-person visits, which is driven largely by the EAP program design (ie, a 3-visit model will cost less than a 6-visit model)

Additional variables that impact cost include the number of eligible employees, which elements from Table 1 are included in the service array, and the degree of customization.

> Employee assistance program pricing can vary as much as 300% based on utilization and benefit design.[26]

The variability in pricing for 2 customers with the same EAP benefit is illustrated in Table 2. ABC Corp and Q-CO both offer an EAP that includes up to 5 in-person counseling visits, management consultation, legal and financial consultation, and a bank of 50 hours for training and CISM. There is no Work/Life benefit. While ABC Corp has a slightly lower per PEPM fee, Q-CO has the better value. Q-CO's EAP is reporting appropriate utilization and receiving a reasonable administrative fee for the program, while ABC Corp's EAP is underperforming and overcharging.

## Table 2. ABC Corp and Q-CO EAP Comparison

| | ABC Corp | Q-CO |
|---|---|---|
| Eligible employees | 10,000 | 10,000 |
| EAP benefit | 5-visit EAP | 5-visit EAP |
| Unique user rate | 2.5% | 5.0% |
| Callers referred to in-person counseling | 55% | 85% |
| Average number of counseling visits per user | 4.0 | 4.0 |
| EAP in-person counseling visits | 550 | 1700 |
| EAP fee PEPM | $1.24 | $1.35 |
| EAP admin and profit margin | 285% | 36% |

Employee assistance program utilization and pricing should be regularly evaluated to ensure employers are getting optimum value and not overpaying. When utilization and pricing are not aligned, the appropriate solution may not be negotiating a price reduction. If utilization is low, steps to increase visibility and utilization of the program may need to be taken, including

- Communication campaigns to increase the program's visibility
- Management and supervisory training to increase referral rates
- Formalizing referral links with other benefit programs to increase referral rates
- Performance guarantees related to implementing each of these steps
- Performance guarantees that tie PEPM rates to utilization thresholds

## Did you know?

Almost 65% of employers invest in solutions that improve the health and productivity of their workforce.[8] However, only 10% position EAP as a wellness resource.[31]

## Ensure EAP and Work/Life benefits reach employees

As noted in the prior section, employers can achieve increased value from an EAP by formally linking their EAP to other health, wellness, and absence programs. This requires establishing formal business requirements for psychosocial and health risk screening, cross referral between vendors and/or programs, and reporting regarding cross-referral rates, as well as monitoring of outcomes as a result of referrals. Vendor partners or programs targeted for EAP integration initiatives include wellness, disease management, medical plans, mental health, and absence. UnitedHealthcare found that 64% of individuals who took advantage of the alcohol counseling offered by their EAP needed no further treatment.[32]

Communicating about EAP can occur through health, medical, and absence programs. Some of the ways to do this include

- Establishing formal procedures with health and absence partners to screen and refer for stress, depression, substance abuse, and psychosocial issues that may be impeding the member's health status
- Establishing reporting requirements regarding cross-vendor screening and referral rates
- Measuring screening and referral rates by establishing performance guarantees with vendor partners
- Implementing procedures that refer members who screen positive on an HRA for stress, depression, or substance abuse to the EAP
- Linking to the EAP Web site via health plan, DM, or wellness Web sites
- Including EAP information in communications from (or about) the health plan or wellness program

### Did you know?

Referrals have more traction when they are made through established relationships (eg, a health coach) and completed via real-time telephone transfers or outreach.

# PHARMACY BENEFITS

## Understand the depth of pharmacy management decisions

Ensuring that employees have access to the proper medications and treatment is important. Therefore you should know how your pharmacy benefit manager (PBM) or health plan chooses which medications are on formulary. What is the process for handling requests for an exception to the formulary? How does your PBM/plan monitor and encourage patients to start and remain on their medications? If you do not carve out benefits, ask your PBM or health plan questions about pharmacy benefits.

## Ensure employees receive optimal treatment

Increasingly, antidepressant medications appear as one of the most highly utilized and most costly prescription drug categories for employers. Many employees prescribed psychiatric drug medications do not receive appropriate referral and management of their psychiatric condition. Similarly, few of these cases are actually identified with a diagnosis of depression despite the patient having been prescribed drugs to treat it. While pharmaceutical intervention to treat psychiatric conditions is key to positive outcomes, many individuals would benefit from a combination of both drug and therapy interventions to enhance and speed recovery, but they often are not referred to or engaged in mental health therapy.

## Did you know?

Approximately 77% of antidepressant medications are prescribed by PCPs.[33]

Although PCPs tend to prescribe antidepressant medication to their patients, there is often little follow-up to ensure that the patient is compliant with the drug treatment, that the medication dosage is at a therapeutic level, and that the patient is assessed for the need for therapeutic treatment in addition to medication.

- 40% to 50% of primary care patients diagnosed with depression discontinue treatment within the first 3 months[34]
- Preventing or delaying relapse or recurrence of depressive disorders can have an economic impact by reducing costly procedures, hospitalization, and other expensive care. More importantly, it can have a profound clinical impact and help maintain normal functioning[35]

Recent studies have demonstrated that the treatment of some mental health conditions, such as depression, is most effective when both medication and therapeutic interventions are combined.

- Most primary care patients with mild-to-moderate major depression can be successfully treated with psychotherapy or antidepressant medication. In cases of severe major depression, treatment with both antidepressants and psychotherapy may be warranted
- Psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone[36]
- 50% to 85% of individuals who suffer major depression experience a recurrent episode, and 50% of those experience recurrence within 2 years of the initial episode[37]
- Pharmacologic treatment of major depression consists of 3 phases[38]
  - Acute phase: 6-10 weeks
    - Goal: to obtain relief of symptoms
  - Continuation phase: 6-9 months
    - Goal: to achieve a more complete restoration of normal functioning and prevent relapse
  - Maintenance phase: 12-36 months
    - Recommended for those at high risk of recurrent depressive episodes
- Poor adherence to antidepressant medication accounts for a surprisingly large proportion of treatment failures
- Patients who receive psychotherapy during the treatment period are less likely to discontinue early[17]
- There is a strong association between medical follow-up and adherence

It is important to work with all healthcare managers as described below to ensure the best care for employees. This will reduce absenteeism and increase productivity.

### Restricted or unduly limited pharmacy benefits may be costing you more money than is saved

Psychiatric medications are not interchangeable. In contrast to many other medications, they have a long phase-in/phase-out period. Psychotropics usually take 4 to 6 weeks to achieve full effect, and it takes just as long for a patient to be tapered off the drug if another has to be tried.[12] If an employee with depression doesn't get the right antidepressant, it could be months before that employee receives optimal treatment and is fully productive at work.

## PERIODIC REVIEW OF FORMULARY

The formulary should be reviewed periodically and adjustments should be made based on information garnered from the review findings with emphasis on medications that, when appropriately used, result in the best patient outcomes and controlled total healthcare costs. Favorable formulary positions should be based on a medication's ability to reduce both total spending and disability. This can be addressed through value-based benefit design.

# PRIMARY CARE PRACTITIONERS AND GENERAL MEDICINE RECOMMENDATIONS

PCPs and other general medical providers are an integral part of mental healthcare in the United States. Both the American Medical Association (AMA) and American Association of Family Practitioners (AAFP) endorse depression screening in adult populations. Many of the recommendations presented here suggest programs, benefits, and practices that will support general medical providers in the provision of high-quality mental healthcare services.

As an employer, you have the financial clout to negotiate with your health plans. NYBGH and our employer members have found that it is necessary for physicians to be compensated in order to screen for depression at the primary care level. When contracting with your health plans, encourage plans to pay practitioners for administering a mental health questionnaire, and make coding and reimbursement relatively easy for providers submitting claims. This includes providing them with proper documentation and codes to cite in order to receive payment for services rendered. Forms are available at www.nybgh.org.

## COLLABORATIVE CARE

Collaborative care approaches are associated with[39]

- Twofold increases in antidepressant adherence
- Long-lasting improvement in depression outcomes
- Increased patient satisfaction with depression care
- Improved primary care satisfaction with treating depression

Research has shown that patients with mental illness and substance abuse disorders do not consistently receive evidence-based care when delivered in the primary care setting.[40,41] The collaborative care model focuses on treatment in general medical settings (eg, PCPs' offices) for most patients. It is also known as the 3-component model because of the 3 professionals involved in the care: the PCP, a care manager (who often speaks with patients telephonically), and a psychiatrist to serve as a resource to the PCP.[3] It usually entails screening, case identification, and proactive tracking of clinical (eg, depression) outcomes, clinical practice guidelines, and provider training.

# ACCURACY AND QUALITY OF PRESCRIBING PSYCHOTROPIC MEDICATIONS

From October 1999 to September 2004, the nation's largest study on depression, Sequenced Treatment Alternatives to Relieve Depression (STAR*D), was conducted. It demonstrated that people who have access to a full array of treatment options have a better outcome. During STAR*D's first phase, just one-third of patients responded to the first selective serotonin reuptake inhibitor (SSRI) they received.[42] In Phase 2, another 25% of patients responded by switching their medication regimen to an alternative antidepressant.[43]

# ANNUAL ASSESSMENT OF PROVIDER PERFORMANCE

Employers should require their healthcare managers to annually assess their providers' performance in relation to the nationally accepted best-practice guideline they have chosen. Employers should also require these managers to provide them with annual summaries of the collected data, problems that were identified, and performance plan improvement recommendations to address these problems. This will assist employers in determining issues of both compliance and noncompliance. The report should feature the following:

## Psychotropic drug prescription patterns of providers and the psychotropic drug use patterns of patients within the plan(s)

All drug classes should be categorized by licensed practitioner prescription pattern (eg, internists, psychiatrists). Prescribers should be identified as to whether they are within the normal range of national best-practice standards for both dosage level and diagnostic appropriateness. Emphasis should be placed on identifying and evaluating providers that underprescribe or overutilize relative to guidelines for each diagnostic category. Both providers and patients who are not within the ranges of national standards should be identified, and a plan for practice improvement should be presented annually.

Recommended interventions should involve all healthcare management vendors. It is critical that the management entities responsible for the management of nondrug interventions, both medical and psychiatric, be involved in the oversight of the psychotropic drug improvement interventions, and that those managers have mental health expertise sufficient to assist in the implementation and management of this plan.

### Patient usage data by drug class

Dosage levels, duration of medication use, diagnostic fit, and adherence to the prescribed medication regimen should be reviewed using nationally accepted best-practice standards.

### Physician adherence to specified plan recommendations regarding the use of medications for specific diagnoses

For example, if a national best-practice standard cautioned against use of antidepressants without a mood stabilizer for patients with bipolar spectrum disorders, this would be a focus of review. In addition, the scientific literature has identified a number of quality problems in the prescription of psychotropic drugs.

# DISABILITY

When companies analyze their disability claims, depression and other mental illnesses are often found to be among the top 5 reasons for short-term claims. To mitigate this impact, work closely with disability vendors to

- Review short-term and long-term disability management programs and instruct vendors to actively manage all mental health disability claims
- Involve a mental health specialist in certification of psychiatric disability and treatment planning
- Involve a mental health specialist in the review of the treatment plan
- Refer employees on disability for a psychiatric condition to EAP for return-to-work assistance
- Train and support managers prior to an employee's return to work
- Establish a communication process between the disability management vendor and your Human Resources department

## Components of Mental Health and Substance Abuse Benefits

A systematic program to identify depression and promote effective treatment significantly improves clinical and workplace outcomes.[44]

If an employee with depression doesn't get the right antidepressant, it could be months before that employee receives optimal treatment and is fully productive at work.


WIRE-O

# CONTRACT FOR QUALITY

Armed with the knowledge of the gaps in the coverage your organization provides, you may begin to strengthen your program by using the following steps:

- Engage your benefit consultants in a discussion about mental health benefits. Find out if they are up to date on the latest mental health data and how they evaluate the mental health services of various vendors. Simply asking questions will demonstrate to your consultant that mental healthcare matters in your company. To determine the best benefits for your organization, see the "Identify Your Organization's Needs" section
- Leverage your purchasing power to obtain quality. This can be accomplished by joining coalitions like NYBGH to ensure health plans are following "best practices" and delivering services that meet your population's needs and your organization's strategy. The united voice of many employers often drives rapid change

Promises made during selection of a mental health specialty vendor should translate into contract terms that govern service delivery. A list of minimum requirements for a scope-of-work statement is offered for consideration in the "Resources" section starting on page 64 of this guide. Please note that the list does not represent the level of detail that would be needed in a scope-of-work statement in a contract.

Contract For Quality

Promises made during selection of a mental health specialty vendor should translate into contract terms that govern service delivery.


WIRE-O

# Internal Promotion of Benefits

# CONNECT EMPLOYEES TO THE BENEFITS

While many employers offer comprehensive mental health benefits, many employees are unaware of them. Using different communication methods is important to increase awareness and, more importantly, use of these benefits.

Employers should communicate benefits such as EAPs and mental health services through several vehicles. Consistent promotion of these benefits should be attempted because individuals respond differently to various communication strategies.

In today's information age, successful communication campaigns need to be targeted to differing employee demographics. If possible, each communication should target individuals based on age and gender. For example, junior members of the workforce may prefer a Webinar while more senior employees may prefer a pamphlet.

Communication is also important to decrease the stigma associated with uptake of benefits related to depression and excessive substance use. Employers should share resources related to substance use counseling with employees through various media. They should stress the confidentiality of their information and the fact that it will not be shared with the company. The employer can also conduct screenings via Internet surveys. Additionally, screenings can be administered through an employee assistance or wellness program. For example, UnitedHealthcare found that 64% of individuals who took advantage of the alcohol counseling offered by their EAP needed no further treatment.[32]

# USING HEALTH FAIRS TO PROMOTE GOOD MENTAL HEALTH

Health fairs are a good way to reach employees with pertinent health information. A health fair involves simply bringing resources on site for employees at the same time on a specified day(s) or week.

Here is a list of resources and companies you might include:

- Health plans
- Representatives of the EAP
- Biometric screenings
- Pharmaceutical companies (which will often provide free or low-cost nonbranded educational materials or screening capabilities)
- Local nonprofits, such as the American Cancer Society and American Diabetes Association
- Local providers, such as hospitals
- Wellness vendors

An employer should make time available to employees to attend the health fair.

If your employees are scattered across the country in multiple locations, it may not be feasible to provide on-site health fairs. Two options for these employees are the "health fair in a bag" and the virtual health fair.

## HEALTH FAIR IN A BAG

"Health fair in a bag" entails giving employees a bag filled with health information that can be reviewed at home. Employees can read about mental health or other issues they may not want to discuss publicly (or be seen showing interest in) in a private location.

## VIRTUAL HEALTH FAIR

Some companies have conducted a virtual health fair on the Web, using a vendor. The idea is that employees, or their dependents, can go to a Web site and see what resources are available to them and click on what is of interest.

## STRATEGIES TO DRAW ATTENTION TO MENTAL HEALTH

One NYBGH member wanted to include information about depression in its recent health fair. Assuming that people would not walk over to a table that only had information on mental illness, it lured employees to a table showcasing a book by a well-known author. The company chose *Darkness Visible: A Memoir of Madness* by William Styron (the author of *Sophie's Choice*). At the table was a medical director from the health plan the company uses, who engaged employees in a discussion about the book and related mental health topics.

## IDENTIFYING AFFECTED EMPLOYEES

Another NYBGH member wanted to screen people for depression at a health fair. As employees entered the health fair, they were given a survey to complete about their health. Included in the questionnaire were questions about mental health. At the fair, the results were discussed, individually, with a nurse. If appropriate, the nurse included a discussion of depression, anxiety, or other mental health issues and referrals were made to the company's EAP or to other healthcare professionals.

Management Involvement—Managers should be able to recognize mental health disorders in their employees and refer them to an EAP. A licensed clinician should be hired to train managers to recognize the signs of mental illness and substance abuse.

There are a number of ways that depression can be identified in someone's behavior, but a supervisor may be unsure of the best way to reach out and provide assistance. The following are tips that can be used when mental illness—specifically depression—is recognized.

- If you recognize symptoms of depression in a member of your team, ensure that employees are reminded of the benefits and resources available to them
- If you're not sure how to raise the issue without singling out a particular employee, use a department memo or a "housekeeping" announcement in a staff meeting to remind employees of the resources at their disposal—including the insurance provider's Web site/hotline and information about your EAP

By directing employees to information on depression treatment, you can help reduce a significant amount of lost productive time among them. At the same time, you may be helping someone who is unaware of how easily he or she can find the healthcare information needed.

## Internal Promotion of Benefits

Many employees are unaware that mental health benefits are available to them.

Communication campaigns should be targeted in order to reach diverse employee demographics.

# Resources

There are numerous resources available via Web sites and other media. This section offers a list of resources and worksheet examples to help implement an effective mental health benefit plan.

# GENERAL RESOURCES

## Mental Health America

http://www.nmha.org/
Includes fact sheets about mental health disorders in English and Spanish. Lists resources for getting help and paying for care.

## National Alliance on Mental Illness

http://www.nami.org/
Includes information on mental health topics and treatment, and links to organizations in your area that can provide support and treatment.

## National Institute of Mental Health

http://www.nimh.nih.gov/index.shtml
Features articles and publications in English and Spanish about mental health disorders, their treatment, and recovery.
Specific article to review: http://www.nimh.nih.gov/science-news/2007/workplace-depression-screening-outreach-and-enhanced-treatment-improves-productivity-lowers-employer-costs.shtml

## National Suicide Prevention Lifeline

www.suicidepreventionlifeline.org
A 24-hour, toll-free suicide prevention service.

## Partnership for Workplace Mental Health

The partnership advances effective employer approaches to mental health by combining the knowledge and experience of the American Psychiatric Association and employer partners.
http://www.workplacementalhealth.org/

# CALCULATORS

## Depression

To calculate costs, including estimated absenteeism, for your organization related to employees with depression.
http://www.depressioncalculator.com/Welcome.asp

## Alcohol and Substance Use

The Alcohol Cost Calculator site includes tools for determining the costs of alcohol use borne by the organization and the ROI of treatment.
http://www.alcoholcostcalculator.org

# PURCHASER WORKSHEETS: MENTAL HEALTH PARITY COMPLIANCE

## Sample Employer Redesign Spreadsheet Pre- and Post-Parity[13]

| | Pre-Parity | | Post-Parity | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Medical** | | | | |
| Deductible | $300/$900 | $500/$1500 | $300/$900 | $500/$1500 |
| Out-of-pocket maximum | $2000/$6000 | $3000/$9000 | $2000/$6000 | $3000/$9000 |
| Inpatient | $250 per admission, then 90% | 60% after deductible | $250 per admission, then 90% | 60% after deductible |
| Outpatient | PCP $15 co-pay; SCP $25 co-pay | 60% after deductible | PCP $15 co-pay; SCP $25 co-pay | 60% after deductible |
| **MH/SA** | | | | |
| Inpatient | 90%; preauthorization required | 70% after deductible | $250 co-pay per episode, then 90%; preauthorization required | 60% after deductible |
| | 30-day annual maximum<br>Substance abuse limited to 3 programs lifetime maximum | | No annual maximum | |
| Outpatient | $15 co-pay; preauthorization required | 70% after deductible | $15 co-pay | 60% after deductible |
| | 30-visit annual maximum | 30-visit annual maximum | No annual maximum | No annual maximum |

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Use the worksheet provided to compare your company's EAP and mental health benefits to an example best practice (shaded columns). Indicate those elements and components that your company's EAP or mental health benefits provide.

## Employer Worksheet for Contracting with Mental Health and/or EAP Vendors[26]

| Minimum Contract Terms | EAP | Mental Health | My Company's EAP | My Company's MH |
|---|---|---|---|---|
| SCOPE OF WORK | | | | |
| Develop and disseminate communication materials to promote program utilization | ✓ | ✓ | ○ | ○ |
| 24/7 toll-free telephone access with live answer by qualified personnel (definitions of qualified personnel vary) for brief assessment, resource and referral to treatment programs and community-based nontreatment programs or resources | ✓ | ✓ | ○ | ○ |
| Telephone response standards for incoming member lines during and after business hours, and claims administration lines during business hours<br>• No busy signals<br>• 90% of all calls answered within 30 seconds or average speed to answer (ASA) is less than 30 seconds<br>• Call abandonment rate less than 3% | ✓ | ✓ | ○ | ○ |
| Maintains a database of community-based resources in locations where members reside | ✓ | ✓ | ○ | ○ |
| Maintains a qualified network of providers for in-person assessment and treatment within specific access standards; access standards vary—the following are offered as examples | ○ | ○ | ○ | ○ |

## Employer Worksheet for Contracting with Mental Health and/or EAP Vendors (cont.)[26]

| Minimum Contract Terms | EAP | Mental Health | My Company's EAP Benefits | My Company's MH Benefits |
|---|---|---|---|---|
| GEOGRAPHIC ACCESS STANDARDS | | | | |
| Two non-MD/EAP practitioners within 10 miles (urban)<br>• Two non-MD/EAP practitioners within 20 miles (suburban) | ✓ | ✓ | ○ | ○ |
| Two MD practitioners within 10 miles (urban)<br>• Two MD practitioners within 30 miles (suburban) | ○ | ✓ | ○ | ○ |
| One acute care facility within 30 miles (urban/suburban) | ○ | ✓ | ○ | ○ |
| IN-PERSON APPOINTMENT ACCESS STANDARDS | | | | |
| Routine within 3 to 10 business days | ✓ 3 to 5 days | ✓ 5 to 10 days | ○ | ○ |
| Urgent within 24 to 48 hours<br>• Emergency immediate to within 6 hours | ✓ | ✓ | ○ | ○ |
| The network is maintained through provider contracts that specify<br>• Minimum requirements regarding appointment availability<br>• Compliance with the vendor's policies and procedures (eg, follow-up, care coordination, utilization review [MH only], quality management)<br>• Prohibitions from holding members liable for the payment of any fees or other member protections as provided by applicable state or federal laws<br>• Maintenance of professional liability and/or malpractice insurance | ✓ | ✓ | ○ | ○ |

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## Employer Worksheet for Contracting with Mental Health and/or EAP Vendors (cont.)[26]

| Minimum Contract Terms | EAP | Mental Health | My Company's EAP Benefits | My Company's MH Benefits |
|---|---|---|---|---|
| The network is maintained through credentialing and regular (eg, every 3 years) recredentialing of providers that verifies appropriate experience, licensure/certification, liability insurance, absence of malpractice claims/complaint history suggesting quality-of-care concerns, utilization, clinical outcomes, facility safety/accessibility, appointment accessibility, etc | ✓ | ✓ | ○ | ○ |
| The EAP network is required to maintain specific knowledge/skill in workplace issues, as distinct from generic psychotherapy skills | ✓ | ○ | ○ | ○ |
| EAP includes in-person sessions (number varies, typically 3) for assessment and referral; for EAP benefits with 3 or more sessions (number varies, average is 5 or 6), the EAP also includes in-person counseling sessions for brief problem resolution<br>Note: Some EAPs offer a telephone counseling option; in this case, the contract should specify that the member is given a choice of in-person or telephone counseling to avoid limiting access to the more costly in-person benefit | ✓ | ○ | ○ | ○ |
| Direct referrals into the MH benefit are limited to situations that cannot be resolved within the EAP benefit (eg, medication management, ongoing treatment of mental health conditions) | ✓ | ○ | ○ | ○ |
| Referrals from the EAP into the MH benefit must be monitored as to timeliness, appropriateness, and adherence with recommended treatment | ✓ | ○ | ○ | ○ |
| 24/7 access to management consultation | ✓ | ○ | ○ | ○ |

## Employer Worksheet for Contracting with Mental Health and/or EAP Vendors (cont.)[26]

| Minimum Contract Terms | EAP | Mental Health | My Company's EAP Benefits | My Company's MH Benefits |
|---|---|---|---|---|
| A bank of training and critical incident stress management (CISM) hours (benefit varies; common is 50 hours per 10,000 employees, although employer may elect to pay only on a per use basis) | ☑ | ○ | ○ | ○ |
| Training on variety of self-help, wellness, and management topics using a formal curriculum | ☑ | ○ | ○ | ○ |
| Timely delivery of on-site CISM services by qualified personnel | ☑ | ○ | ○ | ○ |
| Follow-up of high-risk and substance abuse (SA) cases for education, adherence monitoring, service satisfaction | ☑ | ☑ | ○ | ○ |
| Work/Life services include resource and referral services for any combination of the following<br>• Dependant care<br>• Elder care<br>Other optional services may include<br>• Resource and referral for educational programs and pet care<br>• Relocation assistance<br>• Adoption support<br>• Convenience services<br>• Care kits<br>Note: Work/Life resource and referral should include 3 or more qualified referrals, qualified on cost, availability, location, quality, and special needs | ○ | ○ | ○ | ○ |
| Prior authorization of higher levels of care | ○ | ☑ | ○ | ○ |
| Concurrent review of higher levels of care via live conversation with treating provider | ○ | ☑ | ○ | ○ |

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## Employer Worksheet for Contracting with Mental Health and/or EAP Vendors (cont.)[26]

| Minimum Contract Terms | EAP | Mental Health | My Company's EAP Benefits | My Company's MH Benefits |
|---|---|---|---|---|
| Concurrent review of outpatient care via data-driven algorithms<br>Notes: Not all vendors have this capability; some will do concurrent review via provider treatment plans; if this occurs, suggest requiring policy that specifies some minimum set of triggers for mail-based and telephonic care manager interventions<br>For either data-driven or manual treatment plan reviews, suggest performance guarantee regarding minimum percent of cases kicking out for mail-based and telephonic care management intervention | ○ | ✓ | ○ | ○ |
| Monitoring availability and attendance at ambulatory care appointments following discharge from inpatient settings | ○ | ✓ | ○ | ○ |
| Participation in initial integration meetings with health, wellness, and absence management programs and/or vendor partners to establish integration protocols and processes related to screening, cross referral, and co-management of cases | ✓ | ✓ | ○ | ○ |
| Participation in annual integration meetings with health, wellness, and absence management programs and/or vendor partners to maintain integration protocols and processes | ✓ | ✓ | ○ | ○ |
| Claims administration with a claims audit of charges (against negotiated charges, authorizations, and to guard against up-coding, etc) | ○ | ✓ | ○ | ○ |
| Claims dispute/appeal administration as required by the Employee Retirement Income Security Act of 1974 (ERISA) as amended and in accordance with the terms of the plan | ○ | ✓ | ○ | ○ |
| Terms protecting the plan from claims payment resulting from error, negligence, reckless or willful acts, or omissions by the administrator, its agents, officers, or employees | ○ | ✓ | ○ | ○ |

## Employer Worksheet for Contracting with Mental Health and/or EAP Vendors (cont.)[26]

| Minimum Contract Terms | EAP | Mental Health | My Company's EAP Benefits | My Company's MH Benefits |
|---|---|---|---|---|
| Timely complaint resolution and tracking of complaints by type of complaint | ✓ | ✓ | ○ | ○ |
| Minimum reporting elements with minimum standards related to frequency and accuracy; reports should provide for each measure, the relevant book of business (BOB), or other normative statistics that provide reference points for client-specific data and a comparison to performance in the prior year, and other relevant break-outs (eg, divisional, regional, medical plan) | ✓ | ✓ | ○ | ○ |
| Submission of monthly paid claims reports in an acceptable format | ○ rate renewal | ✓ | ○ | ○ |
| Issuance and preparation of full financial accounting and rate renewal data no later than 90 days after year end | ○ | ✓ | ○ | ○ |
| A single point of contact for all account management needs | ✓ | ✓ | ○ | ○ |
| A designated Account Management Team (for carve-outs) and a designated clinical team (for accounts over 10,000 lives)<br>Note: For carve-in plans, the employer should require that a MH specialist review MH/SA utilization, claims, cross referral, outcomes, and other data at least quarterly to identify opportunities for improvement; without this specific request, MH/SA data will not receive appropriate specialty review | ✓ | ✓ | ○ | ○ |
| Regular (eg, 4) in-person meetings per year to discuss outstanding issues<br>Note: For carve-in plans, the employer should require that a MH specialist attend quarterly account management meetings | ✓ | ✓ | ○ | ○ |

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## Employer Worksheet for Contracting with Mental Health and/or EAP Vendors (cont.)[26]

| Minimum Contract Terms | EAP | Mental Health | My Company's EAP Benefits | My Company's MH Benefits |
|---|---|---|---|---|
| GENERAL CONTRACT TERMS | | | | |
| Will accept electronic transmissions (eg, eligibility, enrollment, disenrollment, and premium payment transmissions) in employer's current proprietary format | ○ | ✓ | ○ | ○ |
| Will submit data feeds to employer or a designated data vendor around necessary data transactions in employer's required format | ○ | ✓ | ○ | ○ |
| Will verify eligibility for and availability of MH benefits | ○ | ✓ | ○ | ○ |
| Eligibility for EAP services is presumed | ✓ | ○ | ○ | ○ |
| Will waive the actively-at-work clause and cover current, future, disabled, and COBRA beneficiaries as actives until they are no longer eligible for coverage, as determined by the employer | ✓ | ✓ | ○ | ○ |
| Allows for vendor to terminate the contract with notice no later than a recommended 120 days prior to the renewal date | ✓ | ✓ | ○ | ○ |
| Allows for employer to terminate contract without cause with a recommended 120 days advance notification | ✓ | ✓ | ○ | ○ |
| Failure to meet performance requirements is cause for termination; contract should allow for notification and brief cure period prior to employer exercising with cause termination | ✓ | ✓ | ○ | ○ |
| Allows for employer to immediately terminate the contract for certain causes | ✓ | ✓ | ○ | ○ |

## Employer Worksheet for Contracting with Mental Health and/or EAP Vendors (cont.)[26]

| Minimum contract terms | EAP | Mental Health | My Company's EAP Benefits | My Company's MH Benefits |
|---|---|---|---|---|
| Full compliance with relevant state and federal privacy, confidentiality, and electronic health information/data security/exchange laws including HIPAA and Federal Confidentiality of Alcohol and Drug Abuse Patient Records | ✓ | ✓ | ○ | ○ |
| Will identify any subcontracted relationships and be responsible for their performance | ✓ | ✓ | ○ | ○ |
| Requires a 90-day notification in a change of any subcontractors | ✓ | ✓ | ○ | ○ |
| Either directly or through its authorized agent(s) and upon reasonable advance notice, the employer reserves the right to conduct a reasonable number of audits of the vendor's compliance with the terms of the contract, including, but not limited to<br>• A claims audit<br>• A clinical performance review, including a medical record audit<br>• Validation of self-reported performance on performance guarantees<br>• Other appropriate review to assess the quality of any services performed<br>Vendor will cooperate with the audit, including providing claims data, medical records, or other data maintained by vendor at no cost to the employer | ○ | ○ | ○ | ○ |
| Requires appropriate general and professional liability insurance and timely notification of cancellation of insurance | ✓ | ✓ | ○ | ○ |
| Indemnification and hold-harmless language | ✓ | ✓ | ○ | ○ |

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