Report to the
OFFICE OF PERSONNEL MANAGEMENT

LARGE EMPLOYER EXPERIENCES AND BEST PRACTICES IN DESIGN, ADMINISTRATION, AND EVALUATION OF MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS –

A LOOK AT PARITY IN EMPLOYER-SPONSORED HEALTH BENEFIT PROGRAMS

Prepared by
Kristen Reasoner Apgar
Washington Business Group on Health
777 North Capitol Street, NE, Suite 800
Washington, D.C. 20002

March 2000

This report was supported through a contract with the U.S. Office of Personnel Management.

PREFACE

The United States Office of Personnel Management's (OPM) initiative to introduce Mental Health and Substance Abuse Parity to the Federal Employee Health Benefit (FEHB) Program is an historic undertaking. The FEHB is the largest employer-sponsored health benefit program of its kind, providing benefits to nearly 9 million federal civilian employees, retirees and their families. The success of its efforts has broad implications for all employer-provided health programs. The Washington Business Group on Health is a member organization with nearly 150 large employer members, who are some of the most innovative public and private purchasers of health care, including mental health and substance abuse treatment benefits. WBGH was honored to be selected to assist OPM in its important mission by providing it with this analysis of the experiences, best practices and recommendations from some of our large employer members, who provide generous, parity or near-parity mental health and substance abuse benefits to their employees and their families. The project was also supported by the National Institute of Mental Health (NIMH) and by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Administration (SAMHSA) of the U.S. Department of Health and Human Services.

The employers who participated in this project were American Airlines, AT&T, Delta Air Lines, Eastman Kodak, General Motors, IBM, the Massachusetts Group Insurance Commission, and Pepsico. They provided extensive information to WBGH on their companies' mental health and substance abuse benefit programs, and took part in two forums with representatives of OPM, NIMH, and SAMHSA. They described how through the introduction of appropriate care management they were able to provide generous mental health and substance abuse benefits, contain and in some cases reduce costs, and at the same time improve their employees' access to quality mental health and substance abuse care.

Their discussion also reported on the many tools and techniques they use to inform their employees about the availability of appropriate mental health and substance abuse treatment, including the role of employee assistance programs (EAP's). They described their use of performance standards for behavioral health care providers and the difficulties they still encounter in measuring quality of care. This information was supplemented by a scan of all WBGH members surveying use of performance standards for behavioral health benefits. The employers also identified barriers to quality mental health and substance abuse treatment that still need to be addressed, most notably the continuing stigma against seeking timely, appropriate treatment for mental and addictive disorders, the need for better coordination with primary care, and the need to manage treatment for individuals with co-occurring mental illness and substance abuse.

However, perhaps the most important finding of this project is that employers provide generous mental health and substance abuse benefits to their employees and their families, because they are convinced that doing so is essential to the corporate "bottom line." Companies look at the big picture, assessing how workplace benefits and programs can enhance employee health and productivity. The costs of providing appropriate treatment for mental and addictive disorders must be measured in a larger context that also considers disability costs, employee absenteeism and lost productivity. Taking these into consideration, employers found that traditional benefit limitations were not cost-effective. Further, increasingly, employers have focused on health system performance based on employee health and functioning. In effect they have moved "beyond parity" to focus on functional outcomes -- improving employee and family member wellness and productivity. OPM's Mental Health and Substance Abuse Parity initiative is a important step in advancing the mental health and substance abuse treatment needs of its 9 million members. We at WBGH hope that this project has served to assist OPM in advancing this vital effort.

Mary Jane England, M.D., President,
Veronica V. Goff, Vice President,
Washington Business Group on Health

ACKNOWLEDGEMENTS

This report is the product of the Washington Business Group on Health (WBGH) Large Employer Experiences and Best Practices in Mental Health and Substance Abuse Benefit Parity project. The project and report would not have been possible without the gracious and unstinting efforts, information, and insights of the eight large employer participants. They are: Dave Carver, District Manager, Benefit Planning and Analysis, AT&T; Ronald Kocher, Benefits Plan Manager and Jackie Quick, Manager, Point of Services Plan, American Airlines; Tara Wooldridge, Manager, Employee Assistance Program, Delta Air Lines; Renee Brownstein, Director of Total Compensation, Eastman Kodak; Delores McFarland, Manager, Health Care Plans and Health Care Initiatives, General Motors; Barbara Brickmeir, Director, Global Benefits, and Karen Orenstein, Program Manager for Mental Health and Substance Abuse, IBM; Dolores Mitchell, Executive Director, Massachusetts Group Insurance Commission; and Ellen Abisch, Manager, Medical and Disability Management and Worker's Compensation, Pepsico. It is their experience, expertise and commitment to the health and wellness of their companies' employees, along with their generous sharing of that knowledge with their colleagues at the Office of Personnel Management and the U.S. Department of Health and Human Services that made the project and this report possible.

The conceptualization and support for the project and this report were provided by the U.S. Office of Personnel Management (OPM). OPM saw the benefit of learning from the experiences of other large employers who provide high quality, cost effective mental health and substance abuse benefits, and the project was conducted under the auspices of Janice Lachance, Director of OPM and William E. Flynn III, Associate Director for Retirement and Insurance. We are especially grateful for the assistance of the many individuals at OPM who provided their insights and information about the issues of greatest concern as it moves forward on its historic effort to introduce mental health and substance abuse parity. They are: Frank Titus, Assistant Director for Insurance Programs; Abby Block, Chief, Insurance Policy and Information Division, Ellen Tunstall, Chief, Insurance Planning and Evaluation Division; Shirley Patterson, Chief, Insurance Contracts Division I, Dan Green, Chief, Insurance Contracts Division II; David Lewis, Chief, Insurance Contracts Division III, and Michael Kaszynski, Policy Analyst, Insurance Policy and Information Division, as well as the other representatives of OPM who attended the policy forums that served as the basis for this report. Their participation created the opportunity for a rich and informative dialogue on the issues of introducing parity.

Also essential to this project was the support of the U.S. Department of Health and Human Services, National Institute of Mental Health (NIMH) and the Center for Substance Abuse Treatment (CSAT), Office of Managed Care of the Substance Abuse and Mental Health Administration (SAMHSA). We especially wish to acknowledge the support and involvement of : Dr. Darrel Regier, Associate Director, Epidemiology and Health Policy Research, Agnes Rupp, Senior Economist and Chief of Financing and the Managed Care Research Program from NIMH, and Dr. Mady Chalk, Director of the Office of Managed Care, CSAT. In addition we wish to acknowledge the participation and support of Virginia Trotter Betts, Senior Advisor on Nursing and Policy to the Secretary and Assistant Secretary of Health, and Kevin Hennessy, Senior Health Policy Analyst of the Office of the Assistant Secretary for Planning and Evaluation.

In undertaking this project and preparing this report Kristen Apgar, Veronica Goff, and I also benefited from the assistance of our project consultants: Suzanne Gelber, and Sandra Hittman along with the support of the entire WBGH staff.

Mary Jane England, M.D., President,
Veronica V. Goff, Vice President,
Washington Business Group on Health

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

A. The Office of Personnel Management Initiative on Introducing Mental Health and Substance Abuse Parity to the Federal Employee Health Benefit Program

On June 7, 1999, President Clinton directed the Office of Personnel Management (OPM) to implement Parity for Mental Health and Substance Abuse coverage in the Federal Employees Health Benefit Program (FEHB) by 2001. The FEHB is the largest employer-sponsored health benefit system of its kind. The Mental Health and Substance Abuse Parity initiative is an historic undertaking that breaks new ground for employer-sponsored health care programs. OPM has charted a course to full parity convinced that it "can be introduced, using appropriate care management, in a way that expands the range of benefits offered and holds costs to a minimum," and "delivered in a fully coordinated managed behavioral health environment that incorporates techniques such as case management, authorized treatment plans, gatekeepers and referral mechanisms, contracting networks, pre-certification of inpatient services, concurrent review, discharge planning, retrospective review and disease management" (FEHB Program Carrier Letter No. 1999-027).

B. Project Description – Analysis of Large Employer Practices and Experiences in Parity Programs

Although the OPM initiative is unique in scope, it parallels other efforts of large employers who have sought to expand mental health and substance abuse benefits for their employees with the goal of achieving parity or near-parity benefits. Through the use of managed-care techniques these employers have been able to provide access to high quality, cost-effective treatment for their employees. They have focused on the "big picture," seeing the benefit to their companies from increased productivity and wellness of their employees and their families. Their experiences, best practices, and recommendations for transition planning, employee education and communications, and standards development for performance management have direct application to OPM's historic undertaking.

For this reason OPM contracted with the Washington Business Group on Health to bring together large employers to provide it with their advice and recommendations, sharing their experiences in addressing parity for mental health and substance abuse employee health benefits. The Washington Business Group on Health (WBGH) is a non-profit, membership organization with an extensive large employer membership with companies who purchase health care for 39 million people, and who represent some of the most innovative public and private purchasers of health care – including mental health and substance abuse treatment benefits. The aim was to provide OPM with suggestions, examples and analysis that may assist it as it moves forward with its parity initiative. This project was also supported and completed under contracts with the National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Administration (SAMHSA).

WBGH convened a group of eight employers – American Airlines, AT&T, Delta Air Lines, Eastman Kodak, IBM, General Motors, the Massachusetts Group Insurance Commission, and Pepsico ("the Employers Group"), who provide generous mental health and substance abuse benefits to their employees. They have extensive experience in evaluating benefit plan design and performance, employee communication programs, and transitions in health benefit plans. They represent industry groups in the transportation, manufacturing, consumer products, technology, and public sectors, with health plans covering over 2.4 million lives and worksite locations throughout the United States. This report analyzes their experiences, the challenges

and considerations they identified, and their recommendations for OPM, as it moves forward to mental health and substance abuse parity. A summary of the most significant findings, and recommendations follows:

- **Benefit Design for Mental Health and Substance Abuse Parity**

All of the employers utilize a managed behavioral care approach in their employee health plans for their indemnity, point of service (POS) or preferred provider organization (PPO) programs. They have found that through this approach they are able to contain costs and, most importantly, to assure quality of services for their employees. They have focused not solely on treatment costs, but also on reducing disability costs, reducing absenteeism and improved productivity from employee wellness. Under their managed-care programs for mental health and substance abuse, they have been able to eliminate most of the day and lifetime limits and significantly decreased co-pays. Employee usage of the mental health and substance abuse benefits has increased overall with greater usage of outpatient and alternative treatment settings, such as half-way houses, intensive outpatient and partial hospitalization, and a decrease in inpatient care. The essential mechanisms utilized to manage quality of care are:

- preferred networks
- pre-approval for treatment
- a full continuum of treatment settings in the networks
- referral mechanisms to connect employees to correct services
- utilization review and financial accountability.

Despite the successes of their programs, however, the employers identified areas which remain problematical:

- managing substance abuse treatment,
- stigma,
- lack of coordination of care, and
- co-occurring disorders.

Special Issues of Substance Abuse: Because of frequency of reoccurrence, most of the employers continue to have limits on inpatient hospitalization (detoxification) that they do not have for other disorders. This stems from their continuing concern that employees and other members "bounce" between episodes of hospitalization without completion of aftercare outpatient treatment – even though these treatment modalities are available to them. Some employers have turned to use of "contracting" for aftercare treatment and conditional reinstatement as tools to assure that employees participate in needed follow-up.

Stigma – Despite generous benefits, employees still may not access available services or use network providers because of the continuing stigma attached to mental illness and substance abuse. Employers continue to make efforts to encourage employees to access needed services through employee education programs, such as depression screening.

Lack of Coordination of Care – Employers cite frequent problems with coordination between primary care physicians and managed behavioral health providers. They are also aware that primary care physicians may not diagnose, properly treat, or refer for treatment, depression or other mental illnesses or substance abuse. Employers are making efforts to improve coordination of care for their employees.

Co-occurring Disorders – Employers recognize the prevalence of co-occurring substance abuse and mental illness. They have made provision for referral from the initial treating entity, for example an inpatient detoxification treatment center, to a mental health provider. However, they recognize that more needs to be done to address this need.

Benefit Design Recommendations:

OPM should expect that its carriers will use coordinated, managed behavioral health techniques including:

- Adequate provider networks
- Mechanisms for referral and treatment, such as referral units, and case managers that provide for 24 hour, 7 days a week access to treatment.
- Availability of a continuum of treatment services and settings, including inpatient, outpatient, partial hospitalization, half-way houses, wrap around services, intensive day treatment, and other comparable settings
- Pre-certification of treatment for appropriateness of fit between patient and provider, provided such pre-certification does not become a barrier to timely access to needed treatment, including internal entities with responsibility for care oversight to see that employee needs are being met, and
- Discharge coordination and planning to assure inpatient treatment is followed by appropriate outpatient care.

Treatment planning to address addiction that assures provision and use of aftercare services, which could include making use of "contracting" for outpatient aftercare or similar mechanisms to prevent repeated episodes of short-term inpatient detoxification without follow-up care in outpatient programs. However, there should not be barriers to accessing treatment, nor should there be a continuation of arbitrary day or lifetime limits on substance abuse treatment.

.

Benefits offered by carriers should provide for networks with:

- Systems for coordination of mental health and substance abuse benefits for members with co-occurring disorders
- Appropriate screening, diagnosis and referral for treatment by primary care providers
- Coordination between primary care physicians and behavioral health care providers and networks.

➢ **Use of Employee Assistance Programs**

The employers use a variety of EAP models, including internal, external and a combination. Their EAP's variously provide employee education and referral for mental health and substance abuse treatment, address general work/life issues, provide direct counseling services, coordinate services, manage all employee substance abuse treatment services, or serve as an adjunct of the managed behavioral health care program. The federal EAP's provide yet another model. They operate under the umbrella authority of OPM, but are separately provided by individual federal agencies. Although they provide referral for mental health and substance abuse services, their main activities are in other work/life areas.

Employee Assistance Program Recommendation:

OPM should arrange for appropriate training and information sharing with the EAP's so that they can provide accurate, timely information covering the entire scope of employee mental health and substance abuse benefit coverage, as well as provide an understanding of the overall purposes and goals of the parity initiative. Ability to access and make use of the extensive OPM website and health plans' "800" information numbers (see recommendations on Employee Education and Communication below) should serve are the focus of this activity.

- **Employee Education and Communication**

Employers use a variety of tools and techniques to assure employee awareness of their mental health and substance abuse benefits. These include:

- group meetings
- health fairs
- enrollment and informational materials mailed to employees' homes
- information "stuffers" included in paychecks
- newsletters
- printed benefit plan descriptions (summary plan descriptions—SPD's)
- Internet/Intranet-based information, and
- member surveys to determine employee satisfaction with health plans and health care delivery.

Increasingly, employers are focusing on making use of Internet and Intranet technology to deliver health care and health benefit information to employees, including on-line information on total compensation, summaries of benefits, and on-line health plan enrollment. Their websites offer links to health plans, health plan report cards and provider directories, as well as health and wellness information. In addition, they also use "800" information numbers and "nurse-lines," so employees know where to call with questions about health plans or for immediate medical information.

There are still barriers to providing effective communication about mental health and substance abuse benefits. Employees are often uninterested in or unaware of their mental health and substance abuse benefits, because they do not expect to use them. In addition, employers may have to provide for additional access to computers, for example by placement of kiosks at worksites for employees who do not have access to computers in the course of their work or at home, or do not know how to use computer technology.

Recommendations on Employee Education and Communication:

OPM should consider use of "800" numbers to assure ready access to triage and referral for treatment, and to provide answers to member questions. Having one number may well be infeasible or inappropriate for the FEHB, given the large number of plans, however, carriers could be required to provide such a service. If a carrier has a separate telephone number to access mental health and substance abuse treatment, that number should be printed on health plan I.D. cards and easily found on the OPM website.

The OPM website should be as accessible as possible to all covered employees. To the extent that some employees do not work in environments with access to terminals, consideration should be given to worksite kiosks.

Carriers should be required to develop and present to OPM their education and communication process for assuring that information on mental health and substance abuse benefits is communicated to FEHB members, and between primary care and behavioral health care providers, so that employee information needs can be met by both.

Employee satisfaction surveys conducted by health plans should include targeted questions involving satisfaction with behavioral health care, as well as knowledge about its availability. These results could be included in the information provided to employees on the OPM and health plans' websites.

- **Transition Planning**

All employers had direct experience in introduction of managed mental health and substance abuse benefit plans. They identified several areas which should be the focus of planning for the OPM transition to mental health and substance abuse parity benefits:

- Addressing adequacy of provider networks for providing services for rural or for special populations, such as adolescents or minorities, credentialling of providers, and developing a continuum of treatment settings. Managed behavioral care vendors need to take the necessary steps to expand networks to meet the needs of changing or expanding workforces.

- Planning for adequate communication and coordination between primary care and behavioral health care plans, referral mechanisms, and employee and provider information. Employers suggested use of distinctive notices to employees and providers, developing of "800" information and referral numbers, and website information as tools to let members and providers know the transition plans.

- Addressing the needs of employees who will be transitioning from current providers to network providers. Employers generally provided 90 days notice to members, who would need to transition to new providers, permitted members who were currently in inpatient treatment to continue with the same provider for a transition period, and made additional special case exceptions.

Recommendations for Transition to Parity:

Require carriers to develop and present to OPM their plans for assuring network adequacy, especially in less populous areas, for special populations such as adolescents and older individuals, and for provider diversity to assure cultural competency. Where such measures will require time to fully implement, require progress reporting and set outside limits on delay in full implementation.

Use distinctively highlighted notices and inserts in plan brochures, and in carrier communication with providers and vendors spelling out the details of the transition to new behavioral health systems and its requirements.

Have carriers send the notifications, describing the transition process and new procedures to follow, to all individuals who had health benefit claims processed within the last 6 months, thereby casting a broad net of communication to the members most likely to be accessing behavioral health services following the transition.

Have carriers provide notice of the pending plan transition to all members currently receiving inpatient treatment.

Require carriers and their behavioral health vendors to participate fully in health fairs and other similar events publicizing health plan benefits.

Use the extensive OPM web-based information system to include frequently asked questions and referral to carrier websites and "800" numbers. Review carrier websites for accuracy of information provided.

In view of the unique visibility of the OPM Mental Health and Substance Abuse Parity Initiative, take advantage of media to increase employee awareness of the changes in available benefits and new systems for accessing them.

- **Use of Performance Standards and Measures**

OPM currently employs performance measures in its contracts with carriers, and its overall system relies heavily on the identification and setting of basic standards to achieve desired health benefit outcomes for its members. It has already notified carriers that it expects that they will make increasing use of nationally accepted measures of medical outcomes and consumer satisfaction, screening and treatment rates, such as those used in HEDIS. And OPM has encouraged carriers to seek accreditation from appropriate bodies such as the National Committee for Quality Assurance (NCQA). However, while there is consensus on the need for such measures, there is still no consensus on the set of measures to be used, nor do employers consistently use a core set of measures in contracting with their health plans.

At OPM's request, the Employers Group described the performance measures they use and recommended standards that should be included as part of the mental health and substance abuse parity initiative. In addition, WBGH conducted a scan of its entire membership to assess their practices on use of performance measures for mental health and substance abuse. Most of the Employers Group have performance measures as part of the contracts with their managed behavioral health care vendors. However they are largely limited to plan administration, financial standards, and network access – such as time standards for treatment, geographic accessibility, provider ratios, and telephone call response. Only two employers identified clinical care standards. Similar, results were found with respect to the larger scan of WBGH employers. Nevertheless, there was agreement among the Employers Group that there is a need to be able to evaluate the quality and cost effectiveness of behavioral health care, and that they currently do not have consistent data or adequate measures to fully accomplish that goal.

National performance measures, such as HEDIS 3.0 and PERMS 2.0, which focus on access and clinical quality, and other developing care standards, such as those being developed by the American College of Mental Health Administrators, and the Washington Circle Group, could advance the ability to measure quality of care, but there must be a broader consensus on their use. The same is true of national accreditation standards applicable to health maintenance organizations, PPO's, and managed behavioral health care organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), NCQA standards for Accreditation of Managed Behavioral Healthcare Organizations, the American Accreditation Healthcare Commission (URAC), and the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Recommendation on Setting Performance Standards:

OPM should continue to press carriers to introduce and utilize generally accepted standards for access and quality. As the agency responsible for the largest employer-sponsored health care plan of its kind, it should continue to play an active role in working with groups on developing a consensus on quality of care and outcomes measures.

II. BACKGROUND

A. The Evolution of Mental Health and Substance Abuse Parity

Mental health and substance abuse coverage has long been characterized by limits that do not apply to health coverage generally. Over the last five years, mental health and substance abuse parity has been the subject of much research and public policy debate. Parity in health benefits has been strongly supported on the grounds of basic equity in treatment for individuals with mental illness or suffering from addictions, and because of the recognition that failure to identify and treat mental illness and addiction imposes great costs and emotional burdens on individuals and their families, and results in lost productivity. Advances in the treatment of mental illness and substance abuse, as well as intensive efforts to reduce the stigma associated with them, have helped fuel the debate. Further, the success of administrative, financial and care management mechanisms used by managed behavioral health care firms has demonstrated that costs can be held down while providing an expanded scope of services and better continuity of care compared to unmanaged indemnity plans. In short, mandating parity and thereby requiring all insurers in a market to offer mental illness and substance abuse treatment coverage equivalent to coverage for all other disorders, when coupled with managed care, offers opportunities to control costs and provide effective treatment, eliminating moral hazard and controlling adverse selection. (*Report of the Surgeon General*, 1999)

The success of managed care has already caused many leading employers to lift the benefit limits characteristic of traditional mental health coverage as they move to managed systems of care. Analysis of mental health and substance abuse benefit design in relationship to psychiatric disability costs was another trigger for significant change in the design of employer-sponsored mental health benefits. During the early to mid-1990's, many employers began to suspect that tightly limited mental health care benefits were contributing to higher psychiatric disability costs and productivity losses. Published studies confirmed their suspicions. A 1998 study by the UNUM Life Insurance Company and Johns Hopkins University found that employer plans with good access to outpatient mental health services have lower psychiatric disability claims costs than plans with more restrictive arrangements (Salkever, 1998; also, Frank, 1999). Leading employers now place less emphasis on managing access to behavioral health care services and more on employee education, early intervention mechanisms, disability prevention, and return-to-work programs (Olfson, 1999; England,1999).

At the same time that employers were revisiting the design of their mental health and substance abuse benefits, states began addressing parity. Maryland became the first state to enact parity for mental illness and drug abuse in 1993. Now, 28 states have parity laws, although they differ in scope and definition (NAMI, 2000). The typical debate to determine state law centers around three issues: financial impact, inclusion of substance abuse, and the definition of mental illness

The federal Mental Health Parity Act of 1996, which became effective on January 1, 1998, requires health insurance issuers (including self-insured plans with more than 50 employees) to adopt the same annual and lifetime dollar limits for mental health that apply to medical benefits. Substance abuse is not covered under the law, and it does not apply to the Medicare and Medicaid programs. A 1998 analysis of the law and behavioral health plans found that many plans still use deductibles, limits and other demand-side mechanisms to manage utilization (Sturm, et al., 1998).

Despite this somewhat limited approach to parity, the experiences of states and actuarial cost-prediction models conclude that costs associated with mental health parity are controllable. A 1998 report by the National Advisory Mental Health Council found that in systems already using

managed care, implementing parity results in a minimal (less than 1 percent) increase in total health care costs during a one year period. In systems not using managed care, introducing parity with managed care results in a substantial (30-50 percent) reduction in total mental health costs (National Institute of Mental Health, 1998; also, Substance Abuse and Mental Health Administration, 1998).

B. Introducing Parity to the Federal Employee Health Benefit Program

On June 7, 1999, President Clinton, in his address to the White House Conference on Mental Health, directed the Office of Personnel Management to implement parity for mental health and substance abuse coverage in the Federal Employees Health Benefit Program (FEHB) by 2001. The FEHB is the largest employer-sponsored health benefit system of its kind The program was established by Congress in 1959 and began covering employees on July 1, 1960. The FEHB Program covers most active, full-time civilian employees and retires of the U.S. Government and the U.S. Postal Service and their families. Annual premiums exceed $16 billion. The Office of Personnel Management (OPM) administers the program and provides policy guidance to participating carriers annually. The program is national in scope and offers members a wide choice of health care delivery systems, including health maintenance organizations (HMO), preferred provider organizations (PPO), point of service (POS) and managed indemnity, fee-for-service (FFS) plans. The program's over 290 health plan options provide a choice of approximately one dozen health plan options in a typical geographic area. It currently has approximately 4.1 million employees and retirees enrolled, and with their families covers about 9 million people. There are approximately 2.7 million members covered by HMO's (including HMO-based POS plans), and approximately 6.3 million members in FFS/PPO plans (including indemnity based POS plans). Currently, like many traditional employer-sponsored health plans, most benefit designs for FEHB plans include limitations on mental health and substance abuse benefits that are not true of coverage for somatic illness.

The President's directive was grounded in a growing consensus on the key issues of the effectiveness of treatment and the efficiency of managed delivery systems in providing care. In addition, OPM, influenced by the research of the National Advisory Mental Health Council, the National Alliance for the Mentally Ill, the Substance Abuse and Mental Health Administration (SAMSHA), as well as the recommendations of the National Institute of Mental Health (NIMH), had already begun to take steps to move employee mental health and substance abuse benefits nearer to parity. Annual and lifetime maximums have been eliminated. Beginning in 1999, pharmacotherapy, medical visits and testing to monitor drug treatment for mental conditions were covered as pharmaceutical disease management. OPM also encouraged the use of preferred provider organizations and utilization management to improve mental health benefits. It expressed its commitment to "significantly increasing accountability in the FEHB Program," actively encouraging carriers "to seek accreditation from the National Committee for Quality Assurance (NCQA)" and "to put systems and processes in place that will produce reliable, consistent, and auditable measures of medical outcomes, customer satisfaction, and screening and treatment rates such as those measured by the Health Plan Employer Data and Information Set (HEDIS) data sets and Foundation for Accountability (FACCT) measures." (OPM 1998). OPM also requires the use of the Consumer Assessment of Health Plan Survey (CAHPS) instrument to survey consumer satisfaction.

In 1998, OPM at its annual carrier conference began discussions on improving mental health and substance abuse benefits, by addressing the ways in which managing behavioral health care can impact the cost, comprehensiveness and quality of mental health and substance abuse services for employer-sponsored health benefit programs. (FEHB Program Carrier Letter, No. 1999-027).

OPM's Mental Health and Substance Abuse Parity initiative breaks new ground for employer-sponsored health care programs in its scope and breadth. It has charted a course to full parity convinced that it "can be introduced, using appropriate care management in a way that

expands the range of benefits offered and holds costs to a minimum." OPM has informed the FEHB carriers it believes that parity can be delivered in a "fully coordinated managed behavioral health environment" that incorporates the following:

- Case management,
- Authorized treatment plans,
- Gatekeepers and referral mechanisms,
- Contracting networks,
- Pre-certification of inpatient services,
- Concurrent review,
- Discharge planning,
- Retrospective review, and
- Disease management.

(FEHB Program Carrier Letter, No.1999-027.)

C. Large Employer Practices – Informing the OPM Mental Health and Substance Abuse Parity Initiative

Parity in mental health and substance abuse benefits has not been implemented by other large employers to the extent that it is being undertaken by OPM, or in as many health care markets across the country. Nearly half of all employers still have significant limits on in-patient and out-patient mental health treatment. (Kaiser Family Foundation and Health Research, 1999) There is still limited experience with substance abuse parity. And, unfortunately, adequate quality standards for either substance abuse or mental health care are still not the norm. Most quality data refers to administrative, customer service and satisfaction, and provider network standards, rather than to patient outcomes. Recent surveys of employer health plan contracts found fewer than half contained performance standards (Deloitte and Touche 1997), although nearly two-thirds of those employers who use a behavioral health care carve-out also had at least one performance measure (Merrick, 1999). Administrative and customer service standards are most common, while HEDIS measures and provider-related standards are the least common. In another study looking at employer purchasing practices, researchers found that many employers are unaware of available clinical quality measures or find the measures irrelevant and/or difficult to incorporate into their purchasing decisions (Hibbard, et al. 1997).

Nevertheless, as it moves forward to carry out the Parity directive, OPM recognized that it could benefit from the expertise of other large employers who have implemented health benefit plans with the goal of providing access to high quality, cost-effective mental health and substance abuse benefits through parity or near-parity benefit plans. The employers' information, practices, and recommendations for standards development, transition planning, employee communications, and quality assessment and performance management could assist OPM in its planning for the transition to parity benefits and in the development of policy guidance for its carriers. This recognition resulted in the design and development of this project for the analysis of large employer practices, experiences, and best practices in benefit design, administration and evaluation of mental health and substance abuse programs.

The Washington Business Group on Health (WBGH), a non-profit, membership organization with extensive large employer membership, contracted with the Office of Personnel Management to provide this analysis. The 150 members of the Washington Business Group on Health are large employers who purchase health care for 39 million people and who represent some of the most innovative public and private purchasers of health care – including mental health and substance abuse treatment benefits. Leading the project at WBGH are Dr. Mary Jane England, a national leader in the development of employer-based systems of health care and in national health and behavioral health system reform policies, and Veronica Goff, who also has extensive experience in issues of health and productivity and who led the Depression Awareness,

Recognition and Treatment (D/ART) program at WBGH. Their experience and expertise served to inform the discussion and analysis that went into this report.

In addition to OPM, this project was funded and supported by the National Institute of Mental Health and by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Administration of the U.S. Department of Health and Human Services.

III. DESCRIPTION OF THE LARGE EMPLOYER MENTAL HEALTH AND SUBSTANCE ABUSE PARITY PROJECT

A. Identifying the Employer Group.

To respond to the information needs identified by OPM, the Washington Business Group on Health convened a small working group of its membership, consisting of eight large employers, asking them to participate in detailed discussions aimed at providing an in depth analysis of their practices with regard to provision of mental health and substance abuse benefits to their employees, focusing on benefits design and administration, access, communication about benefits with employees, and development of performance and quality measures. The members of the Employers Group were selected because they:

- Provide generous mental health and substance abuse benefits that meet or approach parity standards
- Have experience in evaluating benefit plan quality and performance
- Employ successful employee communication programs
- Have relevant experience in addressing behavioral health plan transitions
- Provide benefits to a large number of employees and their families
- Have worksite locations throughout the country, and
- Represent a variety of industry groups.

The large employers who agreed to participate in the project were: American Airlines, AT&T, Delta Air Lines, Eastman Kodak, General Motors, IBM, the Massachusetts Group Insurance Commission (the health care insurer for state employees)[1], and Pepsico. They agreed to share information about their company's programs and to give OPM the benefit of their best thinking on the issues posed by its mental health and substance abuse parity initiative. In addition, WBGH conducted a scan of its entire membership to address their experience with the use of managed behavioral health care providers as part of their employee health plans with particular focus on the use of performance standards for mental health and substance abuse treatment.

B. Profile of the Employer Participants.

The eight employers who participated in the Employer Group represent industry groups from the transportation, technology, consumer products, manufacturing, and public sectors. They employ approximately 1,230,000 employees at worksites located throughout the United States, some of them in less-populous, rural areas, with health plans covering over 2.4 million lives. Their annual expenditures for mental health and substance abuse benefits claims, exclusive of administrative costs, range from $3.6 million to $50 million annually with per member per month

[1] The Massachusetts Group Insurance Commission is not a WBGH member organization, but was included because it is a large public employer and an innovator in the introduction of mental health and substance abuse parity.

costs ranging from $3.53 to $4.58.[2] Their mental health and substance abuse benefits are briefly described as follows:[3]

- Employer A provides a parity benefit for mental health, but its substance abuse benefit, while generous, has lifetime limits. It uses the substance abuse limits as leverage for encouraging compliance with structured aftercare programs, which it feels the data supports as the greatest predictor of successful long term sobriety. Thus, two years of aftercare is available with every treatment episode. Approximately 90% of its employees are in a single POS program with a behavioral health managed-care carve-out. The remainder of its employees is served by a number of HMO's.

- Employer B has been providing parity mental health and substance abuse benefits since 1993, however, it has limitations on coverage for repeated inpatient treatment for substance abuse. Its employees have a choice between a POS plan with a managed-care carve-out or a number of HMO's.

- Employer C has used a managed behavioral health care carve-out for the past 10 years for its indemnity and PPO plans. It has very generous mental health and substance abuse benefits that are close to parity with employee medical benefits and no separate limitations on substance abuse treatment.

- Employer D offers 3 indemnity plans, a POS plan with a differential benefit for in- and out-of-network treatment, and a number of HMO's. The indemnity and PPO plans use a mental health carve-out. Substance abuse treatment is contracted separately through the employer's EAP, which is operated in-house. Employer D provides a parity benefit for mental health and substance abuse, however, it has a limited number of substance abuse treatment episodes (1 per lifetime). It also has a differential pharmacy benefit with higher costs to employees for medications prescribed for mental health treatment.

- Employer E provides generous employee benefits for mental health and substance abuse treatment that mirror those for medical benefits. There are low co-pays and unlimited outpatient visits for all medically-necessary treatment, however, its health plans place lifetime limits on inpatient substance abuse treatment. It has one indemnity plan with a "silent" PPO, 2 POS plans and 160 HMO's. It contracts for a single managed behavioral health carve-out for its mental health and substance abuse treatment benefits, covering the indemnity and POS plans.

- Employer F provides generous, but not parity, mental health and substance abuse benefits with annual limits on both inpatient and outpatient days. The company utilizes a large number of health care vendors: 2 indemnity plans, 6 POS plans and 45 HMO's. The indemnity plans have used a managed behavioral health carve-out since 1988, and the POS plans utilize a "carve-in" with network differentials.

- Employer G's health plans continue to have more traditional annual and lifetime limits on mental health and substance abuse treatment, although the company is working toward enhancing its benefits. It provides employees with an indemnity plan, a POS plan with a managed behavioral health care vendor, and coverage by various HMO's.

- Employer H provides parity mental health and substance abuse benefits with no additional limits for substance abuse treatment. It offers its employees three types of health plans:

[2] Based on 1998 data. Associated administrative costs or fees are estimated to range from approximately $.80 to $2.50 per member per month.
[3] To assure a free-flowing exchange of ideas and information and to avoid any disclosure of proprietary or confidential information, it was agreed that companies would be referenced only by letter.

traditional indemnity, a POS plan with in- and out-of-network differentials and an HMO. It utilizes a behavioral health care carve-out for the indemnity and POS plans.

(Tables providing detailed summaries of the designs for mental health and substance abuse benefit plans are included in Appendix I to the report.)

C. Convening the Employer Group Forums.

WBGH convened two working sessions and a conference call in which the Employer Group, staff from OPM, representatives from NIMH and SAMHSA, participated along with the WBGH project leaders and consultants with specific expertise in behavioral health benefits plans. (A listing of the forum participants is attached as Appendix II.) The discussions were detailed, candid and focused on specific questions and concerns identified by OPM in the areas of benefit design, employee education and communication, transition planning, and setting performance standards.

IV. LARGE EMPLOYER EXPERIENCE, ANALYSIS AND RECOMMENDATIONS

The succeeding sections provide an overview of the matters discussed at the forums, employers experiences, as well as the challenges and considerations identified by the Employer Group. It also sets out the employers practical suggestions and recommendations for consideration by OPM.

A. Benefit Design.

1. Considerations and Employer Experiences:

Managing Cost and Quality – the Decision to Use Managed Behavioral Care Carve-Outs

Each of the employers utilizes a managed behavioral care approach in their employee health plans for their indemnity, POS, and PPO programs.[4] Their stated reasons for that decision are cost containment and quality of services provided to their employees. With regard to cost containment all of the employers had experience with high cost increases under prior fee for service plans, and many had in the past used co-insurance, co-pays and other benefit design limits to manage access to mental health and substance abuse treatment. However, within the last decade most of the employers had turned to managed care as a better mechanism for containing costs.[5] At the same time their goal was to have very similar benefits for physical and mental health and substance abuse treatment, focusing on quality of care and meeting the health needs of their employees. They found they could move to expanded, parity or near-parity benefits, improve the quality of care, and contain or reduce costs.

For example, Employer A noted that in designing their mental health and substance abuse benefit plans, they focused on the bigger picture – looking at disability costs along with mental health and substance abuse treatment costs. By focusing on the impact of appropriate behavioral health care on employee wellness, as evidenced by reduced absenteeism and disabilities dollars, they felt they could do a better job in measuring productivity effects of their mental health and substance abuse treatment benefit packages. Further, their mental health and substance abuse treatment costs have gone down significantly in the last five years, yet they believe that their employees are receiving better quality care.

[4] In general, the employers did not set benefit standards for the HMO plans offered to their employees. HMO's generally provide less generous benefits than other employer sponsored health plans (Buck,1999).
[5] The Employer Group's experiences are consistent with broader analyses of employer sponsored health plans (Otten, 1998; Sturm,1998; Olfson,1999).

Employer B moved to parity benefits with managed care in mental health and substance abuse precisely *because* of high costs and low quality of behavioral health care being provided to employees under its prior generous, but unmanaged, benefit plans. Employees were disproportionately being treated in high-cost, inpatient treatment programs, but were not receiving outpatient follow-up, nor were they getting mental health or substance abuse treatment prior to hospitalization. This was particularly true for adolescents. After introducing a behavioral health managed care carve-out, Employer B found that facility-based inpatient costs dropped by 46% and outpatient costs also decreased by 21%, yet there was no increase in readmission rates for employees discharged from hospitals post-managed care.[6] Further, at full parity enrollees used more services on average than they did before, but the average number of visits decreased from 7.1 to 5.6. It is important to note, however, that in selecting its managed care vendor, Employer B looked to quality of care management as the primary factor rather than cost containment.

All of the employer mental health and substance abuse benefit plans had essential mechanisms to manage quality of care:

- preferred networks
- pre-approval for treatment
- requirements for a full continuum of treatment settings
- referral mechanisms to connect employees to the correct services, and
- utilization review and financial accountability.

Preferred Networks

Several of the employers described initial employee resistance to the introduction of managed care in their health benefit plans, particularly the effort to move employees to network providers. Yet, employers found that member satisfaction increased following the introduction of the managed behavioral health care programs, and over time the percentage of claims under the network benefit increased. The employers believe strongly that using the network benefit does not simply result in cost controls through negotiated discounts, but also works to assure that patients receive better quality services, through tailoring the right treatment to each patient's care needs.

✥Adequacy and Continuum Of Care

Employers negotiated with the behavioral managed care vendors to be assured that their employees would receive the level of service appropriate to their treatment needs. Plans were required to develop networks that could provide for a continuum of care, focusing on outpatient treatment, but also including care in alternative treatment settings, such as half-way houses, intensive day treatment, community-based programs and in-home treatment. Having a range of treatment settings helped to decrease over-utilization of inpatient settings, but it also enabled employees and covered family members to receive services that were better tailored to their needs. Networks were required to offer geriatric and pediatric services, as well as wrap-around care for such high-risk and hard-to-serve populations such as adolescents and older adults. In addition, employers are asking vendors to address their employees desire to receive services from culturally competent providers who reflect the diversity of the workforce.

✥Incentives for Use of Network Providers

In turn, all of the mental health and substance abuse benefit plans provide financial incentives for employees to choose providers who are in-network. For example, Employer E's behavioral health benefit provides for low co-pays and unlimited outpatient visits for any medically necessary mental health or substance abuse condition. The out-of-network benefit in contrast

[6] These results are from a 1997 Ph.D. dissertation of Elizabeth Merrick, (unpublished), cited in the *Report of the Surgeon General.*

only provides 50% reimbursement for treatment by non-network providers. Employers used varying considerations in setting the network differentials: the cost saving to the health plan attendant on the discounts achieved through network provider systems, assuring that employees receive high quality services with the most appropriate providers, and assuring consistency and management of treatment. It was the employers' experience that well-managed networks with sufficient access to well-qualified providers and focused on quality of care will attract employees over time. And, they have found that the percentage of the health claims for in-network treatment increased significantly over time. Employer B noted that in 1998, 90% of the claims were for in-network treatment.

On the other hand, employers still allow exceptions from out-of-network differentials for special cases -- in rural areas and for special populations, such as adolescents, where there are limited numbers of providers available in-network. However, employers also pressed their managed behavioral health care vendors to work diligently to include more diverse providers in the network. All employers agreed that culturally competent treatment services can be essential to assuring that all employees in a diverse workforce seek and complete effective treatment.

Credentialling

Employers required their behavioral health care vendors to assure that the network had appropriately credentialed providers. Some of the employers had specific limitations on the range of behavioral health care providers they will permit in their contracted networks. However, more typically, employers require that behavioral health professionals hold the professional degrees and licenses that are required for the type of services they provide under the licensure standards of the state in which they practice. [7]

Utilization Review

Utilization review served as a mechanism for employers to see where members were receiving services. Its purpose was in part to verify the expected shift from inpatient to outpatient and alternative treatment settings, such as half-way houses, intensive outpatient, and partial hospitalization. Utilization review was also used to be certain that employees were receiving sufficient levels of appropriate services. In the words of Employer E, the expectation was to increase utilization in the settings and with the providers where people will get better care.[8]

Treatment and Referral

All employers had systems and requirements for pre-approval of treatment as conditions for their network benefit, as well as provisions for triage and assessment, using such systems as case managers, diagnostic and referral agencies, and EAP's. Indeed, to assure that referrals to specific providers for treatment are tailored to the employee's or other member's treatment needs, at least two of the Employers (B and E) do not make the list of network providers available to employees, thereby requiring involvement of their care referral professionals. Similarly, Employer C requires a face-to-face assessment and care treatment plan provided by its central diagnostic and referral agencies prior to admission for inpatient care. In order to make this process run smoothly those agencies must provide 24 hour a day triage services. Under Employer D's referral system, employees must call the mental health network to receive referrals to providers in a particular geographic area. They have encountered some difficulties, however, in accessing certain specialists, for example professionals with expertise in ADHD treatment.

[7] This is consistent with HEDIS 3.0.

[8] An example of the use of utilization review to assure that employees are receiving adequate levels of services involving another employer can be seen in the performance requirements used by the Ohio State Employee Program where there was a minimum guarantee of employee utilization of outpatient treatment services (Sturm, et al.1998).

Special Issues of Substance Abuse Benefit Design

Unlike mental health benefits, where nearly all employers had parity or near parity benefits, most of the employers had limits on covered episodes of inpatient treatment for substance abuse. The rationale for these limits was the need to avoid having employees or their family members "bounce" between repeated episodes of in-patient rehabilitation or detoxification treatments without accessing and participating in appropriate aftercare treatment. In addition, some employers are unwilling to risk health resources on employees who they believe are very likely to relapse.

Employer A's description is typical. Formerly, their company had no limits on substance abuse treatment. Many of their employees went through multiple episodes of treatment without completing aftercare. The company now has a limit on the number of treatment episodes. However, recognizing the significant relapse characteristics of addiction, any need for additional care occurring within 180 days of the initial treatment is considered part of a single episode. In addition this employer is covered by federal regulations subjecting employees to random drug and alcohol testing and requiring evaluation and treatment of any substance abuse diagnosis prior to a return to work. Under the current benefit plan employees who fail random alcohol testing must contract for treatment including 2 years of outpatient aftercare and attendance at Alcoholics Anonymous to be reinstated. Typically, treatment for these employees consists of 2 to 3 weeks of inpatient care, followed by intensive outpatient treatment and then weekly aftercare. Further, Employer A found that the average time for relapse was around 90 days (considered to be part of the same episode of care), and therefore, felt that employees were not being denied reasonable access to substance abuse treatment. Similarly, Employer E has day limits on inpatient substance abuse treatment, but finds that less than 1% of its covered members exceed the 30 day limit on inpatient treatment, and there are no limits on outpatient substance abuse treatment.

Employer C emphasized, however, that in order for substance abuse treatment to be successful, it is essential for employees and other members to have ease of access to their benefit. They use their EAP's as the primary referral mechanism, although employees can also be referred through their mental health referral agencies.

To address substance abuse among its employees, Employer D established its own substance abuse provider network under the direction of its in-house EAP program. It also limits employees to one lifetime substance abuse treatment episode. However, its program has a high success rate (70 to 80%), in large part attributable to the close supervision of treatment for employees/ family members by the EAP, to the focus on quality standards for the treatment network, and to the program's credibility with employees.

The employers also emphasized that effective networks for substance abuse treatment must include a range of treatment professionals and continuum of treatment programs and facilities. They have found that in many areas there is an over-supply of hospital (detoxification) and residential rehabilitation facilities and under-supply of out-patient and community-based treatment programs. Managed care vendors must work to stimulate the development of a broader range of network programs, for example by convincing hospitals to develop intensive outpatient programs. And, there may be a need to be flexible with regard to professional licenses accepted, particularly in less-populous areas, and to expand the types of authorized treatment modalities to include pharmacotherapy for drug and alcohol abuse. Most employers were uncertain whether their plans covered such treatments as methadone (heroin addiction), naltrexone (alcohol addiction), or buprenorphine (cocaine addiction).[9] However, Employer F verified that at least one of their behavioral health care plans provided for such therapy.

[9] These treatment modalities are generally excluded from those benefit plans that are limited to inpatient treatment for detoxification and outpatient abstinence programs. Methadone therapy is the least likely to be

Benefit Exclusions

The employers addressed the appropriateness and advisability of OPM allowing many of the so-called "standard exclusions" found in many health plans' benefit designs. There was general consensus that the following exclusions were not appropriate and in many instances ran counter to the purpose and goals of parity and mental health and substance abuse benefit quality:

- Exclusion of chronic mental health conditions, for example schizophrenia or bi-polar disorder (This would be contrary to parity standards, and would provide a different and reduced benefit for individuals with chronic mental disorders, while chronic medical conditions, such as hypertension or diabetes are covered as medical benefits.)

- Psycho-social, vocational rehabilitation, and other life skills (These benefits are provided to members with chronic physical conditions, and can be an essential and integral part of wrap-around services as part of a continuum of treatment for individuals with emotional and behavioral disorders, particularly children and youth. However, to the degree that the benefit plan also limits comparable physical conditions, there can be similar limits under mental health and substance abuse parity.)

- Psychiatric treatment in facilities with educational components and residential treatment for children and youth (There should be efforts to work with parents to involve their pediatricians and schools. Benefits may be limited to medically necessary services within the broader institutions.)

- So-called V codes in DSM IV[10] (The employers' plans generally covered these disorders because they involve significant life issues that adversely affect the ability to work -- although some used their EAP professionals to provide the treatment.)

- Dementia, Tourettes' syndrome, ADHD and other neurological disorders (These are both medical and mental disorders and should not be excluded.)

- Behavior and conduct disorders, anti-social or delinquent behaviors (so-called) (These disorders can be diagnosed and treated successfully with appropriate clinical standards, and the clinical aspects of care should not be excluded.)

- Sleeping disorders to the degree that they are diagnosed as symptoms of depression or other mental or physical disorders.

The Employers agreed that the following standard exclusions were appropriate with certain conditions:

- Court ordered treatment, unless the treatment order is otherwise clinically appropriate and covered by the benefit plan

- Custodial care

- Intelligence testing, unless testing is done in connection with diagnoses of covered conditions, such as ADHD

---

covered in employer sponsored health plans, with such treatment provided largely in public maintenance programs (Buck, 1999).

[10] The DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*) V Codes pertain to social and relational disorders.

- Treatment of mental retardation as a mental health service (However individuals with cognitive disabilities are entitled to receive treatment for emotional or behavioral disorders to the same extent as all other covered members.).

2. Challenges and Barriers in Benefit Design

The employers were in agreement that there are still significant barriers to achieving quality mental health and substance abuse care, most notably: stigma, lack of coordination of treatment with primary care, the need to assure that individuals with addictions receive and participate in follow-up and aftercare treatment, and the need to address co-occurring mental and addiction disorders.

Stigma

There is a persistent perception of stigma associated with mental illness and substance abuse. Too often, this leads employees or their family members to avoid diagnosis or to seek treatment in out-of-network care for fear that their illness will become known to their employer or fellow employees. This was true even though none of the employers felt that there was in fact any stigma or adverse consequences in their company attached to obtaining treatment for mental illness or substance abuse. They also found that the perception of stigma leads employees and their family members to refuse to have treatment information shared with their primary care physicians for fear that this information could adversely affect their relationship with their family doctor.[11]

Lack of Coordination of Care

Employers cited frequent problems with coordination between primary care physicians and the managed behavioral health providers. Some of the coordination of care issues are the result of employee confidentiality concerns creating a barrier to information sharing. Further, health care providers' own concerns about confidentiality of patient records may create barriers to appropriate information sharing or consultation.

Employer A also noted that primary care physicians may not recognize the symptoms of depression or other mental illness or substance abuse when treating patients. Often when they do recognize such symptoms, the prescribed treatment is not consistent with AHCPR guidelines.[12] Similarly, Employer D described on-going concerns about the quality and clinical appropriateness of psycho-pharmacotherapy when provided by primary care physicians rather than mental health or substance abuse professionals. Some health plans have addressed these issues by stationing behavioral health case managers in primary care clinics to provide on-going consultation on diagnosis of mental illness and substance abuse, as well as appropriate pharmacological treatment.[13]

Appropriate Benefit Design for Substance Abuse

The employers expressed frustration with the inability of their present systems of care for employees with addiction disorders to address and prevent the so-called "revolving door" phenomenon of repeated inpatient hospitalizations without completion of aftercare, outpatient treatment. Employer A's use of "contracting" for aftercare as a condition of reinstatement and

[11] These experiences are consistent with the findings on stigma in the *Report of the Surgeon General*.
[12] The Agency for Health Care Policy and Research of the U.S. Department of Health and Human Services, now titled the Agency for Healthcare Research and Quality.
[13] The use of collaborative care systems in primary care settings has been found to improve the quality of diagnosis and treatment for depression (Rubenstein, et al (1999)).

Employer D's carefully-designed network of substance abuse treatment providers under the direction of its in-house EAP and close follow-up by the EAP, appeared to be exceptions with good success rates.

Co-occurring Disorders

In the case of co-occurring mental illness and substance abuse, the employers made efforts to establish procedures to provide for a "hand-off" from an initial or primary treatment provider to another appropriate care professional. For example Employer D uses its EAP professionals to coordinate treatment for employees with substance abuse disorders and ensures that once immediate substance abuse inpatient treatment is completed, the employee will be referred for mental health assessment and treatment as appropriate. None, however, identified the use of integrated treatment programs as part of the health plans available for their employees.[14]

3. Recommendations for Benefit Design

OPM should expect that introduction of parity in the FEHB employee health plans will best be provided in a cost-effective manner that assures quality of outcomes for covered members through the use of:

Coordinated, managed behavioral health techniques – including:

- Adequate provider networks
- Mechanisms for referral to appropriate treatment, such as referral units and case managers that provide for 24 hour, 7 days a week access to treatment referral
- Availability of a continuum of treatment services, including in- and outpatient services, partial hospitalization, half-way houses, wrap around services in the community, intensive day treatment, etc.
- Pre-certification of treatment for appropriateness and assuring a "fit" between patient and treatment provider, provided such pre-certification does not become a barrier to timely access to needed treatment, including internal entities with responsibility for care oversight to see that employees' needs are being met, and
- Discharge coordination and planning to assure that inpatient treatment is followed by appropriate out-patient care.

Treatment planning to address addiction that assures provision and use of aftercare services, which could include making use of "contracting" for outpatient aftercare or similar mechanisms to prevent repeated episodes of short-term in-patient treatment without longer term follow-up care in outpatient programs. However, there should not be barriers to accessing treatment, nor should continuation of arbitrary day or lifetime limits be permitted.

Benefits offered by carriers should address and provide for:

- Creation of systems for coordination of mental health and substance abuse benefits for FEHB members with co-occurring disorders
- Appropriate screening, diagnosis and referral for treatment by primary care providers, and
- Coordination between primary care physicians and behavioral health providers and networks.

[14] Again, the *Report of the Surgeon General* identifies lack of adequate identification and treatment for individuals with co-occurring mental health and addiction disorders as a significant unmet need, and cites research recommending combined or integrated treatment.

B. Use of Employee Assistance Programs

1. Considerations and Employer Experiences.

Employee Assistance Programs (EAP's) have long been available to employees to address work/family issues and for personal counseling, mental health issues and substance abuse treatment. It is estimated that 70% of the largest employers have employee assistance programs. However, the plans differ greatly in scope and style, including internal, external, a combination, or part of a larger managed behavioral heath care system. Further, employee assistance professionals have a wide range of credentials, diagnostic skills and experiences (Muchnick-Baku, 1993). This broad range of EAP models was also evidenced by the Employer Group participants.

Employer A uses its EAP professionals to refer employees to appropriate treatment, and to educate employees about health problems and plan benefits. They are expected to be able to steer employees with questions to the right place for services.

Employer C gradually moved the role of its internal EAP away from provision of substance abuse treatment services to focusing on work/family issues. However, it still felt that it was important to coordinate the EAP with the mental health/substance abuse programs to facilitate collaboration and information sharing, and has worked to improve internal communications to make sure the EAP professionals interface with its diagnosis and referral professionals. The company expects their EAP professionals to be able to explain all aspects of its employee mental health and substance abuse benefit coverage.

When Employer B introduced parity to its employee mental health and substance abuse programs, it expected that strengthening of EAP's would be an important aspect of introducing parity benefits. However, it found that employees' use of the EAP decreased in favor of mental health providers, identified through the case management system, and its EAP also has moved into other work/life areas.

Employer D has a single, internal EAP, which contracts directly with providers to create the network for all substance abuse treatment for its employees. Its EAP sets performance and contracting standards for the provider network and makes referrals for treatment. It also supervises employees' treatment programs and coordinates treatment for individuals with co-occurring disorders with the behavioral health care vendor who provides for mental health services.

Employer E utilizes a single, external EAP, managed by its behavioral health carve-out. It is viewed as a level of care and is designed to assess problems and make referrals for care, although EAP approval is not required to receive treatment services. Similarly, Employer G's EAP professionals provide in-person clinical sessions of up to 3 counseling sessions per employee with a co-pay, and is used to manage access to the mental health network for one of its employee health plans.

In sum the employers' EAP's perform a variety of functions connected to the management of behavioral health care: employee education and training, counseling, assessment and referral, case management and follow-up, collaboration with other actors in the company's behavioral health benefit system, and/or serving as a part of the continuum of services offered to employees and their families.

2. Challenges and Barriers for EAP Programs

Employers identified two primary areas of difficulty in their use of EAP's as part of their overall behavioral health care system. The first is the need to assure adequate communication between the EAP professionals and other health benefits professionals within the organization, so that employees received accurate information and appropriate referrals for treatment. Secondly, in at least some instances employers noted a decreasing willingness of employees to use the EAP's, as opposed to other behavioral health providers, for mental health or substance abuse treatment information and referral, and thus found that their EAP has decreasing relevance to provision of employee mental health and substance abuse treatment.

3. Recommendations for Utilizing the EAP's

The federal EAP program is more decentralized than any of the models described by the Employers Group. Established by Congress in the Federal Employee Substance Abuse Education and Treatment Act of 1986, each federal agency is charged with establishing and maintaining its own EAP program. OPM has an oversight role, provides guidance and information, but does not contract for nor operate the programs. Each agency has an independent EAP, which may provide or refer employees for substance abuse, mental health or a large variety of other services. Indeed, the largest share of the EAP's activities is outside the realm of substance abuse or mental health treatment (Office of Personnel Management, 1998). Given this, the most effective role for the federal EAP programs, as OPM moves to implement mental health and substance abuse parity, would be to serve as *one* of the sources of employee information and education on the FEBH carriers' mental health and substance abuse plans.

OPM should arrange for appropriate training and information sharing with the EAP's so that they can provide accurate, timely information covering the entire scope of employee mental health and substance abuse benefit coverage, as well as provide an understanding of the overall purposes and goals of the parity initiative. Ability to access and make use of the extensive OPM website and health plans' "800" information numbers (see recommendations on Employee Education and Communication below) should serve are the focus of this activity.

C. Employee Education and Communication

1. Considerations and Employer Experiences.

All of the employers engage in extensive efforts to assure that their employees and other health plan members are informed about their mental health and substance abuse benefits, and to the maximum extent possible have the information needed to make choices among health care plans. They also sought employee input on the quality and performance of the mental health and substance abuse benefits plans, as well as on the employer's success in providing them with adequate education and information. In general, the primary responsibility for the overall employee communication and plan information rested with the employers themselves, although their education and communication strategies also placed responsibilities on their behavioral health care vendors.

Employer F is a typical example. It develops and provides most of the education about benefits and benefit changes in-house. It uses various methods to communicate this information, including:

- group meetings
- health fairs
- enrollment and informational materials mailed to employees' homes
- information "stuffers" included in paychecks
- newsletters

- printed benefit plan descriptions (summary plan descriptions—SPD's), and
- Internet/Intranet-based information.

It also operates a "nurseline," 24 hours a day, 7 days a week, to respond to questions about employee and family health, particularly for off-business hours.

Among the lessons learned by Employer F was that in general high-cost, "slick" information campaigns were not well-received by employees, because they believed their health benefit dollars were being spent on marketing not health care. Employees were also not receptive to health plan marketing materials, as opposed to informational publications about the plans' benefits. It is important for the employer to ensure that health plan brochures and other mailings are focused on relevant benefit and employee wellness information.

The Internet/Intranet

Increasingly the employers are making use of Internet and Intranet technology to deliver health care and health benefit information to employees. Employer F now has total compensation information on-line, including its summary of benefits plan and frequently asked questions. Its website has links to the Health Pages website, which provides information on health plans, health plan report cards, comparison information, links to health plan websites, and provider directories. It charges its health plans for the cost of providing comparison information and summaries of benefits for open enrollment periods. This employer also provides modeling diskettes to employees to enable them to see the impact of possible benefit changes and offers communications maps. Employer D also has its benefit plan guide – written in lay-person's language – available on-line at its website and will implement on-line enrollment this year. This year Employer E will also conduct all of its health benefit plan enrollment on-line, and includes links to providers' websites. Employer websites can also serve as important tools for wellness campaigns, such as depression or alcohol abuse screening.

Telephone Communication – 800 Numbers

Telephone information lines are a significant tool used by the employers for communication with employees about their health benefits. A number of the employers have "800" numbers, where employees can call with questions about their benefits. They viewed this as an important means to assure that it was easy for employees to know where to turn with questions and made it easier to provide consistent, accurate information. Employers also use more traditional customer service units to respond to questions, especially during annual enrollment.

Member Surveys

The employers used employee surveys to evaluate their health benefits, including mental health and substance abuse. They conduct employee satisfaction surveys at various intervals throughout the year. Employer F also participates with other industry group employers in a comparative employee satisfaction survey. Employers use plan specific surveys conducted by vendors to help employees evaluate and make decisions about their choice of health plans, especially at annual enrollment periods.

Vendors' Roles

Employers expect their mental health and substance abuse vendor(s) to play a pro-active role in employee communication and education. They work with employees and families to help them understand their benefit program. They are expected to participate in annual health fairs to be able to explain available benefits. They also expect vendors to resolve complaints at the plan – rather than employer – level. One employer uses its medical vendors to serve as central contacts to facilitate information sharing and integration between medical and mental health and

substance abuse care. Employer-sponsored health plans and behavioral health care vendors are also responsible for conducting member satisfaction surveys.

2. Challenges and Barriers to Employee Education and Communication

Lack of employee awareness of available benefits, particularly mental health and substance abuse benefits continues to be a concern for the employers. Many employees do not expect to utilize mental health or substance abuse treatment, so they are unlikely to take note of information that is provided at such events as health fairs, or even targeted wellness programs.[15] The persistent stigma against using these health benefits makes education and communication particularly difficult. Further, for those companies who have many small and especially rural worksites, face-to-face communication techniques, such as group meetings, health fairs and special programs, are often impractical.

There are also limitations to use of the computer-based information for employee communication. Employers whose companies are engaged in manufacturing stated that some of their employees do not have access to computer terminals in the course of their work. For this reason several of the large employers are planning on installing kiosks on shop floors and other worksite locations to increase access to web-based information. In addition, older employees, family members, and retirees may not know how to use or have access to a computer. Some employers now provide employees with home computers Developing health benefit information in a manner that makes best use of this electronic medium can also be difficult. The information in long and complex documents, like employee benefit plans, needs to be organized in a format suitable to the on-line medium, taking advantage of the more visual cues of web pages, and content often needs to be simplified and made "user friendly." Employees should not have to spend significant amounts of time moving from site to site to get needed information (Reese, 2000). Further, information on websites, such as provider directories, can be useful, but only if the information is up-to-date. And, there is a need for a well-designed search capacity. This requires a regular investment of time to keep website information useful and relevant.

3. Recommendations on Employee Communication and Education

The techniques and tools described by the Employers are quite similar to those currently in use by OPM. Those which bear particular consideration are:

OPM should consider use of "800" numbers to assure ready access to triage and referral for treatment, and to provide answers to member questions. Having one number may well be infeasible or inappropriate for the FEHB, given the large number of plans, however, carriers could be required to provide such a service. If a carrier has a separate telephone number to access mental health and substance abuse treatment, that number should be printed on health plan I.D. cards and easily found on the OPM website.

The OPM website should be as accessible as possible to all covered employees. To the extent that some employees do not work in environments with access to terminals, consideration should be given to worksite kiosks.

Carriers should be required to develop and present to OPM their education and communication process for assuring that information on mental health and substance abuse benefits is communicated to FEHB members, and between primary care and behavioral health providers, so that employee information needs can be met by both.

[15] Surveys of employee awareness of their health benefits confirm that employees are generally unknowledgeable about their health plan benefits, particularly mental health and substance abuse benefits (Foote, 1999; Minkus, et al., 2000).

Employee satisfaction surveys conducted by health plans should include targeted questions involving satisfaction with behavioral health care, as well as knowledge about its availability. These results could be included in the information provided to employees on the OPM and health plans websites.

D. Transition Planning

1. Considerations and Employers' Experiences

The employers all had direct experience in the introduction of managed mental health and substance abuse benefit plans. They identified a number of areas which should be the focus of planning for the OPM transition to mental health and substance abuse parity benefits, including

- Addressing adequacy of provider networks for providing services for rural populations and for special populations, such as adolescents and minorities, credentialling of providers and developing a continuum of treatment settings

- Planning for adequate communication and coordination between primary care and behavioral health care plans, referral mechanisms, and employee and provider information, and

- Addressing the needs of employees who will be transitioning from current providers to network providers.

Planning for Network Adequacy

It can be anticipated that potential behavioral health vendors will need to enlarge their existing provider networks both to accommodate FEHB-covered members, and to include a broader and more diverse array of providers required to assure parity and quality of care. When a new company is acquired by one of the Employers Group, the employers expect the behavioral health vendor to start identifying where the new employees are currently receiving care, what their expected treatment needs may be, and to review the service capacity of the current network to address the additional demand. Carriers will need to determine whether they can provide adequate behavioral health networks for FEHB members, addressing such issues as sufficiency of providers in rural areas and assuring that they can provide a provider network able to meet the needs of the diverse federal workforce with cultural competence. In addition the entities which provide for referral to behavioral health treatment need to be prepared and able assess the needs of employees in current mental health and substance abuse programs as they begin to move to other levels of care.

Communication and Coordination

The employers stressed that communication strategies must reach all levels of the health care delivery process. Vendors must be available and known to employees, health plans, and providers. They expect that vendors will participate in health fairs and work to attract employees' attention to the availability of new mental health and substance abuse treatment benefits. This can be a difficult task, because with the exception of employees who already utilize the behavioral health benefit, employees' focus will be on primary, not behavioral, health care. For this reason it was also suggested that employee health benefit ID cards be reissued to include the telephone number for mental health and substance abuse treatment (if different from the general emergency call number) so that members will easily be able to access those services. Where employees have to register to access mental health or substance abuse coverage, the vendor should be required to provide for 24 hour, 7 day a week telephone access.

✥Printed Notices

An effective, “low-tech” technique that all the employers used was the use of distinctive color inserts in written benefit materials, such as the employee benefit plan books, describing the new benefit and especially new procedures required for accessing treatment. Their vendors were also required to provide similar color inserts in health plan descriptions and brochures. Similarly, highlighted information could also be displayed on websites. Employers also required their managed behavioral health vendors to notify every individual who had claims (of any type) paid under the current health plan system within the preceding 6 months of the coming change to a new provider network with a clear explanation – again in a distinctive color -- of the process required to access the mental health and substance abuse network providers.

✥Website Information

Company and health plan websites that provide frequently asked question pages, as well as prominently display telephone numbers and linking websites to contact for additional information. “800” numbers for employee information are especially useful when there is a major transition in health benefits and procedures.

✥Notice to Providers

Current providers also need to be informed of changes in claims and access procedures. Employer E had its new carve-out vendor send out informational packets in a distinctive color to every behavioral health provider currently used by its employees three months in advance of the actual transition. It also required all of its major health vendors to meet together along with its benefits personnel to discuss and resolve issues involved in coordinating with each other. The managed behavioral care vendor worked out protocols with primary care plans on covered treatment and the appropriate referral process.

Once the transition was underway, vendors were expected to identify critical issues and to work with the company and the care managers to communicate how questions were to be resolved. Every effort was made to be sure that all system actors had the same answers to the same questions.

Transitioning Employees Currently Receiving Treatment

All of the employers opted for so-called “soft landing” strategies for transitioning employees to new providers, as the result of the move to new provider networks. Employees who were currently in-patient treatment when the transition occurred, were permitted to keep their current provider and level of care until discharge. Upon discharge the new provider network requirements were applicable. The patient also had the option of transitioning immediately into the new plan. The standard length of time for this transition period used by the employers was 3 months with one employer permitting a 6 month transition.

Employers also made liberal use of special case exceptions for employees and family members in on-going treatment, sometimes transitioning the provider into the network. Where there were providers who were already providing services to 4 of more employees, Employer B simply arranged for that provider to be added to the network – if the provider had appropriate professional credentials.

2. Challenges and Barriers in Planning for Transition

Employers caution that developing networks able to provide a continuum of services and to meet the service needs of diverse and low-incidence populations may take time, and it may be

necessary to implement some aspects of the network expansions in stages, particularly in those areas where there are fewer providers or a more limited range of professional credentials. Existing behavioral health networks also may lack diversity, and vendors may need time to expand those networks to meet the needs of a diverse employee workforce. Vendors should be required, however, to meet specific timeframes to achieve expanded network capacity. The employers suggested that 18 months should be the outside limit.

With respect to communication, the common message is that the techniques used must be consistent and must address all of the areas where employees and professionals need to be informed of new systems and the timetable for the impending changes. They need to plan and to be clear on what is required of them. There will inevitably be glitches and complaints, and there will need to be a system for reporting of this information by vendors to carriers and for OPM to identify areas where systems are not functioning properly.

Finally, with regard to individuals who face transitioning to new providers, as the result of parity implementation, employers caution that provision for flexibility and special case exceptions is important to ease the transition and avoid time-consuming, high-visibility complaints.

3. Recommendations for Transition Planning

Require carriers to develop and present to OPM their plans for assuring network adequacy, especially in less populous areas, for special populations such as adolescents, and for provider diversity to assure cultural competency. Where such measures will require time to fully implement, require progress reporting and set outside limits on delay in full implementation.

Use distinctively colored notices and inserts in plan brochures, and in carrier communication with providers and vendors spelling out the details of the transition to new behavioral health systems and its requirements.

Have carriers send such notifications describing the transition process and new procedures to follow to all individuals who had health benefit claims processed within the last 6 months, thereby casting a broad net of communication to the members most likely to be accessing behavioral health services following the transition.

Have carriers provide notice of the pending plan transition to all members receiving inpatient treatment.

Require carriers and their behavioral health vendors to participate fully in health fairs and other similar events publicizing health plan benefits.

Use the extensive OPM web-based information system to include frequently asked questions and referral to carrier websites and “800” numbers. Review carrier websites for accuracy of information provided.

In view of the unique visibility of the OPM Mental Health and Substance Abuse Parity initiative, take advantage of media to increase employee awareness of the changes in available benefits and new systems for accessing them.

E. Use of Performance Standards and Measures

1. Considerations and Employers' Experiences.

OPM currently employs performance measures in its contracts with carriers, and its overall system relies heavily on the identification and setting of basic standards to achieve desired health benefit outcomes for its members. It does not rely on the imposition of detailed benefit requirements as are used in the typical contracting process of other large employers. Thus, increasing accountability and standard setting should be a central aspect of implementation of mental health and substance abuse parity. In its call letter of April 1998, OPM informed FEHB carriers that it will begin looking for reliable, consistent and auditable measures of medical outcomes and consumer satisfaction, and screening and treatment rate measures, such as those used in HEDIS 3.0, and similar performance measures to be used in assessing carrier health plan performance. It has also encouraged carriers to seek accreditation from appropriate bodies such as the National Committee for Quality Assurance (NCQA).

It is generally agreed nationally that there is a need for standards that can measure and assess the fit between the employee/member's mental health and substance abuse care needs and the actual services provided. However, the typical performance standards focus on plan administration, financial accountability and consumer access, as measured by telephone response times, length of time to treatment, provider network ratios, and travel time/geographic access. Access measures need to be expanded to reflect the impact that age, gender and cultural differences, as well as geographic distance, have on quality of care (Institute of Medicine, 1997.) There are on-going efforts to develop quality reporting systems for managed behavioral health care, such as those of the American Managed Behavioral Healthcare Association (AMBHA), the American College of Mental Health Administrators (ACMHA), and NCQA (*Report of the Surgeon General*, 1999.) Unfortunately, appropriate outcome measures for mental health and substance abuse treatment are still in the developmental stage, and as of yet there is no consensus on the use of generally available measures, such as those identified by OPM.

Use of Performance Measures by Employers Group

As part of this project, OPM asked the Employers Group to describe performance measures they used to evaluate their behavioral health plans and to recommend standards which should be included as part of the mental health and substance abuse parity initiative. In particular they were asked to identify access standards that they use in their contracts with behavioral health care vendors. Most of the employer participants in this project use some form of performance standards. However, their standards center on plan administration, financial standards, and network access. Their access measures included time standards to obtain emergency, urgent and routine treatment; referral for care times; network provider ratios; geographic accessibility to providers (typically permitting longer distances and travel time for rural as opposed to urban and suburban areas); and time standards for telephone call response and abandonment. In addition, many of the employers require health care organizations and facilities to be accredited by organizations such as the Joint Commission on Healthcare Organizations (JCAHO), the American Accreditation Healthcare Commission (URAC), or the Commission on the Accreditation of Rehabilitation Facilities (CARF).[16] (A summary of the standards provided by the employers along with a comparison with those set out in the NCQA's Accreditation of Managed Behavioral

[16] To gain accreditation healthcare organizations provide data and documentation to demonstrate that their delivery of care meets or exceeds specified standards of care to be reviewed through the use of on-site survey teams that determines the degree of consistency with the standards of care. NCQA accredits managed behavioral healthcare organizations and health maintenance organizations. CARF accredits behavioral health care facilities. The American Accreditation Healthcare Commission (URAC) establishes benchmarks for quality and efficiency of healthcare organizations. JCAHO accredits behavioral health care organizations, including those that provide services for mental health and chemical dependency treatment.

Care Organizations (MBCO's) and the Digital Corporation HMO Behavioral Health Standards are set out in Appendix III.)

Of the group, Employer E has perhaps the most extensive standards, addressing all of these areas, but also establishing clinical care standards, including third party sampling of charts for consistency with treatment guidelines, and follow up care for discharges from inpatient mental health or substance abuse treatment. This employer requires its behavioral health care vendor to conduct clinical audits three times a year, and uses company internal audits to review health care plans every 2 to 3 years. Employer D has also developed and instituted performance standards for its employer-contracted substance abuse treatment network, including accreditation of providers, ongoing monitoring of member access to providers, review of clinical charts for appropriateness of treatment, and review of utilization data for compliance with treatment and discharge plans. It also requires the treatment centers with whom it contracts to have JCAHO accreditation or CARF certification as an addiction treatment facility.

Use of Performance Measures by WBGH Member Companies

Our scan of WBGH-member companies also focused on the use of performance standards for mental health and substance abuse treatment. Employers were particularly asked to identify their access standards, but also to share clinical, financial, administrative and accreditation standards that they use. They were also asked if they use a managed behavioral health care carve-out. Thirty-eight (38) member companies responded to the survey, representing more than 2.9 million employees and 5.4 million covered lives. Not surprisingly, based on previous surveys of employer-sponsored health plans, there is somewhat limited use of performance standards for behavioral health.

Of the responders, 39.4% have at least one or more performance standards for mental health or substance abuse treatment. Twenty-three of the companies (60.5%) contract with a managed behavioral health care vendor. As might be anticipated, a significant majority (67%) of those who identified performance standards are employers who also use a managed behavioral care carve-out as part of their employee health plans.

Like the Employer Group, the performance standards in use among the employers in the scan are largely confined to financial and administrative performance, such as claims payment, accuracy and timeliness, and customer service telephone response times, and access standards. With regard to access issues, the measures center on geographic access to network providers (travel and distance times), time standards for emergency, urgent and routine care, and telephone response times. Only 7 companies identified clinical outcome or quality measures apart from professional credentials. In addition, approximately 42% of the employers, including employers who do not require specific performance standards, require NCQA, JCAHO and CARF or other accreditation. [17]

National Measures

Finally, we reviewed comparable behavioral health measures in HEDIS 3.0, the MBHO accreditation standards, the American Behavioral Health Association's PERMS 2.0 recommended measures, as well as the "Desirable Attributes of Performance Measures in Behavioral Health", the draft consensus standards of the American College of Mental Health Administrators,[18] and the draft addiction treatment standards of the Washington Circle Group.[19]

[17] The scan responses are consistent with surveys of large employers use of performance measures (Institute of Medicine (1997); Merrick, et al (2000)).

[18] In addition to the American College of Mental Health Administrators, the workgroup is comprised of representatives of CARF, the Rehabilitation Accreditation Commission, the Council on Accreditation, the Council on Quality and Leadership in Support of Persons with Disabilities, the Joint Commission, and NCQA.

HEDIS 3.0, includes many of the access standards currently used by large employers, however, it also includes other basic measures of access and clinical quality:

- Follow-up after hospitalization for mental illness
- Availability of behavioral care providers
- Mental health utilization – inpatient discharges and average length of stay
- Readmission for selected mental health disorders
- Chemical dependency utilization – percentage of members receiving inpatient, day/night care ambulatory services
- Mental health utilization – percentage of members receiving inpatient, day/night care and ambulatory services
- Substance counseling for adolescents
- Screening for chemical dependency
- Continuation of depression treatment
- Availability of medication management and psychotherapy for patients with schizophrenia
- Appropriate use of psychotherapeutic medications
- Family visits for children undergoing mental health treatment
- Patient satisfaction with mental health care.
- Availability of language interpretation services
- Failure of substance abuse treatment

PERMS 2.0 incorporates the HEDIS 3.0 measures of access to care and quality of care and adds other measures including:

- Percentage of members seeking EAP services
- Percentage of EAP patients referred for mental health and/or substance abuse services
- Ambulatory follow-up within 7 and 30 days.

In addition to telephone and time and telephone standards for accessing care, the MBHO Accreditation Standards include standards on availability of network practitioners, including identification of the linguistic and cultural needs of health care plan members, as well as adequate geographic distribution.

The American College of Mental Health Administrators, "Desirable Attributes of Performance Measures in Behavioral Health, Proposed Common/Core Set of Performance Indicators" also address such matters as individuals' involvement in their treatment decisions, their evaluations of the quality of their care; safe treatment and settings; parental involvement in decisions regarding their child's treatment; recognition of co-occurring mental illness and substance abuse; individual's perception of accessibility of services; productivity outcomes, such as ability to work and/or to attend school; and improved safety for the individual and others. Lastly, the Washington Circle Group is developing consensus on standards for provision of alcohol and other drug prevention treatment services, which address education/prevention, screening for substance abuse and linkages to primary care, treatment engagement and maintenance activities to sustain post-treatment abstinence or reduction in use, and return to functioning.

[19] The Washington Circle Group is a group of national experts on substance abuse, managed care and performance management convened by the Center for Substance Abuse Treatment (CSAT), Office of Managed Care to develop consensus on performance measurement systems for substance abuse treatment.

2. Challenges and Barriers in Setting Performance Standards and Measures

It is evident that a minority of employers utilize performance measures for mental health or substance abuse treatment, as extensive as those measures in HEDIS 3.0, PERMS 2.0 or those under development by the ACMHA or the Washington Circle Group. Nevertheless, the extensive discussion of the employer participants in this project, described throughout this report, touched on and identified virtually all aspects of behavioral health care measured in these standards as important indicators of the quality of behavioral health care being delivered to their employees and other plan members. There are obvious challenges and barriers to introducing these standards. First, there is insufficient consensus on the use of the available performance measures. Secondly, apart from the determining the appropriate measures to be used, the employers found great difficulty in getting consistent, comparable data from their health care and behavioral health care providers. For employers who use a large number of health plans, the problem is compounded, and they may have difficulty in reaching agreement with behavioral or primary care health vendors on establishing such standards. Nevertheless, for the longer term, there is consensus that utilization of performance measures is essential to assure the adequacy and appropriateness of mental health and substance abuse care delivery and performance.

3. Recommendations on Use of Performance Standards and Measures

OPM shares the Employers Group's assessment of the need to establish standards for performance and outcome measures for health care delivery, as evidenced by the direction it has already given to carriers by encouraging them to begin to use national measures of performance like HEDIS, and to seek accreditation from national accrediting organizations, such as NCQA, JCAHO, URAC, and CARF. Further review and a judicious expansion of the more generally-accepted administrative, financial, and access standards for behavioral health care would be consistent with the contracting practices in use by many large employers, especially those who use managed care carve-outs to deliver mental health and substance abuse services to their employees.

However, achieving the broader goal of behavioral health care quality dictates a longer term goal of introducing accepted standards for effectiveness and utilization of mental health and substance abuse treatment, as set out in current and emerging national measures of health quality, like those discussed above. This is a goal that will require a broader consensus among standard setting and accreditation bodies, as well as the research community. As the agency responsible for the largest employer-sponsored health care plan of its kind, and a national leader in implementation of parity for mental health and substance abuse, the Office of Personnel Management should continue to play an important role in working with these groups to bring quality of care standards to the Federal Employee Health Benefit program.

Further, employers are increasingly focusing on evaluation of health system performance based on employee health and functioning. Companies are looking at the big picture, assessing how workplace benefits and programs can enhance employee health and productivity. The effectiveness of mental health and substance abuse health programs must be measured by their capacity to encourage prevention and early intervention, active disability management, and timely return to productive work, school and family. The development of measures for functional outcomes is only in the beginning stages, but this effort must continue if employers are to be able to implement health and behavioral health care programs that truly improve employee and family member wellness and productivity.

REFERENCES

American Managed Behavioral Healthcare Association, (1998) *Performance Measures for Managed Behavioral Healthcare Programs, PERMS 2.0*.

Buck, Jeffrey A., Judith J. Teich, Beth Umland, Mitchell Stein, (1999) "Behavioral Health Benefits in Employer Sponsored Health Plans, 1997," *Health Affairs*, 18(2): 67-88.

CARF—The Rehabilitation Commission, (1999) *1999 Behavioral Health Standards Manual.*

Deloitte and Touche LLP (1998) *1997 Employer Survey on Managed Care Medical Benefits*. 15(10):1-2.

Digital Equipment Corporation, (1997) *HMO Performance Standards, Third Edition*, Maynard, Mass. 2, 28-44.

Edmunds, Margaret, Richard Frank, Michael Hogan, Dennis McCarty, Rhonda Robinson-Beale, Constance Weisner (eds.) Institute of Medicine (1997) *Managing Managed Care: Quality Improvement in Behavioral Health*, Washington, D.C.: National Academy Press: 171-179.

England, Mary Jane, (1999) "Perspective: Capturing Mental Health Cost Offsets." *Health Affairs* 18(5): 91-93.

Executive Order of the President, *Amending the Civil Services Rules Relating to Federal Employees with Psychiatric Disabilities,* June 4, 1999.

Foote, Sandra M., Stanley B. Jones, (1999) "Consumer-Choice Markets: Lessons from FEHBP Mental Health Coverage," *Health Affairs* 18(5):125-130.

Frank, Richard G., Thomas G. McGuire, Sharon-Lise T. Normand, Howard H. Goldman, (1999) "The Value of Mental Health Care at the System Level: The Case for Treating Depression, " *Health Affairs*, 18(5):71-88.

Hibbard, Judith H, Jacquelyn J. Jewett, Mark W. Legnini, et al., (1997) "Choosing a Health Plan: Do Large Employers Use the Data?" *Health Affairs* 16(6): 172-180.

Kaiser Family Foundation and Health Research and Educational Trust, (1999) *Employer Health Benefits*, 1999 Annual Survey, 94-96.

Leifer, Jacqueline C., Roger A. Schwartz, Marcie Zakheim, (1998) *A Guide for Providers of Mental Health and Addictive Disorder Services in Managed Care Contracting*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Merrick, Elizabeth, Deborah W. Garnick, Constance M. Horgan, David Goldin, Dominic Hodgkin, Mark Sciegaj, (2000) "Use of Performance Standards in Behavioral Health Carve-Out Contracts Among Fortune 500 Firms," *The American Journal of Managed Care* (5).

Minkus, Maureen, Christopher C. Colenda, Andrew J. Hogan, (2000) "Knowledge of Mental Health Benefits and Preferences for Type of Mental Health Providers Among the General Public," Psychiatric Services (51)2: 199-202.

Muchnick-Baku, Sonia, Kelly L. Traw, (1993) *Employee Assistance Programs: An Evolving Human Resource Management Strategy*, Washington, D.C.: Washington Business Group on Health, 18-19.

National Committee for Quality Assurance (1997) *HEDIS 3.0, 1998*.

National Committee for Quality Assurance, (1999) *NCQA Standards and Surveyor Guidelines for the Accreditation of MBHO's.*

Olfson, Mark, Merrile Sing, Herbert J. Schlesinger, (1999) "Mental Health/Medical Care Cost Offsets: Opportunities for Managed Care," *Health Affairs*, (18)2: 82-86.

Otten, Alan L., (1998) *Mental Health Parity: What Can it Accomplish in a Market Dominated by Managed Care?* Millbank Memorial Fund, New York, New York: 1-6.

Reece, Shelly, (2000) "A New Boost for Benefits Management: Corporate Intranets can save time and employer employees," *Business & Health*, (18)1, 23-25.

Rosenheck, Robert A., Benjamin Druss, Marilyn Stolar, Douglas Leslie, William Sledge, (1999) "Effect of Declining Mental Health Service Use on Employees of a Large Corporation," *Health Affairs*, (18)5: 193-203.

Rubenstein, Lisa V., Maga Jackson-Triche, Jurgen Unutzer, Jeanne Miranda, Kat Minim, Marjorie L. Pearson, Kenneth B. Wells, (1999) "Evidence-Based Care for Depression in Managed Primary Care Practices," *Health Affairs* (18)5: 90-91.

Salkever, D. (1998) *Predictors and descriptors of psychiatric duration, cost and outcomes study*. UNUM Life Insurance Company, Portland, Maine.

Sing, Merrile, Steven Hill, Suzanne Smolkin, Nancy Heiser, (1998)*The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Sturm, Roland and Joyce McCulloch (1998) "Mental health and substance abuse benefits in carve-out plans and the Mental Health Parity Act of 1996." *Journal of Health Care Finance* 24(3): 82-92.

Sturm, Roland, William Goldman, Joyce McCulloch, (1998) "Mental Health and Substance Abuse Parity: A Case Study of Ohio's State Employee Program," *Research Center on Managed Care for Psychiatric Disorders, UCLA and RAND Working Paper*, No. 128, Los Angeles, California: 1-29.

Sturm, Roland, Rosalie Liccardo Pacula, (1999), "State Mental Health Parity Laws: Cause or Consequence of Differences in Use?" *Health Affairs* (18)5: 186.

The American College of Mental Health Administration and the Accreditation Organization Workgroup on a Core Set, (2000) "A Proposed Common/Core Set of Performance Indicators and Measures," (draft document.)

U.S. Department of Health and Human Services (1999), *Mental Health: A Report of the Surgeon General*, 76-77, 81-86, 89-92, 411-428.

U.S. Department of Health and Human Services, National Institute of Mental Health, (1998) *Parity in Financing Mental Health Services: Managed Care Effects on Cost, Quality and Access: An Interim Report to the Congress by the National Advisory Mental Health Council.*

U.S. Department of Health and Human Services, National Institute of Mental Health (1988), *Parity Benefit and Carve-Out Management Interaction – Reduces Benefit Cost by 30 to 50 Percent*, www.nimh.nih.gov/research/prtyrpt/parityfg1.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (1998), *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers*, Technical Assistance Publication Series No. 22, www.samhsa,gov/oas/tap22.1.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (1998) *Special Report: Mental Illness and Addiction Disorder Treatment and Prevention, Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (2nd Ed.),* www.samhsa.gov/mc/Managed%20Care%20Contracting.

U.S. Office of Personnel Management, Office of Insurance Programs, FEHB, *Program Carrier Letter No. 1998-014*, April 3, 1998.

U.S. Office of Personnel Management, Office of Insurance Programs, FEHB *Program Carrier Letter*, No. 1999-027, June 7, 1999.

U.S. Office of Personnel Management, Office of Workforce Relations, (1998) *Federal Employee Substance Abuse Education and Treatment Act of 1986, Fiscal Year 1997 Report to Congress, Title VI of Public Law 99-570*.

Washington Circle Group, (1999) "Improving Performance Measurement by Managed Care Plans for Substance Abuse," *Year 1 Report of the Washington Circle Group,* www.samhsa.gov/mc/Quality %20Improv..mance%20Measures/07ExecutiveSummary03_08.htm.

APPENDIX I

Table 2.1 ***Employer A-- Mental Health and Substance Abuse Benefits***			
	POS Plan with Managed Care Vendor Administration In-Network	POS Plan with Managed Care Vendor Out-of-Network	HMO*
Mental Health/Substance Abuse -- General Provisions	Medical Necessity Std. No dollar or number of visit limits Medical lifetime limit of $2 million includes mental health/substance abuse benefits	N/A	N/A
Mental Health -- Inpatient (Acute, Intensive Outpatient, Partial Hospitalization, Residential)	$100 co-payment regardless of length of stay	$150 deductible Additional $200 deductible per confinement 50% coverage up to $100 per day 30 days per year	N/A
Mental Health -- Outpatient	100% coverage first visit 80% coverage for all subsequent visits	50% coverage per visit up to $25 20 visits per year	N/A
Substance Abuse -- Inpatient (Acute, Intensive Outpatient, Partial Hospitalization, Residential)	$100 co-payment regardless of length of stay 2 episodes of care per lifetime	$150 deductible Additional $200 deductible per confinement 50% coverage up to $100 per day 30 days per year	N/A
Substance Abuse -- Outpatient	100% coverage first visit 80% coverage for all subsequent visits 2 episodes of care per lifetime	50% per visit with maximum of $25 per visit 20 visits per calendar year 2 episodes of care per lifetime	N/A

* Information on HMO benefits not available.

Table 2.2. Employer B -- Mental Health and Substance Abuse Benefits			
	POS Plan with Managed Care Vendor Administration In-Network	POS Plan with Managed Care Vendor Out-of-Network	HMO's*
Mental Health/Substance Abuse -- General Provisions	No annual deductible Individual out-of-pocket $1000 ($2000 family) $1,000,000 maximum benefit	$200 annual deductible per member $3000 out-of-pocket per member $100,000 maximum benefit	N/A
Mental Health – Inpatient	Full coverage	80% of allowed charges	N/A
Mental Health -- Intermediate Care Facility	Full coverage	80% of allowed charges	N/A
Mental Health -- Outpatient	Visits 1-4 – no co-pay Visits 5-25 -- $20 individual/$10 group Visits 26+ -- $40 individual /$20 group EAP coverage	50% of the allowed charges up to 15 visits per year. No EAP coverage	N/A
Mental Health -- In home	100% coverage	No coverage	N/A
Substance Abuse – Inpatient	Full Coverage	80% of allowed charges	N/A
Substance Abuse -- Intermediate Care Facility	Full Coverage	80% of allowed charges	N/A
Substance Abuse -- Outpatient	Visits 1-4 – no co-pay Visits 5-25 -- $20 individual/$10 group Visits 26+ -- $40 individual /$20 group EAP coverage	50% of the allowed charges up to 15 visits per year. No EAP coverage	N/A

*Information on HMO benefits not available.

Table 2.3 Employer C – Mental Health and Substance Abuse Benefits				
	Indemnity Plans – PP0 Network for Mental Health/Substance Abuse Benefits	PPO In-Network	PPO Out-of-Network(must be authorized)	HMO's
Mental Health -- Inpatient/ Residential	45 days per benefit period	45 days per benefit period	45 days per benefit period	100% coverage
Mental Health -- Day/Night Treatment	Up to 90 visits per benefit period 1 day of inpatient care reduces by 2 the number of days available for day/night treatment	Up to 90 visits per benefit period 1 day of inpatient care reduces by 2 the number of days available for day/night treatment	Up to 90 visits per benefit period 1 day of inpatient care reduces by 2 the number of days available for day/night treatment	100% coverage
Mental Health -- Outpatient	100% coverage for visits 1-20 75% coverage for visits 21-35	100% coverage for visits 1-20 75% coverage for visits 21-35	100% coverage for visits 1-20 75% coverage for visits 21-35	100% coverage
Mental Health -- Psychological Services	100% coverage where authorized	100% coverage where authorized	100% coverage where authorized	100% coverage
Substance Abuse – Inpatient /Residential	45 days per benefit period	45 days per benefit period	45 days per benefit period	100% coverage
Substance Abuse -- Day/Night Treatment	90 days per benefit period 1 day of inpatient care reduces by 2 the number of days available for day/night treatment	90 days per benefit period 1 day of inpatient care reduces by 2 the number of days available for day/night treatment	90 days per benefit period 1 day of inpatient care reduces by 2 the number of days available for day/night treatment	100% coverage
Substance Abuse -- Outpatient	100% coverage for visits 1-35	100% coverage for visits 1-35	100% coverage for visits 1-35	100% coverage

Table 2.4 Employer D – Mental Health and Substance Abuse Benefits				
	Indemnity Plan(3 plans)	POS – In-network	POS – Out-of-Network	HMO*
Mental Health -- Deductibles, Lifetime Limits, Annual Maximums	Mental Health benefit included, except out-of-pocket maximum does not include inpatient mental health treatment .	Medical benefit includes mental health	Out of pocket charges included mental health	N/A
Mental Health -- Inpatient Alternative Mental Health Center	80% covered by plan 50% covered by plan	10% coinsurance 10% coinsurance	50% covered by plan up to 30days/year. 50% covered by plan up to 30 days/year	N/A
Mental Health -- Outpatient	50% covered by plan	$20 co-pay per visit	50% coinsurance, maximum of 60 visits/year	N/A
Substance Abuse – Inpatient Chemical Dependency Rehabilitation (Detox. Covered under regular medical benefit)	80% covered by plan with EAP approval	10% coinsurance with EAP approval	Not covered unless approved by EAP	N/A
Substance Abuse -- Outpatient Chemical Dependency	80% covered by plan with EAP approval	$20 per visit with EAP approval	Not covered unless approved by EAP	N/A

* Information on HMO benefits not available.

Table 2.5 Employer E – Mental Health and Substance Abuse Benefits			
	Indemnity and PPO Plan Managed Health Care Plan Carve-Out In-Network	Indemnity and PPO Plan Managed Health Care Plan Carve-Out Out-of-Network	HMO
Mental Health -- Inpatient	Pre-certification No charge after $250 annual deductible ($750 family)	Pre-certification by Managed Health Care Plan $250 annual deductible ($750 family) 50% coverage for an annual maximum of 30 days per year	No charge Annual Maximum of 30 days per year in-network No out-of-network coverage
Mental Health -- Outpatient	No charge for assessment, Counseling and Referral from Employer EAP program – 8 sessions at no cost. Pre-certification for other services $15 co-pay	No pre-certification 50% coverage of U&C for up to 40 visits per year	Assessment, Counseling and Referral from EAP – 8 sessions at no charge All other services $20 copay Maximum of 20 visits per year in-network No out-of-network
Substance Abuse -- Inpatient	Pre-certification No charge after $250 annual deductible ($750 family) Lifetime maximum of 60 days	Pre-certification by Managed Health Care Plan $250 annual deductible ($750 family) 50% coverage for an annual maximum of 30 days per year Lifetime limit of 60 days	No charge Annual Maximum of 30 days per year in-network No out-of-network coverage
Substance Abuse -- Outpatient	No charge for assessment, Counseling and Referral from Employer EAP program Pre-certification for other services $15 co-pay	No pre-certification 50% coverage for up to 40 visits per year	Assessment Counseling and Referral from EAP – 8 sessions at no charge All other services $20 copay Maximum of 20 visits per year in-network No out-of-network,

Table 2.6 Employer F—Mental Health and Substance Abuse Benefits				
	Indemnity Plans – 2 vendors – with Mental Health Substance Abuse Carve-out	POS with Mental Health Substance Abuse Carve-in – 6 vendors – In Network – Two levels of benefits. (Representative Benefits)	POS – Out-of-Network – Mental Health Substance Abuse Carve-in – 6 vendors – Out-of Network (Representative Benefits)	HMO – 45 vendors (Representative Benefits)
Mental Health -- Inpatient	80% coverage after deductible for 60 days per year hospitalization 60 days per year physician visits Day limits combined with substance abuse treatment Pre-certification required (Basic Extended – 100% coverage for the 60 day periods)	80% coverage for 60 days per year hospitalization 100% coverage for 60 days physician visits per year Day limits combined with substance abuse treatment (Second level – 90% coverage)	60% coverage after deductible 30 days per year hospital 30 days per year physician Day limits combined with substance abuse treatment	100% coverage for 60 hospital days per year 100% coverage for 60 physician visits per year Day limits combined with substance abuse limits
Mental Health -- Outpatient	80% coverage after deductible 60 visits per year including 20 family visits Pre-certification for more than 11 visits per year. Visits limits combined with substance abuse treatment	$15 co-pay for visits 1-3 50% coverage for visits 4-60 Visit limits combined with substance abuse treatment (Second level -- $15 co-pay for visits 1-30 50% for visits 31-60)	50% coverage 20 visits per year Visit limits combined with substance abuse treatment	$15 co-pay 60 visits per year
Substance Abuse -- Inpatient	80% coverage after deductible for 60 days per year hospitalization 60 days per year physician visits Day limits combined with mental health treatment Pre-certification required (Basic Extended – 100% coverage for the 60 day periods.)	80% coverage for 60 days per year hospitalization 100% coverage for 60 days physician visits per year Day limits combined with mental health treatment. (Second level – 90% coverage)	60% coverage after deductible 30 days per year hospital 30 days per year physician. Day limits combined with mental health treatment.	100% coverage for 60 hospital days per year 100% coverage for 60 physician visits per year Day limits combined with substance abuse.
Substance Abuse -- Outpatient	80% coverage after deductible 60 visits per year including 20 family visits Pre-certification for more than 11 visits per year Visits limits combined with mental health treatment	$15 co-pay for visits 1-3 50% coverage for visits 4-60 Visit limits combined with substance abuse treatment (Second level - $15 co-pay for visits 1-30 50% for visits 31-60)	50% coverage 20 visits per year Visit limits combined with mental health treatment	$15 co-pay 60 visits per year

Table 2.7 Employer G -- Mental Health and Substance Abuse Benefits			
	Indemnity Plan	POS Plan with Managed Care Vendor	HMO
Mental Health -- Inpatient	80% coverage for up to 30 days in a year 75 day lifetime limit	80% coverage for up to 30 days in a year 75 day lifetime limit	N/A
Mental Health -- Outpatient	80% coverage for up to 15 visits per year	100% coverage for visits 1-5 80% coverage for visits 6-30	N/A
Substance Abuse --Inpatient	80% coverage for up to 30 days in a year 75 day lifetime limit	80% coverage for up to 30 days in a year 75 day lifetime limit	N/A
Substance Abuse -- Outpatient	No charge for 3 EAP visits 80% coverage for up to 15 visits per year	No charge for 3 EAP visits 100% coverage for visits 1-5 80% coverage for visits 6-30	N/A

Table 2.8 Employer H—Mental Health and Substance Abuse Benefits			
	Indemnity and POS Plans Mental Health Carve-Out In-Network	Indemnity and POS Plans Mental Health Out-of-Network	HMO*
Mental Health -- Inpatient	(Must be referred by Managed Behavioral Health vendor) No charge for first 10 days/year $10 charge per day for all additional days. Unlimited in-network benefit	$500 admission charge 50% of allowable charges covered Pre-certification required or reduction in benefit coverage Limit of 30 days per year.	N/A
Mental Health -- Outpatient	(Must be referred by behavioral health provider) No charge for first 10 visits/year Then $10.00 co-pay per visit Unlimited in-network benefit $200 deductible per person	No co-payment 50% coinsurance of allowable amount 60 visits per year	N/A
Mental Health -- Alternative Treatment	(Must be referred by behavioral health provider) No charge for first 10 visits/year $10 co-pay per visit 11-120 Unlimited benefit	Not covered	N/A
Substance Abuse – Inpatient	(Must be referred by behavioral health vendor) No charge first 10 days/year Then $10 per day for additional days No in-network benefit limit	$500 admission charge 50% coinsurance of the allowable amount Pre-certification required or benefit reduced 30 days/year	N/A
Substance Abuse -- Outpatient	(Must be referred by behavioral health vendor) No charge for first 10 visits/year Then $10 per visit No in-network benefit limit	50% coinsurance of the allowable amount 60 visits per year	N/A
Substance Abuse -- Alternative Treatment	(Must be referred by behavioral health vendor) No charge for first 10 visits/year Then $10 per visit 120 days/year	Not covered	N/A

*Information on HMO benefits not available.

APPENDIX II

FORUM ON LARGE EMPLOYER EXPERIENCES AND BEST PRACTICES ON MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS -- PARTICIPANTS

EMPLOYER PARTICIPANTS:

AT&T
Dave Carver, District Manager, Benefit Planning and Analysis

AMERICAN AIRLINES
Ronald L. Kocher, Benefits Plan Manager
Jackie Quick, Manager, Point of Service Plan

DELTA AIR LINES
Tara Wooldridge, Manager, Employee Assistance Program

EASTMAN KODAK
Renee Brownstein, Director of Total Compensation

GENERAL MOTORS
Delores McFarland, Manager, Health Care Plans and Health Care Initiatives

IBM CORPORATION
Karen Orenstein, Program Manager for Mental Health and Substance Abuse

MASSACHUSETTS GROUP INSURANCE COMMISSION
Dolores Mitchell, Executive Director

PEPSICO
Ellen Abisch, Manager, Medical and Disability Management and Worker's Compensation

OFFICE OF PERSONNEL MANAGEMENT:
Frank Titus, Assistant Director for Insurance Programs

Abby Block, Chief,
Insurance Policy and Information Division

Ellen Tunstall, Chief,
Insurance Planning and Evaluation Division

Shirley Patterson, Chief,
Insurance Contracts Division I

Dan Green, Chief,
Insurance Contracts Division II

David Lewis, Chief
Insurance Contracts Division III

Anne Easton, Branch Chief,
Insurance Contracts Division III

William Stuart, Branch Chief,
Insurance Contracts Division III

Mike Kaszynski, Policy Analyst,
Insurance and Policy Division

Nancy Kichak, Office of Actuaries

Dean Schleicher, Program Analyst,
Insurance Planning and Evaluation Division

Mary P. Tyler, Ph.D., Team Leader,
Employee Health Services, Office of Workforce Relations

DEPARTMENT OF HEALTH AND HUMAN SERVICES:
Virginia Trotter Betts, Senior Advisor on Nursing and Policy to the Secretary,
Assistant Secretary of Health

Kevin Hennessy, Senior Health Policy Analyst
Office of Assistant Secretary for Planning and Evaluation

NATIONAL INSITUTE FOR MENTAL HEALTH
Darrel Regier, M.D., Director
Division of Epidemiology and Services Research

Agnes Rupp, Senior Economist and
Chief of Financing and the Managed Care Research Program,
Division of Epidemiology and Services Research

SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION
Mady Chalk, Ph.D, Director,
Office of Managed Care,
Center for Substance Abuse Treatment

WASHINGTON BUSINESS GROUP ON HEALTH:
Mary Jane England, M.D., President
Project Director

Veronica V. Goff, Vice President
Alternate Project Director

Kristen Reasoner Apgar, Director
Project Manager

WBGH PROJECT CONSULTANTS
Suzanne Gelber, President
SGR Health Alliance, Berkeley, CA

Sandra Hittman,
IDEACO Consulting, Milwaukee, WI

APPENDIX III

Table 3.1
Access – Network Standards

Network Access Stds.	Employer B	Employer E	Employer F	Employer G	Employer H	Digital HMO Behavioral Health Stds.	NCQA –MBHO Stds.
Provider to Member Ratios	N/A	N/A	1 provider to each 6490 members	N/A	1 psych. And 1 non-psych. to 1000 members	.45 provider for 1000 members	Organization is to establ. Standards for sufficient no. of qualified professionals taking into consideration linguistic, cultural needs and preferences.
Geographic Access to Providers	Urban – suburban areas: 1 provider within 20 miles and 30 miles to facility Rural: 1 provider within 45 miles and 60 miles to facility	In 90% of the work locations with 100+ employees – 1 M.D. and 2 non-MD's and 2 EAP therapists within 25 miles	Urban areas -3 providers within 10 miles Rural and Suburban areas- 2 providers within 30 miles	2 providers within 20 miles	Inpatient Care: Metro. areas: 1 facility within 20 miles Rural areas: 1 facility within 40 miles Outpat. Care – Metro. areas: 1 psych./ 3 non-psych. within 10 miles Rural areas: 1 psych/ 3 non-psych. within 30 miles	Inpat. Care: No more than 45 miles or 45 minutes Residential Care: No more than 60 miles or 60 minutes Outpat. Care: No more than 15 miles or 30 minutes	Organization has to set standards for the number and geographic distribution of health care practitioner and providers

Table 3.2 Access – Treatment Time Standards							
Time Standards	Employer B	Employer E	Employer F	Employer G	Employer H	Digital HMO Behavioral Health Stds.	NCQA –MBHO Stds.
Length of Time to Routine Care	N/A	10 business days	Mental Health – 10 business days Subs. Abuse – 2 business days	10 business days	10 business days	5 business days	10 business days
Length of Time to Urgent Care	N/A	Within 48 hours	Mental Health – 48 hours Subs. Abuse – 1 business day	24 hours	24 hours	24 hours	48 hours
Length of Time to Emergency Care	N/A	Within 8 hours	Mental Health – 6 hours Subs. Abuse -- 4 hours	Immediate access	Immediate Access	4 hours	6 hours
Length of Time for Referral – Routine Care	N/A	N/A	Mental Health – 2 business days Subs. Abuse – 2 business days	N/A	N/A	N/A	N/A
Length of time for Referral to Provider – Urgent Care	N/A	N/A	Mental Health – 1 business day Subs. Abuse – 1 business day	N/A	N/A	N/A	N/A
Length of Time for Referral to Provider – Emergency Care	N/A	N/A	Mental Health – 1 hours Subs. Abuse – 4 hours	N/A	N/A	N/A	N/A

Table 3.3 Access – Telephone Response Standards							
Telephone Response Standards	Employer B	Employer E	Employer F	Employer G	Employer H	Digital HMO Behavioral Health Stds.	NCQA –MBHO Stds.
Intake Calls – Average Length of time to Live Response	95% of all calls are answered within 35 seconds	Average response time is 20 to 30 seconds	N/A	N/A	N/A	N/A	Live response within 30 seconds
Abandonment Rate – Intake Calls	Less than 5%	Less than 5%	N/A	N/A	N/A	N/A	Less than 5%
Length of Time to Live Response on Emergency Line	100% of all calls are answered within 15 seconds	Average response time is 20 to 30 seconds	N/A	N/A	N/A	N/A	N/A
Abandonment Rates on Emergency Calls	Less than 1%	Less than 5%	N/A	N/A	N/A	N/A	N/A
Length of Time to Live Response Member Services Call-	Average response time is 45 seconds	Average response time is 20 to 30 seconds	N/A	N/A	Average response time is no more than 35 seconds	Average response time is no more than 30 seconds	N/A
Abandonment Rates on Member Services Call	Less than 5%	Less than 5%	N/A	N/A	Will not exceed 3.5%	No more than 5%	N/A